Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Council of Governors: Wednesday 25 November 2026

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Title:	**Future Arrangements for the Council of Governors**

Status:	**For Discussion**
History:	Initial discussion at the Trust Board seminar on 14 October 2026.

Board Lead:	**Trust Chair**
Presenter:	**Neil Scotchmer, Head of Corporate Governance / Yvonne Christley, Chief Nursing Officer**
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Confidential:	**No**
Strategic Pillar:	**Patients, People, Partnerships, Performance**

Executive Summary

1. This paper invites an initial Council of Governors discussion on future governance, membership and public involvement arrangements, closely following the briefing considered at the Trust Board seminar on 14 October 2026 and informed by the NHS Alliance briefing *What follows councils of governors?* of 6 November 2026.
2. The proposed removal of statutory councils of governors and foundation trust membership requirements remains dependent on Parliament and subsequent commencement arrangements. The Council's existing powers and duties continue. This paper does not seek approval to end the Council or pre-empt the legislation.
3. The Board seminar indicated a direction of travel towards retaining membership as a route for public engagement without retaining a Council of Governors if legislation permits. No decision was taken. The four options in the October briefing remain a framework for discussion rather than a choice already made.
4. Retaining membership would preserve a valuable network but would not replace the Council's statutory accountability role. A developed model should therefore separate public accountability from engagement and participation, with distinct arrangements for Board challenge, strategic patient influence, population representation and wider patient and community voice. This could comprise a Public Accountability Forum and an open Patient and Community Network that reaches the populations that OUH serves and aligns with the OUH Patient and Public Participation Framework. Both could succeed the current Council of Governors and Foundation Trust membership arrangements if legislation permits; no decision has been taken. Governors' contribution, knowledge and community relationships should be valued throughout the process. Further work with governors and the patient experience and engagement team is proposed, with a developed proposal and an update on the legislative position returning to the Council on 18 February 2027 before further Board consideration.

Recommendations

5. The Council of Governors is asked to:
    - note the legislative uncertainty and the continuing powers and duties of the Council, and that no decision on future arrangements has been taken;
    - discuss the four options, the emerging direction of travel and the safeguards needed for meaningful involvement and public accountability; and

- support further joint development work, including appraisal of the proposed Public Accountability Forum, Patient and Community Network, population representation framework and formal Board response arrangements, building on and connecting existing patient, public, community and lived experience partner roles through the OUH Patient and Public Participation Framework, with a developed proposal returning to the Council on 18 February 2027 before further Board consideration, subject to the legislative position.

Future Arrangements for the Council of Governors

1. Purpose

1.1. This discussion paper invites the Council of Governors to consider future governance, membership and public involvement arrangements if the proposed statutory changes proceed. It does not seek a formal decision on the future of the Council or membership at this stage.

1.2. The paper follows the briefing considered at the Trust Board seminar on 14 October 2026 and draws on the NHS Alliance briefing *What follows councils of governors?* of 6 November 2026. The October paper drew on work by King's College Hospital NHS Foundation Trust, adapted for OUH. Governors are invited to identify the purposes and principles that should guide further work.

2. Legislative context and current functions

2.1. The October briefing described proposals in the Health Bill to remove the statutory requirements for foundation trusts to maintain a membership and a council of governors and to transfer or replace governors' current functions. The NHS Alliance's November briefing emphasises that the final provisions, transition arrangements and commencement dates remain uncertain. An anticipated date of 1 April 2027 should not be treated as confirmed.

2.2. Until the relevant law changes, the Council retains its statutory powers and duties. Its two overarching duties are to hold non-executive directors individually and collectively to account for the performance of the Board and to represent the interests of members as a whole and the public. These are collective Council duties, encompassing the public at large and not only existing members.

2.3. The following table summarises the proposals described in the two briefings. It is not a statement of enacted law or a final allocation of functions.

Current statutory function	Proposed position	Implication for OUH
Hold non-executive directors to account for Board performance.	The statutory governor duty would fall away. National oversight arrangements would change.	Consider explicitly how local questioning, challenge and a substantive Board response would be maintained.

Represent members and the wider public.	The statutory representative role and membership requirement would be removed, with an expectation of more dynamic patient, staff and stakeholder insight.	Maintain wider public involvement duties and routes reaching beyond existing members.
Appoint and remove the Chair and non-executive directors and determine remuneration and terms.	Functions would move into national arrangements. The November briefing notes continuing debate about where appointments should sit.	Confirm the final legal route and distinguish any local advisory input from appointment powers.
Approve the appointment of the Chief Executive.	The separate governor approval stage would be removed.	Apply the final appointment framework when it takes effect.
Appoint or remove the external auditor and receive the annual report, accounts and auditor's report.	Audit appointments would move towards NHS trust and ICB arrangements. Receipt and reporting requirements would change.	Confirm the revised audit and reporting routes while preserving transparent public reporting.
Provide views on forward plans and exercise rights concerning constitutional changes, significant transactions, mergers, acquisitions, separations, dissolution and specified non-NHS income matters.	Governor rights would be removed or transferred into revised national oversight and provider governance arrangements.	Confirm each final allocation of responsibility and ensure meaningful involvement in significant decisions.

2.4. The possible removal of statutory powers would not require OUH to abandon local accountability, public voice or constructive challenge. National oversight and local public accountability are distinct: one would not automatically replace the other. Any local advisory mechanism would need a clear remit and could not exercise statutory governor powers simply by reproducing the Council's name or terms of reference.

3. Possible future arrangements for OUH

3.1. The four options in the October briefing remain a framework for discussion. They would be available only to the extent permitted by the final legislation.

Option 1: End the Council and foundation trust membership arrangements

3.2. OUH could allow the Council and membership arrangements to cease once legislation permits, relying on the unitary Board, statutory patient and public involvement duties, established partners and mechanisms under the Patient Experience and Engagement Plan.

3.3. **Potential advantages:** a simpler structure and removal of election, meeting, training and membership-management costs. **Potential disadvantages:** loss of an established route for public and staff voice, relationships and corporate memory, and a risk that accountability becomes more Board-led and less independent.

Option 2: Retain the present model voluntarily so far as practicable

3.4. OUH could retain a Council-style body, membership database, constituencies and periodic elections, with selected activities on a non-statutory advisory basis.

3.5. **Potential advantages:** continuity, recognisable local democratic participation, established links to members and communities and retention of experienced contributors. **Potential disadvantages:** continuing cost and administrative burden, challenges in sustaining representative membership and elections, confusion about authority and duplication of other engagement routes.

Option 3: Establish a smaller successor advisory forum

3.6. OUH could establish a smaller forum for public accountability, community insight and dialogue with the Chair, non-executive directors and Board, with selected, nominated or mixed membership rather than full constituency elections.

3.7. **Potential advantages:** a distinct space for challenge and external insight, tailored to OUH's specialist and system-wide footprint, and a more proportionate structure than the current model. **Potential disadvantages:** weaker democratic legitimacy than elected governors, difficult choices about composition and representativeness, possible overlap with other forums and continuing support costs.

Option 4: End the Council but retain membership as an engagement resource

3.8. OUH could discontinue governor offices and formal Council governance once legally permitted while retaining the membership network as one route for communications, surveys, listening activity and participation opportunities, subject to appropriate data-protection arrangements.

3.9. **Potential advantages:** retaining relationships with people who have expressed an interest in OUH and supporting timely engagement without continuing the Council structure. **Potential disadvantages:** membership may not reflect the wider patient population and maintaining an active database would still require resources. A clear purpose, lawful basis, transparent communication and outreach beyond existing members would be required.

3.10. Governors' views should inform the purposes, safeguards and practical arrangements to be developed, including any gaps that would remain if membership were retained without a Council. Retaining a contact network alone would neither provide meaningful involvement nor replace the Council's accountability role.

4. Proposed strategic model for future public accountability and participation

4.1. Further development should start with the functions OUH needs rather than an assumption that either the present Council or current Foundation Trust membership must be preserved. The proposed model separates four functions that are related but distinct: Board accountability, strategic influence, population representation and patient voice. Existing governors and members would be invited to contribute and transition into appropriate roles, but future participation would not be restricted to the present membership.

Public Accountability Forum

4.2. OUH could establish a Public Accountability Forum, selected through a transparent mixed process to provide independent local challenge and a direct relationship with the Chair, Chief Executive, non-executive directors and Board. The Forum would scrutinise delivery of the Patient Experience and Engagement Plan, major strategic decisions, quality, access and inequalities; consider patient experience, complaints and wider community intelligence; and track the response to significant concerns.

4.3. The Forum should not be described as replacing statutory governor powers. Its authority would derive from Board-approved terms of reference requiring a substantive response to recommendations, publication of themes and actions, and escalation of unresolved matters through an agreed route. Membership should be time-limited and refreshed, with safeguards for independence and against domination by individual interests.

OUH Patient and Community Network

4.4. Foundation Trust membership could be repurposed as an OUH Patient and Community Network, subject to legislation and appropriate information-governance arrangements. This would be an open and continuously refreshed participation network rather than a fixed electorate or mailing list. People could choose to keep informed, contribute views, help shape services or apply for more sustained patient partner and accountability roles.

4.5. The Network could be used to convene decision-specific panels rather than assume that one standing group can represent every population. Participation in maternity, digital, outpatient, cancer or access work, for example, should be drawn from people with relevant experience and from communities most affected by the decision. Recruitment should extend beyond existing members through Healthwatch, community and voluntary organisations, faith and community networks, service-level routes and targeted outreach.

4.6. The Network could operate primarily as a gateway and participation infrastructure, not as another large standing forum claiming to represent everybody. It would support broad listening, identify people with relevant experience, convene decision-specific panels, recruit partners and potential Accountability Forum members, and connect people to community participation opportunities.

Strategic patient, public and lived experience partners

4.7. OUH should build on, connect and where appropriate expand its existing patient, public and lived-experience roles rather than establish a wholly separate cadre. This includes Patient Safety Partners, Independent Lived Experience and Community Improvement Partners, community partners and other established or emerging involvement roles. A trained and supported pool could provide sustained influence within major programme boards, service redesign, pathway transformation, quality improvement, strategy development, selected procurement and business-case development.

Population representation and targeted outreach

4.8. OUH should replace reliance on membership numbers with a population representation strategy. A representation matrix should monitor participation by relevant characteristics including age, disability, ethnicity, deprivation, geography, rurality, sex, caring responsibilities, major service-user populations and communication or accessibility requirements using the OUH patient census as a guide. The aim would not be statistical representativeness in every exercise, but intentional representation

proportionate to the decision and transparent identification of voices that are missing.

4.9. The developing participation dataset should show the relationship between the population served, people providing feedback, people participating and people influencing decisions. Gaps should trigger targeted recruitment and supported involvement, with evaluation of whose views influenced the outcome.

Board accountability and evidence of influence

4.10. The model should include a quarterly public accountability report to the Board showing what patients and communities are saying, what the organisation has decided, what has changed and what has not changed and why. This should triangulate the Patient Experience Survey and dashboard, complaints, PALS, patient stories, participation findings, inequalities intelligence and relevant safety evidence.

4.11. An annual public accountability session should enable patients, members and communities to question the Chair and Chief Executive directly. Material recommendations from the Public Accountability Forum should receive a formal response, recorded as accepted, partially accepted or not accepted, with the rationale and resulting action tracked publicly through the Trust-wide action and impact register.

Contribution to the four Patient Experience and Engagement Plan priorities

4.12. Listen and Act: the Network would provide continuous intelligence and the Accountability Forum would test whether the Board and services have responded.

4.13. Patient and Public Participation: the Network would provide an infrastructure from which panels, partners and co-design groups can be recruited.

4.14. Fair Access for All: the representation matrix and targeted outreach would identify and address communities missing from feedback and decision-making.

4.15. Deciding What Matters Most: patient, public, community and lived-experience partners would influence priorities, transformation and business cases upstream, while the Accountability Forum would scrutinise how patient and community evidence affected final decisions.

5. Relationship with OUH's engagement arrangements

5.1. The Patient Experience and Engagement Plan **2026 to 2031**, approved by the Board in May 2026, provides a foundation for future patient and public involvement. Its four priorities are Listen and Act, Patient and Public Participation, Fair Access for All and Deciding What Matters Most. The Patient Experience, PALS and Complaints Annual Report 2025/26 and the accompanying outcome measures paper describe how these priorities will translate into more systematic listening, meaningful participation and evidence that patient and community insight influences decisions and leads to improvement.

5.2. These arrangements can support the representative purpose of the current governor role but are not in themselves a replacement for its accountability function. Engagement is two-way dialogue that enables influence. Participation includes involvement in service design and improvement. Insight is the understanding drawn from experience and other evidence. Public accountability requires clarity about who must explain decisions, how they may be challenged and what response follows.

5.3. The future model should distinguish four forms of contribution: public accountability, through challenge to the Board and non-executive directors; strategic participation, through influence on strategy, prioritisation, transformation and governance; lived-experience expertise, through knowledge arising from personal experience without an assumption of wider representation; and community voice, through direct engagement with communities affected by a decision. These functions may connect but should not be conflated or assigned automatically to one person or body.

5.4. Participation continuum. OUH should organise its routes as a coherent continuum: Listen, Participate, Partner, Influence and Hold to Account. The Patient Experience Survey, complaints, PALS, patient stories and community intelligence support listening; targeted engagement and Network panels support participation; Patient Safety Partners, lived-experience and community improvement partners support partnership; involvement in programmes and business cases supports strategic influence; and the Public Accountability Forum provides challenge and accountability.

5.5. The NHS Alliance briefing favours a combination of mechanisms rather than assuming one forum can achieve every purpose. It highlights wider reach, a direct connection to Board decisions, visible evidence of impact, local flexibility and use of existing strengths. It reports emerging NHS England principles that arrangements should be proactive, representative,

tangible, proportionate and dynamic. These are developing principles rather than a prescribed national model.

5.6. Future public engagement would build on the Trust-wide Patient Experience Survey and dashboard, the OUH Patient and Public Participation Framework, patient stories, Patient Safety Partners and relationships with Healthwatch and community partners. The intention is to involve patients and communities from the outset of major programmes and service changes rather than seek views only after proposals have been developed. A participation dataset would help assess reach, representation, participant support and influence on decisions. Improved demographic linkage and recording of communication and accessibility needs would help identify gaps in participation and experience. Any retained membership network would be one resource within these wider arrangements rather than the sole route for public involvement.

5.7. The emphasis would be on demonstrating influence and improvement rather than counting engagement activity alone. The proposed two-tier measurement framework provides for six strategic outcome indicators reported quarterly to the Quality and Performance Committee, supported by operational measures through the Patient Experience and Engagement Committee and divisional governance. These would assess whether patients feel listened to and involved in their care, whether inequalities in experience are narrowing and whether early participation demonstrably influences major decisions. A Trust-wide action and impact register would support visible feedback through “You said, we did, what changed”. Year 1 would establish reliable definitions and baselines to inform Year 2 improvement targets. These measures would support assurance on engagement effectiveness but would not resolve the separate question of local public accountability.

5.8. Staff engagement should remain an explicit and distinct part of future arrangements. Consideration will be given to designating a Lead Non-Executive Director for staff engagement to provide a clear Board-level focus for staff voice. Further work should define how this role connects with existing staff engagement routes, how candid staff insight reaches the Board and relevant committees and how responses and resulting actions are communicated. Public engagement arrangements should not be assumed to provide an equivalent route for staff.

5.9. Options for strengthening senior leadership of patient and public engagement, including a possible Patient Experience Directorate, will also be considered as part of the developed proposal, to provide a clear senior connection between public engagement and organisational priorities. No

decision has been taken on the form, remit or reporting line of any such arrangement. These would need to be developed alongside the existing patient experience leadership and governance arrangements, including PEEC, so that responsibilities for outreach, participation, insight and reporting are coherent and avoid duplication.

5.10. Operational responsibility for the participation infrastructure should sit within the Trust's Patient Experience and Engagement arrangements, with clear interfaces to Corporate Governance for public accountability and Board governance, and to relevant clinical, quality, safety, equality, volunteering and improvement functions. The developed model should identify a single coordinating framework and avoid parallel patient-engagement structures.

5.11. OUH's arrangements will sit alongside wider ICB-led arrangements for public engagement. Further development should clarify how Trust-level and system-level engagement connect, particularly for cross-provider pathways and changes affecting communities across the wider system. This should build on shared insight and community relationships while avoiding unnecessary duplication. Wider ICB-led engagement would complement rather than replace OUH's own routes for listening, involvement and a substantive response to public concerns. The developed proposal should explain these interfaces and identify any continuing gaps in public accountability or staff voice.

6. Safeguards for involvement and public accountability

6.1. The potential loss of an elected local body with statutory powers is a substantive change. Governors may reasonably be concerned about reduced independence, weaker public challenge and whether future involvement would have influence.

6.2. The following initial safeguards are proposed for discussion. They are matters for further development, not approved commitments or a fully designed successor model. Further detail on OUH's engagement and involvement arrangements will be needed to test how they could work in practice.

6.3. **A clear Board connection.** Proposals should specify how member, community and staff insight reaches the Board and relevant committees, who is responsible for responding and how it informs strategy, quality and service change. This should be a defined route rather than reliance on individual relationships.

6.4. **Questions, challenge and a visible response.** Options should include opportunities for the public to question the Chair and non-executive directors, published responses to themes raised and a transparent record of action or reasons for not acting. Governors' views are sought on whether a defined expectation to respond and explain, with follow-up of unresolved concerns, would provide sufficient accountability without a Council-style body.

6.5. **Access, breadth and independent perspectives.** Arrangements should combine accessible face-to-face, digital and community-based opportunities, support participation and actively seek voices beyond established members. They should preserve candid staff input and enable constructive challenge without becoming dominated by individual interests or duplicating existing routes.

6.6. **Independence and freedom to challenge.** People undertaking accountability or independent challenge roles should remain free to question OUH and should not be expected to endorse Trust decisions. Recruitment, induction, support, reimbursement or payment arrangements must not compromise that independence.

6.7. **Safe, accessible and properly supported participation.** Arrangements should include proportionate role descriptions, induction and preparation, accessibility and reasonable adjustments, expenses and payment where appropriate, confidentiality and information-governance requirements, feedback on influence and wellbeing support for sensitive work. Trauma-informed practice should include preparation, debriefing, avoidance of unnecessary repetition of distressing experience and the ability to pause or withdraw.

6.8. **Evidence of influence and impact.** Proposals should show how insight would be considered alongside complaints, PALS, surveys, safety and workforce evidence, with feedback to participants. Evaluation should demonstrate changes to decisions, services and experience rather than count meetings or members alone. Any remaining gap in local accountability should be acknowledged explicitly.

6.9. **Formal Board response and follow-through**. Material recommendations from any Public Accountability Forum should receive a recorded Board response, with reasons where recommendations are only partly accepted or not accepted. A quarterly public accountability report and annual public accountability session should provide visible routes for challenge, response and follow-up.

6.10. **Representation by design.** A population representation framework should be used to identify who is reached, who is missing and whose

experience is relevant to each issue. Existing Foundation Trust members should be welcomed as one source of participation, but future arrangements should be actively refreshed and supplemented through targeted community outreach.

7. Maintaining effective arrangements during transition

7.1. The Council should continue to undertake its essential business and be supported to remain legally constituted and quorate until the relevant law changes. The November briefing notes that statutory three-year terms remain and that there is no general dispensation to extend terms or suspend existing requirements. This paper proposes no change to elections, terms or constitutional requirements. Any such proposal would require separate consideration of legal compliance, quoracy and the Trust's constitution.

7.2. Forward planning should identify business requiring governor involvement, including appointments, audit and constitutional or transaction approvals, and review related service contracts. Membership remains a statutory requirement until the law changes. Any later change in its purpose would require a review of the lawful basis for holding and using information, privacy information and consent where required, with clear communication and an opportunity to opt out of future communications.

7.3. Governors are volunteers whose contribution should continue to be recognised and valued. Communications should distinguish known facts from uncertainties and share authoritative developments as they become available. Governors should help shape future arrangements and, if interested, explore further involvement opportunities without any assumption that every governor wishes to take on an engagement role. If the statutory Council ends, appropriate recognition of governors' service should form part of the transition.

8. Risks and further evidence required

8.1. The principal risks are premature withdrawal from statutory arrangements, loss of local accountability and independent challenge, damage to trust and relationships, and future engagement that is unrepresentative or disconnected from decisions. These require legal continuity, honest dialogue, co-design and explicit routes for raising concerns and receiving a substantive response.

8.2. There are also risks of creating duplicative structures, losing staff voice or maintaining membership without a clear purpose. Analysis should identify

existing strengths and gaps, the people reached and missed, governance interfaces and the resources required for facilitation, outreach and participant support as well as administration.

8.3. No costed model or quantified savings are presented in this paper. A developed proposal should include proportionate analysis of costs, legal and data-protection requirements, representativeness, Board connections and transition dependencies. It should explain what accountability would be retained, what would change and how effectiveness would be reviewed. It should also set out the staffing and resources the patient experience and engagement team would need to design and deliver the model.

9. Discussion and next steps

9.1. Governors are invited to discuss which purposes of the present Council most need to be preserved; the strengths and limitations of the four options; what retaining membership without a Council would need to achieve; and which safeguards would make involvement and Board responsiveness meaningful. What would otherwise be lost, particularly in independent challenge, public accountability and staff voice, should be recorded alongside areas of agreement.

9.2. Subject to the Council's discussion, further work is proposed with governors and the patient experience and engagement team to map current arrangements, identify gaps and develop the safeguards in section 6. Public members, staff and relevant community and system partners should help shape the proposals. This work should test the proposed Public Accountability Forum, OUH Patient and Community Network and population representation framework, including governance, selection, support, reimbursement, information-governance and resource requirements. It should map and connect existing Patient Safety Partners, Independent Lived Experience and Community Improvement Partners, community partners and other involvement roles before proposing new roles, and test the distinction between accountability, strategic participation, lived-experience expertise and direct community voice. The work should build on the Patient Experience and Engagement Plan rather than begin with an assumption that a new representative body is required.

9.3. A developed proposal should return to the Council at its next meeting on 18 February 2027, with an updated legislative position, an account of how governors' views have informed the work and analysis of resources, governance and transition requirements. Further Board consideration and any formal decision should follow through the appropriate governance

routes once the legal position is sufficiently clear. If legislation or commencement is delayed or changed, the statutory Council must continue and the planning approach should be adjusted accordingly.

10. Recommendations

10.1. The Council of Governors is asked to:

- note the legislative uncertainty and the continuing powers and duties of the Council, and that no decision on future arrangements has been taken;
- discuss the four options, the emerging direction of travel and the safeguards needed for meaningful involvement and public accountability; and
- support further joint development work, including detailed design and appraisal of a Public Accountability Forum, an OUH Patient and Community Network, a population representation framework and formal Board response arrangements, building on and connecting existing patient, public, community and lived-experience partner roles through the OUH Patient and Public Participation Framework, with a developed proposal returning to the Council on 18 February 2027 before further Board consideration, subject to the legislative position.