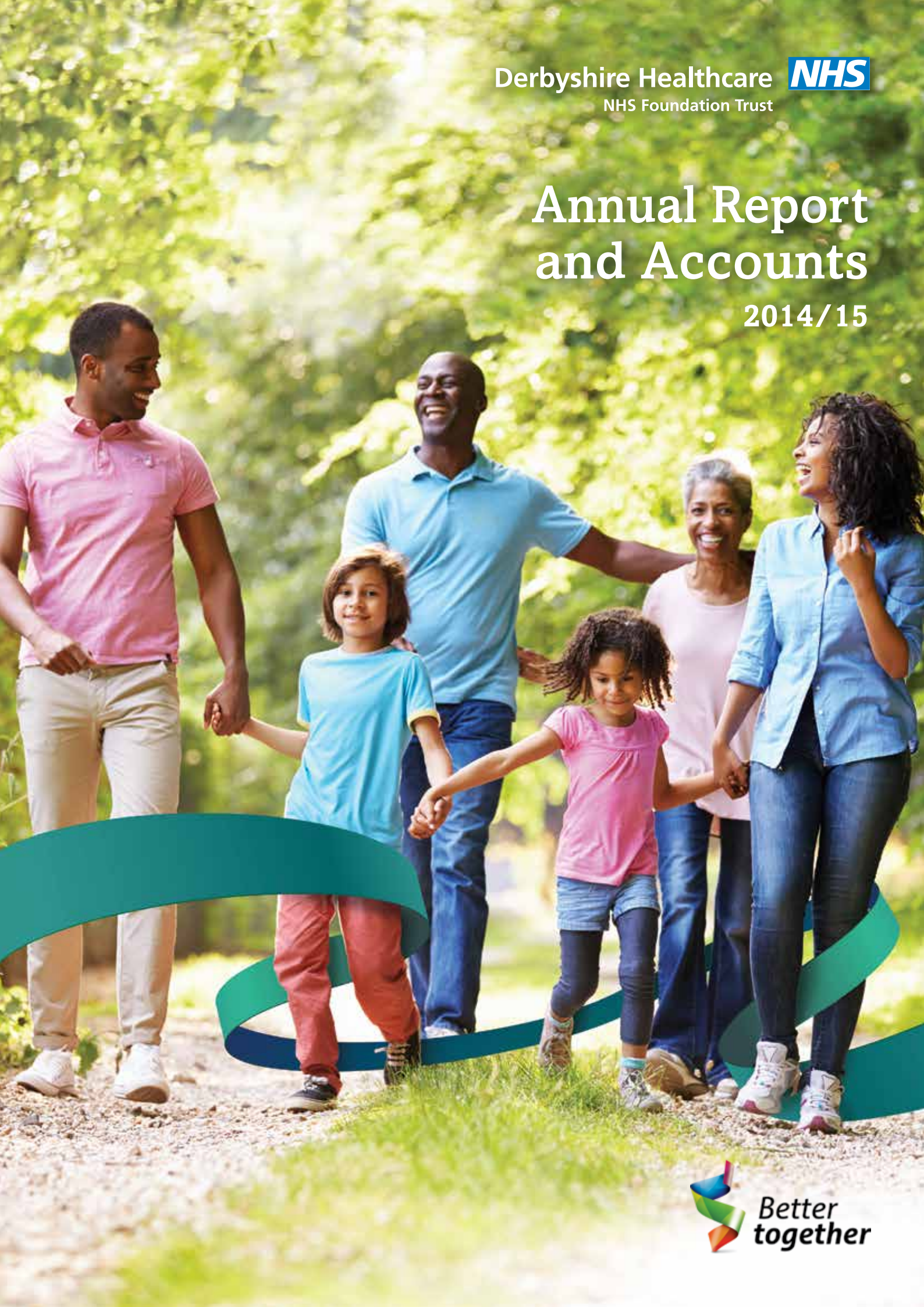
Derbyshire Healthcare NHS
NHS Foundation Trust

Annual Report and Accounts

2014/15



Better together

Derbyshire Healthcare NHS Foundation Trust

Annual Report and Accounts 2014/15

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

Contents

Welcome

to the Annual Report for Derbyshire Healthcare NHS Foundation Trust.

This Annual Report covers the financial year of 2014/15
(1 April 2014 – 31 March 2015)

“Improving lives, strengthening communities, shaping a better future together.”

Chairman's foreword

I am delighted to welcome you to the Annual Report for 2014/15.

This report reflects my first full year as Chairman of Derbyshire Healthcare NHS Foundation Trust. Throughout this year I have visited many teams and services, meeting with staff, provider partners, service receivers, volunteers and carers across the full range of our services.

"I am consistently struck by the commitment and dedication of our people and I would like to express my thanks to everyone who has helped make this a successful year for the Trust."

This report documents the Trust's activities over the last financial year, highlighting a number of key achievements and changes we have made to our services. Our purpose has been to make the care we provide more responsive and effective to the communities we serve. The highlights of the year are shared with you on pages 98-101 of this Annual Report.

During the year I have been delighted to welcome several new members to our Trust's Board of Directors, including two new Non-Executive Directors, Jim Dixon and Phil Harris. Jayne Storey also joined our executive leadership team as Director of Transformation and Mark Powell recently commenced in post as Director of Business Development and Marketing. There has been a significant change in our Board membership over the last 18 months, including the term of office for Lesley Thompson (NED) coming to an end after seven years working with the Trust. Given this level of change, we are currently conducting a review of how we work and the systems that we use, which will continue into 2015/16.

I would like to thank our staff, partners, commissioners, service receivers, carers, volunteers, advocates and members of our Foundation Trust for their support and contributions to our work during 2014/15. My special thanks go to our governors. Our Council of Governors welcomed several new members this year. The knowledge and experience of our governors strengthens our work and their contributions are invaluable.

Mark Todd
Chairman

Chief Executive's introduction

This report reflects a year of transformation for the Trust, as we have started our journey to realign clinical services to a neighbourhood-based model. We want our community services to be truly embedded within the communities that they serve, working in partnership with others to empower people to live independently, with support, and to improve the knowledge and awareness of wellbeing and the benefits of earlier detection and treatment for all conditions across the age range amongst Derbyshire people.

Throughout the year, we have committed to being a key partner with our health and social care colleagues across Derby city and Derbyshire.

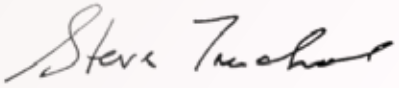
"We collectively face similar challenges and through working together and aligning key programmes of work, we can better tackle these challenges, improve the consistency of services offered to local residents, and develop a model of collaboration, not competition, across the local health economy."

During this period of change, we have continued to develop new services and to provide greater levels of support for our patients at times when they need it the most. Following the successful launch of a new liaison service in Derby during 2013, I was delighted to support the introduction of a new liaison service at Chesterfield Royal Hospital in January 2015. This new service will ensure that people receive appropriate support through A&E and throughout the hospital to address urgent mental health care needs, alongside wider issues relating to drug and alcohol abuse and self-harm.

Recovery has been a key theme for the Trust this year as we have sought to embed a recovery-focused and person-centred approach throughout our services. Of particular note is the opening of the new Hope and Resilience Hub at the Radbourne Unit in Derby. This new service brings together all components of our crisis care pathway and provides a new form of support to people who are on the brink of a hospital admission, or need some additional support to enable their discharge from hospital.

I am proud to say that compassion has remained at the forefront of everything we do, with our values even more firmly embedded across the organisation. We have also embarked on a journey of mindfulness, which helps us to better understand ourselves and others, and to develop more personal resilience, whilst also reducing stress and anxiety at work.

I have been impressed by the dedication of our staff, patients, carers, and partners, working together to improve the quality of our local services and, in turn, the health and wellbeing of our local communities. I look forward to continue working closely with you and our colleagues on new achievements and the exciting developments over the next year.



Steve Trenchard
Chief Executive

1. Strategic Report

Introduction to the Strategic Report

This Strategic Report reflects on the financial year of 2014/15, whilst also taking a forward look at the Trust's challenges and ambitions for 2015/16.

2014/15 has been a successful but also challenging year for the Trust, as we have continued to meet our quality and financial targets within a period of increasing financial pressures and higher activity levels. The year also reflects a period of change across the local health economy, as we have worked closely with our partners to address shared pressures and priorities and establish a collaborative way of working.

To achieve this we have worked closely with partners in the north of the county on the 21c #JoinedUpCare programme, and similarly with our colleagues in Derby city and the south through the STaR (System Transformation and Reconfiguration) board, where we are leading workstreams on mental health and children's services. These two programmes herald the way for health and social care organisations in the county to work differently; to collaborate rather than compete, and to progress towards a common shared goal in transforming local health services to meet the needs of the local population.

We have participated in these programmes alongside progressing with our own transformation work, which has in turn received high levels of participation and input from all our internal and external stakeholders. As this financial year comes to a close we are preparing to launch our shadow neighbourhood teams from 1 April 2015, which will provide an integrated service approach to care within local neighbourhoods. These teams will form a key part of local communities and will build assets and resilience within local communities to enable a higher number of people to self-care and receive appropriate support within a community setting, thereby reducing the number of unnecessary hospital admissions.

Mental health and parity of esteem have received an increasing level of national and local attention this year, namely through politicians and the media, and we have helped shape these conversations at a local and national level. There remains a disparity in the funding and resources available for the number of people with mental illnesses who are in contact with services, in comparison with those who have physical health needs. Nationally and locally this equates to approximately 11% of health and care funding despite it representing 23% of the burden of illness on the whole system. There remains work to be done.

We have been working with our commissioners, partners and governors this year to seek to address the historical imbalance of funding that mental health services have traditionally received. This will remain to be a key priority for the Trust over the forthcoming year.

A number of key reports have been published this year that have shaped and shared our direction of travel this year; including the NHS five year forward view and more recently the Dalton Review.

The NHS five year forward view outlines the changes needed to sustain and improve the NHS, namely how we all need to take our own health seriously and change the way services are provided. This is in line with our own transformation plans, by increasing the capacity and ability to self-care, models of prevention (particularly through our work with children to prevent higher levels of need in adults) and also via our commitment to give patients more control of their own care, through new models of care built around the needs of patients rather than historical or traditional models.

The Dalton Review, 'Examining new options and opportunities for providers of NHS care', published in December 2014, outlined that it was time for system leaders to pursue models of care that will deliver the greatest benefits to the populations they serve, rather than being led by organisational form. At the time of this report being published, the Trust is participating in a 'forerunner' pilot with our partner colleagues in Erewash, to explore new models of care in the area.

We have placed a strong emphasis on whistleblowing this year, to ensure that our staff feel confident in raising concerns at work and feel they will be supported if and when they do so. We are committed to fully implementing the recommendations outlined in Sir Robert Francis's 'Freedom to Speak Up' Review and will continue to progress this work over 2015/16.

We enter the new financial year with a refreshed Trust-wide strategy that reflects the current themes, priorities and focuses of today and the years ahead. Our updated plan for 2015/16, 'Improving lives, strengthening communities, shaping a better future together', reflects today's agenda of integrated services, with partnerships of different providers from the NHS, social care, voluntary and private sectors, that are required to address the whole needs of our patients and service users and offer 'joined up' pathways of care.

We are already working in partnership with others, and beginning to develop integrated services, but there is much more work to be done. Our ambition is to become acknowledged leaders, building on our achievements to date and developing our thinking from our growing experience as a learning organisation.

Building on our communities' needs, we will work with colleagues to deliver some key clinical priorities this year:

- Suicide prevention – to ensure we address all issues in connection with suicide and that our services perform to the highest possible standards in relation to this area, particularly in patient safety planning
- Think! Family - building our approach to safeguarding families, family-inclusive practice and helping teams to set their team objectives in this work
- To improve our clinical performance and clinical variability - ensuring that we are routinely assessing capacity for all decision making and that we work with informed consent in our personalised care planning approaches, to ensure a joint approach to shared care and decision making
- Leading the development of children's care pathways for young people across Derby city.

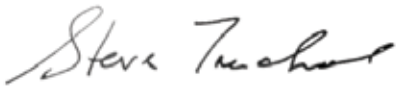
We have additional quality indicators which contribute to our local communities which are detailed in the Quality Report on pages 102-140.

We re-emphasise our intention that all our services will be delivered by compassionate and caring, well-trained, motivated and engaged staff working in high-performing teams. Our staff will be committed to excellence in all they do and to providing patient-centred care of the highest quality.

They will be proud to work for our Trust and will understand their contribution to the delivery of safe, caring, well-led, responsive and effective care delivery.

The annual accounts for 2014/15 show our financial performance for the year. The full set of accounts can be accessed on pages 150-184 of this Annual Report. The Trust's strategy can be accessed via www.derbyshirehealthcareft.nhs.uk

The Trust's directors take responsibility for preparing the Annual Report and Accounts. We consider they are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.



Steve Trenchard
Chief Executive
On behalf of Derbyshire Healthcare NHS Foundation Trust Board
22 May 2015

The Strategic Report is part of Derbyshire Healthcare NHS Foundation Trust's Annual Report and Accounts. To access a full copy of the 2014/15 Annual Report, please visit www.derbyshirehealthcareft.nhs.uk or contact the Trust's Headquarters at: Bramble House, Kingsway, Derby, DE22 3LZ, Tel. 01332 623700, email: communications@derbyshcft.nhs.uk

Better together

Derbyshire Healthcare NHS Foundation Trust (DHCFT) is a multi-specialty provider of community, children's and mental health services across the city of Derby and wider county of Derbyshire. We also provide a range of specialist services across the county including substance misuse, eating disorders and learning disabilities.

The Trust provides services to a diverse population, including areas of wealth alongside significant deprivation. The Trust's catchment includes both city and rural populations, with 71 languages being spoken.

Successful partnership working is key to the delivery of many of our services. The Trust works in close collaboration with our commissioners and fellow providers of local healthcare services, together with local authority colleagues at Derby City Council and Derbyshire County Council, and voluntary and community sector organisations.

Previously Derbyshire Mental Health Services NHS Trust, the Trust was granted Foundation Trust status on 1 February 2011. The Trust integrated with universal children and family services for Derby in 2011, following the dissolution of Derby City Primary Care Trust. Since its authorisation in 2011, the Trust has complied with both its terms of authorisation and the conditions of its provider licence and has not incurred any regulatory action from Monitor.

Our strapline, **'Better Together'** reflects the Trust's ethos of collaborative working, with our service users, carers, partners and staff to collectively improve health and wellbeing.

Our services

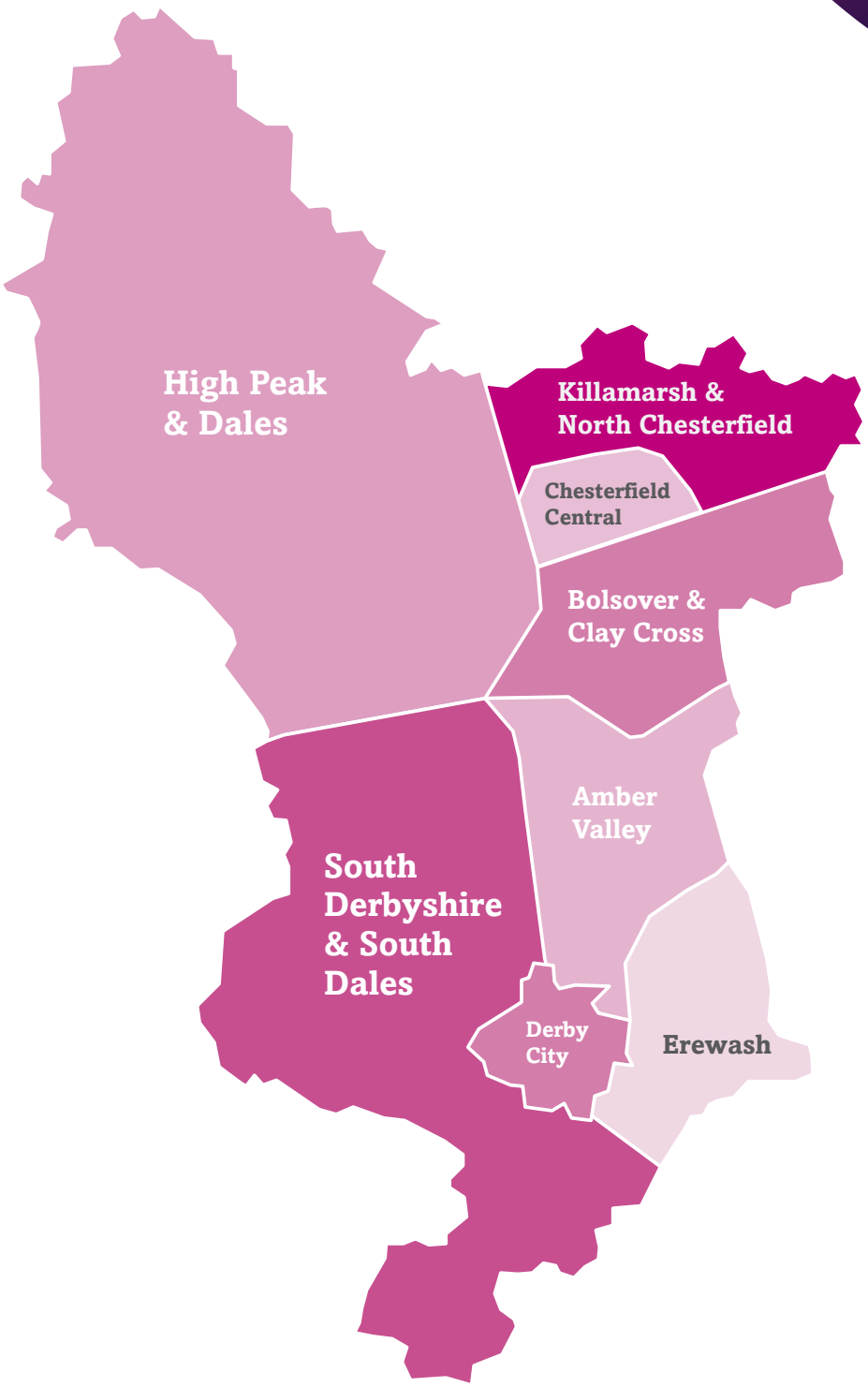
Throughout 2014/15, the Trust delivered care through a structure of two clinical divisions:

- Urgent and planned care – which brings together mental health services for adults and older adults
- Specialist and children's services – including services for children and young people, substance misuse, eating disorders, learning disabilities and forensic services.

A full list of the clinical services provided by the Trust during 2014/15 is provided on page 14 of this Annual Report. Details of new services that commenced within the year are outlined on pages 52-54.

During the year the Trust has developed a neighbourhood-based approach to delivering services and, from 1 April 2015, the Trust's mental health services will commence a shadow neighbourhood-based structure. For more information on the Trust's development of neighbourhood-based services, please see page 53 of this Annual Report.

Our neighbourhoods



This map outlines the Trust's eight neighbourhoods, which commenced in shadow form on 1 April 2015.

Our divisional structures

Urgent and planned care division

Services across Derby and South Derbyshire include:

- The Radbourne Unit in Derby, which provides three acute mental health inpatient wards, an enhanced care ward, mental health and substance misuse liaison services for the A&E department at Royal Derby Hospital, mental health crisis services, occupational therapy services and an ECT (Electro-Convulsive Therapy) suite
- On 1 February 2015 the Hope and Resilience Hub opened at the Radbourne Unit, providing integrated urgent mental health care support by bringing together three of the Trust's existing services – an inpatient ward (ward 35), the Crisis Resolution and Home Treatment service and day hospital services previously located at the Resource Centre at London Road Community Hospital – and applying a recovery-focused approach to support people rebuilding their lives after experiencing acute mental distress
- Older people's mental health services; with two wards based at London Road Community Hospital in Derby, two specialist dementia wards on the Kingsway site in Derby, Midway Day Hospital in Ilkeston, Dovedale Day Hospital in Derby and physiotherapy services.

Services across Chesterfield and North Derbyshire include:

- The Hartington Unit in Chesterfield, which provides three acute mental health inpatient wards, an outpatient unit, mental health crisis home treatment teams, and mental health and substance misuse liaison services for the A&E department at Chesterfield Royal Hospital.

County-wide services include:

- Community mental health teams for older adults
- Mental health pathfinder (assessment and signposting) and recovery services for adults
- IAPT services (Improving Access to Psychological Therapies) including Talking Mental Health Derbyshire
- Memory assessment services.

Specialist services division

The following services are delivered across the city and county, unless otherwise specified:

- Child and Adolescent Mental Health Services (CAMHS) within Derby and South Derbyshire including a hospital liaison service based at the Royal Derby Hospital
- Substance misuse services, including specialist alcohol misuse services and hospital-based alcohol and substance misuse services within the Liaison teams at the Royal Derby Hospital and Chesterfield Royal Hospital
- Learning disability services within Derby and South Derbyshire
- Specialist services for children within Derby and South Derbyshire
- Eating disorder services
- Perinatal care including inpatient and community-based services
- Forensic and rehabilitation services, including gender specific low-secure services on the Kingsway site in Derby, prison in-reach and criminal justice liaison teams
- Universal children's services across the city of Derby including Health Visiting and school nursing
- Clinical psychology within specialist services.

During the year 2014/15, Derbyshire Healthcare...

88,208 service users seen

311 inpatients beds

Number of staff **2,433**

173 Scientific and technical

423 Additional clinical services

498 Administrative and clerical

146 Estates and ancillary

897 Nursing and midwifery

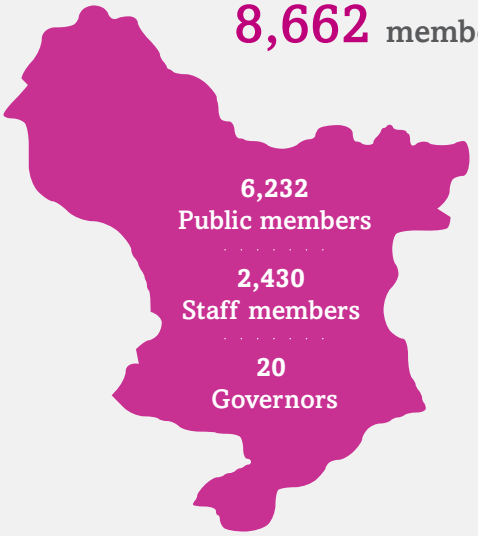
147 Medical

140 Allied health professionals

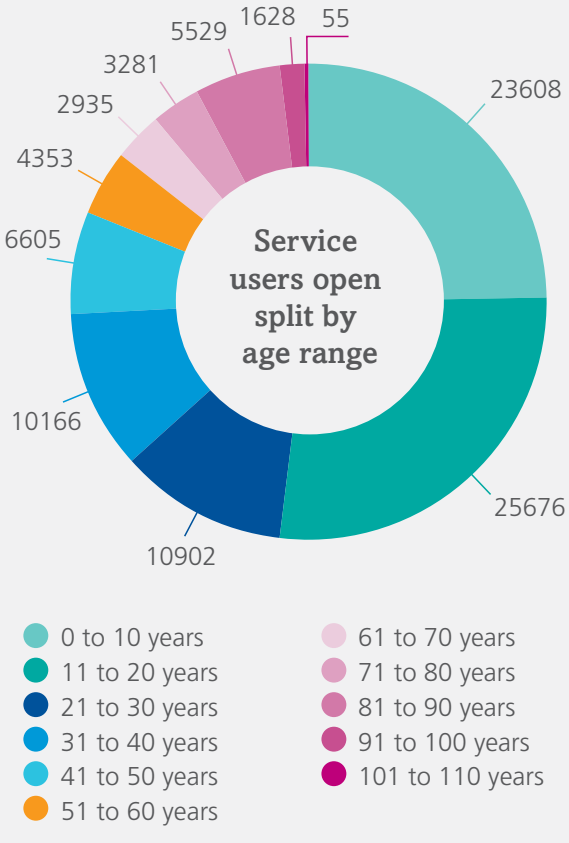
9 Students

The Trust cared for **3948** babies born in Derby City

8,662 members



94,738 service users being supported by Derbyshire Healthcare on 31 March 2015



Trust strategy

The Trust strategy for 2013-16 sets out our commitment to providing excellent quality services – with people at the centre of them. We are doing this against a backdrop of an increasing and changing population. This includes an increase in older people in Derbyshire, a growth in children and the youth population in Derby city and southern Derbyshire, and greater ethnic diversity specifically in the city. There are also financial challenges locally in Derby city, Derbyshire and nationally in the NHS and in social care. We aim to be responsive and flexible to these changing needs and to work closely with commissioners and partner organisations to provide the best care.

People have told us that they want us to view them as whole people with strengths, ambitions and goals who have a life worth living beyond their illness, and to remember their physical and mental health needs are combined. People want safe, recovery-enhancing services that support inclusion in the communities of their choice. We will tirelessly address the stigma and prejudice that people with mental health conditions face and ensure that inclusion and physical and social recovery and personal wellbeing runs like a thread through all our work programmes.

Above all, people want to be at the centre of decisions made about their lives. They want to be fully and actively involved in their care and to have positive experiences of the care they receive. They also want the organisations that support them to work closely together so that pathways of care feel seamless and easy to follow.

Our strategy, 'Improving lives, strengthening communities, getting better together' was adopted in April 2013 and was set against the backdrop of the day, focusing on quality of service delivery. We have recently developed a refreshed plan for its final year (2015/16), titled 'Improving lives, strengthening communities, shaping a better future together'. This updated strategy reflects today's agenda of integrated services with partnerships of different providers from the NHS, social care and voluntary and private sectors, that are required to address the whole needs of our patients and service users and offer 'joined up' pathways of care.

We believe we are well positioned to make a real difference to people's health and wellbeing, and in so doing to help them have hope for the future and to fulfil their ambitions. We look forward to working with people to support them to improve their lives and to make our communities stronger by working together.

Vision, values and pillars of improvement

Our vision:

To improve the health and wellbeing of all the communities we serve.

Strategic outcomes:

This vision is supported by our strategic outcomes, which outline the experience we want our patients and their families to have. These are that:

- People receive the best quality care
- People receive care that is joined up and easy to access
- The public have confidence in our healthcare and developments
- Care is delivered by empowered and compassionate teams.

Derbyshire Healthcare is a values-led organisation and it is critical that our values are reflected through all that we do. We recruit our staff through values-based exercises and expect teams and individuals to be able to demonstrate how they meet the Trust values in their day to day work.

Our values:

The Trust's vision is underpinned by four key values, which were developed in partnership with our patients, carers, staff and wider partners:

- We put our patients at the centre of everything we do
- We focus on our people
- We involve our people in making decisions
- We deliver excellence.

To support our values, the Trust has developed a series of Core Care Standards, which enable all teams to have a consistent way of planning and delivering care, whilst recognising the needs and standards of particular services and the people they serve. The standards aim to increase quality and safety and apply to everyone who uses our services. Resources that support the standards all have the apple 'quality mark' on to indicate this.

CCS quality mark

We will be revisiting this work in 2015/16, to refresh our solid foundation and re-develop some of our standards to encompass mutual expectations.

Compassion

The Trust provides the UK's only Centre for Compassion, at the Kingsway site in Derby. Compassion is a key way of working for all Trust staff, in the knowledge that being compassionate to those we care for and work with, will enable us to offer the highest possible standards of care.

Pillars of improvement:

The Trust's pillars of improvement are programmes of work, designed to enable our vision and ensure our strategic outcomes are realised. The Strategic Report will focus on developments and progress against these pillars, whilst outlining our plans for the future. The pillars are:

1. Quality of services
2. Service delivery and design*
3. Promoting public confidence
4. Relationships and partners
5. Financial performance
6. Workforce and leadership.

*Prior to the publication of the Trust's refreshed strategy, there was an additional pillar focused on integrated care pathways. This has now been combined with pillar 2, 'service delivery and design', to reflect the wider integration agenda taking place within the health care economy and our progress over the last year of developing clearer, integrated working practices with our partners over the last year.

Directors' Report

Pillar 1: Quality of services

We want our services to feel personalised, outcome focused and delivered to the best evidence and highest standards.

Quality is sometimes an over-used word in the NHS; in our Annual Report last year we referred to it as the cornerstone of what we do as an NHS provider trust. This continues to be true, but we also need to consider the concept of quality from a number of perspectives. To truly deliver a high-quality service, it has to be accessible, safe and effective, and feel both therapeutic and sensitive to the needs of the individuals and their families, who use our local community services across the lifecycle.

As an organisation we want our services to be experienced positively and we endeavour to promote a service that is compassionate and sensitive. We do want our staff to be seen as helpful, responsive and soothing. We want to provide and develop services that promote within our community a sense of wellbeing, and are purposeful in their design, and we want to realign our services to meet the needs of our community in their neighbourhoods. We have started this journey of redesign during the year, but we have more work to do.

We are on another journey and it is not an easy road to follow. As an organisation we have begun to accept that we are unable to fully meet the needs of our community in our current form. We have unprecedented challenges to face relating to capacity, demand and expectations from the community on what our services can provide within the financial envelope that we receive and the services we are commissioned to provide.

Our services have been under pressure this year, largely due to the volume of people seeking our support. We have analysed those pressures, and some of the causative and contributory factors, and as a result have a much greater understanding of quality and our service offers. This also means we are more acutely aware of our areas to develop and our gaps in commissioned services.

To address these issues, we need to develop a new way of working with individuals and families that is far more weighted to shared care arrangements. We need to support self-care and teach individuals and families the skills to understand their health conditions far more than we have previously. We have to promote choices more clearly – including patient-informed and family-informed decision making, improvements in personal choices, and strengths and preferences in care planning.

We started work on some key strategies in this area during 2014/15, but our work is not complete and will continue into 2015/16. We need to redesign and develop more opportunities for guided self-help until our services can provide access to appropriate therapies and treatment. This will include more time invested in helping individuals and families to wait well and in guiding them through their care following periods in our community care services, having increasing levels of shared and self-care moving to enable social recovery after symptom or clinical recovery has been achieved.

External feedback and assessment

This year we have had external feedback on our performance. **We have scored above the national average for our care environments in the PLACE (patient-led assessments of the care environment) assessments, with the results as follows:**

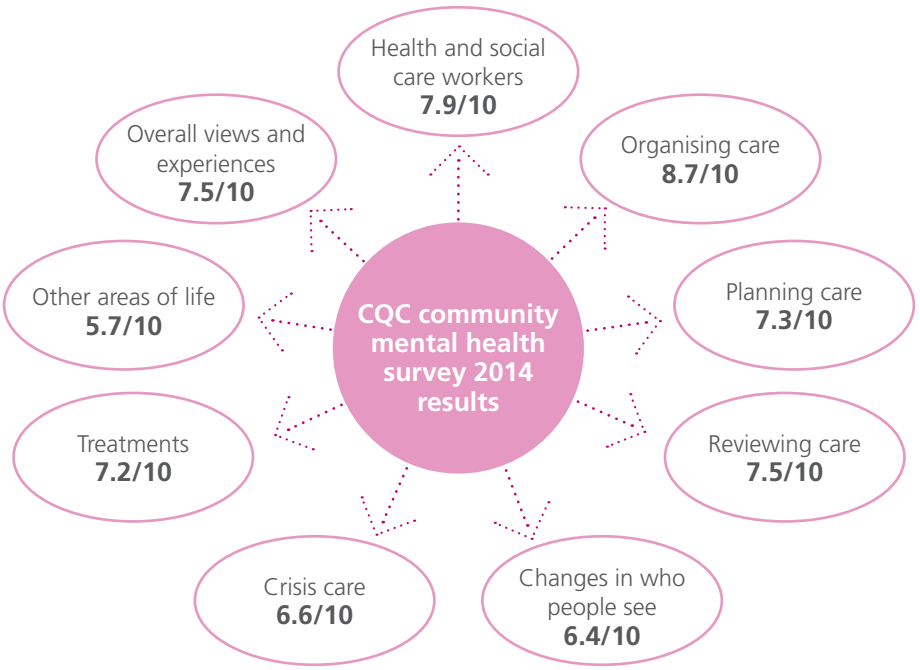
Food
93.05%

Cleanliness
98.75%

Privacy, dignity and wellbeing
89.61%

Condition, appearance and maintenance of the estate
95.9%

We have scored above the national average in a number of domains in the Care Quality Commission (CQC)'s Survey of people who use community mental health services 2014 (patient survey), which looks at the experiences of people receiving community mental health services. The survey asks people to respond to 43 questions, categorised under eight broad sections (see diagram below).



Eight sections of the CQC's survey of people who use community mental health services 2014; the score out of 10 represents the Trust's average score for that section of the survey

The 2014 survey was conducted between February and June 2014. A questionnaire was sent to 850 people who received community mental health services from the Trust and responses were received from 279 people.

In all eight sections of the survey, the Trust rates in line with other trusts:

Section ref	Section title	Lowest trust score achieved	Highest trust score achieved	Our trust score
1	Your health and social care workers	7.3	8.4	7.9
2	Organising your care	8.2	9.0	8.7
3	Planning your care	6.5	7.8	7.3
4	Reviewing your care	6.8	8.2	7.5
5	Changes in who you see	5.1	7.8	6.4
6	Crisis care	5.4	7.3	6.6
7	Treatments	6.7	7.9	7.2
8	Other areas of life	4.0	6.1	5.7
9	Overall	6.7	7.8	7.5

In terms of individual questions, the Trust was ranked in the 'best' or 'average' performing categories for each of the 43 questions – there were no questions where we rated as 'below average'.

In section 8 ('other areas of life') there were two questions where we scored on the cusp of 'best performing trusts' and are rated as above average:

- In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping accommodation?
- Has someone from NHS mental health services supported you in taking part in an activity locally?

Supporting individuals to build a life beyond illness, and to live independently within the community, are key elements of the recovery process.

We have scored in line with the national average in the 2014 national NHS inpatient mental health service user survey. Questionnaires were sent to a sample of 387 adults aged 16 to 64 (inclusive) who had a stay of at least 48 hours in an acute or psychiatric ward at the Trust between 1 July 2013 and 31 December 2013. 83 people completed and returned their surveys.

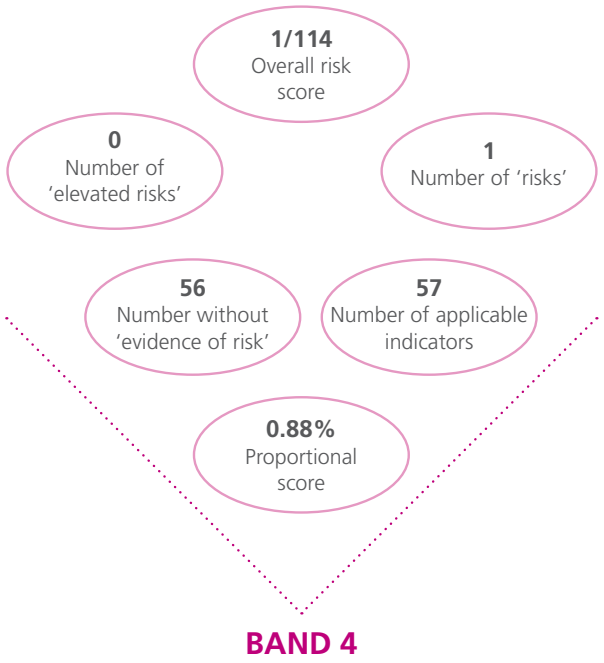
The Trust scored in line with other Trusts on 41 out of 47 questions. The questions where the Trust scored above average and below average were:

Ref	Question	Lowest national score	Highest national score	Trust score
Q1	When you arrived on the ward, did staff make you feel welcome?	76%	96%	90%
Q9	Always able to get specific dietary needs	21%	75%	30%
Q12	Hospital definitely helped keep in touch with family	40%	78%	40%
Q18	Always treated with respect and dignity by psychiatrist	58%	81%	58%
Q34	Definitely felt enough care taken of physical health	36%	75%	56%
Q39	Given enough notice of discharge from hospital	67%	86%	78%

Best performing trusts Worst performing trusts

We have used this information to directly improve our services. Our commissioners have been very responsive to us escalating concerns in this area. Within year, they have supported some additional support in interim dietetics and have commissioned service enhancements in 2015/16 to enable our direct care staff to have specific support in effective dietetics as well as clinical intervention.

We have been assessed as a lower risk than the national average according to the CQC intelligent monitoring report of our mental health services. This report presents the CQC's analysis of 59 key indicators for the Trust, including bed occupancy rates and staff and patient surveys. **The CQC has analysed these to identify possible levels of risk of poor care. The Trust has been classified as one of 16 'band four' organisations posing the 'lowest perceived risk':**

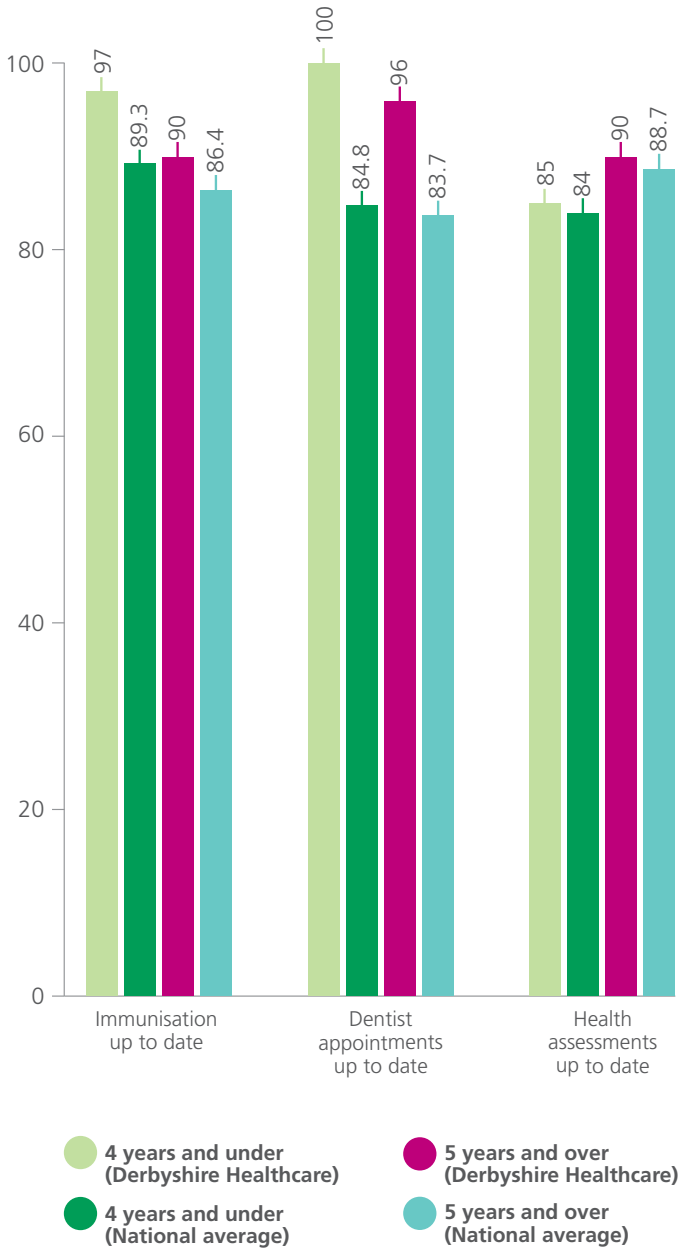


BAND 4

"We are making progress and we are striving to provide the very best service with what we are commissioned to provide. We are very proud of our teams performing above the national average and enabling the Trust to deliver excellence."

In our looked-after children services, we are very proud of our teams for scoring above the national average in every area in in terms of up-to-date health checks:

Percentage (%) of looked after children up to date with health measures by age, 2014



Quality priorities

Each year the Trust sets a range of quality priorities, outlining achievements we are looking to make to improve the quality of our services. For 2014/15 our quality priority measures were focused on achieving improvements in the areas of patient experience, effectiveness and patient safety. We have made good progress against our quality goals for 2014/15, as listed below, and will continue to improve against our priority areas in 2015/16, as outlined in the quality report on pages 102-140.

Our quality goals:

1. Physical healthcare – this continues into its second year in order to embed sustained change
2. Friends and Family Test (see page 34 for details) – this is now part of our NHS Standard Contract with the clinical commissioning groups (CCGs) and NHS England
3. Preventing suicide – through patient safety planning
4. Positive and Safe, formally known as Force Free Futures – reducing the use of restrictive practice in services (our internal quality standard)
5. Think! Family – working with the whole family and co-ordinating all aspects of support to address their full needs
6. To become a recovery-focused organisation – through our neighbourhood model of delivering community services (our internal quality standard)
7. Clinical outcomes as part of our NHS Standard Contract with the CCGs and NHS England
8. Additional quality requirements through the NHS Standard Contract for 2015/16.

There are a number of additional quality goals that have come through the NHS Standard Contract:

a. In mental health, access targets for first episode psychosis, which also include requirements for ageless service and NICE-informed interventions

b. Supporting acute urgent care services to reduce unavoidable admissions in Accident and Emergency departments (A&E)

c. Effective care for people with dementia and delirium.

Some of our services commissioned through our contract with NHS England for specialised services have additional targets which are not Trust wide. These include smoking cessation, specific safety-planning service improvements, and support for carers. There are also targets around family support and the monitoring of timescales for both parental/non maternal engagement and carer engagement, specifically for our perinatal services.

Providing high quality services

The quality of our services is a key focus for the Trust and we regularly monitor this through a series of quality visits. These visits involve every team within the Trust, clinical and non-clinical, and involve service users and carers or family members where appropriate. Each team is visited by a quality visit panel made up of Board members, governors, clinical and non-clinical staff and commissioners.

As part of the visits, teams have the opportunity to showcase three areas that they are most proud of, and to speak to a Board member and discuss how services are delivered. Patients and carers are often invited by the teams to feedback their experience of the service they have received.

Teams are also required to show that they are compliant with performance, workforce and organisational development targets. The results of the quality visit are communicated to the team following a moderation week at the end of the season.

The teams are scored against the key areas of quality which determine whether they are to receive a bronze, silver or gold award. Platinum awards are given to teams who achieve a gold award for three consecutive years.

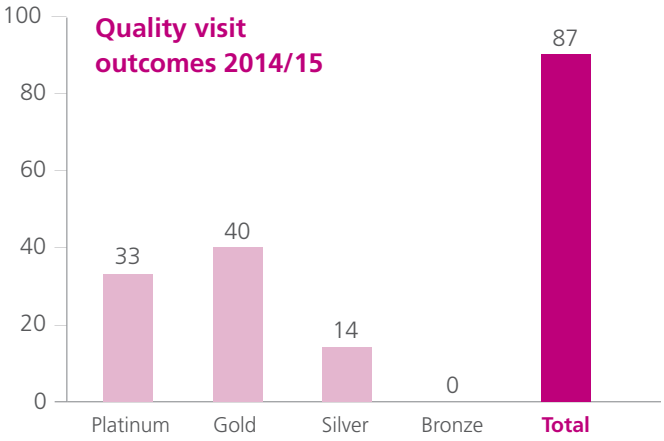
At the end of each year the programme is reviewed by a focus group. **Once again in 2014 there was overwhelming support for the quality visit programme; comments included:**

- "Makes us talk about the positive and be more proactive and innovative"
- "Being able to showcase excellence in partnership with service users"
- "The fact that this year we were listened to and given instant positive feedback."

It was agreed that in 2015 the Care Quality Commission's five key questions would be used to measure and monitor the visit programme. Teams are expected to demonstrate examples of how their services are safe, effective, responsive, caring and well led.

Our quality visits are key to our continued growth. This model showcases what our services do well, whilst being open and candid on the areas where we need to improve, which we promote to our teams to ensure continued learning. This is key to our Trust, our strategy and our progress.

The results for 2014/15 were:



Celebrating the success of our services when they are under continued pressure is key. The Trust holds an annual Delivering Excellence awards ceremony that recognises the success of teams in a variety of different areas. **As well as recognising the achievement of all platinum teams (teams who achieve gold awards for three years in a row through our quality visit programme), the highest-performing platinum teams are shortlisted for four Delivering Excellence awards:**

- Patient safety award
- Patient experience award
- Effectiveness award
- Team of the year award.

In 2014, the Delivering Excellence awards were presented at an evening awards ceremony at Derbyshire County Cricket Club's 3aaa County Ground in Derby.

"It's great to recognise the achievements of staff at all levels. I think that's very important."

The Trust's Quality Report, which focuses on our progress against set quality indicators, can be viewed on pages 102-140 of this Annual Report. Further information about quality governance is available in the Annual Governance Statement, available on pages 141-149.

Andrew Holbrook
– winner of the Trust's 2014 Delivering Excellence award for innovation

Andrew, a healthcare assistant, has supported residents at our mental health rehabilitation unit, Audrey House, to go fishing as a therapeutic activity. The benefits of angling in helping people to recover from poor mental health and prevent relapses have been well documented and, at first, Andrew used his own fishing equipment to ensure patients who have an interest in fishing get to experience the sport. After applying to the Trust Innovation Network for funding, Andrew has been able to develop the project further, and is now providing angling sessions on local waters and encouraging participation in the socially inclusive activities endorsed by the club.

Our performance

From 1 April 2015, the Trust registration with the Care Quality Commission (CQC) was extended without any conditions.

Performance against key health targets

As a foundation trust we are required to comply with our provider licence, as set out in Monitor's risk assessment process. Performance this year has continued to be strong, and the Trust has achieved its targets set for all Monitor indicators.

Target or indicator	Target	2014/15	Achieved / Not achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	95.00%	96.13%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	92.00%	95.77%	Achieved
Care Programme Approach (CPA) patients receiving follow up contact within 7 days of discharge	95.00%	97.30%	Achieved
Care Programme Approach (CPA) patients having formal review within 12 months	95.00%	95.77%	Achieved
Admissions to inpatient services had access to crisis resolution / home treatment teams	95.00%	100.00%	Achieved
Meeting commitment to serve new psychosis cases by early intervention teams	95.00%	100.00%	Achieved
Clostridium Difficile -meeting the C.Diff objective	7	0	Achieved
Minimising MH delayed transfers of care	≤7.5%	1.45%	Achieved
Data completeness, MH: identifiers	97.00%	98.98%	Achieved
Data completeness, MH: outcomes for patients on CPA	50.00%	93.55%	Achieved
Community care data completeness - referral to treatment information completeness	50.00%	92.31%	Achieved
Community care data completeness - referral information completeness	50.00%	72.11%	Achieved
Community care data completeness - activity information completeness	50.00%	89.93%	Achieved

Trust performance dashboard	Target	End of year March 2014	End of year March 2015
Monitor targets			
CPA 7 day follow up	95.0%	97.94%	97.30%
CPA review in last 12 months	95.0%	96.52%	95.77%
Delayed transfers of care	7.5%	1.39%	1.45%
Data completeness: indentifiers	97.0%	99.42%	98.98%
Data completeness: outcomes	50.0%	97.77%	93.55%
Community care data - activity information completeness	50.0%	86.74%	89.93%
Community care data - RTT information completeness	50.0%	92.31%	92.31%
Community care data - referral information completeness	50.0%	74.10%	72.11%
18 Week RTT less than 18 weeks - non-admitted	95.0%	97.98%	96.13%
18 Week RTT less than 18 weeks - incomplete	92.0%	95.57%	95.77%
Early interventions new caseloads	95.0%	121.20%	100.00%
C. Difficile new cases (inpatient)	<7	0	0
Crisis gatekeeping	95.0%	97.59%	100.00%
Locally agreed			
CPA honos assessment in last 12 months	90.0%	93.17%	79.19%
CPA settled accommodation	90.0%	99.85%	99.37%
CPA employment status	90.0%	99.85%	99.55%
Data completeness: indentifiers	99.0%	99.42%	98.98%
Data completeness: outcomes	90.0%	97.77%	93.55%
Patients clustered not breaching today	99.0%	89.70%	82.94%
Patients clustered regardless of review dates	100.0%	98.24%	95.46%
7 Day follow up (all inpatients)	95.0%	97.57%	96.62%
Schedule 4 contract			
Consultant outpatient appointments trust cancellations (within 6 weeks)	5.0%	3.10%	5.44%
Consultant outpatient appointments DNAs	15.0%	14.21%	16.61%
Under 18 admissions to adult inpatient facilities	0	4	1
Outpatient letters sent in 10 working days	90.0%	61.68%	68.97%
Outpatient letters sent in 15 working days	100.0%	78.77%	83.36%
Average community team waiting time (weeks)	N/A	4.87	6.17
Inpatient 28 day readmissions	10.0%	7.36%	7.75%
Crisis home treatments	N/A	1,610	1,418
CPA review in last 12 months	90.0%	90.48%	95.77%
Assertive outreach caseload	N/A	253	266
Mixed sex accommodation breaches	0	0	0
MRSA new cases (inpatient)	0	0	0
Discharge fax sent in 2 working days	98.0%	99.76%	97.45%
Schedule 6 contract			
CPA settled accommodation	N/A	92.76%	90.93%

Monitoring improvements in the quality of healthcare

Monitoring improvements in the quality of healthcare The Trust's last visit from the Care Quality Commission (CQC) took place from 29-31 January 2013, when our annual scheduled inspection took place. The inspection team spent three days with the Trust, visiting 11 locations that provide a range of services including substance misuse services, child and adolescent mental health services, a rehabilitation and recovery unit, and a low secure unit. The inspectors talked with people who use the services, carers and family members and staff, and reviewed information. The service users involved were very positive about the quality of care they received. Staff also told inspectors that they were pleased with the level of training, supervision and support they received from the Trust.

The inspection team identified an additional standard where they found a high level of compliance across all the services they inspected. This standard looked at how well the Trust co-operates with other providers and how people should get safe and co-ordinated care when they move between different services. Although this is not the usual practice for the inspection team, they were so impressed by the Trust's approach to this that they included it in their report. The inspectors concluded that four out of the six standards they inspected were met. They identified two standards where further action was required by a small number of the services they inspected.

The two standards requiring improvement were:

- Outcome 4 (Regulation 9): Care and welfare of people who use services
- Outcome 21 (Regulation 20): Records.

The Trust has not had a formal CQC organisational inspection since 2013. We are due to be visited in the forthcoming financial year, but have not received a confirmed date at the time of writing.

The Trust is regularly visited by the CQC as part of our Mental Health Act CQC visits. We have had feedback on areas to improve (which include care planning, capacity documentation, consent to treatment and redesign of an inpatient seclusion room) alongside positive feedback on our services (in particular, praise for the attitude of staff and their level of care). We have no outstanding concerns at the time of writing this report.

Regulatory ratings

Monitor was established in January 2004 to authorise and regulate NHS foundation trusts. They are independent of central government and directly accountable to Parliament.

The Trust is required to submit quarterly returns to Monitor. Monitor then reviews our returns and publishes risk ratings for governance and finance.

Governance

Under Monitor's old Compliance Framework system, governance risk ratings ranged from 'red' – where Monitor deemed that a Trust was likely to have triggered a significant breach of their terms of authorisation, or had actually triggered such a breach – to 'green' where there were no material governance concerns. Under the Risk Assessment Framework, in place since October 2013, there are three categories to the governance rating:

- Where there are no grounds for concern at a trust, Monitor will assign a green rating
- Where Monitor has identified a concern at a Trust but not yet taken action, it provides a written description stating the issue at hand and the action it is considering.
- Where Monitor has already begun enforcement action, it assigns a red rating.

Finance

For the first two quarters of 2013/14 the Trust reported under the Compliance Framework where financial risk ratings ranged from 1 to 5; 1 was the highest risk, where Monitor deemed that there was high probability of a significant breach of the terms of authorisation in the short-term, and 5 was the lowest risk with no financial regulatory concerns.

Since October 2013 (i.e. for quarters 3 and 4 of 2013/14 and all of 2014/15) the Trust has reported under the Risk Assessment Framework where the Continuity of Service Risk Ratings range from 1 to 4.

The key difference between the two approaches is that the Financial Risk Rating was intended to identify breaches of a Trust's terms of authorisation on financial grounds, whereas the Continuity of Services Risk Rating identifies the level of risk to the ongoing availability of key services, called commissioner-requested services.

The change in regulatory regime has had no effect on our risk ratings.

Monitor updates foundation trusts' risk ratings each quarter. It also updates risk ratings in 'real time' to reflect, for example, a decision to find a trust in significant breach of its terms of authorisation or the Care Quality Commission's regulatory activities.

Below is a table, set out in the format required by the Foundation Trust Annual Reporting Manual 2014/15, summarising the regulatory ratings achieved by Derbyshire Healthcare NHS Foundation Trust. It demonstrates that for each quarter we have met, and at times exceeded, our planned ratings.

	Annual plan 2014/15	Q1	Q2	Q3	Q4
Continuity of service rating	3	4	4	4	3
Governance rating					

	Annual plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Under the compliance framework					
Financial risk rating	3	3	4		
Governance risk rating					
Under the risk assessment framework					
Continuity of service rating				3	3
Governance rating					

In 2014/15 we met our planned governance rating for each quarter. For all quarters we have exceeded our planned rating for finances. Our better-than-plan financial performance was due in part to the impact of some one-off benefits such as the disposal of assets, but primarily to the success of our operational and quality delivery plans, which achieved efficiencies without the need to spend our contingency reserve.

In the previous financial year, 2013/14, our governance was assessed as green throughout the year, as planned. The financial risk rating was planned as 3 at quarter 2 but was scored as a 4 because our financial surplus was better than planned. The rating returned to planned levels for the other quarters.

There has been no formal intervention from Monitor in either year.

Our services

Urgent and planned care

A number of developments and improvements to services within the urgent and planned care division have taken place during 2014/15.

The division has worked collaboratively with commissioners and the wider health and social care community to proactively be part of the solution to key issues such as integrated care and the pressure being experienced by the acute trusts based in Derbyshire. We have participated widely in the integrated pathway work that has been taking place within each clinical commissioning group (CCG) locality. Integrated care is based on a service model of locality-based services working collaboratively with primary care, and it is built on the principles of local area co-ordination.

Throughout the year, 37 gold quality awards were awarded to services that sit within the division through the Trust's quality visit programme (see pages 22-23), demonstrating the motivation and drive of the teams to ensure quality is at the core of all we do.

The Hartington Unit's Occupational Therapy and Recreational Team winning the Trust's annual patient experience award

Urgent care services

A number of developments and improvements to services in urgent care have taken place during 2014/15 with the teams continuing to show drive and commitment towards quality and innovative service provision. This can be demonstrated in the number of platinum and gold quality awards received within urgent care services through the Trust's quality visit programme. An example of this commitment to delivering high quality services was evident at the Trust's Delivering Excellence awards (see page 51), where the Hartington Unit's Occupational Therapy and Recreational Team won the Trust's annual patient experience award.

Urgent care services continue to work collaboratively with commissioners and the wider health community. That collaborative approach was demonstrated in the development of liaison services at both Derby and Chesterfield acute hospitals. We have also worked with Derbyshire Health United to develop a collaborative 111 service model that ensures mental health needs are being provided for out of hours.

The division has also been committed to the Mental Health Crisis Care Concordat and is working collaboratively with commissioners and health and social care partners to deliver a Derbyshire-wide improvement plan to support people in the event of a mental health crisis.

As a result of very clear and robust feedback from service receivers and also through substantial investment from our commissioners, in April 2014, a new ward opened on the Radbourne Unit in Derby, providing additional beds in the hospital. This investment has reduced the number of local people needing to travel outside of Derbyshire to receive inpatient mental health services.

A key outcome of the investment was to enable us to use our inpatient environment differently, creating two gender-specific wards – allowing choice and also creating improvements to our environment. Developing gender-specific inpatient accommodation has been an organisational ambition for some time and a key positive outcome for 2014/15.

The teams are embracing the Department of Health's Positive and Safe agenda which sets out the direction of travel towards reducing restrictive practices within our Trust. To date the Trust has ceased seclusion on all acute mental health inpatient wards and has introduced the Safewards model, which is an evidenced-based approach for 'making psychiatric wards more peaceful places'. This is in line with the Trust's Human Rights Policy, and regulations 9 and 11 of the Care Quality Commission's standards, which require that people experience safe and appropriate care, treatment and support that meets their needs, protects their rights and safeguards them from the risk of abuse. It is also in line with our responsibilities under the Deprivation of Liberty Safeguards (DoLS), ensuring that teams only deprive someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them.

The Trust's overarching vision is to support people to stay living in their home environment wherever possible. It is planned that the temporary increase in hospital bed numbers will decrease again, once wider community services are in place. Urgent care transformation plans continue to be in line with this and can be demonstrated though the transformation of day and inpatient services in Derby, with the creation of the Hope and Resilience Hub.

The new hub brings a greater focus on recovery and prevention into the urgent care pathway within the Radbourne Unit for the population of Derby city and southern Derbyshire. The service places a strong emphasis on the delivery of high quality, evidence-based care in an environment that supports and promotes self-management and self-efficacy. For further information on the Trust's focus on recovery approaches during 2014/15, please see page 38.

The teams providing mental health inpatient services for older people continue to provide high standards of care and are working hard to deliver transformation across services. The teams have been successful in securing innovation funds and plan to develop a dementia rapid response service. This development is strongly aligned with the Trust's vision is to support people to stay living in their home environment wherever possible (for more information please see page 54).

Planned care services

With the growth in the population of older people in Derbyshire, many of the planned care developments and projects in 2014/15 have been dementia focused.

This year has seen the further development of memory assessment services particularly in South Derbyshire, Derby city and Erewash. Permanent funding has been made available to ensure people can access early assessments in relation to memory and dementia. The service offers people a timely diagnosis and offers advice, consultation and access to support services, enabling people to plan ahead for their future care needs. Discussions are underway to establish this service fully in the north of the county.

A project has been undertaken in Derby city to develop support workers within primary care whose role focuses on ensuring referrals to memory assessment service are in place for those that require them.

The Shires project developed the role of a nurse and support worker in a practice to focus on the needs of the older people's population experiencing mental health difficulties. This work has continued throughout the year.

The care homes project in the south of the county has funded a nurse to visit care homes and offer memory assessments, advice and consultation regarding helpful and effective interventions.

CMHTs (Community Mental Health Teams) for older people across Derbyshire have been working closely with colleagues in primary care and social care to work as a part of a newly developed integrated care team. The teams seek to support people with a range of conditions, adopting a holistic approach to prevent unnecessary admissions to hospital and offer timely, co-ordinated cross-agency interventions to people in their own homes.

Ongoing service developments

A key focus of 2014/15 has been the development of the Trust's new neighbourhood model of delivering many of the division's community health services. This model has emerged following a period of substantial engagement with all our stakeholders. Initially through a series of meetings of Pathway and Partnership Teams (PPTs), the Trust has sought to redesign our community services in order to meet our strategic aim of providing care closer to home, whilst also improving and maintaining the patient experience within the financial envelope available.

From 1 April 2015, we formally launch our preparations to transform our services and begin the transition to the neighbourhood model. This change in our structures and approach will be a key focus for the year ahead as we embed new ways of working, build social capital within our local communities to enable a wider level of care and support to be delivered within the home environment, and widen our clinicians' skill base in supporting a wider range of conditions within the community setting.

Alongside this change to our community services, we will be reviewing all inpatient services over the forthcoming financial year. As with other healthcare providers, we are experiencing difficulties in recruiting appropriately trained staff to work in many of our inpatient settings, which has caused significant pressures in relation to ensuring appropriate staffing for our wards.

By increasing our capacity and options to support people within the community, it is only natural that this approach will have a direct impact on our inpatient services. Our patients tell us frequently that they want to receive support at home that allows them to live independently, for as long as it is safe to do so. We know that placing someone in an inpatient setting can disrupt an individual's path to recovery – this is as true for those accessing acute mental health care as it is for people with dementia – and we will seek to support people within their home environment as much as possible.

In time we expect this change in approach will mean we can reduce the number of inpatient beds available across the Trust, when it is safe to do so. A focus and realignment of our inpatient (or campus) based services will be a key focus for 2015/16.

We are modelling and extending our workforce and recruitment strategies to maximise our recruitment options to applicants. We have undertaken extensive in-reach approaches to universities and student nurse conferences, as well as online methods of promoting the Trust as a potential place to work. We have had some success to date, however continued perseverance and commitment is required.

In 2015/16 we will be extending access to RGNs (registered general nurses) in some of our key services.

Specialist services

The specialist services division has worked collaboratively with commissioners and the wider health and social care community on a number of key developments during the year.

This year has seen the development and expansion of the perinatal community team, following investment, to establish a perinatal team for the communities in the north of the county, creating parity with south. The perinatal service has worked hard to achieve level 2 accreditation with the Care Quality Network. This is a national accreditation and this team was nominated for Trust 'team of the year' at our annual Delivering Excellence awards ceremony in 2014, in reflection of this achievement.

The eating disorders service has developed an intensive day service programme which is due to start in April 2015, operating from the Radbourne Unit in Derby.

The Derby city substance misuse services were subject to a tender process this year and working with our partners, Phoenix Futures, were successful in being awarded the contract for the next three years. There has been an extension to the county substance misuse contract for one year.

Wider innovation and achievements were recognised at the annual staff awards ceremony in 2014. Sarah Graham from the Disabled Children's Nursing Team was presented with the 'love our learners' award sponsored by Health Education East Midlands. Sarah has used her MSc in Integrative Psychotherapy and her 'Sleep Practitioner' training to up-skill other team members and to launch 'Good Nights' sleep clinics at Mackworth Children's Centre, to help children with learning disabilities to get a good night's sleep.

Moreover, the Behaviour and Attention Deficit Hyperactivity Disorder (ADHD) Nurse Service, won the Delivering Excellence effectiveness award (a team award) for the work they have completed on developing a 123 Magic Parent programme that increased the uptake of services, frequency of care delivery and offered additional telephone support to families during 2014/15.

The school nurse service were the winners of the Delivering Excellence patient safety award, acknowledging the feedback they have received from children and young people involved in the programmes

being introduced in schools in Derby City. These are classroom-based sessions exploring the risk of sexual exploitation and how young people can keep themselves safe. The school nurse service also contributes to the child exploitation multi-agency team working with local hotels, attempting to raise awareness about the likelihood and indicators of child sexual exploitation. The school nurse service provided further classroom-based sessions regarding domestic violence and worked with young people to help them identify positive and negative aspects within relationships. The service also provides targeted sexual health and contraception advice to young people attending the pupil referral unit.

The health visiting team has continued to expand its workforce in line with commissioner expectations and the HVIP (Health Visitor Implementation Plan). We have facilitated a further two cohorts of 'compassionate mind' training for staff within health visiting and children's and young people's services. We have also embarked on a rolling programme of training regarding antenatal and postnatal promotional interviews to help support parents during the initial stages of parenthood. Various team members within the health visiting service have been contributing to a range of developments taking place at a regional level, including practice teaching and parent-held records.

Both the school nursing and health visiting teams received praise from Healthwatch Derby following the organisation's Think Healthy review (see page 44). The health visiting team was said to "have a good rapport with mothers and babies they are supporting," "good provision of facilities" and the ability to "speak a variety of languages" while the school nurses "have a good rapport with children they are assessing, and good use of engaging and informative assessment formats."

The Trust's child and adolescent mental health services (CAMHS) team is part of a national five-year pilot programme to develop a CYP (children and young people) IAPT (Improving Access to Psychological Therapies) scheme which has improved access to evidence-based interventions. The team has provided a lot of training in cognitive behavioural therapies, advanced parenting therapies, and systemic family practice, all of which are backed by well-researched and validated evidence proving they are effective. The team uses routine outcome measures to measure progress in therapy and demonstrate that what they are doing is making people better.

The CAMHS multi-systemic therapy (MST) service was launched as a pilot in May 2013 in southern parts of Derbyshire. The pilot has been extended for a further year, extending coverage to young people and their families living in Chesterfield. MST is a community evidence - based model targeted at older children, teenagers and their families where the young person is at risk of coming into care or custody; it aims to prevent family breakdown, reduce offending and improve educational outcomes.

Derby City CAMHS team

At the Trust's 2014 Delivering Excellence awards, the Derby city CAMHS team won the Chief Executive's award, acknowledging how the service works with other support services, demonstrating great commitment to the wellbeing and welfare of the children and young people they care for – often in the face of complex social circumstances. The team's consultant nurse, Laurence Baldwin, was chosen to sit on the government's national child mental health taskforce, representing the Royal College of Nursing. The CAMHS service also facilitated a successful national conference in 2014 which Catherine Pugh (Department of Health IAPT lead) attended; Ms Pugh commended the service for the achievements made in relation to the IAPT pilot in Derbyshire.

The division's forensic and rehabilitation services received three platinum team awards through the Trust's 2014 quality visit inspection process (see page 22). In addition, Andrew Holbrook from Audrey House was nominated for a regional NHS Recognition Award for his Angling 4 Health project – a project that won him the Delivering Excellence innovation award (see further details on page 23).

The learning disabilities (LD) service received three platinum team awards through the Trust's 2014 quality visit inspection process (see page 22). On a wider level, several LD nurses received public recognition for their achievements:

- Deb Cooper, senior Macmillan/LD nurse, was nominated for a national learning disability award in the older people's category for her work in palliative care
- Debbie Edwards, in her capacity as acute liaison nurse for LD based at the Royal Derby Hospital, was involved in developing a number of videos providing information for people with a learning disability about what to expect when attending the hospital to receive treatment; the videos were featured in Learning Disability Today magazine
- Gill Baker made the 2014 Health Service Journal shortlist of 'most inspirational women in healthcare' where she was praised for having "a vision for the learning disabilities service".

The LD service is also continuing to address health inequalities through the launch of the health checkers project, where people with learning disabilities have been trained to carry out inspection and assurance visits. The strategic health facilitators are also recruiting and supporting people with a learning disability to accompany Healthwatch Derbyshire on 'enter and view' visits.

Ongoing service developments

In order to maximise engagement and facilitate greater choice, the health visiting service has launched a pilot offering clinic appointments on a Saturday. The pilot is yet to be evaluated but has demonstrated that a number of parents enjoy being able to access the service outside of traditional office hours. As part of building community capacity, the service has also been running health promotion events at the Asda Store in Spondon, Oakwood on a fortnightly basis.

The school nurse service is facilitating health promotion roadshows focusing on 'healthy heart' issues and covering areas such as smoking, lifestyle, exercise, diet, stress management and sun safety. The service is also contributing to the development of the Trust website to ensure that it is accessible and informative.

Staff across all services for children and young people are currently working to develop integrated care pathways that will help improve the responsiveness and effectiveness of the services delivered. Teams have also been keen to work with partner agencies to develop pathways that also relate to other service providers and achieve greater integration across all children's and young people's services in the area. Examples of this have included the development of a single point of access in Derby city. This has improved communication across services and ensured greater effectiveness regarding resource allocation.

The CYP IAPT programme has also provided further integration. Shared training opportunities have been made available to staff at partner organisations who are working with children and young people with mild to moderate presentations of anxiety and depression, including staff working in memory assessment teams, education, school health, CAMHS and the third sector.

The learning disability service continues to ensure access to multi-disciplinary community support. Speech and language therapists have contributed to the development of a 'friends and family test' relevant to people using LD services. The service is developing a range of patient-reported outcome measures which will help to evidence the effectiveness of services being provided. Increasingly the LD service is working with other healthcare organisations to ensure improved joint working and the integration of services enabling people with a learning disability to access the care and support they require.

The substance misuse service has implemented the IT system SystmOne from the end of 2014. This is the system used in the main by primary care and by children's services and will facilitate information sharing between our substance misuse services and our health visitors, building on the development work between these services.

Within our forensic and rehabilitation service, the prison in-reach team at Foston Hall has launched a therapeutic group utilising a DBT (dialectical behavioural therapy) approach which is beginning to achieve some positive outcomes for the women using the service.

Staff within the forensic and rehabilitation service are also developing recovery packages for men with mental health problems within Sudbury Prison, helping to prepare them for settlement into the community.

Kedleston unit

Street triage service

In partnership with Derbyshire Constabulary, the street triage pilot has increased its scope during the year to cover Derby city, South Derbyshire and Erewash, and it is hoped that a county-wide service will be developed in the near future. Through the scheme, mental health nurses accompany police officers to incidents where it is suspected that someone is a risk to themselves or those around them due to their mental ill health. The final evaluation of the project is being prepared for submission to the Department of Health as part of the national pilot programme, which will inform future service delivery models. A local event reflecting upon the experience and evaluation of the pilot will be arranged for spring 2015.

The education programme at the low-secure unit, the Kedleston Unit, has continued and a number of patients have achieved recognised qualifications in numeracy and literacy. The unit is working with Derby College as part of the IT curriculum.

Additional psychological resource will be available to the teams at Melbourne House and the Kedleston Unit during 2015, which will have a positive impact on the therapeutic interventions available in the units.

The Criminal Justice Team has commenced a 12-month pilot providing a mental health assessment for people attending Crown Court. The nursing team is supported by a forensic consultant psychiatrist and a cognitive behavioural therapist. The team is also working with colleagues in learning disability services in order to develop screening and assessment tools to help people with a learning disability.

Developing our services in response to feedback

We are committed to listening to feedback in order to make changes that further enhance and improve our services. There are a range of ways in which we capture this feedback, as outlined below…

Within the urgent and planned care division:

People receiving support on our mental health inpatient wards have told us that their privacy and dignity would be improved if we were to offer single sex accommodation. The changes to our ward structure at the Radbourne Unit in April 2014 provided an opportunity to make improvements in this respect, by introducing two gender specific wards. Due to partition arrangements between the two wards, it is also possible to vary the number of beds in both the male and female wards, creating additional flexibility to accommodate our inpatient requirements.

The layout of the new ward at the Radbourne Unit was also transformed, to enable nursing staff to engage more with patients, creating more of a shared community environment. The number of beds on each ward was also reduced, improving the patient environment and experience.

People also tell us that when they need an inpatient bed, they like it to be close to home, as this can aid their recovery and maintain links with family and friends. The increase in beds at the Radbourne Unit has resulted in fewer out-of-area placements throughout the year.

The responses following these changes have been overwhelmingly positive.

We had previously received feedback regarding the difficulties some people faced on discharge from an inpatient environment, and how to rebuild their lives within the community following a period of mental ill health. One patient remarked that it was like "falling off the edge of a cliff". This feedback formed a central part of the Trust's rationale behind the development of the new Hope and Resilience Hub, which provides recovery-focused support to people both on the brink of a hospital admission and on discharge from hospital. Further details about this development can be found on page 38.

In response to powerful patient feedback, we have worked closely with patient groups throughout the year to reduce the use of restrictive practices on all our mental health wards. We have also embedded the Safewards model to reduce the use of restrictive practices on our acute inpatient wards – initially in the south of the county, and then across all of our wards for adults of working age going forward.

Within our planned care structures, people told us that they would like more information given at the point of receiving a dementia diagnosis. In response to this we improved the depth and breadth of information given by providing dementia packs to take home. We also ensured that Alzheimer's Society support workers were present at diagnostic clinics across northern Derbyshire.

The division also operates a 'you said, we did' programme across all sites, where people can raise minor suggestions and improvements that would enhance their experience of our services. When, for example, people at one of our centres said they were having difficulty gaining attention on arrival when the team administrator was away from the reception desk, a bell was fitted at reception and this issue was resolved. Posters are put up within waiting/ reception areas to outline the changes that have been made in response to such feedback.

Within the specialist services division:

The division has made a range of changes to its activities and ways of working, in response to feedback that has been received from a range of audiences.
These changes include:

Patients at the Kedleston Unit have asked for a review of night-time routines, which will generate greater flexibility and person-centred care. The process to implement this approach is currently underway.

Responses from inspection during the year identified the need to develop patient-centred care planning and, as a result, staff at Cherry Tree Close have implemented a shared approach working collaboratively with patients to make care planning more meaningful. Patients at Melbourne House have asked for increased access to therapeutic interventions and staff are currently undertaking compassion-focused therapy training to extend what's available.

The school nurse service has made great efforts to ensure that the service is accessible to children and young people in a range of ways, utilising technology as well as face to face contact. This is helping the service to generate improved opportunities for service user feedback, which will be vital for future service developments.

IYOD is a participation group that is run by young people for young people 14–18 year olds in order to provide them with a voice and promote positive change within CAMHS. The group works on a variety of key areas, all of which provide young people with skills that they can utilize in future employment. The group has links with national participation groups and has sent representatives to national conferences to present their work and views.

Within learning disability services, carers identified problems with internal referral processes. The teams have focused upon these processes and adjusted them to ensure greater responsiveness and flexibility.

The Friends and Family Test

The Trust, alongside other mental health and community providers across the country, offered patients the Friends and Family Test (FFT) from 1 January 2015, in order to gain regular feedback on people's experience of our services.

When someone is discharged from any of our services, they are now asked to answer the following question: "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" People are invited to respond by choosing one of six options, ranging from "extremely likely" to "extremely unlikely". They also have the opportunity to explain why they have given their answer.

Whilst response to the FFT is voluntary, we are actively encouraging people to participate. All responses are completely anonymous, but they will allow us to identify any common themes or experiences, which we can then look to address in order to improve our services and the experiences people have when in our care.

Good patient experience is associated with improved patient outcomes, and this is just one of a number of tools used to capture information and feedback.

Risk management and assurance

There have been a number of areas of achievement throughout the year, including:

- A review of the internal processes to support serious incident investigations, resulting in a centralisation of all information relating to the serious incident and a reduction in the administrative time required to support the process. A review of the process by internal auditors in November 2014 was positive overall, and the actions resulting from the audit have been completed.
- The Trust has also purchased a new module this year to complement its incident and risk management software. The 4Cs module (Compliments, Comments, Concerns and Complaints), was implemented in January 2015 and allows staff to report compliments, concerns and comments through a single system. This enables team managers to see all their local issues at a glance, including any formal complaints, leading to greater ownership and accountability of issues being raised.
- The Trust's board assurance framework (BAF), which details risks to the achievement of the Trust's strategic objectives, has been strengthened this year, with 'deep dive' presentations by executive directors to the audit committee on each of the risks. This has encouraged appropriate challenge and review and has been well received.

Effective management of Serious Incidents Requiring Investigation (SIRIs)

In accordance with NHS guidelines, the Trust's Serious Incident Requiring Investigation (SIRI) group meets on a weekly basis to review all 'major' and 'catastrophic' incidents and all serious safeguarding incidents as part of the wider management of serious incidents.

The management of serious incidents in the Trust complies with the NHS England Serious Incident Framework (2013) and level three investigatory safeguarding standards.

The organisation continues to demonstrate robust analysis and scrutiny using an evidence-based approach – 'root cause analysis'. Lessons learned and changes in practice are implemented through operational services. The implementation of actions from SIRI investigations is monitored in the divisions with exception reporting presented to the Quality Committee and Board of Directors.

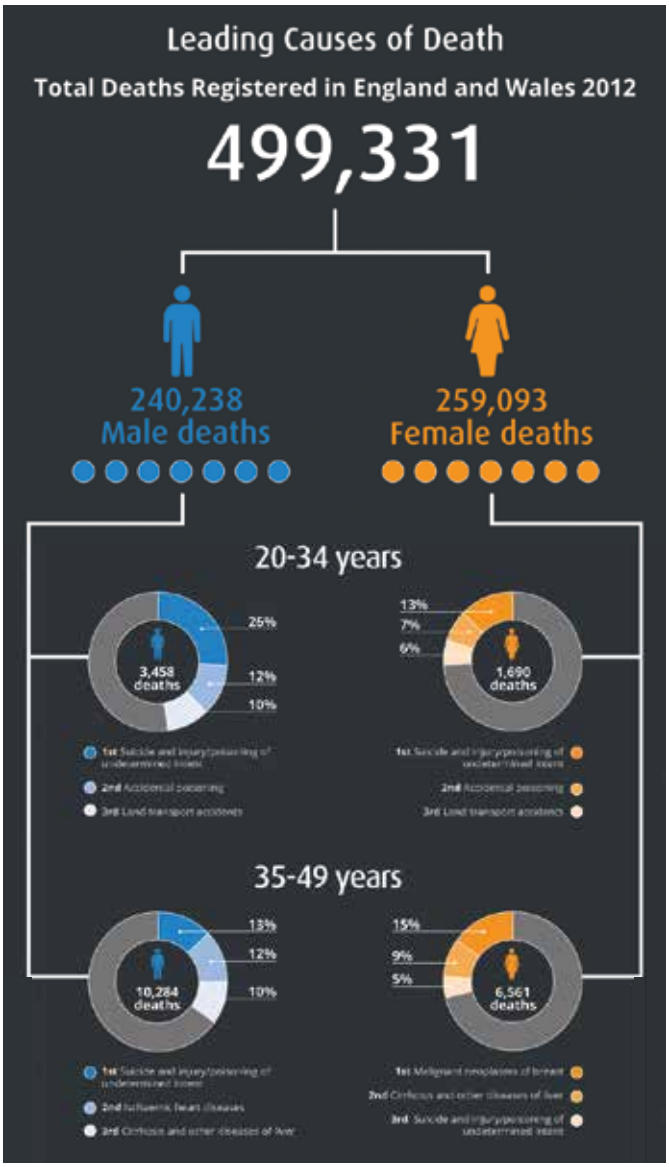
Throughout 2014/15 the organisation continued to promote the reporting of untoward incidents, which gives us the opportunity to learn from the incidents as defined in the National Patient Safety Agency document 'Seven steps to patient safety (2004)'. Information from the National Reporting and Learning System (NRLS) organisational feedback reports indicates that the Trust's reporting rate for patient safety incidents is above the median rate for the mental health and learning disability sector.

Below are examples of changes in practice that have occurred as a result of learning from SIRIs:

- We have developed a revised approach to the assessment and management of clinical risk, which is now based on the assessment of safety needs
- We have placed emphasis on engagement and collaborative working with service receivers with regards to the management of safety needs
- We have improved the way we communicate about risk and relapse with primary care services by utilising the 'special patient notes' facility in primary care
- We have further developed the Trust Preventing Suicide Strategy Group to include service receiver involvement and co-chair arrangements
- The Trust is adopting and promoting the Situation Background Assessment Recommendation Decision (SBARD) approach to ensure information is consistently and effectively communicated between services, agencies and teams
- We have established processes for the implementation of our statutory duty of candour with the recruitment of family liaison workers
- We have further developed and revised the Trust's process for the investigation and management of SIRIs
- We have developed improved processes to disseminate the learning from SIRIs to clinical staff in the divisions through the quality leadership teams.

Analysis of SIRIs and clinical performance is detailed in the Quality Report.

Like many other Trusts, we are currently struggling with our suicide rates, which are currently a major cause of death in UK society (see national leading causes of death below). We are doing extra work to monitor this issue. We are mindful that suicide rates should be monitored over a three to five year period, rather than on an annual basis, but have identified an early warning sign that we are currently above average in our death rates. This may match the national picture of a rising suicide rate, but at this time we cannot confirm that this is either above or below the national average for the three year rolling rate, due to the time required nationally to analyse and publish figures.



Office for National Statistics, infographic showing total deaths registered in England and Wales 2012

Information governance

We have maintained our compliance with information governance (IG) best practice. We achieved a score of 96% through the NHS's national IG self-assessment toolkit, which keeps us at the forefront of our category and maintained our overall rating of satisfactory, demonstrating that we have reached level 2 or above in all attainments.

The Information Governance Committee has met throughout the year and the information governance policies have been consistently at 95% or above in terms of being current and in date. During the year, two incidents were reported to the Information Commissioner's Office (ICO). One involved a patient accessing a staff only area and removing patient files. The other involved confidential records being found in a public place. This was subsequently found to be related to a malicious act and managed through workforce processes. Additional security measures were implemented as a result. Both incidents were investigated by the SIRI Group. The first incident has been closed with no further action from the ICO but the second remains open.

We have also had one concern by a family accepted by the ICO and we have responded as requested.

Pillar 2: Service delivery and design

A new psychiatric liaison service opened in Chesterfield in January 2015

We will embrace contemporary models of service delivery through optimising our use of technology and our estate.

The Trust prides itself on being at the leading edge of innovation in healthcare to ensure that, in collaboration with our partners, we are always able to deliver the highest quality care, treatment and support to people in a way that is meaningful to them. **During 2014/15 we have developed and implemented a number of innovations that support service delivery:**

- A Single Point of Access (SPOA) was created as an approach within the Trust early in the year. It was initially developed by Child and Adolescent Mental Health Services, community paediatrics and school health as an integrated approach to managing referrals through emotional and behavioural pathways.

  The purpose of the SPOA is to improve the quality and appropriateness of referrals into specialist services for children and young people who have emotional health, psychological and mental health needs, usually displayed by a variety of behavioural issues. This is achieved by a co-ordinated approach to managing the specialist assessment process, and by signposting and working collaboratively with multi-agency teams and universal services.

  The SPOA acts as an integrated single entry and exit point for specialist advice and assessment for children and young people, and as a mechanism for managing demand systematically by responding appropriately to the needs of vulnerable families at an earlier stage and at the right level.

- This year the Trust opened the doors of its new Hope and Resilience Hub at the Radbourne Unit in Derby.

  This ground-breaking facility aims to better support individuals recovering from a mental illness, providing the skills, motivation and support for individuals to rebuild their lives and to live independently, with support, in the community.

  We are anticipating that over time this development will result in an improvement of our community resources for adults experiencing acute mental health problems, resulting in a reduction of ward admissions. We know our patients want to stay living at home whenever possible and that being supported to do this can help their recovery process. When people are admitted to the Hub they are provided with meaningful, personalised support and activity to enhance their recovery and enable them to feel empowered to go back into the community.

  For more details on our recovery focused approaches and the opening of the new Hub, please see pages 38-39.

- In November 2014, the Trust fully implemented the first phase of our new electronic patient record system called Paris. The system is now in use in 99 teams and by 1,488 clinicians. It holds records for 22,956 currently active patients and historic records for 116,494 patients. It has replaced a previous 15 year old system called Carenotes.

  The move to a fully electronic record will allow instantaneous access to the patient record from anywhere across the Trust. It will ensure that teams have all the information relating to a patient at the point of care and will reduce the number of times patients are asked for their information.

  New developments are planned to deliver e-prescribing and increased support for mobile working.

- January 2015 saw the launch of our new psychiatric liaison service at Chesterfield Royal Hospital. This service mirrors the already successful integrated liaison service operating in Royal Derby Hospital and ensures that adults with mental health difficulties, including those with dementia, and people with a substance misuse difficulty receive a rapid assessment whilst in Chesterfield Royal Hospital and appropriate treatment is started.

  The core aims of this service are to improve the experience and outcomes for people with mental health difficulties in the acute hospital and to support the avoidance of admissions where possible, or reduce the length of time people are in hospital.

Recovery and wellbeing approaches

Recovery and wellbeing has been an integral theme through the Trust during 2014/15 as we have sought to embed the principles of recovery across all our services. This focus culminated in the opening of the new Hope and Resilience Hub in February 2015.

Hope and Resilience Hub

The first phase of the new Hope and Resilience Hub opened on 2 February 2015. The Hub is based at the Radbourne Unit in Derby and has bought together three urgent care services to bring about a new way of working: Ward 35 at the Radbourne Unit, the Radbourne Occupational Therapy Department and the Day Hospital from the Resource Centre at London Road Community Hospital.

By bringing these services together we now will have a focus on both recovery and prevention of admission in one service. The Hub offers an assessment function for those who would benefit from an alternative to admission. People using this intensive community support part of the service are involved in recreational activities, psychosocial education and one-to-one sessions to support them to manage their symptoms and ensure their medication is working for them.

The people using the intensive community support component will then join the recovery part of the service, with people who are currently receiving inpatient care or have recently done so. This element of the service is about rebuilding a 'life beyond illness' and aims to enable people to think about self-management and wellbeing through recovery education and recovery action-planning courses. The recovery element of the service also focuses on connecting people back into their communities and neighbourhoods, whether that be returning to work, volunteering, engaging in social activity or rebuilding relationships.

The Hope and Resilience Hub works with community resources to create recovery pathways out of the service. To date we have partnerships developed with the Individual Placement and Support (IPS) team at Derby City Council to help people return to work, Citizens Advice Bureau, Derby County Football Club, Common Threads (a group offering history and textile workshops run by Derby Museums) and Quad in Derby.

The Purposeful Inpatient Admission (PIpA) model and wellbeing planning are essential to ensuring a person-centred approach at all times, and these are being rolled out across the Trust's services.

Recovery education

Recovery education continues to develop within the Trust and beyond, with courses now running at the Hartington Unit in Chesterfield and the Hope and Resilience Hub in Derby. Many more courses are planned over the next year, along with the recruitment of peer support tutors and the development of the neighbourhood model for delivering community health services.

Peer support work

We continue to recruit peer support workers and peer support tutors into the Trust and plan to specifically focus on this over the next year. Our aspiration is to have peer support workers available to work with people using our services across all our services and into our neighbourhoods.

The Hope and Resilience Hub team, based at the Radbourne Unit in Derby

Social capital and neighbourhoods

The Trust is working closely with its communities, the voluntary sector and social care to understand and develop community and individual resilience across all our neighbourhoods. It is clear that all neighbourhoods have different needs and community leaders. As such the Trust is getting involved in what is happening; that includes supporting the 'Connect to Recovery' events in Buxton and Matlock and getting involved in the Erewash stakeholder event hosted by Southern Derbyshire Voluntary Sector Mental Health Forum.

Annual Members Meeting (AMM)

Our Annual Members Meeting in September 2014 reflected the year's focus on recovery and was largely produced and presented by people who use our services. Individuals powerfully shared their stories and outlined how they are supporting the Trust to make services more recovery focused. A short film and a collection of recovery stories were produced for the night, to give other people hope that recovery is possible from many different situations.

The film and booklet of recovery stories can be viewed on the Trust website at www.derbyshirehealthcareft.nhs.uk

Volunteer services

Over the past year the Trust's volunteer service has continued to provide opportunities for service users and members of local communities to play a part in the running and shaping of services by becoming volunteers.

Volunteers are becoming a recognised part of the workforce and have been introduced to a wide range of service areas. The volunteering programme actively encourages those who have lived experience of particular health problems, and is supporting their recovery journey with the introduction of volunteer internships with support to obtain paid employment. This will become part of the overarching vocational pathway.

The service works within a recovery framework to support people volunteering to achieve their own goals and ambitions. The volunteer service strives to provide an inclusive and encouraging introduction into the Trust and each volunteer is provided with individualised and tailored support throughout their time as a volunteer.

"I really enjoy helping and being with people that have suffered similar problems like me... I get so much from helping others and I want to pass on what I have learnt through having this mental health condition..."

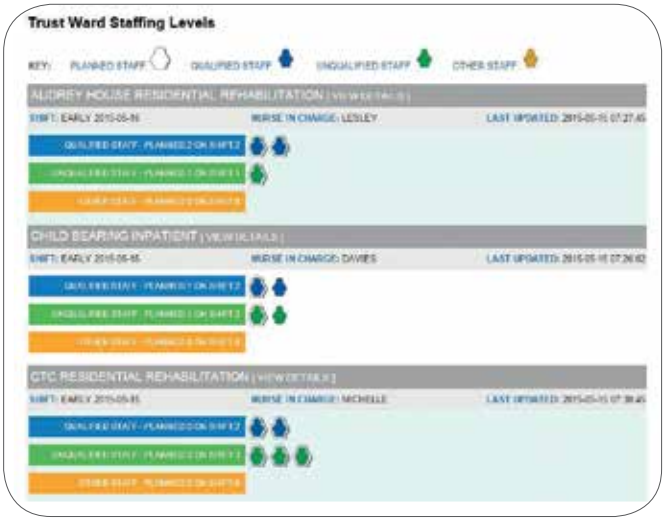
Hope & Resilience Hub

A previous service receiver from the Radbourne Unit in Derby created the hub's new distinct identity.

Using technology to help us work differently

The Trust is committed to making the best use of information technology to develop new ways of working and also to support the ways in which we can engage with our patients and their carers and families. **The following developments took place during 2014/15:**

- The year has been dominated by the implementation of a new electronic patient record (EPR) system, which has been successfully implemented into all mental health teams as referenced on page 37. It will now be rolled out to more teams and electronic forms will be created to allow the Trust to operate as a fully electronic record-based organisation.
- An e-rostering system has been implemented in all wards within the Trust. All temporary staff are now paid on the basis of the roster, replacing the old paper process ensuring the Trust makes the most efficient use of our workforce.
- The Trust now publishes safer staffing information live onto the website. This has been done to ensure we maintain transparency of our services to the public.
- A new internet site has been developed to support the collection of friends and family information (for more information see page 34).
- An IT system has been implemented within drug and alcohol services that has allowed the team to transform the way the service is delivered. The service now utilises a fully electronic record which integrates with primary care.
- Systems have been developed and implemented to support the successful development of a new psychiatric liaison service into Chesterfield Royal Hospital, ensuring that adults with mental health difficulties, including those with dementia, and people with a substance misuse difficulty receive a rapid assessment whilst in Chesterfield Royal Hospital and appropriate treatment is started.
- New systems and process have been implemented to ensure control and co-ordination of commissioner returns.
- A digital dictation solution has been implemented and is used by approximately 480 staff within the business to aid the production of outpatient letters and discharge summaries.
- The Trust has developed additional technology to support the businesses adoption of agile working.
- A programme has been undertaken to refresh and/or migrate the Trust's computers from Windows XP to Windows 7.
- We have made changes to our systems to manage new methods of commissioning services, in line with the new national tariff guidelines.
- The Trust's IT team have contributed to an innovative solution combining information from nine Derbyshire-based organisations, to allow an holistic view of patient flows.
- Our information governance rating was the highest in class at 96%, which demonstrates the level of importance we place on ensuring we maintain good control of the information we hold securely.



The Trust now publishes safer staffing information live onto the website

Environment and sustainability report

The Trust acknowledges that our activities in delivering quality healthcare have an impact on the environment; the challenge that we face is to reduce this impact whilst maintaining and improving our patients' surroundings.

Travel and transport

Travel by staff, patients, visitors and suppliers is a large contributor to carbon emissions and where possible needs to be reduced; this poses a major challenge as we operate over many sites county-wide.

The Trust has continued to introduce new technologies and innovative ways of working, such as agile working, flexible working and 'hot desking'; this reduces the need for staff to travel to a fixed base.

We have introduced a vehicle tracking system which, along with a web-based helpdesk system, enables more efficient use of Trust maintenance transport and staff time.

The Trust is also continuing to promote a cycle-to-work scheme, which includes an assisted purchase scheme, and has installed a considerable number of secure bike boxes, which are well used.

Building energy – utilities

We are constantly looking at ways to conserve energy and reduce carbon emissions; this in turn has financial benefits for the Trust.

There have been several major schemes over the last year to reduce energy consumption and carbon emissions:

- New energy-efficient condensing boilers have been installed at the Radbourne Unit; these replace the original boilers securing heating and hot water for service users, whilst reducing gas consumption.
- We are continuing to upgrade conventional lighting installations with the latest LED technology. Schemes completed over the last financial year include Bolsover, Ripley Resource Centre, Hartington Unit reception and hub, and the Hope and Resilience Hub at the Radbourne Unit. These schemes will also reduce maintenance requirements due to the increased life expectancy of LEDs over conventional fluorescent bulbs.

Monitoring, control and training

Derbyshire Healthcare is the first NHS trust to receive the Carbon Trust longevity logo which recognises organisations that have managed to reduce their carbon footprint continuously over three or more separate assessments.

All Trust staff attend a yearly energy and carbon reduction training session where they are made aware of the benefits of switching off lighting and electrical appliances and turning down heating controls. This raises awareness and understanding that, however small, everything counts and adds up to a real saving.

Environmental sustainability

Sustainability is not a stand-alone subject area but an integral part of the overall strategy of achieving a better environment. It will be a key part of maintaining the improvements we achieve and ensuring that in years to come the improvements we make now are continued.

Wherever possible the estates capital team routinely recycles and reuses fixtures and fittings as part of capital refurbishment projects; these include shelving, notice boards, whiteboards and electrical fittings (where safety is not compromised).

Waste management

The Trust continues to achieve a waste recycling rate of over 70% and in the coming year will introduce recycling to its community properties in the High Peak area.

The estates grounds team continue to recycle our green waste by turning it into bark chippings and mulch, which is put back onto the planted areas of our sites.

Procurement

The procurement process has due regard for both environmental issues and value for money when purchasing goods and services. The Trust promotes the use of products and suppliers with environmental and sustainable policies that accord with our own. The sourcing of local products and services is an area to be encouraged and developed, and this is a key area in the delivery of sustainability.

Green waste is recycled and used in the planted areas of our sites.

Health, safety, fire and security

There has been significant progress with regard to health, safety, fire and security management across the Trust over the last financial year. Specific areas of achievement have included:

- The Trust demonstrated compliance with all relevant health and safety statutes, the Regulatory Reform (Fire Safety) Order 2005 together with the Health and Social Care Act 2010 during the year. This demonstrates that health and safety management systems are embedded across the organisation in accordance with HSG65, 'Successful Health and Safety Management'.
- The Trust's Health and Safety Training Framework (detailing compliance with training that supports the achievement of the corporate objectives) continues to be delivered to a high standard, ensuring that training as a control measure is effective and adequately reduces risk. Compliance is reported to the Trust's Health and Safety Committee on a six-monthly basis.
- The Trust has robust health and safety monitoring arrangements in place to ensure compliance and improvement where required with health and safety requirements.
- During 2014/15 NHS Protect audited the organisation's security management arrangements, the results of which revealed very high compliance levels.
- The Trust's Health, Safety and Security Committee has continued to meet quarterly throughout the year and includes robust representation from recognised union bodies. The committee demonstrates effectively the requirement to consult and communicate on all health and safety-related matters. The committee has a detailed documented work plan to ensure effective business is undertaken and completed.

Pillar 3: Promoting public confidence

We want to be known for our values and the high quality, compassionate care we provide. We want local people and our partners to have confidence in the care we give and the way in which we work.

The Trust has continued to strive to involve our staff, people who use our services and local partners in developing new service models. During this year we have engaged with more than 840 people about the development of our exciting neighbourhood and campus model for delivering services.

In May 2014 the Trust maintained its national profile for successfully developing and implementing a values-based approach to organisational development by being recognised by the Healthcare People Management Association (HPMA) with NHS Employers in their publication 'Meeting the Challenge'. We have also shared our best practice locally both with commissioners and other providers, including primary care.

The Trust was also listed as one of the top 100 places to work in the NHS in a poll published by the HSJ (Health Service Journal) in September 2014 (please see page 99 for more details).

The Trust received a green rating for the safety and security of its services in October 2014, following an assessment and inspection by NHS Protect, who lead on work to identify and tackle crime across the health service. The inspection checked that effective procedures had been put in place to ensure that Trust staff, patients and premises are safe, which ultimately ensures that a safe environment is created for patient care.

During 2014/15 the Trust has retained all of its core business and has worked with commissioners to enhance the quality of care offered to local people by providing the following new services:

- The opening of a new ward at the Radbourne Unit, Derby for adults with acute mental health difficulties. This enabled us to provide a net increase of five new beds, but importantly also allowed the size of all wards at the Radbourne Unit to be reduced, to improve patient experience.

New ward at Radbourne Unit

- A psychiatric liaison service was launched at Chesterfield Royal Hospital in January 2015
- An enhanced memory assessment service commenced in Southern Derbyshire, to ensure that we can deliver a faster diagnosis and support service for people with dementia
- An innovative pilot started in Erewash, to provide intensive home support for people with drug and alcohol problems who are regular attenders at the acute hospitals
- A specialist community mental health nurse adviser started working with NHS 111 this year, supporting the most appropriate triage of people with mental health needs ringing the service
- The Trust further developed the skill mix for the new and developing perinatal community service in North Derbyshire.

In addition to these exciting developments we have also been able to further enhance the number of health visitors we have within Derby City as part of our drive towards achieving the outcomes of the Health Visitor Implementation Plan – 'A Call to Action'.

Working closely with Hardwick CCG we have developed GP practice-level dementia support that works closely with GPs and healthcare practice staff to increase the speed of dementia diagnosis and, importantly, adopting a unified approach to supporting people with memory problems and their family.

The Trust has successfully tendered during this year for the South West Yorkshire locked and unlocked rehabilitation services framework agreement, which means if people from South and West Yorkshire choose to use our rehabilitation services in future they can do so.

We are also delighted to have retained and grown our service to people with a substance misuse in Derby City by winning, in partnership with Phoenix Futures and Aquarius, the integrated substance misuse tender that will commence from April 2015.

The Trust was expecting to have ceased delivering pharmacy services to community hospitals managed by Derbyshire Community Health Services NHS Foundation Trust this year but we were requested to continue to provide the service.

Think Healthy

A collaboration between the Trust and Healthwatch Derby, led to the publication of an in-depth, independent review into our work in the city, in February 2015.

Healthwatch Derby was given access to our services in the autumn of 2014, to see how we support people with mental health problems, people with learning disabilities and Derby's children and families. They were given the opportunity to observe Trust teams first-hand, shadowing the mental health crisis resolution and home treatment team over a 12-hour shift as well as the school nursing and health visiting teams. They also conducted two 'enter and view' sessions at the Radbourne Unit and on Wards 1 and 2 at London Road Community Hospital, to assess the care of adults and older adults experiencing acute mental distress and to collect the views of patients and carers receiving support from each service.

The collaborative 'Think Healthy' review also saw staff from both organisations promoting a questionnaire, and organising and attending face-to-face public feedback events including a trilingual workshop at the Indian Community Centre run in Punjabi, Hindi and Urdu. In total 1,070 items of individual feedback were collected.

Now, the two organisations hope to build on the relationship developed during the period of the review and work together to ensure that services are constantly changing and improving to meet people's needs. The Trust is launching a revised Patient Experience Committee that will act on the recommendations in the Think Healthy review and report back to Healthwatch Derby on its progress.

The full report and recommendations can be accessed at **www.healthwatchderby.co.uk**

Carolyn Green, Director of Nursing and Patient Experience, with Steve Studham, Chair of Healthwatch Derby.

Engaging with our communities

Equality and diversity

Derbyshire Healthcare NHS Foundation Trust is committed to fairness and the delivery of personalised services and employment of the highest quality by enabling people to be the best they can be. We recognise how important it is to respect people's dignity and basic rights and we will act responsibly in fulfilling our obligations and pledges set out in the NHS Constitution and Equality Act 2010.

The Trust uses the national NHS Equality Delivery System2 (EDS2) to drive equality performance and to show that services and employment are equally good and fair for all groups. The EDS2 tool is used to help local NHS organisations review and improve their performance for people with characteristics protected by the Equality Act 2010. The EDS has 18 outcomes grouped under four goals. The outcomes focus on equality issues of most concern to patients, carers, communities, NHS staff and the Board.

This year, building on our success and the insight gained from our equality and engagement work, our 4Es stakeholder alliance of local interests helped to grade our performance against these goals and told us that we are making steady progress. They also highlighted where improvements are needed. Our equality objectives and 29 good practice 'equality in action' case studies can be found at **http://www.derbyshirehealthcareft.nhs.uk/about-us/equality-diversity/eds/**

There are a number of wider examples where the Trust's focus on equality and diversity has been held up as a national example of best practice throughout the year:

- The Employers Network for Equality and Inclusion (ENEI) gave the Trust a Silver Standard Employer 2014 award for our commitment to living our values through promoting equality and diversity.
- The Trust retained its NHS Employers (NHSE) equality and diversity partner status for the second year running. The Trust's submission was independently rated as one of the top scoring submissions nationwide and the Trust was commended for senior leadership, the 'reaching out' visits undertaken by the Chairman, our 4Es stakeholder alliance and tangible examples of EDS2 'equality in action' case studies.
- Representatives from the Trust were invited to present EDS2 case studies produced by Debbie Edwards, Acute Liaison Nurse for Learning Disabilities and Adam Chilcott, volunteer, in December 2014 at the NHSE partners event.

Participants engage in the reverse commissioning pilot

- Our efforts to engage with BME communities were featured as a case study in an NHS Providers report 'Leading by example: the race equality opportunity for NHS provider boards'. The case study highlights the visits made by the Trust's Chairman, Mark Todd, to over 24 community groups over the course of the year. It also gives an example of our subsequent engagement with the Indian community – through mental health first aid training and the Bollywood Blues event. See page 46 for more details on these initiatives.

Reverse commissioning

This year the Trust agreed to be one of a few Trusts to be involved in the NHS BME Network's delivering mental health by reverse commissioning pilot.

The project, which formally commenced in March 2015, looks to develop effective processes to engage BME communities to ensure their health needs are being addressed by the NHS.

This process builds on evidence based working through identifying health needs and working with BME communities as equal partners to address health inequalities. We will use learning from this process and work with CCGs to influence effective commissioning to meet the needs of BME communities.

We look forward to reporting our progress with this pilot over the next year.

Improving access for Deaf people

Derby has the second largest Deaf community outside of London. As such, the Deaf community is an important part of the communities we serve and we have made particular efforts this year to ensure that we are making our services accessible and responsive to the needs of this community.

To express our commitment to the Deaf community, the Trust Board signed the British Sign Language Charter in May 2014. Through the Charter, the Trust has committed to:

- Ensuring access to information and services
- Promoting learning and high quality teaching of British Sign Language
- Supporting Deaf children and their families
- Ensuring staff working with Deaf people can communicate effectively
- Consulting with the local Deaf community on a regular basis.

Robin Ash from the British Deaf Association, supports Trust staff to communicate in sign language.

Robin Ash, from the British Deaf Association, has delivered Deaf equality and BSL training sessions to our staff throughout the year to aid their understanding of the Deaf community, whilst also providing basic sign language skills.

Our experiences in this area were shared with the London Assembly Health Committee expert panel, to share our work to promote access to health services for d/Deaf people and implementing the British Sign Language Charter in partnership with the British Deaf Association.

Mental health first aid training

Mental health first aid training

Throughout the year we have provided mental health first aid training to the deaf community. This was also extended to Asian community groups – including the Sathi Group, Shakti Group and Saheli Group, in partnership with the Indian Day Care Support Services and Derbyshire Mind.

The training was provided bilingually in Punjabi and English, in partnership with Derbyshire Mind. It aims to help communities to spot the signs and symptoms of common mental health problems and advise others in the community about how to get help.

World mental health day

This year the Trust celebrated world mental health day with a moving theatre production 'Other', which told the story of a young mixed race man, working backwards from his detainment in a medium secure forensic unit at aged 19, to his promising beginnings when he was born. The event also provided the opportunities for local communities and students to discuss important issues regarding mental health within BME communities.

To coincide with world mental health day the Trust's consultant psychiatrists delivered a 'Bollywood Blues: understanding mental health in BME communities' event exploring mental health, dementia and stigma through the art of Bollywood films. This was facilitated in partnership with Nottinghamshire Healthcare Trust.

Equality, engagement, tackling stigma, discrimination and fostering good relations

The Trust's senior leaders are committed to engagement and are active inside and outside of organisation. We have shared our approach and the benefits of inclusion with service users, partner organisations and the wider community. A number of organisations have adopted our practices to improve their own organisation and services.

4Es stakeholder alliance - Equality, Experience, Engagement and Enablement

Our 4Es stakeholder alliance has continue to grow and develop over the year, bringing together partners, working together to make a real difference to the quality of life and experiences of people who need our help and support.

The 4Es acts as a platform for working together and delivering social value through capacity building, sharing resources, information, good practice and provision of mutual support to enable people to live a quality life.

Consultations

In the autumn of 2014, the Trust undertook an informal public consultation exercise regarding the development of the new Hope and Resilience Hub, and associated transfer of day hospital services.

A report that outlines the processes undertaken and the views received as part of the consultation can be found on the Trust website **www.derbyshirehealthcareft.nhs.uk.** The report includes key feedback received from a number of stakeholders and outlines the Trust's response to the issues raised.

It is likely that further consultations will take place during the 2015/16 financial year, as our plans to develop service changes come to fruition. This will be particularly applicable to our campus services. However at the time of writing, there are no formed plans or proposals in place.

To access wider documents that relate to the Trust's engagement processes, please visit www.derbyshirehealthcareft.nhs.uk

Communications and involvement

There have been significant changes to the way the Trust communicates and engages with its internal and external audiences this year, as we have sought to build our capacity in this area. Of particular note, the communications, membership, engagement and inclusion teams integrated in July 2014, bringing together a number of small teams who share a common purpose to promote messages and two way information sharing across the Trust and with our communities, patients, members and partners.

The newly formed communications and involvement team aim to further develop its engagement and participation with all audiences over the forthcoming year, in line with new communications and membership strategies, approved by the Trust Board in November 2014.

Following earlier feedback from stakeholders, the Trust refreshed its brand identity in May 2014, to promote a single, recognisable brand by which the Trust would be identified with. This new brand supports wider work to strengthen our reputation and profile on a local and national basis.

The team have focused on developing our communications with school-aged children over the last year, through a series of articles in *First News*, the award-winning national newspaper for young people, with a readership of over two million. Features have covered issues such as anxiety, eating disorders, coping with pressures at Christmas and starting at a new school, all written in collaboration with CAMHS colleagues.

The team has also worked closely with the British Heart Foundation, resulting in a special report in The Guardian on the importance of promoting physical health when supporting people with mental health problems. The article focused on the work of our occupational therapists, community mental health teams and in-patient staff in Bolsover and Chesterfield, who have co-operated with GP surgeries and social care workers to make sure exercise, healthy eating and smoking cessation are always considered along with medication.

The team also continues to encourage an open discussion about dementia care, through a series of newspaper features and radio interviews with clinical staff and carers.

In line with our focus on ensuring equal access to information for the Deaf community, a short film about the Trust's services and recovery based approaches was revealed for the first time at the Trust's Annual Members' Meeting in September 2014. In response to feedback received from our Deaf community, the film was produced in British Sign Language (BSL). The film can be accessed via **www.derbyshirehealthcareft.nhs.uk** Further consideration will be made to improving our corporate information for the Deaf community, over the forthcoming year.

Internally, the DEED (Delivery Excellence Every Day) scheme was launched at the annual staff awards in November 2014. This seeks to celebrate the day-to-day examples of staff and volunteers who demonstrate our values and go the extra mile for patients, carers, partners and colleagues. For further details please see page 51.

First News reports, reproduced courtesy of *First News*

Compliments and complaints

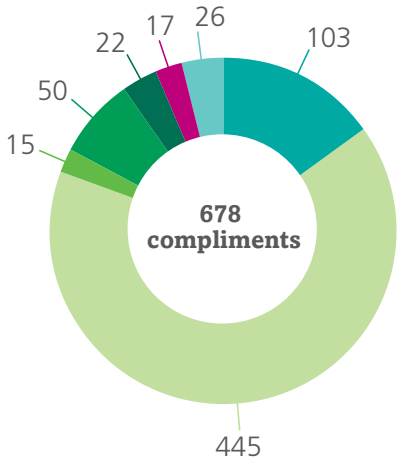
The Patient Experience team is the central point of contact for people to provide feedback and raise concerns about the services provided by the Trust. The team sits within the Nursing, Quality and Governance Directorate and is based at the Trust Headquarters. Staff have direct contact with the Chief Executive and Executive Directors and liaise regularly with senior managers.

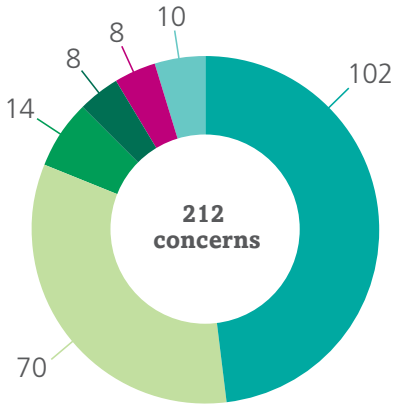
The team's aim is to provide a swift response to concerns or queries raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses including any actions taken. Learning from the feedback the team receives is essential and this is shared with staff through the Trust's 'Practice Matters' publication.

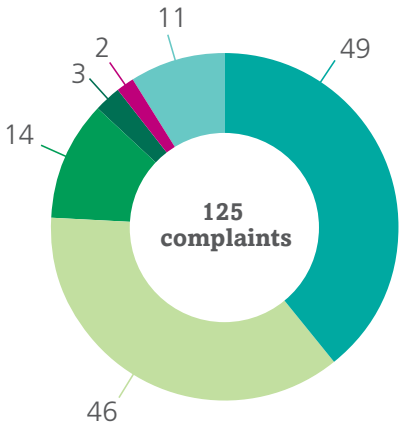
During 2013/14 the Trust logged:

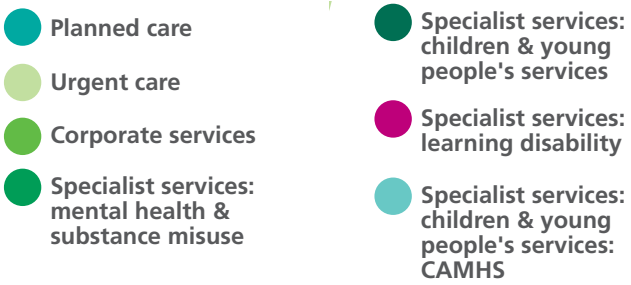
- 678 compliments
- 212 concerns
- 125 complaints.

Complaints are issues that need investigating and require a formal response from the Trust. Concerns need resolving and require a less formal response; this can be through the patient experience team or directly by staff at ward or team level within our services.







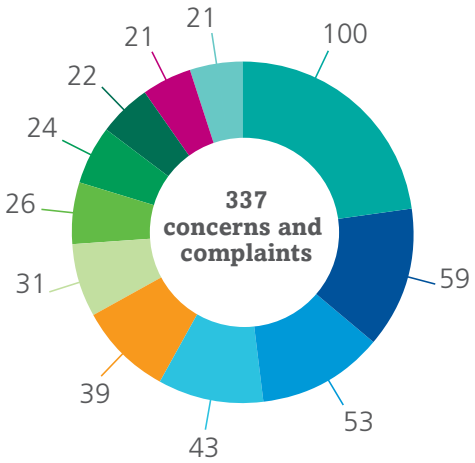


Themes

During the year the Trust logged complaints, concerns and compliments by theme in order to use the information in a more meaningful way.

Most compliments were for the help and care provided by staff and for the support given to relatives.

Of the 337 concerns and complaints the top 11 themes are reported below:



- **Availability of services/activities/therapies**
- **Abruptness/rudeness/unprofessionalism**
- **Care planning**
- **Information provided**
- **Engagement**
- **Medication**
- **Compassion**
- **Waiting times**
- **Nursing care**
- **Patient safety**
- **Assessment**

*This figure reflects the number of complaints and concerns that were ongoing at the end of the financial year. For many complaints or concerns, this timescale continued beyond 31 March 2015. We aim to respond to all complaints or concerns within an agreed timeframe. On occasion a formal response may take longer than our desired 25 working days due to the complexity of the complaint involved.

Of the 125 complaints, 33 were found to be well founded, 15 well founded in part, 26 not well founded, 2 withdrawn and 49* are still being investigated. In regard to the well-founded complaints, 91 separate actions have been taken to improve services and communication, including reflective practice in supervision, policy and protocol reviews, changes of workers and second opinions requested.

During the year the Trust discussed eight cases with the Health Service Ombudsman:

- Three cases where clinical files were requested, and the cases assessed. Outcome: two cases had no further action and one had recommendations
- One case where, following discussions, a payment of £1,000 was made for a breach of confidentiality
- Four contacts where no further action was required.

This provides the Trust with external assurance that complaints are handled in an appropriate manner.

This compliments and complaints data is correct as of 31 March 2015.

New recognition scheme for staff and volunteers

In December 2014, the Trust launched a new recognition scheme to celebrate the day-to-day examples of staff and volunteers who demonstrate our values and go the extra mile for patients, carers, partners and colleagues. Staff were asked to vote on the name of the scheme and chose Delivering Excellence Every Day – or DEED for short. This name links the scheme with our values ('we deliver excellence') and with our annual awards, the Delivering Excellence Awards.

Through a short online nomination form on our website, people inside and outside the Trust can nominate staff and volunteers who will then be featured in the weekly internal bulletin. At the end of the month, a panel of judges (which includes a public governor, a staff governor and a non-executive director) decides which nominee should be the DEED colleague of the month. The winner receives a certificate and a special pin badge that they can wear at work, and will be invited to the annual Delivering Excellence Awards ceremony.

Nearly 50 nominations were submitted during the first three months of the scheme. Winners of the scheme in December 2014, January 2015 and February 2015 were:

- **John Longmate**, a Community Psychiatric Nurse (CPN) based at the Kingsway site in Derby, who received an external nomination from the son of one John's patients. John had helped his father for a number of years, and supported the son through a very difficult time as the father was being moved into sheltered accommodation. John was praised for his commitment and for going out of his way to make sure that there has been an effective handover to a named CPN. The nomination concluded, "I hope the new CPN is as caring, professional and effective as John has been."
- **Sarah Watson**, a Community Psychiatric Nurse in the North East Community Mental Health Team (older people) based at the Hartington Unit in Chesterfield. Sarah was the duty worker on New Year's Eve and responded to a GP request to undertake an urgent assessment.

John Longmate receives the first ever DEED award, in December 2014

This meant she had to work well beyond her normal working hours to ensure the assessment was completed, relevant people were communicated with and essential paperwork was inputted into the electronic patient records system. The person who nominated Sarah described her as "a highly committed and dedicated individual who always strives to do her best for the patients in her care."

- **Craig Neesham**, also a Community Psychiatric Nurse with the North East and Chesterfield Community Mental Health Team (older people). Craig's nomination said he "consistently puts patients at the centre of everything he does". During the last bout of snow, the weather conditions in the Chesterfield area were so extreme that most members of the team ended up having to walk home through driving snow as they were unable to drive their vehicles out of the hospital. Craig was worried about one of the service users on his caseload who needed a change in medication to try and avert a crisis, so he walked through the snow in order to ensure this person had the treatment he required that day before walking home. A couple of days later he was "duty worker" for the day. He took an urgent referral from a GP late in the afternoon and as there were no medics available for a domiciliary visit, he agreed to visit for an assessment. The service user required an inpatient assessment and Craig facilitated this. As a consequence he did not finish work until 9pm, four hours after his usual finish time on a Friday.

Pillar 4: Relationships and partners

We value our relationships with patients, carers, members, governors and commissioners. We aim to be proactive and influential partners, providing specialist advice in our areas of expertise.

The relationships we build with others are key to our success and reputation as an NHS Trust. This pillar has been a key focus of our work this year, as we have sought to develop increasingly collaborative working relationships with our partners across the local health care economy.

We know that Derbyshire is not immune to the challenges faced by the NHS nationally and we know that collectively, health and social care providers need to work differently to address these challenges. As providers we share many of these challenges – a growing population with increasing diversity, with people living longer and therefore experiencing conditions such as dementia. A collective approach is the best way of addressing these issues, so that we work together and adopt a consistent approach, supporting the people of Derbyshire to receive the best and most appropriate health care support.

These challenges impact upon physical healthcare as well as mental health care and one of the big challenges is to align these two areas, which have traditionally been seen as different spheres of the NHS. It is only natural and logical that people with mental health diagnoses will have physical health requirements and also that people with specific physical conditions will require increased emotional support.

Over the last year we have continued to develop our partnership with other local providers to provide healthcare services that bridge this gap. Our liaison services in the two Derbyshire acute hospitals are a good example of this approach. Following the launch of a liaison service in Derby in October 2013, a new liaison service commenced in Chesterfield Royal Hospital in January 2015.

LIAISON team

The service, delivered in partnership between the Trust and the two local acute hospitals, provides 24-hour support to people attending the acute hospital but who are in need of psychiatric support due to mental health problems or substance misuse. This service provides better care to our patients; who can receive prompt, multidisciplinary support in one location, whilst also increasing the knowledge of hospital staff about mental health requirements and vice versa.

In line with the NHS five year forward view, we are aware that being the sole provider of services does not always provide the best service offering to our patients and commissioners, and that there are examples where we can work with partners to offer different elements of a patient pathway. This year we have provided services in collaboration with Phoenix Futures and Aquarius (around alcohol and substance misuse services) and will continue to work in this way over the forthcoming year.

Transformation

The way in which we transform our services has been a key theme throughout 2014/15. Building on the large scale transformation programme launched during 2013/14, we have continued our collaborative engagement approach to ensure our services are transformed to address future challenges and local requirements. In line with other trusts throughout the country, our services must be radically transformed, whilst maintaining quality, patient experience and value for money.

The 2015/16 financial year will see a growing focus on our campus services, which will increasingly be able to provide wider options for supporting in the community, as a result of our increased neighbourhood resilience.

A number of key themes and priorities have emerged for our inpatient services, such as how we increase our support within the community through the neighbourhoods to prevent hospital admissions.

> *"We need a double N in 'NHS' – a National Health Service offering more neighbourhood health support."*

Two clear approaches have developed throughout the year, which involve transforming our community based services (neighbourhoods) and our inpatient services (campuses). These approaches have been clearly shaped by our transformation partners who include a wide range of stakeholders, including partner organisations, patients, carers, local voluntary sector representatives and our staff.

In July 2014 Simon Stevens, Chief Executive of the NHS said: "We need a double N in 'NHS' – a National Health Service offering more neighbourhood health support". We are proud to reflect that we are at the forefront of this and are working towards a shadow neighbourhood based form from 1 April 2015.

This approach will provide an integrated service approach to care within local neighbourhoods. These teams will form a key part of local communities and will seek to build assets and resilience within local communities to enable a higher number of people to self-care and receive appropriate support within a community setting, thereby reducing the number of unnecessary hospital admissions.

Other key areas to explore and focus on include working in partnership with the voluntary sector to deliver step down houses to support early discharges from our acute units, 72 hour assessments and adherence to the PIpA (Purposeful Inpatient Admissions) model.

Staff and wider stakeholders have helped develop the Trust's transformation plans through a series of engagement events

Supporting people to live at home, with dementia

An exciting new development was announced in January 2015 in relation to the Trust's dementia services, following an initial idea that was formed during the older people's Pathway and Partnership Team (PPT).

Derbyshire currently provides more older people's hospital beds than the national average, and yet we know that for people with dementia, admission to hospital is disruptive; breaking fragile routines, and causing confusion, which in turn makes admission to residential or nursing care more likely. Most people want to stay in their own homes as long as possible.

In response to these issues, we have explored the idea of forming a Dementia Rapid Response Team; a group of specialist staff working seven days a week, to help resolve crises without requiring hospital admission. This has been done in a nearby county, where they have been able to substantially reduce hospital admissions, providing additional support to people in the community.

The Trust has been reviewing the model that was used to achieve this in wider NHS services in order to extend this practice to Derbyshire. During the year the Trust was successful in obtaining innovation funding to pilot these ideas and are in the early stages of this development as the financial year draws to a close.

Outlining our commitment to wider transformation across the county

Our collaborative working with wider health and social care partners has been greatly strengthened during the year, as we have worked closely with partners across the county to explore shared transformation plans, and to collaborate in achieving widespread changes throughout Derbyshire.

This approach has brought together physical and mental health providers across primary and secondary care, to share common challenges and plans for the future. The requirement to reduce expenditure at acute hospitals is a challenge we all share and, in line with our own transformation plans, can only be achieved if we build community resilience and extend the support we offer to people in the community to prevent hospital admissions. Whilst difficult, if we get this right there are many benefits to all types of patient care as we know people want to be supported to live within their own homes and only have overnight stays in hospital when it is clinically necessary.

The Trust is committed to working collectively with its partners to ensure we share our plans, and support each other in any potential changes – thereby creating more joined-up care approaches with fewer transfers of care or gaps in services for our patients.

The Trust is working with our local healthcare economy partners to achieve this vision, through the STaR (System Transformation and Reconfiguration) programme in the city and south of the county and through the 21st Century Healthcare (21c #JoinedUpCare) programme in the north. Both groups are responsible for working to the Health and Wellbeing Boards' visions for a combined Derbyshire-wide health and care system. Both systems have five year plans to redesign services, locate care closer to home and drive cost efficiencies.

Parity of esteem for mental health services

The Trust is continuing to work with commissioners to ensure parity of esteem for mental health services, in line with the focus that is given to physical healthcare across Derby and Derbyshire. This has been a key priority throughout 2014/15 and our governors have taken an active interest in this area.

We still have a long way to go before we can claim parity is in place – NHS funding locally and nationally still remains to be focused on acute hospitals and physical health care needs. There also remains a disparity in the number of people with mental illness who are in contact with services, compared to those with physical needs.

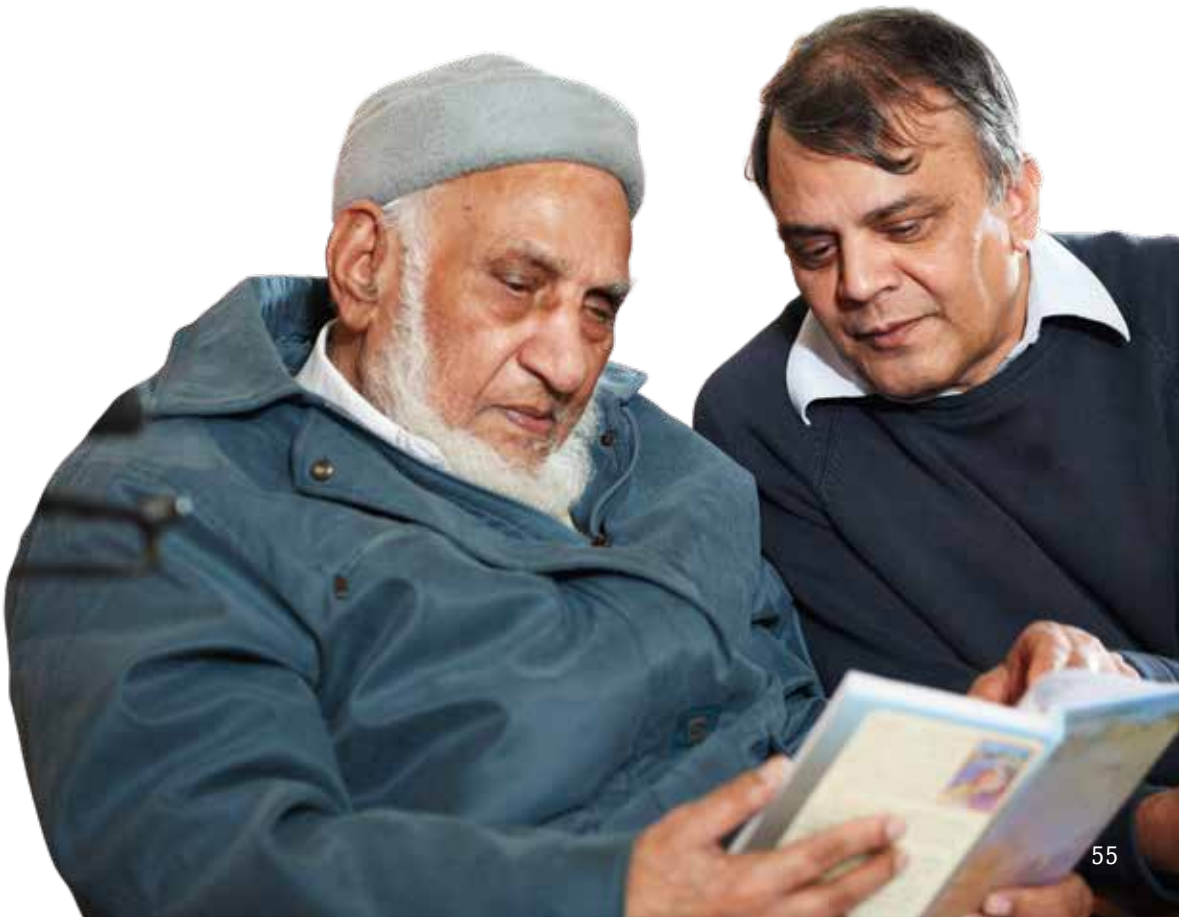
This is in contrast to mental health being a major cause of premature death and a high proportion of people's lives are impacted upon by mental health conditions.

- Among people under 65, nearly half of all ill health is mental illness
- Mental illness is generally more debilitating than most chronic physical conditions.
- Mental health problems impose a total economic and social cost of over £105bn a year
- Yet, only 26% of UK adults with mental illness receive appropriate care
- People with poor physical health are at higher risk of experiencing mental health problems…
- …and people with poor mental health are more likely to have poor physical health.

Working with local commissioners

The Trust has continued to develop and strengthen relationships with local commissioning organisations throughout the year. Hardwick CCG, as lead commissioners for mental health services, have played an active role in the Trusts' transformation programme, and we have broadened engagement with other commissioning stakeholders in order to provide input into the changes required from both the Trust and the wider health economy. Direct relationships with each of the other three CCGs within Derbyshire have grown during this year with Erewash, South Derbyshire and North Derbyshire all commissioning specific new initiatives from us to enhance care for their local population.

The Trust has also worked closely with public health commissioners at Derby City Council during 2014/15 not only in relation to the services that they commission with the Trust, but also in readiness for their increased commissioning role.



Involving and supporting our carers

The Trust values outline our commitment to put our patients at the centre of everything we do. This includes their families and carers, who often play a key part in someone's support and wellbeing.

Our carers group continues to work to improve our support and partnership with carers, and is developing a carers' strategy. The group is made up of carer representatives, staff, and partner agencies including Derbyshire Carers Association, Think Carer, Making Space, Derbyshire County Council, and others.

In December 2014 the group presented its annual report to the 4Es, which included a powerful dramatisation of an episode in a carer's life. This highlighted the need for good communication with families and carers, and was filmed so that it can be used in future staff training.

Carers also nominated the Trust's Core Care Standards Co-ordinator as the 'unsung hero' of the year, which she was presented with at the Staff Awards.

Our membership of the national Triangle of Care scheme has helped us to set and monitor standards. The Trust's mental health inpatient and crisis services have all completed a self-assessment against 39 standards, and are working to improve their identification of and support for carers.

The Triangle of Care

The successful 'carers and cake' innovation was developed further with support from our carers commissioners to work with our partners to reach out to carers, by having local events that give carers respite and links them to support agencies. These have been held at the Radbourne and Hartington Units and across the wider community, in partnership with our voluntary sector colleagues. The Trust continues to be represented at carers' forums across the county and city, working in partnership to improve the quality of services.

The carers' service won a highly commended award for innovative work on information sharing and confidentiality in October 2014. Families and carers sometimes say they don't have the information they need to be able to help, because staff can't share important information. The booklet 'Sharing information with families and carers' includes a self-carbonated advance decision that families and people who use our services can agree together about what information can and should be shared, both routinely and in an emergency.

We also published a new carers and families contact card, and an updated and revised carers and families handbook to improve the information available to carers. We have had funding from commissioners to produce a carers and families infolink resource handbook across Derbyshire. The quarterly *Who Cares?* newsletter continues to be sent to 1500 mental health carers across the county.

Our carers' champions network has continued to develop, and has begun to make links with local carer groups. They now have a clear role description, and we have held two development sessions to support them, bringing in carers and partners to work with us. Our Radbourne carers support group goes from strength to strength, a group is beginning at Hartington Unit, and our older people's services run an excellent series of events to support the carers of people with cognitive problems.

John Morrissey, public governor, attends a carers and cake event

Care Programme Approach (CPA) and Core Care Standards

The Trust's Core Care Standards and the website which supports them continue to be developed and improved. Accessible information for people with learning disabilities has been added, and the glossary has been extended to help explain technical and other terminology.

The 'My CCS' app is being used by staff to support service users and their families, and won two national awards during 2014/15. We are working with volunteers to develop a virtual art gallery to celebrate the diversity of creative work produced by service users and their families, including various painted media, photography, poetry, creative writing, sculpture and textiles.

Last year we outlined plans to focus on care planning. The introduction of self-carbonated care plans emerged through work with our crisis and home treatment teams, who needed a care plan they could share and leave with service users immediately when they first saw them. This was also developed with staff, service users and carers through the Patient Survey Action Group, and at the Innovation Network, which provided the pilot funding. The care plans allow service users and staff to work together and agree a plan in a way that the service user can own; it supports a recovery approach to care planning, gives emergency contact numbers and supports the use of symbols and non-English languages.

Staff training continues to focus on the role of the Care Co-ordinator and CPA and Core Care Standards, including work to develop an e-learning for staff. We have also identified the need for carer awareness training for our staff.

The Trust's Infolink resource directory continues to be used and valued by staff, service users, their families and our partner organisations, as it includes contacts for Trust services as well as primary care, social care, and other local partner organisations and groups, and wider national resources. It has just been updated and revised to include a wider range of BME organisations and other groups, and a carers and families edition is being published.

Working with our League of Friends

The League of Friends is a charity, which raises funds for patients within the Trust through various activities. The group is formed of a set of dedicated volunteers, many of whom are current and/or retired staff and people with a wider interest in mental health services. They tirelessly work throughout the year to fundraise and provide activities for the Trust's service users.

The League of Friends arrange trips and outings for service users and receive financial requests from different services for particular activities/items that will enhance patient experience. In addition, in July 2014 the League held a Summer Fayre. The event took many months to organise, but was thoroughly enjoyed by the 1000+ people who attended.

At Christmas, the League provides a present for every service user who is in hospital at the festive time. This includes wards on the Kingsway site, Radbourne Unit and Audrey House in Derby, and the Hartington Unit in Chesterfield. The charity purchase and wrap the gifts, visiting the wards a few days before Christmas for Father Christmas to deliver the presents, along with the carol singers. Last Christmas, volunteers were joined by Steve Trenchard, Chief Executive of the Trust.

The League also regularly hold bingo sessions at the Radbourne and Kedleston Units, providing prizes and refreshments.

On behalf of our patients and staff, Derbyshire Healthcare NHS Foundation Trust would like to formally express thanks and appreciation to the League of Friends, for their valuable contributions to the Trust during 2014/15.

Members of the League of Friends carol singing on the Kingsway site in Derby

Pillar 5: Financial performance

We will manage, assure and deliver our efficiency requirements and maintain our financial viability, to meet our regulatory requirements and make well informed healthcare decisions. We choose to reinvest surplus funds into making our services better for service users, as opposed to generating excessive profits.

Our Trust strategy and supporting frameworks and strategies, including medium-term financial strategies enable us to deliver the overarching Trust vision to improve the health and wellbeing of all the communities we serve. We are determined to maintain the quality of services and to ensure that our patients remain at the centre of everything we do.

We will continue to use our Foundation Trust status to develop our services and improve patient care. We will do this by working collaboratively across patient pathways with primary care and other partners, supporting integrated care models that are both accessible and easily understood by both the patient and their carer.

We continue to work proactively with our commissioners to make certain that we are able to respond effectively to changes in demand for services, including the delivery of specific local solutions to address specific local issues.

Despite a challenging financial environment, we continue to develop the range of services that we offer, addressing both the expectations and requirements of our commissioners, patients and our primary care colleagues. We are a dynamic organisation which has steadily grown in response to the needs of the local health community and in response to market changes.

Our strategic aim is to continue to achieve robust financial performance and full compliance with regulatory requirements to support and evidence the delivery of best value clinical care.

Our regulatory performance is described at length in our Directors' Report, where it evidences our full compliance and achievement of green governance ratings and financial risk ratings of 3 or 4 across calendar quarters.

An important tool for us in measuring the value of our services is through service line reporting. This allows our teams to assess how well they are contributing to the overall financial health of the organisation.

Our specific pillar goals for our financial performance pillar for 2014/15 have been met by:

- Achieving a Continuity of Service Risk Rating (COSRR) of at least 3 each quarter as evidenced by our submissions to Monitor
- We have been embedding service line reporting as our primary internal financial performance reporting tool.

We have also expanded the range of financial performance KPIs (key performance indicators) we use and have focused on spend analysis on what could be inefficient expenditure and created focus on improvement drives in areas that have been highlighted.

As planned we have also participated in the national Future Focused Finance initiative.

Directors' Financial Report

Fair review of business and analysis of financial key performance indicators

During the year ending 31 March 2015, the Trust generated income of £131 million for the provision of services, principally to the people of Derbyshire. Of that total, £120 million income was for patient care activities, as shown in note 4 of the accounts.

In addition to clinical income, the Trust generated other operating income of £11m as shown in note 5 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.

Overall, 2014/15 was another successful year financially for our Trust. After technical adjustments, we made a surplus of £1.8m, which was above our original plan for the year by about £0.3m. This was due to a combination of factors including better than planned non-clinical income and increased efficiency for the Trust with full delivery of our cost improvement programme. We saw the impact of some non-recurrent financial benefits early in the year as well as some non-recurrent cost pressures through the year particularly later in the year. Financial pressures have primarily been related to costs associated with high levels of activity and acuity needing higher than planned staffing levels. We have also received less income in some areas than planned and incurred more non-pay related costs. The overall impact of the various factors has been a good outturn with a return slightly better than planned. Our financial resilience to deal with the pressures was enabled by our contingency reserve that we created as part of our financial plan.

Our financial surplus was achieved after delivering a £4.3 million cost efficiencies programme. We continue to carefully assess the quality impact of schemes on service delivery and as a result, the Trust is confident that there has not been a negative impact on quality; this would not have been achieved without the continued innovation, hard work and commitment of all our Trust's staff.

We have continued to take actions in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the Trust. Primarily this aim has been delivered through service line reporting to budget holders, public board papers, team briefings and the listening and leadership events, in line with the Trust's overall approach of engaging staff in decision-making, in line with our Trust values.

The headline figures from the Statement of Comprehensive Income on page 2 of our accounts show:

Full year	£m
Operating income from continuing operations	131.4
Operating expenditure from continuing operations	(127.7)
Operating surplus / (deficit)	3.7
Net finance costs	(3.9)
Surplus / (deficit) for the year	(0.2)

Our financial performance as assessed by our regulator, Monitor, excludes the impact of impairments (as a technical adjustment) and when that adjustment is added back to the surplus for the year of £2m, the surplus becomes £1.8m.

In terms of key performance indicators of financial performance, a common measure is "EBITDA". This stands for Earnings Before Interest Tax Depreciation and Amortisation and in simple terms is a way of representing how much our operating income exceeds our operating costs. Our EBITDA for 2014/15 was £8.7m which equates to 6.6%. (This figure is not shown on the face of the accounts in the format prescribed by Monitor.)

This measure demonstrates good financial health and the efficient use of our resources. When assessing our EBITDA performance against those of our peers, our EBITDA is better than the average.

Another KPI which is relevant to understanding our financial performance and direction of travel is our level of net current assets. This can be seen on our statement of financial position within the accounts. In last year's accounts we reported net current liabilities of £2m. We have an improving trajectory on this measure and at the end of the 2014/15 we had net current liabilities of £0.6m. This is good improvement and by the end of next financial year we plan to achieve a position of net current assets.

Although this improvement in net assets is positive, our level of "liquidity" (which is our ability to pay our bills from "liquid" assets, primarily cash and working capital) is significantly below average compared to our peers. So this is an area we will continue to work to improve and remains a strategic financial priority for us in support of our financial resilience.

The use of peer comparison for our key financial performance indicators is made in reference to our relative position within independent benchmark information relating to 2013/14 provided by our External Auditors in 2014/15.

There have been no significant changes in our objectives, activities, investment strategy or in our long term liabilities. Continuing from the strategic direction outlined in last year's annual report with regard to improving our relative position on liquidity, and our cash reserves, we will continue seek to build them up over time. This will continue, in the short-term, to somewhat limit our flexibility to reinvest surplus in patient services through our capital programme.

In terms of assessing our risks and opportunities to a financially sustainable future we will continue to monitor our performance against accepted key indicators of financial performance such as our performance against statutory targets, delivery of our Cost Improvement Programme (CIP), our liquidity improvement objectives and our risk ratings with Monitor. Our current performance overall is strong on all these measures, with the exception of our liquidity. We will continue to use a rolling twelve-month cash forecast, which is seen as best practice. This helps us in our cash-planning and risk management.

We also create contingency reserves to enable us to manage previously-unknown financial pressures as they occur in year. We have agreed an overall robust and deliverable financial plan for 2015/16 which has been approved by our Trust Board. We continue to have the opportunity for a financially sustainable future.

We funded the vast majority of our capital programme of £3.6m for 2014/15 through internally generated resources. Our programme was augmented later in the year by funding secured from a successful bid to the Nursing Technology Fund.

The capital programme supports specific aims we have to embrace contemporary models of service delivery through optimising our use of technology and estate. **We have therefore spent our capital in two main areas;**

- Refurbishments and upgrading of estate (buildings) along with our ongoing backlog maintenance programme. These schemes improve both staff and patient environments.
- Investment into information technology equipment and systems and roll out of the electronic patient record system.

The value of the capital programme for 2015/16 will be approximately £3.4m and will again be spent on priority areas in technology and estate.

Main trends and factors likely to affect our development, performance and position

Although we have performed relatively well financially in 2014/15 this has been within a difficult financial environment locally and nationally. Looking ahead there continue to be a number of key challenges facing the Trust, and the Derbyshire health economy, in the near future – not least of which is the financial pressure facing all public sector organisations across the country. Nationally and locally, the challenges of providing quality health care to an ageing population, with a growing range of mental and physical health needs, within the current financial climate are well understood.

The Derbyshire health economy comes from a strong position of partnership working and a history of using a collaborative cross-organisational approach to meet the challenges it faces. This is already being employed in the whole system redesign which is required to meet the health and social care needs of the community in the future. We have taken this approach to heart, and through our transformation change process, which governs internal redesign, have engaged with the health community on a health system-wide transformational journey via the North and South Derbyshire units of planning.

The financial challenges facing our organisation are in line with those faced across the NHS. However, our forward planning will enable us to continue to operate in line with our Provider Licence and to continue to deliver a Continuity of Service Risk Rating of at least 3.

Looking forward, for 2015/16 we plan to achieve a surplus in the region of 1%. Due to reductions in the level of national funding available via commissioners and the requirement to fund pay and other cost pressures, we anticipate that this will require us to deliver a cost improvement programme of £4.2m in that year.

The Trust has concluded contract discussions with commissioners for the forthcoming financial year.

When considering the principal financial risks and uncertainties for 2015/16 we believe that our primary financial risk is the successful delivery of efficiency savings related to the transformational change programme because of the scale and pace of requirements.

Other high-level financial risks are in keeping with previous years' risks:

- Achieving planned income levels, although the majority of our income is block, the rest is activity- or performance-related
- Containing costs to budgeted levels
- Managing unforeseen costs or loss of income.

We have developed robust plans, systems and strategies to manage these risks but the financial environment continues to be the most challenging the NHS has ever faced.

The robust project assurance infrastructure that we have in place means that we should be well-placed to plan and deliver the required efficiencies and transformational change.

During 2015/16 the new funding structure called National Tariff Payment system (previously called Payment by Results in Mental Health) will continue to operate in its transitional phase. It is another crucial year of development as Department of Health policies are further developed and the Trust works closely with Commissioners to understand the local impact of the new structure and emerging policy.

In the annual accounts it has been necessary to account for a prior period adjustment: During 2014/15 there was a full revaluation of the Trust's estate. During this exercise it was found that some land sizes had been under estimated in previous year's revaluations. This is explained in note 42 of the accounts.

The accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently the Trust's financial statements have been prepared in accordance with the 2014/15 NHS Foundation Trust Annual Reporting Manual issued by Monitor, the accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1 of the annual accounts provides commentary on the accounting policies adopted by Derbyshire Healthcare NHS Foundation Trust.

We did not make any significant changes to our accounting policies during the year other than a change in accounting for 'lifecycle' costs for the PFI buildings which is explained in note 1.11 of the accounts. We compiled our accounts using IFRS standards.

There is no significant difference between the value of land in the Statement of Financial Position and the market value of land.

Our accounts reflect the entirety of Derbyshire Healthcare NHS Foundation Trust's operating activities; no other entities should be included.

Operating as a 'going concern'

The Trust's accounts have been prepared on the basis that the Trust is a 'going concern'. Simply speaking, this means that we expect to continue to operate for the foreseeable future. Because risks and uncertainties change over time as an organisation develops and as its operating environment changes, it is best practice to revisit going concern disclosures every time that annual report and accounts are prepared.

Therefore, each year in supporting evidence of our accounts submissions, the management of our Trust consider a detailed assessment of the evidence supporting our assertion that we are a going concern. This evidence provides assurance that it is correct to compile our accounts on such a basis and is presented to our Audit Committee.

For public sector bodies there is statutory guidance that states "the anticipated continuation of the provision of a service in the future as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern". Because Monitor publishes all Foundation Trusts' forward plans, including our own, this provides further justification of our status as a going concern.

During the year our Trust Board also regularly considers and declares that it is able to continue operating in compliance with our Provider Licence with Monitor.

Accordingly after such considerations, we are confident that we are able to make the following formal statement here in our Annual Report:

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

In addition, in line with the interpretation in the Government Financial Reporting Manual which focuses on the continuation of provision of services, our forward plans have been published which is further evidence of our going concern status

Additional disclosures

Accounting policies for pensions and other retirement benefits are set out in note 1.7 to the accounts and the details of senior employees' remuneration can be found in pages 93-94 of the remuneration report.

Cost allocation and charging requirements

During the year the Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Income disclosures

As an organisation we are required by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) to state whether our income from the provision of goods and services for the purposes of the health service in England is greater than our income from the provision of goods and services for any other purpose. We can confirm that this was the case, as evidenced by our accounts.

We are also required by the same Act to provide information on the impact that other income has had on our provision of healthcare. We can confirm that our other operating income has had no adverse impact on our provision of goods and services for the purposes of the health service in England.

Other disclosures in the public interest:

Countering fraud and corruption

The Trust's counter fraud service is provided by an external organisation named 360 Assurance. They provide our Local Counter Fraud Specialist (LCFS), who works with us to devise an Operational Counter Fraud Work Plan for the year, which is agreed by our Audit Committee. The plan is designed to provide counter-fraud, bribery and corruption work across generic areas of activity in compliance with NHS Protect guidance and Provider Standards.

The Trust has agreed to take all necessary steps to counter fraud affecting NHS-funded services and will maintain appropriate and adequate arrangements and policies to detect and prevent fraud and corruption. We have a Counter Fraud, Bribery and Corruption Policy and a Raising Concerns at work (Whistleblowing) policy and procedures in place which are communicated to staff – for example, through Trust information systems, newsletters and training.

During 2014/15 the Trust planned for and used 65 days of counter fraud activity, across the following areas:

- Strategic governance – 19 days
- Inform and involve – 19 days
- Prevent and deter – 24 days
- Hold to account – 3 days
- Total – 65 days.

The Trust's Audit Committee receives regular updates from the Local Counter Fraud Specialist in order to gain appropriate assurance around our counter fraud work programme.

Better Payment Practice Code

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 by the Trust. The Trust has a policy of paying suppliers within 30 days of receipt of a valid invoice and has paid (by number) 91% of non-NHS invoices and 73% of NHS invoices within this target. This is detailed in note 11 to the accounts.

The Trust did not pay any interest under the Late Payment of Commercial Debts (Interest) Act 1998.

The Trust is a signatory to the Prompt Payment Code, a key initiative designed to encourage and promote best practice between organisations and their suppliers. Organisations which sign up for the code commit to paying their suppliers within clearly defined terms, and commit also to ensuring there is a proper process for dealing with any invoices that are in dispute.

Ill health retirements

The number of and average additional pension liabilities for individuals who retired early on ill-health grounds during the year can be found in note 9.1 to the accounts and totals £61,000. This figure has been supplied by NHS Pensions.

Statement of Accounting Officer's responsibilities

The Directors consider that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the trust's performance, business model and strategy. Our full Statement of Accounting Officer's responsibilities is included on page 140 of this Annual Report.

Pillar 6: Workforce and leadership

We will develop a highly engaged, compassionate and skilled workforce, focused on recovery. Our leaders will be empowered with the best tools to ensure the best delivery of patient care. In line with our values, our people development and organisation transformational work will always ensure that our people are at the centre of all changes. This will be to maximise their expertise, strengthen their engagement and ensure they are coproducing and leading the change process.

2014/15 was the final year of Derbyshire Healthcare's four-year workforce strategy 'Delivering quality through our people' and the Trust has continued to progress each of the four key strands throughout the year:

- Engaging our people
- Educating and developing our people
- Maximising the potential of our people
- Our peoples' working environment.

As a result of our success in these areas, the Trust was identified by the HSJ and NHS Employers as one of the 'best places to work' in the health service.

1. Engaging our people

The Trust has remained committed to engaging with our workforce, knowing that there is a clear correlation between engagement, wellbeing, performance and patient care. The aim is for staff to 'own' the Trust and become ambassadors for the organisation.

Indications are that this has been successful. On the 2014 NHS Staff Survey, our overall score for staff engagement was 3.75 (out of a maximum score of five); although a slight decrease from the 3.78 score achieved in 2013, it is still above the national average for NHS trusts. This score is based on the ability of staff to contribute towards improvements at work, staff recommending the Trust as a place to work and/or receive treatment, and staff motivation at work.

Key developments in terms of engaging our people have been:

- The launch of the Trust's new People Forum in May 2014; see below for further details
- Engagement events across the Trust about our ongoing transformation programme, allowing staff to play a central role in developing the model of how services will be delivered in the future; again, see below for further details
- Revised and revamped internal communications, including a new weekly staff e-bulletin so information is effectively shared
- Regular team visits and drop-ins by the Chief Executive so that staff are listened to and their feedback and ideas are captured
- The introduction of the Staff Friends and Family Test, to 'take the temperature' of the workforce on a quarterly basis and see whether they would recommend the Trust to their family and friends – either as a place to work or if they needed treatment
- A broadening of the number of staff involved in the 2014 NHS Staff Survey, with all employees being eligible to complete the survey rather than just a sample; the participation rate also increased, with 45% of staff completing the 2014 survey, up from 41% in 2013
- The launch of a staff recognition scheme, the DEED scheme, to complement the annual awards scheme and celebrate staff 'delivering excellence every day' (see page 51 for further details)
- Refreshed and positive working with staff-side (trade union) representatives, with shared agendas and open discussions at JNCC (Joint Negotiating Committee) and LNC (Local Negotiating Committee) meetings and collaboration through the Employee Strategy and Engagement Committee (see above).

Employee Strategy and Engagement Committee (ESEC) – the People Forum

ESEC was established in May 2014 to provide assurance that the Trust's workforce strategies and policies are aligned with the organisation's strategic aims and support a patient-centred, quality culture where engagement, development and innovation are supported in line with Trust values.

The committee is chaired by the Chief Executive and its core membership includes the Director of Transformation (before 3 November 2014, the Director of Workforce and Organisational Development), a Non-Executive Director, the Trust Staff-side Secretary and representatives of the Operations, Nursing and Medical directorates.

ESEC's key areas of focus during 2014/15 included:

- Acting on the results of the 2013 NHS Staff Survey, which revealed a relatively high number of staff had not had an annual appraisal, and establishing an 'appraisal amnesty' that significantly improved the appraisal completion rate
- Overseeing the 2014 NHS Staff Survey and recommending that it be sent to all staff, not just a sample, so that the organisation could have an honest conversation with the workforce about what could be improved
- Carrying out deep-dive reviews of areas including staff sickness absence and customer complaints, and developing programmes to assist teams and groups of staff where these are an issue
- Overseeing the launch of the staff recognition scheme, the DEED scheme (see page 51 for further details).

Staff engagement is key to the Trust's workforce strategy

Involving staff in our transformation programme

As part of the Trust's efforts to develop transformation plans from the 'bottom up', regular consultation took place with staff throughout 2014/15 to allow them to have their say in shaping the future delivery of services.

Having developed a five-year vision in 2013/14 by engaging with 500 employees, carers, service users, partners and commissioners, 2014/15 saw staff at the forefront of discussions on how that vision could be put into practice.

- In July and August 2014, over 200 members of staff attended 'world café' sessions – structured conversational sessions in which groups of staff are encouraged to discuss topics at tables, with individuals switching tables periodically and getting introduced to the previous discussion at their new table by a 'table host'. They looked at the opportunities and challenges of wrapping services more closely around the needs of patients by taking a neighbourhood-based approach to delivering services. (see page 53 for further details). Their ideas, comments and concerns were fed back to the Trust Board.
- With the principle of a neighbourhood-based approach having been agreed, staff were then involved throughout the autumn and winter in shaping the detailed plans of how to implement that approach. Almost 1000 staff attended development days to look at the specific requirements of each of the proposed neighbourhoods, as well as the inpatient 'campus' services that would support people when care close to home was no longer viable.
- Throughout the year, the transformation project team held staff drop-in events and attended team meetings to answer questions about the programme. They also provided regular updates to senior staff at the leadership community engagement events (see 'maximising the potential of our people', below). Regular communications were also issued to staff through the internal weekly e-bulletin and staff intranet.

2. Educating and developing our people

This strand of the strategy seeks to ensure that our workforce has the competencies and core skills to meet future challenges and demands.

The Trust continues to invest in our workforce by providing a comprehensive range of training including e-learning for all staff, as well as a range of face-to-face training courses tailored to each individual's and team's professional needs.

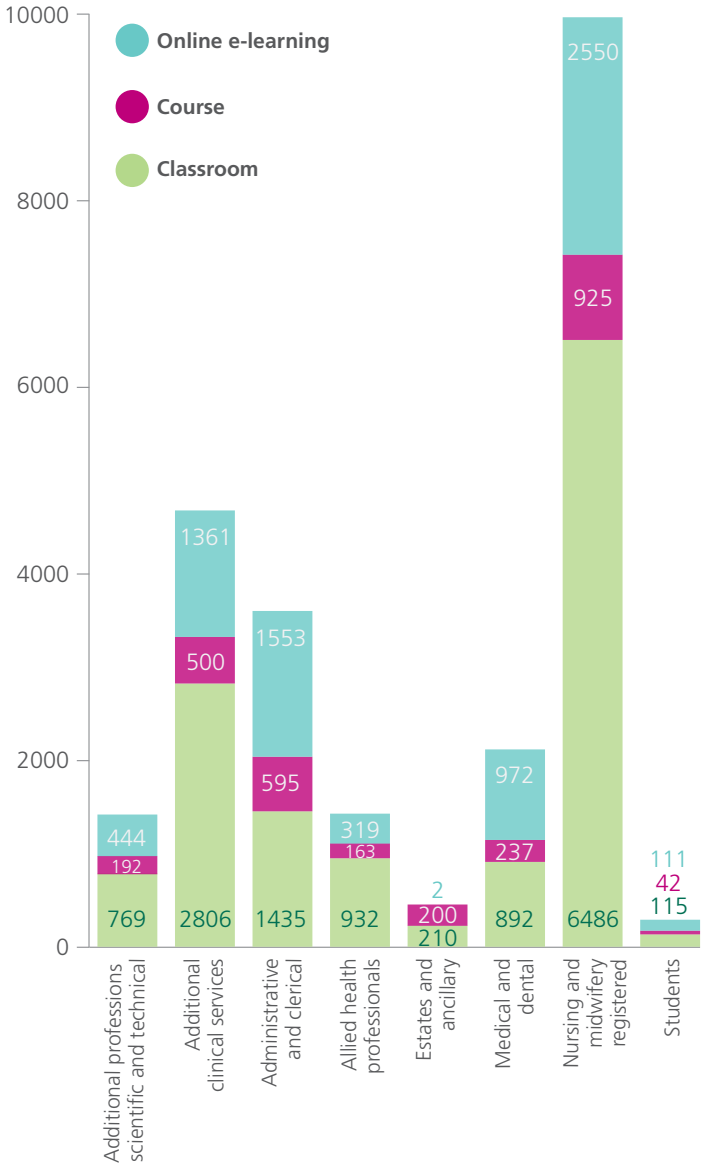
The Trust remains particularly strong on core training around information governance, health and safety and equality and diversity:

- In the 2014 NHS Staff Survey, 87% of employees said they had received health and safety training in the last 12 months
- 70% of employees taking the 2014 NHS Staff Survey said they had completed equality and diversity training in the past year; this is in addition to the cultural capability training provided by the Trust to help staff deliver person-centred, compassionate services across different communities. It is also in addition to the Trust's deaf awareness training – see page 46 for more information.

Recognising the pressures on staff, and the growing complexity of their work, the Trust this year began to provide information and learning in the form of video podcasts, which can be viewed on the staff intranet. The clinical education and advice team has produced video podcasts on the Trust's quality priorities, on the sharing of clinical information and on the CQC clinical team audit tool.

Number of Trust employees completing educational programmes April 2014 to March 2015:

- 'Course' refers to external programmes;
- 'Classroom' refers to internal programmes



Centre for Research & Development

Many of the Trust's face-to-face courses are delivered from the Centre for Research & Development on the Kingsway site in Derby, which boasts the latest technology. In July 2014, the centre started using video conferencing, which allows staff at different locations across the county to attend the same meeting or training course. On 11 July 2014 a conference delivered by Professor Robin Murray, entitled 'The abandoned illness – what can you do tomorrow?', took place at the Centre for Research and Development on the Kingsway Site in Derby and was screened at the Hartington Unit at Chesterfield, saving staff time and saving the Trust money.

Centre for Research & Development

The Centre for Research & Development remains a magnet for high-quality clinical conferences not least because of its 'centres of excellence', which carry out programmes of research supporting the Trust's strategic direction. Each centre provides academic and clinical leadership, delivering improvements in patient experience and outcomes, ultimately leading to service improvements via pathways of care.

Conferences hosted by the Trust during 2014/15 have included:

- A dementia conference organised by Dr Simon Thacker, the Clinical Director of the Trust's Centre for Dementia, entitled 'changing attitudes, improving care' which was attended by Alistair Burns, National Clinical Director for Dementia
- A nursing workshop organised by the mental health and learning disability nurse directors' and leads' forum and entitled 'supportive observations', which was attended by Professor Len Bowers of King's College London, a driving force behind the 'Safewards' initiative
- A Child and Adolescent Mental Health Services(CAMHS) conference organised by CAMHS consultant nurse Laurence Baldwin, which was attended by Kathyn Pugh, NHS England's programme lead for the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme
- A suicide prevention conference organised by Dr Allan Johnston, a consultant psychiatrist at the Trust and chair of the Suicide Prevention Strategy Group, and Steve Edgeley, the Trust's (then) Deputy Chief Nurse and Head of Effectiveness. Keynote speakers included Malcolm Rae OBE, who recently retired as the Joint Strategic Lead for the Acute Care Programme of The National Mental Health Development Unit and remains as an advisor to the Care Quality Commission on the prevention and management of suicide.

Nursing conferences

Two major conferences were held in 2014/15 for the Trust's nursing population. Led by the Executive Director of Nursing and Patient Experience, Carolyn Green, nurses from across the organisation gathered at the Centre for Research & Development to discuss and contribute to a new nursing strategy for the Trust. **Subjects discussed at the two conferences reflected the key priorities for the year and included:**

- Suicide prevention and deliberate self-harm
- Think! Family – working with the whole family and co-ordinating all aspects of support to address their full needs
- Minimising and reducing restrictive practice like seclusion on our wards
- Physical healthcare and harm-free care
- Compassion into practice
- Children and CAMHS clinical practice.

All the presentations at the two conferences were filmed and made available to staff on the Trust's intranet.

A focus on recovery

With the opening of the Hope and Resilience Hub (see pages 38-39), it is more important than ever that staff understand how to support people to manage their conditions and live meaningful and satisfying lives.

The Trust has continued to develop the role of service users in educating staff so that they focus on recovery. The Trust worked with a peer support tutor during 2014/15 who delivered recovery-focused training not only to fellow service users but also to newly qualified nurses on the preceptorship programme, and launched our first ever recovery education programme in North East Derbyshire.

In addition, a group of volunteer patients with lived experience of mental illness are helping fourth-year medical students from the University of Nottingham to become better doctors by giving them feedback on the way they carry out one-to-one assessments.

Alternative models of training have been provided by Pete Bullimore, a service user consultant who provides training in the work model for the Maastrict hearing voices group and the Maastrict interview, which is a non clinical life history and story-telling of individual experiences, thoughts and perceptions. We have trained multidisciplinary team members at the Hartington Unit, Radbourne Unit and from our CAMHS team. This training has been put into practice and the Maastrict interview is available in two pilot areas across the county.

Nursing in Derbyshire Healthcare - proud to care for people of all ages

3. Maximising the potential of our people

This area incorporates workforce planning and profiling, talent management and reward and recognition. The focus for 2014/15 and beyond has been on equipping leaders with the skills required to deliver transformational change whilst delivering continuous improvements in service quality and increasing productivity. **We have aimed to:**

- Accommodate the development needs of leaders at all levels of the organisation
- Maintain our reputation for valuing, nurturing and developing leaders
- Improve satisfaction regarding the quality of communication between staff and senior management
- Promote staff engagement.

Following the staff survey results in 2013/14, we have placed great emphasis this year on the importance of every member of staff undertaking an annual appraisal. We are pleased to see that the number of staff receiving an appraisal has increased this year, yet we are aware that there are wider requirements to build upon this year, for example, ensuring that appraisals are well structured and meaningful. We will continue to build on this approach throughout 2015/16.

Skills programmes

The emphasis has been on giving leaders the communications skills required to help teams in their transition through transformational change. To do this there has been a continuation of coaching skills programmes and managing difficult conversations programmes, which also look at staff motivation, support and guidance through transition.

We have continued to provide skills development programmes for leaders as well as working collaboratively with health and social care partners across the county to design and commission delivery of an innovative programme for aspiring general managers.

Promoting equality

We have sustained our focus on development for women as leaders with the continuation of SpringBoard programmes and the introduction of SpringForward, aimed at encouraging and helping women take up the leadership challenge. We have also run the equivalent programme for men, called Navigator, to address gender specific leadership issues.

Communication and engagement

We have continued to run ten leadership community engagement events a year. The sessions have been used to communicate important, Trust-wide messages but the main content of the programme is owned and delivered by staff, showcasing and sharing service improvements with colleagues. These events were developed in 2014/15 to encompass a more economical method of delivery whilst maintaining inclusivity.

Coaching

We have continued to develop coaching in the Trust – both as a development tool and as our preferred leadership style – to reflect our values and underpin a culture that promotes compassion and excellent patient care. A support network has been developed for coaches where they can share experiences and case studies to develop their own potential. Linked to the coaching initiative is the development of peer leaders. Staff have volunteered to take part in this project in which they support teams through change across the Trust.

The uptake of team coaching has greatly increased within the Trust as a further aid to supporting staff transition through change. This comprises of one or more bespoke sessions designed to help the team explore their current situation and plan for and move forward into the future.

Investing in our workforce for the future

The Trust, with the support of Health Education East Midlands (HEEM), enabled hundreds of staff to access professional development opportunities during 2014/15 that were above and beyond their compulsory or role-specific requirements.

95 employees in clinical roles were supported to study university courses on subjects as varied as mindfulness-based therapy, non-medical prescribing, understanding sensory processing disorders, compassion-focused cognitive behavioural therapy (CBT), dementia care and nutrition.

Many other employees were able to take advantage of individual or group training, including:

- Best Practices: Cognitive Behavioural Therapy for Depression and Suicide (16 staff)
- DBT Skills Workshop (40 staff)
- Maastricht: Hearing Voices (50 staff)
- Model of Human Occupation (MOHO) and the screening tool MOHOST (30 staff)
- Case formulation and goal setting (24 staff).

4. Our people's working environment

This strand of the workforce strategy revolves around the strategic intent to embed good health and wellbeing and ensure the creation of an inclusive culture.

Employees' health and wellbeing

In June 2014, the Trust launched a new Employee Assistance programme to provide emotional and practical support to staff in a completely confidential way. In line with our value of 'focusing on our people', the Employee Assistance programme gives staff counselling, coaching, advice and support 24 hours a day, seven days a week. Members of staff and their spouses or partners can call and speak to an independent adviser or counsellor if they are experiencing any kind of life event that is causing them distress. They can also get practical advice from information specialists on issues including finance, parenting or health. The programme has been introduced at no extra cost to the Trust as it is part of a re-negotiated occupational health package that is saving us money.

The Trust also established a new Health and Wellbeing Board, a sub-group of the Employee Strategy and Engagement Committee, to focus on the wellness of employees. This board oversees the range of health and wellbeing initiatives available to staff. These initiatives include:

- Individual support sessions with the Staff Liaison Manager
- Wellbeing plans – introduced for the first time in 2014/15
- Coaching for anxiety-related conditions
- Post Incident Peer Support (PIPS) for individuals and teams after serious incidents occur
- Schwartz Rounds – meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work
- Training for managers in stress management
- Participation in the government's 'cycle to work' scheme – to encourage employees to purchase a tax-efficient bicycle through payroll and commute to work in a healthier, more sustainable way.

Focusing on equality and diversity at a national EDS event

Creating an inclusive culture

Derbyshire Healthcare continues to be one of the top-performing trusts in terms of staff training around equality and diversity (see 'educating and developing our people, above).

Efforts to create an inclusive culture come from the very top of the organisation, with the Chief Executive one of only a small number of people to be invited by NHS Employers to be a Personal, Fair and Diverse Ambassador.

The Black and Minority Ethnic (BME) Staff Support Network was re-established this year, offering not only support to BME employees but also a forum to exchange views and experiences. The group acts as a reference group to promote diversity and equality impact analsyis in order to improve working lives and service delivery.

In November 2014, members of the group were involved, along with other employees, in assessing and grading the Trust on its success in promoting a 'representative and supported workforce'. As part of the Equality Delivery System – or EDS2, a national performance toolkit around equality and diversity – staff were given the opportunity to spend an afternoon studying information and data on the Trust's workforce policies and practices, and then rating the Trust's performance in harnessing the talents of its diverse workforce. The event resulted in 10 key actions that the Trust is taking forward to improve inclusion for REGARDS groups.

Trust values

We are continuing to embed the Trust's values throughout the organisation, from recruitment through to staff development and training. Values-based recruitment activity is continuing and we have developed flexible approaches to attracting and recruiting staff who demonstrate the attitudes and behaviours which underpin the trusts core values.

Involvement of patient and carer representatives in the process has further developed, with patients and carers now having a greater role in our recruitment and selection training.

In May 2014, the Trust maintained its national profile for successfully developing and implementing a values-based approach to organisational development by being recognised by the Healthcare People Management Association (HPMA) with NHS Employers in their publication 'Meeting the Challenge'.

In July 2014, mental health leaders from Australia, Canada and Ireland came to the Kingsway site in Derby to learn about the Trust's values-based approach to recruitment, as part of an exchange organised through the International Initiative for Mental Health Leadership (IIMHL).

Staffing levels

The Trust now publicly shares information on its website about staffing levels on its inpatient wards, as part of its efforts to increase openness and transparency.

Whilst overall vacancy rates at the Trust remain low compared to many NHS trusts, there is a challenge around recruiting clinical staff – and the Trust recognises that vacant posts place added pressure on existing staff. Recruiting more nurses has become a priority during 2014/15, with greater efforts being made to build bridges with student nurses and encourage former nurses to return to the profession. This campaign will continue in 2015/16.

Staff and service receivers from Melbourne House welcome international visitors

NHS staff survey

A total of 1,057 members of staff – or 45% of the workforce – completed the 2014 NHS Staff Survey, giving feedback on what it's like working at the Trust.

There were some extremely positive results:

- 68% of those who responded said that patient care is our top priority; whilst this is a slight decrease on 2013, it is still above the national average in response to this question
- 91% of those who responded felt their role makes a difference to patients; again, whilst this is slightly lower than the 2013 score (92%) it still compares very favourably with other NHS trusts
- 91% of those who responded said they had had an appraisal in the last 12 months – a significant increase on 2013; again, this puts us amongst the highest-scoring trusts nationwide and reflects well on the role of the Employee Strategy and Engagement Committee (see 'engaging our people', above).

There were also positive scores around our health and safety and equality and diversity training – see 'educating and developing our people', above.

Areas where staff indicated that improvement was necessary were:

- Raising concerns – 64% of those who responded said they would "feel secure in raising concerns against unsafe clinical practice", a figure that is low compared to other trusts. A new Raising Concerns at Work policy has subsequently been introduced and the Trust has committed itself to building on this policy and becoming more open and receptive to those who ask questions about whether our clinical practice could be better. More focus in this area is planned for 2015/16 to ensure an open culture where staff are able to raise concerns.
- Bullying and harassment – 32% of those who responded said they had experienced harassment, bullying or abuse from patients, relatives or public in the last 12 months; while 23% said they had experienced harassment, bullying or abuse from colleagues in the last 12 months. These figures were higher than the number of cases formally reported within the Trust, and had not fallen from the 2013 survey. The Trust has therefore proposed to run staff focus groups to try and understand how it can keep staff safer and further develop a culture of compassion and mutual support. We will keep listening to and learning from our staff until we have a significant impact in this area.

Performance against priority areas

Our priorities for the 2014 survey were to increase our results in the following areas:

- Appraisals – this was achieved, as indicated above; however a note of caution must be sounded as the percentage of staff who said they had had well-structured appraisals decreased by 2%, to 37%, so more work still needs to be done on the quality of the appraisal conversations that are taking place
- Bullying or abuse from other members of staff – as discussed above, the Trust has more to do on this important issue
- Reporting errors or near misses – in the survey, staff were asked whether they had reported errors, near misses or incidents they had witnessed in the previous month. In 2013, the percentage of staff who said they had reported errors, near misses or incidents witnessed in the last month was 90%, which was below the national average for mental health trusts. The Trust further raised awareness of the need to report incidents through local surgeries, to troubleshoot any issues with the Datix IT system, as well as through team workshops and improvements to the information provided at induction, and in 2014 the figure rose to 92%, which was in line with the average for mental health trusts.

Future priorities

The Executive Team has reviewed the results of the staff survey in detail and will be visiting teams and staff to understand the responses in more detail. This will produce an annual health check which will highlight the areas of focus. We will be focusing on our leadership offering, continuing to involve and engage staff at every level and creating a safe environment where staff are energised.

The Executive Team also recognised that we have to be 'brilliant at the basics' – this means we need to focus on streamlining activities and removing bureaucracy when we can.

Staff survey results

Response rate	2013/14 Trust	2013/14 National average	2014/15 Trust	2014/15 National average	Trust improvement/ deterioration
	41%	57%	45%	44%	+4%

Top four ranking scores	2013/14 Trust	2013/14 National average	2014/15 Trust	2014/15 National average	Trust improvement/ deterioration
% of appraised in last 12 months	80%	87%	91%	88%	+11%
% of staff receiving health and safety training in the last 12 months	87%	75%	87%	73%	No change
% of staff agreeing that their role makes a difference to patients	92%	90%	91%	89%	-1%
Fairness and effectiveness of incident reporting procedures (the higher the score the better)	3.63	3.52	3.58	3.52	-0.05

Bottom 4 ranking scores	2013/14 Trust	2013/14 National average	2014/15 Trust	2014/15 National average	Trust improvement/ deterioration
% of staff experiencing harassment , bulling or abuse from patients, relatives or the public in last 12 months (the lower the score the better)	31%	30%	32%	29%	+1%
% of staff experiencing harassment , bulling or abuse from staff in last 12 months (the lower the score the better)	22%	20%	23%	21%	+1%
% of staff having well-structured appraisals in last 12 months	39%	42%	37%	41%	-2%
Effective team working (the higher the score the better)	3.78	3.82	3.76	3.81	-0.02

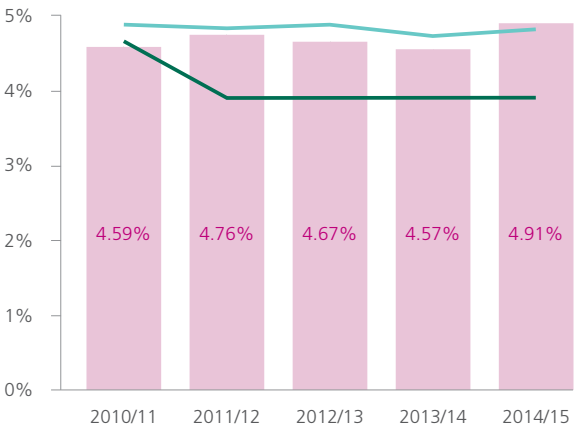
Workforce profile

		Headcount	FTE	Workforce
Trust	Employees	2435	2120.87	
Staff group	Additional professions scientific and technical	173	150.81	7.11%
	Additional clinical services	423	368.81	17.39%
	Administrative and clerical	498	438.02	20.47%
	Allied health professionals	140	106.71	5.75%
	Estates and ancillary	146	112.84	6.00%
	Medical and dental	147	128.64	6.04%
	Nursing and midwifery registered	897	812.90	36.87%
	Students	9	9.00	0.37%
Age	16-20	8	8.00	0.33%
	21-30	255	237.61	10.48%
	31-40	570	490.43	23.43%
	41-50	767	674.12	31.52%
	51-60	690	603.49	28.36%
	61-70	133	107.97	5.47%
	71 & Above	10	6.11	0.41%
Disability	Declared disability	95	81.70	3.90%
	No declared disability	2338	2046.03	96.10%

Workforce profile (continued)

		Headcount	FTE	Workforce
Ethnicity	White - british	1809	1574.07	74.35%
	White - irish	23	19.50	0.95%
	White - any other white background	54	49.12	2.22%
	White northern irish	1	0.53	0.04%
	White unspecified	66	58.93	2.71%
	White english	3	2.44	0.12%
	White other european	2	1.20	0.08%
	Mixed - white & black caribbean	14	12.36	0.58%
	Mixed - white & black african	5	4.59	0.21%
	Mixed - white & asian	8	7.40	0.33%
	Mixed - any other mixed background	8	7.60	0.33%
	Asian or asian british - indian	99	88.54	4.07%
	Asian or asian british - pakistani	27	25.20	1.11%
	Asian or asian british - bangladeshi	3	2.32	0.12%
	Asian or asian british - any other asian background	7	6.40	0.29%
	Asian mixed	1	0.80	0.04%
	Asian punjabi	4	2.61	0.16%
	Black or black british - caribbean	53	48.47	2.18%
	Black or black british - african	36	33.17	1.48%
	Black or black british - any other black background	9	8.52	0.37%
	Black nigerian	1	0.80	0.04%
	Any other ethnic group	17	14.87	0.70%
	Not stated	183	158.29	7.52%
Gender	Female director	1920	1642.16	78.91%
	Male director	513	485.57	21.09%
Gender breakdown	Female director/CEO	2	2.00	33.33%
	Male director/ CEO	4	4.00	66.67%
	Female senior manager band 8c & above	18	14.66	64.29%
	Male senior manager band 8c & above	10	9.70	35.71%
	Female employee other	1899	1624.50	79.22%
	Male employee other	498	470.87	20.78%
Religious belief	Atheism	205	184.62	8.43%
	Buddhism	10	9.37	0.41%
	Christianity	814	714.65	33.46%
	Hinduism	21	19.53	0.86%
	Islam	25	22.92	1.03%
	Judaism	3	2.60	0.12%
	Other	165	146.91	6.78%
	Sikhism	42	36.48	1.73%
	Not stated	1148	990.65	47.18%
Sexual orientation	Bisexual	6	5.67	0.25%
	Gay	12	11.80	0.49%
	Heterosexual	1306	1154.89	53.68%
	Lesbian	11	10.40	0.45%
	Not stated	1098	944.97	45.13%

Annual sickness absence % - previous five years

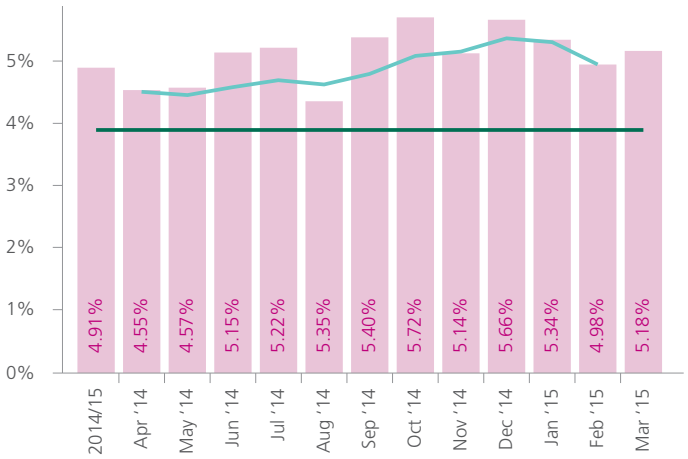


Annual sickness absence %

Trust target 3.90% (previously 4.70%)

National MH & LD Trust Average (Source: NHS iView Information Centre)

Monthly sickness absence % - April 2014 to March 2015



Monthly sickness absence %

Trust target 3.90%

National MH & LD Trust Average Apr 2014 to Feb 2015 (Source: NHS iView Information Centre)

Number of days lost to sickness - January to December 2014

This data was provided by the Department of Health and covers January – December 2014. It is therefore not directly comparable to the annual and monthly sickness data reported above, which cover the full 2014/15 financial year.

FTE days available	FTE days lost to sickness absence	Average sick days per FTE
476,765	22,974	10.8

Membership Review

Foundation Trusts have greater freedom to develop services that meet the needs of local communities. Local people are invited to become a member of Derbyshire Healthcare NHS Foundation Trust, to work with the Trust to provide the most suitable services for the local population.

Membership strengthens the links between healthcare services and the local community. It is voluntary and free of charge and obligation. Members are able to give their views on relevant issues for governors to act on, as well as helping to reduce stigma and discrimination regarding the services offered by Trust.

Members' views are represented at the Council of Governors, by governors who are appointed for specific groups of members known as constituencies. Constituencies cover service users, staff, partner organisations and public members.

Public governors are elected to represent their particular geographical area and have a duty to engage with local members. Appointed governors reside on the Council of Governors to represent the views of their particular organisation and staff governors represent the different staff groups that work for the Trust.

Governors canvass the opinion of the Trust's members and the public and communicate their views to the Board of Directors. Appointed governors also canvass the opinion of the body they represent. The Trust takes steps to ensure that members of the Board of Directors develop an understanding of the views of members and governors though regular attendance at the Council of Governors and wider face to face contact.

Anyone over 16 years of age who is resident in Derbyshire or surrounding areas is eligible to become a public member of the Foundation Trust (subject to certain exclusions, which are contained in the Foundation Trust Constitution).

Increasing our membership

Throughout 2014/15 the Trust proactively sought to work with other local organisations for membership recruitment and, for example, has worked closely with libraries in Derby city and Erewash to reach new members.

The Trust has also participated in number of external events to recruit new and diverse members, that reflect our community groups. These events have included Deaf Information Day, a Cancer Awareness event for BME women and Derby Out – a Lesbian Gay Bisexual and Transgender (LGBT) event.

Alongside this work, in the latter part of the year, the Trust began an analysis of membership composition against local community data. This information gave an indication of areas where membership was low and enabled the Trust to target these areas, ensuring that the membership remained representative of the local communities. This work will continue throughout 2015/16.

Working with Patient Participation Groups (PPGs)

In response to interest generated by our governors, we have focused this year on engaging with local PPGs across Derbyshire to widen links with local communities and GPs, gain new members and promote the work of the Trust and the services we provide. This focus will also continue into the forthcoming financial year.

Membership engagement

During 2014/15 the Trust heavily focused on membership engagement and hosted member events throughout the county, including Chesterfield, Long Eaton and Derby, with themes including mindfulness, dementia and compassion.

The Trust moved towards increasing e-communication with its members so that the information they receive is timelier and, following member feedback, more cost effective. New membership recruitment leaflets were created to capture member interests so that any information dispatched is more streamlined and targeted according to member preference.

The Trust's communication and involvement team continued to assist governors to reach their constituents. In order to further support its governors the Trust looked to recruit 'membership champions'. This voluntary role encourages the most enthusiastic members to help recruit new members and engage with existing ones, often working alongside the governor for that particular constituency.

Over the forthcoming year we will make greater use of the data we hold about our membership, to ensure we are proactively engaging with members in the most appropriate and meaningful ways. This is in line with the Trust's new membership strategy, published in November 2014.

The public membership is broadly representative of the diverse communities in Derbyshire and our engagement events aim to reach all communities. Members can contact governors and via the Derbyshire Healthcare website, **www.derbyshirehealthcareft.nhs.uk** or email **governors@derbyshcft.nhs.uk**

Membership figures

Constituency	Number of members 2013/14	Number of members 2014/15
Public	6287	6232
Staff	2440	2430
Total	**8727**	**8662**

Public governors John Morrissey and Igor Zupnik promote the Trust's membership to local residents

Membership highlights from our volunteers

This year the membership development group and our membership champions have been concentrating on engagement with members and local communities. They have been out and about both in Derby city and across Derbyshire, promoting the work of the Trust and also recruiting new members.

Membership Champion, Christine Williamson, promotes the Trust's activities and membership

"We attended the League of Friends annual Summer Fayre, which is always a very special event as it is attended by so many carers, service users and Trust staff. The governors held a picnic and introduced themselves to the public around the fayre."

"In August 2014 we attended our first Patient Participation Group (PPG) event! We were well received and felt like we made a difference by being there."

"As a membership champion I feel as though engagement with the overall community has been so worthwhile. We managed to sign up more than 200 new members this year, but the main thing is engaging with the community, answering their questions and demonstrating that the Trust cares."

"We have been working with libraries up and down the county to promote membership and have found this very useful as a way to really immerse ourselves in local communities."

"We attended a dementia Q&A session, hosted by the Trust for carers and service users, at Swadlincote. This was a very inspiring event and we really engaged with those who attended, signing up 10 new members."

"In September we attended the 'Derby Out' event at the Lesbian, Gay, Bisexual and Transgender (LGBT) Centre. People were very interested in our membership stall and were keen to find out everything we had to offer on health and wellbeing."

How we are organised

Derbyshire Healthcare NHS Foundation Trust Board

The Trust Board of Directors has a responsibility to make the best use of financial resources and deliver the services people need, to standards of safety and quality which are agreed nationally.

The role of the Board of Directors is to manage the Trust by:

- Setting the overall strategic direction of the Trust within the context of NHS priorities
- Regularly monitoring our performance against objectives
- Providing effective financial stewardship through value for money, financial control and financial planning
- Ensuring that the Trust provides high quality, effective and patient focused services through clinical governance
- Ensuring high standards of corporate governance and personal conduct
- Promoting effective dialogue between the Trust and the local communities we serve.

Our Trust Board meets monthly to discuss the business of the organisation. This meeting is held in public and anyone is welcome to attend and hear about our latest developments and performance.

Responsibilities of the Board of Directors

The Board of Directors ensures that good business practice is followed and that the organisation is stable enough to respond to unexpected events, without jeopardising services, and confident enough to introduce changes where services need to be improved.

Therefore the Board of Directors carries the final overall corporate accountability for its strategies, its policies and actions as set out in the Codes of Conduct and Accountability issued by the Secretary of State. In order to discharge its responsibilities for the governance of the Trust, the Board has established a number of Committees of the Board as described on page 84.

Board of Directors

During 2014/2015 our Trust Board comprised the following members:

Non Executive Directors

Mark Todd, Chairman
Term of office: 20 January 2014 – 19 January 2017

Mark Todd commenced in post as Chairman of Derbyshire Healthcare NHS Foundation Trust on 20 January 2014. He has extensive experience of leading NHS Trusts and has previously chaired NHS Derbyshire County, the Derbyshire cluster of Primary Care Trusts and NHS Derby City. He has significant board experience in both the public and private sectors and was previously the Member of Parliament for South Derbyshire between 1997 and 2010.

Maura Teager, Non-Executive Director and (from 9 December 2014) **Deputy Chair**
Term of office: 31 March 2014 – 30 March 2017

Maura worked in the NHS for 38 years up to her retirement in July 2009. She has significant experience in community and secondary care settings and gained her experience as a qualified nurse and midwife across Derbyshire. Maura has worked as Executive Nurse in Southern Derbyshire Community Health Services and a Primary Care Trust and has held the lead executive role in quality, patient safety, patient experience and safeguarding. Maura was also the vice chair of the Derby City Safeguarding Children's Board and has worked closely with key multiagency partners including the voluntary sector. Maura chairs the Trust's Quality Committee.

Jim Dixon, Non-Executive Director
Term of office: 10 September 2014 – 9 September 2017

Jim is the former Chief Executive of the Peak District National Park Authority, a post from which he retired on 31 December 2014. He has extensive experience of working with a range of diverse stakeholders and in recent years has led the partnership of 15 national parks. In February 2014, he was appointed by the Prime Minister as a National Trustee of the Heritage Lottery Fund. Jim has replaced the former non-executive director Mick Martin, who left the Trust in January 2014 to take up a new role at the Parliamentary and Health Service Ombudsman.

Phil Harris, Non-Executive Director
Term of office: 1 November 2014 – 31 October 2017

Phil brings a significant level of experience to the boardroom in managing large organisational change, designing and implementing plans for the commercialisation of businesses and focusing on revenue-generating activities. In past roles, Phil has been responsible for managing national sales and estimating teams. He has also developed successful sales and marketing strategies as a sales director and as a managing director specialising in construction products, and more recently as Chief Executive of a Chamber of Commerce. Phil will support the Trust as we seek to provide effective and high-quality healthcare services to the local community. He replaces Lesley Thompson (see overleaf).

Caroline Maley, Non-Executive Director and (from 9 December 2014) **Senior Independent Director**
Term of office: 20 January 2014 – 19 January 2018

A qualified chartered accountant by background, Caroline brings to her role more than 30 years of experience across the NHS, private sector and education. Her most recent role was as Chief Operating Officer for the National College for School Leadership, where she oversaw all corporate services and was a member of the strategic leadership team. She was previously Chief Executive of Derbyshire Health United, the out-of-hours medical services provider in Derbyshire, and has held non-executive roles within higher education and the private sector. Caroline chairs the Trust's Audit Committee.

Tony Smith, Non-Executive Director
Term of office: 31 March 2014 – 30 March 2017

Tony has over 20 years' experience in senior people management roles within the public sector. Between 2005 and 2008, Tony was a member of the Chief Officer Team and Director of HR for Nottinghamshire Police, where he led on the development of a new people strategy and integration of learning and development, occupational health and personnel. Tony has also undertaken senior HR roles with Nottingham City NHS Trust and British Coal during periods of significant organisational and cultural change. Tony chairs the Trust's Mental Health Act Committee.

Lesley Thompson, Non-Executive Director, Deputy Chair/Senior Independent Director, chair of the Finance and Performance Committee (up to 30 October 2014).

Executive Directors

Steve Trenchard, Chief Executive

Steve has been a mental health nurse since 1990 and has long been connected to a values and recovery orientated approach to mental health and leadership practice. Steve has been Chief Executive of Derbyshire Healthcare NHS Foundation Trust since February 2013 and prior to this had worked as the Director of Nursing and Patient Experience at West London Mental Health NHS Trust. He has experience of working in the not for profit sector, spending five years as the Director of Nursing and Clinical Services at The Retreat, York. He has retained an academic interest in healthcare delivery, evidence based practice and leadership developments. He is Visiting Professor of Mental Health at the University of Derby. Steve has always been committed to the active involvement of people receiving mental health services, both in their individual experiences of receiving therapeutic care, through to their involvement in service delivery, design and evaluation.

Ifti Majid, Chief Operating Officer/ Deputy Chief Executive

Ifti qualified as a Registered Mental Health Nurse in 1988, training at St George's Hospital in London. He has held a range of clinical posts in adult mental health services, both in acute inpatient and community settings, and has held operational management posts in Nottinghamshire and Derbyshire. In his current role Ifti is responsible for the operational management of the divisions within the Trust and is the lead director for information technology, information management, patient records, contracting and estates. Since 3 November 2014, Ifti has also overseen the operational duties of the Trust's workforce and organisational development team.

Carolyn Green, Executive Director of Nursing and Patient Experience

Carolyn has worked as a mental health nurse since 1995. Working in the west and south of London, she has spent the majority of her nursing career working in inpatient care. Throughout her career, Carolyn has taken a family-orientated approach to service design. She is committed to recovery principles and seeks to involve people with lived experiences of mental health services in her service evaluation and quality improvement programmes.

Dr John Sykes, Executive Medical Director

Dr John Sykes qualified at Sheffield University Medical School in 1981 and became a Member of the Royal College of Psychiatrists in 1985. He was previously a Lecturer in Psychiatry at Sheffield University and was appointed as consultant in old age psychiatry in 1989. John was Chair of the Medical Staff Committee of North Derbyshire's Community Health Care Services NHS Trust before being appointed to his first Medical Director post in 1999.

Claire Wright, Executive Director of Finance

Claire has been a fully qualified management accountant since 1999 and worked in the private sector before joining the NHS Graduate Training Scheme in 1995. During her time in the NHS, Claire has performed roles in both acute and mental health provider organisations, in finance and wider management roles. As Executive Director of Finance, Claire is also the Trust's lead director for estates and facilities.

Other Directors who attend the Trust Board:

Graham Gillham, Director of Corporate and Legal Affairs

Graham joined the NHS in 1973 and has held a variety of managerial posts in Nottingham and Bassetlaw before coming to Derby in 1987. He is the principal source of corporate governance advice to the Board and is responsible for ensuring compliance with all relevant legislation and the constitutional aspects of Foundation Trust status, including the arrangements for members and governors. Graham's responsibilities include all aspects of legal affairs, and the handling of serious and complex issues.

Jenna Davies, Interim Director of Corporate and Legal Affairs

Jenna commenced in post on a part-time basis on 26 March 2015 and on a full-time basis on 27 April 2015. Jenna has over eight years' experience within the NHS, working in a variety of sectors including mental health, acute and community. Previous responsibilities have included governance, communications and membership, and Jenna has served as Trust Secretary at a number of organisations. Jenna has a keen interest in Law and governance models.

Mark Powell, Director of Business Development and Marketing (from 16 March 2015)

Mark has a breadth of NHS experience, developed over ten years working in numerous senior roles. He joined the Trust after serving as Executive Director of Operations at Burton Hospitals NHS Foundation Trust. Mark strengthens the Trust's business function and is working closely with the 21c and STaR boards, supporting our wider partnership work across the city and county. He is responsible for the procurement, contracting, communications and involvement teams.

Jayne Storey, Director of Transformation (from 1 November 2014)

Jayne is our first Director of Transformation and leads on the process of organisational change as we seek to wrap our services around the needs of our patients. Jayne previously worked at Lincolnshire Partnership NHS Foundation Trust, where she was Director of Organisational Development. Previously, she worked in HR and organisational development in the private sector, in industries including financial services and rail engineering. In many of these roles, Jayne has gained valuable experience of delivering large-scale change whilst supporting staff as they adapt to new ways of working.

Lee O'Bryan, Interim Director of Workforce and Organisational Development (up to 3 November 2014).

Further details on the Trust's Board members are available on the Trust website **www.derbyshirehealthcareft.nhs.uk**. For any wider enquiries, please contact Sue Turner, Executive Assistant to the Company Secretary on Tel: **01332 623700** ext. **31203**, email: **sue.turner2@derbyshcft.nhs.uk**

Meetings of the Board of Directors

The Board of Directors held 11 regular meetings during 2014/15:

	Possible attendances	Actual
Jim Dixon - Non-Executive Director (from 9 September 2014)	5	**5**
Carolyn Green - Executive Director of Nursing and Quality	11	**10**
Phil Harris - Non-Executive Director (from 3 November 2014)	4	**4**
Ifti Majid - Chief Operating Officer/ Deputy Chief Executive	11	**10**
Caroline Maley - Non-Executive Director and (from 9 December 2014) Senior Independent Director	11	**11**
Tony Smith - Non-Executive Director	11	**9**
John Sykes - Executive Medical Director	11	**9**
Maura Teager - Non-Executive Director and (from 9 December 2014) Deputy Chair	11	**10**
Lesley Thompson - Non-Executive Director and Deputy Chair/Senior Independent Director (up to 30 October 2014)	7	**6**
Mark Todd - Chairman	11	**11**
Steve Trenchard - Chief Executive	11	**9**
Claire Wright - Executive Director of Finance	11	**11**

Also in regular attendance:

Graham Gillham - Director of Corporate and Legal Affairs
Lee O'Bryan - Interim Director of Workforce and Organisational Development (up to 3 November 2014)
Mark Powell - Director of Business Development and Marketing (from 16 March 2015)
Jayne Storey - Director of Transformation (from 3 November 2014)

Board balance and completeness

In making the most recent Non-Executive appointments, the Nominations Committee of Governors has taken account of the skills requirement advised by the directors.

In its forward plan submission the Board states it is satisfied that all directors are appropriately qualified to discharge their functions effectively, including ensuring management capacity and capability.

The Trust Board's composition and range of skills and experience has been revisited as vacancies arise, for example in prioritising community engagement and marketing expertise in recommending to governors the specification for the two new Non-Executive Director posts. These posts were openly advertised through NHS Jobs and local advertisements. The posts were also ratified by the Council of Governors.

The Board considers all Non-Executive Directors to be independent in their role. The Trust established this through an individual declaration of interests. The requirement for independence is also outlined in NED job descriptions where it specifies that NEDs are responsible for bringing an independent perspective to the boardroom.

The Foundation Trust Constitution sets out the grounds on which a non-executive appointment may be terminated by the Council of Governors. Or a non-executive may resign before completion of their term, by given written notice to the Director of Corporate and Legal Affairs.

NHS Foundation Trust Code of Governance

The Trust complies with section 7 of the NHS Foundation Trust Code of Governance.

The governors have a statutory power (Health and Social Care Act 2012, S 151 (6)) to require one or more of the directors to attend a meeting for the purpose of obtaining information about the corporation's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the corporation's or the directors' performance). This formal power was not exercised by the governors during the year. (The Chief Executive or his deputy routinely attends every council meeting).

There is a recognised need to periodically assess the collective performance of the Council of Governors and how they systematically communicate the ways their responsibilities have been discharged. A process was agreed in the March 2015 Council of Governors for this to form part of the governor's work plan for 2015/16, alongside individual, documented one-to-one reviews with each governor.

The Constitution outlines processes for the removal of any governor who consistently and unjustifiably fails to attend the meetings of the Council of Governors or who has an actual or potential conflict of interest that prevents the proper exercise of their duties.

This year, Governors have been attending local Patient Participation Groups at local GP practices, to ensure they are aware of any wider issues discussed by these forums. This relationship intends to ensure that the public interests of patients and the local community are represented at Council of Governor meetings, and that two-way communication channels are established.

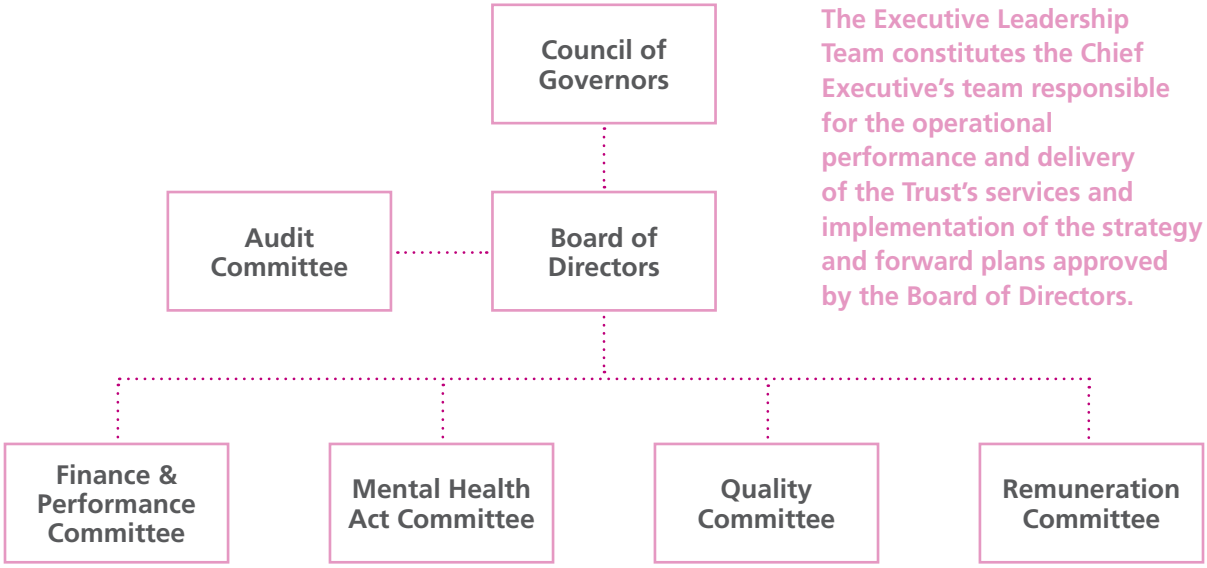
As part of the 'Fit and Proper Person's Test' the Trust's governors were involved in setting appropriate processes for assessing and checking that the individual directors hold the required qualifications and have the competence, skills and experience required to undertake their role.

Expenses

12 governors received trust expenses during the 2014/15 reporting period, equating to a total of £4,328. 11 Executive and Non-Executive Directors received Trust expenses during the same period, equating to a total of £26,310.

Committees of the Board

Trust governance structure



The Executive Leadership Team constitutes the Chief Executive's team responsible for the operational performance and delivery of the Trust's services and implementation of the strategy and forward plans approved by the Board of Directors.

Audit Committee

The Audit Committee is responsible for ensuring the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities in support of the organisation's objectives. It achieves this by:

- Ensuring that there is an effective internal audit function providing appropriate independent assurance to the Audit Committee, Chief Executive and Board
- Reviewing the work and findings of the external auditor
- Reviewing the findings of other significant assurance functions, both internal and external to the organisation
- Reviewing the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work
- Requesting and reviewing reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control
- Reviewing the Annual Report and financial statements (as a delegated responsibility of the Board) and ensuring that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Audit Committee reports to the Board of Directors on an annual basis on its work in support of the Annual Governance Statement, specifically commenting on whether the Board Assurance Framework is fit for purpose, the risk management in the organisation is complete and embedded and that governance arrangements are fully integrated.

With regard to financial statements the committee receives unaudited accounts and considers the accounts and notes on a "page turn" basis. The Committee subsequently receives the audited accounts and notes, which are accompanied by a summary of all changes made.

The Audit Committee throughout the year considers external audit reports, internal audit reports, and counter fraud progress reports. All audit outcomes are overseen by monitoring the delivery of internal and external audit report recommendations. The Trust has an internal audit function which is referenced in the terms of reference for the Audit Committee. A review of the effectiveness of internal and external audit took place this year, alongside assurance on counter fraud.

The Committee considers the Board Assurance Framework, Annual Report, Quality Report, Annual Governance Statement and progress with internal and external audit plans. It also regularly receives updates on losses and compensation payments, exit payments, hospitality and sponsorship, tenders and waivers, debtors and clinical audit.

The Audit Committee reports to the public Trust Board each month and covers significant issues, including assurance and any gaps in assurance.

During the year the Committee received and considered various internal audit reports on areas including financial systems, EPR lessons to be learned from the initial roll out phase, clinical audit, Serious Untoward Incidents (SUIs) and transformation. The committee also received a comparison between planned internal audit activity and actual activity.

The Committee assesses the effectiveness of the external audit process by undertaking the self-assessment each year and by meeting with auditors in private. Auditors attend every meeting of the audit committee, and the Trust's compliance with the audit plan approved by the committee is monitored.

The external audit firm, Grant Thornton, was appointed on 1 November 2012 following an open tender process in the summer of 2012. The contract awarded was for an initial term of three years. The total value of the three year contract was £116,560 + VAT.

In adherence with all requirements, including approval by the Council of Governors, this contract was extended for a further two years. The value of the 2014/15 accounts work is £39,850 + VAT. Grant Thornton also provided non-audit services (employment taxes review) for a fee of £4,000 plus VAT.

Our Audit Committee comprises:
Non-Executive Directors

- **Caroline Maley** – Non-Executive Director (Chair)
- **Phil Harris** – Non-Executive Director (from 3 November 2014)
- **Tony Smith** – Non-Executive Director
- **Maura Teager** – Non-Executive Director (until 3 November 2014).

Non-Executive Directors' attendance at the Audit Committee during the year was as follows:

	Possible attendances	Actual
Caroline Maley	7	**7**
Phil Harris (from 3 November 2014)	2	**2**
Tony Smith	7	**5**
Maura Teager (until 3 November 2014)	5	**5**

Mental Health Act Committee

The Mental Health Act Committee regularly reviews the patient activity under sections of the Mental Health Act. A key role is to consider matters of good practice in accordance with the requirements of the Code of Practice and the Mental Health Act (1983 & 2007). The Committee meets quarterly, is chaired by Tony Smith and is generally attended by one or two other Non-Executive Directors.

Finance and Performance and Quality Committees

The Board is also supported by the Finance and Performance and Quality Committees, whose functions are described in the Annual Governance Statement on pages 141-149 of this Annual Report.

Performance evaluation of the Board

With regard to the strategic objectives of the Trust, the Chairman undertakes an annual appraisal of each Non-Executive Director, whilst the performance review of individual members of the executive team is carried out by the Chief Executive.

The Chairman's appraisal by the NEDs and governors was led by the Senior Independent Director in January 2015 and shared publicly with the Council of Governors in March 2015.

The Chief Executive also participated in a 360 degree appraisal in May 2014, which was publicly shared through an online blog and tweet.

Following the Board's consideration of the appointment of Senior Independent Director and Deputy Chairman, the Council of Governors, at their meeting on 9 December 2014, supported the appointment of Caroline Maley as Senior Independent Director and Maura Teager as Deputy Chairman.

No formal external evaluation of the board took place during 2014/15.

Chairman's commitments

No significant relevant additions to the Chairman's commitments outside the Trust were made during the year.

Board codes of conduct and accountability and Nolan principles

When reviewing their disclosures, each board member has personally reaffirmed in writing their agreement to comply with the NHS Codes of Conduct and Accountability, and the Seven Principles of Public Life (Nolan), and to state whether there is any relevant audit information of which the Trust's Auditors are unaware.

Declaration of interests

It is a requirement that the Chairman, board members and board-level directors who have regularly attended the board during 2014/15, and current members, should declare any conflict of interest that arises in the course of conducting NHS business.

The Chairman and board members should declare any business interest, position of authority in a charity or voluntary body in the field of health and social care, and any connection with a voluntary or other body contracting for NHS services. These should be formally recorded in the minutes of the board, and entered into a register, which is available to the public. Directorships and other significant interests held by NHS board members should be declared on appointment, kept up to date and set out in the annual report.

The Register of Interests is subject to annual review, and will be published with the Annual Accounts 2014/15.

A register of interests is also maintained in relation to all governor members on the Council of Governors. This is available by application to the Director of Corporate and Legal Affairs.

Declaration of interests register

The disclosure and statements referenced within this report are subject to the NHS Code of Conduct and Accountability which is binding upon Board Directors. Interests are disclosed as follows:

NAME	INTEREST DISCLOSED	TYPE
Jenna Davies	Nil	-
Jim Dixon	Trustee – Heritage Lottery Fund / National Heritage Memorial Fund Director – Jim Dixon Associates Patron – Accessible Derbyshire	(a) (a) (d)
Graham Gillham	Nil	-
Carolyn Green	Nil	-
Phil Harris	Director – Phormative Ltd Yorkshire and Humber Enterprises Doncaster Chamber of Commerce (until 31 March 2015) Yorkshire and Humber Chambers of Commerce (until 20 February 2015)	a) (a) (a) (a)
Ifti Majid	Nil	-
Caroline Maley	Director – C D Maley Ltd Non-Executive Director – Employer First Ltd (until 18 February 2015) Trustee – Vocaleyes Ltd.	(a, b) (a) (a, d)
Lee O'Bryan (up to 3 November 2014)	Director – The Camden Partnership Ltd Non-Executive Director – Avon and Wiltshire Mental Health Partnership Trust	(b) (d)
Mark Powell	Nil	-
Tony Smith	Panel Member (Assessor) – Judicial Appointments Commission (from 26 March 2012 to 31 March 2017)	(d)
Jayne Storey	Director of Workforce – Nottinghamshire Cricket Board Ltd	(a)
John Sykes	Nil	-
Maura Teager	Non-Executive Director – Ripplez social enterprise and NHS provider of the Family Nurse Partnership	(a)
Lesley Thompson (up to 30 October 2014)	Director – Beyond Consultants Ltd Associate Consultant – Libra, CMZ2	(a,b,c) (e)
Mark Todd	Chair of Trustees – Motor Neurone Disease Association	(d)
Steve Trenchard	Nil	-
Claire Wright	Nil	-

All other members of the Trust Board have nil interests to declare.

a. Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those dormant companies).

b. Ownership or part ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

c. Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d. A position of authority in a charity or voluntary organisation in the field of health and social care.

e. Any connection with a voluntary or other organisation contracting for NHS services.

The Council of Governors

The Council of Governors performs an important role and is responsible for representing the interests of NHS Foundation Trust members, the public and partner organisations in the governance of the Trust.

The Governors, the majority of whom must be elected from the Trust's membership, have a number of statutory responsibilities including board level appointments (see the Nominations Committee). They are consulted on the Trust's forward plan and ensure that the Trust operates in a way that fits with its purpose and authorisation; this is done via the full quarterly Council of Governors meeting where the directors report to governors on Trust performance.

Derbyshire Healthcare's Council of Governors is made up of elected governors across three constituencies, plus appointed governors from our partner organisations. The constituencies are:

- Public governors, elected by members of the public constituency
- Staff governors, elected from the staff body.

In addition, appointed governors represent stakeholder organisations.

Many governors support the Trust's engagement team, assisting with member recruitment and engagement at events. They are a key link between the Trust and its members. **Governors add value to the Trust by contributing to a variety of committees and working groups, including:**

- Quality Working Group
- Membership Development Working Group
- Governor Development Working Group
- Finance and Strategy Working Group.

The participation of governors in the groups is seen as a valuable and productive means of supporting the Council of Governors in the exercise of its responsibilities whilst also assisting the Trust Board in its running of the organisation.

The Trust is committed to the continuing development of governors and encourages participation in the national "Govern Well" Programme as well as East Midlands Leadership Academy events and workshops. Governors continue to form a key part of the quality visit groups and provide vital feedback about services.

An induction for newly appointed governors was held in December 2014 and a governor handbook has been developed to provide information about all aspects of the role.

The governors were canvassed for their opinion on the Trust's strategy and forward plan at their meeting in March 2015. Their feedback was shared with the Board of Directors.

The Chief Executive/Deputy Chief Executive attend all Council meetings with the Chairman (who is also the Chairman of the Council of Governors) to share the Board's current agenda and forthcoming issues. Other directors attend as required.

The Council of Governors have the right (under the NHS Act 2006) to request directors to attend a council meeting to discuss specific concerns regarding the Trust's performance. This power has not been exercised during 2014/15.

The Council of Governors met four times during 2014/15. Individual attendance by governors is shown in the table on page 89. The Register of Interests of the Council of Governors is available at any time through the office of the Director of Corporate and Legal Affairs. Please contact Annah Swinscoe-Daniels, Telephone: **01332 623700** extension **31206**, email: **annah.swinscoe-daniels@derbyshcft.nhs.uk**

Public governors Rob Quick, Michael Walsh, Ruth Cringle and Martin Smith.

Summary attendance by governors at meetings of the Council of Governors meetings 2014/15

Constituency - PUBLIC	Title	First name	Surname	Number of meetings attended (out of possible number of meetings)
Amber Valley North	Mrs	Victoria	Cassidy	3/4
Amber Valley South	Mr	John	Morrissey	3/4
Bolsover	Ms	Susan	Statter	1/4
Chesterfield North	Mr	Alan Eber	Smith	4/4
Chesterfield South	Miss	Sharon	Bull	0/2
Derby City East	Mr	Igor	Zupnik	4/4
Derby City East	Mr	Peter	Aaser	1/2
Derby City West	Mr	Michael	Walsh	1/2
Derby City West	Mrs	Moira	Kerr	4/4
Derby City West	Ms	Cathy	Cleary	1/1
Derbyshire Dales	Mrs	Ruth L.	Greaves	4/4
Erewash North	Mr	Martin	Smith	1/2
Erewash North	Mr	Lew	Hall	1/1
Erewash South		VACANT		
North East Derbyshire	Mr	Robert	Quick	1/2
South Derbyshire	Mr	Barry	Appleby	3/4
High Peak	Mr	Mark	Serby	2/4
Surrounding Areas	Ms	Ruth Isabella	Cringle	2/2
Constituency - STAFF				
Medical and Dental	Dr	Nitesh	Painuly	4/4
Nursing and Allied Professions	Mrs	Katrina	De Burca	4/4
Nursing and Allied Professions	Mrs	April	Saunders	2/2
Administration and Allied Support Staff	Mrs	Sue	Flynn	3/4
APPOINTED				
Derby City Council	Cllr	Barbara	Jackson	0/4
Derbyshire Constabulary		VACANT		0/4
Derbyshire County Council	Cllr	Rob	Davison	2/4
North Derbyshire Voluntary Action	Mrs	Kathy	Kozlowski	0/4
Southern Derbyshire Voluntary Sector MH Forum	Ms	Wendy	Beer	1/4
University of Derby	Dr	Paula	Crick	3/4
University of Nottingham	Prof	Paul	Crawford	2/4

Attendance by Trust Directors and Non-Executive Directors:

	First name	Surname	Number of meetings attended (out of possible number of meetings)
Director	Jenna	Davies	0/0
	Graham	Gillham	3/3
	Carolyn	Green	2/4
	Ifti	Majid	0/4
	Mark	Powell	0/0
	John	Sykes	0/4
	Jayne	Storey	0/2
	Steve	Trenchard	4/4
	Claire	Wright	2/4
Chairman	Mark	Todd	4/4
Non-Executive Director	Jim	Dixon	1/2
	Phil	Harris	1/2
	Caroline	Maley	2/4
	Tony	Smith	1/4
	Maura	Teager	1/4
	Lesley	Thompson	1/3

Lead governor

The Trust's lead governor is Victoria Cassidy, Public Governor for Amber Valley North. She was elected at the Council of Governors in September 2014.

Victoria is the central point of contact between Monitor and the Council of Governors. It is not anticipated that there will be regular contact but a lead governor is nominated and contact details have been provided to Monitor. The lead governor should take steps to understand the role of Monitor and the basis on which Monitor may take regulatory action.

Prior to Victoria Cassidy's election, Lew Hall was the Trust's lead governor.

Nominations Committee of the Council of Governors

The Council of Governors established the Nominations Committee in line with the Constitution, to oversee the process for the recruitment and appointment of the Chairman and Non-Executive Directors. **The purpose of this committee is to assist the Board of Directors with its oversight role by:**

- Reviewing the numbers, structure and composition (including the person specifications) of Non- Executive Directors, to reflect the expertise and experience required, and to make recommendations to the Council of Governors
- Developing succession plans for Non-Executive Directors, taking into account the challenges and opportunities facing the Trust
- Identifying and nominating candidates to fill Non-Executive Director posts, by overseeing the recruitment process and making recommendations to the Council of Governors and seeking the Council's approval to appoint the recommended candidate(s).

Members of the committee during 2014/15 were: Victoria Cassidy, Paula Crick, Katrina De Burca and Moira Kerr.

Membership and attendance of the Nominations Committee

Membership	Possible attendances	Actual
Mark Todd (Chairman)	2	**2**
Victoria Cassidy	2	**2**
Paula Crick	2	**2**
Katrina De Burca	2	**2**
Moira Kerr	2	**2**

The Nominations Committee met twice during the year – to develop the role specification for forthcoming NED appointments and then to confirm the appointment of two NEDs in September 2014.

Remuneration Report 2014/15

Remuneration Committee

On 14 May 2014 the committee approved the services of an expert search and recruitment agency to provide advice and assistance on the appointment and remuneration of the Director of Transformation. The committee also approved the appointment of temporary Director of Workforce and Organisational Development.

On 16 July 2014 the Remuneration Committee, consisting of Non-Executive Directors only, met and approved a compromise agreement proposal, Board salary proposal and the proposal for the Director of Business Development and Marketing and sought Treasury approval for a severance case.

A virtual meeting of the Remuneration Committee was held in November 2014 to seek Treasury Approval for a severance case.

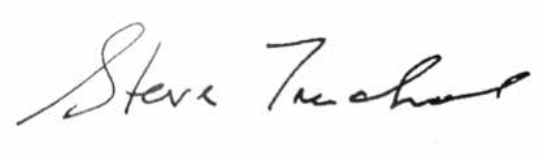
Membership	Possible attendances	Actual
Mark Todd - Chairman	2 plus November virtual meeting	2 plus November virtual meeting
Caroline Maley - Non-Executive Director and Senior Independent Director	2 plus November virtual meeting	2 plus November virtual meeting
Maura Teager - Non-Executive Director and Deputy Chairman	1 plus November virtual meeting	1 plus November virtual meeting
Lesley Thompson - Senior Independent Director and Non-Executive Director (until 30 October 2014)	2	2
Tony Smith - Non-Executive Director	1 plus November virtual meeting	1
Phil Harris - Non- Executive Director (from 1 November 2015)	November virtual meeting	0
Jim Dixon - Non- Executive Director (from 10 September 2014)	November virtual meeting	0
Jayne Storey - Director of Transformation (from 3 November 2014)	November virtual meeting	0
Steve Trenchard - Chief Executive	1	1
Graham Gilham - Director of Corporate and Legal Affairs	2	2

Remuneration Committee of the Council of Governors

The Remuneration Committee makes recommendations to the Council of Governors concerning the remuneration of the Chairman and Non-Executive Directors.

Governor members of this committee include: Victoria Cassidy, John Morrissey, Robert Quick and April Saunders.

The committee met on 26 February 2015 to recommend the remuneration of the Senior Independent Director and Deputy Chairman respectively upon their recent appointments. The committee also reviewed the Terms of Reference and considered the outcomes of the governors' assessment of the Chairman, as part of his appraisal.



Steve Trenchard

Chief Executive

Date: 22 May 2015

Salary and allowances of Executive and Non-Executive Directors for the year 2014/15 (subject to audit)

Title	Name	2014/15						2013/14					
		Salary and Fees (in bands of £5,000)	All taxable benefits (to the nearest £100)	Annual perfor-mance-related bonuses (in bands of £5,000)	Long-term perfor-mance - related bonuses (in bands of £5,000)	All pension-related benefits (in bands of £2,500)	Total (in bands of £5,000)	Salary and Fees (in bands of £5,000)	All taxable benefits (to the nearest £100)	Annual perfor-mance-related bonuses (in bands of £5,000)	Long-term perfor-mance-related bonuses (in bands of £5,000)	All pension-related benefits (in bands of £2,500)	Total (in bands of £5,000) *20
Chief Executive	Steve Trenchard	150-155	166			65-67.5	230-235	140-145	104			80-82.5-	230-235
Chief Operating Officer	Ifti Majid	110-115				17.5-20	130-135	115-120	8			132.5-135	245-250
Executive Director of Finance	Claire Wright	110-115				25-27.5	140-145	110-115				155-157.5	270-275
Executive Medical Director	John Sykes *19	195-200	27			-25 - -27.5	170-175	190-195	27			-42.5 - -45	150-155
Executive Director of Nursing and Patient Experience	Carolyn Green *1	95-100				107.5-110	205-210	10-15				45-47.5	55-60
Executive Director of Nursing and Patient Experience	Paul Lumsdon *2							50-55	20			27.5-30	85-90
Executive Director of Nursing and Patient Experience	Carolyn Gilby *3							35-40	3			112.5-115	150-155
Director of Transformation (renamed from Workforce & OD)	Lee O'Bryan *4	60-65					60-65	40-45					40-45
Director of Transformation (renamed from Workforce & OD)	Jayne Storey *5	45-50	8			110-112.5	155-160						
Director of Transformation (renamed from Workforce & OD)	Helen Marks *6							85-90	36			32.5-35	125-130
Deputy Director of Workforce and OD	Karen Herriman *7	5-10					5-10						
Director of Business Development and Marketing	Mark Powell *8	0-5					0-5						
Director of Corporate and Legal Affairs	Graham Gillham	80-85				30-32.5	110-115	80-85	34			50-52.5	125-130
Director of Corporate and Legal Affairs	Jenna Davies *9	0-5					0-5						
Chairman	Mark Todd *10	45-50					45-50	5-10					5-10
Chairman	Alan Baines *11							20-25					20-25
Non-Executive Director	Lesley Thompson *12	5-10					5-10	10-15					10-15
Non-Executive Director	Caroline Maley *13	15-20					15-20	0-5					0-5
Non-Executive Director	Anthony Smith	10-15					10-15	10-15					10-15

Title	Name	2014/15						2013/14					
		Salary and Fees (in bands of £5,000)	All taxable benefits (to the nearest £100)	Annual perfor-mance-related bonuses (in bands of £5,000)	Long-term perfor-mance - related bonuses (in bands of £5,000)	All pension-related benefits (in bands of £2,500)	Total (in bands of £5,000) *19	Salary and Fees (in bands of £5,000)	All taxable benefits (to the nearest £100)	Annual perfor-mance-re-lated bonuses (in bands of £5,000)	Long-term perfor-mance-re-lated bonuses (in bands of £5,000)	All pension-related benefits (in bands of £2,500)	Total (in bands of £5,000) *20
Non-Executive Director	Maura Teager *14	10-15					10-15	10-15					10-15
Non-Executive Director	Philip Harris *15	5-10					5-10						
Non-Executive Director	Jim Dixon *16	5-10					5-10						
Non-Executive Director	Graham Foster *17							5-10					5-10
Non-Executive Director	Michael Martin *18							25-30					25-30
Band of Highest Paid Director's Total Remuneration (£000)		195-200						190-195					
Median Total Remuneration		27,901						27,901					
Ratio		7.1						6.9					

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

The banded remuneration of the highest-paid director in Derbyshire Healthcare NHS Foundation Trust in the financial year 2014/15 was £195,000-200,000 (2013/14, £190,000-195,000).

This was 7.1 times (2013/14, 6.9) the median remuneration of the workforce, which was £27,901 (2013/14, £27,901).

In 2014/15, 0 (2012/13, 0) employees received remuneration in excess of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

In accordance with Monitor's Annual Reporting Manual the calculation for the Fair Pay Multiple disclosure is based on full-time equivalent staff of the Trust at the reporting period end date on an annualised basis.

It is therefore derived from staff costs of Derbyshire Healthcare NHS Foundation Trust as at 31 March 2015. It is calculated using costs for employed staff in post at that date (with any part-time salaries grossed up to full-time equivalent) and also using appropriate values for staff engaged via an agency or other invoicing.

The resulting combined list of salary figures was sorted into ascending order of value to identify the middle (median) value in the range.

Pound for pound there has been no material movement in the comparators. The director figure has tipped over into a different banding by a small amount which has driven the change in ratio.

*1 **Carolyn Green** started in post 17.2.14

*2 **Paul Lumsdon** left 29.9.13

*3 **Carolyn Gilby** acted up 16.9.13 - 17.2.14

*4 **Lee O'Bryan** interim 1.11.13 - 31.10.14. Adjustment made to 2013/14 salary as this was grossed up to 1.00 from 0.60wte

*5 **Jayne Storey** started in post 1.11.14

*6 **Helen Marks** left 19.2.14

*7 **Karen Herriman** payment made in 2014/15 relating to Director of Workforce and OD responsibilities between 1.8.13 and 31.10.13

*8 **Mark Powell** started in post 16.3.15

*9 **Jenna Davies** interim from 23.3.15 covering staff absence

*10 **Mark Todd** started in post 20.1.14

*11 **Alan Baines** left 30.9.13

*12 **Lesley Thompson** left 31.10.14

*13 **Caroline Maley** started in post 20.1.14

*14 **Maura Teager** existing employee made Deputy Chair from 9.12.14

*15 **Philip Harris** started in post 1.11.14

*16 **Jim Dixon** started in post 10.9.14

*17 **Graham Foster** left 31.8.13

*18 **Michael Martin** left 31.1.14. Acted up as Chair following Alan Baines departing and prior to Mark Todd commencing

*19 **John Sykes** pension frozen 31.5.12

*20 Pension recalculated for 2013/14 leading to banding changes.

The total taxable benefits reported in the table above of £20,111 relate to lease car benefits and accommodation allowance benefit. There is a total of £7,611 relating to lease car benefits and a total of £12,500 relating to accommodation allowance benefit.

The details included in the Remuneration report (salary and allowances of Executive and Non-Executive Directors for the year 2014/15; and pension benefits) are subject to audit.

Pension benefits - 1 April 2014 to 31 March 2015 (subject to audit)

Title	Name	Real increase in pension at normal retirement age (bands of £2,500)	Real increase in pension lump sum at normal retirement age (bands of £2,500)	Total accrued pension at normal retirement age at 31 March 2015 (bands of £5,000)	Lump sum at normal retirement age related to accrued pension at 31 March 2015 (bands of £5,000)	Cash equivalent transfer value at 31 March 2015	Cash equivalent transfer value at 31 March 2014	Real increase in cash equivalent transfer value	Employers contribution to stakeholder pension (to nearest £00)
Chief Executive	Steve Trenchard	65-67.5	0-2.5	10-15	0-5	154	112	40	0
Executive Director of Finance	Claire Wright	25-27.5	2.5-5	25-30	80-85	441	404	30	0
Executive Medical Director	John Sykes	-25--27.5	0-2.5	65-70	205-210	0	0	0	0
Executive Director of Nursing and Patient Experience	Carolyn Green	107.5-110	12.5-15	15-20	50-55	244	172	69	0
Executive Director of Operations	Ifti Majid	17.5-20	2.5-5	40-45	130-135	763	716	35	0
Executive Director of Transformation	Jayne Storey	110-112.5	0-2.5	5-10	0-5	65	0	65	0
Director of Corporate and Legal Affairs	Graham Gillham	30-32.5	5-7.5	40-45	125-130	0	0	0	0

Off-payroll arrangements

Table 1: All off-payroll engagements as of 31 March 2015, for more than £220 per day and last for longer than six months

Number of existing engagements as of 31 March 2015	9
Of which…	
Number that have existed for less than one year at the time of reporting	3
Number that have existed for between one and two years at the time of reporting	2
Number that have existed for between two and three years at the time of reporting	1
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	3

Table 2: Number of new engagements, or those that reached 6 months in duration, between 1 April and 31st March 2015 for more than £220 per day and that last longer than 6 months

Number of new engagements, or those that reached six months in duration, between 1 April and 31 March 2015	5
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	3
Number for whom assurance has been requested	1
Of which…	
Number for whom assurance has been received	1
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

Table 3: For any off-payroll engagements of board members, and or senior officials with significant financial responsibility between 1st April 2014 and 31 March 2015

Number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, during the financial year.	**1**
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements.	**10***

* This figure reflects the number of individuals who served as part of the Trust Board during 2014/15. Only one member of the Board during this period related to a short term off-payroll arrangement (less than six months), to cover an extended period of sickness absence.

Statement on the policy on the use of off-payroll arrangements

The Trust has amended the non-employed contract through procurement and the following terms and conditions were added.

Responsibility for PAYE and NIC's:

- Where [individual] is liable to be taxed in the UK in respect of consideration received under this contract, it shall at all times comply with the Income Tax
- Where [individual] is liable to National Insurance Contributions (NICs) in respect of consideration received under this contract, it shall at all times comply with the Social Security Contributions and Benefits Act 1992 (SSCBA) and all other statutes and regulations relating to NICs in respect of that consideration.
- Derbyshire Healthcare NHS Foundation Trust may, at any time during the term of this contract, request [individual] to provide information which demonstrates how [individual] complies with Clauses 1 and 2 above or why those Clauses do not apply to it.

Furthermore, as you are not considered an employee of Derbyshire Healthcare NHS Foundation Trust, and are responsible for your own contributions for PAYE and NIC's, you are required to comply with the following:

- If you are self-employed you must confirm and provide evidence that you are registered to pay tax (an example of this may be a previous year-end business account statement). If you are recently self-employed then you must be able to provide form SA250 as evidence that you have registered as self-employed with HMRC.
- If you are engaged through a limited company (or other organisation) and are on the payroll of that company and having PAYE and NIC's deducted at source by the limited company, then you must provide evidence that all of the money that you are paid by Derbyshire Healthcare NHS Foundation Trust is put through that body and you are receiving/withdrawing it with PAYE/NICs deducted at source (this can be evidenced by the production of a payslip which will show the salary, and PAYE and NICs deductions).
- Failure to provide satisfactory evidence that you are making the statutory contributions for PAYE and NIC's may result in this contract being terminated with immediate effect.

A reflection on our achievements during 2014/15

April 2014

Derbyshire Healthcare recognised as national lead for employee engagement

Derbyshire Healthcare was identified as one of only eight NHS Trusts recognised by the IPA (Involvement and Participation Association) for our high performance based on employee engagement scores, patient satisfaction and a range of other data. Furthermore, the Trust was one of only two Trusts where mental health services are core to its provision.

This achievement was recognised at the launch of the IPA's research 'Meeting the Challenge: Successful Employee Engagement in the NHS' in Westminster on 29 April, where Derbyshire Healthcare was commended for its focus on values, compassion and its visible and approachable leadership.

Trust representatives are proud to sign the BSL Charter

May 2014

Trust leads the way in signing commitment to Deaf people

During May our Chairman and Chief Executive jointly signed the British Deaf Association's BSL Charter. By doing so Derbyshire Healthcare become the first NHS Trust in the county – and only the second mental health Trust in England – to firmly demonstrate its commitment to equality for Deaf people. The Trust also established itself as the first NHS Trust to fund a mental health awareness training programme for Deaf community groups called 'Mental Health First Aid'.

Through the BSL Charter, the Trust has committed itself to:

- Ensuring access for Deaf people to information and services
- Promote learning and high quality teaching of British Sign Language
- Support Deaf children and families
- Ensure staff working with Deaf people can communicate effectively in British Sign Language
- Consult with its local Deaf community on a regular basis.

June 2014

Top again for patient confidentiality

The NHS Health and Social Care Information Centre rated Derbyshire Healthcare as the best mental health and community trust in the country for ensuring that confidential information, such as patient records, is stored safely. This is the second consecutive year that the Trust has topped the national charts for its commitment to confidentiality, by achieving 96% compliance and an initial grading of satisfactory (the highest grading available).

The Toolkit submission is a self-assessment tool covering 45 achievements and Trusts have to submit over 650 pieces of evidence to demonstrate compliance with these standards; this covers everything from the physical security of computers and policies and procedures dedicated to record keeping.

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The Beeches perinatal unit receive a kite mark for their specialist care

July 2014

Trust's perinatal mental health unit rated as one of the country's best

In July the Trust's perinatal mental health unit, The Beeches, was nationally accredited by the Royal College of Psychiatrists for a second successful time following a visit from external healthcare professionals and 'expert patients' - the Royal College of Psychiatrists' quality network for perinatal mental health.

This kite mark, which lasts for three years, highlights and offers assurance that The Beeches is one of only 15 units offering specialist perinatal care across the country that provides a service of compassion and quality to pregnant women and new mothers who are experiencing mental health issues such as severe postnatal depression, anxiety disorder, schizophrenia and bipolar disorder.

August 2014

"Derbyshire Healthcare food deserves three Michelin stars"

Patients receiving care at two of Derbyshire Healthcare's mental health hospitals in Derby are also receiving the best hospital food in the country, according to national statistics published on 29 August. Wards based at the Radbourne Unit and Kingsway Site both received top scores of 100% for the quality of food they serve to both their patients and staff.

The results follow an assessment earlier in the year by a panel of patient representatives from mental health support group Derbyshire Voice, who judged the quality and choice of all meals served by the Trust. One patient representative said: "The food in this hospital deserves three Michelin stars, it is better than some pubs and restaurants!"

September 2014

Derbyshire Healthcare named as one of the best places to work in the NHS

On 5 September Derbyshire Healthcare was highlighted as one of the top healthcare organisations in the country to work for by the Health Service Journal (HSJ) and NHS Employers. The Trust was selected for the HSJ's Best Places to Work list, compiled in partnership with NHS Employers, which features the top 100 healthcare providers across the acute, community, mental health and primary care sectors. Derbyshire Healthcare was recognised for its high levels of staff engagement, with 92% of staff believing their role makes a difference to patients, and job-relevant training.

October 2014

Trust pulls back the curtain on mental health

To recognise World Mental Health Day, the Trust invited people living across Derby and Derbyshire to a free theatre production event, which aimed to promote awareness and help to reduce stigma and discrimination around mental health issues. The event featured a performance from the Hearth Centre, a performing arts company based in Birmingham, to showcase a production called 'Other', a story of a young mixed race man in reverse, working backwards from his detainment in a medium secure forensic unit at aged 19, to his promising beginnings when he was born.

The Trust celebrated its annual staff awards in November 2014

The Trust's relationship with *First News* includes support to children over the festive period

Reproduced courtesy of *First News*

November 2014

Celebrating the achievements of staff and volunteers

Achievements of staff and volunteers were recognised at the Trust's annual Delivering Excellence Awards ceremony on 27 November. The heart-warming ceremony was a fantastic opportunity to highlight the extraordinary things that staff, volunteers and teams do every day to support the people that Derbyshire Healthcare cares for. Stories about how staff are using innovative ways to help service users into recovery, employees supporting their colleagues' development, and how staff are delivering compassionate care in challenging circumstances were heard by guests, giving a clear reminder about the positive impacts that the NHS delivers day in, day out.

At the ceremony the Trust's monthly staff recognition scheme DEED (Delivering Excellence Every Day) was launched by the Chief Executive, Steve Trenchard.

December 2014

Trust teams up with national newspaper to help young people cope with Christmas

In December Laurence Baldwin, a consultant nurse in our Derby City CAMHS (Child and Adolescent Mental Health Service) team, wrote a special report for the Christmas issue of *First News*, the national newspaper for young people. The article offered advice on how best to cope with the festive period and have some fun. A young person from Derbyshire, Leanne, also provided her top tips for when things get tense. This was the fourth time during 2014 that the Trust had teamed up with *First News* to offer advice and support to children and young people.

January 2015

Care for mental health and substance abuse improved by Chesterfield Liaison Team

The Trust officially launched it new psychiatric liaison service, developed to support adults living in north Derbyshire with mental health needs and/or issues with drugs and alcohol, on 29 January. The Liaison Team was been established by integrating the former Mental Health Liaison and Self Harm Team with the Older Adults Mental Health Liaison Team and the Hospital Alcohol and Drugs Liaison Team (HADLT) to create a 24/7 single point of access service at Chesterfield Royal Hospital.

The launch of the Liaison Team in Chesterfield follows the success of a similar team commissioned for the Royal Derby Hospital during 2013.

February 2015

Healthwatch Derby publishes findings of its Think Healthy review of our services

In February, Healthwatch Derby published the findings of an in-depth independent review into our work in Derby City, following an innovative collaboration that looks set to be continued in the future. Healthwatch Derby was given access to our services in the autumn of 2014, to see how we support people with mental health problems, people with learning disabilities and Derby's children and families.

In total 1,070 items of individual feedback were collected. The full report, recommendations and appendices can be found on the Healthwatch Derby website: **www.healthwatchderby.co.uk**

March 2015

Tree-mendous! Trust plants 26 trees after 260 Trust members go paper-free

To mark NHS Sustainability Day in March, staff and governors from the Trust planted 26 trees and demonstrated their commitment to make NHS services more environmentally-friendly and sustainable for the future. The opportunity to plant these trees is a result of a campaign the Trust has recently been running in partnership with NHS Forest where the Trust has encouraged 262 public members to convert to from postal communication to email. For every 10 members who changed to email communication, NHS Forest provided the Trust with one tree to plant.

Public governors Barry Appleby, Ruth Cringle and Igor Zupnik plant a tree to mark NHS Sustainability Day

2. Quality Report

Part 1

Statement by the Chief Executive

Welcome to the Quality Report for Derbyshire Healthcare NHS Foundation Trust.

Quality is what we are all about and as I visit the different services our Trust provides I see first-hand the pride felt by colleagues in the quality of care being delivered on our wards and in our teams.

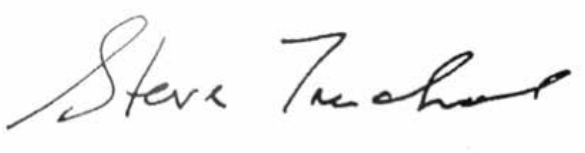
This document includes information on how we have performed against the priorities we set out in last year's report and identifies those areas of work we will make our priority going forward. The document provides us with the opportunity to demonstrate some excellent examples of good quality care at the same time as recognising we have other areas where we want to improve further. We have, where possible, benchmarked our outcomes against those of other community and mental health providers and compared our performance with previous years.

During 2014/15, we have not received an inspection from the Care Quality Commission. This may be in part due to our low level risk rating at this time. We have continued to undertake quality visits to all wards and teams annually. The purpose of these visits is to be confident of a clear link from the Board to ward and for this programme to assist as one small part in being assured of the quality of care being provided to the people of Derbyshire. I would like to take the opportunity to thank our governors and commissioners for their valuable contribution to the quality visit programme.

We continue to work with our service receivers, their families and their carers to hear their feedback on what they think of our services. In the autumn of 2014, we were delighted to open our doors to Healthwatch Derby. They were able to spend time with some of our crisis teams and visited ward areas, school nursing and health visiting teams. A summary of their findings is included in this document.

I would like to take this opportunity to thank everyone who has worked collaboratively with the Trust over the year to make improvements to the quality of our services and also to those who have helped shape our priorities for the forthcoming year. This includes our service users and their carers, our staff and our partners across the communities we serve and our commissioners for their input, support, feedback, scrutiny and challenge, which has been greatly appreciated.

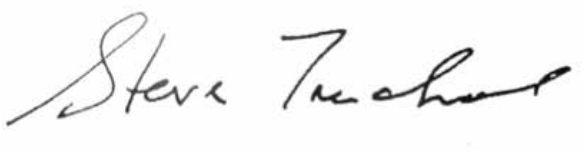
I confirm that to the best of my knowledge, the information contained in this document is accurate. It will be audited by Grant Thornton, in accordance with Monitor's audit guidelines.



Steve Trenchard
Chief Executive
22 May 2015

Statement of accuracy
I confirm that to the best of my knowledge the information contained in this document is accurate.

Steve Trenchard



Chief Executive

Independent auditors' limited assurance report to the Council of Governors of Derbyshire Healthcare NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Directors and Council of Governors of Derbyshire Healthcare NHS Foundation Trust to perform an independent limited assurance engagement in respect of Derbyshire Healthcare NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital
- Admissions to inpatient services that had access to crisis resolution home treatment teams.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditor

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual' issued by Monitor.

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 is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'
- The Quality Report is not consistent in all material respects with the sources specified in Monitor's 'Detailed guidance for external assurance on quality reports 2014/15', and
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports 2014/15.'

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual', 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:

- Board minutes for the period 1 April 2014 to 29 April 2015
- Papers relating to quality reported to the board over the period 1 April 2014 to 29 April 2015
- Feedback from Commissioners, dated 30/04/2015
- Feedback from Governors, dated 19/05/2015
- Feedback from local Healthwatch organisations, dated 30/04/2015
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/04/2015
- The national patient survey, dated 18/09/2014
- The national staff survey, dated 24/02/2015
- Care Quality Commission Intelligent Monitoring Report, dated 04/03/2015
- The Head of Internal Audit's annual opinion over the Trust's control environment, dated 28/04/2015 and
- Feedback from the Health and Well Being Board, dated 07/05/2015.

We did not test the consistency of the Quality Account with feedback from the Overview and Scrutiny Committee involved in the sign off of the Quality Account as the draft Quality Account was sent to them for comment, in accordance with the timetable specified in the Regulations, but no response has been received at the time the quality accounts were signed. We have considered the consistency with the other specified documents and are satisfied that there is no material risk of misstatement arising from this omission.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Derbyshire Healthcare NHS Foundation Trust as a body and the Board of Directors of the Trust as a body, to assist the Board of Directors and Council of Governors in reporting Derbyshire Healthcare 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 2015, to enable the Board of Directors and 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 Board of Directors as a body, the Council of Governors as a body and Derbyshire Healthcare NHS Foundation Trust for our work or this report, except 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'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Analytical procedures
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual' to the categories reported in the quality report and
- Reading the documents.

A limited assurance engagement is smaller 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 affect 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 of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual'.

The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Derbyshire Healthcare NHS Foundation Trust.

Conclusion

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 2015:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual';
- The Quality Report is not consistent in all material respects with the sources specified above; and
- The indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual.'

Grant Thornton UK LLP

Grant Thornton UK LLP

Colmore Plaza, 20 Colmore Circus, Birmingham B4 6AT
22 May 2015

Section 1

1.1 Key achievements in 2014/15

Some of our key achievements in 2014/15 that have contributed to the high quality of care we continue to deliver are as follows:

- On 13 August the Trust received the final report from our annual NHS Protect Quality Inspection which took place on 9 July 2014. The two areas focused on were 'inform and involve', and 'hold to account'. The Trust was pleased to receive the final report which awarded us a green rating for both of these areas. 11 elements were reviewed and we achieved a rating of green for all of the 11 elements.
- We received very positive Patient Led Assessments of the Care Environment (PLACE) results, with all categories scoring above the national average. Well done for the second year running to our estates and facilities staff.
- We received an excellent result from our Markers of Good Practice assessment with the majority areas scoring green, bar one partial improvement area in cleaning toys in the domain of safety, for outreach Health Visitor clinics in non-Trust buildings. This is the safeguarding children's external assurance inspection. The self-assessment Section 11 audit tool is designed to help organisations assess where they need to improve their safeguarding arrangements, or standards, and to ensure the work they undertake with children and young people up to the age of 18.
- On 5 September 2014 the Trust was cited in the HSJ Top 100 best employers in the NHS. To compile the list, Best Companies Group used NHS staff survey findings to analyse each organisation across seven core areas, which included corporate culture and communications; leadership and planning; and role satisfaction.
- We worked with community partners led by Hardwick Clinical Commissioning Group, with police, local authority and partner agencies to sign up to a crisis concordat. This is a multi-agency plan to ensure people in crisis get the right care when they most need it. Derbyshire was confirmed as 'green' (fully compliant) on its crisis care concordat submission and action plan. We were congratulated by Norman Lamb, the then Minister of State for Care and Support. Of particular note were the Derbyshire plans to provide mental health first aid training in the community sector and the focus on housing and accommodation for people serious long term mental health conditions.
- We have discharged our duties under the National Quality Board guidance published in November 2013 on safer staffing. We produce a monthly report which is scrutinised by our Board which looks at actual versus planned staff, shift by shift; where capacity falls below what we require to deliver high quality services, an explanation is provided as to why this has occurred. We have live reporting from our inpatient areas on our staffing levels, which we update on the Trust internet page three times per day. We are taking a proactive approach to the nursing and allied health professional vacancies we have in some areas. On 24 February 2015, our Director of Nursing and Patient Experience attended a national conference at the O2 arena in London entitled 'The Future of Mental Health Nursing' to meet hundreds of newly qualifying student nurses with a Trust stand and resources available describing our Trust. This has been coupled with in-reach recruitment events into universities in the Midlands to promote working in the Trust. We have also engaged a recruitment consultant to undertake online promotion of our Trust directly linked to our employment opportunities.
- We completed clinical and professional leadership reviews including refreshing our Nursing Strategy and we hope to develop our allied health leadership work in early 2015. We have proposed our Positive and Safe Strategy, building upon a number of years' work, to create an open culture to minimise and substantially reduce restrictive practices in our Trust, which we are adjusting following staff feedback.
- The Derbyshire Association of Family Therapy hosted its conference 'Working Systemically with People with Learning Disabilities' at the University of Derby and had its largest meeting with over 100 people attending. This is an important collaboration with the university and a unique model whereby NHS Trust staff work into the university to deliver a highly respected course.
- In May 2014 Derby City and Derby County Health and Wellbeing Boards both agreed for a Derbyshire-wide commissioning group to be established to commission joined-up and integrated children's services.
- In January 2015 we hosted a national suicide prevention conference. This is part of our work to improve our clinical practice in suicide prevention and engage the wider health community in this work.
- We have signed up to 'hello my name is' initiative. This national campaign, founded by Dr Kate Granger,

encourages and reminds healthcare staff of the importance of introductions, compassion and person-centred care in all aspects the delivery of care.

1.2 How we did in 2014/15

In our Quality Report for the financial year 2014/15, we said we would:

Priority 1
Continue our work to improve the physical healthcare of our patients.

Priority 2
Develop our work to reduce suicides wherever possible, so that individuals and their families and friends do not have to experience this tragic and distressing outcome.

Priority 3
Safely reduce the use of restrictive practices, including seclusion, on our acute inpatient wards through our work on the national programme of 'Force Free Futures'.

Priority 4
Develop, refine and renew our focus on clinician and patient reported outcome measures.

Priority 5
Hear the voice of our patients and implement the national Friends and Family Test.

Priority 6
Build on our work to ensure all services Think! Family – that is, take a whole-family approach to providing care.

Priority 7
Implement a true recovery model, where health professionals recommend care pathways and options for individuals to weigh up and decide upon the best route for them, making an informed choice about how to best meet their individual needs.

Progress in 2014 /15 to achieve our priorities

It would be impossible to set out the detail of all we have done to achieve these priorities in this financial year. However in the next section we have set out a brief summary of some of the key work we have undertaken. We have included examples of how these priorities have shaped our thinking and how our operational services have implemented them, resulting in improvements for our patients.

Priority 1

Our work to improve the physical healthcare of our patients in 2014/15

We chose this as a priority for 2014/15 to bring our focus on the strong link between our good physical health and our mental health and wellbeing.

> *"People with poor physical health are at higher risk of experiencing mental health problems and people with poor mental health are more likely to have poor physical health."*
>
> (NHS England Parity of Esteem Programme, 2014).

Data relating to the quality of our care was reviewed and compared with national data from the Royal College of Psychiatrists' National Audit of Schizophrenia. In 2014 the results indicated that, although feedback from patients on their experience of care was positive, monitoring and interventions for physical health risk factors and problems was still below what should be provided.

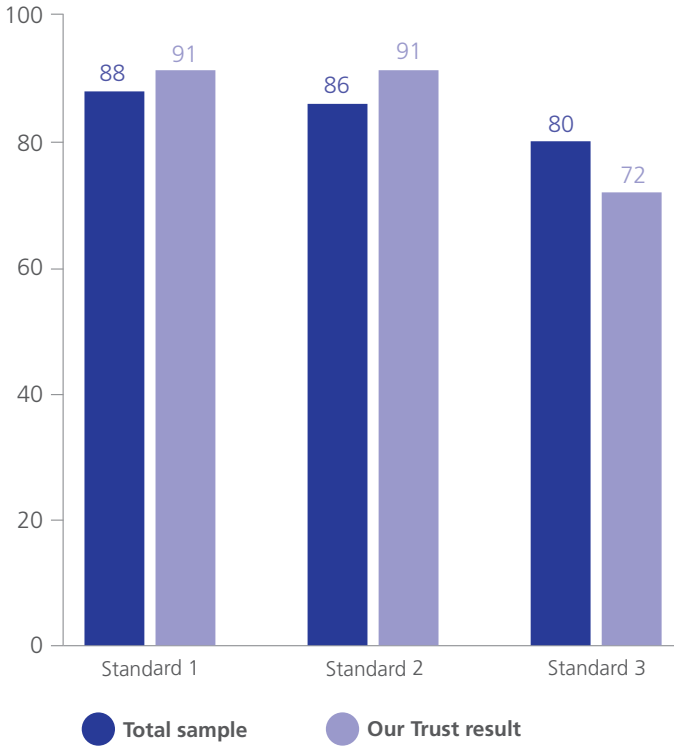
Our results indicated poor monitoring of body mass index (BMI), glucose control lipids and blood pressure. Intervention for elevated BMI, blood pressure and alcohol consumption was poor also. Based on these results, this indicator will remain a priority for 2015/16 and will be monitored and measured by our Quality Committee, who will receive updates on the action plan agreed as a result of the audit. Members on the Physical Healthcare Committee will lead this work.

National Audit of Schizophrenia 2014 results

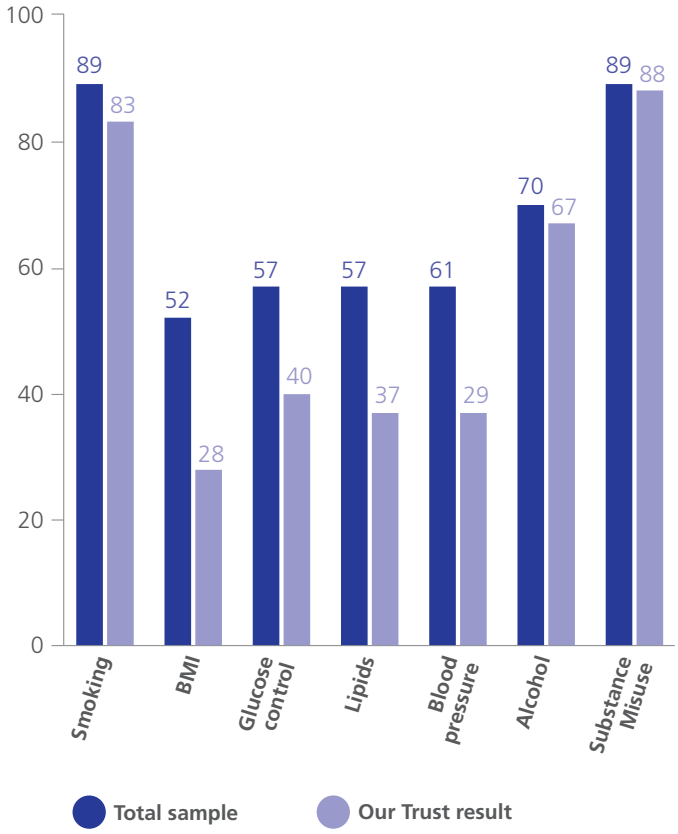
What our patients and carers told us

As part of the audit, NHS trusts were required to send out 200 patient surveys. We had 68 surveys returned by patients and 30 returned by carers on behalf of patients. Patients reported higher levels of satisfaction than the national average from the sample, 3% higher on satisfaction and 5% higher in terms of positive outcomes as a result of our help. Carers however were less satisfied. We plan to work with our carers in 2015/2016 to understand how we can ensure they have the right support and information.

Our results by standard



Standard 1	Proportion of service receivers reporting that they were satisfied with the care they received over the last 12 months.
Standard 2	Proportion of service receivers reporting that services had helped them to achieve good mental health in the last year.
Standard 3	Proportion of carers reporting satisfaction with the support and information they have been provided within the last 12 months.



Standard 4	results of our monitoring of physical health risk factors The audit of practice required 100 sets of notes to be reviewed for each standard. We returned 99 results.

Actions to improve the physical healthcare of our patients include:

- In 2014 we completed work on our inpatient wards to build on the evidence base provided by the Lester UK Cardio Metabolic Risk factor model, which provides a framework to identify likely physical risk and tailor interventions to address those risks. This work will be continued in 2015/16 and it is anticipated that it will help us improve the monitoring of the risk factors as it becomes custom and practice on all our inpatient wards.
- Members of the Physical Healthcare Committee are involved in a project to enable our services, particularly our community services, to be able to record and

interpret ECGs (electrocardiographs). This would be from commencement of a prescription and we would support the transition to physical healthcare monitoring to our primary care colleagues, so that our patients can have equal access to services in their community to monitor their health. Being able to take these important diagnostic/screening procedures is a key requirement of a number of evidence-based best practice standards, namely in this context around the initiation and monitoring of anti-psychotic medication in line with NICE guidance on the treatment of psychosis and schizophrenia (clinical guideline 178 2014).

- Our Board of Directors has agreed to adhere to the NICE Guidance on Smoking Cessation in Secondary Care (NICE CG48 2013), and the planning work for this is beginning. Advanced smoking cessation training will be delivered specifically for mental health clinical staff, considering the specific treatment needs of those receiving treatment for mental illness or substance misuse, so they have evidence-informed knowledge of contra-indications with mental health medicines. Service receiver-designed education on what helps and what is myth in this work is key to our aspirations to become smoke free. Training for clinical staff in the form of e-learning has been secured and is available.
- Other work in 2015/16 will focus on physical healthcare skills of nursing staff, both in inpatient wards and community settings. A list of required key practical skills has been developed by the Physical Healthcare Committee, which has been supported by the Nursing Leadership Group, and the committee will now make recommendations about how this is delivered, engaging with the Training Board on delivery.

Working in partnership to improve the health of people with learning disabilities

Our Learning Disability (LD) Strategic Health Facilitation Team has been involved in a number of initiatives this year, all to improve health outcomes for people with learning disabilities. They have recruited a number of volunteers with learning disabilities to support 'health action plan' checks in care homes. The model of training for the volunteers is being adapted by Derbyshire Healthwatch to use as part of their 'enter and view' checks.

The LD Strategic Health Facilitation Team has created a cancer screening pathway alongside GP and public health colleagues, which has been used by GP practices in the Hardwick CCG area. In addition to supporting the local area commissioners/Derbyshire GPs with physical health checks for adults with learning disabilities, the team have organised training for local opticians and delivered workshops at conferences arranged by NHS England. They have raised the profile of healthy living and obesity issues for people with learning disabilities and this has resulted in both Derby City and Derbyshire County Councils making specific plans for people with learning disabilities as part of their commissioning of healthy lifestyle services. In addition, the team has been instrumental in recruiting physical health champions from within the Trust, and has been central to the delivery of the Royal Society of Public Health (RSPH) course to a number of staff within LD and mental health services. The team has played a major role on behalf of Hardwick CCG and our local authorities in gathering data for the Learning Disability Self-Assessment Framework.

Priority 2

Suicide prevention

We chose this as a priority in 2014/15 and will continue to do so in 2015/16, showing our continued commitment to reduce, wherever possible, this tragic and distressing cause of mortality for individuals and their families and friends. Data is reviewed on serious incidents monthly by the Quality Committee.

We have completed a programme of work in 2014/15 which culminated on 30 January 2015, when the Trust held a national conference on suicide prevention. This was well attended by people from various organisations nationally including; public health, service receivers, State of Mind and other NHS trusts. **The aim of the conference was to:**

- Inspire, motivate and enthuse clinical staff in suicide prevention work
- Demonstrate how the principles are applicable to day-to-day clinical practice
- Launch the Connecting with People risk assessment training for our clinical staff following its successful pilot
- Engage the wider Derbyshire health and social care community in suicide prevention work.

The event had keynote speakers who are nationally recognised specialists in approaches to suicide prevention. Other speakers included staff from the Mersey Care NHS Trust which is implementing a 'zero tolerance to suicide' based on the Detroit model for suicide prevention. The event demonstrated that the Trust's Preventing Suicide Strategy Group chaired by Dr Allan Johnston (Consultant Psychiatrist) and Catherine Ingram (Chief Executive Officer, Derbyshire Voice) is working with national leaders and other trusts to pioneer innovative approaches to suicide prevention, including collaborative working with service receivers, positive risk taking and safety planning.

Following the conference, the Trust has worked with Derbyshire County's Health and Wellbeing Board to re-establish the Derbyshire-wide suicide prevention group which is composed of public health representatives in partnership with key providers and community partners.

We also have a suicide prevention strategy working group. The working group has a membership reflective of clinical, operational and strategic membership with key representatives from the service receiver organisation, Derbyshire Voice. The work of the group over the next 12 months will focus on the development of the capabilities and competencies of our workforce, through training working in partnership with our quality leadership teams. Emphasis has been placed on meeting the needs of the local population and gaining robust and effective feedback through patient experience. This will ensure that any training developed meets the needs of the population that we serve.

As part of our quality agreements with commissioners, our work on suicide prevention remains a priority, with a different emphasis this year into patient safety planning and a Trust-wide roll out of this approach led by our Medical Director. Progress is monitored by the Quality Assurance Group, which is our quality forum with commissioners, and by our Quality Committee and Board of Directors.

Priority 3

Positive and proactive care

Our Trust made this a quality priority in 2014, prior to the release of the Department of Health's positive and proactive care guidance in April 2014. **We chose this as a priority because:**

> *"Alongside national policy, feedback from our patients is the biggest driver for our changes in the Trust, to ensure that we are acting upon what people say and developing our services in line with patient wishes."*
>
> Carolyn Green, Director of Nursing and Patient Experience, 'Positive and Proactive Care: Reducing the Need for Restrictive Intervention in our Trust', February 2015

Members of the Trust's Positive and Proactive Care Strategy Group, made up of clinical staff and staff who specialise in risk and assurance, training, and moving and handling, produced a strategy entitled 'Positive and proactive care: reducing the need for restrictive intervention in our Trust'. The work, being led by the Director of Nursing and Patient Experience, Carolyn Green, aims to minimize the need for staff to restrain people who are in our care. We aim to work with our staff, and our partners in the community including Derbyshire Voice, Mental Health Action Group, clinical commissioners, social care and police. The strategy sets out our two-year plan to reduce the need for restrictive intervention in our Trust.

Some feedback from our staff who have commented on the draft strategy:

"I found it very compassionate and comprehensive. I wonder whether having wards constantly locked would be part of this policy? I know that when it happens patients find this very restrictive and disempowering."

"I wanted to highlight the work we are doing in the Trust signing up to the reverse commissioning pilot. This work is linked to ensuring equitable and appropriate interventions, treatments and outcomes for BME service receivers… can we link this work?"

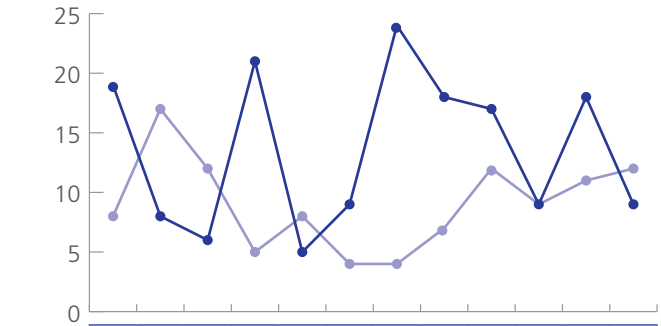
"On the whole it looks good, could it be less instructive and more inclusive?"

"Can we please remember restrictive practices is also about chemical restraint too?"

All comments, including those above, are being incorporated into the revisions of our work and our ongoing progress in our Trust quality priority.

Data reviewed as part of this work includes the number of seclusions, incidents of restraint and in a prone position (lying face down on the floor), in particular, which can sometimes be associated with patient safety concerns. Our Mental Health Act Committee annual report compares the number of seclusions over the two years as follows:

Seclusion incidents per month



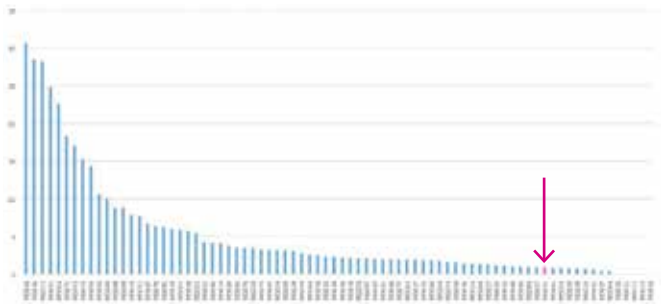
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	jun	Jul	Aug	Sep
2012/13	19	8	6	21	5	9	24	18	17	9	18	9
2013/14	8	17	12	5	8	4	4	7	12	9	11	12

	2012/13	2013/14
Mean	13.6	9.1
Median	13	8.5

Overall seclusion incidents are reducing; September 2012 to September 2013 saw 163 seclusion incidents. In comparison, September 2013 to September 2014 saw 109 seclusion incidents.

National benchmarking available on restraint indicates that our Trust is a low user of this practice. Derbyshire Healthcare NHS Foundation Trust is marked in red (RESO21), nine bars along from the end.

Incidents of Restraint per 10 beds (August 2014)



(This information has been provided by the NHS Benchmarking Network December 2014).

The Quality Committee will monitor and measure progress to achieve the outcomes set out in the strategy. Progress will be included in the monthly quality position statement to the Trust Board and regular reports will be provided to the Quality Committee.

Trust hosts national nursing workshop on improving acute care

The Trust's Centre for Research & Development in Derby hosted a national nursing workshop on 17 June 2014 called 'Supportive Observations', with guest speaker Len Bowers, Professor of Psychiatric Nursing at Kings College London. The workshop was organised by the Mental Health and Learning Disability Nurse Directors' and Leads' Forum, and focused on acute care and the Safewards initiative.

Professor Len Bowers (second from left) attended a national nursing conference at the Centre for Research & Development in June 2014 to speak about Safewards

Len Bowers said afterwards: "It's always heartening to come to a new place and see a new collection of people and find out that they're really committed to improving their practice and making things better and safer for patients. It was also exciting and humbling to find out that my team's research is being used by nurses across the country – we wouldn't get to know that without events such as these."

Priority 4

Improving outcomes for our patients

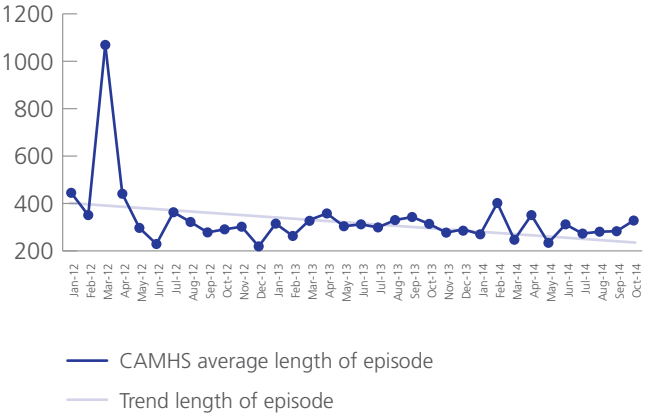
We continue to work on monitoring and improving outcomes as identified as a 2014/15 clinical priority. We continue to choose this as a priority as evidence that we are making a difference for our patients. We review data from the information collected through the National Tariff Payment System (formerly Payment by Results) approach to help in planning the future of Trust services.

The focus for 2015/16 will be to establish additional care pathways across Trust services and make the information accessible to service receivers, carers and other stakeholders. **Two examples of how services are progressing are set out below:**

- Child and Adolescent Mental Health Services (CAMHS) – reduced length of time in treatment
- In CAMHS, our staff are using clinician reported outcome measures to inform improvements in practice, leading to reduced length of time in treatment.
  The principles have been achieved by:
  - *Listening to the service receiver through their self-directed goals and the use of patient reported outcome measures*
  - *Shared decision making with the service receiver when planning their care*
  - *Everyone working together*
  - *Getting the planning of care right.*

Indications are that this approach leads to reductions in length of stay in service:

CAMHS average length of episode
(includes March 2012 outlier)



Learning disabilities – service satisfaction surveys

Psychologists in our learning disabilities service have produced a patient-reported outcome measure (PROM) and patient-reported experience measure (PREM) to obtain service satisfaction data from service receivers.

User-friendly graphics were developed and checked with a focus group of people with learning disabilities, whose ideas were incorporated into the finished measures. Psychologists have successfully been using the measures and analysis of 94 questionnaires showed 79% felt better after interventions, with 100% reporting that they would come and see a psychologist again if needed.

Priority 5

The Friends and Family Test

Since April 2013 the national Friends and Family Test (FFT) has been rolled out across acute trusts, accident and emergency departments and maternity services. In January 2015 the test was extended to GPs, and community and mental health trusts. The FFT question asks people if they would recommend the services they have used and offers a range of responses and the opportunity for free-text comments. It provides a mechanism to highlight both good and poor patient experience.

In response to the comments provided by the Friends and Family Test, services respond through a 'you said, we did' mechanism. An example is set out below:

You said:

We did:

Ward 33 are piloting a 16 week dance movement psychotherapy course which is receiving very positive feedback from the patients. This will be evaluated once the pilot is complete.

The 'Friends and Family Test' is just one way in which we hear from the people who use our services. In early 2015, we introduced 'your feedback cards'; these set out how people can provide us with feedback, including signposting to Healthwatch Derby and Healthwatch Derbyshire, our own website, the Friends and Family Test and NHS Choices.

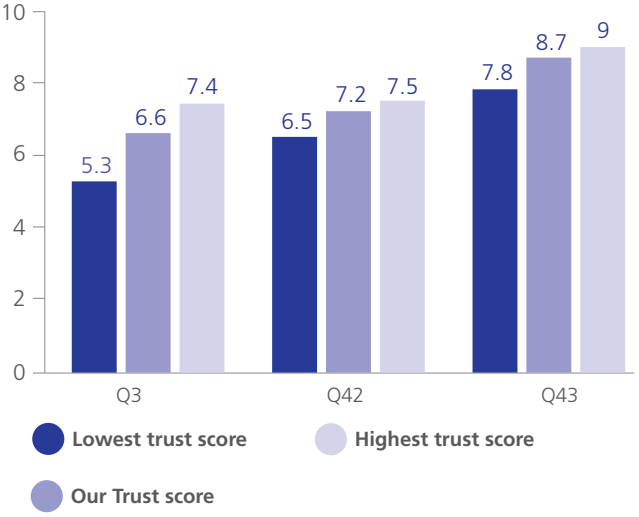
Each year, trusts that deliver mental health services are required to undertake the national community patient survey. This survey enables us to compare what people think about the care and treatment provided by our Trust with the views of care and treatment provided by the 56 other trusts that have been involved in the survey.

In 2014, the survey questionnaire was changed to reflect changes in practice and service delivery and therefore the results are not comparable to previous years. 279 people responded to the survey.

Mental Health Community Mental Health Survey: Our results in 2014

Our overall score

The report shows how our Trust scored for each question compared to other Trusts. The score is out of 10, with 10 representing the best possible score.



Q3	In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?
Q42	Overall care
Q43	Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

Section scores

A 'section score' is also provided as part of the survey data, with each question being grouped according to the section in the questionnaire. We scored in the 'amber' banding for each section, which equates to an average set of scores when compared to other trusts.

Section	Lowest trust score achieved	Our Trust score	Highest trust score achieved
Your health and social care workers	7.3	7.9	8.4
Organising your care	8.2	8.7	9.0
Planning your care	6.5	7.3	7.8
Reviewing your care	6.8	7.5	8.2
Changes in who you see	5.1	6.4	7.8
Crisis care	5.4	6.6	7.3
Treatments	6.7	7.2	7.9

The Patient Experience Group will be reviewing all feedback received from national and local surveys and will report to the Quality Committee on the changes made as a result of the learning from this survey, to continually drive forward our clinical and patient experience in these areas.

Priority 6

Building on our work to ensure all services Think! Family

We chose this as a priority in 2014/15 to ensure our services are co-ordinated and focused on the whole family and to make sure Think! Family principles are a reality in day-to-day practice. **The data we reviewed was based on an electronic baseline self-assessment questionnaire which was piloted in in three areas:**

- Bolsover and Clay Cross Recovery and Pathfinder Service
- Chesterfield and High Peak Crisis Team
- Peartree Child and Family Team.

In total, 64 questionnaires were issued with a return of 49 (76.5% response rate).

The initial review of the completed questionnaires demonstrates an encouraging picture of staff's understanding of the Think! Family principles. It is apparent that staff are starting to 'think family' by applying these principles to their practice. Work has started on introducing the principles within practice over the last couple of years and evidently the culture is changing.

Our children's services, including the safeguarding children service, have successfully integrated themselves within the organisation, and this has helped the 'Think Family' approach to become embedded within the organisation too. A robust infrastructure has to be in place for the current 'Think Family' quality improvement agreement with our commissioners to be successful.

The four main areas of focus are:

- Training
- Supervision
- Assessment
- Information sharing.

Think! Family training is now an on-going rolling programme for all clinical staff. Teams will continue to demonstrate and share examples of best practice across the organisation and plans are in place to roll out the electronic baseline self-assessment questionnaire to the rest of the areas of the Trust in March 2015.

From April 2015, the establishment of a new board-level committee to monitor and gain assurance on safeguarding children, safeguarding adults and safeguarding families was proposed by the Quality Committee and agreed by our Trust Board of Directors. This committee will monitor and measure progress against this priority and will report to the Board, as well as setting the strategic direction for our organisation. This will include a renewed emphasis on carers, family inclusive practice and will include external partners including Healthwatch to advise and drive forward the important area of our services.

Priority 7

Implementing a true recovery model

The recovery approach is gradually being woven into our work throughout the Trust. The original national strategy to implement this approach amongst mental Health Trusts came from ImROC (Implementing Recovery through Organisational Change).

The first principle of recovery practice is that we have true co-production. Co-production means utilising the skills of people who use our services to inform practice and service development; this ensures we are moulding our services to reflect what people using the services need.

This includes roles for:

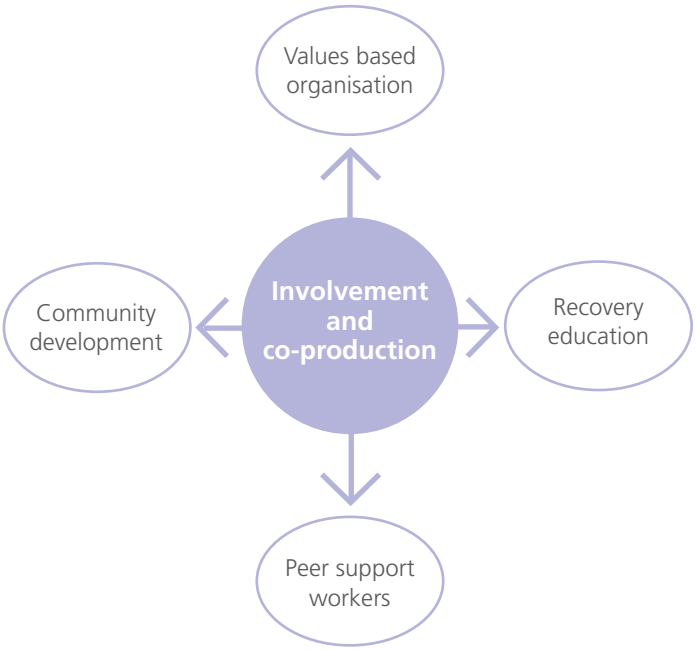
- People working as part of service development teams
- People working into services as part of the delivery team
- People working as peer support tutors in recovery education.

But more subtle changes which are embedded into services are just as important, and include:

- The use of recovery care planning routinely
- The use of self-directed goals for personal as well as clinical symptom recovery
- The routine use of recovery clinician-reported outcome measures in partnership and sharing equal importance with patient reported outcome measures on personal recovery goals.

The full development of clinical practices promote a balance of power, shared patient safety planning and shared decision making in the majority of care decisions.

Elements of recovery



Recovery practice will remain a quality priority for us in 2015/16 when we will concentrate on ensuring that our staff work within these recovery principles and our service receivers feedback that they are experiencing care that focuses upon their journey and their recovery.

As an organisation, we have a long journey to travel in terms of recovery orientated practice and this includes the expansion of the peer recovery workforce. We remain committed to this journey with our local communities.

Recovery education is and will continue to develop in each neighbourhood. It is intended that much of the recovery education prospectus will be populated by community resources, acknowledging that the neighbourhood itself is where there is most resilience and resource, whether that be personal or within communities.

Community development is essential and is very much about integration. Derbyshire Healthcare is part of the health and social care community and indeed should be responding to what people need from their teams and how that fits with other organisations and parts of the community. Not every question has a 'service' answer; many solutions are found by individuals and communities. This will involve our neighbourhood management teams and clinicians becoming increasingly community focused to be able to understand the assets the community has to offer, to signpost individuals and carers to non-NHS community education and befriending services to provide a more well-rounded support option (personal recovery) rather than a purely NHS care offer (clinical recovery). This would be a more holistic mental health and wellbeing plan and draw upon the assets of the community.

Progress will be monitored, measured and reported to the Quality Committee.

International mental health leaders hail Trust's "fantastic" commitment to compassionate care

Mental health leaders from Australia, Canada and Ireland carried out a day-long visit to the Trust's Kingsway site on 10 June 2014 as part of an exchange organised through the International Initiative for Mental Health Leadership (IIMHL). They spent the day learning about the Trust's approach to recovery and the use of compassionate-focused therapy, and the attempts of Derbyshire Healthcare staff to live the Trust values – such as by incorporating them into the recruitment process for new staff. One of the delegates called the day "amazing."

Angling 4 Health – using activity to support personal recovery

This is a recovery initiative to promote service receivers' participation in angling as a therapeutic activity, which is socially inclusive and beneficial in maintaining good mental health and relapse prevention. The national Angling Trust has recognised our work in this area. We are now working in partnership with our local fishing club the Earl of Harrington Angling Club.

Andy Holbrook and Leon – the Angling 4 Health project

Looking forward: our key priorities in 2015/16

Towards the end of 2014/15 we refreshed our quality strategy and framework. This enabled us to review our priorities for 2015/16. It was agreed that we would continue to build on our work from 2014/15 on the seven key priorities set out at the beginning of this section.

We have chosen these as priorities because we want to strengthen the work we completed in 2014/15, and bring stability as the transformation programme is implemented during 2015/16.

Our priorities for 2015/16 are therefore:

- Suicide prevention through patient safety planning
- Think! Family
- Physical healthcare
- Positive and safe including Safewards
- Recovery principles.

In addition, care planning remains a priority until we are confident we have got this right. Some joint working with the A&E department at Royal Derby Hospital is planned as part of our quality and innovation agreements with commissioners.

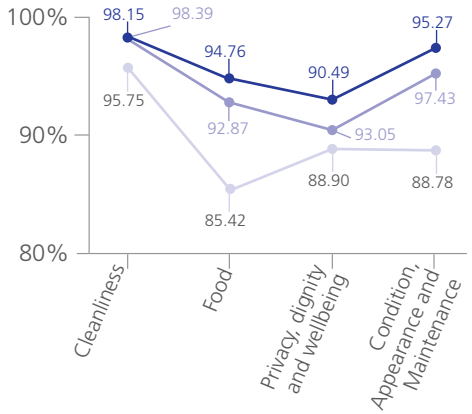
All priorities will be monitored by our Quality Committee and led by the Trust's Medical Director and Executive Director of Nursing and Patient Experience.

Working with our partners

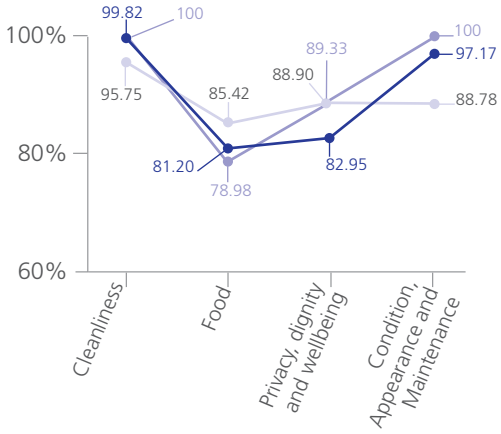
Our service receivers, families and carers

In 2013, Patient-Led Assessment of the Care Environment (PLACE) inspections replaced Patient Environment Action Team (PEAT) inspections. The new inspections are carried out by domestics, senior nurses, staff from our Estates department and service receiver representatives from Derbyshire Voice. The results this year showed continued strong performance across the Trust's inpatient sites:

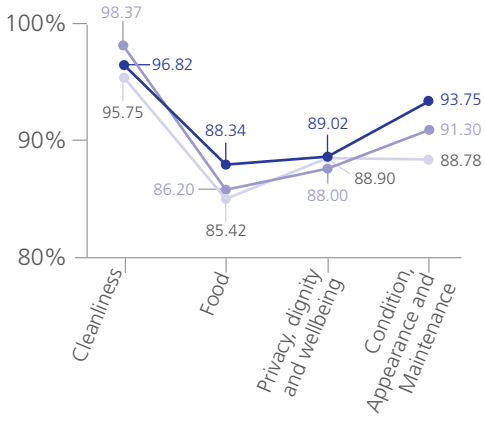
Radbourne Unit



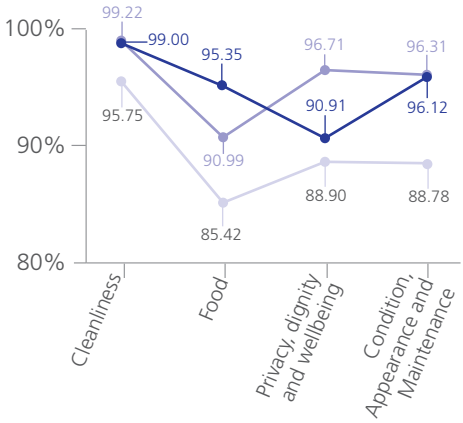
Wards 1 and 2, London Road Community Hospital, Derby



Hartington Unit



Kingsway Site



2014 **2013**
National average 2013

Working with carers and the Triangle of Care

Our membership of the national 'Triangle of Care: Carers Included' scheme has helped us to set and monitor standards for our work with carers. Our mental health inpatient and crisis services have all completed a self-assessment against 39 standards, and are working to improve their identification of and support for carers.

The Triangle of Care

The six key standards of the Triangle of Care state that:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter
2. Staff are 'carer aware' and trained in carer engagement strategies
3. Policy and practice protocols re: confidentiality and sharing information, are in place
4. Defined post(s) responsible for carers are in place
5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway
6. A range of carer support services is available.

During the year we produced a carers and families contact card and an updated carers and families handbook. We were awarded a 'highly commended' rating for our innovative work on information sharing and confidentiality. Families and carers sometimes say that they don't have the information they need to be able to help because staff can't share important information. The booklet Sharing Information with Families and Carers includes a 'self-carbonated' advance decision that families and people who receive our services can use to agree together about what information can and should be shared, both routinely and in an emergency.

Our innovative 'carers and cake' events were developed further with support from our commissioners, by having local events that give carers respite and link them to support agencies. These have been held by our acute mental health teams at the Radbourne and Hartington Units, and by our Outlook learning disabilities service led by our carers champions, in Chester Green with Derbyshire Carers Association, in Long Eaton with the Derby City and South Derbyshire Mental Health Carers Forum and in Chesterfield with the North Derbyshire Mental Health Carers Forum. Areas where we need to do more work include staff training in carer awareness.

Our 4Es Carers Group includes representatives of carer groups, staff, and partner agencies, and has developed a carer's journey through services. In December the group gave its annual report to the main 4Es stakeholder alliance, which included a powerful dramatization by carers and staff of an episode in a carer's life. This highlighted the need for good communication with families and carers, and was filmed so that it can be used in future staff training to continue to promote our families and carers as a key component of care.

We now have 'carers champions' in all mental health inpatient services and recovery teams, who continue to develop the network and have begun to make links with local carers groups and forums. They now have a clear role description and we have held two development sessions to support them, bringing in carers and partners to work with us. Our Radbourne Unit carers support group goes from strength to strength; a group is beginning at the Hartington Unit, and our older people's services run groups as well as an excellent series of events to support the carers of people with cognitive problems.

Carers and cake events provide respite support and signposting to wider services.

Our Core Care Standards audit showed that:

77%	of people we support had family or carers	92%	of whom we recorded their role and involvement
94%	of family/carers had information about who to contact	57%	of family/carers had information about what to do out of hours
53%	of carers felt there were appropriate agencies they could contact	67%	of family/carers were involved in planning care
9%	of service receivers refused to have family/carers involved		

Involving our patients in care planning

One of our key priorities in 2013/14 was to continue our work to improve service receiver involvement in care planning. Discussing the issues with service receivers, carers and staff, we identified the need for a simple flexible option to support involvement in care planning. To enable staff to involve patients more closely and effectively, we developed an innovative approach to care planning, using self-carbonated care plans in pads.

Although they have many positives, IT systems have tended to make service receiver engagement in care planning more challenging, with the in-built delay in typing up and sharing care plans. The 'self-carbonated' care plans allow staff to work on a plan together with the service receiver, agreeing the wording of the plan, and sharing a copy immediately. However, this has had mixed success in full adoption in service areas. We will therefore continue to refine and develop our plans in the forthcoming year. We look forward to designing our pathways in our electronic patient records and finding new and innovative ways of using advanced technology as a communication aid, to establish effective shared care planning approaches.

The Trust was awarded a 'highly commended' rating for the plans in the annual Care Co-ordination Association (formerly the CPA Association) awards for the category 'innovative systems to support an effective care process (IT or non IT)'. We have also been working to introduce a more effective Think! Family approach to how we record and share information about children.

Our annual Core Care Standards and Care Programme Approach Audit, across all our services, showed that:

91.5%	of people using our services had a current care plan	90%	of which included actions to promote recovery or wellbeing
		70%	included actions to promote a healthy lifestyle
89%	of care plans had involved the person (or their family)	95%	showed a person-centred approach
75%	of people were clearly recorded as being given a copy of their care plan	95%	of care plans took the person's diversity into account in providing care
91%	of people (or their families) who could be, were involved in reviews of care	95%	of care plans had a clear record of safety issues and risks.

This positive report would need to be counterbalanced by our community and inpatient survey which states that although we have improved in care planning, we still have a long way to go and sustained improvement to meet our aspiration to be above the national average for our clinical performance of our patients both knowing their care plan and being core to its design.

Our focus on informing and empowering people was recognised nationally with two national awards for the Core Care Standards app 'My CCS'. It won in the category 'excellence in providing information about the care process for service receivers and carers', while the My Plan feature on the Core Care Standards App won in the category 'excellence in the care process'. My Plan is available as part of the app, and enables people to develop their own recovery plan for staying well and managing their illness, including contacts for when they need more help. In addition, our Infolink resource directory has been reviewed, updated and expanded.

We have also expanded the information on care planning on our Core Care Standards website and added accessible information for people with a learning disability, as we now have a licence to use widget symbols more widely. We have added information to our 'need help' section, including extensive information on help with finance, food banks, social care, winter fuel, safety and other issues.

Your service, your say'

'Your service, your say' is an opportunity to support and enable service receivers to have their say and give feedback about the treatment and care they receive at the Hartington Unit.

Here are some examples of the feedback received through the scheme, and how we responded:

You said: "The hub needs new table tennis equipment."
We did: New bats, net and balls were purchased.

You said: "There is nowhere for drink to be put down in the courtyard."
We did: Purchased and fitted benches and tables.

You said: "I would like to use the gym more often."
We did: Opened the gym for all service receivers to access.

East Midlands Academic Health Science Network (EMAHSN)

We continue to work with the EMAHSN Patient Safety Collaborative and they have submitted this statement to be included in our quality account demonstrating our joint working.

Quality Account statement (2015)

EMAHSN (East Midlands Academic Health Science Network) has established a local East Midlands Patient Safety Collaborative (EMPSC) whose role is to offer staff, service receivers, carers and patients the opportunity to work together to tackle specific patient safety problems, improve the safety of systems of care, build patient safety improvement capability and focus on actions that make the biggest difference using evidence-based improvement methodologies.

The Trust is committed to working with the EMPSC and has pledged to contribute to the following emergent safety priorities:

- Discharge, transfers and transitions
- Suicide, delirium and restraint
- The deteriorating patient
- The older person: focussing on what 'good safety' looks like in the care home setting.

In addition we pledge to support the core priorities identified below:

- Developing a safety culture/leadership
- Measurement for improvement
- Capability building.

Working with Healthwatch

We continue to work with Healthwatch Derby and Healthwatch Derbyshire. Healthwatch Derby was given access to our services in the autumn of 2014, to see how we support people with mental health problems, people with learning disabilities and Derby's children and families. Healthwatch Derby staff were given the opportunity to observe Trust teams first-hand, shadowing the mental health Crisis Resolution and Home Treatment team over a 12-hour shift as well as the school nursing and health visiting teams. They also conducted two 'enter and view' sessions at the Radbourne Unit and on Wards 1 and 2 at London Road Community Hospital, to assess the care of adults and older adults experiencing acute mental distress and to collect the views of service receivers and carers receiving support from each service.

The collaborative 'Think Healthy' review also saw staff from both organisations promoting a questionnaire, and organising and attending face-to-face public feedback events including a trilingual workshop at the Indian Community Centre run in Punjabi, Hindi and Urdu.

In total 1,070 items of individual feedback were collected.

Now, the two organisations will continue to build on the close working relationship developed during the period of the review and work together to ensure that services are constantly changing and improving to meet people's needs. The Trust is launching a revised Patient Experience Committee that will act on the recommendations in the Think Healthy review and report back to Healthwatch Derby on its progress.

The report on the Think Healthy review included the following findings:

- Of those who responded to the Think Healthy survey, 70% rated the services they had accessed as fair to very good, 72% rated safety and care at the Trust as fair to very good and 70% rated the Trust's effectiveness of care as fair to very good.
- The Trust's Crisis Resolution and Home Treatment team, which intervenes to support people experiencing acute mental distress, "deals with each patient with empathy, dignity, sensitivity and support" – however because the team operates with handwritten notes "there is a delay in getting information back to base"; there is also feedback from individuals that there was a "long waiting time for counselling referrals" for patients.

- The Trust's health visitors "have a good rapport with mothers and babies they are supporting," "good provision of facilities" and the ability to "speak a variety of languages" – however some consultations "see the mother standing while the health visitor completes assessments and checks," while improvements could be made in terms of efficiency as "all notes taken are paper based."
- The Trust's school nurses "have a good rapport with children they are assessing, and good use of engaging and informative assessment formats."
- General feedback at the workshops indicated that people using the Trust services felt safe within the Trust, had positive patient experiences and benefited from good facilities – however there was also negative feedback about the use of out-of-area beds ("can be restrictive for carers and family members"), the need for "better cohesion between services" and "continuity of care", the need to travel to access services ("hinders and affects patient experience") and the "negative perceptions of the Trust" and of mental health in general.
- There was also some feedback that the Trust could do better in terms of breaking down "language barriers", while there is in some cases more work needed to expand and respond to feedback about a "lack of culturally appropriate services."

In addition we are building upon our foundations of this work to develop new innovative ways of working to meet the needs of our community which include adapting surveys to ask about the patient experience, particularly of service receivers who have been detained under a section of the Mental Health Act or who have experienced a restrictive practice. We are also working in partnership with Healthwatch Derby to represent the voice of the family and the child for our new board level Safeguarding Committee, where we are designing our new approaches and developments in family inclusive practice.

Healthwatch Derby undertook a series of workshops to collect the views of patients and carers using the Trust's services.

Help in a crisis

In 2014/15, we have worked with our partners at Hardwick Clinical Commissioning Group, the police, social care, local authorities and other agencies to sign up to the Crisis Concordat. This is a local agreement which sets out how we work together to make sure people in a mental health crisis get the help they need. Our plans demonstrate our commitment to our shared community approach to service design and delivery.

Our community patient survey results of 2014 includes questions asking patients for their views on getting help in a crisis. The score for the two questions is out of 10. We still have more work to do to ensure that everyone in our care knows how and who to contact in an emergency. Our recovery work is key to this issue, we will invest more time and emphasis on writing relapse signature plans, so individuals and those around them know what an individual's signs are, how to access help and that we communicate this to key partner organisations routinely.

Q21	Do you know who to contact out of office hours if you have a crisis?
Q23	When you tried to contact them, did you get the help you needed?

Section 2

Statements of assurance from the Board

2.1 Review of services

During 2014/15, Derbyshire Healthcare NHS Foundation Trust provided four NHS services from four locations, as registered with the Care Quality Commission. These are:

- Hospital and community-based mental health and wellbeing services
- Community learning disability services
- Substance misuse services
- Children and young people's services.

✓ Derbyshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in four service locations of our NHS services.

✓ The income generated by the relevant health services reviewed in 2014/15 represents 91% of the total income generated from the provision of relevant health services by Derbyshire Healthcare NHS Foundation Trust for 2014/15. The data reviewed covered the three dimensions of quality (see part 3 of the report).

2.2 Participation in clinical audits and national confidential enquiries

Nationally – four clinical audits and one confidential enquiry relevant to our services

During 2014/15, four national clinical audits and one national confidential enquiry covered relevant health services that Derbyshire Healthcare NHS Foundation Trust provides.

Nationally - four (100%) clinical audits and 100% confidential enquiries undertaken

During 2014/15 Derbyshire Healthcare NHS Foundation Trust participated in four (100%) national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries, which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Derbyshire Healthcare NHS Foundation Trust was eligible to participate in during 2014/2015 are as follows:

National clinical audits

1. Mental health commissioning for quality and innovation (CQUIN) 2014/2015 national audit: improving physical healthcare indicator 1
2. POMH-UK (Prescribing Observatory for Mental Health-UK): Topic 14a: Prescribing for substance misuse: alcohol detoxification
3. POMH-UK: Topic 9c: Antipsychotic prescribing in people with a learning disability
4. POMH-UK: Topic 12b: Prescribing for people with personality disorder.

National confidential enquiries:

1. National confidential inquiry into suicide and homicide by people with mental illness

The national clinical audits and national confidential enquiries that Derbyshire Healthcare NHS Foundation Trust participated in during 2014/15 are as follows:

National clinical audits:

1. Mental health commissioning for quality and innovation (CQUIN) 2014/15 national audit: improving physical healthcare indicator 1
2. POMH-UK (Prescribing Observatory for Mental Health-UK): Topic 14a: Prescribing for substance misuse: alcohol detoxification
3. POMH-UK: Topic 12b: Prescribing for people with personality disorder
4. POMH-UK: Topic 9c: Antipsychotic prescribing in people with a learning disability.

National confidential enquiries

National confidential enquiry into suicide and homicide by people with mental illness.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2014/15, 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.

Title	Cases required	Cases submitted	%
Mental health CQUIN 2014/15: improving physical healthcare indicator 1	100	97	97%
Topic 14a: Prescribing for substance misuse: alcohol detoxification	21	21	100%
Topic 12b: Prescribing for people with personality disorder	42	42	100%
Topic 9c: Antipsychotic prescribing in people with a learning disability	147	147	100%
National confidential inquiry into suicide and homicide by people with mental illness	9	9	100%

Review of five national reports resulting in improvements in quality of healthcare

The reports of five national clinical audits were reviewed by Derbyshire Healthcare NHS Foundation Trust in 2014/2015 and it intends to take actions to improve the quality of healthcare provided including the following:

National Audit of Schizophrenia (NAS)

This audit included an audit of practice as well as a service receiver and carer survey. **As a result of our participation in this second round of the National Audit of Schizophrenia and the review of the report, our practice will be further improved in:**

- Monitoring of physical health risk factors and particularly monitoring of BMI, glucose control, lipids and blood pressure
- Intervention for physical health problems for elevated BMI, blood pressure and alcohol consumption
- Availability and uptake of psychological therapies.

Actions that will be taken to achieve improvements in practice and therefore to improve the quality of care for patients will include:

- Gaining agreement across primary care with regard to shared care responsibility for monitoring the physical health needs of our patients
- Improving the monitoring of patients physical health risk factors by enabling teams to embed the LESTER tool for physical health monitoring, which is an intervention framework for people experiencing psychosis and schizophrenia
- Ensuring access to basic equipment for monitoring physical health risk factors
- Improving access to psychological therapies
- Providing training for staff to deliver psychological interventions through places on a forthcoming cognitive behavioural therapy (CBT) programme at the University of Derby.

Topic 4b: Prescribing anti-dementia drugs

As a result of our participation in this audit and review of the report, we have identified the areas for action to improve the quality of care provided to our service receivers. The audit results suggested that there is a low dementia presentation rate amongst ethnic minorities. This has led us to take action to increase dementia awareness amongst GPs, encouraging them to be more pro-active in seeking out these service receivers, as well as amongst Black and Minority Ethnic (BME) groups such as through faith leaders. We also held a Trust Bollywood event using the medium of movies to generate discussions around the dementia themes raised by a Bollywood film.

Nationally there was marked variation in the prevalence of anti-dementia drug prescribing across the 54 participating mental health trusts, so we are taking action locally to understand our decision process behind those cases where anti-Alzheimer drugs (AAD) were not prescribed to increase improvements in appropriate prescribing. We are investigating other actions in memory clinics to record discussion of service receiver/carer views around the prescribing of AADs and also recording of medication reviews routinely taking place, in order to ensure that appropriate blood tests and blood pressure,

pulse and electrocardiogram (ECG) checks are being performed in all cases before prescribing AAD. This is being aided by a locally developed checklist.

Topic 10c: Use of antipsychotic medication in children and adolescents

We have been participating in this national POMH-UK quality improvement programme which is addressing the use of antipsychotic medication in children and adolescents. The audit standards for this programme relate to the assessment of the benefits and side effects of antipsychotic treatment, which are relevant to all service receivers irrespective of diagnosis.

As a result of our participation in this audit we are implementing actions to continually improve our practice. We will ensure there is an explicit rationale for prescribing antipsychotic medication for children and adolescents. Pre-screening tests/measures will be documented before starting someone on antipsychotic treatment: these tests will cover weight/BMI, blood pressure, pulse, blood glucose/HbA1c and blood lipids. A review of therapeutic response and side-effects of antipsychotic medication will be documented at least once every six months – this review will include tests and measures of weight/BMI, blood pressure, glucose/HbA1c, lipids and assessment for the presence of extrapyramidal side effects.

To maintain compliance to the required standards, the clinical teams are implementing refined processes supported by newly developed local guidelines to achieve improved outcomes through the recording of all antipsychotic prescribing and reviews in children and adolescents. The introduction of these processes and guidelines will help ensure that all our patients are treated safely and effectively.

Topic 14a: Prescribing for substance misuse: alcohol detoxification

The Topic 14a baseline report which has been reviewed presents data on prescribing practice for alcohol detoxification conducted in acute psychiatric inpatient settings. The audit included service receivers who had been admitted to an acute adult or intensive care psychiatric ward in the past year (prior to March 2014) and who had undergone alcohol detoxification whilst an inpatient. This national audit of the management of alcohol withdrawal for mental health inpatients examines all aspects of clinical assessment and management against NICE guidelines and quality standards, with a view to implementing a nationally driven locally implemented quality improvement programme.

Our clinical teams have reflected on their performance data and generated action plans to implement improvements in this important area of practice. The quality of care we provide will be improved through reinforcing the application of our detoxification protocol. Feedback on performance to clinicians and particularly junior doctors is an important action to increase awareness, especially regarding completion of the drug and alcohol section of written documentation. To sustain awareness amongst each new intake of doctors, the junior doctor handbook and induction programmes are being updated. Other more specific actions are being taken to remind clinicians to undertake relevant blood tests, use of prophylaxis and monitoring for the physical signs and symptoms of complications. As intended by POMH-UK, this first national audit of alcohol withdrawal will provide a benchmark against which a continuous quality improvement programme can be developed nationally.

Topic 12b: Prescribing for people with personality disorder

We have participated in this audit and our clinicians have reviewed the report and are finalising the actions to be taken to change practice, where needed, and improve the quality of care provided. The audit reviewed against standards of reasons for prescribing antipsychotic medication be documented and a written crisis plan be in place which is accessible in the clinical records and which has been developed to incorporate the service receiver's views in the plan. Treatment targets audited included antipsychotic drugs not being prescribed for more than four consecutive weeks in the absence of a co-morbid psychotic illness; Z-hypnotics or Benzodiazepines not being prescribed for more than four consecutive weeks; and where medication is prescribed for more than four consecutive weeks, these being reviewed to take into account a) therapeutic response and b) possible adverse effects, and also c) be documented in the clinical records. Our final action plan will address the shortfalls identified so that improvements are demonstrated in subsequent audits.

Review of 16 local reports resulted in the following improvements

The reports of 16 local clinical audits were reviewed by Derbyshire Healthcare NHS Foundation Trust provider in 2014/15 and as a result, it intends to take actions to improve the quality of healthcare.

The actions we intend to take to improve the quality of healthcare provided include:

- **Management of patients with dual diagnosis**

  Department of Health guidance on 'psychosis with coexisting substance misuse' suggests that supporting someone with mental health illness and substance misuse problems, alcohol and/or drugs, is one of the biggest challenges facing frontline mental health services. This guidance also highlights that service receivers with dual diagnoses are at a higher risk of relapse, readmission to hospital and/or suicide. This audit was undertaken to provide information on the care of dual diagnosis service receivers within our recovery teams, with a focus on the assessment and management process. As a result of the audit, actions are being undertaken to improve these processes and deliver improvements in multi-disciplinary assessments that include physical healthcare requirements for people with mental health and substance misuse. Actions are also being taken to improve the recording of relevant information in healthcare records, as well as to improve the involvement of service receivers in their care plans. Actions are also being taken to explore opportunities for improved information sharing between different professions and agencies involved to improve the care of dual diagnosis service receivers.

- **Use of the ACE-III in the Derby City Older People's Community Mental Health Team**

  The Addenbrooke's Cognitive Examination - III (ACE) is one of the most popular and commonly used cognitive tests used in the assessment of dementia and of other neurological disorders. It provides a sensitive, reliable, secure and easy to administer clinical tool for teams to assess cognition as part of the process of assessing for dementia. As such it is widely used to screen for cognitive problems by our older people's community teams and in our memory clinics.

  As an updated version of ACE-III has been implemented, this audit was undertaken to assess the accuracy of scoring achieved by those using this relatively new version. Our clinical psychologists who undertook this audit have developed a handy prompt sheet for our clinicians to help them administer and score the ACE-III accurately. As a result of this audit this helpful prompt will be rolled out to all our services where this assessment tool is used, which is likely to result in improved quality of assessments.

- **Seclusion-post incident review involving nurses and service receiver receivers**

  This was an important Trust priority audit, undertaken as an area identified by our service receiver representatives to ensure that processes are followed consistently. The audit project was undertaken collaboratively with involvement from our service receiver representatives, who were actively involved in the content analysis of the audit. The results of this audit have informed the overall work of a wider working group aiming to improve restrictive practices and how our service receivers experience this component of our care.

  The action plan for improvements following the audit has included the development of ward admission packs, to be available to service receivers admitted to our inpatient units and their carers. This will provide information on the use of restraint and post-incident debriefing, including information on the specific rights of service receivers. The Trust policy has been updated to include good practice guidance for post-incident discussions, the need for documentary evidence of a patient-centred approach within any discussion or debrief following a seclusion incident, and the role of senior nurses or their deputies to ensure that a post-incident discussion or debrief is conducted with service receivers.

- **Benzodiazepine prescribing by psychiatrists on discharge from hospital**

  The published evidence suggests that benzodiazepines are psychologically and physically addictive so it is important that service receivers are not prescribed this medication for longer than absolutely essential. Therefore a Trust-wide clinical audit of benzodiazepine prescribing was completed to ensure ongoing quality of care is provided to our service receivers.

  A key criterion of the audit was that a service receiver's GP should be advised regarding benzodiazepines being stopped. The results of this audit showed that our practice in advising GPs had improved significantly as a result of the introduction of an approved template for discharge summaries following a previous audit. Benzodiazepine prescribing standards have also been

reinforced in the teaching sessions for junior doctors. In addition, further improvements are being explored when prescribing is high-dose, long-term or within a complex context, and around whether the outpatient prescriber could take responsibility for the review rather than making the request to the GP.

- **Non-pharmacological intervention prior to prescribing PRN (Pro Re Nata - the Latin for 'as needed') antipsychotic/benzodiazepine medication to service receivers diagnosed with dementia**

  People with dementia often experience behavioral and psychological symptoms of dementia such as aggression, agitation, loss of inhibitions and psychosis (delusions and hallucinations). These distressing symptoms can often be prevented or managed without medication. However, people with dementia can sometimes be prescribed antipsychotic drugs as a first resort and nationally the evidence suggests that around two thirds of these may be inappropriate.

  This audit was commissioned to ensure that the potential clinical risk of harm to patients from inappropriate prescriptions is prevented. The audit reviewed the use of non-pharmacological interventions prior to prescribing PRN antipsychotic/benzodiazepine medication to patients diagnosed with dementia. As a result, a new person-centred care planning approach is being developed in collaboration with a partner organisation involved in the delivery of care. A re-audit will be undertaken to ensure appropriate prescribing is improved and sustained for service receiver under our care.

- **North Derbyshire Dales community mental health multi-disciplinary team meetings – how productive are they?**

  The provision of services by a multi-disciplinary team (MDT) represents one of the quality indicators commonly used in the evaluation and comparison of mental health services, especially for community level services dedicated to people with complex needs. This audit was undertaken by one of our community teams to assess and identify areas for improving the team's productivity and effectiveness. Following the audit, improvement actions are being taken to develop efficient recording processes for decisions and actions agreed, and to plan and organise meetings in advance, to ensure effectiveness during meetings. Joint team ownership and responsibility is being tested through a rolling chair for the meetings, enabling all members to take the lead on a rotating basis. In addition, improvements are being made to ensure effective working with inpatient wards with community psychiatric nurse attendance at ward rounds; this helps to facilitate transfer-of-care arrangements between inpatient and community services for service receivers.

- **Appropriateness of referrals to SCoDAS (Social Communication Disorder Assessment Service) clinic**

  This re-audit reviewed service receivers (under eight years of age) seen for a diagnostic assessment for autism in the SCoDAS clinic. The audit showed some referrals were being made to SCoDAS because of a lack of confidence in diagnosing Autism Spectrum Disorder. As a result, action is being taken to provide training and development as well as sharing of good practice with referring clinicians. In addition, the feasibility and usefulness of a drop-in liaison meeting to discuss cases is being considered. As a result of these audits, it is hoped that there will be a reduction in inappropriate referrals and improvements in the appropriateness and quality of referrals to the clinic; this would reduce waiting times and enable timely diagnoses for service receivers who are referred to the service.

Other local clinical audit reports reviewed in 2014/15, which have either resulted in improvement actions being taken or planned to be taken to ensure that our service receivers benefit from continuous quality improvement of care and services provided, include:

- Management of acutely disturbed service receivers (previously known as rapid tranquilisation)
- Adult ADHD (attention deficit hyperactivity disorder) clinic in Chesterfield
- Lost cohort (due for follow up)
- Triangulated DNA (did not attend) audit; views of parents and doctors
- Physical health monitoring
- Inpatient multi-disciplinary meetings – risk assessments and reviews
- Quality of community paediatricians' clinic letters using Royal College of Paediatrics and Child Health-approved SAIL tool (Sheffield Assessment Instrument for Letters)
- PRN (Pro Re Nata - the Latin for 'as needed') protocols in residential settings
- Monitoring of patients prescribed lithium (local audit to supplement a national audit).

2.3 Participation in clinical research

1,140 service receivers who were receiving relevant NHS health services provided or sub-contracted by Derbyshire Healthcare NHS Foundation Trust were recruited to participate in research approved by a research ethics committee during 2014/15.

Some of the National Institute of Health Research (NIHR) portfolio studies we have hosted in 2014/15 include:

- **Evaluation of Memory Assessment Services (MAS): Main Study (Phase II) - London School of Hygiene & Tropical Medicine**

  25 of our patients with suspected dementia (whether definitively diagnosed with dementia or not) attending MAS for a first appointment, along with 25 of their lay carers, were invited to participate in this study. The study is an evaluation of MAS and aims to determine the impact of MAS on the health-related quality of life (HRQL) of people with dementia and their carers. Participants will be invited to complete HRQL questionnaires at baseline (when they attend their first appointment) and at the six-month follow up.

  There is an increasing challenge to meet the needs of people with dementia. The government is committed to ensuring that auditing the outcome of care takes into account the views of patients and, where relevant, their lay carers. This is a Department of Health-funded study to determine the effectiveness and cost-utility of MAS, the association with service receiver characteristics, and the cost-effectiveness of different types of MAS.

  In this study the chief investigator aims to recruit about 2,000 people with dementia and their lay carers from 80 clinics around the country.

- **Minocycline in Alzheimer's Disease Efficacy (MADE) trial – King's College London and South London & Maudsley NHS Foundation Trust**

  Alzheimer's Disease is a major public health issue and the imperative to discover and develop treatments that can stop or at least delay disease progression is clear. There is a substantial body of evidence to indicate that minocycline may be neuro-protective. Neurodegenerative diseases such as Alzheimer's Disease (AD). MADE is a multi-centre, randomised, controlled trial in very mild AD, which primarily aims to determine whether minocycline is superior to a placebo in affecting the disease course, over a two-year period, as measured by reduced rate of decline in cognition (Standardised Mini-Mental State Examination (SMMSE)) and function (Bristol Activities of Daily Living Scale (BADLS). 10 of our service receivers have already consented to take part in this trial.

- **Improving the experience of dementia and enhancing active life: living well with dementia (the IDEAL study) – Bangor University**

  The IDEAL study is a UK-wide study which started in January 2014. Over the first two years the study will recruit up to 1,500 people who have experienced changes in their memory or other thinking abilities, or in how they manage with day-to-day activities. They will be recruited from multiple sites across the country. 50 out of a planned 100 people with dementia are already participating in this study from our Trust. The findings of this study will provide an understanding of what helps people to live well with dementia and of the needs of those who are not managing to live well. In so doing, the research will help identify better and more effective ways of delivering care and support for people with dementia and primary (usually family) carers. These findings will allow the provision of vital information for people who are newly diagnosed with dementia, and their families, to help them to plan their lives. The research will also provide insights and evidence to support the development of dementia-friendly communities, identifying areas where even quite small changes at community level may significantly improve people's daily lives.

- **Predictive accuracy and clinical acceptability of risk scales for repeat self-harm – Manchester University**

  Suicide is a major public health, economic and clinical problem. The risk of suicide is elevated in people who have self-harmed. People who self-harm are also at increased risk of repeating the behaviour and are considered a key target group in order to reduce suicide rates in the UK. Risk scales are often a core component of clinical assessments following self-harm. The primary objective of this study is to determine how well different risk assessment scales, administered following self-harm, predict repeat episodes within six months. The secondary objective is to investigate clinicians' and service receivers' views on the use of these scales in routine practice. 97 of our patients have already participated in this study and

contributed to this important area of investigation. Eligible participants were individuals aged 18 years or over who are referred for specialist mental health assessment following an episode of self-harm. The initial list of centres participating in the study includes Manchester, Bristol, Oxford, Brighton and Derby.

- **Depression in adolescents and young adults who repeatedly self-harm (e-DASH) – East Midlands Collaboration for Leadership in Applied Health Research and Care**

  This study seeks to test whether a video or telephone-based remotely-delivered problem solving cognitive behaviour therapy (plus treatment as usual) is acceptable, clinically effective and cost effective compared to treatment as usual for adolescents and young adults with depression who repeatedly self-harm. Recruitment is taking place from mental health liaison teams at emergency departments of patients who are assessed by mental health services following an episode of self-harm. The intervention being tested is a problem-solving cognitive behaviour therapy (PS CBT) delivered remotely by video calling or telephone by a CBT therapist. The duration is around 10 sessions over approximately 12 weeks, plus treatment as usual, compared to a control group receiving treatment as usual only.

- **Lamotrigine and Borderline Personality Disorder: Investigating Long Term Effectiveness [LABILE] – Imperial College London**

  People with Borderline Personality Disorder (BPD) experience high levels of emotional distress and often experience other problems including negative feelings about themselves and rapid changes in mood. There are currently no medicines licensed for the treatment of this disorder. The objectives of this study are:

- To test whether adding lamotrigine, a mood stabiliser, to the usual care for adults with BPD improves mental health over a 52-week period, in comparison to a placebo control
- To examine whether the addition of lamotrigine to usual care for adults with BPD improves social functioning and quality of life, reduces the incidence of suicidal behaviour, and lowers the amount of antipsychotic and other psychotropic medication that people are prescribed, in comparison to a placebo control
- To compare the incidence of side effects among those prescribed lamotrigine, in addition to usual care for adults with BPD, in comparison to a placebo control
- To examine the cost, cost-utility and cost-effectiveness of adding lamotrigine to usual care for adults with BPD, in comparison to a placebo control.

  To date six participants from our Trust have consented to take part in this study.

- **Remote monitoring of Attention Deficit Hyperactivity Disorder (ADHD) symptoms using mobile phone technology - University of Nottingham**

  This study is being undertaken to explore barriers and facilitators to using mobile phone technology with children, adolescents and adults receiving care for ADHD under child and adolescent mental health services, paediatric services or adult mental health services. Eligible participants on this study include NHS staff, parents of children with a diagnosis of ADHD, children and young people aged 12 to 15 with a diagnosis of ADHD, and adults aged 16 and over with a diagnosis of ADHD.

2.4 Information on the use of the CQUIN (Commissioning for Quality and Innovation) framework

A proportion of Derbyshire Healthcare NHS Foundation Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between Derbyshire Healthcare NHS Foundation Trust and any person or body they 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 2014/15 and for the following 12-month period are available electronically on the Trust website.

Derbyshire Healthcare NHS Foundation Trust's income in 2014/15, conditional upon achieving quality improvement and innovation goals was £2,607,902. A monetary total received for the associated payment in 2013/14 was £2,632,893.

2.5 Information relating to registration with the Care Quality Commission and periodic/special reviews

Derbyshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and is registered with the CQC with no conditions attached to registration.

- The Care Quality Commission has not taken enforcement action against Derbyshire Healthcare NHS Foundation Trust during 2014/15.
- Derbyshire Healthcare NHS Foundation Trust has not participated in any special reviews or investigations during the reporting period.
- Derbyshire Healthcare NHS Foundation Trust's last inspection was on 11 September 2013. An inspection is due during 2015/16.

2.6 Information on the quality of data

Derbyshire Healthcare NHS Foundation Trust submitted records during 2014/15 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data.

- The percentage of records in the published data which included the patient's valid NHS number was:
  - *99.9% for admitted service receiver care (based on April 2014 – December 2014 published dashboard)*
  - *100% for outpatient care (based on April 2014 – December 2014 published dashboard).*
- The percentage of records in the published data which included the service receivers' valid general practitioner (GP) registration code was:
  - *100% for admitted service receiver care (based on April 2014 – December 2014 published dashboard)*
  - *100% for outpatient care (based on April 2014 – December 2014 published dashboard).*

2.7 Information Governance Toolkit attainment levels

Derbyshire Healthcare NHS Foundation Trust's Information Governance Assessment Report overall score for 2014/15 was 96% and was graded 'green – satisfactory.'

Derbyshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Derbyshire Healthcare NHS Foundation Trust will be taking the following actions to improve data quality: see 2.7.1 below.

2.7.1 Implementation of a data quality policy

The Trust's Data Quality Policy will continue to be implemented, with the following aims:

- To ensure that there is a shared understanding of the value of high quality data on improving service delivery and quality and outcomes of care
- To ensure that the focus of improving data quality is on preventing errors being made wherever possible
- To ensure that regular validation, feedback and monitoring processes are in place to identify, investigate and correct data errors when they occur.

2.8 Reports against a core set of indicators

2.8.1 Seven-Day Follow Up

Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: it calculates the seven-day follow up indicator based on the national guidance / descriptors:

Numerator: Number of service receivers on the Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care (QA).

Denominator: Total number of service receivers on CPA discharged from psychiatric inpatient care (QA).

Derbyshire Healthcare NHS Foundation Trust intends to take the following action to improve this, and so improve the quality of its services by continuing to work to maintain our performance and ensure that all service receiver care is followed up.

Indicator	End of 2013/14	End of 2014/15	National average	Highest and lowest scores
Percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period	97.94%	96.96%	97.2%	100% 93.1%

2.8.2 Crisis gatekeeping

Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: it calculates the crisis gatekeeping indicator based on the national guidance/descriptors:

Numerator: Number of admissions to acute wards that were 'gate kept' by the Crisis Resolution and Home Treatment teams.

Denominator: Total number of admissions to acute wards.

Derbyshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so improve the quality of its services: by continuous monitoring to maintain the high performance against this indicator.

Indicator	End of 2013/14	End of 2014/15	National average	Highest and lowest scores
Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	97.59%	100%	98.1%	100% 59.5%

2.8.3 28 day re-admission rates (aged 16 and over)

Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: it calculates the re-admission rates based on the national guidance / descriptors:

Numerator: Number of re-admissions to a Trust hospital ward within 28 days from their previous discharge from hospital.

Denominator: Total number of finished continuous inpatient spells within the period.

Derbyshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Monitoring and reporting pathways of care.

Indicator	End of 2013/14	End of 2014/15	National average	Highest and lowest scores
28 day re-admission rates for patients aged 16 and over	7.36%	7.92%	Not available	Not available

2.8.4 Staff recommending the Trust as a place to work or receive treatment

Our staff survey results for 2014 have seen a consolidation in how staff perceive the Trust as a place to receive care. In 2014, 68% of respondents felt that service receiver care was our top priority – although this shows a 3% reduction from 2013, it remains 3% better than the national average in response to this question.

The majority of our staff also said they would be happy for their friends or relatives to receive care from us, which is clearly an excellent reflection of the quality of care and values we hold as an organisation. Our score in this area was lower than the responses received to the same question last year and is now in line with the national average.

Similarly, a slightly higher number of people than average said they would recommend us as a place to work and that we always act on concerns raised by our service receivers.

The Trust has continued to emphasise with staff how to raise concerns and promote an open culture where staff can raise concerns. Some progress has been made, and we have had some positive feedback, but more progress needs to be made as this is a key indicator of a healthy organisation. Our concerns in this area were evidenced by the 2013 staff survey results. However the Trust has been identified by the Health Service Journal as being in the top 100 places to work in the NHS. As an organisation we will continue with perseverance and effort in this area of organisational development.

The Trust will continue to develop a highly engaged, compassionate and skilled workforce, focused on recovery. Our leaders will be empowered with the best tools to ensure the best delivery of service receiver care. In line with our values, our people development and organisation transformational work will always ensure that our people are at the centre of all changes.

As with all trusts, there are areas where improvements can be made. One of the areas where perhaps we have the most to do is the question around staff raising concerns. Only 64% of staff said they would "feel secure in raising concerns against unsafe clinical practice". Given that one of our values is about putting patients first, we need to understand how we can give staff more confidence so that they can 'speak up' without feeling anxious or fearful about what happens.

We will build on the new Raising Concerns at Work policy and make sure our Trust is open and receptive to those who ask questions about whether our clinical practice could be better.

Bullying and harassment is another area where there is continued concern. 32% of staff said they had experienced harassment, bullying or abuse from patients, relatives or public in the last 12 months; while 23% said they had experienced harassment, bullying or abuse from colleagues in the last 12 months. These figures are higher than the number of cases formally reported within the Trust, and they have not fallen since last year's survey and are slightly higher than the national average.

Over the forthcoming year we will run staff focus groups and listening events and try to promote and understand how we can keep staff safe and how we can build a culture amongst our workforce that is compassionate and caring, to each other as well as to those we care for. We will continue to work with staff side in these endeavours, until we have a culture that staff can routinely talk about problems, needs, pressures worries, solutions, innovations and aspects of their care that they are also very proud to showcase.

We will continue to encourage as many staff as possible to take part in the 2015 national NHS Staff Survey later this year.

Indicator	Trust score 2014	Trust score 2013	All mental health trusts average	All mental health trusts best score
Staff recommending the Trust as a place to work or receive treatment	3.60	3.68	3.57	4.15

2.8.5 Patient safety incidents and the percentage that resulted in severe harm or death

The Trust considers that this data is as described for the following reason: it is taken directly from the National Reporting and Learning System.

Patient safety incidents reported by Derbyshire Healthcare NHS Foundation Trust to the National Reporting and Learning System (NRLS) between 1 April 2014 and 30 September 2014.		Median rate
Patient safety incidents per 1,000 bed days	1,244 incidents reported during this period = reporting rate of 22.16 incidents per 1,000 bed days	Median rate for the 56 organisations in the cluster is: 32.82 incidents per 1,000 bed days (organisations that report more incidents generally have a better and more effective safety culture).

Degree of harm of the patient safety incidents reported to the NRLS between 1 April 2014 and 30 September 2014:

Degree of harm indicated as a percentage of the total number of incidents reported.				
None	Low	Moderate	Severe	Death
63.8% (794)	28.3% (352)	5.2% (65)	1.3% (16)	1.4% (17)

The Trust has taken the following actions:

- Design of the patient safety planning model
- Suicide prevention training for high risk areas and a defined training plan going forward
- The design of an SBARD (Situation – Background - Assessment - Recommendation - Decision) communication tool for information sharing with Police, and a new model for sharing information with families and carers
- Development and listening events for the neighbourhood and campus transformation model, to listen to our staff and communities about what they want to be different

- Our patient falls protocols and learning reviews from actual or near miss falls as well as our proactive assurance process for reviewing our inpatient setting ligature risks with the coupling of skills from Health and Safety and heads of nursing
- Having our pharmacist reviewing our clinical incidents involving medicines use; this has been a key asset in reflecting on and learning from our prescribing and administration processes
- Our biggest patient safety improvement project this year is our safe transition to a new electronic patient record system with full care pathway records; roll out is being driven by clinicians, patient safety and improvement in 2015/16.

Effective clinical risk management

Senior clinical and managerial staff continue to rigorously monitor the safety of services and work to improve the systems supporting clinical risk management. The Trust aims to provide a recovery oriented service that balances safety awareness with service receivers' rights to have care provided in the least restrictive manner.

2.8.6 Community patient survey results 2014

Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reason: it is taken directly from the National Community Mental Health Patient Survey of 2014.

Derbyshire Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so improve the quality of its services:

- By ensuring it continues to listen to service receiver feedback
- By putting actions in place to improve those areas where Derbyshire Healthcare NHS Foundation Trust has not received positive scores, as reported to the Quality Committee.

Indicator	Trust score 2013 (out of 10)	Trust score 2014 (out of 10)	Highest and lowest Trust score
Patient experience of contact with a health or social care worker during the reporting period	8.7	7.9	8.4 7.3

Section 3

Performance

3.1 Priorities set out in Quality Report 2013/14

This section provides information on achievements on the priorities agreed and set out in the Quality Report 2013/14. Please see part one of this report for further details.

3.2 Progress against selected quality indicators in 2014/15

The Trust in its 'ward to board' approach agreed a number of indicators at the beginning of the year as being common to all services. Performance against these indicators is monitored and reported monthly to the Board of Directors.

Trust performance dashboard	Target	End of year March 2014	End of year March 2015
Monitor targets			
CPA 7 day follow up	95.0%	97.94%	97.30%
CPA review in last 12 months	95.0%	96.52%	95.77%
Delayed transfers of care	7.5%	1.39%	1.45%
Data completeness: indentifiers	97.0%	99.42%	98.98%
Data completeness: outcomes	50.0%	97.77%	93.55%
Community care data - activity information completeness	50.0%	86.74%	89.93%
Community care data - RTT information completeness	50.0%	92.31%	92.31%
Community care data - referral information completeness	50.0%	74.10%	72.11%
18 Week RTT less than 18 weeks - non-admitted	95.0%	97.98%	96.13%
18 Week RTT less than 18 weeks - incomplete	92.0%	95.57%	95.77%
Early interventions new caseloads	95.0%	121.20%	100.00%
C. Difficile new cases (inpatient)	<7	0	0
Crisis gatekeeping	95.0%	97.59%	100.00%
Locally agreed			
CPA honos assessment in last 12 months	90.0%	93.17%	79.19%
CPA settled accommodation	90.0%	99.85%	99.37%
CPA employment status	90.0%	99.85%	99.55%
Data completeness: indentifiers	99.0%	99.42%	98.98%
Data completeness: outcomes	90.0%	97.77%	93.55%
Patients clustered not breaching today	99.0%	89.70%	82.94%
Patients clustered regardless of review dates	100.0%	98.24%	95.46%
7 Day follow up (all inpatients)	95.0%	97.57%	96.62%
Schedule 4 contract			
Consultant outpatient appointments trust cancellations (within 6 weeks)	5.0%	3.10%	5.44%
Consultant outpatient appointments DNAs	15.0%	14.21%	16.61%
Under 18 admissions to adult inpatient facilities	0	4	1
Outpatient letters sent in 10 working days	90.0%	61.68%	68.97%
Outpatient letters sent in 15 working days	100.0%	78.77%	83.36%
Average community team waiting time (weeks)	N/A	4.87	6.17
Inpatient 28 day readmissions	10.0%	7.36%	7.75%
Crisis home treatments	N/A	1,610	1,418
CPA review in last 12 months	90.0%	90.48%	95.77%
Assertive outreach caseload	N/A	253	266
Mixed sex accommodation breaches	0	0	0
MRSA new cases (inpatient)	0	0	0
Discharge fax sent in 2 working days	98.0%	99.76%	97.45%
Schedule 6 contract			
CPA settled accommodation	N/A	92.76%	90.93%

Comments on performance

Generally performance by the Trust during 2014/15 has continued to be good, with 25 of the 35 indicators exceeding the target level. A data quality strategy based on active monitoring and exception reporting supports the Trust in maintaining these levels. There are however 10 areas where the Trust is focused on improving our performance.

In October 2014 the Trust moved from CareNotes to a new electronic patient record system called Paris. The new system is very different from the old system in terms of its use and functionality. This transition has inevitably impacted on performance in a number of areas as it will take time for staff to get used to operating the new system and, as the system is developed over time, to improve its functionality. An improvement plan is in place and is closely monitored and escalated to the Board and is routinely discussed with commissioners at contracts meetings.

HoNOS assessment and patients clustered

Whereas in CareNotes a cluster review document was pre-populated with the previous HoNOS (Health of the Nation Outcome Scales) scores, including the historical scores which would not change, in Paris the clinicians had to complete a new cluster from scratch for each patient at every review, which impacts into the limited clinic time available. This continued to have a significant negative impact over several months. In March 2015 an improvement was made to Paris so that it now pre-populates the cluster review document. This should start to have a positive impact on clustering and HoNOS assessments over the coming months into the next financial year.

Data completeness: identifiers

At a directorate level, this target has been achieved by the urgent and planned care division, but not by specialist services. The reason for this is that, owing to the client group and environment in which people are seen by the Criminal Justice Liaison (CJL) and Street Triage teams in Specialist Services, it is very difficult to collect all the required data. For example, the CJL team see people in police cells, on a one-off basis, for only 15 to 20 minutes. The team will try to collect the data, however this can be very difficult as the mental state of the person is often aggressive or volatile. The Trust is looking into the possibility of linking to the NHS Summary Care Record in order to extract the data from GP records to improve the data completeness of these key teams.

Consultant outpatient Trust cancellations (within six weeks)

The Trust was under the target threshold for the first six months of the year, prior to the move to the Paris system. However since October, performance has been consistently over the target threshold. An audit undertaken in December identified that although it was necessary to cancel some appointments owing to consultant sickness, the vast majority of cancellations did not inconvenience patients and were a mixture of data migration issues and staff still learning a new system (specifically the appointment management process on Paris). The Trust continues to tightly control actual cancellations via a formal approval process. A further audit was planned in March 2015 to ascertain whether there are any staff still not using Paris correctly, to identify training needs, develop confidence and competence in our administrative workforce.

Consultant outpatient appointment 'did not attends' (DNAs)

A text message reminder functionality was added to the Paris system in February 2015. Over the coming months the Trust will be collecting mobile phone numbers from our service receivers and seeking consent to send text message reminders. Appointment reminders will then be sent to all consenting service receivers in an attempt to reduce DNAs. We have had emerging success with some personal reminder telephone calls in children's services and at the Hartington Unit outpatient team. We have received positive feedback from those using our service that a reminder call was helpful, supportive and had a positive human touch, compared to some less personal reminder systems in other care services. The Trust will be using choice and engagement to promote personal reminder services to continually improve effectiveness and efficiency. One service receiver experience reported at a 2015 quality visit panel that it was nice to receive some human contact and made her feel cared for.

Under 18 admissions to adult inpatient facilities

The Trust performance in this area remains strong.

One young person was admitted for one night and nursed in a side room on a one-to-one basis. This was part of a proactive safeguarding plan, reviewed by experienced CAMHS staff to prevent a less appropriate non-NHS environment being used in an emergency. This crisis response was managed effectively and in line with safeguarding children's procedures and with the active involvement of parents and social care. In an emergency situation NHS England was unable to immediately find a suitable specialist placement and this plan was appropriately activated in line with Trust procedures.

Outpatient letters

Over the last year, the Trust has implemented the use of digital dictation in order to speed up communication with GPs. It has taken time to roll out education for all consultants and medical secretaries. There have also been technical issues experienced with software and equipment. However, overall there has been a significant improvement, particularly towards the end of the year, which we endeavour to maintain and continue in an upward trajectory in 2015/16.

Discharge faxes

For eight months of the year, discharge faxes were on target. Where we experienced some delay, reasons given included:

- Awaiting pharmacy checking of medication
- Inadequate cover arrangements, particularly over holiday periods
- No ward administration, intermittent junior doctor cover, and high clinical activity
- Communication issues.

Action has been taken by individual ward managers to address these issues, to put in place practical workarounds and minimise the potential of these issues being sustained going forward.

3.3 Performance against key national indicators set by our regulators

As a Foundation Trust, we are required to comply with our terms of authorisation as set out in Monitor's Risk and Assurance Framework annually. Below is our progress against the indicators set out in the framework for 2014/15 (Appendix B) and the Department of Health's Operating Framework. The Care Quality Commission does not set any quality indicators. However, the Trust is required to comply with the standards of safety and quality under the Health and Social Care Act and Regulations Act. This information supports the Trust's ongoing status of being fully registered as a provider without any conditions.

Target or indicator	Target	2014/15	Achieved / Not achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	95.00%	96.13%	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	92.00%	95.77%	Achieved
Care Programme Approach (CPA) patients receiving follow up contact within 7 days of discharge	95.00%	97.30%	Achieved
Care Programme Approach (CPA) patients having formal review within 12 months	95.00%	95.77%	Achieved
Admissions to inpatient services had access to crisis resolution / home treatment teams	95.00%	100.00%	Achieved
Meeting commitment to serve new psychosis cases by early intervention teams	95.00%	100.00%	Achieved
Clostridium Difficile -meeting the C.Diff objective	7	0	Achieved
Minimising MH delayed transfers of care	≤7.5%	1.45%	Achieved
Data completeness, MH: identifiers	97.00%	98.98%	Achieved
Data completeness, MH: outcomes for patients on CPA	50.00%	93.55%	Achieved
Community care data completeness - referral to treatment information completeness	50.00%	92.31%	Achieved
Community care data completeness - referral information completeness	50.00%	72.11%	Achieved
Community care data completeness - activity information completeness	50.00%	89.93%	Achieved

Never events

'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

There have been no 'never events' in the Trust during 2014/15. We note the issue of a revised list of never events at year end which we will embed in 2015/16.

Annex statements from commissioners, local Healthwatch organisations, Health and Wellbeing Boards and Overview and Scrutiny Committees

As part of the process for developing this document, we were required to share the initial draft with a range of third parties and publish their responses. Below are the comments we received:

Hardwick Clinical Commissioning Group offered the following statement about the initial draft of our Quality Account:

Response to Derbyshire Healthcare NHS Foundation Trust Quality Account 2014/15 from Hardwick CCG

Thank you for inviting us to comment on the Derbyshire Healthcare NHS Foundation Trust's Quality Account for 2014/15. Hardwick Clinical Commissioning Group (HCCG) welcomes the opportunity to provide the narrative on behalf of all local Commissioning Groups in Derbyshire. We have reviewed the account and would like to offer the following comment:

The Commissioners have reviewed the report and we believe that the information published in this Quality Account that is also provided as part of the contractual agreement is accurate. We have continued to work collaboratively and positively with the Trust, building on successes in previous years, and we continue to support the Trusts seven priorities for quality improvement.

We commend the Trust on their continued work in improving outcomes and communicating with service receivers, careers and the public through service satisfaction surveys and the 'Think Family' principles.

The Trust continue to maintain above national standards amongst their peers, achieving 'green' ratings from the NHS Protect Quality Inspection, Patient Led Assessments of the Care Environment (PLACE), Markers of Good Practice assessments and cited amongst the HSJ Top employers in the NHS.

There are well established mechanisms to review and monitor performance, governance arrangements and standards of quality including bi-monthly quality and contract review meetings, on-going dialogue as issues and visits to services as required for further assurance of the quality of services provided to patients.

We note that the Trust has identified a number of areas which require further work and will be carried across into 2015/16. Improvements in physical healthcare monitoring and carer satisfaction will remain a priority and monitored through the Quality Committee.

Suicide prevention and the continued reduction wherever possible remains a key commitment for the Trust and commissioners. During 2014/15 the Trust started a programme of work, which included hosting a national conference on suicide prevention.

The NHS Staff survey has shown that whilst overall satisfaction remains above national average, the overall results as an organisation have reduced in a number of key indicators. The key concern for the Trust is to understand why the proportion of staff who felt that they could raise concerns was so low.

We believe that we have a highly positive relationship with the Trust, and we look forward to further developing this in the pursuit of high quality mental health services for the people of Derbyshire. We will continue to work with the Trust in the monitoring of progress against the priorities outlined in this Account.

Derbyshire County Council's Improvement and Scrutiny Committee:

The draft report was sent to the committee on 1 April 2015 and members were given the opportunity to comment. No comments were received.

Derby City Council's Overview and Scrutiny Committee:

The draft report was sent to the committee on 1 April 2015; no comments were received.

Derby City Health and Wellbeing Board offered the following statement about the initial draft of our quality report:

On behalf of the Derby City Health and Well Being Board Derby City Public Health acknowledges the progress that has been made within each of the quality improvement priorities during the period 2014/15.

We commend the Trust's on-going commitment to work collaboratively with patients, their families and their carers as is demonstrated through the implementation of a true recovery model and the development of a number of innovative ways to support effective shared care planning.

We welcome the development of the 'You Said, We Did' mechanism for providing feedback in response to the Friends and Family Test, it demonstrates that the views of patients, their families and their carers are central to the development and delivery of services.

We look forward to seeing those priorities identified for 2015/16 come to fruition.

Healthwatch Derby City offered the following statement about the initial draft of our quality report:

On behalf of Healthwatch Derby, I would like to present our formal response to Derbyshire Healthcare NHS Foundation Trust's Quality Report 2014/2015. I would like to congratulate the Trust on a very positive year, and we take note of all your key achievements. At Healthwatch Derby we are proud of our partnership work with the Trust, and are delighted to see 'Think Healthy' feature as part of the Quality Report. A few observations about the report from us:

1. *More needs to be done on the poor monitoring of BMI, glucose control lipids, blood pressure, intervention for elevated BMI, alcohol consumption. Apart from monitoring performance in this area, we would encourage the Trust to be more proactive and think of initiatives to ensure progress.*
2. *The Trust mentions 68 patient surveys, part of the 200 surveys NHS Trust audit target. I would encourage the Trust to think about the 116 Think Healthy surveys we have received, 31 of which were in an Easy Read format. These surveys are important as they were wholly independent and provided insight and information about Trust services.*
3. *Feedback from the Trust's Positive and Proactive Care Strategy Group – this section lists some staff feedback and one comment mentions the strategy could be 'less instructive and more inclusive'. Strategic documents need to be more user friendly so that patients and carers who do not have a healthcare background are able to understand and challenge them without having to seek further help.*
4. *We are pleased the Trust recognises FFT is not the only way of getting feedback. It is also noteworthy that some of the services run by the Trust may be extremely personal to people, and they may not wish to even consider recommending the service to friends or family and may feel inhibited when answering FFT format questions. Our recommendation would be to use a combination of different methods to gain insight into what patients and carers truly feel about services accessed.*
5. *Re: Carers Champions – we are also pleased to add the work of the Service Receivers & Carers Group is a good forum for carers to be directly in reviewing strategy and policies of the Trust. This group's formation follows one of our key recommendations for inclusion.*
6. *One significant area of improvement we highlighted in Think Healthy was ensuring staff feel more involved, supported and listened to. This is reflected in your staff survey with 64% saying they feel secure raising concerns. Our recommendation would be to run focus groups and workshops – and perhaps get a third party like your local Healthwatch to help facilitate this. Staff are going to be less hesitant talking to us directly than to yourselves. It is also an area of partnership work we would happily develop and deliver to you.*

The above are some key observations from the Quality Report, and we are pleased to advise you that this year we received the full 30 day consultation period to respond. We look forward to another year of continued successful partnership, with work already underway to support our 'Little Voices' project looking at patient experiences of pregnancy, maternity, and young people's services run by the Trust and other providers.If you would like any further information about this response or wish to have a further discussion please do not hesitate to contact me directly.

Yours sincerely

Samragi Madden

Quality Assurance & Compliance Officer, Healthwatch Derby.

Healthwatch Derbyshire offered the following statement about the initial draft of our quality report:

Healthwatch Derbyshire collects real people's experiences of health and social care services, as told by patients, their families and carers. These experiences, as reported to Healthwatch, will form the basis of this response.

Healthwatch Derbyshire has passed this patient feedback to the Trust during the reporting period in the form of comments. A total of 36 comments have been received about the services provided by the Trust, with a range of positive, negative and mixed sentiments. These comments are regarding a whole range of Trust services and present a variety of themes.

The Trust has fed back to Healthwatch comprehensive responses which demonstrate actions and learning within the organisation based on these comments and experiences. The Trust has also responded quickly to any comments requiring more immediate action, making contact with patients in line with consent received to deal with the concerns raised.

Most recently the Trust has provided feedback indicating a specific change in line with the content of a comment given, which is a useful demonstration of the Trust's capacity to listen to and learn from patient feedback. This feedback is also fed back to the specific individuals who spoke to Healthwatch Derbyshire, and so inspires confidence in Healthwatch Derbyshire, the Trust, and the value of 'speaking up'.

Healthwatch Derbyshire looks forward to working with the Trust in 2015-2016 along similar lines.

Annex: Statement of Directors' responsibilities in respect of the Quality Report

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.

Monitor 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 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:

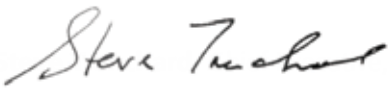
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/2015;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - *Board minutes and papers for the period April 2014 to June 2015*
  - *Papers relating to quality reported to the Board over the period April 2014 to June 2015*
  - *Feedback from the commissioners dated 30/04/2015*
  - *Feedback from governors dated 10/03/15*
  - *Feedback from local Healthwatch organisations dated 30.04.15 and 07/05/15.*
  - *Feedback from overview and scrutiny committees dated (no comments received)*
  - *The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/04/15.*
  - *The [latest] national patient survey (18/09/14)*
  - *The [latest] national staff survey (24/02/2015)*
  - *The Head of Internal Audit's annual opinion over the Trust's control environment dated 28/04/2015*
  - *CQC intelligent monitoring reports (4 March 2015).*
- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards

to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

Mark Todd, Chairman, 22 May 2015



22 May 2015

Statement of Accounting Officer's responsibilities

Statement of the Chief Executive's responsibilities as the accounting officer of Derbyshire Healthcare NHS Foundation Trust

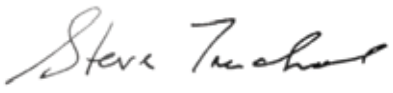
The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper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

Under the NHS Act 2006, Monitor has directed Derbyshire Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Derbyshire Healthcare 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 NHS Foundation Trust Annual Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, 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 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 Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.



Steve Trenchard, Chief Executive, 22 May 2015

3. Annual Governance Statement

1 April 2014 – 31 March 2015

Scope of responsibility

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.

The purpose of the system of internal control

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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Derbyshire Healthcare 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. The system of internal control has been in place in Derbyshire Healthcare NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has continued to provide high quality care and to provide strong leadership with respect to risk management processes. The Trust has taken on board the greater levels of expectations on Trusts following many NHS care reviews and their associated recommendations. The Trust has embraced an organisational culture of being open, including publishing increasingly transparent information such as performance data and information on safer staffing levels.

The Board endorsed Integrated Quality Governance Strategy previously defined the organisational structures in place for the management and ownership of risk, including the responsibilities of Executive Directors for implementing the strategy. This strategy has now been concluded and a new Quality Strategy has been developed and implemented during the latter part of the year. This enables the Trust to meet the requirements of the Care Quality Commission's key lines of enquiry and national standards.

The Executive Director of Nursing and Patient Experience and the Medical Director has joint responsibility for risk and quality on behalf of the Board of Directors. This is supported by a range of work programmes and designated committees of the Board, including policies and procedures such as the Risk Assessment and Untoward Incident Procedures.

There is a Governance structure in place to ensure risk is managed effectively throughout the organisation and embedded in all Trust processes. In addition, the Quality Strategy sets out the Trust's strategic direction to sustain and improve the quality of care. The authority and duties of staff with respect to risk management processes are defined within the Integrated Quality Governance Strategy and subsequent Quality Strategy.

The Trust provides a range of compulsory and role specific training which is detailed in the Trust's Training Framework. Training is supported by procedural guidance, direction from specialist staff and all training includes examples of learning from best practice. Training with respect to safeguarding adults and children has been refreshed during the year in preparation for the Care Act 2014 to be implemented from April 2015.

The risk and control framework

Key elements of the risk management strategy

Risk identification is undertaken both proactively via risk assessments and project plans and reactively via incident, complaints, claims analysis, internal and external inspection and audit reports. Risk evaluation is completed using a single risk matrix to determine impact and likelihood of risk realisation and grading of risk by likelihood and severity of impact resulting in a matrix score. Risk control and treatment plans identify responsibility and authority for determining effectiveness of controls and development of risk treatment plans. This may include assigning appropriate resources, depending upon the risk grade.

The Trust holds a Trust wide Risk Register, a single electronic register (held on DATIX) incorporating all operational and strategic risks, with inbuilt ward/team, divisional and corporate level risk register reports. Part of the Risk Register is the Board Assurance Framework which details key risks and mitigating actions taken in order to achieve the Trust's strategic objectives. This is scrutinised by the Audit Committee prior to submission to the Board. The Board of Directors determines risk appetite by obtaining assurance from controls in place and review of mitigation plans, relative to the level of risk identified.

Incident reporting is openly encouraged and supported by an online incident reporting form (DATIX), accessible to all staff. Incident investigation involves robust systems for reporting and investigating incidents to identify areas for organisational learning and good practice. All serious incidents are reported to the Board of Directors on a monthly basis and action plans are reviewed and monitored.

The use of a 'Blue Light' system is used to rapidly communicate information on significant risks that required immediate action to be taken. 'Practice Matters' and 'Learning the Lessons from Information Governance Incidents' newsletters are used to communicate good practice and actions that have been taken throughout the organisation. The 'Policy Bulletin' informs staff of key messages within new or updated policies and procedures. Furthermore, clinical advisory 'Podcasts' have been developed during 2014/15 to communicate to staff learning from CQC/MHA visits, sharing of information and clinical priorities.

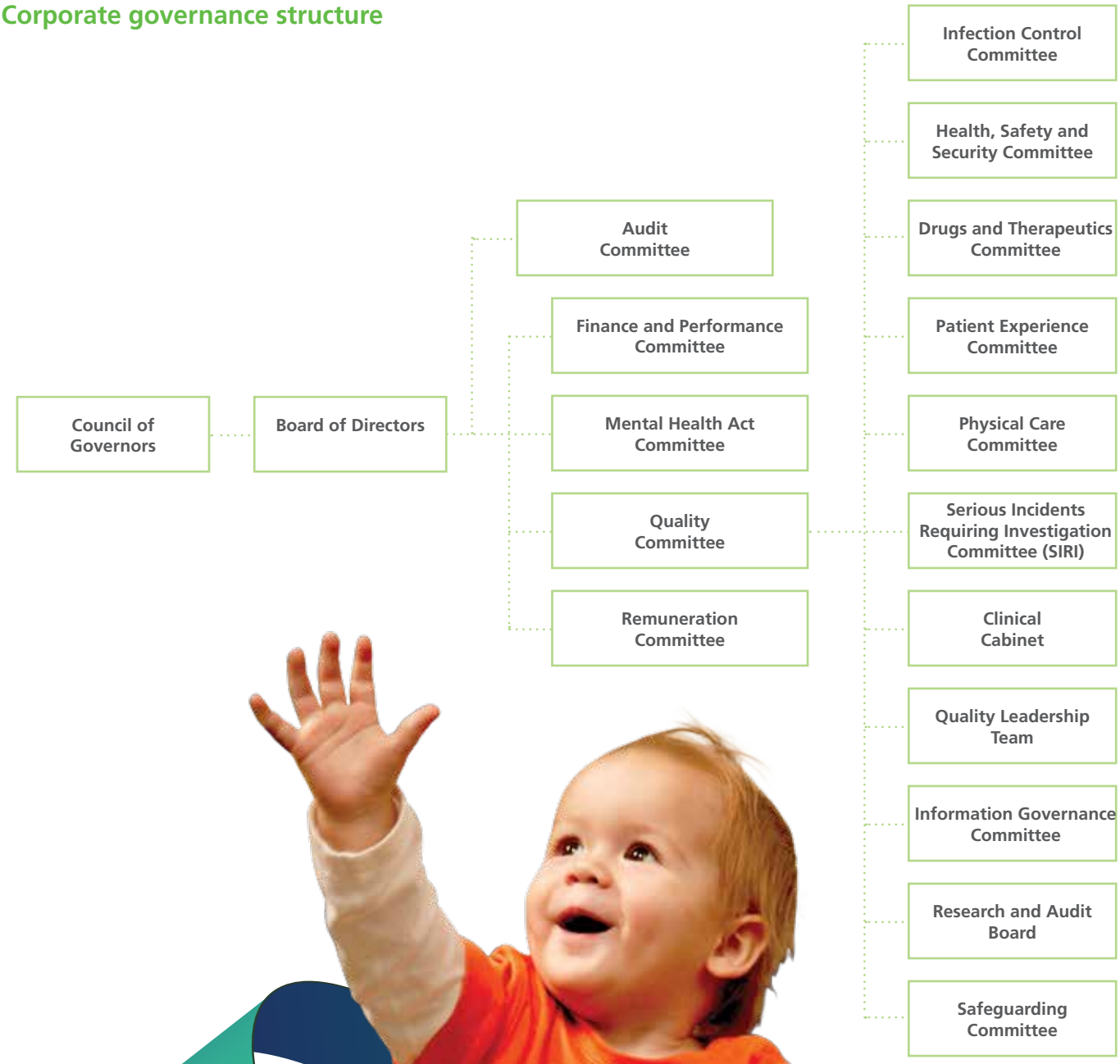
Members of the Board of Directors are involved in an ongoing programme of live Equality Impact Assessments across all service areas, and use this to identify service gaps and improvement opportunities. From Oct 14 the Trust has begun implementation of the 'duty of candour' requirements and is compliant with the 'fit and proper persons test' requirement for Board members. This is being linked to the Board appraisal process.

Effectiveness of quality governance structures.

Reporting line and accountability between the Board, its committees and the Executive Team. Responsibilities of Directors and committees.

The Trust's Quality Governance structure is shown in the diagram below, and details all committees which report to the Quality Committee. Assurance is also received by the Board from other board subcommittees.

Corporate governance structure



Key responsibilities of the sub Board Committees are detailed below.

The **Finance and Performance Committee** oversees and gains assurance on all aspects of financial management and operational performance, including contract compliance, commercial decisions and cost improvement reporting. The Committee also oversees the Trust's business development, commercial and marketing strategies and its approach to helping workforce engagement and development. It is responsible for agreeing terms of reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee.

The **Audit Committee** is the principal Committee for seeking independent assurance on the general effectiveness of the Trust's internal control and risk management systems and for reviewing the structures and processes for identifying and managing key risks. It is responsible for reviewing the adequacy of all risk and control related statements prior to approval by the Board and for seeking assurances on these controls. In discharging its responsibilities, the Committee takes independent advice from the internal auditor.

The **Mental Health Act Committee** monitors and obtains assurance on behalf of the Hospital Managers and the Trust, as the detaining authority, that the safeguards of the Mental Health Act and Mental Capacity Act are upheld. This specifically includes the proactive and active management of the prevention of deprivation of liberty and ensuring DoLS applications as a managing authority are appropriately applied. It also monitors related statute and guidance and reviews the reports following inspections by the Care Quality Commission.

The **Quality Committee** obtains assurance that high standards of care are provided and that adequate and appropriate Governance structures, processes and controls are in place to promote safety and excellence in patient care. The Committee monitors risks arising from clinical care and ensures the effective and efficient use of resources through evidence-based clinical practice. The Quality Committee is responsible for agreeing Terms of Reference and annual work programmes for its supporting sub-committees. It also receives agreed assurance and escalation reports as defined in the forward plan for the Committee. From April - Aug 14, the Committee met bi-monthly. From Sept 14 onwards, due to an increasing agenda, the Committee met monthly.

The **Remuneration Committee** decides and reviews the terms and conditions of office of the Foundation Trust's executive directors [and senior managers on locally-determined pay] in accordance with all relevant Foundation Trust policies.

In addition the **Executive Leadership Team**, as the most senior executive decision making body in the Trust, is responsible for ensuring that strategies and performance targets, approved by the Board of Directors, are implemented to timescale. The group shares a fundamental responsibility to provide strategic leadership to the organisation, consistent with its values and principles. It also ensures that a culture of empowerment, inclusivity, and devolution of responsibility with accountability is strongly promoted.

The Trust successfully integrates clinical and corporate risk management processes, which the Executive Director of Nursing and Patient Experience, in association with the Medical Director, leads on behalf of the Board of Directors. Responsibilities of individual Directors and the Governance Committees are detailed in the Integrated Governance Strategy and subsequent Quality Strategy which defines the Trust's quality priorities.

Strategic approach to risk based audit planning, which addresses key financial, control and risk processes is in place to provide assurance under the Board Assurance Framework (BAF). During 2014/15 the Audit Committee has been responsible for ensuring appropriate assurances are sought for key controls which manage strategic organisational risks. Development of the Board Assurance Framework during the year has included: identification of a named responsible committee for each risk identified to ensure each is challenged and agreed by the committee and its work plan supports the management of the risk; and a programme of 'deep dives' challenge to the responsible director on the assurances and controls of the risks to achieving each strategic objective. The role of the named responsible committee was identified as a gap in the internal audit review mentioned below, and has therefore been strengthened during meetings undertaken during Q4 of 14/15.

A review of Governance arrangement, structures and processes was undertaken by the Trust's Internal Auditors in Nov 14. The report identified strengths in terms of effective operating of the Board, operating in a transparent manner and engagement of stakeholders. Further action was recommended with respect to reviewing the roles and interrelationships of Board

committees, in particular strengthening of the Quality Committee, improving the focus and administration of Board meetings and ensuring risks associated with the Board Assurance Framework are reviewed in line with agreed process.

Submission of timely and accurate information to assess risks to compliance with the Trust's licence

During the year, the Board has conducted reviews of the effectiveness of the Trust's systems of internal control, including financial, clinical, operational and compliance controls and risk management systems as part of the ongoing review of its Corporate Governance Structure. This requirement is outlined in The Foundation Trust Code of Governance issued by Monitor.

As a result of the controls in place, the Trust has not identified any significant risks to compliance with the NHS Foundation Trust condition 4 (FT Governance).

Ways in which the Trust assures the validity of its Corporate Governance Statement, required under NHS foundation Trust condition 4(8)(b)

The Trust has in place a Local Operating Procedure (LOP), the purpose of which is to enable the completion of the template report for the in-year and annual Financial and Governance combined quarterly returns to Monitor. The LOP describes the data validation processes in place which ensure data quality and gives detailed step by step instruction of how to contribute to the completion of the template report. This process is co-ordinated by the Compliance Team and information considered by the Chair of the Audit Committee prior to final sign off by the Board of Directors each quarter.

Degree of rigour and oversight the Board has over the Trust's performance.

Compliance with the Care Quality Commission's new fundamental standards regulations, which came into force on 27th November 2014, is monitored, measured and reported by the Trust Board, the Quality Governance Structure and associated processes. During 2014/15 the Trust took a risk based 'deep dive' approach to the monthly integrated performance reports to the Board which incorporated quality indicators for specific service lines. Key quality indicators are also reported monthly to the Board, with a focus on exceptions. Evidence of compliance with the sixteen essential standards of quality and safety is reported through the Quality Committee and complementary committee structure. Each report references the essential standard of quality and safety and provides evidence of compliance. This process will continue when the remaining fundamental standards come into force in the next financial year. The work of the Quality Committee and associated groups are active and their outputs are clearly evidenced in the Trust's Quality Report. The Report's accuracy is subject to review by internal auditors as well as extensive consultation and feedback internally and externally on its contents.

The Trust has an extensive annual quality visit programme, involving Board members, Governors and stakeholders, which includes planned visits to every ward and team that provides a service (over 90 individual teams and wards).

The Trust publishes its key performance indicators onto the web daily. This supports the Trust's aims to ensure transparency of services to the public is maintained.

Data security risks

The Trust has in place the following arrangements to manage Information Governance risks:

- A Senior Information Risk Owner (SIRO) who is the Trust's Chief Operating Officer, and Caldicott Guardian (Medical Director) at Board Level
- Annually completed Information Governance Toolkit, with reported outcomes to the Quality Committee and Board of Directors
- Risks related to Information Governance reviewed by the SIRO, and the Information Governance Committee
- High uptake of Information Governance compulsory training
- Information Governance incidents reviewed monthly by the Information Governance Group and 'Learning the Lessons' Bulletins issued to staff
- Compared to all other mental health Trusts, the Trust achieved the highest rating of compliance with the Information Governance Toolkit in 2013/14 and again in 2014/15.

Public stakeholders

The key elements in which public stakeholders are involved in managing risks which impact on them include:

- Council of Governors at quarterly meetings take the opportunity to hold the Board of Directors to account on its performance, including quality and risk.
- Trust commitment to the Strategic Commissioning Group, Quality Assurance Group, Chief Officer and CEO meetings and consultation as required with the Overview and Scrutiny Committees and HealthWatch.
- Consultation for the Quality Account involving key stakeholders which is evidenced in our inclusion of their feedback
- Impact assessments for the Transformational Change Programme including a requirement for consultation with key stakeholders
- HealthWatch review of crisis and children's services using 'Enter and View' approach. Extensive questionnaires were completed and over 1000 pieces of evidence collated. Overall positive feedback with 75% of services rated as either good or very good.
- CEO chairs the 4Es (Experience, Enablement, Empowerment and Equality) Group which meets bi-monthly and includes stakeholders from HealthWatch, CCG's, Service User and Carer groups and Voluntary and Community Sectors
- The Integrated Service Delivery Programme Board has commenced a Service Receiver and Carer Reference Group to support the transformational change agenda.

Major risks

Identified major risks identified in year, as at 31st March 2015 are as follows:

- Failure to deliver the agreed transformational change, at the required pace
- Risk that the complexity and bureaucracy of new commissioning arrangements, coupled with the move toward the national tariff payment system, could negatively impact on income and service models
- An increasingly competitive environment could impact on market share resulting in reduced income and loss of services

The full details of these risks, including controls and assurances in place, actions identified and progress made in mitigating the risk, are shown in the Board Assurance Framework which is reported to the Audit Committee and Board on a regular basis.

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission and continues to have no restrictions on our registration. The intelligence monitoring report identifies the Trust as high performing with a low (green) risk to continuing to maintain compliance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Board of Directors carries the final overall corporate accountability for its strategies, policies and actions as set out in the Codes of Conduct and Accountability issued by the Secretary of State.

Internal Audit Services provide the Trust with an independent and objective opinion on the effectiveness of the systems in place for Risk Management, Control and Governance. The Audit Committee approves the annual audit plan, informed by risk assessment. The annual clinical audit plan is approved by the Quality Committee.

Under the chairmanship of a Non-Executive Director, the Quality Committee has taken the lead on Trust wide quality performance, focussing on driving continuous improvement, achievement of clinical standards and dissemination of best practice.

Monitor's Governance Risk Rating has remained 'green' for each quarter during 2014/15.

Information Governance

During the year two incidents were reported to the Information Commissioner's Office (ICO). One incident involved confidential records being found in a public place. This was subsequently found to be related to a malicious act and managed through workforce processes. The other incident involved a patient accessing a staff only area and removing patient files. Additional security measures were implemented as a result. The incidents were investigated as serious incidents by the Trust. Both have been closed by the ICO with no sanction. The Trust has also received one concern by a family which has been accepted by the ICO. The concern his has been responded to as required.

Annual Quality Report

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

The Trust publishes a Quality Report as part of the Trust's Annual Report. The Executive Director of Nursing and Patient Experience is the Director lead for the overall report with individual Directors taking responsibility for signing off their areas of accountability. The report is formulated using the national guidance. Stakeholders receive a draft copy for comment and feedback is responded to within the final draft. Policies and plans to ensure the quality of care provided are referenced within the document. The Quality Committee has a key role in monitoring the content of the report. The Governor Working Group for Quality and our Lead Commissioning Team are also consulted on the content. Clinical leads responsible for key areas of improvement contribute to the report. The data included is based on the national descriptors in the guidance and is subject to the routine Trust data quality checks. The full Council of Governors selects a further indicator to be reviewed by the auditor. The completed quality report, including two mandatory indicators and comments from our stakeholders, is subject to review by internal and external auditors.

Review of effectiveness

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 the 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 on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of

the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, and Risk and Quality Governance Committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board 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:

- Monitor's Risk Rating return and Quality declaration which has been graded green since the Trust became a Foundation Trust
- Registration with the Care Quality Commission from 1st April 2010 – without conditions at year end
- The Trust achieved compliance with NHS Litigation Authority Risk Management Standards compliance at Level 2 in June 2010 and contributions continue to decrease over the last year
- Compliance with Monitors Quality Framework
- Reviews of Corporate Governance and associated Committees
- Internal Audit reports received during year following on from the Internal Audit and External Audit Plans agreed by the Trust's Audit Committee
- Clinical Audits
- Outcomes from visits from the CQC, including regular visits from the Mental Health Act arm of the CQC.

The following gaps in control were identified:

- **Embedding of Governance structures.** Following an advisory audit the Trust has taken forward a number of recommendations and actions to strengthen the roles and relationships of Board Committees. The Trust will be undertaking its formal Governance Review in early 2015/16.
- **Clinical audit processes and monitoring to achieve Plan.** The clinical audit monitoring systems require additional refinement and scrutiny of the timeliness of audit completions and performance. A full action plan is in place and this is being robustly monitored by the Audit Committee.
- The monitoring and effectiveness of **NICE guidelines** requires redesign and a more sophisticated level of assessment of compliance to drive service improvement of clinical standards.
- Understanding of the reasons for **suicide rates** being higher than the national average. Mitigations include: modelling work led by the suicide prevention group focusing on compassion led and collaborative patient safety approach; negotiations with Commissioners on CQUIN to ensure continued approach to patient safety; continued roll out of suicide prevention training; undertaking clinical audit against NICE self harm guidelines and implementation of a low threshold for external peer review on suicide rate with adoption of recommendations.
- Control of **capacity and demand on Trust services**. The Trust is both working with commissioners to increase capacity and is implementing a detailed transformational plan to support changes to flow of demand.
- Processes to ensure **approved clinicians** are appropriately trained and registered in order to legally administer the relevant Sections of the Mental Health Act. Gaps in the control have been investigated through the serious incident processes.
- Non-compliance for part of year with **HMRC requirement** with regard to high cost off payroll monitoring. We continue to analyse the gaps in process and assurance that have been highlighted in this review and to take actions to strengthen process.

The processes applied in reviewing and maintaining the effectiveness of internal control are described above. In summary:

The Board of Directors:

- Is responsible for approving and monitoring the systems in place to ensure there are proper and independent assurances given on the soundness and effectiveness of internal control.

The Audit Committee:

- Is responsible for independently overseeing the effectiveness of the Trust's systems for internal control and for reviewing the structures and processes for identifying and managing key risks.
- Is responsible for reviewing the establishment and maintenance of effective systems of internal control.
- Is responsible for reviewing the adequacy of all risk- and control-related statements prior to endorsement by the Board.
- In discharging its responsibilities takes independent advice from the Trust's internal auditor and Grant Thornton (external auditors).

Internal Audit:

- The *Internal Audit Annual Report 14/15* provided by PwC includes the Head of Internal Audit's annual opinion which is as follows:

  We are satisfied that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, it should be noted that assurance can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

Our opinion is as follows:

Adequate and effective	Improvement required	Major improvement required	Unsatisfactory

There are weaknesses in the framework of governance, risk management and control which potentially put the achievement of organisational objectives at risk and there is non-compliance with controls that may put the achievement of organisational objectives at risk.

Improvements are required in those areas to enhance the adequacy and effectiveness of governance, risk management and control.

In summary, the opinion is based on the following:

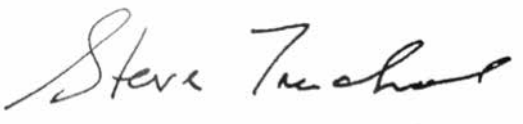
- Medium risk rated weaknesses were identified in individual assignments but these were not significant in aggregate to the system of internal control; and
- No High risk rated weaknesses were identified in individual assignments; and
- None of the individual assignment reports had an overall classification of critical risk.

External Audit:

- The Trust's External Auditors, Grant Thornton, provide the Trust with external audit services which include the review of the annual accounts and a review of the value for money achieved by the Trust.

Conclusion

No significant internal control issues have been identified and my review confirms that Derbyshire Healthcare NHS Foundation Trust has a generally sound system of internal controls that supports the achievement of its objectives and that control issues have been or are being addressed.



Steve Trenchard, Chief Executive, 22 May 2015

4. Annual Accounts

Independent auditor's report to the Council of Governors of Derbyshire Healthcare NHS Foundation Trust

Our opinion on the financial statements is unmodified.

In our opinion the financial statements:

- Give a true and fair view of the state of the financial position of Derbyshire Healthcare NHS Foundation Trust as at 31 March 2015 and of its income and expenditure for the year then ended; and
- Have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

Who we are reporting to

This report is made solely to the Council of Governors of Derbyshire Healthcare NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

What we have audited

We have audited the financial statements of Derbyshire Healthcare NHS Foundation Trust ('the Trust') for the year ended 31 March 2015 which comprise the statement of comprehensive income, the statement of financial position, the statement of cash flows, the statement of changes in taxpayers' equity and the related notes.

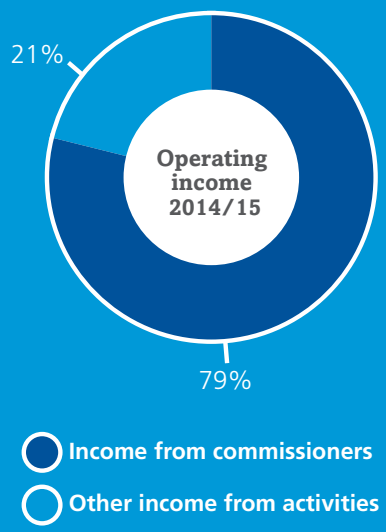
The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

Our assessment of risk

In arriving at our opinions set out in this report, we highlight the following risks that are, in our judgement, likely to be most important to users' understanding of our audit.

Valuation of contract income from commissioning bodies and associated receivables

The risk: The Trust receives a large proportion of its income from commissioners of healthcare services. It invoices its commissioners throughout the year for services provided, and at the year-end estimates and accrues for activity not yet invoiced. Invoices for the final quarter of the year are not finalised and agreed until after the yearend and after the deadline for the production of the financial statements. There is therefore a risk that the income from commissioners (and associated receivables) recognised in the financial statements may be misstated. We identified the accounting for the contract arrangements with commissioning bodies (in particular the consistency of the income with contract terms) as one of the risks that had the greatest impact on our audit strategy.



Our response: Our audit work included, but was not restricted to, assessing the Trust's accounting policy for revenue recognition, understanding management's processes to recognise this income in accordance with the stated accounting policy, performing walkthroughs of management's key controls over income recognition (for example controls over contract billing, pricing and agreement of contract variations) to assess whether they were designed effectively and substantively testing the income and associated receivables.

Our substantive testing included:

- Testing the reconciliation of the income figures in the financial statements for material contracts with commissioning bodies to signed contracts;
- Review of month 12 agreement of balances exercise; and
- Review of estimates of contract income where agreement with commissioners had not been met by year end.

The Trust's accounting policy on revenue recognition is shown in note 1.6 to the financial statements and its analysis of its total operating income is included in note 4.

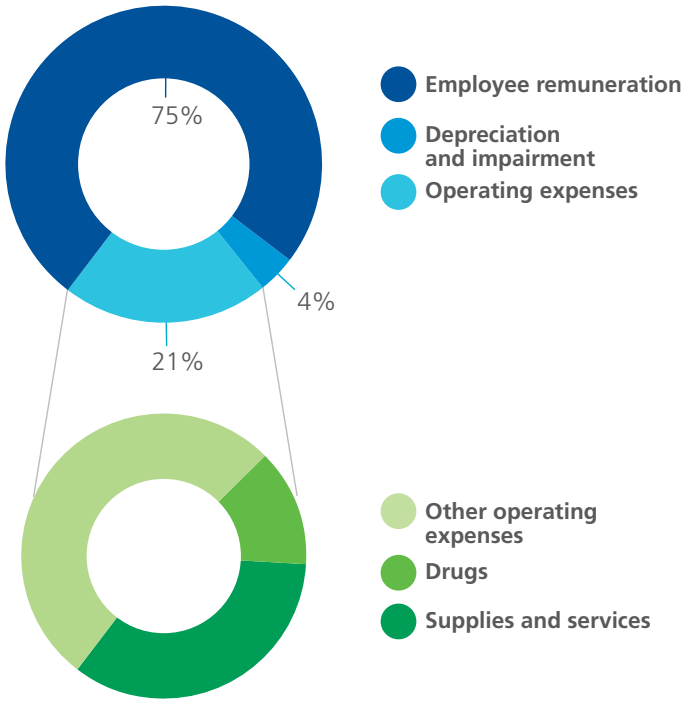
Our findings:

We did not note any exceptions from our work on this income.

Completeness of employee remuneration and operating expenses and associated payables

The risk: The majority of the Trust's expenditure relates to employee remuneration and operating expenses. Together they account for 96% of the Trust's gross expenditure. The Trust pays the majority of this expenditure through its payroll and accounts payable systems and at the year-end estimates and accrues for un-invoiced expenses. Invoices for the final weeks of the year are not received and processed until after the year-end and in many cases after the deadline for the production of the financial statements. There is therefore a risk that the expenses (and associated payables) recognised in the financial statements may be misstated. We identified the completeness of employee remuneration and operating expenses (in particular the understatement of accruals) as risks that had the greatest impact on our audit strategy.

Expenditure 2014/15



Our response: Our audit work included, but was not restricted to, understanding management's processes to recognise payroll and accounts payable expenditure and year-end accruals for unprocessed invoices and expenditure incurred and not yet invoiced (GRNI), walking through management's key controls over recognition of expenditure (for example authorisation of expenditure subsystem interfaces, processing of adjustments and authorisation of payments) to assess whether they were designed effectively and substantively testing expenditure and associated payables.

Our substantive testing included:

- Testing the reconciliation of employee remuneration expenditure in the financial statements to the general ledger and payroll subsystems;
- Performing a trend analysis of payroll costs to identify any unusual cost variations for follow up;
- Reviewing large or unusual payroll transactions;
- Sample testing payroll expenditure to source documents;
- Agreement of employee remuneration disclosures in the financial statements and annual report to supporting documentation;

- Assessing whether the Trust's processes for accruing for GRNIs were sufficiently robust to ensure that uninvoiced expenditure had been accrued for appropriately;
- Review of calculation of significant accruals and other items;
- Review of month 12 agreement of balances exercise in relation to NHS payables and accruals; and
- Testing a sample of post year-end payments to confirm the completeness of accruals.

The Trust's accounting policy for recognition of expenditure is shown in notes 1.7 and 1.8, its analysis of employee remuneration costs is included in note 9 and its analysis of operating costs is included in note 7 to the financial statements.

Our findings:

We did not note any exceptions from our work on this expenditure.

Our application of materiality and an overview of the scope of our audit

Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the judgement of a reasonably knowledgeable person would be changed or influenced.

We determined materiality for the audit of the financial statements as a whole to be £2,510,000, which is 2% of the Trust's gross operating costs. This benchmark is considered the most appropriate because users of the financial statements are particularly interested in how healthcare funding has been spent. We use a different level of materiality, performance materiality, to drive the extent of our testing and this was set at 75% of financial statement materiality. We also determine a lower level of specific materiality for certain areas such as related parties and patient monies.

We determined the threshold at which we will communicate misstatements to the Trust's Audit Committee to be £125,500. In addition we communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

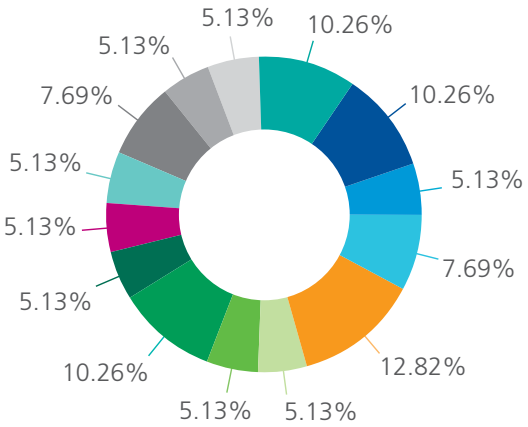
Overview of the scope of our audit

We conducted our audit in accordance with International Standards on Auditing (ISAs) (UK and Ireland) having regard to the Financial Reporting Council's Practice Note 10 'Audit of Financial Statements of Public Bodies in the UK (Revised)'. Our responsibilities under the Code and the ISAs (UK and Ireland) are further described in the 'Responsibilities for the financial statements and the audit' section of our report. We believe that the audit evidence we have obtained from our audit is sufficient and appropriate to provide a basis for our opinion.

We are independent of the Trust in accordance with the Auditing Practices Board's Ethical Standards for Auditors, and we have fulfilled our other ethical responsibilities in accordance with those Ethical Standards.

Our audit approach was based on a thorough understanding of the Trust's business and is risk based. The Trust outsources its Employee Service Records administration to McKesson Information Solutions; and outsources the processing of its general ledger, purchase ledger, and sales ledger to NHS Business Services. Accordingly, our audit work was focused on obtaining an understanding of, and evaluating, relevant internal controls at both the Trust and its third party service providers.

Allocation of audit fieldwork time



- Income from activities
- Employee remuneration
- PPE revaluation, depreciation and impairments
- Other income and costs
- Non current assets
- Inventories
- Cash and borrowings
- Other net current assets
- Public dividend capital and reserves
- Cash flow statement and changes to taxpayers equity
- Journal entries
- Accounting policies and other disclosures
- Annual governance statement and consolidation schedules
- Annual report

We undertook substantive testing on significant transactions, balances and disclosures in the financial statements, the extent of which was based on various factors such as our overall assessment of the Trust's control environment, the design effectiveness of controls over significant financial systems and the management of risks.

Other reporting required by regulations

Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- The part of the Directors' Remuneration Report subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15 issued by Monitor; and
- The information given in the strategic report and directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following:

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

- The Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with the information of which we are aware from our audit;
- We have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- The Trust's Quality Report has not been prepared in line with the requirements set out in Monitor's published guidance or is inconsistent with other sources of evidence.

Under the ISAs (UK and Ireland), we are also required to report to you if, in our opinion, information in the annual report is:

- Materially inconsistent with the information in the audited financial statements; or
- Apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- Otherwise misleading.

In particular, we are required to report to you if:

- We have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable; or
- The annual report does not appropriately disclose those matters that were communicated to the Audit Committee which we consider should have been disclosed.

Responsibilities for the financial statements and the audit

What an audit of financial statements involves:

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, we read all the financial and nonfinancial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially inconsistent with the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

What the Chief Executive is responsible for as accounting officer:

As explained more fully in the Chief Executive's Responsibilities Statement, the Chief Executive as Accounting Officer is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Direction issued by Monitor and for being satisfied that they give a true and fair view.

What are we responsible for:

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts issued by Monitor, and ISAs (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Certificate

We certify that we have completed the audit of the financial statements of Derbyshire Healthcare NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor

Grant Thornton UK LLP

Mark Stocks
Director for and on behalf of Grant Thornton UK LLP

Colmore Plaza, 20 Colmore Circus, Birmingham
West Midlands B4 6AT
22 May 2015

Statement of comprehensive income for the period ended 31/03/2015

	NOTE	2014/15 £000	2013/14 Restated £000	2012/13 Restated £000
Operating income from continuing operations	4 & 5	**131,433**	127,549	124,672
Operating expenses of continuing operations	7	**(127,720)**	(123,801)	(121,259)
Operating Surplus/ (Deficit)		**3,713**	3,748	3,413
Finance costs				
Finance income	13	**29**	25	25
Finance expense - financial liabilities	15	**(2,489)**	(2,082)	(1,938)
Finance expense - unwinding of discount on provisions		**(50)**	(61)	(68)
PDC dividends payable		**(1,369)**	(1,109)	(1,036)
Net finance costs		**(3,879)**	(3,227)	(3,017)
Surplus/(deficit) for the year		**(166)**	521	396
Surplus/(deficit) of discontinued operations and then the gain/ (loss) on disposal of discontinued operations		**0**	0	0
Retained surplus/ (deficit) for the year		**(166)**	521	396
Other comprehensive income		**6,162**	4,413	8,452
Total comprehensive income(expense) for the year		**5,996**	4,934	8,848

The notes on pages 7 to 52 form part of these accounts.

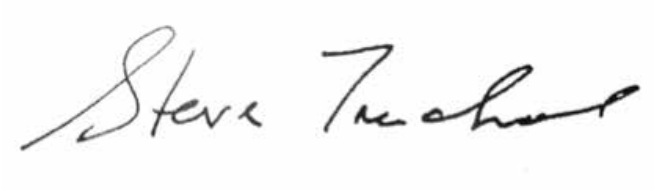
In year there has been a prior year adjustment for a change in land values, full details of the changes can be found in Note 42.

Statement of financial position as at 31/03/2015

	NOTE	31/03/2015 £000	31/03/2014 Restated £000	31/03/2013 Restated £000
Non-current assets:				
Intangible assets	17	**3,481**	3,931	2,216
Property, plant and equipment	16 & 42	**84,627**	79,957	77,297
Trade and other receivables	21	**280**	1,364	1,095
Total non-current assets		**88,388**	85,252	80,608
Current assets:				
Inventories	20	**165**	172	187
Trade and other receivables	21	**3,213**	4,568	3,018
Non-current assets for sale	25	**210**	166	261
Cash and cash equivalents	24	**11,642**	6,848	7,416
Total current assets		**15,230**	11,754	10,882
Current liabilities				
Trade and other payables	26	**(12,340)**	(11,626)	(9,510)
Borrowings	27	**(866)**	(764)	(735)
Provisions	34	**(1,852)**	(820)	(1,578)
Other liabilities	28	**(828)**	(494)	(747)
Total current liabilities		**(15,886)**	(13,704)	(12,570)
Total assets less current liabilities		**87,732**	83,302	78,920
Non-current liabilities				
Borrowings	27	**(28,652)**	(30,438)	(31,051)
Provisions	34	**(2,754)**	(2,534)	(2,473)
Total non-current liabilities		**(31,406)**	(32,972)	(33,524)
Total assets employed:		**56,326**	50,330	45,396
Financed by: taxpayers' equity				
Public dividend capital		**16,085**	16,085	16,085
Revaluation reserve	42	**34,069**	28,090	23,756
Merger Reserve		**8,680**	8,680	8,680
Income and expenditure reserve		**(2,508)**	(2,525)	(3,125)
Total taxpayers' equity:		**56,326**	50,330	45,396

The notes on pages 7 to 52 form part of these accounts. The financial statements on pages 1 to 6 were approved by the Audit Committee on behalf of the Board on the 22nd May 2015 and signed on its behalf by:

Signed



Chief Executive
22 May 2015

Statement of changes in taxpayers' equity for the period ended 31/03/2015

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total reserves
	£000	£000	£000	£000	£000
Taxpayers equity at 01/04/2014	**16,085**	**28,090**	**8,680**	**(2,525)**	**50,330**
Surplus/ (deficit) for the year	0	0	0	(166)	(166)
Impairments	0	(146)	0	0	(146)
Revaluations	0	6,308	0	0	6,308
Asset disposals	0	(88)	0	88	0
Other reserve movements	0	(95)	0	95	0
Taxpayers' equity at 31/03/2015	**16,085**	**34,069**	**8,680**	**(2,508)**	**56,326**

Statement of changes in taxpayers' equity for the period ended 31/03/2014 - restated

	Public dividend capital	Revaluation reserve	Other reserves	Income and Expenditure Reserve	Total reserves
	£000	£000	£000	£000	£000
Taxpayers equity at 1 April 2013	**16,085**	**23,756**	**8,680**	**(3,125)**	**45,396**
Transfers from Primary Care Trusts	0	0	0	3	3
Surplus/ (deficit) for the year	0	0	0	521	521
Transfers between reserves	0	(88)	0	88	0
Revaluations	0	4,422	0	0	4,422
Other reserve movements	0	0	0	(12)	(12)
Taxpayers equity at 31 March 2014	**16,085**	**28,090**	**8,680**	**(2,525)**	**50,330**

Statement of changes in taxpayers' equity for the period ended 31/03/2013 - restated

	Public dividend capital	Revaluation reserve	Other reserves	Income and Expenditure Reserve	Total reserves
	£000	£000	£000	£000	£000
Taxpayers equity at 1 April 2012	**15,953**	**15,698**	**8,680**	**(3,783)**	**36,548**
Surplus/ (deficit) for the year	0	0	0	396	396
Transfers between reserves	132	(340)	0	208	0
Revaluations	0	8,943	0	0	8,943
Impairments	0	(489)	0	0	(489)
Asset disposals	0	(47)	0	47	0
Other reserve movements	0	(9)	0	7	(2)
Taxpayers equity at 31 March 2013	**16,085**	**23,756**	**8,680**	**(3,125)**	**45,396**

The prior period adjustment as led to a change in the revaluation reserve opening balances above, this has changed from £19,856k to £23,756k.

Statement of cash flows for the period ended 31/03/2015

	NOTE	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Operating surplus/deficit from continuing operations		**3,713**	3,748
Operating surplus/deficit		**3,713**	3,748
Non cash income and expenses			
Depreciation and amortisation		**3,336**	3,159
Impairments		**2,244**	1,349
Reversal of impairments		**(260)**	0
Gains and losses on asset disposals		**(348)**	(8)
(Increase)/decrease in inventories		**7**	15
(Increase)/decrease in trade and other receivables		**2,493**	(1,813)
(Increase)/decrease in other assets		**(928)**	0
Increase/(decrease) in trade and other payables		**169**	2,305
(Increase)/decrease in other current liabilities		**335**	(253)
Increase/(decrease) in provisions		**1,202**	(758)
Net cash inflow/(outflow) from operating activities		**11,963**	7,744
Cash flows from investing activities			
Interest received		**29**	25
Purchase of financial assets		**(375)**	0
Purchase of intangible assets		**(1,157)**	(2,450)
Purchase of property, plant and equipment		**(1,945)**	(2,109)
Sales of property, plant and equipment		**860**	105
PFI lifecycle prepayments (cash outflow)		**(132)**	0
Net cash inflow/(outflow) from investing activities		**(2,720)**	(4,429)
Cash flows from financing activities			
Capital element of private finance lease obligations		**(902)**	(718)
Interest element of private finance lease obligations		**(1,918)**	(1,803)
Interest element of finance lease obligations		**(206)**	(168)
PDC dividend paid		**(1,423)**	(1,194)
Net cash inflow/(outflow) from financing activities		**(4,449)**	(3,883)
Net increase/(decrease) in cash and cash equivalents		**4,794**	(568)
Cash and cash equivalents at beginning of the period		**6,848**	7,416
Cash and cash equivalents at year end	24	**11,642**	6,848

Notes to the accounts

1. Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the FT ARM, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2014/15 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

These accounts have been prepared using the going concern convention.

1.2 Consolidation

Subsidiaries

The NHS Foundation Trust does not have any subsidiary arrangements. Charitable funds are managed by Derbyshire Community Health Services NHS Foundation Trust on behalf of the Trust and do not have to be consolidated into the accounts.

Associates

The Trust is not involved in any associate company arrangements.

Joint ventures

The Trust is not involved in any joint venture arrangements.

Joint operations

The Trust is not involved in any joint operation arrangements.

1.3 Pooled budgets

The Trust does not have any pooled budget arrangements.

1.4 Critical judgments in applying accounting policies

The following are the critical judgments, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Asset lives

The Trust has to make assumptions and judgments when determining the length of an asset's estimated useful life. This will take into account the view provided during the professional valuation and also the Trust's assessment of the period over which it will obtain service potential from the asset.

In determining the estimated useful lives of assets the Trust has taken into consideration any future lifecycle replacement that will enhance and prolong the life of the asset; specifically in relation to assets capitalised under PFI contract arrangements.

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

PFI

The PFI scheme has been reviewed under IFRIC 12 and it is deemed to meet the criteria to include the scheme on balance sheet.

1.5 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimating uncertainty at the end of the reporting period, which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Property valuation estimation

Assets relating to land and buildings were subject to a formal valuation during the financial year ending 31st March 2015. This resulted in an increase in asset valuations, reflecting the trend in market prices. The valuation was based on prospective market values at 31st March 2015, which has been localised for the Trust's estate. The Trust has formal valuations where assets have been classified as "available for sale" during the period, note 25. In years where there is not a formal valuation, an indexation factor is applied based on the BICS indices supplied by DVS Property Services.

Intangible assets estimation

The Trust has two types of intangible assets:

- Smaller projects which involve the development of exiting systems, which is spent and capitalised in year.
- Intangible assets with a significant carrying value which have been developed over several years and accounted for in assets under construction. When the system goes live, a full fair value review is undertaken and only the costs directly attributable to the development are capitalised, all other costs are impaired or allocated to revenue.

Provisions estimation

The Trust holds a provision for pensions and by its nature this includes a degree of uncertainty in respect of timings and amount, due to the uncertainty over life expectancy. Future liability is calculated using actuarial values, note 34.

There was an employment tribunal held that concluded on 1st May 2015, at which the Trust received a provisional view on the outcome. The Trust will know the final outcome in September 2015.

1.6 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 received. The main source of income for the Trust is from contracts with commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following 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.

1.7 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.8 Expenditure on other goods and services

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable for 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.

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to, the Trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably; and
- The item has an individual cost of at least £5,000 or collectively, a number of items have a cost of at least £5,000 and individually have cost more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment is measured initially at cost, representing the cost 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. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period, in years where a revaluation does not take place, an indexation factor is applied.

Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction 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, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset.

This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where all impairments were taken to the revaluation Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

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".

De-recognition

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use.

This condition is regarded as met when the sale is highly probable the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to the income and expenditure reserve. 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 that is due to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.10 Donated, government grant and other 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 imposes 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.

1.11 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as "on-Statement of Financial Position" by the Trust. In accordance with IAS17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

Services received

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to "Finance Costs" within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and

the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ("lifecycle replacement") are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

The above is a change to previous years where the Trust accounted for lifecycle using a smoothed method where a prepayment was placed in the accounts and released to capital or revenue when works have been completed.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a "free" asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme.

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.12 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when:

- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- Where the cost of the asset can be measured reliably, and
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operating of hardware, for example an operating system is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use
- The intention to complete the intangible asset and use it
- The ability to sell or use the intangible asset
- How the intangible asset will generate probable future economic benefits or service potential the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

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 fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis),

and indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out cost formula. This is considered to be a reasonable approximation due to the high turnover of inventories.

1.14 Cash and cash equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash deposits held by the Trust are available without notice or penalty.

1.15 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-Financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "loans and receivables."

Financial liabilities are classified as "other financial liabilities."

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and "other debtors".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to "Finance Costs". Interest on financial liabilities taken out to finance property, plant

and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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.

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 the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account/bad debt provision.

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.

1.16 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/ (deficit).

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. Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

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

1.17 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 HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.30% (2013/14: 1.8%) in real terms.

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 on-going activities of the entity.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed in note 34 to the NHS Foundation Trust accounts, however is not recognised.

Non-clinical risk pooling

The NHS Foundation 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 the NHS Litigation Authority 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.

1.18 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 35.2 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35.1, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 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 Trust. HM treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A Charge, reflecting the cost of capital utilised by the NHS foundation 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 NHS foundation 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 and National Loan Fund (NLF) deposits, excluding cash balances held in GBS accounts that relates to short-term working capital facility

(iii) PDC dividend receivable or payable.

In accordance with the requirements laid down by the Department of Health (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 occurs as a result of the audit of the annual accounts.

1.20 Value Added Tax

Most of the activities of the NHS Foundation 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.

1.21 Corporation Tax

The NHS Foundation Trust has determined that it has no corporation tax liability, based on the NHS Foundation Trust undertaking no business activities.

1.22 Foreign exchange

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise. Foreign exchange transactions are negligible.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 40 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.24 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 NHS Foundation Trusts 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.

1.25 Acquisitions and discontinued operations

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 sector body to another.

1.26 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Income on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.27 Accounting standards that have been issued and have not yet been adopted

The Treasury FReM does not require the following standards and interpretations to be applied in 2014/15. The application of the standards as revised would not have a material impact on the accounts for 2014/15, were they applied in that year:

IFRS 9 Financial instruments

IFRS 13 Fair value measurement

IFRS 15 Revenue from contracts with customers

2. Operating segments

The Trust has only one operating segment; that is the provision of healthcare services.

The total amount of income from the provision of healthcare services during the accounting period is £119,634k, including £111,223k from Clinical Commissioning Groups (CCGs).

	2014/15	2013/14
	£000	£000
Clinical income	**119,634**	116,735
Non clinical income	**11,799**	10,839
Pay	**(95,079)**	(94,046)
Non pay	**(36,520)**	(33,007)
Surplus /(deficit)	**(166)**	521

The Trust generated over 10% of income from the following organisations:

	2014/15	2013/14
	£000	£000
Southern Derbyshire CCG	**62,081**	61,332
North Derbyshire CCG	**21,965**	20,124

3. Income generation activities

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes.

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care, although those activities do not provide material sources of income or have a full cost of over £1m.

4. Income

4.1 Income from patient care activities (by type)

	2014/15	2013/14
	£000	£000
Clinical Commissioning Groups	**111,223**	107,697
NHS Other	**56**	0
Foundation Trusts	**236**	212
Local Authorities	**7,688**	8,301
Non-NHS Other	**431**	525
	119,634	116,735

4.2 Income from patient care activities (class)

	2014/15	2013/14
	£000	£000
Cost and Volume Contract income	**6,689**	6,838
Block Contract income	**108,179**	105,397
Other clinical income from mandatory services	**4,766**	4,500
	119,634	116,735

As part of the NHS Provider licence and the Continuity of Services Condition the Trust has a significant proportion of patient care activities designated as Commissioner Requested Services. The total income from Commissioner Requested Services is contained in note 4.3.

4.3 Income from commissioner requested services

Out of the services provided by the Trust through the main Commissioner contract for Mental Health including Child and Adolescent Mental Health Services (CAMHS), Learning Disabilities, Prisons and Children's Services a significant proportion (99%) are deemed through the contract to be Commissioner Requested Services. The value of the income for those Commissioner Requested Services is £103m. All other income stated in the accounts is generated from non-Commissioner Requested Services.

	2014/15	2013/14
	£000	£000
Commissioner requested services	103,246	100,873
Non-commissioner requested services	28,187	26,676
Total income	**131,433**	**127,549**

4.4 Overseas visitors

The Trust has not received any income from overseas visitors.

5. Other operating income

	2014/15	2013/14
	£000	£000
Research and development	**347**	309
Education and training	**3,875**	3,997
Staff costs	**2,151**	1,884
Reversal of impairment	**260**	0
Profit on disposal of land and buildings	**348**	8
Other revenue	**4,818**	4,616
	11,799	10,814

Other revenue includes:		
Estates recharges	**82**	418
PFI Land contract	**60**	60
Property services facilities contract	**537**	432
Catering	**198**	194
Property rentals	**27**	55
Pharmacy sales	**2,443**	1,811
Services to specialist schools	**340**	630
Other income elements	**1,131**	1,016
	4,818	4,616

6. Income

	2014/15	2013/14
	£000	£000
From rendering of services	**131,433**	127,549

Income from the sale of goods is Nil.

7. Operating expenses

	2014/15	2013/14
	£000	£000
Services from NHS Foundation Trusts	**2,788**	2,398
Services from other NHS bodies	**826**	1,276
Services from CCGs & NHS England	**96**	43
Purchase of healthcare from non NHS bodies	**4,796**	3,907
Employee expenses - Executive Directors	**871**	821
Employee expenses - Non-Executive Directors	**117**	111
Employee expenses - staff	**94,048**	93,114
Drug costs	**3,647**	3,226
Supplies and services - clinical (excluding drug costs)	**226**	318
Supplies and services - general	**916**	973
Establishment	**2,921**	1,296
Transport	**1,517**	1,794
Premises - business rates payable to local authorities	**603**	0
Premises	**3,496**	5,585
Rentals from operating leases	**1,599**	1,816
Increase / (decrease) provisions	**1,420**	308
Depreciation on property, plant and equipment	**2,797**	2,708
Amortisation of intangible assets	**539**	451
Impairments of property, plant and equipment	**747**	1,063
Impairments of Intangibles	**907**	286
Impairment of financial assets	**544**	0
Impairments of assets held for sale	**46**	0
Audit services- statutory audit	**48**	47
Clinical negligence costs	**316**	266
Legal fees	**243**	150
Consultancy costs	**70**	286
Training, courses and conferences	**521**	388
Patient travel	**15**	29
Car parking & security	**0**	25
Redundancy	**43**	271
Hospitality	**28**	20
Insurance	**19**	31
Other services, e.g. external payroll	**467**	380
Losses, ex gratia and special payments	**10**	10
Publishing	**92**	106
Other	**381**	298
	127,720	123,801

8. Operating leases

8.1 As lessee

Operating lease commitments relate to properties rented by the Trust and also leased car arrangements.

Payments recognised as an expense	2014/15	2013/14
	£000	£000
Minimum lease payments	**1,599**	1,816

The figures above include lease car payment and are reflected net, during the period the Trust has received employee contributions equating to £386k (2013/14 £420k).

Total future sublease payments expected to be received: £nil

Total future minimum lease payments	2014/15				2013/14
	Buildings	Land	Other	Total	Total
	£000	£000	£000	£000	£000
Payable:					
Not later than one year	**1,084**	**0**	**90**	**1,174**	1,189
Between one and five years	**3,764**	**0**	**613**	**4,377**	4,508
After five years	**14,180**	**0**	**0**	**14,180**	14,534
Total	**19,028**	**0**	**703**	**19,731**	20,231

8.2 As lessor

The Trust does not have any operating lease arrangements relating to property that the Trust owns and leases to a third party.

9. Employee costs and numbers

9.1 Employee costs

	31 March 2015			31 March 2014		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	**73,060**	**67,960**	**5,100**	70,754	66,421	4,333
Social security costs	**5,230**	**4,896**	**334**	5,293	4,930	363
Employer contributions to NHS pension scheme	**9,230**	**8,641**	**589**	9,234	8,601	633
Other employment benefits	**43**	**43**	**-**	-	-	-
Agency/contract staff	**8,139**	**-**	**8,139**	10,104	-	10,104
Termination benefits	**-**	**-**	**-**	271	271	-
Employee benefits expense	**95,702**	**81,540**	**14,162**	95,656	80,223	15,433
Of the total above:						
Charged to capital	**740**			1,450		
Employee benefits charged to revenue	**94,962**			94,206		
	95,702			95,656		

There has been 1 case of early retirements due to ill health in year at a value of £61k (2013/14 – 3 cases at £179k).

9.2 Average number of people employed

	31 March 2015			31 March 2014		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	**142**	**142**	**-**	148	148	-
Administration and estates	**462**	**462**	**-**	473	473	-
Healthcare assistants and other support staff	**426**	**426**	**-**	431	431	-
Nursing, midwifery and health visiting staff	**825**	**825**	**-**	839	839	-
Scientific, therapeutic and technical staff	**265**	**265**	**-**	232	232	-
Other	**289**	**-**	**289**	233	-	233
Total	**2,409**	**2,120**	**289**	2,356	2,123	233
Of the above:						
Number of whole time equivalent staff engaged on capital projects	**11**			22		

9.3 Management costs

	2014/15	2013/14
	£000	£000
Management costs	**7,696**	7,517
Income	**131,433**	127,549
Management costs as a percentage of total Trust income is	**5.86%**	5.89%

9.4 Directors' remuneration and other benefits

The aggregate of remuneration and other benefits receivable by directors from 1 April 2014 to 31 March 2015 is £988k (2013/14 £932k).

Included in the above costs are employer pension contributions of £100k (2013/14 £100k)

9.5 Exit packages

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Guidance. Exit costs in this note are accounted for in full in the year the Trust has legally committed to the departure. 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.

This disclosure reports the number and value of exit packages taken by staff legally agreed in the period.

During the period Derbyshire Healthcare NHS Foundation Trust incurred exit costs for a number of employees.

Reporting of other compensation schemes – exit packages 2014/15

Exit Package cost band (including any special payment element)	Number of Compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
<£10,000	3	18	0	0	3	18	0	0
£10,001-£25,000	1	25	0	0	1	25	0	0
£25,00-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,001	0	0	0	0	0	0	0	0
Total	4	43	0	0	4	43	0	0

Reporting of other compensation schemes - exit packages 2013/14

Exit Package cost band (including any special payment element)	Number of Compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
<£10,000	4	17	0	0	4	17	0	0
£10,001-£25,000	0	0	1	24	1	24	0	0
£25,00-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	2	128	0	0	2	128	0	0
£100,001-£150,000	1	102	0	0	1	102	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,001	0	0	0	0	0	0	0	0
Total	7	247	1	24	8	271	0	0

10. Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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 the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits

provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation."

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11. Better Payment Practice Code

	31 March 2015		31 March 2014	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	**21,985**	**27,227**	20,502	27,552
Total non NHS trade invoices paid within target	**20,035**	**23,536**	19,015	24,159
Percentage of non-NHS trade invoices paid within target	**91%**	**86%**	93%	88%
Total NHS trade invoices paid in the year	**1,088**	**14,225**	1,039	12,708
Total NHS trade invoices paid within target	**789**	**10,394**	779	9,759
Percentage of NHS trade invoices paid within target	**73%**	**73%**	75%	77%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

12. The Late Payment of Commercial Debts (Interest) Act 1998

No payments were made in respect of the Late Payment of Commercial Debt (Interest) Act 1998.

13. Finance income

Finance income was received in the form of bank interest receivables totalling £29k (2013/14 £25k).

14. Other gains and losses

The Trust made no other gains or losses during the period of account

15. Finance costs

	2014/15	2013/14
	£000	£000
Finance lease costs	**296**	168
Interest on obligations under PFI contracts:		
- main finance cost	**1,722**	1,077
- contingent finance cost	**471**	726
Total interest expense	**2,193**	1,803
Other finance costs	**0**	111
Total	**2,489**	2,082

16. Property, plant and equipment

2014/15	Land £000	Buildings excluding dwellings £000	Assets under construction (AUC) £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation:								
At 31 March 2014	16,290	68,983	801	1,650	108	6,245	1,949	96,026
Additions	0	947	1,522	0	0	129	53	2,651
Impairments	0	(146)	0	0	0	0	0	(146)
Reclassifications	0	162	(565)	0	0	103	300	0
Reclassification – write back of depreciation on-revaluation	0	(9,490)	0	0	0	0	0	(9,490)
Revaluations	155	6,153	0	0	0	0	0	6,308
Transferred to disposal group as asset held for sale	0	(90)	0	0	0	0	0	(90)
Disposals	(350)	(367)	0	(11)	0	(1,456)	0	(2,184)
At 31 March 2015	**16,095**	**66,152**	**1,758**	**1,639**	**108**	**5,021**	**2,302**	**93,075**
Depreciation								
At 31 March 2014	0	8,491	16	1,127	72	5,336	1,027	16,069
Provided during the year	0	2,134	0	115	15	328	205	2,797
Impairments	0	659	88	0	0	0	0	747
Reclassification – write back of depreciation on revaluation	0	(9,490)	0	0	0	0	0	(9,490)
Disposals	0	(208)	0	(11)	0	(1,456)	0	(1,675)
At 31 March 2015	**0**	**1,586**	**104**	**1,231**	**87**	**4,208**	**1,232**	**8,448**
Net book value at 31 March 2015	**16,095**	**64,566**	**1,654**	**408**	**21**	**813**	**1,070**	**84,627**
Net book value	£000	£000	£000	£000	£000	£000	£000	£000
Owned	16,095	28,086	1,654	408	21	813	1,070	48,147
Finance lease	0	700	0	0	0	0	0	700
PFI	0	35,780	0	0	0	0	0	35,780
Total at 31 March 2015	**16,095**	**64,566**	**1,654**	**408**	**21**	**813**	**1,070**	**84,627**

During 2014/15 there was a full revaluation of the Trust's estate. During this exercise it was found that the land sizes at Kingsway site and the Radbourne Unit had been under estimated in previous year's revaluations. The value of the change is £3.9m, which has led to a Prior Period Adjustment in the accounts. The accounting statements and Note 16 in 2013/14 have been restated to show this adjustment, as if it had shown in the accounts last year. This has changed the opening balances for land in the above table. Details of the adjustment are provided in Note 42.

16.1 Revaluation reserve balance for property, plant and equipment

	Land	Buildings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
At 1st April 2014	12,653	15,405	11	0	1	20	28,090
Movements	127	5,883	(11)	0	(1)	(20)	5,978
At 31 March 2015	**12,780**	**21,288**	**0**	**0**	**0**	**0**	**34,068**

The balances on non Land and Buildings have been transferred to the Income and Expenditure Reserve in the Statement of Change in Taxpayers Equity.

16.2 Property, plant and equipment - Restated

2013/14	Land	Buildings excluding dwellings	Assets under	Plant & machinery	Transport equipment		Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2013	16,290	62,559	1,737	1,756	251	7,763	1,927	**92,283**
Absorption costing	0	0	0	3	0	0	0	**3**
Additions	0	1,246	453	0	0	271	38	**2,008**
Reclassifications - AUC	0	815	(1,149)	0	(2)	142	194	**0**
Reclassifications - Other	0	0	(240)	(24)	(71)	(995)	(199)	**(1,529)**
Revaluations	0	4,422	0	0	0	0	0	**4,422**
Disposals	0	(59)	0	(85)	(70)	(936)	(11)	**(1,161)**
At 31 March 2014	16,290	68,983	801	1,650	108	6,245	1,949	**96,026**
Depreciation								
At 1 April 2013	0	5,532	240	1,088	198	6,879	1,049	**14,986**
Prior year adjustment	0	0	0	0	0	0	0	**0**
Provided during the year	0	1,983	0	137	15	387	186	**2,708**
Impairments	0	1,033	16	11	0	1	2	**1,063**
Reclassifications - other	0	0	(240)	(24)	(71)	(995)	(199)	**(1,529)**
Disposals	0	(57)	0	(85)	(70)	(936)	(11)	**(1,159)**
At 31 March 2014	0	8,491	16	1,127	72	5,336	1,027	**16,069**
Net book value at 31 March 2014	16,290	60,492	785	523	36	909	922	**79,957**
Net book value	£000	£000	£000	£000	£000	£000	£000	**£000**
Owned	16,290	25,939	785	523	36	909	922	**45,404**
Finance lease	0	1,454	0	0	0	0	0	**1,454**
PFI	0	33,099	0	0	0	0	0	**33,099**
Total at 31 March 2014	16,290	60,492	785	523	36	909	922	**79,957**

The opening balance figure above has been restated to £16,290k from £12,390k to reflect the change in land sizes. See Note 42 for details.

16.3 Revaluation reserve balance for property, plant and equipment restated

	Land	Buildings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2013	12,653	11,071	11	0	1	20	23,756
Movements	0	4,334	0	0	0	0	4,334
At 31 March 2014	**12,653**	**15,405**	**11**	**0**	**1**	**20**	**28,090**

The above note has been restated due to the Prior Period Adjustment detailed in note 16.2, changing the opening balance for Land from £8,753k to £12,653k.

16.4 Valuation

A full valuation has been performed on the Trust's land and buildings by the DVS Property Specialists in year. Assets have been valued at market value for land and non-specialised buildings or at depreciated replacement cost for specialised buildings.

Overall there was an increase in buildings of £6,015k and Land £4,055k which includes the prior year adjustment of £3.9m.

16.5 Economic life of property, plant and equipment

The following table shows the range of estimated useful lives for property, plant and equipment assets.

	Min life	Max life
	Years	Years
Land	50	90
Buildings excluding dwellings	2	90
Assets under construction and POA	5	90
Plant and machinery	5	15
Transport equipment	5	10
Information technology	5	5
Furniture and fittings	5	15

16.6 Property plant and equipment: Commissioner requested services

One building has been sold in year which Commissioner Requested Services were provided from. The service provision has continued and the service is being delivered from another existing Trust property which was previously under-utilised. The Trust's obligation to provide the Commissioner Requested Service has not been affected through the disposal of this property. This property had been declared surplus in 2012/13 but as it was still in use until its sale, it did not show in assets held for sale. The property was sold for £860k and had a NBV of £510k, Note 5 shows a profit of £347k, the £3k adjustment relates to legal fees of the sale.

17. Intangible assets

2014/15	Software licences (purchased)	Information Technology (internally generated)	Assets under Construction (AUC)	Total
Cost or valuation:	**£000**	**£000**	**£000**	**£000**
At 1 April 2014	484	2,158	2,701	**5,343**
Additions purchased	354	468	174	**996**
Reclassifications	117	1,470	(1,587)	**0**
Reclassification of amortisation	0	0	(1,193)	**(1,193)**
Disposals	0	(450)	0	**(450)**
At 31 March 2015	**955**	**3,646**	**95**	**4,696**
Amortisation				
At 1 April 2014	138	988	286	**1,412**
Provided during the year	101	438	0	**539**
Impairments	0	0	907	**907**
Reclassification to cost	0	0	(1,193)	**(1,193)**
Disposals	0	(450)	0	**(450)**
At 31 March 2015	**239**	**976**	**0**	**1,215**
Net book value at 31 March 2015	**716**	**2,670**	**95**	**3,481**
Net book value				
Owned	716	2,670	95	**3,481**
Total at 31 March 2015	**716**	**2,670**	**95**	**3,481**

17.1 Intangible assets

2013/14				
Cost or valuation:				
At 1 April 2013	150	2,727	945	**3,822**
Additions purchased	204	52	2,196	**2,452**
Reclassifications	127	313	(440)	**0**
Revaluations	3	(896)	0	**(893)**
Disposals	0	(38)	0	**(38)**
At 31 March 2014	**484**	**2,158**	**2,701**	**5,343**
Amortisation				
At 1 April 2013	55	1,551	0	**1,606**
Provided during the year	80	371	0	**451**
Impairments	0	0	286	**286**
Reclassifications	3	(896)	0	**(893)**
Disposals	0	(38)	0	**(38)**
At 31 March 2014	**138**	**988**	**286**	**1,412**
Net book value at 31 March 2014	346	1,170	2,415	**3,931**
Net book value				
Owned	346	1,170	2,415	**3,931**
Total at 31 March 2014	**346**	**1,170**	**2,415**	**3,931**

All intangible assets both those internally developed and purchased have an economic life of five years except the development of the Electronic Patient Records system which is amortised over 10 years.

18. Impairments

Impairments have arisen in year due to several factors, these include buildings with substantial capital work being undertaken in year being revalued, de-recognition of replaced assets and writes offs through asset verification. In year there have been impairments of £2,130k, £1,984k has been charged to income and expenditure and £146k to the revaluation reserve. The reversal of impairments relate to a change in the Finance Lease calculation.

	2014/15	2013/14
	£000	£000
Impairments for land and buildings classified as held for sale	**46**	0
Impairments for property, plant and equipment	**747**	1,063
Impairments for intangibles	**907**	286
Impairments of financial assets (PFI)	**544**	0
Reversal of impairments on financial assets (Finance Lease)	**(260)**	0
Impairments written to income and expenditure	**1,984**	1,349
Impairments for property, plant and equipment to revaluation reserve	**146**	0
	2,130	1,349

19. Commitments

19.1 Capital commitments

The trust does not have any capital commitments as at 31 March 2015.

20. Inventories

20.1 Inventories

	2014/15	2013/14
	£000	£000
Finished goods	**165**	172
Total	**165**	172
Of which held at net realisable value:	**0**	0

20.2 Inventories recognised in expenses

	2014/15	2013/14
	£000	£000
Inventories recognised as an expense in the period	**2,477**	2,583
Write-down of inventories (including losses)	**0**	
Reversal of write-downs that reduced the	**0**	0
Expense	**0**	0
Total	**2,477**	2,583

21. Trade and other receivables

21.1 Trade and other receivables

	Current	Non-current	Current	Non-current
	2014/15	2014/15	2013/14	2013/14
	£000	£000	£000	£000
NHS receivables-revenue	**1,190**	**0**	1,809	0
Related party receivables	**685**	**0**	1,415	0
Provision for the impairment of receivables	**(131)**	**0**	(306)	0
Prepayments and accrued income	**806**	**280**	811	1,364
VAT receivables	**138**	**0**	162	0
Other receivables	**525**	**0**	677	0
Total	**3,213**	**280**	4,568	1,364

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

21.2 Receivables past their due date but not impaired

	2014/15	2013/14
	£000	£000
By up to three months	**2,598**	2,290
By three to six months	**46**	26
By more than six months	**61**	104
Total	**2,705**	2,420

Invoices are raised on a 30 day payment term basis.

21.3 Provision for impairment of receivables

	2014/15	2013/14
	£000	£000
Opening balance	**(306)**	(122)
Amount written off during the period	**0**	0
Amount utilised	**67**	38
(Increase)/decrease in receivables impaired	**108**	(222)
Balance at 31 March	**(131)**	(306)

22. Other financial assets

There are no other financial assets as at 31st March 2015.

23. Other current assets

There are no other current assets as at 31st March 2015.

24. Cash and cash equivalents

	31 March 2015	31 March 2014
	£000	£000
Balance at 31 March	**6,848**	7,416
Net change in period	**4,794**	(568)
Balance at period end	**11,642**	6,848
Made up of		
Cash with Government banking services	**11,613**	6,814
Commercial banks and cash in hand	**29**	34
Cash and cash equivalents as in statement of cash flows	**11,642**	6,848

25. Non-current assets held for sale

	Land	Buildings	Total
	£000	£000	£000
Balance at 31 March 2014	80	86	**166**
Plus assets classified as held for sale in the year	0	90	**90**
Less impairments of assets held for sale	0	(46)	**(46)**
Balance at 31 March 2015	**80**	**130**	**210**
Balance at 31 March 2013	125	136	261
Less assets sold in the year	(45)	(50)	(95)
Balance at 31 March 2014	80	86	166

Assets have been declared as available for sale because they have been considered as part of the Trusts overall review of its estate, the operating requirements have been deemed surplus to the Trust Board. Only two buildings are included as held for sale.

26. Trade and other payables

	Current	Current
	2014/15	2013/14
	£000	£000
NHS payables	**2,386**	2,454
Trade payables - capital	**773**	228
Other trade payables	**3,168**	3,119
Payables with related parties	**2,440**	1,283
Other payables	**111**	1,347
Tax payable	**820**	820
Social Security costs	**848**	829
Accruals	**1,794**	1,546
Total	**12,340**	**11,626**

The Trust does not have any non-current liabilities.

Related parties include:

£1,296k outstanding pensions contributions at 31 March 2015, last year these were included in other payables (31 March 2014 £1,250k). These were paid in April 2015.

27. Borrowings

	Current	Non-current	Current	Non-current
	2014/15	2014/15	2013/14	2013/14
	£000	£000	£000	£000
Finance lease	**0**	**1,098**	19	1,621
PFI liabilities	**866**	**27,554**	745	28,817
Total	**866**	**28,652**	764	30,438

The Trust has a PFI contract with Arden Partnership to operate and service buildings to provide patient care and clinical support services. The contract is due to expire during 2039. The finance leases relate to St Andrews House, the contract is due to expire during 2037. In 2013/14 there was an additional finance lease on Dale Bank View, in year this building was purchased by the Trust.

28. Other liabilities

	Current	Current
	2014/15	2013/14
	£000	£000
Deferred income	**828**	494
Total	**828**	494

The Trust has no other liabilities.

29. Finance lease obligations

The Trust has one finance lease, this is St Andrews House in Derby which is used to provide clinical and admin services.

Details of the lease charges are below:

	2014/15	2013/14
	£000	£000
Not later than one year	**168**	205
Later than one year, not later than five years	**672**	818
Later than five years	**2,907**	3,367
Sub total	**3,747**	4,390
Less: interest element	**(2,649)**	(2,750)
Total	**1,098**	1,640

30. Finance lease receivables

The Trust does not have any finance lease arrangements as a lessor.

31. Finance lease commitments

The Trust has one finance lease and is committed to paying the following.

	2014/15	2013/14
	£000	£000
Not later than one year	**168**	205
Later than one year, not later than five years	**672**	818
Later than five years	**2,907**	3,367
Total	**3,747**	4,390

32. Private Finance Initiative contracts

32.1 PFI schemes on-statement of financial position

The Trust has a PFI contract with Arden Partnership to operate and service buildings to provide patient care and clinical support services. The contract is due to expire in 2039.

Under IFRIC 12, the asset is treated as an asset of the Trust; that the substance of the contract is that the Trust has a finance lease and payments comprise two elements - imputed finance lease charges and service charges.

Details of the imputed finance lease charges are shown in the table below:

Total obligations for on-statement of financial position PFI contracts due also below:

	2014/15	2013/14
	£000	£000
Not later than one year	**2,285**	1,795
Later than one year, not later than five years	**8,725**	7,178
Later than five years	**38,099**	36,057
Sub total	**49,109**	45,030
Less: interest element	**(20,690)**	(15,468)
Total	**28,419**	29,562

32.2 Charges to expenditure

The total charged in the period to expenditure in respect of the service element of on-statement of financial position PFI contracts was £900k (prior year £897k).

At present value the Trust is committed to the following charges:

	2014/15	2013/14
	£000	£000
Not later than one year	**939**	904
Later than one year, not later than five years	**3,804**	3,661
Later than five years	**19,115**	19,382
Total	**23,858**	23,947

The Trust's PFI model is updated for inflation each year, the 2014/15 figures below shows the Trust's commitments if a 2.5% RPI increase is applied each year:

	2014/15	2013/14
	£000	£000
Not later than one year	**958**	927
Later than one year, not later than five years	**4,127**	3,993
Later than five years	**27,882**	28,818
Total	**32,967**	33,738

32.3 Future unitary payments

The table below shows the Trust's total commitments for the PFI scheme until 2039.

	Within 1 year	2-5 Years	Over 5 years	Total
	£000	£000	£000	£000
Operating costs	958	4,127	27,882	**32,967**
Financing expenses	1,942	7,921	43,154	**53,017**
Capital repayments	866	3,484	24.070	**28,420**
Lifecycle costs	212	1,399	13,329	**14,940**
Total	**3,978**	**16,931**	**108,435**	**129,344**

33. Other financial liabilities

The Trust has no other financial liabilities.

34. Provisions

	Current	Non-current	Current	Non-current
	2014/15	2014/15	2013/14	2013/14
	£000	£000	£000	£000
Pensions	**190**	**2,754**	185	2,534
Legal claims	**89**	**0**	66	0
Redundancy	**209**	**0**	454	0
Other	**1,364**	**0**	115	0
Total	**1,852**	**2,754**	820	2,534

	Pensions relating to other staff	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2014	**2,719**	**66**	**454**	**115**	**3,354**
Arising during the period	186	66	302	1,249	1,803
Change in discount rate	211	0	0	0	211
Used during the period	(189)	(19)	(422)	0	(630)
Reversed unused	(33)	(24)	(125)	0	(182)
Unwinding of discount	50	0	0	0	50
At 31 March 2015	**2,944**	**89**	**209**	**1,364**	**4,606**
Expected timing of cash flows:					
Within one year	190	89	209	1,364	1,852
Between one and five years	758	0	0	0	758
After five years	1,996	0	0	0	1,996
	2,944	**89**	**209**	**1,364**	**4,606**

The Trust holds a provision for pensions and by its nature this includes a degree of uncertainty in respect of timings and amount, due to the uncertainty of life expectancy. Future liability is calculated using actuarial values.

Other provisions - There was an employment tribunal held that concluded on 1 May 2015, at which the Trust received a provisional view on the outcome. The Trust will know the final outcome in September 2015. Also included in this figure are other employee related claims.

£191k is included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities of the Trust (31 March 2014 £399k).

35. Contingencies

35.1 Contingent Liabilities

From time to time trusts are subject to employment claims made against them which could give rise to a possible future obligation. The Trust has one such claim ongoing.

35.2 Contingent assets

Contingent assets are disclosed where a possible asset exists as a result of past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control. Contingent assets are disclosed only where the future inflow of economic benefit is considered to be probable. The Trust has one contingent asset that relates to a contract clause in a sale of land, the timing is currently unknown.

36. Financial instruments

36.1 Financial assets

	2014/15	2013/14
	Loans and receivables	Loans and receivables
	£000	£000
Trade receivables	**2,340**	3,895
Cash at bank and in hand	**11,642**	6,848
Total at 31 March	**13,982**	10,743

36.2 Financial liabilities

	2014/15	2013/14
	Other	Other
	£000	£000
Trade payables	**8,105**	8,203
PFI and finance lease obligations	**29,517**	31,202
Total at 31 March	**37,622**	39,405

IFRS 7 requires the Foundation Trust to disclose the fair value of financial liabilities. The PFI scheme is a non-current Financial Liability where the fair value is likely to differ from the carrying value. The Trust has reviewed the current interest rates available on the market and if these were used as the implicit interest rate for the scheme the fair value of the liability would range from £26,327k to £30,251k.

36.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with clinical commissioning groups and the way those clinical commissioning groups 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. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity 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 rate fluctuations.

Interest rate risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Derbyshire Healthcare NHS FT is not, therefore, exposed to significant interest rate risk.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's cash flows are mainly stable and predictable. Operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated sources. The Trust has access to a working capital facility of £9.3m which is available as and when required, although it has not used this facility in the accounting period. The Trust is not, therefore, exposed to significant liquidity risks.

37. Events after the reporting period

There were no post balance sheet events for the period ending 31 March 2015.

38. Audit fees

The analysis below shows the total fees paid or payable for the period in accordance with the

Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008 (SI 2008/489).

	2014/15	2013/14
External audit fees	**£000**	**£000**
Statutory audit services	48	46
Other professional fees	4	0

39. Related party transactions

Derbyshire Healthcare NHS Foundation Trust is a public benefit corporation authorised by Monitor - the Independent Regulator for NHS Foundation Trusts. 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.

The value of transactions with government bodies and other related parties with which the Trust has had material dealings and which therefore require disclosure are:

	Income	Expenditure	Receivables	Payables
2014/15	**£000**	**£000**	**£000**	**£000**
Related parties with other NHS bodies	120,739	8,743	1,569	3,443
2013/14				
Related parties with other NHS bodies	115,538	11,690	2,155	2,834

During the financial period no Board Members of Derbyshire Healthcare NHS Foundation Trust have had related party relationships with organisation where we have material transactions and could have a controlling interest.

The Department of Health is regarded as a related party. During the period Derbyshire Healthcare 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 Department. These entities are listed below:

Southern Derbyshire Clinical Commissioning Group

North Derbyshire Clinical Commissioning Group

Hardwick Clinical Commissioning Group

Erewash Clinical Commissioning Group

Derby Teaching Hospitals NHS Foundation Trust

Derbyshire Community Health Services NHS Foundation Trust

NHS England

Health Education England

Chesterfield Royal Hospital NHS Foundation Trust

Sheffield Health and Social Care NHS Foundation Trust

NHS Purchasing and Supply Agency

East Midlands Ambulance Service NHS Trust

NHS Business Authority

NHS Shared Business Services

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with Derby City Council and Derbyshire County Council.

The Trust has also received payments from a number of charitable funds. The members of the NHS Trust Board are also the Trustees for Charitable Funds. The audited accounts for the Funds Held on Trust are available from the Communications Department. From the 1 July 2011 the management of the charitable funds was transferred to Derbyshire Community Health Services NHS Foundation Trust.

The Register of Interests is available from the Legal Department.

40. Third party assets

The Trust held £72k cash and cash equivalents at 31 March 2015 (£113k 31 March 2014) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

The Trust administers deposit accounts on behalf of the patients. These are held in external accounts in the patient's names at a value of £28k.

41. Losses and special payments

There were 30 cases of losses and special payments worth £29k (2013/14 - there were 34 cases totalling £62k).

	2014/15 Total number of cases	2014/15 Total value of cases	2013/14 Total number of cases	2013/14 Total value of cases
	Number	£000's	Number	£000's
Cash losses	**4**	**1**	2	0
Bad debts and claims abandoned	**3**	**1**	8	11
Loss of stock	**1**	**0**		
Special payments				
- compensation payments	**8**	**24**	15	50
- ex gratia payments	**14**	**3**	9	1
	30	**29**	34	62

Compensation payments relate to NHS Litigation Authority insurance excess paid on legal claims.

There were no clinical negligence, fraud, personal injury, compensation under legal obligation or fruitless payment cases where the net payment exceeded £250,000.

The above have been reported on an accruals basis and exclude provisions for future losses.

42. Prior Period Adjustment – Restated Statements and Notes

There has been a restatement of the 2012/13 and 2013/14 accounts and notes for a change in property values.

A full revaluation was undertaken in 2014/15 by the district valuer on the land and buildings owned by the Trust. It was found that the land sizes at the 2 sites had been undervalued by £3.9m in previous valuations due to incorrect land sizes on record. Under accounting standard IAS 1, it states that the Trust should restate the beginning of the preceding period to bring the change into the accounts, which is 2012/13, it should be noted that the error did not occur in this year.

The Statement of comprehensive income (SOCI), the statement of Financial Positions (SOFP), the Statement of Changes in Taxpayers Equity (SoCTE) and Note 16 have been affected by this change.

The following figures have been adjusted by £3.9m for the change in value:

	Original value	Restated value
	£000	£000
SOCI – Other comprehensive income 2012/13	4,552	8,452
SOFP – Property plant and equipment 2012/13	73,397	77,297
SOFP – 2012/13 revaluation reserve	19,853	23,756
SoCTE 2012/13 – Opening balance on revaluation reserve	5,043	8,943
Note 16 – Opening balance on land 2014/15	12,390	16,290

To obtain further copies of this Annual Report please contact **communications@derbyshcft.nhs.uk** or visit **www.derbyshirehealthcareft.nhs.uk**

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