Council of Governors

Minutes of the Council of Governors Meeting on Wednesday, 5 July 2017 at 18:00 in Classroom 2, Saïd Business School, Park End Street, Oxford.

Present:	Dame Fiona Caldicott	FC	Chairman
	Ms Ruth Barrow	RB	Public Governor, Cherwell
	Mr Steve Candler	SCa	Public Governor, Rest of England & Wales
	Ms Lucy Carr	LC	Staff Governor, Clinical
	Mr Chris Cunningham	CC	Staff Governor, Clinical
	Mrs Sally-Jane Davidge	SD	Public Governor, Bucks, Berks, Glos & Wilts
	Dr Elizabeth Gemmill	EG	Nominated Governor, Oxford University
	Dr Cecilia Gould	CGl	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 Anita Higham OBE	AH	Public Governor, Cherwell
	Mr Martin Howell	MHo	Nominated Governor, Oxford Health NHS Foundation Trust
	Dr Ian Roberts	IR	Public Governor, South Oxfordshire
	Mr Richard Soper	RS	Staff Governor, Non-Clinical
	Mr Brian Souter	BSo	Public Governor, Bucks, Berks, Glos & Wilts
	Mr Blake Stimpson	BSt	Public Governor, Northamptonshire & Warwickshire
	Ms Julie Stockbridge	JS	Staff Governor, Clinical
	Dr Chris Winearls	CW	Staff Governor, Clinical
	Mr Mariusz Zabryznski	MZ	Staff Governor, Non-Clinical
In Attendance:	Mr Paul Brennan	PB	Director of Clinical Services
	Ms Susan Brown	SB	Senior Communications Manager
	Mr Jason Dorsett	JD	Chief Finance Officer
	Mr Christopher Goard	CGr	Non-Executive Director
	Dr Bruno Holthof	BH	Chief Executive
	Ms Susan Polywka	SP	Head of Corporate Governance and Trust Secretary
	Ms Caroline Rouse	CR	Foundation Trust Governor and Membership Manager
	Mr Geoffrey Salt	GS	Non-Executive Director
	Dr Neil Scotchmer	NS	Programme Manager
	Ms Eileen Walsh	EW	Director of Assurance
	Mr Peter Ward	PW	Non-Executive Director
	Ms Susan Young	SY	Interim Director of Workforce
Apologies	Mrs Sue Chapman	SCh	Public Governor, West Oxfordshire
	Cllr Judith Heathcoat	JHe	Nominated Governor, Oxfordshire County Council
	Dr Paul Park	PP	Nominated Governor, Oxfordshire Clinical Commissioning Group
	Ms Rachel Pearce	RP	Nominated Governor, NHS England
	Dr Astrid Schloerscheidt	LK	Nominated Governor, Oxford Brookes University
	Hannah		Young People's Executive (YiPpEe)
	Millie		Young People's Executive (YiPpEe)

CoG17/03/01 Apologies and declarations of interest

Apologies were received from Sue Chapman, Judith Heathcoat, Paul Park, Rachel Pearce, Astrid Schloerscheidt, Hannah and Millie.

Dr Elizabeth Gemmill was welcomed to the meeting as the new governor for Oxford University. It was also announced that Dr Astrid Schloerscheidt had taken on the role of the governor for Oxford Brookes University.

The Chairman informed the Council that Simon Clarke had informed the Trust that he had been elected to Oxfordshire County Council in May and had been appointed to the Joint Health Overview Scrutiny Committee. He had therefore stood down as a governor as he was no longer eligible under the Constitution under these circumstances.

CoG17/03/02 Minutes of the meeting held on 7 April 2017

The minutes of the meeting were **accepted**.

CoG17/03/03 Matters arising from the minutes

AH asked if there had been any developments regarding the possibility of Jane Hervé attending the Council of Governors to discuss her role as Freedom to Speak Up Guardian. NS confirmed that it was planned that Jane would attend a seminar in November if possible. He also indicated that the possibility of a joint session with Healthwatch was being explored and that it was hoped that a schedule for future seminars would be proposed to governors shortly.

The Chairman noted that the process of refreshing declarations of interest for the Council of Governors was still to take place.

CoG17/03/04 Chairman's Business

The Chairman informed the Council that a draft action plan had been submitted to the Care Quality Commission [CQC] by the required deadline, following its recent report. This was due to be considered by the Board at its meeting on 12 July 2017..

The Chairman also explained that, following the Grenfell Tower fire, Oxfordshire Fire and Rescue had inspected all Trust sites. Once the Trust had received the report on findings, the Trust would be able to report on the outcome of the inspections.

CoG17/03/05 Response to Staff Survey 2016

Susan Young, Interim Director of Workforce provided a presentation on the staff survey. This presentation had been requested by the Patient Experience, Membership and Quality (PEMQ) Committee. The importance of the staff survey was highlighted in the light of the impact that staff engagement was recognised to have on other key metrics. SY noted that the overall staff engagement measure for OUH had been increasing since 2011.

The Trust had agreed three areas of focus:

- Bullying, harassment & abuse (both from staff and patients)
- Quality of appraisal
- Health and wellbeing

SY explained that the Trust had low reported rates of bullying, harassment and abuse that placed it in the top 20% of trusts. However, there was also evidence that staff were less confident than in other trusts at reporting incidents of bullying, harassment and

abuse, and the need to create a culture where staff could speak up was recognised. Actions to address this included a new dignity and respect at work policy, the appointment of 'Freedom to Speak Up' guardians, an employee assistance programme and a specific 'Values into Action' event which was to be held in the coming weeks. The quality of appraisals at the Trust was reported as high compared to elsewhere, and in comparison to previous years. However, the proportion of appraisals completed was lower. The Trust compared well with elsewhere for staff health and wellbeing, both to the extent that staff wellbeing was reported as good and the extent to which staff felt it was deemed important by the Trust.

CW noted that figures had previously been given regarding whether staff would recommend the Trust as a place to be treated and as a place to work. He asked whether these figures were now better or worse. SY explained that she did not have the relevant numbers readily available as this related to the Friends and Family Test. This information was to be provided following the meeting.

Action: SY

JS asked how the response rate to the Staff Survey could be improved. SY explained that the results were better than for many trusts but that the response rate was lower and this was a concern. She explained that it was important to encourage engagement through feeding back actions that had been taken in response to previous results. JS also noted that there had been no facility to submit a paper copy of the Staff Survey this year. SY explained that the formats to be available in the future were to be agreed with the provider.

IR asked how results of the Staff Survey linked to the vacancy rate and bank usage, noting that a key issue was the potential future problem with staffing levels. He highlighted that this was a particular concern in the light of Brexit. SY recognised the importance of these issues, noting that, although the Trust's current vacancy rate of 14% was not as high as in many trusts, this was a key focus for the Executive Team. It was **agreed** that a response to IR's queries would be provided in a note submitted to the next meeting of the Governors' Performance, Workforce and Finance (PWF) Committee.

Action: SY

CGl noted that the PWF Committee had heard that bullying of PFI staff had been reported. SY explained that she would ask that any details be passed on so that the issues could be dealt with, although it would not be appropriate to discuss specific allegations within an open meeting. SP confirmed that some specific concerns raised by a governor had been referred to the Director of Clinical Services to be addressed.

BSt expressed his shock that staff suffered abuse from patients. SY confirmed that instances of patient abuse were reflected in the survey results, commenting that these captured the perceptions of the individual members of staff who had responded to the Staff Survey.

CoG17/03/06 Performance in relation to waiting times: Update on analysis of demand, activity and capacity

The Director of Clinical Services provided a presentation to governors on analysis of demand, activity and capacity. This illustrated that increasing elective (planned) activity levels had plateaued in 2015/16 and 2016/17 under block contract arrangements with the Oxfordshire Clinical Commissioning Group [OCCG]. Over the same period, referrals and Emergency Department [ED] attendances had continued to increase year

on year. As a result the incomplete waiting list had continued to increase. PB highlighted that this included not just a backlog of patients awaiting operations and that significant numbers were also waiting earlier in the pathway for outpatient appointments and diagnostics. As a result of the increase in the length of the waiting list, performance against the national standard had deteriorated. Whilst some improvement had been seen during May, this showed 90.12% of patients starting consultant-led treatment within a maximum of 18 weeks after first being referred, against the national standard of 92%.

PB presented figures illustrating the scale of the task to equalise the run-rate, recognising that this represented a huge cost pressure for the local system. He noted that for each of outpatients, day cases and elective inpatients, around half of the work required related to a 'top five' of specialties: Dermatology, Ear Nose & Throat, Gynaecology, Ophthalmology and Trauma & Orthopaedics. PB emphasised that simply clearing the backlog was not the fundamental issue, as the length of the waiting list would only build back up again, unless equilibrium were achieved between the rate at which patients were referred, and the rate at which treatment could be delivered.

The agreed activity plan for Q1 and Q2 was presented to governors. It was noted that activity was above the original plan but sufficient only to slow the current deterioration, rather than equalise the run-rate. PB explained that during the six months from April to the end of September, the aim was to develop a system wide plan for the following six months and subsequent year 2018/19. This might include additional measures to manage the demand for services, changes in patient care pathways and possibly the rationing of certain services.

SJD asked if figures were available by hospital. PB explained that they were available by specialty but not hospital. The majority of services were currently delivering activity at or slightly above the plan. Ophthalmology was slightly below plan but actions were in place to address this.

CW commented that if demand were tightly managed then the Trust would be undertaking less work and receiving less income. PB advised that there were a large number of patients already on the waiting list and there was no proposal to deny treatment to those patients (although, to the extent that different clinical thresholds were used in some cases, there was a need to ensure consistency). Demand management measures would primarily be aimed at constraining further growth in the rate of referral. The level of clinical activity required to treat all those patients already waiting, and for treatment to keep pace with a sustainable run-rate, would represent a significantly higher level of activity than was currently being delivered. Now that the Trust had negotiated a cost and volume contract with OCCG for 2017/18 (rather than the block contract that had applied in earlier years), this additional activity would attract additional commissioning income.

AH asked whether it was felt that these proposals would allow the issues highlighted by the recent NHSI report to be resolved. PB explained that the Trust had undertaken to implement a plan which was being delivered to date. The plan for October 2017 and beyond needed to be delivered by September 2017. Overall, PB confirmed that he regarded the Trust as currently being on the right track.

RS noted that there were no financial figures attached to the proposals. PB explained that the worst case scenario was that this activity brought in £2.5m of additional income and also cost a similar amount. It was hoped, however, that the impact would be more positive than this, to the extent that some of the additional activity required could be delivered by improvements in productivity, without incurring additional costs.

MHa asked where the greatest strains in the system were most evident. PB expressed the opinion that the biggest challenge currently faced by the Trust was the ability to recruit into vacant nursing posts to maintain the current bedstock.

MHa also asked whether the proposals would place a strain on clinical and other staff. PB explained that the plan for the first six months was developed following discussion with clinical colleagues and their teams. This was not an executive-led plan and there had been challenge back from executive directors to establish deliverability. It was noted that theatres posed a significant challenge because this was a hard pressed area in relation to recruitment. There was an aim to get ahead of plan during Q1 because it was recognised that patient choice was a significant factor during the summer months and patients might opt not to receive treatment during this period, impacting adversely on the percentage of patients who received treatment within 18 weeks.

CoG17/03/07 Financial performance

The Chief Finance Officer presented an outline of the Trust's financial performance in 2016/17, and provided an indication of what the most recent report on financial performance was expected to show. The latest report on financial performance (up to 31 May 2017) had only become available on 5 July, and would be submitted for consideration by the Trust Board at its meeting on 12 July 2017.Governors had been sent a copy of the previous report on financial performance up to 30 April 2017.

The Chief Finance Officer highlighted that the Trust had reported a small surplus achieved in 2016/17, in contrast to the position of many trusts reporting a deficit at year end. There had, however, been a deterioration in financial performance during the last five months of the year. As in previous years, the Trust had been reliant on one off items, and the underlying position had been in deficit. This was in part because the Trust had taken the decision to make investments in clinical services, taking on additional cost because it was the right thing to do for patients. An example was the purchase of care home and nursing home beds, to provide a better environment for the intermediate care of patients who were medically fit for discharge from the hospital, but whose transfer of care had been delayed as a result of a lack of available domiciliary care. In addition, there had been further additional costs which were not anticipated at the start of the year. For example, the temporary suspension of obstetric services at the Horton General Hospital [HGH] had led to additional costs being incurred, such as the provision of a dedicated ambulance for transfers from the midwifery led unit at HGH. Furthermore, costs in the organisation had continued to increase without balancing savings being realised.

JD noted that because trusts were not profit-making organisations, the aim was generally to achieve a small surplus, representing a relatively narrow margin given the scale of the organisation's finances (with a turnover of almost £1b in 2016/17). JD confirmed that there had been fewer one off items in 2016/17, and the key challenge for the future would be to improve underlying financial performance, and reduce the reliance on one off items.

JD explained that the financial performance in 2017/18 showed a deterioration in performance from March to April due to the full effect of pay increases, and because deflation of prices commenced without mitigations sufficient to offset these. Financial performance reported up to 31 May 2017 showed a £4.3m improvement compared to April, and it was expected that further measurable improvement should be seen in June 2017. Nonetheless, this was not sufficient to deliver financial sustainability.

JD reported on a number of actions that were being taken to improve the Trust's financial position. In late April 2017, executive directors had taken the decision to tighten control over expenditure on non-patient facing elements of pay and non-pay costs. This had been necessary to stabilise the position in the short-term, but it was recognised that this did not constitute a long term solution. The approach created significant additional work for staff in order to scrutinise discretionary expenditure and reduce a few percentage points of spend. In the longer term the Trust would wish to devolve these decisions to be taken locally but with the same level of rigor applied.

The Trust was also looking to make savings on procurement and agency spend, though it was recognised that these could be hard to achieve, and could involve difficult decisions involving clinical trade-offs. A programme of work was also looking at the reduction of administrative costs associated with the corporate functions supporting clinical teams. It was believed that a better service could be provided at lower cost, taking into account that the Trust had already established better Information Technology [IT] infrastructure than many other trusts, supporting electronic communications and patient records.

In addition the Trust was looking to change patient pathways in both planned and urgent care, with the primary objective of improving the quality and safety of patient care. Whilst this also had high potential to deliver financial benefits, these were not likely to be realised in the current year. JD suggested that there should be scope for efficiency savings associated with the changes that had been made in urgent care during 2016/17.

JD confirmed that there would also be a programme of some one-off items of financial benefit, such as the development of land for staff housing at a discount.

JD explained that he was currently unable to attach numbers to these various elements as they were dependent on final decisions by the Board.

BSo asked what the financial impact of the 1% addition to the wage bill would be. JD explained that, as the current staff bill was approximately £40m per month, the impact of this was £400,000 per month.

CW noted that there was currently a significant level of vacancies within the Trust and asked if this masked a worse financial situation. JD explained that this was currently balanced by the cost of temporary staffing.

JD also clarified that there was no freeze on recruitment. The Trust had imposed a process of additional scrutiny on recruitment but this did not cover all roles and the aim was to speed up recruitment to 'rank and file' clinical posts. Data on offers made to staff and on recruitment campaigns was scrutinised weekly. The aim was to see the volume of non-patient facing posts decline and that of patient-facing roles increase. Recruitment to clinical roles had slowed during May but this was an unintended temporary effect and work had since taken place to ensure that clinical hiring was not being delayed. JD noted that the clinical hiring environment was difficult, with other organisations increasingly offering 'golden hellos' and other enticements.

CW asked about the income impact of having a block contract with the Trust's main purchaser. JD clarified that this had ceased to be the case from the end of March 2017. OUH now had a cost and volume contract with Oxfordshire Clinical Commissioning Group [OCCG]. The final contract included a risk share arrangement across the Oxfordshire system, which was aimed at incentivising each of the system partners to engage with appropriate demand management. This meant that the Trust would receive payment at 100% tariff up to a certain level, and payment at 60% tariff above that level.

JD's view was that this was the best deal possible without going to arbitration. He also commented that it was the right type of arrangement for Oxfordshire in that it compelled organisations to work in partnership to develop sustainable solutions.

IR noted that the month 1 figures under the new contract appeared to show a consistent level of loss with the previous year. JD explained that the table in the Finance and Performance Committee report was an analysis of EBITDA[1]. This did not measure the bottom line but the operational income and costs and was considered to be the best single measure of sustainability. For the Trust to be in a break even position at year end, a positive EBITDA at an average of £5m per month was required.

JD explained that the largest components of 'other income' (other than commissioning income) related to education and training and research and development (R&D). This income was not guaranteed but was not regarded as being at significant risk. The Trust had a good track record of securing R&D funding from both national and commercial sources.

JD accepted that the figures didn't show a shift in M1 and it was for this reason that decisive actions had been taken by the Board and management executive. He noted, however, that income was linked to working days whereas costs were fairly consistent each month; April had an unusually low number of working days.

The situation was nonetheless taken very seriously and the executive team had begun meeting weekly rather than fortnightly and was looking at a suite of weekly data rather than merely waiting for final monthly figures.

JS highlighted the importance of communication with front line staff. The Trust needed to be clear in its messages to prevent perceptions being shaped only by what staff heard through the media.

CoG17/03/08 Report from Performance, Workforce and Finance Committee

Feedback on the most recent meeting of the Governors' Performance, Workforce and Finance Committee [PWF] was provided by CGl as the committee chairman. She recognised the helpful presentations that had been provided to the Council by executive directors. These had been presented at the request of the PWF Committee as members wished the whole Council to be aware of the concerns involved.

CGl informed the Council that an Audit Working Group had been established and would be meeting shortly. The Committee had been pleased to hear of the appointment of a new Chief Nurse but was concerned by the fact that the Trust had thus far been unable to appoint a Director of Workforce.

In relation to the challenge presented by the referral to treatment (RTT) standard as outlined by PB, CGl noted that a Director of Improvement and Culture was to be appointed and that work with NHSI's Intensive Support Team (IST) was thought to be helpful.

CGl noted that PWF had requested that they see summary outcomes from the efficiency work being undertaken by Deloitte and highlighted that recruitment and retention was the key risk on which the Committee wished to seek further assurance.

CGl noted the 'Values into Action' event that was to be held by the Trust on 19 July 2017. The Committee had expressed the hope that staff governors in particular would

[1] Earnings before interest, tax, depreciation and amortization

be able to attend this. The staff survey was recognised to be a high priority due to the correlation between staff engagement and patient experience.

MHa reiterated the importance of workforce issues. He commented that PWF was in particular interested in looking at the link between the good work that that was happening internally (eg on accommodation) and the actual impact that this was having on recruitment in the current market.

FC agreed that the Committee should be provided with further detail on the work that the Trust was undertaking in this area.

Action: SY

CoG17/03/09 Report from Patient Experience, Membership and Quality Committee

Feedback from the Governors' Patient Experience, Membership and Quality Committee [PEMQ] was provided by SJD in the absence of SC who had given her apologies. SJD informed the Council that the Chief Information and Digital Officer had given PEMQ a presentation on the 'Go Digital' scheme which had been regarded as both helpful and encouraging. PK had agreed to continue to work with governors through the Committee, especially in relation to the development of the patient portal.

SC had also met with the Deputy Medical Director and GS following the meeting of the Committee to discuss how the quality account was presented and how the quality conversations were to work in future in order to make these more appealing.

End of Life Care had been agreed as the quality priority to be 'adopted' by the Council of Governors, but it was agreed that there was a need to consider what it meant to adopt a particular quality priority. It was agreed that the Committee would invite a member of the End of Life Care Group to provide an update to a future meeting.

A Member Surveys Working Group was being established and a visit to see the Trust's HART Service was being planned.

RB asked if it would be possible for the wider Council to have more information about 'Go Digital'. It was agreed that PK's presentation would be posted to the Web Forum.

CoG17/03/10 Overview of quality, operational and financial performance

A verbal update was provided by the Chief Executive. BH noted the presentations that had already been provided on workforce, elective performance and finance. He therefore chose to highlight other dimensions of the Trust's work such as quality, teaching and research. He noted the difficulty of juggling these elements of the Trust's remit, developing new high quality services whilst dealing with waiting lists and improving financial performance. The Trust's primary goal was emphasised as being to improve the health of the population in Oxfordshire and beyond. It needed a route to seek assurance that all competing priorities were being appropriately addressed by each of the 67 clinical service areas consistently over time, and consideration was being given to how the Trust should best be organised to facilitate this. BH noted that currently Board scrutiny did not commonly delve below the level of the five clinical divisions, and the formal organisational structure did not provide an accountability framework below the level of the current 17 clinical directorates.

SCa expressed concern that organisational change could be a distraction at a time when the Trust was under pressure. BH explained that he and the Board were aware of this risk and were not contemplating a whole new organisational structure. The aim

would be to create accountable care teams closer to the level at which care was delivered.

CC asked whether in devolving responsibility to that level the Trust could be sure that there were a sufficient number of individuals with the right skills. BH explained that the Trust needed different types of leadership. The Focus on Excellence programme had identified areas with performance improvement potential if the Trust were able to put in place the right leadership. There had also been clinical service areas identified where challenges required the right kind of leadership. It was recognised that this required a supportive programme to develop leaders across the organisation.

AH asked what had been BH's proudest achievement in his first two years as Chief Executive. BH highlighted the work that had been done to redesign the urgent care pathway including the liaison hub, ambulatory pathway and establishment of the Home Assessment and Re-ablement Team [HART] service. He recognised that there was still more to do in partnership with Oxford Health, OCCG and Oxfordshire County Council. AH remarked that partnership may not be seen by some as a strength of the organisation. BH commented that the Trust may have been seen in the past as insular but that it certainly did work hard in partnerships now, for example as part of clinical networks.

CoG17/03/11 Appointment of Non-Executive Director

Governors were asked if they had any questions regarding the information that had been provided about the appointment of a new Non-Executive Director. AH noted Monitor's comment about the lack of diversity in gender and ethnicity on the Trust Board, and asked how the Appointment Panel felt that they had addressed this point. FC noted that no candidates had been presented to the Panel from an ethnic minority. SY noted that a number of conversations had taken place with the recruitment company to ask them to broaden the search as far as possible when seeking suitable candidates. MHa explained that some candidates from ethnic minorities were reviewed at long listing stage but couldn't be matched with key requirements in the person specification. The Panel had discussed how this could be addressed in the future. FC confirmed that a paper on this subject was to come to the Board the following week and that this issue was very much on the Board's agenda. MHo explained that Oxford Health has experienced similar issues despite the efforts of recruiters. He suggested that the appointment of an Associate NED might be a possible approach.

SJD noted that it had been recommended that the Council ensure that the financial expertise of the candidate stepping down was being replaced appropriately. CGl reiterated this from the viewpoint of the PWF Committee, highlighting that Peter Ward was also shortly stepping down as a NED. MHa explained that a large number of people with financial expertise had applied, considering that the person specification had been adjusted so as not to focus too narrowly on this. His view was that the Panel was recommending a candidate who offered financial sophistication along with a number of other strengths.

CC commented that the candidate profiles were impressive but that he was surprised at the low remuneration which would immediately limit applicants. It was noted that this had already been reviewed by governors and was a fairly typical rate for foundation trusts although in NHS trusts the level would typically be lower.

The Council **agreed** that it was happy to accept the recommendation of the Appointment Panel.

The Council was also informed that a report on learning from the appointment process was to be prepared.

Action: SY

CoG17/03/12 Governor elections and proposals relating to the period of transition for turnover in the membership of Council

Governors were reminded that elections for those seats on the Council with terms expiring after an initial two years were shortly due to commence. Current incumbents were encouraged to consider standing again.

Governors were asked to consider what arrangements for transition might be required. AH noted the value of handing over the expertise that governors had built up in the Council's first two years. CC commented that the induction days had been extremely valuable and suggested that a truncated version of these would probably be beneficial for everyone.

CW expressed the view that the choice of electoral system should be discussed more fully at the Council of Governors. FC clarified that the recommendation to continue with a 'first past the post' had come to the Council and had been approved but commented that this could be reviewed again in the future.

CoG17/03/13 Update from Young People's Executive

It was noted that, although unfortunately neither had been able to attend, the meeting had been the last at which Hannah and Millie would be the YPE governors. FC agreed to write on behalf of the Council of Governors to thank them for their contribution.

CoG17/03/14 Any Other Business

AH noted that comments about OUH's governance had been made at a recent meeting of OCCG at which she had been present. FC asked that any concerns be communicated to her directly.

CoG2017/03/15 Date of the next meeting

The Council of Governors will meet in public on **Thursday, 5 October 2017** at **18:00** in The Town Hall, Bridge Street, Banbury, Oxfordshire OX16 5QE.