Council of Governors
Minutes of the Council of Governors Meeting held on **Wednesday 12 February 2025** at the John Radcliffe Hospital, Oxford.

Present:

Name	Initials	Job Role
Prof Sir Jonathan Montgomery	JM	Trust Chair, [Chair]
Ms Ariana Adjani	AA	Public Governor, Oxford City
Mr Tony Bagot-Webb	TBW	Public Governor Northamptonshire and Warwickshire
Mr Stuart Bell CBE	SB	Nominated Governor, Oxford Health NHS Foundation Trust
Dr Robin Carr	RC	Public Governor, West Oxfordshire
Prof Lorraine Dixon	LD	Nominated Governor, Oxford Brookes University
Dr Gareth Evans	GE	Nominated Governor, Local Medical Committee
Mr Alastair Harding	AH	Public Governor, Vale of White Horse
Prof Helen Higham	HH	Nominated Governor, University of Oxford
Dr Jeremy Hodge	JH	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
Ms Aliki Kalianou	AK	Staff Governor, Non-Clinical
Mrs Janet Knowles	JK	Public Governor, South Oxfordshire
Ms Claire Litchfield	CL	Staff Governor, Clinical
Mr Tony Lloyd	TL	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
Prof David Matthews	DM	Public Governor, Vale of White Horse
Ms Chris Montague-Johnson	CMJ	Public Governor, Cherwell
Mrs Nina Robinson	NR	Public Governor, South Oxfordshire
Mr Graham Shelton	GS	Public Governor, West Oxfordshire
Mrs Pauline Tendayi	PT	Staff Governor, Clinical
Mrs Megan Turmezei	MT	Staff Governor, Non-Clinical

Mr Jonathan Wyatt	JW	Public Governor, Rest of England and Wales
Niamh	YPE	Nominated Governor, Young People's Executive

In Attendance:

Prof Meghana Pandit	MP	Chief Executive Officer
Ms Veronica Barry	VB	Executive Director, Oxfordshire Healthwatch
Dr Andrew Brent	AB	Chief Medical Officer
Ms Yvonne Christley	YC	Chief Nursing Officer
Mr Paul Dean	PD	Non-Executive Director
Miss Daljit Dhariwal	DD	Consultant
Ms Claire Flint	CF	Non-Executive Director
Ms Katharine Howell	KH	Oxfordshire Healthwatch
Mr Terry Roberts	TR	Chief People Officer
Mrs Caroline Rouse	CR	Governor and Membership Manager (minutes)
Prof Ash Soni	AS	Non-Executive Director
Dr Neil Scotchmer	NS	Head of Corporate Governance
Ms Felicity Taylor-Drewe	FTD	Chief Operating Officer
Ms Joy Warmington	JW	Non-Executive Director

Apologies:

Cllr Tim Bearder	TB	Nominated Governor, Oxfordshire County Council
Ms Gemma Davison	GD	Public Governor, Cherwell
Mr George Krasopoulos	GK	Staff Governor, Clinical
Mrs Jane Probets	JP	Public Governor, Oxford City
Ms Sneha Sunny	SS	Staff Governor, Clinical
Mr Mark Whitley	MW	Public Governor, Northamptonshire and Warwickshire

Ben	YPE	Nominated Governor, Young People's Executive

CoG25/01/01 Welcome, Apologies and Declarations of Interest

1. Jonathan Montgomery welcomed Niamh, from the Young People's Executive and Gareth Jones from Oxfordshire LMC to their first meeting. JM recognised that GJ would not always be able to attend and it was agreed that he could send a deputy if necessary to ensure LMC representation.

CoG25/01/02 Minutes of the Meeting Held on 13 November 2024

2. The minutes were approved as an accurate record.

CoG25/01/03 Matters Arising

3. JM asked Yvonne Christley, Chief Nursing Officer, for an update on the West Wing escalator. YC reported that a patient had been injured using the escalator, leading to its closure and an immediate investigation. The investigation was assessing both the escalator and the location of the Eye Hospital. Future Eye Hospital visitors would be redirected, and bollards would be placed to slow people down before they entered the escalator area. New signage would also be installed before the escalator reopened.

CoG25/01/04 Chair's Business

4. JM thanked Jonathan Wyatt and Pauline Tendayi for their support and contributions to the Council as they were not standing for re-election. JM encouraged everyone to use their vote when they received their ballot for the coming governor elections with new governor terms commencing on 1 April 2025.
5. It was noted that Committee memberships would be reviewed and dates confirmed following the coming elections.
6. JM confirmed that approval had been given for his contract as Trust Chair to be extended by two years concluding on 31 March 2027.

CoG25/01/05 Chief Executive's Briefing

7. The Chief Executive Officer provided her usual update to governors.
8. MP reported that the Trust faced significant operational and financial challenges but continued to provide high-quality care. Staff were thanked for their dedication.
9. The financial plan for the year had been for a £8.1m deficit. However with NHS England deficit support this had been revised to a £200k deficit. This relied on reducing temporary staffing by 700 WTE. A reduction of 330-350 had been

achieved, reducing costs by £3.5million without impacting care quality. This had been alongside a small increase in substantive staff, however.

10. The Trust was required to deliver operational standards for elective and emergency care, including ensuring no patient waited more than 65 weeks for elective treatment after the end of March. This was a challenge for the Trust given the wide range of treatment it provided and a mismatch in demand and capacity. Efforts to balance work distribution and capacity included outsourcing and insourcing schemes.
11. The Trust's financial plan required a 5.8% CIP of £92m to be delivered, with £60m achieved at that stage. To manage the pay budget and workforce growth, a temporary recruitment pause had been implemented with exceptions based on safety.
12. Planning guidance had been issued the previous week and ensured that safety remained a priority, with higher standards set for emergency care, treatment referrals, and cancer care. System-wide collaboration would be needed to ensure equity among BOB patients. There was a clear requirement for trusts to live within their financial means making the next year challenging. However the Chief Executive noted that the Trust had a well-established Productivity Committee to support the work required.
13. GS noted that governors had expressed some concern about the scale of workforce and budget growth and whether this indicated a lack of control over costs. MP explained that during the COVID pandemic for 2.5 years, the trust had been given increased flexibility for additional staffing with budgets balanced, resulting in many temporary and additional permanent staff. Rebalancing this growth subsequently was difficult. MP noted, however, that ward nursing ratios were often 1:5 compared to 1:8 in many hospitals.
14. The emphasis in the national plan on the reduction of bank and agency staff was noted. MP said that OUH had the lowest agency usage in the country, with further reductions in the use of bank staff also planned.
15. Work had been undertaken to assess the drivers for establishment growth and the Board had reviewed two iterations of this analysis. Some was driven by requirements such as the Ockenden review whilst services such as Genetics had invested in staff where this would deliver a return on investment. Further reviews of the establishment were being undertaken including analysing medical productivity to ensure growth was in the correct specialties.
16. The Chair noted the need to link workforce analysis to productivity informed by benchmarking nationally. A national benchmarking pack had been produced and was being reviewed by the Trust to assess areas of focus.

17. Non-executives present acknowledged that there was work to be done but noted that the executive team was undertaking appropriate reviews to ensure the right people were in the right place to ensure patient safety.
18. MT noted that the recruitment pause had impacted staff morale significantly. MP explained the broader context, highlighting changes in the NHS and variations across local organisations. The importance of clear communication and openness were emphasised and it was noted that an exception process had been in place. The Chief People Officer had completed work on the process review to support the recommencement of regular recruitment.
19. NR noted the impact of staff morale on productivity and the benefit of improving processes collectively. The optimisation of the use of new technology and equipment was also important.
20. JK expressed concern about early discharges making home management difficult but noted some reassurance from the unchanged readmission rates. Monitoring of home transitions and maintaining care quality were noted to be important. MP highlighted the importance of timely appropriate placement, rather than just hospital discharge. Monitoring readmission rates was crucial, and the Hospital at Home program was proving effective. Collaboration with families was necessary to avoid unexpected discharges.
21. SB asked about the implications of reforecasting the financial position later in the week and whether this would impact the following year's starting position. MP noted the need to address the underlying deficit in the following year. The need to avoid entering the restrictive level 4 oversight framework where the Trust would have very limited freedom to operate was also noted.
22. DM raised concerns regarding EPR and IT and the delays in implementing changes that were needed by staff. Ben Atwood, the newly appointed Chief Digital and Information Officer, was noted to be leading the prioritisation of key programmes and would keep the Board informed.
23. The Council noted the update from the Chief Executive Officer.

CoG25/01/06 Healthwatch Update

24. JM welcomed Veronica Barry, Executive Director at Oxfordshire Healthwatch, and Katharine Howell, Senior Research and Projects Officer, to discuss Healthwatch's work. The small team listened to users of health and care services across Oxfordshire, operating a review-linked website and engaging in outreach, including face-to-face interactions and seldom-heard community research on topics important to the community.
25. This year's projects had included examining eye care experiences in Oxfordshire. Despite significant constraints, feedback had been positive regarding care and compassion. Frustrations had stemmed from accessing appointments, services,

parking, and food. "Enter and view" visits offered a layperson's perspective of services at the Eye Hospital, discharge lounge, and Surgical Emergency Unit, providing practical suggestions and recommendations.

26. Veronica noted that place-based meetings were conducted through open discussions, with OUH appearing as a collaborative partner in implementing changes. VB regularly communicated with Caroline Heason, Head of Patient Experience, who demonstrated a willingness to listen and cooperate with Oxfordshire Healthwatch to enhance services. Healthwatch attended patient incident workshops and collaboration with had improved the extent to which its recommendations now fed into patient experience forums and quality meetings where they could be tracked.

27. There had been a particular focus on the discharge process regarding which concerns had been expressed by the public, particularly in relation to patients not being ready for discharge and not getting the support that they needed.

28. Healthwatch were particularly interested in hearing from people who had been discharged to assess. This approach involved getting people home with what they needed and then assessing them at home, which often resulted in lower care needs than if they remained in hospital.

29. There had been a lot of positive feedback regarding good practice including good communication and patients feeling listened to. People were generally happy to be home. The transfer of care hub based at OUH was praised. Teams met three times a day and multidisciplinary teams and assessor teams were able to coordinate care, sharing notes between different data systems and providing high-quality referrals when needed.

30. However, there were also gaps in planning for discharge and formal assessment and patients sometimes did not feel involved or kept up to date. Work was underway to tackle these issues which was sometimes linked to the right care package not being in place. Some patients had not been prepared for morning discharges, with delays in medication, discharge letters and transport. There was sometimes a lack of information on what would happen next and what to do or who to contact if something went wrong. Some patients did not have the social care they felt they needed or the provision of this care was delayed placing a burden on unpaid carers.

31. The considerable efforts made by staff to support patients were acknowledged. Recurring themes in the report included communication and aftercare expectations. The rapid discharge process led to challenges with discharge letters and referrals. Patients were sometimes unaware of the reason for their hospital admission.

32. In November, a comprehensive action plan addressing the recommendations had been published. A new discharge leaflet, developed with input from patients, carers, and Oxfordshire Healthwatch, was introduced. A pilot program for

individuals with complex needs was expanded county-wide, with Oxfordshire County Council and OUH working together to implement carers' passports. Healthwatch continued to gather feedback on discharge processes to ensure optimal experiences.

33. LD noted that the feedback was consistent with expectations. She asked whether patient expectations were evolving and if the implemented recommendations would result in different feedback in two years. VB observed a significant cultural shift; previously, people felt the hospital was the optimal place for recovery, but now recognised that home was the healthiest environment. There was a communication gap regarding the benefits of home recovery, and last year's extensive outreach efforts had helped patient groups understand this concept. There had been a transition to more community-based services closer to home, with health professionals adapting their approach to better engage communities that did not utilise mainstream services.
34. HH noted the population's ethnic diversity and asked whether the methodology used was reaching different populations within the county. Oxfordshire Healthwatch aimed to reach more communities, as internet surveys were insufficient. They focused on building ground relationships and used community research to address issues. Although challenging, this approach centred on trust, relationships, and ensuring that people felt that their voices mattered.
35. TBW asked about the use of community hospitals and FTD confirmed that community beds were utilised, with individual patient needs considered. Community hospitals aided in rehabilitation through collaboration with Oxford Health, and home adaptations could be made as necessary.
36. TL asked who Oxfordshire Healthwatch was accountable to. Veronica explained that Healthwatch Oxfordshire was funded by Oxfordshire County Council, with each Healthwatch funded by central government via local authorities. However Healthwatch answered to the people of Oxfordshire, planning and executing their work based on community feedback but without handling individual complaints. They used non-political voices for strategy development, balancing projects driven by community needs, such as addressing the cost of living in East Oxford and health determinants. The discharge project had received significant support from health and care systems.
37. The Council noted this update from Healthwatch and Veronica and Katharine were thanked for their attendance.

CoG25/01/07 Working Party on Sexual Misconduct in Surgery

38. JM welcomed Daljit Dhariwal to feed back on the results of the working party. DD recognised that it was important to acknowledge that individuals in the room may have experienced this issue. There were three key points to focus on:

- Acceptance and recognition that this issue exists and is common.
- Senior individuals should empathise with junior colleagues by considering how it feels and how it impacts behaviour and patient safety.
- Taking ownership of the problem and addressing it effectively.

39. DD noted that this issue extended beyond medicine and was rooted in societal power dynamics. She highlighted that female surgeons achieved better outcomes, and that having over 33% women in surgical teams improved results. Low-level behaviours could contribute to a culture of enablement leading to ore severe issues. Changing hierarchical culture was challenging.
40. Trainees had alerted DD to ongoing problems and she had realised that data was needed to gauge the problem's extent. Reluctance had persisted among organisations to research, but an independent working party had revealed that two-thirds of women had faced sexual harassment, and that one-third had been assaulted. Men were affected too but perceived behaviours differently. Media coverage in the previous year had emphasised the need for national collaborative change.
41. National and regional efforts had been ongoing and education had been emphasised as a key factor in changing culture and ensuring psychological safety within institutions.
42. The General Medical Council (GMC) had introduced staff surveys to monitor progress, anticipating an initial increase in reports as individuals felt safer to come forward, followed by a decrease as issues were effectively managed. The working party on sexual misconduct had convened three meetings with the GMC and the Royal College of Surgeons, focusing on enhancing sexual safety.
43. The GMC's guidance promoted appropriate behaviour and safety, aligning with new standards that encompassed ambulance services, other trusts, and deaneries. The Royal College of Surgeons had developed educational content and hosted roundtable discussions to address these issues. Medical schools, being particularly vulnerable, needed to ensure that students had access to the same support services as staff. High-risk specialties and high-pressure environments were key focal points.
44. Amanda Pritchard had announced the introduction of anonymous reporting, and a case in Oxford received national media coverage. Focus groups with medical students and trainees had emphasised the need for anonymous reporting to influence organisational culture.
45. A regional working group, comprising five trusts, the Deanery, and the University, had been formed to collaboratively address these challenges. All five trusts had committed to the sexual safety charter.

46. GMC assessments should ideally promote learning, and this should be incorporated into curricula and examinations. Focus groups and training for investigators were important, highlighting the need for independent investigation. OUH educators had released guidance on handling disclosures without worsening trauma.

47. The Chief People Officer thanked DD for her commitment in advancing this agenda and speaking up on this challenging issue. He agreed that much work remained to be done. TR explained that OUH had launched a sexual safety programme and a working party to develop the charter principles and language. The Trust had identified gaps and was conducting an analysis with training and specialist support for affected individuals being developed. TR reported that business cases for bystander and survivor training were being developed.

48. Upcoming staff surveys would identify hotspots and gauge sexual safety. The investigations unit was undergoing training, and good governance and reporting were being established. The Trust was engaging with networks and collaborating with DD and colleagues. TR was meeting with Oxford University colleagues to discuss further steps. The Trust was also providing staff support, including occupational health and psychological services. These actions were part of the sexual safety charter, and efforts to review and address the issue would continue.

49. NR praised this work by DD and her colleagues. DD advised that this work had been done in her and her colleague's own time without funding but that the Trust was now funding some hours to support this work but that she would like to see more resources devoted to it.

50. TR reported that the new training was role-specific, but that the Trust would be monitoring this and would track participation. TR explained that the Trust would triangulate this with staff survey results to focus on those who needed the training the most.

51. LD noted that the research was focused on surgeons, but that similar issues existed in other disciplines and asked how the findings could be incorporated into education at Oxford Brookes University and Oxford University, as a whole-system approach was needed. DD explained that she had discussed this with Oxford Brookes in relation to nursing and with the ambulance service. It was recognised that the issue was not limited to doctors and affected all staff.

52. The Council praised DD and the entire team for their dedication and hard work on this issue.

53. TR confirmed that the Board and Governors would be kept updated on progress.

CoG25/01/08 Feedback from Quality Conversation

54. The Chief Medical Officer explained that quality priorities had on this occasion been developed before the quality conversation event, which had allowed the

event to focus on developing and defining them. AB explained that quality priorities were defined by the Trust's core business to enhance quality and that the quality conversation had served as a check to confirm that the Trust was on track and to expand on the content.

55. AB reported that there had been a really good turnout with a good mix of attendees and rich conversation. Thanks were extended to everyone who had contributed. Quality priorities sat in three domains of patient safety, clinical effectiveness and patient experience. AB provided an overview of the priorities for the coming year: the SEND (System for Electronic Notification and Documentation) system, medicines reconciliation, the fragility fracture pathway, the use of standard work, the critical care outreach service, the discharge process, maternity experience, ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and supporting vulnerable patients.
56. Niamh asked if there were elements of these priorities that were relevant beyond adult services. She reported that as part of the Trust' Young People's Executive, they looked at improving the children's hospital and discussed quality priorities to enhance it. AB confirmed that many of the priorities were cross-cutting and not just for adults.
57. AB explained that a core motivation for the SEND system was to improve communication between the day and night teams and handovers. This allowed for better planning, resource allocation, and anticipation of deteriorating patients.
58. AA highlighted that she was aware of an example of a poor patient experience in Maternity and sought advice on giving constructive feedback. AB suggested that this could be done through the Friends and Family Test, direct feedback to staff or teams, PALS, or emailing the Maternity Voices Partnership.
59. The Council noted this overview of the Quality Priorities for the coming year.

CoG25/01/09 Governor Attendance at Integrated Assurance Committee (IAC)

60. JM reported that GS, TBW and JH had had the opportunity to observe the recent IAC meeting. The hope in the future was to continue to support observation of the Committee, maintaining some continuity while implementing a regular rotation to avoid overwhelming IAC with observers and whilst allowing governors to monitor how issues were followed through.
61. GS said he appreciated the opportunity to attend the meeting although governors were not allowed to contribute directly. He believed that this was not the complete answer to how governors should interact with non-executive directors and noted the important role of governor committees. JH agreed that the inability to raise questions highlighted the need for face-to-face, two-way conversations with non-executive directors.

62. The Chair commented that it was important for governors to see non-executive directors at work, noting that if governors became part of the Committee, this would alter its dynamic.
63. TBW had found it useful to observe the non-executive directors at work and noted that at another trust, once the meeting had concluded, observers were allowed to make comments.
64. LD noted the need to consider the demands on non-executive directors and staff and to consider how governors could best be supportive of non-executive directors.
65. TL suggested a session in which non-executive directors and governors were split into three or four groups to facilitate discussions on how the non-executive directors sought and obtained assurance on issues raised in Board meetings. He suggested that this would encourage participation, especially amongst newly elected governors and build confidence, making it more rewarding for non-executive directors to participate.
66. JM was comfortable with this approach but emphasised the need to consider the demands on non-executive directors and to find the right balance. He suggested the approach proposed be trialled.

CoG25/01/10 Lead Governor Report

67. GS outlined reflections from the governors pre-meeting regarding the Better Leaders Programme which not all participants had found helpful and how the benefits from development time for governors might be optimised.

CoG25/01/11 Any Other Business

68. No additional business was discussed.

CoG25/01/12 Date of Next Meeting 14 May 2025

69. The meeting would take place in seminar room 2A/B, in the George Pickering Education Centre, John Radcliffe Hospital from 1pm until 3pm.