

**Oxford Health NHS Foundation Trust**

**Council of Governors**

Minutes of the Meeting on 09 March 2016 at

18:00 at The Spread Eagle Hotel, Thame, Oxfordshire

In addition to the Trust Chair, and Non-Executive Director, Martin Howell, the following Governors were present:

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| Mike Appleyard | Reinhard Kowalski |
| Gillian Evans | Alan Jones |
| Geoffrey Forster | Lynda Lawrence |
| Maureen Ghirelli | David Mant |
| June Girvin | Chris Roberts *(Lead Governor)* |
| Julia Grinsted | Sula Wiltshire |
| Andy Harman | Soo Yeo |
| Judith Heathcoat | Judy Young |

In attendance:

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| John Allison | Non-Executive Director |
| Jonathan Asbridge | Non-Executive Director |
| Stuart Bell | Chief Executive |
| Alyson Coates | Non-Executive Director |
| Anne Grocock | Non-Executive Director |
| Dominic Hardisty | Chief Operating Officer |
| Mike McEnaney | Director of Finance |
| Clive Meux | Medical Director |
| Kerry Rogers | Director of Corporate Affairs & Company Secretary |
| Jane Kershaw | Acting Head of Quality & Safety |
| Mandy Mckendry | Patient Involvement and Experience Project Lead |
| Teresa Twomey | Temporary PA to Director of Corporate Affairs & Company Secretary (minutes) |
| Elaine Arnott | MSK Physiotherapy Operational Lead |
| Lee Griffin | MSK Locum Physiotherapist |

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| **COG 01/16**a | **Introduction and Welcome**The Chair brought the meeting to order and welcomed all those present. |  |
| **COG 02/16**abcd | **Apologies for Absence**Apologies were received from: John Bidston; Martha Kingswood; Gary Gibson; Diana Roberts; Martin Dominguez; Louise Willden; Mark Tattersall.Absent without formal apology were: Dave Pugh; Taufiq Islam; Samantha Mandrup; Hafiz Khan.Apologies had been received from the following members of the Board of Directors: Ros Alstead, Director of Nursing and Clinical Standards; Sue Dopson, Non-Executive Director; Lyn Williams, Non–Executive Director; Mike Bellamy, Non-Executive Director.The meeting was confirmed to be quorate. |  |
| **COG 03/16**abcdefg | **Staff Experience Presentation (Older People’s Directorate): Musculoskeletal (MSK) Physiotherapy Pilot – Rapid Access to Reduce Absence**The MSK Physiotherapy Operational Lead and Specialist MSK Physiotherapist presented their findings and outcomes of the MSK pilot scheme in the Older People’s Directorate. This investment utilising charitable funds allowed for a six month pilot offering clinical staff rapid and very local access to musculo-skeletal advice and treatment and was aligned with the Trust’s commitments around staff health and well-being. The pilot reported significant positive impact, including:* A reduction of 50 episodes of sickness relating to back and other MSK problems with 356 episodes in 2014 and 306 in 2015 .
* A reduction of 875 WTE days lost due to sickness absence with a total of 2979 WTE days lost in 2014 and 2104 WTE days lost in 2015.
* A reduction of 1.4 days on the average duration of absence where 8.3 days was the average duration in 2014 and 6.9 days was the average in 2015.
* A saving of £36,743 in the cost of days lost due to sickness absence (using the mid pay-point of each pay band) with the cost based on actual salary of staff members absent in 2014 being £183,043 and £146,300 in 2015. These figures exclude the cost of agency/locum staff to cover absences as this data was not available.
* Of the 90 patients who completed a well-being evaluation on completion of treatment, 27 presented with a slight to moderate level of anxiety and depression on the initial assessment. On discharge from treatment, 18 of these patients showed a reduction in their anxiety and depression, 8 patients had no change and 1 patient had an increase in their anxiety and depression despite a perceived improvement of 100%.
* A breakeven position had been achieved from the money invested and the savings made.

Anne Grocock welcomed the presentation to the Governors, following the same at the Charity Committee, noting that the pilot was a very interesting example of how to maximise use of a small amount of money. She highlighted the significance of the pilot being carried out in the Older People’s Directorate, where there were higher levels of sickness absence amongst staff, and where they were more susceptible to back injuries.Maureen Ghirelli congratulated the team on their successful pilot and queried whether, with a breakeven point achieved, it would be possible to roll this pilot out to a wider group of staff over the longer term.The Chief Executive explained that this had been considered in the wider planning for the next financial year, and additionally as part of ambitions to reduce the use of agency staff to cover absences. He noted that the impact on the morale of staff was as important as the financial impact, and that the pilot showed that this practical approach really made a difference to that morale.The Trust Chair concurred.**The Council of Governors thanked the team for their presentation.**  |  |
| **COG****4/16**ab | **Patient Experience Presentation**Mandy Mckendry presented the story of a community hospital patient who had been diagnosed with bipolar condition and, following several traumatic episodes in his life, had been hospitalised, twice under section. The range of interventions provided by the Trust over several years meant that he was now well. The Trust Chair thanked the presenter, noting the positive feedback, and successful outcome for this patient. |  |
| **COG****05/16**abcdefghijkl m | **Delayed Transfers of Care (DToC) pilot** The Chief Operating Officer provided an update on the DToC pilot in Oxford. He said that an average of 20% of patients needed more care after hospital and in the past week 147 patients who did not need to be in hospital were unable to leave because after-care placements were not available. He explained that quality, safety and patient experience can be adversely affected by long hospital stays, with acute hospitals not being an appropriate long term solution for elderly people due to issues such as muscle wasting, and pressure ulcers.With regards to the pilot, he noted that it was not yet evident that the team had made a significant difference. There were however, some positive outcomes and these were being used as learning actions on how to improve the whole system. He explained that a team known as the Complex Discharge Hub was now tracking and managing every patient through the system but that whilst they were getting through many significant issues, more were appearing from which all parties were learning future lessons.He explained that the team was working jointly with Oxfordshire County Council (OCC) to prepare a model of what a ‘good pathway’ looks like, but more detailed demand and capacity modelling was needed to design interventions on a cost benefit system basis.The Trust Chair noted that as a result of the pilot, relationships had been enhanced between OCC, Oxford Health, and Oxford University Hospitals NHS FT.June Girvin asked how closely family and carers were involved in decisions about care for patients. The Chief Operating Officer explained that patient/carer conversations happened as a normal course of events and that efforts were being made to make it more efficient.The Chief Executive explained that the Hub had developed intermediate care capacity in nursing homes and discussions with families were more involved with nursing homes being more sympathetic to family/carer needs and concerns.June Girvin explained that she felt that assumptions and decisions were often made by staff and not discussed with family/carers. She added that she did not feel that the use of the term ‘DToC’ was a helpful use of language.Mike Appleyard questioned how many patients annually were involved in delayed transfer, and what the cost to the Trust was.The Chief Operating Officer explained that this could be looked at in greater detail in a Council sub-committee which was supported.Judith Heathcoat confirmed that relationships between hospitals and providers such as OCC had indeed improved, and that there were currently 6,500 patients with care packages in Oxfordshire. She added that each patient was treated very much as an individual within what was a very complex system, dealing as it did with such high numbers and, for example, twice daily teleconferencing and tracking of individual patients.She added that it would be useful to invite a representative from the Adult Social Care Team to a future meeting/Committee to explain this further.**The Council of Governors noted and thanked the Chief Operating Officer for his update.** |  |
| **COG 06/16**ab | **Declarations of Interest**The Council of Governors confirmed that interests listed in the current Register of Governors’ Interests (CG 01/16) remained correct and there were no declarations arising out of matters pertaining to the agenda.The Trust Chair asked that any changes in the declaration of interests be forwarded in writing to the Director of Corporate Affairs & Company Secretary. |  |
| **COG 07/16**abc | **Minutes of Last Meeting on** **04 November 2015 and Matters Arising (CG02/16)**The Minutes of the meeting were approved as a true and accurate record of the meeting. **Matters Arising****COG 44/15, 29/15(b) , 18/15(b) Nominations from Buckinghamshire Healthcare NHS Trust and Chiltern CCG for the Council of Governors**Both had been invited to nominate representatives and would continue to be followed up until nominations were received**COG 49/15 (l) Working Together Group**The Working Together Group had been formed and had met for the first time in February. |  |
| **COG 08/16**abccdefghijklmnopqrst | **Update Report on Key Issues from Chief Executive**The Chief Executive presented his quarterly report (CG03/16) which had previously been circulated with the agenda. He highlighted the following:**CQC Inspection Report**The Chief Executive said that the report was a recognisable portrait of the Trust and the CQC had provided helpful feedback which would enable the Trust to improve quality of provision. Of the 75 specific assessments, 49 were rated ‘good’, 6 ‘outstanding’ and 20 as ‘requires improvement’. None were found to be ‘inadequate’ and there were no enforcement notices issued.The Trust was over-all rated ‘good’ in three out of five quality domains – caring, responsive and well-led and ‘requiring improvement’ in the remaining two, effective and safe. Within this, the majority of the Trust’s core services were over-all rated ‘good’ (10) and one, our children and young people’s community service, which includes school health nurses, health visitors and children’s community nurses, was rated as ‘outstanding’.The CQC found that the Trust was well-led with: accessible visible management at all levels and good working governance systems. Patients and staff knew how to raise concerns and there was good learning from incidents and complaints. Staff were found to be caring. A focussed re-inspection was planned for the summer.**Monitor Inspection**The Chief Executive explained that Monitor had concluded its investigation into the Trust’s finances, and had decided to take no formal regulatory action. The Trust’s governance rating had since returned to green. He explained that the investigation had been triggered because the Trust had posted a deficit figure and that he expected close monitoring to continue, given the financial situation nationally within the NHS. He added that the Trust was already very efficient in its provision of services against a number of benchmarking indicators, but that this made significant cost reduction even more challenging.**Trust’s response to Mazars report into Mental Health and Learning Disabilities deaths in Southern Health NHS Foundation Trust**The Chief Executive explained that the Trust had a system so that all serious incidents and unexpected deaths were clinically reviewed by a group on a weekly basis, and further investigations were commissioned as appropriate.He added that the Trust was carrying out a self-assessment against the recommendations made by Mazars into the deaths at Southern Health NHS alongside other national recommendations e.g. Monitor’s mortality governance guide, to test its current processes and systems pertaining to how it reviewed, learnt and analysed data around deaths. He concluded that a sensible balance was needed, with the right people carrying out each review.**Oxon Devolution**The Chief Executive noted that this was an on-going development and that strengthening the relationship between health and social care was key to its success on the health front.**Junior Doctors**The Chief Executive explained that the impact of the new contract was being examined by the Trust. He said that whilst the impact was described as ‘cost neutral’ by the government, it would in fact be costly for mental health trusts because the uplift in junior doctor salaries was not offset by savings from onerous rotas. Initial assessment suggested that it would cost the Trust in the region of £400,000 in the short term and £200,000 in the longer term.**Board Appointments**The Chief Executive reported that Dr Mark Hancock had been appointed as Medical Director to succeed Dr Clive Meux upon his retirement at the end of March. The post of Chief Operating Officer and Deputy Chief Executive had been accepted by Mr Dominic Hardisty, formerly Deputy Chief Executive of Northamptonshire Healthcare NHS Foundation Trust, and Dominic commenced working for the Trust on 22nd February 2016. The Chief Executive expressed his sincere appreciation to Dr Clive Meux, for his tireless commitment to the role of Medical Director and his extensive contribution to the Trust. Chris Roberts, on behalf of Martha Kingswood, asked how the Oxon Devolution would affect services in Buckinghamshire and the Chief Executive explained that there would be minimal impact.Sula Wiltshire highlighted the use of language – ‘Patient involvement’ vs ‘joint endeavour’ and the philosophical basis for this.Maureen Ghirelli pointed out that there were 10 new housing developments in the Trust area and asked whether any of those involved had approached the Trust for contributions to making the developments fit for ‘mentally healthy’ living.The Chief Executive explained that the Trust had been approached over the Bicester development but that there was a clear emphasis on physical rather than mental health issues. Geoffrey Forster queried how the ‘esprit de corps’ amongst junior doctors was faring and the Medical Director explained that there was a good collaborative and co-operative relationship between the Trust and the junior doctors and that excellent communication was being maintained throughout each phase of the industrial action. He said that patient safety had not been compromised. Chris Roberts asked what the percentage of ‘out of area’ treatment was for the Trust, and how this compared to other trusts.The Chief Executive explained that this figure fluctuated on a daily and weekly basis, but that, for example, on that day there were 7 adult patients being treated ‘out of area’, compared with in the region of 40 patients in trusts in the London area. He said that ideally the Trust would like to eliminate the use of ‘out of area’ treatment except where there was a clinical need, but that would require an average occupancy rate of 85% in order to have beds available, where the Trust had an average occupancy rate in the region of 95%.**The Council of Governors noted the update and the intention where relevant to continue to keep the Council apprised of developments.** |  |
| **COG 09/16**a | **Update Report from Chair.** The Trust Chair provided an oral update and was pleased to confirm that the Working Together Group had met. He also reported that he had attended an NHS Improvement seminar in London led by Monitor and the NHS Trust Development Authority, which he had found most informative and encouraging. |  |
| **COG 10/16**abcdefgh | **Quality Account 2015/16 update and agreement of Governors Quality Indicator for Quality Account 2016/17** The Acting Head of Quality & Safety presented a Quality Account update CG04/2016, which had previously been circulated with the agenda and explained that the Quality Committee had recently agreed to:* continue to use the same four overarching priorities in 2016/17
* re-organise the quality priority re improving patients’ and carers’ experiences and involvement from priority 4 to priority 2.
* the re-wording of the quality priority around improving patients’ and carers’ experiences and involvement
* the alignment with the trust wide quality improvement approach
* the timescales for the development of the annual quality account

She explained that as part of the submission for the 2015/16 Quality Account the external auditors undertook substantive sample testing on two mandated performance indicators and one locally selected indicator.The Council of Governors was required to select each of these indicators and the governor representatives at the joint Quality and Safety and Patient Experience sub-committee meeting on 28th January 2016 proposed national indicators 1 and 2:  1. 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital  2. minimising delayed transfers of care in mental health servicesbe sample tested, and that the local indicator selected for testing in the 2015/16 Quality Account would be‘reduce avoidable grade 3-4 pressure tissue damage’.Reinhard Kowalski queried whether the Trust had learnt from the restructuring of the Adult Mental Health Teams (AMHT), now that a Flexible Assertive Community Team (FACT) model was being introduced. The Acting Head of Quality and Safety explained that technically the AMHT had not been restructured, and that the smaller sub-teams would still work as part of the larger team within AMHT catchment areas. Reinhard Kowalski noted that under quality priority 3, the service model for psychological therapies was being reviewed to improve access and waiting times for those needing specialist psychological interventions. He felt that remodelling was being carried out to address waiting lists and demand, but that there was insufficient capacity with some patients waiting 18months for treatment, and that this needed to be addressed.Mike Appleyard highlighted the importance of having targets that were measurable, and the Acting Head of Quality and Safety explained that these would be in the full Quality Account and quarterly updates.**The Council of Governors noted the update and agreed to the choice of performance indicators.** |  |
| **COG****11/16****a****b****c****d** | **Update Report from Council Sub-groups and Governor Forum (CG 05/16):****• Nominations & Remuneration**The Trust Chair explained that, following the resignation of some members, a new governor was needed for this committee. There had not been a need for a meeting of this committee since August 2015. The knowledge and skills audit would be utilised to ensure members with recruitment and selection experience were invited onto the Committee.**• Finance**The Trust Chair explained that Andy Harman had volunteered to join the Finance sub-committee. The Director of Finance explained that it was difficult to find mutually convenient times for all members of the sub-committee to meet but that all information would always be circulated. The meeting of 27th November had been cancelled.**• Quality & Safety/Patient Experience** Linda Lawrence explained that these two committees had met jointly and that it was intended to do this annually. She explained that the committees had discussed the criteria for the quality account, and the outcome of the CQC inspection. **• Working Together Group/Governor Forum**Chris Roberts explained that the Working Together group had met prior to the inaugural Governors’ Forum on 16th February and had been given a presentation on methods of improving communication via specialist IT software. Chris explained that both groups were at the very early stages of development but were proving encouraging.   |  |
| **COG****12/16****a****b****c****d****e****f****g****h****i**  | **Update on Trust Financial Position / Finance Report**The Director of Finance presented CG 06/2016, which had previously been circulated with the agenda. He highlighted:* EBITDA (Earnings before interest, taxation, depreciation and amortisation) of £8.3m, which was £0.5m ahead of plan (£7.4m, £0.2m ahead of plan at month 9).
* An Income and Expenditure deficit of £2.0m, £0.2m ahead of plan (£1.9m deficit, in line with plan at month 9).
* A cash balance of £10.2m, £2.0m below plan, (balance was £12.1m at month 9). This was primarily due to lower than planned receipts from sales of land and buildings, and decrease in trade and other payables. Cash balances overall remained relatively strong and were forecast to be at £14.1m at the year-end.
* Financial Sustainability Risk Rating (FSRR). Under the revised FSRR the Trust had achieved an overall risk rating of ‘3’ at month 10.
* A cost improvement target of £5.1m had been set for this financial year and cost improvements of £3.8m had been delivered for the year-to-date, £0.4m behind plan (£3.1m achieved at month 9).
* Capital expenditure of £3.6m had been incurred for the year-to-date, £1.6m below plan (£3.3m, £1.5m lower than plan at month 9).

The Director of Finance explained that he was able to take some risk out of the forecast due to the imminent completion of the sale of Manor/Tindal site and that he was looking at ways of increasing revenue streams for the next financial year.**The Council of Governors noted the report** |  |
| **COG****13/16****14/16****a****b****c****d****e****f****g****h****i****j****k****l****m****n****o****p****q****r****s** | **Workforce Performance Report/ Performance Report**The Director of Finance presented CG 07/16, and CG 08/16 both of which had previously been circulated with the agenda. He highlighted the following: Bank & Agency Spend: 7.41%Vacancy Rate: 9.60% Trust Turnover Rate: 14.20% Sickness Absence Rate: 4.21%The Director of Finance explained that Monitor had placed price caps on agency spend and that whilst there had been a recent lowering of agency spend, it had increased again in the last month. He added that the turnover rate was in line with other NHS trusts, that recruitment was a problem generally for the NHS and especially in the south east, but that this was being addressed with recruitment activity.He concluded by saying that, whilst figures for stress and anxiety related illness continued to be the highest of all sickness absence reported, not all stress and anxiety was work related, and that there was support in place.Reinhard Kowalski queried the phrase ‘*combined HR and management pressure to reduce periods of short term sickness’* The Director of Finance explained that this referred to the self-certification process.The Chief Executive noted that in the Staff Survey, the Trust had performed well in the question ‘Did you go to work when sick?’ Reinhard Kowalski asked whether a pilot similar to the MSK one might be introduced to address high levels of stress within the Trust. The Trust Chair agreed that this was a something that should be explored.Maureen Ghirelli asked how the Trust assured itself that the exit data gathered was meaningful and accurate. The Director of Finance agreed that this was indeed difficult and was based on a ‘tick box’ form, and a discussion with the relevant manager.Maureen Ghirelli suggested that entry data and an interview shortly after commencing employment might be helpful.The Director of Finance explained that a questionnaire was issued to staff during their probation period.Judith Heathcoat noted that the many targets were missed with regards to workforce performance.Alan Jones noted that ‘tick box’ forms were not always the best way of eliciting exactly how a person was feeling and that it was always important to talk to employees to find this out. He said that information coming out at an exit interview should not come as a surprise as managers should already be aware of the real reasons for staff leaving.Geoffrey Forster suggested that the Trust should consider paying a bonus to staff who worked continuously for three months without sickness absence.Judy Young commented that staff quite often did feel under pressure to come into work when sick, particularly outpatient staff. She said that the position on the wards, however, was different.Gillian Evans queried the cause of the vacancy rate. The Chief Executive explained that location was an issue for the Trust. Potential staff living in the Buckinghamshire area were often attracted to the London trusts because of the London weighting on salaries. He added that Oxford had the highest ratio of average earnings: house price in the country, higher than London and 5 times higher than, for example, Middlesbrough.June Girvin highlighted that many nurses who had qualified in the 1970’s were retiring.David Mant raised the issue of provision of affordable housing for key workers.The Chief Executive explained that the CEO’s of District Councils had met recently *and had decided that a key worker could only be defined as one if they lived and worked within the District Council area; that they would not qualify as a key worker if they worked in a hospital outside the District Council area, even if the hospital served that area*. He added that this was a problem for domiciliary care workers also.**The Council of Governors noted the report and current performance** |  |
| **COG 15/16****a****b****c****d****e** | **External Audit fee** The Director of Finance presented CG 09/2016, which had previously been circulated with the agenda and it was explained that the Council of Governors was required to approve the increased external audit fee for Deloitte’s of £63,000. The Audit Committee had considered the proposed increase along with the performance of the provider of External Audit services and was assured by the quality of the work provided, in particular in relation to the additional work which had been required on and the approach to, the 2014/15 External Audit. The Director of Finance reported that he had benchmarked the fees proposed and they were in the middle/reasonable compared to other providers. The Audit Committee was recommending the increased annual fee of £63,000 to the Council of Governors for approval and the Audit Committee chair, Alyson Coates, explained that she and the Committee had found the external auditors to be rigorous and responsive.Andy Harman expressed concern about the extra charges incurred by the external auditors and queried why they had been made and Alyson Coates explained that extra work had been incurred on the Quality Account Indicators.Geoffrey Forster asked when the next tender process was due and the Director of Finance explained that the procurement process would commence in accordance with future approvals of the Council of Governors.**The Council of Governors noted the report and approved the External Audit Fee.** |  |
| **COG 16/16****a****b****c** | **Governor Development Programme**The Director of Corporate Affairs & Company Secretary presented CG 10/2016, which had previously been circulated with the agenda and outlined the proposal to offer a Governor Development Programme in order to meet the requirements of the Health and Social Care Act 2012, and the collective needs of the Council of Governors as determined by the responses to the February 2016 Knowledge and Skills Audit. She explained that the courses would be in addition to the induction programme, and those offered by NHS Providers and that the key areas of focus would be:* Governance and Regulation
* Quality and Safety, to include triangulation of the external assessments of care
* Patient Experience, to include triangulation of feedback sources
* Finance, Performance and Commissioning to include benchmarking sources
* Directorate structures/services

David Mant asked for consideration of the provision of electronic versions of the courses, for those unable to attend and June Girvin offered to support any interest in live streaming or the creation of podcasts.**The Council of Governors noted the report and approved the Governor Development Programme.** |  |
| **COG****17/16****a****b****c** | **Governor Election Strategy**The Director of Corporate Affairs & Company Secretary presented CG 11/2016 previously circulated with the agenda and explained that in preparation for the forthcoming Governor Elections in Oxfordshire and Buckinghamshire, she had commissioned the development of a Communications and Engagement Strategy in order to safeguard the optimum success of the Trust’s Governor Election process for 2016. This was being rolled out to raise awareness of the elections and to encourage the public, patients, carers, and staff to become a member of the Trust, and stand for election. She added that, whilst there had been interest in attending awareness events from members in Oxfordshire, the response had not been the same in Buckinghamshire.Reinhard Kowalski explained that he was no longer eligible to represent the CYP directorate due to the recent restructure. He was encouraged to stand again under the reformed structure.**The Council of Governors noted the report.** |  |
| **COG 18/15**a | **Questions from the Public**No members of the public were present during the meeting. |  |
| **COG 19/15**a | **Any Other Business****Retirement of Clive Meux**The Trust Chair reiterated his sincere thanks to the Medical Director on behalf of the Council of Governors. |  |
| b | Geoffrey Forster suggested that the maximum expense amount of £55 for reimbursement of overnight accommodation for governors attending training courses was too low. The Director of Finance said that he would follow this up should that figure not be in accordance with reimbursement agreements for staff.**There being no further business the Chair declared the meeting closed at 20:15hrs.** |  |