Council of Governors
Minutes of the Council of Governors Meeting held on **Wednesday 10 July 2024** 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
Mr Alastair Harding	AH	Public Governor, Vale of White Horse
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
Mr Graham Shelton	GS	Public Governor, West Oxfordshire
Ms Sneha Sunny	SS	Staff Governor, Clinical
Mrs Megan Turmezei	MT	Staff Governor, Non-Clinical

In Attendance:

Prof Meghana Pandit	MP	Chief Executive Officer
Dr Andrew Brent	AB	Chief Medical Officer
Ms Yvonne Christley	YC	Chief Nursing Officer
Ms Olivia Clymer	OC	Director of Strategy and Partnerships
Ms Janet Dawson	JDa	Ernst & Young LLP

Mr Paul Dean	PD	Non-Executive Director
Mr Jason Dorsett	JDo	Chief Finance Officer
Mr Martin Earwicker	ME	System Transformation and Recovery Board Chair
Ms Claire Feehily	CFe	Non-Executive Director
Ms Claire Flint	CF	Non-Executive Director
Ms Lisa Glynn	LG	Acting Chief Operating Officer
Mr Matt Harris	MHa	Acting Chief Digital and Partnership Officer
Mr Mark Holloway	MH	Chief Estates and Facilities Officer
Ms Sarah Hordern	SH	Non-Executive Director
Ms Katie Kapernaros	KK	Non-Executive Director
Ms Laura Lauer	LL	Deputy Head of Corporate Governance
Mrs Caroline Rouse	CR	Governor and Membership Manager (minutes)
Dr Neil Scotchmer	NS	Head of Corporate Governance

Apologies:

Cllr Tim Bearder	TB	Nominated Governor, Oxfordshire County Council
Ms Gemma Davison	GD	Public Governor, Cherwell
Prof Helen Higham	HH	Nominated Governor, University of Oxford
Ms Viv Lee	VL	Children's Patient Experience Team
Mr George Krasopoulos	GK	Staff Governor, Clinical
Ms Chris Montague-Johnson	CMJ	Public Governor, Cherwell
Mrs Nina Robinson	NR	Public Governor, South Oxfordshire
Mrs Pauline Tendayi	PT	Staff Governor, Clinical
Mr Mark Whitley	MW	Public Governor, Northamptonshire and Warwickshire
Mr Jonathan Wyatt	JW	Public Governor, Rest of England and Wales

Annabelle	YPE	Nominated Governor, Young People's Executive
Ishaan	YPE	Nominated Governors, Young People's Executive

CoG24/03/01 Welcome, Apologies and Declarations of Interest

1. Apologies were noted as recorded above. Martin Earwicker, System Transformation and Recovery Board Chair was welcomed to the meeting.
2. David Matthews declared that he is Chair of Trustees at Oxford Hospitals Charity

CoG24/03/02 Minutes of the Meeting Held on 30 April 2024

3. The minutes were approved as an accurate record of the meeting.

CoG24/03/03 Matters Arising

4. JM announced that the joint event with governors from Oxford Health would take place in July in Thame.
5. The CQC Report into Maternity Services at the Horton and the recent publication of a dossier of negative experiences by women using OUH's maternity services were noted. The Chief Nurse Officer was to provide an update later in the meeting.
6. A note had been sent to governors regarding their queries on the elective waiting list and the proportion of out of county activity.

CoG24/03/04 Chair's Business

7. JM reported that the Board was in the process of reviewing the functioning of the Integrated Assurance Committee. It was proposed that some governors attend the Committee in the future to observe the work of the non-executive directors. Should this approach be taken then the impact on the requirements of the Performance, Workforce and Finance Committee (PWF) and the Patient Experience, Membership and Quality Committee (PEMQ) would be considered. A seminar session would be organised in the autumn to discuss the approach to these issues.
8. The Chair confirmed that the Trust had proactively initiated early actions in response to the Infected Blood Enquiry in advance of the formal government response with further steps to be taken following this if required.
9. JM informed the governors that Professor Meghana Pandit, the Chief Executive Officer, had been recognised as one of the NHS's top CEOs by the Health Service Journal.

CoG24/03/05 Chief Executive's Briefing

10. MP advised that all staff had been thanked for their extremely hard work in challenging circumstances. The Trust had gone through a four-day period of industrial action during June, which had involved the cancellation and rescheduling of patient activity to maintain patient safety. The Chief Executive confirmed that the Trust was still facing challenges but hoped that, following the change of government, the new Secretary of State and the junior doctors would be able to have constructive discussions to resolve the ongoing dispute.

11. MP reported that an unreserved apology had been sent to all patients and families connected to the Infected Blood Inquiry. She noted that practices at OUH had significantly changed since the events that had been investigated by the Inquiry. Measures had been put in place for psychological support for those affected and Andrew Brent, the Chief Medical Officer, had played an important role supporting staff involved in the service.

12. The Council heard that mortality figures for the Trust remained lower than expected and noted that the new Patient Safety Framework had been successfully implemented.

13. Operational performance in the emergency department (ED) had improved thanks to the hard work of staff in the ED, ambulatory care, and medical wards. These efforts had halved the number of medically optimised patients awaiting discharge compared to the previous year, resulting in fewer patients waiting over 12 hours in the ED. The Observations and Recovery Unit (ORU) allowed for timely investigation, review and discharge. The Trust had collaborated with the ICB and Council to secure recurrent funding to maintain this new model of care. Additionally, there was funding to enhance medical and nursing services overnight in the ED.

14. For elective care the 78-week wait was gradually reducing, while the number of patients waiting over 65-weeks remained a challenge, particularly in ENT and Plastics. The Trust was working with colleagues across the ICS to address this issue with a view to ensuring that where appropriate patients can be seen at any of the acute hospitals.

15. The Council was informed that the final annual plan was for an 8.1% deficit. This involved a large Cost Improvement Program (CIP) for which 50% of the measures had already been identified. This plan included a commitment to reducing temporary staffing by 700 WTE (whole time equivalents), with a reduction of 439 WTE to date, the equivalent of a £643k saving. This was recognised to be a challenging task, but the Chief Executive emphasised that it would not negatively impact the quality of care offered.

16. SS highlighted the impact on nurses if overtime hours were cut, noting that this could affect staff morale as many staff relied on the additional money from bank shifts. The impact on the take-home pay of staff was recognised and the Trust had support in place to assist where possible such as the salary finance scheme, which provided advice and short-term loans and Vivup which could help with day-to-day bills.

17. The Chief Nursing Officer noted that not all bank shifts were filled and that opportunities therefore remained available. It was noted that no changes to numbers of falls and pressure ulcers that might indicate an impact of patient safety had been observed. The Chair noted that the position would continue to be monitored.

18. TBW highlighted specific pressures in Maternity, noting the significant growth in population. He noted that this could have an impact on staff wellbeing and retention and suggested that more capacity was needed at the Horton. It was noted that this a complex issue and the Council was reminded that the consultant-led unit at the Horton had been removed on safety grounds due to the inability to recruit appropriate medical staff and that any reinstatement would be a decision for commissioners. JM informed the Council that discussions had taken place with the Director of Public Health as to whether it would be possible to replicate the Oxford Early Pregnancy Assessment Unit in Banbury.

19. AK asked how the Trust was able to assess whether there might be issues with other services. MP explained that the Trust used internal performance reviews and soft intelligence as well as looking at benchmarking against other hospitals, NHS England's model hospital data and other specific indicators. JM commented that governors had seen the information presented in the Trust Quality Account. He noted that what was exposed by the dossier related primarily to patient experience and whether patients felt they were being looked after compassionately and that it was important that the Trust focussed on these issues which were much harder to measure.

CoG24/03/06 External Audit Annual Report including a Summary of the 2023/24 Annual Accounts

20. The Chief Finance Officer provided an overview of the Trust's financial performance in 2023/24 which had been slightly worse than its plan with a control total deficit of £10.7m. Inflation had been high and while income had grown by 9%, costs had increased by 11%, much of this related to energy costs.

21. The Council heard that the Trust had continued to invest in its estate including the completion of public sector decarbonisation works at the Horton and their commencement at the John Radcliffe site. The cash balance had been £46m at year end.

22. Over three years the impact of the pandemic could be seen with the position £10m than in the previous year, noting that energy costs had increased by £25m.

23. The statement of financial position shows a continued increase in non-current assets, reflecting significant investment in the Trust's estate. Long-term liabilities had increased due to accounting changes.

24. The majority of OUH income was derived from core NHS commissioners, primarily the BOB ICB and specialist commissioners, with the largest contribution still coming from

specialist commissioners. The primary expense was pay costs, followed closely by clinical supplies and services.

25. Capital investment had been directed towards several key projects, including spending towards the theatres project and public sector decarbonisation efforts. Additionally, there had been substantial investment in digital infrastructure and the establishment of a Secure Data Environment (SDE). Investment had also been made in equipment, including the life-cycling of PFI equipment and investment in critical infrastructure within the estate. A small amount of RAAC remediation has been undertaken, with some funding provided by the Department of Health.

26. Mr Dorsett outlined two areas of material judgement for the accounts. The first was the implementation of IFRS16 for PFI which changed accounting for the impact of inflation, resulting in a £144m increase in PFI liability and increased interest charges.

27. The second related to capital valuation with an in-year restatement of property values using the Modern Equivalent Asset (MEA) approach. This valuation is based on a hypothetical replacement asset of equivalent capacity and function to current provision. This had reduced asset values, depreciation and PDC dividend charges in year, but no prior year adjustments were necessary.

28. Ms Janet Dawson presented the Auditor's Annual Report to the governors, providing an overview of the responsibilities of the external auditor.

29. The auditors report was unqualified and concluded that the financial statements gave a true and fair view of the financial position of the Trust as at 31 March 2024 and of its expenditure and income for the year then ended.

30. There had been some non-material adjustments and recommendations in relation to areas where controls could be tightened and improved such as in the management of fixed assets.

31. The auditor is required to consider where the Trust had suitable arrangements in place to ensure value for money and identified no significant weaknesses in these arrangements.

32. Ms Dawson indicated that this represented a fairly clean final audit and that the Trust's Finance team were to be commended.

33. The Council noted that it was unclear whether the government would use PFI arrangements for future hospital infrastructure projects. JDo advised the Council that PFIs represented long-term financing arrangements, with investors having funded them based on the assumption of long-term, very secure, and low-risk investments. Contracts were, however, very expensive to break and buy out.

34. The Council noted that a shift towards investment in prevention had been signalled and considered the implications for the Trust. It was noted that there was a lag time before prevention investment reduced acute demand and that this approach therefore required a period in which there were additional costs supporting both. The need to consider the

overall return on investment on changes to the system was highlighted, considering the need to be good stewards of public money. The Council heard that the Trust had invested in schemes such as the emergency community response team in order to reduce pressure on acute services through admissions and improve patient experience. JDo noted that performance was generally measured on the basis of waiting times and financial outcomes, with little emphasis on prevention.

35. The Council recognised that the Trust was a large recipient of R&D and Education income. DM suggested that OUH should consider whether it was maximising this opportunity. The Chair noted that income from research formed part of the Trust's commercial strategy and that being research active also drove better patient outcomes. The Trust had Strategic Partnership Boards with both the University of Oxford and Oxford Brookes University in recognition of the importance of these relationships.

36. TL asked whether future claims against the Trust's insurance were considered during the annual audit. JDa explained that auditors were required to consider the risk of non-compliance with laws and regulation and the impact of financial losses. Auditors must assess governance and clinical risks, maintaining direct communication with the legal team to monitor potential cases and indications of possible actions. JDo noted that the Trust was insured against claims through its participation in the clinical negligence scheme for trusts.

37. JH asked whether claims in relation to fraud regarding the procurement of COVID-19 PPE might impact the Trust. The Council noted that the Board had a duty to maintain a system that managed fraud risks. The Trust engaged TIAA for its counter-fraud services and proactively reviewed its controls. The external auditor's responsibilities included identifying fraud risks that could manipulate the financial position, which was a material issue. This area was closely monitored by the Audit Committee.

38. LD noted that the late negotiation of contracts presented a challenging situation and appeared to be a recurrent issue. JDo noted that prior to the pandemic the Trust was usually successful in signing contracts before the start of the year but that there was relatively little that OUH could do to control this especially in relation to the large number of small contracts that it held outside of the immediate region.

39. The Council received and noted the Auditor's Annual Report.

CoG24/03/07 Trust Sustainability Update

40. Mark Holloway, Chief Estates Officer and Wendy Cheeseman, Head of Sustainability and Carbon Management joined the meeting. MH explained that the NHS had set a target to achieve net zero carbon emissions by 2040 for activities under its control. This included its estates, water, energy, waste, gases and business travel. The aim was then to achieve net zero plus by 2045, meaning that every single decision and activity that the Trust undertook needed to be reviewed.

41. Over the past year, the Trust had been measuring the impact of its activities, including those related to fossil fuels. The Trust's carbon footprint had fluctuated, with some increasing and some decreasing. Based on last year's data, the Trust had reduced emissions by 2,818 tons annually.

42. The PSDS project aimed to improve energy efficiency across the estate. The Trust was heard to be at the forefront of a new approach to carbon accounting, working alongside colleagues elsewhere. It had detailed insights into the hip replacement pathway, providing a good understanding of where it was possible to make a difference. Understanding the sources of emissions to was important to identify actionable areas.

43. 74% of Trust emissions were related to the estate and to travel. Transport facilities had been improved around the estate and the Trust had conducted a travel survey to understand staff commuting challenges. This would help develop solutions to support staff. The uptake of the Park and Ride scheme, offering free travel to and from sites, had been positive.

44. The decarbonisation project at HGH, which included the installation of 500 solar panels, had shown a reduction in electricity consumption, now supplemented by green energy generate by the Trust.

45. The intention was to develop a comprehensive roadmap outlining the projects to be undertaken and their anticipated savings with a specific focus on travel and energy for the upcoming year.

46. JH asked about the level of support that was being provided by suppliers. WC advised that there was a significant amount of information available and that the team was beginning to understand it better. Some suppliers had proved very keen to work with the Trust in this area.

47. TBW asked what the financial cost was. WC explained that the most cost-effective approach was to focus on reducing carbon-generating activities. It was recognised that achieving net zero would require substantial investment.

48. RC praised this proactive work but noted that the lack of reliable public transport could be a barrier to reducing transport emissions. WC explained that she had recently met with the bus service team at the County Council to discuss current commuting patterns at the Trust. The Trust were working collaboratively with the City and County Councils, as well as the Zero Carbon Oxford Partnerships and the Active Travel Sprint Group, to develop solutions. It was essential to coordinate efforts for groups that need to travel at the same time. Congestion in the city remained a significant issue.

49. The Council noted this update.

CoG24/03/08 Acute Provider Collaborative

50. The Chief Executive explained that the APC was made up of three acute providers: Buckinghamshire Healthcare, the Royal Berkshire and OUH and aimed to reduce

inequality in access, outcomes, and the care patients received. The APC encompassed three workstreams: clinical services, corporate services, and elective care.

51. Clinical services are focusing on rheumatology, fracture services and bariatric surgery. Corporate services were focussed on coordinating to achieve efficiencies. The Elective Care Board was focussed on access and equalising waits across the ICS through mutual aid and innovation. The three organisations had quality improvement teams looking at opportunities for changes.

52. Specific arrangements for governance and the scheme of delegation would need to be agreed at the respective boards.

CoG24/03/09 Horton General Hospital Maternity Services

53. The Chief Nursing Officer confirmed that a dossier containing 50 accounts of birth experiences had been received and that these accounts were primarily of women who had given birth at the JR. YC reported that the dossier had been diligently reviewed with a plan to complete a response during July.

54. These cases had been thoroughly investigated and safety elements would be prominently addressed. Areas for improvement had been identified, including antenatal care, parking and transport. The dossier spanned a significant period, including during the pandemic, when access to birth partners was a substantial issue affecting birth experiences. There were opportunities to improve information dissemination, care, and compassion during the postnatal period. The report would focus in particular on patient experience and how OUH could enhance it.

55. Assurance was sought that the Trust was supporting staff who may have found this a challenging experience. YC confirmed that she and the Deputy Chief Nursing Officer had been meeting regularly with the Maternity team. She emphasised that these experiences were within the context of thousands of births over this period, and that it was important to maintain perspective.

56. SB emphasised the importance of having a firm grasp of patient experience. YC confirmed that the Trust was working to systematically obtain real-time patient experience through developing BadgerNet and by working with the Maternity and Neonatal Voices Partnership. The Trust was systematically reviewing CQC inpatient surveys and attempting to incorporate its questions into OUH services to gather feedback.

57. The Council noted this update.

CoG24/03/010 Patient Experience, Membership and Quality Committee Report

58. Janet Knowles noted that Gemma Davison was the new chair of the Committee. JK presented the report from PEMQ in Gemma's absence. This had included overseeing the Quality Account annual process. The final document had now been approved and submitted to NHS England.

59. The Committee had also received an update from the Patient Experience team, highlighting their work in evaluating services and patient care. The team had also reviewed complaints to identify correlations between complaints and response time, addressing any difficulties and requesting additional information when necessary. Changes in the translation services had also been discussed with a commitment to keep the Committee informed.

CoG24/03/11 Performance, Workforce and Finance Committee Report

60. JH provided an update on topics discussed at the last Committee meeting. These included the People Plan which was regarded and proceeding successfully despite significant constraints.

61. The Chief Operating Officer had provided a report on the Delivery Plan, highlighting positive progress on waiting times though with substantial work still to be done.

62. JDo had updated the Committee on the financial plan, which was in its final stages. Regular updates had been provided on likely commitments and plans to address the deficit. Key risks included industrial action.

63. The Committee received assurance that the Trust was adequately prepared following the recent cyber-attack on pathology services in London hospitals. A future agenda item would address how quality improvements were managed and rolled out, focusing on cost-effectiveness in patient care.

CoG24/03/12 Lead Governor Report

64. GS advised that governors would like to strengthen their interaction with the Board. GS suggested that more joint seminars be arranged to facilitate collaborative efforts.

65. Additionally, GS mentioned that BOB had no governors but that lead governors from other trusts were meeting regularly every month to look at BOB-wide issues.

CoG24/03/13 Report from the Vice Chair and Chair of the Investment Committee

66. Ms Sarah Hordern provided some comments on her various formal roles as a non-executive director. She noted that her background was as an accountant who now worked primarily on regeneration and development. SH was now the Vice Chair of the Trust and the Chair of the Investment Committee.

67. In chairing the Investment Committee SH had endeavoured to allocate more time for strategic discussions, focusing on significant issues, with capital estates being a major component.

68. A substantial part of the Committee's focus had revolved around the theatres business case, which had required considerable preparatory work. The Committee had also been addressing the capital and estates position, including the backlog maintenance issue, which was now being monitored through the Integrated Assurance Committee.

69. The new Chief Estates and Facilities Officer and his team had been working to ensure that capital allocations were spent within the year. The first-quarter spending for 2024/25 was on budget which was a notable improvement from previous years.
70. Detailed discussions on PFI strategy were also taking place during board seminars and at the Investment Committee. A Commercial Strategy was being developed. The Committee also considering OUH's commercial business plan and opportunities, particularly how to best leverage assets to sustain our operations.
71. The Churchill site presented an opportunity for redevelopment, allowing the Trust to modernise some of our older estate.
72. The Council noted this update on the work of the Investment Committee.

CoG24/03/14 Provider Licence Self -Certification

73. This self-assessment against the Trust's foundation trust licence conditions was to be received by the Board subsequently.
74. Governors noted the Self-Certification templates.

CoG24/03/15 Any Other Business

75. There was no additional business on this occasion.

CoG24/03/16 Date of Next Meeting

76. A meeting of the Council of Governors was due to take place on **Wednesday 13 November 2024**.