Council of Governors

Minutes of the Council of Governors Meeting held on **Wednesday 14 May 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 Charles Adomah-Boadi	CAB	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
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
Dr Gerald Clancy	GC	Nominated Governor, Berkshire, Buckinghamshire and Oxfordshire Local Medical Council
Prof Lorraine Dixon	LD	Nominated Governor, Oxford Brookes University
Mr Damian Haywood	DH	Public Governor, Oxford City
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
Dr George Krasopoulos	GK	Staff Governor, Clinical
Mr Andrew Lawrie	AL	Public Governor, Northamptonshire and Warwickshire
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
Ms Fiona Morrison	FM	Public Governor, Cherwell
Ms Jacqueline Palace	JP	Staff Governor, Clinical

Mrs Nina Robinson	NR	Public Governor, South Oxfordshire
Mr Graham Shelton	GS	Public Governor, West Oxfordshire
Ms Sneha Sunny	SS	Staff Governor, Clinical
Dr Ascanio Tridente	AT	Public Governor, Rest of England and Wales
Mrs Megan Turmezei	MT	Staff Governor, Non-Clinical
Ms Hannah Watkins	HW	Public Governor, South Oxfordshire
Niamh	YPE	Nominated Governor, Young People's Executive

In Attendance:

Mr Simon Crowther	SC	Acting Chief Executive Officer
Mr Paul Dean	PD	Non-Executive Director
Mr Jason Dorsett	JD	Non-Executive Director
Mrs Claire Feehily	CFe	Non-Executive Director
Mr Mark Holloway	MH	Chief Estates and Facilities Officer
Ms Sarah Hordern	SH	Non-Executive Director
Ms Katie Kapernaros	KK	Non-Executive Director
Mr Terry Roberts	TR	Chief People Officer
Mrs Caroline Rouse	CR	Governor and Membership Manager (minutes)
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
Dr Gareth Evans	GE	Nominated Governor, Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee
Mr Alastair Harding	AH	Public Governor, Vale of White Horse
Ms Claire Litchfield	CL	Staff Governor, Clinical

Ben	YPE	Nominated Governor, Young People's Executive
Niamh	YPE	Nominated Governor, Young People's Executive

CoG25/05/01 Welcome, Apologies and Declarations of Interest

1. Jonathan Montgomery, Chair of OUH, congratulated and welcomed the new governors to the Council.

CoG25/05/02 Minutes of the Meeting Held on 12 February 2025

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

CoG25/05/03 Matters Arising

3. JM confirmed that the date for the discharge planning session was still being confirmed, with the intention to hold a joint seminar of the Board and Council of Governors after the summer. JM reported that this would not hold up the work on the quality plan but allowed for a deeper dive into the various components of discharge.
4. JM advised that some governors had observed the recent Integrated Assurance Committee meetings.

CoG25/05/04 Chair's Business

5. JM advised that discussion had taken place regarding the rotation of the chair of the Acute Provider Collaborative, which was the body that examined how the three trusts should work more closely together on projects. They had agreed to map in more detail what they hoped to achieve.
6. JM commented that it was the first time to formally record the secondment to the NHS England (NHSE) transition team of Professor Meghana Pandit, the Trust Chief Executive Officer. JM added that Prof Pandit was on an eighteen-month secondment.
7. JM thanked governors who had put their names forward to join governor committees. The process of confirming membership of committees was proceeding and it was hoped that committees would have a balance of new governors and those who had been in place for longer. JM thanked Robin Carr for agreeing to chair the Patient Experience, Membership and Quality Committee.

CoG25/05/05 Chief Executive's Briefing

8. Simon Crowther, Acting Chief Executive Officer referred to the paper presented at the public Board meeting that morning, highlighting some of the fantastic work the organisation had been doing in maintaining quality, safety and innovation. He pointed out a number of service achievements, including several UK firsts, and expressed

immense pride in what the services had accomplished. The focus was on staff and the plans in place to recognise their achievements, including quarterly staff recognition awards and listening to colleagues via staff surveys.

9. It was noted that the NHS was undergoing significant changes, with many big announcements and changes to its architecture and fabric. The merger of NHSE into the Department of Health and Social Care was being implemented by a transition team over 18 months. Further changes and cost savings were anticipated and there were more aggressive cuts to Integrated Care Boards (ICBs) than had been expected, with 50% cuts to funding announced.

10. The architecture for running the NHS was being reviewed, and communication with staff and the public was essential to explain changes to how the NHS was run. A recent document produced an ICB blueprint, which expected fewer ICBs clustering rather than merging, resulting in fewer ICBs overall. The functions carried out at that level were being reviewed. Over the last couple of years, the Trust had been performance managed and held to account by the ICB but this function was reverting to regional teams. The ICB would focus on strategic commissioning, which was the original intent for ICBs, but the Trust was working through what that meant and how it would look.

11. This transition meant that some of the functions of ICBs would be passed to providers, such as place-based working and neighbourhood teams. The Trust was working on how to be proactive around this, ensuring they did not have to do everything on their own and exploring collaborations with other entities.

CoG25/05/06 Update on 2024/25 Annual Plan

12. Simon Crowther outlined the challenges faced by the NHS which needed to be communicated effectively with staff. The organisation had to balance delivering short-term outcomes while simultaneously planning for the long-term to meet the needs of the population. OUH was in the final year of a five-year strategy which would need to be reviewed. Annually, the NHS was required to produce a plan detailing what it intended to deliver for patients and staff. This focus on a single year was noted to be limiting in not encouraging forward-looking thinking.

13. The Trust had reflected on its response to national guidance. The annual plan had been approved by the Board in March. However, subsequent external changes introduced additional funding and revised guidance on access targets. The Trust was expected to meet a high number of performance targets.

14. A summary of the core standards and targets assigned to OUH was provided, along with the organisation’s projected compliance. While the majority of targets were expected to be met, there were some core standards where compliance was not anticipated. This was not due to a lack of motivation or willingness, but rather a realistic assessment of the available evidence and resources, which did not support a viable path to compliance.

15. Key areas of focus included urgent care access, referral-to-treatment times, and cancer services. Encouraging patients to seek care elsewhere for more timely treatment for elective care where appropriate helped reduce demand on OUH and ensured quicker access to treatment for those individuals. Targets were also set for workforce headcount and the management of bank and agency costs. Where possible, employing staff in substantive roles was preferred for organisational stability and continuity of patient care.
16. Financially, the organisation aimed to meet its breakeven requirement and was on track to do so, despite challenges. However, it acknowledged non-compliance with the 62-day cancer target, the 18-week referral-to-treatment standard, and the number of patients waiting over 52 weeks. The organisation had been transparent with regulators, stating that unless it could assure the Board of a credible delivery plan, it would not claim compliance.
17. JM explained that the reported £2 million surplus was a result of system-wide financial balancing. Additional funding had been allocated to the BOB ICB, and this had been distributed across the system. Some acute trusts were in deficit, and OUH's surplus was used to offset those deficits, thereby achieving balance across the entire ICB.
18. There was a national requirement that 78% of patients in ED be admitted or discharged within four hours. The Trust had identified a credible path to achieving this target. In March, the Board confirmed that performance against the four-hour standard stood at 74%, falling short of the 78% benchmark. It was acknowledged that this standard could not be met without expanding physical capacity. A bid for national funding was submitted and successfully secured in early April, enabling a clear trajectory for completing the necessary works. It was anticipated that the Trust would be compliant with the target by year-end.
19. Attention was also directed towards 12-hour waits and referral-to-treatment times, including 104-week, 78-week, and 65-week waits. OUH was tasked with ensuring that 65% of patients met the standard or demonstrated a 5% improvement. Given the existing long waits and backlogs, significant effort was dedicated to achieving this. The organisation remained compliant with the faster diagnostic standard and continued to focus on cancer services.
20. A letter concerning cancer performance tiering had been received, indicating that the issue was systemic rather than specific to OUH. Historically, each organisation had been tiered individually, with OUH previously placed in Tier 1 due to long waits. Following improvements, OUH was reclassified into Tier 2, as was the entire ICS. However, the Trust had not waited for regulatory intervention to drive improvement but proactively monitored and addressed its own performance.
21. The Trust had a compliant financial plan, which included a £100 million savings programme. Although such programmes were a routine part of annual operations, they remained challenging. The savings target represented 5.6% of total resources, a figure considered average across the NHS. The broader public sector faced similar

constraints, and it was important to contextualise the NHS's position within this landscape.

22. Jason Dorsett, Chief Finance Officer, reported that the Cost Improvement Programme target was 4%, equating to £83 million. Similar discussions were taking place across all organisations, with staff costs accounting for at least 70% of NHS expenditure. The organisation developed delivery plans through a bottom-up approach, collaborating with services to identify feasible contributions. It was necessary to evaluate how services were provided and whether some should be transferred to other trusts.

23. Capital resources encompassed both pay and non-pay elements, including buildings, medical equipment, and digital infrastructure. Relative to the organisation's overall size, the capital plan was modest, prompting difficult discussions. A significant portion of capital was allocated to maintenance due to the age of the estate.

24. Achieving £99 million in savings necessitated a review of workforce expenditure, which had risen significantly since the COVID-19 pandemic. Workforce costs had outpaced the growth in activity, resulting in a financial imbalance. The organisation had expanded its workforce and was now required to implement robust vacancy control measures. Forecasts indicated that, while growth was still needed in areas such as referral-to-treatment and maternity services, the overall workforce would need to be reduced by 575 FTE to offset that growth. This was a difficult and sensitive message for staff. The organisation was not alone in this; some trusts were already implementing redundancy schemes. The preferred approach was to manage reductions through turnover.

25. Plans were in place to expand capacity in theatres to reduce the backlog and meet future demand. This included targeted workforce growth in key areas, such as the surgical elective centre, which continued to progress.

26. A focus was also placed on non-clinical and corporate services, with each provider asked to reduce corporate expenditure by 50% of growth since 2019/20, amounting to approximately £8 million. JM highlighted areas where productivity had already improved and controls were in place. The Trust maintained transparency with staff through regular staff briefings, acknowledging that the full implementation plan was still being developed. An informal session with the Board was scheduled for the end of May to review progress.

27. JM discussed with the Board the importance of clearly defining accountability throughout the organisation. Monitoring mechanisms were in place to track delivery against the plan and validate the underlying assumptions. Ensuring alignment with the plan was deemed essential for successful implementation.

28. The reduction of 575 FTE was profiled to occur in phases throughout the year, beginning at the end of May and continuing steadily through December. An establishment review of nursing staff had identified where vacancies were likely to arise, with the aim of resolving reductions through natural attrition rather than redundancies. Terry Roberts, Chief People Officer, advised that any discussions around redundancy schemes should be handled with care to avoid demoralising staff.

29. The need for planning to account for factors such as increased life expectancy, medical innovation, and population growth was noted. SC acknowledged that this represented a broader systemic issue within the NHS. Public satisfaction with the NHS was at an all-time low, and rising demand underscored the need for innovation—particularly in treating more patients in the community and at home to reduce hospital admissions. The ICB function was expected to transition to strategic commissioning, where such questions would be addressed.

30. GK reflected on the successes at OUH, saying the Trust treated an increasing number of patients, with an expectation of even higher numbers in future years. SC confirmed that the Trust had attempted to represent demand within the planning process by accounting for a 5% increase in urgent care.

31. NR agreed with Terry Roberts approach to staff management and questioned whether reskilling, retraining and education had been sufficiently considered. SC acknowledged the need for a 4% productivity improvement and confirmed that efforts were underway to identify realistic opportunities. Reviews were being led by Yvonne Christley for nursing, Andrew Brent for medical productivity and Corporate Services had also been tasked with identifying efficiencies. Staff feedback had indicated a strong preference for simplifying internal processes. A waste reduction programme, led by Felicity Taylor-Drewe, Chief Operating Officer, was underway, with staff encouraged to contribute ideas for streamlining operations.

32. Discussions with divisional teams had focused on key priorities, including the potential designation of certain posts as internal-only to support the retention and development of high-performing staff.

33. AL raised a query regarding patient reallocation, particularly concerning the Northamptonshire and Warwickshire border areas, and whether a defined target existed. FTD explained that the primary aim was to reduce patient waiting times across the BOB system, noting that the Trust was managing a high volume of complex cases and delivering many services that were unique within the system.

34. Efforts had been made to equalise waiting times, as neighbouring trusts were achieving significantly shorter waits, with some seeing 80% of patients within 18 weeks. The Trust had worked to offer patients alternative options for faster access to care and was collaborating with other trusts on this.

35. DM asked what the consequences were of failing to achieve the planned savings. JM advised that there would be early indications if things were going wrong.

36. GS inquired about the organisation’s understanding of individual patient journeys, from arrival through to discharge and suggested that analysing these pathways could help identify delays and cost drivers. FTD referred to a recent cancer workshop that examined specific care pathways. Delays had been attributed both to capacity constraints and to internal processes requiring improvement.

37. LD raised concerns about career development and the reorganisation of the ICB blueprint, noting that education had not been adequately reflected. With the transition of NHSE, she questioned whether future funding would be held by the Department of Health or at provider level. She had emphasised the importance of safeguarding educational funding at provider level to support workforce development and aid recruitment and retention. SC acknowledged the broader challenge of balancing immediate needs with long-term sustainability. HH referenced a recent conference where she had engaged with the central team, noting that while the future model remained uncertain, educators on the ground were committed to maintaining educational priorities during the transition.

38. HH discussed a research group within her unit focused on healthcare as a dynamic system. She referenced journalist Shaun Linton, who had exposed the Mid Staffordshire case, and noted that similar warning signs, such as reductions in headcount were beginning to emerge in other organisations. She expressed hope that strong voices would continue to raise safety concerns at this level.

39. JM highlighted the value of Prof Pandit's secondment, with SC agreeing and emphasising the Board's role in asking the right questions and maintaining both developmental and external perspectives. He stressed the importance of robust internal challenge and confirmed that all initiatives would undergo a quality assessment.

40. JM further noted that the organisation must be prepared to make significant decisions to protect safety, including evaluating whether certain activities should be discontinued in the next phase of planning.

41. JP raised concerns about the vacancy control procedures, highlighting the bureaucratic burden at ground level when staff left and the time-consuming process of producing business cases. She questioned how efficiency could be improved without introducing unnecessary barriers.

42. SC emphasised the need to streamline processes, suggesting that efforts should align with a clear list of priorities. He advised that if a business case did not support those priorities, staff should pause and seek guidance. He reiterated that funding was available for essential areas, particularly those linked to quality and safety, and encouraged an open dialogue.

43. JM added that, from a Board perspective, much would depend on refining central processes and clarifying where accountability should lie.

44. JH noted that OUH accounted for 40% of the secondary care project within BOB and questioned the likelihood of other trusts meeting their targets. He expressed low confidence in their ability to do so and anticipated that OUH would face additional pressure as a result. He emphasised the need for stronger mutual accountability across the system.

45. AA asked how the public could be better supported in reducing unnecessary use of NHS resources and how communication could be improved to inform local communities

effectively. SC emphasised the need for clearer NHS communication, including better signposting, website content, and early engagement around planned care and postcode-related work. He stressed the importance of initiating a broader public conversation.

46. SC also noted that over 60% of the increase in A&E attendances in March had been walk-ins, often due to limited access to pharmacy or GP services. He had questioned who should lead this public dialogue, cautioning against fragmented messaging and expressing optimism that place-based leadership might be better positioned than the ICB to take this forward.

CoG25/05/07 2024 Staff Survey

47. TR observed that staff morale remained a challenge, as confirmed by the staff survey. He noted that this was a wider NHS issue, not unique to OUH, and that the survey results had not revealed any major surprises. The People Plan remained relevant to the issues identified.

48. TL raised a question regarding the government's newly announced immigration policy and asked whether there would be a coordinated response from the NHS to protect the public. TR confirmed that regional and national discussions were already underway, particularly concerning the impact on lower-paid workers. Internal conversations had focused on how to address the issue without disadvantaging staff, with efforts aimed at retaining those who might soon become ineligible to work. Lobbying efforts had also begun, with discussions on how best to support staff and communicate OUH's position.

49. GK expressed concern about inefficiencies in the recruitment process. JM acknowledged the need to review recruitment processes. TR stated that while values-based interviews were important and should be retained, divisions were expected to take a proportionate approach. He committed to raising the matter with corporate colleagues.

50. AL asked whether the time taken at each stage of the hiring process had been analysed and whether specific targets had been set. TR confirmed that this analysis was underway and that service-level agreements were being established across all divisions to address time-to-hire.

CoG25/05/08 Patient Experience, Membership and Quality Committee Report

51. RC encouraged the Council to read the Committee report. He also reported progress on the West Wing escalator and expressed appreciation to the Estates team for their support. Several actions had already been taken, including the installation of bollards where feasible. Additionally, the former COVID-19 system had been reinstated in the Eye Department, providing reassurance that the Trust had taken all reasonable steps to ensure safety.

CoG25/05/09 Performance, Workforce and Finance Committee Update

52. JH provided a brief update on the sexual harassment issue, noting encouraging progress and affirming that efforts would continue. He had also referenced the financial plan, stating that a more up-to-date version had been received earlier that day, aligning with the discussions held. He acknowledged that the Non-Executive Directors (NEDs) had remained closely engaged throughout.

CoG25/05/10 RNAC Progress Update

53. RNAC were progressing the recruitment process, with three search consultants offering support. The preferred provider had been identified, and the team had communicated this preference to Procurement. Recruitment was to take place for three new NED roles, noting the need in addition to replace the Chair in due course.

CoG25/05/11 Lead Governor Report

54. FTD reported on issues identified regarding the Immunology lab during the Board safety walkaround. Alternative accommodation was under review, and Mark Holloway, Chief Estates Officer had provided a structural report identifying the site as one of the poorest areas. Ground-level zones had been deemed out of bounds, and capital works had been costed with efforts underway to integrate them into the broader plan. The long-term aim was to decommission the building and implement a three-way relocation to Level 4 of the JR, with a short-term focus on completing safety and environmental improvements.

55. GS raised concerns about operational issues linked to the new IT system, noting that the team had been working under significant pressure. FTD agreed to provide a written update.

56. The transition to a new patient transport provider had been implemented successfully. While there had been minor issues from an outpatient perspective, overall feedback had been positive.

57. A suggestion had been made to increase engagement with NEDs, as seminar attendance had been limited. It was proposed that sessions on the long-term strategy be scheduled.

CoG25/05/12 Any Other Business

58. There was no further business.

CoG25/05/13 Date of Next Meeting 4 September 2025

59. The meeting will take place on Wednesday 4 September, venue to be confirmed.

Part II Confidential

60. No additional confidential discussion was required on this occasion.