Derbyshire Healthcare NHS
NHS Foundation Trust

Annual Report and Accounts

2013/14

Better together

Derbyshire Healthcare NHS Foundation Trust

Annual Report and Accounts 2013/14

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 2013/14

(1 April 2013 – 31 March 2014).


“Improving lives, strengthening communities, getting better together.”

Chairman's foreword

I have great pleasure in opening this Annual Report as the Chairman of Derbyshire Healthcare NHS Foundation Trust.

Since my appointment in January 2014 I have been impressed with the commitment of people involved with our services. I have met dedicated staff, empowered patients, and have seen strong working relationships with those with whom we develop and provide our services. The Trust's values are central to the work of the organisation and are embedded in our day to day activities.

The forthcoming year holds a number of challenges for the Trust as we seek to transform our services. We must strive to maintain the quality of care we provide whilst ensuring value for money. This will be a difficult task for Derbyshire Healthcare and our partner agencies. We are committed to working together for the people of Derbyshire.

The Trust has faced a number of changes and challenges over the last year, yet has maintained a strong performance throughout. We move into the new financial year with a refreshed Board, committed to achieving our vision of compassionate care in line with the strategic vision of the Trust. I particularly welcome Carolyn Green, Executive Director of Nursing and Patient Experience and Caroline Maley, Non-Executive Director who have joined the Board this year.

Many key achievements and developments have taken place over the last year and we have conceived and launched new services that demonstrate the commitment we have to work with our partners to deliver appropriate and responsive care to local people. Our highlights of the year are shared with you on pages 88-91 of this Annual Report.

I would like to thank our staff, partners, commissioners, service users, carers, advocates and members of our Foundation Trust for their support and contributions to our work during 2013/14. My special thanks go to our Governors. Their contributions are invaluable.

Mark Todd
Chairman

Chief Executive's introduction

This Annual Report reflects my first full year as Chief Executive for Derbyshire Healthcare NHS Foundation Trust. Throughout the year I have been impressed by the dedication of staff, service users, carers and partners working together to improve the quality of our services and, in turn, the health and wellbeing of our local communities.

2013/14 has been a year of strong underlying performance and development for the Trust. During the year we launched a number of new initiatives that innovatively provide greater levels of support for our patients when they need it most – for example a new Liaison team has been developed at the Royal Derby Hospital and a Street Triage pilot has been launched in partnership with Derbyshire Constabulary, bringing together support for people with urgent mental health needs in the evening and at weekends. On 1 April 2014 a new ward opened at the Radbourne Unit in Derby, reducing the need for local people to travel outside of Derbyshire to receive care.

The Trust has developed a mature response to the Francis Report, which has been implemented across both clinical and non-clinical areas of practice to enable all teams to understand the importance of their role and their responsibilities to ensure patients are at the heart of everything we do. We have also strengthened our quality visits to further embed our values into our culture and provide teams an opportunity to reflect on, and celebrate their practice.

This year has seen a number of shared challenges relating to the increasing financial pressures faced by the NHS and our social care colleagues and the Trust is working closely with our partners within the local economy to address this. As a Trust we are committed to working in partnership to do things differently, and we have embedded that approach across the Trust this year through our collaborative work on transforming our services.

I am proud to say that compassion is at the forefront of all we do within Derbyshire Healthcare and the values, which we have placed a real emphasis on embedding across the Trust, were truly reflected in our staff survey results this year. This is a credit to all our teams, who have worked hard over the last year to ensure our values and meaningful staff engagement is embedded throughout the Trust.

We have a number of exciting developments taking place over the forthcoming year as we continue to work closely with our staff, services users and community groups to adopt a 'no force first' approach and reduce the use of seclusion on our acute inpatient wards. We will also be strengthening our work around recovery; to embed recovery principles and education models across the Trust.

I look forward to working closely with all our colleagues, patients, carers and partners to achieve these developments during the forthcoming year.

Steve Trenchard
Chief Executive

1 Strategic Report

Introduction to the Strategic Report

This Strategic Report reflects on the financial year of 2013/14, whilst also taking a forward look at the Trust's challenges and ambitions for 2014/15.

2013/14 has been a year of significant change; externally we have felt the impact of increasing pressures from the UK's economic climate and internally we have embarked upon a programme of transformation, to ensure we are offering the very best and innovative care to our local community, whilst working within an ever tightening financial envelope.

We have seen the publication of a number of important reports – The Francis Report (Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry), The Keogh Report (Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England) and The Berwick Report (Improving the Safety of Patients in England). In response, our services have been working to ensure learning from these reviews is well communicated and implemented across our Trust, to ensure quality and openness of communication is integral to all we do. The commissioning landscape has continued to evolve and we have sought to consolidate good working relationships with our new commissioners.

The Trust's overarching strategy is to provide care to people in or as close to home as possible. We are aware that approximately 20 - 25% of local acute care admissions following an Accident and Emergency (A&E) attendance could be avoided, and we have supported our health economy partners by developing a Liaison Service based on the RAID (Rapid Assessment, Interface and Discharge) model in Derby, which will soon be replicated in Chesterfield. This service reduces the need for admissions and can reduce the length of stay for patients presenting at the acute sector providers with both mental and physical health needs. Our transformation plans include an initial increase in acute inpatient beds to address demand and the current need for out-of-area placements, with a later reduction of mental health inpatient beds over the five year period as community care provision is increased.

The Trust's two clinical priorities are to:

- Establish stronger ties with patients' and service users' families, through an initiative called Think! Family
- Address all issues in connection with suicide, to ensure that our services perform to the highest possible standards in relation to these areas.

Over the forthcoming year we will be working to ensure that the national principles relating to Parity of Esteem for mental health are applied across Derby and Derbyshire. There remains a disparity in the number of people with mental illness who are in contact with services, compared to those with physical health needs, yet mental ill health is a major cause of premature death and a high proportion of people's lives are impacted by mental health conditions. Mental ill health represents the largest proportion of the disease burden within the UK (22.8%), larger than cardiovascular disease (16.2%) or cancer (15.9%) and yet only 26% of adults with mental illness receive appropriate care.

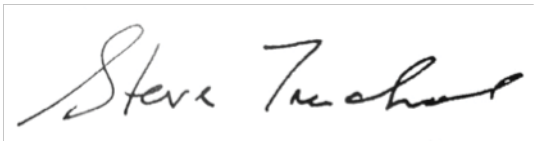
Over the forthcoming years we expect to see a rise in demand for our services. Our forecast modelling shows an ageing population across Derbyshire, with areas of continued deprivation. In response to this projection, we anticipate significant increased need for dementia and general mental health services and we are working to model services based in local communities for people of all ages that minimise the need for admission to hospital. We are committed to transforming our services in order to provide care in a different way, to effectively address these challenges and the needs of our local communities. We are proactively looking at different models of health care delivery across the world, in order to learn from best practice and align any potential changes to support recovery principles.

This commitment to innovation and the needs of the local population, driving the way in which we deliver services, will require a cultural shift in order to truly embrace the principles of co-production (for more about our focus on a recovery based approach to services, please see page 35 of this Annual Report. Our transformation work has started to identify ways in which the Trust will be able to address the workforce challenges that these changes present. Transformation and recovery will continue to be major themes for the Trust over the forthcoming year and further details on our work in these areas can be found on pages 33 and 35 of this strategic report.

During 2014/15 and 2015/16 we will continue to lead the local development of the clinical outcomes linked to the National Tariff Payment System (NTPS) for mental health services whilst engaging nationally to influence future design.

The Annual Accounts for 2013/14 show our financial performance for the year. The full set of our accounts can be accessed on pages 138 - 176 of this Annual Report. The Trust's Strategy and Operational Plan can be accessed via **www.derbyshcft.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
On behalf of Derbyshire Healthcare NHS Foundation Trust Board
28 May 2014

The Strategic Report is part of Derbyshire Healthcare NHS Foundation Trust's Annual Report and Accounts. To access a full copy of the 2013/14 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 an integrated provider of specialist mental health services across the city of Derby and wider county of Derbyshire. We also provide a range of children's physical and mental health services in Derby, and 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.

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

The Trust delivers care through a structure of two clinical divisions; urgent and planned care – which brings together services for adults and older adults; and specialist and children's services – including services for children and young people, substance misuse, eating disorders, learning disabilities and forensic services.

In 2013/14 the Trust provided the following clinical services across the whole of Derby and Derbyshire:

- Services for adults of working age (inpatient, community and emergency/crisis care)
- Forensic services (low secure, prison in-reach and court diversion schemes)
- Perinatal mental health services (inpatient and across the community)
- Community services for older people
- Memory assessment and treatment
- District nursing services
- Safeguarding children services.

The Trust provided the following services for the population of South Derbyshire:

- Community paediatric services
- Child and adolescent community mental health services
- Learning disability services.

In addition, the Trust provides the following in Derby City only:

- Universal children's services.

Throughout the year we have developed a new mental health liaison team at the Royal Derby Hospital and on 1 April 2014 a new acute inpatient ward opened at the Radbourne Unit in Derby. Due to changes in commissioning arrangements, the Trust will reduce its level of provision for alcohol services in Derby City from 1 April 2014.

Our locations

The Trust business model includes the following structures:

Urgent and planned care division

Services across Derby and South Derbyshire include:

- The Radbourne Unit in Derby (which comprises three acute inpatient wards, an enhanced care ward, A&E liaison services, crisis services, occupational therapy services and an ECT (Electro-Convulsive Therapy) suite
- The Resource Centre at London Road Community Hospital
- Older people's services; with two wards based at London Road Community Hospital, two specialist dementia wards on the Kingsway site in Derby, Midway and Dovedale Day Hospitals and physiotherapy services.

Services across Chesterfield and North Derbyshire include:

- The Hartington Unit in Chesterfield (which comprises three acute inpatient wards, an outpatient unit, crisis home treatment teams and A&E liaison services).

County-wide services include:

- Community mental health teams for older adults
- Pathfinder and Recovery services for adults
- APT services (Improving Access to Psychological Therapies)
- 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
- Substance misuse services, including specialist alcohol misuse services and a hospital alcohol liaison team
- Learning disability services
- Specialist services for children
- Eating disorder services
- Perinatal care
- 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
- Clinical psychology within specialist services.

During the year 2013/14, Derbyshire Healthcare...

90,747 service users seen

Number of staff **2,356**

233 Scientific and technical staff

431 Additional clinical services

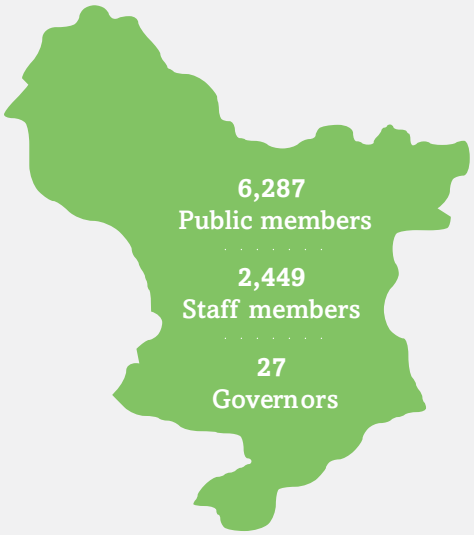
473 Administrative and estates

148 Medical staff

839 Nursing and midwifery

233 Other

8,376 members



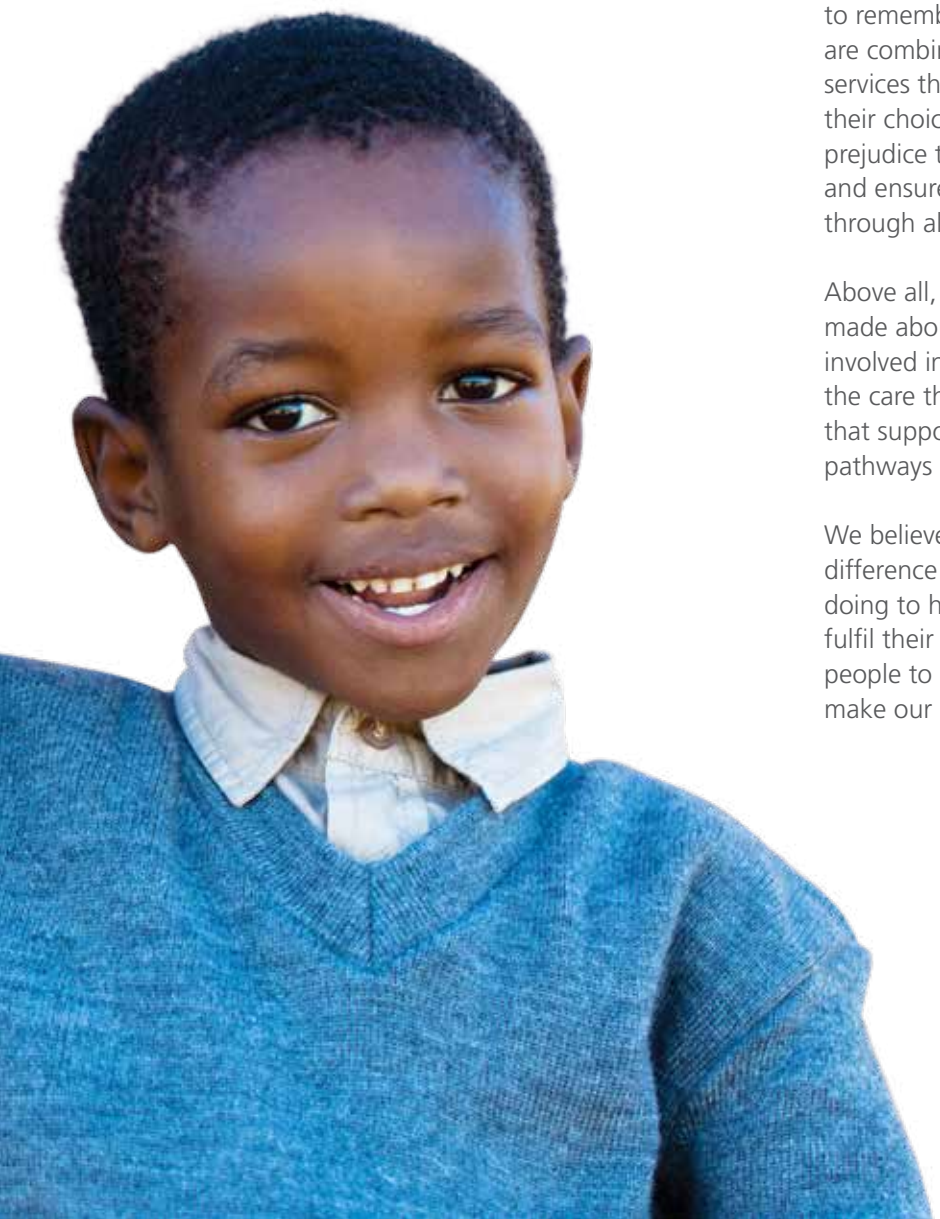
6,287 Public members

71 Languages spoken

180 Number of nationalities

Trust strategy

“Improving lives, strengthening communities, getting better together.”



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, including an increase in older people and greater ethnic diversity. There are also financial challenges locally in 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 communities of their choice. We will tirelessly address the stigma and prejudice that people with mental health conditions face and ensure that inclusion and recovery 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.

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.

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.

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.

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.

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

The Trust formally opened the UK's only Centre for Compassion, on 17 April 2013 at the Kingsway site in Derby. Compassion is a key way of working for all DHCFT 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. Integrated care pathways
3. Service delivery and design
4. Promoting public confidence
5. Relationships and partners
6. Financial performance
7. Workforce and leadership.

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 the single most important factor that governs the services we provide. Keeping people safe and providing high quality healthcare is the cornerstone of what we do as a Trust and we are committed to providing excellent quality services, with people at the centre of them.

We strive to give every service user and carer that comes into contact with our services, the safest, most effective care and the best experience possible. We do this by ensuring that we listen to and learn directly from our patients and carers to continually improve the care we provide.

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 2013/14 our quality priority measures were focused on achieving improvements to patient experience, effectiveness and patient safety. The Trust has made considerable progress against each of these quality priorities over the last year, as outlined in our Quality Report on pages 92-127 of this Annual Report. Given their importance, many of these priorities will also remain in place for the coming year, to ensure we continue to make further progress and developments in these key areas. We have also added additional local priorities for the forthcoming year, which reflect some of the intentions we have developed through our quality work during 2013/14.

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/family members where appropriate.

As part of the visits, teams have the opportunity to showcase three areas that they are most proud of; one of these areas must always include reference to changes that have been made as a result of any learning – for example from an incident, complaint or wider feedback that has been received from either staff or patients. Each quality visit season is themed – for example the theme for the start of 2014 was how teams contribute to the Trust vision.

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 following criteria, 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.

- Patient safety
- Clinical effectiveness
- Patient experience
- How teams contribute to the Trust vision
- Core standards.

Our performance

Performance against our key health targets has been consistently strong, building on our reputation of high performance and delivery.

Care Quality Commission (CQC) registration

From 1 April 2014, the Trust's registration with the 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 Framework. Performance this year has been strong, and the Trust has exceeded the targets set for all Monitor indicators. These targets are challenging and staff in the Trust's operational services are to be commended for their commitment and hard work in ensuring these targets were met throughout the year.

The Trust is subject to a number of other national targets, as described in the NHS Outcomes Framework, as well as local targets agreed with our commissioners.

Generally performance of the Trust during 2013/14 has remained at a high level, with 32 of the 43 indicators exceeding their target to date. A data quality strategy, based on active monitoring and exception reporting, supports the Trust in maintaining these levels.

There are however seven areas where the Trust is focused on improving performance, or where the target was not achieved due to exceptional circumstances. These seven areas fall into three thematic areas (under 18 admissions, National Tariff Payment System clustering and letters). These are specifically examined below:

- Under 18 admissions: During the year, four patients were admitted to adult wards for their own safety, owing to a lack of availability of Child and Adolescent Mental Health Services (CAMHS) beds, until such time as an appropriate placement could be found.
- National Tariff Payment System: The Trust is performing favourably nationally in terms of the number of patients we have clustered, in line with the national tariff system. The latest NHS Benchmarking Network Report states that nationally on average 80% of mental health patients were clustered. In comparison, 98.24% of DHCFT patients were clustered. However we have further work to do on clustering to reach our 99% target.
- The Trust is working to improve communication through our clinical letters specifically our correspondence with primary care. A digital dictation system has now been purchased for full implementation from 1 April 2014. The system removes a number of delays from the process, enabling more rapid processing of correspondence. The Board are actively monitoring and pursuing this issue until we are meeting this standard.

Monitoring improvements in the quality of healthcare

Between 29 and 31 January 2013, Derbyshire Healthcare NHS Foundation Trust received its annual scheduled inspection by the Care Quality Commission. The inspection team spent three days with the Trust, visiting 11 locations, providing 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/or family members, staff and reviewed information. 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 working in 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 coordinated 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 level of impact of both standards was judged by them as minor. The Care Quality Commission requested a formal response describing the action we were going to take to meet the regulation. An action plan was submitted to the Care Quality Commission and all the actions were completed by 30 August 2013. A follow up inspection took place on 11 September 2013 following which the Care Quality Commission confirmed that the Trust had delivered the improvements required and was now fully compliant with all the standards.

In the autumn of 2013, the Care Quality Commission announced their new approach to inspections of mental health providers. In 2014 they plan to carry out reviews of crisis services provided by all mental health trusts and unannounced visits to services using the new inspection model. The Trust welcomes the inspections and the external assurance these provide of the high quality of our care for our service users and their families.

Progress towards quality targets

In April 2013, six Commissioning for Quality and Innovation (CQUIN) agreements were made with our lead commissioner, Hardwick Clinical Commissioning Group (CCG), as part of our contract to deliver high quality services.

The six included the following areas:

1. To strengthen our feedback from service users about their experience of our services, using the national question which asks if they would recommend the particular service they had received to a family member or friend.
2. To assess the safety of our frontline services by collecting data on falls, pressure ulcers, new venous thromboembolism and urinary tract infections using the national data tool called the safety thermometer.
3. To reduce premature mortality in service users through improved assessment, communication and treatment in relation to their physical health.
4. To improve the experience of service users from specified REGARDS communities (race, economic disadvantage, gender, age, religion, disability and sexual orientation).
5. To use clinical outcomes, in particular care clusters, to measure the impact our care has had on their quality of life and on changes to their mental wellbeing.
6. To consider how we get feedback from people using our children's services, and explore if the nationally agreed Friends and Family test could be used to collect the views of people accessing the broad range of interventions this service provides.

In 2013/14 we made solid progress in implementing the agreements and therefore improving the quality of care for our service users, their families and those who care for them. Some of the areas of achievement as a result of the quality agreements are summarised below:

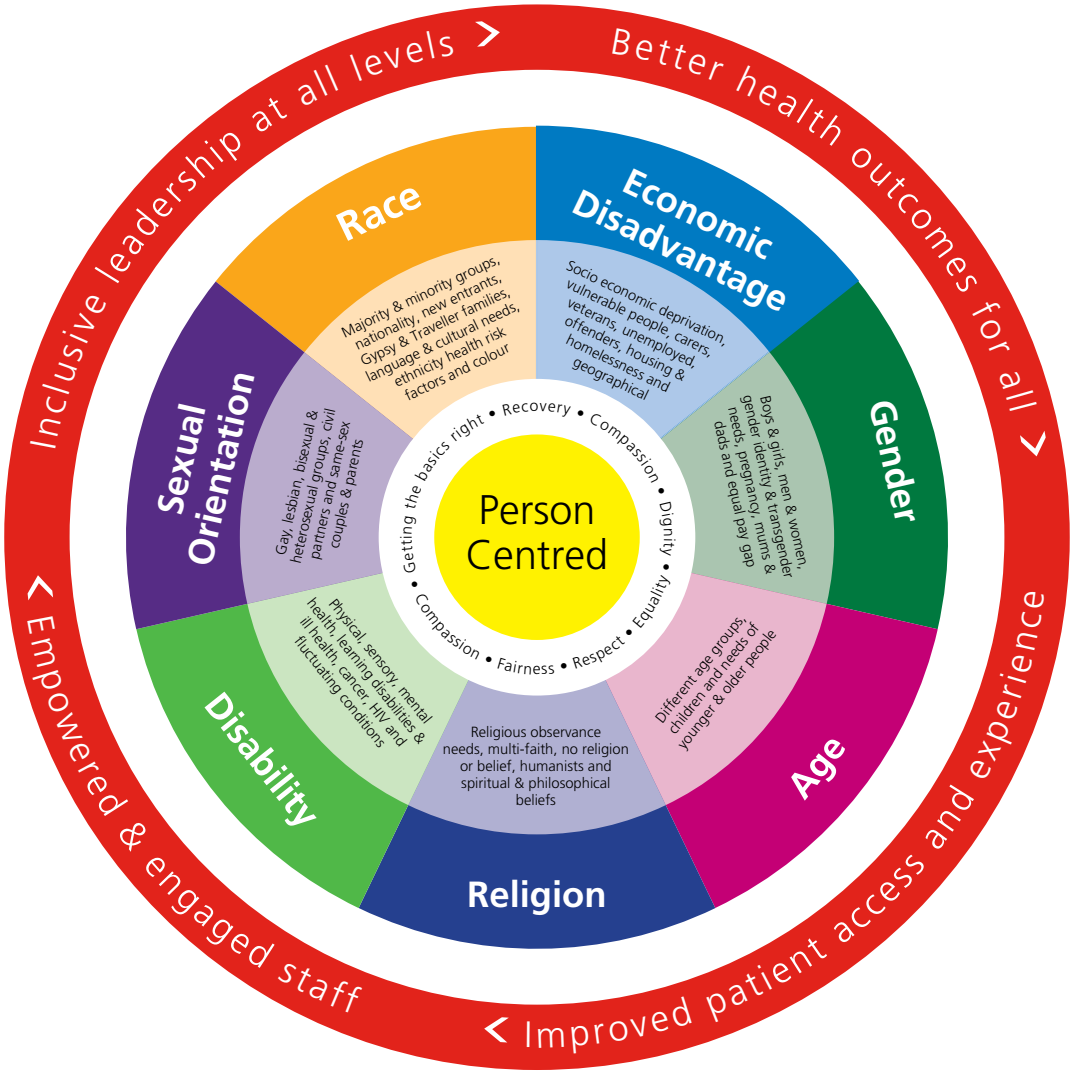
Collecting and acting on the views of our service users

The NHS Friends and Family Test is an important opportunity for individuals to provide feedback on the care and treatment they receive and help us to improve services. We were not part of the national roll out in 2013/14, however we undertook our own 'golden question' across 13 areas of our Trust. The local overall score has gradually improved in these areas over the 12 months, moving us towards a higher score, that respondents would in fact recommend our services to families and friends if they need similar care.

As part of the responses to this question, we successfully developed 'You said, we did' posters in clinical areas to inform service users what we have done as a result of their feedback. In 2014/15 we plan to implement the formal friends and family test question "How likely are you to recommend our ward /services to friends and family" to all areas of the Trust, including asking the same question as a minimum of three times a year to all of our staff.

During the first part of the Trust public Board meetings, as part of our commitment to being open and transparent, the Trust invites service users and/or carers to share their experiences and give honest feedback on the services we provide to Executive and Non-Executive Directors. So far our Board has heard about our Community Mental Health teams, Learning Disability services, Recovery team, Dovedale Day Hospital, Audrey House (community rehabilitation unit) and the Radbourne Unit.

Further details of changes that our services have made in response to patient feedback can be found on pages 24 and 27 of this Annual Report.



REGARDS wheel

Improving the physical health of our service users

Over the last 12 months we have been jointly working with the Clinical Commissioning Groups and GPs across the city and county around requesting health information prior to Care Programme Approach (CPA) reviews and supporting our patients to access their annual physical health check in primary care. We have targeted work in Derby City with diverse communities and have implemented weight management work with inpatient services. We have also worked to raise our patients' awareness of health issues and offered support to help them live healthier lifestyles.

Working with our patients to share personal stories of positive lifestyle change to help inspire others is a significant area of development for all mental health care providers, as the physical health outcomes for those experiencing mental distress is generally significantly poorer that those that do not. This is a key focus of 'Closing the Gap' (2014) and will be of strategic focus to the Trust.

Improving the experience of service users from specified REGARDS communities

Over the last 12 months we have worked in partnership with local communities, the voluntary sector and local authorities to develop new ways of working. We have introduced a programme of ongoing engagement with specified REGARDS group community organisations to address issues of stigma associated with mental health and are developing plans to overcome resistance to mental health services. In 2013 we worked with the farming community network to support and care for vulnerable and isolated people in the rural communities. We are commencing work on improving access for deaf people to information and using mental health and wellbeing services. This work is being undertaken in partnership with the British Deaf Association. Further details are included on page 45.

The Trust's Quality Report, which focuses on our progress against set quality indicators, can be viewed on pages 92-127 of this Annual Report. Further information about quality governance is available in the Annual Governance Statement, available on page 128.

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. As a Trust, we are required to submit quarterly returns to Monitor. Monitor then reviews our returns and publishes risk ratings for governance and finance.

2013/14 regulatory ratings

	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					

2012/13 regulatory ratings

	Annual plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Under the compliance framework					
Financial risk rating	3	4	4	4	3
Governance risk rating					

Under the Compliance Framework, which was in place for the first two quarters of 2013/14, Governance risk ratings range from "red" where Monitor deems the Trust is likely to or actually has triggered a significant breach of their terms of authorisation to "green" where there are no material governance concerns. Under the new Risk Assessment Framework, applicable from 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 they are considering. Where Monitor have already begun enforcement action, they assign a red rating.

For 2012/13 and the first two quarters of 2013/14 the Trust reported under the Compliance Framework where financial risk ratings range from 1 to 5; under this framework 1 is the highest risk and Monitor deems that there is high probability of significant breach of terms of authorisation in the short-term, and 5 is the lowest risk with no financial regulatory concerns.

From October 2013 (i.e. for quarters 3 and 4) the Trust has reported under the new 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. They also update 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.

In 2012/13 both the governance and financial risk ratings were better than planned for the first three quarters and for the final quarter they met the plan. In 12/13 the Trust exceeded its planned surplus which was the main reason for the better-than-planned risk ratings earlier in the year. The amber/green rating at plan time was related to uncertainty of reporting certain indicators which subsequently was resolved, enabling the green rating to be achieved each quarter.

In 2013/14 our governance has been assessed as green throughout the year, as planned. The financial risk rating was planned as 3 and was better than plan at quarter two because our financial surplus was also 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 division

A number of developments and improvements to services within the Urgent and Planned Care division have taken place during 2013/14. Throughout the year, 20 gold quality awards were awarded to services that sit within the division, demonstrating the motivation and drive of the teams to ensure quality is at the core of all we do. 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 the pressure being experienced by the acute trusts based in Derbyshire and the need to review cross organisational pathways. We have participated 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 built on principles of local area co-ordination.

Older people's services have worked hard to continue to provide Memory Assessment Services on a timely basis across the county, despite increasing demands for the service. During the year the Trust undertook a project to review models of memory assessment across Derbyshire, which led to an option appraisal being developed. This resulted in us reaching general agreement on one model based on a flexible modular service delivery across the county. The division has also established clear links with the integrated pathway work that each CCG is developing such as the development of the "virtual ward" in the north of the county; a model that supports people to stay living at home and thereby reducing hospital admissions.

Across Derbyshire the Pathfinder, Recovery and Early Intervention services have worked to enhance community engagement by participating in a wide range of events and partnership meetings. Listening events have taken place across Derby and Derbyshire and the division has sought to ensure that improvements have been made to our services in accordance with the suggestions made. Over the past year the Pathfinder services have been merged with locality teams to ensure that a local assessment service is available across the county and to promote integrated multi-disciplinary model of working with the Recovery teams and local GPs.

Our talking therapy service 'Talking Mental Health Derbyshire' has focused on consolidation of the new service under the structure of Any Qualified Provider (AQP) commissioning arrangements. The service has developed and expanded to the point where it now delivers interventions to people across the county. We have also developed partnerships with Derwent Rural Counselling and RELATE in order to provide a range of support options for local people.

The division has seen the further development of monthly Schwartz rounds within the inpatient settings and these have proved highly successful this year. The Schwartz rounds provide a forum for clinical and non-clinical staff from all backgrounds and levels of the Trust to come together and explore the impact that their job has on their feelings and emotions.

New services during 2013/14 and looking forward to 2014/15

The Trust's collaborative work with acute hospital providers has led to significant investment in liaison services, which support the mental health needs of individuals attending Accident and Emergency (A&E). Given the time of austerity, this is a major achievement for our organisation and demonstrates the confidence we have developed with our commissioners.

A new acute inpatient ward opened at the Radbourne Unit on 1 April 2014, providing additional inpatient beds in the hospital. This investment will reduce the number of local people who need to travel outside of the county to receive inpatient care. Given the Trust's overarching vision to support people to stay living within their home environment where possible, it is planned that this temporary increase in bed numbers will decrease again, once wider community support services are in place. The Trust's transformation plans for Urgent and Planned Care aim to achieve this change in our service model.

Developing our services in response to feedback

The division is committed to listening to feedback in order to make changes that further enhance and improve our services. Two engagement forums are in place to facilitate feedback and, as part of the review of the Urgent Care pathway, an additional piece of work was co-produced with Derbyshire Voice, focused on how people who use our services would wish them to develop over the forthcoming years.

Older People's services continue to hold successful question and answer evening sessions for carers and have been involved in local engagement events with a view to improving relations with groups that are under-represented. A recent dementia event, held in Ilkeston, was commended by Secretary of State for Health, Jeremy Hunt, where he described it as a "fantastic initiative". Plans are in place to continue these events throughout 2014/15, across a range of venues.

The division has made a number of changes to its activities and ways of working, in response to feedback that has been received from a range of different stakeholders. Patient meetings are held once a week on the inpatient wards to discuss where changes have been made in response to feedback received.

Occupational therapy

Kedleston Unit staff

Examples of these changes include:

- Opening hours at the Hub (the canteen and recreational facility at the Hartington Unit) were extended from 9am - 7pm Monday to Friday and to include Saturday and Sunday opening hours between 10am - 4pm
- In June 2013 Ward 36 implemented a system for protected time between 1pm - 2pm for named nurse sessions. Due to its success, this was extended to a second hour between 7pm and 8pm from September 2013 for therapeutic engagement (1:1 sessions)
- A regular care record, audited by a senior nurse, has been introduced to record all 1:1 activity
- The reconfiguration of the Multi-Disciplinary Meeting (MDM) review sheet following all reviews to ensure all patients know what has been agreed in all meetings
- Catering managers have reviewed menu options for meals
- Staff are receiving increased training to improve physical health knowledge
- Morton Ward is part of the 'Releasing Time to Care' project to increase the amount of time staff can spend with patients
- There is an activity folder on the ward, highlighting forthcoming patient activities
- Recreational workers attend the ward on Thursdays to carry out patient activities.

Specialist services division

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:

The Learning Disabilities service continues to demonstrate innovation and creativity and the team's physiotherapist and occupational therapy service won a staff award for their development of a new bath mould for people with learning disabilities. The service is continuing to address health inequalities with the launch of the Health Checkers project where people with learning disabilities are trained to carry out inspection and assurance visits.

The Children in Care team have experienced an increase in the uptake of health assessment reviews for children under five years who are placed in Derby City, as a result of developing a further skill mix within the team.

The Health Visiting team continues to expand its workforce in line with commissioner expectations, supporting a significant number of trainee opportunities. The development of our current workforce is being enhanced with the training and implementation of a child screening and monitoring system "Ages and Stages" and the Sandwell speech and language tool.

The Trust's CAMHS service is part of a national five year pilot programme to develop a CAMHS IAPT scheme. As a result, CAMHS staff have improved access to training in evidence based practice and ensuring the development of care pathways within the service. The CAMHS Multi-Systemic Therapy (MST) service was launched in May 2013 and is a community evidenced based model directed at older children, teenagers and their families. The approach is targeted at those families in which the young person is at risk of coming into care or custody and will aim to prevent family breakdown, reduce offending and improve educational outcomes.

Perinatal services have been accepted onto the 'Leadership Across Boundaries' programme, to explore the challenges set by the new service delivery patterns arising from the 'Every Child Matters' agenda, whilst maintaining accreditation status.

Eating Disorders services have gained improved access to psychological therapy within the service and further developed the access criteria, ensuring that the service is available to a wider range of people.

The Safeguarding Children team have moved into new offices on the Kingsway site in Derby and safeguarding children supervision has been successfully embedded within children's services and extended to CAMHS, perinatal and substance misuse services. The safeguarding team also offer advice to all staff within Derbyshire Healthcare, in order to support teams, raise the awareness of safeguarding children and facilitate case discussion as appropriate.

Substance misuse services are working with staff, commissioners and service users to develop a service delivery model which will support recovery and provide opportunities to develop skills within the current workforce, including non-medical prescribing for nursing staff. The year also saw the Hospital Alcohol Liaison Team (HALT) became integrated in to the new Liaison team at Derby Royal Hospital after having achieved a platinum quality award.

The forensic and rehabilitation service line has continued to embed compassion focused therapy within the service provided from Melbourne House. The Kedleston Unit has introduced adult education into activities available within the unit and further work is underway to develop therapeutic activity across the entire service line.

The open door rehabilitation services have been successful in the framework agreements for the East Midlands and Sheffield, meaning that the Trust is an approved provider for male and female unlocked rehabilitation services provided from Cherry Tree Close and Audrey House, should support be required for residents living in neighbouring districts.

Ongoing service developments

The Trust's Learning Disability services are currently exploring options for future service delivery and considering the implementation of an assessment and intervention model which should ensure speedier access to the required service within the geographical areas covered.

The Children in Care team continue to work closely with our partners in social care to improve outcomes for all children and young people who are in their care. Collecting meaningful data to evidence the patient experience of all children and young people will help us improve the service to meet the needs of children, young people and their carers.

Our Children's services are exploring ways in which improvements can be made to care pathways to ensure easier access and avoid duplication, whilst enhancing stages of transition from one service to another.

The Department of Health confirms that having access to the correct care pathway improves patient outcomes by 15%. Therefore, CAMHS IAPT services have developed specific care 'bundles' that guide clinicians and other professionals through the evidence-based models of care, assessment and treatment supported by NICE (the National Institute for Clinical Excellence).

Due to changes in the way services are provided across the East Midlands, the Trust's perinatal services are anticipating an increase in demand for their specialist community service over the forthcoming year. As a result, the team has been expanded to allow a pilot service to be provided in the North Derbyshire area.

The 'Think! Family' agenda continues to be at the forefront of the organisation's mind and the safeguarding team has played a significant role in strengthening channels between adults and children's services and embedding this agenda throughout the organisation as a whole. The team are being involved in multidisciplinary meetings throughout the organisation to provide advice and support to those meetings and to raise awareness of the importance of safeguarding children.

Substance Misuse services have continued to build upon the culture of recovery and service user involvement with the introduction of further peer-led recovery groups. The service continues to provide localised services in all areas and, together with children's services, have delivered joint training to team members as part of lessons learned following a serious case review.

In partnership with Derbyshire Constabulary, the Trust launched a new Street Triage scheme in February 2014. This pilot scheme is an innovative assessment and liaison service (provided by the Forensic and Rehabilitation service line) and will support people who come into contact with the police, but need urgent mental health support.

The Street Triage scheme is launched at the Kingsway site in Derby

Developing our services in response to feedback

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 in Melbourne House asked for a meeting with the Trust's Catering Manager to discuss changes to the menu and mealtime arrangements. In consultation the meeting was arranged and changes were made to the menu that improved choice and better reflected individual nutritional needs. Calorie Counters have also been introduced, as well as food vouchers to be used on site, which ensure greater flexibility and integration into the community.

Growing vegetables at Melbourne House

- Patients at Melbourne House also promoted the recent change in staff uniforms and assisted with the development of a therapeutic programme and changes to the garden courtyard areas. These changes have included the introduction of vegetable growing areas, outside dining facilities and flower/planting areas to enable patients to engage in these requested activities.
- The Children in Care team received negative feedback regarding the implementation of the health history booklet and, in consultation with children and young people, has produced an improved version of this document which young people feel better reflects their needs.
- Children and young people accessing the CAMHS service suggested that they wanted more use of information technology to help in their treatment. As a result, the service, in partnership with young people, has enabled the development of an interactive application (app), called 'Aim App' which targets goals, treatment aims, and monitors mood. The service continues to build on this with the development of virtual online drop-in facilities and by providing online support to parents, carers and young people. Further information about the Trust's use of apps can be seen on page 37 of this Annual Report.
- Feedback from service users identified the need for a refurbishment of the reception area at one of the bases used by substance misuse services. This was carried out and the service has received some very positive feedback.
- The Derby City Substance Misuse team moved to the new premises at St Andrews House and shortly afterwards the live Equality Impact Assessment was completed, promoting community engagement and leading to a number of changes to the building and service delivery. Some examples include welcome notices in a number of different languages, which are now available in the reception area. Meanwhilethe waiting area was reconfigured to make it more welcoming. This assessment has also resulted in substance misuse services completing joint sessions with local charity Derbyshire Friend. Further feedback from service users identified the need for a refurbishment of the reception area at one of the other bases used by substance misuse services, which was subsequently completed with very positive feedback from service users.
- Mothers from the Trust's perinatal ward, The Beeches, requested to use Moses baskets on the unit. This change has been enabled, to create a more home-like arrangement, whilst maintaining adherence to safety regulations.

Risk management and assurance

The system for the reporting of untoward incidents has continued to develop during 2013/14, supporting patient and staff safety throughout the Trust. The system has been extended during 2013/14 to include notifications to medical staff of incidents involving their patients and also notifications to medical educators to support medical staff in training.

The Trust's Board Assurance Framework (BAF), which details risks to the achievement of the strategic objectives, continues to be reviewed and updated by the relevant Executive Director and regularly reported to the Board of Directors.

The project implementing electronic reporting and management of risk assessments using DATIX Web:Risks has been shortlisted for two national awards, including:

- HSJ Patient Safety Awards 2013 in the Data/ Information Management category
- HSJ Awards 2013 in the Improving Care with Technology category.

The initiative was shortlisted as it has led to much greater local ownership and accountability for managing risks resulting in actions being driven forward at a greater pace.

Effective Serious Untoward Incident (SUI) management

In accordance with the NHS Executive guidelines, the Trust Serious Untoward Incident Panel meets on a weekly basis and reviews all major and catastrophic safeguarding serious untoward incidents as part of the wider SUI management. This is matched against National Patient Safety Agency (NPSA) standards and level 3 investigatory safeguarding standards. The organisation continues to demonstrate robust analysis and scrutiny using the evidence based approach – 'root cause analyses'. Lessons learned and changes in practice are then brought into place with monitoring through the SUI panel, Safeguarding Committee and Trust Risk Management Committee.

As an organisation we have embraced the importance of learning from the reporting of untoward incidents as defined in the National Patient Safety Agency: Seven Steps to Patient Safety (2004).

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

- Developing our practical implementation of the Duty of Candour
- Developing our knowledge and skills and competence in supporting families in being open
- Learning from our risk assessment process and developing proposed models for the full implementation of our Electronic Patient Record
- Further development of Core Care Standards
- Use of a collaborative approach with staff involved in a Serious Untoward Incident
- Our continued approach of highlighting good practice and learning from our errors, and embedding this into our work.

We intend to streamline and review our incidents process in 2014/15 and review it in line with recent changes in our commissioner's operating policy.

We have listened to feedback on our publication Practice Matters and we will be looking to redevelop it and its focus in 2014.

Information governance (IG)

The Trust has increased compliance with the Information Governance Toolkit from 95% to 96%, which keeps us at the forefront of our category and maintains our overall rating of 'satisfactory', demonstrating that we have reached level 2 or above in all attainments. The Information Governance Toolkit is the national standard and measures the policies, processes and procedures that we have in place to ensure compliance with the Information Governance agenda and effectively and lawfully manage information correctly. The Information Governance Committee has met monthly throughout the year and the Information Governance policies have been consistently at 95% or above. This year we have had one reportable level 2 Serious Incident Requiring Investigation (SIRI) which has now been closed with no further action from the Information Commissioner's Office (ICO).

The Trust has also had four complaints upheld by the ICO's office. Again no further action has been taken by the ICO office and learning gained from the complaints has been disseminated throughout the Trust.

Melbourne House patient artwork

Pillar 2: Integrated care pathways

We will support our teams to work better and work closely with external partners to ensure flexible and responsive care is delivered as close to home as possible.

Derbyshire has a long history of partnership working and good examples of integrated working. The financial challenges facing the public sector nationally over the next few years are unprecedented and require radical whole system solutions to meet the savings required in the health and social care economy. The challenges facing the Derbyshire health economy reflect the national picture, but our history of partnership working, and our open and collaborative approach to addressing the future challenges places us in a very strong position to meet the future needs of the health economy.

The Chief Executives and Chief Operating Officers across the Local Health Economy (LHE) have been meeting regularly throughout 2013/14 to understand pressures faced by the health and social care systems. We are working closely with Clinical Commissioning Group (CCG) officers and Local Authorities on the content, planning and prioritisation of the two Derbyshire proposals for the government's Better Care Fund, to support health and social care services to work more closely together in local areas, as well as whole system planning for services not yet impacted on by the Better Care Fund.

The vision for Derbyshire moving forward is based on a shared understanding of risk and opportunities for the organisations involved, and a key element of the vision has been co-developed by National Voices, which places the local person at the centre of our actions. The

> *"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."*

definition of integration produced by National Voices is to be adopted by the care community in Derbyshire (both City and County Health and Wellbeing Boards) as a central tenet to the changes being developed:

There is general agreement across the county that our goal is to achieve a seamless health and social care service and we will work together to overcome organisational boundaries to achieve this goal. To provide the foundation for this work, as a Trust we have developed our strategic and operational plans in line with CCGs, NHS England Local Area Teams, Local Authorities, the Health and Wellbeing Boards and Units of Planning.

Across Derbyshire there is agreement that the aim is to deliver integrated public sector services that:

- Support people to remain independent and in control of their lives
- Provide support in the community when needed
- Reduce the need for hospitalisation or admission to long term care
- Improve outcomes and the quality of services provided
- Reduce inequalities
- Are delivered within the resources available, ensuring that value for money is achieved.

CCG's have involved the Trust in population-based needs modelling to determine a better understanding of health and social needs through a risk stratification process. We are also engaging extensively with Derby City Council to look at how we provide mental health, adult care and children's services which includes developing a strategy for shared clinical models and the implementation of Local Area Co-ordination (LAC), which is a model of community development introduced from evidence in Western Australia. We have engaged with the County Council to support their plans around intermediate care and to agree opportunities for shared efficiencies and improvements to patients' experiences of our services.

We are committed to ensuring that the people we support have information about their care, treatment and the progress of their care, through the routine use of outcome measures. This year we have developed a specific section on our Core Care Standards website that enables people to understand more about the pathway they are on, whilst also providing a helpful resource for the whole health and social care community. This enabling approach is very much in tune with our drive to support people towards recovery and wellbeing. In addition we are proud to have supported the establishment of a number of community-based initiatives directly linked to recovery education, for example the Recovery Hub in Swadlincote and Hope Springs in Chesterfield. Please see page 35 for more information on our commitment to recovery principles.

We have recognised that internal integration is vital to supporting the best experience of our services as well as helping people to have the best outcomes. We have therefore worked this year to set up a single point of entry for our children and young people's services, ensuring a 'right support, first time' approach is adopted.

In the autumn of 2013, Derby City Council undertook a consultation relating to social care professionals, who to date had sat under the management of Derbyshire Healthcare NHS Foundation Trust. On 1 April 2014, all Derby City Council staff were moved to be directly managed within Derby City Council's management structures. The Trust worked closely with Derby City Council to manage these changes and appropriately reviewed management roles within the Planned Care service in response.

Integration

The forthcoming year holds a number of challenges for Derbyshire Healthcare, as it does for our many partner agencies and organisations across Derbyshire, the East Midlands and further afield, as we operate in times of greater financial challenge, where funding to the NHS is remaining flat. This is set against a backdrop of a changing society; people are living longer, we are seeing an increase in frailty and complex long term conditions such as dementia, more people are struggling to mentally cope with the pressures of everyday life, the costs we all incur are continually increasing yet expectations of the quality of care we provide are also rising.

It has been identified nationally that if NHS services continue to be delivered in the same way, this will result in a funding gap which could grow to £30bn between 2013/14 to 2020/21. Derbyshire is not immune to these challenges and our own local health economy enters the new financial year with increased pressures. Together with our neighbouring health and social care colleagues, we have a combined savings target of approximately £500m over the next five years. This is clearly significant and, for Derbyshire Healthcare alone, the Trust faces efficiency savings of approximately £20m over the next five years.

Over the last year, the Trust has been working to proactively address these challenges through our transformation programme, which has been exploring ways in which to transform our clinical and corporate services over the next five years, in order to ensure we are providing care in the best possible way, but also in a way that offers value for money. This is with the intention that the Trust can continue to operate effectively – retaining our current business and identifying services that we want to provide over the forthcoming years.

A key challenge we will face is being able to demonstrate that these changes will not have any impact on the quality of services we provide. As a Trust we are committed to upholding the quality of services that we provide, but this can lead to difficult decisions about the services we continue to deliver. This year the Trust has had to withdraw from providing city alcohol services as we could not provide a quality service within the financial envelope being offered from our commissioners. These are very difficult decisions to take, yet we have a duty to maintain safety and quality in all that we do.

The Trust's school nurses measure children's height and weight

Despite these challenges, the Trust remains well placed to proactively transform our services. We come from a background of innovation, good staff engagement and a positive culture, based on clear values that we have developed together. We need to ensure that we continue to grow our innovations and creative thinking and work collectively with our partners to truly change our systems and pathways in a way that will work for the communities of Derby and Derbyshire.

We already have good working relationships with our partners in the local health economy and are working closely with our fellow providers across health and social care in Derbyshire, and our commissioners, to ensure that we are working together to collectively address these challenges and work more collaboratively in our provision of services.

Parity of esteem

The Trust is working with local 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. There remains a disparity in the number of people with mental illness who are in contact with services, compared to those with physical health needs, yet mental ill health is a major cause of premature death and a high proportion of people's lives are impacted by mental health conditions.

Only 26% of UK adults with mental illness receive appropriate care.

Transformation

During 2013/14, the Trust launched a large scale transformation programme, aimed at transforming our services for the future. The programme, which focuses on all clinical and corporate services, has used a collaborative engagement approach to ensure our services are transformed to address future challenges and local requirements. Over the next five years, services must be radically transformed, whilst maintaining quality, patient experience and value for money.

People who work in our services, service users, carers, commissioners and other partners were brought together to agree a collaborative vision for the future. This process was aimed at encouraging innovation and creativity whilst putting service users at the heart of everything we do; to take on board feedback and ideas from people who have received our care and work with our partners to address shared challenges across the local health economy. Throughout the year approximately 500 people were involved in shaping a series of five-year visionary plans, which will start to be implemented over the forthcoming year.

Central to transforming our services is the further strengthening of our values in all that we do. This includes embedding a deeper understanding of compassion, to help create the right organisational context, where compassionate relationships can thrive. Our mental health services are also being designed to ensure that the hope, optimism and spirit of recovery is visible and experienced by those who receive our service in everything that we do.

Pillar 3: Service delivery and design

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

Derbyshire Healthcare is committed to working with partners and commissioners to develop new and innovative models of service delivery. During the last year the Trust has seen many changes to the way we provide healthcare services across Derby and Derbyshire.

One of these new initiatives includes equipping our wards with the latest pop-up reminiscence pods or RemPods (as seen on the BBC's Dragon's Den). The RemPods are reminiscence rooms which aim to help change the quality of life and enhance the care of those with dementia by turning any care space into a therapeutic and calming environment.

Over the past year Melbourne House has been integrating compassion focussed therapy into the care pathway for women with long standing, severe and complex mental health needs. This science-based model of compassion indicates the importance of two distinct psychologies and resulting behaviours. Melbourne House facilitate compassion-focused therapy opportunities to all service users for new learning, personal insight, change and growth, with a special focus on developing capacities to integrate into society and live independently.

On 3 February 2014, the Trust launched a new Street Triage pilot service in partnership with Derbyshire Constabulary, which aims to improve the way people with a mental illness are treated in emergency situations. The new service involves Derbyshire Healthcare nurses working alongside and supporting police officers on the beat where they believe someone needs immediate mental health support in Derby. Upon arrival at the incident, the nurse may carry out an assessment or hold a brief clinical conversation with the person to make a professional opinion regarding their current health needs. Advice will then be provided if an appropriate referral into the healthcare service is needed.

Ifti Majid celebrates dementia awareness week with patients and carers in the Cubley Court RemPod

Derbyshire Healthcare was the first NHS Trust to launch Schwartz Rounds in prison settings. Recognising the potential emotional impact of working within a challenging environment, the Trust extended its Schwartz Rounds to colleagues working in HMP Swinfen Hall. Staff are invited to attend these monthly informal sessions and are encouraged to speak about the impact their work role has on their emotional wellbeing and find solutions to problems.

The Trust supports innovative ideas from our staff; this year our learning disability team produced moulded bath seats to make taking a bath easier. Following a combined assessment with a service user, our staff were able to work alongside partner organisations to produce the first adult bath moulds in the country. These moulds now support many people within our community to take a relaxing bath without the worry of having to stay in a sling whilst being bathed. The mould is easy to lift in and out of the bath which is much safer for staff moving and handling.

Our staff have also worked on developing a falls assessment and monitoring processes and a specific Falls Observation Pathway has now been ratified which is available for use across all inpatient areas.

Recovery and wellbeing approaches for 2013/14

Developing a recovery culture

Derbyshire Healthcare has demonstrated a commitment to embed recovery and wellbeing approaches into and throughout our culture during 2013/2014.

The Trust co-hosted a national conference with the UK Recovery Federation on 6 September 2013. This event promoted and explored all aspects of the recovery and wellbeing approach, with speakers from Public Health England and ImROC (Implementing Recovery through Organisational Change). This was the first national conference to bring mental health and substance misuse experts, peers and workers together generating an agreed set of principles and values for recovery.

Data from both Derby City and Derby County Substance Misuse teams has been analysed in order to ensure recovery orientation is taking place in practice, and that people leaving our services are adequately prepared and have sufficient recovery capital to maintain their drug free status, and are aware of local services/groups where they can access further support if needed.

UKRF coaching sessions with planned care teams

Currently the UK Recovery Federation is delivering coaching with our staff and service users across the organisation. This focuses on the five ways of wellbeing (Connect, Be Active, Take Notice, Learn and Give) and the ABCD (Asset Based Community Development) approach and enables localities to challenge and explore how they involve the community in delivering a recovery-focused, outward-facing service, acknowledging the importance of peer supporters.

The Trust works creatively to ensure individuals are supported on their individual path to recovery, including for example working with animals across our more rural locations

Urgent care

A Recovery and Resilience Hub model is being developed within the Radbourne Unit over the next 12 months, which will promote a recovery-orientated practice and enable a community-facing approach to acute care; preventing admission in favour of home treatment and enabling supportive and sustainable transition into community services and resources. The service will enable people to rebuild their lives after an acute episode of illness through the use of therapeutic intervention, recovery education, peer support and volunteer workers, and pathways into third sector and other community resources.

Recovery Colleges

Our first recovery course was delivered in Chesterfield from September to December 2013; this was co-produced and co-delivered by peer supporters and the occupational therapist from the North East Recovery team. This was an eight week course at Hope Springs Recovery Centre.

The Derbyshire model

The Recovery and Wellbeing approach for Derbyshire is centred around communities. We take the essential elements of recovery-orientated practice and enable each locality and community to interpret it locally. For example, the strength in South Derbyshire is from volunteers co-producing, and co-delivering in, a Recovery Hub that is community based. In the High Peaks the local advocacy group are working closely with the Recovery team. In Derby City there are links to Local Area Co-ordination (LAC).

The success of this approach is local ownership and a sense of community belonging and being clear that mental health services should not be separate, but fully integrated into communities. We are working closely with our partners in social care, public health, the third sector and adult education to ensure a joined up approach and are keen to identify and support personal and group assets within the communities we work within.

Upcoming events in the next financial year

Currently each community is being supported to work on its own recovery and wellbeing education network with the aim of launching a Derbyshire-wide prospectus for recovery education in September 2014; this will be done through a recovery senate that brings together all our partners in recovery and wellbeing within Derbyshire to celebrate progress to date.

We are also working with the LAC in Derby to develop a community recovery approach in Derby City that brings both organisations and communities together, so they take an approach that recognises local strengths/assets and develop a joint approach to solving local issues.

Volunteer services

Over the past year the Trust's Volunteer Manager has been developing and providing 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 gradually 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 to become volunteers and 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.

Using technology to help us work differently

The Trust is committed to making best use of new technologies to develop new ways to engage with and support our patients and their carers/families. During 2013/14 the Trust has led the development of a number of apps (interactive applications), to meet the needs of different audiences. These developments have taken place in response to feedback from our patients, in regards to how they wish to be supported and engaged with.

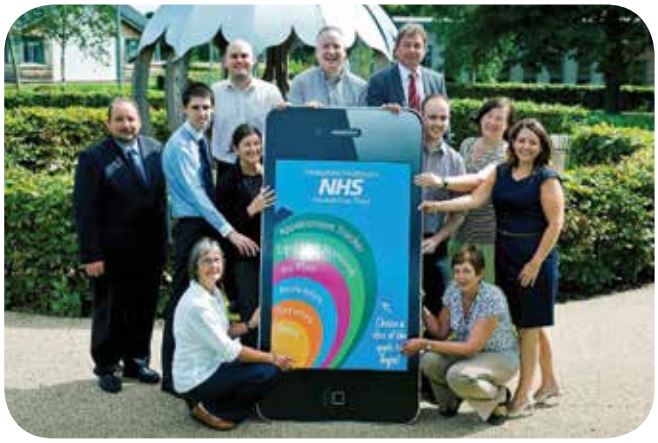
Buddy app

During 2013, a new digital therapy tool that enables service users to record their daily thoughts and share them with their clinicians was established within Derbyshire Healthcare.

Using SMS text messaging, the Buddy app empowers service users to create a secure online mood diary, which is shared with their clinician to help gain a rich insight into the user's life and progress between therapy sessions. Daily text messages are sent to the user from Buddy asking how their day was and to write about how they felt. The user's text responses are then automatically converted by Buddy into an online diary, where they can easily review their own diary entries, helping them to spot patterns and reinforce positive behaviours.

Buddy also supports behavioural activation by allowing the user and clinician to agree on single text message prompts to be automatically sent to the user at agreed times. Buddy also helps to reduce the rate of non-attendance at appointments and to support session planning by automatically sending the user a text reminder of their appointment the day before.

During 2013/14 we saw 354 service users and 175 clinicians actively using the Buddy app to enhance the quality of care received.



Launching 'My CCS' app in November 2013

Core Care Standards app

Our patients can now benefit from an app for smartphones and tablets which breaks new ground for the NHS in the way it improves people's health and wellbeing. The app, called My Core Care Standards (My CCS) boasts a novel feature that enables users to be just a touch away from rating services and giving feedback on their patient experience.

The app is designed to give the Trust a unique real-time insight into the quality of care it provides, equipping us with an important new source of information in an instant which it can act upon to improve its range of services. A key benefit of the free-to-download app is the way it can be personalised to meet the different health needs of users. My CCS features an appointment tracker, which serves as a reminder for people to know where they need to be and when; and links to advice on what to do when they need help in an emergency.

The app also offers users the ability to shape their own care plan for keeping well. It achieves this by enabling them to add do's and don'ts for staying well day-to-day, highlighting warning signs and trigger points and listing sources of help for staying on top of their recovery process. This can also be emailed to family, friends or carers.

There is a wealth of general information about all the Trust's services and locations, as well a plain English summary of its Core Care Standards – which set out the minimum rights and expectations that the community can expect throughout their care.

I found it hard when I first started therapy. I knew there were areas in my life that I wanted to change but couldn't quite see what. I found talking about my problems extremely difficult. I wanted to talk but didn't know how to explain what the issues were.

Leanne

AIM app

Our Child and Adolescent Mental Health Services (CAMHS) have launched an interactive app which empowers young people throughout their therapy. The app, called AIM (Achieve Improved Mental Health), enables young people to become aware of areas in their life that they would like to focus on, including home life, how they feel about the world and themselves.

AIM encourages the young person to begin to talk about issues in their life in a simple, friendly and relaxed manner, helping them to engage in their therapy by working with their therapist to create SMART (Specific, Measurable, Achievable, Realistic and Timely) goals. The young person is empowered to achieve their set goals by using the app's goal tracker to 'target their life', keep track of their goals and monitor progress.

AIM also has a mood tracker tool which the young person can use daily; this tracks how the individual is feeling on a day to day basis. The use of the emotion icons help the young person begin to understand how they feel, working together with their therapist to understand the link between mood, thoughts and behaviours.

The use of apps to engage with our service users was a new and innovative development for the Trust during 2013/14. Over the forthcoming year we will be evaluating these models to determine their effectiveness and shape our ongoing activities in this area.

Information technology (IT)

The Trust has continued to develop its use of IT over the last year and has developed a range of programmes that improve our services through an efficient and creative use of IT.

A key project through the year has been the development of PARIS; a new, single electronic patient record (EPR). Unfortunately, the Trust was not able to implement the new EPR within the financial year as planned. However, this commenced in the Trust's learning disability services in April 2014 and be extended across wider clinical services throughout the year. This development will bring a number of improvements to our current system, by providing a single place for all information about a patient's care notes to be kept, recorded and accessed as appropriate.

Wider developments include:

- An eRostering system has been implemented in four wards across the Trust and is due to be rolled out to all wards in 2014/15. This system will help the business make most efficient use of our workforce.
- The Trust now publishes key performance indicators onto the website each day. This has been done to ensure we maintain transparency of our services to the public.
- A system has been implemented within children's services, which has allowed the service to transform the way it is delivered. The service now uses a fully electronic record which integrates with primary care.
- Systems have been developed and implemented to support the successful development of a new liaison service into the Royal Derby Hospital.
- Our integrated reporting systems have been enhanced with information from our IAPT, children's, drug and alcohol services. A new quality dashboard has been developed which provides managers and clinicians with quick access to quality measures.
- New systems and processes have been implemented to ensure control and co-ordination of commissioner returns.
- A digital dictation solution has been implemented within the organisation to aid the production of outpatient letters and discharge summaries.
- A system has been piloted with many Trust services called 'Buddy'. The system enables service users to create a text message based diary to support their clinician.
- We have completed a number of process changes within the Trust using facilities within SharePoint 2010. Two examples are the Shared Care Audit where we replaced a paper process plus a lot of inputting with a SharePoint based questionnaire with inbuilt analysis. We have also used SharePoint to replace our own paper process for requesting equipment with an electronic one which has speeded up the process significantly.
- Delivery of technology to support the business' adoption of flexible working practices, for example to enable remote working as appropriate.
- We have migrated the Trusts computers from Windows XP to Windows 7.
- Changes to our systems have enabled the Trust to manage new methods of commissioning services, in line with Payment by Results (PbR).
- The Trust has contributed to an innovative solution combining information from nine Derbyshire based organisations to allow an holistic view of patient flows.
- Access has been granted to pharmacists to access the Summary Care Record. This allows them to quickly check what medication a patient is taking.

Environmental sustainability

We acknowledge that our activities in delivering quality healthcare have an impact on the environment. The challenge we face is to reduce this impact whilst maintaining and improving the service users' surroundings.

Carbon management

The Government has set very ambitious targets which we as a Trust need to meet. The Trust is accredited by the Carbon Trust having met all their standards; this is awarded to organisations that have genuinely reduced their carbon footprint and have committed to making further year-on-year reductions. Achieving the Carbon Trust Standard demonstrates a genuine commitment to a delivery in the reduction of carbon emissions, and confirms the organisation's green credentials.

Travel and transport

Travel by staff, service users, 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 is introducing new and innovative ways of working such as agile-working, flexible working, hot desking, phone and video conferencing, which reduce the need for staff to travel.

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 promoting 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

Derbyshire Healthcare is constantly looking at ways to conserve energy and reduce carbon emissions; this in turn has financial benefits for the Trust. We have a number of initiatives ranging from low tech-passive systems such as improved insulation to buildings to high-tech active systems; these range from Building Management Systems (BMS) controlling heating and hot water requirements to LED lighting schemes which are now fitted as standard, many using proximity sensors for automatic switching.

Monitoring, control and training

The Estates Department monitors energy consumption and compares like-for-like buildings; this enables high usage areas to be targeted and energy saved. All major and geographically remote sites have BMS systems installed; these can be accessed remotely enabling investigation and system parameters such as operating times and room temperatures to be changed.

We involve our staff as much as possible and we have an active network of Green Champions. All Trust staff attend a yearly mandatory training session where they are made aware of carbon reduction and energy saving initiatives. This all raises awareness and understanding which helps to save energy and carbon.

Environmental sustainability

Sustainability is not a different subject area but an integral part of the overall strategy of achieving a better environment. It will be a key part of maintaining the reduction we achieve and ensuring that in years to come the reductions we make now are continued. The main focus is on the future and what we do now that will affect it.

The Trust takes part in various events such as the NHS Sustainability Day which involves service users in planting trees at the Kingsway site. In March 2014, the Trust participated in the national 'plant two at 2pm' scheme and planted two new trees at Cherry Tree Close and Tissington House on the Kingsway Site, Derby. NHS Sustainability Day is an annual event aimed at healthcare organisations taking action on climate change and helping improve the environment on or near NHS land.

Waste management

Food waste has greatly reduced since the Trust moved to a homemade style of locally sourced food and we are exploring the introduction of a web-based patient food ordering system.

Recycling bins have been introduced, as well as bagless bins in all inpatient areas throughout the Trust, and all our waste now goes through a further off site recycling process so that over 70% of our waste is now recycled.

Other initiatives have taken place including recycling furniture from former staff houses, (the furniture was donated to Derbyshire Mind) and the use of furniture supply companies that are also accredited to recycle our old furniture which is beyond repair.

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 services of suppliers whose environmental and sustainable policies are in 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.

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 12 months. 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 health and safety guidance (HSG65), 'Successful Health and Safety Management'.
- The Trust's Health and Safety Training Framework (detailing training compliance to 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 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 necessary with health and safety requirements.
- During 2013/14 the Health and Safety Specialist Advisor has developed their portfolio to include security management, to ensure that the team continue to meet the demands of changes expected to legislation.
- The Trust Health and Safety 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. During 2013/14 security management has been brought under the committee's overarching health and safety umbrella. The Trust Health and Safety committee has a detailed documented work plan to ensure effective business is undertaken and completed.

Pillar 4: 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.

Our strategy places an emphasis on developing relationships to build confidence in the Trust and the services we provide. This ambition covers a range of different stakeholders, including our service users and carers, the local population of Derby and Derbyshire and our commissioners and partner organisations.

We want to be recognised as a flexible, responsive and influential partner and an opinion leader in our field. Over the last year we have built upon our reputation for having a highly engaged, values driven workforce and have received local recognition for the quality of services we provide.

Compassion at the core

Derbyshire Healthcare NHS Foundation Trust houses the Centre for Compassion, which builds on Professor Paul Gilbert's extensive research into the scientific understanding and application of compassion. Over the years, Professor Gilbert has developed the model of Compassion Focused Therapy and the team has an international reputation.

The Trust's focus on compassion has been embedded into our services and is a key value for how we work. Compassion drives our relationships and interactions both with our service users and staff; being compassionate brings a wide range of benefits to patient care, whilst also mitigating against some of the risks identified through recent reports such as the Francis Report.

Compassion Focused Therapy has now developed to the point where it can be identified as a specific kind of psychological therapy with a growing evidence base. Compassion is a complex concept, especially when used clinically, and draws on scientific research, psychology and neurophysiology. Compassion is linked to other associated emotions and motivational systems, which underpin experiences of wellbeing, and can help counter-act feelings of threat, shame and self-criticism.

Business development

The Trust has retained all of its core business throughout the last year. During 2013/14 we provided new services in the following areas:

- Psychiatric liaison within the Royal Derby Hospital.
- Street triage, in partnership with the police in Derbyshire Constabulary.
- CAMHS tier 3+ services were recurrently funded – this service works closely with those children who in normal circumstances would have been admitted to an inpatient ward, in order to prevent admissions. As there are no Tier 4 beds provided within Derbyshire, admissions would mean children being placed out of area.
- A pilot project in North Derbyshire to offer perinatal care, in line with the service currently offered across Derby and South Derbyshire.
- A primary care dementia liaison pilot service for Southern Derbyshire (this pilot runs for one year, up to September 2014).
- We received additional money from Derbyshire County Council to add speech and language therapy as part of our county substance misuse service. We also received non-recurrent income for 12 months for a self-help care post.
- A Nurse Care Facilitator was funded, to work in the CARE (Choices Actions Relationships and Emotions) team at HMP Foston.
- CAMHS multi-systemic therapy in the county started in May 2013.

The Trust has been successful in being listed as an approved provider for locked and unlocked rehabilitation services for residents of Sheffield and the wider East Midlands. This contract covers the provision of both female and male unlocked rehabilitation services provided from Cherry Tree Close and Audrey House and female locked rehabilitation services provided from Melbourne House. Under this contract there is no guarantee of volume but the Trust is registered as an approved provider of this type of care, in the event that more local services cannot be identified for Sheffield or East Midlands residents.

During 2013/14 the Trust ceased to provide a service to Turning Point at Mastin Moor as the unit was closed. There was also a disinvestment from Derby City Council in four primary mental health worker posts from our CAMHS team.

Commissioners have also invested in the following new services, for 2014/15:

- The development of a psychiatric liaison service in the Royal Chesterfield Hospital, based on the RAID (Rapid Assessment, Interface and Discharge) model operating in Derby. This reduces admissions or lengths of stay for patients presenting at the acute sector providers with both mental and physical health needs.
- Transition funding for dementia and memory assessment services - we will continue the current service level, and further develop a permanent Memory Assessment Service with our CCG partners. The Memory Assessment Service offers a service to diagnose new patients who would not normally be seen by the Community Mental Health Teams for older people (CMHT). This provides early diagnosis for dementia patients and is a key development in support of the Dementia Strategy.
- A new acute inpatient ward opened at the Radbourne Unit on 1 April 2014. This development will provide gender specific accommodation and creates an additional five beds, meaning fewer people will need to travel outside of Derbyshire to receive their care. This development is an interim measure, whilst the Trust works with commissioners to develop increased support within the community.
- A new court liaison service, which will provide a mental health assessment and support to individuals with mental health problems within the criminal justice system.
- Crisis 111 – aligning the crisis resolution service with the 111 service run by Derbyshire Health United in order to provide dedicated mental health expertise alongside the 111 service to most effectively support callers who have a mental health concern.

From 1 April 2014 Derby City Council's Public Health department has stopped commissioning the city's specialist community alcohol management service and hence the service provided by the Trust has ceased.

Derbyshire Healthcare NHS Foundation Trust will cease to provide pharmacy services to Derbyshire Community Health Services NHS Trust in the south of the county from 1 June 2014.

National and local recognition

Over the last year, the Trust has received national and local recognition for our services and ways of working. Of particular note is the focus we have placed on developing a set of meaningful values that are embraced throughout the Trust. For instance, the Trust's recruitment process now includes a values assessment, to ensure that all considered applicants are 'in tune' with our values. In response to this work, the Workforce and Organisational Development team were shortlisted for four categories in the Healthcare People Management Association (HPMA) Excellence in HR Management Awards.

As a result of the Trust's high performance, based on employee engagement scores, patient satisfaction and other data from the national staff survey, Derbyshire Healthcare was identified as a case study for a national research project on employee engagement. Led by the IPA, Britain's leading organisation delivering partnership, consultation and employee engagement in the workplace, the research highlighted a range of key strengths across the organisation. For more details please see page 58 under our workforce and leadership pillar.

The Trust also held its first 'Delivering Excellence' staff awards ceremony in September 2013, which recognised team and individual contributions to the Trust values. Winners for example included the Trust's Deputy Head of Estates and Facilities, for her dissemination of the Francis Report to facilities staff, and the Trust's carers lead, who was nominated for an unsung hero award by carers throughout Derbyshire.

The Trust's Lighthouse team also won a national award for being the best children's service in the local government MJ (Municipal Journal) Achievement Awards in June, for their innovative commitment to children's services. The team were commended for their links with partners, which ensured their inclusion of all children, especially those who are most in need of support and the ability to provide services in an integrated and joined up way.

The Electro Convulsive Therapy (ECT) team at the Radbourne Unit were accredited 'with excellence' by ECTAS (the ECT accreditation service) for their practice and services.

Our Chief Executive and Executive Directors participate in a wide range of local and national events, in order to further build the profile and reputation of the Trust. For example during 2013/14 this has included presentations, clinical talks and key note speeches relating to leadership and the importance of a strong values base, visions of services for the future and putting relationships at the centre of care. Steve Trenchard, Chief Executive, was a member of the Advisory Board for the Point of Care Foundation, an independent charity working to improve service user's experience of care and increase support for the staff who work with them. The Trust also hosted a national 'force free' conference and a dementia showcasing event, visited by Sir David Nicholson, Chief Executive of the NHS.

Steve Trenchard welcomes Sir David Nicholson to Derbyshire in November 2013

National innovation work

Derbyshire Healthcare hase become involved in the national Rethink Innovation Network looking at 'Interventions for Implementation and Evaluation'. This network, involving 12 organisations across the country, has been developed in response to the 'Abandoned Illness' Report published by the Schizophrenia Commission in November 2012. The Network has identified five priorities themes; inpatient care, physical health, employment, recovery focused care and secure care.

As an organisation we are getting involved in the work around inpatient care, physical health and employment. This entails feeding back information around our own developments into the network where we are all sharing and learning from each other's progress. This Innovation Network will run for two years.

Engagement and equality

Equality, diversity and human rights are enshrined in the NHS Constitution and the Trust is committed to ensuring equality of opportunity for our workforce and to providing safe, high quality healthcare for all our local population, which is inclusive of all protected characteristics – including age, disability, gender reassignment, marriage and civil partnership, pregnancy and paternity, race, religion and belief, sex and sexual orientation.

2013/14 has been a particularly active and successful year as the Trust made significant progress in responding to the requirements of the Equality Act 2010. We believe equality and engagement is at the core of providing safe, compassionate and high-quality care to all our communities and particularly to groups that are seldom heard or seen. We are fully supportive of equalities, engagement, experience and enablement (the 4Es) and are very proud of our partnership work, led through members of our external facing 4Es stakeholder committee. This forum is an alliance of stakeholders with a common purpose to 'connect' with people and make a difference through community development and capacity building approaches. Following the principles of co-production, the committee seizes the opportunity to tap into people's natural assets and enables stakeholders to work as equal partners to improve the quality of services, quality of life and experiences of our local communities.

The Trust has committed to the national Personal, Fair and Diverse (PFD) campaign, led by NHS Employers, and has been cited as an example of good practice in this area. A personal, fair and diverse NHS is one where everyone's contribution matters and everyone counts.

Improving access for deaf communities

The Trust has undertaken particular research, in conjunction with the British Deaf Association (BDA) this year. With a concentration of Deaf people that is approximately three times the national average, Derby has the second largest deaf population in the UK outside of London and, in January 2014, the Board of Directors signed up to the British Sign Language (BSL) Charter, to help to deliver the Trust's vision and strategic objectives to improve the health and wellbeing of all communities.

Community engagement

'Reaching Out' community visits and 'keeping physically fit and emotionally well' sessions continue to take place. The purpose of these visits and sessions is to raise awareness, promote early intervention, service improvement and reduce the stigma of mental health conditions within our communities. We have delivered tailored workshops and provided a named Pathfinder link to each organisation so there is a first point of contact for advice and signposting.

Tackling stigma, discrimination and fostering good relations

The Trust continues to reach out to all communities to tackle stigma, discrimination, and raise awareness of mental health issues. We have forged a strong link with Time to Change; a national organisation dedicated to the same aims, and with our local voluntary sector group called "Changing Minds". We believe that mental health is everyone's business, particularly those who employ or work with people who experience mental distress. To help us spread this message across Derby and Derbyshire, we have hosted the first Time to Change Organisational Learning Network (Midlands) and delivered a 'Mental Health Everyone's Business' event in May 2013. We have teamed up with renowned theatre companies to help us use creative arts to explore mental illness through a series of drama productions and interactive discussions at events and in our inpatient units and the productions have received overwhelmingly positive feedback.

Chesterfield FC sign the 'Time to Change' pledge

The Trust signed the national Time to Change pledge in May 2013 and has encouraged local organisations to sign up, pledging to work together to tackle stigma and promote recovery. During the year Derby City Council, Chesterfield County Council, Chesterfield Football Club and the University of Derby all also signed the pledge, following the Trust's engagement work.

Derbyshire Healthcare was the first Trust to be awarded the verified accessible building Credibility status to show we are a committed provider of services to disabled people. We had the privilege of accompanying Nimbus/ Disability Direct to launch the accreditation at the House of Commons on 10 July 2013.

During the year we have updated our Carenotes system to capture information on service user's protected characteristics to enable us to highlight differences in access and wider potential barriers. Work is underway to ensure that our new patient information system, PARIS, reflects all the protected characteristics as defined in the Equality Act 2010. We will continue to build on this work and further enhance data recording and the training around religion and sexual orientation.

Communications

During 2013/14 the Trust has sought to build its communications infrastructure. This forms part of our commitment to ensuring open and transparent communications with all our internal and external audiences.

The Trust continues to communicate regularly with our staff, partners, members and governors and we are increasingly making use of online and social media in order to engage with new and wider audiences.

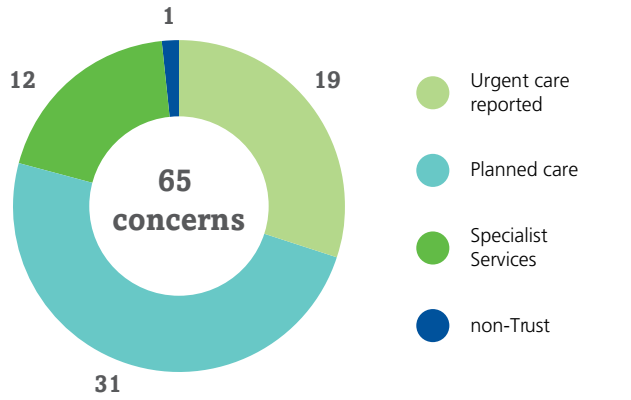
In response to the feedback we have received about confusion arising from the Trust's lack of a clear brand identity, work took place over the last year to strengthen our brand and ensure there is clear recognition of the services provided by the Trust. The Trust was proud to launch its new brand identity in May 2014 and this Annual Report is designed in line with this new identity.

The Trust will be working to develop and implement a new Communications Strategy during 2014/15 and is committed to more effectively align our communications, membership and engagement work.

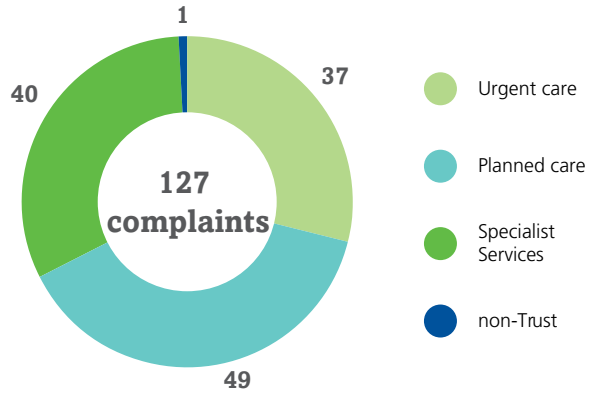
Compliments and complaints

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 with the Trust Headquarters. Staff have direct contact with the Chief Executive and Executive Directors and liaise regularly with senior managers. Our 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 we receive is essential and this is shared with staff through the Trust 'Practice Matters' publication.

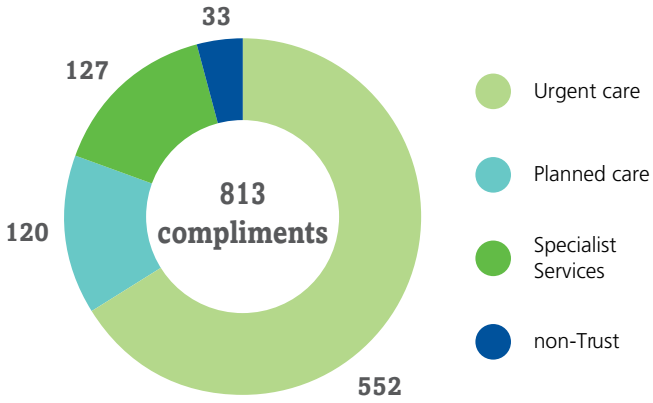
During 2013/14 the Trust logged:



19 clinical treatment, 13 staff attitude, 13 communication



57 all aspects of clinical care, 29 staff attitude, 15 communication



Most were in relation to the kindness shown by staff and for the care given to loved ones.

Of the 127 complaints, 51 were deemed to be well founded, in all or in part, 38 not well founded and 38 are still being investigated. In regard to the well founded complaints 400 separate actions have been taken to improve services and communication: including reflective practice, standardisation of assessment process, changes of workers, improved signage and better safe keeping of patient's property.

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

Two - complaints and clinical files requested, cases being assessed.

Six - contacts where no further action was required. This provides the Trust with assurance that complaints are handled appropriately.

We received one report in November 2013 regarding a complaint raised in 2012/13, which required an action plan. We also received confirmation in April 2013 that no further action was required in relation to an assessment from the previous year.

In order to use the information in a more meaningful way from 1 April 2014 the Trust started to log concerns, complaints and compliments by main category and then log the issue within a theme. This will improve the analysis of the feedback. We will also theme the actions taken as a result of the investigations and identify key overarching themes. Each will have an action plan to address the key issues.

Pillar 5: 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.

Our partnership approach

Derbyshire Healthcare has recognised that to provide optimum outcomes for people who use our services, we need to provide of a range of choices around service delivery. To achieve this we have developed and maintained formal partnership arrangements with a variety of organisations during the past year. Rapid access to primary care mental health interventions as close to home as possible has been significantly enhanced by our partnerships with Derwent Rural Counselling Service and RELATE; these partnerships have also fostered a more seamless transition for people from the point of referral out of primary care to receiving appropriate interventions in our services.

During this year we have also recognised the importance of working with non-statutory providers, through a lead contracting arrangement, to deliver a wide range of support to people with more specialist needs. For example we have maintained and developed a strong partnership with Phoenix Futures to ensure the delivery of a multifaceted drug misuse service, enabling the commencement of innovative work such as our Eastern European Clinic (a specialist clinic to increase engagement with this community). Furthermore our work with First Steps, a local eating disorder charity, has significantly contributed to ongoing support for people who used our secondary service offering access to recovery focused support in local communities.

The Derbyshire health community has focused this year on the development of locality based teams to support frail elderly people. Our Trust has contributed to this development through the engagement of our expert clinicians and by holding community-based dementia question and answer sessions, as well as by leading a dementia showcase event attended by Sir David Nicholson, Chief Executive of the NHS, which involved all local provider and commissioner organisations.

In addition we have worked with partners at the Royal Derby Hospital to develop an advanced psychiatric liaison service to ensure that people with mental health and substance misuse difficulties receive specialist mental health help as soon as possible.

Our adult mental health assessment service (Pathfinder Service) has been moved from being a central service in the southern part of the county to be integrated with locality teams, giving improved access for local people.

Think! Family is an essential drive for all our clinicians and this year we have strengthened this with joint training and supervision between our health visiting team and our substance misuse service in Derby City, as well as augmenting Think! Family support to all teams within the organisation. This ensures people who use our services receive the support they and their family need during their recovery.

- From April 2014 the responsibility for providing adult and older adult psychiatrist input to people in the High Peak area of Derbyshire has transferred to the Trust from Pennine Care FT. This provides a great opportunity to work with local communities and partners such as local GPs to ensure that more people than ever are treated close to home and, wherever possible, admission to a hospital bed is avoided.

Working with local commissioners

The Trust has developed and consolidated relationships with local commissioning organisations throughout the year, following the implementation of new Government strategy relating to the commissioning of NHS services. Hardwick CCG, as lead commissioners for mental health services, have played an active role in the Trust's transformation programme, in order to provide input into the changes required from both the Trust and the wider health economy. Relationships with each of the other three CCGs within Derbyshire have developed 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 our colleagues at Derby City Council during 2013/14 to agree arrangements for their programme of organisational change. Throughout the year Derby City Council staff were managed within the Derbyshire Healthcare management structure but from 1 April 2014 this will no longer be the case and all Derby City Council staff will be directly managed within Derby City Council's management structures.

The Trust has worked closely with Derby City Council to manage these planned changes and has reviewed management roles within the Planned Care service line, in order to respond appropriately to these changes.

Funding of partnership work

The Trust's partnership relationship with Derwent Rural Counselling service is funded as an integral part of the local IAPT any qualified provider contracting arrangements and the partnership is a significant factor in enabling a high quality IAPT offer to residents across the whole of Derbyshire.

Our work with Phoenix Futures is funded as part of the contract for the delivery of drug services within Derbyshire. Phoenix are an organisation that are highly experienced in the delivery of low intensity interventions and as such augment the Trusts specialism in working with individuals with more complex needs.

The Trust's partnership work with First Steps is funded as part of our main contract from Derbyshire CCGs and First Steps operate as a sub-contractor for some elements of service delivery. However, service receivers are able to access the whole range of support offered by First Steps, not just those elements we sub-contract for, ensuring a far greater choice of support for individuals in Derbyshire with an eating disorder

The work the Trust has undertaken with Royal Derby Hospital to successfully implement an intensive liaison service was funded directly by CCGs as a quality improvement initiative.

Positive and safe futures

A major piece of work throughout 2013/14 relates to the Trust's ongoing commitment to reduce the use of restrictive practices, such as seclusion across our acute inpatient wards. This area of work forms one of the Trust's quality priorities for 2014/15.

Derbyshire Healthcare is working closely with staff, local community groups and service user representatives to explore our use of seclusion and look at how we can safely reduce this; improving patient experience of our services whilst also maintaining their safety and that of our staff.

On 1 March 2014, NHS Change Day, Chief Executive Steve Trenchard pledged to support our staff to safely reduce the use of seclusion on our inpatient wards. Throughout the next year, teams will be working together with our service user representatives to share best practice and ideas on how to achieve this.

20 March 2014 saw the launch of Safewards at the Radbourne Unit in Derby. This national project looks to make sure all staff working on wards have the passion, skills and confidence to reduce harm and improve patient safety.

Involving and supporting our carers

The Trust sees carers as a highly important stakeholder in our organisation, being key to an individual's support and recovery. We work closely with carers and carer organisations to develop and improve our communication and engagement. Through the 4Es meetings (see page 45), we have established a Carers Group, who inform and guide the Trust about the needs of carers.

During Carers Week in June 2013, we celebrated with events in Derby and Chesterfield where carers and our partner organisations came together to celebrate the work of carers around the Trust. Making Space provided a 'singing for the brain' session for family members with dementia to support this in Derby, and Toby Perkins MP opened our Chesterfield event.

During the last year we launched our Carers Handbook and Carers Information Pack, to make it easier for carers to access respite, emotional support, carers services, peer support and groups, and to gain an assessment of their needs.

The Trust signed up to the national 'Triangle of Care: Carers Included' membership scheme in June 2013. As part of this we launched our Carers Champions network, with champions in all our inpatient services and many community teams. We are undertaking a self-assessment of how we support carers, and working on plans to make improvements where necessary.

Building on the success of the celebration of carers, we have used innovation funding to hold three 'carers and cake' events in Buxton, Ilkeston, and Normanton in Derby; to reach out to local carers who may not access any other support. These events have been held with a number of different partners including social care colleagues, the Citizens Advice Bureau (CAB), Derbyshire Carers Association, Think! Carer, Making Space, the Alzheimer's Society, Rethink, and Talking Mental Health Derbyshire, who offered support and advice on the day.

In November 2013 the Trust launched our 'My CCS' App for iPhone and Android phones, which is also installed on all computers in the Trust. This includes our Core Care Standards and principles, service information, an appointment diary, and My Plan, a Wellbeing and Recovery Plan that anyone can use to help them stay well. The app also allows for real-time feedback, as people can rate our services and our standards, and send us comments and complaints. Further information on the Trust's use of apps can be accessed on page 37 of this report.

The Core Care Standards website won a national award for its information for carers and service users in June 2013. The site has been developed further over the year, with a section for service users about urgent help they can access, such as food banks. We have also done some work to focus more on safety rather than risk, changing our risk standard to 'keeping yourself and others safe', and the safeguarding section has also been developed further.

The Trust's Infolink resource directory continues to be used and valued by staff, service users, their families and our partner organisations. It is currently in the process of being updated and revised to include a wider range of BME organisations and other wider groups.

The Triangle of Care

Working with our League of Friends

The League of Friends is a charity, which raises funds for the patients within the Trust through various activities. These include a very popular annual Summer Fayre, which is held in July each year, within the grounds of Kingsway Hospital, Derby. Retired employees, staff from the Trust and people who have an interest in mental health sit on the Committee. All monies raised are used to enhance the patient experience; the League provides the funding for outings and activities such as games and theatre trips and for developing activities on the Trust's inpatient wards at Christmas.

Pillar 6: 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.

The Trust's strategic aim is to maintain its robust financial performance and full compliance with regulatory requirements in order 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 all 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 have been met in full by developing responsive financial modelling, increasing the speed of production of service line reports and by embedding the roll-out of our viability assessment framework tool across all our service lines.

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 service users 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, and supporting integrated care models that are both accessible and easily understood by both the service user 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, service users and our primary care colleagues. The Trust is a dynamic organisation which has steadily grown in response to the needs of the local health community and in response to market changes.

Directors' Financial Report

Fair review of business and analysis of financial key performance indicators

During the year ending 31 March 2014, the Trust generated income of £127 million from the provision of services, principally to the people of Derbyshire. Of that total, £116 million income was from 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, 2013/14 was another very successful year financially for our Trust. After technical adjustments, we made a surplus of £1.9m, which was above our original plan for the year by about £0.6m. 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 have managed financial pressures within that overall financial performance. The pressures have primarily been related to costs associated with high levels of activity and acuity needing higher than planned staffing levels in some areas.

Our financial surplus was achieved after delivering a £4.4m 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 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 140 of this Annual Report show:

Full Year	£m
Operating Income from continuing operations	127.5
Operating Expenditure from continuing operations	(123.8)
Operating Surplus / (Deficit)	3.7
Net finance costs	(3.2)
Surplus / (Deficit) for the year	0.5

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 £1.4m, the surplus becomes £1.9m.

In terms of Key Performance Indicators (KPI) 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 13/14 was £8m which equates to 6.2%. (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.

Another KPI which is relevant to understanding our financial performance and direction of travel is our level of net current assets. Currently we operate with net current liabilities rather than assets, but our financial plans over the next few years will enable us to deliver net current assets. Our position at the end of the financial year with regard to this measure was net current liabilities of £2m. This can be seen on our statement of financial position within the accounts.

There have been no significant changes in our objectives, activities, investment strategy or in our long term liabilities. There has however been one minor change in direction relating to liquidity measures. As an organisation we wish to improve our relative position on liquidity, i.e. our cash reserves, and accordingly we will seek to build them up over time. This will, in the short-term, to some degree, limit our ability to reinvest surplus funds in patient services through our capital programme.

We funded our entire capital programme of £4.4m for 2013/14 through internally generated resources.

The major schemes from our capital expenditure programme were:

- A major acute ward refurbishment to support new patient environment at the Radbourne unit, which will come into operation in 2014/15
- Clearing the building maintenance backlog maintenance and delivering other refurbishments and improvements
- Significant investment into information technology equipment and systems - in particular into developing our new electronic patient record project
- The balance of our capital programme was invested in various pieces of clinical equipment.

The value of the capital programme for 2014/15 will be circa £3.3m.

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

Although we have performed relatively well financially in 2013/14, this has been within a difficult financial environment locally and nationally. Looking ahead there are 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 five year transformational journey for service user pathways from 2014/15 to 2018/19.

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 2014/15 we plan to achieve a surplus in the region of 1.2%. 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 £4.3m.

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

The principal financial risks and uncertainties for 2014/15 can be summarised as follows:

- Achieving the planned CIP (Cost Improvement Programme), whilst maintaining acceptable levels of quality in service provision
- Achieving planned activity related income, including IAPT
- Achieving CQUIN and other performance related income
- Containing costs within risk share agreements
- Electronic Patient Record (EPR) system delivery within planned budgets
- Management of emergent cost pressures.

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 2014/15 the new funding structure called the 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.

Prior period adjustment

In the Annual Accounts it has been necessary to account for a prior period adjustment. This relates to an error in the valuation of our Private Finance Initiative (PFI) building. The error in valuation was notified to us during 2013/14. As a result, the value of the PFI in the notes 16.2 has had to be corrected accordingly using a prior period adjustment.

Preparation of the Annual Accounts

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 2013/14 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 and compiled our accounts using International Financial Reporting 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 the Annual Report and accounts are prepared.

Therefore, each year in supporting evidence of our accounts submissions, the Trust's management team 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.

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 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.

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 on pages 82-85 of the remuneration report.

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.

Countering fraud and corruption

The Trust's counter fraud service is provided by an external organisation named 360 Assurance, previously called East Midlands Internal Audit Service (EMIAS). They provide our The 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.

Derbyshire Healthcare NHS Foundation Trust has agreed to take all necessary steps to counter fraud which may affect NHS funded services and will maintain appropriate and adequate arrangements and policies to detect and prevent fraud and corruption. We have a Fraud Strategy and a Whistleblowing procedure in place which is communicated to staff, for example, through Trust information systems, newsletters and training.

During 2013/14 the Trust planned 65 days, and used 67 days, of counter fraud services, across the following areas:

Holding to Account 7.5 days
Informing and Involving 29 days
Prevention and Deterrence 15.5 days
Strategic Governance 15 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) 93% of non-NHS invoices and 75 % 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 – the total was £179,000. This figure has been supplied by NHS Pensions.

Cost allocation and charging requirements

During the year the Trust has complied with the cost allocation and charging requirements set out in the HM Treasury and Office of Public Sector Information guidance.

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 127 of this Annual Report.

Pillar 7: 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 co-producing and leading the change process.

Derbyshire Healthcare has a four-year workforce strategy; 'Delivering Quality Through Our People'. 2013/14 was the third year of implementing the strategy, which has four key strands:

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

Throughout the year, the Trust has made considerable progress in each of these areas, which we believe is reflected in a positive set of staff survey results.

Staff engagement

Derbyshire Healthcare is committed to engaging with our workforce and to develop two way methods of communication to ensure that, whilst we effectively share information, we have mechanisms in place to listen and to capture feedback and new ideas from our staff.

Our Chief Executive prepared a regular blog and a large number of staff follow the Trust's corporate Twitter account @derbyshcft. These communication methods are an opportunity for staff to share news and views on key topics relating to the work of the Trust and wider relevant developments. The Trust also has a well-used intranet site and staff/member magazine. In January 2014 a new weekly e-bulletin was introduced, to ensure regular useful information was disseminated across the organisation and discussed at team meetings.

During this year, Derbyshire Healthcare was identified by the Involvement and Participation Association (IPA) as a centre of good practice with regard to staff engagement. We were pleased to have been selected as one of only eight English Trusts, and one of only two mental health Trusts for inclusion in the 2014 IPA NHS review. Our inclusion was on the basis of previous staff survey results, alongside a range of other business results, including quality and financial performance, and a wider awareness of good practice, which included:

- The creation of a clear set of Trust values, through widespread involvement with our teams, which were then embedded in our everyday processes; for example by including values based assessments in our recruitment processes.
- A project with Health Care Assistants (HCAs) focused on increasing ownership of their work.
- The Trust's participative approach regarding transformational change, including widespread involvement of staff and external partners from the very start of the process, with a commitment to a shared and participative approach. Further detail about this process can be accessed on page 33 this Annual Report.
- The Trust's leadership has undergone significant change over the past few years, which has led to a refreshed strategy and vision. Our feedback indicates that this has led to an open and approachable leadership style, where a focus is placed on listening, acting on what people say, and being prepared to change minds.

The framework, which will inform the Trust's future engagement strategy, is taken from the work of Professor Michael West working with the Department of Health (DH), where engagement is seen as having four main components as follows:

1. A compelling strategic narrative
2. An inclusive leadership and management style
3. Putting staff in charge of service changes
4. Values and integrity.

It is positive to note that the IPA has identified strengths which align with the Department of Health's model, and we will seek to build on this as we move forward. We do not think that one size fits all when it comes to engagement, and we are very aware that effective engagement looks and feels different to different staff groups, with age, occupational/ professional group and work location all relevant in this context. Consequently, based around a Trust-wide core, we will seek to segment our staff, and tailor our approaches accordingly, to ensure that specific engagement requirements are effective.

To ensure that the employee voice is heard and acted upon at Board level and throughout the Trust, a new Employee Strategy and Engagement Committee will be established during 2014/15, chaired by the Chief Executive, with Non-Executive Director and cross functional membership.

Wide areas of focus for the Workforce and Organisational Development team have also included:

- Meaningful partnership working and appropriate consultation with our Staffside representatives
- The creation of a meaningful narrative to ensure that staff understand the wider journey and how specific changes 'fit' within that journey
- Ensuring that Trust structures and team composition/ gradings reflect our services and financial priorities, so that the best quality care can be provided to the people of Derbyshire.

The Trust has not needed to engage in any major formal Staffside consultations during 2013/14. It is anticipated that the Trust's urgent care team will undertake a formal consultation with its staff in the early part of 2014/15, given proposals to develop a recovery and resilience hub at the Radbourne Unit in Derby; this change is needed in order to develop and model our services to focus on recovery-centred care.

Health visitors at Peartree Clinic in Derby

Involving teams in transformation plans

Throughout 2013/14 the Trust has placed a focus on transformation and the members of our workforce have been key stakeholders in shaping this process. Each Pathway and Partnership Team (PPT) has had a good representation of clinicians and managers from the service, who have worked with a range of different audiences to create a new vision for their team going forward. Regular events are held and communication messages are circulated to ensure messages about this process have been shared with wider teams.

Derbyshire Healthcare is acutely conscious that many staff will be affected by the transformational change programme; therefore a focus on consistent and compassionate application of employee policies and procedures to ensure that people affected by change are treated with dignity and respect has, and always will be, core to our management of change.

Values

We have made a positive start in introducing values-based assessments for all new staff and have developed a process for assessing current staff against our Trust values. This is through specific assessment interventions and a revised approach to appraisals. We are working with service user representation groups to assist in the design and deployment of this approach.

2013 saw the development and launch of the Nursing Career Framework and the establishment of the Derbyshire Nursing values and behaviours. Building on this, our HCAs have progressed their work to make explicit the compassionate behaviours that can be expected for all people through 'My 20 commitments to compassionate care and living the values'.

With the support of Professor Paul Gilbert, the Trust has undertaken a series of workshops around compassionate care, and has instigated regular Schwartz rounds to encourage our teams to talk about any distressing experiences and receive support. This remains an area of focus for Derbyshire Healthcare and will be developed further over the forthcoming year.

Leadership

The Trust has focused on developing leadership skills at different levels amongst our teams. Trust-wide leadership events have taken place, which have proved tremendously effective in bringing leaders together from across the Trust to share learning and experiences.

These sessions have often included guest speakers, to talk about key issues pertinent to the business of the Trust. For example, given the Trust's focus on developing compassionate relationships, a leadership event in November 2013 was dedicated to compassionate leadership. This was led by Dr Paquita de Zulueta, a GP in North West London and Lecturer of medical ethics at Imperial College, London.

We have also delivered the Institute of Learning Management (ILM) level 2 programmes for aspiring leaders, a Personal Impact programme for our more senior staff and delivered a leadership programme for new consultants. During the year, the Trust's leadership programme was shortlisted as one of six finalists out of over 200 entries for the annual Training Journal Awards.

Navigator and Springboard leadership programmes have also taken place throughout the year to ensure development of both male and female leaders within the organisation.

Earned autonomy

Earned autonomy is also something which we have commenced modelling and will be a vital way of empowering leaders, including clinicians, to have even greater independence in running their services. This approach has been based directly on the feedback from service users, carers and commissioners during our transformation programme.

A focus on Health Care Assistants

During 2013/14 the Trust has initiated an engagement programme with our Health Care Assistants. As we recognise that HCAs have the most time directly with patients out of any occupational group, a series of workshops has been set up which has produced a range of relevant outputs, including work to define 'quality' and the application of our values in terms of the work which HCAs do. Non-qualified staff have also had the opportunity to engage with the programme, helping them to find a voice should they observe poor quality care. This programme has gained national attention and plaudits and we will build on this work during 2014/15 with further workshops and training needs assessments.

Promoting equality and diversity

The Trust is committed to embedding the principles and legislation within the Equality Act 2010, inclusive of people with a disability. Along with the legislation, the Trust values promote an inclusive, people centred approach to both the way we provide healthcare services and the way we treat our colleagues. The more formal Trust policies include Equal Opportunities, Dignity at Work, Chronic Illness/ Disability and the Equal Opportunities Code of Practice. All Trust policies promote a positive approach to recruiting and employing people with a disability and the Trust has continued to retain its 'Positive about disabled people' accreditation. All applicants meeting the required skills and qualifications for a post who have a disability will be guaranteed an interview.

The Trust continues to support staff and colleagues who may become disabled at any time in their employment. Medical support and advice through Occupational Health is provided by Derby Hospitals NHS Foundation Trust, which is part of our inter-Trust contract. Personal support and advice is also provided through our Staff Liaison Manager and an individual's needs are assessed on a case by case basis.

Both managers and individuals can complete a referral request to occupational health for advice and support, which can include medical advice, physiotherapy, counselling and therapy services in addition to regular health screening and surveillance and vaccination programmes.

Staff survey results

The results from the 2013 staff survey are extremely positive for our Trust, with 71% of respondents saying that patient care is our top priority. This is an increase in 6% from the previous year, when the Trust was already above the national average in response to this question.

Our overall score for staff engagement was 3.78 (out of a maximum score of five), which reflects an increase from the 3.76 score achieved in 2012/13. This score is based on the following:

- The ability of staff to contribute towards improvements at work
- Staff recommending the Trust as a place to work and/ or receive treatment
- Staff motivation at work.

The vast majority of our staff said they would be happy for their friends or relatives to receive care from the Trust, which is clearly an excellent reflection on the quality of care and values we hold as an organisation. Our score in this area was higher than the responses received to the same question last year and is also higher than the national average. Similarly a higher number of people than average said they would recommend the Trust as a place to work and that we always act on concerns raised by our service users.

In comparison with other NHS Trusts that have a similar breadth of services, we are amongst the highest scoring Trusts nationwide for the following achievements:

- The percentage of staff who feel their role makes a difference to patients
- The number of staff who feel able to contribute towards improvements at work
- The fairness and effectiveness of our incident-reporting procedures
- The number of staff who have received health and safety training and equality and diversity training in the last 12 months.

There are of course areas of concern that we need to understand and build upon over this forthcoming year. Most notable is the number of staff who report they have not received an annual appraisal in the last year. Whilst there have been system changes that may have affected our results in this area, we are committed to every individual having an appraisal each year and have strengthened our messages and monitoring of our performance, to ensure improvement in this area going forward. We will also be focused on understanding and addressing any issues of staff being bullied or harassed by other staff, and also ensuring that staff feel free to report any incidents or near misses.

Future priorities

The Executive Team have reviewed the results of the staff survey in detail and have agreed three Trust-wide areas of improvement, which will be supplemented by local actions. These are:

1. **Appraisals -** Many people reported that they had not received an appraisal in the last 12 months. We will proactively work to understand reasons for this, and improve our internal processes to support people to receive an annual review. This will include consideration of the format we currently use for appraisals, and also the time of year we expect them to be undertaken.
2. **Bullying or abuse from other members of staff -** 22% of staff reported that they had experienced abuse or bullying from other members of staff in the last year. Whilst this percentage is the same as was expressed last year, it still feels high and we would like to understand more about this. We will be looking at our results in more detail to identify if this is more common amongst specific occupational groups, service lines or functions in order to determine whether there are any issues that need to be addressed.
3. **Reporting errors or near misses -** Our results in this area fell in this year's survey, and we now sit slightly below the national average for the percentage of staff who report errors or near misses. This is clearly of concern and we will be further reviewing the data we received in response to this question to identify any specific concerns which we need to address.

We will monitor the completion of appraisals through the Trust's real time performance review system, and any site or function-related issues around bullying, reporting errors or near misses will be addressed via action planning. These results will then inform the development of a new Employee Engagement Strategy.

Performance against priority areas

Our priorities for the 2013 survey were to increase our results in the following areas:

- Health, safety and wellbeing
- Communication, involvement and engagement.

The Trust focused on increasing the number of staff who received health and safety training in the last 12 months and our results in this area are now 12% higher than the national average.

The Trust has made positive progress around involvement and engagement, as outlined at the start of this pillar. This will be of ongoing importance to the Trust and will be supported by the development of a new communications strategy and an increased focus on this area.

We will continue to encourage as many staff as possible to take part in the 2014 national staff survey later this year. We will use our engagement and communication mechanisms to discuss progress with our staff and will explore alternative ways of how to increase the number of people who participate in the 2014 survey.

Staff survey results

Response rate	2011/12		2012/13		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
	48%	51%	41%	57%	-7%

Top four ranking scores	2011/12		2012/13		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
% of staff agreeing that their role makes a difference to patients	89%	90%	92%	90%	+3%
Fairness and effectiveness of incident reporting procedures (the higher the score the better)	3.60	3.52	3.63	3.52	+0.03
% of staff receiving health & safety training in last 12 months	90%	73%	87%	75%	-3%
% of staff able to contribute towards improvements at work	72%	71%	77%	72%	+5%

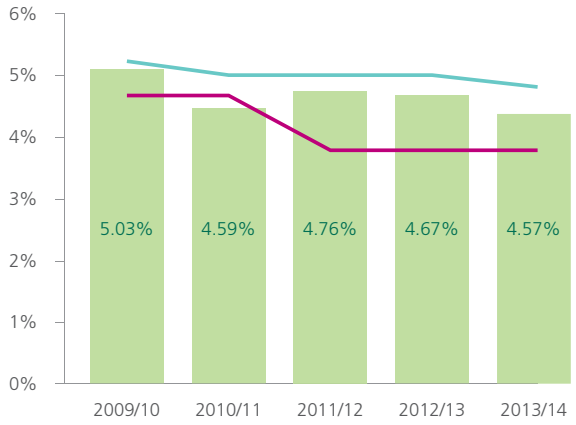
Bottom 4 ranking scores	2011/12		2012/13		Trust improvement/ deterioration
	Trust	National average	Trust	National average	
% of staff appraised in last 12 months	90%	87%	80%	87%	-10%
% of staff reporting errors, near missies or incidents witnessed in the last month	93%	93%	90%	92%	-3%
Effective team working (the higher the score the better)	3.83	3.83	3.78	3.83	-0.05
% of staff experiencing harassment, bulling or abuse from staff in last 12 months (the lower the score the better)	22%	21%	22%	20%	

Workforce profile

Trust		Headcount	FTE	Workforce
	Employees	2435	2120.87	
Staff group				
	Add Prof Scientific and Technic	162	142.01	6.65%
	Additional Clinical Services	428	368.77	17.58%
	Admin and Clerical	512	446.57	21.03%
	Allied Health Professionals	135	107.69	5.54%
	Estate and Ancillary	155	119.85	6.37%
	Medical and Dental	150	128.35	6.16%
	Nursing and Midwefery Registered	865	779.63	35.52%
	Students	28	28.00	1.15%
Age				
	16-20	9	8.40	0.37%
	21-30	235	216.01	9.65%
	31-40	577	492.33	23.70%
	41-50	790	696.55	32.44%
	51-60	686	599.18	28.17%
	61-70	127	101.48	5.22%
	71 & above	11	6.92	0.45%
Disability				
	Declared Disability	84	73.64	3.45%
	No Declared Disability	2351	2047.23	96.55%
Ethnicity				
	White - British	1813	1578.09	74.46%
	White - Irish	22	18.30	0.90%
	White - Any other White background	53	47.21	2.18%
	White Northern Irish	1	0.53	0.04%
	White unspecified	75	65.72	3.08%
	White English	3	2.44	0.12%
	White Other Ex-Yugolav	1	1.00	0.04%
	White Other European	2	1.40	0.08%
	Mixed - White & Black Caribbean	12	10.36	0.49%
	Mixed - White & Black African	5	4.79	0.21%
	Mixed - White & Asian	5	4.40	0.21%
	Mixed - Any other mixed background	7	5.92	0.29%
	Asian or Asian British - Indian	94	82.21	3.86%
	Asian or Asian British - Pakistani	28	25.60	1.15%
	Asian or Asian British - Bangladesh	3	2.13	0.12%
	Asian or Asian British - Any other Asian background	6	5.40	0.25%
	Asian Mixed	1	0.80	0.04%
	Asian Punjabi	4	2.61	0.16%
	Black or Black British - Carribean	50	45.25	2.05%
	Black or Black British - African	29	27.73	1.19%
	Black or Black British - Any other Black background	11	10.52	0.45%
	Black Nigerian	1	0.80	0.04%
	Any other Ethnic Group	18	15.44	0.74%
	Not Stated	191	162.22	7.85%

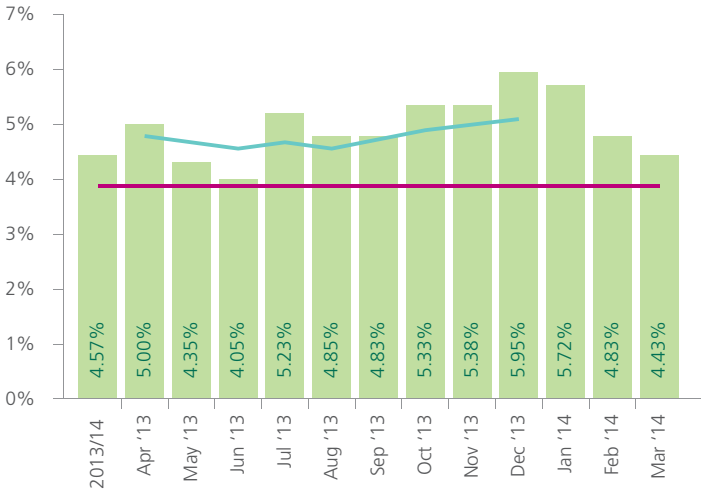
Trust		Headcount	FTE	Workforce
	Employees	2435	2120.87	
Gender				
	Female	1914	1630.45	78.60%
	Male	521	490.42	21.40%
Gender breakdown				
	Female Director/CEO	2	2.00	33.33%
	Male Director/ CEO	4	4.00	66.67%
	Female Senior Manager Band 8b & above	15	15.00	68.18%
	Male Senior Manager Band 8b & above	7	7.00	31.82%
	Female Employee other	1897	1613.65	78.81%
	Male Employee other	510	479.22	21.19%
Religious belief				
	Athesism	196	177.59	8.05%
	Buddhism	8	7.37	0.33%
	Christianity	763	668.63	31.33%
	Hinduism	22	20.53	0.90%
	Islam	25	22.13	1.03%
	Judaism	2	1.60	0.08%
	Other	156	138.56	6.41%
	Sikhism	36	29.82	1.48%
	Not Stated	1227	1054.64	50.39%
Sexual orientation				
	Bisexual	4	3.67	0.16%
	Gay	9	8.80	0.37%
	Heterosexual	1225	1081.37	50.31%
	Lesbian	11	10.40	0.45%
	Not Stated	1186	1016.63	48.71%

Annual sickness absence % - previous 5 years



- Annual sickness absence %
- Trust target 3.90% (previously 4.70%)
- National mental health and learning disabilities Trust Average (Source: NHS iView Information Centre)

Monthly Sickness Absence % - April 2013 to March 2014



- Monthly sickness absence %
- Trust target 3.90%
- National mental health and learning disabilities Trust Average Apr to Dec 2013 (Source: NHS iview information Centre)

Number of days lost to sickness (January to December 2013)

This data was provided by the Department of Health and covers January – December 2013. It is therefore not directly comparable to the annual and monthly sickness data reported on page 66, which cover the full 2013/14 financial year.

FTE days available	FTE days lost to sickness absence	Average sick days per FTE
476,727	22,296	10.5

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

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).

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.

Increasing our membership

Throughout the year, a number of activities have taken place to further build the Trust's membership. We have led and participated in a number of events to outline the work of the Trust and the role of members and have held listening events throughout Derbyshire to gain feedback on how the membership function currently operates. These events have resulted in the recruiting of new members and encouraged existing members to stand for election as governors.

Membership engagement

During 2013 the Trust launched a new monthly members e-bulletin, to ensure members were kept up to date with developments and activities taking place across the Trust. We have developed a new area for members and governors on the Derbyshire Healthcare website and have increased our email communications with members and governors. At the end of 2013/14 the Trust's communications and membership teams were proactively working with governors to develop a new working group to revise and refresh all information for members, to further develop the profile of Governors' work within the Trust, and to establish closer links with the members they represent.

Governors have been increasingly involved in the Trust's quality visits this year and have reported that they find them interesting and informative, providing a unique opportunity to witness quality improvements first hand and be involved in conversations about the impact of quality improvements on patients and their carers. Governors have also attended specially delivered training schemes, for example relating to the financial processes and procedures of the Trust.

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 directors via the Derbyshire Healthcare website:
www.derbyshirehealthcareft.nhs.uk
or email **communications@derbyshcft.nhs.uk**

Membership figures

Constituency	Number of members 2013/14	Number of members 2012/13
Public	6287	6141
Staff	2440	2432
Total	8727	8573

Membership highlights from our volunteers

Christine Williamson, Membership Champion, with Barry Appleby, Governor for South Derbyshire

"The League of Friends had a Summer Fayre on the Kingsway site in July. It was a very hot day but everyone enjoyed the events. There were stalls and entertainment for the children and even the adults enjoyed them too. We managed to get 130 new members and made some lovely friends in the process."

"We had an event at the Indian Community Ladies Day where we talked to the ladies and answered questions about the Trust and how it can help them. It was an empowering event, providing an opportunity for local women to ask questions and receive information about the services the Trust provides."

"We have had two events at the West Indian Community Association where we signed up over 30 new members. The members get to know our faces and we can make friends; hopefully they feel at ease to approach us if they have any concerns or need answers about anything regarding the Trust."

"We attended two college events in September. The students were very keen to join the Trust and said they wanted to give something back to their community. We managed to get nearly 200 new members and increased participation in the Trust's volunteer programme. This programme is an excellent chance for young people to get into the workplaces of mental health providers and see first-hand how treatment is delivered. It is also helps our work in eradicating stigma."

"At Osmaston Church we signed up 20 members - we made new friends and learned about the pressure and stigma people have experienced after suffering with particular illnesses."

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 75.

Board of Directors

During 2013/2014 our Trust Board comprised the following members:

Non Executive Directors

Mark Todd, Chairman
(from 20 January 2014)
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 the Member of Parliament for South Derbyshire between 1997 and 2010.

Lesley Thompson, Non-Executive Director and Deputy Chair/Senior Independent Director (from 20 January 2014) Term of office: 31 October 2011-
30 October 2014

Lesley is a Chartered Marketer and a Director of her own consultancy, working with not for profit organisations. She is also a Specialist Lecturer for Sheffield Hallam University and delivers on strategy development and managing people for the MSc in Charity Resource Management. Lesley's key area of expertise lies in strategic business and marketing planning, capacity building and performance development and management. Lesley chairs the Trust's Finance and Performance Committee.

Caroline Maley, Non-Executive Director
(from 20 January 2014)
Term of office: 20 January 2014-
19 January 2018

A qualified chartered accountant by background, Caroline brings to her new role more than 30 years of experience across the NHS, the 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.

Maura Teager, Non-Executive Director
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.

Alan Baines, Chairman (up to 19 August, 2013)

Mick Martin, Non-Executive Director (up to 19 January 2014) and Acting Chairman and (from 19 September 2013). Senior Independent Director (up to 19 January 2014)

Graham Foster, Non-Executive Director (to 31 August 2013).

Executive Directors

Steve Trenchard, Chief Executive

Steve has been a mental health nurse for 23 years and has long been connected to a values and recovery-orientated approach to mental health and leadership practice. Prior to becoming Chief Executive of Derbyshire Healthcare NHS Foundation Trust in February 2013, Steve held Director of Nursing posts at West London Mental Health NHS Trust and The Retreat in York. Outside of work, Steve is Chair of ISPS UK (International Society for the Psychological and Social Approaches to Psychosis), a small charity dedicated to talking therapies and humane approaches to the recovery of people experiencing psychosis.

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.

Carolyn Green, Executive Director of Nursing and Patient Experience (from 17 February 2014)

Carolyn has worked as a mental health nurse for 19 years. 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 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 a BA (joint hons) degree from Keele University and worked in the private sector before joining the NHS Graduate Training Scheme in 1995. She has been a fully qualified Management Accountant since 1999. 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 procurement, estates and facilities.

Carolyn Gilby, Interim Director of Nursing and Patient Experience (from 9 October 2013 to 16 February 2014)

Paul Lumsdon, Executive Director of Nursing and Quality (to 27 September 2013)

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.

Lee O'Bryan, Interim Director of Workforce and Organisational Development (from 18 November 2013).

Prior to working with Derbyshire Healthcare, Lee O'Bryan was the Human Resources Director for the Royal Mail Customer Services Business. As Interim Director of Workforce and Organisational Development, his responsibilities include human resources, education, leadership development, equality and diversity and community engagement. Lee is also a Non-Executive Director at Avon and Wiltshire Mental Health Partnership NHS Trust.

Helen Marks, Director of Workforce and Organisational Development (upto 19 February 2014).

All appointees are considered by the Board to be independent (as defined in the Code of Governance).

Meetings of the Board of Directors

The Board of Directors held 11 regular meetings during 2013/14:

	Possible attendances	Actual
Mark Todd - Chairman	3	**3**
Lesley Thompson - Non-Executive Director/Senior Independent Director	11	**7**
Caroline Maley - Non-Executive Director	3	**3**
Tony Smith - Non-Executive Director	11	**10**
Maura Teager - Non-Executive Director	11	**10**
Alan Baines - Chairman	5	**5**
Graham Foster - Non-Executive Director	5	**5**
Mick Martin - Non-Executive Director/ Senior Independent Director, Acting Chairman	9	**7**
Steve Trenchard - Chief Executive	11	**11**
Ifti Majid - Chief Operating Officer/ Deputy, Chief Executive	11	**9**
Carolyn Green - Executive Director of Nursing and Quality (from March 2014)	1	**1**
John Sykes - Executive Medical Director	11	**9**
Claire Wright - Executive Director of Finance	11	**11**
Carolyn Gilby - Interim Director of Nursing and Patient Experience	3	**3**
Paul Lumsdon - Executive Director of Nursing and Quality	6	**3**

Also in regular attendance:

Graham Gillham - Director of Corporate and Legal Affairs
Lee O'Bryan - Interim Director of Workforce and Organisational Development (from 18 November 2013)
Helen Marks - Director of Workforce and Organisational Development (upto 19 February 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 financial acumen in recommending to governors the specification for the Non-Executive Director who is also Chair of the Audit Committee.

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).

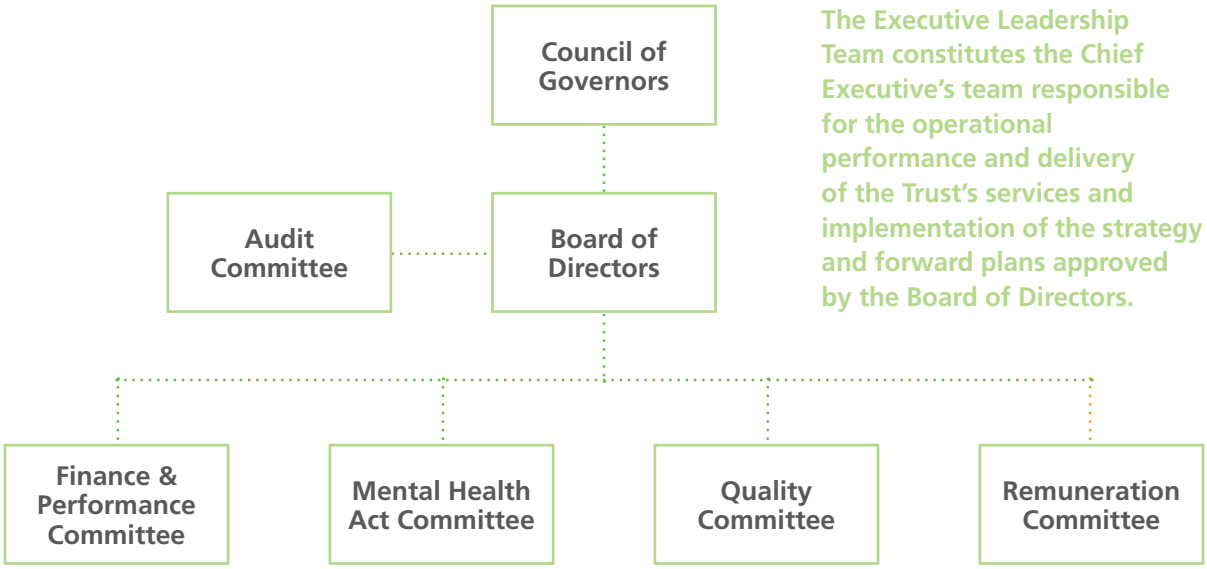
There is a recognised need to periodically assess the collective performance of the Council of Governors and how they systematically communicate the ways their responsibilities have been discharged. This will form part of the Governor's work plan for 2014/15. The Constitution also outlines processes 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.

Expenses

Eight Governors received trust expenses during the 2013/14 reporting period, equating to a total of £5,883.70. Six Executive Directors received trust expenses during the same time period, equating to a total of £37,335.87.

Committees of the Board



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 before submission to 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, the governance arrangements are fully integrated and the self-assessment against the Care Quality Commission Standards is appropriate.

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. In the 2012/13 accounts there was one significant disclosure amendment relating to future payments for PFI. However, the adjustment had no impact to the figures reported in the balance sheet and statement of comprehensive income and an unqualified opinion was issued on 29 May.

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 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 Committee also considers governance and compliance documents - for example the evolving role of the audit committee, and changes in compliance regime when the Risk Assessment Framework replaced the Compliance Framework.

During the year the Committee received and considered various internal audit reports including the governance of patient experience data, data quality, review of the Cost Improvement Programme and the Electronic Patient Record (EPR) project. Due to the size and complexity of the EPR project, the Committee also requested further information and assurance relating to project progress and accounting treatment.

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 is for an initial term of three years. The total value of the three year contract is £116,560 + VAT. The value of the 2013/14 accounts work is £38,850 +VAT.

Our Audit Committee comprises:
For part of the year:

- **Graham Foster –** Non Executive Director – Chairman of Committee for part of the year
- **Maura Teager –** Non-Executive Director
- **Caroline Maley –** Non-Executive Director (Chairman as from January 2014)
- **Lesley Thompson –** Non-Executive Director.

For the full year:

- **Tony Smith** – Non Executive Director.

Audit Committee attendance during the year was as follows:

	Possible attendances	Actual
Graham Foster	3	**3**
Caroline Maley	1	**1**
Tony Smith	6	**5**
Maura Teager	5	**4**
Lesley Thompson	2	**1**

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 128-137 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 Audit Committee undertakes an annual effectiveness and impact review, in accordance with the Audit Committee handbook. The Committee submits to the Board an Annual Report on its activities.

No formal external evaluation of the board took place during 2013/14.

Chairman's commitments

No significant relevant additions to either the former or current 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 2013/14, 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 2013/14.

A register of interests is also maintained in relation to all Governor members on the Council of Governors. This is available for viewing on the Trust website or 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
Carolyn Gilby	Nil	-
Graham Gillham	Nil	-
Carolyn Green	Nil	-
Ifti Majid	Nil	-
Caroline Maley	Director C D Maley Ltd	(a, b)
	Non-Executive Director Employer First Ltd.	(a)
	Trustee Vocaleyes Ltd.	(a, d)
Lee O'Bryan	The Camden Partnership Ltd. – Director	(b)
	Non-Executive Director Avon and Wiltshire – Mental Health Partnership Trust	(d)
Anthony Smith	Panel Member for the Judicial Appointments Commission (from 26th March 2012 to 31st March 2015)	(d)
John Sykes	Nil	
Maura Teager	Non-Executive Director on the board of RIPPLEZ, Social Enterprise for the Family Nurse Partnership	(a) (d) (e)
Lesley Thompson	Director – Beyond Consultants Ltd	(a,b,c)
	Associate Consultant – Libra, CMZ2	(e)
Mark Todd	Chair of Trustees Motor Neurone Disease Association	(d)
Steve Trenchard	Chair of ISPS (UK) – The International Society for Psychological & Social Approaches to Psychosis (ceased October 2013)	(d)
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 is consulted on the Trust's forward plan and hold the Board of Directors to account for the performance of the Trust. This is done at the quarterly meetings of the full Council, which are open to the public.

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.

The Council is supported by four active working groups looking at key issues in greater depth: strategy and finance, governor development, membership development and quality.

The Trust is committed to the continuing development of governors and encourages participation in the national "Govern Well" Programme. Local development events have included a faith centre tour (Mosque, Hindu Temple and Sikh Gurdwara), a dementia day event at Royal Derby Hospital, disability equality training, a voluntary sector training session and a finance training day. An induction day has been held for newly elected governors, which also served as a refresher for those re-elected. The Chief Executive attends all Council meetings with the Chairman (who is also the Chairman of the Council of Governors) to present the Board's current agenda and forthcoming issues. Other directors attend as required. The Council of Governors met five times during 2013/14.

Individual attendance by governors is shown in the table on page 80. 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, Graham Gillham. Telephone: **01332 623700** extension **31212** email: **graham.gillham@derbyshcft.nhs.uk**

Summary attendance by governors at meetings of the Council of Governor meetings 2013/14

Constituency - PUBLIC	Title	First name	Surname	Number of meetings attended (out of possible number of meetings)
Public Amber Valley North	Mrs	Victoria	Cassidy	4/5
Public Amber Valley South	Dr	John	Morrissey (from January 2014)	2/2
Public Bolsover	Ms	Susan	Statter	2/5
Public Chesterfield North	Mr	Alan Eber	Smith	4/5
Public Chesterfield South		Vacant		
Public Derby City East	Mr	Igor	Zupnik	5/5
Public Derby City East	Mr	Peter	Aaser	4/5
Public Derby City West	Rev	Moira	Kerr	5/5
Public Derby City West	Mrs	Catherine	Cleary	5/5
Public Derbyshire Dales	Mrs	Ruth	Greaves (from January 2014)	2/2
Public Erewash North	Mr	Lew	Hall	4/5
Public Erewash South	Mr	Vacant Christopher	Williams (up to December 2013)	1/5
Public North East Derbyshire	Mr	Vacant Kenneth	Stevenson (up to December 2013)	2/3
Public South Derbyshire	Mr	Barry	Appleby	3/5
High Peak	Ms	Louise	Glasscoe	1/5
	Mr	Mark	Serby (from January 2014)	2/2
Public Surrounding Areas		Vacant		4/5
Constituency - STAFF				
Staff Medical and Dental	Dr	Edward	Komocki	1/5
	Dr	Nitesh	Painuly (from January 2014)	2/2
Staff Nursing and Allied Professions	Mrs	Katrina	De Burca	4/5
Staff Nursing and Allied Professions	Miss	Vacant Anne	Shead (up to December 2013)	0/5
Staff Administration & Allied Support Staff	Mrs	Sue	Flynn	4/5
APPOINTED				
Derby City Council	Cllr	Barbara	Jackson (from January 2014)	0/2
Derbyshire Constabulary	Asst. Chief Constable	Dee	Collins (up to December 2013)	2/5
	Inspector	Gary	Knighton (from January 2014)	0/2
Derbyshire County Council	Cllr	Paul	Jones (up to February 2014)	0/4
	Cllr	Rob	Davison (from February 2014)	0/1
North Derbyshire Voluntary Action	Mrs	Kathy	Kozlowski	2/5
Southern Derbyshire Voluntary Sector Mental Health Forum	Ms	Wendy	Beer	3/5
University of Derby	Dr	Paula	Crick	0/4 3/5
University of Nottingham	Prof	Paul	Crawford	2/5

Lead governor

The lead governor has a particular role in facilitating direct communication between Monitor and the Council of Governors, in the event that this is required. 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.

The Council of Governors has nominated Lew Hall as lead governor for a second term from March 2014.

Nominations Committee

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 this Committee were: Edward Komocki, Lew Hall, Moira Kerr, Victoria Cassidy, Dee Collins and Kathy Kozlowski.

Detailed below is the Nominations Committee membership and meeting attendances.

Membership	Possible attendances	Actual
Mick Martin (Acting Chairman)	3	**3**
Edward Komicki	3	**3**
Lew Hall	3	**2**
Moira Kerr	3	**2**
Kathy Kozlowski	3	**2**
Dee Collins	3	**0**
Victoria Cassidy	3	**3**

Under the guidance of the Acting Chairman, the Nominations Committee met on three occasions to consider the appointment of a Non-Executive Director (also chair of audit committee) and the appointment of the Foundation Trust Chairman.

In the case of the recruitment of the Chairman the committee obtained the advice and assistance of an external search and recruitment agency with regional and public sector expertise (total £26,600 including regional advertising costs.)

Having conducted a fully open and rigorous assessment and recruitment process, the committee unanimously recommended to the Council of Governors the appointment of Mark Todd as Chairman, and Caroline Maley as Non-Executive Director. These appointments were duly approved at a general meeting of the Council of Governors.

Remuneration Report 2013/14

Remuneration and Terms of Service Committee

The Committee met on three occasions during 2013/14, to consider the recruitment, the appointment and remuneration of the Executive Director of Nursing and Patient Experience. The Remuneration Committee previously determined that the contracts and terms and conditions of Executive Directors would mirror Agenda for Change pay awards for staff. Consequently there was no pay uplift during 2013/14.

The Committee approved the services of an expert search and recruitment agency to advise and assist the Committee on the appointment and remuneration of the Executive Director of Nursing and Patient Experience, taking account of market factors.

The Remuneration Committee will take account of latest Monitor guidance on executive remuneration and benchmarking data available through the Foundation Trust Network (FTN), alongside external market comparisons.

There are as yet no immediate plans to introduce performance-related elements to executive remuneration. All executive contracts, with the exception of one interim appointment, are permanent.

The Remuneration Committee was charged by the Trust Board to manage the executive recruitment process in lieu of a separate Nominations Committee. In determining levels of remuneration account was taken of benchmarking data from a comparator trust. Detailed below is the Committee membership and meeting attendance.

Membership	Possible attendances	Actual
Alan Baines - Chairman	2	2
Mick Martin - Non-Executive Director	2	1
Graham Foster - Non-Executive Director	2	2
Maura Teager - Non-Executive Director	3	3
Caroline Maley - Non-Executive Director	1	1
Anthony Smith - Non-Executive Director	3	3
Lesley Thompson - Non-Executive Director	3	1
Steve Trenchard and **Graham Gillham** are also in regular attendance		

The Chief Executive's appraisal was conducted by the Chairman at the half year point in November 2013, and again at the end of the year. The Chief Executive has also undergone a 360' appraisal by members of the Trust Board and the outcome of this is to be communicated across the Trust in May 2014.

The appraisal of NEDs eligible for re-appointment were conducted by the Deputy Chairman and presented to the Governor's Nominations Committee. All other NED appraisals have been completed by the Chairman at year end. The appraisals include objective setting for the forthcoming year. Due to changes in personnel occurring in the year, the appraisal of the Chairman and NEDs was not fully completed, except where reappointments were recommended to the governors. However a system has now been commenced whereby the Chairman presents his appraisal of each NED to the governors' Nominations Committee. In turn the Chairman's appraisal by the NEDs and governors will be led by the Senior Independent Director.

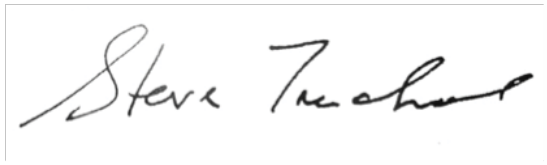
The Trust did not make any payments for loss of office during 2013/14.

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.

Members of this Committee: Lew Hall, Wendy Beer, Dr Edward Komocki, Victoria Cassidy and Barry Appleby.

The Committee did not meet during 2013/14 and no changes to the remuneration of Chairman and non-Executive Directors have taken place.



Steve Trenchard
Chief Executive
Date: 28 May 2014

Salary and allowances of Executive and Non-Executive Directors for the year 2013/14

Title	Name	2013/14						2012/13					
		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-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
Chief Executive	Steve Trenchard *1	140-145	104			82.5-85	230-235	20-25				27.5-30	50-55
Chief Executive	Mike Shewan *2							125-130	34			17.5-20	145-150
Acting Chief Executive	Kathryn Blackshaw *3							90-95	30			125-127.5	220-225
Chief Operating Officer	Ifti Majid *4	115-120	8			152.5-155	265-270	95-100	14			22.5-25	120-125
Executive Director of Finance	Claire Wright *5	110-115				165-167.5	275-280	55-60	5			67.5-70	120-125
Executive Director of Finance	Tim Woods *6							50-55				50-52.5	105-110
Executive Medical Director	John Sykes *18	190-195	27			-2.5 - -5	205-210	185-190	41			5-7.5	195-200
Executive Director of Nursing and Quality	Paul Lumsdon *7	50-55	20			57.5-60	115-120	105-110	41			87.5-90	195-200
Executive Director of Nursing and Quality	Carolyn Green *8	10-15				52.5-55	65-70						
Executive Director of Nursing and Quality	Carolyn Gilby *9	35-40	3			127.5-130	165-170						
Director of Workforce & OD	Helen Marks *10	85-90	36			40-42.5	125-130	95-100	41		32.5-35	135-140	
Director of Workforce & OD	Lee O'Bryan *11	70-75					70-75						
Director of Corporate and Legal Affairs	Graham Gillham	80-85	34			70-72.5	150-155	75-80	41		107.5-110	185-190	
Chairman	Alan Baines *12	20-25					20-25	45-50				45-50	
Chairman	Mark Todd *13	5-10					5-10						
Non-Executive Director	Lesley Thompson *14	10-15					10-15	10-15				10-15	
Non-Executive Director	Graham Foster *15	5-10					5-10	15-20				15-20	
Non-Executive Director	Michael Martin *16	25-30					25-30	15-20				15-20	
Non-Executive Director	Caroline Maley *17	0-5					0-5						
Non-Executive Director	Anthony Smith	10-15					10-15	10-15				10-15	
Non-Executive Director	Maura Teager	10-15					10-15	10-15				10-15	
Band of Highest Paid Director's Total Remuneration (£000)		190-195						180-190					
Median Total Remuneration		27,901						27,625					
Ratio		6.9						6.7					

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 2013/14 was £190,000-195,000 (2012/13, £185,000-190,000).

This was 6.9 times (2012/13, 6.7) the median remuneration of the workforce, which was £27,901 (2012/13, £27,625).

In 2013/14, 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 this 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 31st March 2014. 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 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 **Steve Trenchard** started in post 01.02.13

*2 **Mike Shewan** retired/termination date following his external secondment 06.02.13

*3 **Kathryn Blackshaw** left 31.12.12. Kathryn Blackshaw was Acting Chief Executive in 2011/12.

*4 **Ifti Majid** title change to Chief Operating Officer (also undertakes role of Deputy CEO) 01.01.13

*5 **Claire Wright** started in post 01.10.12

*6 **Tim Woods** left 30.09.12. Tim Woods (when the Executive Director of Finance) was released to serve as a non-executive director of NHS Elect, as listed in the declaration of interests. He retained his earnings whilst doing so.

*7 **Paul Lumsdon** left 29.09.13

*8 **Carolyn Green** started 17.02.14

*9 **Carolyn Gilby** acted up 16.09.13-17.02.14

*10 **Helen Marks** left 19.02.14

*11 **Lee O'Bryan** interim started 01.11.13

*12 **Alan Baines** left 30.09.13

*13 **Mark Todd** started 20.01.14

*14 **Lesley Thompson** acting Deputy Chair 1.11.13

*15 **Graham Foster** left 31.08.13

*16 **Michael Martin** left 31.01.14

*17 **Caroline Maley** started 20.01.14

*18 **John Sykes** pension frozen 31.05.12

*19 2013/14 based on actual figures. 2012/13 based on the higher bandings of each element.

Off-payroll arrangements

Table 1: All off-payroll arrangements as of 31 March 2014, for more than £220 per day and that last for longer than six months.

Number of existing engagements as of 31 March 2014	8
Number that have existed for less than one year at time of reporting	2
Number that have existed for between one and two years at time of reporting	3
Number that have existed for between two and three years at time of reporting	0
Number that have existed for between three and four years at time of reporting	0
Number that have existed for four years or more at time of reporting	3

All existing off-payroll engagements have details included in their contracts of employment to ensure that the individual is paying the right amount of tax.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014, for more than £220 per day and that last for longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	11
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	11
Number for whom assurance has been requested	0
Of which…	
Number for whom assurance has 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 1 April 2013 – 31 March 2014.

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.	10*

*This figure reflects the number of individuals who served as part of the Trust Board during 2013/14. 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.

A reflection on our achievements during 2013/14

April 2013

Trust opens new Centre for Research & Development

The grand opening of our Centre for Research & Development (R&D), by Jane Cummings, Chief Nursing Officer for England, took place on 17 April. The Centre for R&D focuses on building upon the Trust's existing compassion research profile as well as bringing together other strands of research activity already being undertaken.

Centres of Excellence for compassion and dementia, have also been established which are housed within the Centre and focus on 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.

May 2013

Showcasing local recovery initiatives for drug and alcohol users

Derbyshire Healthcare, working in partnership with Phoenix Futures, hosted a conference on 16 May to help those in recovery get clean.

Focusing on the promotion of recovery in drug and alcohol misuse across Derbyshire, the conference showcased local recovery initiatives and enabled participants to learn about other inspiring recovery-oriented organisations and social enterprises in the UK. Professionals and the recovery community came together to learn and share the knowledge, skills and assets which exist within communities in Derbyshire and nationwide.

Centre for Research & Development

June 2013

Pledging to end mental health discrimination

In June our Chairman and Chief Executive both signed the Time to Change pledge to help improve public attitudes towards people with mental ill health and help those experiencing mental health problems to access the help and support they need.

Time to Change is England's largest anti-stigma campaign run by the leading mental health charities Mind and Rethink Mental Illness. Their aim is to change the attitudes and behaviours of 29 million people towards those with mental health issues.

July 2013

Mad Pride comes to Derbyshire

On 10 July 2013, Derbyshire Voice and Derbyshire Healthcare hosted an Alice in Wonderland themed event for Mad Pride called the Queen of Hearts Tournament. The event broke down barriers, reduced stigma around mental illness and focused on the positive impact of working together – all whilst having some fun!

Mad Pride is a global mass movement, starting in Toronto, Canada in 1993, which seeks to reclaim terms like "mad", "nutter" and "psycho" from misuse, such as in tabloid newspapers. It aims to re-educate the general public on mental health and the experiences of those that have used the mental health system.

Mad Pride

August 2013

Excelling in professional development

Our Finance Department was accredited by the world's largest professional body of management accountants in August. The Chartered Institute of Management Accountants (CIMA) awarded the department its highest level of accreditation, that of Premier Partner, due to their excellence in supporting lifelong professional development. This makes the department an Employer of Choice for both CIMA students and members.

September 2013

Mental health services in Derbyshire amongst the best in the country

Derbyshire Healthcare was highlighted as a "high performer" in a national survey of people who have used community mental health services across the UK. Whilst performing well in all eight categories, we were specifically highlighted for our commitments to treat service users with dignity and respect; scoring 9.5 out of 10, this highest score nationally!

Service users aged 18 and over were eligible to complete the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 July 2012 and 30 September 2012.

October 2013

New mental health service offers round-the-clock care

In October we launched a pioneering 24 hour-a-day new service to help patients attending the Royal Derby Hospital who are suspected of needing psychiatric support. The service involved the merger of the Mental Health Liaison Team (MHLT), Hospital Alcohol Liaison Team (HALT) and Confusion Teams to create one fully functioning 24/7 psychiatric Liaison team.

The team now provides a rapid response; high quality assessment and engagement service which offers advice and support to people attending the Royal Derby's Accident and Emergency Department with a physical problem where potential associated mental health issues are identified.

Liaison launch

Sir David Nicholson visit

November 2013

Dementia support at its finest in Derbyshire

On 22 November 2013, we were proud to welcome Sir David Nicholson, Chief Executive of the NHS, as he visited Derbyshire to learn more about local NHS care for dementia patients.

Sir David visited and learnt more about two of our dementia wards that offer a unique level of support to patients, working closely with Local Authority and third sector colleagues to identify early signs of dementia, to raise awareness of the condition amongst the local community and tackle any stigmas associated with dementia. He was also able to witness key innovations, such as memory boxes, which enable people to bring items that hold precious connections and memories on to the ward, as part of an individual's care.

December 2013

Trust is leader for developing staff

We received national recognition for offering an extensive and innovative workplace coaching programme to our workforce in December, by taking home a highly regarded bronze award at the prestigious Training Journal (TJ) Awards in the Best Coaching Programme category. This award was presented to the Trust for its work in creating an inclusive coaching network within the workplace that can be accessed by every member of staff.

This fresh approach in cultivating a coaching culture was launched by the trust in 2010, by delivering a series of three-day coaching training programmes which were very well received, resulting in extensive waiting lists for staff to undertake the training.

January 2014

Derbyshire man appointed to Derbyshire Healthcare

To start 2014, we were delighted to announce the appointment of our new Chairman, Mark Todd. Mark brings to his new role an 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 the Member of Parliament for South Derbyshire between 1997 and 2010.

Mark replaced Acting Chairman, Mick Martin, who led the Trust on an interim basis from 19 September 2013.

February 2014

New Street Triage scheme to improve mental health care

As part of a national pilot commissioned by the Department of Health, the Trust launched a Street Triage service, where nurses from Derbyshire Healthcare will work in partnership with police officers in Derby to improve the way people with a mental illness are treated in emergency situations.

The Street Triage pilot will see our mental health nurses accompany police officers on the beat seven days a week between 4pm and midnight, where it is believed that someone is suspected to be a risk to themselves or those around them due to their mental ill health. Upon arrival at the incident, the nurse may carry out an assessment or hold a brief clinical conversation with the person to make a professional opinion regarding their current health needs. Advice will then be provided if an appropriate referral into the healthcare service is needed.

March 2014

Reducing conflicts and containments on our inpatient wards

As part of our commitment to provide compassionate and effective services with the service user at the heart of everything we do, during March our staff signed up to the national Safewards model to work together with patients work together to reduce conflict and containment as much as possible.

By implementing this new model, based on years of research by nursing leader, Professor Len Bowers, our clinical staff will undergo successfully proven intervention training to help limit potential harmful events such as self-harm, aggression, seclusion and absconding. De-escalation techniques such as clear mutual expectations, talk down and a 'Know Each Other' booklet will be produced for each ward detailing staff and service users' likes and dislikes to help build therapeutic relationships.

Further information about the Safewards model can be found at: **www.safewards.net**

Teams from the Trust, Derbyshire Constabulary and Ron Brooks Toyota launch the Street Triage scheme

2 Quality Report

PART ONE

Statement by the Chief Executive

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

Quality is the single most important factor that governs the services we provide. Keeping people safe and proving high quality healthcare is the cornerstone of what we do as a Trust and we are committed to providing excellent quality services, with people at the centre of them.

I am delighted to present this Quality Report, which demonstrates many of the Trust's achievements in striving for quality over the last year. The report demonstrates progress against the quality priorities we set last year, and presents a new set of quality priorities for 2014/15, as agreed with our partners and stakeholders.

Last year our quality priority measures were focused on achieving improvements to patient experience, effectiveness and patient safety. I am pleased to report that the Trust has made considerable progress against each of these quality priorities over the last year. Given their importance, many of these priorities will also remain in place for the forthcoming year, to ensure we continue to make further progress and developments in these key areas. Further details on our progress against last year's quality priorities can be found in this report.

We have also added additional local priorities for the forthcoming year, which reflect some of the intentions we have developed through our quality work during 2013/14.

Our overall ambition for the forthcoming year is to increase people's positive experiences of our services and to implement a true recovery model, where people report that they not only shape and influence, but also lead their care. This will develop a new relationship and culture in our Trust, where health professionals recommend care pathways and options for individuals to weigh up and decide upon the best route for themselves, making an informed choice about how to best meet their own individual needs.

We want to offer a collaborative way of working with families and individuals, as a partnership team, rather than the service dictating the care offer or treatment route. We aspire to make significant headway on embedding a recovery approach throughout every aspect of our care in all services that we provide. This will be challenging and will require new working practices and service redesign to get it right. In order to achieve this we will set clear expectations of our staff, in full partnership with our service users, using an education-based approach.

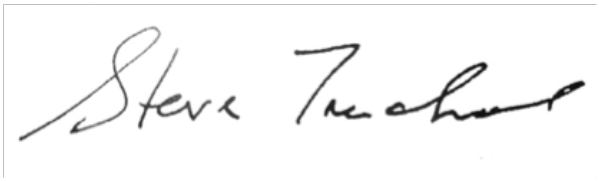
We will also retain a focus on the quality and safety of our care. Our ambition is to make our inpatient environments as safe as possible, for both service users and staff. We will be introducing the nationally researched 'Safewards' model of care, which will include work to make sure all our staff working on our wards have the passion, skills and confidence to reduce harm and improve patient safety.

We will be developing, refining and renewing our focus on clinician and patient reported outcome measures. We will use nationally identified outcomes and patient reported experience measures to assess the impact of what we do, and how experiences of our service users have improved as a result of our care. We need to continue our excellent work and strive to use this information both clinically and at a wider organisational level to share best practice and identify any potential areas that require further analysis, action or support.

We are committed to the families living in our communities and to seeing the individuals we support in the wider context of their role within a family unit. Our work in 2014/15 will look at how well we think about the impact of ill health on the whole family. We will share best practice and innovative ways of working from within our children's services with other parts of our organisation including substance misuse, learning disabilities and adult and older people's services.

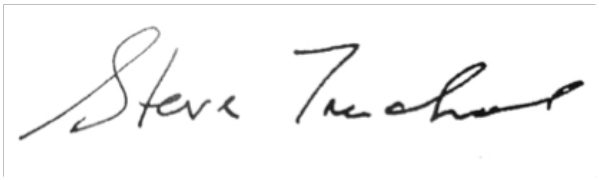
I would like to take this opportunity to thank everyone who has worked with the Trust over the year to make improvements to the quality of our services and also to those who have helped shape our priorities for the forthcoming year. This includes our service users and their carers, our staff and our partners across the communities we serve and our partners and commissioners for their input, support, feedback 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
1 April 2014

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 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 2014 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of those national priority indicators mandated by Monitor:

- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital
- minimising delayed transfers of care

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

Respective responsibilities of the Directors and Auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the 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 *2013/14 Detailed Guidance for External Assurance on Quality Reports*; 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*.

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 April 2013 to 28 May 2014;
- Papers relating to quality reported to the Board over the period April 2013 to 28 May 2014;
- Feedback from the Commissioners dated 24/04/2014;
- Feedback from local Healthwatch organisations dated 29/04/2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2014;
- The latest national patient survey dated 17/09/2013;
- The latest national staff survey dated 25/02/2014;
- Care Quality Commission quality and risk profiles dated 01/04/2013 to 31/03/2014; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated 28/05/2014.

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, to assist the 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 Trust's Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Derbyshire Healthcare NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). 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
- Testing key management controls
- [Analytical procedures]
- Limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report
- 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 impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *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 2014:

- 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*.

Mark Stocks

Senior Statutory Auditor for and on behalf of
Grant Thornton UK LLP

Colmore Plaza, 20 Colmore Circus, Birmingham, B4 6AT

29 May 2014

Introduction

Our approach to quality healthcare

Derbyshire Healthcare NHS Foundation Trust is fully compliant with the conditions of registration with the Care Quality Commission (CQC). Our most recent visit, which took place in September 2013, resulted in a positive outcome, with no further actions required.

A new CQC inspection regime has been introduced for mental health and community providers and during 2014/15 we will learn from the pilots of this new regime to provide assurance of our ongoing compliance through our solid structure and processes of quality governance. An implementation plan sets out our plans to ensure our staff are well prepared for the new inspections and can harness the opportunity to showcase the high standards of care we provide.

The Trust Board derives assurance on the quality of its services through the use of a wide range of methods. The Board uses Monitor's Quality Framework to appraise the quality arrangements in place and commissions auditors to carry out routine reviews of the quality of our governance. Informal methods have also been developed such as inviting regular patient testimonies at Board meetings, and a minimum of one Board member has participated in each of over 90 quality visits. This provides real-time assurance of the quality of our service delivery through the voice of our staff, patients, carers and their families.

We have worked hard to ensure the environments in which we care for our service users are clean and welcoming. This year we demonstrated strong performance in the Trust's first Patient Led Assessment of the Care Environment (PLACE) inspection - which replaced PEAT (Patient Environment Action Team) – and will endeavour to continue this performance throughout 2014/15.

We welcomed the establishment of Healthwatch Derby and Healthwatch Derbyshire in April 2013. Healthwatch was set up by the Government in order to give local people a say in how local health and social care services are designed and delivered.. Healthwatch carry out enter and view visits to hospitals to talk to patients about their experience of the care provided. The Trust has worked in partnership with both organisations since their formation. In 2014 the Trust commenced a consultation on 'Think Healthy' with Healthwatch Derby which will provide independent patient feedback.

Our Trust Board received an annual report in February 2014, on our progress one year on since the publication of the Francis Report, the inquiry into the Mid Staffordshire NHS Foundation Trust. Our work this year has focused on the main recommendations relevant to us; the impact and quality of our services. How these issues are experienced is the driving theme of this Quality Report and our future work.

Our governor working group for quality

During 2013/14 the Governors working group for quality have met frequently and been very involved in shaping the quality improvements achieved this year. The group has a programme of work going forward which includes participating in the quality visit programme as part of the quality visiting teams, helping to determine our response to key publications by the government and our regulators such as 'Closing the Gap: priorities for essential change in mental health' (published February 2014) and representing the local people who they represent.

Quality visit programme

The quality visit programme commenced in April 2010 and has operated for four seasons. The programme commences in October each year through to July. Results from the visits are moderated to ensure consistency of scoring across all the quality visit teams. The quality visits finish each year with an annual review. The ideas and comments from the review shape the programme for the following year. At the end of season four the key highlights were:

- Season four has received outstanding feedback.
- At the end of season four the number of platinum teams has increased to a total of 30 with 24 teams achieving three golds in a row at the end of season four.
- The number of gold teams has increased.

- Teams recognize the value of the board to ward, the importance of showcasing best practice and embedding quality as our organizing principle.
- We have extended our fourth place to a wider range of commissioners, GP's and members of other trusts. This has received excellent feedback.
- The programme has received interest from other trusts and organisations.
- In season four we have seen an increase in the number of patients and carers involved in visits.
- Teams have used a range of formats to showcase their work i.e. use of technology
- Governors continue to play a key role in the visits.
- The theme for season five will be 'How teams contribute to the trust vision'

Quality improvement priorities 2014/15

In our Quality Report of 2012/13 we agreed the following five priorities for 2013/14:

- To improve patient involvement in care planning
- To extend our use of the Friends and Family test
- To establish a research and development centre
- To improve the physical healthcare of patients
- To ensure our patients are cared for in a clean environment.

Our Quality Report described where we were starting our work and what we expected to do over the next 12 months. The following table sets out our progress and looks forward to the forthcoming 2014/15 financial year, when we will continue to build and improve further on these areas of work.

Looking back at our quality priorities 2013/14: what we achieved

Patient experience

We said we would improve the involvement of our patients in their care plan and to ensure that it reflects their needs, strengths and aspirations.

Why we chose this as a priority?	The Trust is committed to service users and carers being at the centre of decisions made about their lives. Our aim is for all our service users to be fully and actively involved in their care and to have positive experiences of the care they receive.
What did we aim to do?	Our ambition in 2013/14 was to improve the number of patients who reported to have been involved in their care planning. In the 2012/13 national community survey we scored 7.2 points out of 10. Whilst this was in line with other specialist mental health trusts, we aimed to improve our results to 7.5 in the 2013/14 community survey.
How well did we do?	The results showed that we scored 7.6 out of a possible 10. This exceeded our aim for 2013/14 in regard to improving service user involvement in care planning.
How did we compare to other mental health trusts?	The range for other mental health trusts was between 6.3 and 7.8. This reflects that our score was at the high end of performance for this element of care planning.
What do we aim to do next?	As part of our drive to be 'brilliant at the basics' we will be working to ensure we are doing the core things right and deploying them well to ensure and assure experience and safety. We will continue to focus on care planning as one of our key priorities for 2014/15 and will place a particular emphasis on the areas of care planning where we performed the least well. For example, there has been a decrease in service users' understanding of what is in their care plan, and whether the care plan effectively sets out an individual's goals. In 2014/15 we will implement a new Core Care Standards and Minimum Standards for Healthcare Records Audit Tool which has been devised and tested in 2013/14. It is anticipated that learning from the results of these audits will further improve the quality of care we provide. This will be a key ongoing area of work, covering all experiences that individuals, families, parents and key named carers will experience.

Celebrating our work with carers

We work closely with carers and carer organisations to develop and improve the way in which we work with carers and families. The Trust facilitates a 4E's Stakeholder Committee (Equality, Engagement, Experience, and Enablement) chaired by the Chief Executive. This alliance is a community of external stakeholders and partners with a mission to connect and work together to genuinely make a real difference to the quality of life and experiences of people who need our help and support. There is also a Carers Group which informs and guides us about the needs of carers, and which regularly attends the North Derbyshire Mental Health Carers Forum. During Carers Week in June, we celebrated the important role of carers through events in Derby and Chesterfield. Trust representatives, carers and our partner organisations came together to celebrate the work of carers around the Trust, Making Space provided a 'singing for the brain' session for family members with dementia in Derby, and Toby Perkins MP opened our Chesterfield carers event.

During the year we launched our Carers Handbook and Carers Information Pack, to make it easier for carers to access respite, emotional support, carers' services, peer support, groups, and an assessment of their needs. We signed up to the national 'Triangle of Care: Carers Included' membership scheme. As part of this we launched our Carers Champions network, with champions in all our inpatient services and many community teams and we will also be inspiring them to consider our organisational approach to Think Family and support us in our endeavours. We are undertaking a self-assessment of how we support carers, and working on plans to make improvements where needed.

Building on the success of the celebration of carers, the team have used innovation funding to hold three 'Carers and Cake: Reaching out to Carers' events in Buxton, Ilkeston, and Normanton in Derby, to reach out to local carers who may not access any other support. Partners from social care and the Citizens Advice Bureau, Derbyshire Carers Association, Think! Carer, Making Space, Healthwatch Derby, the Alzheimer's Society, Rethink, and Talking Mental Health Derbyshire all attended and offered valuable support and advice. Staff and colleagues from our primary care partners also joined us.

The Trust's Core Care Standards website, which won a national award for its information for carers and service users, has been developed further, with a section for service users about urgent help they can access, such as food banks. In keeping with recovery focused cultures, we are emphasising more of a focus on safety rather than risks, changing our risk standard to 'Keeping yourself and others safe', and developing our safeguarding section further.

The Infolink resource directory continues to be used and valued by staff, service users, families and partner organisations, and is being updated and revised to include a wider range of diverse groups.

Ensuring equal quality

We said we would improve the Ensuring equal quality for diverse people through accessible services and quality assurance is another way that the Trust can improve patient involvement. We hosted our fourth live Equality Impact Assessment day, by opening our dementia care wards at Cubley and Tissington to our community stakeholders and partners. The focus of the day was to ensure the unit meets the needs of diverse patients, their carers, and families and to address any potential myths, barriers, and make any reasonable adjustments. Participants were asked a word association question before and after the event ('when you think of a dementia care ward, what's the first word that comes to mind?') and it's clear that impressions of staff, the environment and the person-centred care have improved among participants, with a shift in perception from 'confusing', 'scary' and 'institutional' to 'caring'. The unit was presented with verified CredAbility status from Disability Syndicate/Nimbus for the work the unit has done in making the service accessible to disabled people.

Patient experience

We said we would extend the golden question (nationally called the Friends and Family Test) to a wider range of services.

Why we chose this as a priority?	Hearing the voice of our patients is very important to us. We call this indicator the golden question as it asks one simple question: "How likely is it that you would recommend this service to friends and family?" In 2013/14 we extended the question to all older adult inpatients from wards 1 and 2, over 65s on Pleasley ward, Health Visitor clinics, inpatient and community perinatal services, planned discharges from Substance Misuse services, and a recovery team.
What did we aim to do?	We aimed to increase our score to +65 for positive feedback, and to luse the results to celebrate our successes and use all feedback to promote improvements.
How well did we do?	Our score for 2013/14 is +68. We have also trialled the question in our Health Visitor clinics and the results have been very positive with a score of +70.
How did we compare to other mental health trusts?	We are not able to benchmark our scores against other mental health trusts as this quality improvement was not mandatory in 2013/14. However from April 2014 all mental health trusts are required to implement the Friends and Family Test.
What do we aim to do next?	In line with the new national requirements we will continue to focus on this as a priority in 2014/15 for all services we provide. The extension of the Friends and Family Test to staff will ensure staff have the opportunity to give their views about the organisation at least once a year.
How this priority will be monitored and reported in 2014/15?	This will remain as one of our priorities for 2014/15. Reports will be provided to the Quality Committee, the Board of Directors and to commissioners. The responsible officer for this priority is the Executive Director of Nursing and Patient Experience, as the Board of Directors' Lead for Quality.

Our health visiting staff celebrates their success

When our children's services were asked to test if the Friends and Family Test could be used to gain feedback from parents attending their clinics, they embraced the opportunity. In all it was introduced in 26 clinics in Derby City. The Health Visiting service is very proud of all the positive feedback it received and plans for 2014/15 include introducing the Friends and Family Test into paediatrics, school nursing and child therapies.

Health Visiting service - Friends and Family Test results 2013/14:

How likely are you to recommend our service to friends and family if they needed similar care or treatment?			Response Percent	Response Total
1	1- Extremely likely		71.58%	481
2	2- Likely		26.64%	179
3	3- Neither likely nor unlikely		1.34%	9
4	4- Unlikely		0.15%	1
5	5- Extremely unlikely		0.00%	0
6	6- Don't know		0.30%	2
			answered	672
			skipped	53

What parents said we did well when they attended the health visitor clinics in Derby City.

- There are so many toys for children and they welcome us. The interpreter service is excellent.
- Everything!
- Nice atmosphere – supportive staff. Really nice staff.
- Great support, all my questions were answered.
- Advice there when needed.
- Good professional manner and very caring for the child's well-being.
- Everything that my baby needs to be weighed. They explained me everything nicely.
- Happy with the team. When I needed help they came to my house for support.
- Quick – not a long wait.
- Very good staff. Nice environment.
- You are very prompt.
- All what I see in this clinic is good in the place for playing and more.

Children's Therapy Services, 'you said, we did' input to 'Hemi-hearts' group

Parents of a group of children with Cerebral Palsy-hemiplegia set up a charity for children with hemiplegia and asked the Occupational Therapy and Physiotherapy team to support the group. The children come from all over our area and have individual therapy programmes and therapists, but the group provides an additional social element and peer support for families and these are very much valued. The parents also value the professional advice given.

Child and Adolescent Mental Health Services successful service user participation programme

The service now has participation groups for young people and parents within Child and Adolescent Mental Health Services. They are now routinely part of all staff recruitment panels, service development forums, routine outcomes review forums and they support the embedding of the key principles around improving access to psychological therapies (IAPT). There has also been the development of a recovery-focused app that improves access to services. Through the development of service user participation, a service user had developed a mobile app that empowers young people and improves access to services.

We said we would establish a research and development centre (see detailed report in section 2)

Why we chose this as a priority?	Our ambition is to achieve a national reputation for driving research into practice to enhance quality, improve patient outcomes and improve the experience of those who use our services.
What did we aim to do?	In 2013/14 we wanted to establish two centres of excellence.
How well did we do?	The research centre opened in April 2013 with a Centre for Compassion, followed by Centre for Dementia in August 2013. We also continued to build on our established reputation in our research and collaborations on Self-harm and Suicide Prevention. We delivered compassion awareness training to staff in our Learning Disability Services, and to Southern Derbyshire Clinical Commissioning Group and to Amber Trust. We also held an international compassion conference in 2013.
How did we compare to other mental health trusts?	See section 2 of this report
What do we aim to do next?	We aspire to consolidate our initial centres and review our centres of excellence up to 2015. Our Medical Director, as the executive lead, is overseeing this important work and is championing our research portfolio, working with his team on new ideas and innovations. The Research and Development strategy is being refined and in early 2014 will be released for consultation. We aim to embed a culture of research, clinical audit and evaluation as a core activity which routinely implements the outcomes into practice and increases opportunities for participation.

How Child and Adolescent Services (CAMHS) are making improvements in effectiveness

Providing the right approach at the right level at the right time by the right person in the right place and using evidence-based pathways of care

Child and Adolescent Mental Health Services have introduced a Choice and Partnership Approach which is an evidence-based organisational model aiming to keep the family central throughout a child's journey through treatment. (York and Lamb 2012).

In addition having the right pathway improves patient outcomes by 15% (Department of Health, 2013). Therefore this service has re-designed the approach and developed specific care pathways that operate seamlessly for the families who are using Specialist Child and Adolescent Mental Health Services.

Good practice and effectiveness: improving access to psychological therapies for children and young people

Parenting

As part of the on-going service re-designs, there are now two Parenting Therapists who have completed advanced training, and a third in training. The National Institute of Clinical Evidence (NICE) (2006), recommends parenting interventions for parents of children experiencing conduct and oppositional behaviours and ADHD. There is also evidence of it being beneficial for conditions such as Autism Spectrum Disorder and Anxiety.

New service for children on the edge of care (Multi-Systemic Therapy Team)

The Southern Derbyshire Multi-Systemic Team was launched in May 2013 . The Team offers an intensive service for families of children aged between 11 and 17 living in Southern Derbyshire.

Multi-systemic Therapy (MST) is a community evidence-based model directed at older children, teenagers and their families. The approach is targeted at those families in which the young person is at risk of coming into care or custody and will aim to prevent family breakdown, reduce offending and improve educational outcomes.

A formal MST Programme implementation review was undertaken on 1 December 2013 led by Tom Bowerman, MST UK Lead Consultant. The Derbyshire Healthcare NHS Foundation Trust has been commended for achieving 39 of the required and recommended MST Programme practices.

Governance of therapies and treatments

The Trust's Register of Approved Therapies/Treatments was formally adopted in 2010/11, as part of a protocol designed to ensure sound governance of therapeutic practice in the Trust through a rigorous assurance framework. The protocol provides processes and procedures for managing the Register, including mechanisms for determining approval and review of all therapies and treatments placed on the Register. Each therapy or treatment listed on the Register has a clear description of the therapy/treatment, a summary of the evidence for effectiveness, mechanisms for outcome monitoring or agreed outcome measures, and details for how practice and supervision of the practice should be maintained, including training and competency standards.

Effectiveness of our memory assessment services

Derbyshire Healthcare NHS Foundation Trust has been piloting the Memory Assessment Service since February 2011. Nationally, referral rates have increased fourfold since 2010 and referral rates across Derbyshire have doubled in the past year.

The Memory Assessment Service is an evidence-based service and diagnosis is achieved following the NICE Clinical Guidelines. The initial pilot in 2011 offered 13 new patient appointment slots per week; this year the service assessed over 1,500 new patients and current referrals rates suggest the service will assess upwards of 2,200 new patients in the coming year.

Effectiveness

We said we would improve our patients' physical healthcare

Why we chose this as a priority?	We chose this as a priority as it clearly brings out the important link between good physical and mental health.
What did we aim to do?	Working with our Recovery mental health teams and rehabilitation services we aimed to improve the assessment and care planning of physical health problems and improve staff skills around health promotion. This work began in 2012/13 in the county, and in 2013/14 we extended the work of the programme into Derby city. We are also a pilot with the national Rethink improvement programme and are focusing on the physical health needs of people experiencing psychosis.
How well did we do?	We are proud to report that we achieved the standards set by our commissioners for improving the assessment and care planning of physical health. We also focused on reducing obesity and prevention of weight gain in people with severe mental illness. We are continuing to improve joint working with GPs around supporting our patients to access their annual physical health check in primary care. We have established a network of health and wellbeing champions in clinical teams. We have completed packages of work to raise our patients' awareness of health issues and offered support to help them have healthier lifestyles. Working with our community health partners, we continue to raise mental health awareness and are encouraging partnership working so people can more easily access lifestyle services.
What do we aim to do next?	Recognising that there were some things that we did not do as well during the year, we will continue to improve the physical healthcare of patients, where required, as a priority. In 2014/15 we will: • Work with our partners in primary care across Derbyshire County • Identify patient champions to help promote health • Improve partnership working with the wider health community to tackle health inequalities, enabling a recovery approach. Health and wellbeing will be embedded into the core of the Recovery Colleges/ network as they develop • Complete focused work on smoking cessation and prevention of weight gain with our service users experiencing severe mental illness, drawing upon existing and emerging evidence on what does and doesn't work • We need to find innovative solutions that inspire self-care, and enable increased access to all health services, regular health checks and a collaborative approach across pathways to meet the challenge of 'Closing the Gap' – in order to meet the objective that more people will have good physical health.
How this priority will be monitored and reported in 2014/15?	This will remain as one of our priorities for 2014/15. Reports will be provided to the Quality Committee, the Board of Directors and to commissioners. The responsible officer for this priority is the Executive Director of Nursing and Patient Experience, as the Board of Directors' Lead for Quality.

How our work to improve the physical healthcare of our patients is making a difference

Patients have recognised the excellent work our staff do to help make their physical health better whilst in our care, across all the services we offer. Comments have included:

> *I was encouraged to continue favourite hobbies, drawing, being outside in fresh air - in the garden*

Older People's ward

> *I feel the gym scheme has really been beneficial to my recovery in a physical and mental health way*

Mother and Baby unit

In the Occupational Therapy and Recreation Centre at the Hartington Unit, all patients are offered healthy lifestyle advice as part of their Occupational Therapy assessments and interventions. Specific health promotion activities include gym instruction and support, which includes tailored exercise programmes for mood and mental wellbeing. Partnership working with the healthy lifestyle hub in the community enables exercise to be built into recovery pathways for patients who have been discharged. Chair-based exercise is offered three times a week. Gardening as an activity is offered in season and the foods that have been grown are used in cooking. Cooking skills address balanced meals and healthier options, and the staff team offer ideas to service users on the unit, about improving their physical health whilst staying on the unit.

Physical literacy project: creating quicker and timelier access to therapy services

The Physical Literacy tool supports education partners to identify and implement initial core stability work with children at Year 2 who have co-ordination difficulties. After an eight to 10 week programme, if progress is not as expected, education colleagues can refer children directly to therapy services.

This work has led to the establishment of Physical Literacy Partnership groups in the city and the county as well as further work with Early Years services and the development of an 'Every Child a Mover' strategy in the county.

Patient safety

We said that we would ensure our patients are cared for in a clean environment, which is free from the risk of infection and harm

Why we chose this as a priority?	The safety of our patients and staff will always be paramount to the Trust.
What did we aim to do?	We aimed to ensure all our environments were clean and free from infection.
How well did we do?	We are very proud of the high standards we continue to achieve and the comparatively low rates of infection we see. There have been no ward closures as a result of norovirus-type illnesses in the period from April 2013 to February 2014. Individual suspected cases have been well managed on wards with minimal clinical impact and no evidence of cross infection. Surveillance of healthcare-associated infections (HCAI alert organisms) has shown no cases of MRSA bacteraemia between April 2013 and February 2014 (none were reported in 2012/13) and zero cases of Clostridium difficile in the same time period (one was reported in 2012/13). Cleaning scores, measured against the national standards of cleanliness, have continued to meet the nationally defined 'excellent' standard in clinical areas across the year. Patient Led Assessment of the Care Environment (PLACE) inspections replaced PEAT for the first time, with continued strong performance.
What do we aim to do next?	We aim to continue to achieve these high standards of safety and cleanliness in our environments.

How our facilities staff took time to consider the Francis Report and its recommendations

The Francis Report was published at a time when our organisation launched a new set of Trust values, applicable to all staff across the Trust. The values resonated with many of the outcomes of Francis, with an emphasis on developing a culture of compassion within the workplace, to better equip ourselves to deliver improved and more compassionate care. We wanted to ensure that the recommendations of the Francis Report were shared with and owned by all facilities staff, in a way that demonstrated not only the impact of the team on supporting clinical staff to deliver safe, effective and compassionate services, but also each individual's own role within the patient's journey. The staff were provided with an overview of the findings and then each member of the team looked at how they could contribute to these recommendations - to ensure that clinical staff were supported to meet their requirements and that our patients had a positive experience.

In our Trust the Clinical Cabinet (a set of multi-professional leaders) will continue this work to drive forward the key learning from a Trust perspective. This will also include our Governors, who through the Governors' Quality working group will monitor the Trust's actions to date to ensure we are listening to service users' experiences and using feedback meaningfully.

How we are improving access in Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) have developed self-referral systems to improve access to Specialist CAMHS –the current programme includes drop-in clinics at Connexions in Derby City for young people aged 14 to 18. CAMHS Liaison Service was created from existing resources to assess young people attending the Royal Derby Hospital following episodes of self-harm. It works closely with the Royal Derby Hospital staff on Puffin Ward, the medical assessment unit, ward 101 and the Royal Derby Safeguarding Team.

Concerns, compliments and complaints

What we achieved this year

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 is located within the Nursing and Patient Experience 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. Our aim is to provide a swift response to concerns or queries that are raised and to ensure a thorough investigation takes place when required, with complainants receiving comprehensive written responses that describe any actions taken.

Face to face meetings are routinely offered when people express concerns, as well as at the start and/or end of the formal investigation process. If we are unable to resolve complaints satisfactorily, people are advised of their right to contact the Health Service Ombudsman who can investigate complaints on their behalf.

Learning from the feedback we receive is essential; this is shared with staff through the Trust 'Practice Matters' publication. During the year we have included pieces on medication and information about side effects, on identifying the named nurse and on improving communication with families and carers.

Patient Experience training has been provided for clinical staff, incorporating elements of compassion training. The feedback has been very positive and staff have commented that they will be more mindful of their interactions with service users and carers having completed the training.

Of the completed investigations so far this year, we reduced the mean average for complaints investigations from 49 days to 44 days.

So far we have recorded over 800 compliments this year.

What we did not achieve this year

A significant reduction in the number of extensions to the investigation timeframes.

How we will go the extra mile in 2014/15

We will work hard to significantly reduce the average time that it takes to handle complaints and to lessen the number of deadlines that are extended.

We will ensure that complainants are kept up to date with the progress of their investigations.

We will ensure that the complainant feels that their views have been heard throughout the process.

We will theme the actions taken as a result of the investigations and produce action plans for the key themes to ensure we target and improve on key areas.

How we have and will continue to monitor and report

Reporting of concerns, complaints and compliments will be by 'main subject' and then by 'theme'. All responses to complaints are reviewed and signed off by the Chief Executive.

The Trust currently uses a manual system of data collection for concerns and compliments at a local level. In 2014/15 the Trust will commence using an electronic system which will allow for local data capture at source, and will allow for a more thorough data interrogation and more detailed reports.

Our focus on quality through our own internal priority areas and Commissioning for Quality and Innovation (CQUIN) agreements

We work in partnership with our commissioners, drawing upon the national guidance and local priorities, to set these new quality and innovation standards around what is important to the NHS and our local communities.

We have also included an additional Trust internal requirement and an emerging Department of Health priority, as this work in reducing restrictive practice is important to our organisation.

Looking forward: our key priorities in 2014/15

Our existing key priorities in 2014/15

There are two priorities from 2013/14 which we will extend into the forthcoming year, in order to make further improvements in these key areas. These are:

1. Changing the Golden Question to incorporate the phased expansion of the Friends and Family Test
2. The physical healthcare of our patients.

Safety	Patient Experience	Effectiveness
• Physical Health Care	• Family and Friends Test	

New priorities for 2014/15 can be grouped under three key themes and include:

Safety	Patient Experience	Effectiveness
• Preventing suicide • Force Free Futures - to safely reduce the use of restrictive practices, including seclusion, on our acute inpatient wards	• Think! Family • A recovery focused organisation	• Clinical outcomes

Safety:

Preventing suicide

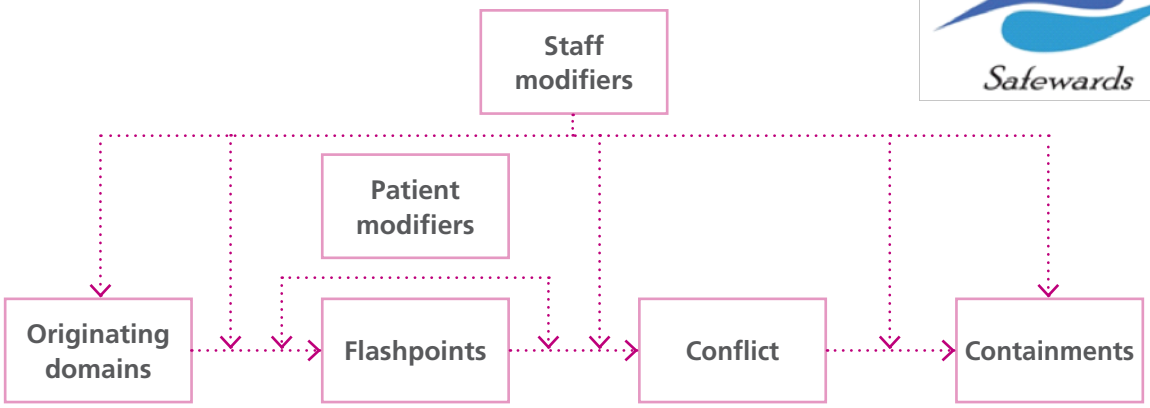
We have chosen this as a priority, showing our continued commitment to reduce wherever possible this tragic and distressing outcome for individuals and their families and friends. In 2014/15 we will measure our practice across all services, to include the following areas; training, supervision, recording and communication. National best practice and learning lessons from our own experiences will be shared with other parts of our organisation and year-on-year improvements will be agreed in partnership with our commissioners.

There will be comprehensive work over two years looking at suicide and learning from serious incidents. With our partners who provide care across Derbyshire, we will be developing innovative approaches to the prevention of suicide, using input from service users and carers – as experts by experience – to inform the design of our training. We will continue our engagement in the Derbyshire-wide multi-agency suicide prevention strategy and use the skills and knowledge of national leads in this area of work to further enhance our learning and embed this into all aspects of our practice.

Force Free Futures and reducing the use of restrictive practices, including seclusion on our acute wards

We have chosen this as a priority for 2014/15 as 'Force Free Futures' is nationally endorsed and an effective way to reduce conflict and containment in inpatient settings. The model will be known from March 2014 as "Positive and Safe" and is a two-year Department of Health programme to end the use of outdated and damaging restraint and restrictions in health care services. This internal quality priority has a number of components; we will implement the Safe Wards Project – a model based on years of research by national nursing leader, Professor Len Bowers. Safe Wards looks at different approaches that can be applied to reduce potential harmful events happening to patients as a result for example of self-harm, aggression, seclusion and absconding. Staff are trained in interventions which have been researched and are proven to make a difference to the outcomes for patients.

Safe wards model simple form



'Closing the Gap' (February 2014) committed the Government to "radically reduce the use of all restrictive practices and take action to end the use of high risk restraint, including face down restraint and holding people on the floor". 'Positive and safe' is the NHS strategy for achieving and delivering this. This work nationally and in our Trust will be working on the changes and developments in leadership, culture and professional practice of all members of our teams, both in the inpatient setting and in the community, to achieve this.

Patient experience:

Think! Family

We have chosen this as a priority, showing our continued commitment to helping families to flourish by providing the best possible family focused services. Think! Family practice makes sure that all services we provide are as coordinated as possible. When this is done well it results in better outcomes for children, young people and families. As a provider of mental health and children's services, we are well placed to build upon our systemic approach and the thinking of our teams. We will draw upon other unique and innovative models of integrated working such as the Kaleidoscope service model in Lewisham in South London, and we will also inspire our teams to have truly innovative family inclusive practice in everything that they do.

In 2014/15 we will measure our practice across all services, including the following areas:

- Training,
- Supervision,
- Recording and
- Communication.

Best practice within our children's services will be shared with other parts or our organisation and year-on-year improvements will be agreed in partnership with our commissions.

A recovery-focused organisation

Our priority is to continue to promote recovery and learn from other inspiring recovery-oriented organisations. This internal quality priority has a number of components and, as a member of Implementing Recovery through Organisational Change (ImROC), we will embed this approach through every level of the organisation. We hope to develop educational resources to support other Derbyshire organisations (subject to securing additional resources) in working effectively with those with a lived experience of mental distress, in our capacity as the largest provider of specialist mental health and community services in Derbyshire. We will draw upon our Child Health CAMHS resources to ensure the voice of the child and family is heard in this work.

Effectiveness:

Clinical outcomes

We have chosen this as a priority for 2014/15 as we are committed to taking nationally prepared outcomes and reflecting them at a local level. Clinical outcomes measure changes in health and quality of life as a result of our care, and that knowledge is incredibly important to our clinicians.

We are taking a multi-year approach to Commissioning for Quality and Innovation (CQUIN) planning with our commissioners to make sure we provide the right types of care to each person using our services. During 2014/15 and 2015/16 we will continue to lead the local Derbyshire development of the clinical outcomes linked to the National Tariff Payment System (NTPS) for mental health services, whilst engaging nationally to influence future design.

We will be further developing our approach to quality and outcome measures, both clinician- and patient-reported, to develop and refine them to assure our Board that our values and priorities are being met.

All priorities will be reported to the Quality Committee, the Board of Directors and to our local commissioners. The responsible officer for this priority is the Executive Director of Nursing and Patient Experience, as the Board's lead for Quality.

How we measure against other healthcare providers

Improving outcomes for children and young people

The Child Adolescent Mental Health Service (CAMHS) is part of the current five year National Improving Access to Psychological Therapies pilot (CAMHS IAPT) which is a significant service transformation project. Its aim is to improve outcomes for children and young people, providing of a range of treatments based on best evidence that is outcome-focussed and client-informed whilst ensuring a culture of continuous service improvement and quality. The Trust is the only provider service in the East and West Midlands (other provider services being concentrated in the South, and the North East and North West of the country). The routine outcome measures and combined Children and Young People IAPT programme has reduced the patient's length of stay in service by 12%, a figure which will continue to improve.

Results of the community patient survey 2013

The 2013 survey of people who use community mental health services involved 58 NHS trusts in England. (including combined mental health and social care trusts, Foundation Trusts and community healthcare social enterprises that provide mental health services). The table below sets out Derbyshire Healthcare Foundation Trust's score against a number of questions in each section, compared to the highest and lowest score attained. This information enables us to benchmark the quality of our services against other trusts.

Indicator	Trust score 2013 (out of 10)	Benchmark lowest to highest Trust score
Health and Social Care Workers	8.7	8.0 to 9.0
Medications	7.4	5.6 to 7.9
Talking Therapies	7.8	7.3 to 8.6
Care Co-ordinator	7.8	7.3 to 8.6
Care Plan	6.6	6.0 to 7.3
Care Review	7.0	6.4 to 8.0
Crisis Care	5.9	5.3 to 7.7
Day to Day living	5.4	4.0 to 6.2
Overall rating for quality of care	6.8	6.2 to 7.4

2013 inpatient survey comparison

This survey is conducted voluntarily by Derbyshire Healthcare NHS Foundation Trust (DCHFT) in addition to the Community Survey conducted and published by the CQC annually. As the inpatient survey is voluntary, not all Trusts continue to conduct it and consequently the number of responses that we can benchmark against our own is lower than for the Community Survey.

Results for the overall experience of care

Overall, how would you rate the care you received during your recent stay in hospital?

	Survey 2012	Survey 2013	All Trusts	Better/ Worse than 2012.
Excellent	21%	27%	21%	+6%
Very Good	32%	23%	28%	
Good	17%	23%	21%	
Fair	17%	18%	17%	
Poor	12%	8%	13%	

Of the 45 questions analysed in this report, 28 (62%) have improved results compared to the 2012 Inpatient Survey, 5 (11%) have worse results, 5 (11%) have remained static to within 1%, and 7 (16%) are not indicative of improved or worsened results.

Two examples of significant improved results

Were you given enough privacy when discussing your condition or treatment with the hospital staff? Percentage stating "Yes, always"

Survey 2012	Survey 2013	All Trusts	Better/ Worse than 2012
66%	70%	56%	+4%

Did the nurses listen carefully to you? Percentage stating "Yes, always"

Survey 2012	Survey 2013	All Trusts	Better/ Worse than 2012
40%	52%	45%	+12%

Two examples where improvements are required

During your most recent stay, were there enough activities available for you to do during evenings and/or weekends? Percentage stating "Yes, all of the time"

Survey 2012	Survey 2013	All Trusts	Better/ Worse than 2012.
14%	12%	13%	-2%

During your most recent stay, did you have any medical tests about your physical health? Percentage stating "Yes"

Survey 2012	Survey 2013	All Trusts	Better/ Worse than 2012
89%	87%	84%	-2%

Physical healthcare is an identified priority for 2014/15 and work has commenced to extend the availability of activities at weekends and evenings.

PART TWO

2.1 Review of services

During 2013/14 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.

The Derbyshire Healthcare NHS Foundation Trust has reviewed all the data available to us on the quality of care in all four service locations of our NHS services.

The income generated by the NHS services reviewed in 2013/14 represents 92% of the total income generated from the provision of NHS services by the Derbyshire Healthcare NHS Foundation Trust for 2013/14. 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 – Six clinical audits and one confidential enquiry relevant to our services

During 2013/14, six national clinical audits and one national confidential enquiry covered NHS services that Derbyshire Healthcare NHS Foundation Trust provides.

Nationally - Six (100%) clinical audits and 100% confidential enquiries undertaken

During 2013/14, Derbyshire Healthcare NHS Foundation Trust participated in six (100%) national clinical audits and 100% 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 2013/14 are as follows:

National clinical audits

1. National audit of schizophrenia
2. POMH-UK. The national Prescribing Observatory for Mental Health (POMH-UK) Topic 4b - Prescribing anti-dementia drugs
3. POMH-UK. Topic 7d - Monitoring of patients prescribed lithium
4. POMH-UK. Topic 10c - Use of antipsychotic medication in CAMHS
5. POMH-UK. Topic 13a - Prescribing for ADHD Attention deficit hyperactivity disorder (ADHD)
6. POMH-UK. Topic 14a - Prescribing for substance misuse: alcohol detoxification (data collection to be completed in 2014/15).

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 2013/14 are as follows:

National clinical audits National Audit of Schizophrenia

1. POMH-UK. Topic 4b - Prescribing anti-dementia drugs
2. POMH-UK. Topic 7d - Monitoring of patients prescribed lithium
3. POMH-UK. Topic 10c - Use of antipsychotic medication in CAMHS
4. POMH-UK. Topic 13a - Prescribing for ADHD
5. POMH-UK. Topic 14a - Prescribing for substance misuse: alcohol detoxification (data collection to be completed in 2014/15).

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, and for which data collection was completed during 2013/14, 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	%
National audit of schizophrenia • Audit of practice	80	98	123%
• Service user survey	44	44	100%
• Carer survey	30	30	100%
POMH-UK. Topic 4b - Prescribing anti-dementia drugs	186	186	100%
POMH-UK. Topic 7d - Monitoring of patients prescribed lithium	77	77	100%
POMH-UK. Topic 10c - Use of antipsychotic medication in CAMHS	40	40	100%
POMH-UK. Topic 13a - Prescribing for ADHD	121	121	100%
National confidential inquiry into suicide and homicide by people with mental illness	6	6	100%

Review of three national reports resulted in the following improvements

The reports of three national clinical audits were reviewed by the provider in 2013/14 and Derbyshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided including the following:

National audit of psychological therapies

This second round of the national audit has demonstrated some improvements in service quality against agreed standards of care. Following the review of the reports, actions to be taken will consider national recommendations for the sustainability of accessible, effective, safe and acceptable services for psychological therapies. Our action plan will include the improvement of the quality of services provided through improved communications, resulting from better quality patient information, the provision of training for staff in psychological therapies, and a reduction in 18 week waiting times.

POMH-UK topic 7d Monitoring of patients prescribed lithium

As a result of our participation in this audit and the review of the report, our practice will be further improved to provide service users with patient information leaflets which include a section where clinicians can personalise the recording of investigations and information that has been discussed with the patient. There will also be an ongoing emphasis on processes to remind medical staff of documentation standards for recording discussions with patients about potential side-effects/toxicity. This will include relevant supervision and awareness-raising of junior doctors to ensure that relevant standards are understood and followed by all.

POMH-UK audit topic 13a Prescribing for ADHD in children, young people and adults

This audit covered a wide span of our services, including adult mental health, child and adolescent mental health and community paediatrics, and provides assurance on compliance to National Institute for Health and Care Excellence (NICE) guidelines. Following the review of the audit report, the intended actions to improve our prescribing practice and treatment services will include the development and use of standard documentation by relevant services covering the initiation and maintenance of drug treatment for ADHD, which is based on NICE standards. In addition, consistent application and recording of relevant standardised rating scales will be established in all services to ensure routine recording of outcomes and review of ADHD treatment at least annually.

The reports of 15 local clinical audits were reviewed by the provider in 2013/14 and Derbyshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided including the following:

Review of three national reports resulted in the following improvements

The reports of 15 local clinical audits were reviewed by the provider in 2013/14 and Derbyshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided including:

Prescribing for people with a personality disorder - local audit based on POMH-UK topic 12a

No drug treatments are currently licensed for personality disorder (PD) and very few studies have been conducted to examine the risks and benefits of drug treatment for most types of PD, except for borderline PD. This audit reviewed our prescribing practice based on the national POMH-UK audit standards and, as a result of this review of our practice, improvement actions are being undertaken. These actions include improving our medical staff knowledge and awareness of management of patients with personality disorder, through appropriate training and education. The aim is to consistently meet the standards to improve written crisis plans in clinical letters which have taken the patient's views into consideration, as well as continuing to document the clinician's reasons for prescribing antipsychotic medication in clinical records.

Improving annual physical health assessments through partnership working with primary care (Care Programme Approach (CPA) patients)

This was a further re-audit of a commissioner contract CQUIN requirement. This re-audit demonstrated that high levels of compliance were continuing to be achieved in all quality standards measured and patients are receiving improved physical health assessments and care. This year this included support for improved cancer screening attendances where relevant, through partnership working with primary care. As part of the development processing of co-working, individual CCGs and GP practices continue to be supported as part of the 'Healthy body healthy mind' programme, in conjunction with local Recovery teams.

Improving services for newly diagnosed dementia patients

This was specified again this year as part of our commissioner contract quality schedule requirement. The previous audit provided assurance that the teams were already complying well with the specified quality standards and this second re-audit continued to provide assurance that these standards are being maintained. In addition, the recent audit demonstrates a high level of involvement from patients and positive patient experience.

Core Care Standards audit

This annual audit is undertaken to identify how well we are meeting our Core Care Standards, which apply to everyone using the services of the Trust. It also gives assurance about compliance with Care Programme Approach (CPA) requirements. The results were mostly a great improvement on the previous year's compliance and continuous improvement is maintained through relevant actions. This year this focuses on clear communication to patients of medication arrangements; care plans documenting emergency contact number, caring responsibilities, employment and physical health problems (where identified as a need and desired by the service user), information and support for carers; and awareness raising that where care reviews are held, service users can involve friends, relatives or advocates.

This audit received the Care Programme Approach Association Good Practice Award for the category 'Excellence in Monitoring and Evaluating the Care Process'.

Audits of hearing loss

Regular audits of hearing loss continue to be carried out within our paediatric services. The three audits completed were: diagnosis and late diagnosis of significant hearing loss, aetiological investigations offered to and appointments accepted by families of children with significant permanent hearing loss, and waiting times for medical appointments for children diagnosed with significant permanent hearing loss. These audits demonstrate that we are continuing to achieve high levels of compliance in all quality standards measured.

Quality of community paediatric clinic letters: Re-audit using the Sheffield Assessment Instrument for Letters (SAIL)

This audit, undertaken in paediatric services, demonstrated that we are not only meeting but also improving upon these quality standards (up to 96% in 2013 from 83% in 2009). The audit methodology used a validated audit tool and is a collaborative approach with GP participation in the audit. The audit also confirmed that paediatricians are complying with Department of Health guidance relating to copying letters to patients and carers.

Audit of PRN (Pro Re Nata - the latin for 'as needed') protocols in residential settings (Learning Disabilities)

This audit provided assurance that our patients with a learning disability (LD) who live in residential homes, and are on PRN (as needed) medications for challenging behaviours, have a written personalised protocol (care plan) for using these medications, and that PRN medication is being used only as part of a number of strategies to manage these behaviours. As this audit reviews practice in social care residential home settings, improvement actions planned are being developed in collaboration with commissioners and social care.

Audit of Deprivation of Liberty Safeguards (DoLs) procedure in an older people's dementia ward setting

DoLS safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty (DoL) appears to be unavoidable in a person's best interests. This audit was carried out to assess compliance with DoLs procedures which include a referral for assessment for DoLS and the DoL authorised, or urgent authorisation put in place while assessment is pending, or decision otherwise justified in the record. As a result of this audit, documentation for a 'best interest decision checklist' is being produced and implemented to support capacity assessment and associated best interest judgements for patients with dementia on inpatients wards. Capacity to consent to admission and treatment will be reviewed by medical/nursing staff at the point of admission and/or at multidisciplinary meetings, whenever clinically indicated for all inpatients on dementia wards.

Other local clinical audit reports reviewed in 2013/14 which have either resulted in improvement actions being taken or planned to be taken to ensure that our patients benefit from continuous quality improvement of care and services provided include:

- Audit of physical examination of patients on inpatient wards
- Absent Without Leave (AWOL) audit
- Infection control audits
- Audit of the usage and effectiveness of the significant events sheet
- PbR clustering red rules compliance and validation audit
- Audit of medical record keeping on inpatient wards
- Health and safety audits.

2.3 Participation in clinical research

The number of patients receiving NHS health services provided or sub-contracted by Derbyshire Healthcare NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 1,545

Some of the National Institute of Health Research (NIHR) portfolio studies we have hosted in 2013/14 include:

Anxiety Symptoms Prevention Investigation (ASPI) - University of Sussex

Our patients have had the opportunity to participate in this research, which aims to cast some light on the reasons why so many children of anxious parents go on to develop anxiety disorders themselves and to also explore ways of preventing this. Children of anxious parents are up to seven times more likely to have an anxiety disorder than other children, and, although genes play a part, it is thought that parents' actions might also be very important. The research has three main parts: first, to try to find out whether anxious parents do things that might inadvertently make their children more anxious. Secondly, to see if some of these behaviours in parents can be changed or not. Finally, all of this knowledge will be put together to produce a brief training package for anxious parents. It is hoped that this training will help parents to reduce the risk of transmitting their anxiety to their children. In order to test the package, a number of anxious parents will be asked to try it out and give feedback which should allow a decision on whether it is worth carrying out a larger trial of the training package, and if so, this will help effective planning of it.

Enhanced Relapse Prevention (ERP) online - Lancaster University

Individuals with bipolar disorder (BD) typically experience periods of extreme high and low mood (mania and depression). BD is treated with medication, yet many people continue to experience relapses. Enhanced Relapse Prevention (ERP) is a psychological approach developed and found to be effective in reducing relapse and improving functioning in BD. Limited NHS resources restrict the availability of face to face ERP. This study will translate ERP into an interactive web resource (ERPonline), which has the potential to increase accessibility. Patients receiving services within our Trust have had the opportunity to take part in this study. The main purpose of this study is to assess the feasibility and acceptability of ERPonline. Individuals with BD who have had three relapses in their lifetime, with one falling in the past two years, are invited to take part. Half will use ERPonline for 12 months alongside current treatment, and their outcome compared with the other half, who will receive current treatment only. Some participants who have used ERPonline will be invited to an interview to provide feedback on whether ERPonline is an acceptable intervention they want to use. Friends or health professionals of participants, who have chosen to be involved in the intervention as a way of understanding their experiences of this process, may also be invited to interview.

Molecular Genetics of Adverse Drug Reactions (ADRs) - University of Liverpool

Adverse drug reactions are a common cause of drug related morbidity and may account for about 6.5% of all hospital admissions. A meta-analysis of studies performed in the USA has shown that ADRs may be the fourth most common cause of death. ADRs are also a significant impediment to drug development, and a significant cause of drug withdrawal. Some of our patients are participating in this research study, the purpose of which is to (a) identify patients with different types of adverse drug reactions; (b) using DNA obtained from blood or urine samples from participants, identify genetic factors which predispose to adverse reactions. The net effect of the research will be the development of genetic tests which can help in predicting individual susceptibility to adverse reactions, and thereby prevent these through testing before drug intake.

DNA Polymorphisms in Mental Illness (DPIM) – University College London

People with bipolar affective disorder and schizophrenia have had the opportunity to participate in this study, to help in the development of a better understanding of the genetics behind these disorders. This research and others like it have already begun to pave the way for new treatments and preventative strategies. These may be more personalised and also associated with fewer or absent side effects. It is strongly believed that learning more about genetics will begin to make a practical difference for creating new treatments for people with bipolar disorder and schizophrenia.

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 2013/14 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 2013/14 and for the following 12 month period are available electronically at:

http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

Derbyshire Healthcare NHS Foundation Trust's income in 2013/14, conditional upon achieving quality improvement and innovation goals was £2,632,893. A monetary total received for the associated payment in 2012/13 was £2,473,422.

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 2013/14.

Derbyshire Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

On 11 September 2013, the Care Quality Commission inspection team carried out an unannounced inspection to check whether Trust HQ had taken action to meet the following essential standards:

Outcome 4 (Regulation 9): Care and welfare of people who use services

Outcome 21 (Regulation 20): Records.

During this inspection the Care Quality Commission followed up on the action plan submitted on 21 March 2013. They visited Cherry Tree Close and Derbyshire Low Intensity Drug Service and found that we had put into place all the actions stated in our action plan. We are fully compliant with the conditions of our registration with the Care Quality Commission. In September 2013 the follow-up to our annual visit resulted in no further actions and a positive outcome.

In 2014/15 we will learn from the pilots of the new inspection regime and provide assurance of our ongoing compliance through our solid structure and processes of quality governance. An implementation plan sets out our plans to ensure staff are well prepared for the new inspections and harness the opportunity to showcase the high standards of care we provide.

The Board derives assurance on the quality of its services using a wide range of methods. This includes use of Monitor's Quality Framework to appraise the quality arrangements in place, and the commissioning of auditors to carry out routine reviews of the quality of our governance. Informal methods have also been developed such as inviting regular patient testimonies at Board meetings and a minimum of one Board member has participated in each of over 90 quality visits. This provides real-time assurance of the quality of our service delivery through the voice of our staff, patients, carers and their families.

2.6 Information on the quality of data

Derbyshire Healthcare NHS Foundation Trust submitted records during 2013/14 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 patient care (based on April 2013 –February 2014 published dashboard)
- 99.9% for outpatient care (based on April 2013 February 2014 published dashboard).

The percentage of records in the published data which included the patients' valid General Practitioner registration code was:

- 99.9% for admitted patient care (based on April 2013 -February 2014 published dashboard)
- 100% for outpatient care (based on April- 2013 February2014 published dashboard).

2.7 Information governance toolkit attainment levels

Derbyshire Healthcare NHS Foundation Trust's Information Governance Assessment Report overall score for 2013/14 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:

2.8 Reports against a core set of indicators

2.8.1. Implementation of a data quality policy

The Trust's data quality policy will continue to be implemented:

- 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.

2.8.2 Seven-day follow up

The Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: We calculate the seven-day follow up indicator based on the national guidance / descriptors:

Numerator: Number of patients on CPA who were followed up within seven days after discharge from psychiatric inpatient care (QA)

Denominator: Total number of patients on CPA discharged from psychiatric inpatient care (QA)

The Derbyshire Healthcare NHS Foundation Trust has taken the following actions to improve this, and so improve the quality of its services.

- We strive to continue to ensure that the high performance is maintained and that all patients are followed up.

Indicator	End of 12/13	End of 13/14	National average	Highest and lowest scores
The percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric in-patient care during the reporting period	99.39%	97.94%	97.6%	100% 92.5%

2.8.3. Crisis gatekeeping

The Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: We calculate the Crisis Gatekeeping indicator based on the national guidance / descriptors:

Numerator: Number of admissions to acute wards that were gate kept by the CRHT teams (QA)

Denominator: Total number of admissions to acute wards (QA)

The 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 12/13	End of 13/14	National average	Highest and lowest scores
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	98.88%	97.59%	98.4%	100% 90.7%

2.8.4. 28 day re-admission rates (aged 16 and over)

The Derbyshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons: We calculate 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.

The Derbyshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by service modernisation of pathways of care.

Indicator	End of 12/13	End of 13/14	National average	Highest and lowest scores
28 day re-admission rates for patients 16 and over	4.99%	7.69%	12.32%	15.56% 8.35%

2.8.5. Staff recommending the Trust as a place to work or receive treatment:

Our staff survey results for 2012 and 2013 have demonstrated notable progress in a number of key areas. We are particularly proud to share the results that reflect how staff perceive the Trust as a place to receive care. In 2013, 71% of respondents felt that patient care was our top priority – this in an increase in 6% from 2012, when we were already above the national average in response to this question.

The vast 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 higher than the responses received to the same question last year and is also higher than the national average.

Similarly a 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 users.

The Trust has a good foundation, as evidenced by the 2013 staff survey results, and has also been identified by the Involvement and Participation Association (IPA) as a centre of good practice with regard to staff engagement.

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 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 co-producing and leading the change process. Our three key areas of emphasis are:

- Create a compassionate culture across the organisation - firstly by identifying the characteristics of such a culture as this will assist in understanding success
- To design a framework that supports decision making closer to direct patient care and creates autonomous teams
- To design a process that enables all of our workforce to carry out a values-based assessment over the next three years.

We will continue to encourage as many staff as possible to take part in the 2014 national NHS Staff Survey later this year.

Indicator	Trust score 2013	Trust score 2012	All MH Trusts average	All MH Trusts best score
Staff recommending the Trust as a place to work or receive treatment	3.68	3.62	3.55	4.04

2.8.6. Patient safety incidents and the percentage that resulted in severe harm or death.

The Derbyshire Healthcare NHS Foundation 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 2013 and 30 September 2013		Median rate
Patient Safety Incidents per 1,000 bed days	1,459 26 incidents were reported during this period = reporting rate of 26.37 incidents per 1,000 bed days	The median reporting rate for the 55 mental health organisations was 26.37 incidents per 1,000 bed days

Degree of harm indicated as a percentage of the total number of incidents reported				
None	Low	Moderate	Severe	Death
60.9% (888)	33.3% (471)	4.5%(66)	0.5%(7)	1.9% (27)

Patient Safety Incidents reported by Derbyshire Healthcare NHS Foundation Trust to the National Reporting and Learning System (NRLS) between 1 October 2012 and 31 March 2013		Median rate
Patient Safety Incidents per 1,000 bed days	1,286 incident reported during this period = reporting rate of 22.72 incidents per 1,000 bed days	The median reporting rate for the 55 mental health organisations was 38 incidents per 1,000 bed days.

Degree of harm indicated as a percentage of the total number of incidents reported				
None	Low	Moderate	Severe	Death
64.46% (829)	25.6% (374)	29%(65)	0.5%(5)	1.0% (13)

The 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 has an effective safety culture.

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 patients' rights to have care provided in the least restrictive manner.

2.8.7. Community patient survey results 2013

The 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 2012.

The 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 patient feedback and puts actions in place to improve those areas where the Trust has not received positive scores.

Indicator	Trust score 2012 (out of 10)	Trust score 2013 (out of 10)	Highest and lowest Trust score
Patient experience of contact with a Health or Social Care Worker during the reporting period	8.4	8.7	9.0 to 8.0

PART 3
Performance

3.1 Priorities set out in Quality Report 2012/13

This section provides information on achievements on the priorities agreed and set out in the Quality Report 2012/13.

Please see part one of this report for further details.

3.2 Progress against selected quality indicators in 2013/14

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 Permance Dashboard	Target	End of year March 2013	End of March 2014
Monitor Targets			
OPA 7 Day Follow up	95.0%	99.39%	97.94%
CPA review in last 12 months	95.0%	98.56%	96.52%
Delayed Transfers of Care	6.8%	0.50%	1.39%
Data Completeness Indentifiers	99.0%	99.53%	99.42%
Data Completeness Outcomes	90.0%	97.62%	97.77%
Crisis Gatekeeping	95.0%	99.04%	97.59%
Early Interventions New Caseloads	95.0%	108.00%	121.20%
NHS Outcomes Framework			
CPA HoNOS Assesment in last 12 months	90.0%	92.49%	93.17%
CPA in Paid Employment	8.0%	11.34%	11.95%
CPA Employment Status	90.0%	99.95%	99.85%
CPA Settled Accommodation	90.0%	99.98%	99.85%
Under 18 Admissions To Adult Inpatient Facilities	0.0	4.0	4.0
Date Completeness Indentifiers	99.9%	99.53%	99.42%
mixed Sec Accommodation Breaches	0.0	0.0	0.0
Data Completeness Outcomes	90.0%	97.62	97.77%
Locally Agreed			
Consultant Outpatient Appointments Trust Cancellations	4.0%	3.21%	3.10%
Consultant Outpatient Appointments DNAs	15.0%	14.64%	14.21%
CPA 7 Day Follow Up (all Inpatients)	95.0%	98.75%	97.57%
Discharge Letters Sent in 5 Working Days	90.0%	54.79%	35.44%
Discharge Letters Sent in 10 Working Days	100.0%	80.99%	66.80%
Outpatient Letters Sent in 10 Working Days	90.0%	71.11%	61.68%
Outpatient Letters Sent in 15 Working Days	100.0%	86.59%	78.77%
Schedule 4 Contract			
CPA Review in last 12 Months	90.0%	92.31%	90.48%
Patients Clustered not Breaching Today	99.0%	85.44%	89.70%
Patient Clustered Regardless of Review Dates	100.0%	56.34%	98.24%
Discharge Fax Send in 5 Working Days	90.0%	N/A	100.0%
Discharge Fax Send in 10 Working Days	100.0%	N/A	100.00%
Complex Needs: Assertive Outreach Clinician Caseload	12.0	10.30	10.95
Delayed Transfers of Care	6.8%	0.26%	0.64%
Delayed Transfers of Care - Rehab	6.8%	0.00%	0.50%
Deputy Care Co-ordinator Assignment	90.0%	*98.6%	97.90%
18 week RTT Less Than 18 weeks - Incomplete	92.0%	95.99%	95.57%
18 week RTT Less Than 18 weeks - Non-Admitted	95.0%	96.30%	97.98%
Early Interventions New Caseloads	126.0	148.0	161.0
C. Difficile New Cases (In-Patient)	<10	2	0
MRSA New Cases (in-patient)	<5	0	0
Schedule 6 Contract			
CPA Settled Accommodation	N/A	94.68%	92.76%
Average Community Team Waiting Time (Weeks)	N/A	5.01	4.87
Inpatient 28 Day Readmissions	10.0%	4.99%	7.36%
Crisis Home Treatments	N/A	1,650	1,610
Assertive Outreach Caseload	N/A	254	253

Comments on performance

General performance of the Trust during 2013/14 has continued to be good with 34 of the 41 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 seven areas (four of which concern letters) where the Trustis focused on improving our performance. These are specifically examined below;

Under 18 admissions:

All four admissions were appropriately reported and investigated. All were found to have been necessary, appropriate interventions to maintain the safety of the service users.

Letters:

Implementation of the primary care-approved faxed discharge letter continues to be successful, with 100% faxes being sent to the GP within five working days, providing the GPs with the key discharge information they need in a timely manner.

Digital dictation implementation continues. Some issues have slowed progress, including emailing of letters and development of standardised letter formats, but the trajectory since the launch of digital dictation is continuing to rise.

Payment by Results clustering:

The trust is performing favourably when compared with the national picture. The latest NHS Benchmarking Network report states that around 80% of mental health inpatients were clustered. In comparison, at the end of March the position was that 98.24% of our inpatients were clustered. The Associate Clinical Directors continue to review clustering through one to one meetings with individual consultants.

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 Compliance Framework annually. Below is our progress against the indicators set out in the compliance framework for 2013/14 (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	2013/14	Achieved/ not achieved
Maxium time of 18 weeks from point of referral to treatment in aggregate, non-admitted patients	95.00%	97.98%	Achieved
Maxium time of 18 weeks from point of referral to treatment in aggregate, patients on incomplete pathways	92.00%	95.57%	Achieved
Care Programme Approach (CPA) patients receiving follow up contact within 7 days of discharge	95.00%	97.94%	Achieved
Care Programme Approach (CPA) patients having formal review within 12 month	95.00%	96.52%	Achieved
Admissions to inpatient services had access to crisis resolution/home treatment teams	95.00%	97.59%	Achieved
Meeting commitment to serve new psychosis cases by early interventions teams	95.00%	142.70%	Achieved
Clostridium Difficile-meeting the C.Diff objective	7	0	Achieved
Minimising MH delayed transfers of care	≤7.5%	1.39%	Achieved
Data completeness, MH: indentifiers	97.00%	99.42%	Achieved
Data completeness, MH: outcomes for patients on CPA	50.00%	97.77%	Achieved
Community care data completness - referral to treatment information completeness	50.00%	92.31%	Achieved
Community care data completness - referral information completeness	50.00%	72.33%	Achieved
Community care data completness - activity information completeness	50.00%	83.40%	Achieved

Progress this year has been strong with many indicators exceeding the target set. The targets are challenging and the staff in operational services are to be commended on their commitment and hard work to ensure these targets have been met throughout the year.

Benchmarking our performance against other trusts nationally

The Trust is committed to working with patients to reduce their length of stay. As soon as someone is admitted, we start the process of considering when they might be discharged. This is reflected in our average delayed transfers of care, which stands at just 1.39%. The latest data published by NHS England places the Trust as the 12th best performing mental health trust in the country for the number of delayed days in the reporting period (with a figure of 149 days; nationally performance ranges from 31 to 1471 days, with a national average of 498 days). **http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2013-14/**

The Trust is committed to ensuring our patients receive timely support following discharge from our wards. The latest national data published by NHS England places us as joint 14th best performing Trust in England for seven-day follow-up (with a percentage of 98.5%; nationally performance ranges from 93.3% to 100% with a national average of 97.4%). **http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/**

The Trust is committed to ensuring care is provided in the appropriate setting. One of the ways we do this is through the crisis teams, who 'gatekeep' potential admissions. The latest national data published by NHS England places us as joint 15th worst performing Trust in England (with a percentage of 97.7%; nationally performance ranges from 90% to 100%, with a national average of 98.3%). We will work to improve this position over the course of 2014/15. **http://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/**

Older People's Nurses

Measuring the quality of our data

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information. The Trust takes the Information Governance very seriously and ensures that is complies as fully as possible with the standards set by the Health and Social Care Information Centre. Each year the Information Governance toolkit allows Trusts to compare their compliance level to other like Trusts. In 2013/14 Derbyshire Healthcare was 96% compliant. This places the Trust top of like Trusts for the second consecutive year. In comparison, the average compliance level of like organisations in 2013/14 was 79%.

Derbyshire Healthcare understands that accurate information is fundamental to high quality care. We constantly strive to ensure all the information we hold is as accurate as possible. As part of our quality assurance approach, we compare the quality of our data to that of other health organisations. The table below shows that our information submitted to NHS England in the Commissioning Data Set has better data quality than the national average in the majority of the key fields.

Inpatients (APC)	National Average	Derbyshire Healthcare NHS Foundation Trust (RXM)
NHS Number	99.1	99.9
Patient Pathway	59.9	100.0
Treatment Function	99.7	100.0
Main Specialty	99.9	100.0
Reg GP Practice	99.9	99.9
Postcode	99.9	100.0
Org of Residence	97.8	99.9
Commissioner	99.1	99.9
Primary Diagnosis	98.6	99.9
Primary Procedure	99.8	100.0
Ethnic Category	97.9	99.4
Site of Treatment	96.9	100.0
Health Resource Groups4	98.3	100.0

Outpatients (OP)	National Average	Derbyshire Healthcare NHS Foundation Trust (RXM)
NHS Number	99.3	99.9
Patient Pathway	49.6	100.0
Treatment Function	99.7	100.0
Main Specialty	99.8	100.0
Reg GP Practice	99.9	100.0
Postcode	99.8	100.0
Org of Residence	97.4	100.0
Commissioner	98.3	100.0
First Attendance	99.7	100.0
Attendance Indicator	99.6	100.0
Referral Source	98.3	100.0
Referral Rec'd Date	96.2	100.0
Attendance Outcome	98.7	100.0
Priority Type	97.3	100.0
OP Primary Procedure	98.3	100.0
Ethnic Category	92.8	95.4
Site of Treatment	97.9	100.0
Health Resource Groups4	99.0	100.0

Key:

- Above or equal to national average
- Below national average

Never events

There have been no never events in the Trust during 2013/14.

Changes made to this report as a result of our consultation process and feedback from our partner agencies.

As a result of our consultation and comments received from our partner agencies the final publication includes information on the wider children's services we provide, benchmarking on our performance and data quality, some information about our partnership working with Healthwatch and some minor amendments. We would like to thank everyone that has contributed and taken the time to send us their comments. We will be using all the feedback to help shape our report for 2014/15.

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:

The Derbyshire Healthcare NHS Foundation Trust (the Trust) Quality Account 2013/14 broadly reflects the information received by Hardwick Health Clinical Commissioning Group (the CCG), the co-ordinating commissioner, through its contract and quality monitoring arrangements.

Measuring and improving performance

The CCG continues to monitor the performance of the Quality Schedules contained in the Contract with the Trust.

We are pleased to the see the progress against the priorities set last year especially in relation to service user experience of the Health Visiting services and improving patient's physical healthcare needs.

In addition we note the work the trust has done in response to the Francis Inquiry especially in relation to the wider trust team's contribution to the findings of the inquiry.

The CCG notes the quality improvement areas for 2014/15 and welcomes the focus on suicide prevention and the Think Family approach both which have been areas that the CCG and the Trust feel that further improvements can be made.

The CCG particularly welcomes the expansion of the Centre for Research and Development and the focus that it will have, through the Centres for Excellence on compassion, suicide, dementia and recovery. We fully support this initiative and look forward to the improvements in service user care that it will bring in the future.

The CCG has been involved in the Quality Visit Programme and is impressed with the board to ward interface and the improvement made as illustrated in the Quality Account.

Additional comments

We would ask the Trust to consider in the next quality account the following:

- To provide where possible benchmarking data to show the public how performance compares with other providers of similar services.
- Ensuring that quality account is able to tell the quality story for the full portfolio of services and that future quality priorities reflect the range of services offered by the Trust.

Derbyshire County Council's Improvement and Scrutiny – Health Committee:

Derbyshire County Council's Improvement and Scrutiny – Health Committee responded that they had received the Quality Report and have arranged a Health Scrutiny Stakeholder event on 9 June 2014 where partner agencies will discuss the Committee's responsibilities and health providers' obligations to the Committee in undertaking its role.

Derby City Council's Overview and Scrutiny Committee

Derby City Council confirmed that the Quality Report was presented to the Adults and Public Board on Monday 28 April and they noted it.

Healthwatch Derby offered the following statement about the initial draft of our Quality Report:

Since its establishment in April 2013 Healthwatch Derby has been successfully working with Derbyshire Healthcare NHS Foundation Trust. We have an information sharing protocol in place and are currently working with the trust on a consultation on 'Think Healthy'. We welcomed the quality report and have provided the trust with our comments which they have responded to. We look forward to continuing our work with the trust in 2014/15.

Public Health Derby City offered the following statement about the initial draft of our Quality Report.

We are pleased to receive the Derbyshire Healthcare Foundation Trust Quality Report for 2013/14. Due to the tight timescales this year the Health and Wellbeing Board will not make a formal comment. We welcome the opportunity to be involved in the consultation process for 2014/15 and have discussed with the trust our plans to include this in our agenda as early as possible in 2015 when our governance arrangements for public health will be firmly established.

Healthwatch Derbyshire offered the following statement about the initial draft of our Quality Report:

Healthwatch Derbyshire
Suite 14, Riverside Business Centre
Foundry Lane, Milford, BELPER
Derbyshire, DE56 0RN
Tel 01773 880786
enquiries@healthwatchderbyshire.co.uk
www.healthwatchderbyshire.co.uk

RECEIVED
- 6 MAY 2014

healthwatch Derbyshire

29 April 2014

Carolyn Green
Executive Director of Nursing & Patient Experience
Derbyshire Healthcare NHS Foundation Trust
Bramble House
Kingsway Site
Derby
DE24 3LZ

Dear Carolyn

RESPONSE TO QUALITY ACCOUNT

Healthwatch Derbyshire (HWD) came into operation on the 1st April 2013 and was very much in its infancy when asked to submit a response to last year's Quality Account for Derbyshire Healthcare NHS Foundation Trust. However, having now been operating for 12 months as the consumer champion for health and social care services, HWD is now in a much better position to strengthen the collective voice of patients and the public in Derbyshire, and ensure that voice is used to help influence and improve the delivery and design of local services.

HWD is responding to this Quality Account largely in relation to the 'Patient Experience' priority as this is where our evidence is based.

HWD is pleased to have a seat on the Equalities, Engagement, Experience and Enablement Stakeholder Committee (4Es). This gives HWD the opportunity to put forward the voice of service receivers, carers and the public from information we have gathered through relevant independent focussed engagement activities.

This representation will be further strengthened once the imminent HWD Information Sharing Protocol has been agreed and signed by the Trust. This will grant access, on a monthly basis, to all relevant intelligence, both concerns and compliments, gathered by HWD. This data is a valuable source of independently collated patient feedback and is designed to complement the Trust's own internal patient experience reporting mechanisms. By learning from patient feedback will help with the identifying of priorities and effecting improvement in service delivery.

Additionally, the Trust will respond back to HWD as to how they have used this information to improve patient experience. This, in turn, will be fed back to the service receivers, carers and the public through HWD's own communication routes, thereby demonstrating a reciprocal and consequential process in the exchange of information.

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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.

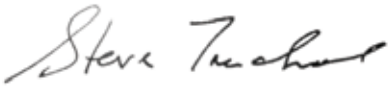
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- 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 2013 to June 2014*
  - *Papers relating to Quality reported to the Board over the period April 2013 to June 2014*
  - *Feedback from the commissioners dated 24/04/2014*
  - *Feedback from governors dated 11/03/2014*
  - *Feedback from Local Healthwatch organisations dated 29/04/2014*
  - *The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2014;*
  - *The [latest] national patient survey 17/09/2013*
  - *The [latest] national staff survey 25/02/2014*
  - *The Head of Internal Audit's annual opinion over the trust's control environment dated 29/04/2014*
  - *CQC quality and risk profiles dated 01/04/13 to 31/03/14.*
- 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, 28 May 2014



Steve Trenchard, Chief Executive, 28 May 2014

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.

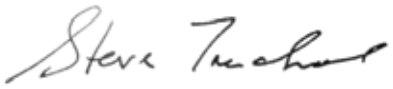
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- 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.

Signed



Steve Trenchard, Chief Executive

3 Annual Governance Statement

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 2014 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 in a uniquely changing and challenging environment which has included system leadership and process changes around commissioning, plus greater expectations on trusts following the Francis Report and the associated recommendations arising from this.

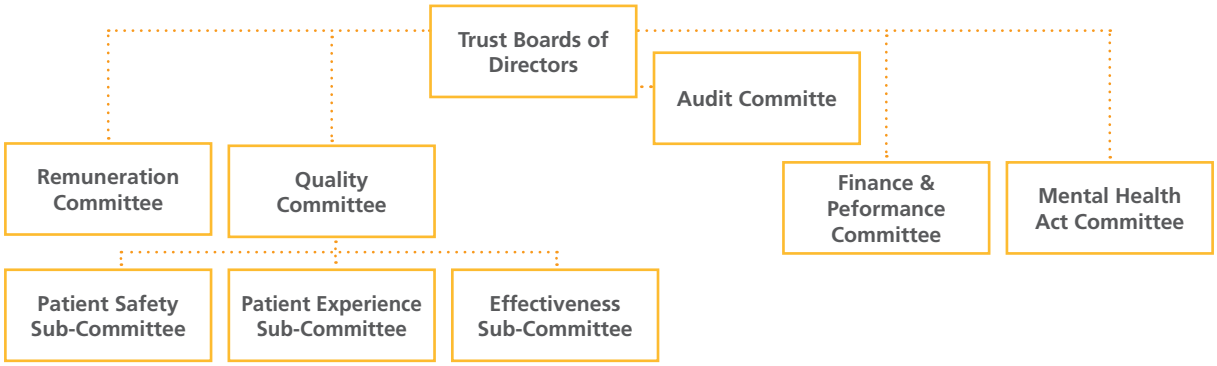
- There is a Board endorsed Integrated Quality Governance Strategy which defines the organisational structures in place for the management and ownership of risk, including the responsibilities of Executive Directors for implementing the strategy. The Executive Director of Nursing and Patient Experience in association with the Medical Director, has the responsibility for risk and quality on behalf of the Board of Directors. This is supported by a range of policies and procedures, including 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 Framework 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
- 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.

The risk and control framework

Key elements of the risk management strategy

- Risk identification – proactively via risk assessments, project plans and reactively via incident, complaints and claims analysis, internal and external inspection and audit reports
- Risk evaluation - using a single risk matrix to determine the 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 – responsibility and authority for determining the effectiveness of controls, and for developing risk treatment plans, including assigning appropriate resources, is dependent upon the risk grade
- 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
- Board Assurance Framework – detailing key risks to achieving the Trust's strategic objectives, and ways to mitigate those risks. The Board of Directors determines the 'appetite' for risk by obtaining assurance from controls in place and reviewing mitigation plans, relative to the level of risk identified
- Incident reporting – openly encouraged and supported by an online incident reporting form (DATIX), accessible to all staff
- Incident investigation – there are 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
- Communication – the use of a 'Blue Light' system to rapidly communicate information on significant risks that requires 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. 'Policy Bulletin' informs staff of key messages within new or updated policies and procedures
- The Board of Directors is involved in an ongoing programme of live Equality Impact Assessments across all service areas, and uses this to identify service gaps and improvement opportunities.

Corporate governace structure (from May 2013)



Effectiveness of governance structures

Reporting line and accountability between the board, its committees and the executive team. Responsibilities of directors and committees:

The revised governance structure shown in the diagram above was agreed by the Board of Directors in May 2013.

All of the following meetings have been reviewed to ensure their work plans are active and they are escalating information and any issues to the Board.

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.

The **Quality Committee** enables the Board to obtain assurance that high standards of care are provided by the Trust and in particular that adequate and appropriate governance structures, processes and controls in are in place throughout the Trust. In May 2013 the Quality Committee became the principal committee concerned with the management of risk, supported by the Patient Experience, Patient Safety and Effectiveness sub committees.

The **Audit Committee** reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), which in turn supports the achievement of the Trust's objectives.

The **Finance and Performance Committee** oversees all aspects of financial management and operational performance on behalf of the Board. This includes: detailed oversight of financial performance, forward projections and assumptions which underpin forward plans; scrutiny of reports on performance; workforce; the cost-improvement programme; and review of the Foundation Trust's capability and capacity to meet the commercial and marketing requirements of potential business opportunities.

The **Mental Health Act Committee** obtains assurances on behalf of the "Hospital Managers" and the Trust as the detaining authority, that the safeguards and provisions of the Mental Health Act are appropriately applied; the Committee takes account of the provisions of related statute and guidance, such as the Mental Capacity Act, Deprivation of Liberty Safeguards (D.O.L.S) and Human Rights Act.

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 also shares a fundamental responsibility to provide strategic leadership to the organisation, consistent

with its values and principles, whilst ensuring 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, on 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 is detailed in the Integrated Governance Strategy.

The scheduled review of the structure coincided with a period of change and transition of positions at Board level. Although the plan was for the Quality Committee to meet monthly from May 2013 onward, the Quality Committee did not convene for two of its planned meetings due to one cancellation due to unforeseen circumstance and one meeting not quorate and so cancelled at short notice. This is recognised as a gap in the Trust's mechanisms of internal control. However, as governance reporting to the Board of Directors and external governance reporting requirements were met during this period, the gap is not identified as significant.

A 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. During 2013/14, the Quality Committee became responsible for ensuring appropriate assurances are sought for key controls which manage strategic organisational risks. The Board of Directors has reaffirmed that the Audit Committee will be the key committee in terms of oversight of the Board Assurance Framework from April 2014 onwards.

At the year end, the corporate governance structure and its supporting sub-structure is undergoing further review. This will be informed by an independent audit which will take account of Monitor's forthcoming guidance on 'Governance Reviews' which includes the requirement for regular review of Board and Committee structures.

Submission of timely and accurate information to assess risks to compliance with the Trusts 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. Papers outlining the key themes and recommendations were submitted to the Board of Directors in May 2013 and Feb 2014. 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 that 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 is considered by 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

The Care Quality Commission requirements are underpinned and delivered through the Quality Governance Structure and associated processes. During 2013/14 the Trust took a 'deep dive' approach to integrated performance reports, incorporating quality indicators for specific service lines. Key quality indicators are reported monthly to the Board, with a focus on exceptions. Evidence of compliance with the 16 essential standards of quality and safety is reported through the Quality Committee and complementary committee structure, with each report referencing the essential standards for which it provides evidence of compliance. The work of the Quality Committee and associated groups are active and their outputs are clearly evidenced in the Trusts Quality Account, the accuracy of which is subject to review by internal auditors as well as extensive consultation and feedback internally and externally on the contents of the report.

The Trust has an extensive annual quality visit programme, involving Board members, Governors and stakeholders, which includes announced and unannounced Care Standards assurance visits to wards and teams as a further method of assuring compliance with the CGC requirements. The Trust is an active member of the East Midlands Registration Benchmarking Forum.

The Trust publishes its key performance indicators onto the web daily. This supports the Trust's aim of making sure that 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 (Chief Operating Officer) and Caldicott Guardian (Medical Director) at Board Level
- An annually completed Information Governance Toolkit, with reported outcomes to the Audit Committee and Board of Directors
- Risks related to Information Governance are reviewed by the Executive Director Lead and the Information Governance Committee
- A high uptake of information governance compulsory training
- Information governance incidents are reviewed monthly by the Information Governance Group and 'Learning the Lessons' Bulletins are issued to staff.

There has been no internal audit on the Information Governance Toolkit submission carried out this year, however access and security was considered in the 2013/14 Internal Audit EPR Project Review II and the risk was identified as 'green'.

During the year, one incident was reported to the Information Commissioner's Office (ICO). The incident involved an email containing patient sensitive information being sent to a wider mailing list than was intended. No sanction was imposed by the ICO.

Public stakeholders:

The key ways in which public stakeholders are involved in managing risks which impact on them include:

- The Council of Governors at quarterly meetings take the opportunity to hold the Board of Directors to account on its performance, including quality and risk
- The Trust's 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 involves key stakeholders, and this is evidenced in our inclusion of their feedback
- Impact assessments for the Transformational Change Programme including a requirement for consultation with key stakeholders.

Major risks:

Identified major risks in year, up to 31 March 2014 were:

Failure to fully implement an electronic Patient Record (EPR).

This risk has been regularly reviewed and updated by the responsible Director throughout the year and updates tracked on the Board Assurance Framework. The risk has been identified due to both the complexity of the implementation and the potential impact of an EPR in allowing the Trust to transform the way services are delivered based upon the new software. The EPR project has twice been audited by PwC: during the development stage (July 2012) resulting in a report classification of Medium Risk; and during the 'go-live' planning stage (March 14) resulting in a report classification of High Risk.

During the second audit the project team was in the process of planning for the 'go-live' of the first team to implement the EPR (the Learning Disability team). A number of the audit findings related to the clarity of the plan which was in the process of being developed. The audit also highlighted that the contract, which is OJEU compliant, had not yet been signed and a closer working relationship was required to ensure successful delivery of the project. Actions taken following the audit include: a supplier executive attending all board meetings, the Civica Project Manager attending all project team meetings and Trust clinicians working collaboratively with Civica on the development of new functionality such as ePrescribing. The audit also recommended that regular updates be provided to the Trust Board on the project's progress. These will be delivered via quarterly updates.

The remaining risks associated with the project relate to outstanding functionality to support batch tracing, ePrecribing and mobile working. These risks are being closely monitored and reviewed by the project team and project board.

The Electronic Patient Record is due to go-live in the first teams between 18 and 21 April 2014. A roll-out to all other mental health wards and teams will follow during 2014/15.

Future risks will be identified through the development of the Board Assurance Framework for 2014/15. Individual risks to the achievement of the Trust's strategic objectives will be detailed together with controls and mitigations as part of the dynamic process of identification and review of risks. During 2014/15 the Board Assurance Framework will be reported to the Audit Committee and then the Board of Directors on a regular basis.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. The planned annual inspection in 2012/13 resulted in two compliance actions. A follow-up review in September 2013 confirmed that the action plan had delivered all the required improvements and the Trust was fully complaint with the terms of its registration.

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 Trust has carried out 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 for Health.

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 approve the annual audit plan, informed by risk assessments and the annual clinical audit plan.

All clinical services have carried out viability assessments as part of transformational planning. This includes corporate functions which have participated in the NHS Benchmarking Network exercise.

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 2013/14.

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 its 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 of Directors, the Audit Committee, and the 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 1 April 2010 – without conditions at year end
- NHS Litigation Authority Risk Management Standards compliance with Level 2 Standards, achieved in June 2010
- Compliance with Monitors Quality Framework
- Reviews of Corporate Governance and associated committees
- Internal Audit reports received during the 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 are identified:

- Electronic Patient Records (EPR) project
- Meetings of the Quality Committee.

Further description and mitigation to close these gaps in control are detailed earlier in the Annual Governance Statement.

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 2013/14 provided by PwC includes the Head of Internal Audit's annual opinion which is as follows:** Our opinion is based on our assessment of whether the controls in place support the achievement of management's objectives as set out in our Annual Internal Audit Plan and Risk Assessment. We have completed the program of internal audit work for the year ended 31 March 2014. Our work identified low- and moderate-rated findings and one high-rated finding. Based on the work we have completed, we believe that there is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and / or effectiveness of governance, risk management and control.
- The most recent Risk Management and Governance Review (February 2013) was carried out in order to understand and evaluate the risk management and governance processes in place in the Trust. The review concluded that overall "the processes in place in the Trust are well designed and are working effectively". The overall report classification of the report was low risk and the single action identified has been completed.

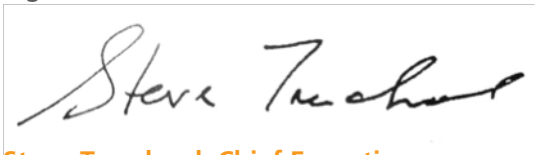
External Audit:

- The Trust's External Auditors, Grant Thornton, provide the Trust with external audit services including 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. Control issues have been or are being addressed.

Signed



Steve Trenchard, Chief Executive

4 Annual Accounts

Independent auditors' report to the Council of Governors and Board of Directors of Derbyshire Healthcare NHS Healthcare NHS Foundation Trust

We have audited the financial statements of Derbyshire Healthcare NHS Foundation Trust ('the Trust') for the year ended 31 March 2014 which comprise the statement of comprehensive income, the statement of financial position, the statement of cash flow, the statement of changes in taxpayers' equity and 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.

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

- The table of salaries and allowances of senior managers and related narrative notes
- The table of pension benefits of senior managers and related narrative notes
- The table of pay multiple and related narrative notes.

The report is made of solely to the Council of Governors and Board of Directors of Derbyshire Healthcare NHS Foundation Trust NHS Foundation Trust, as a body, in accordance with paragraph 24(25) 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 Governors and Directors those matters we 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, the Trust's Governors as a body and the Trust's Body of Directors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of accounting officer and auditor

As explained more fully in the Chief Executive's Statement, the Chief Executive as Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they given a true and fair view.
The Accounting Officer is responsible for the maintenance and integrity of the corporate and financial information on the Trust's website. Legislation in the United Kingdom governing the preparation and dissemination of the financial statements and other information included in annual reports may differ from legislation in other jurisdictions.

Our responsibility is to audit and express an opinion on the financial in accordance with applicable law, the Audit Code for NHS Foundation Trusts issued by Monitor, and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's (APB's) Ethical Standards for Auditors.

Scope of the audit of the financial statements

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 the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implication for our report.

Opinion on the financial statement

In our opinion the financial statements:

- give a true fair view of the state of the financial position of Derbyshire Healthcare NHS Foundation Trust at 31 March 2014 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.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006 and the NHS Foundation Trust Annual Reporting Manual 2013-14 issued by Monitor
- the information given in the annual 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 matters where the Audit Code for NHS Foundation Trusts requires us 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 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
- the Trust Quality Report has not been prepared in line with the requirements set out in the NHS Foundation Trust Annual Reporting Manual or is inconsistent with other source of evidence.

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 Trust issued by Monitor.

Mark Stocks

for and on behalf of Grant Thornton UK LLP

Colmore Plaza
20 Colmore Circus
Birmingham
B4 6AT

29 May 2014

Statement of comprehensive income for the period ended 31/03/2014

	NOTE	2013/14 £000	2012/13 Restated £000	2012/13 Original £000
Operating income from continuing operations	4 & 5	127,549	124,672	124,672
Operating expenses of continuing operations	7	(123,801)	(121,259)	(121,259)
Operating surplus/ (deficit)		3,748	3,413	3,413
Finance costs				
Finance income	13	25	25	25
Finance expense - financial liabilities	15	(2,082)	(1,938)	(1,938)
Finance expense - unwinding of discount on provisions		(61)	(68)	(68)
PDC dividends payable		(1,109)	(1,036)	(1,036)
Net finance costs		(3,227)	(3,017)	(3,017)
Surplus/(deficit) for the year		521	396	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		521	396	396
Other comprehensive income		4,413	4,552	264
Total comprehensive income(expense) for the year		4,934	4,948	660

The notes on pages 143 to 176 form part of these accounts.

The restated statement above shows the impact of the prior period adjustment on other comprehensive income, with an increase from £264k to £4,552k. Full details of the prior period adjustment are contained in note 43.

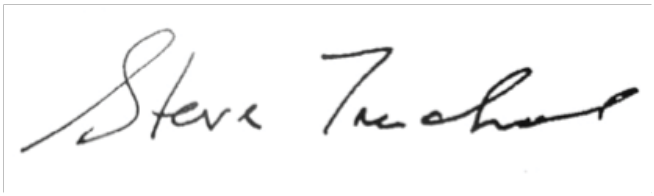
Statement of financial position as at 31/03/2014

	NOTE	31/03/2014 £000	31/03/2013 Restated £000	31/03/2013 Original £000
Non-current assets:				
Intangible assets	17	**3,931**	2,216	2,216
Property, plant and equipment	16 & 43	**76,057**	73,397	69,109
Trade and other receivables	21	**1,364**	1,095	1,095
Total non-current assets		**81,352**	76,708	72,420
Current assets:				
Inventories	20	**172**	187	187
Trade and other receivables	21	**4,568**	3,018	3,018
Non-current assets for sale	25	**166**	261	261
Cash and cash equivalents	24	**6,848**	7,416	7,416
Total current assets		**11,754**	10,882	10,882
Current liabilities				
Trade and other payables	26	**(10,806)**	(8,632)	(8,632)
Borrowings	27	**(764)**	(735)	(735)
Provisions	35	**(820)**	(1,578)	(1,578)
Tax Payable	26	**(820)**	(878)	(878)
Other liabilities	28	**(494)**	(747)	(747)
Total current liabilities		**(13,704)**	(12,570)	(12,570)
Total assets less current liabilities		**79,402**	75,020	70,732
Non-current liabilities				
Borrowings	27	**(30,438)**	(31,051)	(31,051)
Provisions	35	**(2,534)**	(2,473)	(2,473)
Total non-current liabilities		**(32,972)**	(33,524)	(33,524)
Total assets employed:		**46,430**	41,496	37,208
Financed by: Taxpayers' equity				
Public dividend capital		**16,085**	16,085	16,085
Revaluation reserve		**24,190**	19,856	15,568
Other reserves		**8,680**	8,680	8,680
Merger Reserve		**0**	0	0
Income and expenditure reserve		**(2,525)**	(3,125)	(3,125)
Total Taxpayers' Equity:		**46,430**	41,496	37,208

The notes on pages 143 to 176 form part of these accounts.

The financial statements on pages 138 to 142 were approved by the Board on 28/05/2014 and signed on its behalf by:

Signed



Chief Executive

Statement of changes in taxpayers' equity for the period ended 31/03/2014

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total reserves
	£000	£000	£000	£000	£000
Taxpayers equity at 01/04/2013	16,085	19,856	8,680	(3,125)	41,496
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 31/03/2014	16,085	24,190	8,680	(2,525)	46,430

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 01/05/2012	**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
Impairments	0	(489)	0	0	(489)
Revaluations	0	5,043	0	0	5,043
Asset disposals	0	(47)	0	47	0
Other reserve movements	0	(9)	0	7	(2)
Taxpayers' equity at 31/03/2013	**16,085**	**19,856**	**8,680**	**(3,125)**	**41,496**

The prior period adjustment as led to a change in the revaluation reserve above, the revaluations figure has increased from £755k to £5,043k

Statement of cash flows for the period ended 31/03/2014

	NOTE	2013/14 £000	2012/13 £000
Cash flows from operating activities			
Operating surplus/deficit from continuing operations		**3,748**	3,413
Operating surplus/deficit		**3,748**	3,413
Non cash income and expenses			
Depreciation and amortisation		**3,159**	2,668
Impairments		**1,349**	2,551
Reversal of impairments		**0**	(1,463)
Gains and losses on asset disposals		**(8)**	54
Interest and dividend accrued - not paid		**0**	(381)
(Increase)/decrease in Inventories		**15**	(13)
(Increase)/decrease in trade and other receivables		**(1,813)**	(863)
Increase/(decrease) in trade and other payables		**2,305**	749
(Increase)/decrease in other current liabilities		**(253)**	365
Increase/(decrease) in provisions		**(758)**	(7)
Net cash inflow/(outflow) from operating activities		**7,744**	7,073
Cash flows from investing activities			
Interest received		**25**	25
Purchase of intangible assets		**(2,450)**	(764)
Purchase of property, plant and equipment		**(2,109)**	(2,984)
Sales of property, plant and equipment		**105**	429
Net cash inflow/(outflow) from investing activities		**(4,429)**	(3,294)
Cash flows from financing activities			
Capital element of private finance lease obligations		**(718)**	(797)
Interest element of private finance lease obligations		**(1,803)**	(1,801)
Interest element of finance lease obligations		**(168)**	0
PDC dividend paid		**(1,194)**	(957)
Net cash inflow/(outflow) from financing activities		**(3,883)**	(3,555)
Net increase/(decrease) in cash and cash equivalents		**(568)**	224
Cash and cash equivalents at beginning of the period		**7,416**	7,192
Cash and cash equivalents at year end	24	**6,848**	7,416

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 2013/14 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 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.

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

Assets relating to land and buildings were subject to both a formal and interim valuation during the financial year ending 31st March 2010. This resulted in significant downward movement of asset values during the period reflecting the general trend in market prices. The most recent full interim valuation performed was based on prospective market values as at 31st March 2010 and provides the most up to date professional valuation data, which has been localised for the Trust's estate. The Trust has also had formal valuations for assets transferred from "assets under the course of construction" and 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.

Provisions relating to pensions

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 35.

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. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter 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 reserve to the extent that a balance was held for that asset and thereafter to expenditure. 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 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. The trust account for lifecycle using a smoothed method where a prepayment is placed in the accounts and released to capital or revenue when works have been completed.

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 fair value. 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 1.80% (2012/13: 2.35%) 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 35 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 36.2 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 36.1, 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. for 2013/14 only, net assets and liabilities transferred from bodies which ceased to exist on the 1 April 2013
iv. 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 41 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 2013/14. The application of the standards as revised would not have a material impact on the accounts for 2013/14, were they applied in that year:

IAS 27 Separate financial statements

IAS 28 Investments in associates and joint ventures

IFRS 9 Financial instruments

IFRS 10 Consolidated financial statements

IFRS 11 Joint arrangements

IFRS 12 Disclosure of interests in other entities

IFRS 13 Fair value measurement

IPSAS 32 Service concession arrangement

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 £116,735k, including £107,697k from Clinical Commissioning Groups (CCGs), in 2012-13 the income was received from Primary Care Trusts.

	2013/14	2012/13
	£000	£000
Clinical income	**116,735**	113,275
Non clinical income	**10,839**	11,422
Pay	**(94,046)**	(90,282)
Non pay	**(33,007)**	(34,019)
Surplus /(deficit)	**521**	396

The Trust generated over 10% of income from the following organisations:

	2013/14	2012/13
	£000	£000
Southern Derbyshire CCG	**61,332**	
North Derbyshire CCG	**20,124**	
Derbyshire County PCT		64,750
Derby City PCT		43,206

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)

	2013/14	2012/13
	£000	£000
Clinical Commissioning Groups	**107,697**	0
Primary Care Trusts	**0**	112,193
Foundation Trusts	**212**	174
Local Authorities	**8,301**	389
Non-NHS Other	**525**	519
	116,735	113,275

Primary Care Trusts ceased to exist on the 31 March 2013, income previously received from these organisations is now received from Clinical Commissioning Groups, NHS England and Local Authorities.

4.2 Income from patient care activities (class)

	2013/14	2012/13
	£000	£000
Cost and volume contract income	**6,838**	7,021
Block contract income	**105,397**	102,026
Other clinical income from mandatory services	**4,500**	4,228
	116,735	113,275

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 £101m. All other income stated in the accounts is generated from non-commissioner related services.

	2013/14
	£000
Commissioner requested services	100,873
Non-commissioner requested services	26,676
Total income	**127,549**

4.4 Private patient income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no-longer required.

5. Other operating income

	2013/14	2012/13
	£000	£000
Research and development	**309**	65
Education and training	**3,997**	3,339
Staff costs	**1,884**	2,182
Reversal of impairment	**0**	1,463
Profit on disposal of land and buildings	**8**	0
Other revenue	**4,616**	4,348
	10,814	11,397

Other revenue includes:		
Estates recharges	**418**	579
PFI Land contract	**60**	242
Property Services Facilities Contract*	**432**	439
Catering	**194**	156
Property rentals	**55**	43
Pharmacy sales	**1,811**	993
Services to specialist schools	**630**	597
Other income elements	**1,016**	1,299
	4,616	4,348

***In 2012/13 this contract was held with Derby City PCT, from the 01/04/2013 this transferred to NHS Property Services Ltd when the PCT ceased to exist.**

6. Income

	2013/14	2012/13
	£000	£000
From rendering of services	**127,549**	124,672

Income from the sale of goods is Nil.

7. Operating expenses

	2013/14	2012/13
	£000	£000
Services from NHS Foundation Trusts	**2,398**	3,112
Services from other NHS bodies	**1,276**	1,247
Services from CCGs & NHS England (PCT's 2012-13)	**43**	2
Purchase of healthcare from non NHS bodies	**3,907**	2,827
Employee expenses - executive directors	**821**	909
Employee expenses - non-executive directors	**111**	123
Employee expenses - staff	**93,114**	89,250
Drug costs	**3,226**	2,482
Supplies and services - clinical (excluding drug costs)	**318**	343
Supplies and services - general	**973**	877
Establishment	**1,296**	2,242
Transport	**1794**	721
Premises	**5,585**	5,737
Rentals from operating leases	**1,816**	2,038
Increase/(decrease) provision	**308**	338
Depreciation on property, plant and equipment	**2,708**	2,372
Amortisation of intangible assets	**451**	296
Impairments of property, plant and equipment	**1,063**	2,310
Impairments of intangibles	**286**	0
Impairments of assets held for sale	**0**	241
Audit services- statutory audit	**47**	48
Other auditors remuneration - internal audit	**68**	74
Clinical negligence costs	**266**	333
Legal fees	**150**	182
Loss on sale of assets	**0**	54
Consultancy costs	**286**	733
Training, courses and conferences	**388**	740
Patient travel	**29**	20
Car parking and security	**25**	24
Redundancy	**271**	557
Hospitality	**20**	7
Insurance	**31**	31
Other services, e.g. external payroll	**380**	371
Losses, ex gratia and special payments	**10**	4
Publishing	**106**	0
Other	**230**	614
	123,801	121,259

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	2013/14	2012/13
	£000	£000
Minimum lease payments	**1,816**	1,651

The figures above include lease car payment and are reflected net, during the period the Trust has received employee contributions equating to £420k (2012-13 £387k).

Total future minimum lease payments	2013/14				2012/13
	Buildings	Land	Other	Total	Total
	£000	£000	£000	£000	£000
Payable:					
Not Later than one year	1,062	0	127	1,189	1,825
Between one and five years	3,763	0	745	4,508	4,788
After 5 years	14,534	0	0	14,534	17,245
Total	19,359	0	872	20,231	23,858

Total future sublease payments expected to be received: £nil

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 2014			31 March 2013		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	**70,754**	**66,421**	**4,333**	69,376	67,576	1,800
Social security costs	**5,293**	**4,930**	**363**	5,106	4,788	318
Employer contributions to NHS pension Scheme	**9,234**	**8,601**	**633**	8,842	8,292	550
Other pension costs	**-**	**-**	**-**	-	-	-
Agency/contract staff	**10,104**	**-**	**10,104**	7,621	-	7,621
Termination benefits	**271**	**271**	**-**	549	549	-
Employee benefits expense	**95,656**	**80,223**	**15,433**	91,494	81,205	10,289
Of the total above:						
Charged to capital	**1,450**			786		
Employee benefits charged to revenue	**94,206**			90,708		
	95,656			91,494		

The national clinical audits and national confidential enquiries that Derbyshire Healthcare NHS Foundation Trust participated in during 2013/14 are as follows:

9.2 Average number of people employed

	31 March 2014			31 March 2013		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	**148**	**148**	**-**	135	135	-
Administration and estates	**473**	**473**	**-**	477	477	-
Healthcare assistants and other support staff	**431**	**431**	**-**	436	436	-
Nursing, midwifery and health visiting staff	**839**	**839**	**-**	800	800	-
Scientific, therapeutic and technical staff	**232**	**232**	**-**	219	219	-
Social care staff	**-**	**-**	**-**	2	2	-
Other	**233**	**-**	**233**	225	-	225
Total	**2,356**	**2,123**	**233**	2,294	2,069	225
Of the above:						
Number of whole time equivalent staff engaged on capital projects	**22**			13		

9.3 Management costs

	2013/14	2012/13
	£000	£000
Management costs	**7,517**	7,636
Income	**127,549**	124,540
Management costs as a percentage of total Trust income is	**5.89%**	6.13%

9.4 Directors' remuneration and other benefits

The aggregate of remuneration and other benefits receivable by directors from 1 April 2013 to 31 March 2014 is £932k (2012/13 £1,033k).

Included in the above costs are employer pension contributions of £100k (2012/13 £105k).

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 pension's 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, as outlined overleaf.

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 £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000	Number of departures where special payments have been made	Cost of special payment element included in exit packages £000
<£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

Reporting of other compensation schemes - exit packages 2012/13

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000	Number of other departures agreed	Cost of other departures agreed £000	Total number of exit packages	Total cost of exit packages £000	Number of departures where special payments have been made	Cost of special payment element included in exit packages £000
<£10,000	1	10	0	0	1	10	1	8
£10,001 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	3	127	0	0	3	127	0	0
£50,001 - £100,000	4	345	1	67	5	412	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	8	482	1	67	9	549	1	8

Exit packages: other (non-compulsory) departure payments – 2013/14

	2013/14 Payments agreed Number	2013/14 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	1	24
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HMT approval	0	0
Total	1	24

of which:		
non-contractual payments made to individuals where the payment value was more than 12 months' of their annual salary	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. The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. **An outline of these follows:**

a. 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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay. From 1 April 2013, the employee contributions are on a tiered scale from 5% up to 13.3% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b. Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2014, is based on detailed membership data as at 31 March 2013 (the latest midpoint) updated to 31 March 2014 with summary global member and accounting data.

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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

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.

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 statement of comprehensive income at the time the trust commits itself to the retirement, regardless of the method of payment.

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.

On 22 June 2010 the government announced in the Emergency Budget that in future the consumer Price Index (CPI) would be used to calculate the minimum pension increases for index-linked pensions rather than the Retail Price Index (RPI) that has been used to date. This change will result in a reduction of any defined benefit pension liability for FTs (or where a net pension is recognised, an increase in that asset). The UK's Urgent Issues Task Force has issued Abstract 48 on the treatment of this gain by entities. The FT ARM has adopted this abstract and these accounts have been prepared accordingly.

11. Better Payment Practice Code

	31 March 2014		31 March 2013	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	20,502	27,552	18,978	22,858
Total Non NHS trade invoices paid within target	19,015	24,159	17,947	22,006
Percentage of Non-NHS trade invoices paid within target	93%	88%	95%	96%
Total NHS trade invoices paid in the year	1,039	12,708	1,107	13,187
Total NHS trade invoices paid within target	779	9,759	952	11,042
Percentage of NHS trade invoices paid within target	75%	77%	86%	84%

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 £25k (2012/13 £25k).

14. Other gains and losses

The Trust made no other gains or losses during the period of account.

15. Finance costs

	2013/14	2012/13
	£000	£000
Finance lease costs	168	132
Interest on obligations under PFI contracts:		
- main finance cost	1,077	1,101
- contingent finance cost	726	705
Total interest expense	1,803	1,938
Other finance costs	111	0
Total	2,082	1,938

16. Plant and equipment

2013/14	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 1 April 2013 - Restated	12,390	62,559	1,737	1,756	251	7,763	1,927	88,383
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	**12,390**	**68,983**	**801**	**1,650**	**108**	**6,245**	**1,949**	**92,126**
Depreciation								
At 1 April 2013	0	5,532	240	1,088	198	6,879	1,049	14,986
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	**12,390**	**60,492**	**785**	**523**	**36**	**909**	**922**	**76,057**
Net book value	£000	£000	£000	£000	£000	£000	£000	£000
Owned	12,390	25,939	785	523	36	909	922	41,504
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	**12,390**	**60,492**	**785**	**523**	**36**	**909**	**922**	**76,057**

A desktop valuation review was undertaken in 2012/13 by the district valuer on the buildings owned by the trust. In 2013/14 it was found that the PFI had been undervalued by £4,288k, which has led to a Prior Period Adjustment in the accounts. The accounting statements and Note 16 in 2012/13 have been restated to show this adjustment, as if it had shown in the accounts last year. This has changed the opening balances for cost and valuation in the above table. Details of the adjustment are provided in Note 43.

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 1 April 2013	**8,753**	**11,071**	**11**	**0**	**1**	**20**	**19,856**
Movements	0	4,334	0	0	0	0	4,334
At 31 March 2014	**8,753**	**15,405**	**11**	**0**	**1**	**20**	**24,190**

16.2 Property, plant and equipment - Restated

	Land	Buildings excluding dwellings	Assets under construction (AUC)	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2012/13	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:								
At 1 April 2012	12,630	59,361	1,006	2,029	251	9,775	2,002	**87,054**
Prior year adjustment	0	(3,403)	0	0	0	0	0	**(3,403)**
Additions purchased	0	1,141	1,735	0	0	298	25	**3,199**
Additions leased	0	1,375	0	0	0	0	0	**1,375**
Impairments	0	(489)	0	0	0	0	0	**(489)**
Reclassifications	0	69	(1,004)	27	0	65	86	**(757)**
Revaluations1 - Restated	0	5,043	0	0	0	0	0	**5,043**
Transferred to disposal group as asset held for sale	(240)	(453)	0	0	0	0	0	**(693)**
Disposals	0	(85)	0	(300)	0	(2,375)	(186)	**(2,946)**
At 31 March 2013	12,390	62,559	1,737	1,756	251	7,763	1,927	**88,383**
Depreciation								
At 1 April 2012	0	6,722	35	1,220	183	8,916	1,040	**18,116**
Prior year adjustment	0	(3,403)	0	0	0	0	0	**(3,403)**
Provided during the year	0	1,679	0	152	15	338	188	**2,372**
Impairments	0	2,082	205	16	0	0	7	**2,310**
Reversal of impairments	0	(1,463)	0	0	0	0	0	**(1,463)**
Disposals	0	(85)	0	(300)	0	(2,375)	(186)	**(2,946)**
At 31 March 2013	0	5,532	240	1,088	198	6,879	1,049	**14,986**
Net book value at 31 March 2013	12,390	57,027	1,497	668	53	884	878	**73,397**
Net book value	£000	£000	£000	£000	£000	£000	£000	£000
Owned	12,390	23,811	1,497	668	53	884	878	40,181
Finance lease	0	1,538	0	0	0	0	0	1,538
PFI	0	31,678	0	0	0	0	0	31,678
Total at 31 March 2013	12,390	57,027	1,497	668	53	884	878	73,397

[1]The revaluations figure above has been restated to £5,043k from £755k. This has impacted on the cost and valuation at 31 March 2013, and the net book value at 31 March 2013. See below and Note 43 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 2012	8,788	6,875	12	0	1	22	15,698
Movements	(35)	4,196	(1)	0	0	(2)	4,158
At 31 March 2013	**8,753**	**11,071**	**11**	**0**	**1**	**20**	**19,856**

The above note has been restated due to the prior period adjustment detailed in note 16.2. More detail is provided in Note 43.

16.4 Valuation

Assets relating to land and buildings have been valued during the period as follows:

The trusts last full valuation was performed as at 31 March 2010 and was based on prospective market values. In the interim years an indexation factor has been applied to the assets values using the BICS indices which are supplied by DVS Property Specialists. The exception was 2012/13 when DVS Property Specialists were commissioned to undertake a desktop review . Assets have been valued at market value for land and non-specialised buildings or at depreciated replacement cost for specialised buildings.

In 2013/14 indexation has been applied to the Trust's owned buildings and this has led to an increase in value of £4,194k, approximately 8% of the value.

A desktop review of the Radbourne Unit was also undertaken in year as work was completed to convert office space into a ward, this led to an overall reduction in value of £635k following indexation.

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	1	93
Buildings excluding dwellings	1	93
Assets under construction & POA	1	93
Plant and machinery	1	20
Transport equipment	7	7
Information technology	2	15
Furniture and fittings	1	25

16.6 Property plant and equipment: commissioner requested services

One building has been sold in year which commissioner related 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 related service has not been affected through the disposal of this property. This property had been declared surplus in 2012/13. The property was sold for £105k and had a NBV of £95k, Note 5 shows a profit of £8k, the £2k adjustment relates to legal fees of the sale.

17. Intangible assets

	Software Licences (Purchased)	Information Technology (Internally Generated)	Assets under Construction (AUC)	Total
Cost or valuation:	**£000**	**£000**	**£000**	**£000**
At 1 April 2013	150	2,727	945	3,822
Additions Purchased	204	52	2,196	2,452
Reclassifications – AUC	127	313	(440)	0
Reclassifications -Other	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 – Other	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**
Cost or valuation:				
At 1 April 2012	134	2,276	0	2,410
Additions purchased	0	192	572	764
Reclassifications	16	368	373	757
Disposals	0	(109)	0	(109)
At 31 March 2013	**150**	**2,727**	**945**	**3,822**
Amortisation				
At 1 April 2012	28	1,391	0	1,419
Provided during the year	27	269	0	296
Disposals	0	(109)	0	(109)
At 31 March 2013	55	1,551	0	1,606
Net book value at 31 March 2013	95	1,176	945	2,216
Net book value				
Owned	95	1,176	945	2,216
Total at 31 March 2013	95	1,176	945	2,216

All intangible assets both those internally developed and purchased have an economic life of five 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 £1,349k, all have been charged to income and expenditure.

	2013/14	2012/13
	£000	£000
Impairments for land and buildings classified as held for sale	**0**	241
Impairments for property, plant and equipment	**1,063**	2,799
Reversal of impairment on property, plant and equipment	**0**	(1,463)
Impairments for intangibles	**286**	0
	1,349	1,577

19. Commitments

19.1 Capital commitments

The trust does not have any capital commitments as at 31 March 2014.

20. Inventories

20.1 Inventories

	2013/14	2012/13
	£000	£000
Finished goods	**172**	187
Total	**172**	187
Of which held at net realisable value:	**0**	0

20.2 Inventories recognised in expenses

	2013/14	2012/13
	£000	£000
Inventories recognised as an expense in the period	**2,583**	2,490
Total	**2,583**	2,490

21. Trade and other receivables

21.1 Trade and other receivables

	Current	Non-current	Current	Non-current
	2013/14	2013/14	2012/13	2012/13
	£000	£000	£000	£000
NHS receivables-revenue	**1,809**	**0**	1,575	0
Related party receivables	**1,415**	**0**	143	0
Provision for the impairment of receivables	**(306)**	**0**	(122)	0
Prepayments and accrued income	**811**	**1,364**	368	1,095
VAT receivables	**162**	**0**	17	0
Other receivables	**677**	**0**	1,037	0
Total	**4,568**	**1,364**	3,018	1,095

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

	2013/14	2012/13
	£000	£000
By up to three months	**2,290**	1,793
By three to six months	**26**	0
By more than six months	**104**	218
Total	**2,420**	2,011

21.3 Provision for impairment of receivables

	2013/14	2012/13
	£000	£000
Opening balance	**(122)**	(89)
Amount Utilised	**38**	9
(Increase)/decrease in receivables impaired	**(222)**	(42)
Balance at 31 March	**(306)**	(122)

22. Other financial assets

There are no other financial assets as at 31st March 2014.

23. Other current assets

There are no other current assets as at 31st March 2014.

24. Cash and cash equivalents

	31 March 2014	31 March 2013
	£000	£000
Balance at 31 March	**7,416**	7,192
Net change in period	**(568)**	224
Balance at period end	**6,848**	7,416
Made up of		
Cash with Government banking services	**6,814**	7,383
Commercial banks and cash in hand	**34**	33
Cash and cash equivalents as in statement of cash flows	**6,848**	7,416

25. Non-current assets held for sale

	Land	Buildings	Other property, plant and equipment	Intangible assets	Total
	£000	£000	£000	£000	£000
Balance at 31 March 2013	125	136	0	0	**261**
Less assets sold in the year	(45)	(50)	0	0	**(95)**
Balance at 31 March 2014	80	86	0	0	**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.

During the period one of the buildings held for sale has been has been sold with a small profit of £8k. Two buildings remain held for sale.

26. Trade and other payables

	Current	Non-current	Current	Non-current
	2013/14	2013/14	2012/13	2012/13
	£000	£000	£000	£000
NHS payables	**3,151**	**0**	1,810	0
Trade payables - capital	**228**	**0**	338	0
Other trade payables	**3,119**	**0**	1,272	0
Payables with related parties	**586**	**0**	0	0
Other payables	**1,347**	**0**	2,216	0
Social Security costs	**829**	**0**	823	0
Accruals	**1,546**	**0**	2,173	0
Total	**10,806**	**0**	8,632	0

Other payables include:
£1,250k outstanding pensions contributions at 31 March 2014 (31 March 2013 £1,119k). These were paid in April 2014.

27. Borrowings

	Current	Non-current	Current	Non-current
	2013/14	2013/14	2012/13	2012/13
	£000	£000	£000	£000
Finance lease	**19**	**1,621**	17	1,490
PFI liabilities	**745**	**28,817**	718	29,561
Total	**764**	**30,438**	735	31,051

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 Andrew's House, the contract is due to expire during 2037, and Dale Bank View, this lease is due to expire during 2027.

28. Other liabilities

	Current 2013/14 £000	Current 2012/13 £000
Deferred income	**494**	747
	494	747

The Trust has no other liabilities.

29. Prudential borrowing limit

The prudential borrowing limit requirements in section 41 of the NHS Act 2006 have been repealed by the Health and Social Care Act 2012, the financial statement disclosures outlined in this act are no longer required.

The continuity of service risk ratings which replaced the previous financial ratios are published in the annual report.

30. Finance lease obligations

The Trust has two finance leases, these are St Andrew's House in Derby which is used to provide clinical and admin service and Dale Bank View at Swadlincote which also provides clinical services.

Details of the lease charges are below:

	2013/14 £000	2012/13 £000
Not later than one year	205	134
Later than one year, not later than five years	818	706
Later than five years	3,367	3,031
Sub total	4,390	3,871
Less: interest element	(2,750)	(2,364)
Total	1,640	1,507

31. Finance lease receivables

The Trust does not have any finance lease arrangements as a lessor.

32. Finance lease commitments

The Trust has two finance leases and is committed to paying the following.

	2013/14 £000	2012/13 £000
Not later than one year	**205**	134
Later than one year, not later than five years	**818**	706
Later than five years	**3,367**	3,031
Total	**4,390**	3,871

33. Private Finance Initiative contracts

33.1 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:

	2013/14 £000	2012/13 £000
Not later than one year	**1,795**	1,795
Later than one year, not later than five years	**7,178**	7,178
Later than five years	**36,057**	37,851
Sub total	**45,030**	46,824
Less: interest element	**(15,468)**	(16,545)
Total	**29,562**	30,279

The obligations relating to the PFI contracts are an estimate based on a series of assumptions with regard to imputed finance lease charges. The obligations set out above are based on our estimation of the imputed finance lease charges and the work of our advisors. The actual obligation may vary from our estimate. We consider that the possible range is as follows:

	Range	
	£000	£000
Not later than one year	1,795	2,360
Later than one year, not later than five years	7,178	8,906
Later than five years	36,057	40,203
Sub total	45,030	51,475
Less: interest element	(15,468)	(22,154)
Total	29,562	29,321

33.2 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 £897k (prior year £905k).

At present value the trust is committed to the following charges:

	2013/14	2012/13
	£000	£000
Not later than one year	904	872
Later than one year, not later than five years	3,661	3,530
Later than five years	19,382	19,672
Total	23,947	24,074

The Trusts PFI model is updated for inflation each year, the 2013/14 figures below shows the trusts commitments if a 2.5% RPI increase is applied each year (the 2012/13 comparative assumed 3.7%):

	2013/14	2012/13
	£000	£000
Not later than one year	927	905
Later than one year, not later than five years	3,993	4,018
Later than five years	28,818	36,467
Total	33,738	41,390

33.3 Future unitary payments

The table below shows the Trusts total commitments for the PFI scheme until 2039.

	Within 1 year	2-5 Years	Over 5 years	Total
	£000	£000	£000	£000
Operating costs	927	3,993	28,818	**33,738**
Financing expenses	1,835	7,676	47,555	**57,066**
Capital repayments	744	3,254	25,563	**29,561**
Lifecycle costs	370	1,573	10,748	**12,691**
Total	**3,876**	**16,496**	**112,684**	**133,056**

34. Other financial liabilities

The Trust has no other financial liabilities.

35. Provisions

	Current	Non-current	Current	Non-current
	2013/14	2013/14	2012/13	2012/13
	£000	£000	£000	£000
Pensions relating to other staff	**185**	**2,534**	179	2,473
Legal claims	**66**	**0**	211	0
Redundancy	**454**	**0**	815	0
Other	**115**	**0**	373	0
Total	**820**	**2,534**	1,578	2,473

	Pensions relating to other staff	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000
At 1 March 2013	2,652	211	815	373	4,051
Arising during the period	110	77	177	120	484
Change in discount rate	148	0	0	0	148
Used during the period	(184)	(176)	(458)	(300)	(1,118)
Reversed unused	(68)	(46)	(80)	(78)	(272)
Unwinding of discount	61	0	0	0	61
At 31 March 2014	2,719	66	454	115	3,354
Expected timing of cash flows:					
Within one year	185	66	454	115	820
Between one and five years	738	0	0	0	738
After five years	1,796	0	0	0	1,796
	2,719	**66**	**454**	**115**	**3,354**

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 are employee related claims.

£399k is included in the provisions of the NHS Litigation Authority at 31/3/2014 in respect of clinical negligence liabilities of the trust (31/03/2013 £153k).

36. Contingencies

36.1 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.

36.2 Contingent assets

The Trust has no contingent assets in either period.

37. Financial instruments

37.1 Financial assets

	2013/14	2012/13
	Loans and receivables	Loans and receivables
	£000	£000
Trade receivables	**3,895**	2,755
Cash at bank and in hand	**6,848**	7,416
Total at 31 March	**10,743**	10,171

37.2 Financial liabilities

	2013/14	2012/13
	Other	Other
	£000	£000
Trade payables	**8,203**	5,219
PFI and finance lease obligations	**31,202**	31,786
Total at 31 March	**39,405**	37,005

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. Financial close for the PFI was in 2009 and the SWAP rates as at the 31 March 2014 are slightly higher than in the financial model, based on these rates, the Trust would not consider re-financing the PFI scheme, therefore the fair value is not materially different to the carrying value.

37.3 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.

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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 2014 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.

38. Events after the reporting period

There were no post balance sheet events for the period ending 31 March 2014.

39. 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).

	2013/14	2012/13
External audit fees	£000	£000
Statutory audit services	46	48
Non statutory audit fees		
Internal audit services	68	56
Counter fraud	18	18
Total	86	74

40. 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
2013/14	£000	£000	£000	£000
Related parties with other NHS bodies	115,538	11,690	2,155	2,887
2012/13				
Related parties with other NHS bodies	119,688	9,003	1,575	2,352

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:

South Derbyshire Clinical Commissioning Group
North Derbyshire Clinical Commissioning Group
Hardwick Clinical Commissioning Group
Erewash Clinical Commissioning Group
Derby Hospitals NHS Foundation Trust
Derbyshire Community Health Services NHS 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 were transferred to Derbyshire Community Health Services NHS Trust.

The Register of Interests is available from the legal department.

41. Third party assets

The Trust held £113k cash and cash equivalents at 31 March 2014 (£124k 31 March 2013) 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 administer deposit accounts on behalf of the patients. These are held in external accounts in the patients names at a value of £27k.

42. Losses and special payments

There were 34 cases of losses and special payments worth £62k (2012/13 - there were 24 cases totalling £29k).

	2013/14 Total number of cases	2013/14 Total value of cases	2012/13 Total number of cases	2012/13 Total value of cases
	Number	£000's	Number	£000's
Cash losses	**2**	**0**	2	0
Bad debts and claims abandoned	**8**	**11**	0	0
Special payments				
- compensation payments	**15**	**50**	11	26
- ex gratia payments	**9**	**1**	11	3
	34	**62**	24	29

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.

43. Prior period adjustment – restated statements and notes

There has been a restatement of the 2012/13 accounts and notes for a change in property values.

A desktop review was undertaken in 2012/13 by the district valuer on the buildings owned by the Trust. In 2013/14 it was found that the PFI had been undervalued by £4,288k, which has led to a prior period adjustment in the accounts.

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 £4,288k for the change in value.

	Original Value	Restated Value
	£000	£000
SOCI – Other comprehensive income	264	4,552
SOFP – Property plant and equipment	69,109	73,397
SOFP – Revaluation reserve	15,568	19,856
SoCTE 13.14 – Opening balance on revaluation reserve	15,568	19,856
SoCTE 12.13 – Revaluations adjusted	755	5,043
Note 16 – Opening balance on buildings	52,739	57,027
Note 16.1 – Opening balance of buildings revaluation reserve	6,783	11,071
Note 16.2 – Revaluations in cost	755	5,043
Note 16.3 – Movements in buildings revaluation reserve	(92)	4,196

To obtain further copies of this Annual Report please contact **communications@derbyshcft.nhs.uk** or visit **www.derbyshirehealthcareft.nhs.uk**

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