Council of Governors

Minutes of the Council of Governors Meeting on Thursday, 28 April 2016 at 18:00 in Classroom 2, The Saïd Business School, Park End Street, Oxford OX1 1HP.

Present:
- Dame Fiona Caldicott FC Chairman
- Mrs Teresa Allen TA Public Governor, Cherwell
- Mrs Margaret Booth MB Public Governor, Oxford City
- Mrs Sue Chapman SC Public Governor, West Oxfordshire
- Mrs Sally-Jane Davidge SD Public Governor, Bucks, Berks, Glos & Wilts
- Ms Jane Doughty JD Public Governor, West Oxfordshire
- Dr Cecilia Gould CGI Public Governor, Oxford City
- Mr Martin Havelock MHa Public Governor, Vale of White Horse
- Mrs Jill Haynes JHa Public Governor, Vale of White Horse
- Mrs Rosemary Herring RH Public Governor, Northants & Warks
- Mrs Anita Higham OBE AH Public Governor, Cherwell
- Mr Martin Howell MHo Nominated Governor, Oxford Health NHS Foundation Trust
- Dr Tom Mansfield TM Staff Governor, Non-Clinical
- Dr Roger Morgan OBE RM Public Governor, Rest of England & Wales
- Dr Paul Park PP Nominated Governor, Oxfordshire Clinical Commissioning Group
- Dr Catherine Paxton CP Nominated Governor, University of Oxford
- Dr Ian Roberts IR Public Governor, South Oxfordshire
- Mr Brian Souter BSo Public Governor, Bucks, Berks, Glos & Wilts
- Mr Blake Stimpson BST Public Governor, Northants & Warks
- Ms Jullie Stockbridge JS Staff Governor, Clinical
- Dr Chris Winearlts CW Staff Governor, Clinical
- Millie Young People’s Executive (YiPpEe)

In Attendance:
- Dr Tony Berendt AB Medical Director
- Ms Susan Brown SB Senior Communications Manager
- Dr Clare Dollery CD Deputy Medical Director
- Mr Christopher Goard CGr Non-Executive Director
- Mr Scott Lambert SL Children’s Patient Experience Project Lead
- Ms Susan Polywka SP Head of Corporate Governance and Trust Secretary
- Ms Caroline Rouse CR Foundation Trust Governor and Membership Manager
- Dr Neil Scotchmer NS Programme Manager
- Mr Andrew Stevens AS Director of Planning and Information
- Ms Anne Tutt AT Non-Executive Director

Apologies
- Prof June Girvin JG Nominated Governor, Oxford Brookes University
- Cllr Judith Heathcoat JHe Nominated Governor, Oxfordshire County Council
- Ms Rachel Pearce RP Nominated Governor, NHS England
- Hannah Young People’s Executive (YiPpEe)

CoG16/02/01 Apologies and declarations of interest

Apologies were recorded from June Girvin, Judith Heathcoat, Rachel Pearce and Hannah.
CoG16/02/02 Minutes of the meeting held on 14 January 2016

The minutes of the meeting were accepted.

CoG16/02/03 Matters arising from the minutes

No matters arising were raised which were not already on the agenda.

CoG16/02/04 Chairman's Business

FC reiterated the key elements of the governors’ role: to hold non-executive directors to account for the performance of the Board and to represent the interests of members and the public.

Governors were also reminded that under the Constitution issues of concern should be communicated via the Trust Secretary, the Chairman or the Deputy Chair. It was noted that recently a number of enquiries had been made directly to Executive Directors. It was suggested that governors contact the Trust Secretary in the first instance and that they may wish to review the Code of Conduct and the previous paper on governor communications (CoG2015.03).

FC briefed governors on issues relating to the junior doctors’ contract. The Trust had met with representatives of the junior doctor workforce to acknowledge the current circumstances and to provide an opportunity for them to discuss issues of concern. These discussions had been described as engaged, positive and highly informative.

A suggestion had been made that Foundation Trusts such as OUH might elect to ignore the national mandate and not seek to introduce the contract. FC explained that all Foundation Trusts had received explicit advice from both NHS Improvement (formerly Monitor) and Health Education England (HEE) that a situation where local employers effectively offer different terms will not be acceptable. Furthermore, implementation of the national contract will be a key criterion for HEE in making its decisions on future investment in training posts. The Trust would therefore stand to lose training posts if it did not implement the contract.

During the strike action the Trust had been well supported by consultant medical staff and by nursing and therapy staff to maintain safety. No incidents of concern had been reported. However, the Trust had cancelled around 7,000 outpatient appointments, elective procedures and investigations. It was recognised that there would be pressures in reinstating these lost appointments and admissions.

It was clarified that this statement was specifically for governors but that a condensed version had been provided to the media.

FC informed governors that a report on the staff survey would be brought to a future meeting.

CoG16/02/05 Trust Quality Account and Quality Priorities

AB and CD provided an overview of the Trust’s quality priorities for governors. A covering paper on the requirements of the quality account was provided, with a summary of the quality priorities for the year indicating why they have been selected.

AB noted that a requirement of FTs is that governors participate actively in this process and that they either choose their own priority or support one of the current priorities for particular focus. The latter option was recommended given the large amount of work
that had gone into developing these, including the quality event that was attended by some governors. End of life care was proposed as the governors’ selected priority for 2016-17.

RH commended a thorough and interesting document but noted that it did not include the Government initiative on still births. AB clarified that these priorities did not encompass all that we were required or wished to do. He confirmed that there was a national priority on still births which the Trust was pursuing but it hadn't been chosen as a specific priority.

MB highlighted the discharge process as an area of concern for Healthwatch. CD explained that this was included, although the reference was specifically to the monitoring of discharge documents which had been agreed with the CCG as a priority. It was agreed that the language would be extended to encompass the whole discharge process rather than a single metric.

Action: AB/CD

RM asked for clarification of what impact governors’ selection of an area of focus had in practice. AB explained that this could be discussed but could involve regular reporting to the Council of Governors. Were end of life care not selected by governors it would still be pursued as a priority. CD explained that the selected priority would be reviewed by our auditors, Ernst and Young, and so would receive greater scrutiny with any concerns being reported on.

RM also asked what happened when something was no longer target of the year. CD noted that, whilst some priorities were novel, some built on last year's as there were changes that would take time. She agreed that a stop and start approach was not helpful.

IR commented that quality would be an issue for one of the Council’s subcommittees and that the timing might not therefore be right to select a priority. He noted that end of life care was already rated 'good' and that the Council should focus on an area that was currently more negative.

AB commented that this was a rapidly moving target and that performance in the national audit was not where we wished it to be. It was also an area that all governors and their constituents were likely to feel strongly about. Acute kidney injury (AKI), as a comparison, was very important but fewer people would have direct experience of it.

AB recognised that the timing was not optimal but explained that there was a specified timeline for the quality account. Whilst a novel area of focus would be difficult to include in a late draft it would not be a concern if governors wished to adopt a different choice from the list. AB recognised that this might be frustrating and agreed that in future years the Trust would wish to engage earlier with the relevant Council subcommittee as IR suggested.

CW asked whether there was evidence that sepsis and AKI were issues for OUH. CD explained that an electronic system of alerts to monitor AKI suggested these possibilities are triggered about 30 times a day. Work was already underway on sepsis, which was also a CQUIN (Commissioning for Quality and Innovation) priority, with new criteria for antibiotics to be rolled out. Deaths from sepsis appeared to be low but an audit was being carried out to confirm this.

AH asked how the Trust could monitor that a culture of safety was being created. AB explained that the Board quality report links all domains for quality and was seen either by the Board in public or by the Quality Committee. A high volume of incident reporting
was evidence of a good quality culture, and OUH had been improving this using electronic systems. The weekly SIRI (Serious Incidents Requiring Investigation) forum provided a transparent way to highlight events, and learn from them quickly, and drove compliance with the duty of candour.

AH also asked why areas rated 'requires improvement' as part of the CQC inspection have not been selected. AB explained that issues such as those relating to operating theatres were already a major stream of work through the improvement programme. CD added that additionally this was an area of focus for human factors training and linked to the sepsis work in ED.

MHa suggested that end of life care was a good choice in being of interest to constituents. He asked, following the formation of a committee with a quality remit, how much involvement governors would have in developing future priorities.

AB highlighted that involvement should be through non-executive directors and that the approach should be discussed with the Chairman. However there was a goal of greater clarity for the quality report. To support an understanding of quality governance some governors have already attended Quality Committee and there was the opportunity for more to do so.

SC noted that she had found attending Quality Committee informative and had been impressed by the quality and detail of information provided. She encouraged other governors to attend.

SC agreed that end of life care was a very relevant priority choice for constituents and asked how the Trust was working with other organisations on the priorities. It was confirmed that there is regular interaction with OCCC on end of life care; their lead for this area attended the OUH group and vice versa where possible. This supported initiatives such as the development of telephone support for carers of patients dying at home to reduce deaths in ED or within 24 hours of admission.

MHo recognised that there was a timing issue this year and that it made sense to accept the recommendation. He suggested that in future this would be worked on by the Council’s quality committee with a recommendation to the Council.

AB supported this approach. He suggested that another quality event would be held in September/October with a further date in January to update on progress and the plan for the next year.

PP supported end of life care as a key priority, noting that it was a rapidly developing area where joined up care really mattered. There was evidence that a large proportion of patients wanted to discuss this and felt that it was an important priority for the hospital.

By vote the governors agreed to support the recommendation to adopt end of life care as their quality priority.

CoG16/02/06 Development of the Trust Business Plan

AS introduced the draft business plan.

The plan was a combination of top down and bottom up processes and brought together different parts of the planning process e.g. inclusion of quality priorities. This was a transitional year as the Trust had previously been working with plans used during the FT application but a new strategic development was now being prepared with five strategic themes.
AS noted the concern highlighted by JHe via email regarding the impact of the late agreement of contracts for this year. He highlighted the impact of the late issuing of guidance this year and of the reorganisation of relevant teams. Contracts were therefore at a late stage but for OCCG and specialist commissioners OUH did have an agreed position. These might change but the degree of certainty was sufficient for divisions and services on which to base plans.

AS also recognised that questions had been raised about the cost improvement programme. He emphasised the requirement for performance standards, financial targets and quality all to be delivered. This year’s cost improvement scheme had a value of £51m. This was made up of both small divisional schemes and large transformations with the balance shifting towards the latter. Around £12m-15m was expected to be delivered through ‘good housekeeping’ with the bulk through major schemes such as medicines management, procurement standardisation, the agency cap and different models of care to reduce acute beds.

AS explained that in future years the Trust anticipated involving governors at an earlier stage in the process.

RM asked about the impact of downward pressures on spending on specialised services. AS confirmed that a financial position had been agreed with specialist commissioners and that the contract would be fully compliant with payment for all patients seen. Regionally pressures related more to other trusts. In the future it was likely that there would be greater use of lead contractors who would be able to deliver clinical protocols and new models across an entire network.

RM also highlighted an oversight in omitting the use of services by Welsh patients and AS confirmed that this would be corrected.

TA noted the tight timescales for development and consultation on the sustainability and transformation plan (STP), including plans for the Horton Hospital and asked what engagement had occurred to date.

AS explained that NHSE had divided the country into ‘footprints’ which must develop individual STPs. The STP was to be developed by June with the Transformation Board developing plans to shape services that were financially and clinically sustainable. This included looking at the natural catchment area of the Horton to try to double outpatient and day case activity there so that people could be seen and treated locally.

Engagement had been through the community partnership network; RH and AH had been involved in this. Workshops had been arranged with the CPN and a public meeting held in Banbury town hall with presentations from OUH and OCCG. A communication and engagement strategy was being developed replicating these events with an intention to include the Trust’s membership. All aspects of these would be included in the consultation during September.

MB commented that work on delayed transfers of care had allowed the Trust to cut beds. She expressed concern that this capacity was not being used to better move patients through ED and to avoid discharging patients during the night.

AS clarified that beds were not permanently closed but kept in reserve and that the proposals had been taken to the Health Overview and Scrutiny Committee. 40-50 beds had been redeployed to enhance capacity focused on the timely admission of patients on an urgent care pathway. AS emphasised that the focus should increasingly be less on bed numbers and more on capacity to treat patients.
PP supported this approach from the perspective of the CCG. He highlighted that it was recognised that it is not best to have large numbers of acute beds. The emphasis should be on assessing patients quickly as it was better for patients not to be admitted for longer than necessary.

**CoG16/02/07 Update from Membership Working Group**

SC provided an update on the Membership Working Group. Two meetings had been held so far with a paper to be brought to the Council’s July meeting.

The Web Forum now included information on constituency membership numbers including a demographic breakdown and the need to continue to recruit to maintain those was emphasised, although it was suggested that the focus should be less on numbers than on quality of the membership.

RM was developing a survey of members to seek their views.

New posters, leaflets and membership forms had been developed with input from the Group. In addition a governors’ pack was being developed to include relevant information and documents to support communication of the governor role through the media or at events.

Governors were encouraged to attend events and to assist CR who was recognised as doing very well but needed support from governors. These events provided an opportunity to recruit and to talk to members of the public. It was also suggested that it was important for governors to have a presence at the AGM.

Governors who provided support at the BRC event and the OX5 run were thanked for their assistance.

**CoG16/02/08 Update on Young People’s Executive**

Millie provided an update on the Young People’s Executive. Membership had increased to 30 and two meetings had been held.

Input had been given to a research study on nail-bed injuries and a discussion held about the impact of health inequalities on children. The creation of a Youth Board had been discussed and YiPpEe had looked at how it could promote itself in conjunction with the Trust’s brand.

The Chief Executive of OUH had agreed to come and speak to the group at a future meeting.

Members of the group attended the Trust’s ‘Quality Conversation’ event.

YiPpEe participation had been requested on appointment panels for a new paediatric consultant.

The group was praised for the proactive approach that it was taking.

SL indicated that changes to the local youth parliament were currently underway and it was expected that YiPpEe would be involved in this.

**CoG16/02/09 Governor Vacancies**

FC outlined details of three current vacancies on the Council of Governors and presented a paper making recommendations for filling these.
AT endorsed the recommendation to offer vacancies to the next highest placed candidates, explaining that she felt by-elections would not be a good use of public money.

SC suggested that a by-election might be merited in South Oxfordshire as there was a large gap in numbers of votes to the next person on list and because the cost would be lower than in the staff governor constituencies.

It was confirmed that the two year term of office would conclude in October 2017.

RM suggested that there was a democratic imperative for a by-election given the low level of support by the membership for the remaining candidates at the previous election.

It was agreed that the staff governor vacancies should be offered to the next highest placed candidates and that a by-election would be held in South Oxfordshire.

**Action:** NS

CoG16/02/10 Future Working Arrangements for the Council of Governors

FC presented a paper outlining proposals for future working arrangements for the Council including options for possible subcommittees.

RH suggested that it would be difficult to combine all items into two committees and proposed a revised version of Option C.

CGI expressed a concern that four committees in total would create a lot of work and that a higher number of committees might reduce their quality.

Governors expressed varying preferences between creating two or three additional committees.

TM noted that topics like workforce would be picked up under other areas where appropriate and didn’t need to be explicitly covered by a committee.

MHa supported having as few committees as possible and noted the need for them to be disciplined in focusing on their role. He highlighted that agreeing terms of reference was key.

The Chairman clarified that Option A closely mirrored the existing Board committees although the question of membership did not arise for the Board. FC proposed that draft terms of reference be developed for Option A with governance and strategy being regarded as belonging to the Council of Governors itself. It was noted that this was a starting point and did not preclude a later move to create a third committee.

This approach was agreed along with the proposal that governors be invited to express their interest in these committees prior to the July meeting.

**Action:** NS/SP

The Council of Governors also agreed that the role of the Lead Governor and the frequency of meetings would be discussed in July.

**Action:** NS/SP

FC indicated that a combined meeting with NEDs would be arranged to follow the event with Oxfordshire CCG, Oxford Health and Oxfordshire Council which was being coordinated.
CG asked whether there would be any benefit to a deputy for the Lead Governor. AH indicated that this would depend on the future nature of the role. She informed the Council of a recent lead governors’ teleconference that was coordinated by NHSI.

SP thanked AH for copying her in to various useful items regarding the Lead Governor role. SP agreed to bring a paper to the July meeting, as the basis upon which the Council could consider whether it wished to broaden the role beyond that defined by Monitor (now NHS Improvement), bearing in mind that any expanded role should be agreed in consultation with the Trust Board, and would trigger a new election (ref Paper CoG2015.09 as considered at the meeting held on 21 October 2015).

Action: SP

CoG16/02/11 Any Other Business

FC highlighted a note from David Smith, Chief Executive of Oxfordshire CCG, regarding a stakeholder event on 6 June for which two governors were sought.

CoG2016/02/12 Date of the next meeting

The Council of Governors will meet in public on Friday, 1 July 2016 at 14:30 in the Witney Corn Exchange, 19 Market Square, Witney, Oxfordshire OX28 6AB.