NHS
Derbyshire Healthcare
NHS Foundation Trust

Operational Plan 2017/19

March 2017

DHCFT @derbyshcft
www.derbyshirehealthcareft.nhs.uk

Better together

Approach to activity planning

Activity plans for 2017/18 were initially modelled at a system level as part of the Sustainability and Transformation Plan (STP) development as at month five. However, the final contract values have been refreshed and are now based on month eight forecast.

As a system, the STP plans produced provided a 'do nothing' baseline which was recognised as unaffordable. However, inherent in this is the knowledge 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. The STP work streams for mental health, children and LD take into account the levels of transformation, investment and cross boundary working that are required to meet our populations needs over the next two years and beyond. In addition to these pressures, the introduction of national access standards, which form part of the Single Oversight Framework, present further challenge for the organisation in evidencing the achievement of those standards.

Our most significant areas of growth in demand have been for Improving Access to Psychological Therapies (IAPT), adult mental health and LD services. We have seen significant growth in the numbers of service users open to our mental health and LD services over the last three years. We had until quite recently experienced high levels of demand for some inpatient services which, despite every effort to minimise where possible, has resulted in some out of area placements for our patients.. In addition we continue to work at a system level to secure additional funding for community resources, this has not yet been finalised.

The STP work streams are closely aligned to our internal strategy implementation process and are aimed at providing services at 'place' level in order to signpost people to the most appropriate service level of support. Enhanced integrated community teams are a key element of the STP to provide support as near to the service receivers home and reduce the need for a hospital admission and/or assist discharge. The aim is to lower the demand for inpatient beds where appropriate by providing additional support in the community. This work builds on our transformation programme from previous years and extends it to ensure greater synergy with key partners.

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 was previously commissioned to carry out independent simulation modelling of the assumptions within the programme, to give this assurance. A number of key areas continue to be addressed and will be incorporated into STP planning including:

- The level of acute inpatient beds to provide for local people with mental health problems
- The configuration of community services delivering the right pathways for each care cluster
- Identifying the staffing and skill mix that are required to provide optimal services within available resources
- The level of service required to manage the impact of demographic change

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, which the STP aims to address.

Application of the Department of Health (2002) Mental Health Policy Implementation Guide - Community Mental Health Teams showed that our capacity in community teams needed enhancing in order to ensure each locality is staffed to best practise national guidance around caseloads. Commissioners have partially funded this need and we continue to review commissioning gaps in community services e.g. Dialectical Behavioural Therapy and Forensic and Rehabilitation pathways. We also continue to address 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 that we mitigate the clinical risks this may pose. Reasonable caseload levels are modelled into the STP work. However, workforce supply remains an issue and more innovative approaches to skill mix are being considered.

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 the STP.

Negotiations with commissioners with respect to the new national access standards for Early Intervention Services have been implemented and the funding allocation to support the changes required to deliver the step-change in access times and treatment choices continues to be reviewed. We are currently achieving relevant constitutional and mental health standards and are forecasting that we will continue to do so in 2017/18.

Approach to quality planning

Section 1: Approach to quality improvement

The named joint executive leads for quality improvement are the Director of Nursing and the Medical Director.

Quality standards for our clinical services are based upon the Care Quality Commission (CQC) quality and safety standards, organisational clinical incidences, Trust clinical audits and national learning from other Trusts' inspections as well as our own inspections (the latest being June 2016). The quality standards for patient services are built into our organisational quality framework and we have fully embraced the NHS Constitution and the fundamental standards of quality and safety published by CQC. These quality standards continue to define the expectations of our services and are the standards against which services showcase their clinical and service innovations during our clinical and corporate Board, governor and commissioners visits. The 'Quality Visit' model will be revisited to include a compulsory compliance check by a member of the quality visit panel to test the quality governance is in place and triangulated with a newly implemented ward and community service dashboard with integrated metrics.

The Trust is redefining its accountability framework to put in place a Trust Management Team meeting, releasing time and middle clinical management capacity through a redefined accountability framework. Through embedded quality governance structures, we will ensure a clinical compliance, quality governance and improvements in performance are driven through the Trust Management Team and its reporting groups. The compliance models will be further enhanced by the achievement of full roll out of electronic patient records and a wider set of quality dashboards. The Quality Committee, Trust Management Team meeting and sub groups will monitor clinical performance targets and data validation to make sure a robust process is in place to ensure the Trust Board's oversight of the triangulated data. Data will be used to identify gaps or dips in performance from which mitigation and improvement plans will be produced to ensure the quality of care and enhance productivity against the Trusts key quality standards.

Our Governance Improvement Action Plan will be nearing completion in early 2017/18 and we will have met our improvement trajectory based upon our Well Led Review. By demonstrating a solid evidence base and strong governance architecture we will have fully mitigated the gaps identified and embedded our improvements to gain the full assurance of the Board that these lessons have been learned. Through these processes we will also rebuild the confidence of our regulators that our improvements can and will be sustained.

Section 2: Summary of the quality improvement plan (including compliance with national quality priorities)

The quality priorities have been defined in line with national quality priorities and the requirements of the STP.

We will be focusing upon our clinical competency and building upon our investment in 2016 in lean methodology and quality improvement. We have trained a number of our leaders in quality improvement and will provide additional cohorts of training. In

our existing projects, we will further embed waste reduction, quality circles and lean methodology. Our new Deputy Medical Director and Deputy Director of Nursing and Quality Governance will write a revised Quality Improvement Strategy and define measures for success. The investment in lean methodology will continue in 2017/18 and be enhanced by further initiatives through the Kings Fund learning opportunities, external service visits and benchmarking. We are investing in our middle management to increase our organisational capacity and capability. In addition we have put in place requirements in the CQC action plan for all clinical teams to have their staff undertaking clinical compliance and audits to ensure continuous improvement and a continual learning cycle.

We are 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 safe wards, safer staffing levels, clinical stability both in nursing, children's services and in inpatient psychiatry which we will continue to roll out across all services and measure our progress through baseline measures, post project reviews of impact on patient experience and quality measures.

Our quality priorities will remain in place until they are achieved; these include:

1. Physical healthcare – this continues into its third year in order to embed sustained change in our diligence in physical healthcare and to minimise diagnostic overshadowing.
2. To become a recovery-focused organisation – through our neighbourhood model of delivering community services (our internal quality standards). We will design new metrics through nationally mandated measures such as Recovering Quality of Life (ReQol) and or Patient Activation Measures (PAMs) following a trial and proof of concept audit in 2016/17. The aim is for a 20 per cent improvement year on year in its up-take and clinical performance. This is key to the Five Year Forward View, enabling patients to gain far greater control of their own care.
3. We will maintain our focus on Mental Capacity Act and Mental Health Act compliance and ensure these clinical practice and quality governance aspects are fully embedded and maintained in practice to expected regulatory standards.
4. We will complete our roll out of Electronic Patient Records (EPR) and measure its impact on improvements in clinical record keeping. This will be key to improve our compliance and data validation and reliability checks.
5. One measure of patient safety defined by the clinical divisions identified from a performance issue (reducing suicide/ reducing violence / effective children's healthcare and / or a clinical pathway identified risk).
6. Clinical outcomes as part of our NHS Standard Contract with the Clinical Commissioning Groups (CCGs) and NHS England.

We will continue to monitor our CCG contract requirements and clinical standards This will include:

- Our sign up to safety plan, focussing on reduction of suicide and violence (and service-defined needs)
- A roll out of autism awareness training across the organisation
- Our integrated performance dashboard in line with the Oversight Framework
- Sustained performance in Transforming Care and our reduction of any patient admitted without a Care and Treatment Review.
- Additional equality monitoring in quality and organisational standards.

Our plans for implementing the key national quality priorities will include our CQUINS and nationally mandated standards these are:

- NHS Staff Health and Wellbeing- through a number of health related behaviour modifications to improve the welfare of our staff. The Trust is already 'Smoke Free'.
- Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI) - Assessment and early interventions offered on lifestyle factors for people admitted with serious mental illness (SMI) through continuing the work of our Physical Healthcare Committee. This will be monitored through our performance dashboard and use of the Lester tool in our roll out of EPR.
- Improving services for people with mental health needs who present to A&E - Ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E. This is in line with improvement in capacity in our community services and the continued positive work of our effective mental health liaison teams. We will develop monitoring targets and improvement plans to support the system wherever possible.
- Transitions out of Children and Young People's Mental Health Services - To improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services into appropriate services to meet their needs. Our Quality Leadership Teams are working on this key national standard.
- Preventing ill health by risky behaviours – alcohol and tobacco. To support people to change their behaviour to reduce the risk to their health from alcohol and tobacco, through our smoke free improvement plan and our new integrated Alcohol and Substance misuse services.

We will ensure that we are compliant with our quality standards and are monitoring all aspects of anti-microbial resistance, maintain our strong performance in infection prevention and control, reduce falls and maintain our falls prevention work, contribute to identification and prevention of sepsis, maintain our strong performance in effective management of imported pressure ulcers and low incidence of hospital acquired pressure ulcers and maintain our good performance in patient experience and the 'Good' rating for 'Caring' by our quality regulators.

We will contribute towards the Derbyshire system's developments, actively engaging our clinicians in design, quality monitoring and clinical delivery. We will be enabling

teams through our neighbourhood and integrated care developments to see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases. The proposals are designed to enhance community services, reduce relapse rates (and therefore the need for hospital beds), provide an improved patient experience and create greater flexibility to meet future challenges undertaking this work safely building upon our successful developments in Child and Adolescent Mental Health Services (CAMHS) Rapid Intervention, Support and Empowerment (RISE) and our Dementia Rapid Response Team.

In addition, our immediate focus for 2017 will be ensuring that any residual improvements from our CQC comprehensive inspection action plan, our warning notice and enforcement action are fully implemented with the aim of lifting our Trust from 'requires improvement' to a 'good' rating Our key capital investments for ligature reduction and rebuilt seclusion suites for the Kedleston unit will be completed. The Quality Committee and Trust Management Team will maintain a strong grip on the significant headway made in 2016, in line with required actions.

We have further learning to ensure both our patient and staff equalities data is in line with contemporary practice in this area and we will ensure we make significant improvement in a joined up approach to our workforce and clinical equalities requirements.

Section 3: Summary of quality impact assessment (QIA) process

Quality governance and developments are subject to our programme assurance monitoring systems through project vision, which include checks and balances on quality impact assessments. These are scrutinised both at a service line, division and Trust wide level through a quality impact assessment panel, led by the Medical and Nursing Director, to ensure a helicopter view of risks and how these accumulated schemes or pressures could adversely affect the quality of care.

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 three, six and 12 months following implementation.
- Our Cost Improvement Programme (CIP) is underpinned by a 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. This includes adapting programmes, ceasing projects and offering alternative models or solutions if the collective schemes are either too restrictive, not dynamic enough and or not measuring the full and accumulative clinical impact.

We have a redeveloped quality dashboard and will have both inpatient and community skill mix in reviews in place prior to acquisition and service changes. This clear baseline data, with associated waiting times for access to services, will be formally logged on the programme assurance process before internal transformation changes are implemented. The project vision model gives the ability to review service changes and CIP schemes over time to spot changes, as well as considering the duration of this data, to enable monitoring to capture seasonal variations such as winter pressures or key hotspot periods.

Each scheme would have specific metrics supplemented by our integrated quality dashboard measures, and this data and intelligence is interrogated through the Trust Management Team and the Quality Leadership Groups, which enables challenge of poor performance and ensure any concerns with regard to patient safety or effectiveness do not result in deterioration of patient safety. It is, however, expected that some non-urgent patient experience may be adversely affected by waiting times.

The Board receives oversight of any potential cumulative impact of several schemes on a particular pathway, service, team or professional group through its committee structures and clear escalations from Clinical Reference Groups (CRGs) or Quality Leadership Teams (QLTs) to the Trust Management Team, and Quality Committee both thorough DATIX reporting of incidents, complaints, commissioning concerns and staff raising concerns through the risk management systems and processes.

Section 4: Summary of triangulation of quality with workforce and finance

We are embedding an integrated dashboard approach at every level of the organisation and this formal triangulation of information will be more frequent than at six monthly intervals. This will be supplemented with additional intelligence from hotspots, cold reporting areas for quality governance and using the oversight framework dashboard and the mental health dashboard supplemented by additional local indicators.

To better enable the triangulation of indicators at a Trust Board level, we have 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.

We will be designing a ward and community service dashboard with integrated metrics. This may be similar to the model used within South London and Maudsley NHS FT which will be redefined to consider our specific goals and integrated into our monitoring developments. This new addition to our quality monitoring and a dashboard from community services will complement our quality governance offer

and ensure proactive identification of service failure. This will enable proactive management action and targeted interventions at QLT, CRG and the Trust Board, providing the additional safety net and assurance level monitoring.

Approach to workforce planning

In the development of the Derbyshire five year STP, all workforce leads have worked together to prepare a five year workforce plan and strategy in response to the five key focus areas identified in the STP:

- Place Based Care
- Prevention and Self-Management
- Urgent Care
- System Efficiency
- Transforming System Management

The Derbyshire wide workforce plan and strategy covers four key areas:

- Workforce Planning
- Workforce Development
- Workforce Capacity and Productivity
- Organisational Development

The Derbyshire Local Workforce Advisory Board (LWAB) is overseeing the delivery of the system plan. The Trust has a People and Culture Committee that focuses on key workforce and cultural challenges. We have just refreshed our workforce plan to reflect the new models of care identified in the STP and the significant challenges we are facing with workforce supply and retention. The Trust has a number of supply workforce challenges within its medical and nursing workforce and has increased its resources to look into more innovative approaches to recruitment and alternative workforce model designs and over the forthcoming months, some of the following key actions will be taken:

- Exploring overseas recruitment for key medical posts
- Strengthening our employment offer for hard to appoint to posts
- Working closely with Health Education England (HEE) and local Higher Education Institutions (HEIs) to attract the return to practice nurses and retired employees to return back to work
- Engaging with the nursing associate national pilot; to grow our own workforce
- Redesigning our model of care to be prepared for predicted workforce shortages. We have key and emerging challenges in recruiting paediatricians and CAMHS psychiatrists, and in time we will struggle to recruit psychiatrists as the uptake of training courses is not fulfilling the future need.
- We will be developing Advanced Clinical Practitioners, Advanced Specialist Practitioners and Physicians Associates across a range of areas.
- Increasing retention rates through increased reflective practice groups, supervision access and interesting Continuing Professional Development (CPD) training to enable our practitioners to be reenergised and replenished in their knowledge and ability to return with new ideas, inspired to put acquired knowledge into practice and change or enhance behaviours at the clinical front line.
- Redistributing our workforce to ensure we have the right skills in the most impactful areas to have the best clinical outcome. For example, if we have staff with highly required therapy skills working in areas where their skill set is not fully utilised, we will address this.

- Redesigning our working practices to enable the most effective use of our available resource both in cost and effectiveness.
- Our registered nurse stock is challenging, and we will look to protect that staff group in key roles and skill mix in areas where skills set are not as effective.
- Our physical healthcare skills set is still not yet at an optimal level of functioning, physical healthcare and testing is critical to our safe management of individuals with higher risks of complex health conditions and prolonged long term conditions. We will continue to address this in our CQC action delivery
- We are preparing to utilise the apprenticeship levy to support development for our existing staff to aid retention.

Aside from volume changes on existing services, we also expect to see a commissioning investment to extend our Liaison and Diversion service in Speech and Language Therapists, psychologists, nursing and care support. Additionally our Substance Misuse service will see more investment.

With the workforce challenges we have across the Trust this is currently impacting on our ability to achieve our agency expenditure spend reductions. There is significant Executive focus on this and additional resources being put into place to drive improvement towards the achievement of our agency ceiling. We are developing new approaches to recruitment and more cost effective solutions to the staffing gaps we have. We will be looking at our workforce supply based on what we need substantively, building a flexible workforce pool that can respond to gaps across the organisation, changing how we run our bank and tightening further the criteria for using agencies across the trust. The template therefore reflects the success of these measures and subsequent achievement of the agency ceiling through reductions in agency, more utilisation of bank staff and increases in substantive staff.

As a member of the Derbyshire STP workforce group we have jointly reviewed the findings and suggested recommendations made by the Lord Carter's team and have developed a range of efficiency opportunities. We will be focusing on reducing our vacancies as this is contributing to our agency spend and will enable a reduction in lost time through staff absence lost through stress. Staff absence rate in October was 5.62%, which has been static for some time, and we will take a fresh approach to improving this over the course of the plan. We have work to do on improving our rostering efficiency by fully embedding across all our services.

The Trust is also working collaboratively across Derbyshire to explore back office efficiencies.

Approach to financial planning

As per *Strengthening financial performance and accountability in 2016/17* this operational plan is stretching from a financial perspective and aims to deliver the financial control totals £2.764m and £3.022m surplus.

We are currently in SoF Segment 3. On the Use of Resources assessment alone the template shows the organisation's expected segment being 1 (see below). We acknowledge that other aspects would also need to improve against the other Single Oversight Framework indicators to enable us to come out of segment 3, in particular the CQC and Governance Improvement Action Plan delivery.

USE OF RESOURCES RISK RATING EXTRACT

Plan Risk Ratings	Forecast Out-turn 31/03/2017 Year Ending Rating	Plan 31/03/2018 Year Ending Rating	Plan 31/03/2019 Year Ending Rating
Capital Service Cover rating	2	2	2
Liquidity rating	1	1	1
I&E Margin rating	1	1	1
Variance From Control Total rating	1	1	1
Agency rating	3	1	1
Plan Risk Rating after overrides	2	1	1

Procurement

With reference to Lord Carter's provider productivity work programme, we have reviewed non-pay expenditure and contracts including taking account of transferable learning as it relates to estates, purchasing and medicines management such as;

- Review of potential savings through NHS Supply Chain through the use of more cost effective products and product standardisation.
- Collaborative procurement.
- A refresh of category spend analysis to identify other potential savings.

We lead on a number of pan-Derbyshire collaborative procurement projects. These collaborative procurement projects include:

- Power and Gas (involving DTHFT, DCHSFT and DHcFT)
- Waste (involving CRHFT, DCHSFT and DHcFT)
- Printing (involving DTHFT, DCHSFT and DHcFT)
- Meat and Chilled and Frozen (involving DCHSFT and DHcFT)

We are committed to working with any national procurement initiatives and will engage with any new opportunities that are identified as the 11 Procurement Towers are developed.

Agency rules

We acknowledge that, given the 2016/17 agency performance, we have significant work to do to ensure that we deliver our agency ceiling in 2017/18 and 2018/19 (noting that the costs of agency in 2016/17, although in excess of ceiling, were contained within the pay budgets).

The current status of agency actions, as well as additional planned actions, are described in our agency self certification submission 30 November. These cover improvements in governance and accountability, the processes for approving agency use, actions to reduce demand for agency staffing and local health economy work.

The key driver in reducing our agency reliance will be through successful recruitment – the varied measures being taken are described in the workforce section. The increase in substantive posts and reduction in agency are evident in the workforce and main templates.

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

In February 2016 it was confirmed that Derbyshire County and Derby City would form one 'footprint' area for the development of the STP. This was accepted by NHS England and an embryonic governance structure, led by the Chief Officer of Southern Derbyshire CCG, was set-up to take planning forward. The Acting Chief Executive of our Trust has played a pivotal role in the 'Chiefs Group' who drove forward plans at the pace and scale required.

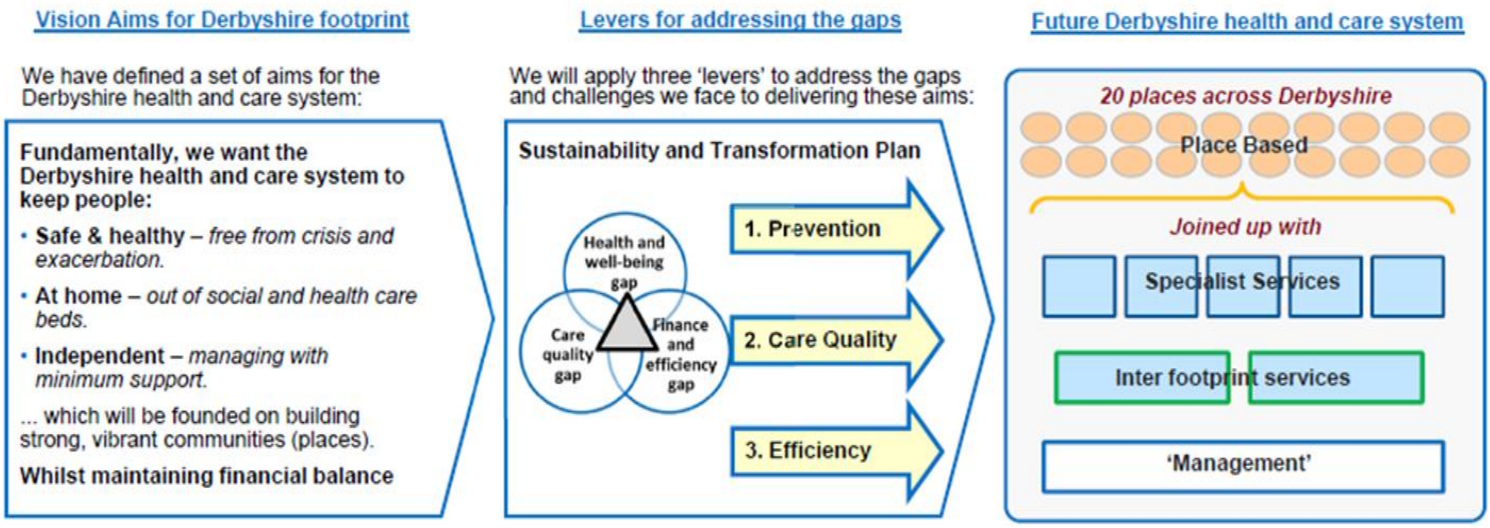
The initial draft STP was submitted in April, with subsequent submissions as per NHS England timescales. Feedback has been received from both NHS England and NHS Improvement. At each stage, senior members of our organistion played an integral role in the development of the STP for mental health, children, learning disabilities and 'place'.

We have been working with CCGs and other providers to develop proposals for integrated care by creating joined up services; for instance through the Erewash Vanguard and the North Derbyshire Community Hubs model; this will develop further in a move towards place based care across the whole of the County and City. We are a key strategic STP partner and will play a crucial role in ensuring the success of place based care as proposals are developed into firmer plans. Furthermore, our existing priorities are aligned to those of the Derbyshire health and care system.

Included as part of the STP, we are working with Derbyshire Community Health Services NHS Foundation Trust (DCHS) on the hypothesis that the closer working between the two organisations could have a significant impact on all three STP gaps identified. In particular, through delivering 'Place Based Care', and bringing together physical and mental health. We have produced a Strategic Outline Case (SOC) for consideration that was approved by both our trust boards at their meetings on 27 October 2016. Our thought-processes have been very much influenced by the broader transformation agenda, in streamlining services and removing any organisational barriers to providing the very best quality care. The SOC provided an in depth analysis of the various options for how closer working might be achieved in order to close the three gaps of health and wellbeing, care quality and finance and efficiency. A preferred option for both organisations has been identified through these considerations, which is for this Trust to merge, through an acquisition by DCHS. The aim of the new, integrated organisation would be to create and deliver genuine parity of esteem, so that physical and mental health are treated equally and care is not differentiated. Subject to NHSI approval we will move to through outline and full business case stages.

The STP is predicated around 20 'places' across Derbyshire (to be finalised). Whilst many of our services will be at the specialist level, spanning 'places', there will be some i.e. Primary Care Low Level Support. The need for differential place-based services is recognised within the individual workstream plans.

The diagram below highlights how increased collaboration would enable strong, capable providers to transform our services to support the system vision and challenges from a position of strength.



In May 2016, our Strategy 2016-21 was approved by the Board. The strategy is in-line with the direction of travel of the STP and a strategy implementation process was launched in June 2016. This effectively aligns the identified STP workstreams with internal transformation. We recognised that any redesign of services need to align with system priorities and be completed in collaboration with other stakeholders such as commissioners, social care and the voluntary sector.

The STP outlines a number of investment and saving areas for mental health, learning disabilities and children. It is hoped that these will at some point be reflected within the contract and within operational plans. However contract negotiations did not result in confirmed agreement of STP investment. Indeed the STP is assessing next steps. It will need to take account of the aggregate impact of four sets of bilateral negotations with the four providers and four CCGs and compare these to the assumptions in the STP proposals.

Membership and elections

To maintain our commitment to a full and active cohort of governors, we hold elections at set stages throughout the year, capturing vacancies that arise, and tenures that come to an end. During 2016 we have sought to consolidate these election periods to align the terms of office of our governors. Three election periods have been scheduled for 2016/17:

- May 2016 - new governors were elected to the following constituencies: Bolsover, Chesterfield North, Derby City East (two seats), Erewash North, High Peak, Surrounding Areas and Nursing and Allied Professions (staff).
- October 2016 - new governors were elected to Chesterfield South, Erewash South and Derby City West.
- The third set of elections will take place towards the end of this year, with new governors being sought for the following seats: Amber Valley North, Amber Valley South, Derbyshire Dales, North East Derbyshire, South Derbyshire, Derby City West and Staff Medical and Dental. We are aware that a number of long standing governors, whose terms of office come to an end this winter, are included in these vacant seats and we expect a number of existing governors to stand for re-election during this period.
- We have recently filled a vacant appointed governor seat for Nottingham University and we are in the process of providing this new governor with an induction into their role.

Throughout the year we have sought to increase the understanding and accessibility of the work of the Council of Governors with its members by proactively encouraging members to attend Council meetings and wider engagement events, and by providing a wider range of opportunities for members to meet with their governors. For example, we have held large scale community events to recognise world mental health day and world suicide prevention day. We have also identified a prominent guest speaker at our Annual Members' Meeting (AMM), to encourage members to attend the event and meet with fellow members, governors and staff.

We plan to further increase our knowledge of members to shape our communication and engagement activities. Our newly established governance committee has a regular focus on membership and we are actively providing governors with details about the demographics of their members and the constituency they serve, to develop meaningful engagement. We are currently developing a member survey and considering options for a further Membership Week in 2017. Our membership engagement and recruitment continues to be enhanced through the support of a membership champion volunteer.

All newly elected governors receive a detailed induction and there is an ongoing programme of training and development. Joint training (between the Trust and DCHS) took place in November with an external facilitator, regarding the role of the governor. Governors receive additional briefings when required (for example on publication of the Trust's CQC report). They are also encouraged to take part in Governwell training and participate in ongoing development and attend the regional mental health Trusts governors' conferences. Over the next year we will continue to build the training and development programme for governors, with full governor input, to ensure they are fully equipped to undertake their role.