Oxleas NHS
NHS Foundation Trust

35th Meeting of the Council of Governors
Applegarth Suite, Bexleyheath Marriott
11th December 2014, 3.00 pm – 5.00 pm

Governors shall withdraw from any item at meetings or discussions where they have or are likely to have an interest.

AGENDA

Item		Purpose	Presented by	Enc.
1	Apologies	To note	Ann Rozier Trust Secretary and Head of Governance	-
2	Minutes of the Council of Governors meeting 18th September 2014	To agree	Dave Mellish Chairman	**1**
3	Matters arising	To note	Dave Mellish Chairman	-
4	By-election results	To note	Ann Rozier Trust Secretary and Head of Governance	**2**
5	Volunteering and Social Inclusion	To note	Estelle Frost Director of Older Peoples' Mental Health Services	**3** **Presentation**
6	Redesign of Community Mental Health Services	To note	Iain Dimond Director of Adult Mental Health	**4** **Presentation**
7	Update on acute mental health bed changes	To note	Helen Smith Deputy Chief Executive and Director of Service Delivery	**5** **Verbal**
8	Annual Plan Target Setting	To note	Raymond Sheehy Lead Governor	**6**
9	Nominations Committee update	To note	Dave Mellish Chair	**7** **Verbal**
10	Holding NEDs to Account - working group update	To note	John Woolgrove Governor	**8a&b**
11	Board of Directors Meeting Governors update	To note	Baeti Mothobi Governor	**9**

Oxleas NHS
NHS Foundation Trust

35th Meeting of the Council of Governors
Applegarth Suite, Bexleyheath Marriott
11th December 2014, 3.00 pm – 5.00 pm

Item		Purpose	Presented by	Enc.
12	Membership Update	To note	Jo Mant Head of Stakeholder Engagement	**10**
13	Chief Executive Update	To note	Stephen Firn Chief Executive	**11** **Presentation**
14	**Advance Questions**			-

Date and Time of the next meeting
19th March 2014 – Bexleyheath Marriott
3.00pm

improving lives

Oxleas NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 2
Enclosure 1

Agenda item	Minutes of the last meeting of the Council of Governors 18th September 2014
Item from	Dave Mellish, Chair
Attachments	Minutes of 18th September 2014

Summary and Highlights

Key Benefits:

Recommendation:

The Council of Governors to agree the minutes as a true record.

Oxleas NHS
NHS Foundation Trust

34th Meeting of the Council of Governors

18th September 2014
3pm – 5pm Applegarth Suite,
Marriot Hotel, Bexleyheath

Agenda

Chair: Dave Mellish
Trust Secretary and Head of Governance: Ann Rozier

Public Governors	**Service user/ carer Governors**	**Appointed Governors**
Stephen Brooks	Fola Balogun	Maureen Falloon
Richard Diment	Katherine Copley	Carl Krauhaus
Amanda Finlay	Alan Cork	Raymond Sheehy
Jennifer Grant	Baeti Mathobi	Malcolm Wood
Dalla Jenney	Chris Purnell	
Eimear Mallen	Stephen Seabrooke	
John Woolgrove	Lesley Smith	
Staff Governors		**Guests**
Barbara Cawdron	Kaye Jones	Anne Hinds-Murray Bexley Healthwatch
Steve Francis	Mary Titchener	
Maggie Grainger		

In attendance:

Non Executive Directors	**Executive Directors**	**External presenters**
Anne Taylor	Stephen Firn – Chief Executive	Mathew Hall – Deloitte
Archie Herron	Dr Ify Okocha – Medical Director	Ben Sheriff - Deloitte
James Kellock	Wilf Bardsley – Director of Nursing and Governance	Bob Kitchin – CEO SEEC Tracy Douthwaite – Operations SEEC
Steve James	Iain Dimond – Director of Adult Mental Health Services	

	Item	**Action**
1.	**Apologies** Marcos Da Silva, Alan Downing, Judith Ellis, David Gardner, Rob Hayles, Jenny Kaye, David Palmer, Raymond Pope, Ken Thomas, Anne Voce, Judy Wolfram, Jason Morgan, Eleanor Jones, Helen Smith	**Noted**
2.	**Minutes of the last meeting of the Council of Governors 19th June 2014** Apologies were received from Chris Purnell. Item 5 Nominations Committee Update – *from* October 2015 there will be a number of changes to the Board. Subject to these changes the minutes were agreed.	**Agreed**
3.	**Matters Arising** **Recruitment Campaign page 2** – 30 people were shortlisted from the 'helpline'. 6 were appointed and one declined the offer. The costs were less than using an employment agency and the number of applications for vacancies has risen significantly following the campaign. There will be a similar campaign for Health Visitors and Allied Health professionals in the Autumn. **Annual Plan page 6 –** an update will be given under the Chief Executive's item. The Annual Plan process for 2015/16 will be main agenda items at the Dec 14 and March 2015 meetings. **Reconfiguration of Mental Health Services page 7 –** RD reported that Bexley Healthwatch and a Bexley	**Noted** **HS**

	Councillor had raised some concerns with him regarding the consultation around this decision and that of closing North House. RD requested an explanation around these concerns. DM introduced Iain Dimond, Director of Adult Mental Health Services. ID – The ideas around reconfiguration in Adult Mental Health are at a very early stage. Over the next year there will be more detailed discussions with patients, staff and other stakeholders. Every year we have conversations with our commissioners about what efficiencies may be made. The CCG agreed that the plan to close North House had the least impact on patients in meeting these efficiencies. North House is a 14 bed rehabilitation unit. All families have been offered a visit. All patients moving on will be found appropriate accommodation within the Borough. Staff have been consulted and we have met with colleagues from Healthwatch. **New requirements about publishing staffing levels page 8 –** This is being monitored very closely. Funds have been allocated to staffing budgets. Progress will be reported at the December meeting.	**WB**
4.	**External Audit Report to the Governing Body 2013/14** Mathew Hall, Partner and Ben Sheriff, Director from Deloitte presented the reports. **External audit report to the Governing Body on the audit of the Trust's 2013/14 financial statements –** The audit of the Trust's 2013/14 financial statements has been completed. Deloitte issued an unmodified report for the year and this is included in the Trust's Annual Report. There were no reports on any items 'by exception'. • The key areas of focus were: o NHS revenue and provisions; o Property valuations; o Accounting for Queen Mary's, Sidcup; and o Management override of controls (a required risk under auditing standards). Other specific issues this year were the transfer of community assets and the consolidation of the charity. The Trust adopted an "adjusted" presentation for the income statement this year, showing results before the impact of the QMS transaction and revaluations. Although not usually necessary in the NHS, this is relatively common for listed companies as it shows the underlying performance of an organisation. The presentation adopted follows the guidance for presenting adjusted results. **Findings and Recommendations from the 2013/14 NHS Quality Report External Assurance Review –** Deloitte completed the review, including validation of the selected indicator of: o Crisis Resolution Home Treatment Team access; o Care Programme Approach 7 day follow-up; and o As a local indicator, the Patients who would recommend the Trust to friends or family. Deloitte issued an unmodified opinion for inclusion in the 2013/14 Annual Report. The scope of the work is to support a "limited assurance" opinion, which is based upon procedures specified by Monitor in their "Detailed Guidance for External Assurance on Quality Reports 2013/14". In response to the growth of performance indicators across the NHS, Deloitte have developed a framework of considerations for evaluating data quality. This framework was used in evaluating the findings and the recommendations raised. Recommendations have been given on audit trails to evidence the reported figures for two of the three indicators tested, and a general review of the process for reporting data. The report sets out recommendations for improvement in the Trust's data quality which have been accepted by management. SS – On Page 7 - The Trust debt has gone up from £3.4m in 12/13 to £8.3m in 13/14. Is this due to Queen Marys? BT – This is the biggest element. SB – It states on page 7 that changes to commissioning structures means that a significant part of the Trust's income is now commissioned by NHS England. BT – 18% of our income now comes from NHS England (Forensic and prisons and some children's services).	**Noted**

	SB – Please explain more about the surplus and underlying surplus. BT – Last year was an exceptional year for the Trust e.g. in terms of the acquisition of Queen Marys and changes to property values. This had a big impact on the accounts. We have taken these exceptional items out so that our audience can see the underlying surplus of £3.4m. SS – The Trust Special Administrator said that a Trust ought to aim to have 1% surplus to be viable. Is 1.5% reasonable? BT – We planned for 1.5% last year but this is reduced for next year. SB – How well is external audit helping to make sure we stay healthy? AH – This is where the Trust Risk Register comes into play. We look at all the potential risks to the organisation carefully every two months. Working on a 1-2% margin is tight and we continue to keep strict controls over this. SF – The 1% surplus is also in the context of having to make 4% savings each year. Our auditors look at the risks around being able to deliver those savings and how good and realistic our plans are. BT – We can control what we spend and our strategy but we cannot control what decisions commissioners make. AH – All decisions made to make savings are carefully considered for their impact on quality. DM – This is one of the big issues for the Board. How to maintain quality while demand rises and resources are going down.	
5.	**Serious Incident Inquiry Report** CP gave the report into a serious incident involving an Oxleas patient who, on 3 March 2014, was charged with the murder of an elderly neighbour. On 2 December 2013 following a relapse the patient was admitted to Betts ward and due to his mental state and behaviour on the ward was transferred to the Tarn PICU (Psychiatric Intensive Care). On 15 January 2014 he was assessed as suitable for on-going treatment within the low secure services at Memorial hospital. However as his mental state improved he was able to go on leave in the company of his parents. In light of his improvement and his concern that a long inpatient admission would impact on his housing tenancy he was reassessed and with the full involvement of the patient and his family it was agreed that he should be discharged to the care of the Assertive Outreach Team. In the days immediately prior to his discharge he met with his care coordinator and consultant clinical psychologist from the Assertive Outreach Team and was discharged home on Friday 28 February 2014 with a plan to see the Consultant Psychiatrist of the Assertive Outreach Team the following Monday. During the morning of Sunday 2 March he called 999 stating that he had killed a neighbour. On 3 March 2014 he was charged with murder. The Inquiry Panel carried out an investigation into the circumstances as laid out in the Inquiry Panel's detailed terms of reference. The family of the perpetrator and victim were invited to participate but declined. Root Cause Analysis methodology was used but the inquiry panel did not identify a root cause. However they did make recommendations from their findings in relation to discharge arrangements, assessment of risk of violence and alcohol and illicit drugs. **The Inquiry made the following recommendations** 1. Where a person has a recent history of substance misuse there should be a consideration of its impact with a documented assessment of risk (including risk of violence). A clear plan addressing the risk and relapse should be agreed and in place prior to discharge. 2. Outcomes of meetings with family and discussion about risk should be documented in RiO. 3. There should be a clear policy describing the circumstances and arrangements for leave with family members or carers from the Tarn. 4. If a low secure bed is not available at the time of referral and assessment there should be a case conference to agree and document a plan of care. 5. All conclusions of clinical discussions are to be recorded within the primary clinical record, RiO. 6. If a patient is discharged from acute adult mental health inpatient services over the weekend the care plan must take into account the support required in the immediate period after discharge. 7. In the circumstance that discharge to the community is considered from the Tarn such discharge should not take place at the weekend. Furthermore, there must be a formal hand over of care from consultant to consultant to manage transition and ensure the availability of a robust care plan with clearly outlined crisis and contingency plans prior to discharge.	**Noted**

	RS – One of the most dangerous times for patients is being discharged from a highly structured setting into a setting with all the freedoms available – alcohol, drugs etc. I would suggest we consider that people may need some help in the transition period. This doesn't have to be the AOT but just a visit would be helpful in these circumstances. SS – Concern on this is that the person was assessed as being suitable for low secure services 6 weeks before discharge from the PICU into the community. PICUs are institutionalised environments and not perhaps as therapeutic as general mental health inpatient services. They have very disturbed and challenging patients. It seems a less than optimal arrangement that a patient could be discharged from this to the community under any circumstances. IO – I think discharge from PICU to home is an exceptional circumstance. The Panel spent a lot of time speaking to staff on the Tarn about this and to establish that it was a rare event. This is why it was clear in the recommendations that no discharge should take place on Friday. EM – What was the average stay for this unfortunate young man before he improved? WB – He was admitted at the beginning of December. Broadly speaking, admissions to Tarn are between a month and 3 months. His admission was not unusual in terms of the amount of time he spent on this ward. LS – Is there a contact number or helpline out of hours? WB – He did have contact numbers for the Crisis Team. SF – To check my understanding, his family were at the discharge meeting and he had regularly spent as much as 10 hours on leave with them. He spent the Friday evening with his family and they took him home on Saturday. The incident happened on the Sunday. SS – My other point on this is that someone spent 6 weeks unnecessarily on the intensive care ward. This seems unfair to over institutionalise someone who doesn't need that level of support. CP – I would say the reverse is true. He was in intensive care and he improved enormously there. That apparent improvement swayed people's judgement. AF – Fully support the point about weekend discharge. Does the crisis line number get patients through to a person or is it to leave a message? The movement from a structured environment to the community has arisen in a previous case a few years ago when a young man committed suicide. Staff were 'over' impressed by his wanting to get back to work and his flat. There was a halo effect. WB – Yes, the call to the crisis line will get through to a person. SF – This is a good challenge but we are looking at this now knowing it went wrong. Decisions like this are being made all the time. There are some extraordinary things around this case – discharge from the Tarn PICU at the weekend. Even though this is exceptional the Panel needed to focus on whether this was a reasonable decision taken by that team at that time. Should they have known? IO – When sitting with someone in a clinical encounter, you want to be hopeful and supportive. Risks need to be weighed. Here was a young man who had improved, was engaged and had support from his family who were keen for him to come home. It seemed to discharge was the right thing to do. SJ – I would like to echo the comments already made as I was on the Panel. It was clear that this incident was not predictable. We were convinced that the decision to discharge was not influenced by resources. Many people were involved in this decision. DM – This was a terrible and tragic event. An important part of the Inquiry process is to learn lessons to help in making sure the same mistakes do not happen again. If any Governors have further questions on this Inquiry or the action plan please do not hesitate to contact members of the Panel or Iain Dimond who will be ensuring the action plan is implemented.	
6.	**Changes to the Constitution** The changes to be put to the vote at the AMM are: 1. As agreed at the June meeting of the Council of Governors - To add a further public constituency by introducing a fourth named 'Rest of England'. People living outside Bexley, Bromley and Greenwich will be able to join this constituency. 2. The primary care trust appointed seats will be removed from the Council of Governors numbers. 3. Our Council of Governors can formally require directors attend their meetings. 4. Any mergers, acquisitions, separations, dissolutions or significant transactions must be supported by more than half of the Council of Governors. 5. Vote to allow our Governors and board to agree changes in the Constitution. A leaflet explaining the changes has been sent out with the AMM invitations. It was agreed at the June meeting that the technical changes (2-5 above) were to be overseen by the Governors Standards Committee. The Council of Governors agreed the Governors Standards Committee recommendations outlined above.	**Agreed**

7.	**Election Results** **Lead Governor -** Raymond Sheehy has been re-elected Lead Governor for a further 3 years. **Service User Carer governors** Chris Purnell (re-elected), Hannah Chamberlain, Irene Bajedo There were no nominations to the Learning Disability or Adult Community Health vacancies. **Staff Governors** Joe Nhemachena – Corporate, Kaye Jones re-elected Learning Disability, No nominations were received for CAMHS or Bexley Community Health staff classes. **Public Governors** **Bexley** - Carole Wilson **Greenwich -** Amanda Finlay re-elected, Rob Imeson **Bromley -** Frazer Rendell, Shouvik Datta, Tanya Thuy Nguyen DM welcomed and congratulated all newly elected and re-elected governors and thanked all outgoing governors for their hard work and contribution to the success of Oxleas.	**Noted**
8.	**FTN and FTGA merger** A ballot of members to merge was successful and the FTGA has agreed to join forces with the Foundation Trust Network (FTN). The FTN is the membership organisation for NHS public provider trusts. It represents over 200 Foundation Trusts and aspirant FTs. From an operational perspective, the FTGA and FTN have been acting as one organisation from the beginning of September 2014. Services for governors will continue to include development days and networking opportunities along with enhanced policy support including the provision of written advice and publications, as well as high quality member communications. The Governwell Programme will be unaffected by this change. RS – I served on the Board of the FTGA for 2 years. I was opposed to this arrangement as I felt that Governors need to have a strong voice and remain independent. I will be looking to be involved and influencing this.	**Noted**
9.	**Holding NEDs to account working group update** JW fed back on the progress of the working party. We are trying to interpret the duty of 'holding NEDS individually and collectively to account for the performance of the board' and what processes are needed to support this. At first the membership of the working party was just governors as we wanted it to be governor led. We wanted also to work in partnership with NEDs. After a couple of meetings we asked for NED representation and JK volunteered to join us. This has worked well. Governors are invited to contact JW with suggestions. Meetings are held on a regular basis. The Council of Governors approved the proposed terms of reference for the group. An extract (4.1) from Monitor's guidance 'Your Statutory Duties – A reference guide for NHS foundation trust governors' was included with the papers. Anyone who does not have a copy of the whole document please contact AR. The group are developing the policy that will outline the process. Whilst the policy document will need the Council of Governors approval, some of the common sense processes are being introduced as we go along: • Papers for Board of Directors meetings – these are available on the Oxleas Website. • Governor attendance at Board meetings. • Board pre meetings between Governors and NEDS with the opportunity to ask questions. The consensus was that governors feel that they would benefit from more training in this area. • At the end of the Board there are also opportunities for questions as it is a meeting held in public. These are recorded in the minutes. • Board minutes will be included in the papers for Governors meetings. • Getting to know NEDs. We are committed to working in partnership. We see a lot of some NEDs but some others we see less of. • Looking at information requirements. DM – Thanks to all governors involved in this piece of work. To come back to the meeting in December with another progress report.	**Approved** **JW**
10.	**Board of Directors meeting update** Stephen Brooks gave the update.	**Noted**

Part of the Governing Body's duties is to monitor and hold to account our Non-executive Directors (NEDs) for the performance of the Board. It was decided there would be a rota of Governors detailed to attend the Board meetings. As part of the rota of visiting Governors, I attended the July and September Board meeting along with Baeti Mothobi (July & September), Mary Titchener (September), Fola Balogun (July), Ken Thomas (July) and Judith Wolfram (July).

Pre-Meeting Questions

The arrangements for the process of asking questions at the NEDs/ Governors' pre-meet before the Board meeting are still in flux so at the July meeting there was no pre-meeting with the NEDs. However, by the September meeting it was established that the visiting Governors would each ask a question at a pre-meeting. This procedure itself is still experimental, but the three questions which were forwarded to the NEDs were as follows:

"What have the NEDs done so far and how will they proceed in ensuring that the 'Sign up to safety' strategy announced by the Secretary for Health in March 2014 is in force within the FT and what measurement is being used to check progress?"

NEDs explained that there was no one factor but a combination of elements that went towards their objective of ensuring patient safety. It was already a major feature of their work with quarterly reports on matters such as pressure sores, falls, medication errors, reductions in avoidable harm. Reviewing why things go wrong and taking corrective steps, working with others, CQC reports, the risk register, patient experience responses and above all honest reporting. Other information came from Mental Health Act commissioner visits. The regular series of visits to Oxleas services they made also enabled them to check for themselves against the reports they received. The point was also made that although the strategy was launched in March very little else had been heard from the DoH.

"Do they have a feel for what are going to be the biggest dangers facing Oxleas?"

It was considered that there were a number of factors which presented dangers to the Trust but the significant feature was that demand for services was going up but resources were going down. The challenge was to take these factors on board but not lose attention to the quality of the Trust's services. It was suggested that currently the Trust was big enough and had sufficient cash reserves (a condition absent in many Trusts) to be able to take some knocks.

"How as NEDs do they assure themselves of the accuracy of the quality reports that are presented at the Trust Board?"

The NEDs considered that as already mentioned their own observation of the Trust's services during personal visits to services, talking to staff (who were not afraid to speak frankly), external scrutiny from organisations such as Monitor and the CQC, internal and external audit reports and meeting Executives outside of the Board meetings, all help paint a picture of the Trust's workings and environment.

In response to a quick question about frustrations it was suggested that the NHS was a big system ("big slow beast") with a lot of vested interest which impacted on the working of the Trust.

Board Meetings

In meetings of the Board, with agendas consisting of some 17 items, there are regular reports on some 30+ key performance indicators (such as maximum time before treatment), individual service developments, quality, compliance, staff and finance. Reports of external monitoring visits are presented. Included will also be specific reports on certain aspects of the Trust's functioning for example in July the estates strategy was looked at. Also presented are reports on issues the Board have requested. For example in September, meeting the level of the use of bank and agency staff and therapy waiting times were reviewed. In the formal board meeting itself NEDs were observed to ask detailed question of the information presented to them seeking clarification, questioning the reasoning or background for decisions or actions taken, asking detailed questions and suggesting courses of action. Also, it should be noted NEDs are very present in the sub-committees of the Board where possibly far more detailed review, questioning and holding to account is possible.

General Observations

In attempting to assess the success of NEDs in holding the management of the Trust to account, an important factor in my opinion is the climate within which the relationship between the two parties works. My perception is that we have a knowledgeable, perceptive and demanding NEDs team responded to by an open, honest and challengeable group of senior executives. The same reaction was similarly exhibited by the NEDs to our questioning.

DM – We have decided that there will now be a formal board every first Thursday of the month (except August) and 2 x all day informal meetings each year, one in December and one in June to discuss strategy

	and annual planning etc. There will be invites to governors to attend.	
11.	**Membership Committee update** The Committee has not met since the last Council of Governors meeting. For various personal and business reasons the members have not been available. However, at the last Council of Governors there was a discussion about the need for a strategic overview. There are a number of issues that we need to address relating to membership numbers and the problem of Governors being elected with a very low number of votes (2/3 votes). This may become an issue with Monitor if we do not address it. The Membership Committee cannot resolve these on its own. A concerted strategy, not just on how members are recruited but also how governors are elected and how they act as a bridge between their member constituencies and the Trust. The proposal is that a small group will get together to form the head of the new strategy which will include all of this. We would like to present this to the Council of Governors for comment and then to the Board with recommendations. DM – The direction of travel is good. Much of the efforts around this are not reported, for example, RS and I were at Charlton Athletic FC last Saturday which had a theme to encourage relationships between the Club and Oxleas particularly around membership. There was a full page in the programme (written by our own appointed governor, CK) and at half time there was a video of one of the players signing up as a member of the Trust encouraging supporters to do the same. The organisation will support the new strategy, not just for the numbers, but for better engagement which is what we are all about. SS – For the short length of time we have had a formal relationship with CACT (partnership organisation/ appointed governor), the support from them has been phenomenal.	**Noted**
12.	**Chief Executive's update** **Performance** The King's Fund Report shows their analysis put Oxleas at the top in the country for Staff engagement score, 2012 – 2009. This has now been published. Since this, there has been continued positive feedback from staff. The Health Service Journal Ratings named Oxleas in the 10 Best Places to Work in the NHS. The Friends and Family Ratings show that the Trust scored +24 (range +44 to +5) in recommending the Trust as place to receive treatment and care. The score of +18 (range +48 to -8) was given to: 'recommend Oxleas as a place to work'. This result here seems to be the best of any London Trust. The only service with a negative score was Bexley Community Health. There is an action plan to support District Nursing. RD – As a Public Governor from Bexley this is concerning. SF – I would be happy to go through the detail of the variety issues in Bexley with governors. Greenwich was more positive. One part of the context is that there are fewer District Nurses in Bexley and much fewer professions working alongside them such as podiatry and speech and language. The workload is higher also. Those are givens and we must support staff. It is reassuring that there is no evidence that this is impacting on patient care. There has been very good feedback about Bexley services. The National Mental Health Patient Annual Survey was positive. It focusses on Adult and Older Adult Community Mental Health Services. 850 Questionnaires were sent out to a sample population and our response rate was 27% (223 service users). The National average for response was 29%. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing. There were no sections where the results for Oxleas were among the worst performing trusts. In 8 Sections we were about the same as other trusts and in one section, Crisis Care, we were statistically better than others. For a London Trust, this is a good result. SS - The result for Crisis Care superb in relation to the position a few years ago. Monitor ratings – Our plan was to be a '4' for Finance (lowest risk rating) and 'green' for Governance. We received our 1st Quarter Report from Monitor confirming that we had achieved this. There are no regulatory issues to report. **Tender Activity** Bromley Older People's Service - This is from Bromley Council to provide social care/ supported living due to start April 2015. We are bidding for a very large contract of £13m relating to the three prisons in Greenwich in conjunction with GPs in Maidstone as they are already partners. There is a defensive bid for the Greenwich CAMHS service in partnership with SLAM (who provides inpatient). We hope to be re-awarded that for next April. A mixture of defensive and new tenders is taking place for Bexley Integrated Children's Services. We are putting ourselves forward to be the prime contractor for a large range of services. Greenwich Urgent Care Service is also going out to tender. We will work with	**Noted**

	Lewisham and Greenwich and GPs. We will not be a prime contractor in this case. **Queen Mary's Hospital** Huge amount going on at Queen Marys. We are building a specialist unit for the intermediate care and neuro-rehabilitation ward due for completion in October. F Block is being developed as a Children's Centre for integrated children's care. Guys will be the providers for the new Kidney Treatment Centre located where the restaurant used to be. This will open next June. There is also a new build Cancer Treatment Centre due to open in 2016. This will provide outpatient radiotherapy and chemotherapy. LS – Are there any plans for a maternity unit? SF – That was the Kent Women's wing. That was closed before we took over the site (along with A&E) and a residential home had already been planned to be built there.	
13	**Social Enterprise Employment Company (SEEC)** One of the key priorities since becoming a Foundation Trust has been to support the social inclusion of service users. Governors have been very much involved with the Executive of the Trust in trying to improve employment opportunities for patients. A few years ago Oxleas took the decision to fund an independent social enterprise company to lead our efforts. This company, SEEC is managed by Twining Enterprise charity and serves Bexley, Bromley and Greenwich. The aim of SEEC is to improve the quality of life, confidence and self-esteem of people within Oxleas' service users with mental health issues or other disability by helping them engage with paid work. 250 people have been supported, 72 jobs have been secured. 22 people have received further training and 59 have gone into volunteering. We monitor clients' wellbeing and 85% report improved wellbeing. SEEC provides support through a named advisor and by providing support with personal and practical steps into work e.g. writing CVs. There is also Work Club Plus funded by Jobcentre Plus. This is a 5 week employment skills course followed by 13 weeks individual support. Peer support and reducing isolation is an important element. The next steps are to develop relationships with Jobcentre Plus, widen the funding base and strengthen and sustain the service. We are now moving to a stage where there are too many clients for one premises so we are looking at how we can work with partners on this on an outreach basis. SEEC continue to develop the service model. The next steps for Oxleas are to undertake a pilot in Learning Disability and engage more closely with service directors to establish needs. RS – The numbers look impressive. However, I have not been able to find SEEC via the internet and cannot find a link to you from the Oxleas website. Can you improve this please? BK – We recognise the need to improve in this area and we are working with the Communications team. AC – How much contact do you have with the big employers who may tell you what you want to hear but don't deliver, particularly around mental health stigma? BK – The Board are keen to make sure that we are not just concentrating on gaining employment but provide a follow through into the workplace. Our job searches tend to be on a case by case basis that is tailored to the client. Policies on mental health in big companies are increasing but changing culture is a slower process. Progress is being made but there is still a way to go. CP – To what extent do you brief your clients on their employment rights? TD – We do a lot on this early on and throughout the process. We also will speak to employers on this subject. LS – What is the proportion of part time and full time work and the effect on benefits? TD – It is around 50/50. DM – We will ask for a further progress update from SEEC at the end of 2015.	**Noted**
	AOB The Annual Members Meeting is on Wednesday, 24th September at Indigo at the O2. The main speaker will be Dr Geraldine Strathdee, National Clinical Director for Mental Health.	
	Time and Date of the next meeting **11 December 2014** **Applegarth Suite, Marriott Hotel, Bexleyheath** **3.00 – 5.00pm**	

I confirm that the minutes of the Council of Governors meeting of 18th September 2014 are a true record
Signed Date:

Dave Mellish Chairman

improving lives

Oxleas NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 4
Enclosure 2

Agenda item	By-election Results
Item from	Ann Rozier, Trust Secretary and Head of Governance
Attachments	ERS Report of Voting

Summary and Highlights

Election Results:

Service User/Carer Governors
Renuka Abeysinghe – Adult Community Health
Mary Stirling – Adult Community Health
Ken Thomas – Adult Community Health

There were no nominations to the Learning Disability Special Interest vacancy.

Staff Governors
There were no nominations received for the CAMHS or Bexley Community Health staff classes.

Key Benefits:

Recommendation:

To note.

22nd October 2014

OXLEAS NHS FOUNDATION TRUST
ELECTION TO THE COUNCIL OF GOVERNORS 2014

Further to the deadline for nominations for the above election at noon on Wednesday 15th October 2014, the following constituency is uncontested:

Service User/Carer: Adult Community Health 3 to elect
The following candidates are elected unopposed: Renuka Abeysinghe Mary Ellen Stirling Ken Thomas

Service User/Carer: Learning Disability 1 to elect
No Nominations received

Staff: Child and Adolescent Mental Health 1 to elect
No Nominations received

Staff: Bexley Community Health Services 1 to elect
No Nominations received

John Box
Returning Officer
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Oxleas NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 5

Enclosure 3

Agenda item	Volunteering and Social Inclusion
Item from	Estelle Frost, Director of Older Peoples' Mental Health Services
Attachments	Front Sheet only

Summary and Highlights
This item is a presentation.

Key Benefits:

Recommendation:

To note.

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Oxleas NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 6

Enclosure 4

Agenda item	Redesign of Community Mental Health Services
Item from	Iain Dimond, Director of Adult Mental Health
Attachments	Front Sheet only

Summary and Highlights
This item is a presentation.

Key Benefits:

Recommendation:

To note.

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Oxleas NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 7

Enclosure 5

Agenda item	Update on acute mental health bed changes
Item from	Helen Smith, Deputy Chief Executive and Director of Service Delivery
Attachments	Front Sheet only

Summary and Highlights
This is a verbal item.

Key Benefits:

Recommendation:

To note.

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Oxleas NHS
NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 8
Enclosure 6

Agenda item	Annual Plan Target Setting
Item from	Raymond Sheehy, Lead Governor
Attachments	Briefing paper for annual targets 15-16

Summary and Highlights

Key Benefits:

Recommendation:

To note.

OXLEAS NHS FOUNDATION TRUST

Setting the trust's annual targets for 2015 – 2016

Executive summary

Governors were invited to two workshops in November 2014, to prepare the PEST and SWOT analysis and draft the 2015/16 annual targets. The proposed targets will be presented to the Trust Board on 4 December 2014 and the Council of Governors on 11 December 2014.

The draft annual targets are as follows:

1. The trust continues with the following annual targets from 2014/15: extending opening hours; promoting self management; and offering an integrated service for physical and mental health needs.

2. The trust continues with the current set of development programmes (listed in sections 3.7.1 and 3.7.2) in order to meet the overall three year objectives of the SDS (2013/14 – 15/16), with a particular focus on: supporting the workforce; implementing our IT strategy; and maintaining financial strength.

3. It is recommended that for 2015/16, the trust has one new target, that is, to increase the level of integration and partnership, including: integration with social care; partnerships with the voluntary sector and other statutory partners; integration with primary care; and supporting contractual frameworks that promote integration.

It is proposed that the trust's four must dos[1] remain the same but that the wording is amended; for the fourth must do, a small number of options are presented.

1. Introduction

Our three-year service development strategy (SDS) has been in place since April 2013. Our SDS had four strategic priorities that ensure the trust continues to offer high quality care and remains financially strong during this period. Each strategic priority has a small number of goals. A summary of the SDS priorities and goals is contained in appendix 1.

[1] The four must do's have been in place since 2006 and form the framework of our work in relation to patient experience and quality. They are: support families and carers; provide information for patients and their carers; enhance care planning; improve the way we work with patients and carers.

For each year of the SDS, we focus on a small set of targets that help us deliver the four SDS strategic priorities – these are called the annual targets. An update on our progress towards this year's targets (2014/15) is in appendix 2.

2. Setting the annual targets

Each year, the annual targets are identified through the following steps:

1. November: two workshops with governors
2. December: board awayday
3. December: discussion of the draft annual targets by Council of Governors
4. January: trust board agrees draft annual targets to put to the members focus groups
5. February: consultation with members through a focus group in each borough
6. March: trust board agrees final set of annual targets and informs governors
7. June: plan is submitted for Monitor's approval

Progress towards achieving the annual targets is monitored through a quarterly meeting of corporate directors and each directorate management team, chaired by the chief executive and feedback to the Board and Council of Governors.

It is important to remember that there are a large number of other programmes that run alongside the SDS, these include the programme to achieve our required savings, the quality programme, and a number of programmes to redesign our services, including the mental health redesign work and our continuing integration with social services.

3. What will impact on Oxleas over the next year?

To identify our targets for 2015/16, we need to look forward and predict what will impact on Oxleas over the coming year. This is done though a PEST and SWOT analysis[2].

3.1 Political

3.1.1 NHS Five Year Forward View

The Head of the NHS, Simon Stevens, led a coalition of six organisations[3] to publish a five year plan for the NHS. The document identifies three gaps in the NHS.

The **health and wellbeing** gap: to be addressed through a 'radical upgrade' to tackle chronic public health problems, including support to people to stay in work and to be healthy in the

[2] A PEST analysis looks at external factors: political, economic, social and technological. A SWOT analysis is a more internally focused analysis of the trust's strengths, weaknesses, opportunities and threats.

[3] NHS England, NHS Health Education England, Public Health England, Trust Development Agency, Monitor, Care Quality Commission

workplace. A new initiative will introduce integrated personal commissioning based on a 'year of care' budget for people with complex needs – this could transform health care for this patient group.

The **care and quality** gap: addressed through a range of different models, including new models of integration with primary care, new urgent and emergency care networks, new ways of making small hospitals viable and enhancing care in Care Homes. It is expected that up to two-thirds of England will be covered by these models by 2021.

The 'new deal' for primary care specifies two new organisational models:

- **Multispecialty providers** – GP practices can federate to employ other health staff, take over running community hospitals, expand diagnostics, admit to acute care, delegated responsibility or combined health and social care budgets, etc.

- **Primary and acute care systems** – successful trusts can provide NHS list-based GP and hospital services together with mental health and community care services.

The five year ambitions for mental health include genuine parity of esteem and waiting times for psychological therapies and early intervention in psychosis services.

With regard to the **funding and efficiency** gap, the document makes the case for £8bn additional funding for the NHS, although reinforces the need for the Health Service to make at least 1.5% efficiencies each year.

3.1.2 2015 Election

The NHS will be a key issue in the Election next year.

The **Conservatives** have reinforced their commitment to keeping the marketplace in the NHS. At this year's Annual Conference (2014), Jeremy Hunt stated their commitment to personal control over care, achieved through integration of health and social services.

There are plans to train an extra 5,000 GPs and everyone will have access to weekend/ 8.00am – 8.00pm appointments. Over 75s already have a named GP responsible for their care; from 2015, every person will have a family doctor named on their record. In addition, every patient in England will be able to access their own medical record online.

Nick Clegg in the **Liberal Democrats** Annual Conference committed to putting mental health on the same legal footing as physical health. Waiting times for talking therapies will be introduced so that most people are seen in six weeks, 18 weeks maximum. Young people experiencing psychosis for the first time will be seen within 2 weeks.

Norman Lamb committed to a £1bn transformation fund. He announced: incentives for people to stay healthy; promoting integrated care and pooling the health and social care budget, an annual Carers bonus of £250 for carers to spend on whatever they want and a carers passport for extra support, such as free hospital parking or access to the gym.

The **Labour Party's** vision for the NHS[4] is: 'one service, one team, one person to call'. They will repeal the Health & Social Care Act and make the NHS the preferred provider. Hospital trusts and other NHS bodies will evolve into NHS integrated care organisations, working from home to hospital coordinating all care – physical, mental and social.

There is a commitment to recruit new teams of home care workers, physios, OTs, nurses, midwives, with GPs at the centre. Mental health nurses and therapists will be included in these teams. There will be new support for carers, including the right to care in their home if they wish it.

The result of the election could be a political instability if no party wins overall control. This may delay the implementation of the Five Year Plan and could lead to 'planning blight' if there is no clear political forward view. All parties are likely to increase the pressure to achieve ever greater value for money. Another economic slump and/or an increasing number of failing trusts could see the NHS budget being reallocated from successful trusts to financially struggling trusts.

3.1.3 Care Act 2014

Under the Care Act 2014, local authorities will have to ensure that local people:

- Receive services that prevent their care needs from becoming more serious
- Get information and advice to make good decisions about care and support
- Have a range of high-quality care providers to choose from

New duties to promote people's wellbeing will apply also to carers. For the first time, people can appeal against council decisions on eligibility and funding for care and support. There will be a duty for local authorities to cooperate generally with partners and specifically with other local authorities and their statutory partners.

3.1.4 Health & Wellbeing Boards (HWB) & the Better Care Fund

Health and wellbeing boards assess their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. They undertake the Joint Strategic Needs Assessment for the borough and develop a joint strategy for how these needs can be best addressed. This includes recommendations for joint commissioning and integrating services across health and care.

We have now been invited to join the Greenwich and the Bexley HWBs.

HWBs oversee the Better Care Fund. The Better Care Fund is made up of monies transferred from local NHS budgets into a shared pooled fund. The aim is to incentivise the NHS and local government to work together more closely around people, placing their well-being at the centre of health and care services.

The Better Care Fund plans have to show how emergency admissions will be reduced and how the provision of social care will be protected. In addition, Health and Wellbeing Boards need to set improvement targets against:

• admissions to residential and care homes
• effectiveness of reablement and delayed transfers of care

[4] Speech by Andy Burnham MP to Labour's Annual Conference, Manchester, 2014

• patient / service user experience

The Better Care Fund plans will have significant implications for our community services.

3.2 Economic

3.2.1 What are our CCGs' plans?

All our CCGs remain focused on diverting activity from acute care, particularly unplanned activity, through new service models in primary and community services. They increasingly are looking to award a single contract to a group of NHS and non-NHS providers to work together to deliver all aspects of care for particular condition or service.

Greenwich have committed to developing a single contract approach to the provision of MSK[5], COPD, cardiac care and frailty services. Relationships are positive and the CCG has acknowledged our efforts in responding to recent A&E pressures.

Bexley are committed to a prime contractor approach with a significant reduction in contract value. Their commissioning intentions for 2015/16 note only children's services and adult mental health.

Bromley CCG have not given any indication that they are planning to tender mental health services although have indicated that they may tender day services, including our Horizon House.

3.2.2 What are our local authorities' plans?

Bexley and Bromley local authorities are moving towards being commissioner-only organisations.

In **Bromley**, ALD staff are being seconded into Oxleas and if we are successful with the older adult social care bid (see below), there will be further Tupe of LBB staff to Oxleas.

In **Bexley**, we are at the start of exploring the integration of health and social care provider services into a new integrated care organisation (ICO).

The **Royal Borough of Greenwich** is undergoing a number of personnel changes: there is a new chief executive and the director of adult services and both associate directors of adult services posts are vacant. We would like to consider establishing an ICO in Greenwich and will seek their views over the next few months. We would in addition, like to put an integrated children's service in place if we are successful in the tender process.

3.2.3 What are our GPs' plans?

We have seen a major change in the last year in the level of involvement of our CCG GP bodies with commissioning and managing our contract. This is welcome, although it can be a cause of significant tension between GPs and the trust (eg., some GP's concerns re district nursing in Bexley).

[5] MSK: musculo-skeletal services for conditions affecting muscles and joints. COPD: chronic obstructive pulmonary disease, a deteriorating ling condition mostly caused by smoking.

Greenwich GPs are federating into primary care networks. We have been approached to explore how we might support this development. Relationships are very positive.

We are working with **Bexley CCG** to realign our community and mental health services onto their three GP localities. Relationships remain strained with some GPs.

Relationships with **Bromley GPs** are largely positive, although overall, there is less contact. The CCG GP body has wished to oversee our mental health redesign, although it has been difficult to get the process established.

The move to GP federations may have significant implications for the trust next year, both in terms of whether the federations take on micro commissioning responsibilities and/or work with the trust in a provider partnership.

3.2.4 NHSE commissioning plans

It is not clear how our public health departments will respond once they have commissioning responsibility for universal children's services (aged 0-5) in October 2015 – a number of services will be mandated but we can anticipate some changes in how our health visitors work.

In our forensic services, the pressure on the national specialist services commissioning budgets means that we can anticipate further cuts in our forensic contracts.

We have a good relationship with the UKBA, including a number of discussions as to how we can better support them with forensic patients who will be deported.

3.2.5 Our position in the marketplace

The 2014/15 income breakdown by our key commissioners is as follows:

Commissioner	%	£'000,000s
Greenwich CCG	34	64
Bexley CCG	21	40
Bromley CCG	16	31
NHS England	17	32
Local Authorities	5	9
Other	7	12
	100	**187**

This is our best ever 'spread' of risk across our commissioners.

We have performed well in bidding for services. In 2013/14, we had a 100% success rate at getting through the PQQ and a 77% success rate once into the ITT (up from 55% in 2012/13). We have been successful as a single organisation and in partnerships with other trusts, social services and third sector organisations.

In 2013/14 we successfully bid for:

- Bexley Integrated MSK services, with Kings as prime contractor

- Primary care and pharmacy services across Kent prisons
- Adult mental health care across Kent prisons
- Bexley Integrated Cardiac services, Guy's is prime contractor
- Bexley mental health day services, in partnership with Bexley Mind

Our two unsuccessful defensive bids have been for the urgent and unscheduled care services in Bexley and the emotional wellbeing service in Bromley.

Ongoing bids are:
- Integrated children's services in Greenwich
- CAMHS in Greenwich
- Integrated services for children and young people in Bexley
- Adult social care services for older people in Bromley
- Greenwich urgent care services
- Belmarsh prison health services
- Medway secure training centre

3.3 Social

The population will increase in our three boroughs. This will impact most on our services for those over 65s. National estimates are that 12% of people over 65 now have three or more long term conditions, 34% two or more and 67% one long term condition.

3.3.1 Demand for our services

We are predicting a rise in demand across most of our services next year and already have programmes to manage this within each directorate:

Older people's mental health services: caseloads are predicted to grow by 200 cases each year. We will deliver the Dementia Strategy and meet demand through new technologies and the development of 'primary care plus', through our community services redesign.

Adult mental health services: the mental health redesign programme and closer working with GPs through shared care, will help manage caseloads; we also are developing our IAPT service better to manage demand. We anticipate in Greenwich that demand for our crisis service will remain high.

Adult community health services: demand for long term conditions services are predicted to grow, with greater numbers having more than one long term condition. Projections for musculo-skeletal services point to a 20% increase in activity in Greenwich over the next two years. District nursing services are seeing increasing complex patients. The pressure on intermediate care and admission avoidance/ discharge services remains high, as local acute services struggle to meet the demand for unplanned care. Demand for our rehabilitation services is also growing.

Children and young people's community health services: referrals to universal children and young people's community health services in Bexley are expected to grow by 14% in 2014/15 and 10% in 2015/16. Specialist children's services in Greenwich expect to see an 8% increase in demand and activity by the end of 2015/16.

The most pronounced growth in demand and activity in Greenwich is predicted in Health Visiting. This is being addressed through additional posts, as part of NHS England's national programme of investment, although we are struggling to meet the national recruitment targets.

Children's specialist services are out to tender in Bexley and Greenwich and we are developing new pathways to manage demand within the CCG's financial envelope.

Forensic inpatient services: we have seen an increase in referrals to our medium secure inpatient services, resulting in increased bed usage within the Bracton Centre. For the first time in many years, NHS England are placing NHS patients in private sector beds on our behalf. We are considering a business case for a new unit that will include patients who are the responsibility of the UKBA.

Prison services: the extension of our Kent Prisons contract from July 2014, increases the number of primary care patients seen by approximately 10%.

The West Kent prison estate is to be reconfigured with the anticipated closure of one of the smaller prisons. HMP Maidstone has been re-rolled to deal with foreign nationals, as a result we do not anticipate any increase in demand for our primary care services.

Children and adolescent mental health services: referral and activity numbers have remained relatively consistent over the past four years. The service has seen an increasing number who self-harm and often require intensive treatment plans.

Learning disabilities: demand will rise in particular areas, notably the increased number of surviving premature babies with complex and long term conditions and an increase in dementia in younger adults with Downs syndrome. It is not clear if all those who might benefit from the service are being identified in childhood and a planned improvement in assessment and identification may increase caseloads.

In addition, there are a number of learning disability patients who are placed in step down treatment units outside of area. We are investigating the development of a step down facility on the Atlas House site.

3.3.2 Public health and other social issues

Our role in raising awareness of public health issues will become more prominent and we will be expected to address obesity, smoking and alcohol use within all services. We will be expected to raise awareness of dementia and to work closely with GPs to coordinate support for people who receive an early diagnosis.

We must make every effort to be accessible to growing immigrant populations so that they are confident in using our services and do not use A&E as the 'default' position to receive healthcare.

Loneliness increasingly is recognised as an important factor in mental wellbeing and recovery from physical health problems. For our patients, this is a significant issue and, if services are to be fully effective, we will need to support people to be less lonely.

As the 'squeeze' on welfare benefits increases, supporting people to work or return to work will become increasingly important. Tackling the stigma associated with mental ill-health will continue to be central to our values.

3.4 Technology

In the last year, there has been a huge national impetus to implement new technologies in health and social care and there are many new technologies that improve self management and the delivery of care and increase productivity.

We have allocated £8.5m of capital over the next five years to improve our IT infrastructure. This will include implementing our new clinical system, developing live information dashboards, video conferencing to reduce staff travel between bases, and stepping up the introduction of new technologies into the workplace. This will improve care and enhance our reputation with commissioners as an innovative provider.

The culture change needed for staff fully to embrace these developments is significant and will require a major change programme. We must also support our patients to change their view about how they receive healthcare. Some may need help to use the benefits of technology to become 'expert patients' and to interface with our service in different ways (through for example, the use of an app or through texting).

3.6 SWOT

Our **strengths** are long standing. Our values are prominent and visible. We remain financially strong, with the best staff engagement, a strong reputation for quality and clinical governance, an open and transparent culture, good links between the Board, the executive team and clinicians, and with a culture of innovation and drive towards 'being the best'. We have a national profile for integration and a good reputation with other statutory and voluntary sector stakeholders.

Our size may be a strength – we are neither too small nor too large. We are well placed strategically, to put ourselves at the centre of our local health and social care systems.

We are aware of our **weaknesses**. Whilst improved, clinical data quality remains inconsistent in some services. Care planning performance remains variable. Our use of bank and agency staff is high and we need to focus particularly on reducing agency use.

We could do more to encourage staff to contribute to innovation and put forward their ideas to improve care. We have not fully embraced using new technology and we need to maintain progress to embed this in our culture.

We need to offer our governors every support to be fully involved in the trust.

'Brand recognition' of Oxleas remains a problem both within our three boroughs and within London/nationally.

There are a wealth of **opportunities** in the market environment and in the changes in primary care. We must continue to develop innovative models of integrated care. Our financial strength enables us to invest in proof of concept schemes and promote new financial frameworks and contractual arrangements; this also makes us an attractive partner organisation for other providers. New partnerships with the voluntary sector and other NHS organisations are a good opportunity to enhance the quality of our services and increase the number of people who have contact with the Trust.

There are opportunities in the increasing number of tenders and in our greater involvement in Southeast London emergency planning to promote Oxleas. Owning Queen Mary's Hospital also gives us a platform to increase the recognition of Oxleas within the local community.

There are **threats** in the relatively high level of competition locally, although we have responded well. We better need to understand the cost of our services and communicate these and our clinical outcomes, to commissioners. We need to be responsive to local GPs and support greater involvement of the GP body in commissioning and contract management. The new freedoms for primary care may mean that some GP localities may start to offer services in competition to the trust.

We already offer some services outside of office hours but if we are to remain competitive, we need a step change in the number of community services open in the evening and weekends. When we do make changes to services, we need to ensure that our marketing is 'fit for purpose' and that we don't allow other local or new providers to be seen by the public as *the* local health service.

3.7 Ongoing trust transformation programmes

The ongoing transformation programmes listed in this section will continue into 2015/16 and take a great deal of our time and resource. The list below does not include the work that is underway to respond to current bids.

3.7.1 Trust wide programmes

1. Development control plan for Queen Marys Hospital: £25m redevelopment of the site, including a new kidney centre and new cancer treatment centre.

2. Exploration of mutuality: we are one of nine trusts in the national *Mutuals in Health* programme. We are doing this to learn how we can further develop our staff engagement and involvement.

3. Our CRE savings plans are across a range of themed areas, including:
    - Integration: providing services with partners to ensure best quality and value for money
    - Estates: more flexible use, greater utilisation, rationalisation, income generation
    - Sub-contract delivery: use of other providers to improve quality and value for money through new models of delivery under our governance
    - Improve procurement
    - Reduce spend on temporary bank & agency staff

- Performance/productivity: bringing all teams to the levels of 'best in class'

4. Implementation of new technologies to enhance quality, increase productivity and implement a new clinical system: this will require a cultural change programme to embed these new ways of working for staff and patients.

5. Alliance contracting in Greenwich: a CCG-led programme to redesign cardiac care, COPD, MSK and frailty services, in partnership with Lewisham & Greenwich Trust, Royal Borough of Greenwich and the CCG.

6. New partnerships with primary care: explore options for new business arrangements with individual or networks of GP practices.

3.7.2 Major service change programmes

1. Rollout of the Greenwich Pioneer initiative to Woolwich and across Greenwich.

2. Mental health services redesign: reconfigure adult and older adult community mental health services to provide better support to patients and GPs

3. Realign our adult community health services in Bexley to map onto the three GP localities: part of a CCG-led development of primary care.

4. Explore establishing an integrated care organisation with Bexley Council.

5. The district nursing development programme in Bexley.

6. Secondment of Bromley social care learning disabilities staff into the trust.

7. Expansion of intermediate care with the opening of Eltham Hospital, early in 2015.

8. Developing closer working with primary care in Greenwich

4. Priorities for 2015/16

Based on the PEST and SWOT, it is proposed that the annual targets for 2015/16 are:

4.1 Continuation of current targets
It is recommended that the trust continues to focus on: extending opening hours; promoting self management; and offering an integrated services for physical and mental health needs

4.2 Continuation of current programmes
It is recommended that the trust continues with the current set of development programmes (listed in sections 3.7.1 and 3.7.2) in order to meet the overall three year objectives of the SDS (2013/14 – 15/16); with a particular focus on: supporting the workforce; implementing our IT strategy; and maintaining financial strength.

4.3 New target for 2015/16

It is recommended that for 2015/16, the trust has one new target, that is, to increase the level of integration and partnership, including: integration with social care; partnerships with the voluntary sector and other statutory partners; integration with primary care; and supporting contractual frameworks that promote integration.

5. Review of the Four 'Must Do's'

It is proposed that the focus of the four must dos remain the same but that the wording is amended as follows:

	Current must do	Proposed must do
1.	Support families and carers	Improve the quality of integrated physical/ mental health support for families and carers
2.	Provide information for patients and their carers	Provide accessible information to patients and carers to manage their care and their condition(s), to achieve better health and wellbeing.
3.	Enhance care planning	Enhance care planning and care coordination.
4.	Improve the way we work with patients and carers	Ensure we relate to patients and carers in a way that enhances their care. *OR*: Improve the quality of our relationship with patients and carers in a way that enhances their care. *OR*: Communicate and listen to patients and carers in a way that enhances their care. *OR*: Always treat patients and carers with respect and dignity.

APPENDIX 1: Service development strategy 2013/14 – 2015/16, strategic priorities and goals

1.	**<u>Enhance quality: ensuring excellence for every patient</u>**
1.1	Improve care planning through better patient and carer involvement
1.2	Improve patient and carer feedback from all services, particularly 'you said, we did'
1.3	Ensure strong leadership in all services
1.4	Building on the Chief Nurse for England's strategy, ensure high quality and compassionate nursing care in all trust services, with a focus on effective supervision and appraisal for all nursing staff.
1.5	Monitor and publish waiting times in psychological therapies, therapies and children's services.
1.6	Develop a quality dashboard
2.	**<u>Promote innovation: redesign services with patients, families and commissioners</u>**
2.1	Enable patients to access benefits of Patient Choice
2.2	Promote self management and self care across services, including the use of telehealth/telecare and physical aids equipment
2.3	Implement integrated care planning and care pathways for all services, including a named professional coordinating the care of those with complex needs, and through the Better Care Fund, integrate in relation to: • A patient's mental and physical health needs • Delivery of health and social care
2.4	Extend working hours in all relevant mental and physical health community services

2.5 Continue our work on social inclusion through supporting user-led/Expert Patient initiatives (such as Recovery or Wellbeing colleges), with a continuing focus on employment.

3. **<u>Increase productivity: be resilient and resourceful to thrive in difficult times</u>**

3.1 Monitor and improve productivity:

- Develop a regular productivity report for the Executive, including cost and service levels
- Improve procurement processes
- Introduce more systematic benchmarking
- Achieve our CREs

3.2 Implement our marketing strategy:

- Ensure our values are visible and understandable
- Implement a stakeholder management strategy
- Develop different contractual frameworks with commissioners

3.3 Ensure we remain competitive through establishing:

- competitive terms and conditions
- effective performance management
- effective recruitment processes
- high levels of staff satisfaction

3.4 Ensure new staff are recruited to plan, into the expanded health visiting service

4.	**<u>Transformational Change</u>**
4.1	Implement the Pioneer initiative in Greenwich and transfer learning to Bexley.
4.2	Implement the mental health redesign programme in our adult and older person's mental health services.
4.3	Agree and implement the QMH development control plan.
4.4	Develop an estates strategy to underpin the delivery of integrated services and optimise the use of our estate for service delivery and team accommodation.

APPENDIX 2: Progress on the annual plan targets for 2014/15

	Annual plan targets	Progress as at Sept 2014
1	As part of patient choice, extend opening hours for all community services	• Each directorate now has at least one service with extended hours. • Directorates should plan to open extended hours across range of services by Oct 2014; this is unlikely to be achieved: o Mental health will include extended working in their consultation on service redesign o Children's directorate are including in their bids o Adult community services will put plans to the January annual plan meeting
2.	95% of patients receive treatment in 18 wks Publish on our website.	• 65% of psychological therapy & 66% therapy referrals seen in 6 wks • 3.2% (610) therapy referrals wait 18+ wks • 10% (283) psychological therapy referrals wait 18+ wks • For CAMHS, waits over 18wks are 44.4% in Bromley, 15.4% in Bexley and 0% in Greenwich • This information is not yet on the website
3.	Undertake unannounced night visits to all wards and Board visits to all services	• Achieved.
4.	Publicise staffing levels on inpatient units	• Achieved.

	Annual plan targets	Progress as at Sept 2014
5.	Introduce self-management/self-care approach in all Long Term Conditions services	• Each directorate should introduce self management in at least 2 services by Sept 2014; this is unlikely to be achieved.
6.	Meet physical and mental health needs of patients with Long Term Conditions	• The Pioneer integration project has mental health input in Greenwich • The redesign of mental health services will base community MH teams alongside LTC and other physical care teams, linked to GP localities • Screening tool for depression & anxiety and dementia is agreed and used by LTC teams. • Screening for dementia in place in intermediate care wards.
7.	Undertake review of best practice in 4 adult community services and 2 children's services	• Multiagency review in Greenwich of cardiac care, MSK, COPD and frailty; report in Feb 2015 • Commissioning of CAMHS in Bromley & Greenwich and children's services in Bexley has led to a review of practice.
8.	Publish results of Friends & Family Test	• In progress.
9.	Implement new performance management framework	• New performance management framework agreed. • New supervision policy in place and monitored
10.	Improve procurement processes	• 'Amazon style' ordering system will be in place by March 2015
11.	Agree a trust Estates strategy	• Achieved; implementation plan now being produced.

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Oxleas NHS
NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 9
Enclosure 7

Agenda item	Nominations Committee update
Item from	Dave Mellish, Chair
Attachments	Front Sheet only

Summary and Highlights
This is a verbal item.

Key Benefits:

Recommendation:

To note.

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Oxleas NHS Foundation Trust

Council of Governors
11th December 2014

Item 10

Enclosure 8

Agenda item	Holding NEDs to Account - working group
Item from	John Woolgrove Public Governor Bromley
Attachments	a) Oxleas NHS Foundation Trust Council of Governors' ("CoG") policy on the exercise of their duty to hold Non-Executive Directors ("NEDs") individually and collectively to account for the performance of the board of Directors of the Trust. b) Guidance notes for Governors attending Board meetings

Summary and Highlights

Report to CoG 11.12.14
Council of Governors Working Group on Holding NEDs to account individually and collectively for the performance of the Board

a) **Membership of Working Group -** Fola Balogun, Richard Diment, Dalla Jenney, James Kellock, Eimear Mallen, Baeti Mothobi, Chris Purnell , Raymond Sheehy, John Woolgrove

b) **Meetings since last CoG -** 2.10.14, 3.11.14.

c) **Policy on holding NED's to account, including the process to be used –** for approval

d) Guidance notes for Governors attending Board meetings – for approval

Recommendation:

To approve

Oxleas NHS Foundation Trust Council of Governors' ("CoG") policy on the exercise of their duty to hold Non-Executive Directors ("NEDs") individually and collectively to account for the performance of the board of Directors of the Trust.

1. Reasons for policy

The Health and Social Care Act 2012 imposed a new duty ("the duty") on Governors to hold NEDs individually and collectively to account for the performance of the Board of Directors of the Trust ("the Board").

2. Background

2.1 The aim of both the CoG and the Board is to ensure that by working together the Trust successfully fulfils its purpose, namely

"to serve the community by the provision of goods and services for the purposes of the health service in England"[1]

2.2 " The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organization so as to maximise the benefits for members of the trust as a whole and for the public"[2]

3. Principles

3.1 The overall responsibility for running an NHS foundation trust lies with the board of directors.

3.2 The CoG is the collective body through which the directors explain and justify their actions, and the CoG should not seek to become involved in running the trust.

3.3 Governors must act in the best interests of the trust and should adhere to its values and code of conduct.

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1 Oxleas constitution. This is the principal purpose, see section 3 for the complete purpose

2 The NHS Foundation Trust Code of Governance 1/4/14 at Section A.1.b

3.4 Directors are responsible and accountable for the performance of the trust; governors do not take on this responsibility or accountability.

4. Process

4.1 The duty is an ongoing one and the exercise of the duty requires ongoing interaction and partnership between the CoG and the Board.

4.2 During each year the CoG will at one of their meetings

- assess the performance of the Trust against previous targets and
- review the Trust's plans for the next year

4.3 Throughout the year Governors will acquire information relevant to their exercise of the duty by

a) being provided with Board papers and minutes, including Quality reports and accounts and information on proposed significant transactions, mergers, acquisitions, separations or dissolutions.

b) receiving information relating to non - NHS income, including any proposal to increase the proportion of the trust's income earned from non – NHS work by at least 5%

c) receiving the annual report and accounts of the trust

d) attending and observing Board meetings

e) asking questions at Board meetings, both informally before the meeting and formally at the conclusion of the meeting

f) inviting the chief executive or other executive and non-executive directors to attend meetings of the CoG and use these opportunities to ask questions.

g) sharing any concerns the CoG has with NEDs.

h) attending trust events (e.g. Borough Focus Groups and the Annual Members' Meeting)

i) receiving performance information for the chair and other NEDs

j) informal contact between Governors and NEDs, other members of the Trust, Trust employees and members of the public

k) considering information relevant to the performance of the board from other external sources, for example the Care Quality Commission, Monitor, local Healthwatch and local service user groups.

l) discussing during the year, at meetings of the CoG other than at 4.2 above, the performance of the Board in light of the information gathered at a) to k) above.

5. Concerns about the performance of the Board

5.1 If the CoG has a concern about the performance of the Board, or any individual Director's performance of his duties, it shall in the first instance raise that concern with the Chair, or if that is not appropriate, with the Senior Independent Director.

5.2 If the CoG continues to have a concern, having taken the action in 6.1, it may consider exercising the power to require one or more directors to attend a meeting of the CoG for the purpose of obtaining information about the trust's performance of its functions or the directors' performance of their duties ("the power").

5.3 The power can only be exercised following a majority of the CoG voting in favour of exercising the power.

5.4 If the CoG does exercise the power the CoG must give at least 28 days notice of the date of the meeting and of the information it wants to the directors concerned.

5.5 Following the meeting referred to at paragraph 6.4 the lead governor shall provide information on the exercise of the power to require one or more directors to attend a meeting to the Trust Secretary in order that that it can be included in the trust's annual report.

5.6 If having used all other methods of communication the CoG is concerned that the trust has failed, or is failing, to act in accordance with its constitution or Chapter 5 of the National Health Service Act 2006 ("the act") it may refer a question to the panel appointed by Monitor for advising governors under the act. It shall only refer a question if more than half of the members of the council of governors voting approve the referral.

5.7 If having exhausted the steps at 6.1 to 6.6 above the CoG is still unsatisfied it may engage in a dialogue with Monitor through the lead governor.

6. Support

In discharging the duty the CoG will be supported by the Trust Secretary and the Board. The CoG will also be supported by its Working Group on the duty.

7. Changes to the policy

Changes to this policy can only be approved if more than half of the members of the council of governors voting approve the change.

Date

Guidance Notes for Governors attending Board Meetings.

Attendance at Board meetings is important in helping Governors to hold Non-Executive Directors (NEDs) to account for the performance of the Board. Governors have an opportunity to meet with NEDs at a pre meeting before the Formal Board to put questions.

The Working Group on Holding NEDs to Account offers Governors these notes to help with this task.

1. Raymond Sheehy (RS) will compile a list of Governors attending each Board meeting and circulate this to all Governors

2. If your name is on the list but you cannot attend a Board meeting, please notify RS and Anne Rozier (AR) in good time – they will try to find a replacement for you.

3. Any governor not on the list may also attend a Board meeting. If you require a hard copy of the Board papers please request these from Anne Marie Hudson no later than the Monday prior to the meeting.

4. We encourage Governors to liaise together regarding questions for NEDs.

5. We encourage Governors to send questions to Ann Rozier in advance so that answers can be prepared and therefore more comprehensive. This is not always possible and new questions can be asked at the meeting.

6. Board papers are available online on the Oxleas website a few days before the meeting: governors are encouraged to read the agenda and the cover sheet of each item as it is helpful to understanding the topic and can save time.

7. The meeting of Governors and NEDs starts half an hour before the Board meeting, please arrive in good time for this.

8. Questions can also be asked in the public sesssion at the end of the Board meeting if invited by the chair, the answers will be recorded in the minutes.

9. Consult with the other Governors present to see who will report back to the next Council of Governors meeting and let AR know.

10. The reporting Governor should write a short report, they may like to use Stephen Brooks report (attached) as a model.

11. The report should be submitted to AR at least 10 days before the next Council of Governors Meeting.

12. If you have any problems or queries please contact RS or AR.

Example taken from 18th September 2014 Council of Governors Meeting

Report of Governor's visits to the Oxleas Board meetings

Governors will recall that part of the Governing Body's duties is to monitor and hold to account our Non-executive Directors (NEDs) for the performance of the Board. It was decided there would be a rota of Governors detailed to attend the Board meetings. As part of the rota of visiting Governors, I attended the July and September Board meeting along with Baeti Mothobi (July & September), Mary Titchener (September), Fola Balogun (July), Ken Thomas (July) and Judith Wolfram (July).

Pre-Meeting Questioning

1. The arrangements for the process of asking questions at the NEDs/ Governors' pre-meet before the Board meeting are still in flux so at the July meeting there was no pre-meeting with the NEDs. However, by the September meeting it was established that the visiting Governors would each ask a question at a pre-meeting. This procedure itself is still experimental, but the three questions which were forwarded to the NEDs were as follows.

2. ***What have the NEDs done so far and how will they proceed in ensuring that the 'Sign up to safety' strategy announced by the Secretary for Health in March 2014 is in force within the FT and what measurement is being used to check progress?***

   In response to this question the NEDs explained that there was no one factor but a combination of elements that went towards their objective of ensuring patient safety. It was already a major feature of their work with quarterly reports on matters such as pressure sores, falls, medication errors, reductions in avoidable harm. Reviewing why things go wrong and taking corrective steps, working with others, CQC reports, the risk register, patient experience responses and above all honest reporting. Other information came from Mental Health Act commissioner visits. The regular series of visits to Oxleas services they made also enabled them to check for themselves against the reports they received. The point was also made that although the strategy was launched in March very little else had been heard from the DoH.

3. ***What do they have a feel what are going to be the biggest dangers facing Oxleas?***

   It was considered that there were a number of factors which presented dangers to the Trust but the significant feature was that demand for services was going up but resources were going down. The challenge was to take these factors on board but not loose attention to the quality of the Trusts services. It was suggested that currently the Trust was big enough and had sufficient cash reserves (a condition absent in many Trusts) to be able to take some knocks.

4. ***How as NEDs do they assure themselves of the accuracy of the quality reports that are presented at the Trust Board?***

   The NEDs considered that as already mentioned their own observation of the Trust's services during personal visits to services, talking to staff (who were not afraid to speak

frankly), external scrutiny from such as Monitor and the CQC, internal and external audit reports and meeting Executives outside of the Board meetings, all help paint a picture of the Trust's workings and environment.

5. In response to a quick question about frustrations it was suggested that the NHS was a big system ("big slow beast") with a lot of vested interest which impacted on the working of the Trust.

Board Meetings

6. In meetings of the Board, with agenda consisting of some 17 items, there are regular reports on some 30+ key performance indicators (such as maximum time before treatment), individual service developments, quality, compliance, staff and finance. Reports of external monitoring visits are presented.

7. Included will also be specific reports on certain aspects of the Trust's functioning for example in July the estates strategy was looked at. Also presented are reports on issues the Board have requested. For example in September, meeting the level of the use of bank and agency staff and therapy waiting times were reviewed.

8. In the formal board meeting itself NEDs were observed to ask detailed question of the information presented to them seeking clarification, questioning the reasoning or background for decisions or actions taken, asking detailed questions and suggesting courses of action. Also, it should be noted NEDs are very present in the sub-committees of the Board where possibly far more detailed review, questioning and holding to account is possible.

General Observations

9. In attempting to assess the success of NEDs in holding the management of the Trust to account, an important factor in my opinion is the climate within which the relationship between the two parties works. My perception is that we have a knowledgeable, perceptive and demanding NEDs team responded to by an open, honest and challengeable group of senior executives. The same reaction was similarly exhibited by the NEDs to our questioning.

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Oxleas NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 11

Enclosure 9

Agenda item	Board of Directors Meeting Governors update
Item from	Baeti Mothobi, Governor
Attachments	Report of Governors visits to the October and November 2014 Board of Directors meetings

Summary and Highlights

Key Benefits:

Recommendation:

To note.

Council of Governors 11th December 2014

Governors update

Baeti Mary Mothobi, Governor

Summary and Highlights

Report of Governor's visits to the October and November 2014 Oxleas Board meetings

Pursuant of fulfilling the ongoing role of the Governing Body's duty of holding to account the Trust's Non-Executive Directors (NEDs) for the performance of the Board, governors have continued as per rota, to sit in and observe at every monthly meeting of the Board. The October Governor attendees were, Chris Purnell, Baeti Mothobi, Fola Balogun and Marcos Da Silva while in November they were, Barbara Cawdron, Tanya Nguyen, Baeti Mothobi and Fola Balogun.

The Lead Governor has ensured adequate governor coverage for the Board meetings including the two extra Board meetings announced at short notice. Although the duty of holding the NEDs to account is still in its infancy, the attendee governors are coping fairly well. Many thanks are extended to Anne Rozier, the Trust Secretary who has been instrumental in guiding the governors into making their questions more effective in order to yield more comprehensive answers from the NEDs. In the same vein she has advised deferment of complex parts of the questions which could be of interest to all Trust governors, to appropriate forums such as the future Informal/Formal CoG meetings.

Pre-Meeting Questioning of NEDs

This is now an established exercise which the involved governors have found to be beneficial and informative. Some attending governors have not put questions forward. However, all Governor attendees collaborate on the production of the CoG reports. Below are the questions, answers and reasons for deferment where applicable.

October Board of Directors

1. To what extent have the NEDs quizzed Simon Hart about the proportionately high levels of black Africans subject to disciplinaries?

It was explained that the underlying reason was that these complaints were from customers/patients which, on investigation, were very often unfounded. It was not entirely clear though whether the proportion of Black Africans to workers generally who were subjected to a full disciplinary was statistically significant. Simon Hart later said on this more contingent point, except that he did make it fairly clear that one of the reasons for the disproportionately high level of initial complaints may have been

prejudice. He also stressed that those subject to investigation and disciplinaries have a right to representation at both stages.

The Governors still feel there is a need to examine things further to see if there could be underlying factors such as culture etc, also that maybe in addition to supervision there could be mentoring and mediation services added, if not already in place.

2. What measures have been taken to ensure that the 'new RIO' (IT system) will impact the service better?

The question was very searching and the response from the NEDs indicated that they are applying themselves quite well to the IT issues especially about how the project is to be governed so that it meets the needs of both service users and clinicians.

3. Will the new Rio output provide valid, quality and updated current data?

This question was deferred because of its operational and technical ICT nature which the NEDs wouldn't be required to know. In addition, it requires a more detailed answer (from the (IT) Director), in order to provide full assurance to all Trust Governors who would then be better placed to make a judgement if they were more informed about what is in place currently, what is planned for the future and what the limitations/opportunities are.

November Board of Directors

1. How can the NEDs ensure that the policy of completing Inquiries within 45 days is followed?

It was said that this can occur because of needing to involve outside agencies, and because of staff holidays. The NEDs see their role as pushing things along and being hands on, and there is an important role for the Patient Safety Group in naming and shaming when inquiries overrun. The NEDs emphasised the importance of communicating with all parties if/when an inquiry does overrun and they stressed the importance of following up on the outcomes of any inquiry. It was felt that the NEDs were well aware of this issue and shared the Governors' view of the importance of upholding the time scale of inquiries.

2. What are the NEDs doing to ensure that the Oxleas Trust meets its duty to provide training for governors?

This question was deferred because; The provision of Governor training is the responsibility of the Trust, while the NEDs are concerned with the Board's Performance. Governor Development needs are for the Chairman, Lead Governor and Trust Secretary. According to Ann Rozier, an audit was completed recently and a wider discussion is to be had on this subject.

3. How can the NEDs be assured that the data on the staff uptake of the flu vaccine is correct and that it takes into account the increased numbers of temporary staff being used currently?

The NEDs were satisfied that the data was correct and that staff were cooperating. The Trust is concerned about staff health hence the huge free flu campaign. Wilf Barsley later concurred adding that so far 2700 vaccines had been ordered/used and another 500 were on order. Temporary staff were included free of charge.

4. Is there any national evidence/intelligence on what the direct impact of staff not receiving the vaccine is on the delivery of services in terms of cost, safety and quality?

The answer was NO because the flu vaccine does not cover all flu virus strains. The Trust could never be sure that staff who got the flu did so because they didn't have the jab. Staff are encouraged to have the jab but can opt out as desired. The impact in terms of cost is immediate but on safety and quality it may be realized only if realistic.

5. How can NEDs ensure continuity of care for specific care groups/ pathways when services are being delivered by different providers?

The NEDs do probe/push for answers. They are satisfied and the Board is in turn satisfied due to the effective collaboration and cooperation across the many platforms of care both internally and externally. Some GPs still need to cooperate. A role was proposed to be created in the hospital with overall responsibility to review patient status and discharge them to appropriate services within the community.

Observations and impressions on the Board meetings

Governors feel that the NEDs are definitely holding the Board to account. In the Board meetings NEDs do ask deep and searching questions to get comprehensive and knowledgeable answers on Trust issues. The Governors have continually observed that the Board relationships are consistently professional and there is no hint of disquiet in the Boardroom atmosphere. It is becoming apparent that since attending Board meetings more Governors have become familiar with reading the Board papers and can now fully appreciate the amount of work done by the Board.

It was impressive to realise the Trust's value for money strategies such as the introduction of new IT systems to provide a better quality of services to Service Users/Carers to reduce time/resource costs. Secondly, the recent recovery of monies owed to the Trust which ensures the Trust maintains its strong financial position. Most importantly, this has been a steep learning curve for attendee Governors which hopefully will be perfected by the proposed training sessions at future Informal meetings.

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Oxleas NHS
NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 12
Enclosure 10

Agenda item	Membership update
Item from	Jo Mant, Head of Stakeholder Engagement
Attachments	Front Sheet only

Summary and Highlights

Recent membership recruitment activity has included:

1. MES, our membership provider, was recently commissioned to undertake face to face recruitment with a target of recruiting 500+ members to boost our membership. The recruitment started on Thursday, 20 November for one day in Eltham, and ended on Friday, 28 November, with the remaining activity in Bromley. It is hoped that we will have picked up 'Rest of England' members, as well as members from our local boroughs. I'm pleased to say that MES have recruited 565 new members and they are currently entering this data for us.
2. A communication will soon be sent to all associate members (we now have over 100) from the Chair, to encourage them to also join as individuals (as public or service user/carer members). This communication will also promote the role of Governors (a new leaflet has been developed regarding this), and encourages them to stand should they independently join; encourages them to promote our membership within their networks, and asks for any opportunities for the Trust to promote membership at their events.
3. Through a communication from Raymond Sheehy, we have asked Governors to volunteer to recruit members within our services. Several Governors have put themselves forward and have been visiting, or are scheduled to visit, sites to recruit. Joe Moore from the V2W scheme is due to start working with the team tomorrow and it is hoped he will also be able to promote membership within services.
4. An A-Z directory is being built on the Intranet of all associate members http://theox.oxleas.nhs.uk/support-services/patient-experience-and-quality/partner-organisations/. This area will hold information about all associate members - key contacts, specific projects, access/referral routes into services, work opportunities etc, to enable staff to seek information and support for our patients/ service users from third sector and other organisations. This will be a key resource for staff and will be publicised through One Oxleas and the Intranet. This directory has just started to be populated.

Key Benefits:

Recommendation:

To note.

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Oxleas NHS Foundation Trust

35th Council of Governors
11th December 2014

Item 13
Enclosure 11

Agenda item	Chief Executive Update
Item from	Stephen Firn, Chief Executive
Attachments	Front Sheet only

Summary and Highlights
This item is a presentation.

Key Benefits:

Recommendation:

To note.