Council of Governors

Minutes of the Council of Governors Meeting held on **Wednesday 13 January 2021** via Videoconference.

Present:

Name	Initials	Job Role
Prof Sir Jonathan Montgomery	JM	Trust Chair, [Chair]
Mr Tony Bagot-Webb	TBW	Public Governor, Northamptonshire & Warwickshire
Ms Ruth Barrow	RB	Public Governor, Cherwell
Mr Stuart Bell	SBe	Nominated Governor, Oxford Health Foundation Trust
Dr Art Boylston	AB	Public Governor, South Oxfordshire
Dr Simon Brewster	SBr	Staff Governor, Clinical
Ms Rebecca Cullen	RC	Staff Governor, Non-Clinical
Mrs Sally-Jane Davidge	SJD	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
Dr Cecilia Gould	CG	Public Governor, Oxford City
Dr John Harrison	JH	Public Governor Oxford City
Mr Martin Havelock	MH	Public Governor, Vale of White Horse
Mrs Jill Haynes	JHy	Public Governor, Vale of White Horse
Mrs Rosemary Herring	RH	Public Governor, Northamptonshire & Warwickshire
Mr David Heyes	DH	Public Governor, West Oxfordshire
Mrs Anita Higham OBE	AH	Public Governor, Cherwell
Dr Shad Khan	SK	Staff Governor, Clinical
Mrs Janet Knowles	JK	Public Governor, South Oxfordshire
Dr Tom Law	TL	Staff Governor, Clinical
Dr Astrid Schloerscheidt	AS	Nominated Governor, Oxford Brookes University
Mr Graham Shelton	GS	Public Governor, West Oxfordshire
Mr Tommy Snipe	TS	Staff Governor, Non-Clinical
Ms Jules Stockbridge	JS	Staff Governor, Clinical
Mrs Sue Woollacott	SW	Public Governor, South Oxfordshire
Mr Jonathan Wyatt	JW	Public Governor, Rest of England and Wales

Ruby	R	Nominated Governor, Young People's Executive

In Attendance:

Ms Caroline Rouse	CR	Foundation Trust Governor and Membership Manager, [Minutes]
Dr Bruno Holthof	BH	Chief Executive Officer
Mr Jason Dorsett	JD	Chief Finance Officer
Ms Claire Flint	CF	Non-Executive Director
Ms Paula Hay-Plumb	PHP	Non-Executive Director
Ms Sarah Hordern	SH	Non-Executive Director
Ms Katie Kapernaros	KK	Non-Executive Director
Mr Terry Roberts	TR	Chief People Officer
Prof Tony Schapira	AS	Non-Executive Director
Ms Anne Tutt	AT	Vice Chair and Non-Executive Director
Ms Eileen Walsh	EW	Chief Assurance Officer
Ms Viv Lee	VL	Children's Patient Experience
Dr Neil Scotchmer	NS	Head of Corporate Governance
Ms Katy Whife	KW	Corporate Governance Manager
Ms Susan Polywka	SP	Corporate Governance Consultant
Rosalind Pearce	RP	Healthwatch Oxfordshire [Item 5]
Tracey Rees	TR	Healthwatch Oxfordshire [Item 5]
James Kent	JK	ICS Lead [Item 6]
Jo Phillips	JP	Director of Culture and Leadership [Item 8]
Simon Prangnell	SP	Clinical Director of Psychological Medicine [Item 8]
Jay Mistry	JMi	Commercial Director [Item 14]

Apologies:

Prof Helen Higham	HH	Nominated Governor, University of Oxford
Mr David Radbourne	DR	Nominated Governor, NHS England

CoG21/01/01 Welcome, Apologies and Declarations of Interest

1. Apologies were received from Helen Higham.
2. It was noted that the meeting had been preceded by some ‘virtual coffees’ between governors and non-executive directors. The Chair noted that Board

business had been prioritised to free up executive director time given operational pressures and for this reason only non-executive Board members had taken part in these sessions.

3. No declarations of interest were given.

CoG21/01/01 Minutes of the Meeting Held on 2 November 2020

4. RH had been omitted in error from the attendance list on the minutes, but did attend the meeting.

5. The minutes were otherwise accepted as a true and accurate record.

CoG21/01/02 Matters Arising and Review of the Action Log

Appointment of Lead Governor

6. The Committee noted that the six month extension to the term of office of the Lead Governor, ending on 1 June 2021, had been approved.

LMC

7. The Lead Governor updated the Council following Oxfordshire LMC's approach to the Council of Governors regarding concerns around routine referrals held by GPs that were unable to be forwarded to the Trust as a result of the COVID Pandemic.

8. Funding had since been made available to practices in line with their historic referral numbers to each of the challenged specialities over the period April 2019 to March 2020 to enable them to undertake clinical reviews and harm assessments on this group of patients.

9. CG confirmed that she had received some very positive responses from practices about this in relation to this arrangement. Practices continued to hold some routine referrals but the numbers had reduced.

10. It was noted that GPs were keen for the arrangement to be extended. The Chair emphasised that this decision was not one for governors but commented that he was pleased to hear that the steps taken seemed to have improved the relationship.

ANPR

11. JM noted that the APNR was on action log, but that there was no movement on this issue at that stage.

CoG21/01/03 Chair's Business

Board Meeting

12. Having been in attendance as an observer CG shared her view that the Board meeting that day had been productive and the time well used.

Election Schedule

13. JM highlighted that elections would start on 21 January with the results available on 26 March 2021. Governors whose terms of office end in September 2021 would be offered the opportunity to be co-opted back to the Council, to allow for the next set of elections to take place early in 2022. This would enable the cycle of elections to continue to take place in the spring, instead of the summer in future.

Katharine House Hospice

14. JM reported that the Board had approved a plan for the transfer of Katharine House Hospice services to the Trust in the spring. Further legal work was required and the hope was that COVID-19 would not delay this process. The Trust was pleased to be able to protect palliative care services in the north of the county.

15. SB reiterated that this was very good news for the service, but asked about funding flows. JD reported that the fundamental reason for doing this was that the standalone hospice was not financially sustainable. In the future commissioner funding would transfer to the Trust and KHH would become a fundraising charity as its primary focus.

16. RH asked if the Trust was intending to continue to use the KHH building and JD confirmed that the service would continue to operate from its existing location. Staff would become OUH employees and the Charity would provide a long term lease on a peppercorn rent of the current building to the Trust. The Trustees of the Charity retained the building. It was emphasised that this was not a question of moving palliative services away from north Oxfordshire, but of providing a sustainable future for inpatients. The hospice Trustees would not have contemplated this arrangement if there was any risk to the service.

17. RH requested that any relevant communications be shared with both Northants Council and Cherwell.

Development of 2021/22 Annual Plan.

18. JD informed the governors that the planning guidance for 2021/22 had not yet been received and there were strong indications that NHS England would delay the planning process. JD reported that this meant that engagement with governors on annual plans was not likely to take place until the spring.

CoG21/01/03 Healthwatch Update

19. JM welcomed Rosalind Pearce and Tracy Rees from Healthwatch Oxfordshire. RP reported that it had been some time since Healthwatch last attended a meeting and that, due to the pandemic, they had not been able to have any stands in the Trust's hospitals since February 2020. RP explained that Healthwatch's key role was to listen, influence and challenge.

20. RP reported that the Trust hospitals featured on the feedback part of the Healthwatch website. The hospitals received an average 4 star rating, with comments of "good quality of care" and "friendliness of staff" being common. Challenges around parking and access to getting appointments were also regularly mentioned. RP confirmed that the feedback received was shared with service providers and commissioners, along with the community that comments were received from.

21. It was noted that Healthwatch had a strong belief in working face-to-face with people but that during the pandemic this had not been possible. Links had been developed with the Trust's Patient Experience team with quarterly meetings taking place to provide feedback on what had been heard from the community. Any specific concerns were escalated to the Chief Nurse. Healthwatch provided comments annually on the Quality Account and felt that these were listened to, with changes made based on suggestions on a number of occasions.

22. RP reported that, during the lull between lockdowns, visits to Didcot had taken place to hear from the community. Lockdown had been very challenging in allowing access to communities to hear people's views. Healthwatch had therefore made use of online services and links with organisations within different communities. Feedback that had been received related mostly to delays in accessing care.

23. RP reported that COVID had had a huge impact on appointments. She was concerned about the impact this would have on individuals, but realised that OUH staff were not ignoring this challenge. RP highlighted that communication was vital to ensure patients understood the situation.

24. RP understood that many lessons had been learned and improvements made to service delivery, and that organisations were working differently. She highlighted, however, that the approaches used were not working for everyone, noting that digital exclusion was an important issue for some individuals and communities. She noted that some people preferred not to have an outpatient appointment via video. Even with access to the internet, barriers could exist, due to hearing and language which were exacerbated by the lack of a face-to-face appointment. RP, therefore, emphasised that this was not the most appropriate mechanism for everyone.

25. CG expressed the gratitude of governors for the input from Healthwatch Oxfordshire. She noted from regional NHS Providers meetings that the relationship Healthwatch Oxfordshire had with the Board differed significantly from that at some other Trusts, where, in some cases, governors had never heard of Healthwatch. RP agreed that Healthwatch in other regions worked very differently, and was very pleased to be welcomed at the Trust.

26. In response to a query RP confirmed that the aim of Healthwatch was to make contact with all PPGs in due course.

COG21/01/04 ICS Update: Public Involvement and Collaboration Arrangement

27. JM welcomed JK to the meeting. JK expressed thanks to the senior leadership team at OUH for the system-orientated way in which the Trust had moved into the third wave of the pandemic. The Council noted that a meeting took place on most mornings to review critical care capacity and discuss as a system how to balance clinical risk.

28. JK reported that since the last meeting consultation on two options for the future of the ICS had been undertaken, with a preference to subsume the commissioning architecture into the ICS as a statutory body.

29. JK noted that most of the document published reiterated the current direction of travel, emphasising the need for a strong emphasis on place, in line with national policy. There was a requirement for providers to join collaboratives which allowed different footprints to be drawn.

30. JK commented that document was silent on a number of things, which were yet to be worked out. It did not explain how the ICS would be governed and how governors, non-executive directors and local authorities would play their parts. It was also not clear what happened to the primary care voice without the existence of the current membership organisations.

31. JK acknowledged the challenge of effective patient engagement but indicated that this would be organised at system level with patient participation groups. He indicated an intention for renewed vigour in linking with hard to reach groups. The ICS would also take the opportunity to look again at how to engage patients in the development of their own care without introducing further inequalities. This would open up a much richer future on how care will be delivered. However, he highlighted that the local system received 12% less than average per head in funding, because of the wealthy population served.

32. JK recognised that the role of governors in the new system was unknown at that stage but that there would be a need for good representation though there was currently no guidance on this.

33. GS added that the operation of elected governors at the Trust was a powerful way to give patient input from every corner of Oxfordshire. He was concerned that this could not be replicated across as large an area as the BOB ICS. JK agreed that consideration needed to be given to whether the FT-type model was replicated within the ICS, or whether a provider collaborative approach (like the Thames Valley Cancer Alliance) might be better.

34. RH pointed out that patient flow was not as defined geographically as the ICS or Council boundaries and that appropriate representation was able to reflect these fluid borders.

35. JM asked how the Council could help shape the way forward. JK emphasised that that the real value would probably be in the shaping of the final legislation that was drafted rather than the current consultation.

36. JM emphasised that although engagement with the public would be helpful to the ICS, it should be recognised that it was not the Council's job to hold JK to account for this.

37. JK highlighted that thanks were due to OUH for all the Trust had done over last few weeks, not just as hospital but as a system partner.

CoG21/01/05 Update on COVID-19 Response and Recovery

38. The Chief Executive Officer informed governors that a significant number of admissions to Trust hospitals were taking place due to the surging second wave in the community. Twice the number of patients had been admitted as at the peak of the first wave and numbers were still increasing.

39. BH commented that due to better treatment models, fewer patients needed invasive ventilation. However, there was an increase in the number of staff absent due to self-isolation or illness. This had a high impact on other patient treatments with routine elective treatments cancelled.

40. BH noted that other urgent treatments were being maintained, but that the Trust was looking at alternative options should it become unable to cope.

41. BH was happy to report that the vaccination programme was escalating at speed. The Trust now had three vaccination hubs at the Churchill, the John Radcliffe Hospital and the Horton General Hospital in Banbury.

42. Vaccinations at the Churchill Hospital had started with the Pfizer vaccine and the other hubs were using the Astra Zeneca vaccine. The Trust was prioritising front line and high risk staff to receive their vaccinations first. So far half of front line staff had already received their vaccination and the hope was that all front line staff would have done so by the end of January. It was planned that all other staff would be offered their first vaccination by the middle of February.

43. BH advised that he hoped that due to the latest lockdown and the roll out of the vaccination programme the Trust would be in a very different position by the end of February and certainly during March. However, he recognised that the next couple of weeks were going to be extremely tough and the Trust was working with staff members to make sure they got through this difficult period and that appropriate support was available.

44. SJD thanked BH for the hard work of staff and asked how the Trust was coping with discharging patients. BH reported that there was still an issue repatriating patients to referring trusts for ongoing care. This remained a key focus and the Trust was working with system partners, recognising that the situation was difficult for everyone.

45. MH asked whether the Trust had any supply issues. BH advised that oxygen was at a critical point and was being monitored regularly. The Trust could not exclude the possibility of disruption to supplies due to Brexit, but had the support of the national supply chain. The welfare of Trust staff was the greatest concern.

46. RB asked if there was a possibility of cancer and other elective surgery needing to stop due to the numbers in intensive care. BH explained that there was twice the number of patients in ICU as in the first wave. Routine elective treatments had been cancelled, which meant patients would have to wait even longer. Cancer services, however, had so far not had to cancel any urgent treatments and the Trust was working within the Cancer Alliance and South East region to ensure that any patient in the South East region could receive treatment. However it was acknowledged that the situation was precarious and subject to change.

47. JM highlighted that some patients had been treated within the Trust who were not from its normal catchment area to help relieve the situation elsewhere.

48. TBW thanked the executives for their hard work, and asked how confident the Trust was with the decision to implement a three month delay for the second dose of the vaccine. BH confirmed that the Joint Vaccination/Immunology Committee felt that both vaccines offered good protection against severe illness with one dose.

49. SB commented that it was a very good gesture of the Trust to offer staff an additional day of annual leave on their birthday for their hard work during the pandemic, and that this was much appreciated. However, he added that many staff had not used their annual leave entitlement this year due to work pressures and asked if there would be a change in Trust policy to allow the rolling over of leave from the current year. BH emphasised that it was important that staff be encouraged to take a break even with the current restrictions in place. He emphasised that the Board would be leading by example and that he had asked executives to take breaks and use their leave

entitlement, to avoid burnout and fatigue. BH stressed that the Trust needed to take care of patients, but also must take care of its staff.

CoG21/01/06 Staff Welfare Briefing

50. TR introduced Jo Phillips, Director of Culture and Leadership and Simon Prangnell, Clinical Director for Psychological Medicine who had been leading work to ensure the health and wellbeing of staff. It was emphasised that the work had not been undertaken in isolation but with the support of the Oxford Hospitals Charity and all parts of the Trust.

51. JP summarised the presentation for governors explaining that the project was informed by the Trust strategy of “looking after our people” with the health and wellbeing of staff underpinning this.

52. The project had four key pillars: self-care for all, team wellbeing, individual targeted support and support for leaders. There are internal and external resources and the guide has been made available on the internet so that information is accessible to all staff.

53. JP reported that the Trust had appointed a new Health and Wellbeing lead to co-design the wellbeing initiatives with BAME staff. The virtual delivery group undertook to review a range of feedback received regarding what was working well.

54. The Trust had secured respite space to ensure that staff had somewhere to go during their downtime.

55. The Wellness Matters campaign has launched, with a weekly ‘wellness matters’ email, drawing out key aspects every week for staff.

56. CG commended the presenters and asked if there would be a review infrastructure and resource for Occupational Health, noting that a lot of staff would have long term problems and that good physical space could assist wellbeing. TR recognised that this was an issue and reported that the team had expanded into the GP space in the building.

57. SP reported that a range of measures had been put in place. The fundamental principle was that teams across the hospitals were generally resilient due to good leadership and mutual support. However where teams were encountering difficulties, early support was provided. The project involved co-ordination with the Hospital Charity for respite rooms and other basic needs. The Trust had established a dedicated staff support service, which gave rapid access to psychological medicine colleagues.

58. SJD emphasised that it was pleasing to hear about the equality and diversity aspects of the plan. She strongly encouraged improved support to disabled staff who might be reluctant to ask for help.

59. EW explained that the Trust had relaunched the Disabled Staff Network, and that she was the Executive Sponsor for this. She recognised that there was a 'hidden voice' with this staff group, but hoped that the Network would amplify this and indicated that the Board were committed to work to ensure this happened.

60. RH asked how the Trust could assure governors that all staff would get access to this new support. JP reported that when the launch took place, communications went out using every available channel. Posters were produced and slips were attached to payslips of all staff. Information was also sent out via email and the OUH staff text service.

61. JP confirmed that team leaders were coming forward to be wellbeing leads and that the Trust was making sure that leads were supported to undertake the role. The Trust was also monitoring hits on the guide to health and wellness to see how many staff were accessing this information.

CoG21/01/07 OUH Constitution Review

62. JM reported that the Board had approved the changes to the Constitution, which had also been through extended discussions with the Patient Experience, Membership and Quality Committee's working group. JM felt that the paper reflected the discussions and encouraged the Council to approve the recommendations.

63. The Council approved the paper.

CoG21/01/08 Council of Governors Schedule for 2021/22

64. JM asked governors to note the paper. He explained that the Trust was aiming to get a consistent pattern for its committees to facilitate attendance from executive and non-executives Board members.

CoG21/01/09 Lead Governor's Report

65. CG highlighted that NS had circulated the Lead Governors Association response to the ICS consultation.

CoG21/01/10 Any Other Business

66. JM noted that the Trust had approved revised governance arrangements during the pandemic to provide appropriate governance whilst releasing executive time for operational priorities.

67. These arrangements included stripping out priorities that could legitimately be deferred and a weekly call with non-executive directors providing a dashboard of details of COVID patients and staff absences, as well as picking up

vaccination coverage. These were ways of ensuring the focus was on the governance of what makes a difference to patient care and staff wellbeing.

68. JM advised that the Quality Conversation would not take place as usual that year and that governors would be informed once it was agreed how this work could be taken forward.

CoG21/01/11 Date of Next Meeting

69. A meeting of the Council of Governors was to take place on **Wednesday 31 March 2021**.