Council of Governors

Minutes of the Council of Governors Meeting held on **Thursday 5 February 2026** at Unipart House, Oxford.

Present:

Name	Initials	Job Role
Prof Sir Jonathan Montgomery	JM	Trust Chair, [Chair]
Ms Ariana Adjani	AA	Public Governor, Oxford City
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
Mr Damian Haywood	DH	Public Governor, Oxford City
Dr Jeremy Hodge	JH	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
Ms Aliki Kalianou	AK	Staff Governor, Non-Clinical
Mr George Krasopoulos	GK	Staff Governor, Clinical
Mr Andrew Lawrie	AL	Public Governor, Northamptonshire and Warwickshire
Ms Claire Litchfield	CL	Staff Governor, Clinical
Prof David Matthews	DM	Public Governor, Vale of White Horse
Ms Fiona Morrison	FM	Public Governor, Cherwell
Dr 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:

Name	Initials	Job Role
Mr Simon Crowther	SC	Acting Chief Executive Officer
Ms Rupali Alwe	RA	Head of Strategy and Partnerships Digital Services

Ms Veronica Barry	VB	Executive Director, Healthwatch Oxfordshire
Ms Olivia Clymer	OC	Head of Strategy and Partnerships Corporate
Mr Jason Dorsett	JD	Non-Executive Director
Ms Sarah Hordern	SH	Non-Executive Director
Dr Rustam Rea	RR	Deputy Chief Medical Officer/Director of Clinical Improvement
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

Apologies:

Mr Charles Adomah-Boadi	CAB	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
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 Gareth Evans	GE	Nominated Governor, Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee
Prof Helen Higham	HH	Nominated Governor, University of Oxford
Mr Tony Lloyd	TL	Public Governor, Buckinghamshire, Berkshire, Wiltshire and Gloucestershire
Ms Chris Montague-Johnson	CMJ	Public Governor, Cherwell
Dr Ascanio Tridente	AT	Public Governor, Rest of England and Wales
Ben	YPE	Nominated Governor, Young People’s Executive
Niamh	YPE	Nominated Governor, Young People’s Executive

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

1. Jonathan Montgomery, Chair of Oxford University Hospitals (OUH), apologies from governors as indicated above.

CoG26/01/02 Minutes of the Meeting Held on 12 November 2025

2. NR asked that reference to the issues she raised regarding the release of bodies was included. NS agreed to this and would contact the Patient Experience team to send an update on the progress made to NR.
3. The minutes were approved subject to this addition.

CoG26/02/03 Matters Arising

4. A briefing note outlining progress in the delivery of improved discharge processes, procedures and experience from Yvonne Christley would be sent to governors once available.
5. GS was to attend the Discharge Insurance Group meeting and would feedback his observations.

CoG26/02/04 Lead Governor Report

6. Graham Shelton (GS) reported that he would be standing down as lead governor at the end of March and that George Krasopoulos had taken on the role of Deputy Lead Governor until 31 March 2026. Nominations will be sought for both the Lead Governor and Deputy Lead Governor roles in March for the 2026/27 period.
7. GS reflected on what had been achieved during his tenure, as well as on the broader purpose of governors. He noted that, if the Trust wished to continue having governors in the future, it would be essential to emphasise what the role required going forward.
8. He observed that governors met many of their statutory obligations, although not all had yet been fully completed. Responsibilities such as remuneration, approval of significant transactions, corporate governance, and the appointment of auditors were all carried out. He added that he wished to pay tribute to the executive team who had been responsive in responding to queries, enabling him to report back to the community with confidence.
9. He highlighted that one of the major strengths of the governing body was its ability to act as the voice of the public. He reflected on the three broad types of governors, each bringing a different perspective, and stressed the importance of understanding those differing viewpoints.
10. He acknowledged that one area of difficulty had been holding Non-Executive Directors to account and emphasised the need for greater engagement with Non-Executive Directors, which he regarded as the most important aspect of the role. He expressed confidence that GK would look to further develop this.

11. JM reminded the Council that Non-Executive Directors had only two days a week to give to their roles, and governors already had access to some of that time.
12. GS also noted that, across the NHS, the commissioning of services needed to take greater account of the needs of patients. He concluded that close collaboration between governors and the executive team was essential to secure the best possible outcomes for patients.
13. JM noted that GS's frustration had often been the difficulty of knowing where governors had genuinely made a difference. JM emphasised that, as Lead Governor, GS had made a meaningful impact. He reflected that the whole NHS system was in a considerable state of flux, with the ICB only beginning to understand its future direction and not yet acting on it. He added that it was not only governors who were in a state of uncertainty.
14. JM noted that the Council still had another year of GS's support as a governor. JM confirmed that GK had already met with him for initial discussions, and he looked forward to developing that relationship further.
15. Thanks were expressed to GS for the support he had provided to the governors, whilst lead governor.

CoG26/02/05 Chair's Business

16. JM noted several further changes to Committees. Damian Haywood would become Vice Chair of the Patient Experience, Membership and Quality Committee (PEMQ) and, although there was no PEMQ report available, the quality item later in the meeting would provide an opportunity for comment. JM looked forward to continuing strong challenge on quality and membership matters.
17. Andrew Lawrie became Vice Chair of the Performance, Workforce and Finance Committee (PWF). At the 30 January PWF meeting it was agreed that AL and JH would exchange roles and that AL would become the Committee Chair moving forwards.
18. Anthony Bagot-Webb had a little longer to serve on the Remuneration, Nominations and Appointments Committee (RNAC) and Nina Robinson would assume leadership of that committee from August. A major part of her new role would be overseeing the recruitment of a new chair, as JM's term of office ended in March 2027. JM stressed the time it would take to get the recruitment process right and that the RNAC was already actively engaged in this.
19. NR reported that the AI Working Group, which she had attended along with GS and RC, had undertaken a significant amount of work. They had spent considerable time establishing the principles and criteria against which AI investment should be assessed, and they had also examined how risks ought to be evaluated before any projects were initiated. NR noted that, for any project, particularly in IT, there needed to be a clear vision or roadmap outlining the problem to be addressed, and she believed this element was still missing from the group's work. She explained that there was a need for a clear

roadmap and that it was an opportune moment for the Trust to bring together the clinical and technological perspectives.

20. JM observed that this work overlapped with discussions at Board level concerning governance around technology more broadly. He had asked Katie Kapernaros, Kenny Kamal and Ben Attwood to consider what governance arrangements were required and that arrangements would be made to brief governors at a future meeting.

CoG26/02/06 Chief Executive's Briefing

21. Simon Crowther, Interim Chief Executive reported that current themes centred on delivering the annual plan, maintaining quality and safety, and acting as a good system partner within the wider ICS, with several additional areas of focus identified by the executive team.
22. SC reported that the University of Southampton had experienced a significant fire at the weekend, resulting in the loss of 200 beds. This had affected OUH, which had offered support and accepted patients where possible. Their Chief Operating Officer had expressed thanks earlier that day for the assistance provided. Appreciation was also given to FTD for her work with partners to re-provide lost capacity.
23. The Trust had received an unannounced two-day CQC visit to neonatal services by a small inspection team. Formal feedback was awaited, but informal feedback had been positive. Further information was currently being supplied to the inspectors.
24. Nationally, there was intense focus on closing the financial year strongly in relation to patient access. NHS England was concentrating on how services could be accelerated in Q4. FTD and her team were working hard to identify what could be achieved and how current performance could be exceeded.
25. Financially, the Trust remained on plan for the current year with a strong focus on maintaining this position through to year-end. There was positive news in the form of a £29 million capital allocation from the region, primarily for the Surgical Elective Centre (SEC). JD and his team were working to determine what work could be brought forward. The allocation was regarded as recognition of the Trust's delivery against its commitments.
26. Planning for the next and future years was a major area of focus, with extensive system-level work underway, particularly with the ICB, to determine how constitutional targets would be met. Strategy work had also continued following the previous update on the strategy refresh, with feedback from stakeholders being collated.
27. The festive period and January had been challenging, with exceptionally high levels of activity and increased demand. The hard work of staff had been recognised, and it was acknowledged that staff remained under pressure, which had implications for morale and wellbeing. Despite this, the Trust had coped extremely well over Christmas and January, and thanks were extended to staff for their efforts. It remained important for the Board to listen to staff and continue offering strong support.

28. AL asked whether further information was available regarding the issues related to maternity services and the campaign group representing families who felt they had been harmed by OUH. SC reported that it continued to be an extremely busy and difficult period for the maternity team, and that time and resources were being invested in staff wellbeing. Media interest had reduced compared, although articles were still appearing locally.
29. Engagement with patient groups continued and a first engagement session had been held, with an open invitation extended to families who had raised complaints. The session focused on listening to their experiences, hearing their stories, and sharing what had already been learned. Feedback had been largely positive. The Baroness Amos review remained active and had moved into the stage of interviewing individuals, including members of the leadership team. It was expected to report in the spring.
30. LD shared that she had attended the stakeholder event and thought it went very well from an outsider's viewpoint. The Director of Midwifery and her team had given a clear and open update on where things stood, and there was plenty of active listening. She appreciated knowing that the teams were being supported, especially given the scrutiny they faced. CL mentioned that a support plan had been shared with staff, offering three levels of assistance. Schwartz Rounds were included as part of this initiative.
31. JM noted that whilst previous data had showed the Trust as an outlier on stillbirths this was based on very small numbers though need to be closely monitored. Recent perinatal data did not indicate that the Trust was an outlier, and there was confidence in the areas being reviewed.
32. JM confirmed that the next Board meeting would include a thematic review of the issues emerging from maternity complaints.
33. JM noted that Yvonne Christley (YC), Chief Nursing Officer had appointed a new deputy and commended her work in support of the maternity and neonatal teams, acting as the primary point of engagement with regulators and families.
34. GK reported that, in many services, staff continued to experience ongoing stress and that the Trust should look to implement measures to improve this and to consider what funding should be allocated to do so. He emphasised that improvements could not rely solely on the goodwill of staff who were already under pressure.
35. FTD noted that the Trust must ensure its actions align with national standards. She observed that, at times, the Trust took on tasks it had not been commissioned for, which posed difficulties. Getting the fundamentals right remained essential. Staff consistently exceeded expectations, and she highlighted the need for fairness and balance over the next three years.
36. GS brought up concerns about morale and support, underscoring the necessity of comprehensive psychological support. JM pointed out that OUH had led the way in this field, having developed a psychological medicine service over several years. Schwartz

Rounds offered a structured method, and leadership training was designed to prepare leaders with vital skills.

37. AK welcomed reassurance regarding staff support and asked if the Trust analysed staff data to identify trends. SC explained that, under the People Plan, data was collected and updated for each pledge over the next three years, which could be reviewed in future meetings to clarify decision-making. Staff survey outcomes would also be presented to governors. Joy Warmington and JM met regularly with the Freedom to Speak Up Guardians as part of a self-assessment process, and insights from the national FTSU review would shape future initiatives. They were exploring ways to gather information from the Guardians to demonstrate that speaking up resulted in change, as staff were often unaware of the outcomes.
38. RC expressed concerns about financial savings possibly affecting staff morale and questioned whether sufficient attention was being given to care quality, as excessive enthusiasm or frustration might impact staff well-being. SC explained that whilst there could be a tension between managing finances and maintaining morale, the executive team had worked diligently to find the correct balance and had introduced additional channels for staff to express concerns.

CoG26/02/07 Performance, Workforce and Finance Committee Report

39. JH reported that a PWF meeting had taken place the previous week and expressed his thanks to FTD, JD and the two NEDs involved. It had been a valuable opportunity to review the first iteration of work on the annual plan. He also noted that Andy Lawrie would be taking over as Chair of the Committee.
40. JH reported that workforce reductions and the associated risks to morale had been highlighted in Committee discussions, along with the financial risks linked to these changes. The Trust had performed reasonably well in achieving early savings through reductions in temporary staffing and bank usage, although progress on substantive staffing was more challenging. Thanks were extended to Claire Flint who had attended her final meeting of the Committee.
41. The Committee intended to consider future topics to ensure that PWF could fulfil its role effectively and develop expertise in the areas requiring deeper scrutiny, particularly planning and finance. Work would be undertaken to clarify what the Council needed to focus on. Kenny Kamal would be joining to support discussions on technology. Governors would need to identify the areas where further attention was required.

CoG26/02/08 2026/27 Annual Planning Update

42. FTD noted that this year's NHS planning required not only a one-year plan but also three- and five-year plans submitted earlier than usual, with an emphasis on consistency across domains. The initial plan had been submitted in December, with the final three-year plan was set for Board approval in February, and a five-year narrative also requested.

43. National priorities remained urgent and emergency care, four- and twelve-hour standards, RTT, and cancer performance. Longer-term planning enabled more realistic forecasts: key operational standards were expected to be met in year three, aided by changes to radiotherapy tariffs and new funding for the Surgical Elective Centre, which would expand capacity for both emergency and elective treatments and was critical for the delivery of the plans. Seven new operating theatres were scheduled to become operational in the summer, with funding secured for outfitting a second floor.
44. The Board was required to approve assurance statements detailing completed work and relevant information. The plan aligned with national expectations and mandated priorities. While aiming for innovation as both a general hospital and specialist centre, the Trust faced challenging three- and five-year plans but was positioned to set a break-even budget for the next year.
45. JD indicated that the workforce plan entailed a net reduction of several hundred staff, though certain areas—most notably surgical teams—would see an increase. NHS England had stressed the importance of addressing the productivity challenge across the NHS, highlighting that national productivity had not returned to pre-pandemic levels. OUH's productivity was comparatively robust at only 2.8% below pre-pandemic figures. However staffing numbers and expenditure on additional activities had grown considerably.
46. A clinical and corporate services efficiency target of 3.5% had been set. Furthermore, a strategic review was underway to evaluate how effectively each activity aligned with the Trust’s strategic objectives. There were limits to further demands on staff and non-strategic activities might need to be discontinued.
47. GK discussed NHS productivity, noting that there was substantial variance and questioning whether the goal should be to improve low points or enhance high points, warning that focusing only on troughs might hinder high performing areas.
48. JD noted that urgent care pathways had seen major improvements in waiting times with very little additional investment. There was not always a direct correlation between increased resources and improved care delivery.
49. JM remarked that many organisations had initiated formal redundancy procedures, whereas OUH had concentrated on establishing optimal workforce sizing. The objective was to approach a professional baseline of requirements. A nursing establishment review had been completed, and it was acknowledged that the Trust employed more doctors than comparable trusts, although the underlying causes remained unclear with work underway in this area.
50. Emergency Department performance and waiting times were closely monitored, and the Trust now ranked among the top 20 nationally for ED performance. However, it remained in the lower half concerning waiting lists. JM noted that some degree of extended waiting times would persist due to specialist team requirements and limited capacity.

51. JP enquired about the monitoring of sickness absence, observing that some teams operated with reduced staff due to illness. FTD confirmed comprehensive reviews for paediatric teams, as well as administrative and clerical divisions, identifying hotspots for ongoing surveillance through quarterly performance reports.
52. LD welcomed the longer-term planning and noted the need to consider, digital developments and community provision as part of the three-shifts. FTD explained that the Trust had worked closely with system partners and needed to reflect on services it already delivered and recognise its responsibility to help make system-wide changes happen.
53. NR supported the plan whilst advocating for cultural change as a key enabler so that teams were empowered to take responsibility instead of relying on direction from leadership. SC agreed, emphasising the need for openness and patience to support cultural transformation, which depended on trust and staff support.
54. DM argued morale isn’t just tied to headcount, and cited improved environments, such as new equipment in the Eye Hospital, as boosting diagnostic speed and staff wellbeing. He recommended routinely assessing the time saved and impact on staff by such upgrades.

CoG26/02/09 OUH’s Partnerships and Networks

55. Olivia Clymer, Director of Strategy, provided an overview of partnership arrangements, highlighting improvements and efforts to translate research into community benefit, notably through the Oxford Local Policy Lab and the Primary Care Interface Network. Shelford highlighted as a collaborative forum for teaching hospitals, providing advocacy and benchmarking opportunities, though with limited participation. Partnerships with organisations like Marmot, LNPB, DEFRA, OHC, and specialist charities deepened understanding of patient needs in specific areas.
56. A diagram mapped various partnership types, and next steps were outlined. JM referenced recent Board discussions about identifying interested partners and leveraging existing connections effectively.
57. SC commented that Shelford added value through policy influence, feedback, and benchmarking, such as comparing BAF across trusts, while also supporting chief officers with peer support.
58. GK stated partnerships extend locally and nationally, but noted that the organisation was globally recognised and attracted interest from companies due to clinicians’ desire to collaborate. JM noted much activity goes unrecorded at the organisational level and that whilst historically viewed as inward-focused, the organisation has become more outward-looking.

CoG26/02/10 Future Patient Engagement Arrangements

59. Dr Veronica Barry, Executive Director of Healthwatch Oxfordshire, explained that the organisation was part of a national network of 152 independent charities funded by central government via local councils. Their small team gathered feedback from health and care service users through surveys, community engagement, and collaboration with partners. They reported to the Health and Wellbeing Board and had reached over 49,700 people since 2020 including activities such as travelling along the canals to speak with people living on boats about their access to services.
60. This year, their focus had included digital health, women's health services, trans and non-binary services, GP practices, and urgent care navigation. Their statutory "enter and view" function allowed them to visit health services, leading to recommendations and educational films. They used community research to reach underrepresented groups and track impact on their website.
61. A county-level report addressed the upcoming abolition of Healthwatch England and local bodies, with April 2027 as a tentative date and no clear replacement model yet proposed. Oxfordshire County Council supported maintaining an independent voice, and Healthwatch Oxfordshire aimed to be involved in future discussions.
62. Questions arose about collaboration between Healthwatch and governors, with both agreeing they offered parallel but distinct functions and could work together effectively. The value of Healthwatch's independent feedback was emphasised, and there was a need for a new model to fill the anticipated gap. Governors were invited to share input for ongoing discussions.

CoG26/02/11 Quality Conversation and Quality Priorities

63. Deputy Chief Medical Officer Rustam Rea gave an update on recent Quality Conversation discussions and the Trust's quality priorities which were soon to be reviewed by PEMQ.
64. Nine priorities had been shaped through feedback from events like the Quality Conversation, attended by seventy-two people who provided valuable insights into defining quality and ensuring consistent standards across the Trust. Several previous priorities would continue into the following year.
65. Dr Rea gave an overview of key priorities including ongoing work in venous thromboembolism prevention including both technological and cultural improvements and Martha's Rule, a national patient-safety initiative for escalation when patients or families feel unheard. Processes for patient discharge were also under review for safety and reliability. The Trust was exploring AI to support staff, patients, and daily operations, as well as reviewing the visibility and use of ReSPECT forms. Aletha Bicknell was leading efforts in public and patient involvement, focusing on partnership and engagement. Improving maternity patient experience also remained a key priority, with continued efforts to listen to women and families.

66. These areas would be examined further through PEMQ. GK asked how the Trust would measure progress and it was noted that SMART metrics would be developed and benchmarked against relevant peers, with annual reviews to identify routine practices versus those needing further attention.
67. JM stated that once priorities were integrated, new areas could be addressed, while some might persist or change over time. LD enquired about methodologies and staff training, highlighting the need for robust quality-improvement methods, including knowing how many staff are trained and involved. RR explained that several training modules existed, including student involvement, and emphasised the Trust's commitment to the consistent application of QI methodology.
68. AA asked how members of her constituency should raise challenges and concerns. RR responded that PALS should be the first contact for service-specific issues, followed by the complaints service or the patient-safety team for safety concerns. The Trust aimed to listen and learn for future improvements. AK asked about communication with the community; RR outlined various channels, including social media and partner Trusts via the Communications team, striving to share both positive developments and areas needing attention. Simon added that while engagement was strong, there was room for improvement and the Trust must balance efforts to maintain effective relationships.

CoG26/02/12 Any Other Business

69. There was no further business.

CoG26/02/13 Date of Next Meeting 27 May 2026

70. The meeting will take place on Wednesday 27 May.