Derbyshire Healthcare NHS
NHS Foundation Trust

Operational Plan 2016/17

April 2016

Better together

Approach to activity planning

We acknowledge that demand for our mental health and learning disability (LD) services are growing and that, in order to meet this demand, large-scale transformation and investment is required.

Our most significant areas of growth in demand have been for Improving Access to Psychological Therapies (IAPT), adult mental health and LD services. We continue to experience sustained high levels of demand for our inpatient beds which, despite every effort to minimise where possible, has had a resulting impact on the number of out of area placements for our patients.

The Trust has already undertaken significant transformation of services to meet these levels of demand. We intend to continue along this transformation journey, aligned to the development of the Derbyshire health and care system's Sustainability and Transformation Plan (STP), to deliver both a neighbourhood and campus model of care which delivers the most effective services.

Given the significance of the transformation programme, the Trust Board wanted to ensure that our plans and assumptions were rigorously and independently tested. A company called Sim:pathy were commissioned to carry out independent simulation modelling of the assumptions within the programme, to give this assurance. A number of key questions have been addressed through this process, including:

- How robust are the current plans and assumptions as to how many inpatient beds should be provided for local people with mental health problems?
- How robust are the current plans and assumptions as to how community services should be configured to deliver the right pathways for each care cluster?
- What mix of staffing and skills are required to provide optimal services within available resources?
- What level of services is required to manage the impact of demographic change?
- Will our planned and proposed model of care be deliverable in practice?

During quarter 4 of 2014/15, Sim:pathy, through use of simulation modelling, confirmed that the new neighbourhood model will be more effective than the system we have now. In addition, they have also confirmed that, when applying the resource reductions expected in future years, the neighbourhood model still works better than the current system.

However, despite the significant transformation of services to meet demand, there remains capacity issues associated with either the increase in demand or historic underinvestment across many services, the most substantial of which is within community mental health services.

We are jointly addressing the assessed shortfall in capacity and associated investment required in community resources with commissioners. We are working with commissioners to balance this need with the growing demand for other services, ensuring we mitigate the clinical risks this may pose.

Over the past year, many of our services have been going through a process of transformation to move to a neighbourhood model which has necessarily impacted upon speed of recruitment and will have impacted on short-term capacity. This is currently being addressed and we expect this to be resolved during 2016/17.

We produce activity reports on a monthly basis and share these with commissioners discussing any changes in demand and activity. Activity targets are then only changed following Contract Variations to reflect any agreed changes in service delivery. When we agree service developments, associated activity implications are agreed and reflected in the plan. We have established a joint working group with commissioners to review the activity targets in light of proposed changes to contracting and payment models for 2017/18.

Negotiations with commissioners with respect to the new national access standards have been positive and the Trust is working with commissioners to establish the funding allocation to support the changes required to deliver the step-change in access times and treatment choices. The process of adapting to these changes will be tightly governed by the Trust's operational management teams and progress will be monitored through a clear line of sight to the Trust Board.

Approach to quality planning

Approach to quality improvement

The quality standards for patient services are built into our organisational quality framework and our organisation has fully embraced the NHS Constitution and the fundamental standards of quality and safety published by Care Quality Commission (CQC). These quality standards continue to define the expectations of our services and during our clinical and corporate Board, governor and commissioners visits these are the standards against which services showcase their clinical and service innovations.

Our Trust has defined its quality priorities, and these are connected to the needs of the local population and also reflect national priorities. Our Quality Priorities for 2016-2017 are:

1. **Physical healthcare** – this continues into its third year in order to embed sustained change and focus on the mortality gap of those with severe and enduring mental ill health. This is in part due to the number of deaths we have due to physical health and long term conditions. It will include baseline measures, service improvement plan and clinical audit.
2. **Preventing suicide** – through patient safety planning. Although our Trust has a lower than national average suicide rate of individuals open to our services, our community suicide rate is rising and we need to support the wider system in their endeavours. The leading cause of death in some key age profiles is suicide and therefore we continue to see suicide prevention to be a key priority.
3. **Positive and Safe**, formally known as Force Free Futures – reducing the use of restrictive practice in services. Our service receiver community groups have fedback that they would like to see continued and on-going reductions in seclusion and restrictive practices. We believe this is a key component of a contemporary health service.
4. **Think! Family** – working with the whole family and co-ordinating all aspects of support to address their full needs, is a learning action from a serious case review. Although we have made significant progress in key areas such as Substance Misuse, we want to fully embed this work in every aspect of our Trust.
5. To become and embed our Trust as **a person centred and recovery-focused organisation** – through our neighbourhood model of delivering community services to develop our new models of care and self-care, shared care and drawing upon clinical models such as Patient Activation Measures (PAM - Kings fund/ copyright of Insignia) to embed individualised personalised care.

We revise and review these priorities annually in partnership with our senior clinical leaders and through our Quality Assurance Group with commissioners to ensure our work is defined by the needs of the system and the population. This will inform the key areas of work for the Quality Committee and its sub groups. These priorities are reflected and measured within our Commissioning for Quality and Innovation (CQUINs) and internal key performance indicators (KPIs),

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

a) In mental health, access targets for first episode psychosis, which also include requirements for ageless service and NICE-informed interventions which we will be embedding in 2016.
b) Individualised personalised care which has been developed in a collaborative manner will be present for all of our service receivers, community service receivers and families in our care. There is still room for improvement in this area and this will be a key quality priority until we get it right in 2016. This will be evidenced in our in-patient survey, community survey, CQC Mental Health action visit reports and service receiver experience feedback and monitored by our quality committee.

We will strengthen Clinical Leadership, Clinical ownership of Clinical performance management through a golden thread of quality running from the Board to the service areas. We do this to enable the strength of all of our staff's clinical voices working towards quality improvements, transparency in Patient Safety in every aspect of care that we provide and in everything that we do. It will be demonstrated through an effective Quality Committee, Quality Leadership Team (QLT) and Clinical Reference Groups through their work plans, ownership and demonstrable impact on key clinical priorities. This year we will be putting in place a Governance Monitoring Group which will be chaired by an executive director and will monitor the quality priorities and performance of the QLT against quality priorities and a clinical performance dashboard. This will be the same key information which will be used to triangulate information in our new Board Integrated Performance Report, which will be critical in our work to improve the quality of care and enhance productivity.

Our Quality Committee sets the strategy and oversight of our clinical assurance systems in all aspects of quality. This year we are introducing our clinical dashboards for our Campus and Neighbourhood services to enable live tracking of our clinical performance against our quality priorities and CQUINs. This work will be completed in the first quarter of 2016/2017 with refinement of measures throughout the year.

Our Safeguarding Committee sets the strategy and oversight of our safeguarding assurance systems for our Trust and community. There are significant challenges related to historical sexual abuse, child sexual exploitation, domestic violence, significant levels of familial sexual abuse and community cohesion and radicalisation. The Trust has a role to play in addressing and tackling these issues going forward.

Our Mental Health Act Committee sets the strategy and oversight of all of our mental health and capacity legislation and working within our legal requirements. The committee monitors our performance in the use of the Mental Health Act and Deprivation of Liberty and are closely monitoring our full implementation and progress of embedding the new code of practice changes into policy and practice.

Our named executive leads are Carolyn Green, Executive Director of Nursing and Patient Experience, and Dr John Sykes, Medical Director.

Our number one key clinical risk remains community capacity and overall capacity outstripping demand. This is as a result of historic underinvestment in mental health

services. This is a risk that is jointly owned with commissioners. Some investment in community capacity has been agreed for 2016/2017 and this will go some way to addressing the identified risk. Further mitigation is in place via our new clinical dashboards that will monitor caseload, serious incidents and complaints for the Board.

The national suicide rate has been increasing significantly since 2006 particularly in middle aged men. This is likely to be linked to economic factors often compounded by social isolation with alcohol or substance misuse representing a "final pathway". We have seen these trends replicated in our patient population. The Trust has no more suicides than other similar organisations but the problem is increasing in Derbyshire as elsewhere in the country. We therefore need to do everything possible to address this public health concern with our partners and the people of Derbyshire and this remains a key priority for the Trust and in April 2016 we hope to ratify our Suicide prevention strategy and embed this in the year and measure our performance against it.

The Trust will be participating in the annual publication of avoidable deaths per trust. The Trust has reviewed its death reporting, analysis and learning systems in January 2016 in light of the Southern Health / MAZARS report. . At this time we are confident in our current process, family liaison service and that the Board has significant oversight of patient safety agenda and analysis of our performance in this area. Any additional national requirements from this will be embedded across our organisation.

We are carefully monitoring all of our death rates and specifically our physical health care rates and sudden death rates. We are awaiting our new scorecard from the national homicide and suicide enquiry, to enable the Trust to benchmark its performance. The Trust has above average compliance with data submissions and a culture of learning in this area and this year we will be embedding our new Adult Death Overview Panel (ADOP). ADOP will undertake mortality analysis and review benchmarking data on our performance. We continue to have a strong focus upon physical health care, our pharmacological interventions, deaths relation to new and novel psychoactive substances, smoking cessation until we understand our physical healthcare deaths fully in line with our public health and population data for Derby city and Derbyshire where our communities have a worse than national average mortality rate.
The Trust is compliant with the recommendations of the Academy of Medical Royal Colleges and Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients.

The Trust is revisiting its organisation-wide improvement methodology, as part of the Trust strategy redesign. At this time our approach is continued learning from serious untoward incidents, complaints and focusing on errors to reduce clinical variation. We are exploring a redefined model of analysis of both service failures and our quality visit programmes where services showcase good practice. We plan to add in a clinical good practice compendium approach to analyse clinical success, the contributing factors and model the organisational and cultural factors that created the environment for success. We believe this work, redefining and redeveloping our clinical leadership teams, are the keys to effectiveness in managing our quality and safety, wherever possible, within the financial envelope available.

Seven day services

We are currently working with NHS England to understand how we can meet our requirements for seven day services beyond the mental health liaison services that we currently provide within the two acute hospital trusts in Derbyshire. Whilst the initial focus of seven day services remains concentrated on acute services (to which our liaison services contribute), we have already entered into discussions with NHS England about the potential impact on our services in the system wide move to availability of seven day services.

Quality impact assessment process

The key components to our quality review of potential cost improvement schemes are as follows:

- The Project teams are responsible for considering quality and ensuring it is appropriately monitored and recorded. Following an initial assessment of potential quality impact, reviews of quality are mandatory at 3, 6 and 12 months following implementation.
- Our Cost Improvement Programme (CIP) is underpinned by a Quality Impact Assessment (QIA) process. Each project with a potential clinical impact identifies a Quality Lead with responsibility for ensuring quality is properly assessed. This provides a framework through which quality can be addressed across the projects, including provision of training and support, and linking to the Programme Assurance Board (PAB).
- The PAB has responsibility for monthly consideration of reports on issues affecting time, finance or quality for projects, and initiating necessary action. This is the focal point where quality risks are monitored and issues raised.
- The process also includes an Escalation Exception Group (EEG), a sub group of PAB, that explore in more detail projects where there are important issues including those affecting quality that are difficult to resolve.

All clinical projects with a potential adverse quality impact are referred to a panel consisting of at least the Medical Director and Director of Nursing to review and mitigate any potential risks. If a project does not meet approval by the panel, the project team are required to review the scheme and seek alternative proposals.

Triangulation of indicators

To better enable the triangulation of indicators at a Trust Board level, the Trust has recently developed an integrated performance report which includes finance, operational, quality and workforce information to ensure that balanced and informed decisions are made around service related issues discussed at the Board.

The Trust is focusing on quality interventions in our Quality Strategy. Some work in 2014 and 2015 has seen some early returns in our analysis of our inpatient survey with significant improvement in our results. Our focus has been on clinical evidence such as restrictive practices, research led mental health, safe wards and clinical interventions. We will continue to focus on these areas to embed a culture of continuous reflection, learning and service improvement. Our early impressions of our improvements are a combination of Safewards, safer staffing levels, clinical stability both in nursing and in in-patient Psychiatry

which we will continue to roll out across all services and measure our progress through baseline measures and post project reviews of impact on patient experience and quality measures.

Approach to workforce planning

The shift in delivery model away from traditional individual mental health teams to one of shared ownership for a population area under the neighbourhood model will require the following high level movements in workforce profile and skill mix:

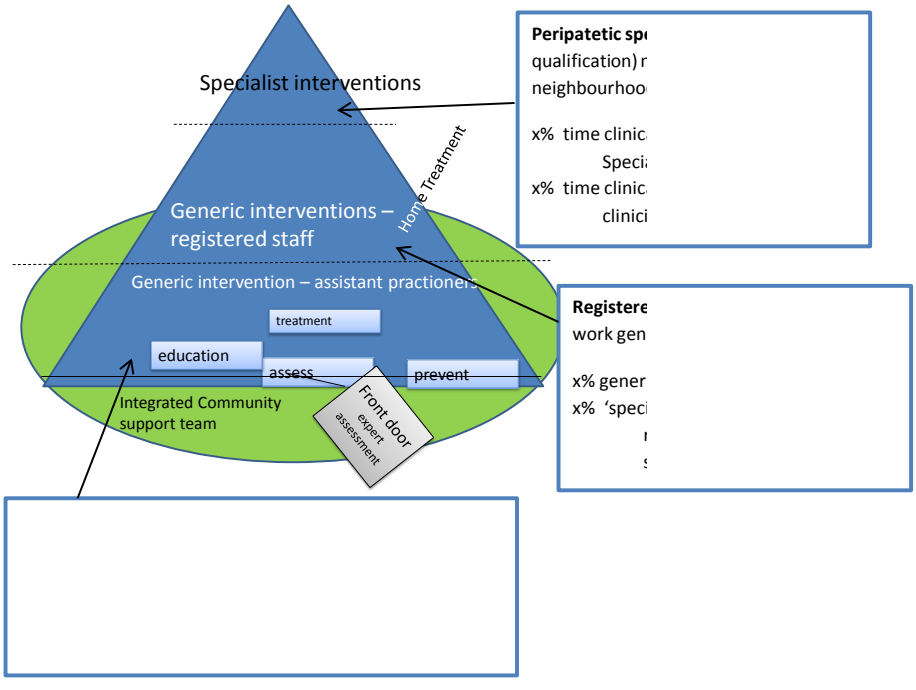
- Reduction in the amount of in-patient specialist staff and a growth in staff skilled in working in the community
- Increased number of staff with a wider skill-set to deliver more holistic interventions in both symptom and social recovery
- Increased number of other support staff and assistant practitioners with the ideal skill set to be used to meet key aspects of social recovery
- Increased number of peer support workers with a lived experience of ill health
- Increased volunteers used appropriately
- An increase in staff with the skill set to work across organisational boundaries
- Changes to move away from traditional working patterns for senior clinical leaders such as consultants – for example the start of seven-day working.

The neighbourhood service will have a workforce skilled in the delivery of interventions that have a sound evidence base in treating and supporting patients in their recovery, as well as reducing their likelihood to relapse. For patients not requiring ongoing secondary services, there is a need to work closely with GPs and voluntary sector providers to support their independence. Staff within the neighbourhood service will work alongside GPs to support this transition of care between secondary and primary care services for people with stable mental health needs.

Workforce changes

It is proposed that each neighbourhood will have three tiers of trained, skilled staff within it to deliver care as required to meet their mental health needs. We will be working towards embedding this during 2016/2017. This is indicated below:

Proposed workforce reconfiguration to support neighbourhood team development



The Trust has mapped across National Tariff Payment System (NTPS) data set information, activity and financial data, NICE guidance, Sim:pathy outputs and information pertaining to the levels of intervention within a Neighbourhood. From this we have been able to derive a workforce profile for each Neighbourhood. All teams have been asked to use the internal capacity calculating tool to determine a localised workforce picture for each Neighbourhood based on working practices

The demand and capacity modelling tool (WorkPro) is being used to provide information for workforce and training needs planning. Utilising a mental health acuity model, based on Care clustering and a locally developed complexity escalator, WorkPro is being used to model community mental health, (neighbourhood) demand - in terms of both volume and level of complexity, - capacity and skills profile. Levels of intervention within each Neighbourhood are predicated on clinical coding to support capacity analysis.

The cluster profiles of the neighbourhoods indicate that most interventions occur in levels 2 and 3, resulting in an increase in Band 3 and Band 5 clinicians and fewer band 6 and above. The outputs from WorkPro are subject to validation with individual teams. This is as much about involvement and engagement as it is about the sense check.

It is clear from discussions within teams that capacity assumptions based upon average sickness, training and time of clinical contact need to be reflective of the Neighbourhood need.

There are a number of key risks that have been identified that relate to the operational implementation of the WorkPro model. There are appropriate mitigations in place and these are being monitored through the Trust's People and Culture Committee.

Whilst further development of WorkPro will see the tool adapted for non-mental health currency services and inpatient care, the Trust identified the need for a skill mix review of inpatient services and have adopted a service in-reach approach supporting the Senior Nurses to review their own skill mix and support their own analysis of their team requirements based upon a critique and review of the year. Using a new trust designed narrative, judgements of professional's model of skill mix review and decision making completed in 1:1 sessions with each senior nurse from each unit. This analysis considers incidents, patterns, themes, the view of the senior team, stability in team and a site visit rather than a HURST model skill mix review which is primarily a number and a spreadsheet analysis without review of the wider environmental of patient presentation factors.

The methodology used for the skill mix review was as follows:

- Benchmarking team skill data against safe staffing funded resource establishment.
- Reviewing against safer staffing monitoring data.
- Reviewing against workforce metrics including sickness absence staff turnover/use of temporary staffing.
- Interviewing each inpatient Senior Nurse using a standardised approach to collect their narrative, mapping against their team data. The team data included, safe staffing data, serious untoward Incident data, patient experience data and workforce establishment data.

As part of the review consideration has been given to the organisations' wider processes concerning safer staffing. The Trust Board receives an integrated report which includes finance, operational, quality and workforce information to ensure that balanced and informed decisions are made around service related issues.

Policies and systems are in place to enable staffing establishments to be met on a shift-by-shift basis. Each inpatient area uses e –rostering and have escalation processes in place to support staffing decisions on a shift by shift basis.

The Director of Operations leads on the routine monitoring of shift by shift staffing levels. This is inclusive of temporary staffing solutions. The routine monitoring includes shift by shift reporting on planned versus actual staffing levels, datix reporting and escalation of actual levels lower than planned; regular review of temporary staff usage and actual fill rate. The Trust's Executive Leadership team reviews and signs off any shifts that do not meet agency price cap requirements but are required to maintain patient safety. Where staffing shortages are identified staff have an escalation policy and reporting structure through datix in order to provide clarity about the actions needed to mitigate problems identified.

We will continue to improve on and maintain a positive culture within operational teams to raise concerns regards staffing. Safe staffing is regularly discussed at weekly team meetings. In addition to this a monthly safe staffing meeting is held to review any identified problems, emerging difficulties or themes.

The Trust, in common with other mental health organisations, is experiencing major pressures around nurse recruitment, levels of adult acuity and demand for beds. The risks associated with these areas are being rigorously monitored as part of the internal escalation plan associated with the Trust's emergency planning processes. A detailed mitigation plan is in place supported by senior operational and clinical leaders and the situation has been under constant review. The Trust Board and Executive team are kept appraised of risks and mitigation plans.

Staffing levels, concerns around recruitment and retention and their associated impact on service capacity are included on our Trust Board Assurance Framework as a risk to the organisation. This has been subject to a deep dive review at F&P Committee to provide the Board with assurance on our approach and risk mitigations.

The Trust has recently established a project to look at resource management in terms of rostering and staffing, with the aim of delivering an implementable and safe plan which focusses towards a reduction in temporary staffing and effective rostering.

As a multispecialty provider which also includes Children's community and mental health services, we have been training staff on various therapies within the national Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme for the past few years. This is helping to develop an evidence based practice within the Child and Adolescent Mental Health Service (CAMHS). Due to the commitment involved with the

programme, we have decided that 2016/2017 will be a period of consolidation. As a result we will not be training additional staff on the CYP IAPT programme during this year.

Following a sustained period of supporting health visitor training (up to 15 students per year), we envisage a considerable reduction in health visitor trainees during 2016/17. We will continue to support trainees but the number will be significantly reduced (approx. 5 students per year).

The People Strategy update was presented to the Trust Board in May 2015 and includes a spotlight on education which demonstrates training in continuous improvement such as inter-professional practise learning, strengthening the compassionate care culture, and Maastricht hearing voices training. The Board has recognised concerns around assurance routes for educational governance because of changes to the focus of the People Forum. Whist the Trust can demonstrate examples of quality improvement we recognise we do not have a consistent methodology.

Although we have an Education Strategy in place and educational governance arrangements for compulsory training, the need for a comprehensive training approach to support new developments and transformation change is acknowledged. Furthermore, we recognise we are in the early stages of the development of a continuous improvement methodology and this needs to be fully developed and embedded throughout the organisation.

The Trust is in the process of developing a new Trust Strategy and this will be underpinned by the quality goals. Moving forward, we are aware of the need to develop a new People's Strategy, in parallel with the new Trust Strategy.

As part of our assurance to the Board regarding our workforce related risks, we have reported that we have full spend of Health Education East Midlands (HEEM). The funding has been received and has been allocated or committed to ensure full spend by year end.

Link to the emerging 'Sustainability and Transformation Plan' (STP)

Historically in Derbyshire two strategic leadership groups and associated transformation programmes have been in place to address the system-level operational and financial pressures facing the health and care economy as a whole. As a Trust we span both these groups. In the north of the County, the 21C Board is composed of North Derbyshire and Hardwick CCGs (plus local authorities and NHS providers) and, in the South of the County, the Joined Up Care Board has representation from Southern Derbyshire and Erewash CCGs (plus local authorities and NHS providers).

In response to the 'Five Year Forward View', we have been working closely with Erewash Clinical Commissioning Group (CCG), Derbyshire Community Health Services (DCHS), Erewash GP Provider Company and Derbyshire Health United after NHS England chose the Erewash area to be an Multi-specialty Community Provider(MCP) vanguard site for more integrated health services. Erewash wellbeing was one of the 29 sites across the country selected by NHS England to receive additional support as part of its national New Care Models programme. The aim is to develop an Erewash prevention team across two hubs made up of health and care professionals including GPs, advanced nurse practitioners, mental health nurses, extended care support and therapy support. It delivers services to people who do not require hospital services and can be treated for their conditions in a community setting. The Acting Chief Executive Officer (CEO) is leading one of the core work streams within the Vanguard building on the expertise and experience of the Trust in enhancing Community Resilience.

With regard to the requirement for an STP to be developed, it has been agreed that the footprint for this will be across the whole of Derbyshire. Whilst this poses risks in terms of scope of alignment of planning, this is a very positive step forwards for the Trust as a Provider who delivers services across the County. It is evidently clear that there is work to do to align current plans across 21C, Joined Up Care and Erewash Vanguard, however we are of the belief that significant progress can be made and that risks in alignment of plans can managed. A defined governance structure, 11 key principles and a programme plan for the delivery of the STP has been developed and agreed by all organisations. The essence of the approach of the emerging STP is that the health and wellbeing gap, care quality gap and the finance and efficiency gap will be closed through focus on:

- Prevention
- Right care
- Efficiency

Whilst this transition takes place, DHcFT continues to lead a number of specific developments on behalf of the wider health economy. These are focused on development of the community hubs, the significant changes around older people's mental health services, development of dementia rapid response teams and community and personal resilience.

Community Hubs are a critical element of the North Derbyshire system plan to improve how care is provided for the people of North Derbyshire. Fundamentally, the aim of the whole system plan is to keep people:

- Safe & healthy – free from crisis and exacerbation.
- At home –out of social and health care beds.
- Independent – managing with minimum support.

This is founded on building strong, vibrant communities. 'Community Hubs' is also the name of the work stream which is co-ordinating the development of the hubs. Crucially, it will link with, and be dependent upon, other work to develop joined up care services. The development of Community Hubs should be seen as a 'progressive process' that will evolve over the coming years as the needs and expectations of people develop; this is not just a one off 'project'.

We know that there is general agreement across the two Health and Wellbeing Boards (Derby City and Derbyshire County Council), in line with what has become known locally as the 'Derbyshire Health and Care Wedge', that:

- Children and families should get the best start in life
- People should enjoy good health and wellbeing
- People have aspirations and achieve their ambitions through education, training and lifelong-learning
- People in Derbyshire live in safe and sustainable communities and are protected from harm
- Sustainable economic growth for all our communities and businesses
- People can live independently and exercise control over their lives
- The resource and activity supporting acute care needs to focus equally on prevention, early detection and keeping people in their communities avoiding hospital admission wherever possible.

Specifically with regard to mental health services, the four Derbyshire CCGs are committed to:

- A reduction in the number of people in residential care, spend on registered care, and also on supporting more people to live in their own homes
- A greater emphasis on community based care to avoid the use of institutional care
- A drive towards more personalised recovery focused services, where people have greater choice and control over the support they receive
- Engagement of service users in the co-design of services
- Improved support for carers, alongside a new statutory duty to provide more support to carers, as a result of the Care Act
- To address financial hardship and unemployment as contributors to ill health and early death in people with mental health issues
- Address health choices made by people with mental health problems, especially smoking
- Support strong parenting as key to a child's future mental wellbeing throughout its life
- Better support and management for people with dementia, their families and carers.

These remain the key focus of the developing STP coupled with the outcomes of the newly released 'Five Year Forward View for Mental Health'.

Derbyshire County Council, Public Health and the four Derbyshire CCGs – Hardwick CCG, Southern Derbyshire CCG, North Derbyshire CCG, Erewash CCG – have produced a joint strategic 'direction of travel' for mental health, called the Joint Vision and Strategy for Mental Health in Derbyshire County 2014 – 2019.

The proposed strategic themes have been developed in response to key policy drivers, local consultation and engagement feedback, and the commissioning intentions of Derbyshire CCGs (NHS) and Derbyshire County Council working to a joint strategy. All commissioning intentions will meet at least one of the six themes, with a strong focus on outcomes and agreed actions for each theme. Each action will have clearly identified work streams and governance arrangements, and progress and delivery of outcomes will be monitored by the Joint Mental Health Commissioning Board.

Theme 1 - Personalisation
Theme 2 - Promotion, prevention and early intervention
Theme 3 - Enablement and recovery
Theme 4 - Social Inclusion, fair access and equity
Theme 5 - Keeping people safe from avoidable harm
Theme 6 – Integration.

Finally, the Trust is developing a new Strategy for April 2016. This will be reflective of the 'Five Year Forward View' as well as being aligned to, and supportive of, the whole system STP.

Membership and elections (NHS foundation trusts only)

We hold elections on an ongoing basis throughout the year, either when a number of vacancies arise, or annually when tenures come to an end. For 2014/2015 elections were held in Derby City West (one of two seats) and Surrounding Areas. Candidates for Chesterfield South, Erewash North, North East Derbyshire and Nursing and Allied Professions (staff) were elected unopposed. For 2015/2016 elections were held in Derby City East (one of two seats), Erewash South and Administration and Allied Support (staff). Each of these constituencies received interest from more than one candidate and members were invited to elect a chosen governor. Members of staff were invited to stand for the Nursing and Allied Professions (staff, one of two seats) seat and as one candidate stood, they were elected unopposed.

A number of methods and activities were used in order to recruit to these seats. This included targeted events within each constituency focusing on different services and therapies of interest to the local community. Each event was delivered in a community setting, by a clinician with the support of existing governors and the Chairman. The events were advertised to members in the local area, to offer service and governor information, with the opportunity to ask questions directly to the chair and fellow governors.

Elections for governor positions to cover Amber Valley North, Bolsover, Chesterfield North, Chesterfield South, Derby City East (2 seats), Erewash North, High Peak, Surrounding Areas and Nursing and Allied Professions (staff) commenced in February 2016 , with High Peak and were Nursing and Allied Professions (staff), open to election as this plan was written. Candidates for Bolsover, Chesterfield North, Derby City East (2 seats), Erewash North and Surrounding Areas were elected unopposed leaving vacancies in Amber Valley North and Chesterfield South.

Governors are actively encouraged to engage with their local community to increase governor/member contact. In 2015 a large piece of governor/public engagement activity commenced, which involved approaching all PPGs throughout Derbyshire offering a meeting between them, the Trust and their local governor. Visibility of local governors was also improved by providing a poster, with contact details, to display in surgery waiting areas. This dedicated activity led to a number of governors taking part in PPG meetings and an increase in membership across this sector. We also held our first ‘Membership Week’, coinciding with World Mental Health Day, to create a platform for governors to better engage with their members and members of the public.

All newly elected governors receive an induction, which includes presentations from the Chairman, Executive Directors and wider members of staff. In 2015 we introduced a new model of induction - the whole council and Non-Executive Directors were invited to attend an afternoon workshop to meet the new governors and brainstorm ideas surrounding working groups and membership engagement. We recently held a joint training session with two neighbouring Trusts, ‘Effective questioning of NEDs’, which was well received by the governors and also gave them the opportunity to network with other councils. Governors are also encouraged to take part in Governwell training.

More recently we have begun informal Council of Governors to NED sessions prior to each Council of Governors meeting, to improve working relationships and enhance the council's ability to hold the NEDs to account. This also supports the introduction of an additional two council meetings per year and two Board to council development days. All have been received well from the council and Board. In addition to this, a new programme of developmental training sessions have been set (subject to approval from the council) encompassing training gaps highlighted in the well-led review and feedback from governors themselves.

The governors approved the commencement of a new 'Governance Committee' in January 2016 which will meet monthly and report directly to the Council of Governors. This will be chaired by a public governor and cover issues including changes to the constitution, the governance improvement action plan and setting the Council of Governors agenda. New terms of reference for the lead governor role were agreed by the council in January and a new public governor was elected into the post in February.

The membership strategy (2014 – 2017) outlines an intention to know more about the membership of the Trust and target communication and engagement appropriately. This is supported through the use of a new membership database, which was introduced in 2015.