Trust Board Meeting in Public

Minutes of the Trust Board Meeting in Public held on **Wednesday 30 September 2026**, Unipart House, Garsington Road, Cowley, Oxford

Present:

Name	Job Role
Sir Andrew Morris	Trust Chair
Prof Meghana Pandit	Chief Executive Officer
Mr Simon Crowther	Interim Chief Executive Officer
Dr Ben Attwood	Chief Digital and Information Officer
Prof Andrew Brent	Chief Medical Officer
Mr Paul Dean	Non-Executive Director
Mr Jason Dorsett	Chief Finance Officer
Dr Claire Feehily	Non-Executive Director
Mrs Lynne Graham	Non-Executive Director
Ms Lisa Hofen	Chief Estates and Facilities Officer
Ms Sarah Hordern	Non-Executive Director
Mr Kenny Kamal	Non-Executive Director
Mr Jay Mistry	Interim Chief Strategy Officer
Mr Terry Roberts	Chief People Officer
Prof Gavin Screaton	Non-Executive Director
Ms Felicity Taylor-Drewe	Chief Operating Officer
Ms Joy Warmington	Non-Executive Director [from Minute TB26/09/06]

In Attendance:

Dr Neil Scotchmer	Head of Corporate Governance
Dr Laura Lauer	Deputy Head of Corporate Governance [Minutes]
Ms Laura Bick	Director of Workforce [Minute TB26/09/07 only]
Ms Nona Stevenson	Assistant Director of Workforce [Minute TB26/09/07 only]
Dr Amit Gupta	Clinical Lead for Neonatal Care [Minute TB26/09/08 only]
Ms Milica Redfearn	Director of Midwifery [Minute TB26/09/08 only]
Mr Florian Stoermer	Divisional Director of Nursing, SuWOn [Minute TB26/09/08 only]
Prof Katie Jeffery	Director of Infection Prevention and Control [Minute TB26/09/10 only]

Dr Larry Fitton	Divisional Director, MRC [Minute TB26/09/15 only]

Apologies:

Ms Yvonne Christley	Chief Nursing Officer
Prof Ash Soni	Non-Executive Director

TB26/09/01 Welcome, Apologies and Declarations of Interest

1. Apologies were received as recorded above.
2. The Chair reported that he had resigned as an NHS England (NHSE) Non-Executive Director (NED) with effect from 31 August 2026.
3. The Chair reported that his term as NED at University Hospitals Birmingham NHS Foundation Trust would end on 30 November 2026. The Chair would recuse himself from any discussions with the potential to create a conflict with his role as Chair of Oxford University Hospitals NHS Foundation Trust.
4. There were no other declarations of interest.

TB26/09/02 Minutes of the Meeting Held on 29 July 2026 [TB2026.70]

5. The minutes were approved.

TB26/09/03 Action Log and Matters Arising [TB2026.71]

6. The Board agreed to close actions TB25/11/11, TB26/07/15 and TB26/07/18, noting respectively that the Learning from Deaths Annual Report described how resulting actions had been implemented and embedded; the Integrated Assurance Committee had received assurance on positive patient identification and WHO checklist compliance through the Patient Safety Incident Response Framework report; and the Trust Management Executive report now included the required statement on active enforcement notices.
7. The Board received updates on actions TB26/07/09, TB26/07/12 and TB25/07/15. Proposals to simplify and consolidate perinatal management and governance arrangements, including estates and digital risks, would be considered by the Trust Management Executive before returning to the Board. Chief Officer discussions on the levers available to prevent staff suffering detriment after speaking up remained in progress as part of the Freedom to Speak Up review. A proposal on predictive modelling and demand forecasting with system and research partners would be presented to the Quality and Performance Committee in October 2026.

TB26/09/04 Chair's Business

8. Following discussion at the Integrated Assurance Committee on 9 September, the Chair took action on 24 September to approve the Oxford University Hospitals Maternity and Neonatal Services baseline assessment return and accompanying Maternity Triage Specification Benchmarking Audit Tool ahead of its submission to NHSE on 28 September 2026. The submitted return formed part of the papers for the meeting.
9. The Council of Governors approved the appointment of two NEDs: one of whom will chair the Quality and Performance Committee and the other to chair the Audit and Risk Committee. It is hoped that both will be able to join the Board before the end of the year and an announcement would be made at the appropriate time.
10. A strategy session would be held in October to consolidate previous work on alignment with the three shifts in the NHS 10 Year Plan and to focus on alternative models of care. The intention was to bring the strategy to the Board in November 2026, having undertaken consultation with the Council of Governors.
11. The Chair reported that the Care Quality Commission (CQC) were conducting an unannounced inspection of Maternity services at the John Radcliffe Hospital. The service had previously been rated as Good. He noted that the Good rating for Maternity and Neonates put the Trust in the top third of trusts.

TB26/09/05 Chief Executive's Report [TB2026.72]

12. The Interim Chief Executive Officer reported that the Chief Nursing Officer was coordinating the Trust's response to the unannounced Care Quality Commission inspection of maternity services. He recognised the work undertaken by staff following the service's existing Good rating and noted investment in maternity services at the John Radcliffe and Horton General Hospitals, together with investment in audiology and laparoscopic services at the Horton. The Surgical Elective Centre remained scheduled to open in early November 2026.
13. The Trust had begun reviewing the recommendations of the Thirlwall Inquiry Report and was responding to NHS England's immediate requirements, including those concerning safeguarding. The full implications and the Trust's response would be considered formally by the Board in November 2026.
14. The Board noted the launch of the NHS Staff Survey and associated engagement activity, including "You Said, We Did" sessions. It also noted the review of the Trust's values and its intended contribution to the strategy refresh. Urgent and emergency care performance remained comparatively strong but had not reached the required level. The Trust was also working with Thames Valley Police in response to an increase in incidents of violence and aggression.
15. The Trust Board noted the report.

TB26/09/06 Proposed Board Objectives, October 2026 – March 2027 [TB2026.73]

16. The Interim CEO introduced the proposed six organisational objectives for the period October 2026 to March 2027. He explained that the objectives were intended to focus the organisation on its key priorities for the remainder of 2026/27 and to provide a clear framework for executive leadership, organisational prioritisation and Board oversight.

17. The Board welcomed the proposed approach and emphasised the importance of ensuring clarity and alignment between the objectives agreed at Board level and their delivery throughout the organisation. Members considered that there should be a clear line of sight from the Board's priorities through to individual services and teams, enabling staff to understand how their work contributed to delivery of the Trust's objectives.

18. The Interim CEO confirmed that a grid-style progress report would be brought to future Board meetings. The Board requested that this should include more granular information for each objective, including the responsible executive lead, relevant measures, targets, progress, and committee oversight.

19. The Board requested that the relevant NHS Oversight Framework metrics should be mapped against each objective. Members also considered the proposed strategic transformation objective and agreed that approval of the refreshed Trust strategy should be identified explicitly as an objective.

20. Committee Chairs would receive an appropriate suite of information on the relevant leads, targets and progress to support effective scrutiny.

21. The Trust Board:

    - Approved the six organisational objectives for the period October 2026 to March 2027.
    - Agreed that progress against these objectives would be monitored through the Integrated Performance Report, Board Assurance Framework and committee reporting arrangements.
    - Agreed that these objectives provided the framework for executive focus, organisational prioritisation and Board oversight for the remainder of 2026/27.

TB26/09/07 Staff Perspective

22. The Chief People Officer introduced the anonymised experiences of two members of staff following a report of sexual harassment. He thanked them for sharing their account and confirmed that tackling bullying and harassment remained a priority within the People Plan.

23. The account, read by the Director of Workforce and Assistant Director of Workforce, highlighted the importance of keeping those involved in investigations appropriately informed. The Board recognised the need to balance confidentiality with timely communication and appropriate support for those who had raised concerns.
24. Members considered the competence, experience and capacity required of case managers. The Chief People Officer advised that trained case managers needed sufficient protected time away from their substantive duties and that aptitude for sensitive case management should be considered when recruiting senior leaders. The Board recognised the additional complexity of cases involving medical staff and the operational and resource implications of releasing senior staff to undertake investigations.
25. The Board examined the psychological and welfare support available to complainants, respondents and others affected by investigations. Round-the-clock staff support and psychological-support leads were available; however, the existing staff psychological support service did not support individuals while they were undergoing these investigation processes. Further options were being considered through Chief Officers.
26. Members considered whether a clearly accountable liaison role was required to maintain contact throughout an investigation. The Chief People Officer advised that responsibilities were shared between the case manager and welfare officer. The Board emphasised that these arrangements depended on clear accountability, adequate resources and sufficient time.
27. The Board noted that the quality and consistency of investigations affected organisational culture, psychological safety and confidence in speaking up. The Chief People Officer referred to the Trust's "No Excuses" approach. Forthcoming NHS England guidance was expected to strengthen the rigour and consistency of investigations; poor practice could have profound consequences, including employment tribunal proceedings.
28. Staff Survey data indicated that approximately 1,000 staff had reported sexual harassment by a colleague, with a greater number reporting harassment by patients. Members emphasised responsible and consistent use of organisational and professional authority and the need to consider at an early stage the effects of investigations on teams and patient services.
29. The Trust Chair asked the People Committee to scrutinise the effectiveness and consistency of investigation processes, support and protected time for case managers, communication and liaison arrangements, and psychological and welfare support for all parties, and to develop an appropriate protocol.
30. The Trust Board noted the Staff Perspective.

TB26/09/08 Maternity and Neonatal Reporting

Perinatal Quality Oversight Report [TB2026.74]

31. The Director of Midwifery advised that the Trust's perinatal safety systems remained stable and that outcome measures had remained consistent. However, only partial assurance could be provided in relation to compliance with venous thromboembolism (VTE) risk assessments and the endorsement of test results, where further improvement and evidence of sustained compliance were required.
32. 592 women had given birth to 598 babies during the reporting period and that there had been no Never Events. Compliance with core requirements remained above 90%.
33. The revised fetal growth surveillance pathway had been fully aligned with the Saving Babies' Lives Care Bundle and compliance with the Care Bundle remained strong.
34. VTE risk assessment compliance had improved but remained below the required target. Improvement work had therefore focused on embedding VTE assessment within admission processes, ward rounds and safety huddles, alongside strengthening the digital VTE assessment tool. All exceptions had been reviewed. No cases had been identified in which an assessment had not been completed within 14 hours, and no associated patient harm had been reported. Compliance with the endorsement of test results also remained below target, and a similar improvement approach was being applied.
35. It was noted that implementation of the electronic patient record had been expected to support improvement of results endorsement, but that difficulties remained, including in relation to requests made by community midwives. The Director of Midwifery confirmed that work had been undertaken to ensure that requests were followed up. The Board considered whether further work was required to provide the required assurance.
36. It was clarified that individual clinicians remained responsible for endorsing their own results and it was intended to appoint a clinical lead to oversee the wider improvement work.
37. 286 incidents had been reported, of which 53 had been graded as moderate or above. All had been managed through the Patient Safety Incident Response Framework. Considerable progress had been made in reducing the backlog of overdue incidents, from 98 cases to 38 in August and subsequently to 15 in September.
38. Incident information was being triangulated with complaints data to identify themes and learning. In relation to one Grade C case, the Board was advised that the case had been considered through the Perinatal Mortality Review Tool

process, that learning had been identified and that a Patient Safety Incident Investigation was under way.

39. The Director of Midwifery reported that community maternity services had supported 107 births during the first quarter and that there had been no closures of midwifery-led units. There had been no red Operational Pressures Escalation Level shifts, no loss of one-to-one care in labour and no suspension of community services. Recruitment was progressing, with 21.72 whole-time equivalent newly qualified staff expected to commence employment between September and November 2026. The Board was also assured that none of the 25 reported intrapartum transfers had resulted in an adverse outcome.

40. Improvement priorities included maternity triage, implementation of the Birmingham Symptom-specific Obstetric Triage System, listening to women, pain management and postnatal self-medication. The Board was advised that the Maternity Assessment Unit had experienced high acuity during August, but an improvement sprint had increased the proportion of women receiving an initial assessment within 15 minutes to 72%.

41. The Clinical Lead for Neonates reported that activity had remained stable. Forty-eight per cent of nurses were qualified in specialty, which remained below the desired level but was on an improving trajectory. Approximately 90% of nurses deployed on each shift were qualified in specialty, and all eligible preterm babies had been born in the appropriate place. Work was continuing to accelerate improvements to the patient-record pathway and address estates issues.

42. The Board noted that the Maternity Incentive Scheme remained on track, although further assurance was required in relation to equity, workforce capacity and Board-level oversight. A level one Maternity Outcomes Signal System alert had been received on 27 August 2026 and the required safety check had been completed.

43. Members discussed the immediate recommendations arising from the Thirlwall Report, including the possible use of CCTV. Concern was expressed about the implications of staff being recorded continuously. The Board was advised that the Thirlwall recommendations, as well as medical gases and the Trust’s response to the local Amos plan were being considered through an established task and finish group. Progress had been made in relation to medical gases, supported by a Trust-wide programme led by the Chief Pharmacist.

44. The Board welcomed the revised format of the report but requested that quantitative information should be accompanied by clearer trend data, including trajectories showing how identified risks and areas of non-compliance were expected to improve towards target and whether these represented material concerns. Statistical process control charts were available within the appendices, but members considered that the principal report should make the relevant assurance and supporting evidence easier to identify.

45. The Board noted the estates risks affecting maternity and neonatal services. It was advised that significant work was under way to resolve the immediate flooding issue, while longer-term work would be required to address constraints relating to space.

46. The Trust Board:

- Noted the assurance provided that perinatal safety systems were in place and outcome measures remained stable.

- Noted partial assurance provided regarding VTE risk assessment and test result endorsement compliance, where further work was required to demonstrate sustained improvement.

National Maternity and Neonatal Investigation Submission – 10 Point Plan [TB2026.75]

47. The Trust Board noted the submission, which had been discussed at Integrated Assurance Committee and approved by Chair's Action.

Maternity Incentive Scheme Year 8 Safety Action C and Perinatal Mortality Quarter 1 2026/27 Report [TB2026.76]

48. The Chief Medical Officer (CMO) introduced the report and advised the Board that all cases reviewed under the Perinatal Mortality Review Tool (PMRT) had been graded A or B.

49. The Director of Midwifery reported that there had been ten perinatal deaths during the first quarter. All cases reviewed through the PMRT process. The reviews had included appropriate national input and involvement from the Oxfordshire Maternity and Neonatal Voices Partnership, providing an external and patient-focused perspective within the review process.

50. The principal recurring themes identified through the reviews and wider safety intelligence had related to communication, shared decision-making, fetal monitoring, escalation, the quality of clinical documentation and postnatal pathways. These themes were being used to inform improvement priorities and ongoing monitoring arrangements. The Board was advised that there were emerging signs of improvement, including significant reductions in issues relating to induction of labour and postpartum haemorrhage.

51. The Board sought assurance on the current position in relation to postnatal readmissions. The Director of Midwifery advised that improvement was being seen and that postnatal readmissions had not emerged as an exception within the current reporting period. Multidisciplinary work to address the contributing factors, including infant feeding and other elements of the postnatal pathway, was underway. The CMO reminded the Board that the exception reported in the previous month had been investigated and that no concerns regarding the care provided had been identified.

52. The Board noted that completeness of equity data remained an identified assurance gap and that the current information did not enable sufficiently robust assessment of whether outcomes, experiences or access to care varied between diverse groups. Addressing this gap would form a key part of the Trust's response to the 10-Point Plan.
53. The Chair observed that maternity services were subject to an exceptional level of scrutiny and that it was right to aspire to and Excellent rating from the CQC. He observed that the service had some outstanding clinicians and staff commitment to improvement was palpable.
54. The Chair thanked Ms Redfearn, Director of Midwifery, who would shortly leave the Trust to take up a position at Great Western Hospitals NHS Foundation Trust.
55. The Trust Board:

- Noted the findings of the Quarter 1 PMRT and Maternity Safety Intelligence and Learning Report.
- Took assurance that learning from PMRT reviews, incidents, MNSI investigations, claims intelligence, patient experience and governance processes was being triangulated in accordance with MIS Year 8 Safety Action C requirements.
- Noted the recurring themes relating to communication, shared decision-making, fetal monitoring, escalation, documentation quality and postnatal pathways.
- Supported ongoing delivery of improvement actions and monitoring arrangements associated with these themes.
- Continued oversight of MIS Year 8 requirements and emerging national maternity safety programmes.
- Noted the current assurance gaps relating to evidence of sustained impact, workforce metrics, equity data completeness, parental involvement outcomes and independent scrutiny, and support strengthened reporting of these areas in future quarterly updates.

TB26/09/09 Learning from Deaths Annual Report [TB2026.77]

56. The CMO reported that the Trust continued to benchmark favourably against the principal national mortality indicators, with no clinical areas showing higher-than-expected mortality. The report described how learning from reviews had been translated into service and organisational improvement and how resulting actions had been implemented and embedded.
57. Two deaths had been assessed as potentially avoidable. Following the death of an adult patient admitted with a pulmonary embolism, actions had been identified

for the relevant service and the wider Trust concerning venous thromboembolism assessment and management.

58. Following the death of an infant from sepsis after a rectal biopsy, a Patient Safety Incident Investigation had identified an absence of relevant national or local guidance. The Trust had developed guidance and shared the learning; a wider review had found no comparable gaps for other procedures.

59. The CMO confirmed that the duty of candour had been discharged.

60. The Trust Board noted the report.

TB26/09/10 Infection Prevention and Control Annual Report [TB2026.78]

61. The Director of Infection Prevention and Control reported a positive overall position and confirmed that external reporting requirements had been met. Clostridioides difficile infections had reduced by 33% and remained below the national trajectory; MRSA infections had reduced from nine to six, although the target remained zero. Staphylococcus aureus and E. coli continued to present challenges.

62. The Board noted the Trust's designation as an Airborne High Consequence Infectious Diseases Centre and continuing water-safety challenges, particularly at the Churchill Hospital.

63. Prof Jeffery reporting continuing challenges relating to water safety, particularly at the Churchill Hospital. Work was under way to address the outstanding matters, and it was anticipated that these could be brought to closure.

64. The implementation of the ICNET surveillance system was expected to provide more comprehensive coverage and improve the reliability of the available information.

65. In discussing the Trust's position against the NHS Oversight Framework, members questioned why the Trust was not achieving a higher score despite the improvements reported. The Trust's size contributed to the absolute number of infections reported and that the Trust's strong blood-culture ascertainment rate meant that infections were more likely to be identified.

66. The Board sought further information about the extent and distribution of surgical site infections. Prof Jeffery advised that the implementation of ICNET, which would link to theatre data, was expected to strengthen the Trust's ability to identify and monitor surgical site infections. Specialist infection prevention nursing capacity was not available in all areas following the loss of posts during budget-setting. Spinal surgery had been identified as the principal area of concern.

67. The Chief Digital and Information Officer confirmed that ICNET had required a third-party solution. The possible move towards locally developed solutions would be considered in private session.

68. The Trust Board noted the report.

TB26/09/11 Responsible Officer's Revalidation Annual Report [TB2026.79]

69. The CMO reported that the medical appraisal completion rate had remained high. Performance had improved from 96%, which had itself been above the previous year's position, to 98% at the time of the meeting. The CMO recorded his gratitude to the Trust's medical appraisers for their contribution to maintaining this level of performance.

70. The CMO advised that growth in the number of doctors employed by the Trust had placed additional pressure on the available pool of appraisers, which would likely need to increase. In the interim, the pressure was being mitigated through agile allocation of appraisal capacity across the organisation.

71. The Board noted an increase in recommendations to defer revalidation. It was explained that deferral did not necessarily indicate a concern about an individual doctor's practice and could arise where required supporting information had not been completed within the relevant timescale. Delayed patient feedback had been a frequent reason for deferral. The Trust had also identified non-consultant doctors as a group for whom additional support should be focused.

72. The CMO clarified the distinction between revalidation and annual appraisal. Revalidation was a General Medical Council process, normally undertaken every five years, through which a doctor demonstrated continued fitness to practise. Annual appraisal provided a broader opportunity for reflection and consideration of practice. Where concerns or development needs were identified during appraisal, these were escalated appropriately. Such matters could relate to support required by an individual doctor or could identify wider issues requiring organisational attention.

73. Doctors undergoing appraisal were required to evidence their practice against the principal domains of professional medical practice, which included behaviour. Concerns about conduct or behaviour would generally also be addressed through the Trust's employee relations processes. Where such a process was under way, the doctor would be expected to declare it as part of the appraisal and revalidation arrangements.

74. The Trust Board:

- Noted the report;
- Noted that the report would be shared with the Trust Board and Tier 2 Responsible Officer at NHS England.

- Noted the Statement of Compliance which confirmed that the Trust, as a Designated Body, was in compliance with the Regulations. This would be signed by the OUH Chief Executive as required by NHS England.
- Noted the Statement of Compliance for Helen and Douglas House for which the Trust provided Responsible Officer Services, which confirmed compliance with regulations. This would be signed by the Board of Helen and Douglas House as required by NHS England.

TB26/09/12 NHS Oversight Framework 2026/27 [TB2026.80]

75. The Chief Operating Officer reported that the Trust had been placed in segment 3 for Quarter 1, reflecting its overall position across the Framework indicators and informing NHS England's continuing oversight and engagement.
76. The Trust's mid-year review with NHS England was scheduled for 5 October 2026. Key lines of enquiry had been received and were being reviewed with accountable officers; the outcome would inform subsequent performance oversight and reporting.
77. The Trust Board noted the Framework summary, new measures and governance arrangements; approved publication within the Integrated Performance Report of a new summary covering the new indicators, the timing methodology used in scoring, consistent templates and accountable officers aligned with existing metrics; and noted continued monitoring through the OUH Performance Management and Accountability Framework.

TB26/09/13 Integrated Performance Report Month 5 [TB2026.81]

78. The Interim Chief Executive Officer advised that the report would be developed to present performance more directly against the agreed Board objectives. The metric for establishing clinical research trials had improved and was expected to improve further in Quarter 3.
79. The Trust had scored 4 against the national readmission metric because NHS England's revised methodology differed from the Trust's established data collection approach. Other Shelford Group trusts using the same approach were similarly affected, and the methodological issue had been escalated to NHS England.
80. A rapid review had found no evidence of clinical harm. The CMO cited the Trust's extensive use of same-day emergency care as a key factor, as activity delivered through that model was captured as admissions.
81. Response performance for complaints, Freedom of Information requests and Subject Access Requests had deteriorated owing to increasing volume, complexity and capacity pressures. The Freedom of Information position included

a one-month spike. The Delivery Committee continued to monitor performance and the Board requested an update on response rates.

82. Cancer performance had improved by approximately 2.5%, although Cambridge University Hospitals had achieved a greater improvement of approximately 12.5%. A visit was planned to understand its approach. The Trust remained on plan for the Faster Diagnosis Standard; the 62-day standard and backlog remained the principal concerns, with marked but sustainable improvement anticipated in Quarter 4. The Chief Operating Officer clarified that the Surgical Elective Centre would support delivery but would not itself improve cancer performance. Urology performance had improved by approximately 50%, radiology and MRI reporting delays had been addressed, and local and national support remained in place.

83. Members requested clearer exception reporting, including a traffic-light presentation and clearer information on the timing of data sources. The Trust Board noted the report.

TB26/09/14 Finance Report Month 5 [TB2026.82]

84. The Chair of the Finance Committee, Ms Hordern, provided a verbal update from the Committee meeting held earlier that morning.

Alert

85. The Board was advised that the Trust's financial position was £2.5 million adverse to plan. One-off adjustments had mitigated the immediate effect of increased expenditure on temporary staffing; however, the Finance Committee had emphasised that temporary staffing costs needed to be brought under control.

86. The delivery of the Cost Improvement Programme (CIP) remained heavily weighted towards the latter part of the financial year. The Trust was delivering the required level of savings, but there was limited scope for slippage and delivery needed to remain on track during the remaining six months of the year. The financial route map agreed with NHSE contained significant challenges and required the Trust to deliver its underlying financial assumptions in full.

87. The Finance Committee had requested improvements to CIP reporting so that the timing, status and sustainability of delivery could be seen more clearly. Divisions were generally making satisfactory progress, while also continuing to recover elements of the previous year's position.

88. SuWOn was identified as the division facing the most significant challenge with concerns about the effectiveness of pay controls and activity-driven income being behind plan. These pressures were directly connected to the Division's operational performance and could not therefore be addressed solely through

financial controls. Improvement would require coordinated action to strengthen workforce and pay management while also improving the delivery of activity and the associated income. Chief Officers were supporting the Division to deliver improvement.

89. Ms Hordern provided an update on cash. Following consideration by the Trust Management Executive, the risk rating associated with cash had been reduced. The forecast indicated that a cash pressure was likely to arise during Quarter 4 and that external cash support might be required. The relevant risk-rating score should increase to reflect the forecast position.
90. The Chair emphasised the importance of delivering its 2026/27 financial plan and establishing a balanced position.
91. The Trust Board noted the report.

TB26/09/15 Winter Preparedness Plan 2026/27 [TB2026.83]

92. The Chief Operating Officer (COO) introduced the Winter Preparedness Plan 2026/27, supported by the Divisional Director for MRC. The Plan had been developed and stress-tested with divisional teams, the Integrated Care Board and local authority partners, drawing on learning from the previous winter and periods of pressure caused by summer heatwaves.
93. The COO outlined risks and dependencies, including delays to the development of Level 1, the impact of Surgical Elective Centre (SEC) activity on the existing bed base, and staff sickness. The Board heard that the impact of SEC activity had been planned for and the issue was well understood.
94. Members noted delays associated with the high-rise building works and emphasised that delivery of the resulting capacity should remain under close review.
95. The Horton General Hospital (HGH) had implemented a “perfect week” exercise; HGH’s importance to Trust-wide flow and performance was recognised.
96. The number of patients medically optimised for discharge had remained above 100 during recent months against a preferred level of below 80.
97. Assurance was provided on relationships with the ambulance service and the establishment of clear divisional escalation arrangements.
98. The COO confirmed that corridor care was not used on inpatient wards, and only in two areas across the Trust. A task and finish group was reviewing the position at the John Radcliffe Hospital. The Trust’s self-assessment on corridor care compliance was 73%.

99. The Trust remained focused on releasing ambulances within 45 minutes, maximising use of the discharge lounge and refining length-of-stay and safe-discharge arrangements.

100. Members expressed concern about the potential impact of cost-of-living, heating and transport pressures on lower-paid staff be considered separately.

101. The Trust Board:

- Noted the national requirements for Winter Planning 2026/27;
- Approved the Winter Preparedness Plan 2026/27 and supporting Board Assurance Statement for submission by 30 September 2026, subject to incorporation of outputs from the regional and Place level winter stress-testing exercise;
- Noted the key risks and dependencies, including Level 1 capacity, Ward 5B, Surgical Elective Centre activity, discharge performance, workforce resilience, vaccination uptake and Launch Point implementation;
- Supported completion of surge and extreme-surge stress testing and recognise financial risk to EDF, if additional capacity requirements were enabled through the correct governance channels;
- Supported escalation unresolved system dependencies to the ICB, including community alternatives, social care, intermediate care, cross-border discharge, urgent transport and plans to reduce occupancy before Christmas; and
- Required ongoing monitoring of surge-capacity utilisation and associated workforce and financial impacts throughout winter 2026/27, in line with previous winter periods.

TB26/09/16 Regular Reporting Items

Finance Committee Report [TB2026.84]

102. The Trust Board:

- noted the Finance Committee's report from its meeting held on 26 August 2026, considered the matters escalated under Alert, noted the areas of partial assurance set out under Advise, took assurance from the matters set out under Assure; and
- approved the updated Finance Committee Terms of Reference.

Integrated Assurance Committee Report [TB2026.85]

103. The Trust Board noted the Integrated Assurance Committee report from its meeting held on 9 September 2026, considered the matters escalated under

Alert, noted the areas of partial assurance set out under Advise, and took assurance from the matters set out under Assure.

Trust Management Executive Report [TB2026.86]

104. The Trust Board noted the Trust Management Executive report from its meetings held on 30 July, 13 August, 27 August and 10 September 2026, considered the matters escalated under Alert, noted the areas of partial assurance set out under Advise, and took assurance from the matters set out under Assure.

Consultant Appointments and Sealing of Documents [TB2026.87]

105. The Trust Board noted the Medical Consultant appointments made by Advisory Appointment Committees under delegated authority and noted that signings had been undertaken in line with the Trust's Standing Orders since the last report to the Trust Board at its meeting on 29 July 2026.

TB26/09/17 Any Other Business

106. None.

TB26/09/18 Date of Next Meeting

107. The next meeting of the Trust Board in Public will take place on **Wednesday 25 November 2026**.