Council of Governors

Draft minutes of the Council of Governors meeting held on **Thursday 24 September 2026** in Rooms 4A/4B, George Pickering Education Centre, John Radcliffe Hospital.

Present:

Name	Initials	Job Role
Sir Andrew Morris	AM	Chair
Ms Ariana Adjani	AA	Public Governor, Oxford City
Mr Charles Adomah-Boadi	CAB	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
Prof Lorraine Dixon	LD	Nominated Governor, Oxford Brookes University
Mr Damian Haywood	DH	Public Governor, Oxford City
Dr Jeremy Hodge	JH	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
Dr George Krasopoulos	GK	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 Christine Montague-Johnson	CMJ	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
Mrs Megan Turmezei	MT	Staff Governor, Non-Clinical
Ms Hannah Watkins	HW	Public Governor, South Oxfordshire

In Attendance:

Mr Simon Crowther	SC	Interim Chief Executive Officer
Ms Yvonne Christley	YC	Chief Nursing Officer
Mr Paul Dean	PD	Non-Executive Director
Mr Jason Dorsett	JD	Chief Finance Officer
Ms Sarah Hordern	SH	Non-Executive Director

Mr Terry Roberts via MS Teams	TR	Chief People Officer
Mrs Caroline Rouse	CR	Governor and Membership Manager (minutes)
Dr Neil Scotchmer	NS	Head of Corporate Governance
Mr Adrian Balmer	AB	Ernst & Young (Item 7)

Apologies:

Mr Tony Bagot-Webb	TBW	Public Governor, Northamptonshire and Warwickshire
Cllr Tim Bearder	TB	Nominated Governor, Oxfordshire County Council
Mr Stuart Bell CBE	SB	Nominated Governor, Oxford Health NHS Foundation Trust
Dr Robin Carr	RC	Public Governor, West Oxfordshire
Mr Alastair Harding	AH	Public Governor, Vale of White Horse
Prof Helen Higham	HH	Nominated Governor, University of Oxford
Ms Aliki Kalianou	AK	Staff Governor, Non-Clinical
Mr Andrew Lawrie	AL	Public Governor, Northamptonshire and Warwickshire
Dr Ascanio Tridente	AT	Public Governor, Rest of England and Wales

CoG26/09/01 Welcome, Apologies and Declarations of Interest

1. Sir Andrew Morris, newly appointed Chair of Oxford University Hospitals (OUH), welcomed those present. He thanked colleagues for the welcome he had received and reflected positively on the commitment of staff and Board members. He said that it was a privilege to take up the role and that he looked forward to working with governors and colleagues across the Trust.
2. Apologies for absence were noted as set out above. The Council recorded its thanks to Stuart Bell for his contribution as nominated governor for Oxford Health NHS Foundation Trust, ahead of the end of his term of office on 15 October 2026. No declarations of interest were recorded.

CoG26/09/02 Minutes of the Meeting Held on 27 May 2026

3. The minutes of the meeting held on 27 May 2026 were approved as an accurate record.

CoG26/09/03 Matters Arising

4. The Council received updates on the questions raised by governors at the previous meeting. Whistleblowing and statutory and mandatory training would be considered under item CoG26/09/08. Legal claims were being taken forward through the Performance, Workforce and Finance Committee. The Committee had also received a briefing on digital, IT and AI developments and a fuller response would follow once the Trust Strategy had been approved. Work on organisational culture, values and behaviours was continuing with a further update to be brought back to governors.

CoG26/09/04 Lead Governor Report

5. George Krasopoulos, Lead Governor, reported that governors were continuing to progress their questions to the Board. He raised the anticipated legislative changes affecting Councils of Governors. AM advised that legislation was still being progressed with further detail expected before Christmas. The emerging proposals also concerned Healthwatch and a greater role for Integrated Care Boards (ICBs) in public engagement with a focus on population health and deprived communities.
6. AM considered it premature to determine the Trust's future engagement arrangements before the overall legislative and system framework became clearer. Suitable alternatives would nevertheless be needed if governor and Healthwatch arrangements were removed to avoid a gap in patient and public involvement. The Trust would need to operate within the eventual legislative framework including any changes to governor powers.
7. CMJ raised concerns about the visibility of the patient voice within ICB arrangements and the risks to meaningful engagement between primary and secondary care. AM acknowledged variation between systems and described neighbourhood engagement intended to hear from diverse communities. GS emphasised that scrutiny and holding the system to account were important aspects of the governor role alongside patient engagement.
8. GK highlighted the risk of losing feedback from staff, universities, general practice and the wider community if arrangements focused only on current patients. SC noted that existing mechanisms supported some of these relationships although they were not perfect. AM suggested testing their effectiveness once the overarching framework was clearer, including opportunities to strengthen university engagement.
9. JH asked whether additional engagement responsibilities would fall to Non-Executive Directors. AM noted that NHS trusts already operated without governors and used other mechanisms. He emphasised avoiding competing engagement groups and focusing on services and outcomes rather than an attachment to locations.

10. LD raised concerns about inconsistent approaches to neighbourhood working, national leadership and policy changes and the difficulty of engaging all stakeholders. SC explained that local flexibility was part of the policy approach. A recent ICB visit by the national director responsible for neighbourhoods had provided an opportunity to share learning between areas developing different models.
11. NR reported feedback from a recent constituency event on Hospital at Home. Neighbourhood arrangements with GPs had supported delivery in North Oxfordshire, while alignment across Primary Care Networks had been more difficult in South Oxfordshire. AM considered that the ICB had a role in bringing partners together and establishing clear local leadership.
12. AM concluded that the implications of the legislation would need to be revisited at a future meeting once further detail was available. Future strategy discussions would consider how the Trust would support delivery of the NHS 10-Year Plan, including neighbourhood working and population health.

CoG26/09/05 Chair's Business

13. AM reminded governors that the Annual Public Meeting would take place on 30 September 2026 and encouraged attendance and engagement with members of the public. MT invited governors to support the governor and membership stand at the event.
14. The departures of Fiona Morrison, Public Governor for Cherwell, and Gareth Evans, Nominated Governor for the Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee, were noted. The Council agreed that the Cherwell public governor vacancy would remain unfilled until the scheduled elections in early 2027 in line with precedent. A replacement nomination from the Local Medical Committee was not anticipated.
15. AM reported that the strategy refresh was intended to produce a completed strategy by the end of the calendar year. Culture, values and behaviours would be an important part of this work.

CoG26/09/06 Chief Executive's Briefing

16. Simon Crowther, Interim Chief Executive Officer, reported that the Care Quality Commission (CQC) had rated neonatal services Good. He thanked the team for its response during a period of considerable scrutiny, while recognising that further improvements were required. He also drew attention to the Thirlwall Inquiry report. The Board would consider the full report and the immediate actions identified by NHS England with a further update to governors in due course. Governors were encouraged to read the report.

17. SC reported that OUH had remained in Segment 3 of the NHS Oversight Framework. The financial override that had affected the previous rating had been removed but research indicators and readmissions had affected the current position. Improvement work was underway in both areas, with a possible data quality issue being examined in relation to readmissions.
18. Cancer and elective care remained challenging, although access performance was broadly in line with planned trajectories. Urgent care performance had reached 81% in the preceding week against a planned 84%. SC emphasised the need for further improvement, particularly in cancer and elective services.
19. The annual Staff Survey was underway with an ambition to achieve a 50% response rate. SC encouraged participation and emphasised the importance of demonstrating that staff feedback made a difference.
20. The flu vaccination programme was due to commence and governors were asked to support it. In response to a question from DM, YC confirmed that funding was for flu vaccination only and that COVID-19 vaccination would not be included in the programme.
21. SC reported that the Surgical Elective Centre (SEC) was now expected to admit its first patient in early November following a delay caused by an electrical equipment issue. Preparatory work was continuing with progress reviewed weekly.
22. NR welcomed the Trust's ambition to improve beyond national targets but challenged the lack of improvement in sickness absence. She asked whether additional external support should be sought. SC acknowledged the difficult environment for staff and explained that the Trust already used external psychological support. He reported investment of £750,000 in wellbeing services, including charitable funding and noted that benchmarking and analysis of the causes of absence supported the response.
23. Terry Roberts, Chief People Officer, explained that mental health and musculoskeletal conditions were key causes of absence. Support included psychological services available around the clock and direct access to fast-tracked physiotherapy through Occupational Health. Further improvement was required in the consistent application of sickness absence processes. In response to LD, he clarified that the increase in the injury and poisoning category largely reflected staff recovering from surgery.
24. DH welcomed the CQC outcome on behalf of the Patient Experience, Membership and Quality Committee and asked that the Council's support and congratulations be conveyed to the neonatal team.
25. DM asked about the implications of remaining in Segment 3 and how close the Trust was to Segment 2. SC advised that OUH was near the upper end of Segment 3. The principal implications concerned regulatory scrutiny, escalation

and performance management. He reiterated that the purpose of improvement was better access and care for patients, rather than achievement of targets alone.

26. AM emphasised the importance of improving performance against the 62-day cancer standard and the capacity required to achieve it. He noted that OUH compared favourably with other Shelford Group organisations in some areas, while recognising the need for improvement.

CoG26/09/07 Summary of the 2025/26 Annual Accounts and Auditor's Annual Report

27. Jason Dorsett, Chief Finance Officer, presented the summary of the 2025/26 annual accounts (CoG2026.10). He reported a control total surplus of £7m but emphasised that the Trust had an underlying deficit of £87.1m. The distinction between the reported position and recurrent financial sustainability remained important.

28. The Trust had delivered £85.1m of efficiencies, equivalent to 86% of plan. JD noted that the full efficiency programme had not been delivered and that too much reliance had been placed on non-recurrent savings and additional support.

29. Capital expenditure was £137.7m and closing cash was £75.9m. JD explained that the timing of capital expenditure affected the cash position and that the balance should not be interpreted as evidence of recurrent financial strength. Increased capital investment was supporting equipment replacement and improvements to the estate.

30. The Trust had achieved a 4.5% productivity improvement on the NHS England measure. JD reported that productivity had returned to pre-pandemic levels, while noting the need for further improvement over time.

31. Income had increased by 5.2%, with pay costs growing more slowly than income. JD highlighted the control of pay expenditure and the continuing need to manage non-pay costs. He noted that the income position did not indicate a significant shift in funding away from acute services.

32. The key accounting judgements concerned the SEC, the PFI debtor and expected credit losses. Following practical completion of the SEC, a right-of-use asset and corresponding lease liability had been recognised. AM noted that the SEC approach might offer a model for future developments.

33. GK asked how workforce changes had influenced productivity. JD explained that the NHS England measure compared activity-based output with costs and did not measure the effectiveness of care. Staffing had peaked previously while healthcare activity had continued to increase. The effect on staff morale was an important consideration.

34. LD asked about the risk of funding changes associated with national policy. JD explained that ICB allocations reflected population need, while acute providers were largely paid for the activity they undertook. He noted that Oxfordshire was below its needs-based allocation.

35. Adrian Balmer, Ernst & Young, presented the Auditor's Annual Report for the year ended 31 March 2026 (CoG2026.11). EY had issued an unqualified opinion on 25 June 2026. The accounts had been submitted on time and there were no material matters to report on the audited parts of the remuneration and staff report.

36. The value-for-money review covered financial sustainability, governance, and economy, efficiency and effectiveness. No significant weaknesses had been identified. A risk relating to maternity services had been examined, with EY concluding that there was no evidence of a significant weakness in arrangements following its review of the CQC findings.

37. The audit had examined management judgements, accrued liabilities, land and building valuations, capitalisation and the accounting treatment of the SEC. No material issues had been identified in the SEC accounting or capital additions tested. The papers distinguished corrected reporting misstatements from immaterial uncorrected differences, including the continuing difference between EY and NHS England's interpretation of PFI accounting requirements.

38. AM welcomed the audit findings and NR thanked EY for the clarity of its reporting. PD emphasised that the underlying deficit remained the principal financial issue and that reliance on non-recurrent support posed an ongoing risk. AM highlighted the need to achieve recurrent balance and a modest surplus to support future investment.

39. GK sought assurance about plant and machinery capacity. JD explained that the audit finding related to fully depreciated items remaining on the fixed asset register when they were no longer in use or could not be evidenced. It did not in itself demonstrate that operational equipment was inadequate. Work was underway to reconcile operational and accounting records and remove obsolete entries.

40. PD confirmed that the assets concerned had no net book value and therefore did not affect the net asset balance although the records required correction.

41. JH asked about the risk that funding would depend on the performance of other providers. JD explained that the Health and Care Act 2022 had introduced a collective system duty but that NHS England had subsequently placed greater emphasis on individual provider financial accountability.

42. The Council noted the annual accounts summary and Auditor's Annual Report.

CoG26/09/08 Whistleblowing Processes and Effectiveness

43. TR presented the response to governors' questions on raising concerns and statutory and mandatory training (CoG2026.12). He outlined the established Freedom to Speak Up (FTSU) routes and the use of Staff Survey evidence to assess whether staff felt safe to raise concerns, were listened to and believed that action would follow. Concerns covered patient safety, culture, leadership, bullying and harassment, conduct and operational matters.
44. TR acknowledged an assurance gap in end-to-end tracking. Some concerns were addressed through FTSU while others entered patient safety, employee relations or local management processes. A single measure of timeliness across these pathways was not available and FTSU had limited capacity to follow matters after referral.
45. Work was underway to improve categorisation, tracking and reporting of the time between receipt, referral, investigation, outcome and feedback, including the number and age of open matters. FTSU intelligence was considered alongside Staff Survey, patient safety and workforce information. Opportunities to use AI to support triangulation were being explored with the Chief Digital and Information Officer.
46. GK challenged the absence of consolidated numbers and outcome information. TR confirmed that the response described the processes but that the systems needed to provide a complete cross-pathway picture were still being developed.
47. AM drew attention to the FTSU report to the Board. Sarah Hordern explained that the Lead Guardian's report was public and accessible to governors, providing anonymised activity information. Work in Confidence offered an additional source of information, although identifying themes and local areas of concern had to be balanced with protecting anonymity.
48. SS asked how satisfied staff were with the responses they received. TR explained that experiences varied, particularly where concerns overlapped with employee relations or grievance processes. The aim was to enable staff to raise concerns safely and reach an appropriate decision, while recognising that a person might remain dissatisfied with the outcome. Tracking concerns across several pathways remained a development need.
49. SH highlighted the difficulty of providing feedback when a concern resulted in confidential disciplinary proceedings. YC emphasised the importance of closing the feedback loop and providing as much assurance as possible without disclosing confidential information. She also stressed the need to consider the substance of a concern even where it had not been raised through the expected route.
50. SS described directing colleagues to FTSU and Work in Confidence, while recognising that some sought trade union support when dissatisfied. AM

emphasised that managers needed to listen and act promptly to prevent concerns escalating unnecessarily.

51. LD asked about correlating FTSU intelligence with other indicators and stressed that this should extend beyond HR data to patient outcomes and financial information. TR described triangulation of Staff Survey and workforce information and the requirement for divisional teams to report their response. YC explained that ward performance processes considered a range of signals to identify areas needing support earlier.

52. GK emphasised that concerns could also relate to teaching and research or be raised by university partners. TR clarified that FTSU was predominantly designed for staff. AM and SH noted other routes for partner organisations to raise concerns and the importance of remaining receptive to feedback from all partners.

53. TR introduced the statutory and mandatory training response and invited governors to send him further comments.

54. The paper set out modelling covering 14,346 staff and 151,927 assigned training requirements, with estimated annual staff time of 91,791.4 hours and an estimated staff time cost of £3.49 million. These were estimates of release time and salary cost rather than a separate cash-releasing budget. Training was managed through the Core Skills framework and My Learning Hub.

55. DM challenged whether the assumed training hours and staff costs reflected the actual burden on physicians and surgeons, including training undertaken in their own time. He emphasised the need for accurate data before conclusions could be reached about the scale of the issue.

56. TR confirmed that the figures were estimates and acknowledged the burden of mandatory training. He noted that much of the requirement was statutory or nationally mandated and that the Trust had raised concerns nationally about streamlining it. AM advised that further NHS England guidance to rationalise requirements was expected.

57. In response to LD, TR confirmed that the Trust held information on non-completion. He reported overall compliance above 90% against the Trust target of 85%.

58. JP queried the variation in requirements for doctors undertaking comparable roles and the relevance of some role-specific training. TR distinguished core skills from role-specific requirements and confirmed that the relevant committee was reviewing role-specific training.

CoG26/09/09 New Board Committee Structure

59. The Council considered the revised Board committee structure (CoG2026.13), approved by the Trust Board on 29 July 2026. The model would replace the Integrated Assurance Committee with portfolio-based arrangements covering Quality and Performance, Finance and People, alongside Investment, Digital and Estates, Audit and Risk, and Remuneration and Appointments. AM explained that the Board expected the structure, with Non-Executive Directors chairing the committees, to strengthen scrutiny. Its effectiveness would be tested in practice and reviewed in September 2027.

60. MT welcomed the changes as a positive step and highlighted reporting to the public Board. The Council noted the revised structure and the further work required to align governor committee remits and reporting arrangements, including regular contact with the relevant Non-Executive Director chairs, while avoiding duplication and excessive meeting commitments.

CoG26/09/10 Performance, Workforce and Finance Committee Report

61. In Andrew Lawrie's absence, Jeremy Hodge presented the report of the Performance, Workforce and Finance Committee meeting held on 10 July 2026 (CoG2026.14). He noted the opportunity to meet Lynne Graham and Kenny Kamal, newly appointed Non-Executive Directors. Digital infrastructure, reliability and the opportunities and governance requirements associated with AI had been considered, including progress on Ambient Voice Technology.

62. The written report also summarised scrutiny of workforce productivity, deployment and establishment reviews across clinical and non-clinical services. Further consideration of productivity and effectiveness measures, particularly in corporate and support functions, would be beneficial. The Council noted the report.

CoG26/09/11 Patient Experience, Membership and Quality Committee Report

63. Damian Haywood presented the Patient Experience, Membership and Quality Committee report (CoG2026.15), covering its meetings on 17 July and 14 September 2026. The written report included the Quality Account, transition from children's to adult services, the new Board committee structure and member engagement. DH highlighted liaison with Aletha Bicknell to clarify working arrangements with the Patient Experience and Engagement Committee and avoid duplication. The Council noted the report.

CoG26/09/12 Any Other Business

64. There was no further business.

CoG26/09/13 Date of Next Meeting

65. The next meeting was scheduled for Wednesday 25 November 2026 at Unipart House, following the public Board meeting with an opportunity for informal discussion between governors and Board members over lunch.