NHS
Derbyshire Community Health Services
NHS Foundation Trust

70 YEARS OF THE NHS 1948 - 2018

Derbyshire Community Health Services NHS Foundation Trust

Annual Report and Accounts 2017/18

Derbyshire Community Health Services NHS Foundation Trust
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of the National Health Service Act 2006

Annual report contents

Foreword

Welcome to our 2017/18 annual report and accounts. It provides a detailed look at how we have performed during a challenging year for the NHS on behalf of our patients – the reason why we do what we do.

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

You'll read in the following pages about the achievements, challenges and milestones in the life of our organisation during 2017/18. We are pleased to be able to share it with you and to have an opportunity to thank our staff, governors, volunteers, service users and their families for contributing so much to the vitality of our healthcare community.

Chris Sands
Acting Chief Executive

Prem Singh
Chairman

Performance report

Overview

A summary of our purpose and activities, the key risks to our business, how we have managed those risks and pursued our objectives, as well as key performance data for 2017/18.

Who we are

Derbyshire Community Health Services NHS Foundation Trust is one of the largest providers of specialist community health services in the country.

We serve a population of over one million in Derby and Derbyshire delivering 3,500 patient contacts every day. We employ more than 4,400 staff serving a widespread local patient population.

We care for patients in 12 community hospitals and more than 30 health centres, as well as in clinics, GP practices, schools, care homes and, increasingly, in people's own homes. Service transformation to provide more care in community settings is ongoing, with our partners in health and social care in Derbyshire.

We have operated as a standalone NHS organisation since April 2011 and became a fully-fledged foundation trust on 1 November 2014. Our 31-seat Council of Governors is responsible for holding the Board of Directors to account, sharing opinions and providing appropriate challenge on any major decisions.

This year we have continued to work closely with our partners in health and social care towards greater integration of services in line with the forward-looking aims of the Derbyshire Sustainability and Transformation Partnership. Being able to provide greater levels of care out of hospitals and closer to people's homes in their own communities is a cornerstone of the future plans.

Our services

Our services are managed across three divisions: integrated community-based services, planned care and health, wellbeing and inclusion.

Integrated community-based services

Our services cover conditions associated with frailty, end of life care, falls rehabilitation, long term conditions and neurological rehabilitation (amongst others) – predominantly, but not exclusively, for older people:

- Acquired brain injury
- Cardio/respiratory services, including:
  - cardiac liaison
  - cardiac rehabilitation
  - pulmonary rehabilitation
  - respiratory nursing
  - respiratory physiotherapy
  - heart failure specialist nursing
  - ambulatory heart failure clinics
- Care home advisory service (CHAS)
- Immediate/rapid response assessment and rehabilitation including: single point of access and rapid response care teams
- Integrated community teams, including:
  - community/district nursing
  - community nursing
  - community therapy
  - care coordinators
- Day centre and day rehabilitation services
- Discharge facilitation/clinical navigation in local acute trusts
- IV administration service
- Learning disability services
- Older peoples mental health
- Specialist continence service
- Specialist neurological services, including:
  - early supported stroke discharge
  - outpatient neuro rehabilitation
  - Parkinson's disease specialist nurse
- Inpatient rehabilitation
- Minor injury units.

Planned care

- Consultant outpatients
- Day surgery
- Occupational therapy
- Musculoskeletal service
- Physiotherapy
- Occupational therapy
- Podiatry and podiatric surgery
- Specialist wheelchair service
- Speech and language therapy.

Health, wellbeing and inclusion

- Children's services, including:
  - Starting Point
  - Health visitors
  - School nursing
  - School-age immunisation
  - Children's continence
  - Infant and toddler nutrition
- General practice services
- Diabetes education and falls prevention services
- Integrated sexual health services
- Tier 3 weight management services
- Health psychology services
- Community and specialist dental services.

The following health promotion services transferred to Public Health, Derbyshire County Council:

- smoking cessation, wellbeing services and community weight management. We also ceased to provide specialist dental services in Leicester, Leicestershire and Rutland.

We employ more than **4,400 STAFF**

We carry out **3,500** patient contacts each day

Our vision is to be:

The best provider of healthcare and a great place to work

Our values are:

- To get the basics right
- To act with compassion and respect
- To make a difference
- To value and develop teamwork
- To value everyone's contribution to our service delivery and development

98%

of the more than 29,000 patients we surveyed would recommend our Trust to their family and friends

Who we are at a glance

- We are rated good overall by the Care Quality Commission – and outstanding for caring (inspection May 2016)
- We are compliant with all our financial obligations
- We scored 1 in NHS Improvement's Single Oversight Framework – achieving the highest level of autonomy for our performance
- We carry out 3,500 patient contacts each day
- We employ more than 4,400 staff
- 98% of the more than 29,000 patients we surveyed would recommend our Trust to their family and friends
- Our NHS Staff Survey results are above average for staff engagement
- We monitor our performance across a total of 300 performance indicators
- 99.9% of patients attending our minor injury units were seen within the A & E four hour target and most were seen within an hour
- We achieved 99.51% for the cleanliness of our hospitals in annual PLACE (patient led assessments of the care environment) scores.

Key objectives and risks

Despite many challenges for the NHS we met our objectives and performed well – operationally and financially – during 2017/18.

We are compliant with all our financial obligations while also achieving ratings consistently above average in measures to test the quality of our care for patients and our workplace for staff.

Maintaining our healthy position throughout the year has required careful attention to manage the strategic risks to our delivery during a period of significant change and unprecedented pressure on services, particularly in the winter months.

The system-wide transformation plans, locally-led and as part of the Derbyshire Sustainability and Transformation Partnership, are reliant on community services being able to lead the way in providing care closer to home. This means developing more integrated teams where new systems of management and governance are required.

This has involved significant work during the year, and changes to traditional ways of working for some of our teams, which has been challenging. Our gratitude goes to all individuals and teams who have met the challenges of adaptation to new ways of working and without whose support we would not be able to transform the delivery of care.

Workforce transformation, ensuring sufficient resources are available to meet growing demand on our services and that solid governance arrangements are in place for changing ways of working are among the main challenges we are taking action to mitigate.

The big strategic risks are governed by the Trust Board via the Board Assurance Framework (known as BAF) which also feeds the key strategic priorities of the Trust Board's sub-committees.

This established system of governance and management is known internally as the DCHS Way and organised into three distinct domains as **Quality People, Quality Service and Quality Business**. Regular reports are provided at each Trust Board meeting from each of the three committees.

Within this governance framework we manage and identify risks to our organisation.

Quality People

Our Quality People Committee operates as a sub-committee of the Trust Board and is chaired by a non-executive director.

Workforce transformation, to enable us to adapt to the changing way we provide care, is an ongoing challenge. Much effort has been put into recruiting and retaining staff in areas where services are shifting focus away from hospital to being community based.

The staffing challenge remains real around having sufficient numbers of qualified and suitably experienced staff to be able to lead and manage the system-wide changes. In the face of national recruitment issues, particularly in some key clinical professions, we have remained successful in keeping agency usage to an absolute minimum – recording one of the lowest expenditures on agency staff in the NHS.

CASE STUDY

Our service resilience was put to the test when freezing temperatures and snow caused the worst weather for a decade in early March 2018, nicknamed #snowmageddon. Clinical and non-clinical staff all responded magnificently to the challenges of keeping services going and community hospital and clinic sites open. "We heard about people walking miles to patients' homes and clinics when other transport was impossible, arranging lifts on tractors and 4X4s, cycling long distances when public transport was at a standstill, and persevering with car journeys in very difficult conditions in the interests of patients and keeping care going. Others covered extra shifts, stayed overnight away from home and filled in wherever an extra pair of hands was needed, away from their usual bases. As ever, our grounds people/sites and services staff did a great job of keeping our premises open and safe underfoot in the most extreme conditions." Chris Sands, director of finance, information and strategy/deputy chief executive.

Quality Service

Our Quality Service Committee operates as a sub-committee of the Trust Board and is chaired by a non-executive director.

Our clinical quality assurance model of assessment and accreditation, known as Quality Always, is supporting the delivery of high quality care. The need for appropriate and thorough quality, equality and risk impact assessments has been a priority across our services. We have worked with partners to implement effective governance systems to support new care models as part of our Sustainability and Transformation Partnership, including Joined Up Care Derbyshire and Wellbeing Erewash, which are described in more detail further on in this report.

Quality Business

Our Quality Business Committee operates as a sub-committee of the Trust Board and is chaired by a non-executive director.

Our challenge has remained around ensuring sufficient resources are available to meet increasing demand on our services against a worsening financial position faced by our commissioners, requiring renegotiation during the year. Our systems are designed to promote an efficient and effective use of resources, exploiting the benefits of information technology. Our dynamic dashboard system, known as the Big 9, ensures we keep focus on the key priorities each month. It is easy to see any areas which are red rated and which might pose a risk.

Details of our Commissioning for Quality and Innovation (CQUIN) targets are included in the performance analysis section of this report. These are targets set by our commissioners to support innovation and improvement in care across our clinical services. We met all our NHS Improvement Single Oversight Framework assurance targets for 2017/18.

CASE STUDY

In May 2017 we responded swiftly to the threat posed by the worldwide cyber-attack. We weren't directly infected but it was necessary to take immediate precautionary action in switching off our IT systems while we checked/updated security software. Cyber security remains a threat, so we have introduced One person: One device to reduce the number of devices in circulation and promoted a basic IT 'kit list' for staff, including advice to staff on making sure that security on their devices is regularly updated.

Clinical strategy

We continue to work to deliver our clinical strategy, following the Triple Aim approach of: "simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and reducing the per capita cost of care for the benefit of communities."

Our strategy is supported by a number of key specific clinical strategies. During 2017/18 we have worked to develop these further, including developing strategies for:

- End of life care
- Tissue viability
- Patient safety.

In addition, our corporate strategies, such as our people, estates and procurement strategies are all key pillars to enabling us to deliver our organisation's overarching clinical strategy. We are also developing a volunteers' strategy.

CASE STUDY

Safe staffing remains a top priority for us in providing quality care and we made some difficult operational decisions this year in the interests of patient care which affected some of our ward-based staff at short notice. In August 2017 we closed Riverside Ward at Newholme Hospital after careful deliberation of how to maintain safe staffing across our older people's mental health wards, amid ongoing recruitment challenges and low patient admission levels.

Difficulties in retaining and recruiting qualified nursing staff, in the light of 15 months of uncertainty regarding how the NHS should look after patients in the community in north Derbyshire, prompted the temporary closure of Hudson Ward at Bolsover Hospital in September 2017. Additional services were instead provided at Clay Cross Hospital and in the community. A decision has since been taken not to reopen it.

These measures, taken on safety grounds to protect patients and ensure nursing staff are not stretched too thinly, are nevertheless consistent with the strategic direction for the future shape of NHS care delivered out of hospital settings when appropriate for patients.

Quality Always

Assuring high quality services across DCHS

Quality Always

Quality Always is an assessment accreditation system for our clinical care, first introduced in 2014 as part of our Quality Improvement and Assurance Framework. Frontline teams who achieve the highest standards are Gold Award winners. As this is a continuous process, teams must work hard to maintain their Quality Always Gold Awards.

More than 600 quality and safe care champions now work in our frontline care. They help us drive forward improvements in safety and in promoting person centred care for our patients. More than half attended specific training events this year to help them in their roles.

In 2017/18, teams who regained their Quality Always Gold Awards were:
Linacre Ward, Walton Hospital
Alton Ward, Clay Cross Hospital
Spencer Ward, Cavendish Hospital
Hillside Ward, Newholme Hospital
Robertson Road Core Unit, Buxton
Rockley Way Core Unit, Shirebrook
Orchard Cottage, Darley Dale
Amberley House Core Unit, Eckington
Valley View Unit, Ash Green Learning Disability Service
Baron Ward, Babington Hospital
Minor Injury Unit, Whitworth Hospital

The accreditation panel deferred Buxton Minor Injury Unit. Melbourne Ward, Walton Hospital, is working on its bid for reaccreditation after an unsuccessful attempt.

New teams who achieved Gold Accreditation in 2017 were:
Riverside Ward, Newholme Hospital
Hudson Ward, Ilkeston Community Hospital
Adult Speech and Language Therapy
Chesterfield North/East Dental Service
Learning Disability Community Teams
Lea Hurst Older People's Mental Health Day Hospital
Butterley Ward, Ripley Community Hospital
Oker Ward, Whitworth Hospital
Hopewell Ward, Ilkeston Community Hospital
Chesterfield North/East Podiatry

More than 600 quality and safe care champions now work in our frontline care

Modernising facilities

Careful financial management over the years has helped us achieve two particular milestones in the regeneration of our healthcare facilities during 2017/18. Replacing old and unsuitable buildings as bases for healthcare is vital in meeting our strategic aims in the delivery of care.

In January 2018 we agreed a deal worth almost £1.8m to purchase part of the old Buxton Water site for the development of new health facilities in Buxton. An outline planning application was submitted to High Peak Borough Council in March 2018 for two-thirds of the site as a base for NHS and other public sector services. Retirement homes builder McCarthy and Stone are proposing to develop specialist extra care accommodation on site too.

The brand new Heanor Memorial Health Centre opened its doors in December 2017, marking the end of a successful £3.5m project for the benefit of patients in Heanor. From a muddy plot in January 2017 there grew a state-of-the-art health centre with six treatment rooms and a further six consulting rooms for a whole range of outpatient care. It marked the end of a long journey to create health facilities fit for the future after the closure and demolition - on asbestos safety grounds - of the community's well-loved but outdated former hospital.

The broader environment in which we are working

Joined Up Care Derbyshire

Health and social care organisations across England have been working together more closely than ever before to develop a total of 44 Sustainability and Transformation Partnerships (STPs). Joined Up Care Derbyshire is the name given to Derbyshire's STP and it brings together a total of 11 partner organisations setting out our collective ambition for the county's health and care system.

The final plan for Derbyshire was submitted to NHS England back in November 2016 and outlined priorities plus detail on financial and workforce planning, development of provider-commissioner collaborations and development of governance arrangements. All organisations are focused on new ways of working to help keep people healthy, give people the best quality care and run services well while making the most of available budgets. Our aim locally is "to deliver the most effective and efficient health and social care system for the citizens of Derbyshire delivered through a place-based care system which is effectively joined-up with specialist services and managed as a whole."

Better Care Closer to Home

Between 29 June and 5 October 2016 the two north Derbyshire clinical commissioning groups led a consultation on proposed changes to some of our services under the banner of 'Better Care Closer to Home'. It was focused on how we can better provide both inpatient and community services for older people with physical issues and for older people with dementia. The roll out of clinically proven models of home-based care in northern Derbyshire is part of a national move to provide more care at the right time and in the right place, in line with the Service Transformation Partnership.

Since the decisions to progress with Better Care Closer to Home were taken, we have been working hard on the implementation plan, in conjunction with healthcare commissioners, in order to create a logical time line for the new models of care to be introduced. The outcomes are proving fundamental to the way our services are being delivered in north Derbyshire, now and into the future.

Joined Up Care in Belper

NHS Southern Derbyshire Clinical Commissioning Group and care organisations in south Derbyshire have come together to plan changes to the way Belper's local services are provided for patients. The 'Joined Up Care in Belper' review began a few years ago, firstly to understand what is needed, then to make the best plans possible so that services are fit into the future.

The immediate priority is to concentrate on care provided from the Babington Hospital site, including Belper Clinic, and what needs to be done. The review has provided some insight into health services in Belper, which they are factoring in as they make plans for how people are cared for in the town.

Babington Hospital is a much-loved iconic building, but as an old building it has limitations which are now becoming a barrier to making the service improvements needed in the area. Parts of this former workhouse are listed, it has significant maintenance issues associated with an old building and it is on a site at risk of flooding, which are just some of the reasons why it is not practical to convert Babington Hospital into a 21st century healthcare facility.

The clinical commissioning group and care organisations have carefully looked at local needs and opportunities to help decide what should happen next. They've also gathered views of local people to see what is important to them about their services during a public and staff engagement programme. You can read more here: www.southernderbyshireccg.nhs.uk

Wellbeing Erewash

We are a key partner in Wellbeing Erewash, the multispecialty community provider vanguard project in Derbyshire. This was one of 15 such partnerships selected nationally to lead the way in developing innovative approaches to health and social care in the community. The aim has been to accelerate the involvement of people and communities in their health and wellbeing.

We work in partnership with NHS Erewash Clinical Commissioning Group, Derbyshire Health United, Derbyshire Healthcare NHS Foundation Trust and Erewash Health, as well as the voluntary and social care sector. Wellbeing Erewash has produced a guide aimed at other organisations that want a similar focus for their work with local communities which has being shared across the health and care system.

One of its focus areas has been what is known as 'person-centred approaches', and shifting from a culture of 'doing to' people to 'doing with' people, hence a more collaborative approach.

Person-centred approaches are based on the premise that the person/patient is the expert in their own life, the healthcare professional is the expert in their field, and that these experts come together to look at the person's health. 'What matters to you', as opposed to 'what's the matter with you'. For more information, visit: www.wellbeingerewash.org.uk

Operational plan for 2018/19

In December 2016 we developed a two-year operational plan for 2017-19, in accordance with NHS Improvement guidance. In collaboration with our clinical and corporate teams we have refreshed our operational plan for year two.

Our operational plan is crucial to helping us to deliver the aims and aspirations within our clinical strategy and ensure that we develop actions to meet the strategic priorities of the organisation.

Our operational plan continues to place significant emphasis on 'place-based care' and how we will continue to work with our partners to develop the necessary services based on the investment available. We recognise that in delivering place-based services our actions need to be universal, to address inequalities and improve outcomes, and to be delivered at a scale and with an intensity that is proportionate to the level of need.

The operational plan supports how we work with our partners across health and social care in delivering Joined Up Care Derbyshire as we transform services for the future. It places great emphasis on our public health efforts and reaching our potential to impact positively on the health and wellbeing of each person every time that we come into contact with them.

Prevention and wellbeing are at the heart of our approach. A commitment to quality improvement, patient safety and workforce planning to ensure we have the right skill-mix to care for our patients are also key aspects of our operational planning.

The operational plan is dependent on the successful delivery of an efficiency programme of £10.1m (5.2%) in 2018/19. This challenging financial context means that the effective governance of the delivery of the plan is extremely important and therefore the plan has been structured to reflect the way this will be implemented through the Board's Quality Service, Quality People and Quality Business committees, taking account of the key aims of service sustainability, viability, public accountability and transparency.

Whilst this plan sets out our own operational priorities it is significantly reliant on the plans of our health and care system partners and their commitment to an integrated delivery and risk-sharing approach.

We will therefore continue to work hard to support system delivery and work closely with these partners to achieve joint aims whilst promoting the continued provision of our own high quality care, delivered every day by our passionate and skilled staff.

Overview

In my capacity as acting chief executive I am of the view that we have achieved an excellent consistent performance, meeting all our objectives, delivering good patient outcomes and performing well operationally and financially during the year, as summarised earlier in this chapter, and discussed in more detail in the performance analysis section ahead.

However, it has only been possible to achieve these results with the significant commitment of our teams across the organisation, often going above and beyond what's expected to deliver on our behalf and in the interests of high quality care for our patients and their families.

It is clear to me that we need to remain stringent in our efforts in all areas of leadership, governance and financial control if we are to maintain our good record of achievement in the coming year.

We have already mentioned that our operational plan for 2018/19 is dependent on the successful delivery of an efficiency programme of £10.1m. In this we are not alone, the NHS is facing its most challenging times yet and we are in a stronger starting position than many, thanks to meeting all our objectives during 2017/18.

Going concern

Derbyshire Community Health Services 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 supporting evidence of our accounts submissions each year.

This evidence provides assurance that it is correct to compile our accounts on such a basis and is presented to our Audit and Assurance Committee. Our directors have considered and declared that: After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the 'going concern' basis in preparing the accounts.

Chris Sands
Acting Chief Executive
23 May 2018

Performance analysis

Our performance against standards and targets

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

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

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

Performance reporting

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

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

Significant areas of risk are monitored in a more detailed performance report under the key areas of Quality Service, Quality People and Quality Business on a monthly or bi-monthly basis. Any risk which is likely to impact on the delivery of the Trust's strategic goals and objectives is captured in the Board Assurance Framework (BAF).

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

Clinicians, managers and corporate services colleagues are all involved in the contribution to the performance reporting process and are fully engaged in the discussions around any key performance indicators that indicate a performance risk.

Areas of performance measurement include the reporting of:

- Board Single Oversight Indicators - NHS Improvement has implemented a new Single Oversight Framework during 2016/17 to assess the performance of NHS Trusts and NHS Foundation Trusts. The framework replaced Monitor's Risk Assessment Framework and the Trust Development Authority's Accountability Framework.
- NHS Improvement Community Indicators Scorecard - the scorecard is a set of indicators that can be used to compare trusts to peers on patient and staff experience, and the effectiveness and responsiveness of their services.
- Our internal Big 9 – key priority targets set within our organisation for the Quality Service, Quality People and Quality Business Committees.
- Performance reporting for commissioners – reporting against key contractual targets, including the development of a Commissioner Quality Dashboard.

Commissioning for Quality and Innovation (CQUIN)

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

During 2017/18 we agreed five CQUIN measures. The themes for these were:

- Health and Wellbeing: Staff Survey, healthy food, flu vaccination uptake
- Supporting proactive and safe discharge
- Preventing ill health through risky behaviours (i.e. alcohol and tobacco)
- Improving the assessment of wounds
- Improving the degree of personalised care planning for patients with long term conditions.

A total of 1.88% of our patient care income in 2017/18 was conditional on achieving nationally-set milestones in these areas as agreed between us in Derbyshire Community Health Services NHS Foundation Trust and North Derbyshire and Southern Derbyshire Clinical Commissioning Groups (CCGs) as the lead commissioners on behalf of our four local CCGs. This was part of our contract for the provision of NHS services, through the CQUIN payment framework.

The total CQUIN value available for 2017/18 was £3.42m and we are predicted to earn approximately 100% of this value. More details are provided in the quality report, section 2.2.4.

Areas of under achievement

We have conducted risk-assessments in relation to the achievement of CQUINS during 2017/18 and anticipated that some of the targets would be difficult to fully achieve; partly because they were set nationally within the context of acute care with no opportunity to localise them for community providers. However throughout the year we have maintained a focus on improving the quality of services for patients and as a result significant progress towards milestones in each of these areas has been achieved.

The uptake of flu vaccinations for frontline clinical staff was 68%. This was a significant improvement on previous years (52.5% in 2016/17) although remained below the national target of 70%.

Various measures were taken during the year to improve proactive and safe discharge and excellent progress has been made overall through partnership working with other providers across the system. However this CQUIN required clarity and support from commissioners to define the interdependencies between acute providers and Derbyshire Community Health Services NHS Foundation Trust and has since been suspended for the upcoming financial year.

Performance against the Preventing Ill Health CQUIN has varied each quarter, impacted upon by the electronic clinical record system, and plans are in place to restore performance.

The Personalised Care Planning CQUIN is still ongoing with the intention to achieve key milestones by the end of the financial year.

Big 9

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

During 2017/18 we set three new quality priorities focusing the whole organisation on quality improvement in areas of patient safety, clinical effectiveness and patient experience.

Progress on all three objectives was monitored through the Big 9 report, part of the regular performance report to directors, updated monthly and shared with staff to enable us to see how we are doing against those priorities. Achieving them will ultimately mean we provide the best quality care for our patients and provide a good environment for staff.

More details about the Big 9 are available in the quality report. Our annual quality reports are also published separately and are available online at NHS Choices (www.nhs.uk) as well as on our website (www.dchs.nhs.uk)

Big 9 - March 2018

	Objective	Priorities 2017/18	Target	Plan to end of March	Achieved to end of March	Forecast
Quality Service	To deliver high quality and sustainable services that echo the values and aspirations of the community we serve	Insulin safe administration - Right dose, right time	80% (Revised figure of 80% of 598) of Community Nurses have completed Insulin Safety e-learning Training by March 2018	478 (80%)	511 (85%) (GREEN)	511 (85%) (GREEN)
		Proportion of services adopting patient related service outcome measures	37 services reporting to CEG by March 2018	37 (100%)	37 (100%) (GREEN)	37 (100%) (GREEN)
		Identification of carers on TPP	Identify 75% of carers who access our services, a total of 2,880	2,880 (100%)	2,028 (70%) (RED)	2,028 (70%) (RED)
Quality People	To build a high performance work environment that engages, involves and supports staff to reach their full potential	Increase average 12-month attendance rate across the Trust by 0.5% by year end	Average 12 month attendance to be 95.75%	95.75%	94.85% (RED)	94.85% (RED)
		Increase staff engagement in teams with a low engagement score by 10%	57	57 (100%)	59.5 (104%) (GREEN)	59.5 (104%) (GREEN)
		Increase the reporting of Health and Safety Near Misses by 20% during 2017/18	140	140 (100%)	142 (101%) (GREEN)	142 (101%) (GREEN)
Quality Business	To ensure an effective, efficient and economical organisation which promotes productive working and which offers good value to its community and commissioners	Demonstration of efficiency across all DCHS services through the delivery of the Sustainable Quality Improvement Plan (SQIP)	Delivery of £7.2m SQIP Plan	£7.2m (100%)	£7.253m (101%) (GREEN)	£7.253m (101%) (GREEN)
		Delivery of effective services within the Community	Delayed Transfer of Care (%) to be 3.5% by March 2018	3.5%	5.0% (RED)	5.0% (RED)
		Responding to the main issue raised through staff feedback by monitoring the perceived improvement in IT connectivity for staff	Less than 35% of staff Often or Always Experiencing Connectivity Problems	35%	30% (GREEN)	30% (GREEN)
		Notes:	*Delayed Transfer of Care in DCHS Control*	4.0%		

Financial performance analysis

In 2017/18 we delivered a net surplus of £8.647m which was in excess of our original plan of £4.923m by £3.724m. The next table details our financial performance and over-achievement on the control total set by NHS Improvement.

The year-end surplus figure includes Sustainability and Transformation Funding (STF) of £4.061m. This is made up of £1.537m core STF, £1.052m incentive STF, a further £0.494m incentive STF and bonus STF of £0.978m. Removing the impact of STF funding, the Trust has over-performed against its control total by £1.2m.

Reconciliation of audited accounts to adjusted surplus	£000's
Surplus / (deficit) for the year	-9,145
Remove impact of donated assets	-155
Add back impairments charged to I&E	17,947
Adjusted Surplus / (deficit) for the year	8,647
Control Total	4,923
Performance Above Control Total	**3,724**

	£000's
Adjusted surplus/(deficit) for the year	8,647
Less STF funding	-4,061
Adjusted surplus/ (deficit) for the year excluding STF	4,586
Control Total excluding STF	3,386
Performance Above Control Total excluding STF	1,200

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

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

Financial statements

Our annual report and accounts cover the 12 month period from the 1 April 2017 to 31 March 2018. Our accounts have been prepared in accordance with directions given by the Department of Health and NHS Improvement.

They are also prepared to comply with International Financial Reporting Standards (IFRS) and are designed to present a true and fair view of our financial activities.

Going Concern

Our accounts have been prepared on the basis that the Trust is a going concern. This means that our assets and liabilities reflect the ongoing nature of our activities.

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

External audit

Our auditors for 2017/18 are:
PricewaterhouseCoopers LLP (PwC)
Donington Court
Pegasus Business Park
Herald Way
East Midlands
DE74 2UZ.

The total fees for external auditors for 2017/18 accounts were £47,282 (plus VAT) in respect of the completion of the statutory audit work, made up of:
PwC (appointed auditors)
£47,282 (plus VAT)

NHS foundation trusts are required to seek external assurance over their annual quality report. The audit work undertaken by PwC in relation to quality reports must be done in accordance with the detailed guidance issued by NHS Improvement.

PwC provided non-audit services on the quality accounts. A charge of £7,314 (plus VAT) was made for the quality account audit. The fee for the quality account audit is immaterial in the context of the audit fee to both our Trust and PwC, as the work has no correlation or impact on the financial audit and has an entirely separate scope.

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

The Governance Sub-Committee of the Council of Governors had a series of update meetings with PwC. The first of these took place on 27 June 2017 and a further two on 3 January and 27 February 2018. These meetings provide an opportunity for PwC to report on the cycle of audit work and for the governors to ask questions on points of clarification.

Appointment process for external auditor

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

A process for the appointment of auditors was carried out during 2015/16. In December 2014, the Council of Governors approved a proposal to go out to tender for our external auditors for 2015/16 onwards. Subsequently, the Council of Governors confirmed at their meeting on 9 September 2015 that they were content with the recommendations arising from the process to appoint PwC as our external auditors for an initial three year term from September 2015 with the option of two one-year extensions. The optional extension is subject to satisfactory performance and will need to be recommended through the Audit and Assurance Committee and then approved by the Council of Governors.

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 2017/18 financial year will continue to be reported within a separate annual report and accounts for the funds held on trust. This report is published on the Charity Commission website.

Financial performance

Despite the current financial difficulties facing the NHS and economy as a whole, we have ultimately performed well during 2017/18. We made a net surplus of £8.647m was which in excess of our original plan of £4.923m by £3.724m.

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

2017/18 Performance	£'000
Surplus	8,647
EBITDA	12,918
Cash balance at period end	26,619
Better payment practice code	98.2%

EBITDA stands for Earnings Before Interest, Tax, Depreciation and Amortisation and in simple terms is a way of representing how much of our operating income exceeds our operating costs. Our EBITDA for 2017/18 was £12.918m which equates to 6.50%. This measure demonstrates sound financial health and the efficient use of our resources.

Investments

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

Working capital and liquidity

Our cash position is maximised through efficient working practices regarding the day-to-day management of our working capital.

We have appropriate governance in place to monitor performance in key areas and additional metrics are embedded into the routine reporting to the Quality Business Committee which is chaired by a non–executive director.

We ended 2017/18 with a healthy cash balance of approximately £26.6m which equates to 40 days' worth of operating expenditure. We have continued to invest surplus cash in 2017/18 in the National Loans Fund to generate a modest return on investment.

Events after the reporting period

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

Overseas operations

We have no overseas operations.

Accounting policies

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

Insurance cover

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

Capital expenditure

Our capital plan for 2017/18 was £6.4m.
The most significant scheme is the investment into early preparatory work in relation to a new health development in the Buxton locality, with the purchase of land for £1.78m.

In addition to our routine capital investment programme, we successfully bid to secure STP funding to support the development of a new health facility in Belper. The total value of the scheme is £5.9m with £670,000 being drawn down in 2017/18. This is reflected in the increase in our Public Dividend Capital in the balance sheet.

During the year, we completed the sale of surplus land at Walton Hospital in Chesterfield to Home England for £4.46m, whereupon £1.417m was paid to the Department of Health and Social Care as overage.

Following the opening of the New Heanor Memorial Health Centre, the old Heanor Health Centre was decommissioned and subsequently disposed of for £245,000.

The table summarises our capital expenditure for 2017/18.

Capital expenditure schemes 2017/18	Cost £'000
Estate – Purchase of land in Buxton	1,780
Estate – Heanor site	2,518
Estate – Belper site	381
Estate – Ilkeston Community Hospital - theatre air handling unit	364
Estate – Ash Green Learning Disability Service - refurbishment	84
Information management and technology (IM&T) - mobile working	322
IM&T - desktop renewal and local infrastructure	310
IM&T - LAN/WAN Infrastructure	107
IM&T - PAS replacement	103
IM&T – VOIP	141
Equipment – Ilkeston Community Hospital	152
Other Schemes	3
Total capital expenditure	**6,265**

NHS pensions and directors' remuneration

The accounting policy in relation to employee pension and retirement benefits is set out in the full set of the financial accounts for 2017/18.

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

Policy and payment of creditors

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

The government accounting rules state: "The timing of payment should normally be stated in the contract. Where there is no contractual provision, departments should pay within 30 days of receipt of goods and services or on the presentation of a valid invoice, whichever is the later". As a result of this policy, we ensure that:

- A clear consistent policy of paying bills in accordance with contracts exists and that finance and procurement divisions are aware of this policy
- Payment terms are agreed at the outset of a contract and are adhered to
- Payment terms are not altered without prior agreement of the supplier
- Suppliers are given clear guidance on payment terms
- A system exists for dealing quickly with disputes and complaints
- Bills are paid within 30 days unless covered by other agreed payment terms.

Efficiency

During 2017/18 we generated efficiency savings of £7.253m against a target of £7.2m. The savings were required to deliver a 4% national efficiency requirement for commissioners. This was a national requirement for NHS providers. A summary of our main savings delivered during 2017/18 is shown below:

Service Area	£m
Health, wellbeing and inclusion	1.088
Integrated facilities management	0.780
Integrated community-based service	0.937
Planned care and outpatients	0.163
Corporate and estates	3.660
Other – Connecting for Health	0.625
Total	**7.253**

Future financial performance

The Board of Directors has set out a detailed financial plan for 2018/19. We intend to achieve a surplus of £4.072m in 2018/19. This will achieve the maximum continuity of service rating of 1 against which we will be assessed as an NHS foundation trust.

Our 2018/19 financial plan is predicated upon the successful delivery of a challenging efficiency requirement of £6.4m. We have taken further measures through 2017/18 to improve our financial governance processes to prepare for the more challenging times ahead.

Our project management office, which was set up in 2012, has become embedded across the Trust to ensure that a structured process is in place for the delivery of our major change programmes, which will result in future efficiencies. We also continue to improve our financial reporting to ensure we are more forward-looking and have the information to enable us to manage performance proactively.

In our future plans, it is clear that we need to maintain our core business by providing high quality and efficient services to our patients and commissioners. We have produced our quality account in 2017/18 and have plans in place to ensure quality improvements in our services are included, measured and evidenced.

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

The scale of the efficiencies required will demand fundamental changes in how services are provided across health and social care communities and closer collaboration and joint planning between organisations.

We are working to develop a Sustainability and Transformation Partnership (STP) plan across the planning footprint of Derbyshire with statutory NHS commissioners and providers and Derby City Council and Derbyshire County Council.

The STP sets out a five year plan as to how the organisations will work collaboratively to improve health and wellbeing, improve the quality of services provided, and to provide services that are financially sustainable.

We are well positioned to manage in the more difficult financial environment and will ensure we work positively with partners to maintain best use of public resources.

In summary, 2017/18 has been another successful year for us. The environment for 2018/19 and beyond is becoming more challenging, however we believe that we are well placed to meet these challenges.

Anti-bribery

The Board of Directors is committed to the elimination of financial crime by ensuring there is a strong anti-fraud, bribery and corruption culture. The counter fraud, bribery and corruption policy details our commitment to the proper use of public funds and outlines roles and responsibilities for the prevention of fraud, bribery and corruption within the Trust, in addition to the approach to be taken regarding matters of suspected financial crime. Our Trust Board has undertaken a risk assessment to determine the extent to which bribery and corruption may affect us and proportionate procedures are in place to mitigate the identified risk.

Equality, diversity, inclusion and human rights

In accordance with the Equality Act we are committed to eliminate unlawful discrimination against our staff and service users, to advance equality of opportunity for all and to foster good relations between all people.

We have refreshed our equalities and inclusion strategy 2017/20 which identifies our current priority objectives and the actions we are taking to achieve these, which are discussed further in the staff report and also the quality report sections of this annual report.

Sustainability

Our established sustainable development management plan identifies how we aim to meet our corporate and social responsibilities, including our carbon reduction targets. It will be updated for ongoing Trust Board approval during 2018/19.

During 2017/18 we have continued to meet or exceed our targets, making excellent carbon and cost reductions and putting us on target to achieve 34% carbon reduction emissions by 2020, using 2007/08 as our baseline.

We have achieved this through: capital investment schemes to enhance energy efficiencies, innovative use of information management and technology in agile and mobile working, teleconferencing, back office efficiencies, effective estates management and space utilisation. Encouraging people to adopt good habits in areas of energy usage and waste management has also been crucial to our sustainability plans.

To measure our overall progress across a range of sustainable development areas we use the NHS Sustainable Development Unit good corporate citizenship toolkit[1]. This helps us assess how sustainable we are and provides us with a benchmark to measure our progress, not just by measuring fuel bills, waste or water usage, but by evaluating sustainability across a range of areas.

The toolkit requires us to assess ourselves against a series of statements and awards a score which is converted to a percentage. The target percentage scores in this toolkit are:

Year	NHS Sustainable Development Unit targets
2015	50%
2020	75%

[1]. http://www.sduhealth.org.uk/gcc/about.aspx

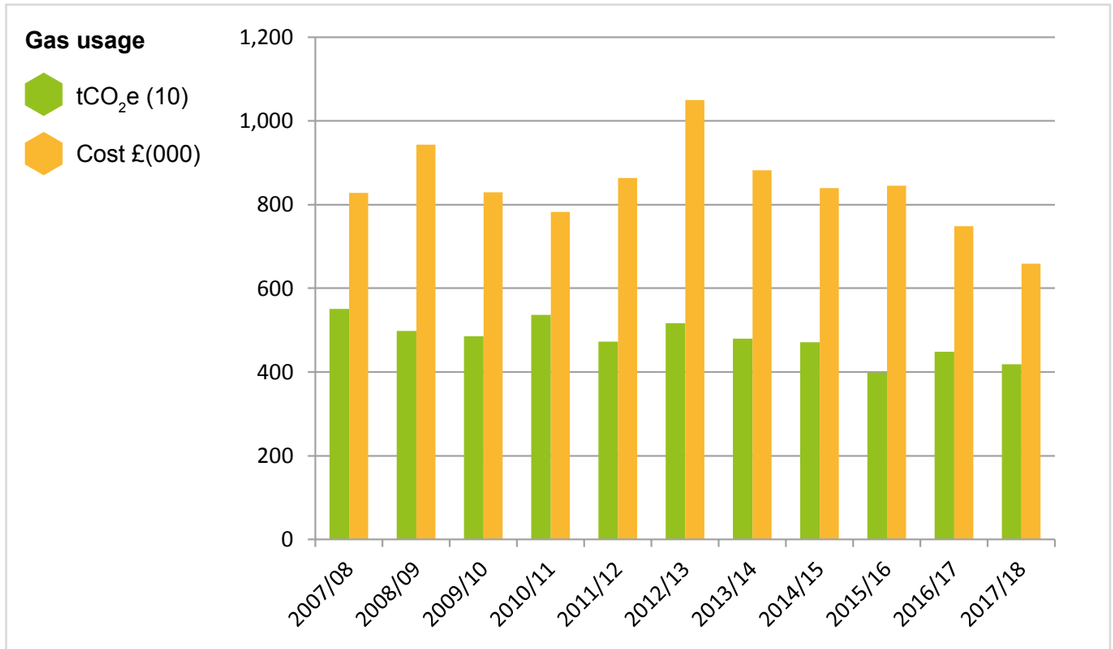
Our scores, using this toolkit, continue to improve across all areas. The following table shows we are already meeting some of the 2020 targets and are well on the way to meeting others:

Good corporate citizen area	Score (%)
Organisation	72%
Travel	69%
Procurement	53%
Facilities management	92%
Workforce	69%
Community engagement	63%
Buildings	90%
Adaptation	90%
Models of care	76%
Total score	**75%**

As well as using this toolkit to measure our wider sustainable development, we also measure specific total carbon emissions from our usage of energy and water, waste management and work-related travel.

Energy (gas and electricity)

Energy is one of the most difficult assets to manage in a large, complex and diverse organisation like ours. In addition, increasingly unpredictable seasonal temperature changes and oil price volatility make it extremely challenging to stay on course to meet our targets. Despite this, we are making good savings year-on-year and staying on target. This is due to capital investments in recent years and a sustainable culture now embedded within the organisation.

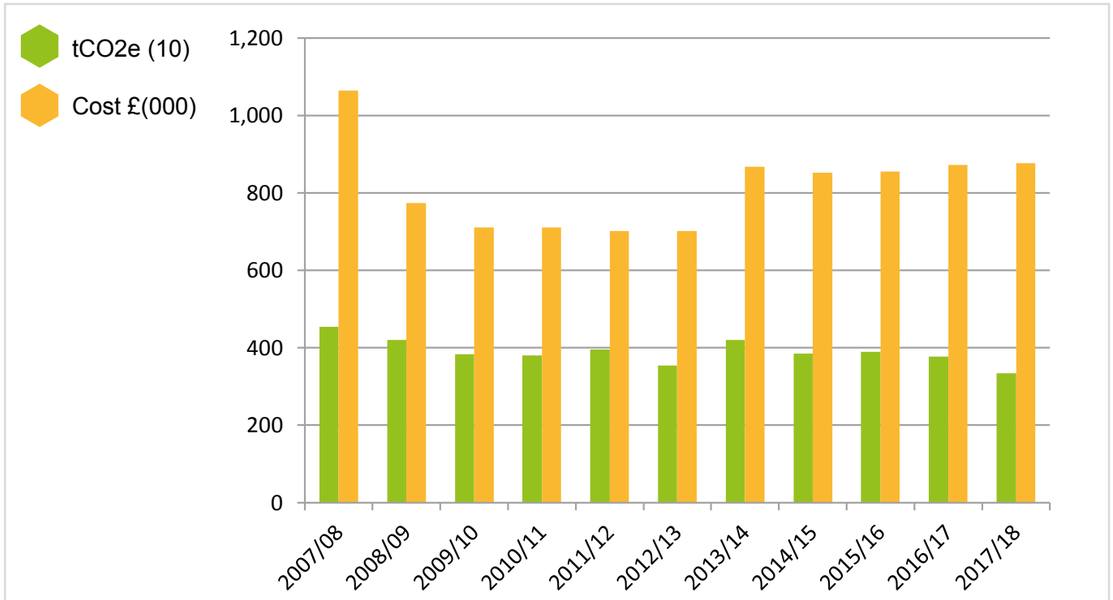


Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Gas MWh	29487	26647	25913	28737	25211	27634	25651	25187	21287	23995	22399
tCO2e	5514	4983	4845	5374	4715	5168	4796	4710	3981	4487	4187
Cost £(000)	828	944	829	783	863	1050	882	840	845	748	659

Gas emissions and savings

Between 2007/08 and 2017/18, we have reduced our carbon emissions from gas usage by 3,968 tonnes (30%) and gas costs by £741,000 (28%). This has been achieved despite an average gas price increase of 25%. Emissions of CO_2 reduced by 7% in 2017/18 compared with the previous year, despite 2017/18 being cooler than 2016/17, and our gas costs reduced by £89,864 (12%) during the year

Electricity usage

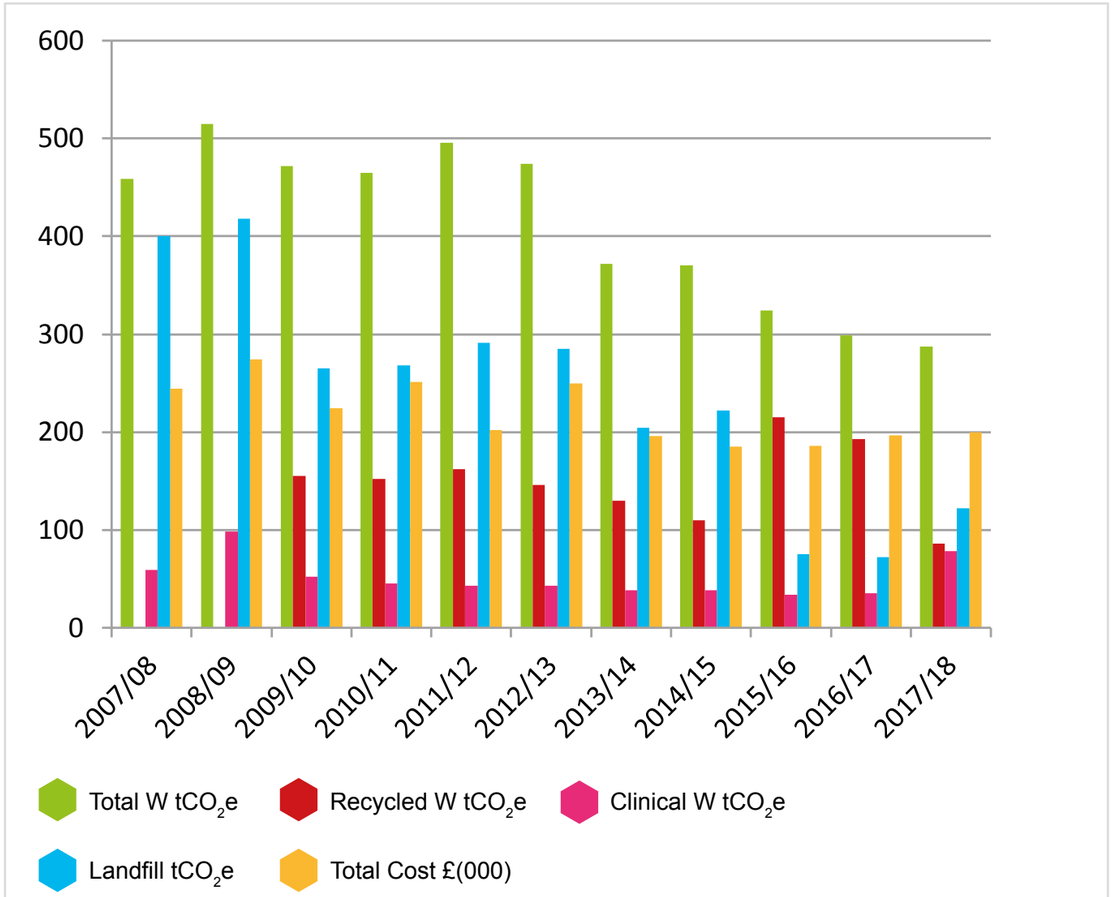


Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Elect MWh	8677	8012	7332	7590	7558	6781	8013	7347	7449	7209	6387
tCO2e	4546	4198	3842	3977	3960	3553	4199	3850	3903	3778	3347
Cost £(000)	1065	774	711	711	701	702	868	852	856	872	877

Electricity emissions and savings

Between 2007/08 and 2017/18, through efficiencies, we have saved 1,200 tonnes of CO_2 (26%) and achieved £188,036 (18%) in cost reductions on our electricity usage, against an average price increase of 32%. Compared with last year CO_2 has been reduced by 11% and the cost of our electricity usage increased by £3,748 (0.5%) due to average price increases of 9%.

Waste



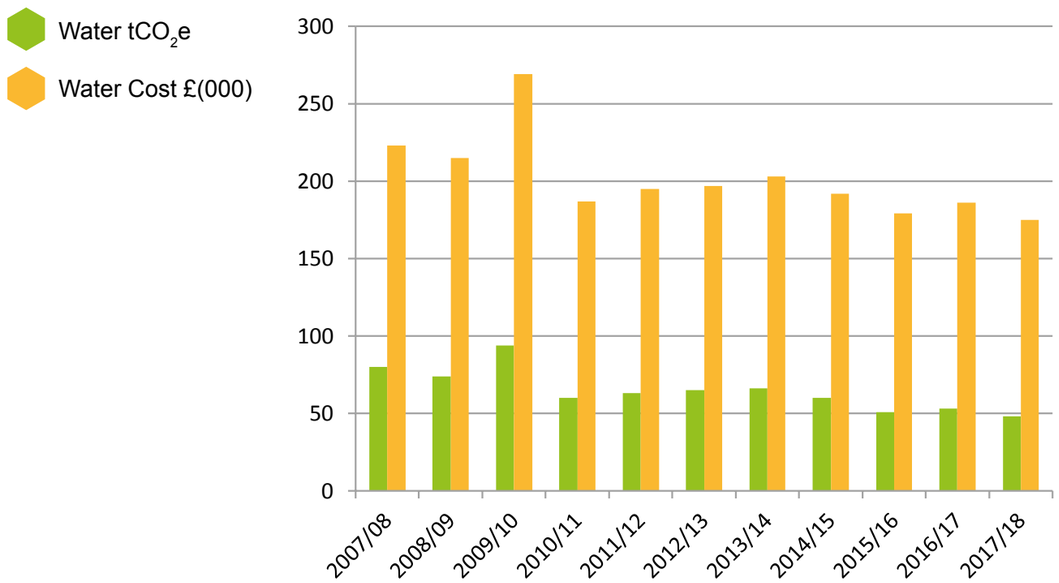
Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total tCO2e	459	515	472	465	496	474	372	370	324	299	287
Recycl-able tCO2e	0	0	155	152	162	146	130	110	215	193	86
Clinical tCO2e	59	98	52	45	43	43	38	38	34	35	78
Landfill tCO2e	400	418	265	268	291	285	204	222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

Waste disposal and savings

Between 2007/08 and 2017/18, our waste management activities have saved 172 tonnes of CO_2 (37%) and £45,000 (18%), against an average price increase of 20% in waste disposal. Compared with last year, CO_2 has been reduced by 4% and the cost increased by £3,000 (1.5%) due to price increases.

Water

We have comprehensive measures for water conservation and are able to detect leaks and other issues quickly when they occur. We continue to look at ways in which we can reduce our water usage, but options are relatively limited compared with the other areas of energy and waste. Deregulation came into force in April 2017. It is too early to see if any significant savings have been made due to the change.



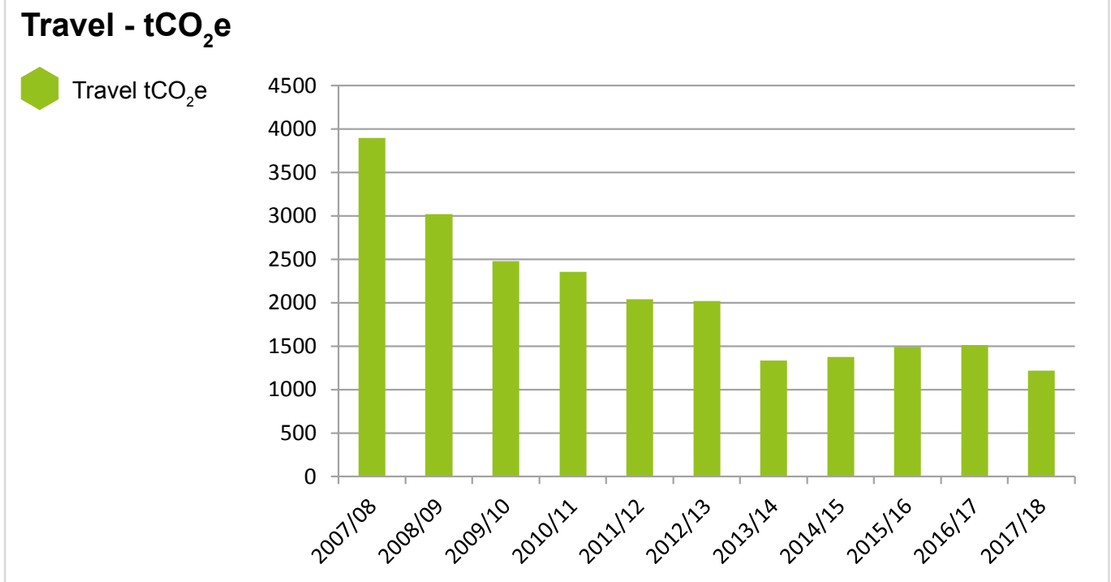
Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
tCO²e Water	80	74	94	60	63	65	66	60	51	53	48
Cost £(000)	223	215	270	187	195	197	203	192	179	186	175

Water savings and costs

Between 2007/08 and 2017/18, we saved 27 tonnes of CO_2 (40%) and achieved cost reduction of £48,000 (22%) against an average water price increase of 12%. Compared with last year, CO_2 has been reduced by 10% and costs reduced by £11,000 (6%) due to reduced water usage.

Travel

Apart from a few fluctuations, the overall trend is seeing our grey fleet mileage continuing to fall. This is due to a selection of measures taken as part of an overall efficiency drive.

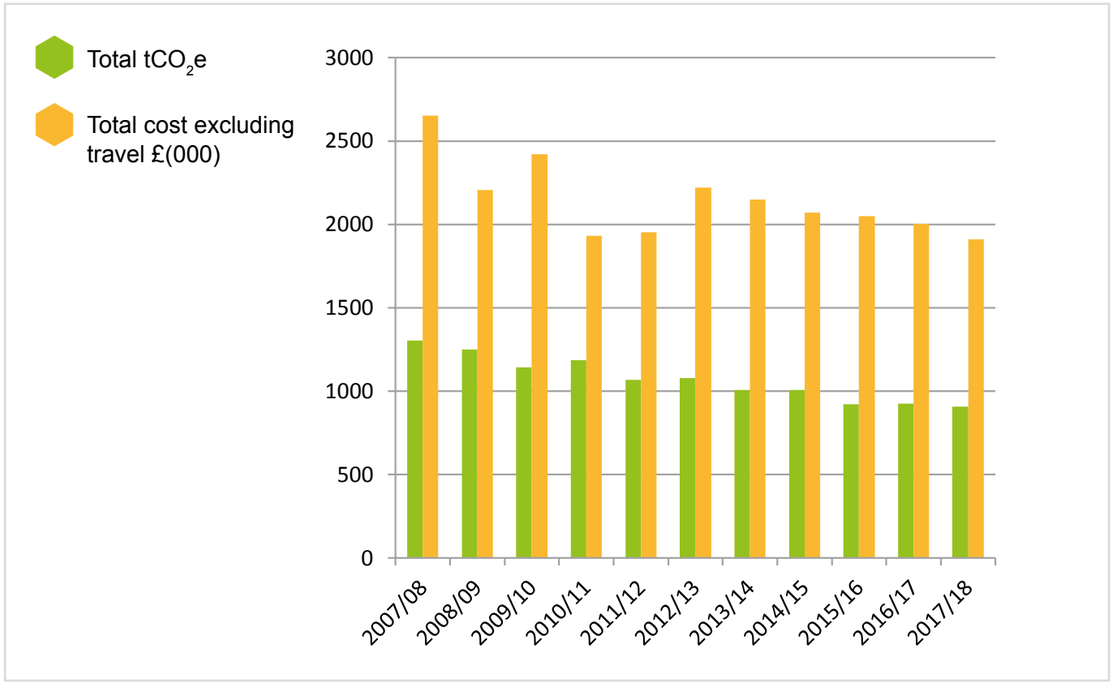


Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Miles (000)	12993	12902	10596	10064	8723	8630	4450	4578	4967	5031	4048
tCO_2e	3900	3018	2479	2354	2041	2019	1335	1373	1490	1509	1215

Travel CO_2 emissions

From 2009/10 (reliable data from Energy Trust) to 2017/18, we reduced our grey fleet mileage by over 6.5 million miles, equating to 1,264 tonnes of CO_2 (50%).

Organisation-wide progress on sustainability



Year	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Total tCO_2e	13052	12480	11418	11858	10659	10768	10058	10084	9228	9244	9084
Total Cost £(000)	2652	2206	2421	1932	2220	2149	2070	2070	2048	2004	1911

All CO_2 emissions and costs (excluding travel)

Between 2007/08 and 2017/18 we reduced our carbon emissions and costs by 3,968 tonnes (30%) and £741,000 (28%). Compared with last year CO_2 emissions have been reduced by 1.7% and costs reduced by £93,000 (4.6%) through a carbon saving plan and strategy. We are on target to achieve NHS and UK targets of 34% carbon emission reductions by 2020.

CASE STUDY

Outstanding Way – solutions in technology

Delayed Transfers of Care whole system integration initiative

Before this year, our systems were not able to provide readily accessible information to know which patients were in delay on a daily basis or allow a forecast to be predicted for the month. The informatics team undertook an intensive piece of work to design a system and process to report delayed transfers of care (DToC), into which clinical staff would readily be able to input the required data. This process was implemented across all wards in March 2017.

The delivery of the target was heavily reliant on support from other health and social care providers including the private sector and necessitated a collaborative approach with partner organisations to reduce delays and facilitate timely discharges. The technology implemented has enabled the “live” DToC position to facilitate:

- A daily email to health and social care managers enabling them to support staff to manage individual delays.
- A weekly conference call managed by our DToC lead with hospital matrons and social care leads to support the proactive management of patients in delay, provide early resolution for potential delays and validate reporting. In the early days these calls were daily, however as the DToCs reduced and staff could be relied on to escalate issues they became weekly.
- A dashboard view of current patients and analysis of total pathways across all wards, responsibilities, and local authority areas.

TEN memorable moments

1

Our school age immunisation team was named Nursing Times' Team of the Year 2017 for delivering over 67,000 vaccinations to 45 senior schools and 235 primary schools during the year. Team leaders Susie Scales and Amy Sims were also leaders of the year in the RCNi Nurse Awards.

2

In November 2017 we became the first NHS Trust in Derbyshire to sign up to the Armed Forces Covenant. It was a public declaration of our support for NHS staff who give up their spare time as reservists. We are also the first NHS Trust in the county to introduce three weeks' paid leave for reservists to carry out their reserve forces duties.

ARMED FORCES COVENANT

Georgina Robinson (right) with her daughter Claire Smith and granddaughter Georgia Smith

3

Catering assistant Georgina Robinson from St Oswald's Hospital was a finalist in February 2018 in the national Unsung Hero Awards for lifetime service – after 30 dedicated years' service.

4

Our first ever #DCHSCommunityWeek in October 2017 celebrated our staff and our communities with a week-long programme of events. The idea was repeated in summer 2018 to coincide with the fifth Extra Mile Awards ceremony, our established recognition scheme for outstanding staff.

5

We won a Point of Care Foundation award for implementing Schwartz rounds into a community trust setting, giving staff a safe environment in which to explore the emotional impact of working in healthcare.

6

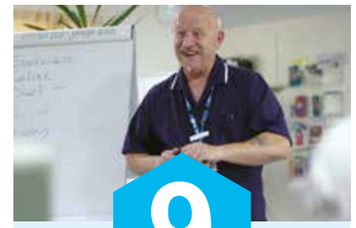
In April 2017 Ilkeston Community Hospital's new main entrance was opened after a major refurbishment in collaboration with the hospital's League of Friends. The family of Stephen Harrison who donated a large bequest to refurbish the café were VIP guests.

7

In October 2017 construction work started on a brand new £215,000 extension at Ripley Community Hospital to create better facilities for patients coming in for blood tests (phlebotomy), all funded by the hospital's League of Friends. The new phlebotomy unit opened in February 2018 and a ceremony to thank league members was held in April 2018.

8

The Ambulatory Heart Failure Unit, run by our specialist heart failure team within the Coronary Care Unit of Royal Derby Hospital, celebrated its first anniversary in December 2017. More than 200 heart failure patients have benefited from the seven-day care provided by Mandie and her team in the past 12 months, whilst also reducing the number of admissions to hospital.



9

In May 2017 we hosted the third annual Chesterfield Memory Market with a total of 31 different organisations. This brings together, under one roof, a whole range of support organisations for patients, their carers and families living with dementia. More than 3,800 patients are living with a diagnosis of dementia in North Derbyshire and Hardwick and it is estimated a further 2,000 patients are living with the early signs of the illness.

Podiatrists rolled out new Silhouette® digital imaging cameras to our hospitals and health centres in a collaboration with Derby Teaching Hospitals NHS Foundation Trust and the East Midlands Academic Health Science Network, allowing for accurate assessment of foot ulcers. The project was a finalist in the inaugural HSJ Healthcare Partnership Awards for "best innovation in medical technology."

10

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.

NHS Improvement's well-led framework has been adhered to and the arrangements we have in place to support the provision of well-led services are discussed in more detail in the performance report analysis, with an update on our approach to the five domains of safe, caring, effective, responsive and well-led services.

In 2017 the Care Quality Commission published a new and updated Key Lines of Enquiry (KLOE) framework, which incorporates further focus on patient safety and leadership. We have updated our local assurance model and the associated documentation to incorporate these changes. More details about how we use this framework to undertake reviews as part of continuous improvements, is included in the quality report, section 3.5.5 on quality assurance visits.

Directors

The following directors were appointed to membership of the Board of Directors, and were in post during the year 1 April 2017 to 31 March 2018:

Designation	Date	Name
Chairman	1 April 2017 to 31 March 2018	Prem Singh
Vice chairman	1 April 2017 to 31 March 2018	Nigel Smith
Chief executive	1 April 2017 to 31 March 2018	Tracy Allen
Director of finance, information and strategy	1 April 2017 to 31 March 2018	Chris Sands
Director of operations/chief operating officer	1 April 2017 to 31 March 2018	William Jones
Director of quality/chief nurse	1 April 2017 to 31 March 2018	Carolyn White
Director of people and organisational effectiveness	1 April 2017 to 31 March 2018	Amanda Rawlings
Medical director	1 April 2017 to 31 March 2018	Dr Rick Meredith
Associate director of corporate governance/trust secretary	1 April 2017 to 31 March 2018	Kirsteen Farrar
Non-executive director	1 April 2017 to 31 March 2018	Ian Lichfield
Non-executive director	1 April 2017 to 31 March 2018	Chris Bentley
Non-executive director	1 April 2017 to 31 March 2018	Kaye Burnett
Non-executive director	1 April 2017 to 31 March 2018	James Reilly

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

- **Nigel Smith** was appointed as vice chairman on 1 April 2017 following the departure of the previous vice chair Barbara-Anne Walker on 31 March 2017.

Further details about the Board of Directors can be found in the accountability section of this report.

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.

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 2017/18.

Better payment practice code performance

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

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

	NHS	Non NHS
Value	98.20%	98.10%
Volume	96.30%	98.10%

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

NHS Improvement's Single Oversight Framework

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

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led).

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

The Single Oversight Framework applied from quarter three of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place.

The Trust achieved the maximum autonomy score as detailed in this table.

Area	Measure	2017/18 scores	2016/17 scores
Financial sustainability	Capital service cover	1	1
Financial sustainability	Liquidity	1	1
Financial efficiency	I&E margin	1	1
Financial controls	Distance from control total	1	1
Financial controls	Agency	1	2
Overall rating		**1**	**1**

This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Area	Metric	2017/18 Quarter 1 score	2017/18 Quarter 2 score	2017/18 Quarter 3 score	2017/18 Quarter 4 score
Financial sustainability	Capital service capacity	1	1	1	1
	Liquidity	1	1	1	1
Financial efficiency	I & E margins	1	1	1	1
Financial controls	Distance from financial plan	1	1	1	1
	Agency spend	1	1	1	1
Overall score		**1**	**1**	**1**	**1**

Income disclosures

During the year ending 31 March 2018, our Trust generated income of £199m for the provision of services, principally to the people of Derbyshire.

Of that total, £181m income was for patient care activities, as shown in note three of the accounts. We 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 from any other services.

In addition to clinical income, we generated other operating income of £17.9m 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 various services that supported healthcare services being provided. This has not impacted our delivery of services.

Disclosure of information to auditors

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

Chris Sands
Acting Chief Executive **23 May 2018**

Annual report on remuneration

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

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

As chairman 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 Companies Act 2006
- Regulation 11 parts 3 and 5 of schedule 8 of the large and medium-sized companies and groups regulations (accounts and reports) 2008
- Parts 2 and 4 of schedule 8 of the regulations adopted by the NHS Foundation Trust Annual Reporting Manual
- Elements of the NHS Foundation Trust Code of Governance.

Major decisions on senior managers' remuneration

Annually the committee receives and reviews national and local benchmarking data on executive director remuneration. From the benchmarking it was identified that the chief executive's remuneration was below peer comparators for small to medium sized Trusts and in relation to gender equality. The chief executive's salary was approved by both NHS Improvement and the Treasury to move to £150,000 per annum.

Substantial changes to senior managers' remuneration

The chief executive's salary moved from £143,113 to £150,000 in line with national comparators for small to medium-sized NHS community trusts during 2017/18.

Prem Singh
Chairman

23 May 2018

Senior managers' remuneration policy
Future policy table 2017/18 - executive directors

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

Notes on future policy table 2017/18

No new components of the remuneration package were introduced in 2017/18, 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 under the section headed Remuneration Policy.

The chief executive was paid £146,408 (pro-rata £151,500 including 1% inflation increase) during 2017/18 (2016/17 £143,113). Our Trust is satisfied that this remuneration is reasonable by undertaking benchmarking work, both in terms of salaries of chief executive officers of small to medium sized trusts and gender equality.

Non-executive directors

Component	*Additional fees*	*Other remuneration*
Annual flat-rate non pensionable fee, with a higher rate payable for the chair of the trust	Not applicable – flat rate fees	Not applicable

Use of external advisors

Our Remuneration and Terms of Service Committee have 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 us as employers 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 approach to executive director remuneration is to ensure that we can attract, motivate and retain the high calibre executives we need through paying a market remuneration package, taking account of our financial conditions and providing value for money for tax payers.

The Remuneration and Terms of Service Committee has responsibility for ensuring that the remuneration packages that are paid to executive and associate directors are in line with board room pay in the NHS, and reflect the performance of the organisation and the individual. The exact remuneration package is determined by the committee based on market position to comparable trusts and our 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 committee with the aim of attracting and retaining high calibre directors who will ensure the continued success of our 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, including senior managers, are remunerated in accordance with 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 our non-executives' terms 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 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 our Nomination and Remuneration Committee.

Remuneration

Information not subject to audit

Service contracts for executive directors at 31 March 2018

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, information and strategy	1 August 2011	17 April 2015			✓
Carolyn White	Chief nurse/ director of quality	2 September 2013	17 April 2015	✓		
Amanda Rawlings	Director of people and organisational effectiveness	10 April 2007	17 April 2015		✓	
Rick Meredith	Medical director	6 June 2011	17 April 2015	✓		
William Jones	Chief operating officer	6 June 2011	17 April 2015		✓	
Kirsteen Farrar	Trust secretary/ associate director of corporate governance	18 June 1991			✓	

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 our 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. The committee met on eight occasions during the period 1 April 2017 to 31 March 2018. The membership and attendance at the committee is detailed in this table.

Attendance at Remuneration and Terms of Service Committee		27 April 2017	25 May 2017	4 July 2017	27 September 2017	30 November 2017	21 December 2017	22 February 2018	29 March 2018
Prem Singh	Chairman	✓	✓	×	×	✓	✓	✓	✓
Chris Bentley	Non-executive director	✓	✓	×	✓	✓	✓	✓	✓
Kaye Burnett	Non-executive director	✓	✓	×	✓	✓	✓	✓	✓
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓	✓	✓	×
James Reilly	Non-executive director	✓	✓	✓	✓	×	✓	×	✓
Nigel Smith	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓

Remuneration and Terms of Service Committee Other attendees (as specified by our terms of reference)		27 April 2017	25 May 2017	4 July 2017	27 September 2017	30 November 2017	21 December 2017	22 February 2018	29 March 2018
Amanda Rawlings	Director of people and organisational effectiveness	✓	✓	✓	✓	✓	✓	✓	✓

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.

Use of external advisors

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 awards 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 2017/18.

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 our policies.

Expenses

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

	2017/18			2016/17		
	Number		Expenses £ ‘00	Number		Expenses £ ‘00
	Total	Receiving expenses		Total	Receiving expenses	
Directors	7	7	16	7	7	19
Non-executive directors	6	6	7	7	6	5
Governors	31	16	4	30	16	5
Total	44	29	27	44	29	29

Payments for loss of office

There have been no payments for loss of office in 2017/18 for Derbyshire Community Health Services NHS Foundation Trust.

Payments to past senior managers

There have been no payments to past senior managers in 2017/18 for Derbyshire Community Health Services NHS Foundation Trust.

Information subject to audit

Trust Board salaries and allowances

		1 April 2017 to 31 March 2018					
		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*	£000	£00	£000	£000	£000	£000
Prem Singh	Chairman	45 - 50	-	-	-	-	45 - 50
Tracy Allen	Chief executive	145 - 150	41	-	-	45.0 – 47.5	195 - 200
Chris Sands	Director of finance, information and strategy	125 - 130	41	-	-	27.5 - 30.0	160 - 165
Carolyn White	Chief nurse/director of quality	105 - 110	48	-	-	-	110 - 115
Amanda Rawlings	Director of people and organisational effectiveness	60 - 65	12	-	-	15.0 – 17.5	75 - 80
Rick Meredith	Medical director	125 - 130	41	-	-	-	130 - 135
William Jones	Chief operating officer	110 - 115	48	-	-	*15.0 – 17.5*	135 - 140
Kirsteen Farrar	Trust secretary/associate director of corporate governance	95 - 100	7	-	-	70.0 – 72.5	165 - 170
Chris Bentley	Non-executive director	10 - 15	-	-	-	-	10 - 15
Nigel Smith	Non-executive director	10 - 15	-	-	-	-	10 - 15
Ian Lichfield	Non-executive director	10 - 15	-	-	-	-	10 - 15
James Reilly	Non-executive director	10 - 15	-	-	-	-	10 - 15
Kaye Burnett	Non-executive director	10 - 15	-	-	-	-	10 - 15

		1 April 2016 to 31 March 2017					
		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*	£000	£00	£000	£000	£000	£000
Prem Singh	Chairman	40 - 45	-	-	-	-	40 - 45
Tracy Allen	Chief executive	140 - 145	41	-	-	40.0 – 42.5	185 - 190
Chris Sands	Director of finance, information and strategy	120 - 125	41	-	-	35.0 -37.5	160 - 165
Carolyn White	Chief nurse/director of quality	105 - 110	48	-	-	-	110 - 115
Amanda Rawlings	Director of people and organisational effectiveness	60 - 65	13	-	-	20.0 – 22.5	80 - 85
Rick Meredith	Medical director	125 - 130	41	-	-	-	130 - 135
William Jones	Chief operating officer	110 - 115	48	-	-	*22.5 – 25.0*	140 – 45
Kirsteen Farrar	Trust secretary/associate director of corporate governance	90 - 95	15	-	-	72.5 - 75	160 - 165
Chris Bentley	Non-executive director	10 - 15	-	-	-	-	10 - 15
Nigel Smith	Non-executive director	10 - 15	-	-	-	-	10 - 15
Barbara-Anne Walker	Vice chair/non-executive director (01.04.2016 – 31.03.2017)	10 - 15	-	-	-	-	10 - 15
Ian Lichfield	Non-executive director	10 - 15	-	-	-	-	10 - 15
John Coyne	Non-executive director	10 - 15	-	-	-	-	10 -15
James Reilly	Non-executive director (01.08.2016 to 31.03.2017)	5-10	-	-	-	-	5-10
Kaye Burnett	Non-executive director (01.08.2016 to 31.03.2017)	5-10	-	-	-	-	5-10

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

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

Name	Title	1 April 2016 to 31 March 2017					
		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)
		£000	£00	£000	£000	£000	£000
Amanda Rawlings	**Director of people and organisational effectiveness**	115 - 120	13	-	-	40.2 – 42.5	115 - 120

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.

Pensions

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash equivalent Transfer Cash equivalent transfer value at 31 March 2015 (bands of £1, 000)	Real increase Real increase cash equivalent transfer value (bands of £1, 000)	Cash equivalent transfer value at 31 March 2016 (bands of £1,000)	Employer's contribution to stakeholder pension (bands of £1,000)
Tracy Allen	Chief executive	2.5 -5.0	0 - 2.5	45 - 50	120 - 125	740	88	836	22
Chris Sands	Director of finance, information and strategy	0 – 2.5	0 - 0	35 - 40	95 - 100	517	60	582	18
Carolyn White *	Chief nurse/ director of quality	-	-	-	-	-	-	-	-
Amanda Rawlings	Director of people and organisat-ional effective-ness	0 – 2.5	0 - 2.5	25 - 30	65 - 70	408	51	463	16
William Jones	Chief operating officer	0 - 2.5	2.5 – 5.0	50 - 55	150 - 155	962	82	1,054	17
Rick Meredith *	Medical director	-	-	-	-	-	-	-	-
Kirsteen Farrar	Trust secretary/ associate director of corporate governance	2.5 - 5.0	10 -12.5	40 - 45	125 -130	744	116	867	13

* There are no entries for Carolyn White and Rick Meredith as they have opted out of the NHS Pension Scheme.

Cash equivalent transfer value

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

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

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

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

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

Real increase in CETV

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

Fair pay multiples

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

The banded remuneration of the highest paid director at our Trust during 2017/18 was £145,000-£150,000 (2016/17 £140,000-£145,000), this was 6.44 times more than the median pay of £24,842 (2016/17 5.82 times or £24,569).

We are required to calculate the fair pay multiple based on all staff in post as at the end of March 2018 on an annualised basis. Where staff members are employed on a part-time basis, their salary is calculated as if they were in our 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 2017/18 one employee received remuneration in excess of the highest paid director, although they only worked for us during the year on a part-time basis. This employee provided medical sessions. Their full-time equivalent remuneration would have been £156,884 (2016/17 £153,821) on a full time annualised basis.

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 2017/18, there are no significant changes on either side of the ratio.

Chris Sands
Acting Chief Executive
23 May 2018

Staff report

We employ just over 4,400 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 have a stable and growing workforce within our internal bank, with approximately 1,100 staff supporting us to deliver quality patient care and ensuring our agency usage is kept to a minimum. This year our agency spend is 0.7% of our total pay bill. We are proud to report this continues to be one of the lowest with the NHS. We are committed to continue staffing our clinical areas with our own staff, wherever possible, as we firmly believe this is the best way to deliver high quality care.

Staff turnover has remained stable over the past 12 months and the rate stands at 7.60% which is significantly lower than the East Midlands NHS turnover average of 10.79% (based on most current iView data for East Midlands in January 2018).

Analysis of the reasons staff left us has not highlighted any trends or causes for concern. Currently our vacancy rate is 5.72%. All of this assures us that Derbyshire Community Health Services NHS Foundation Trust has a largely stable workforce which can only serve to support us in providing the very best care to our patients.

The workforce strategy

Our workforce development strategy for 2016/19 sets out the steps the organisation is taking to develop its workforce in support of the ambitions of the Derbyshire Sustainability and Transformation Partnership (STP).

The underlying principle of the workforce development strategy is based upon the future health and care needs of the local population and the skills our teams need to support patients across the system.

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

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

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

We recognise the important contribution that the voluntary and community sector make in the delivery of care and the promotion of social value. We will continue to work with our partners in these areas as we develop our volunteer strategy, recognising their contribution and working to explore new opportunities for volunteers to make a difference to the wellbeing of our patients.

The implementation of our plans will require effective leadership to ensure that we are confident in our aspirations. We need to work effectively with partners to co-create solutions and manage complexity, whilst leading with courage and conviction. Leaders will need support and development to help them rise to this challenge and this will need to be underpinned by effective communications and change management. We have embedded the concept of compassionate leadership, reflecting our values, and this will be developed further as part of our new leadership strategy in 2018/19.

Our workforce priorities up to 2019 will help us:

- Develop a people strategy to include workforce development and education
- Increase our registered workforce, specifically advanced clinical practitioner roles, to support the integrated model of community care
- Develop an integrated support worker role across health and social care
- Ensure a continuous supply of a high calibre workforce which is able to work flexibly across the organisation and provide seven-day services
- Increase awareness amongst our workforce of the principles of using a public health approach to the delivery of care and to create capacity and capability to allow them to engage fully with this approach through the adoption of health coaching and other public health approaches
- Support skill mix within primary care settings
- Collaborate with Health Education England and the local workforce action board to ensure we can access learning beyond registration funding to meet service delivery and transformation requirements
- Develop a 'learning organisation' approach to ensure we provide high quality education and placements for trainees and students from all disciplines inclusive of school children, people with a learning disability and those who have experienced a period of unemployment
- Sustain and embed our leadership work to equip our workforce to lead internally and across the system
- Further develop our mandatory training delivery model, reducing the frequency with which staff have to repeat mandatory training and enhance use of learning technologies
- Develop clear career pathways across both the clinical and non-clinical workforce
- Increase the number of apprenticeships we offer, particularly clinical apprenticeships to support workforce transformation
- Work with higher education institutes to increase the range of pre-registration training available for local people, including part time/ flexible routes into registered professions.
- Complete the accreditation process to become an accredited training centre
- Further develop our work experience offer
- Review and implement systems and processes to support development of a new shared learning and development function between us and Derbyshire Healthcare NHS Foundation Trust
- Enhance and increase the development of the associate nurse role
- Enhance the internal training provision for non-clinical staff and allied healthcare professionals.

Developing and supporting our people the DCHS Way

We have embedded the DCHS Way within our organisation; put simply, it is “the way we do things around here”. It is our bedrock to ensure we fulfil our ambition to be the best provider of local healthcare, a great partner and to provide a happy place to work.

To achieve this ambition we recognise that we must engage, involve and develop our teams to be the best they can be. Our five year people strategy: Quality People - The DCHS Way 2014/2019, sets out our approach. This strategy will be refreshed in 2018.

2017/18 has, however, seen the implementation of what we know will be many years of transformational service change directly affecting our workforce.

In north Derbyshire we began to implement commissioners’ plans for delivering some community services in a different way, as part of the Better Care Closer to Home programme. This has required extensive partnership collaboration with trade unions, staff partnership and other NHS organisations to enable us to attract, retrain and develop our workforce to deliver the new models of care required to meet the health needs of our local populations.

We are confident that the foundations we have created, building on our strong focus on staff health and wellbeing, creating a robust safety culture and our emphasis on partnership working, will place us in a good position to support staff through times of change whilst maintaining morale and excellent patient care.

Attendance

Our average absence rate for 2017/18 is 5.06%, which is slightly higher than the previous year (2016/17 4.73%). The top three reasons for absence remain stress/anxiety, musculoskeletal conditions and gastrointestinal problems. We have made strong efforts to help reduce the burden of these conditions amongst our staff, to support their health and reduce absence.

Supporting staff health and reducing absence

In 2017/18 we completed our most successful ever staff flu campaign, with over 68% of frontline staff vaccinated against influenza, surpassing the previous best of 52.5% last year. This has helped to reduce the amount of absence due to influenza over the winter, as well as supporting wider population health.

A musculoskeletal (MSK) group has been developed, bringing together health and safety, occupational health, outpatient physiotherapy, patient handling and staff wellbeing teams with the aim of focusing efforts to support reductions in MSK absence. This group has conducted data analysis to highlight the highest risk groups and is now implementing a combined action plan into these areas.

Our Trust-wide mental health strategy continues to be implemented and developed with an aim to create a positive culture for emotional wellbeing and reducing stress/anxiety related absence.

Key components of this strategy have included increasing resources within the Resolve Staff Support Service to increase the uptake of 1-1 counselling for staff, rolling out Schwartz rounds across the organisation, creating a network of trained mental health champions, running a calendar of mental health awareness days and highlighting and supporting ‘cause of the cause’ issues, such as caring responsibilities, as part of the ‘I wish my manager knew’ campaign.

A suite of resources has also been made available which includes ‘working together through change’ materials to support staff and managers through periods of transformation, managers’ guides for mental health and the “I wish my manager knew” initiative, to support staff who take absence due to stress/anxiety.
We have continued to roll out an ever increasing range of staff benefits that include discounts on holidays, phone contracts, cinema tickets, utility bills, family days out and high street shopping.

We have also recently announced a new benefit from Neyber, the financial wellbeing organisation, which provides a suite of financial wellbeing support along with low cost loan consolidation through payroll to help out in situations where staff members may be struggling with a debt burden.

The wellbeing team continues to offer a suite of training options for staff, including stress management and building resilience, time management and personal effectiveness and courageous conversations.

DID YOU KNOW?

In 2017/18 the wellbeing team delivered 175 training sessions which included bookable ‘stress to resilience’ sessions and ‘time management’ sessions along with numerous other bespoke team sessions, inductions, preceptee forum and foundations in care sessions. All the training is evaluated at 98% for quality of content and delivery.

We have a 100 strong network of wellbeing champions who run local initiatives, signpost to resources and raise awareness of staff wellbeing across our Trust. The network meets quarterly and we’ve recently launched a new network for mental health champions. Both networks connect into the wider Derbyshire network, run through Derbyshire County Council’s Healthy Workplaces.

Key workforce achievements in 2017/18

Apprenticeships

We have worked both regionally and nationally as part of a number of apprenticeship trailblazers to develop and enhance our apprenticeship offer. Working collaboratively across divisions we are developing a refreshed apprenticeship delivery plan to meet workforce need. The plan will outline the range and numbers of apprenticeships that we will offer over the next two years. This will provide significant learning and development opportunities across all levels of the workforce and assist in the transformation of the workforce to meet changing service requirements. As we develop new services and models of care we will use the apprenticeship levy as a key vehicle to equip our staff with the skills and competencies required, whilst also offering opportunities for career progression.

Nurse associate pilot

We have commenced our second trainee nurse associate programme providing new opportunities for 10 trainees. We will see an additional 10 trainees commence the programme in September 2018. We have been a key player in the development of the new associate nurse role across Derbyshire.

Advanced clinical practitioners

We continue to support the establishment of a Derbyshire-wide 'ACP academy' which will help ensure we have the right people with the right skills to deliver new models of care.

Learning disabilities internship programme

We continue to offer an internship programme for individuals with learning disabilities. The second cohort is going extremely well, with four interns on the programme. One of the current interns has joined our bank and is working with the patient safety and risk management team. The remaining three are progressing well on their programme of study.

Practice placement development

We continue to be recognised for the quality of practice placements provided for pre- registration students. We are committed to providing a learning environment that supports and enables our workforce to attain the right skills, competence and professional capabilities to deliver excellent care in a challenging and changing environment. We will continue to build upon the good work and seek to extend our placement opportunities over the coming year.

Quality Mark

We are in the final stages of applying for the Skills for Health Quality Mark and are due to have a final assessment in July 2018. The Quality Mark endorses the quality of the delivery of training and learning we offer.

Developing professional practice

- We have conducted a review of role-specific training requirements which has led to a revised training offer
- We led a successful Return to Practice project which has led to returnees obtaining jobs with us
- We led a successful project to develop competency profiles across the workforce. This will help to support appropriate training programmes to meet service need and the continued alignment of our competencies to roles
- We have continued to make a significant contribution to supporting practice development across community teams, including the introduction of an integrated preceptor programme for all newly qualified nurses and allied health professionals
- We have made full use of available learning beyond registration funding based upon service/business priorities to support continuing professional practice.

A safe and healthy workplace

During 2017/18 we appointed a new head of health and safety to continue the positive work of the Stay Safe health and safety programme. We firmly believe that no-one should be injured or suffer ill health as a result of their work.

There has been a good response to the health and safety for managers training - we believe that developing our leaders is an important part of building the right safety culture, where we all play our part in making our Trust an even safer place to work.

The past year has seen increased reporting of near misses which has enabled action to be taken to address those risks, as well as helping to prioritise future proactive work. In 2016/17 there were 118 near misses and for 2017/18 there were 142.

Unfortunately 2017/18 saw an increase in the number of incidents resulting in colleagues being injured or suffering ill health, totalling 523 incidents, compared with 472 in 2016/17. Any injury is one too many, and we will work hard to reduce this in 2018/19, monitoring progress throughout the year.

Examples of work planned for 2018/19 include reducing needlestick injuries, a revised approach to assessing work with display screen equipment, and working alongside the wellbeing team on topics such as musculoskeletal ill health.

Essential training

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

Training programmes reported against a target of 95% of available staff	Compliance 31 March 2017	Compliance 31 March 2018	Target
Essential learning	97%	87%	96%
Information governance	93%	94%	96%
Fire training	93%	93%	96%
Appraisal	94%	87%	96%

The configuration of essential learning has changed to include seven elements (formerly five) and now include fire and information governance training. This change has resulted in a lower overall compliance figure.

The method by which appraisals are recorded on our employee system changed in April 2017 resulting in some managers having difficulty in submitting completed appraisals. Further guidance has been communicated to staff to resolve this issue.

An inclusive organisation

We are committed to being an inclusive organisation for our staff, patients and families.

During 2017/18 we were confirmed as being a Disability Confident Leader – one of only five NHS organisations to receive this award, run by the Department of Work and Pensions. The focus of the scheme is to ensure that disabled people and those with long term health conditions have the opportunities to fulfil their potential and realise their aspirations as employees within the Trust.

As a founder member of the Derbyshire-wide LGBT network, we were pleased to be involved in the first ever LGBT network conference at Derby University in February 2018 with other public sector organisations across Derby and Derbyshire. It brought together colleagues across local public sector partnership bodies, with around 200 participants, to share information, hear about people's experiences and demonstrate a commitment to LGBT inclusion.

We have a well-established Equality, Diversity and Inclusion Leadership Forum which has been very active during the year. A key piece of work is currently underway to refresh our equality approach, including a complete review of governance, terms of reference and membership.

Much work has been undertaken internally during the year – including a 'confirm and challenge' session facilitated by Ernst & Young in October 2017 – to strengthen and simplify our overarching strategic focus on inclusion and the EDS2 NHS national equality performance framework.

Our mission is to articulate the positive impact of inclusion and ensure accountable and inclusive leadership is seen at all levels in our structures, systems, processes, roles and relationships.

The new inclusion model and strategic approach has been drafted and aligned to the DCHS Way to enable a shared understanding and help everyone to connect with our inclusive and compassionate values and behaviours.

Our refreshed Equality, Diversity and Inclusion Strategy 2017/2020 will continue to be simplified to concentrate efforts on a few key areas/equality objectives requiring attention and doing these well.

We have signed up to a research project in partnership with University of Nottingham on 'reverse mentoring' to promote compassionate and inclusive leadership.

We have continued to support our three employee network groups for our lesbian, gay, bisexual and trans (LGBT) employees, our black and ethnic minority employees and our employees with a disability or long-standing condition. Each group has open membership for equality allies.

In September 2017 we submitted information to the Stonewall Workplace Equality Index to assess our progress on LBGT inclusion in the workplace. This is the definitive benchmarking tool for employers on LGBT inclusion and we use the outcomes each year to help build upon our inclusive environment and culture.

To meet our requirements under the Public Sector Equality Duties (PSED) Equality Act 2010 we published our Annual Workforce Race Equality Submission to NHS England in August 2017 and our Annual Workforce Equality and Diversity Analysis report in January 2018. We also met the deadline for reporting details for the Government Equalities Office's gender pay gap initiative and further work is being undertaken.

Our recruitment guidelines ensure that all staff are treated fairly and equitably in appointment processes, as outlined in the Equality and Human Rights Commission's employment statutory code of practice and our own policy on equality, diversity and inclusion.

We provide a reasonable adjustments passport to ensure that where information is volunteered any disabilities are identified and reasonable adjustments put in place prior to interviews taking place. Similarly the sickness absence policy, occupational health and counselling services ensure that staff who become disabled are given a reasonable adjustment passport to record appropriate training, support and redeployment opportunities. The passport idea gained us a finalist place in the national Healthcare People Management Association awards for partnership working between employers and trade unions.

We also monitor our policies to ensure actions are taken to avoid unlawful discrimination - direct, indirect or by association.

Engaging with our staff

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

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

- We have a strong staff representation on our Council of Governors involved in making decisions affecting our workplace and the services we provide
- A quarterly Staff Forum brings together staff representatives with executives to discuss matters of interest and concern to staff, on topics chosen by staff
- 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 offer an informal drop-in opportunity for staff to find out more about what's planned and raise any questions face-to-face with an executive
- Big Conversations are bi-monthly bookable two-hour sessions which are open to all staff; the agenda is set before the meeting and covers key issues relating to the current climate
- Leadership Forums are monthly two-hour sessions for people managers to discuss the latest developments with executives, and then share with their teams.

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

During 2017/18 we held a series of executive-led briefing sessions around the Joined Up Care in Belper Review and Better Care Closer to Home Consultation, both commissioner-led projects for the future shape of care with an impact on our staff, which it was important for us to share directly with staff.

We have a strong culture of appraisals, training, learning, development and raising concerns which are all designed to promote our approach to staff engagement. We also hold topic specific engagement events and also arrange for these to be held at locations across the patch.

#DCHSTTT
thank you,
time and
tea

Saying thank you

We think it is important to celebrate the achievements of individuals and teams whose dedication and commitment shines through, including those who devote decades of their working life to the NHS and to our organisation.

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

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

Freedom to Speak Up

We are committed to encouraging staff to speak up regarding any issues that are troubling them to enable us to look into these. We have a range of processes to enable all staff to speak up promptly and in ways that they are comfortable with. These include the Freedom to Speak Up (FTSU) Guardian, Frontline Care Council or Staff Forum which meets with the executive directors on a regular basis to enable specific issues, raised by staff, to be discussed. More details are included in the quality report.

Modern slavery statement 2017/18

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

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

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

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

Trade Union Regulations 2017

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

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

In line with The Trade Union (Facility Time Publication Requirements) Regulations 2017 we have also published details of "facility time" carried out by our trade union representatives during the 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.

We had 21 employees who were accredited union officials during 2017/18, including one representative who was on a career break for the majority of the year and needs to re-accredit.

Percentage of time union officials spent on facility time	Number of employees
0%	4*
1-50%	6
51%-99%	5
100%	0

*Additionally, during 2017/18 three other representatives were confirmed as accredited but inactive, one was awaiting re-accreditation, one was on long-term sick leave and one was on maternity leave.

A total of 5,087 hours were spent by employees who were relevant union officials during 2017/18 on paid trade union activities.

As a percentage of total paid facility time hours, the number of hours spent by employees who were relevant union officials during the relevant period on paid trade union activities = 8%.

Feedback

We are committed to seeking and acting on feedback throughout the year, gauging how staff are feeling and getting an early heads-up on areas we might need to address to attract and retain the best staff, maintain staff wellbeing, and ultimately improve patient experience.

NHS Staff Survey 2017

A total of 2,433 staff at our Trust took part in the NHS Staff Survey 2017. This equates to a response rate of 55% which is above average for community trusts in England, and compares with our response rate of 54% in 2016.

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, Big Conversations, 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.

Full survey results are also shared via all staff emails and on our intranet where there is the facility to post comments on the discussion forum.

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 2017, we are focusing on five key areas for improvement during 2018:

- The role of managers
- Improving communications
- Challenging the extra hours culture
- A review of training and development needs of staff
- Increasing the autonomy of our staff.

Progress on a more detailed action plan of our future priorities and targets to improve staff satisfaction in each of these key areas will be reported bi-monthly at our Quality People Committee. Our Pulse Check results, three times a year, give us added opportunities to monitor and improve staff feedback, details of which are included further on in this chapter.

Details of key findings from the latest NHS Staff Survey

The detailed results from the Staff Survey 2017, performed independently by the Picker Institute Europe to ensure absolute confidentiality and support detailed analysis, are given here.

The next table gives a summary of ranking, compared with all community trusts in 2017 of the 32 key findings and where we were in 2015 and 2016:

	2017	2016	2015
Above (better than) average	17	21	17
Below (better than) average	3	5	7
Average	10	5	6
Above (worse than) average	2	1	2
Below (worse than) average	0	0	0

Overall staff engagement

This year the overall staff engagement score for our organisation was 3.89 out of 5; this is above the national average of 3.78 out of 5, however a decrease on last year which was 3.96 out of 5.

Despite a slight decline on last year's score, coupled with all of the transformational changes affecting us at the moment, our performance against other community trusts is still above average.

The overall indicator for staff engagement is calculated by NHS England using the questions that make up key findings 1, 4 and 7. These key findings relate to the following aspects of staff engagement:

- Staff members' willingness to recommend the trust as a place to work or receive treatment
- The extent to which staff feel motivated and engaged with their work
- Staff members' perceived ability to contribute to improvements at work.

	2015/16		2016/17		2017/18		Trust improvement / deterioration
Response rate	Trust	National average	Trust	National average	Trust	Average	
	57%	48%	54%	51.5%	55%	50%	Improvement

Areas of improvement from previous year

According to the National NHS England data our key areas of improvement from 2016 to 2017 are as follows:

- KF24. Percentage of staff / colleagues reporting most recent experience of violence
  - 7% variance from average

Top five ranking scores

According to the National NHS England data the five key findings for which we compare most favourably with other community trusts in England are:

- KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
  - 4% variance from average
- KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 month
  - 3% variance from average
- KF1. Staff recommendation of the organisation as a place to work or receive treatment
  - 0.17 out of 5 variance from average
- KF19. Organisation and management interest in and action on health and wellbeing
  - 0.8 out of 5 variance from average
- KF6. Percentage of staff reporting good communication between senior management and staff
  - 4% variance from average

Areas of deterioration

According to the National NHS England data our key areas of deterioration are as follows:

- KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
  - 4% variance from 2016 DCHS score
- KF5. Recognition and value of staff by managers and the organisation
  - 0.1% reduction when compared to 2016 DCHS score
- KF8. Staff satisfaction with level of responsibility and involvement
  - 0.05 reduction when compared to 2016 DCHS score
- KF7. Percentage of staff able to contribute towards improvements at work
  - 3% reduction when compared to 2016 DCHS score
- KF6. Percentage of staff reporting good communication between senior management and staff
  - 5% reduction when compared to 2016 DCHS score

Bottom five ranking areas

According to the National NHS England data the five key findings for which DCHS compares least favourably with other community trusts in England are:

- KF23. Percentage of staff experiencing physical violence from staff in last 12 months
  - no variance from average
- KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
  - 2% variance from average
- KF16. Percentage of staff working extra hours
  - no variance from average
- KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month
  - 1% variance from average
- KF10. Support from immediate managers
  - no variance from average

Top five ranking scores	2016/17	2017/18		Trust improvement / deterioration
	Trust	Trust	Benchmarking group (trust type) average	
KF28. Staff witnessing harmful errors, near misses or incidents in the last month		17%	21%	No change
KF25. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	19%	20%	23%	Deterioration
KF1. Staff recommendation of the organisation as a place to work or receive treatment	4.03 out of 5	3.92 out of 5	3.76 out of 5	Deterioration
KF19. Organisation and management interest in and action on health and wellbeing	3.89 out of 5	3.83 out of 5	3.75 out of 5	Deterioration
KF6. Staff reporting good communication between senior management and staff	45%	40%	36%	Deterioration

Bottom five ranking scores	2016/17	2017/18		Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (trust type) average	
KF23. Staff experiencing physical violence from staff in last 12 months	1%	1%	1%	No change
KF22. Staff experiencing physical violence from patients, relatives or the public in the last 12 months	9%	10%	8%	Deterioration
KF16. Staff working extra hours	70%	71%	71%	Deterioration
KF29. Staff reporting errors, near misses or incidents witnessed in the last month	92%	92%	93%	No change
KF10. Support from immediate managers	3.91 out of 5	3.86 out of 5	3.86 out of 5	Deterioration

Pulse Check

Three times a year we encourage all our staff to complete a ten-question (three-minute) Pulse Check to test the mood and wellbeing of employees and teams, as a mini-internal staff survey. This helps us pinpoint where and how we need to give extra support and intervention on a rolling basis to maintain staff morale.

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

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

The overall engagement scores for each quarter in 2017/18 are:

- April to June 2017: 78%
- October to December 2017: this was the NHS Staff Survey quarter so we didn't run a Pulse Check
- January to March 2018: 76%.

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?

- April to June 2017: 92%
- October to December 2017: this was the NHS Staff Survey quarter so we didn't run a Pulse Check
- January to March 2018: 90%.

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

- April to June 2017: 73%
- October to December 2017: this was the NHS Staff Survey quarter so we didn't run a Pulse Check
- January to March 2018: 72%.

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 360 Degree Assurance. 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: 0115 883 5323.

2017 National NHS Staff Survey
Results Summary

NHS
Derbyshire Community Health Services
NHS Foundation Trust

Overall staff engagement

We scored **3.89 out of 5**

3.96 Our score for last year (2016)

3.78 The national average for community trusts

Our best areas

- Percentage of staff reporting good communication between senior management and staff
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- Staff recommendation of the organisation as a place to work or receive treatment
- Organisation and management interest in and action on health and wellbeing

Areas we need to improve on

- Percentage of staff working extra hours
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- Percentage of staff experiencing physical violence from staff in last 12 months
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- Support from immediate managers

Where staff experience has improved

- Percentage of staff / colleagues reporting most recent experience of violence

Where staff experience has deteriorated

- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
- Recognition and value of staff by managers and the organisation
- Percentage of staff able to contribute towards improvements at work
- Staff satisfaction with level of responsibility and involvement
- Percentage of staff reporting good communication between senior management and staff

Staffing statistics

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

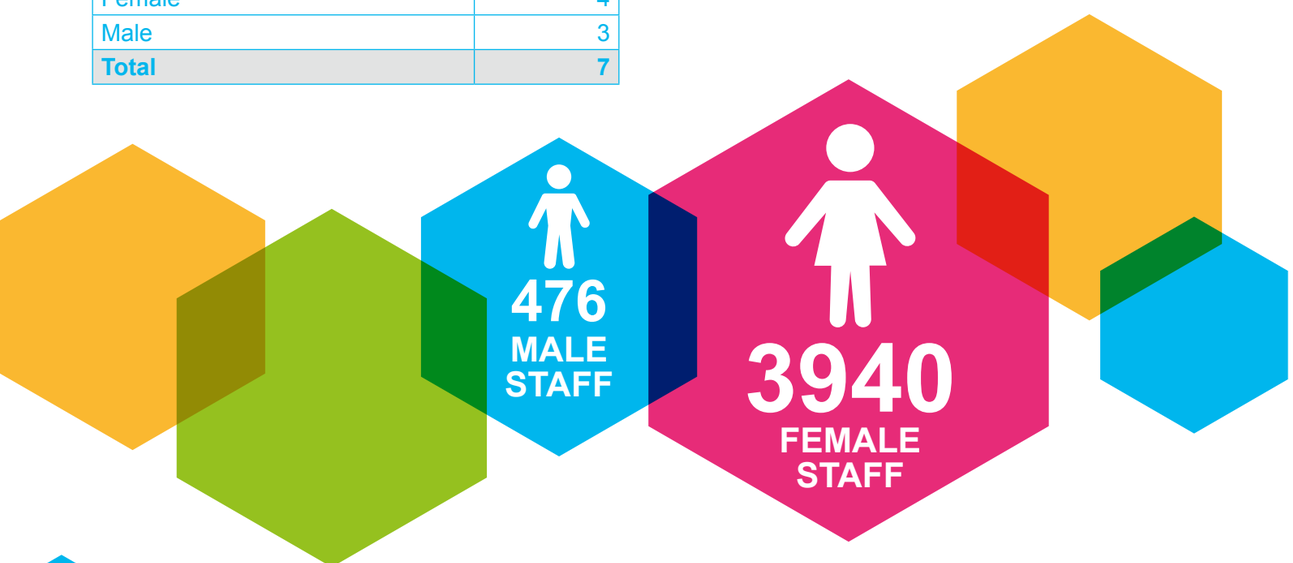
Staff groups 2017/18	Average of fixed term temporary staff*	Average of permanently employed staff*
Administration and estates staff	29.61	734.21
Ambulance staff	00.00	00.00
General payments	00.00	00.00
Health care assistants and other support staff	8.80	1000.57
Healthcare science	0.07	16.03
Medical and dental staff	3.46	43.94
Nursing, midwifery and health visiting learners	5.42	5.17
Nursing, midwifery and health visiting staff	10.77	1137.75
Scientific, therapeutic and technical staff	9.98	578.25
Total	68.11	3515.92

Total staff as at 31 March 2018 *	
Gender	**Total**
Female	3,940
Male	476
Total	**4,416**

Executive directors as at 31 March 2018*	
Gender	**Total**
Female	4
Male	3
Total	**7**

Senior managers as at 31 March 2018*	
Gender	**Total**
Female	11.8
Male	5
Total	**16.8**

* Based on staff employed at 31 March 2018 as whole-time equivalents.



Staff costs

	2017/18			2016/17		
	Total	Permanent	Others	Total	Permanent	Others
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	105,404	103,879	293	103,842	103,573	269
Social security costs	8,882	8,882		8,790	8,790	
Apprenticeship levy	520	520				
Pension cost - defined contribution plans employer's contributions to NHS pensions	14,087	14,087		13,932	13,932	
Pension cost - other	8	8		9	9	
Termination benefits	359	359		386	386	
Other employment benefits	-			1,271	1,271	
Temporary staff – agency contract staff	2,317		3,549	1,551		1,551
Total gross staff costs	**131,577**	**127,735**	**3,842**	**129,781**	**128,230**	**1,820**
Total staff costs – included within:						
Costs capitalised as part of assets	229	229		79	79	
Employee expenses - staff	130,966	128,356	3,842	129,292	127,472	1,820
Employee expenses - executive directors	23	23		24	24	
Analysed into operating expenditure						
Employee expenses - staff	130,966	127,124	3,842	129,292	127,472	1,820
Employee expenses - executive directors	23	23		24	24	
Redundancy	359	359		386	386	
Total employee benefits excluding capitalised costs	**131,348**	**127,506**	**3,842**	**129,702**	**128,151**	**1,820**

Average number of employees (WTE basis)

	2017/18 permanent number	2017/18 other number	2017/18 total number	2016/17 total number
Medical and dental	44.94	3.46	47.40	55
Ambulance	0	0	0	6
Administration and estates	734.21	31.19	765.40	812
Healthcare assistants and other support staff	1,001.57	8.89	1,009.46	1,062
Nursing, midwifery and health visiting staff	1,143.92	16.34	1,159.26	1,191
Scientific, therapeutic and technical staff	594.28	10.04	604.32	611
Other	0	0	0	3
Total average numbers	**3,518.92**	**69.92**	**3,585.84**	**3,740**
Of which: Number of employees (WTE) engaged on capital projects	7		7	3

Expenditure on consultancy

2017/18	£'000
Service integration	68
Governance review	37
Costing system	23
Tender support	13
Workforce development	12
Development of skills and capability	8
Other	14
Total	**175**

Off-payroll engagement

The Public Expenditure (PES) paper (2017)11 published by HM Treasury sets out disclosure on the Trust's highly paid and/or senior off-payroll engagements.

During 2017/18 there were 43 off-payroll engagements in place costing more than £245 per day and for a period in excess of six months, as detailed in the table below.

	Number
Number of existing engagements as of 31 March 2018	43
Of which the number that have existed:	
for less than 1 year at the time of reporting	43
for between 1 and 2 years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

New off-payroll engagements

During 2017/18 there were 43 new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that lasted for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	43
Of which:	
Number of assessed as within the scope of IR35	18
Number of assessed as not within the scope of IR35	
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	18
Number of engagements reassessed for consistency/assurance purposes during the year and	43
Number of engagements that saw a change to IR35 status following the consistency	18

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 the consequences of failing to identity correctly whether an individual is an employee in terms of HMRC's employment tests and
- Documentation maintained to identify the individuals requiring assurance.

Off-payroll engagements of board members, and/or senior officials with significant financial responsibility

During 2017/18 there have been no off-payroll engagements put in place for senior managers or those with significant financial responsibility.

	2017/18 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.	15

Information subject to audit - exit packages

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

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

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

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

Exit packages cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	2017/18		
Less than £10,000	12		12
£10,001 - £25,000	*11*		*11*
£25,001 - £50,000	*9*		*9*
£50,001 - £100,000	*(1)*		*(1)*
£100,001 - £150,000	*(1)*		*(1)*
£150,001 - £200,000			
Total number of exit packages by type	*30*		*30*
Total resource cost	£359,000		£359,000

Exit packages cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	2016/17		
Less than £10,000	3		3
£10,001 - £25,000	*6*		*6*
£25,001 - £50,000	*7*		*7*
£50,001 - £100,000	-		-
£100,001 - £150,000	*1*		*1*
£150,001 - £200,000	-		-
Total number of exit packages by type	*17*		*17*
Total resource cost	£385,000		£385,000

Non-compulsory departure payments

There have been no non-compulsory departure payments made during 2017/18 and 2016/17.

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 2017/18.

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 service we provide in each area: Amber Valley, Erewash and Southern Derbyshire (6), Bolsover, Chesterfield and North East Derbyshire (5), Derbyshire Dales and High Peak (4), Derby City (2) and Rest of England (1).

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 2017/18 the Council of Governors met six times:

- Wednesday 10 May 2017
- Wednesday 12 July 2017
- Wednesday 13 September 2017
- Wednesday 15 November 2017
- Wednesday 10 January 2018
- Wednesday 14 March 2018.

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 2017 to 31 March 2018, 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) 1st November 2017 (Second term)	31 October 2020	4/6
Valerie Broom		1 November 2014 (First term) 1 November 2016)	31 October 2019	5/6
Paul Gibbons		1 November 2017	31 October 2019	3/3
Paul Mason		1 November 2016	31 October 2019	6/6
Kevin Miller		1 November 2017	31 October 2020	3/3
Terence Watson		1 November 2017	31 October 2020	3/3
Janet Hitchenor	Bolsover, Chesterfield & North East Derbyshire	1 November 2016	31 October 2019	4/6
Julian Miller		1 November 2016 (First term) 1 November 2017 (Second term)	31 October 2020	5/6
Julia Ward		1 November 2017	31 October 2020	2/3
Ann Button	Derbyshire Dales & High Peak	1 November 2016	31 October 2019	5/6
Andrea Cooke		1 November 2014 (First term) 1 November 2016 (Second term)	31 October 2019	5/6
John Dick		1 November 2017	31 October 2020	2/3
Helen Knight		1 November 2017	31 October 2020	2/3
Merrilee Briggs	City of Derby	1 November 2017	31 October 2020	1/3
Bernard Thorpe		1 November 2014 (First term) 1 November 2017 (Second term)	31 October 2020	5/6

Elected staff governor	Constituency	Term of office began	Term of office ends	Attendance (actual/ possible)
Hannah Edwards	Administration, clerical and managers	1 November 2017	31 October 2020	3/3
Louise Holmes	Facilities and estates	1 November 2016 (First term) 1 November 2017 (Second term)	31 October 2020	5/6
Wendy Hodgkinson	Healthcare support staff	1 November 2016	31 October 2019	4/6
Melanie Baker-Hunt	Nursing	1 November 2017	31 October 2020	2/3
Veronica Hunting- Young	Nursing	12 March 2015 (First term) 1 November 2016 (Second term)	31 October 2019	4/6
Janine McKnight-Cowan	Nursing	1 November 2016	31 October 2019	5/6
Lynne Bakewell	Other registered professionals	1 November 2016	31 October 2019	5/6
Sara Nash	Other registered professionals	1 November 2014 (First term) 1 November 2017 (Second term)	31 October 2020	4/6
Nominated governor	**Constituency**	**Term of office began**	**Term of office ends**	**Attendance (actual/ possible)**
Carol Hart	Derbyshire County Council	1 September 2017		2/4
Jenny Swatton	Southern Derbyshire Clinical Commissioning Group	22 September 2015		2/6

The following governors resigned from their post during 2017/18:

Elected public governor	Constituency	Term of office began	Term of office ends	Attendance (actual/ possible)
Ray Asher	Amber Valley, Erewash & South Derbyshire	1 November 2014	31 October 2017	2/3
Roz Coldicott		1 November 2014	31 October 2017	3/3
Michael Perry		1 November 2014	8 August 2017	1/2
Lorraine Culpin	Bolsover, Chesterfield & North East Derbyshire	27 May 2014	7 December 2017	3/4
Peter McDonald		11 April 2017	31 October 2017	1/3
Maureen Strelley		1 November 2014	31 October 2017	2/3
Brenda Greaves	Derbyshire Dales & High Peak	1 November 2014	31 October 2017	2/3
Paul Kirtley		1 November 2014	31 October 2017	1/3
Diana Wood	Rest of England	1 November 2014	31 October 2017	2/3
Elected staff governor	**Constituency**	**Term of office began**	**Term of office ends**	**Attendance (actual/ possible)**
Adam Short	Administration, clerical and managers	1 November 2014	31 October 2017	3/3
Tabitha Crapper	Healthcare support staff	1 November 2014	31 October 2017	1/3
Amanda Smith	Medical & dental	1 November 2014	31 October 2017	2/3
Sally-Ann Coope	Nursing	1 November 2014	31 October 2017	3/3
Nominated governor	**Constituency**	**Term of office began**	**Term of office ends**	**Attendance (actual/ possible)**
Paul Jones	Derbyshire County Council	10 February 2014	5 May 2017	0/0
Steve Allinson	North Derbyshire Clinical Commissioning Group	16 November 2016	15 September 2017	0/3

Five seats were vacant within the financial year and elections were held in February/March 2018. The following successful candidates were announced by Derbyshire Community Health Services NHS Foundation Trust on 20 March 2018 to take up position from 1 April 2018.

Elected public governor	Constituency	Term of office began	Term of office ends
Jackie Healy	Bolsover, Chesterfield & North East Derbyshire	1 April 2018	31 October 2019
Lynn Walshaw		1 April 2018	31 October 2020
David Boddy	Rest of England	1 April 2018	31 October 2020
Elected staff governor	**Constituency**	**Term of office began**	**Term of office ends**
Jennifer Kirk	Healthcare support staff	1 April 2018	31 October 2020
Alex Carberry	Medical & dental	1 April 2018	31 October 2020

In February 2018 the Council of Governors elected Julian Miller as the deputy lead governor replacing Ray Asher who resigned from his post on 31 October 2017.

Governor elections

During 2017 a total of 18 places on the Council of Governors were up for election which included six staff governor posts in the constituencies of administration, clerical and managers (one post), facilities and estates (one post), nursing (one post), other registered professionals (one post), healthcare support (one post) and medical and dental (one post).

There were also 12 public governor posts in the constituencies of Bolsover, Chesterfield and North East Derbyshire (three posts); Amber Valley, Erewash and Southern Derbyshire (four posts), Derbyshire Dales and High Peak (two posts), City of Derby (two post) and Rest of England (one post). Nominations closed on 15 August 2017 and following a voting period the results were announced on 3 October 2017 with newly appointed governors taking up post on 1 November 2017.

Following those elections there were five spaces on the Council of Governors which were unfilled. Consequently further elections took place for public governor posts in the constituencies of Bolsover, Chesterfield and North East Derbyshire (two posts), Rest of England (one post) and two staff governors in the constituencies of healthcare support (one post) and medical and dental (one post). Nominations closed on 31 January 2018 and following a voting period the results were announced on 20 March 2018 with newly appointed governors taking up post on 1 April 2018.

Contacting the Council of Governors

Members and the public can contact the Council of Governors via email: DCHST.Governors@nhs.net

Council of Governors' meetings

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

Governor groups

There are four informal governor sub-groups of the Council of Governors. The groups support governors to be involved in key areas of our organisation's work and to meet with the executives and non-executives that lead that work. Governors report back to the full council meetings regarding the work of each of the groups.

- **The strategy group** contributed to the review of the strategic and operational plans for 2017/18, oversaw our winter planning arrangements and 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 our Board of Directors. They canvass the opinion of members via:

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

Constitution

The Council of Governors provided valuable input to the review of our constitution, the latest version of which is available on our website: http://www.dchs.nhs.uk/home/dchs_publications/foundation-trust-authorisation.

Nominations and Remuneration Committee

In 2017/18 the committee:

- Took assurance from the completed annual appraisals, including key successes and objectives for the chairman and non-executive directors
- Recommended amendments to the code of conduct for governors
- Monitored the conduct of governors
- Reviewed the remuneration of the chair and non-executive directors and made recommendations.
- Monitored the process for elections to the committee.

During 2017/18 we did not appoint any non-executive directors.

Board and governors' relationship

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

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

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

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

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

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

Governor training and development activities in 2017/18

- 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.

Attendance at Council of Governors' meetings

Trust Board members	Attendance (actual/possible) April 2017 - March 2018
Prem Singh (chairman)	6/6
Tracy Allen (chief executive)*	4/6
Chris Bentley (non-executive director)	3/6
Kaye Burnett (non-executive director)	3/6
Kirsteen Farrar (associate director of corporate governance/ trust secretary)	5/6
William Jones (chief operating officer)	4/6
Ian Lichfield (non-executive director)	2/6
Rick Meredith (medical director)	2/6
Amanda Rawlings (director of people and organisational effectiveness)	2/6
James Reilly (non-executive director)	2/6
Chris Sands (director of finance, information and strategy)	4/6
Nigel Smith (non-executive director)	5/6
Carolyn White (chief nurse/director of quality)	4/6

*During 2017/18 Tracy Allen, chief executive, was absent from the Trust due to illness for a number of months. During that time Chris Sands (director of finance, information and strategy) was appointed as acting chief executive (1 October – 31 December 2017) and attended the Council of Governors' meetings in that capacity.

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 2017	May 2017	June 2017	July 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018
Prem Singh	Chairman	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Tracy Allen	Chief executive	✓	✓	✓	✓	✓	×	×	×	✓	✓	×
Chris Bentley	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	✓
Kaye Burnett	Non-executive director	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
Kirsteen Farrar	Associate director of corporate governance/ trust secretary	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	✓
William Jones	Director of operations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	×	✓	×
Rick Meredith	Medical director	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓
Amanda Rawlings	Director of people and organisational effectiveness	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓
James Reilly	Non-executive director	✓	✓	✓	✓	✓	✓	×	✓	✓	×	✓
Chris Sands	Director of finance, information and strategy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nigel Smith	Non-executive director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Carolyn White	Director of quality and chief nurse	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	×

Audit and Assurance Committee

The Audit and Assurance Committee, chaired by Nigel Smith, provides the Board of Directors with an independent review of financial and corporate governance and risk management. It provides an assurance of independent external and internal audit, ensures standards are set and monitors compliance in non-financial, non-clinical areas of our organisation. Our internal clinical audit function is described in more detail in the quality report.

We have an internal audit function, provided by 360 Assurance, 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 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. During the year there was an area of high risk identified around sexual health services and their governance arrangements. An action plan was put in place and the progress of that action plan was monitored by the Audit and Assurance Committee. All actions were completed. 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 takes lead responsibility for data quality.

Audit and Assurance Committee Members attendance		21 April 2017	22 May 2017	21 July 2017	20 October 2017	19 January 2018
Nigel Smith	Chair, non-executive director	✓	✓	✓	✓	✓
Ian Lichfield	Non-executive director	✓	✓	✓	✓	✓
Kaye Burnett	Non-executive director	✓	×	✓	×	✓

Audit and Assurance Committee Other attendees		21 April 2017	22 May 2017	21 July 2017	20 October 2017	19 January 2018
Kirsteen Farrar	Associate director of corporate governance/trust secretary	✓	✓	✓	✓	✓
Rick Meredith	Medical director	✓	✓	×	✓	✓
Chris Sands	Director of finance, information and strategy	✓	✓	✓	✓	✓
Carolyn White	Chief nurse/director of quality	✓	✓	✓	✓	✓

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		27 June 2017	23 August 2017	10 October 2017	27 February 2018
Prem Singh	Chair, non-executive director	✓	✓	✓	✓
Bernard Thorpe	Public governor - City of Derby	✓	✓	✓	✓
Roz Coldicott	Public governor - Amber Valley, Erewash & South Derbyshire	✓	✓	✓	
Brenda Greaves	Public governor - Derbyshire Dales & High Peak	✓	×	✓	
Adam Short	Staff governor - administrative, clerical and managers	✓	✓	✓	
Paul Kirtley	Public governor - Derbyshire Dales & High Peak	×	✓	✓	
Nigel Smith	Non-executive director	✓	✓	×	✓
Julian Miller	Public governor - Bolsover, Chesterfield and North East Derbyshire				✓
Hannah Edwards	Staff governor - administrative, clerical and managers				✓
Terence Watson	Public governor - Amber Valley, Erewash and South Derbyshire				×

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

Nominations and Remuneration Committee Other attendees		27 June 2017	23 August 2017	10 October 2017	27 February 2018
Kirsteen Farrar	Associate director of corporate governance/trust secretary	✓	✓	×	✓
Amanda Rawlings	Director of people and organisational effectiveness	×	×	✓	×

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 2017/18 the Board membership consisted of the following executive directors:

Tracy Allen (chief executive); Kirsteen Farrar (associate director of corporate governance/ trust secretary); William Jones (chief operating officer); Rick Meredith (medical director); Amanda Rawlings (director of people and organisational effectiveness); Chris Sands (director of finance, information and strategy and acting chief executive 1 October – 31 December 2017) and Carolyn White (chief nurse/director of quality).

The Board included the following non-executive directors: Prem Singh (chairman); Chris Bentley (non-executive director); Nigel Smith (non-executive director and vice chairman), Ian Lichfield (non-executive director); and Kaye Burnett (non-executive director).

In addition there were two non-voting associate directors in attendance: Jim Austin (associate director of transformation) and Tim Broadley (associate director of strategy).

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

Members and governors are actively encouraged to attend the monthly public Trust Board meetings to influence discussion and raise awareness of constituents' views. Other feedback channels and engagement opportunities for our members and governors are routinely publicised via our regular membership communications, for example, participation in PLACE (patient led assessments of the care environment) visits and sharing opinion on corporate publications.

Trust Board

The Trust Board leads by undertaking three key roles:

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

A number of sub-committees, and some individual officers, have delegated powers and 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.

Our 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.

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 a community NHS trust.

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

Director of finance, information and strategy: Chris Sands

Chris Sands joined us in August 2011. He is responsible for finance, performance, contracting and strategy. He is also our deputy chief executive.

Before joining us he was director of finance and compliance for Lincolnshire Partnership NHS Foundation Trust for six years. Chris has over 20 years' experience of working in the NHS across acute, community and mental health sectors. He is a chartered management accountant and holds an honours degree in economics. Chris is also a member of the Healthcare Financial Management Association and sits on the East Midlands branch committee.

Associate director of corporate governance/trust secretary: Kirsteen Farrar

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

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

Chief operating officer: William Jones

William Jones joined us in June 2011 and is responsible for the delivery of all our operational services. He has a strong interest in primary care and leads our liaison with GP commissioners. 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 non-voting member of the Trust Board.

Medical director: Rick Meredith

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

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

Director of people and organisational effectiveness: Amanda Rawlings

Since September 2016 Amanda Rawlings has been in a shared post as the director of people and organisational effectiveness with Derbyshire Healthcare NHS Foundation Trust. Amanda was appointed as the director of people and organisational effectiveness for us in April 2011. She was previously director of human resources and organisational development across Derbyshire County Primary Care Trust and Derbyshire Community Health Services as one statutory organisation.

Amanda joined the NHS in April 2007, having previously spent her career in the private sector; mainly for Caterpillar, Perkins Engines Co Limited and British Sugar. She has an MSc in management, is a fellow of the Chartered Institute of Personnel and Development and a co-optee of a Peterborough housing association, Cross Keys Homes.

Director of quality/ chief nurse: Carolyn White

Carolyn White joined us in September 2013 as chief nurse and director of quality, following a successful secondment into the post. She is a registered sick children's nurse and registered general nurse, specialising in children's intensive care. Her clinical roles include ward sister in paediatric intensive care at Great Ormond Street Hospital for Sick Children and research nurse for the British Heart Foundation.

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

Board members – non-executive directors

Chairman: Prem Singh

Prem Singh joined us as chairman in December 2013. He has served at Board level for over 27 years, is a highly experienced chairman and was previously chief executive of several primary care trusts.

He is currently the senior independent trustee of the NHS Confederation Board and a member of the Chairs' Advisory Partnership of 25 chairs nationally hosted by the chairman 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. Originally from Malaysia, he started his NHS career in general and psychiatric nursing. Prem's wide-ranging experience in health and social care management, includes leading community, mental health and learning disability services and developing high performing Boards with clear strategic direction, robust governance and assurance frameworks. He is also an experienced leadership mentor and an ILM 7 qualified executive coach.

Non-executive director: Chris Bentley

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

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

Non-executive director: Ian Lichfield

Ian Lichfield headed up Tarmac Building Products, as chief financial officer (2008 – 2011) and chief executive (2011 – 2014), completing the successful sale of the company. He is a qualified chartered accountant with expertise in restructuring, reorganising and rationalising businesses and has led the acquisition, integration and sale of several companies.

He has held senior finance and commercial roles and has extensive board level management and leadership experience, including managing a number of joint-ventures. During an international career in the commercial sector he has lived in the Czech Republic, France, Germany, Hong Kong and the People's Republic of China. He chairs our Quality Business Committee and sits on the Audit and Assurance Committee.

Non-executive director: Nigel Smith

Nigel Smith joined us in April 2012. He is a member of the Chartered Institute of Public Finance and Accountancy and has an honours degree in economics from Lancaster University. He worked in a variety of senior executive roles in the Post Office, Consignia and Royal Mail for over 30 years, including regional director of finance, head of shared services, head of health and safety and head of occupational health.

He has been our senior independent director since April 2016 and our vice chair since April 2017. He is also chair of the Audit and Assurance Committee. He is a trustee at Hope Springs, a charity for recovering addicts in Chesterfield, and treasurer at Age UK Sheffield.

Non-executive director: Kaye Burnett

Kaye Burnett held senior roles in the NHS and police service and has over 25 years consultancy experience, delivering leadership development, coaching and major change programmes with diverse clients including NHS trusts, local authorities, national charities, and international companies.

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

Non-executive director: James Reilly

James Reilly was chief executive of Central London Community Healthcare NHS Trust, the largest community healthcare organisation in London, from 2011 until his retirement in February 2016.

He spent 27 years in local government roles, 10 of these serving as 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 two charities: Methodist Homes for the Aged and Standing Together Against Domestic Violence. He is the independent chair for the Adult Safeguarding Partnership Boards in the London Boroughs of Camden and Islington. He chairs our Mental Health Act Committee which works to safeguard the interests of all people detained under the Mental Health Act 1983.

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.

Evaluation

The Trust commissioned an external review against the domains of the NHS Improvement well-led framework by Deloitte in 2018. NHS Improvement requires trusts to commission an external review of governance at least every three years. The preliminary findings from Deloitte have not highlighted any significant areas of concern however their report will be shared with the Trust's governance groups and the Council of Governors.

In addition there has been significant internal evaluation. All of our committees and groups undertake an annual review against their terms of reference and a paper on the work of the main sub-committees of the Board is discussed at the Audit and Assurance Committee.

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

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

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

Name	Role	Appointment Date	Expiry Date
Prem Singh	Chairman	1 December 2013	30 November 2017 20 January 2017 given extension to **30 November 2020** (with effect from 1 December 2017)
Chris Bentley	Non-executive director	21 November 2011	20 November 2015 21 May 2015 given extension to 31 October 2017 1 March 2017 given 12 months extension to **31 October 2018**
Nigel Smith	Non-executive director	1 April 2012	31 March 2016 21 May 2015 given extension to 31 March 2018 1 March 2017 given 12 months extension to **31 March 2019**
Ian Lichfield	Non-executive director	1 April 2015	31 March 2018 1/3/17 second term of office agreed to **31 March 2021**
Kaye Burnett	Non-executive director	1 August 2016	31 July 2019
James Reilly	Non-executive director	1 December 2016	30 November 2019

Our membership

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

In 2017/18, Live Life Better Derbyshire and Leicestershire Dental Services were re-tendered and are no longer provided by us. As a result our staff membership figures were reduced by 135.

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 both Derbyshire and Derby, and local religious leaders.

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

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

During 2017/18 we were not engaged in any specific recruitment targets on our membership numbers, having previously reached our overall membership target. Our overall membership target by volume is to maintain more than 1% of the population we serve in Derbyshire.

During 2017/18 we undertook to maintain membership levels and to ensure our membership remained representative of our communities. This is measured and reported every month to the Trust Board.

We held drop-in sessions at targeted venues and clinics and recruited new members as a result. During the spring and summer of 2017 we also joined several fairs and promoted the benefits of becoming a public member. We routinely promote membership through our social media channels, external website and via leaflets and posters at our NHS sites.

16,539
TOTAL MEMBERS

12,066
PUBLIC MEMBERS

4,473
PUBLIC MEMBERS

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

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

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

- Its established sub-committee reporting structure
- 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 2017/18

Our membership stands at 16,539, comprising 12,066 public members and 4,473 staff members* (figures accurate on 31 March 2018). See opposite for a breakdown of constituencies in both public and staff membership and an illustration of constituency boundaries.

Membership profile by constituency (March 2018)

Public	
Amber Valley, Erewash and South Derbyshire	3,196
Bolsover, Chesterfield and North East Derbyshire	2,690
City of Derby	2,263
Derbyshire Dales and High Peak	1,339
Rest of England	2,578
Total	**12,066**
Staff	
Medical and dental	79
Nursing	1,376
Other registered professionals	733
Administrative, clerical and managers	869
Healthcare support staff	976
Facilities and estates	442
Total	**4,473**

*Staff who are members of our flexible workforce (bank staff) are not included in the staff membership figures. There are currently 409 bank staff registered with Derbyshire Community Health Services.

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

Chris Sands
Acting Chief Executive
23 May 2018

Becoming a member

You can securely sign up to be a public member online at: www.dchs.nhs.uk/sign_up_to_be_a_member
Trust members and members of the public who wish to contact the Council of Governors can do so via email: DCHST.Governors@nhs.net

Constituency boundaries

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

We are always keen to hear members' views and anyone who wants to find out more or get in touch should contact:
The Chief Executive's Office
Babington Hospital
Derby Road
Belper
DE56 1WH
Telephone: 01773 525065
or email: dchst.members@nhs.net

Statement of accounting officer's responsibilities

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Direction which requires Derbyshire Community Health Services NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Derbyshire Community Health Services NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the Department of Health 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 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, and
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Chris Sands
Acting Chief Executive **23 May 2018**

Annual governance statement 1 April 2017 – 31 March 2018

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 2018 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 The Board has the ultimate responsibility for risk management and the review and approval of high risk treatment options. The Trust's risk management framework encompasses a Risk Management Policy which describes Derbyshire Community Health Services NHS Foundation Trust's approach to risk management including the processes, roles and responsibilities which underpin it.

3.2 The Trust has an effective Board, with an appropriate balance of skills and experience and with constructive challenge from the non-executive directors. There is an induction and development programme in place for Board members and a formal and rigorous evaluation of Board effectiveness has been undertaken.

3.3 The chief executive has overall responsibility for the management of risk by the Trust. The director of quality/chief nurse is responsible for the risk management strategy and policy. The executive team exercise lead responsibility for specific types of risk.

3.4 The Quality Services Committee takes the lead committee role for ensuring the risk register is robust. The committee reviews the "Top X" risk register at every meeting, and undertakes quarterly reviews of the full risk register.

3.5 The Audit and Assurance Committee takes the lead role in ensuring the risk management control system is robust. The Audit and Assurance Committee reviews the Board Assurance Framework at each meeting to ensure risks to the achievement of strategic objectives are being effectively managed.

3.6 The Audit and Assurance Committee annually reviews attendance at Trust committees, and will report any concerns around quoracy through to the Board for action.

3.7 The role of each executive director is to ensure that appropriate arrangements are in place for the:

- Identification and assessment of risks and hazards
- Elimination or reduction of risk to an acceptable level
- Compliance with internal policies and procedures, and statutory and external requirements
- Integration and implementation of functional risk management systems and development of the assurance framework.

3.8 These responsibilities are managed operationally through corporate managers supporting the executive directors and working with designated lead managers within operational divisions.

3.9 The Trust has a risk management strategy in place. The objectives in the strategy are regularly reviewed during the year to ensure that risk is fully embedded in the day to day management of the organisation and conforms to best practice. The strategy defines risk and identifies individual and collective responsibility for risk management within the organisation. It also sets out the Trust's approach to the identification, assessment, scoring, treatment and monitoring of risk.

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

- Formal in-house training for staff as a whole in dealing with specific everyday risk, e.g. fire safety, health and safety, moving and handling, infection control, information governance and security
- Training and induction in incident investigation, including documentation, root cause analysis, steps to prevent or minimise recurrence and reporting requirements
- Developing shared understanding of broader business, financial, environmental and clinical risks through collegiate clinical, professional and managerial groups
- Use of a reporting database to support risk management, Datix, which is recognised as best in class.

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

4. The risk and control framework

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

4.2 The key elements of the risk management strategy are that:

- Risk is a key organisational responsibility
- All staff must accept the management of risks as one of their fundamental duties
- Every member of staff must be committed to identifying and reducing risk
- The management of risk is best achieved through an environment of honesty and openness, where mistakes and untoward incidents are identified quickly and dealt with in a positive and responsive way and lessons learnt are communicated throughout the organisation and best practice adopted.

4.3 The tools used to identify, evaluate and control risks are those outlined in ISO 31000 using the 5x5 matrix for consequence and likelihood. The use of this tool ensures consistency of risk assessment across the organisation.

4.4 Risks that are assessed as low indicate management by routine procedures. Moderate risks require specific management responsibility and action. High risks require senior management attention. Extreme risks require immediate action, including informing the Board of Directors.

4.5 The key ways in which risk management is embedded in the activity of the organisation is through ensuring staff are aware of their responsibilities and accountabilities as set out in the risk management strategy. Assurances on how effectively the risk management system is working are through inspections – such as, environmental, infection control, security, workplace and fire safety – and through the health and safety and clinical governance activities.

4.6 This is supported through the Trust's induction programme, training updates and individual training as a result of needs assessments. The Trust has introduced a performance management framework which includes the effective management of risk as a key element. The organisation undertakes equality impact assessments on all functions it carries out to ensure that service delivery and employment practices comply with legal requirements.

4.7 The Trust involves key stakeholders in the management of risks. This includes:

- Patients and their carers
- The general public through consultations
- Council of Governors
- Trust membership
- Staff Partnership Committee
- Staff Forum
- Trust Management Executive
- Frontline Care Council
- Mental Health Act Committee (MHAC)
- Health and Safety Committee (HSC)
- Operations senior management team
- Clinical commissioning groups (CCGs)
- Local health providers
- Local authorities (LAs)
- Improvement and Scrutiny Committee (ISC)
- Health and Wellbeing Boards
- Care Quality Commission (CQC)
- NHS England
- NHS Improvement
- Healthwatch.

4.8 The Trust has developed an integrated assurance framework to ensure that there are proper internal and independent assurances given on the soundness and effectiveness of the system and on the processes in place for meeting its objectives and delivering appropriate outcomes.

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 were no high risk recommendations identified.

4.14 The Trust ensures a strong relationship between the assurance framework and risk register. The two documents are cross referenced, with the assurance framework including strategic risks, and the risk register operational risks.

4.15 Sections of the assurance framework have been assigned to the Board and its committees to ensure that there is clear oversight of all areas. Where lack of assurance, or gaps in control are identified, these are escalated to the Board of Directors. The Audit and Assurance Committee is responsible for maintaining the overview of the framework.

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

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

4.18 The Quality Service Committee has responsibility for reviewing assurances over clinical quality. The Board committees have responsibilities for ensuring assurance is obtained routinely on compliance with CQC registration requirements. The Audit and Assurance Committee maintains an overview of compliance.

4.19 The Trust routinely reports on data quality to the Board of Directors on a monthly basis as part of its performance dashboard. The Audit and Assurance Committee provides Board oversight of data quality and monitors implementation of the data quality improvement plan on a bi-annual basis. The information management and technology (IM&T) group has lead responsibility for data quality.

4.20 The Trust has a process in place for the revalidation of medical staff. This process is overseen by the medical director.

4.21 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 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.

4.22 The Trust has a Raising Concerns policy in place. The policy sets out how these concerns will be investigated. We also have a dedicated Raising Concerns web page with the facility for direct reporting.

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

4.24 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 members' pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

4.25 The Trust has undertaken a climate change risk assessment and developed an adaptation plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

4.26 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.

4.27 The Trust is fully compliant with the registration requirements of the Care Quality Commission.

4.28 For the financial year 2017/18, PwC are the Trust's external auditors and 360 Assurance 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 as required by NHS Protect. The Quality Business Committee receives an assurance report with progress against the plan.

4.30 There have been no serious clinical incidents in year that were classed as Never Events by our commissioners following investigation.

4.31 On the afternoon of Friday 12 May 2017, a cyber-attack was initiated which infected a number of NHS organisations. As a precautionary measure, the Trust took the decision to disable a number of external connections including its connection with the N3 network, which resulted in the loss of connectivity to information systems for a number of our staff. The Trust initiated emergency planning arrangements and called a major incident. Emergency planning arrangements worked well, and access to clinical systems was completely returned by the following Monday with minimal patient impact. The risk to cyber attack has been escalated to the Trust Board Assurance Framework, and has been an area of focus for management and our internal audit resource in 2017/18 and will continue to be in 2018/19.

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

5.1 The Trust uses a range of key performance indicators (KPIs) which include non-financial measures, to manage the day to day business. This approach helps to provide a comprehensive and balanced view of performance. More information about KPIs can be read in our Quality Report.

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

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

5.4 The Board of Directors has also received assurances on the use of resources from agencies outside the Trust, including NHS Improvement. The Board of Directors self-assess on a quarterly basis and NHS Improvement scores 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 During the financial year, the Trust had no data security breaches at Level 2, and therefore no incidents were reported to the Information Commissioner.

6.4 Were Level 2 incidents to occur, these would be reviewed through the information governance group so that learning can be shared and actioned.

7. Annual Quality Report

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

7.2 The directors are required to satisfy themselves that the Trust's annual quality report is fairly stated. In doing so the Trust is required to put in place a system of internal control to ensure that proper arrangements are in place. The Trust has appointed a member of the Board, the director of quality/chief nurse, to lead and advise on all matters relating to the preparation of the Trust's quality report.

7.3 To ensure that the Trust's quality report presents a properly balanced view of performance over the year, the Quality Services Committee provides scrutiny and challenge over Trust clinical performance. The Trust also has quarterly quality meetings with its main commissioner, and submits quarterly information to NHS Improvement as part of the governance risk rating review.

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

8. Review of effectiveness

8.1 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn upon the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

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 1 April 2017 to 31 March 2018 is as follows: **Significant assurance can be provided that there is a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently.**

- The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives have been reviewed.

- The Care Quality Commission (CQC) inspection of our services in May 2016, which resulted in an overall rating of "Good", and their unannounced visits and reports in 2017/18, provides me with assurance over our clinical governance systems and quality of care of the services provided.

- The Trust's development of its Quality Assurance Framework, and Quality Always accreditation, provides me with assurance of the quality of services provided by our services.

- Our categorisation under the Single Oversight Framework (SOF) as a segment one trust by our regulator, NHS Improvement, which is a provider with maximum autonomy, provides me with assurance as to our overall governance systems.

- An independent review of leadership and governance across the Trust by Deloitte, using the Well Led Framework, provides me with assurance that it is effective. In particular, Deloitte noted the following areas of good practice:
  - Strongly embedded vision and values
  - A highly respected executive team
  - Positive culture
  - Focus on assurance and risk management.

- The work of our external auditors to review the arrangements in place for producing the quality report, and to advise us of best practice to inform our development in this area, provides me with assurance.

- The work of our external auditors to review the arrangements in place for producing the financial accounts, and providing an opinion on them, provides me with assurance.

- The work of our internal auditors in completing their risk-based targeted programme of reviews provides me with assurance on the effectiveness of controls.

- The work of our clinical audit team provides me with assurances of the effectiveness of controls in clinical areas.

- The quarterly governance returns to the Board provide me with assurance that the trust met the requirements of its licence conditions.

- Our performance in keeping our spend significantly below our agency cap issued by NHS Improvement for 2017/18, provides me with assurance that controls are robust and we are using resources effectively.

- Our engagement score of 3.89 from the 2017 Staff Survey provides me with assurance that our staff feel supported and involved in the work of the Trust, and triangulates with the findings of the Well Led Review earlier in the year.

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

- The Trust undertook an internal audit against the information governance toolkit, which provided evidence to support the Trust's view that it was compliant with the standards. The Trust continues to take action to ensure the standards of information governance are improved further in line with best practice.

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

9. Significant control issues

9.1 During the year, there have been no significant control issues:

10. Conclusion

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

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

Signed (on behalf of the Audit and Assurance Committee)

Chris Sands
Acting Chief Executive
23 May 2018

NHS
Derbyshire Community Health Services
NHS Foundation Trust

70 YEARS OF THE NHS 1948 - 2018

Derbyshire Community Health Services NHS Foundation Trust

Annual Quality Report 2017/18

Contents

Part 1 - Introduction

Welcome to the 2017/18 Annual Quality Report

It is my pleasure to introduce our Annual Quality Report for 2017/18. This report describes in detail the work we have been undertaking during the year to improve the quality of the services we provide and achieve our vision of being the best provider of local healthcare and a great place to work.

2017/18 has seen increasing pressure on our health and social care community. We continue to be challenged with increasing patient numbers and pressure on our resources and therefore it becomes more and more important that we have a strong focus on quality assurance and continuous quality improvement.

During the year we have continued to embed our Quality Always clinical assessment accreditation programme and it is always rewarding to hear the patient focused initiatives teams have led to achieve their gold awards. This programme allows us to drive quality improvements from a grass roots level and ensure that changes are sustainable.

The management of chronic wounds including pressure ulcers, leg ulcers, diabetic foot wounds and complex surgical wounds continues to utilise a significant amount of our community nursing teams and it is therefore gratifying to see that the introduction of the chronic wound management programme is having such a positive impact for patients and staff.

Further to the Care Quality Commission's comprehensive inspection in 2016 we have completed all of the advised actions and have welcomed the CQC back on a number of informal networking visits during the year. All the issues within the sexual health services have been successfully addressed including the introduction of a single patient results management system. Further improvements have been made in our medicines management systems including the training and support of our independent non-medical prescribers and the number of staff who have received specific training regarding safe administration of insulin.

Other highlights of the year have included:

- 98% of the more than 29,000 patients we surveyed recommending our Trust to their family and friends
- Being recognised nationally for the implementation of Schwartz rounds in a community setting
- Introducing patient related outcome measures, measuring what's important to our patients
- Our Time to Heal programme tackling chronic wounds and in particular significantly reducing healing times for patients with debilitating leg ulcers
- Implementing the agreed changes following the clinical commissioning group led Better Care Closer to Home consultation, minimising the impact of change on patients, their families and our staff
- Once again being recognised as a great place to work, as reported by our staff within the national NHS Staff Survey where our colleagues reported performance that was average or above average against 30/32 key areas, compared with our peer community trusts
- A score of 3.89 out of 5 for overall staff engagement compared to a national average of 3.78 out of 5 despite the significant changes in services in year
- Implementation of our new processes for reviewing and understanding unexpected deaths and sharing the learning from these events
- Continuing to improve the health and wellbeing of our staff through a range of interventions in particular we have improved our flu vaccination rate to 68% this year, just short of the 70% national target.

This report reflects on our achievements and challenges in improving quality during 2017/18 and where we have not always got things right how we have learned from this. We hope that you will agree that much progress has been made as a result of the great commitment of our staff and I would like to take this opportunity to recognise and thank them for their continued dedication.

As we look forward to 2018/19 we recognise that there continues to be significant change ahead and increasing fiscal challenge. We will continue to strive to improve services for our local people and support our most valuable asset, our staff.

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

Our staff are our greatest asset and we recognise that to provide great services we need to look after them well and to continue to recruit the very best calibre staff. During 2018/19 we will launch our leadership strategy and use the findings from the annual NHS Staff Survey to work with our teams to build on our vision of being a great place to work.

I can confirm on behalf of the Trust's Board that to the best of our knowledge and belief, the information contained in this Annual Quality Report is accurate and represents our performance in 2017/18 and our priorities for continuously improving quality in 2018/19.

Chris Sands
Acting Chief Executive
23 May 2018

Part 2 - Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement
This quality report demonstrates our achievements for the year 2017/18, describes the areas where we would still like to make improvements and our quality objectives for the coming year.

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

During 2017/18 we set three new quality priorities focusing the whole organisation on quality improvement in areas of patient safety, clinical effectiveness and patient experience. Progress on all three objectives was monitored through the Big 9 report section of the performance report to the Board of Directors.

These priorities in detail were:

1. **Patient Safety – Insulin safe administration - right dose, right time**
   Insulin is a widely used drug across our services and the incidence of errors associated with administration can be high. It is important that we have well trained staff and as far as possible well educated patients who are able to self-administer. Our objective was to ensure that insulin is always administered in accordance with the prescription.
2. **Clinical Effectiveness – Number of services adopting a patient related outcome measure**
   Patient related outcome measures are an important way of evaluating the effectiveness of a service from a patient's perspective and provide vital feedback for developing improvement plans. Our objective was to develop effective patient related outcome measures and to introduce these across a range of services
3. **Patient Experience – Identification of carers on SystmOne**
   Carers make a huge contribution to the overall health and social care workload. Working more closely with carers will facilitate better outcomes for our patients. Our objective was to identify carers accessing our services and ensure that they were signposted to support services effectively.

Table 1: Quality Service Committee (QSC) Big 3

Quality Big 3	Objective	Priorities	Target	Achieved end Mar	Forecast year end
Quality Service	To deliver high quality and sustainable services that echo the values and aspirations of the community we serve	Insulin safe administration – right dose, right time	80% of community nurses (598) have completed Insulin Safety e-learning training by March 2018	85% GREEN	85% GREEN
		Proportion of services adopting patient related outcome measures	37 services reporting to CEG by March 2018	100% GREEN	100% GREEN
		Identification of carers on SystmOne	Identify 75% of carers who access our services, a total of 2,890	70% RED	70% RED

During 2017/18 we have achieved two of our quality targets and made significant progress with the third related to identifying carers.

Patient Safety – Insulin safe administration - right dose, right time
We set a target for 80% of our community nurses to complete a nationally recognised online training programme regarding the administration of insulin in year. By the end of the year 85% of nursing staff (both registered nurses and health care support workers) had successfully completed the training programme and logged this onto their electronic staff training record. Going forward it will be a requirement for all staff administering insulin to complete this training as part of their medicines management updates.

Clinical Effectiveness - Number of services adopting a patient related outcome measure
Typically, quality measurements for services are based on how quickly we can see patients and this does not measure the outcome for the patient of our service interventions. During 2017/18 we piloted a variety of specific outcome measures and implemented the most appropriate measures across a range of services. In total we were able to implement patient related outcome measures across 37 services and during 2018/19 we will be looking at the results of these measures to improve our patient services further as well as rolling out patient related outcome measures in other services.

Patient Experience – Identification of carers on SystmOne
Experience has taught us that many of our patients also care for other family members. Admission to our services can therefore impact on carers' responsibilities. This quality improvement aimed to identify as many of our patients as possible who assume caring responsibilities for others and ensure that, where continuity of care was impacted, other services were alerted. In the absence of any local data the target we initially identified was based on our best estimate of how many patients may be carers and was probably an over estimate. Whilst we did not meet the target set we feel that good progress was made in year with 70% of our patients able to notify us of their caring responsibilities. We will continue to collect this important information and signpost carers and their families to alternative support services.

2.1.2 Things we want to do better in 2018/19
We are continually striving to improve the quality of the services we provide and to learn from things that did not go so well. In identifying improvement goals for this year we have listened to feedback from our patients, staff and governors about what concerns them and have discussed suggestions made via staff meetings to identify those issues where we feel we can make the most difference. For 2018/19 our Board of Directors has agreed three new strategic quality improvement priorities which will be reported monthly via our Big 9 performance report to Trust Board:

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

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

Target: To train 240 community nurses in optimum leg ulcer management.
Twenty registered community nurses per month to undertake two-day training in the care and treatment of leg ulcers.

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

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

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

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

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

Monthly trajectory

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

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

Rationale: The 0-19 years team have worked hard for us to be recognised as UNICEF breast feeding friendly organisation. During 2018/19 they will be applying for Gold accreditation.

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

Target: A total of 40 sites based on seven hospitals, 29 health centres and four general practice sites.
Year-end target is to have all 40 sites registered.

Monthly trajectory

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

2.2 Statements of assurance from the Board

2.2.1 Contracted services

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

During 2017/18 DCHS provided and/or sub-contracted 41 relevant health services.

DCHS has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by DCHS for 2017/18.

2.2.2 National audits

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

During 2017/18 10 national clinical audits and two national confidential enquiries covered relevant health services that DCHS provides.

During that period DCHS participated in 60% of the clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2017/18 are below.

The national clinical audits and national confidential enquiries that DCHS participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 2: National audits

Title	Eligible	Participated	% Submitted
Child Health Clinical Outcome Review Programme	Yes	No – Waiting to analyse the data from the first round last year before deciding if this is useful to us in future	N/A
Elective Surgery (National PROMs Programme)	Yes	No – Our local activity for the four categories of surgical procedures is now minimal	N/A
Falls and Fragility Fractures Audit programme (FFFAP) Inpatient Falls)	Yes	No – We trialled the inpatient audit tool last year but no further local learning is likely to be gained this year. A local audit looking at inpatient falls for over 65s who have fallen multiple times is replacing this.	N/A
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes, across all our services	No target set for number to report
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK)	Yes	Yes, our primary care services are participating	No target set for number to report
National Audit of Intermediate Care (NAIC)	Yes	No – we are locally developing patient related outcome measures and the additional staff burden of using this audit's measures would not be justified.	N/A
National Diabetes Audit - Adults - National Diabetes Foot Care Audit	Yes	Yes, community podiatry teams who perform this procedure are participating	No target set for number to report
National Diabetes Audit - Adults - National Diabetes Transition	Yes	Yes, our primary care services are participating	No target set for number to report
National Diabetes Audit - Adults - National Core Diabetes Audit	Yes	Yes, our primary care services are participating	No target set for number to report
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes, our specialist community neurological services are participating	No target set for number to report
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes, any relevant incidents are reported across all services	No target set for number to report
UK Parkinson's Audit: (incorporating occupational therapy, speech and language therapy, physiotherapy, elderly care and neurology)	Yes	Yes, our specialist community neurological services are participating	No target set for number to report

The reports of one national clinical audit were reviewed by the provider in 2017/18 and DCHS intends to take the following actions to improve the quality of healthcare provided. See table 3 for outcomes and actions on page 113.

The reports of six local clinical audits were reviewed by the provider in 2017/18 and DCHS intends to take the following actions to improve the quality of healthcare provided. See table 3 for outcomes and actions.

Clinical Effectiveness and Audit Programme 2017/18
30 clinical audit projects were carried out across Derbyshire Community Health Services NHS Foundation Trust including national audits. These are listed in table 3 on the next page.

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

Projects to date include the following:

Table 3: clinical audit programme

No	Title	Purpose	Outcome	Actions
1	**Improving the assessment of wounds CQUIN audit (Q2)**	Failure to complete a full wound assessment can contribute to ineffective treatment which can delay the rate of wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal and impact on quality of life.	The CQUIN measures how many of the wounds on the caseload that have failed to heal for 4 weeks or more have received a full wound assessment in line with the minimum data set specified. The outcome for this baseline audit is that the level of compliance for a full wound assessment is 0%. It should be noted that the minimum data set was not available to our tissue viability team when they developed the wound assessment template. The minimum data set was made available by NHS England in June 2017.	1. Documentation reviewed to assist clinical assessment of a wound 2. Where possible automated reporting is enabled 3. A plan is in place to provide training and education to staff regarding current evidence based practice for wound assessments 4. Plan will be required to provide training and education to staff regarding current evidence based practice for wounds which have failed to heal for four weeks or more, with particular attention paid to wounds classified as traumatic 5. Liaison with SystmOne clinical lead re codes required for reporting.
2	**Improving the assessment of wounds CQUIN Re-audit (Q4)**	Failure to complete a full wound assessment can contribute to ineffective treatment which therefore delays the rate of wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal and impact on quality of life.	Significant improvements have been made in the level of compliance with completion of our wound assessment template, and in the amount of data which is captured in the template and can be reported on automatically through SystmOne. The expertise of the tissue viability team has been instrumental in achieving and surpassing the target of 15%, with a final outcome of 19% of the wound assessments being fully completed for the audit sample of 150 patients.	1. Tissue viability team to review the template and amend, in conjunction with the informatics team, so that more fields are mandatory and can be automatically reported on SystmOne 2. Liaise with SystmOne clinical lead and informatics team to add a question relating to impact on quality of life within generic patient record 3. Share Q4 audit findings with relevant staff 4. Decide on target improvement rate for re-audit to be completed in June 2018 5. consider roll-out of new template to other areas with training and support from tissue viability team.
3	**Pilot survey of people who have recently experienced the death of a significant person in the care of our community nursing teams**	Trust priority to provide qualitative information relating to the patients' and their families' experience of end of life care.	Data collection continues, due to complete report on 02/08/18.	

No	Title	Purpose	Outcome	Actions
4	**End of Life Audit**	Identify areas of good practice and share this across the service. Start to review qualitative information relating to the patients' and their families' experience of end of life care. Compare end of life information with other sources – Quality Always, training, friends and family test, complaints and comments. Identify unexpected deaths and trigger an in-depth review of the circumstance by the clinical lead for advanced practice. Identify areas where practice can be improved and share the findings across the services.	Community teams response rate at 32.97%. Audit identifies a number of issues with partner organisations. Issues have also been identified with inadequate documentation in some areas. There is evidence that spiritual/social/cultural/psychological needs of patients are not always being considered. Issues were identified in delays in symptom management due to syringe driver issues. Difficulty ascertaining End of Life preference of patients with severe dementia. The Trust identified that care home staff may fail to recognise early signs of tissue damage. Staff report difficulty obtaining/returning equipment.	The audit continues to recognise the excellent end of life care that we provide. Areas for additional improvement include – 1. Increase the number of community teams completing the audit 2. Continue with training 3. Ensure that psychosocial and spiritual needs are recorded in individualised inpatient care plans 4. Ensure preferred place of care is recorded consistently 5. Identify within the notes a lead professional who coordinates care 6. Head of patient safety to liaise with partnership organisations 7. Development of Quality Conversations training.
5	**Controlled Drugs Audit**	To ensure safe storage and management of controlled drugs.	Although the overall trend of locations achieving 100% compliance for all standards is slightly down this quarter, special mention should be made of Fenton Ward, Heanor Ward, Buxton MIU and Ilkeston MIU who have all achieved 100% compliance for a complete year.	1. All audit reports are discussed with the nurse in charge at the time of the audit and a copy left with them. A copy is also sent to the matron or service manager for information or action 2. All issues identified by the audit are rectified at the time of the audit where possible. Any outstanding actions are left with the ward managers/ senior nurses to ensure they are actioned 3. The medicine management team follows up individual actions agreed at ward level 4. The audit results to be discussed at the joint matrons and ICM meetings 5. All controlled drugs registers have had a poster added to the front to prompt staff to correct errors properly.

No	Title	Purpose	Outcome	Actions
6	**Emergency Equipment Audit**	To ensure that we have a uniform and systematic approach to basic life support thereby improving patient outcomes following cardiac arrest or other medical emergency.	Whilst overall compliance has reduced slightly to 95.36% (including call bells being checked) the overall quality and maintenance of equipment has improved and the audit team witnessed some examples of excellent practice. The level of compliance is largely affected by failure to complete and/or document weekly checks every week. Some minor issues with the actual equipment were also identified with most being administrative issues.	1. Copy of report sent to assistant directors for dissemination 2. Clinical effectiveness team to manage a spot check audit of a random sample of non-compliant sites 3. Unannounced re-audit during 2018 to be planned with CQUIN and operational quality team 4. Info-graph of audit findings to be sent to the responsible clinician for each emergency equipment location.
7	**Mental Capacity Act (MCA) older people mental health wards and learning disability inpatients and core units.**	Review of compliance with the MCA. Making sure that people who lack the capacity to make decisions are cared for in a way that is consistent with their known wishes, and supported in the safest and least restrictive way.	There were significant positive changes in practice between the baseline audit and the re-audit that provide significant assurance, including increased use of the Mental Capacity Act, improved recording of MCA and Deprivation of Liberty (DoL) applications and selective use of an independent mental capacity advocate.	1. Areas for improvement included the identification of delays in local authority responses to DoL application 2. Educational poster shared with staff 3. Further audit planned in other services.
8	**Pressure Ulcer - SSKIN self-assessment**	Our chronic wound management group supports the use of a self-assessment tool by trust wide pressure ulcer improvement groups (PUIGs) and quality and safe care champions (Q&SCCs) to review the use of the SSKIN bundle pressure ulcer prevention plan on SystmOne, and to allow local improvement action planning. An organisational collection of data will take place annually to gain a wider picture of improvements made and those still required to ensure high level support where needed and to reflect good practice.	Data collection and reporting dates moved due to clinical winter pressures. Data collection started 12/03/18. Tissue viability clinical trainer and clinical effectiveness facilitator are working with Q&SCCs and PUIGs to support teams to use the self-assessment tool and to develop improvement plans which will mean the organisational audit in Q4 can act as a local re-audit allowing teams to monitor any improvements made. PUIGs are being encouraged to use the learning from the audit to develop improvement plans for their locality.	Data Analysis and report during Q1 2018/19

No	Title	Purpose	Outcome	Actions
9	**National Diabetes Audit - adults - National Diabetes Foot Care Audit**	Ensuring patients are referred to specialist diabetes foot-care services for an expert assessment on a new diabetic foot ulcer	Annual report and analysis of 24-week review outcomes planned for Q1 2018.	Assurance that our local community podiatry services are commissioned to meet the recommendations of the national audit, including participation in the audit from this year onwards.
10	**FP10 Security Audit**	All departments ordering, storing and using FP10 prescription pads must have audit procedures in place to provide assurance of the safety of the process. There should be a minimum of an annual audit and these should appear in the department's audit plan and the results forwarded to the head of service and clinical audit advisor. This should include an audit trail to confirm the whereabouts of pads that have been ordered and received.	Four areas were audited and all achieved 100%. There were some comments and questions raised by the audit and these were used to form an action plan.	1. Following pilot, amend audit to include question on how many FP10 pads are kept at each site 2. Amend policy to state a maximum of two FP10 pads can be ordered at any one time.
11	**Medication Safety Thermometer**	Pharmacy priority therefore Trust priority	All locations with patients submitted monthly data. The results were good overall. In November three wards reported omissions with "high risk" drugs: one IV antibiotic, one anticoagulant, one Parkinson's medication and one controlled drug. All wards were contacted immediately as Pharmacy obtained this data through SystmOne and the reason for the omissions were interrogated.	1. Continue to follow up on individual ward action plans 2. Ensure the process for checking "due medication" at the end of every drug round on e-prescribing wards 3. Consider expanding the audit to look at approved codes for omitted doses eg. out of stock, patient refused etc.
12	**Learning Disability Mortality Review (LeDeR)**	The Learning Disabilities Mortality Review (LeDeR) Programme is delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. Work on the LeDeR programme commenced in June 2015 for an initial three-year period.	The three main causes of death in patients with a learning disability in the Trust were aspiration pneumonia, pneumonia and sepsis.	1. learning shared with critically ill patient prevention group (CIPP) and mental health oversight group (MHOG) 2. CIPP are scoping training for learning disability staff on sepsis 3. Robust process for sharing of information, data and learning being developed to create a direct link from LeDeR to our mortality review group.

No	Title	Purpose	Outcome	Actions
13	**Parkinson's Audit**	The UK Parkinson's Audit is a clinical audit to help measure services for people with Parkinson's against national guidelines (NICE guideline in England, Wales and Northern Ireland and SIGN guideline in Scotland). It's central to the core objective of the UK Parkinson's Excellence Network in driving up service excellence across the UK. The audit was developed in 2009 to address the concerns of professionals, patients and their families and carers about the quality of care given to people with Parkinson's across the UK	National report will be available in May 2018	
14	**Susceptibility to medications**	This has arisen from a national audit tool that was used locally and showed that there is an inconsistent approach in the assessment of medications that increase falls risk. This audit or improvements as a result will give assurance that medication reviews in relation to falls and delirium will take place on admission and as clinically indicated thereafter.	59% of patients audited had a primary reason of fall for admission to our services. Of these patients 19% suffered a fall during admission. 12.2% of all the patients audited had presented with a new onset of confusion. Results are limited due to lack of evidence related to medication reviews.	1. Inclusion of the clinical records audit within the monitoring section of the policy. This is a key area of monitoring compliance with falls documentation 2. Policy clarification added regarding exemption of mobility wristbands for learning disability and older people's mental health (OPMH) services in regards to documentation 3. Updated policy regarding consideration of foot care to reflect amendments to policy documentation and current NICE guidance 4. Audit findings and written report to be shared with OPMH inpatient matrons and ward managers 5. Cascaded for action for all clinical staff including medical 6. 360 documentation audit tool to be adapted and utilised by Quality Always champions to support achievement of compliance

No	Title	Purpose	Outcome	Actions
15	**Evaluation of SSKIN switch tool (Surface, Skin, Keep patients moving, Incontinence/ moisture, Nutrition/ hydration)**	The tool is designed to help patients to understand the rationale for planned pressure prevention care and to make informed decisions about their planned pressure prevention care.	There is some evidence that using the SSKIN switch tool improves documentation especially with regard to supporting patients to make informed choices and supporting them to find solutions that will meet their needs.	1. Identify teams and arrange to visit to provide training on how to use the tool and education around the theory and management of non-concordance 2. Liaise with work force planning and development to plan how to achieve this 3. Non-concordance is discussed as part of the induction and essential skills training, and SSKIN switch given out at this opportunity 4. To be completed at Q&SCC tissue viability training sessions.
16	**Stopping Over-Medication of Patients with Learning Disabilities (STOMPwLD) Review**	The aim of this audit is to establish a baseline of current prescribing practice of all psychotropic medication in our specialist learning disability service (outpatient and inpatient) and promote improvement.	Findings summary: Local audit of 42 patients and 98 prescriptions (37 outpatients and five inpatients). Majority of prescriptions were completed by permanent medical staff. There were no surprises in the observed pattern of prescriptions, and the sample was agreed to be reasonably representative of the service. Prescriptions were generally not backed up by documentation of the process standards. The best score of 24% compliance was for recording clinical indicators. 10% of prescriptions were stopped or reduced at reviews. No assurance can be taken from the results for recording the process standards when initiating or reviewing a prescription.	The results were discussed at three meetings with the LD service prescribers on 09/10/17, 20/10/17, 11/12/17, and the improvement plan agreed at MHOG on the 18/01/18 and the following improvement actions have now been completed: As part of the trial of the prescribing support document, a spot check was carried out at Ash Green on 7 March, showing a success rate for usage of the form of 67% for inpatients and 86% for outpatients, though in outpatients this was often not fully completed. This has been fed back to the prescribers. Medicines management are considering re-deploying a generic pharmacist to attend the Hillside Ward round in due course. Setting a date for the full re-audit is the next action to be considered.

No	Title	Purpose	Outcome	Actions
17	**The Sentinel Stoke National Audit Programme (SSNAP)**	The clinical audit collects a minimum dataset for stroke patients in England, Wales and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of 6 month assessment. SSNAP is included in the National Clinical Audit and Patient Outcomes Programme (NCAPOP) managed by HQIP on behalf of the Department of Health, and is therefore part of the Trust's clinical effectiveness and audit plan.	Our early supported stroke discharge teams (ESSD) are consistently performing above the national average for rehabilitation goals set and actual time spent with patients per day of each profession of therapy.	No immediate improvements required, area of non-compliance reflects non-commissioned services. Plan to extend to all ESSD services.
18	**National Diabetes Audit Adult Core (NDA)**	The NDA collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes.	National report	The clinical lead has identified that no improvement actions are required as a result of this audit.
19	**Identifying Disability**	Our commissioners required us to "demonstrate that reasonable adjustments are made for people with a learning disability to allow improved access to all DCHS community services" and that services "have a reliable mechanism in place for coding and flagging patients with a Learning disability."	Only 6.5 % of first contacts in SystmOne in Oct 2016 had an Equality & Diversity (E&D) Questionnaire started. Of the audit sample of 80 E&D Questionnaires, 56 (70%) identified at least one disability, suggesting that staff do not complete the questionnaire unless they see a disability. A total of 79 disabilities were identified, but there was evidence of some staff confusing long term medical conditions with disabilities. In 40 out of the 56 (71%) the record ended there, with no account of what sort of adjustment was needed. Only 11 records had an entry for a reasonable adjustment. Care planning for reasonable adjustments and evaluation of the care plan actions was non-existent in the audit sample. This is similar to the results of the previous two years' results from the Identifying Learning Disability Audit.	The staff info-graphic poster of the results has been circulated. But plans for a staff focus group to look at why the results are so poor have not proved feasible due to lack of staff availability to lead the groups. Progress on the improvement plan was discussed at the Equality, Diversity and Inclusion Leadership Forum meeting on 30/11/17 and it was agreed to abandon the staff focus group project, set-up a small working party to review the improvement plan, liaise with Outstanding Way over this, but the meeting planned for early March was postponed due to snow. Feeding back the results to the governors meeting is provisionally booked for May.

No	Title	Purpose	Outcome	Actions
20	**Integrated Sexual Health Services Management of Results Audit**	Following CQC findings, 360 follow up and a previous audit an improvement plan has been fully implemented. This audit is to measure the success of the improvement plan in ensuring all positive results are managed appropriately and safely.	22,789 tests completed with 1,439 positive results. 68 positive tests took more than 10 days for the patient to be notified. For 61 results this was due to the test going to a reference laboratory which is normal practice and outside of the control of ISHS. This left seven results which fell outside the 10-day response standard once the result was with the ISHS. On further review, six of these were excluded which left only one positive test result that was not managed within 10 working days.	1. The findings of this audit received significant assurance. 2. The senior health advisors and senior sisters use the business intelligence report to interrogate the management of positive results and provide on-going assurance to the service that positive results are being properly managed. 3. Recommendation to clinical effectiveness group that this audit is removed from our clinical effectiveness plan and returns for service level management.
21	**Prescribing antipsychotic medication for people with dementia (POMH Topic 11)**	The Derbyshire Community Healthcare NHS Foundation Trust is a member of the Prescribing Observatory for Mental Health (POMH), and provide medical services to our four Older People's Mental Health (OPMH) inpatient wards in the north of the county. As members of POMH they participated in the audit for "Topic 11 Prescribing antipsychotic medication for people with dementia" in their 2016 programme. This audit supersedes the antipsychotic prescribing audit (item 22 in our 2015/16 priority audit programme) which was abandoned in favour of the POMH audit.	The results for the three OPMH wards that participated, c/o the Derbyshire Community Healthcare Trust medical staff, show that in 2016 there are more antipsychotic medications prescribed for people with dementia than in 2012, but this is for a smaller number of patients admitted and a higher level of severity of dementia. Compliance with standards for the prescription process has reduced. The draft final report and improvement plan is out for consultation before being finalised.	1. Meeting with medicines management on 14/02/18 agreed to support a spot check of the use of the prescribing pro-forma. 2. The spot check was completed on 14/03/18, which showed a success rate of 78% for use of the antipsychotics prescribing pro-forma for new prescriptions and reviews.
22	**National Audit of Dementia (Community Hospitals Pilot)**	This audit is the community hospitals trial element of the longer-established National Audit of Dementia. Our participation will assist the audit organisers in creating a community hospital version of the Acute Inpatient Audit. This will also allow us to measure our performance against the national standards for inpatient dementia services.	We did well in several areas: • staff being positive about personalised care • clinical records having assessments completed (including Mental Capacity Act), • early discharge plans and sharing these • protected mealtimes • assessing the dementia friendly environment • training strategy.	1. Initial list of areas for improvement and draft actions agreed at working group 05/12/17, reported to Frailty Strategy Group 05/02/18 2. A revised and simpler draft improvement plan is to be submitted to the next Dementia and Frailty Strategy Group meeting on the 12/04/18.

No	Title	Purpose	Outcome	Actions
23	**Mental Capacity Act (MCA)**	The board had asked for an audit on our compliance with the MCA as part of this year's clinical effectiveness and audit programme, and the agreed objective for the audit is "Making sure that people who lack the capacity to make decisions are cared for in a way that is consistent with their known wishes, and supported in the least restrictive and safe way."	Summary of findings: There were significant positive changes in practice between the baseline audit and the re-audit that provide significant assurance. There were two new poor results from questions not asked in the baseline audit: 1. Delays in local authority responses to DoL which is essentially a local authority issue. 2. Improve recording implementation of any conditions imposed.	1. Info-graph circulated to staff 2. Detail to be added to training and review of training to be completed 3. New registration form agreed for re-audit. 4. Dates for re-audit set with CQUIN and quality team 5. Audit tool redesigned.
24	**Frailty Audit**	To audit the effectiveness of the frail elderly early discharge and admission avoidance across Derbyshire.	Positive results including an 80% success rate in achieving Admission Avoidance of Facilitated Discharge. Teams respond quickly to acute referrals. We have now adopted the Rockwood frailty measure as a standard frailty assessment tool. Care plans are effective and personalised, reflecting patients' wishes and objectives and in easy to understand language.	1. Staff info-graph of the results shared with the teams audited 2. Rockwood scale - fed back scores data to Frailty strategy group 05/02/18. To improve this data for the next meeting. 3. Delirium pathway training uptake - fed back training data to frailty strategy group 05/02/18 4. Re-audit proposals agreed, to include a broader sample of clinical services and a Patient Reported Experience Measure.
25	**VTE – Planned Care**	To ensure that all relevant planned care patients are risk assessed for venous thromboembolism (VTE) and a clinical decision made and documented as to the necessity for prophylaxis taking into account the overall risks and benefits for individual patients.	Data Analysis and report due during Q1 2018/19	

No	Title	Purpose	Outcome	Actions
26	**Re-audit to measure the impact of improvement actions on the diagnosis and management of Catheter Acquired Urinary Tract Infections (CAUTI).**	Re-audit to measure effectiveness of changes made following same audit in 2015/16 and 2016/17	Out of 33 Datix incidents, 29 CAUTI patients had a set of observations documented, four had their pain assessed, four had a bowel review, one had their blood sugars measured and 19 were advised to increase their fluid intake. The re-audit indicated that urinalysis dipstick is still being used within the Trust to help diagnose a CAUTI. The reporting suggests overall reduction in the number of clinicians performing urinalysis. These figures should not be taken in isolation as it is evident that the overall management of patients with a CAUTI has improved immensely. 90% of CAUTIs reported during Q3 2017/18 were treated with antibiotics. It should be noted that the Datix report does indicate that all of these infections were symptomatic.	1. Continue to respond to all Datix but not to focus on the use of dipstick urinalysis if the catheter has been changed, a CSU taken from the clean catheter and the CSU has been sent for culture 2. Undertaking patient observations and reporting symptoms form part of a full clinical assessment 3. Continue to monitor completed incident forms and provide feedback to reporters 4. Continue to include education and training in "working together to keep patients safe" training 5. Share audit findings at ICM / matrons meeting 6. Consult Quality Always team for support embedding the lessons learnt with clinical staff e.g. quality and safe care champions. Suggest an audit of appliances within district nursing teams 7. Review current storage and transportation of urine samples within the Trust and adherence to national guidance.
27	**Equality and Diversity**	To ensure compliance with national standards		Due to the persistent challenge in developing an improvement action plan this audit is now paused whilst the equality, diversity and inclusion strategy is being developed.
28	**Patient related outcome measures**	To establish an organisational approach to the introduction and reporting of patient related outcome measures. To introduce clinical outcome reporting to 37 services within the Trust by 31 March 2018 to support the Big 9 agenda.	Derby Outcome Measure (DOM) indicates 95% of patients have improved during their admission. East Kent Outcome System indicates that for one pilot site 43% fully achieved, 52% mostly achieved and 4% did not achieve their expected goals and for the other pilot site 82% fully achieved, 6% mostly achieved 3% partially achieved and 9% did not achieve their goals.	Introduce EKOS across more community teams. Arranging meetings with matron and ICTL to discuss report findings. Meet with ward therapist to discuss DOM. Speech and language therapy to develop templates on SystmOne. Discussions underway to ensure patient related outcome measures are part of the quality dashboard. Shared progress with NHS Improvement.

No	Title	Purpose	Outcome	Actions
29	**Geographical spread of Health, Wellbeing and Inclusion (HWI) referrals**	To ensure that all health and wellbeing services are accessible to all patients regardless of the socio-economic status of their address.	Integrated sexual health services - The activity data for the time period used indicates that there is a clustering effect, with the attendance rate highest in Chesterfield. This would suggest a need for marketing of the services outside Chesterfield. The data suggests that the 'M1 corridor' area of relative deprivation doesn't appear to stand out as having relatively more presentations than other areas of the county. Breastfeeding peer support service - While this data demonstrates the coverage of the service is good and meets the aim of the audit, it does not evidence whether a referral into the service was received, who opted in/out or level of support received.	Both ISHS and breastfeeding support services are using the data gained to plan targeted marketing to encourage access to services.
30	**Audit of referrals made by DCHS GP practices to LLBD smoking cessation service**	Local concern - There is a risk to population health through the failure to fully embed public health principles within our service delivery impacting on the ability to reduce inequalities in access and outcomes for our populations.	Data analysis in progress.	

2.2.3 Research

The number of patients receiving relevant health services provided or sub-contracted by DCHS in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee is 151; an increase of 121 when compared to 2016/17 activity.

2.2.4 Commissioning for Quality and Innovation (CQUIN)

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

During 2017/18 we agreed five CQUIN measures; the themes for our CQUINs included:

- Health and Wellbeing: Staff Survey, healthy food, flu vaccination uptake
- Supporting proactive and safe discharge
- Preventing ill health through risky behaviours (i.e. alcohol and tobacco)
- Improving the assessment of wounds
- Improving the degree of personalised care planning for patients with long term conditions.

A proportion of DCHS's income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between DCHS and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and the for the following 12 month period are available in section 3.

The total CQUIN value available for 2017/18 was £3.42m and we are predicted to earn approximately 100% of this value, this indicates a total CQUIN payment of £3.42m. The monetary total for the associated payment in 2016/17 was £2.617m.

Although not all targets were fully met, the full CQUIN payment was made by commissioners as part of an in-year agreement to fix the total contractual payment.

Areas of under achievement

We have conducted risk-assessments in relation to the achievement of CQUINs during 2017/18 and anticipated that some of the targets would be difficult to fully achieve; partly because they were set nationally within the context of acute care with no opportunity to localise them for community providers. However throughout the year we have maintained a focus on improving the quality of services for patients and as a result significant progress towards milestones in each of these areas has been achieved.

The uptake of flu vaccinations for frontline clinical staff was 68%. This was a significant improvement on previous years (52.5% in 2016/17) although remained below the national target of 70%.

Various measures were taken during the year to improve proactive and safe discharge and excellent progress has been made overall through partnership working with other providers across the system. However this CQUIN required clarity and support from commissioners to define the interdependencies between acute providers and DCHS and has since been suspended for the upcoming financial year.

Performance against the Preventing Ill Health CQUIN has varied each quarter, impacted upon by the electronic clinical record systems; plans are in place to restore performance.

The Personalised Care Planning CQUIN is still ongoing with the intention to achieve key milestones by the end of the financial year.

2.2.5 Care Quality Commission (CQC)

DCHS is required to register with the CQC and its current registration status is registered with the Care Quality Commission with no conditions attached to registration.

The Trust is currently rated as good overall. The CQC has not taken enforcement action against us during 2017/18.

DCHS has not participated in any special reviews or investigations by the CQC during the reporting period.

2.2.6 Ratings for primary care services

The three GP practices continue to build on the improvements made since CQC inspection in February 2017 when they were rated as good in all domains and for all specific patient care groups and they successfully continue in their integration into the organisation. The GP strategy group's role is to monitor both the quality and performance of the practices, whilst maintaining the balance of engagement to be mutually beneficial. We have learned some valuable lessons from developing our services into primary care. Improvements continue to be developed with the practices that benefit both the patients' experience and responsiveness of the service.

2.2.7 Secondary uses service data

DCHS submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data up to and including March 2018

- which included the patient's valid NHS number was:

- 99.96% for admitted patient care
- 100% for outpatient care
- 99.58% for accident and emergency care

- which included the patient's valid General Medical Practice Code was:

- 99.90% for admitted patient care
- 99.97% for outpatient care
- 99.21% for accident and emergency care.

2.2.8 Information governance

DCHS' information governance assessment report overall score for 2017/18 was 75% (a 2% improvement over last year) and was graded as green - satisfactory. Further details can be found at Appendix 3.

2.2.9 Payment by Results

DCHS were not subject to the Payment by Results clinical coding audit during 2017/18 but we did initiate our own internal audit, which measured the accuracy of clinical coding, the results of which are detailed in this table.

Table 4

Coding field	DCHS percentage correct 2017/18	DCHS percentage correct 2016/17	DCHS percentage correct 2015/16	IG Req 505 Level 2	IG Req 505 Level 3
Primary diagnosis	96.50%	92%	93.5%	90%	95%
Secondary diagnosis	92.26%	93.53%	94.6%	80%	90%
Primary procedure	98.92%	96.84%	95.3%	90%	95%
Secondary procedure	92.66%	93.71%	91.6%	80%	90%

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

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

- improving electronic clinical coding capability
- further training for staff on clinical coding.

2.2.10 Learning from Deaths Analysis (Schedule 27)
Schedule 27.1
The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.

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

During 2017/18, 785 of DCHS' patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Table 5: Quarterly reporting of deaths

Patient deaths 2017/18	Q1	Q2	Q3	Q4
	207	180	185	213

Schedule 27.2
The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

By 31 March 2018, 17 case record reviews and one investigation have been carried out in relation to 18 of the deaths included above.

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

Table 6: quarterly reporting of case reviews

	Q1	Q2	Q3	Q4
Case Note Review	1	5	6	5
Investigation	1	0	0	0

Schedule 27.3
An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

One representing 0.1% of the patient deaths during the reporting period are judged to have been more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: zero representing 0% for the first quarter; zero representing 0% for the second quarter; one representing 0.1% for the third quarter; zero representing 0% for the fourth quarter.

There is currently no prescribed methodology for case note reviews in community trusts. We have developed a hybrid of the community section of the Global Trigger tool, RCA tool and this template has been used for the case record reviews. We used the Royal College of Physicians (RCP) structured judgement review avoidability scale to determine the level of avoidability although in year this has been revised to ask whether 'the death is thought to be more likely than not due to a problem in care'.

Schedule 27.4
Information requirement: a summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified:

- Need to ensure that patients' weights are monitored
- Prescribers must follow the antimicrobial guidelines especially when prescribing to asymptomatic patients
- Swift action is required when a referral is received by the wrong team to ensure that the patient receives the care they need from the correct team without delay
- There was no sharing of the SystmOne record in place with the practice which could have improved communication.

Schedule 27.5
Information requirement: a description of actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4)

The lessons learned have been communicated to the wider Trust through the Lessons Learned Panel and the integrated community manager/ matron meeting.

Schedule 27.6
Information requirement: an assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

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

Schedule 27.7
The number of case records or reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.

0 case record reviews and 0 investigations completed after 1 April 2017 which related to deaths which took place before the start of the reporting period.

Zero representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. There is currently no prescribed methodology for case note reviews in community trusts. We have developed a hybrid of the community section of the Global Trigger tool, RCA tool and this template has been used for the case record reviews. We used the RCP Structured Judgement Review Avoidability Scale to determine the level of avoidability.

Schedule 27.8
An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

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

Schedule 27.9
A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant documents for that previous reporting period, taking into account of the deaths referred to in item 27.8.

Zero representing 0.1% of the patient deaths during the previous reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Core indicators

Since 2012/13 all NHS foundation trusts are required to report performance against a set of core indicators using data made available to them by NHS Digital. Many of the core indicators are not relevant to community services. Those that are applicable to us appear in table 7 below. For completeness the full set of core indicators can be found at appendix 8.

Table 7: Core indicators applicable to DCHS

	Prescribed information	Related NHS Outcomes Framework Domain and who will report on them	2015/16	2016/17	2017/18
21	The data made available to the National Health Service trust or NHS foundation trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	4: Ensuring that people have a positive experience of care **Trusts providing relevant acute services**	90%	87.5%	82%
DCHS considers that this data is as described for the following reasons: we have worked actively with our staff to engage them in service development and delivery. DCHS has reported consistently excellent staff survey results for the last three years.					
DCHS intends the following actions to improve this percentage score and so the quality of our services, by continuing to actively engage with staff and to build upon our well-developed staff engagement processes.					
Comparative Data taken from NHS England Staff Friends and Family Test website When asked whether, if a friend or relative needed treatment, they would be happy with the standard of care provided by their organisation, 82% of staff agreed or strongly agreed (the average for community trusts is 73%) (data for 2016/17 = 86%).					
21.1	Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2). Please note: there is not a statutory requirement to include this indicator in the quality accounts reporting but NHS provider organisations should consider doing so.	4: Ensuring that people have a positive experience of care **Trusts providing relevant acute services**	98%	98%	97.8%
DCHS considers that this data is as described for the following reasons: we have worked with our patients to ensure effective and robust feedback from across the breadth of our services and this is monitored by our patient experience and engagement group.					
DCHS has taken the following actions to improve this percentage score: engage with patients and carers, actively seek feedback, encourage completion of FFT cards, collate the findings from feedback and report on changes through our patient experience and engagement group. Develop patient engagement groups for specific service areas and undertake engagement events on key issues.					
Comparative Data taken from NHS England Friends and Family Test data website Data for 2017/18 shows average of 97.8% of patients would recommend their local community services to friends and family.					

	Prescribed information	Related NHS Outcomes Framework Domain & who will report on them	2015/16	2016/17	2017/18
23	The data made available to the National Health Service trust or NHS foundation trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	5: Treating and caring for people in a safe environment and protecting them from avoidable harm **Trusts providing relevant acute services**	99.8%	99.6%	99.9%
Derbyshire Community Health Services NHS Foundation Trust considers that this data is as described for the following reasons: Derbyshire Community Health Services NHS Foundation Trust has trained its staff well and has clear clinical policies.					
Derbyshire Community Health Services NHS Foundation Trust has taken the following actions to improve this percentage score and the quality of our services, routine reporting through our patient safety thermometer and by reviewing in detail any venous thromboembolism case to ensure any learning is shared throughout the organisation.					
Comparative data for community trusts is not available.					
25	The data made available to the National Health Service trust or NHS foundation trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	**All trusts** 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	**Total - Patient Safety Incidents**	10,227	10,002	10,018
			Severe harm or death	39	7	9
			% severe harm or death	0.38%	0.07%	0.08%
DCHS considers that this data is as described for the following reasons: DCHS has a culture of high reporting of clinical incidents as reported by National Reporting & Learning Scheme (NRLS). There has been a focus during the year on improving the timeliness of reporting.						
DCHS has taken the following actions to improve this rate and the quality of our services, by developing a supportive reporting culture and ensuring that lessons learned from clinical incidents are shared organisation wide.						
Comparative data NRLS April – Sept 2017 DCHS remains as having the highest reporting culture rate per 1000 bed days compared with 17 NHS community trusts. <1% of incidents in this period were reported as resulting in severe harm or death.						

Part 3 - Review of quality improvements 2017/18

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

The Trust has chosen to include performance against a broad range of quality and performance indicators which are reported to the Board of Directors rather than specifically selecting three patient safety, three clinical effectiveness and three patient experience indicators. Performance against this range of indicators is included in table 8 below. Where possible we have included benchmarking information to show how we compare to other NHS organisations and comparative year on year performance. On a monthly basis a balanced score card of performance indicators is presented to the Board of Directors and where there is underperformance exception reports are provided which include actions that are being taken to improve outcomes.

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

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

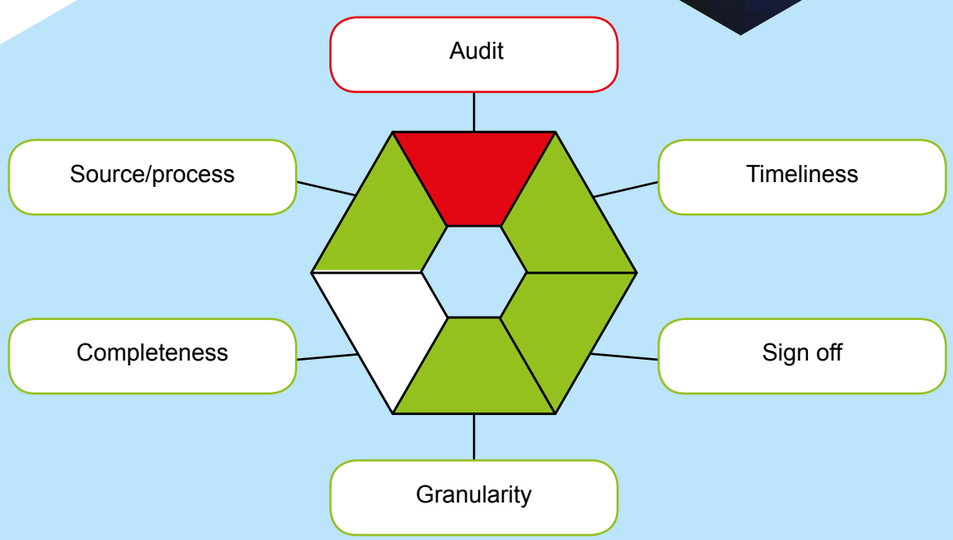
Key to colour coding – data quality kite mark scoring

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

Key to symbols

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

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



During 2017 the Audit and Assurance Committee proposed that the minimum threshold for a ‘sufficient’ data quality kite mark score be raised from 12 to 16. This is due to the sustained programme of electronic clinical system roll outs during 2017 meaning that 99% of clinical staff are now using an electronic clinical system and 77% completing full electronic patient records (64% of electronic records completed within 30 minutes of the patient consultation). We are now in a programme of re-evaluating all services based on these new criteria which will run through 2018 and beyond.

Table 8: Range of indicators

KPI	Primary data source	Data quality score	Target 17/18	Average monthly score 15/16	Average monthly score 16/17	Average monthly score 17/18	Year-end data	Benchmarked performance**
Friends and Family Test scores	Datix	14	98%	98.20%	97.9%	97.8%	98%	95.8%
Complaints – number received	Datix	14	No target	11	11	13	152	-
Complaint cases completed within agreed timescale	Datix	14	80%	-	73%	84%	84%	80%
Number of responses from Family and Friends Test	Datix	N/A	No target	1,879	2,101	2,428	29,139	-
Turnover %	ESR	12	14%	10%	9.9%	8.5%	8.5%	14.40%
Total sickness rate	ESR	12	3%	4.6%	4.7%	5.2%	5.2%	4.3%
Sickness long term	ESR	12	No target	2.8%	2.7%	3.2%	3.2%	-
Sickness short term	ESR	12	No target	1.8%	2%	2%	2%	-
Vacancy rate %	ESR	12	No target	6.1%	6.8%	5.6%	5.6%	-
Annual reviews (staff appraisals) carried out %	ESR	12	96%	90%	92%	87%	87%	88.4%
Clinical supervision %	Internal Spread sheet	N/A	100%	*	59.29%	65.51%***	Not available at time of reporting	-
Mandatory training	ESR	12	96%	94%	96%	89%	89%	88.4%
Mandatory training - information governance %	ESR	12	96%	92%	93%	95%	95%	96%
Medication errors causing serious harm (no.)	Datix	14	0	0	0	0	0	
Never Events (no)	Datix	14	0	0	0	0	0	-
Avoidable grade 2, 3 & 4 pressure ulcers developed or deteriorated in Trust care (no.)	Datix	14	34	5	5	5	58	-
Clostridium difficile incidence	Internal Spread sheet	N/A	0	0.7	0.5	0.2	2	10
MRSA bacteraemia incidence	Internal Spread sheet	N/A	0	0	0	0	0	0
Total grade 3 & 4 pressure ulcers developed or deteriorated in Trust care (no.)	Datix	14	0	16	7	4	49	-

**Data not collected **Benchmarked Performance Data taken from October 2016 Aspirant FT Benchmarking Group*

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

Table 8: Range of indicators

KPI	Primary data source	Data quality score	Target 17/18	Average monthly score 15/16	Average monthly score 16/17	Average monthly score 17/18	Year-end data	Benchmarked performance**
Safety thermometer all harms - % harm free care *	ST Tool	14	94%	93%	93%	92%	92%	94%
STEIS serious incident reporting – open serious incidents	STEIS	14	No target	48	20	18	215	-
OPMH mental health delayed transfers of care - % attributable to the Trust	BI	14	3.5%	2.0%	1.7%	3.8%	3.8%	3.5%
Inpatients – delayed transfers of care	BI	14	3.5%	10.1%	10.5%	8%	8%	3.5%
OPMH & Inpatients – delayed transfers of care	BI	14	3.5%	8.3%	8.4%	7.1%	7.1%	3.5%
A&E 4 hour wait for A&E attendances (%) (MIUs)	BI	16	95%	100%	100%	99.9%	99.9%	95%
RTT waits - admitted patients seen within 18 weeks - (2a) (%)	SystmOne	16	No target	*	93%	95%	95%	-
RTT waits - non admitted patients seen within 18 weeks - 95% (target) (1B)	SystmOne	16	95%	97.8%	95.2%	93.4%	93.4%	n/a
RTT waits - incomplete pathway - 92% (target) (2) (%)	SystmOne	16	92%	98%	96%	95%	95.25%	96.7%
Minimising mental health delayed transfers of care	BI	16	3.5%	2.0%	1.7%	3.8%	3.8%	3.5%
Mental health data completeness: identifiers	SystmOne	16	97%	100%	100%	100%	100%	-
Certification against compliance with requirements regarding access to health care for people with a learning disability	EDILF report	n/a	Yes	Yes	Yes	Yes	Yes	Yes
Data completeness: community services - referral to treatment information	CIDS	16	95%	92%	92%	97%	97%	95%
Data completeness: community services - referral information	CIDS	16	95%	85%	91%	96%	96%	95%
Data completeness: community services - treatment activity information	CIDS	16	95%	85%	91%	96%	96%	95%

We have added two new indicators this year

1. Complaint cases completed within agreed timescales - last year this featured as one of our big 3 and we committed within our annual quality report to continue to monitor and measure this indicator.
2. Inpatient delayed transfers of care and combined OPMH and inpatient delayed transfers of care have been added to provide further information regarding this key performance indicator as it is an area the trust recognises needs to be continuously improved.

Trust risk ratings (Single Oversight Framework (SOF))
As a foundation trust we are required to meet certain conditions including those in respect of:

- Continuity of services – a measure of financial sustainability and resilience. The purpose of this measure is to identify any significant risks to the financial sustainability of the Foundation Trust which would endanger the delivery of key services. From 1 April 2016 to 30th September 2016 Continuity of service was measured on a scale of 1-4 with 1 being the highest risk and 4 the lowest risk
- From 1 October 2016 a new SOF became effective and replaced the previous continuity of services risk rating with a finance and use of resources metric. A rating of 1 now represents the lowest financial risk with a score of 4 being the highest risk
- Governance – how a foundation trust oversees care for patients, delivers national standards, and remains efficient, effective and economic. Trusts are rated from green (low risk) to red (high risk). This rating was in place from 1 April 2016 to 30 September 2016
- From 1 October 2016, under the new SOF, the governance rating was replaced with a segment rating. Trusts are segmented based upon the scale of issues faced by individual providers, with segment 1 providers having maximum autonomy, and segment 4 providers being those in special measures.

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

We have performed in line with our annual plan during 2017/18 and have achieved consistently good ratings and continue the success of the previous year - see table 9.

There have been no formal interventions in year.

Table 9: Table of analysis

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

2017/18	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	Low risk	4	4		
Finance and use of resources	Low risk			1	1
Governance rating	Green	Green	Green		
Segment	Segment 1			Segment 1	Segment 1

2017/18	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	Low risk	4	4	4	4
Governance rating	Green	Green	Green	Green	Green

3.1 What have we done to improve patient safety?

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

3.1.1 Sign up to Safety
Sign up to Safety is a national patient safety campaign intended to harness the commitment of staff across the NHS in England to make care safer for patients. We formally signed up to the campaign on 3 July 2015. Following the sign up launch, a ‘National Kitchen Table’ initiative was introduced to facilitate patient safety discussions with teams across different services. Owing to its popularity we have continued the format as ‘Mini Kitchen Tables’.

The informal and relaxing sessions encourage discussion and exploration of responses to concerns and an opportunity to share the role of the Freedom to Speak Up guardian. Through an appreciative enquiry approach staff are encouraged to share stories and particularly their successes. These successes are published in the patient safety newsletters and through the Lessons Learned Panel to encourage wider learning across the organisation.

The Sign up to Safety campaign requires that organisations commit to five safety pledges which are regularly reviewed and updated. Our pledges and progress are listed in table 10. These pledges remain dynamic and services continue to offer new pledges.

Table 10: Sign up to Safety pledges and progress to date

Pledge	Progress made
Pledge 1 **Putting safety firs**t - commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.	Continence services set a new pledge to reduce the inappropriate use of antibiotics in patients with a catheter and ensure correct diagnosis, management and treatment of catheter related infections and this is being achieved. The safe care movement team reduced the number of avoidable falls resulting from lapses in care on inpatient units despite increasing challenges faced in respect of acuity and complexity of patients. Tissue viability team redesigned and launched A Time to Heal programme to ensure all staff know their responsibilities in relation to chronic wound management. This programme is designed to assist in reducing the number of avoidable pressure ulcers and improve the healing time of chronic leg ulcers.
Pledge 2 **Continually learning** - make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring the safety of our services.	All patient safety incidents are reviewed by the patient safety team and all staff incidents are reviewed by the health and safety team to ensure that as an organisation we learn from the incidents investigated. Feedback is given to the Lessons Learned Panel, as well as to the investigating manager so that local and trust wide dissemination of information can occur. Regular 'Mini Kitchen Table' discussions are held with teams using appreciative enquiry so that examples of excellence can be shared across the Trust.
Pledge 3 **Being honest -** be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.	The patient safety team continues to ensure that duty of candour is exercised when serious harm occurs and those patients and their advocates are informed of any lessons learnt. The Trust Root Cause Analysis (RCA) training now incorporates patient experience and duty of candour elements to provide an insight in to the relationship between being open and honest and its reduction in possible complaints.
Pledge 4 **Collaborate -** work closely with our commissioner stakeholders and the serious incident network so that wider learning can occur. Actively consult with our workforce and nurture an open attitude to health and safety issues, encouraging staff to identify and report and suggest innovative solutions so that we can all contribute to creating and maintaining a safe working environment.	The patient safety team meets regularly with the commissioner stakeholders and the serious incident networks to ensure wider learning occurs. The patient safety team are interactive with Sign up to Safety taking an active role in webinars to share patient safety experience in addition to the 'Mini Kitchen Table' discussions with teams across the trust. Feedback on incidents is routinely reported to the quality assurance group (QAG) held with our lead commissioner. Planet FM (the Trust's equipment asset register) is now up to date. All maintenance requests for buildings or equipment are now being reported to the estates help desk and this system ensures that medical devices (either electrical or requiring calibration) have a planned preventative maintenance process in place. The training department are ensuring that staff are deemed competent in their use and this is linked to their profile on the Electronic Staff Record (ESR).

Pledge	Progress made
Pledge 5 **Being supportive -** help our people understand why things go wrong and how to put them right. Give them the time and support to improve and celebrate progress	We continue to strive to create a positive health culture. This is embedded into our policies and procedures. This year, key staff members attended human factors (HF) training with nationally recognised provider Atrainability. This is now being incorporated into incident investigations to understand the crux of the problem and provide our staff with training, support and confidence to learn and improve.

3.1.2 Risk management

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

Graph 1 shows how incidents are cross referenced on the Trust risk register. All three top reported incidents are reported on the risk register.

The actions and progress to mitigate these related risks and incidents are discussed and agreed with clinicians with an overview at the safe care priority group and medication operational safety team (MOST) meetings. Any new initiatives are shared and further communicated across services.

Graph 1: Top 3 reported patient incidents by category (April 2017 to March 2018)

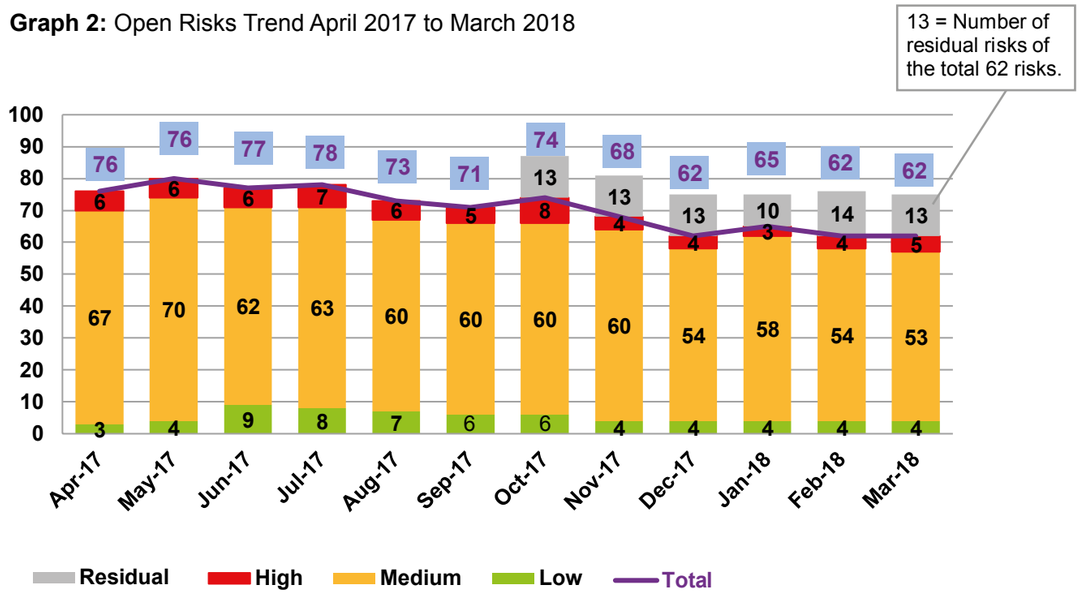
3.1.3 Risk review

Risks are reviewed on a regular basis by managers through established governance meetings in accordance with our risk policy. To assist rating of a risk, a 5 x 5 risk grading matrix (see table 11) is used to identify the likelihood of a risk occurring against its resulting consequence. To ensure overview of all risks the senior operational and management teams along with the Trust's Board review all risks rated 10 and above monthly and QSC bi-monthly. Risks rated 9 and below are reviewed on a quarterly basis by QSC. There has not been any risk overdue a review for 13 consecutive months. Risks are discussed at each divisional governance meeting. An overall trend line of risks through the financial year is shown in graph 2.

Table 11: Risk grading matrix

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

Graph 2: Open Risks Trend April 2017 to March 2018



3.1.4 Risk assurance

Assurance regarding risk management has been taken by the Board throughout the year and at year end, significant assurance was taken by the Audit and Assurance Committee. An Internal Audit (360 Assurance) review during 2017 recorded significant assurance following the audit of incident management. The report considered the alliance between incidents and risks.

3.1.5 Risk maturity

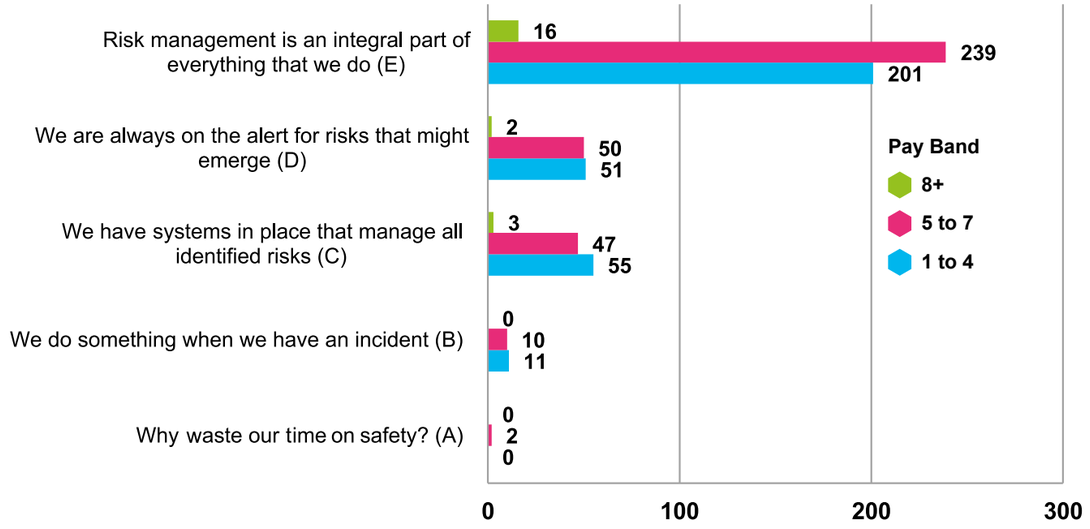
There is evidence of a good and increasing risk maturity across our organisation. This is demonstrated in the risk register, as risks are better described in the controls and further controls sections. To help determine awareness of risk management below service management team level, a Trust-wide risk maturity matrix has now commenced and is measuring how staff place importance on risk management in their workplace. Going forward in 2018/19 the aim is to promote and provide further support to improve awareness of risk management across the Trust.

From 1 April 2017 the risk management team have used a new simple matrix of five questions to gain staff responses in terms of levels of risk maturity (table 3). This is an innovative success which has been shared with other organisations.

The data yielded in quarters 1 to 3, (consisting of 395 responses from 406 issued questionnaires) shows that there is a positive culture to risk management. The responses yielded a 97.2% return and of these 67.0% rated risk management as an integral part of everything that we do. This data enables the risk management team to identify the effectiveness of existing risk management training and awareness. The details will help to provide internal audit with measurements to provide a level of assurance.

Graph 3: Responses during April 2017 – March 2018

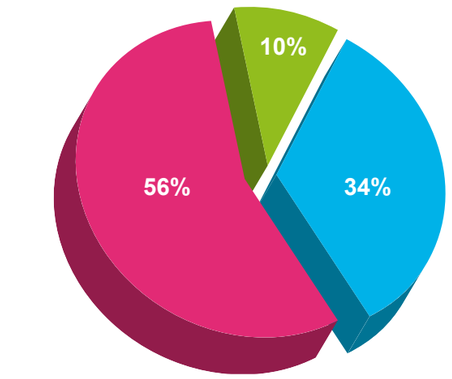
Graph 3: Risk Maturity Matrix by Pay Band



3.1.6 Risk training

Robust measures are in place to ensure that all our staff are trained in risk management. Training is provided through our induction, essential, preceptorship and introduction to risk management face to face training sessions. In addition to this, the patient safety team provides bespoke training when additional support is required and offer a Datix helpline service from Monday to Friday.

Graph 4: Risk Management & Datix Training



Other training includes 1:1 and staff group sessions where individuals and teams receive bespoke training sessions.

During 2017/18 the patient safety team has provided risk management and Datix training to 1,274 members of staff, this is approximately 28% of staff. This is based on a total of 4,529 substantive staff as recorded in the 2016/17 annual quality report. Training includes induction, essential, preceptorship and risk management training. This is supplemented by bespoke individual or team training.

3.1.7 Clinical policies, guidelines and procedures

Clinical policies, guidelines and procedures provide evidence-based standards which enable clinicians to provide optimum evidenced-based care with the aim of ensuring positive outcomes for patients. These documents are available for all clinicians on our SharePoint site. They are reviewed regularly by operational, specialist and governance groups. Reviews identify best practice and ensure that clinical policies reflect the most up-to-date evidence-base is available to clinicians.

Since July 2016 there have been no clinical policies which have breached their review date. The process for guidance, procedures and leaflets has strengthened with only a few overdue for a review, subject to local and national changes.

3.1.8 Incident matrix - patient safety incident reporting and culture

Our staff continue to report a high number of patient safety incidents, highlighted by NHS England's National Reporting and Learning System (NRLS) as a strong patient safety culture. From 1 April 2017 to 31 March 2018 a total of 10,018 patient incidents have been reported with each one receiving a comprehensive review. A high volume of incidents reported sometimes results in managers having incidents which are overdue for a review, weakening assurance. During this year the patient safety team has been working with operational leads, adapting available systems and processes to maximise the use of available resource to ensure strong governance continues and that all incidents are reviewed in a timely way. A matrix has been developed to enable staff to determine the level of investigation and review required.

3.1.9 National Reporting & Learning System (NRLS)

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

During the period 1 April 2017 to 31 March 2018, there have been a total of 10,018 patient safety incidents reported (excluding 470 rejected reports). Of these 6,675 have already been communicated to the NRLS. At the time of reporting there were 180 (404 last year) patient incidents in the Datix system in the review process i.e. 92 (240 last year) awaiting review by manager, 27 (70 last year) actively being reviewed by manager and 61 (94 last year) waiting follow-up by the patient safety team. This is a significant improvement to last year's figures. This improvement is attributed to active management in response to a current corporate risk describing overdue incidents.

April 2016 – March 2017	
In holding area, awaiting review	240
Being reviewed	70
Awaiting final approval	94

April 2017 – March 2018	
In holding area, awaiting review	92
Being reviewed	27
Awaiting final approval	61

Table 12 compares incident rate by severity classification. This is a much improved picture compared with last year. There have been no major harm incidents. There were nine catastrophic incidents reported. The mortality review process ensures these are reviewed to determine if our clinicians had provided all reasonable care in foreseeable situations.

The catastrophic events comprise one each of: inpatient cardiac arrest; patient found dead in bath at home; cardiac arrest in patient's home; suspected suicide in patient's home; death at home (LeDER notification); suspected death from sepsis during pressure ulcer management; death at home rare bone cancer; death on ward suspected fall – later identified as unforeseeable intracranial bleed; unforeseeable death on ward i.e. no identified symptoms in advance (currently in review).

Table 12: Incidents by severity comparable data	2015/16	2016/17	2017/18
No injury or harm	3,958	3,574	3,905
Minor harm/injury	5,528	5,897	5,851
Significant harm/ injury	695	344	253
Major harm/ injury including permanent disability	39	2	0
Death/multiple deaths or catastrophic event (e.g. flood/fire)	7	5	9
Totals:	10,227	10,002	10,018

3.1.10 Never Events

Never Events are defined as incidents that are wholly preventable. Never Events are revised and relisted on an annual basis by NHS England. The revised list was launched in January 2018 where there have been a small number of changes which the patient safety team is in the process of incorporating onto the Datix system. During 2017/18 there have been no Never Events reported by the Trust which meet the NHS England's Never Events listed fields.

Table 13: The top five reported incidents and trends over the past three years

2015/16		2016 /17		2017/18	
Pressure relief care	**4,436**	Pressure relief care	**4,507**	Pressure relief care	**5,180**
Slips, trips and falls (patient)	**1,093**	Slips, trips and falls (patient)	**974**	Slips, trips and falls (patient)	**931**
Medication	**576**	Ambulance/taxi/ transport issue	**603**	Medication	**699**
Injury or damage to skin (not pressure ulcer)	**552**	Medication	**545**	Discharge or transfer problem	**509**
Discharge or transfer problem	**465**	Discharge or transfer problem	**419**	Safeguarding adults	**469**
Totals:	**7,122**	Totals:	**7,048**	Totals:	**7,788**

Information on actions we are taking to reduce pressure ulcers and falls and managing medicines are included later in this report.

Managing the transfer of patients safely between different health care facilities is essential. The patient safety team sends details of all discharge/ transfer incidents to our acute trust partners. Responses are shared through our risk reporting system to the relevant manager so that any lessons learned are communicated. The number of discharge/transfer incidents needing to be raised appears to rise in line with the winter pressures and this will be incorporated into our future winter planning.

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

Pressure ulcer-related incidents continue to be the top reported incidents. It is important to note that 2,223 (43%) of the incidents reported this period relate to patients who have a pressure ulcer when coming into our care. An alternative IT solution for capturing this detail is currently being explored. This is to free up the resource required for incident processing by the reporter, manager, tissue viability team and patient safety team as this is time consuming, costly and not necessarily a reportable incident.

3.1.11 Central Alert System and Strategic Executive Information System (STEIS)
The Central Alert System is a national reporting system which distributes alerts from NHS England, alerting health organisations of safety issues. During the financial year of 2017/18 a total of 128 alerts were received compared with 139 in the previous financial year. Each alert is reviewed for its relevance to our Trust and distributed to the services where the alert applies. All alerts were responded to within the required time frames and the implementation of any required actions is followed up by the patient safety team to ensure it has been executed.

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

The patient safety team processes all serious incidents and checks that, where appropriate, learning is shared across the organisation. The process for which pressure ulcer incidents are reviewed and investigated was reviewed during 2017/2018. An incident matrix has been developed, helping staff to determine the level of care lapses against the impact of harm and this is linked to Datix for incident managers to utilise.

Table 14: Incidents reported on STEIS

Category	Number of STEIS incidents 2016/17	Category	Number of STEIS incidents 2017/18
Pressure ulcers	60	Pressure ulcers	62
Slips/trips/falls	23	Slips/trips/falls	4
Delayed diagnosis	1	Infection prevention and control	1
Medical equipment	1	Medication	2
Pending review	2	Pending review	0
Sub-optimal care	1	Sub-optimal care	1
Total	88		70

3.1.12 Human factors (HF)
Human factors principles aim to understand the ‘fit’ between an employee, their equipment and the surrounding environment, which can include learning styles, behaviours and values, leadership, teamwork, the design of equipment and processes, communication and organisational culture. Having strong HF knowledge can lead to safer working and a reduction in human error–related harm.

In addition to already being embedded within the root cause analysis (RCA) training, to further improve HF awareness across the Trust an external company Atrainability was contracted this year to provide HF training over a two day period. The training was provided to key clinicians selected to be ‘culture carriers and changers’.

To further strengthen delivery of HF the head of patient safety and risk management attended a ‘train the trainers’ Human Factors in Healthcare course with an aim to become a qualified trainer. This experience and qualification will then help develop HF across the Trust. As a result of this learning, new tools such as ‘DuPont’s Dirty Dozen’ will be introduced into policies and processes providing staff with a simple way to capture why an error occurred.

3.1.13 Standardised clinical kit bags
Through 2017/18, a medical devices project has focussed on developing a standard kit bag for use by clinicians in the community. This equips clinicians with a robust kit bag containing essential basic equipment including a sphygmomanometer and a thermometer. £200,000 investment has been made to provide new equipment to all community clinicians.

3.1.14 Planet FM (facilities maintenance)
The process of having medical devices equipment listed on Planet FM has improved. This enables maintenance and tracking of key essential equipment.

Operational and safety managers are working to ensure consistent and robust reporting is sustained.

3.1.15 Developing patient safety links

As a result of our continued work relating to the National Safety Standards for Invasive Procedures 2015, we have been developing our links with Derby Teaching Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust.

As clinical staff work across both centres, our day case theatre managers now attend a safer surgery meeting hosted by Derby Teaching Hospitals NHS Foundation Trust. This supports the review of our local processes for invasive procedures ensuring that they are compliant with national standards. In addition we are ensuring that we are working in collaboration with other partner organisations to develop local safety standards for invasive procedures.

The improved links and joint development of standards, guidelines and policies will support the provision of safer care and the reduction in the number of patient safety incidents in line with the principles of the national standards.

3.1.16 Chronic wound management - patient safety chronic wounds

Chronic wounds include, but are not limited to, diabetic foot ulcers, leg ulcers, pressure ulcers and non-healing surgical wounds. These types of wounds have a significant impact both on the quality of life of those who have them as well as the health care system. Wound management is estimated to account for between 39% and 50% of community nurse time, with patients often having three or more visits per week. Our aging population, with increased co-morbidities and complexities has resulted in an increase in the prevalence of chronic wounds in all care settings. In conjunction with care closer to home, earlier discharges and admission avoidance, the complexity of some wounds can be particularly challenging in a community setting. In an effort to address these challenges we have developed our tissue viability strategy for 2017-2020 which has been approved by QSC.

3.1.17 Leg ulcers

In December 2016 we undertook a leg ulcer prevalence audit which identified a number of variances in care which contributed to a delay in healing. These included delays in assessment and confirmed diagnosis as well as inconsistent application of appropriate pathways. This inconsistency was attributed to changes in nurse training, lack of knowledge, skills and confidence in relation to assessing patients, using Doppler and applying compression bandaging.

These findings have resulted in a refocus on leg ulcer management within the Trust. To address this we developed the leg ulcer project A Time to Heal, which has become one of the Outstanding Way service improvement work streams being embedded to improve the prevention and management of lower limb wounds. This includes a five day leadership programme that aims to equip the community nursing team leads with the skills and knowledge to lead local clinical care improvements. Additional support and coaching is provided by senior nurses from quality and improvement standards as well as the issue viability team for a period of three months, to support and embed changes in practice.

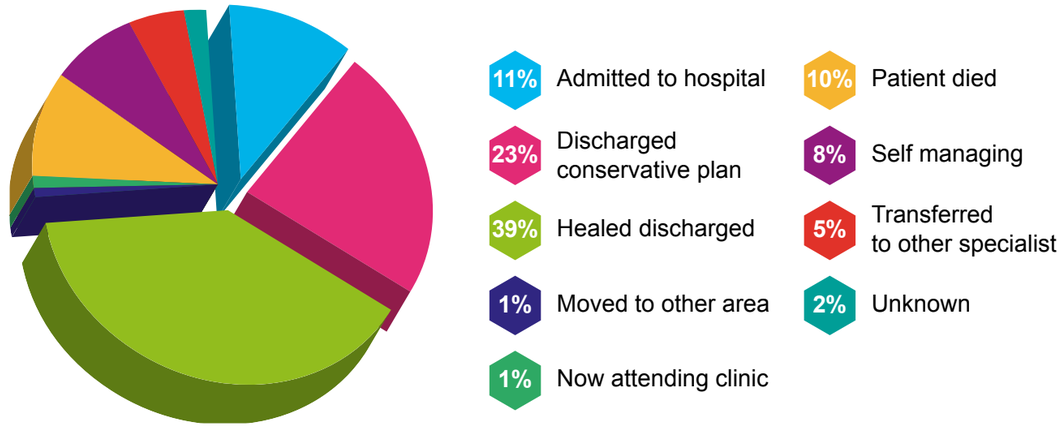
In addition work has been undertaken in relation to patients identified with various types of chronic wounds, including pressure ulcers, surgical wounds and leg ulcers who have been on community nursing caseloads for prolonged periods of time. Outcomes of these patients following appropriate reviews and care pathways being implemented are being monitored for a period of 12 weeks so that we can demonstrate that evidence based care works, as well as gaining a greater insight and recognition of the barriers to implementation of appropriate care pathways.

3.1.18 Chronic wound reviews

We have recruited a chronic wound care lead nurse who has, to date, reviewed 128 patients with various types of wounds that have failed to heal over a prolonged period. Some of these patients have had their wounds for over two years. These reviews have focused on using health coaching principles whilst engaging with patients, carers and community nursing teams. This ensures that an appropriate diagnosis is made and that evidenced-based standards are put in place by guaranteeing effective role modelling in order to support community nurses develop the skills for ongoing assessments, reviews and management and prevention or reoccurrence of wounds in the future.

To date, 92 patients have now been reviewed at week 12, see graph 5.

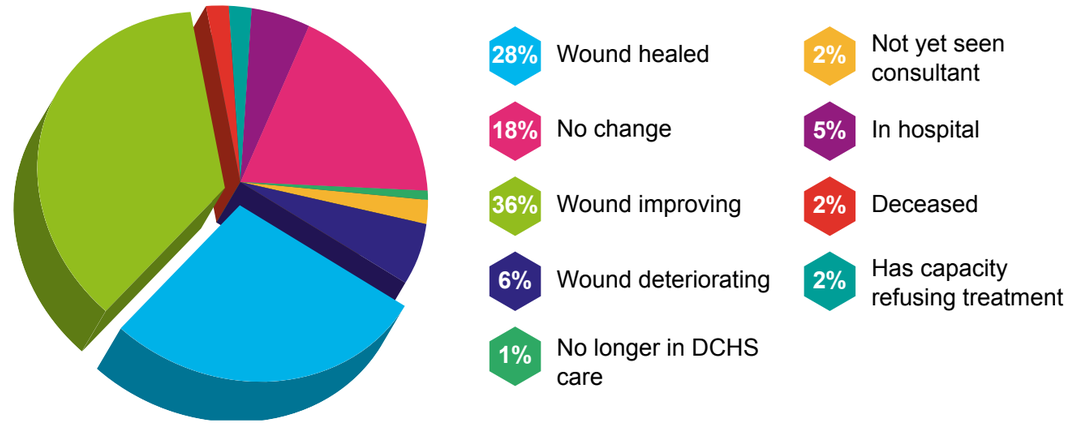
Graph 5: Outcomes on discharge of 92 patients following chronic wound review



In addition to the above, we have also recruited a lower limb lead specialist nurse and five leg ulcer champion secondment posts to support clinical nursing teams to develop competency and practical skills in relation to leg ulcer management. Using the same health coaching approach 399 patients have now been assessed by community nurses under supervision of leg ulcer specialists.

The following outcomes were identified in 289 of these patients who had reached the six week review stage, see graph 6. The outcomes demonstrate clear evidence that the leg ulcer specialist secondment posts are having a positive impact on patient outcomes in that 64% of wounds were described as healed or improved. In addition these specialist champions are facilitating sustained improvements by ensuring competency skills are embedded within community nursing teams.

Graph 6: Outcomes at six week review of 289 patients with leg ulcer wounds

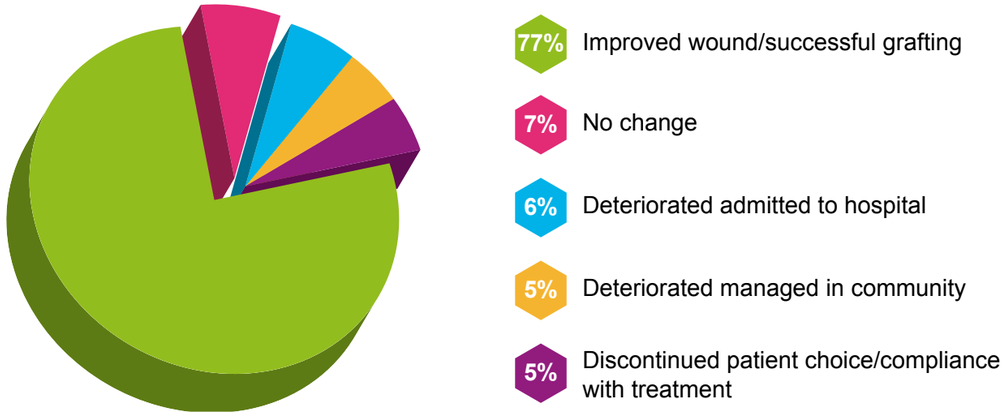


3.1.19 Negative pressure wound therapy (NPWT)

NPWT is used in the management of complex post-surgical wounds and complex chronic wounds that are not responding to conventional dressings. The evidence is that wounds treated with this therapy will heal two and a half times quicker than conventional therapy. However, there are increased risks to managing some patients in the community with this therapy because of challenges in maintaining the dressing without close supervision and difficulties maintaining staff competency as the majority of community nursing teams will only care for one or two of these types of patients over the course of the year. We have introduced a number of strategies to control risks to ensure safety of patients receiving this therapy.

During 2017/18 we have treated 101 patients with NPWT in the community of which 78 patients have had positive outcomes, in that their wound has either reduced in size, developed increased healthy tissue or become ready for grafting, see graph 7. Seven patients had no change due to unstable general condition. Five patients had therapy discontinued as patients struggled to tolerate the therapy and requested removal. Six patients deteriorated and required readmission to hospital due to infection and an additional five patients had an infection which was managed successfully in the community.

Graph 7: Outcomes of 101 patients receiving NPWT 2017



3.1.20 Diabetic foot ulcers

The effective management of diabetic foot ulcers is extremely important. Patients with diabetes can develop neuropathy of the feet causing lack of sensation and therefore may not notice where ulcers occur.

During this year the diabetic foot team have introduced a number of actions to improve care including the implementation of a foot protection service for preventing diabetic foot problems and the development of systems to monitor and report prevention outcomes in relation to the numbers of patients on low, medium and high risk pathways who progress through the risk classification over time. (MDFT evaluation framework - Derbyshire March 2018).

Utilising national best practice is fundamental to our practice and we actively contribute to the National Monitoring of Foot Ulcer Problems and have implemented the annual diabetic foot ulcer screening pathway - Putting Feet First.

In addition we implemented the Derbyshire diabetes pathway supported by the multidisciplinary team to ensure that professionals work together to achieve common goals, focusing on staying healthy and centred around patient preferences. We continue to raise awareness of appropriate referral pathway for assessment of active foot ulcers within our teams and primary care, through PLACE area training opportunities.

Ensuring that our patients are fully informed and engaged in their care is very important. During the year we have been engaging people at risk of developing diabetes at an early stage promoting a culture of self-responsibility for personal health management. Working with the patient experience team we have captured patient feedback to feed back into our patient care planning.

Our efforts to ensure service improvement has resulted in the introduction of a new TCC-EZ casting system service to effectively offload damaged areas so as to improve healing rates and the introduction of diabetes foot tele-health service new model of care system (Silhouette®) to help monitor wound outcomes and ensure MDT involvement without patients having to attend acute care.

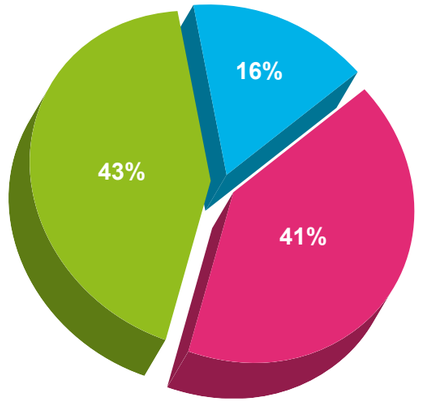
3.1.21 Pressure ulcers

Pressure ulcer prevention and management remains a major challenge in the community healthcare settings. There are a wide range of influencing factors which impact on our prevention strategy, including input from a variety of care teams across the health and social care community, patient choice and compliance, and the ability to monitor and supervise care delivered by other care providers in a home setting. In addition, we are seeing increased numbers of complex, frail, advanced aged and deteriorating patients being looked after closer to home. Complete avoidance of pressure ulcers is not always possible even when a patient is closely observed and well cared for as some patient factors can unfavourably affect health outcomes. This may include frail, elderly and end of life patients who are mostly commonly cited as being susceptible to unavoidable pressure ulcers.

Pressure ulcers reported by us in 2017/18

Graph 8 below provides a breakdown of all incidents of pressure damage reported by our staff. We are working with other healthcare providers to identify how the number of patients referred to our services with existing pressure damage can be reduced. We have recruited a clinical trainer and facilitator to help raise awareness with other healthcare providers, providing pressure ulcer prevention awareness training to practice nurses. This has also included collaborative work with other agencies including participation in the national prevalence measurement of quality of care (LPZ) project for local nursing homes, to help identify prevalence of pressure damage and nursing home staff's educational needs.

The majority of pressure damage reported within the Trust occurs in patients' own homes where there is less control over the patients' environment. Our community staff work closely with patients, carers, family members and other organisations to increase awareness of how to prevent pressure damage.

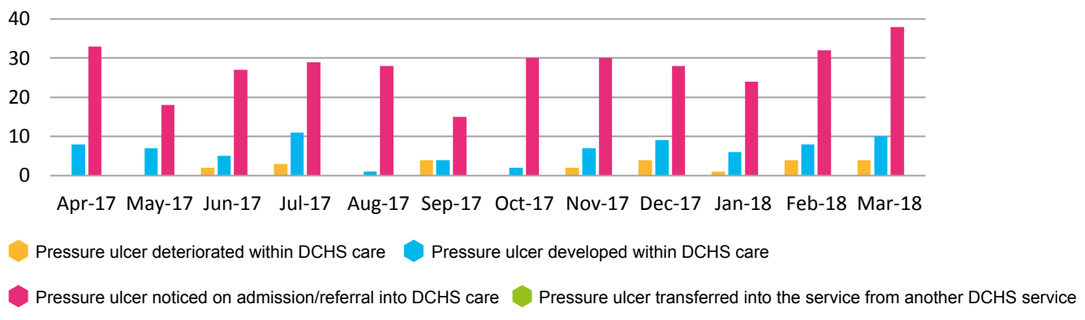


Graph 8: Percentage of total pressure ulcer incidents reported 2017/18

- Pressure ulcer deteriorated within DCHS care
- Pressure ulcer developed within DCHS care
- Pressure ulcer noticed on admission/referral into DCHS care

Graph 9 below demonstrates the incidence of pressure ulcers acquired or deteriorated within our community hospitals which remain small, however we are mindful that this is a controlled environment and ongoing work is required to continue to reduce this number even further.

Graph 9: Total number of pressure ulcers by community hospitals 2017/18



We recognise that there is still a significant amount of work to be undertaken in relation to prevention of pressure ulcers and will be focusing our efforts in the coming year on supporting our community clinical teams to utilise all the resources available to them to reduce the burden of pressure ulcers across our whole community.

- The introduction of a pressure ulcer prevention strategy, with associated key performance measures, will facilitate ongoing monitoring and implementation of actions to ensure progressive improvements in delivery of care
- Each locality to hold pressure ulcer improvement groups to share learning and initiatives of what really makes a difference to patient care to ensure improvements in care is sustained
- Development of our district nurses/clinical leads through the A Time To Heal leadership programme promoting holistic reviews and health coaching of patients on caseloads so that all aspects of care are proactively monitored.

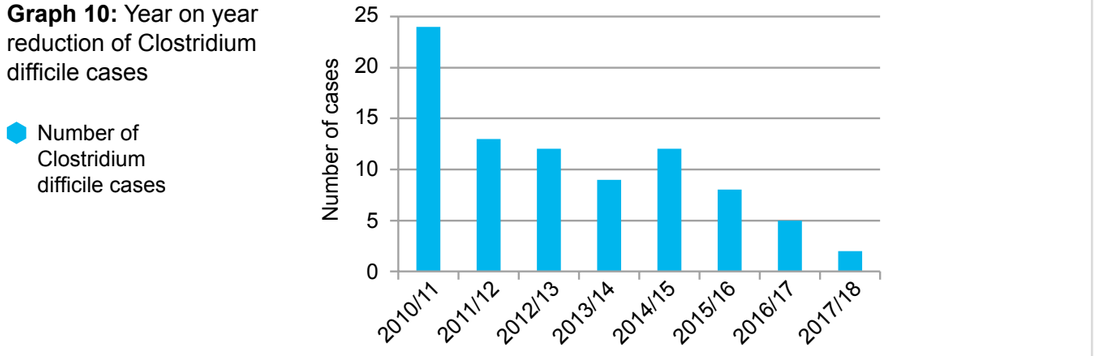
3.1.22 Infection prevention and control (IP&C)
Reducing the risk of infection and preventing cross infection continues to be an important aspect of our daily work in our hospitals and in the wider community. This year saw the addition of two infections to the national monitoring data i.e. Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia and e.coli bacteraemia. Once again we can report that our infection rates remain low, with only two cases of Clostridium difficile infection this year, (see graph 10 for our year on year reductions) and no blood stream infections (bacteraemia) reported.

We continue to audit effectiveness of hand hygiene; this audit checks that staff prevent cross infection to patients by appropriate hand washing. We have continued to audit hand washing across all our services, including community services. We have continued to report compliance above 99%. Reviews of hand hygiene and infection control practice is now an integral part of other organisational reviews such as the Quality Always programme, back to the floor visits, triangulation visits and reviews by the clinical practice facilitators. This has ensured that where poor practice is identified it is addressed at the time with additional support from the IP&C team.

Antibiotic prescribing audits completed by our antibiotic pharmacist have shown that our practices are very good and, in line with the prescribing guidelines, we only prescribe when we need to.

We have been working with the wider healthcare community to address the increasing number of patients who present at the acute hospitals with e.coli bacteraemia. We have reviewed a number of patients and identified that the majority are admitted from home as emergencies. The blood stream infection is often associated with a urine infection, chronic wound or biliary (gall bladder) problem. Clinical specialists have been working together to raise awareness of avoiding urine infections and effective wound management within community teams and ensuring that staff are aware of the early warning signs of sepsis. The teams are also working with the wider healthcare community to support a public campaign around avoiding or managing urine infections and when to ask for help. The number of cases of e.coli bacteraemia will continue to be monitored by the acute hospitals and it is anticipated that with the work above we should start to see a reduction in the number of incidents.

Graph 10: Year on year reduction of Clostridium difficile cases



3.1.23 Falls prevention assessment and care planning
Following the audit conducted during 2016/17 focussing on the assessment and care planning for patients who are at risk of falls, we have continued to build on the work this year. We have reviewed the falls documentation to ensure that it is easy for staff to complete and less time consuming whilst ensuring that the patient's individual needs can be identified.

Regular reviews of the documentation have been undertaken and we can say that we are very good at identifying those people in our service at risk of falls and identify what needs to be done, however we are not quite so good at making sure we record the fact that we have put these things in place. The falls prevention specialist has been working with clinicians to improve on this element. What we have found is that staff do implement the required falls prevention measures but do not always record it in the patient records. This element of the documentation has been changed so that it is easier for staff to complete. The new documentation is to be introduced in February 2018 so we are expecting to see an improvement in documentation standards after this date.

Wrist bands evaluation
The colour coded mobility wristbands which identify a patient's risk of falling continue to be used across inpatient services with the exception of learning disabilities and older people's mental health. An audit was conducted during 2016/17 which highlighted that the wristbands provided a visible indication of the patient's mobility needs especially for staff visiting the wards who may not be as aware of the patient's individual needs. The impact of the mobility bands on reducing falls was more difficult to ascertain as staff awareness of falls prevention strategies generally has increased over the same time period. The audit concluded that the colour coded mobility wristbands have a place within the suite of measures that can be used to prevent falls within our inpatient areas.

3.1.24 Falls management
A key component of the care that we provide is rehabilitation of elderly patients; with this there is a potential risk of patients falling which is always risk assessed and mitigated as far as possible.

This year we have been focussing on those patients who fall more than once within our care. We review all the falls incidents that are reported and we have identified that there are a high number of patients who fall more than once within our older people's mental health (OPMH) wards. This relates to the patient's ability to recognise that their behaviour and/or posture may be increasing their risk of falling or it may be that the patient 'forgets' that they have to use a walking aid now as they are not as independent as they used to be. The teams on the OPMH wards have utilised a number of different strategies to try to prevent their patients falling more than once. The most effective strategy is an increase in observation levels for those at high risk of repeat falls. Staff can anticipate when patients may be exhibiting high risk behaviour or prompt patients to use walking aids thus helping to reduce the risk of falls. Ensuring staff are visible can also have a calming and reassuring effect on the patients again reducing the risk of a fall. By adopting this approach we have seen a reduction in the number of patients who fall more than once. Where patients do fall, we see a reduction in the level of harm as staff are able to respond quickly to the situation.

This learning has been shared with the other inpatient areas that have patients with delirium which can present as confusion. By adopting 'Bay Watch' we have seen a reduction in the number of patients who fall more than once across all our wards.

This year we have focussed on the community elements of falls prevention, working alongside colleagues in social care, health and voluntary sectors across Derbyshire and Derby City. A falls prevention strategy has been developed and further work is taking place to bring together all the falls prevention services into one directory. This will enable staff to refer service users at risk of falls to appropriate services and to ensure that those people who do have a fall resulting in a fracture are able to receive the most appropriate care for them when they return home.

The falls prevention specialist has been working with the community teams to raise awareness of falls prevention strategies within the community setting. The development of integrated community teams that combine therapy and nursing elements will help to support this work. It is anticipated that the community teams will be able to provide exercises, home assessments and trigger medication reviews that will all help to reduce the risk of falls in the patient's own home.

This work will be ongoing for the next financial year and there will always be improvements that we can make. What we can say though is that our rate of falls within the inpatient wards has reduced, as has the number of patients who fall more than once.

3.1.25 Safeguarding service - stronger families, safer children

Safeguarding children, young people and adults from abuse and harm is everybody's business and is an important part of everyday healthcare practice and should be an integral part of patient care. We have a dedicated safeguarding team of nurses/health professionals and administration staff.

The team comprises of a head of safeguarding, supported by a lead named nurse safeguarding children (providing clinical leadership to the team and wider organisation, so fulfilling our statutory duties for safeguarding children) and a lead named nurse safeguarding adults (providing clinical leadership to the team). In addition there are eight named nurses for safeguarding a named professionals, a specialist safeguarding practitioner, a safeguarding co-ordinator and two safeguarding support officers. Each named nurse and professional covers a locality to support partnership working within the Trust and also with external agencies.

On call advice service

A named nurse for safeguarding children and adults is available to provide expert safeguarding advice between the hours of 09.00 and 17.00 hours, Monday to Friday.

The children's team will also provide advice to health care staff working with children and families in Derbyshire. This may include independent contractors e.g. GP practice staff. The named nurse for safeguarding children and adults will provide relevant information to support social care and police in child protection investigations and adult safeguarding concerns.

Although the safeguarding service is involved in many aspects of safeguarding children and vulnerable adults, our primary responsibilities are:

- Training
- Safeguarding supervision
- Providing advice and support.

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

Safeguarding training

Think Family is promoted through the training we provide to our staff. This ensures that professionals understand the vulnerabilities of patients, children and families and they are clear about their safeguarding reporting duty. Safeguarding children training is also delivered to staff that are identified as requiring additional core competencies, knowledge and skills.

We ensure that individuals are placed at the centre of any safeguarding concerns and their views are listened to. Attendance at training is reviewed on a monthly basis.

Providing advice

Both teams have shown a large increase in the number of advice calls over the past year which supports an increasing awareness amongst our staff and a more complex workload for our staff to manage.

Graph 11: Number of training sessions delivered per quarter 2017/18

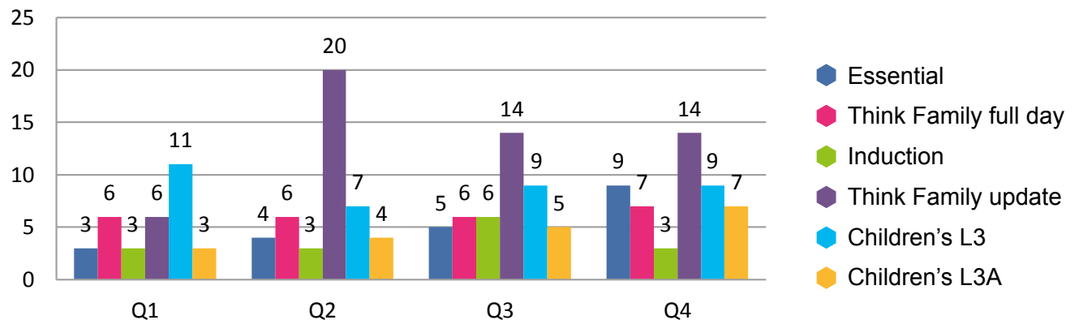


Table 15: Total advice calls for safeguarding adults

Advice Calls	Q1 16/17	17/18	Q2 16/17	17/18	Q3 16/17	17/18	Q4 16/17	17/18
1st Contact	162	313	205	335	191	592	194	417
Follow up	203	378	283	403	314	390	309	507
Total	365	691	488	738	505	983	503	924

Table 16: Total advice calls for safeguarding children

Advice calls	2015/16	2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Total 2017/18
1st contact	1688	2192	553	593	746	738	2630
Follow up	Not available	908	133	148	229	288	798

Prevent
There has been an increasing national focus on Prevent (Government's strategy to reduce the risk of radicalisation of vulnerable individuals). Particularly over the past year, terrorist attacks have highlighted the risk and threat that exists within local communities. The team have been mindful that Derby City is a Home Office identified priority area for Prevent. The team has continued to deliver the Home Office approved Workshop to Raise Awareness of Prevent (WRAP) training package as part of Level 2 safeguarding training to embed understanding of this as part of the safeguarding agenda.

Safeguarding supervision
Safeguarding supervision is recognised by the Trust as an important element within clinical supervision and the safety culture of the Trust and provides vital support for our staff working with complex cases.

In addition to an individual's knowledge, skills, experience and training, effective safeguarding practice relies on a professional's curiosity and vigilance. Safeguarding supervision provides an opportunity to both sustain and foster these qualities and ensure staff are updated on current safeguarding issues.

Safeguarding children supervision is a formal process of professional support and learning, which aims to ensure that clinical practice, promotes the child and young person's welfare. This is achieved by facilitating reflective discussion, assessment, planning and review, thereby supporting the development of good quality, innovative practice provided by safe, knowledgeable and accountable practitioners.

Table 17: Total number of safeguarding children supervision sessions delivered

Year	Q1	Q2	Q3	Q4	Total
16/17	216	194	179	207	796
17/18	235	237	211	167	850

Unlike children's safeguarding, there is no requirement to provide safeguarding supervision to staff caring for adults. However, it is recognised that specific services have a greater likelihood of encountering adults at risk, complex social circumstances and potential safeguarding concerns.

The provision of safeguarding adult's supervision has developed into a programme of regular sessions to services identified as high risk with one to one or group sessions provided at staff request in response to specific incidents and/or safeguarding concerns.

Sexual health staff and Minor Injury Unit (MIU) staff receive supervision at least six monthly from the safeguarding service; this is a joint supervision session attended by both a named nurse for children and adults. The sessions provide an opportunity to reflect upon current/ historic situations and also provide an opportunity to emphasise the Think Family approach for these services that see both adults and children as part of their daily work.

We have safeguarding governance arrangements in place and a safeguarding governance group is held alternate months. The meeting supports the organisation to meet its statutory responsibilities for both adults and children and enables information sharing in relation to learning. The meeting is attended by the designated nurse safeguarding children and a representative of the safeguarding adult team from the clinical commissioning groups.

As a member of Derbyshire Safeguarding Children's Board and Derbyshire and Derby City Safeguarding Adults Board the team deputises/ attend all meetings, aiming for 100% attendance. This includes the sub groups of the Boards.

The team contributes to a number of reports/ reviews to include domestic homicide reviews, serious case reviews, serious incident learning reviews, multi-agency learning reviews and safeguarding adults reviews.

3.1.26 Modern slavery statement
This statement is made pursuant to Section 54 of the Modern Slavery Act (2015) and sets out the steps that we have taken and will continue to take to ensure that modern slavery or human trafficking is not taking place within this organisation or those we are affiliated to.

Modern slavery encompasses slavery, servitude, human trafficking, forced labour, sexual exploitation and forced criminality. We have a zero tolerance to any form of abuse and thus modern slavery is incorporated within both children and adults safeguarding work streams.

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

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

We are responsible for providing a range of health services for people living in Derby City and Derbyshire. The care we provide is monitored by the CCGs across the area through regular compliance visits and processes to ensure that we are compliant with the Modern Slavery Act (2015).

3.2 Ensuring services are clinically effective

As well as our developing clinical audit programme we continue to develop mechanisms for improving and evaluating the effectiveness of care of patients. This section provides examples of how we have achieved this across our range of services.

3.2.1 Schwartz rounds

We have run monthly Schwartz rounds since October 2016. The rounds were developed by the Schwartz Centre in the USA and have been implemented in over 120 organisations in the UK. Schwartz rounds provide a structured, confidential, one-hour forum for staff from all disciplines to discuss difficult emotional and social issues that arise in caring for patients. The purpose of the rounds is not to solve problems, but to explore the human and emotional aspects of the experience of delivering care and the challenges that staff face from day to day. Rounds can help staff feel more supported in their jobs, to give them the time and space to reflect on their roles which they might not otherwise have in their everyday routines on busy hospital wards.

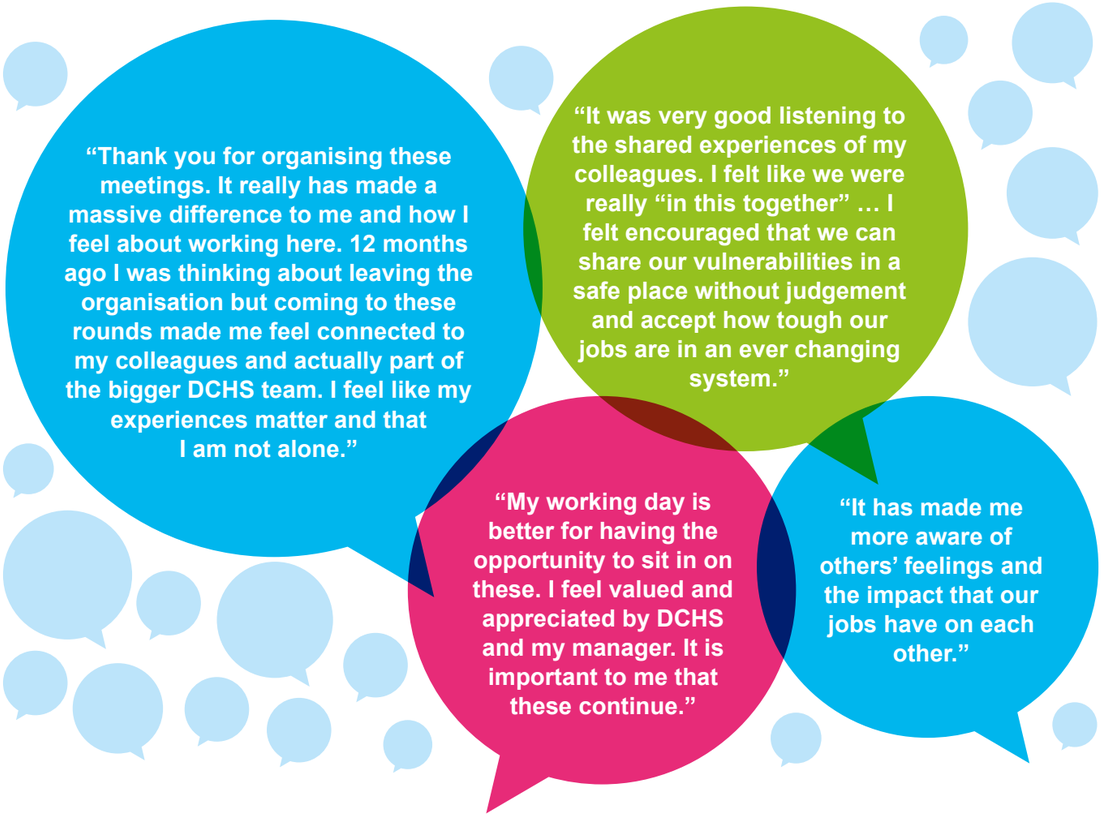
The rounds provide an opportunity for staff to reflect on the emotional impact of the work they undertake in confidence. We know that staff experience and patient experience are closely related. It is vital that we look after the emotional wellbeing of our staff to equip them to continue in the work they undertake. Schwartz rounds are one of the many ways that this Trust supports the wellbeing of our staff.

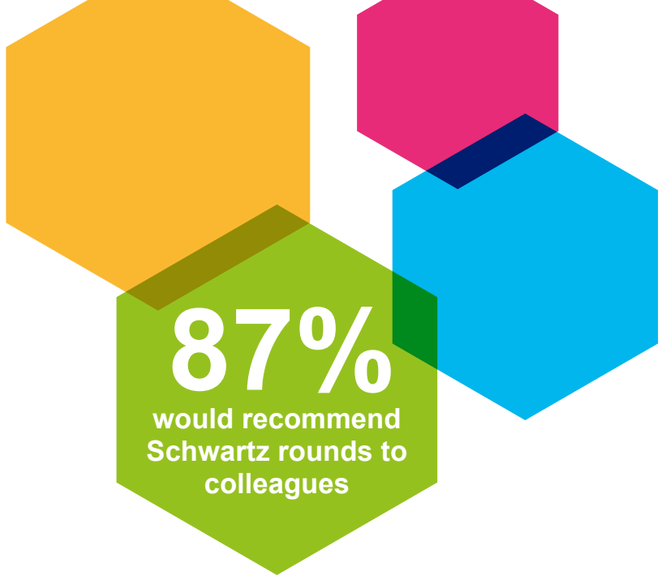
A study (pending publication) showed that:

- Staff who regularly attend rounds suffer less stress than their colleagues who do not attend
- Staff who attend rounds report increased empathy and compassion for patients and families
- Staff who attend rounds report better relationships with colleagues and report changes in hospital culture and practice.

Traditionally Schwartz rounds have been run in acute hospitals. Based on our first year of delivering Schwartz rounds in different locations, we won a Point of Care Foundation prize for innovation, our prize winning poster appears opposite.

Some of the comments from staff who had attended a round are shown below:





We ask all those attending rounds for feedback and in a survey of those who had attended 87% of those who responded agreed with the statement that "I would recommend Schwartz rounds to colleagues."

In 2018/19 we will continue to run Schwartz rounds and our focus is on making it easier for more colleagues to attend a round.


NHS
Derbyshire Community Health Services
NHS Foundation Trust

SR

REACHING OUT..
RUNNING SCHWARTZ ROUNDS ACROSS A LARGE RURAL COMMUNITY TRUST

Who we are and the challenges we face?

What we are doing from here

What staff have to say about their experience of Schwartz Rounds

What we are doing from here

Tracy Allen
Chief executive

3.2.2 Patient related outcome measures

This year we have focused on raising the profile of patient related outcome measures across our services. Patient related outcome measures enable clinicians and patients to assess the impact of the health care that has been provided and may include reviewing agreed goals, measuring function or completing a patient questionnaire. Patient related outcome measures ensure that we review the quality of our services and share best practice. We have developed a patient related outcome measures database to capture this information and are currently working with our informatics team to incorporate this information into the quality dashboard so leaders of our services can see the results of their patient related outcome measures easily and use this to inform practice or celebrate success.

3.2.3 Clinical Effectiveness Showcase

We held our annual Clinical Effectiveness Showcase on 26 September 2017. The theme this year was 'More than just a patient' focusing on the personalisation of care. The day was attended by 63 people from across the Trust. There were two keynote speakers: Stephen Reid, person centred approaches coordinator from Wellbeing Erewash/ Southern Derbyshire Clinical Commissioning Group and Darryl Thompson, deputy director of nursing and quality governance, Derbyshire Healthcare NHS Foundation Trust, delivered a presentation on 'Utilising the lived experience in staff training'. 12 of our clinicians presented and held workshops sharing the journey they have been on to use clinical effectiveness techniques to improve the patients' experience and support patients to achieve what matters to them. Themes included: personalisation of care, an exploration of how we motivate patients for best outcomes in diabetic foot care and a patient's journey on the LD dementia pathway. The day evaluated very positively, some of the comments received included:

- Good. Inspiring stories about person centred care across a wide variety of DCHS services
- Inspiring speakers with some instantly transferrable approaches
- Beautifully organised, great content
- Hearing from all levels of the organisation and good practice. Giving a voice to people who are not always heard. Time out of day job to 'think'.

Planning is underway for the 2018 showcase.

3.2.4 Research and innovation strategy implementation

During 2017/18, we have continued to develop our research capacity and capability. This year has seen us strengthen our research governance processes in recognition that good governance of health research is the foundation that will provide our participants as well as the organisation's leaders with assurance that the research we offer and take part in is of high quality, safe and ethical. We have raised awareness of research governance within the organisation and moved to the provision of a local in-house support service for all internal and external researchers wishing to undertake research at the Trust. This has helped to improve the visibility of our local research team who are offering an accessible support and advisory service closer to our front-line clinical staff.

The implementation of clinical leads as research champions extended members of the research team and has also resulted in research and innovation increasingly becoming an integral part of the routine operational delivery agenda this year. These research champion roles have been critical to embedding research at the core of front-line services.

Our research champions have led the way in developing our clinical research capacity and capability, successfully publishing their experience to a wide audience and securing externally funded development opportunities. Successes have included:

- A successful application for a National Institute for Health Research/Health Education England funded place on the Masters in Research Methods programme at Nottingham University
- Our research champion from health, wellbeing and inclusion has been awarded a Silver Clinical Scholar award (funded by Health Education East Midlands) for the development of their doctoral fellowship application with the University of Nottingham
- Our planned care research champion began the year with a publication of their experience as the local principal investigator for the National Institute for Health Research (NIHR) funded project called Big CACTUS. This was led by the University of Sheffield across 19 other NHS trusts in the UK. It is a multicentre, randomised controlled trial evaluating the clinical and cost effectiveness of computer therapy for people with aphasia post stroke. (*Palmer, R & Witts, H (2017). The benefits of involvement in research for clinicians. RCSLT Bulletin, January issue, page 23. Available at: www.org./docs/bulletin/2017/Jan_bulletin_pdf*)

This year we have also been working towards increasing our involvement in research in our ambition to become a more research active organisation so that our staff and patients have improved choices to participate in and benefit from research opportunities. As a result we have successfully increased the number of participants who consented to take part in a research study this year to 151. This is 107 (243%) more people taking part in clinical research compared to last year's 44 participants.

The research and innovation strategy identified clinical priorities for our research and innovation portfolio and as such we have taken part in a wide variety of studies which align with our clinical priorities:

1. Developing a public health ethos: focus on 'Healthcare Public Health'

- PrEP Impact Trial: a pragmatic health technology assessment of PrEP and implementation
- Two year plus follow up of Live Life Better.

2. Frailty: dementia, living well, bone protection, long term conditions, tissue viability

- Scaling the Peaks; Understanding the barriers and drivers to providing and using dementia friendly community services in rural areas: the impact of location, cultures and communities in the Peak District National Park on sustaining service innovations
- FinCH (Falls in Care Homes)
- Comprehensive Geriatric Assessment in Primary Care: a feasibility randomised control trial
- The influence of socio-demographic characteristics on the preferred format of patient education delivery in individuals with Type 2 Diabetes Mellitus and Cardiovascular disease: a questionnaire study.

Another area of development in research this year has focused on building and strengthening our strategic partnerships with research networks, universities and other NHS providers.

- We have worked closely with the East Midlands Clinical Research Network to support our clinical research delivery and developments
- Locally we have participated regularly at the Derbyshire Clinical Commissioning Group Research Forum ensuring a joined up Derbyshire wide research perspective particularly as the Derbyshire Sustainability and Transformation Plans develop
- We have commenced early discussions with the University of Derby's Health and Social Care Research Centre which is the dedicated research centre for the College of Health and Social Care
- A Collaboration for Mental Health Research and Teaching has been facilitated by the Mental Health Research Unit of the School of Health and Related Research (SchARR) of the University of Sheffield
- Led by the Birmingham Community Healthcare NHS Foundation Trust and supported by the West Midlands Clinical Research Network, we joined the first meeting of other community healthcare organisations to explore and develop a new community network: CHART – Community Healthcare Alliance of Research Trusts.

Our strategy is to develop research competencies in front line service staff so that research increasingly becomes seen as a core clinical competency essential for the improvement of the quality of service and experience of our patients and carers. This year in response to an identified need to develop specific clinical research skills and experience such as those required for principal investigator roles and other supporting clinical research team roles, we have been working with the East Midlands clinical research workforce development team to offer a tailored learning and development programme to upskill our clinicians and boost our capacity and capability to deliver clinical research in 2018/19.

During the year we identified that we have many talented clinicians across a wide range of professional groups who are leading and collaborating in research, service evaluations and innovations. The 18 publications in peer reviewed journals over January 2016 to January 2018 suggest a supportive research culture at the Trust. As such there is already a growing internal network of potential mentors for others wishing to undertake research and publish their work.

We are ending the year looking forward to understanding the results of a research staff survey which we developed and distributed across the organisation to engage and consult with our colleagues. We will listen to what people tell us through the survey and develop a responsive implementation plan to further deliver our research strategy in 2018/19.

3.2.5 Medicines management

The role of the medicines management team is to provide advice and support in the clinical, cost-effective and safe use of medicines to ensure patients get the maximum benefit from the medicines they need, while at the same time minimising harm. Medicines are the most common intervention for the prevention and treatment of illness and conditions and biggest cost after staff in healthcare. Getting the most from medicines for both patients and the NHS is becoming increasingly important as more people are taking more medicines.

Safe
During 2017/18 electronic prescribing was rolled out to all inpatient wards. This involved pharmacy staff converting prescriptions to the electronic system as well as training and supporting ward staff with the new prescribing system. Electronic prescribing is recognised as offering important safety benefits over paper based systems including legibility of prescription, dosing guidance and contra-indication and interaction alerts. As such its introduction is a significant achievement.

The medicines management team continued to provide twice weekly clinical pharmacy ward visits by both pharmacists and senior technicians, completing medicine reconciliation, screening prescriptions for safety and effectiveness as well as offering support and advice to staff prescribing and administering medicines at the point of care.

There are approximately 150 qualified V300 non-medical prescribers (NMP) working in our community and inpatient settings. The V300 NMPs are mainly nurses but also include physiotherapists, podiatrists and health visitors. During 2017/18 we introduced a new process for supporting the NMPs. This involved developing and delivering an interactive training event which is described in detail in section 3.2.6.

Learning from medication incidents is key to ensuring safe medicine practice. We review all reported medication incidents and reflect on learning. One example from 2017 related to storage of high risk medicines in patients' homes and involved adopting best practice from hospital settings to the patient's home to reduce risk of patients or their carers selecting the wrong strength of injection and also adjusting training of health care staff to this practice and sharing with other organisations.

Effective
The medication and optimisation safety team (MOST) met nine times during 207/18 and developed and approved six new guideline/ procedures/drugs and updated eighteen. New procedures included introduction of pre-filled infuser devices which enable patients to receive a range of intravenous antibiotic treatments in their own homes and so helps with quicker discharge from hospital. Other new developments included the introduction of Sayana Press which allows patients to self-administer long acting contraceptive injections which improves convenience for patients and reduces attendance in sexual health services and also the introduction of botulium surgical management for anal fissures which avoids the need for patients to attend the acute hospitals for this treatment.

In 2017/18 the medicine management team undertook an extensive audit programme including quarterly audits on standards of controlled drug storage and recording, omitted doses, medication storage (Duthie) and antibiotic prescribing. Where necessary an action plan was agreed to address any shortfalls and these were reported to MOST.

The medicine management team leads on the management of patient group directions (PGDs). PGDs enable defined and trained health care staff to administer or supply medicines to patients who meet specific criteria, for example a course of antibiotics to treat cellulitis or prescription only analgesic for pain relief following a trauma or surgery. These are essential in the current provision of many front-line services including MIU, sexual health services and podiatric surgery. In 2017/18 we reviewed and updated 47, archived five and developed four new PGDs. It is envisaged that the reliance on PGDs will diminish over time with the training of more NMPs.

Caring and responsive
The medicines management team work with ward inpatients to help prepare them for discharge. We counsel patients on their medication and produce individualised medication reminder prompt charts and tailor drug regimens to suit each patient's needs and manual dexterity. We regular contact community pharmacies and patients' carers to keep them informed of medication changes on discharge and to help aid a smooth transfer back into the community.

Well-led
We play an active role in the Derbyshire Joint Area Prescribing Committee and are one of the quorate members. We help review policies in response to NICE guidelines and implement pan-Derbyshire prescribing decisions to help best manage resources. In 2017 we reviewed the choice of emollients and moisturisers available as stock and revised stock lists to reflect the most cost effective formulary options. On inpatient wards in the north this should save approximately £6,000 pa. Review of NICE guidance has also enabled us to develop a role for non-registered staff to administer medicines to patients in the community.

3.2.6 Non medical prescribing (NMP)
In 2016 the 360 audit report on NMP identified significant shortfalls in governance and assurance for non-medical prescribing in the Trust. These included an absence of an up to date register of NMPs and a shortfall in supervision of prescribing and prescribing support. In addition the Care Quality Commission (CQC) report 2016 noted a failure in recording FP10 prescription serial numbers. As part of the work to address and mitigate these concerns and to give assurance the new head of medicines management designed, organised and introduced a NMP (V300) prescribing review.

The first NMP annual review events were held over six weeks at the Strutts Centre, Belper. A total of 96% (149 out of 156) registered NMPs attended the event from a range of staff including, ACPs, community matrons, health visitors, community nurses, heart failure nurses, physiotherapists and podiatric surgeons.

The review process included:

- Completion of a pro-forma relating to individual prescribing practice
- 1:1 meeting with an experienced doctor, pharmacist prescriber or other senior pharmacist
- 60 minute workshop/presentation covering, reflection, evidence based medicine, FP10 security and prescribing/de-prescribing scenarios.

Pharmacy staff were on hand to provide prescribing advice and support and to guide delegates to information stands, interactive computer programmes and provide resources to take away e.g. antibiotic guardianship, Stopp Start App, plus a list of useful prescriber websites.

Feedback on the event was received from 86% (129) delegates and was overall very positive. All of the delegates thought the event very productive and enjoyed the interaction and learning with other delegates.

Delegates were issued a certificate of attendance, with a copy of actions to follow. Discussions are currently taking place with the training and education team on adding the annual review as a mandatory event on ESR for NMPs.

Individual one to ones
These provided an opportunity to review the delegate's prescribing with the delegate, considering both Derbyshire medicines management formulary and guidelines as well as the delegate's professional registration and scope of practice. A standard pro-forma was completed by the mentor/supervisors to ensure consistency and a copy of the event recorded. The aim was to provide advice, support and guidance. Some areas for improvement were highlighted. Mostly these related to changes in formulary and best current practice guidelines, also gaps in knowledge and practice were identified including prescribing legislation.

Presentation
An interactive presentation/workshop covered general tips for safe prescribing, highlighting internet sources for prescribing advice including Derbyshire medicine management traffic light list, managing abnormal test results, reporting adverse reactions, managing lost FP10 pads, the role of pharmaceutical representatives and workshops based on dilemmas i.e. prescribing for friends and colleagues, repeat prescribing etc.

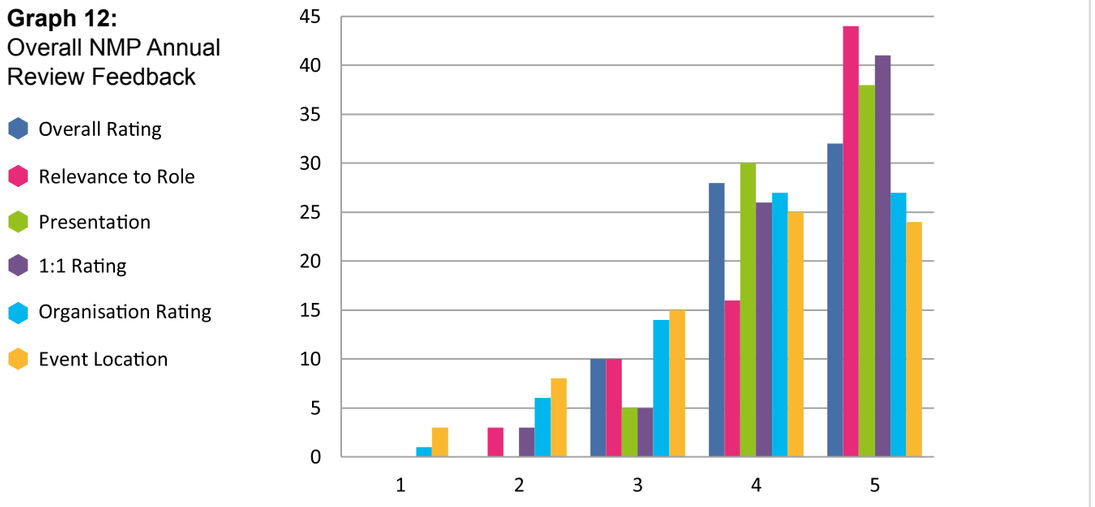
Feedback
86% ranked the event good or very good (score 4 or 5) and 14% ranked the event average (score 3).
Feedback comments included:

- Excellent opportunity to review practice
- Very informative, excellent session, update was needed, gained confidence
- Useful contact details obtained and good to network with other NMPs
- Very useful day. Feel reassured that on the whole I am following the NMP role according to guidelines
- Really enjoyed the afternoon and feel it will continue to keep me updated and improve my prescribing
- Individual review good
- Very helpful with future CPD
- It seems more supportive of prescribers than in the past. Lots of feedback and information available
- Think NMP prescribing review yearly is necessary. Good to receive our EPACT data.

One delegate noted this was the first time anyone had sat down with him to discuss his prescribing practice in the 12 years he has been working for the Trust as an independent NMP
Request for more CPD events

The presentation and one to one session both ranked highly at 93% and 89% respectively as good or very good (score 4 or 5).

Graph 12: Overall NMP Annual Review Feedback



Forward plan
Discussions are underway to enable organisers to record the event on ESR and to repeat the event annually. A copy of each delegate's 1:1 is to be scanned and emailed to them in order to remind delegates of advice and potential CPD. A similar event is planned for the 300 community nurse formulary prescribers (V100/150) in June.

3.2.7 Patient led assessments of the care environment (PLACE)
PLACE is a system for assessing the quality of the care environment and involves local people and Council of Governor representatives working alongside Trust staff in assessing the quality of patient areas across a range of criteria including privacy and dignity, food cleanliness and general building maintenance. For the first time this year the assessments have included meeting the needs of patients with a disability.

The percentage scores for each category shown in table 18 below have been awarded by the NHS Information Centre based on the information returned by us for our 2017 assessments. All assessments were delivered through self-assessment. The programme was undertaken between March and June 2017.

Table 18: PLACE scores 2015-2017

Hospital	Cleanliness			Food			Privacy and dignity		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Ash Green	100	100	100	93.62	96.72	95.44	96.77	91.51	93.86
Babington	99.79	100	99.70	94.79	98.96	96.13	90.45	86.41	92.5
Bolsover	99.18	100	100	87.79	96.13	96.40	86.16	83.91	84.18
Cavendish	100	99.87	100	96.97	96.6	93.49	87.81	85.9	92.24
Clay Cross	98.83	98.42	99.28	96.93	90.70	94.21	71.35	76.27	82.75
Ilkeston	99.15	99.01	99.59	97.23	99.09	94.95	81.40	76.41	91.79
Newholme	100	99.80	99.91	97.16	97.9	96.38	83.12	84.22	78.85
Ripley	100	100	100	93.66	96.56	94.47	92.71	94.39	91.04
St Oswald's	99.61	98.24	96.92	97.21	98.31	96.10	92.19	84.57	93.75
Walton	99.86	100	99.81	83.51	95.87	95.98	89.68	91.82	89.72
Whitworth	100	100	99.85	97.36	97.03	94.69	90.19	84.55	83.49

Hospital	Condition and maintenance			Dementia			Disability		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Ash Green	94.85	98.05	98.10	73.48	82.36	82.60	*	92.90	87.75
Babington	91.96	98.64	96.57	78.68	82.21	73.57	*	92.02	87.06
Bolsover	96.64	97.32	98.99	82.92	86.61	80.37	*	93.46	88.48
Cavendish	94.49	98.0	98.54	80.78	77.57	82.73	*	85.55	91.84
Clay Cross	92.65	99.01	95.40	72.80	79.7	83.96	*	94.05	96.69
Ilkeston	89.88	93.84	98.06	74.31	76.46	81.99	*	83.08	91.09
Newholme	94.44	94.57	94.63	81.77	83.24	69.38	*	81.38	78.13
Ripley	96.09	98.83	99.25	79.93	79.76	85.76	*	85.75	95.25
St Oswald's	100	99.36	98.26	80.16	79.72	90.24	*	90.69	94.52
Walton	95.45	99.82	97.89	85.67	86.66	85.59	*	91.0	91.93
Whitworth	97.06	100	98.99	86.60	82.64	84.14	*	84.85	94.24

Some of the elements we look for under disability within the PLACE assessment include:

- Are there handrails in corridors?
- Is there at least one toilet big enough to allow space for a wheelchair and carer?
- Where there are steps to the reception area, is there a ramp to assist those with mobility difficulties?
- Is there space in reception areas for wheelchairs?
- Is there a hearing loop at the reception desk?
- Where appropriate, have kerbs been adapted to facilitate wheelchair access?
- Are spaces for disabled users appropriately located closest to the building entrances?
- Is there an audible/verbal appointment alert system for the visually impaired?
- Is there a visual appointment system for the hearing impaired?

The overall scores for our hospitals were very favourable, as indicated in table 19.

Table 19: PLACE national average scores

Derbyshire Community Health Services NHS Foundation Trust	Cleanliness	Food	Privacy and dignity	Condition and maintenance	Dementia	Disability
2017	99.51%	95.29%	88.63%	97.66%	81.59%	90.57%
2016	99.57%	96.65%	84.81%	97.81%	81.47%	88.36%
2015	99.67%	94.13%	87.43%	94.86%	79.73%	Not reported on
National average score 2017	98.4%	89.7%	83.7%	94.0%	76.7%	82.6%

Data source PLACE audit results

Dementia not reported in 2014; Disability not reported in 2015, new for 2016

Some issues that have been identified at various sites during the PLACE audits and require ongoing works are:

- No contrasting fittings in main bathroom
- Repaint hand rails in corridors as they are not contrasted against the wall colour
- Drain covers made of bricks, trip hazard identified, to be replaced
- Taps identified as not being dementia friendly
- Alarm bell cord broken
- Walls requiring redecoration
- Yellow lineage in car park needs relining
- Garden to rear of unit requires attention not suitable for patient use.

An estates action plan has been prepared which is monitored and updated on a regular basis and some items are monitored through contract review meetings.

3.3 Caring - what have we done to improve patient experience?

3.3.1 Patient engagement and experience

We measure and monitor people's experiences in lots of different ways to help us improve services. This includes general feedback, complaints, concerns, compliments, the NHS Friends and Family Test (FFT), surveys and online sources such as NHS Choices and Care Opinion (previously known as Patient Opinion) as well as social media. We have also heard many patient and carer stories this year.

Listening to patient, carer and relative voices

"My stepfather had a stay there following illness. Superb in every way, helping him and other elderly people return to the community wherever possible."

"Each and every one of the staff do a good job and support patients in every way. If I needed help, I got it."

"As our GP is closed on Saturdays we attended the MIU Dressings Clinic this afternoon, where my husband received excellent care from the nurses when they changed the dressings on some nasty scalds. They were kind, compassionate and very professional. The MIU is a brilliant asset for Ripley. We are most grateful."

"From arriving to going home the care and consideration I received was wonderful. Also, the hospital is spotlessly clean. Thank you all very much."

"They are very good; I am a diabetic so I have to come here to the eye clinic and podiatry. I make my own appointments and I never have any issues. I feel well cared for and I do come here quite regularly."

"Very professional, helpful and good advice which was much appreciated and very nice, I was made to feel at ease."

"I would like to praise all the staff on these units who do a fantastic job under certain circumstances. I don't think many people realise how much you all do throughout your daily shifts."

"The therapist has gone above and beyond to help our son; she has visited us at home and at school. Thank you."

Did you know? 98% of people would recommend our services to their friends or family if they needed similar care or treatment. *(*FFT results 2017/18)*

3.3.2. GP Patient Survey results
The General Practice (GP) Patient Survey is an independent survey that is sent out to over a million people across the United Kingdom. The results show how people feel about their local GP. Our three general practices (Castle Street Medical Centre, Creswell and Langwith Medical Centre and Ripley) had fair return rates to the survey based on their patient list sizes. The total average return rate was 42%.

The results showed that all general practices scored higher than local and national averages in the following areas:

- People find telephoning the practice easy
- People felt the GP they saw or spoke to was good and gave them enough time
- Castle Street Medical Centre has also shown significant improvement across 80% of the questions, performing 8% higher than local and national averages, which is a great achievement.

The following areas of improvement will be a focus in 2018/19:

- Promoting the good work across all general practices to improve public perceptions and overall reputation
- To continue to improve accessibility to appointments and to reduce waiting times
- Improving patient involvement so people feel they have a choice in decisions about the care and treatment
- Improving systems to monitor patient feedback and opportunities to learn.

Quality Outcomes Framework (QOF)
The Quality and Outcomes Framework (**QOF**) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is a set of 77 quality indicators which indicate how well practices look after people, particularly those with long term conditions such as heart or lung disease. All of our practices have improved their scores during the last year as illustrated below.

Table 20: QOF results 2017 and 2018

Practice	Points	Percentage 2017	Percentage 2018
Castle St	534.5	91%	98%
Ripley	542.5	98%	99.5%
Creswell	540.5	96%	99.2%
Service aggregate is 98.9%			

3.4 Ensuring our services are responsive to patients' needs

We are continually reviewing the provision of services to understand how we can ensure that our services are responsive to the needs of our patients, and patient stories enable us to do this.

3.4.1 Patient stories
Patient stories provide a very powerful and human account of the way that the care we deliver impacts on individual people, carers and families. Every meeting of our Trust Board, QSC, Council of Governors and patient experience and engagement group starts with a story. The stories are either told by a member of staff or by a person who used our services. We aim to hear about the positive impact of our services (for example a patient who was supported during their gender transition) as well as where improvements are needed to be made (for example where our services identified improvements in the way we manage and care for pressure ulcers).

Members of the Board or committee that hear the story are often challenged and moved by what they hear, lessons are identified and actions agreed.

The telling of the story at the start of the meeting sets the tone for the remainder of the agenda, 'putting the patient in the room', and ensuring that the patient is at the centre of everything we do. Our Quality People Committee (QPC) also presents a staff story at the start of each of their meetings. These stories help us to better understand the issues and challenges our staff face and how we can support them and become a better employer.

3.4.2 Volunteers
We continue to work closely with a number of community and voluntary organisations.

We are partnering with Derby City Chaplaincy with the aim of providing pastoral support in each of our integrated community teams. Volunteers are carefully selected and trained as chaplains, and introduced to community teams. Members of the team, or the care coordinator, can refer any patient who will benefit from some individual support, for example at the point of bereavement or on receipt of a new diagnosis. Initially this service is available in the Belper area, with plans to extend it to localities across Derby and Derbyshire in the future.

3.4.3 Carers
Our Charitable Funds Committee made a significant investment in improving the support available for carers this year. As a result, the Family Centred Care Project was launched to build stronger community links with carer groups, to gain insight into carers' experiences and to enhance the resources available to better support carers who access our services.

2,028 carers have come into contact with a health professional in the last year. We have sustainable systems in place to record their information and signpost them for appropriate support.
We also had an extremely successful carers week, speaking to over 600 people in our local involvement events.

3.4.4 The Friends and Family Test (FFT)

The FFT is an important feedback tool that asks a patient "How likely are you to recommend our (ward/service) to friends and family if they needed similar care or treatment?" on a scale from extremely likely to extremely unlikely. The FFT helps us to identify good and poor patient experiences.

Throughout the year we have monitored responses to the FFT and the reasons why people have given higher or lower scores. We follow the national guidance for undertaking and scoring of the FFT results and report on our performance monthly so that we can benchmark our results.

The FFT feedback has been overwhelmingly positive with comments describing high quality services, compassionate and empathetic staff as well as satisfactory overall patient experiences where often expectations are exceeded.

29,139 patients completed the FFT April 2017 – March 2018, (a 23% increase from last year, and 25,378 cards). We also continue to perform well above the local and national FFT results.

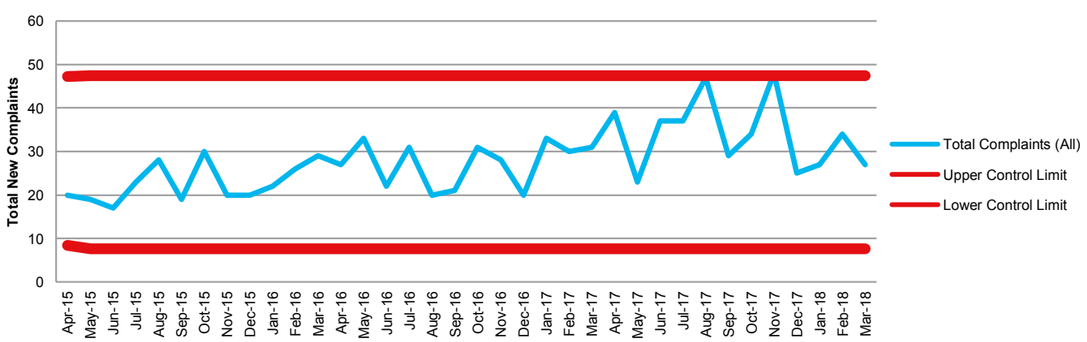
Whilst the overall feedback given is positive about the care provide to patients, their relatives and carers, we also often get suggestions for improvement. Most typically this has related to improving communication, extending service opening times, reducing waiting times and making some service environments more comfortable (e.g. with better seating and refreshments).

3.4.5 Complaints and concerns

We know that sometimes people's experiences may be poorer than expected. This can be as a result of many different factors. It is important for us to hear about people's experiences, so that we have the opportunity to find out what happened and to put things right if needed. We have complaints handling processes to ensure that patients, relatives and carers have the opportunity to tell us about their care and treatment and to let us know when things go wrong. Listening and learning from complaints is very important to us. We make every effort to ensure the complaints process is accessible to all. Complaints can be made by telephone, email, through our website, in writing or in person. Leaflets are available throughout our services describing the process, contact details and support available. When we are contacted by someone who needs help with their complaint, we provide clear contact details for the local NHS complaints advocacy services, which can provide support and make the complaint on a person's behalf. Complaint response letters can be provided in different formats to accommodate needs, for example large fonts and alternative languages.

During 2017/18 a total of 406 complaints (all types) were received; this is a 38% increase compared to the previous year. We have seen a significant increase in type 1 complaints, which do not require a full investigation and these concerns are resolved very quickly.

Graph 13: Complaints activity 2015-18



Graph 13, above, shows an upward trend in the overall complaints activity over time. The number of type 2 complaints received, i.e. those which are investigated (under NHS regulations) has also increased from 101 in 2016/17 to 152 (2017/18).

We have monitored the increase in complaints throughout the year and we have concluded that the reason for this has been a result of some of the internal changes we have made to our complaints reporting systems as well as greater awareness of how to raise concerns as a result of our marketing and publicity efforts.

Subject of complaints

The main reason for complaints has usually been a result of poor communication. We are trying to address this through greater awareness and staff training around 'words matter' and improving the patient experience. On review of patient experience data year to date the following four areas have shown to be the most important to people when sharing their concerns. We will continue to monitor these areas to identify any specific learning for individual teams.

- Values and behaviours
- Clinical treatment
- Communications
- Appointments.

We have responded to 84% of complaints in fewer than 40 working days, which is a 12% improvement from the previous year where we responded to 72% of complaints within this timescale.

3.4.6 Listening into Action - complaints review panel

We completed an internal review of complaints to determine whether we are meeting expectations of raising concerns, as set out by the Parliamentary and Health Service Ombudsman (PHSO). We used the PHSO best practice criteria ('I statements') to gain insights into each stage of the complaints journey, from making the complaint through to getting a response. People who made complaints were also invited to share their experiences as part of the review.

The review found:

- Overall complaints handling across the Trust is good and well reflects our ambitions to 'Listen, Act, Respond and Learn' (complaints and concerns policy)
- Improvements in the quality of complaint investigations. However there are opportunities to improve investigation methodologies and for better evidence to be reviewed. We are addressing this through Trust wide investigation training.
- Most response letters give a sincere apology, clear explanations, and no jargon, but we recognise this needs to be more consistent. We have introduced new internal quality standards and checks to achieve this.
- There are opportunities to improve our systems for evidencing learning to prevent similar situations from happening again. This will be an area of focus in 2018/19.

This year we have seen further improvements in complaints investigations and we have set the bar even higher than before around the quality of reviews undertaken by multi-disciplinary investigation teams. We have also participated in the national NHS England Complaint Satisfaction Survey Pilot. The survey was sent to 127 people and 27% of people who complained completed the survey.

3.4.7 Lessons Learned Panel

When something significant happens (whether negative or positive) we need to share the learning. One of the challenges is how we share local learning effectively across such a large and diverse organisation.

The Lessons learned Panel meets to identify how key local learning from internal events, including incidents, coroner's inquests, complaints and claims, and external sources i.e. national reports and research will be disseminated in order to improve the quality of our services. The agenda for the panel is driven by reporting from those sources.

We are committed to ensuring learning happens in local teams where the event or incident has occurred, and that this learning is shared with others to raise awareness and improve practice. Lessons Learned are included on every monthly divisional governance meeting agenda. Where the need for shared learning is identified a referral to our Lessons Learned Panel is made. The panel is made up of divisional representatives, public governors and a lay member who agree the key messages to be shared across the Trust in order to champion wider learning.

Examples of lessons learned:

Professional challenge can help safeguard adults and children

Whether we are caring for children or adults we need to remember that families are often complicated and care arrangements may not always be as they seem.

We need to encourage team members to be confident to challenge appropriately if they are concerned about aspects of patients'/clients' home lives.

Remember if something feels wrong it probably is.

Improving the safe and effective use of medications

Where patients have a delayed swallow and are on oral medication, ask for a review to ensure that the drugs will not cause harm by being held in the mouth longer than intended and to highlight relevant precautions.

Where additional support is required remember that we have a large number of teams who could help and remember to maximise the expertise of specialist services when patients highlight issues.

The safe use of bisphosphonates

Please be aware that bisphosphonates are widely used to treat and prevent bone-related conditions.

The need to continue bisphosphonate treatment for osteoporosis should be re-evaluated periodically based on the benefits and potential risks of bisphosphonate therapy for individual patients, particularly after five or more years of use.

Bisphosphonates can, in rare cases, cause osteonecrosis of the jaw and atypical fractures of the femur.

3.4.8 Healthwatch

We continue to work in partnership with both Healthwatch Derbyshire and Healthwatch Derby. Their on-going involvement in sharing patient feedback and ensuring local people's voices are at the heart of shaping services has been invaluable this year.

Areas of particular success in 2017/18 which exemplify our partnership working include:

- Regular receipt of feedback from Healthwatch Derby and Healthwatch Derbyshire, including comments collected from our sites and other local areas highlighting how the population of Derbyshire experience our services. These are responded to by service leads.
- Support to Healthwatch Derbyshire with their annual enter and view training activity. Feedback was given to ward areas and learning shared.
- Support and development and sharing of a 'STOP' poster for people with learning disabilities.

3.4.9 Involvement

We have over 40 network groups which consist of local people and service users. We have worked with these groups to co-design and develop our services in the last year. Our most successful example of working in partnership with local people is around the development of our dementia strategy. We held a successful focus group where people had the opportunity to share their experiences and help shape the development of this strategy.

We hope to continue our work with the general practice Patient Participation Groups (PPGs) to develop new initiatives to support our three practices and improve opportunities to gather patient feedback and improve our performance on the annual survey.
Other areas of collaborative involvement approaches:

- We actively participate and support the Good Health Group in Derbyshire
- Our Stroke Services Patient Group has won external funding to support their increasing activities
- School Nurse Takeover Day saw the involvement of local students to shape services. A great day shared by both staff and young people.

3.4.10 An inclusive organisation

During 2017/18 we have been confirmed as being a Disability Confident Leader – one of only five NHS organisations to have received this award. The focus of the scheme is to ensure that disabled people and those with long term health conditions have the opportunities to fulfil their potential and realise their aspirations as employees within the Trust.

In February 2018 we became a founder member of the Derbyshire-wide LGBT+ network, together with Derbyshire fire, police and ambulance services, Derbyshire County Council and the University of Derby at the first joint role models conference.

We have a well-established Equality, Diversity and Inclusion Leadership Forum which has been very active during the year. A key piece of work is currently underway to refresh our equality approach, including a complete review of governance, terms of reference and membership.

Much work has been undertaken internally during the year – including a 'confirm and challenge' session facilitated by Ernst & Young in October 2017 – to strengthen and simplify our overarching strategic focus on inclusion and the EDS2 NHS national equality performance framework.

Our mission is to articulate the positive impact of inclusion and ensure accountability and inclusive leadership is seen at all levels in our structures, systems, processes, roles and relationships.

The new inclusion model and strategic approach has been drafted and aligned to the DCHS Way to enable a shared understanding and help everyone to connect with our inclusive and compassionate values and behaviours. This will be refined following feedback in readiness for formal launch and implementation from 2 April 2018.

Our refreshed equality, diversity and inclusion strategy 2017/2020 will continue to be simplified to concentrate efforts on a few key areas / equality objectives requiring attention such as service delivery strands and patient experience and doing these well.

We have signed up to a research project in partnership with University of Nottingham on "reverse mentoring" to promote compassionate and inclusive leadership.

We have continued to support our three employee network groups for our lesbian, gay, bisexual and trans (LGBT) employees, our black and ethnic minority employees and our employees with a disability or long-standing condition. Each group has open membership for equality allies.

To meet our requirements under the Public Sector Equality Duties (PSED) Equality Act 2010 we have published the following: our annual workforce race equality submission to NHS England in August 2017 and our annual workforce equality and diversity analysis report in January 2018. In March 2018, having already registered with the Government Equalities Office around gender pay gap, we published our findings as required and in September 2017 we submitted our Stonewall Workplace Equality Index. We also produced our annual understanding service users equality and diversity analysis report.

We completed a comprehensive equality impact assessment of our policies, undertaken by a task and finish group, when the work was approved by a sub-committee of our Trust Board, the Quality People Committee, in March 2018.

3.4.11 Duty of candour

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

The Trust is committed to providing an open and honest explanation to patients and an apology where serious harm has happened. During the reporting period 2017/18 there have been 63 incidents meeting the duty of candour criteria. Patients have been contacted and a full explanation provided following investigation.

Duty of candour is a thread throughout Trust induction, essential training, RCA training and incident managers Datix training as well as Sign up to Safety Mini Kitchen Table discussions.

3.4.12 Minor Injury Unit (MIU) waiting times

We have four MIUs providing urgent care as part of the wider out of hours and emergency care pathway across the health community. Ensuring our patients receive timely care is a key priority and this is measured against a four-hour standard set by the Department of Health. As the table below illustrates we have performed well in this area.

DCHS considers that this data is as described for the following reasons**:** there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the Trust's data kite mark quality assurance system.

This data is governed by standard national definitions.

Table 21: MIU 4 hour waits

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
2017/18	99.9%	99.9%	100%	99.9%	99.9%	99.9%	99.9%	100%	99.9%	100%	100%	100%	99.9%
2016/17 (A)	100%	100%	99.9%	99.9%	100%	100%	99.9%	100%	100%	100%	100%	100%	100%
2015/16 (A)	100%	100%	99.9%	100%	100%	99.9%	100%	100%	100%	100%	100%	100%	100%

Data Source SystmOne PAS (A) *these figures were independently audited*

We will continue to monitor the quality of our services using our quality improvement and assurance framework and to work with the wider health community to maintain the high percentage performance within our Minor Injury Units.

3.4.13 Comparative data A&E 4 hour wait

It should be noted that our emergency provision is limited to four Minor Injury Units and that comparative data includes data from type 1 accident and emergency departments.

Table 22

Period	Performance	Rank	Total in cohort	National average	Highest	Lowest
2017/18	100%	Joint 1st	238	85.0%	58 trusts	Princess Alexandra Hospital NHS Foundation Trust
2016/17	100%	Joint 1st	241	99.9%	56 trusts	Princess Alexandra Hospital NHS Foundation Trust
2015/16	100%	Joint 1st	237	91.9%	65 trusts	Tameside Hospital NHS Foundation Trust

Source NHS England February 2018 A&E wait figure

Criteria for percentage of patients with a total time in Minor Injuries Unit of four hours or less from arrival to admission, transfer or discharge

The Trust uses the following criteria for measuring the indicator for inclusion in the quality report:
The indicator is expressed as the percentage of unplanned attendances at Minor Injuries Units (whether admitted or not) in the year ended 31 March 2018 that have a total time in Minor Injuries Unit of four hours or less from arrival time (as recorded by the clinician (nurse or doctor) carrying out initial triage, or Minor Injuries Unit reception, whichever is earlier) to admission, transfer or discharge home.

3.4.14 Referral to treatment times Ⓐ

When our patients need care we aim to see them and undertake their treatment as quickly as possible. The table below reports on our performance in year against the 18 week referral to treatment times and demonstrates that performance has been consistently good in all areas.

DCHS considers that this data is as described for the following reasons: there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the Trust's data kite mark quality assurance system.

Table 23: Referral to treatment times (RRT)

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
Referral to treatment times Incomplete pathway (where treatment is part of a pathway) against a standard of 92%													
2017/18 Ⓐ	96.9%	97.3%	96.7%	95.8%	93.9%	95.3%	94.7%	93.9%	95.0%	95.1%	95.5%	95.0%	95.4%
2016/17 Ⓐ	97.69%	97.35%	95.66%	93.20%	97.87%	97.24%	95.95%	95.54%	94.58%	94.60%	96.68%	97.60%	96.0%
2015/16	97.9%	99.2%	97.9%	97.6%	97.5%	95.2%	97.6%	98.0%	97.9%	97.7%	97.9%	98.1%	97.7%
RTT waits - admitted patients seen within 18 weeks - 90% (target) (%)													
2017/18	96.9%	96.5%	96.6%	97.3%	91.4%	92.4%	94.7%	95.5%	93.1%	93.1%	95.2%	92.9%	94.6%
2016/17		95.1%	90.9%	91.4%	94.8%	95.7%	90.7%	87.8%	89.8%	95.0%	94.0%	96.0%	92.8%
2015/16	95.3%	96.5%	95.7%	96.6%	95.0%	97.5%	94.9%	94.9%	94.0%	94.4%	96.0%	94.4%	95%
RTT waits - non admitted patients seen within 18 weeks - 95% (target) (%)													
2017/18 Ⓐ	94.9%	94.3%	94.3%	95.0%	95.3%	93.2%	93.6%	93.8%	91.8%	90.8%	92.5%	91.0%	93.4%
2016/17	97.05%	98.90%	95.39%	97.34%	97.42%	95.72%	95.11%	95.33%	93.7%	92.05%	94.34%	91.29%	95.2%
2015/16	98.1%	98.4%	97.0%	97.8%	99.9%	97.0%	98.0%	97.3%	97.3%	97.7%	97.3%	96.6%	98%

Data Source SystmOne PAS

Criteria for percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The Trust uses the following criteria for measuring the indicator for inclusion in the quality report:

- The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2017 to March 2018
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance
- The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

Criteria for percentage of non-admitted patients seen within 18 weeks at the end of the reporting period

The Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of non-admitted patients seen within 18 weeks for patients on non-admitted pathways at the end of the period
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2017 to March 2018
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance
- The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

3.4.15 Delayed transfers of care (DTOC)

A delayed transfer of care (DTOC) occurs when a patient is ready for discharge from one of our community hospitals to home or a residential care setting yet is still occupying one of our hospital beds. We work to minimise DTOCs through effective discharge planning and joint working between services to ensure safe, person-centred transfers. This year we have differentiated between DTOCs resulting from delays identifying ongoing social care and delays which are purely related to NHS care.

We consider that this data is as described for the following reasons**:** there are proper internal controls for the collection and reporting of this measure of performance and the controls are subject to quality assessment using the Trust's data kite mark quality assurance system.

Comparative data - DTOC monitor compliance calculation is not available.
This data is governed by standard national definitions.

Table 24: Total DTOC: inpatients including older people's mental health (OPMH)

Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
2017/18 3.5%	7.6%	12.4%	9.8%	11.3%	8.8%	4.8%	4.9%	3.8%	5.6%	5.0%	5.3%	5.0%	7.0%
2016/17 5.5%	6%	7.9%	10.1%	7.6%	8.4%	9.5%	6.1%	8.0%	10.6%	7.5%	9.1%	9.8%	8.4%
2015/16 7.5%	9.8%	7.8%	7.5%	8.2%	6.9%	8.9%	6.8%	5.3%	7.1%	8.4%	10.7%	11.26%	8.4%

Data Source SystmOne PAS

Table 25: Total DTOC: older people's mental health (OPMH) data:

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2017/18 3.5%	0%	1.7%	1.3%	2.0%	7.0%	3.5%	4.0%	2.7%	4.1%	4.8%	13.1%	8.5%	3.8%
2016/17 5.5%	0%	3%	0.9%	0%	1.2%	0%	0%	3.2%	5.7%	3.2%	2.3%	0%	1.7%
2015/16 7.5%	2.6%	6.7%	5.2%	0.0%	0.0%	0.0%	0.0%	0.9%	0.2%	0.3%	4.8%	1.2%	1.83%

Data Source SystmOne PAS

Key

Less than target

Greater than target by up to 0.5%

Greater than target by more than 0.5%

Although we have not met the revised national target of 3.5% DTOC in 2017/18, working with partners across Derbyshire we have made significant improvements and are currently the best performing health economy in England. During 2017/18 we will be focusing on ensuring a more consistent and robust process for DTOC data collection and to continue to drive improvements in delayed transfers of care.

In an attempt to drive improvements in DTOCs, during 2017/18 we started to specifically performance manage DTOCs in situations where we had direct control of the whole patient pathway. The three tables below illustrate the performance for 2017/18 and compare this with the previous year. The target for 2017/18 set by NHSE remained at 3.5% however we set our own improvement trajectory which it reported against to board each month.

The improvement trajectory is detailed below:

DTOC NHS delays improvement trajectory

Improvement Trajectory	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2017/18	3.5%	3.4%	3.3%	3.2%	3.1%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.5%

Table 26: DTOC: OPMH (NHS delays only):

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2017/18	0.0%	0.0%	0.7%	1.0%	5.4%	3.0%	2.6%	1.6%	3.5%	4.6%	13.1%	8.5%	3.0%
2016/17	0.0%	1.6%	0.9%	0.0%	1.2%	0.0%	1.0%	1.1%	2.3%	2.7%	0.0%	0.0%	0.9%

Data Source SystmOne PAS

Table 27: DTOC Inpatients (NHS delays only):

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2017/18	3.7%	6.8%	4.4%	6.1%	5.0%	2.1%	3.7%	3.8%	3.8%	3.0%	2.3%	3.5%	4.0%
2016/17	2.9%	5.4%	7.0%	4.0%	3.6%	4.6%	3.8%	3.1%	3.3%	2.8%	4.9%	4.9%	4.2%

Data Source SystmOne PAS

Table 28 DTOC: OPMH & Inpatients (NHS delays only)

Target	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Full year
2017/18	2.9%	5.2%	3.4%	4.7%	5.1%	2.3%	3.5%	3.3%	3.8%	3.3%	3.8%	4.0%	3.8%
2016/17	2.3%	4.5%	5.5%	3.1%	3.0%	3.4%	3.1%	2.6%	3.0%	2.8%	3.9%	3.9%	3.4%

Data Source SystmOne PAS

3.5 Ensuring our services are well-led

3.5.1 CQC report

As part of their report (2016), the CQC issued two requirement notices and made a number of recommendations for quality improvements across our services which have now been addressed.

The introduction of quality assurance summits throughout 2017 enabled outstanding actions to be closed. Where actions remained open, leads were requested to outline the rationale and their long term management strategy. Summits were chaired by the director of quality, supported by the chief operating officer and the non-executive director lead for quality. Significant progress and closure of these actions are reported into the Trust governance structures. It is important to note that CQC issued requirement notices cannot be formally closed until we receive a further comprehensive inspection.

Our integrated sexual health services received an overall rating of requires improvement in 2016. As part of our self-assessment prior to inspection we had rated this service as requiring improvement, based on the work required to merge three independent sexual health services under a single managed service. The focus of these improvements included: work to improve the safety of the service, timeliness and accuracy of results reporting, improving access to a broader range of services and the development of clinical leadership. We invited the CQC to review progress against these improvements.

In September 2017 as part of the new 'engagement' process CQC visited sexual health services and an extract from the lead inspector following the site visit has been included:

"Following our engagement visit to the Wheatbridge ISHS clinic…..It was very clear to us both that the ISHS service as a whole have been very busy since our inspection in May 2016. We looked at new systems which have been implemented for reporting of results as well as looking around the department to see changes which have been made to maintain confidentiality of patients using the service. Staff also told us about projects which are ongoing ….as well as projects they hope to work on going forward…… We can both see that the changes made since May 2016 have been positive and this is evident in the responses from staff who took the time to speak with us……

Prior to this our independent auditor visited the service and they also positively concluded:
"Through meeting with staff and reviewing documentary evidence it is clear that the service has significantly evolved in a short space of time, with the improvements made reaching beyond the actions agreed as part of our review. Well done to all of the team, who have obviously worked hard to achieve the improvements."

In 2017 we continued to report to the CQC on a monthly basis through the submission of data and narrative; this reflects our current risk status against a list of risk indicators. Positively, due to the confidence in the robustness of our reporting, the CQC have amended this reporting schedule to bi-monthly.

3.5.2 Development of markers of good practice (MoGP) within the integrated facilities management team (IFM)

In 2017 metrics relating to each CQC domain of safe, effective, caring, responsive and well-led have been mutually developed with the IFM team and the clinical effectiveness team. Peer reviews using these metrics have commenced and by using the MoGP as guidance, ensure consistency in both monitoring and measuring of quality.

Outcomes from the peer review process will allow for a clear understanding as to the quality of service delivered by the integrated facilities management service and identify areas, both locally and service-wide, that require improvement, whilst also identifying and demonstrating areas of good practice. Reporting of these findings is scheduled to take place in April 2018 through the divisional governance structure.

3.5.3 Raising concerns (Freedom to Speak Up)

We are committed to encouraging staff to speak up regarding any issues that are troubling them to enable us to look into these. We have a range of processes to enable all staff to speak up promptly and in ways that they are comfortable with. These include the Freedom to Speak Up (FTSU) guardian, Frontline Care Council or Staff Forum which meets with the executive directors on a regular basis to enable specific issues, raised by staff, to be discussed.

The majority of our concerns are raised informally with senior managers. We have a dedicated area on our website which provides information and support to staff who wish to formally speak up – this is supported by a range of materials including a video featuring the Freedom to Speak Up guardian and the senior independent director and an information leaflet. We now provide a session to all newly employed staff members at the corporate Trust induction programme.

In the past year, we have received thirteen formal concerns that have been dealt with in line with our policy. Of the seven element categories, the top three were 29.4% due to systems/ processes and 17.6% for both behaviours/ relationships and bullying/harassment. Patient safety/quality of care came in 4th at 11.8%. After an initial discussion with the Freedom to Speak Up guardian action has taken place to gain further information and where necessary investigations are undertaken to ensure that these are addressed accordingly. Staff continue to feel more confident in the process and this is evidenced by the continued low number of anonymous concerns and feedback shared with us and external reviewers. As a result of this, we have been able to provide feedback to the relevant individuals regarding the action we have taken to address the concern and to provide any needed support to them. The key learnings are shared anonymously across the Trust to ensure that issues do not recur.

This year we plan further work to raise awareness to staff by distributing credit card sized information cards with key links and meeting with minority and hard to reach staff groups. To enable us to hear about staff's experience of speaking up, we are implementing a feedback form to identify how we could make the process easier for staff and how they first heard about raising concerns.

Quality Always – Assuring high quality services across DCHS

3.5.4 Quality Always (QA) – our quality assurance and improvement scheme

We want each person to experience high quality healthcare, whenever they use our services – delivering 'Quality Always.' In 2014 there was a strategic drive by our Trust Board to identify and implement a method of continuous quality improvements within our clinical services that could be the main building block of the Trust's quality assurance model; a method to measure and make sure we were meeting our patients' aspirations. The model is known as Quality Always. QA comprises of four main elements:-

- **Clinical assessment and accreditation scheme (CAAS) -** CAAS is a process of assessment, review and accreditation. An assessment template is used, based on 14 standards. Teams develop and implement an improvement plan and repeat assessments are then carried out, with the frequency being determined by their overall score. Teams can apply for 'Gold' accreditation once the required level of quality has been reached and sustained over a 12 month period.
- **Leadership development scheme (LDS) -** The Leadership Development Scheme aims to help leaders heighten their self-awareness about the way in which they lead and drive quality improvements.
- **Quality and safe care champions -** Quality and safe care champions embed best practice identified within the CAAS standards. They are nominated members of front-line staff who receive support to carry out their role throughout the year.
- **Dashboard -** The dashboard facilitates efficient CAAS assessment and has been developed to identify 'hot spots' and areas of best practice. It also enables in-depth data analysis for staff from board to front-line clinician level.

Progress in 2017 - CAAS

Throughout 2017 the QA team carried out 97 assessments across 61 teams: 51 assessments were undertaken in teams taking more than one day of visits to assess; 46 assessments were carried out in teams only requiring a single day visit.

All divisions are now included in the CAAS process and all localities have been visited by the QA assessment team. On average during 2017/18 the team have undertaken eight assessments each month. The team were set a key performance indicator (KPI) of assessing 18-24 new areas during 2017 and by the end of December 2017 24 new teams were included.

Below is a table summarising assessment ratings to the end of December 2017.

Table 29: CAAS ratings

	CAAS rating			
Division	Red	Amber	Green	Gold
ICS	3	12	8	16
Planned Care	0	6	7	2
HWBI	0	4	2	0
Totals * (56)	3	22	13	18

Gold panels
Seven gold accreditation panels have taken place during 2017**.** Support for the panel process including refining the detail and expectations has been gratefully received from executive and non-executive colleagues, public governors, assistant directors, staff partnership, previous gold award achievers and heads of service and quality.

The teams presenting to the panels have continued to impress with the diversity of their presentations and the commitment to excellence in patient centred quality care.

Table 30: Gold achievers in 2017

Month	Gold accreditation awards in 2017
April	Riverside Ward Heanor
June	Hudson Ward Adult speech and language therapy
July	Chesterfield N/E Dental Service Learning disability community teams Lea Hurst OPMH Day Hospital
August	Butterley Ward
November	Oker Ward
December	Hopewell Ward

Teams who fell backwards within the process in 2017
One team did not retain their gold status, and one team was deferred by the accreditation panel. Both teams have returned to the CAAS assessment process and are currently rated as amber and green. Three teams' overall ratings returned to amber after reaching green at the previous assessment.

The following teams regained their gold award:-
Linacre Ward
Alton Ward
Spencer Ward
Riverside Ward
Hillside Ward
Robertson Rd, Rockley Way, Orchard Cottage and Amberley House Core Units
Valley View Unit
Baron Ward
Whitworth Minor Injury Unit

Quality and responsive summits
During 2017 quality and responsive summits were arranged to support teams and their leaders with the development of a robust plan to move them forwards with their quality improvement journey. A process was agreed which helped decide whether a quality summit led by the chief nurse was required or a responsive summit led by the assistant director for the division. These processes have been implemented to support teams with any specific challenges they may encounter.

Leadership development scheme (LDS)
Two cohorts of the LDS have been run in 2017 for 54 leaders. This process helps our clinical leaders to manage effective change and lead team improvements. Looking forwards this development will be included within our overarching leadership strategy.

Quality and safe care champion (QSCC) programme
45 training sessions facilitated by the QA improvement leads and specialist leads/practitioners for safe and person centred care have been held for the champions across the following subjects:

Continence	Infection control and prevention	Nutrition	Patient experience and dignity	Tissue viability
Safeguarding	Falls forum	End of life care	Dementia	Pain

304 champions have attended, estimated to be 47**%** QSCC registered to attend the sessions provided in 2017 (total head count 642), March 90, May 75, September 75, November 64.

QSCC have also become influential members of several key clinical groups in the Trust, such as the nutrition steering group and the end of life care group where their input has been valued. Dementia champions also took part in developing our dementia strategy.

A frailty event was organised with the support of the deputy medical director to embed frailty as a key aspect of all QSCC roles. The event was really well supported by Trust specialists and volunteer services such as the Alzheimer's Association. The QSCC also supported 'Stop the Pressure' a national event on 16 November 2017 in conjunction with the tissue viability team and the QSCC as a social media campaign storm.

Quality Always dashboard and reporting tools
Significant progress has been made in 2017 building and developing the assessment reporting tool on the quality dashboard page and the informatics lead has developed a range of reports that can be accessed by all leaders and teams. This is enabling teams, specialist leads and the QA assessors to drill down on all the data held within the system to identify achievement, hots spots and themes and trends against the clinical standards.

National and local events
Quality Always was presented to the Queen's Nursing Institute Conference in October 2017 and published in the British Journal of Community Nursing in March 2018. A case study regarding the process has been commended by NHS England following submission under their Leading Change Adding Value initiative and locally we delivered a presentation to 250 undergraduate nurses and radiologists at Derby University.

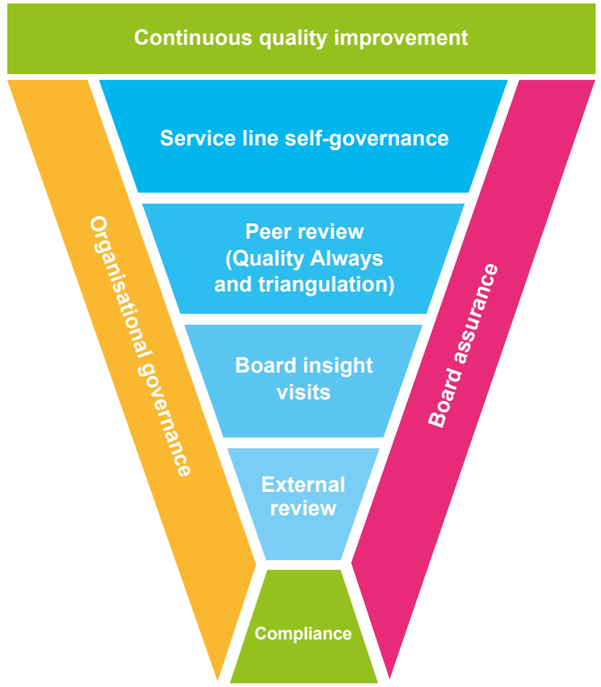
3.5.5 Quality assurance visits

In July 2017 the CQC published a new and updated key lines of enquiry (KLOE) framework, which incorporates further focus on patient safety and leadership. These changes were released following national CQC consultation and were representative of the direction of travel for the CQC going forward. In 2017 we have updated our local assurance model and the associated documentation to incorporate these changes. Updated documentation has been shared with our assistant directors and subsequently discussed at each divisional governance meeting, so that these changes can be integrated into the current assurance visits.

We continue to have unannounced organisational triangulation visits on a quarterly basis where operational and quality team managers assess clinical services against agreed key lines of enquiry. These are further supported by monthly insight visits where members of the Board accompanied by Council of Governor representatives and senior managers undertake announced visits with clinical teams to better understand the day to day issues of working within different service areas.

It is the intention of the wider quality improvement framework to focus on local engagement and a 'business as usual' approach. This is summarised by the following diagram (taken from 'DCHS Quality Improvement and Assurance framework – Improving Patient Care through Quality Assurance') which demonstrates the level of accountability within the different assurance strands and which clearly identifies the importance of local self-governance through the use of the KLOEs through local triangulation and peer review.

Each division continues to adapt and develop their KLOE schedules and tracking methods to support their service models. For example sexual health services intend to undertake KLOE visits out of hours, as this reflects some aspects of their services and supports teams to understand the service from the patient's perspective.



Each division continues to report their KLOE assurance activity and findings through divisional governance meetings in order that lessons can be learned and shared.

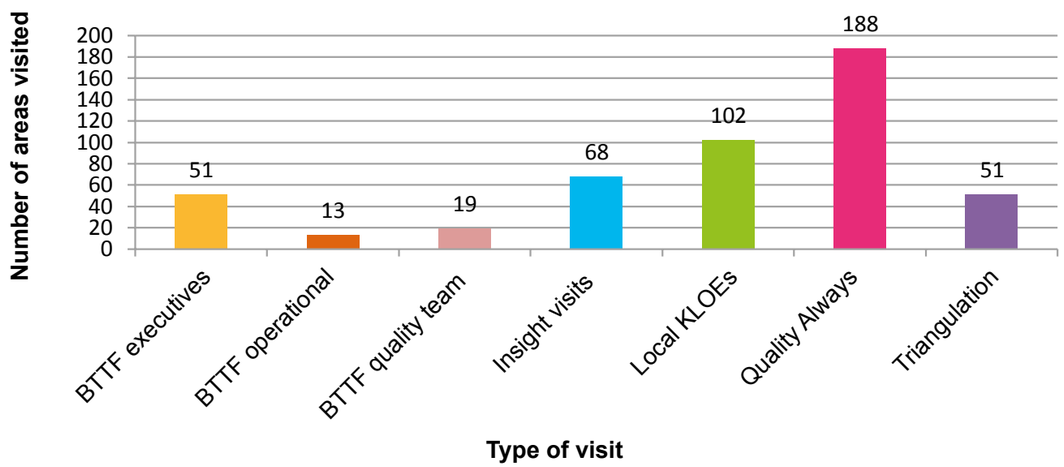
Back to the floor (BTTF) visits continue to give all managers time to work with clinical teams to observe and share best practice and identify issues which inhibit delivery of care. BTTF visits also enable us to look Trust-wide at key issues and each session has an identified theme for managers to focus on.

Monitoring the activity of assurance visits and ensuring that visit capacity is maximised within a complex organisation resulted in the development of the assurance tracker. The tracker supports the efficacy of the assurance model to reduce duplication of visits and maximises the impact of assurance visits across the whole of the assurance model. Visit numbers and their location support quality leads to 'map' assurance visit activity across the year, highlighting areas yet to be visited by one of the components of the assurance model.

Building a business intelligent system (dashboard) to report all assurance activity
Electronic Reporting in Care ERiC

Work is being undertaken to scope the possibility of building a repository that captures all the assurance model activity. The dashboard will be built on the same service level framework to mirror the capabilities of a similar dashboards built for the QA assessment process. It is essential that the dashboard is able to produce reports informing both clinical and non-clinical teams on assurance activity within their locality and services.

Graph 14: Internal assurance tracker 2016 - 2018



Appendix 1 - Workforce

NHS Staff Survey 2017

We invited our staff to complete the annual NHS Staff Survey 2017 to provide valuable feedback on how they feel about the NHS and our organisation as a place to work. This was performed independently by Picker Europe which ensured absolute confidentiality and supported detailed analysis.

The survey was conducted between Monday 25 September and Friday 1 December 2017, with 2,433 employees completing the survey. This equates to a response rate of 55% which is above average for community trusts in England, and compares with a response rate of 54% in our Trust in 2016.

Details of key findings from the latest NHS Staff Survey

The table below gives a summary of ranking, compared with all community trusts in 2017 for the 32 key findings in the survey and where we were in 2015 and 2016:

	2015	2016	2017
Above (better than) average	17	21	17
Below (better than) average	7	5	7
Average	6	5	6
Above (worse than) average	2	1	2
Below (worse than) average	0	0	0

For more details about the NHS Staff Survey 2017 results see the Staff Report section of this document.

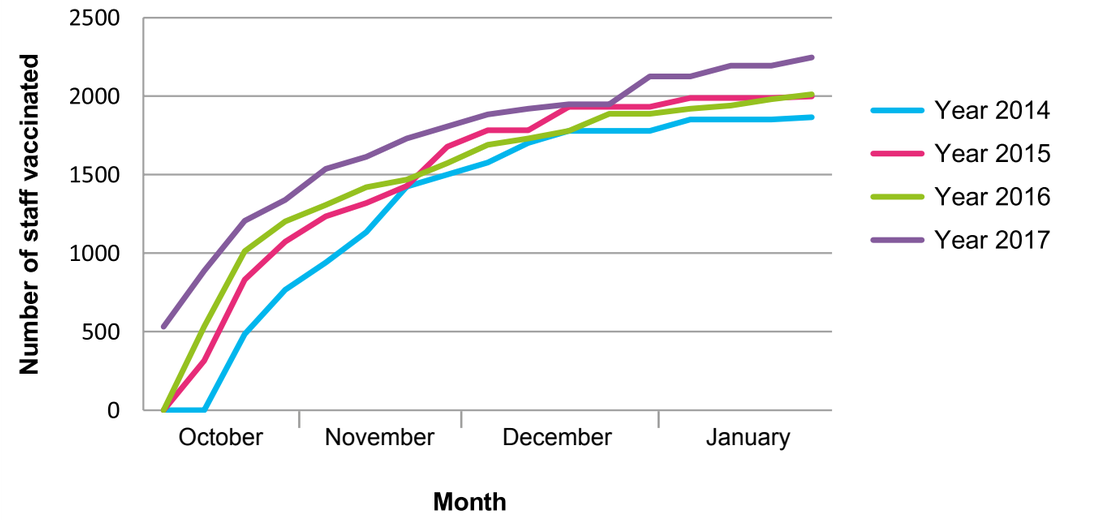
Flu campaign for staff

The 2017/18 flu campaign has now closed with 2,247 front-line staff vaccinated. This equates to 68.5% of front-line staff. This figure represents a serious step change in our performance with the staff flu campaign. The previous highest total was 51.5% in 2016/17.

The success of the campaign can be attributed to a number of improvements on previous years, most notably the appointment of a responsive roving vaccinator who was able to visit teams and training sessions as required, a 'school register' style approach to ensure all staff were offered a vaccine and improved reporting via local reps.

We are now conducting a thorough review of the campaign, identifying areas where further improvements could be made for 2018/19.

Graph 18: Uptake of flu vaccine 2014 - 2017



How we develop and support our staff

Appraisals

We are committed to ensuring all our staff have a quality, meaningful appraisal every year. Our appraisal system has enabled alignment of the NHS leadership framework and the process is now embedded within the Trust providing a valuable mechanism for measuring performance whilst, also identifying the development areas and support required by staff to enable them to achieve their full potential.

Appraisal training continues to be offered across the Trust to ensure both the appraiser and appraisee are equipped with the knowledge and skills to develop and receive an effective, meaningful appraisal. 90.4% of our staff received an appraisal within the year and we will be working hard during the coming year to improve on this.

Leadership development

Leadership development is a key priority for 2018/19. We will continue to develop our leaders through a wide range of targeted leadership interventions to equip our clinical leaders, business leaders and people managers with the necessary values, skills, behaviours and experience to maximise their potential in leading the Trust forward. We will build the capacity and capability of our clinical leaders through a robust development and assessment model and invest in developing our talent management and succession planning processes to ensure we are well equipped to lead in the increasingly complex environment that we are operating in.

Appendix 2 - GP Patient Survey results

Table 35: Patient Survey results	Castle Street	Creswell	Ripley	National average	Hardwick CCG average	Southern Derbyshire CCG average
Ease of getting through to someone at the GP surgery on the phone	91%	86%	73%	71%	77%	67%
Helpfulness of receptionists at GP surgery	91%	84%	82%	87%	88%	86%
Able to get an appointment to see or speak to someone	94%	85%	72%	84%	88%	50%
Rate of getting to speak to their preferred GP	81%	40%	29%	56%	60%	50%
Convenience of appointment	92%	84%	71%	81%	87%	81%
Overall experience of making an appointment	92%	71%	58%	73%	76%	71%
Time of wait less than 15 mins after the appointment time	79%	70%	40%	64%	65%	69%
Impression of waiting time at surgery	69%	56%	36%	58%	62%	61%
Rate of GP giving enough time	90%	83%	81%	86%	87%	87%
Rate of GP listening to you	91%	83%	84%	89%	89%	90%
Rate of GP explaining tests and treatments	91%	79%	82%	86%	86%	87%
Rating of GP involving you in decisions about your care	94%	67%	83%	82%	82%	83%
Rating of GP treating you with care and concern	94%	84%	83%	86%	86%	86%
Confidence and trust in GP	99%	97%	90%	95%	95%	96%
Rating of nurse giving you enough time	92%	91%	90%	92%	96%	92%
Rating of nurse listening to you	93%	92%	91%	91%	96%	92%
Rating of nurse explaining tests and treatments	89%	90%	87%	90%	94%	91%
Rating of nurse involving you in decisions about your care	92%	87%	85%	85%	90%	87%
Rating of nurse treating you with care and concern	93%	94%	90%	91%	96%	91%
Confidence and trust in nurse	97%	97%	99%	97%	98%	97%
Satisfaction with surgery's opening hours	86%	77%	68%	76%	82%	79%
Overall experience of GP surgery	92%	73%	72%	85%	86%	86%
Recommending the GP surgery to someone who has just moved to the local area	87%	56%	62%	77%	79%	79%

Appendix 3 - Information governance toolkit submission for 2017/18

Table 36: IG Submission toolkit

Assessment	Level 0	Level 1	Level 2	Level 3	Total Req'ts	Overall Score (%)
Information governance management	0	0	2	3	5	86%
Confidentiality and data protection assurance	0	0	6	3	9	77%
Information security assurance	0	0	13	2	15	71%
Clinical information assurance	0	0	4	1	5	73%
Secondary use assurance	0	0	1	1	2	83%
Corporate information assurance	0	0	3	0	3	66%
Overall	0	0	29	10	30	75%

Appendix 4 - Progression of Quality Always, the DCHS Way

It is important to note that individual teams are recruited to this programme at different times and therefore some areas have had fewer assessments than others. Whilst a red rating indicates areas for improvement it **does not** signify that poor care is being delivered in this clinical environment. A1 is the most recent assessment conducted.

Table 37: Quality Always areas of assessment		A1	A2	A3	A4	A5	A6	A7	A8	A9	A10
Community Teams	Amber Valley SPA	R	R								
	Belper district nursing	A	A	R							
	Bolsover community	R	R	R	R						
	Central CHES community	A	A	R	A						
	Clay Cross community	R	A	A	R						
	Derby City community – Darley	R									
	Dronfield community	A	A	A	A	R					
	Eastern CHES community	A	R	R	R	A					
	HPD Integrated community – Central High Peak	A									
	Learning Disability – community	G Gold	G								
	North Erewash Community	A									
	SDD North district nursing	R									
	SDD South district nursing	A	A								
Minor Injury Units	Buxton	G	A	G	G	A					
	Ilkeston Hospital	G	A	G	A	G	A				
	Ripley Hospital	P	A	G	A	G	A				
	Whitworth	G Gold	G Gold	G							
HWI – Children's Services	Children's 0-19 service Bolsover – South	G									
	Children's 0-19 service – Derbyshire Dales	A									
	G29264 Children's 0-19 service Erewash	A									
	G29271 Children's 0-19 service Chesterfield	G	A	G	A						
	G29272 Children's 0-19 service Bolsover	G	G	A							
	Immunisation and vaccination team	G									
HWI – Sexual Health Services	Derby County North	A									
	Derby City	A	A								

Table 37: Quality Always areas of assessment		A1	A2	A3	A4	A5	A6	A7	A8	A9	A10
Inpatients	Ash Green Hillside	G	G Gold	G	A	A					
	Ash Green Valley View	G	G Gold	G	R	A					
	Babington Baron Ward	G	G Gold	G	A	A	A				
	Buxton Fenton Ward	G	A	R	A	A	A	A	R		
	Clay Cross Alton Ward	G Gold	G Gold	G	A	A	A				
	Rockley Core Unit	G Gold	G Gold	G	A	G	A				
	Robertson Road Core Unit	G Gold	G Gold	G	R	A					
	Orchard Cottage Core Unit	G Gold	G Gold	G	A	R					
	Amberley Core Unit	G Gold	G Gold	G	A						
	Heanor Inpatients Manors Ward	G Gold	G Gold	G	A	A	A	R	R		
	Ilkeston Inpatients Hopewell Ward	G	G	R	R	A	A	A	R		
	Newholme Rowsley Ward	G	A	A	A	A	R	R	A	R	R
	OPMH Cavendish Spencer Ward	G Gold	G Gold	G	A	R					
	OPMH Newholme Riverside Ward	G Gold	G	A	A	A	R	R			
	OPMH Walton Linacre Ward	G Gold	G	G	A	R					
	OPMH Walton Melbourne Ward	A	A	G Gold	G	G	R	R			
	Ripley Butterley Ward	G Gold	G	A	A	A	A	A			
	St Oswald's Okeover Ward	G	A	G	A	A	A	R	R		
	Whitworth Oker Ward	G	G	A	A	R	R	R	R		
Planned Care DTC	Buxton Podiatric Surgery	A									
	Day Care Erewash	G									
Planned Care - Outpatients	Babington Day Unit	A									
	Dental – Chesterfield	G Gold									
	Ripley Hospital	G	G								
	Heanor Hospital	G	G	A							
	Ilkeston Community Hospital	A	A								
	Wheelchair services team	A									
	Wheelchair services north	G	A								
	MSK Amber Valley	G	A								
	MSK Chesterfield and North East Derbyshire	G Gold		A							
	MSK Erewash	A									
	High Peak and Dales	A	A								
	Podiatry Chesterfield and North East Derbyshire	G Gold	G	A							
	Speech and language therapy – adults	G Gold	G								
	Speech and language therapy - Erewash	A									

Appendix 5 - Third party statements – CCGs/Healthwatch

Erewash CCG
Hardwick CCG
North Derbyshire CCG
Southern Derbyshire CCG
NHS

Commissioner Statement – 2 May 2018

Services from Derbyshire Community Healthcare Services NHS Foundation Trust (DCHS) are collaboratively commissioned by the four Derbyshire Clinical Commissioning Groups (CCGs). Providers of NHS healthcare are required to publish a quality account each year and are based on the quality accounts regulations published by the Department of Health and Social Care. It is the responsibility of the quality team working across the four CCGs to provide a joint Commissioner Statement and we would recognise the collaborative working relationship the Trust shares in relation to quality, performance and contracting process.

The following statement is provided in the wake of reviewing the information provided and feel that this Quality Account demonstrates the Trust's commitment to ensuring the provision of high quality of care, making sure that this is safe, effective and of a high standard.

In 2016 CQC visited the Trust and awarded an overall rating of 'good', with the domain of 'care' being rated as 'outstanding'. Inspectors also issued two requirement notices relating to Sexual Health Services and on a return visit in September 2017 CQC acknowledged the positive work and improvement taken resolve the required improvements. The Trust continues to deliver its own Quality Always clinical assessment and accreditation scheme, consisting of assessment and observation of care against the CQC fundamental standards. The CCG have been positively welcomed to contribute to this process and results of the scheme are open and transparent. The scheme enables the trust to promote and celebrate achievements in quality of care, whilst supporting areas requiring improvement.

In relation to safe care, the Quality Account clearly outlines how the organisation manages and responds to identified risks and assurance process against these. The report outlines the number of incidents that have happened within care and describes the systems and processes used to learn from these. The three key incident themes identified relate to pressure relief, slips and medication. For each, work is identified going forward to transfer learning into improvements and changes. We note that the Trust recognises that it still has significant work to undertake in relation to the prevention of pressure ulcers and commissioners will work with the Trust to monitor progress on how the work progresses throughout the coming year. Commissioners can confirm that there have been no Never Events reported by the Trust as outlined in the Quality Account.

To underpin safe care and working the Trust has successfully implemented its Sign up to Safety campaign and commissioners would like to acknowledge the success of this in terms of engaging with staff as part of commitment to the five safety pledges.

The Trust recognises the importance of ensuring that all clinical audit activity is meaning and purposeful and results in learning, and improvements in care. A patient related outcome measures database has been developed and implemented to capture information about peoples care and recovery and this will be incorporated into the quality dashboard to enable leaders to review how the care provided by teams impacts on people and their care.

Assessing the quality of the care environment through PLACE demonstrates that the Trust has achieved a higher than national average score across all domains. However, Commissioners have noted very small decreases in the scores related to both cleanliness and food and the Trust have confirmed that they have actions in place to address this.

In relation to patient and carer experience, the Quality Account outlines how the Trust measure and monitor people's experiences to help improve services. As part of this commissioners recognise the Trust's commitment to this by way of ensuring a patient story is embedded into key meetings.

Additional key metrics include:

- An increase by 12% in relation to Friends and Family Test feedback with overall positive feedback
- 30% increase in complaints compared to the previous year and a review of this has identified internal changes to process and increased publicity. It is important to also note that the Trust has also identified an 8% improvement in responding to complaints within 50 working days
- It is noted however that the Trust have not met one of their key quality priorities and this relates to the identification of carers on TPP, with the aim of identifying 75% of carers in order to communicate and support them. The Trust report that a plan is in place to achieve the additional 6% to meet their target
- The importance of leadership is recognised across the organisation and at all levels within structures, systems, processes, roles and relationships. Commissioners would like to note the importance of the leadership development scheme identified by the Trust which aims to help leaders heighten their self-awareness about the way in which they lead. Linking quality of care and leadership in this way is fundamental to ensuring staff are well supported to provide a high quality of care.

This 2017/18 Quality Account provides an annual report to members of the public with the objective of demonstrating that the Trust is committed to ensuring it assesses and provides a high quality of care across its commissioned services. Within this statement the CCG would like to acknowledge and thank Derbyshire Community Healthcare Services NHS Foundation Trust for working positively and collaboratively with commissioners and key stakeholders to ensure our patients receive a high quality of care at the right time and in the right care setting. We look forward to continuing to work with the Trust and the people it serves over the coming year and beyond.

Phil Sugden | **deputy director of quality** | **NHS Hardwick CCG**

DERBYSHIRE County Council
Improving life for local people

"Derbyshire County Council's Health Scrutiny Committee received the Derbyshire Community Health Services NHS Foundation Trust draft Quality Account 2017/18 at its meeting on 1 March 2018. The Committee noted that the Trust was currently rated as good overall by the Care Quality Commission and rated 1 by NHSI in respect of financial governance (lowest risk) and green in respect of quality governance. Section 3 of the report gave details on quality improvements around patient safety, clinical effectiveness, patient experience, and responsiveness.

The committee will take the opportunity, over the coming year, to monitor the activities and progress of the Trust and both support and challenge the Trust as appropriate"

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Derby
DE1 2FS

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Email:Samragi.Madden@healthwatchderby.co.uk

Ms Carolyn White
Chief Nurse Director of Quality
Derbyshire Community Health Services NHS Trust
Walton Hospital
Chesterfield
S40 3HW

26th April 2018

Dear Carolyn

Re Quality Report 2017/2018

On behalf of Healthwatch Derby, I would like to present our formal response to Derbyshire Community Health Services (DCHS) NHS Trust's Quality Report 2017/2018.

In the past year we have further developed our partnership with DCHS with attendance at PEEG (teleconference) and Joint EDS grading with Derbyshire Healthcare NHS Foundation Trust, as well as picking up feedback about DCHS services.

We are pleased our DCHS colleagues have attended Healthwatch Derby's Insight Derby Engagement Network or IDEN. We have also shared advice and information updates throughout the year. Recently we have also connected with the lead DCHS Governor for Derby city.

Our continued partnership has produced some joint work opportunities most of which will take place in 2018. We will be conducting workshops and hosting partnership patient experience events. We will also extend our outreach programme to include more DCHS services as identified through partnership and local intelligence sharing meetings.

We are pleased DCHS share similar values and a commitment to hear not only from patients, but from Carers - a vital link to the whole process of recovery from short or long term illness.

Our current outreach programme has not provided any significant negative feedback about DCHS services. Where we have come across concerns, these were received in an open and transparent manner. This has led to stronger information sharing and ultimately towards a stronger partnership.

We will continue to report on what we hear from patients, carers, stakeholders, and continue to liaise and raise patient experience testimonies with the Trust.

Company Registration Number: 8233546
Registered Office: The Council House, Corporation Street, Derby DE1 2FS

We look forward to another year of positives, and our joint efforts to hear from patients, and to improve services for all. If you have any enquiries about this response or require any further information please do not hesitate to contact me directly.

Yours Sincerely

Samragi Madden
Quality Assurance & Engagement Manager
Healthwatch Derby

Derbyshire Community Health Services NHS Foundation Trust
Governor statement
11/05/2018

Governors are pleased to receive this well documented, easy to read, non-abbreviated Annual Quality Report 2017/18, and will continue to monitor and support the excellent achievements, and maintain the confidence to support the Trust in its efforts to achieve at times impossible targets, due to financial constraints imposed, and applaud all staff involved in the continued quality of care, and services, for the patient.

John Dick
Deputy Lead Governor

Healthwatch Derbyshire (HWD) is an independent voice for the people of Derbyshire. We listen to experiences of using health and social care services, and share this with people who have the power to make change happen.

We gather experiences from patients and members of the public through a small team of Engagement Officers, supported by volunteers. We undertake both 'general engagement' to hear about a variety of different experiences, and 'themed engagement' which we use to explore a particular topic in more detail.

The findings of our themed engagement work is analysed and written up into reports, which include recommendations for improvement. Service providers and commissioners are then asked to respond to these recommendations. All our reports, including the responses we receive are published on the Healthwatch Derbyshire website.

The experiences gathered through our 'general engagement' are fed through to organisations on a regular basis throughout the year to give an independent account of what is working well, and what could be improved. Anyone who shares an experience with HWD is able to request a response, and we encourage organisations to consider responses carefully and indicate where learning has taken place as a result of someone's experience. The Trust reply to these comments thoroughly and with rigour, setting out learning and next steps that will follow.

We have read the Quality Account for 2017/18 prepared by the Trust with interest. We have considered if and how the content reflects some of the topics which have emerged in the feedback that Healthwatch Derbyshire has collected during the past year.

Healthwatch Derbyshire welcomes the priority for 2017/18 around identifying, and working more closely with carers. We regularly collect feedback from carers that very powerfully illustrate the huge contribution that they make, and the extent of the workload they undertake. We very much welcome a priority that recognises, supports and builds on this contribution.

We also welcome the work planned around identifying disability, and making reasonable adjustments. Again, this is a topic that Healthwatch consistently collects feedback about, and we are very aware of the positive impact that this has for people when it happens. Specifically, the Quality Account mentions the partnership work undertaken between Healthwatch Derbyshire and the Trust this year, including the sharing of a 'STOP' poster for people with learning disabilities. This is one example of a way in which Healthwatch Derbyshire and the Trust can work collaboratively to help develop and improve services for patients.

We look forward to continuing positive working relationships with the Trust in 2018/19.

Helen Henderson-Spoors
Intelligence and Insight Manager
01/05/2018

Healthwatch Derbyshire

Regulation 5 – No changes have been made to the final quality account after receipt of the statements referred to above.

Appendix 6 - Statement of directors' responsibilities in respect of the Quality Account

"The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes for the financial year, April 2017 and up to the date of this statement (the period);
  - Papers relating to quality report reported to the Board over the period April 2017 to the date of this statement;
  - Feedback from the Commissioners dated 2 May 2018;
  - Feedback from Governors dated 10 May 2018;
  - Feedback from Local Healthwatch Derby and Derbyshire organisations dated 26 April 2018 and 1 May 2018; Feedback from Overview and Scrutiny Committee dated 19 April 2018;
  - The latest national staff survey 2017;
  - Care Quality Commission inspection report, dated 23 September 2016; and
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 22 May 2018
- the quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account's regulations) as well as the standards to support data quality for the preparation of the quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

23/5/18 .....Date.....chairman

23/5/18 .....Date.....chief executive

Appendix 7 - Independent Auditors' Limited Assurance Report to the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust to perform an independent assurance engagement in respect of Derbyshire Community Health Services NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria*** (exact page number where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Pages 172 and 173
Percentage of non-admitted patients seen within 18 weeks from referral	Pages 172 and 173

The three mandated indicators for community foundation trusts to choose from were:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- Emergency re-admissions within 28 days of discharge from hospital; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

As the Trust does not receive emergency readmissions to its inpatient rehabilitation beds and does not provide diagnostic and treatment services for patients with cancer, the latter two indicators were not considered relevant for the Trust. Therefore, only the indicator for 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' was tested from the mandated indicators.

As we are required to provide limited assurance on two indicators, the Trust's Council of Governors selected the following alternative indicator:

- Percentage of non-admitted patients seen within 18 weeks from referral.

Respective responsibilities of the Directors and Auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages 172 and 173 of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2017/18" issued by Monitor (operating as NHS Improvement) ("NHSI").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2017 and up to the date of signing this limited assurance report (the period);
- Papers relating to quality report reported to the Board over the period April 2017 to the date of signing this limited assurance report;
- Feedback from the Commissioners dated 2nd May 2018;
- Feedback from Governors dated 10th May 2018;
- Feedback from Local Healthwatch Derby and Derbyshire organisations dated 26th April 2018 and 1st May 2018;
- Feedback from Overview and Scrutiny Committee dated 19th April 2018;
- The latest national staff survey dated 20th February 2018;
- Care Quality Commission inspection report, dated 23rd September 2016; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 22nd May 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.
We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust as a body, to assist the Council of Governors in reporting Derbyshire Community Health Services NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Derbyshire Community Health Services NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Derbyshire Community Health Services NHS Foundation Trust.

Basis for disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period and Percentage of non-admitted patients seen within 18 weeks of referral

The indicator 'Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal.
The data reported is subsequently updated by the Trust for any identified errors through a monthly validation process. The process is however not applied to the whole data set, as it focuses only on cases which have breached the indicator.

In our testing we found a number of instances where the clock had not been stopped at the end of applicable month end. Therefore, some patients had been incorrectly included in the indicator, until they were picked up by the validation team at a later stage. The Trust was not able to review and update the whole data set. Therefore, we were unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

The indicator 'Percentage of non-admitted patients seen within 18 weeks of referral' follows the same process as above, with the difference being that the data includes non-admitted patients whose pathway has ended in the reporting period, rather than patients on incomplete pathways. The same validation process occurs for these patients, focused on cases which have breached the indicator.

Although our sample of testing on the non-admitted patients indicator did not identify any issues with the 'clock start' or 'clock stop' dates, due to the known issues outlined above with the data, our conclusion is the same for this indicator.

Basis for qualified Conclusion – consistency checks

The following issues have come to our attention that lead us to believe that the Quality Report is not consistent with the other information sources defined by NHSI's "Detailed requirements for quality reports 2017/18".

- The figures included in the performance reports to the Trust Board for RTT non-admitted performance do not agree to the figures included within the 2017/18 Quality Report. The incorrect figures were included in the performance reports across the year.

- We identified that the figures for the May and November 2017 RTT incomplete pathways indicator included some errors within the Leicestershire dental data set. The figures were updated in the Quality Report. As a result, there will be small differences (0.3% for May and 0.7% for November) in these months between the Quality Report figures and those reported in the performance report for RTT incomplete pathways.

Conclusion (including Disclaimer of Conclusion on indicators and Qualified Conclusion on consistency)

Because of the significance of the matter described in the 'Basis for disclaimer of conclusion' paragraphs above, we have not been able to form a conclusion on the RTT incomplete pathways and RTT non admitted indicators.

Based on the results of our procedures:

- nothing has come to our attention that causes us to believe that for the year ended 31 March 2018, the Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- except for the matter described in the 'Basis for qualified conclusion – consistency checks' above, nothing has come to our attention that causes us to believe that the Quality Report is not consistent in all material respects with the documents specified above.

PricewaterhouseCoopers LLP .

PricewaterhouseCoopers LLP
PricewaterhouseCoopers LLP, Donington Court, Pegasus Business Park, Castle Donington, DE74 2UZ

29 May 2018

The maintenance and integrity of the Derbyshire Community Health Service's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Appendix 8 - The core quality account indicators

Where the necessary data is made available to the NHS trust and non NHS bodies by the Health and Social Care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the trust and non NHS bodies (as applicable) should be included for each of those listed in the table with

a) The national average of the same; and

b) With those NHS trusts and NHS foundation trusts with the highest and lowest of the same for the reporting period.

Table 38: Complete list of core indicators.

	Prescribed information	Type of trust	2015/16	2016/17	2017/18
12	(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	Trusts providing relevant acute services	n/a	n/a	n/a
13	The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	Trusts providing relevant mental health services	n/a	n/a	n/a
14	The percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.	Ambulance trusts	n/a	n/a	n/a
14.1	The percentage of category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period.	Ambulance trusts	n/a	n/a	n/a
15	The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period.	Ambulance trusts	n/a	n/a	n/a
16	The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.	Ambulance trusts	n/a	n/a	n/a
17	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	Trusts providing relevant mental health services	n/a	n/a	n/a

	Prescribed information	Type of trust	2015/16	2016/17	2017/18
18	The trust's patient reported outcome measures scores for— (i) groin hernia surgery, (ii) varicose vein surgery (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.	Trusts providing relevant acute services	n/a	n/a	n/a
19	The percentage of patients aged - (i) 0 to 15; and (ii) 16 or over, Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	All trusts	n/a	n/a	n/a
20	The trust's responsiveness to the personal needs of its patients during the reporting period.	Trusts providing relevant acute services	n/a	n/a	n/a
21	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	Trusts providing relevant acute services	90%	87.5%	82%
21.1	Friends and Family Test – patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2). Please note: there is not a statutory requirement to include this indicator in the quality accounts reporting but NHS provider organisations should consider doing so.	Trusts providing relevant acute services	98%	98%	97.8%
22	The trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	Trusts providing relevant mental health services	n/a	n/a	n/a
23	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Trusts providing relevant acute services	99.8%	99.6%	99.9%
24	The rate per 100,000 bed days of cases of C difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	Trusts providing relevant acute services	n/a	n/a	n/a
25	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	All trusts	10,227 39 0.38%	10,002 7 0.07%	10,018 9 0.08%

Independent Auditors' Report to the Council of Governors of Derbyshire Community Health Services NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Derbyshire Community Health Services NHS Foundation Trust's financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 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 2017/18.

We have audited the financial statements, included within the Annual Report (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income for the year then ended; the Statement of Cashflows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Our audit approach

Context

Our audit for the year ended 31 March 2018 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 areas of focus was largely unchanged, apart from our approach to the revaluation of land and buildings. Since the Trust has adopted a new methodology with regards to the valuation of land and specialised buildings this was a particular area of focus.

Overview

Overall materiality: £3.977 million, which represents 2% of total revenue.

All work was performed by a single audit team who assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement and determined the extent of testing we needed to do over each balance in the financial statements.

Our key audit matters were:

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

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. This is not a complete list of all risks identified by our audit.

Key audit matter	How our audit addressed the key audit matter
Risk of fraud in the recognition of revenue and expenditure ***See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 2-5 for further information.*** We focused on this area because there is a heightened risk as: • the Trust reported achievement against its control total of £4.92 million. Given the likelihood of increasing pressure in future years to make further cost savings due to government funding cuts and increasing demand for services there is an incentive to reduce reported income and defer income into 2018/19; • there is an incentive to recognise additional expenditure in 2017/18 relating to future periods, to improve the financial results in future periods when there is expected to be greater financial strain. Expenditure relating to judgemental estimates, including provisions and accruals could be over-estimated in order to ease pressures in the future; and • the service level agreements with the CCGs are renegotiated annually and consist of standard monthly instalments with a settlement for under / over performance against agreed contract levels. Over / under performance is negotiated with commissioners and is, therefore, subject to management judgement regarding its value and recoverability. Given these incentives, we focussed our work on the elements of income and expenditure that are most susceptible to manipulation, being: • year-end healthcare income settlements with CCGs; • items of expenditure where the value is dependent upon estimates, in particular provisions and accruals; • non-standard journal transactions; and • unrecorded income and receivables.	We read the accounting policy for income and expenditure recognition and found it to be consistent with the requirements of the Department of Health Group Accounting Manual 2017/18. **Income from Activities** For a sample of healthcare income, we obtained and agreed the income received during the year to a signed contract with the CCGs. For a sample of income recognised in relation to under / over performance against contract we agreed these to contract variations signed by the relevant CCG and the Trust. No issues were identified from the work performed. We used the mismatches report provided by NHS Improvement to auditors to identify any differences between income, expenditure, debtors and creditors reported by other NHS organisations. We checked that management had investigated all disputed amounts over £0.25 million. We read correspondence with the counterparties, and then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements and determined that there was no material impact. **Provisions** We obtained an understanding of the movement for each category of expenditure provision and performed testing on the restructuring provision by agreeing the provision to supporting evidence, confirming the accuracy of the provision calculations and that the Trust had a constructive obligation at 31 March 2018. **Expenditure Accruals** We agreed a sample of accruals back to the supporting evidence available. In addition, we confirmed whether it was appropriate for our sample of accruals over one year old to be recognised within the financial statements. Where invoices had not been received at the time of our audit, we obtained details of how the accrual had been calculated and confirmed the accuracy of the calculation. We also obtained the information that had been used to form the estimate in order to substantiate the accrual. Significant balances relate to the holiday pay accrual, employee payment error, payments for services provided by Derbyshire County Council and travel claims. We also tested some lower value accruals to consider their completeness. **Journals** We tested a sample of journal transactions that had been recognised in both income and expenditure, focusing particularly on those: • that were raised by senior members of the finance team; and • that used unusual account combinations. We agreed the journal entries to supporting documentation, for example invoices and cash transactions. Our testing found that they were supported by appropriate documentation and that the income and expenditure was recognised in the appropriate accounting period. **Other Year End Procedures** For a sample of transactions recognised during the year and around (both before and after) the year end, we confirmed that income and expenditure had been accounted for in the correct accounting year. We found no material issues.
Valuation of property, plant and equipment ***See note 1 to the financial statements for the directors' disclosures of the related accounting policies for Property, Plant and Equipment and note 12 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 Property, Plant and Equipment were appropriate and correctly applied. The PPE balance at 31 March 2018 had a net book value of £72.7 million, of which £67.6 million relates to land and buildings, which are subject to revaluation. The Trust has changed its valuation methodology in 2017/18, undertaken a significant exercise and had a full revaluation of its entire estate as at 1 April 2017 and 31 March 2018. For specialised assets, this has been applied using a modern equivalent asset basis and non-specialised assets have been valued at market value for existing use. Our specific areas of focus were: • accuracy and completeness of detailed information on assets used as the input data for each valuation; • whether the Trust's assumptions underlying the classification of properties were appropriate; • the basis of revaluation, assumptions and underlying data; and • the accounting transactions resulting from this valuation were accurately recorded in the financial statements.	We have tested a sample of land and building site plans and asset information held by the Trust. We have understood how the existing estate has been used to develop a new "optimised" estate based on reducing the size of existing specialised buildings reflecting how future services would be delivered if the entire estate was to be redesigned. We have assessed the assumptions and estimates used in developing this optimised estate and considered the reasonableness of these using our experience of Trust operations. We have also considered the professional capabilities of the Trust's external consultant who has supported in the development of the optimised estate. We obtained and read the relevant sections of the full valuation performed by the District Valuer. We assessed the assumptions and the estimates used in the valuation and considered the reasonableness of these using our valuation expertise and consideration of wider industry trends. We 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. Our testing did not identify any issues.

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 accounting processes and controls, and the environment in which the Trust operates.

In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

Derbyshire Community Health Services NHS Foundation Trust prepares individual Trust accounts. We conducted the audit work on the Trust financial statements at Walton Hospital, which is where the finance function is based.

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	£3.977 million (2017: £3.8 million)
How we determined it	2% of revenue used as the basis in both 2017 and 2018.
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £194,000 (2017: £189,000) 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 when:

- the directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

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 2017/18 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.

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 38, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, 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 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.

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter, which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

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

Opinions on other matters prescribed by the Code of Audit Practice

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 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

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 2017/18.

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 2018. We have nothing 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 85, 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 members 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 82, 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 2017/18 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- We have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- We have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- We have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Alison Breadon (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Donington Court
Castle Donington
East Midlands

Date: 29 May 2018

Annual Accounts

for the year ended 31 March 2018

Foreword to the accounts

Derbyshire Community Health Services NHS Foundation Trust

These accounts, for the year ended 31 March 2018, 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 Chris Sands

Job title Acting Chief Executive

Date **23rd May 2018**

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	180,930	188,339
Other operating income	4	17,911	6,251
Operating expenses	5, 7	(207,101)	(186,656)
Operating surplus/(deficit) from continuing operations		**(8,260)**	**7,934**
Finance income	10	68	50
PDC dividends payable		(1,834)	(2,352)
Net finance costs		**(1,766)**	**(2,302)**
Other gains / (losses)	11	881	70
Surplus / (deficit) for the year from continuing operations		**(9,145)**	**5,702**
Surplus / (deficit) for the year		**(9,145)**	**5,702**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(12,383)	-
Revaluations	15	16,350	4,586
Other reserve movements		-	(950)
Total comprehensive income / (expense) for the period		**(5,178)**	**9,338**

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	12	2,236	2,535
Property, plant and equipment	13	72,737	83,613
Trade and other receivables	16	151	179
Total non-current assets		**75,124**	**86,327**
Current assets			
Trade and other receivables	16	10,461	7,223
Non-current assets held for sale / assets in disposal groups	17	-	3,100
Cash and cash equivalents	18	26,619	21,402
Total current assets		**37,080**	**31,725**
Current liabilities			
Trade and other payables	19	(14,784)	(16,175)
Provisions	21	(875)	(647)
Other liabilities	20	(129)	(306)
Total current liabilities		**(15,788)**	**(17,128)**
Total assets less current liabilities		**96,416**	**100,924**
Non-current liabilities			
Provisions	21	(20)	(20)
Total non-current liabilities		**(20)**	**(20)**
Total assets employed		**96,396**	**100,904**
Financed by			
Public dividend capital		913	243
Revaluation reserve		29,050	25,162
Income and expenditure reserve		66,433	75,499
Total taxpayers' equity		**96,396**	**100,904**

The notes on pages 212 to 244 form part of these accounts.

Signed 

Name Chris Sands
Job title Acting Chief Executive
Date **23rd May 2018**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(8,260)	7,934
Non-cash income and expense:			
Depreciation and amortisation	5.1	3,459	3,960
Net impairments	6	17,947	-
Income recognised in respect of capital donations	4	(228)	(59)
(Increase) / decrease in receivables and other assets		(2,615)	640
Increase / (decrease) in payables and other liabilities		(1,375)	(601)
Increase / (decrease) in provisions		228	182
Other movements in operating cash flows		(1)	(943)
Net cash generated from / (used in) operating activities		**9,155**	**11,113**
Cash flows from investing activities			
Interest received		68	50
Purchase of intangible assets		(302)	(850)
Purchase of property, plant, equipment and investment property		(6,170)	(3,719)
Sales of property, plant, equipment and investment property		4,231	-
Receipt of cash donations to purchase capital assets		-	44
Net cash generated from / (used in) investing activities		**(2,173)**	**(4,475)**
Cash flows from financing activities			
Public dividend capital received		670	-
PDC dividend (paid) / refunded		(2,435)	(2,210)
Net cash generated from / (used in) financing activities		**(1,765)**	**(2,210)**
Increase / (decrease) in cash and cash equivalents		**5,217**	**4,428**
Cash and cash equivalents at 1 April - brought forward		**21,402**	**16,974**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**21,402**	**16,974**
Cash and cash equivalents at 31 March	18.1	**26,619**	**21,402**

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 2017/18 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 accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

The Trust has reviewed its working capital requirements for the next twelve months. Under a set of reasonable sensitivities , it can be demonstrated that the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the 2017/18 accounts.

Note 1.2 Critical judgements and estimations 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

The Trust's specialised buildings have been re-valued on a modern equivalent asset basis during 2017/18.

Accounting for leasese

Judgements have been made regarding whether the risks and rewards of ownership pass to the lessee under lease arrangements.

Compensated Absences Accrual

In accordance with IAS19, the Trust accrues for untaken annual leave at the end of the financial year. This accrual is based on a sample which is then extrapolated across the population.

Accounting for doubtful debts

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

Note 1.3 Interests in other entities

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

Charitable Funds

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

Following Treasury's agreement to apply IAS27 to NHS Charities from 1st April 2013, the Trust ahs estbalished that as the Trust is the corporate Trustee of the linked NHD 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 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. Income related to in-patient spells is based on discharged patients, with no work in progress adjustment being made.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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.

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 e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, 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. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost 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 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Measurement

Valuation

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

Land and buildings used to deliver services or for administrative purposes are recognised in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed at regular intervals . Fair values 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

In accordance with RICS guidance, depreciated replacement cost valuations are based on modern equivalent assets and where it would meet the location requirements of the service being provided, an alternative site can be valued.

Subsequent expenditure

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

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively. Estimated useful lives and residual values are reviewed every year end with the effect of any changes recognised on a prospective basis.

As IT hardware is routinely replaced very 5 years, any IT equipment fully depreciated and greater than 5 years old is disposed of in the accounts.

Revaluation gains and losses

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

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

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

Impairments

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

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

Note 1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Note 1.7.4 Donated and grant funded assets

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

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

Note 1.7.5 Useful economic lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	16	100
Dwellings	-	-
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	5	10

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets

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

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Intangible assets in the course of development for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately. Amortisation commences when they are brought into use.

Software

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

Note 1.8.2 Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

Amortisation

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

Note 1.8.3 Useful economic lives of intangible assets

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

	Min life Years	Max life Years
Software licences	5	10
Licences & trademarks	5	10

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 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 three 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 1.11 Financial instruments and financial liabilities

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial assets.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The Trust considers that the fair values of financial assets and liabilities are materially the same as the carrying value so no valuations have been undertaken.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Note 1.12 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose

separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

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.

Note 1.13.1 The Trust as lessee

Finance leases

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

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

Note 1.13.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' 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 NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it.

The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

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 21.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),

(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and

(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 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 (other than financial instrument measured at “fair value through income and expenditure”) 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 (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s FReM.

Note 1.20 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, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

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

For functions that have been transferred to the Trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity’s accounts are preserved on recognition in the Trust’s accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Trust’s accounting policies are applied after initial recognition and are adjusted directly in taxpayers’ equity.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

Standard	Accounting Standards	Published by ISAB	Financial year for which the standard first applies
IFRS 9	IFRS 9 Financial instruments	July 2014	Application required for an entity’s first annual financial statements for periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 15	Revenue from contracts with customers - new revenue standard incorporating a single model that applies to contracts with customers	May 2014	Application required for an entity’s first annual IFRS financial statements for periods beginning on or after 1 January 2018, b ut not adopted by the FReM: early adoption is not therefore permitted.
IFRS 16	IFRS16 Leases published	January 2016	Application required for an entity’s first annual financial statements for periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 22	IFRIC 22 Foreign currency Transactions and Advance Consideration	October 2015	Application required for an entity’s first annual financial statements for periods beginning on or after 1 January 2018

The adoption of IFRS 15 Revenue from contracts and customers may have a future material impact on revenue recognition within the consolidated NHS foundation trust financial statements but this standard has not yet been adopted for the public sector by HM Treasury and may be subject to interpretation and/or adaptation. As such, it is not currently possible to estimate the potential impact.

The adoption of IFRS 16 Leases are expected to be significantly impacted by the changes in the new lease requirements. This is especially the case where leased properties form a significant part of the Trust’s business model. The Standard requires the Trust to recognise most leases on the balance sheet, but this standard has not yet been adopted for the public sector by HM Treasury and may be subject to interpretation and/or adaptation. As such, it is not currently possible to estimate the potential impact.

The remaining new standards are not anticipated to have a future material impact.

Note 2 Operating Segments

No segmental analysis is shown as the sole activity of Derbyshire Community Health Services NHS Foundation Trust in 2017/18 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 2017/18 dependent upon the information received by the Chief Operating Decision Maker.

The Trust has five customers that account for more than 10% of its total revenue derived from providing specialist community services. Customers are defined for this purpose as “Clinical Commissioning Groups and NHS England” and Local Authorities.The total income that the Trust received during the period 1st April 2017 to 31st March 2018 was £181m 2016/17: £181m) for the provision of specialist community services.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017/18	2016/17
	£000	£000
Acute services		
Elective income	4,474	-
Non elective income	32,611	-
First outpatient income	2,618	-
Follow up outpatient income	2,991	-
A & E income	5,050	-
Mental health services		
Block contract income	9,956	-
Community services		
Community services income from CCGs and NHS England	96,280	157,789
Income from other sources (e.g. local authorities)	22,681	29,574
All services		
Other clinical income	4,269	976
Total income from activities	**180,930**	**188,339**

A change in re-classification of 2017/18 income from patient care activities resulted in 2016/17 figures not directly comparable.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18	2016/17
	£000	£000
NHS England	8,596	-
Clinical commissioning groups	148,576	157,789
Other NHS providers	96	5,188
Local authorities	22,681	24,386
NHS injury scheme	280	297
Non NHS: other	701	679
Total income from activities	**180,930**	**188,339**
Of which:		
Related to continuing operations	180,930	188,339

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	87	95
Education and training	1,113	1,043
Receipt of capital grants and donations	220	59
Charitable and other contributions to expenditure	8	-
Non-patient care services to other bodies	-	650
Sustainability and transformation fund income	4,061	2,585
Other income	12,422	1,819
Total other operating income	**17,911**	**6,251**
Of which:		
Related to continuing operations	17,911	6,251

Other income includes recharges to other NHS providers for the provision of services. This is a change in classification from 2016/17.

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	-	-
Income from services not designated as commissioner requested services	180,930	188,339
Total	**180,930**	**188,339**

Note 5.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	9,682	10,519
Purchase of healthcare from non-NHS and non-DHSC bodies	3,516	3,509
Staff and executive directors costs	130,989	129,316
Remuneration of non-executive directors	127	130
Supplies and services - clinical (excluding drugs costs)	11,810	11,276
Supplies and services - general	1,411	1,495
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	2,262	2,345
Inventories written down	-	-
Consultancy costs	175	535
Establishment	2,115	5,832
Premises	8,927	7,591
Transport (including patient travel)	4,437	554
Depreciation on property, plant and equipment	2,858	3,471
Amortisation on intangible assets	601	489
Net impairments	17,947	-
Increase/(decrease) in provision for impairment of receivables	(28)	50
Audit fees payable to the external auditor		
audit services- statutory audit	56	57
other auditor remuneration (external auditor only)	4	19
Internal audit costs	106	111
Clinical negligence	436	356
Legal fees	209	247
Insurance	18	42
Education and training	784	561
Rentals under operating leases	6,962	6,922
Redundancy	359	386
Car parking & security	74	100
Hospitality	4	7
Losses, ex gratia & special payments	3	1
Other	1,257	735
Total	**207,101**	**186,656**
Of which:		
Related to continuing operations	207,081	186,656

Note 5.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
7. Corporate finance transaction services not falling within items 1 to 6 above	-	10
8. Other non-audit services not falling within items 2 to 7 above	4	9
Total	**4**	**19**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	17,947	-
Total net impairments charged to operating surplus / deficit	**17,947**	-
Impairments charged to the revaluation reserve	12,383	-
Total net impairments	**30,330**	-

During the year, the Trust has revalued its land and buildings. Specialised buildings have been 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 is recognised initially against the Revaluation Reserve with the balance being recognised as an impairment.This has resulted in the Trust recognising impairments of £29.7m in the 2017/18 Accounts (2016/17: £Nil)

Note 7 Employee benefits

	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	104,172	103,842
Social security costs	8,882	8,790
Apprenticeship levy	520	-
Employer's contributions to NHS pensions	14,087	13,932
Pension cost - other	8	9
Other employment benefits	2,808	1,271
Termination benefits	359	386
Temporary staff (including agency)	741	1,551
Total gross staff costs	**131,577**	**129,781**
Recoveries in respect of seconded staff	-	-
Total staff costs	**131,577**	**129,781**
Of which		
Costs capitalised as part of assets	229	79

Note 7.1 Retirements due to ill-health

During 2017/18 there were three early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £127k (£297k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 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 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

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 2017 to 31st March 2018 the Trust has contributed £8226.77 (2016/17: £8226.77)

Note 9 Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where Derbyshire Community Health Services NHS Foundation Trust is the lessee.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	6,962	6,922
Total	**6,962**	**6,922**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	7,297	6,622
- later than one year and not later than five years;	2,494	2,492
- later than five years.	6,331	6,229
Total	**16,122**	**15,343**

Note 10 Finance income

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

	2017/18	2016/17
	£000	£000
Interest on bank accounts	68	50
Total	**68**	**50**

Note 11 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	949	242
Losses on disposal of assets	(68)	(172)
Total gains / (losses) on disposal of assets	**881**	**70**
Total other gains / (losses)	**881**	**70**

During the year the Trust has disposed of surplus land and building assets, resulting in a profit on sale of £949k.

Note 12.1 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**3,668**	**222**	**3,890**
Transfers by absorption	-	-	**-**
Additions	-	302	**302**
Reclassifications	486	(486)	**-**
Gross cost at 31 March 2018	**4,154**	**38**	**4,192**
Amortisation at 1 April 2017 - brought forward	**1,355**	**-**	**1,355**
Provided during the year	601	-	**601**
Amortisation at 31 March 2018	**1,956**	**-**	**1,956**
Net book value at 31 March 2018	**2,198**	**38**	**2,236**
Net book value at 1 April 2017	**2,313**	**222**	**2,535**

Note 12.2 Intangible assets - 2016/17

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**2,552**	**-**	**2,552**
Additions	-	850	**850**
Reclassifications	1,202	(628)	**574**
Disposals / derecognition	(86)	-	**(86)**
Valuation / gross cost at 31 March 2017	**3,668**	**222**	**3,890**
Amortisation at 1 April 2016 - as previously stated	**948**	**-**	**948**
Provided during the year	**489**	-	**489**
Disposals / derecognition	(82)	-	**(82)**
Amortisation at 31 March 2017	**1,355**	**-**	**1,355**
Net book value at 31 March 2017	**2,313**	**222**	**2,535**
Net book value at 1 April 2016	**1,604**	**-**	**1,604**

Note 13.1 Property, plant and equipment, as at 31 March 2018

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	**£000**
Valuation/gross cost at 1 April 2017 - brought forward	**15,645**	**69,406**	**1,393**	**4,621**	**17**	**5,203**	**1,458**	**97,743**
Additions	1,779	-	4,426	-	-	-	-	**6,205**
Impairments	(6,605)	(26,254)	-	-	-	-	-	**(32,859)**
Revaluations	49	10,829	-	-	-	-	-	**10,878**
Reclassifications	110	3,038	(4,310)	175	-	987	-	**-**
Transfers to/ from assets held for sale	(154)	-	-	-	-	-	-	**(154)**
Disposals / derecognition	-	-	-	(86)	-	(135)	(162)	**(383)**
Valuation/ gross cost at 31 March 2018	**10,824**	**57,019**	**1,509**	**4,710**	**17**	**6,055**	**1,296**	**81,430**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**6,514**	**-**	**3,795**	**17**	**2,638**	**1,166**	**14,130**
Provided during the year	**-**	**1,698**	**-**	**209**	**-**	**852**	**99**	**2,858**
Impairments	-	(2,529)	-	-	-	-	-	**(2,529)**
Revaluations	-	(5,472)	-	-	-	-	-	**(5,472)**
Disposals / derecognition	-	-	-	(50)	-	(108)	(136)	**(294)**
Accumulated depreciation at 31 March 2018	**-**	**211**	**-**	**3,954**	**17**	**3,382**	**1,129**	**8,693**
Net book value at 31 March 2018	**10,824**	**56,808**	**1,509**	**756**	**-**	**2,673**	**167**	**72,737**
Net book value at 1 April 2017	**15,645**	**62,892**	**1,393**	**826**	**-**	**2,565**	**292**	**83,613**

Note 13.2 Property, plant and equipment - 2016/17

	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 2016 - as previously stated	**16,809**	**63,288**	**2,925**	**5,532**	**17**	**4,084**	**1,627**	**94,282**
Additions	254	500	2,933	15	-	-	-	**3,702**
Revaluations	1,150	3,436	-	-	-	-	-	**4,586**
Reclassifications	532	1,948	(4,465)	225	-	1,186	-	**(574)**
Transfers to / from assets held for sale	(3,100)	-	-	-	-	-	-	**(3,100)**
Disposals / derecognition	-	234	-	(1,151)	-	(67)	(169)	**(1,153)**
Valuation/ gross cost at 31 March 2017	**15,645**	**69,406**	**1,393**	**4,621**	**17**	**5,203**	**1,458**	**97,743**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**4,198**	**-**	**4,633**	**17**	**1,940**	**1,098**	**11,886**
Provided during the year	**-**	**2,317**	**-**	**259**	**-**	**746**	**149**	**3,471**
Disposals/ derecognition	-	(1)	-	(1,097)	-	(48)	(81)	**(1,227)**
Accumulated depreciation at 31 March 2017	**-**	**6,514**	**-**	**3,795**	**17**	**2,638**	**1,166**	**14,130**
Net book value at 31 March 2017	**15,645**	**62,892**	**1,393**	**826**	**-**	**2,565**	**292**	**83,613**
Net book value at 1 April 2016	**16,809**	**59,090**	**2,925**	**899**	**-**	**2,144**	**529**	**82,396**

Note 13.3 Property, plant and equipment financing, as at 31 March 2018

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	10,824	53,901	1,509	756	-	2,673	167	**69,830**
Owned - donated	-	2,907	-	-	-	-	-	**2,907**
NBV total at 31 March 2018	**10,824**	**56,808**	**1,509**	**756**	**-**	**2,673**	**167**	**72,737**

Note 13.4 Property, plant and equipment financing - 2016/17

	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 2017								
Owned - purchased	15,645	59,427	1,393	716	-	2,565	292	**80,038**
Owned - donated	-	3,465	-	110	-	-	-	**3,575**
NBV total at 31 March 2017	**15,645**	**62,892**	**1,393**	**826**	**-**	**2,565**	**292**	**83,613**

Note 14 Donations of property, plant and equipment

During the year 1st April 2017 to 31st March 2018, the Trust received donated assets totalling £228,878 (2016/17: £59,039)

Note 15 Revaluations of property, plant and equipment

During the year, the Trust undertook a full revaluation exercise in respect of the land and building assets held. Specialised buildings are revalued at depreciated replacement cost on a modern equivalent asset basis. This is consistent with the NHS accounting policies and principles which are detailed in the Department of Health Government Accounting Manual. Land and non-specialised buildings have been valued at market value for existing use. During 2017/18 two valuations have been transacted. One at the 1st April 2017 and one at 31st March 2018. In both cases, the valuations were carried out by the District Valuer.

Note 16.1 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	4,654	2,187
Capital receivables (including accrued capital related income)	38	22
Accrued income	3,857	3,522
Provision for impaired receivables	(140)	(174)
Prepayments (non-PFI)	766	808
PDC dividend receivable	601	-
VAT receivable	369	320
Other receivables	316	538
Total current trade and other receivables	**10,461**	**7,223**
Non-current		
Provision for impaired receivables	(45)	(44)
Other receivables	196	223
Total non-current trade and other receivables	**151**	**179**
Of which receivables from NHS and DHSC group bodies:		
Current	6,975	7,223

Note 16.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**218**	**176**
Increase in provision	(28)	50
Amounts utilised	(5)	(8)
At 31 March	**185**	**218**

Note 16.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	-	-
30 - 60 Days	-	-	-	-
60 - 90 days	-	-	-	-
90 - 180 days	20	-	24	-
Over 180 days	164	-	194	-
Total	**184**	**-**	**218**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,855	-	(635)	-
30-60 Days	409	-	(106)	-
60-90 days	104	-	15	-
90- 180 days	18	-	6	-
Over 180 days	547	-	18	-
Total	**2,933**	**-**	**(702)**	**-**

Note 17 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**3,100**	**-**
Assets classified as available for sale in the year	154	**3,100**
Assets sold in year	(3,254)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**3,100**

Note 18.1 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.

	2017/18	2016/17
	£000	£000
At 1 April	**21,402**	**16,974**
Net change in year	5,217	4,428
At 31 March	**26,619**	**21,402**
Broken down into:		
Cash at commercial banks and in hand	-	6
Cash with the Government Banking Service	26,619	21,396
Total cash and cash equivalents as in SoFP	**26,619**	**21,402**
Total cash and cash equivalents as in SoCF	**26,619**	**21,402**

Note 18.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	5	5
Total third party assets	**5**	**5**

Note 19 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	4,958	8,102
Capital payables	657	850
Accruals	4,092	3,357
Social security costs	1,367	1,406
Other taxes payable	796	810
PDC dividend payable	1	1
Other payables	2,913	1,649
Total current trade and other payables	**14,784**	**16,175**
Of which payables from NHS and DHSC group bodies:		
Current	2,910	3,621

Note 20 Other liabilities

	31 March 2018	31 March 2017
	£000	£000
Current		
Deferred income	129	306
Total other current liabilities	129	306

Note 21.1 Provisions for liabilities and charges analysis

	Legal claims	Re-structuring	Total
	£000	£000	£000
At 1 April 2017	**123**	**544**	**667**
Arising during the year	16	827	843
Utilised during the year	(18)	(87)	(105)
Reversed unused	(42)	(468)	(510)
At 31 March 2018	**79**	**816**	**895**
Expected timing of cash flows:			
- not later than one year;	59	816	875
- later than one year and not later than five years;	20	-	20
- later than five years.	-	-	-
Total	**79**	**816**	**895**

The restructuring provision relates to the liability from service re-design and a number of individual redundancies

The legal provision relates to 10 cases currently with the NHS Litigation Authority.

Note 21.2 Clinical negligence liabilities

At 31 March 2018, £79k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Derbyshire Community Health Services NHS Foundation Trust (31 March 2017: £123k).

The restructuring provision relates to the liability from the decommissioning of a service line and a number of individual redundancies

Note 22 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	-	1,192
Intangible assets	-	-
Total	-	1,192

Note 23 Financial instruments

Note 23.1 Financial risk management

Financial Reporting standard IFRS7 requires the disclosures of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking activities. Because of the continuing service provider relationship that the Trust has with its commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Trust's Treasury Management operations are carried out by the finance department , within the parameters defined formally by the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust's treasury activities is 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 exposure to credit risk. The maximum exposures as at 31 March 2018 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.

Liquidity Risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust funds it's capital investment plans from internally generated cash resources. The Trust is not, therefore, exposed to significant liquidity risks.

Note 23.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	8,876	-	-	-	**8,876**
Cash and cash equivalents at bank and in hand	26,619	-	-	-	**26,619**
Total at 31 March 2018	**35,495**	**-**	**-**	**-**	**35,495**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	7,223	-	-	-	**7,223**
Cash and cash equivalents at bank and in hand	21,402	-	-	-	**21,402**
Total at 31 March 2017	**28,625**	**-**	**-**	**-**	**28,625**

Note 23.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Trade and other payables excluding non financial liabilities	12,654	-	12,654
Total at 31 March 2018	**12,654**	**-**	**12,654**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Trade and other payables excluding non financial liabilities	12,621	-	12,621
Total at 31 March 2017	**12,621**	**-**	**12,621**

Note 23.4 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	12,654	12,621
Total	**12,654**	**12,621**

Note 24 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Special payments				
Ex-gratia payments	12	3	13	1
Total special payments	**12**	**3**	**13**	**1**
Total losses and special payments	**12**	**3**	**13**	**1**

Note 25 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

Jenny Swatton declared that she is the Director of Joint Commissioning of Southern Derbyshire CCG. 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'. Carol Hart declared that she is Cabinet Member for Public Health and Committee of Derbyshire County Council. Transactions are in the normal course of business and are on an arms-length basis. Transactions with this local government body are disclosed under 'Transactions with Other Related Parties'.

Transactions with Board Members

Prem Singh is also appointed as Chairman of George Eliot Hospital NHS Trust. Transactions are in the normal course of business and are on an arms-length basis. There are no transactions with this NHS Body during 2017/18.

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 contracts. Transactions are in the normal course of business and are on an arms-length basis.

Tracy Allen declared that her partner is employed as Director of Transformation and Clinical Programmes of Hardwick CCG. He has no direct commissioning responsibility for DCHS contracts. 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'.

Amanda Rawlings, Director of People and Organisational Effectiveness, was also appointed to 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 NHS body are disclosed under 'Transactions with Other Related Parties'.

Transactions with Other Related Parties

The Department of Health is regarded as a related party. During the year to 31 March 2018 Derbyshire Community Health Services NHS Foundation Trust has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent entity. The value of transactions with Government bodies and Other Related Parties with which the Trust has had significant dealings and which therefore require disclosure are as below:

	Receivables		Payables	
Receivables/payables over £250k	**31.03.2018**	**31.03.2017**	**31.03.2018**	**31.03.2017**
	£000	**£000**	**£000**	**£000**
Chesterfield Royal Hospital NHS Foundation Trust	321	576	224	320
Derby Teaching Hospital NHS Foundation Trust	442	275	910	509
Derbyshire Healthcare NHS Foundation Trust	209	25	322	250
NHS England	3,062	1,870	-	20
North Derbyshire CCG	11	33	35	732
Southern Derbyshire CCG	1,514	735	24	28
Hardwick CCG	93	(365)	8	8
Erewash CCG	222	116	41	489
Community Health Partnership	46	458	145	648
NHS Property Services	3	80	951	384
Derbyshire County Council	1,724	1,057	276	207

	Income		Expenditure	
Income/expenditure over £1m	**2017/18**	**2016/17**	**2017/18**	**2016/17**
	£000	**£000**	**£000**	**£000**
NHS England	12,771	12,870	112	1,854
North Derbyshire CCG	54,931	54,005	370	247
Southern Derbyshire CCG	56,158	54,406	146	196
Hardwick CCG	18,933	17,035	77	79
Erewash CCG	19,691	19,297	588	1,087
Derbyshire County Council	20,827	21,813	637	(85)
Derby City Council	2,171	2,347	44	40
Derby Teaching Hospital NHS Foundation Trust	2,625	2,306	4,896	4,891
Derbyshire Healthcare NHS Foundation Trust	1,129	1,165	2,101	1,944
Chesterfield Royal Hospital NHS Foundation Trust	677	541	1,694	2,188
Community Health Partnership	458	460	6,401	5,010
NHS Property Services	9	118	2,341	1,607
Health Education England	1,082	1,001	3	1
Department of Health	149	-	1,422	4
NHS Arden & GEM CSU	204	205	1,974	1,759

Note 26 Staff costs

			2017/18	2016/17
	Permanent	**Other**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	105,111	293	**105,404**	103,842
Social security costs	8,882	-	**8,882**	8,790
Apprenticeship levy	520	-	**520**	-
Employer's contributions to NHS pensions	14,087	-	**14,087**	13,932
Pension cost - other	8	-	**8**	9
Other employment benefits	-	-	**-**	1,271
Termination benefits	359	-	**359**	386
Temporary staff		2,317	**2,317**	1,551
Total gross staff costs	**128,967**	**2,610**	**131,577**	**129,781**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**128,967**	**2,610**	**131,577**	**129,781**
Of which				
Costs capitalised as part of assets	229	-	**229**	79

Average number of employees (WTE basis)

			2017/18	2016/17
	Permanent	**Other**	**Total**	**Total**
	Number	**Number**	**Number**	**Number**
Medical and dental	49	1	**50**	55
Ambulance staff	2	-	**2**	6
Administration and estates	763	18	**781**	812
Healthcare assistants and other support staff	1,012	46	**1,058**	1,062
Nursing, midwifery and health visiting staff	1,147	45	**1,192**	1,191
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	612	10	**622**	611
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	2	-	**2**	3
Total average numbers	**3,587**	**120**	**3,707**	**3,740**
Of which:				
Number of employees (WTE) engaged on capital projects	3	-	**3**	3

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	12	-	**12**
£10,001 - £25,000	11	-	**11**
£25,001 - 50,000	9	-	**9**
£50,001 - £100,000	(1)	-	**(1)**
£100,001 - £150,000	(1)	-	**(1)**
Total number of exit packages by type	**30**	**-**	**30**
Total resource cost (£)	£359,000	£0	**£359,000**

Reporting of compensation schemes - exit packages 2016/17

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	3	-	**3**
£10,001 - £25,000	6	-	**6**
£25,001 - 50,000	7	-	**7**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	1	-	**1**
Total number of exit packages by type	**17**	**-**	**17**
Total resource cost (£)	£385,000	£0	**£385,000**

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