**Meeting of the Oxford Health NHS Foundation Trust**

**Council of Governors**

**CoG 27/2019**

(Agenda item: 4)

Minutes of a meeting held on

12 June 2019 at 18:00

Spread Eagle Hotel, Thame

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

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| **Present:** |  |  | |  |  |
| Chris Roberts (Lead Governor) | (CR) |  | Dr Mary Malone | | (MM) |
| Angela Conlan | (AC) |  | Richard Mandunya | | (RM) |
| Maureen Cundell | (MC) |  | Andrea McCubbin | | (AMcC) |
| Gillian Evans | (GE) |  | Jacky McKenna | | (JM) |
| Benjamin Glass | (BGl) |  | Paul Miller | | (PM) |
| Louis Headley | (LHe) |  | Neil Oastler | | (NO) |
| Joy Hibbins | (JH) |  | Abdul Okoru | | (AO) |
| Dr Mike Hobbs | (MH) |  | Gillian Randall | | (GR) |
| Allan Johnson | (AJ) |  | Myrddin Roberts | | (MRo) |
| Alan Jones | (AJo) |  | Hannah-Louise Toomey | | (HLT) |
| Reinhard Kowalski | (RK) |  | Chelsea Urch | | (CU) |
| Davina Logan | (DL) |  | Sula Wiltshire | | (SW) |

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| **In attendance:** |  |  |
| John Allison | (JA) | Non-Executive Director |
| Jonathan Asbridge | (JAsb) | Non-Executive Director |
| Stuart Bell | (SB) | Chief Executive |
| Tim Boylin | (TB) | Director of Human Resources |
| Marie Crofts | (MCr) | Chief Nurse |
| Bernard Galton | (BG) | Non-Executive Director |
| Dominic Hardisty | (DH) | Chief Operating Officer & Deputy CEO |
| Dr Mark Hancock | (MHa) | Medical Director |
| Donna MacKenzie-Brown | (DMcK) | Patient Experience & Involvement Manager |
| Aroop Mozumder | (AM) | Non-Executive Director |
| Claire Page | (CP) | Head of Performance and Information |
| Kate Riddle | (KRi) | Deputy Director of Nursing & Clinical Standards |
| Kerry Rogers | (KR) | Director of Corporate Affairs & Company Secretary (Minutes) |
| Lucy Weston | (LW) | Non-Executive Director |

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| **Observing:** |  |
| Ben McCay | Co-Chair of trustees for the independent charity and self-advocacy organisation ‘My Life My Choice’ |
| Rachel Miller | Patient Experience Lead - Learning Disabilities service |
| Dellisha Strain | Corporate Governance Officer |
| Katariina Valkeinen | Senior Communications and Engagement Officer |
| Surangi Weerawarnakula | Corporate Governance Administrator |

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| **1.**  a  b  c  d  e  f  g | **Introduction and Welcome**  The Trust Chair brought his first Council of Governors’ meeting to order and welcomed all those present.  The Trust Chair noted changes on the Board and: welcomed Marie Crofts, Chief Nurse, to her first Council of Governors’ meeting; thanked Kate Riddle, Deputy Director of Nursing & Clinical Standards for her work as Acting Director of Nursing; and thanked Dominic Hardisty, Chief Operating Officer for his work and noted that he would be leaving the Trust to take up the role of Chief Executive of Avon & Wiltshire Mental Health Partnership NHS Trust.  The Trust Chair noted changes to the Council of Governors and:   * thanked former Governors: Kelly Bark; Mark Bhagwandin; Cally Birch; and Karen Holmes; * welcomed nine newly elected Governors:   + Dr Hasanen Al Taiar (representing Staff: Specialised Services);   + Angela Conlan (representing Staff: Community Services);   + Benjamin Glass (representing Patient: Service Users Buckinghamshire and Other Counties);   + Louis Headley (representing Staff: Oxfordshire, BaNES, Swindon & Wiltshire Mental Health Services);   + Joy Hibbins (representing Public: Rest of England & Wales);   + Mike Hobbs (representing Public: Oxfordshire);   + Myrddin Roberts (representing Staff: Community Services);   + Hannah Toomey (representing Public: Oxfordshire); and   + Chelsea Urch (representing Public: Buckinghamshire); and * welcomed back re-elected Governors: Chris Roberts (Lead Governor); Gillian Randall; Reinhard Kowalski; and Madeleine Radburn.   The Trust Chair welcomed observers to the meeting in particular colleagues and representatives of the Learning and Disability community including: Rachel Miller, Patient Experience Lead for Learning Disabilities from the Trust; Ben McCay, Co-Chair of the trustees for ‘My Life My Choice’; and Katariina Valkeinen, Senior Communications and Engagement Officer, who was involved in developing easy read documents which would be more accessible to people with learning disabilities.  The Trust Chair commented upon the role of both Governors and Non-Executive Directors (**NEDs**) to be able to look in two directions at once:   1. into the Trust’s operations, performance and service delivery; and 2. outwards to the places, people and other organisations which made up the environment within which the Trust operated.   Whilst both roles were vital, he noted that the second role to look more outwards might be slightly less familiar, especially to newly elected Governors. He explained that it encompassed outreach, conversations, challenge and even closer contact with the Trust’s neighbours in primary care, county councils, the acute sector, voluntary sector, patient groups and community forums. These were all areas where healthcare was practised and discussed and which the Trust should participate in through its Governors’ as citizen activists and ‘NHS people’.  The Trust Chair referred to the creation of Integrated Care Systems (**ICSs**) by April 2021 and how these were envisaged to bring together local organisations in a pragmatic and practical way to deliver integration of: primary specialist care; physical and mental healthcare; and health with social care. He emphasised the importance of the Governors and the Board together being proactive at an early stage in the development of ICSs in order to be able to shape their emerging structure. Integration would not, however, happen overnight; it would require willingness to open-up and reach out and it might be characterised by more sharing of Governor positions/joint membership between this and other Councils of Governors and/or other bodies. He noted that the talents which the Trust had its disposal should be put to maximum use and that this may require a new flexibility. | **Action** |
| **2.**  a  b  c | **Apologies for absence and quoracy check**  Apologies were received from the following Governors: Hasanen Al-Taiar; Geoff Braham; Gordon Davenport; Vicky Drew; Tom Hayes; Lin Hazell; Dr Tina Kenny; Madeleine Radburn; Debbie Richards; Lawrie Stratford; and Soo Yeo.  Apologies were received from the Board: Sue Dopson and Chris Hurst, Non-Executive Directors; Mike McEnaney, Director of Finance; and Martyn Ward, Director of Strategy & Chief Information Officer (**CIO**).  The meeting was confirmed to be quorate as over a third of the total number of Governors were present, including at least 5 Governors representing the public or patients’ constituencies. |  |
| **3.**  a | **Declarations of Interest**  No interests were declared pertinent to matters on the agenda. |  |
| **PATIENT EXPERIENCE** | | |
| **4.**  a  b | **Patient Experience Presentation**  The Patient Experience & Involvement Manager played an audio recording of a patient story being read out (by an actor) which described the experiences of a service user from the Healthy Minds service in Buckinghamshire. The story described how the service user had found counselling sessions to be more beneficial than medication alone and to have given her tools to help herself. After years of having been prescribed antidepressants, when she changed GP she was offered access to support other than medication for the first time. She recommended the service but wished that the waiting time to access it could be shorter so that more people could learn the tools and benefit.  **The Council of Governors noted the presentation.** |  |
| **5.**  a  b  c | **Young People’s Ambassadors update**  The Patient Experience & Involvement Manager provided an oral update and noted that although work had taken place in Buckinghamshire to try to introduce the Governor role to young people and to encourage young people to participate, this had stalled since the staff member in charge of the participation group had gone on maternity leave and the two young people who had been interested had moved on from the group. The work therefore needed to be re-invigorated and more young people approached.  Sula Wiltshire noted that in Oxfordshire, the local authority operated an active young persons’ group and that she could provide the Patient Experience & Involvement Manager with some contacts into this.  **The Council of Governors noted the oral update.** |  |
| **6.**  a  b  c  d  e  f  g  h  i  j  k  l  m  n | **Patient Experience – data quality and collection mechanisms**  The Lead Governor led the meeting in discussion of a question which Governors had raised in relation to the way in which the Trust collected data on patient experience and how valid this was in terms of the Trust monitoring its own performance. The Governors’ Forum had developed this into a question for NEDs as follows: “*How have the NEDs reassured themselves that the various systems that the Trust has in place to give them data on the performance of the Trust are accurate? In particular, the measures that are derived from service users, patients, carers and family members, including IWantGreatCare (****IWGC****). IWGC is one of the main tools that the Trust uses to gauge satisfaction of Trust services. The Governors are concerned that some of the methods of collecting data (e.g. surveys on hand-held iPads given to respondents at the end of appointments with clinicians present) may invalidate the data produced and that the number of responses in some areas may be too low to be able to give the results and scores any real robustness*”.  Aroop Mozumder noted that he had been present at the Governors’ Patient & Staff Experience Group when this had been raised and that he wanted to reassure Governors that patient experience and the quality of the data was taken very seriously. He cited by way of example the regular Patient Story presentations at Board meetings in public and the Quality & Safety reporting which regularly focused upon patient experience and which the Board also received in public. He commented that the Board received a significant amount of information about patient and staff experiences and had opportunities to discuss this. He suggested that the issue may not be around the tools which the Trust used to collect data on patient experience but perhaps not using ‘The NHS website’ (formerly known as ‘NHS Choices’) enough. He added that whilst he could understand concerns about the use of iPads as a method of collecting data, especially if this was done immediately after treatment, when considered as part of the totality of the patient experience feedback which was received he was still assured that the Board received good and varied information which was in line with that received by other trusts, using similar methods, and also by the Care Quality Commission (**CQC**).  The Lead Governor noted that Governors were concerned as to whether IWGC and related performance measures were scrutinised by the audit team and whether the Trust was assured that the data provided was accurate and robust. Otherwise, he noted that the Trust could be making decisions based on data which was erroneous.  The Patient Experience & Involvement Manager noted that the Trust was not prescriptive about how patients could provide feedback and that patient experience data was received from a variety of sources including: via links on the Trust’s website; social media posts; the Patient Advice & Liaison Service; paper copies of feedback forms which were available in clinics and some services; and iPads. If patients and carers did not want to provide feedback at a particular time then they did not have to and could choose to feedback later. The number of responses received via IWGC had increased from 2,800 in the first year of its use to 13,248 in the third year of its use. She explained that the Trust linked more to IWGC as its feedback tool rather than a website such as NHS Choices as the Trust had been through a rigorous public tender process to procure IWGC (including a mixed group of staff and patients who had been involved in reviewing tender applications).  The Lead Governor asked about the ratio between population and responses to get a sense of interactions with patients and carers. The Patient Experience & Involvement Manager noted that it may be possible to work out response rates through analysing national Friends and Family Test (**FFT**) patient data; FFT data had also been included in previous reports to the Board as well as used in the Quality Account.  The Trust Chair added that the Trust triangulated quantitative and qualitative data about services and experiences to try to form a continuous overall picture as to how well the Trust was servicing its local populations. In terms of auditing this data, he noted that the quality of data and processes was considered and appraised by the Director of Strategy & CIO and his team. The Chief Nurse commented upon further ways to triangulate data and noted that services in the mental health directorates would be accredited by the Royal College of Psychiatrists and this data, appropriately anonymised, could also be used in further triangulation.  Neil Oastler reflected upon a personal experience and highlighted that what would have improved that particular experience would have been if clinical staff had communicated what the next steps in the process would be.  Alan Jones noted that it would have been wrong not to use IWGC after the procurement process it had been subject to. However, he suggested that it should also be recognised that it may be difficult for patients to feel like providing feedback if they have recently had a difficult consultation or experience.  The Chief Operating Officer added that the Caring & Responsive (**C&R**) quality sub-committee also considered patient experience and that whilst IWGC was an important source of patient data, the C&R committee did not just rely upon IWGC but also used other sources such as complaints data. He emphasised the importance of continuing to work to increase the quantity of data in order to increase the richness/depth.  Ben Glass asked about the Trust having faith in staff using/offering survey materials to service users and whether there was an expectation that this material would be offered to service users. The Patient Experience & Involvement Manager replied that this depended upon the service and even then it was not necessarily expected that every staff member would offer survey materials at every interaction; she noted that there could also be reasons for different teams to do things differently even within the same service line. The Deputy Director of Nursing & Clinical Standards added that depending upon the circumstances of interactions, it may not always be the right time to offer survey materials e.g. to urgent care patients.  The Lead Governor asked what the Trust was doing about negative reviews which were left on some NHS/jobs websites and the potential impact upon its reputation, noting that this had been raised by former Governor Mark Bhagwandin. The Chief Operating Officer replied that these websites tended to be outside of the Trust’s control but in response to suggestions from Mark Bhagwandin, the Trust had changed its own website to make the link to IWGC more prominent so that it would be easier for people to feedback concerns.  Ben Glass asked why the Trust did not want patients to see negative feedback about its services. The Chief Operating Officer replied that that was not the issue; the issue was more that some websites were not representative of views about the Trust and/or did not provide data which could be validated. He noted that he did not mind if feedback was negative but he did want to see lots of feedback so that it could be validated; the more feedback there was then the more that the Trust could do with it and in response to it and if some of that feedback was critical then the Trust should still receive it.  The Trust Chair moved the meeting onto the next item.  **The Council noted the discussion.** |  |
| **MINUTES & UPDATE REPORTS** | | |
| **7.**  a | **Minutes of the last meeting on 20 March 2019 and Matters Arising**  The minutes of the last meeting were approved as an accurate record of the meeting subject to: at item 13(e) on page 13, “MR” should read “MC”. |  |
| **8.**  a  b | **Update report from the Chair**  The Trust Chair provided an oral update and highlighted, from the initial discussions which he had had with colleagues, Governors and partners, a discussion with the Chief Constable of Thames Valley Police about ‘county lines’ (criminal exploitation of young and vulnerable people in criminal drug supply chains in shire counties). He noted that there were nodes of activity which the Trust should be closely aware of and working in partnership with other organisations to tackle. Care of young people could be one such example, as could care of older people. He commented positively upon Age UK, MIND (the mental health charity) and the active voluntary sector in the Trust’s localities.  **The Council noted the oral discussion**. |  |
| **9.**  a  b  c  d  e  f | **NED update report**  Bernard Galton provided an oral update and set out that since his last update to the Council of Governors, he had: participated on consultant appointment panels; been part of the judging of the Staff Awards; been the guest Chair of the Charity Committee, noting it had been interesting to see in more detail how charitable funds could be distributed around worthy causes within the Trust; been a member of the Quality Committee and the Nominations, Remuneration & Terms of Service Committee; and become the Chair of the Audit Committee.  He reflected upon the rationale for people to become Executive Directors, based on factors such as: their professional background; personal or family experience; and through having a particular interest or a more general interest in wanting to contribute to the local community. He explained that he had two main motivations for becoming a NED: (i) his professional background in Corporate Services, Human Resources, Organisational Development and work in the NHS; and (ii) his personal experience as a carer of a mental health service user of another trust.  In relation to his professional background, he explained how this gave him a particular interest in People Matters (including how the Trust might influence the implementation of the recently published NHS Draft People Plan) and he noted that he worked with the Director of HR on the HR strategy and difficult issues such as bullying which could be a problem across many different types of organisations.  He shared his personal experiences as a carer with the meeting and explained how this helped him to contribute to the work of the Board from participation in Serious Incident (**SI**) panels to striving to see the Trust improve patient experience and engage with families. He commented upon the variety of quality in care which he had seen, from being well involved in conversations about care provided to being marginalised and excluded. He emphasised the importance of clinicians engaging families early in care and using professional common sense especially when applying principles of confidentiality. He explained that when he participated on SI panels, he was keen to check how proactively the family had been involved in the care plan prior to the incident.  He noted that he was assured that the Board was properly interested in family and patient experiences, including what this could feel like. As a Board member, he sought to be assured that the Trust was doing all that it could to engage with families and to respond in appropriate ways. He noted that there were many different ways in which Board members could receive assurance as to whether or not an organisation was running properly. He also referred to recent ward visits which he had conducted with the Director of Corporate Affairs & Company Secretary, noting how impressed he had been with the care that patients were receiving (further to discussions he had had with the matrons and patients). When an organisation was well led and staff were well engaged then that led through to patients being well looked after and families being considered.  **The Council of Governors noted the oral update.**  *The Chief Executive joined the meeting*. |  |
| **10.**  a  b  c  d  e  f  g  h  i  j | **Workforce report – bullying and harassment**  The Director of HR provided an oral update and acknowledged the contribution of Bernard Galton and Sue Dopson, Non-Executive Directors, in helping to form the Trust’s people strategy. He noted that the NHS Draft People Plan gave him some encouragement with its messages on: making the NHS the best place to work; improving leadership and culture; tackling the nursing challenge; and dealing with bullying and harassment. He reported that he had been working with a group of HR Directors from local organisations, including social care, and within the Buckinghamshire, Oxfordshire and Berkshire West (**BOB**) ICS to develop a draft regional people plan. This regional people plan would have four main themes (supported by goals which were being developed): supporting staff; productivity; recruitment and resourcing; and workforce planning. He noted that the Trust’s activity to support the people agenda fitted with the local and national direction of travel. He provided updates on: the implementation of the TRAC recruitment tool; and the development of a bullying and harassment action plan (as required by the CQC), the draft of which had been shared with staff side representatives, the Trust’s Stress Group and with the CQC.  The Lead Governor asked how NEDs had assured themselves that actions taken on stress, harassment, racial abuse and bullying were successful for staff at all levels (including senior staff) and what evidence there was of this. He noted that Governors were still disappointed that this appeared to be work in progress and he recalled that it had been an issue since he started in the role.  The Director of HR noted that the draft bullying and harassment action plan would be shared with NEDs and with the Extended Executive as part of its development.  The Trust Chair noted that the NEDs used the opportunity of visits to wards and services to discuss these issues with staff and triangulate with other data which they received from reports and the Staff Survey. He commented upon how this could provide a more rounded picture. Aroop Mozumder added that the Trust’s data and issues were also not unrepresentative of the rest of the NHS as this was a national challenge, not unique to the Trust.  Bernard Galton noted that it was also challenging to reach a shared understanding of what was meant by/incorporated within ‘bullying’ as some staff might interpret managerial instructions or criticism as ‘bullying’ when it may instead be legitimate performance management. ‘Bullying’ could also cover a spectrum of issues. A lot of work may be required to get to that shared understanding/definition of ‘bullying’, including with staff side representatives bringing the benefit of their experience. He noted the importance of starting from a shared understanding of “bullying” before it could be managed effectively and even then, spot surveys and trend analysis would be required in order to interrogate and analyse the data.  The Director of HR noted that when the Trust had participated in a Health & Safety Executive survey about workplace stress which had included more direct and defined questions about bullying and harassment, the Trust had achieved better scores than in the national Staff Survey (although he emphasised that the Trust should not be complacent in this area).  Governors noted that this did not necessarily improve the situation for staff and emphasised the importance of:   * more frontline work with frontline staff; * better work planning and scheduling to reduce caseload and stress (and increase the time for work to be implemented within); * staff writing down examples of what they considered to be bullying to help to identify what was being reported as it was difficult to fix a situation if it was unclear to managers what they were trying to fix; * recognising how/the manner in which one person approached another could contribute to some behaviour being considered ‘bullying’; * taking time to allow staff to unwind; and * categorising behaviours and identifying where potential issues were, not getting lost in analysis of ‘big data’.   The Chief Executive noted that it was important to be clear about what the issue was and what ‘bullying’ is. However, it was also important to consider the culture of the organisation in particular in situations which had perhaps become taken for granted and accepted. He referred to the risk of having become blind to some issues such as tolerating verbal racist abuse of staff from patients; he emphasised that this was not acceptable. He commented upon the relationship between stress and bullying, especially when the pressure of work which staff were experiencing became stressful. The Trust had reached a point where, for some services, it was becoming untenable to continue to do what was expected of the Trust for the amount of resources it was provided with.  Ben Glass commented upon the rise of the influence of extremists upon people with mental health issues and which were targeted at the vulnerable, noting the importance of challenging attempts to groom or incite extremism or racism.  **The Council noted the oral update and the discussion on bullying and harassment.** |  |
| **11.**  a  b  c  d  e  f  g  h  i  j  k | **Update report from the Chief Executive**  The Chief Executive presented the report COG 12/2019 and re-emphasised the point he had made at item 10(h) above about the important relationship between demand and capacity and the impact which this could have upon staff; as set out in the Overview section of his report, a demand and capacity model was being developed.  He also expanded upon the section in the report on the temporary closure of City Community Hospital Ward for patient safety reasons as there had been insufficient registered nursing staff to ensure safe staffing of the unit. He provided an update on recent developments with the Oxfordshire Health Overview and Scrutiny Committee (**HOSC**), including the vote of no confidence, and re-emphasised that when dealing with a patient safety issue then it was the Trust’s responsibility to act and not deliver services if it would be at risk to patients to do so. The closure was a temporary one and the Trust would consider reopening the ward if it could be safely staffed to do so.  He referred to his report and the upcoming annual CQC inspection.  He referred to his report and developments around Crisis Resolution and Home Treatment Teams, noting the progress which had been made in contractual discussions with Buckinghamshire commissioners to develop these teams. In Oxfordshire, the Trust had emphasised with commissioners that it was a high priority to also provide these teams. The Trust would also be submitting a bid to NHS England for funding to support these teams; however, even if successful the funding would not cover the full cost of these teams but would provide a boost to be able to make progress.  He referred to his report and the changes in the senior leadership team, thanking: Pauline Scully, Deputy Chief Operating Officer, on her retirement; Kate Riddle for her work as Acting Director of Nursing; and Dominic Hardy for his service as Chief Operating Officer.  Reinhard Kowalski referred to the moves to reintroduce Crisis teams and asked about the rationale for having done away with them a few years previously. He noted that currently Adult Mental Health Teams in Buckinghamshire seemed to be mainly doing crisis intervention work.  The Chief Executive replied that the previous models of the Crisis teams may not have been as effective or following standard models and, at a time when there were not opportunities for further investment, decisions had needed to be made about use of resources. At the time, staffing levels on inpatient wards had been low so some of these posts had been redeployed to boost staffing establishment on inpatient wards. It had become apparent since then how challenged mental health services were, especially in Oxfordshire, and how community teams were increasingly becoming involved in crisis care as the Trust needed to focus on looking after the most unwell patients especially when it had limited overall resources. The development of new Crisis Resolution and Home Treatment Teams could help the Trust to augment the services which it delivered, rather than just redistribute resources, and potentially help to relieve pressure on Out of Area Placements. However, a limiting factor could be ability to recruit staff in the area and as this required shift work.  Davina Logan asked about the delay in signing contracts with Oxfordshire CCG, when these were expected to complete and whether there were risks to the Trust because of the delay. The Chief Executive replied that the Trust had also experienced delays in agreeing contracts last year but that it was important to try and take a longer term view to try to avoid facing the same problems year on year. Therefore, with Oxfordshire CCG, the Trust was trying to agree the overall picture for the next 2-3 years. Especially now that commissioners had recognised the historic funding gap, it was necessary to try to address this.  Governors Davina Logan and Mike Hobbs commented upon the interaction with HOSC and the impact upon the Trust’s reputation, which could be damaging. The Chief Executive noted that the media coverage had been balanced and whilst this type of situation was never edifying, the Trust was not prepared to compromise on an issue of patient safety. Mike Hobbs asked whether more could be done to enhance relationships with the HOSC and County Council. The Chief Executive noted that relationships were generally positive and that the HOSC held an independent status within the County Council.  The Lead Governor put forward a question which had been submitted by Madeleine Radburn as to whether the Headington/central Oxford area was the right place from which to provide mental health services, given issues with recruiting staff, and whether other areas may be easier. The Chief Executive replied that this had been considered and he acknowledged the challenges. However, he noted that there were also unique opportunities offered by the location such as collaboration with local universities for research, which helped to inform the Warneford master plan. He commented upon the development of the Warneford master plan, noting that this was progressing well, the layout of plans for the ward area were being considered, ‘green transport’ was being considered to help support the site and regulators were being kept informed. Next steps would involve the Board considering the business case.  **The Council noted the report.** |  |
| **12.**  a  b | **Finance report**  The Chief Executive presented the report COG 13/2019 on behalf of the Director of Finance. In response to a query on the Cost Improvement Programme (**CIP**) he explained that this was a regular challenge and although the Trust had achieved better last year than in the previous year, there were issues with making recurrent savings. This year, a more focused approach to a smaller number of projects was being taken, such as reducing spend on high cost agency.  **The Council noted the report.** |  |
| **13.**  a  b  c  d  e  f  g  h  i  j  k | **Performance report**  The Head of Performance and Information presented the report COG 14/2019 and highlighted that overall at the end of Quarter 3, the Trust achieved 78% compliance across a range of national and local reported indicators, which was consistent with previous performance.  She noted challenges in relation to performance against targets for:   * % of clients in settled accommodation. She added that the Performance team was getting to the root cause of the issue and had identified that it was a reporting issue which could be addressed through configuration of systems; * waiting times for access to community mental health services in Oxfordshire and Buckinghamshire. This was linked to historic underinvestment in mental health services and high demand for services; and * Continuing Health Care and demand exceeding commissioned capacity.   She added that the Performance and Business Services team was initiating work to develop an understanding of the clinical risks associated with these targets/reports, for operational services. As this work developed, the Director of Strategy & CIO would be able to update the Council. Sula Wiltshire hoped that this work would highlight the clinical risks which may be of most concern so that work could take place to minimise or mitigate any such risks.  Sula Wiltshire referred to the Operational Performance Headlines and performance against the 4-hour waiting times target in Minor Injury Units (**MIUs**). She noted the reference to the national average of 86.6% and asked if that average figure related to MIUs or to Emergency Departments. The Chief Operating Officer replied that this comparative average figure was related to Emergency Departments but emphasised that reporting of performance was set against the Trust’s target of 95%. Against the Trust’s 95% target, performance had dropped to 94.3%.  Sula Wiltshire also emphasised the importance of maintaining oversight of Out of Area Placements as these could represent quality and financial issues and involved vulnerable patients.  Davina Logan referred to the performance indicators which were not achieved and asked which could cause the most sleepless nights.  The Trust Chair replied that he was concerned about what lay behind performance indicators, especially in relation to the provision of mental health services. Although the Trust could measure what activity was taking place, what happened subsequently in terms of outcomes could be both more important and more difficult to measure. He noted his concern about people who returned to services as this could imply that the Trust had been unable to equip them to live sustainably outside of services. This could, however, also be exacerbated by the challenges around lack of resources. Aroop Mozumder added that the Trust did not have the capacity (in terms of staff and/or funding) to treat everyone it may wish to but this was also a national problem.  The meeting discussed Out of Area Placements, noting that sometimes these could result in people being transferred to specialist inpatient units where they could experience treatment which they would not have been able to access locally. The Medical Director added that, for such reasons, a number of Out of Area Placements may be entirely appropriate. Alan Jones noted that it would be useful if Out of Area Placements could be analysed in order to highlight whether or not they were prompted by clinical need.  Ben Glass asked, in the context of earlier discussion around bullying, harassment, dignity and respect, whether it was the view of the Council of Governors that the Trust Chair had used a respectful term to describe patients with mental health needs. The Trust Chair apologised for his earlier phrasing and noted that he should not have used the term. He explained that his concern had been that if he asked clinicians if they had seen a patient before, and if they confirmed that they had, then this could imply that the Trust had been unable to help a patient move into a situation whereby they would no longer need Trust services.  Gillian Evans added that it was an unfortunate fact of life that there were people with enduring mental health issues who needed ongoing support in the community. It was, therefore, not realistic to expect that every patient could reach an ultimate point of recovery so as not to need to access services again. She agreed with the need to divert resources to support crisis care but noted that if robust care in community was also available then it could prevent people from needing to access crisis care in the first place.  **The Council noted the report and the discussion**. |  |
| **14.**  a  b  c | **Governor Elections Report**  The Director of Corporate Affairs & Company Secretary presented the report COG 15/2019 on the process to elect Governors to sit on the Council and on the outcome. With the exception of the Public Buckinghamshire constituency, all seats had been filled. In the Public Buckinghamshire constituency however, two seats remained vacant as only one of the available three seats had been filled. More work would therefore be needed in Buckinghamshire for the next round of elections to encourage members to stand for election as Governors. She thanked all who had engaged in the elections process, including the recently elected Governors.  Ben Glass referred to the two vacant Governor seats in the Public Buckinghamshire constituency and asked whether unsuccessful candidates who had contested other seats could be put forward to fill these vacancies. The Director of Corporate Affairs & Company Secretary explained why this would not be possible given that candidates stood for election from the members of their specific constituency; if a vacant seat were given to an unsuccessful candidate who had been contesting the position for another constituency then they would not have been elected by the members voting from the relevant constituency for the specific seat on the Council.  **The Council noted the report.** |  |
| **15.**  a  b  c | **Provider Licence self-certification**  The Director of Corporate Affairs & Company Secretary presented the report COG 16/2019 and invited the Council to support the declarations made by the Board, as set out in the report, and/or to provide their views especially in relation to the declaration on providing necessary training to Governors. She noted that the report set out the Board’s considerations in making declarations. She confirmed that the declarations would be published on the Trust’s website and could be subject to spot-checks by the regulator.  The meeting discussed the provision of necessary training to Governors, whether there was a budget for training and commented upon support available for Governors including compared to other trusts which may provide officers whose full-time job was to look after Governors. No specific training was suggested or identified as lacking. Governors commented that although training may be provided/offered, whether this was taken up by Governors was a different matter.  **The Council noted the report and supported the declarations.** |  |
| **16.**  a  b  c  d  e  f  g  h  i | **Update report from Council sub-groups and Governor Forum**  ***Membership Involvement Group (MIG)***  The Director of Corporate Affairs & Company Secretary reported that the MIG had discussed the Governor elections and the Membership Strategy which had been approved at the last meeting. No matters to escalate to the Council.  ***Patient & Staff Experience Group (PSEG)***  Gillian Randall noted that the Council meeting this evening had already covered matters which had been escalated by the PSEG. She extended an invitation to new Governors to join the group.  ***Safety and Effectiveness Group***  The Lead Governor reported on behalf on Madeleine Radburn that areas which had been discussed included:   * the Oxfordshire Night Team/Out Of Hours Team; * the wording of the new quality objectives for the Quality Account and whether these were the same as/had moved on from the old objectives; * Out of Area Placements and need for appropriate, rather than fast, treatment; * outstanding/overdue CQC actions as the group had requested an update; and * lack of need for clinical audits to continue where they consistently achieved results of 99-100%, unless externally mandated.   He noted that the group was also in contact with Governors from other local trusts, such as OUH and SCAS, regarding matters of joint interest.  ***Governor Forum***  The Lead Governor noted that the Council meeting this evening had already covered matters which had been escalated. He added that he had also opened discussions with fellow Lead Governors of BOB ICS organisations and they hoped to have a meeting with the Chair of the BOB ICS when they were in post. He referred to the Trust Chair’s opening remarks at item 1(e)-(g) above and suggested that the Trust and Governors should try to be at the forefront of change, including in influencing the ICS. The Trust Chair added that when the appointment of the Chair of the BOB ICS was made public then it may be appropriate to invite them to attend a meeting in the future.  ***Other sub-groups and general update***  The Council noted that the following sub-groups had either not met or there was no update to bring:   * Governors’ Nominations & Remuneration Committee; and * Finance sub-group   The Lead Governor noted that new Governors were invited to join Governor sub-groups and there was no limit on the number of groups they could join; other/existing Governors were also welcome to attend meetings on an ad-hoc basis and were requested to contact the Governor chair of a particular group if they wished to do so. He added that the Governance sub-group would also be meeting presently and he encouraged Governors to attend to discuss governance and the Constitution.  Reinhard Kowalski asked whether an additional sub-group could be set up to focus on Staff Working/Experience. The meeting discussed and noted that whilst this was already part of the remit of the PSEG, the agenda which this group managed may now be too large to be able to devote sufficient time to matters of staff experience. The Lead Governor expressed concern that some existing groups were not well attended, such as Finance. The Chief Executive recommended considering carefully the staff and governor time which went into supporting and attending these groups, noting that with all groups it was important to ensure that value was being achieved for the time spent. The Medical Director suggested that Governors could instead attend some of the existing Staff Wellbeing groups/meetings and participate in that way, rather than through setting up a new Governor sub-group.  **The Council noted the updates.** |  |
| **17.** | **Questions from the public**  None. |  |
| **18.** | **Any Other Business**  None. |  |
|  | Meeting close: 20:15  Next meeting: Thursday, 05 September 2019 at 18:00, Spread Eagle Hotel, Cornmarket, Thame OX9 2BW |  |