# Oxford University Hospitals NHS Foundation Trust

# Annual Report and Accounts 2023-2024

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# Foreword and Statement on Performance

**Welcome to the Annual Report of Oxford University Hospitals NHS Foundation Trust for the period 1 April 2023 to 31 March 2024.**

***Introduction***

On behalf of the Board of Directors of Oxford University Hospitals (OUH) NHS Foundation Trust, I would like to thank all our people for working together as OneTeamOneOUH towards achieving our OUH Vision of being an exemplar in healthcare delivery that is compassionate, and enabled by the highest levels of research and innovation.

During my first full year as the Trust's permanent Chief Executive Officer, my Chief Officer colleagues and I have developed a Three-year Plan 2024-27 to enable us to deliver the OUH Vision. The Plan is underpinned by four strategic pillars, People, Patient care, Performance and Partnerships, which are the building blocks of all that we can achieve together.

The Three-year Plan is aligned to our Clinical Strategy 2023-28, which was co-created with colleagues across the Trust and launched in March 2023. The Three-year Plan will deliver against the ambitions set out in the Clinical Strategy.

I am proud to have led our OneTeamOneOUH as we supported each other to face challenges and to provide excellent, compassionate care for our patients and populations.

***People***

We made positive progress in 2023/24 in delivering against our OUH People Plan priorities in order to make OUH a great place to work where we all feel we belong. We saw improvements against a range of workforce metrics including staff turnover reducing to 10.2% from 11.4% in 2022/23, and sickness absence rate reducing to 3.8% from 4.3% in 2022/23.

Our annual NHS Staff Survey results, published in March 2024, also showed some encouraging improvements. The Trust scored above the national average on 77% of questions in the survey. The key areas where our survey scores improved year-on-year showed that 79% of staff agreed that care of patients is OUH's top priority, and 74.8% of staff would be happy with the standard of care provided at OUH if a friend or relative needed treatment.

The introduction of a Values-Based Appraisal (VBA) window at OUH for the last two years has had a positive effect. 93.4% of OUH staff who took part in the Staff Survey in 2023/24 reported that they had an appraisal in the previous 12 months, compared with 72% in 2021/22 before we changed to this new approach.

Following feedback from staff that they would like to see a holistic approach to recognising our people, we introduced a new Staff Recognition Programme including instant recognition and monthly recognition of staff contributions.

Wellbeing support for our people in 2023/24 included the installation of rest and relaxation equipment and outdoor gym equipment on three of our hospital sites, as well as the embedding of a Staff Support Service to provide psychological health support.

Our cost of living support for our people was recognised nationally in November 2023 when this important programme of work was shortlisted for the *Health Service Journal* Awards.

We launched the latest phase of our public-facing *No Excuses* campaign in February 2024 to reiterate that we will not tolerate physically or verbally abusive and aggressive behaviour towards our people by patients and visitors. A new 'Raising a concern' facility on the Trust website was also launched in March to make it easier for our people to navigate the various routes and channels available to them if they have a concern or believe something is wrong.

### *Patient care*

2023/24 was another year of groundbreaking developments across the Trust, and we further embedded Quality Improvement methodology across the Trust to drive not only in clinical but also in operational improvements.

- A new procedure to treat patients with severe heart valve disease was carried out for the first time in the UK at the Oxford Heart Centre, based at the John Radcliffe Hospital in Oxford. Minimally invasive Transcatheter Tricuspid Valve Replacement (TTVR) operations took place in December 2023 to treat two patients with severe tricuspid regurgitation, a condition with debilitating symptoms such as fluid retention and breathlessness.
- OUH is now a highly specialised NHS centre offering CAR-T therapies to cancer patients. CAR-T, which uses a patient's own immune cells to create a tailored treatment, is a complex treatment but has shown in trials to cure some patients, even those with advanced cancers, when other available treatments have failed.
- Our Stroke Unit is now providing life-changing mechanical thrombectomy treatment 24/7. Mechanical thrombectomy, removing a blockage in a large blood vessel in the brain, can reduce disability and prevent or limit long-term care needs following a stroke. It relies on rapid transfer of acute stroke patients to regional centres with specialist teams like OUH.
- Our Oncology team recruited the first patient for the cancer vaccine trial.

We also continued to build for the future to improve both patient and staff experience.

- In August 2023, the new Transitional Care Unit, which allows mothers to be with their babies if they need extra care after birth, opened in the Women's Centre at the John Radcliffe Hospital in August 2023.
- The opening of a new Pharmacy Clinical Trials Unit on the Churchill Hospital site has enabled the preparation of a new range of medicines known as advanced therapy medicinal products, based on gene, tissue or cell therapy products, for OUH patients.
- The new Targeted Lung Health Check Programme gives current and past smokers the chance of having lung conditions detected and treated earlier as part of a national NHS scheme. Scans are now underway at the Horton General Hospital with plans for mobile units in community settings in the future.

### *Performance*

Industrial action had a significant impact on our performance as more than 14,000 outpatient appointments, and a total of 2,089 elective inpatient and day case admissions were postponed. We worked closely with our people and local trade union representatives to ensure that patient safety and staff wellbeing were paramount at all times, while supporting the legal right of staff to take industrial action if they chose to do so.

This year we saw improvements in our urgent and emergency care performance, despite a 4.4% increase in attendances at our Emergency Departments (EDs) at the John Radcliffe

Hospital in Oxford and the Horton General Hospital in Banbury. 65.1% of patients were seen, treated and either discharged or admitted within four hours in 2023/24 compared with 62.1% in 2022/23. In March 2024, our ED four-hour performance for all patients was 72.2%.

We continued to focus on increasing activity across our elective pathways including cancer services. Compared to 2022/23, in 2023/24, we saw a 0.6% increase in inpatient activity, 21.5% increase in cancer treatment and a 5.5% increase in diagnostics.

We reduced the number of patients waiting more than two years, as measured at the end of the financial year, for elective care from four at the end of 2022/23 to one at the end of 2023/24, but we were disappointed that the number of patients waiting more than 18 months for elective treatment increased from 59 at the end of 2022/23 to 80 at the end of 2023/24. We are committed to reducing waiting times for elective and cancer treatment.

Nationally, failings in maternity care have been identified in many hospitals and we were disappointed that the Care Quality Commission (CQC) inspection of the Midwifery-Led Unit at the Horton General Hospital in October 2023 resulted in a 'Requires improvement' rating for the Safe and Well-led domains when the CQC's report was published in March 2024. As an organisation that values learning and continuous improvement, we are committed to work on the requirements identified in the report that had not yet been implemented by the time it was published.

However, we saw improvements in Maternity indicators relating to 3rd and 4th degree tears, postpartum haemorrhage and stillbirths. We were delighted by other tangible progress delivered through our Maternity Development Programme which formally closed in February 2024, including maternity staff turnover reduced from 20.3% in August 2022 to 12.9% in March 2024.

We reported a £10.7m deficit in our Annual Accounts against an original plan of £2.8m deficit, based on the revenue budget performance measure used by NHS England. While the original plan was not met, the in-year forecast was achieved. This result is worse than the prior year and reflects non-pay inflation above the levels funded by NHS England, the growth in the size of our workforce, and the withdrawal of pandemic era additional funding. The Trust over-delivered on its efficiency programme for the year, but this was more than offset by the increase in the overall cost of staffing which we are addressing in the 2024/25 financial year.

### *Partnerships*

Working in partnership at Place and System level for the benefit of our patients and populations, with effective collaboration to reduce health inequalities and fulfil our role as an Anchor Institution, is one of our six strategic objectives. We have key partnerships with health, social care and voluntary sector organisations across not only the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) geography but also regional and national clinical networks for specialist services.

One successful partnership improving patient care, Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL), launched its third phase, Hospice Outreach, during the year. This innovative partnership between OUH, Sobell House Hospice Charity, Macmillan Cancer Support and Social Finance supports people at the end of their life whose choice is to die at home rather than in hospital.

The Whitehouse Renal Dialysis Unit in Milton Keynes which opened in December 2023 provides specialist care closer to home. The service is run by OUH staff and the development was made possible by a partnership with Milton Keynes City Council and Milton Keynes University Hospital NHS Foundation Trust.

Our strong partnerships with the University of Oxford and Oxford Brookes University, and our hosting of the Oxford Biomedical Research Centre (BRC) and Health Innovation Network Oxford and Thames Valley (HIN), have a positive impact on patient care. For example, an AI tool that can predict the 10-year risk of fatal heart attacks could transform treatment for patients who undergo CT scans to investigate chest pain, according to world's first research carried out at the John Radcliffe Hospital in Oxford, supported by the Oxford BRC, and published in November 2023.

Environmental sustainability is a key responsibility for OUH as a major employer and provider of healthcare services. We are an active player in the Zero Carbon Oxford Partnership whose goal is for Oxford to achieve net zero carbon emissions across the city as a whole by 2040, 10 years before the legal deadline set by Government. We made significant progress this year as we aim to achieve net zero carbon for emissions over which we have direct responsibility by 2040, in line with national NHS targets.

Following the receipt of grant funding to decarbonise the estate to reduce carbon emissions and our environmental impact, work has been completed at the Horton General Hospital in Banbury. Moving away from the combustion of fossil fuels in our boilers, we installed new heat pumps, upgraded our building energy management system controls, and improved the insulation of pipes and buildings to make the hospital more energy efficient. The installation of solar panels is generating green, zero carbon electricity to power the new heat pumps.

OUH represented the healthcare sector in piloting a global programme of carbon accounting using a methodology called E-liability, developed by experts at Harvard and the University of Oxford. E-liability allows organisations to produce real-time, accurate and auditable data on their direct and supplier carbon emissions. The methodology helps inform purchasing decisions through reliable reporting of the emission impacts of making a product or delivering a service. We mapped a primary joint replacement pathway and performed the associated carbon calculations, a world first for a healthcare organisation using E-liability.

Our position as an Anchor Institution at the heart of our community to identify and address health inequalities is one of the three key roles which we aim to play as an organisation over the next five years, as set out in our Clinical Strategy 2023-28.

OneTeamOneOUH has delivered high quality care throughout the year via a relentless focus on our safety culture, and quality improvement routinely embedding best practice in the care provided to our patients. Further details of this can be read in the subsequent reports of this Annual Report.

Signed: Professor Meghana Pandit
Chief Executive Officer
26 June 2024

# Performance Report

The Performance Report provides information about Oxford University Hospitals NHS Foundation Trust and its main objectives, and outlines how the Trust performed during the year 2023/24.

## About Oxford University Hospitals NHS Foundation Trust

Oxford University Hospitals NHS Foundation Trust is one of the largest NHS teaching hospital trusts in the UK, with a national and international reputation for the excellence of its services and its role in education and research.

Oxford University Hospitals NHS Trust was formally established on 1 November 2011 when the Nuffield Orthopaedic Centre NHS Trust merged with Oxford Radcliffe Hospitals NHS Trust. On the same date, a formal Joint Working Agreement between the Trust and the University of Oxford came into effect. This agreement was built on existing working relationships between the two organisations. The Trust became a Foundation Trust on 1 October 2015.

Oxford University Hospitals NHS Foundation Trust is an acute hospital Trust providing local, regional and some national hospital services to the population of Oxfordshire and beyond. It is registered with the Care Quality Commission and licensed to provide regulated activities by NHS England. The Trust has four main hospital sites, the John Radcliffe Hospital, Churchill Hospital and the Nuffield Orthopaedic Centre, all located in Oxford, and the Horton General Hospital in Banbury, North Oxfordshire. The Trust provides local hospital services to the population of Oxfordshire, South Northamptonshire and South Warwickshire and provides tertiary services to the surrounding counties of Buckinghamshire, Berkshire, Gloucestershire, Northamptonshire, Warwickshire and Wiltshire.

The Trust provides a wide range of services including emergency care, trauma and orthopaedics, maternity, obstetrics and gynaecology, newborn care, general and specialist surgery, cardiac services, critical care, cancer, renal and transplant, neurosurgery, maxillofacial surgery, infectious diseases and blood disorders. The Trust also treats patients from across the country for specialist services and leads networks in areas such as trauma and vascular.

Most of the Trust's services are provided in our hospitals, but some are delivered across more than 100 satellite locations across the region, including renal dialysis units, midwifery-led units and radiotherapy treatment centres. We also provide some services in patients' homes across the region. The Trust is also responsible for a number of screening programmes, including those for bowel cancer, breast cancer, diabetic retinopathy and chlamydia.

More information on Oxford University Hospitals NHS Foundation Trust and its services is available on the Trust website at [www.ouh.nhs.uk](http://www.ouh.nhs.uk).

## Trust Strategy

During 2023/24, the Trust began work on a new strategic framework. We expect to retain our focus on patients and people, but also to add new dimensions covering performance and partnerships. This reflects our renewed focus on delivering for all patients after the COVID-19 pandemic and also the increasing importance of partnership working in everything we do.

***Our Values***: ***Learning, Respect, Delivery, Excellence, Compassion and Improvement,*** remained unchanged as does ***Our Vision: Delivering Compassionate Excellence for Our People, Our Patients and Our Populations.***

Over the last four years, we undertook extensive work in embedding and aligning our Trust Strategic Framework, enabling strategies such as the Digital Strategy and People Plan, and programmes of work from both internal and external perspectives. Work towards the development of the next five-year strategy is currently underway with an emphasis on refining our strategic objectives.

### Our Clinical Strategy

In 2023, the OUH Trust Board approved the OUH Clinical Strategy 2023-2028, which is a blueprint for our clinical services, our sites, and the role we aim to play as an organisation over the next five years. The Clinical Strategy sets out how we will deliver the highest quality of care for our patients, and priorities to guide our future decision-making by:

- playing our part in the delivery of integrated patient pathways for the population of Oxfordshire
- building on our role as a regional and national specialist provider
- adopting a more system-focused approach to the design and delivery of our services, making decisions with our partners so that services are joined-up and delivered in the context of the right patient pathway, location or provider.

The Trust has developed Clinical Strategy Implementation Plans to support delivery of the Clinical Strategy across the years 2023-2028. Oversight from the Clinical Strategy Implementation Planning Group has connected work across our services and broad range of partners. Our plans form an essential part of the organisation's future annual planning process and ensure continuous alignment to other key strategies, such as the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) Strategy, the Oxfordshire Health and Wellbeing Strategy and our own Trust Strategy and priorities.

**Our partnerships**

The Trust works closely with a variety of partners to care for our patients, support our people and make wide scale changes for our populations. Some of our partnerships are listed below.

***Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System***

We work closely with health, social care and voluntary sector partners across Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) to deliver joined-up and integrated care for our populations. Our involvement in the BOB ICS is primarily through provider collaboratives and our Place-Based Partnership.

***Provider Collaboratives***

Provider Collaboratives support joint working between NHS providers to plan, deliver and transform services, and in doing so, deliver greater collective value for the patients and communities they serve.

OUH works closely with Oxford Health NHS Foundation Trust as part of the Oxfordshire NHS Provider Collaborative for Integrated Care. This collaboration initially focuses on urgent care in the home and the community.

We have also formed an acute provider collaborative with Royal Berkshire Hospitals NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust. This collaboration focuses on elective care.

***Place-Based Partnership***

The Trust plays a role in Oxfordshire's Place-Based Partnership, the local Health and Wellbeing Board and its sub-group Oxfordshire Prevention and Health Inequalities Forum. The Place-Based Partnership has played an increasingly important role during 2023/24 in co-ordinating the delivery of urgent care in Oxfordshire.

***Networks and collaborations***

The Trust plays a leadership role, hosting and contributing to multiple regional and national clinical networks, to deliver and improve specialist clinical services. These include, but are not limited to, the Thames Valley Cancer Alliance, Thames Valley Trauma Network and a variety of Operational Delivery Networks.

The Trust is an active participant in the Oxfordshire Inclusive Economy Partnership and is playing a leading role in the establishment of an Oxfordshire Anchor Network.

We host Health Innovation Oxford and Thames Valley which leads efforts to spread innovation across healthcare in the Thames Valley.

We are part of Oxford Academic Health Partners which brings together the Trust, Oxford Health NHS Foundation Trust, the University of Oxford and Oxford Brookes University to co-ordinate the interface of healthcare, education and research across Oxford.

We are a member of the Shelford Group, a collaboration of 10 of the largest teaching and research Trusts in England, learning from each other and benchmarking the performance which we describe later in this report.

***World-class universities***

*University of Oxford*: we partner with the University of Oxford to deliver world-leading scientific research, pioneering discoveries that transform care for millions of people worldwide and working together through a world-leading medical school. Together we operate a leading biomedical research centre and carry out an extensive programme of clinical trials.

*Oxford Brookes University*: we partner with Oxford Brookes University to deliver nursing, midwifery, allied health professional and management education as well as research, in order to train and equip the healthcare leaders of the future.

***Volunteers***

Our volunteers continue to offer much-needed support to our patients and across our workforce. The Trust, including its host services, has nearly 800 volunteers with around 100 joining within the last 12 months.

We have seen an increase in the request for volunteers across the Trust with many new and interesting role profiles added to the portfolio. These include a Liaison Volunteer role supporting staff and relatives of patients of Oxford Critical Care Unit. We also have volunteer readers who read to patients on the children's wards in Oxford Children's Hospital. Volunteers play the part of patients during practical clinical exams and support with the Pets as Therapy (PAT) dogs which are well received in key areas of the Trust.

Voluntary Services has recently received funding from Oxford Hospitals Charity to procure an online platform to support with both onboarding and volunteer wellbeing. The feedback for this new integration has been largely positive, and 70% of existing volunteers are engaged on the platform currently. Our recent phase for onboarding new volunteers commenced in April 2024.

***Oxford Hospitals Charity***

Oxford Hospitals Charity supports the work of the Trust by funding state-of-the-art medical equipment as well as major enhancements to the hospital environment, such as improving wards, waiting rooms, play spaces and staff areas. The Charity also funds research, specialist staff training, and extensive support for patients and staff across our hospitals.

A few highlights during 2023/24 include the following.

- Approving £250,000 of funding for haematology cancer research, thanks to a legacy gift.
- Approving £186,000 of funding for cancer nurse specialist roles in children's oncology.
- Funding of £71,000 for specialist breast cancer surgical equipment at the Horton General Hospital.
- Funding for two pieces of high-definition ultrasound equipment to support Cryoneurolysis Clinic in Oxford Centre for Enablement (OCE).
- Supporting a programme of music and arts to help patients with dementia.
- Providing support for staff wellbeing and improvements in staff facilities across the Trust.
- Funding a youth worker to support teenage patients in Oxford Children's Hospital.

For information and to get in touch with the charity, please visit www.hospitalcharity.co.uk.

## Performance Overview

This section summarises the Trust's operational and financial performance and achievements during 2023/24. The dashboard overleaf provides an overview of the performance against the key indicators from the NHS priorities and planning guidance, and the Trust's Quality Priorities. It includes indicators measuring:

- elective care, including cancer and diagnostic services
- urgent and emergency care
- quality of care, access and outcomes
- leadership and looking after our people
- finance and use of resources.

Further information and additional indicators are included in the Performance Analysis section found later in this report, including references to the national average where possible.

We report on the following objectives.

- ***Increased activity in elective care and cancer services*** compared to 2022/23, most notably in inpatient activity (+0.6%), cancer treatment levels (+21.5%) and diagnostic activity (+5.5%), but the increase was noticeably less than the national average, owing to capacity constraints. High elective demand, which grew faster than the activity provided, resulted in increases in the number of patients on our elective waiting lists and patients waiting over 52, 65 and 78 weeks.
- ***Timelier urgent and emergency care*** evidenced by an improvement in the proportion of patients seen within four hours in our Emergency Departments to 65.1% from 62.1% in 2022/23. Additionally, we recorded a lower proportion of patients spending more than 12 hours in an Emergency Department (ED), which improved to 4.4% from 6.8% in 2022/23. Despite this improvement, our four-hour ED performance remained below the national standard and national average for all types, but was better than the national average for type 1 (departments with 24-hour consultant-led services and full resuscitation facilities) attendances. The performance improvement compared to 2022/23 was delivered alongside further year-on-year growth in patient demand in our emergency settings, and the increase was above the national average.
- ***Improvements and high standards in measures recording the delivery of safe and high-quality care*** included our mortality indicators, maternity indicators relating to stillbirths, postpartum haemorrhage, 3rd and 4th degree tears, *Clostridioides difficile* cases, results endorsed and hospital outpatient cancellations. We also achieved our target for pressure ulceration incidents for category 3 and 4 ulcers. Measures not meeting our standards included *MRSA (Methicillin-resistant Staphylococcus Aureus)* bacteraemia cases, *MSSA (Methicillin-sensitive Staphylococcus Aureus)* cases and the rate of violence and aggression incidents recorded.
- ***Further development in our leadership and looking after our people*** by improving people's psychological wellbeing through the Kindness into Action training programme, whilst continuing to tackle violence and aggression by patients towards our staff. We also focused on staff recognition, reward and career development. Our sickness levels and staff turnover decreased as a positive outcome of our People Plan in 2023/24.
- ***Our management of finance and the use of resources*** saw the Trust record a £10.7m deficit as measured by the NHS, which did not meet the original plan of a £2.8m deficit, but did meet the forecast submitted to NHS England in-year. We invested £80.0m in new buildings and equipment.

## Performance Dashboard[1]

| Domain and indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| **Elective Care, Cancer and Diagnostics** | | | | |
| Elective inpatient activity (FCEs[2]) | n/a | 95,207 | 94,651 | 0.6% more inpatient activity |
| Elective outpatient activity (attendances) | n/a | 1,291,257 | 1,247,056 | 3.5% more outpatient activity |
| Patients waiting over 52 weeks (RTT[3]) | <950 | 3,586 | 2,226 | 1,360 more patients waiting |
| Patients waiting over 65 weeks (RTT[3]) | 0 | 685 | 473 | 212 more patients waiting |
| Patients waiting over 78 weeks (RTT[3]) | 0 | 80 | 59 | 21 more patients waiting |
| Cancer referral treatment levels[4] | n/a | 3,671 | 3,021 | 21.5% more activity |
| Patients waiting longer than 62 days[5] | <171 | 170 | 205 | 35 fewer patients waiting |
| 28-day faster diagnosis standard | ≥75% | 80.4% | 79.1% | 1.3 percentage point improvement |
| 31-day general standard | ≥96% | 85.9% | 88.5% | 2.6 percentage point deterioration |
| 62-day general standard | ≥85% | 63.0% | 57.2% | 5.8 percentage point improvement |
| Diagnostic (DM01)[6] performance | ≥95% | 83.6% | 89.4% | 5.8 percentage point deterioration |
| Diagnostic activity levels (elective) | n/a | 240,545 | 227,990 | 5.5% more diagnostic activity |
| **Urgent and emergency care** | | | | |
| General and acute bed occupancy | <92% | 94.6% | 95.9% | 1.3 percentage point improvement |
| Proportion of ambulance arrivals delayed over 30 minutes | n/a | 9.6% | 9.8% | 0.2 percentage point improvement |
| Patients medically fit to discharge | n/a | 11.7% | 9.9% | 1.8 percentage point deterioration |
| ED[7] performance within 4 hours (all types) | ≥95% | 65.1% | 62.1% | 3.0 percentage point improvement |
| **Quality of care, access and outcomes** | | | | |
| Neonatal deaths per 1,000 live births | <3.2 | 4.5 | 3.8 | Deterioration by 18.4% |
| Stillbirths per 1,000 total births | <4.0 | 3.7 | 4.7 | Improvement in the rate per 1,000 by 1.0 |
| Postpartum haemorrhage (PPH) | n/a | 3.0% | 3.5% | 0.5 percentage point improvement |
| 3rd and 4th degree tear rate | n/a | 2.9% | 3.5% | 0.6 percentage point improvement |
| Medication incidents causing moderate harm, major harm or death | n/a | 26 | 24 | Increase of two incidents (deterioration) |
| Harm from falls per 10,000 bed days (moderate and above) | n/a | 1.3 | 1.8 | 0.5 fewer falls per 10,000 bed days (improvement) |
| Unwarranted hospital outpatient cancellations under six weeks | n/a | 106,407 | 108,872 | 2.3% fewer cancellations (improvement) |
| SHMI range[8] | <1 | 0.86 *CL[9] 0.89-1.12* | 0.96 *CL[9] 0.90-1.1* | Statistically 'lower than expected' (fewer deaths) |
| HSMR range[10] | <100 | 90.3 *CL[9] 85.3- 92.9* | 93.7 *CL[9] 89.8-97.8* | Statistically 'lower than expected' (fewer deaths) |
| *MRSA* bacteraemia cases[11] | 0 | 6 | 4 | Increase of two cases |
| *C. difficile*[12] cases | 103 | 130 | 124 | Increase of six cases |
| *E. coli*[13] bloodstream infection cases | 153 | 173 | 208 | Reduction of 35 cases |
| *MSSA[14] cases (HOHA[15] and COHA[16])* | n/a | 70 | 66 | Four additional cases (deterioration) |

| Domain and indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Results endorsed within 7 days | >85% | 82.5% | 82.2% | 0.3 percentage point improvement |
| Pressure ulceration incidents per 10,000 bed days (hospital acquired category 3 and 4) | <3.0 | 2.5 | 2.2 | Deterioration in rate per 10,000 bed days by 0.3 |
| Incident rate[17] of violence and aggression (rate per 10,000 bed days) | n/a | 51.5 | 40.7 | Deterioration in rate per 10,000 bed days by 10.8 |
| **Leadership and looking after our people** | | | | |
| Employee Engagement Index (EEI) Staff Survey | n/a | 7.1/10 | 7.0/10 | 0.1/10 improvement |
| Sickness absence rate | 3.1% | 3.8% | 4.3% | 0.5 percentage point improvement |
| Proportion of BAME[18] staff in senior leadership roles[19] | n/a | 4/19 | 4/19[20] | No change |
| Proportion of women in senior leadership roles[18] | n/a | 9/19 | 12/19[20] | Reduction of 3 women in senior leadership |
| Total number of permanent staff (average WTE[21]) | n/a | 13,410 | 12,854 | 4.3% increase |
| Staff turnover | ≤12% | 10.2% | 11.4% | 1.2 percentage point improvement |
| Core Skills Training | ≥85% | 88.7% | 90.2% | 1.5 percentage point deterioration |
| Appraisals (non-medical) | ≥85% | 94.1% | 94.2% | 0.1 percentage point deterioration |
| **Finance** | | | | |
| Financial performance surplus/(deficit) £m | n/a | -28.2 | -5.5 | £22.7m adverse compared to 2022/23 |
| Adjusted financial performance surplus/(deficit) £m | -2.8 | -10.7 | 0.1 | £7.9m adverse to plan 2023/24 |
| Value-weighted activity % of 2019/20 | 103.0% | 102.4% | 94.5% | 7.9 percentage point improvement but below target |
| ICS[22] CDEL[23] capital expenditure £m | 28.5 | 31.6 | 27.5 | 10.8% agreed overspend |
| **Sustainability** | | | | |
| Annual reduction of Carbon emission $tCO_2e$ | 2,819 | 3,897 | - | 2022/23 was base year, met target in 2023/24 |

*Notes:*

1. *All figures represent the full year position except RTT[3] waiting time indicators which are measured at 31 March.*
2. *A finished consultant episode (FCE) is a continuous period of admitted patient care under one consultant within one healthcare provider.*
3. *Referral to Treatment (RTT) pathway.*
4. *Indicator includes all 62-day pathways.*
5. *Indicator includes patients waiting longer than 62 days on a cancer pathway.*
6. *DM01 - National Standard for Diagnostics Waiting Times and Activity. Measured at March 2023 vs 2024*
7. *ED - Emergency Department.*
8. *SHMI - Summary Hospital-level Mortality Indicator.*
9. *CL - Confidence Limit.*
10. *HSMR - Hospital Standardised Mortality Ratio.*
11. *MRSA - Methicillin-resistant Staphylococcus Aureus.*
12. *C. difficile - Clostridioides difficile.*
13. *E. coli - Escherichia coli bloodstream infections.*
14. *MSSA - Methicillin-sensitive Staphylococcus Aureus.*
15. *HOHA - hospital onset, healthcare associated.*
16. *COHA - community onset, healthcare associated.*
17. *Reported rate on Trust's incident management system.*
18. *Black, Asian and Minority Ethnic (BAME) staff.*
19. *Senior leadership roles defined as Board level roles.*
20. *Both Joint Chief Officers in post as of 31 March 2023 are included in the total number of Board members.*
21. *WTE - Whole Time Equivalent.*
22. *ICS - Integrated Care System. The Trust's capital and revenue expenditure were aligned to the plans of the ICS.*
23. *CDEL - Capital Departmental Expenditure Limit. This is capital expenditure as measured by HM Treasury. In effect, a subset of Trust's overall capital expenditure.*

## Performance Analysis

Oxford University Hospitals NHS Foundation Trust's (OUH's) Performance Management and Accountability Framework governs the oversight and the delivery of the Trust's strategic and performance goals. This incorporates strategic and 'business as usual' objectives, and contractual indicators within the organisation, including those set to cover delivery over multi-year periods. The Framework provides a focus from Board to ward on Corporate Governance, Risk Management, Accountability and Performance Management, which is integrated across Trust Divisions (Clinical and Corporate).

This section describes the key measures within the NHS Oversight Framework relating to the NHS Long Term Plan as well as local priorities. This is followed by a description of performance and risks for these and related measures.

All indicators reported within this section represent the full year position unless stated otherwise.

### Quality of care, access and outcomes

#### *Elective care*

Elective activity provided by OUH in 2023/24 increased by 0.6% overall for inpatient services, and 3.5% for outpatient services. Over this period, the utilisation of our elective theatre lists improved, which was supported by the implementation of a new theatre system and also an improvement in recording. The value-weighted activity, reflected as a percentage of 2019/20 activity in £millions, improved by 7.9 percentage points.

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Elective inpatient activity levels (FCEs[1]) | n/a | 95,207 | 94,651 | 0.6% more inpatient activity |
| Elective outpatient activity levels (attendances) | n/a | 1,291,257 | 1,247,056 | 3.5% more outpatient activity |
| Elective theatre utilisation | ≥85% | 97.3% | 84.0% | 13.3% percentage point improvement in utilisation |
| Value-weighted activity % of 2019/20 | 103.0% | 102.4% | 94.5% | 7.9 percentage point improvement but below target |

*Note:*

1. *A finished consultant episode (FCE) is a continuous period of admitted patient care under one consultant within one healthcare provider.*

The increase in elective activity was supported by specific elective care funding streams, and using capacity available within the Independent Sector and from insourcing.

### *Impact of industrial action*

The Trust worked closely with staff to ensure that patient safety was paramount at all times, whilst supporting the right of staff to take industrial action if they chose to. We worked with colleagues to ensure that staffing was maintained at safe levels in every area during the day, rescheduling planned appointments, procedures and operations where necessary.

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Elective inpatient postponements | n/a | 469 | 160 | 309 more elective inpatient postponements |
| Elective day case postponements | n/a | 1,620 | 637 | 983 more elective day case postponements |
| Elective outpatient appointment postponements | n/a | 14,138 | 168 | 13,970 more outpatient appointment postponements |
| Elective theatre sessions stood down | n/a | 664.5 | 69 | 595.5 more elective theatre sessions stood down |
| Estimated cost of industrial action[1] £m | n/a | 5.2 | 0.5 | £4.7m more due to full year of industrial action in 2023/24 |

*Note:*

1. *Estimated costs for covering shifts and rotas from the clinical Divisions and excludes pay clawback, and do not factor in the wider potential impact on efficiencies or income opportunities that couldn't be realised due to the strikes.*

Notwithstanding the increase in elective activity, the industrial action across clinical staff groups in 2023/24 resulted in postponement of at least 469 inpatient admissions, 1,620 day case admissions and 14,138 outpatient appointments. This corresponded to, in effect, the curtailment of growth in elective inpatient and day case activity in 2023/24 by 2.2%, and elective outpatient activity by 1.1%.

The effect on theatre lists was also significant with 664.5 theatre sessions stood down due to industrial action in 2023/24 compared to 69 theatre sessions stood down due to industrial action in 2022/23. The elective inpatient and day case postponements referenced above are included within these theatre sessions that were stood down, where the postponed activity was scheduled for a theatre location.

The directly measurable cost of industrial action of £5.2m was the pay cost of covering shifts on medical rotas for gaps created by staff taking industrial action. There were wider costs from the impact of industrial action such as reduced income from lost patient activity, or the opportunity cost of management time diverted away from transformation or efficiency schemes. The Trust received funding of £18.7m from NHS England for the overall impact of industrial action which was allocated to provider Trusts in proportion to the numbers of medical staff employed.

### *Patients waiting for elective care*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Patients waiting for consultant-led treatment (RTT[1]) | n/a | 82,990 | 72,744 | 10,246 more patients waiting |
| Patients waiting over 52 weeks (RTT[1]) | <950 | 3,586 | 2,226 | 1,360 more patients waiting |
| Patients waiting over 65 weeks (RTT[1]) | 0 | 685 | 473 | 212 more patients waiting |
| Patients waiting over 78 weeks (RTT[1]) | 0 | 80 | 59 | 21 more patients waiting |
| Patients waiting over 104 weeks (RTT[1]) | 0 | 1 | 4 | Three fewer patients waiting |

*Note:*

1. *Referral to Treatment (RTT) pathway. All indicators are measured as at the position on 31 March.*

Patient demand for elective care continued to grow above the level of our capacity and other measures to manage growth, resulting in an increase in the total number of patients waiting for consultant-led treatment (+10,246 patients), and increases in patients waiting over 52 weeks (+1,360), 65 weeks (+212) and 78 weeks (+21). There were fewer patients waiting over two years (104 weeks), with one patient waiting at the end of March 2024, compared to four patients waiting at the end of March 2023.

### *Benchmarking: OUH elective activity performance compared to national average*

*Benchmarking data from April to March 2019/20, 2022/23 and 2023/24.*

| 2023/24 compared to 2022/23 | 2023/24 compared to 2019/20 |
|---|---|
| • OUH elective inpatient and day case activity increased in 2023/24 at a rate lower than the national average (0.6% vs 6.4%).<br>• OUH total outpatient activity increased in 2023/24 at a rate below the national average (3.5% vs 7.1%). | • The level of elective inpatient activity at OUH was -7.7% below the pre-pandemic level. Nationally, elective activity was 7.9% above the pre-pandemic level.<br>• OUH outpatient activity was above pre-pandemic levels and higher than the national average (34.7% vs 18.3%). Some of this growth was due to a change in the way in which outpatient activity was classified at OUH. |

*Notes:*

- *At the time of reporting, March 2024 data were provisional (did not include final Secondary Uses Services freeze).*
- *Source: Hospital Episode Statistic (HES).*

### *Benchmarking: patients waiting on a Referral to Treatment (RTT) pathway*

*Benchmarking data as at 31 March 2020, 31 March 2023 and 31 March 2024.*

| 2023/24 compared to 2022/23 | 2023/24 compared to 2019/20 |
|---|---|
| • Patients on an RTT waiting list at OUH increased by 14.1% from 2022/23 to 2023/24. This was higher than the 7.7% increase recorded nationally. | • The OUH RTT waiting list remained higher than pre-pandemic levels by 68.1%. This was lower than the 89.2% increase recorded nationally. |

*Note:*
- *Source: NHS England.*

### *Patients waiting over 52 weeks on a Referral to Treatment (RTT) pathway*

*Benchmarking data at 31 March 2020, 31 March 2023 and 31 March 2024.*

| 2023/24 compared to 2022/23 | 2023/24 compared to 2019/20 |
|---|---|
| • Patients waiting over 52 weeks on a RTT waiting list at OUH increased by 61.0% from 2022/23 to 2023/24. This increase recorded was higher than the national average which increased by 27.6%, and the result of high referral growth in specific challenged specialties. | • There were 3,557 more patients waiting over 52 weeks on a RTT waiting list in 2023/24 compared to 2019/20. This was higher than the national average (across all providers), which increased by 1,616 patients waiting over the same period (per provider). |

*Note:*
- *Source: NHS England.*

### *Cancer performance*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Cancer referral treatment levels (all 62-day pathways) | n/a | 3,671 | 3,021 | 21.5% more activity, noting some of the increase is due to increased recording of consultant upgrade pathways. |
| Patients waiting longer than 62 days on a cancer pathway | <171 | 170 | 205 | 35 fewer patients waiting |
| 28-day faster diagnosis standard | ≥75% | 80.4% | 79.1% | 1.3 percentage point improvement |
| 31-day general standard | ≥96% | 85.9% | 88.5% | 2.6 percentage point deterioration |
| 62-day general standard | ≥85% | 63.0% | 57.2% | 5.8 percentage point improvement |

*Note:*
- *Source: NHS England.*

In 2023/24, compared to 2022/23, OUH delivered 21.5% more cancer activity for our patients. Some of this increase was due to improved recording of cancer upgrades resulting from the integration of our core patient administration system and cancer administration system. We achieved the 28-day faster diagnosis standard (80.4% vs 75%) and benchmarking identified that the OUH performance was 7.4 percentage points better than the national average. The achievement of the 28-day faster diagnosis standard has been supported by the Trust's additional activity, as seen in the next section, resulting from investment in diagnostic capacity as well as capacity from the Community Diagnostic Centre.

The number of patients waiting more than 62 days on a cancer pathway, as measured by the 62 day - GP standard, which was the standard used by NHSE in 2023/24 to monitor long waiting cancer patients, reduced from 205 to 170 (35 fewer patients) and achieved the target of <171 within the NHS England Operating Plan.

From October 2023, cancer targets were consolidated to the 28-day faster diagnosis standard and a general standard for 31-day and 62-day. The latter standards were not achieved and are the focus of specific initiatives within the Trust's improvement programmes. These will address the key challenges relating to patient delays within each tumour group, late transfers to OUH from other providers, and patient choice.

***Benchmarking: OUH cancer performance compared to national average***

| 2023/24 compared to 2022/23 | 2023/24 compared to 2019/20 |
|---|---|
| • OUH's performance relative to the national average was higher compared to the 28-day faster diagnosis standard (80.4% vs 72.9%), but lower than the national average for both the 31-day and 62-day general standard (85.9% vs 90.0%, and 63.0% vs 64.6%, respectively). | • N/A – new standard in 2023/24 and 2019/20 data not able to be re-generated to match new standards. |

*Note:*
- *Source: NHS England.*

***Diagnostic activity***

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Diagnostic (DM01[1]) performance | ≥95% | 83.6% | 89.4% | 5.8 percentage point deterioration |
| Diagnostic activity levels (elective) | n/a | 240,545 | 227,990 | 5.5% more diagnostic activity |

*Notes:*
1. *DM01 - National Standard for Diagnostics Waiting Times and Activity.*
2. *DM01 performance is measured using the position on 31 March for each financial year. Activity encompasses all months in the financial years.*

An important part of elective treatment for patients includes diagnostic pathways. In 2023/24 compared to 2022/23, OUH provided 5.5% more elective diagnostic activity. In addition to supporting faster diagnoses for all elective pathways, the additional activity directly supported the achievement of the cancer 28-day faster diagnosis standard, as outlined previously.

The standard measuring the number of patients waiting no more than six weeks was not achieved in 2023/24. Performance deteriorated from 89.4% to 83.6% (5.8 percentage point decrease).

### *OUH diagnostic performance compared to national average*

*DM01 performance within six weeks is measured using the position on 31 March for each financial year for 2019/20, 2022/23 and 2023/24. Activity encompasses all months in the financial years.*

| 2023/24 compared to 2022/23 | 2023/24 compared to 2019/20 |
|---|---|
| • OUH diagnostic activity increased at a lower rate compared to the national average in 2022/23 (6.7% vs 9.7%), including emergency and elective activity[1].<br>• Full year diagnostic performance against the standard measuring patients waiting within six weeks was 1.3 percentage points better than the national average (83.6% vs 82.4%), but deteriorated by higher level (-5.8 percentage points), compared to an improvement in the national performance (+2.4 percentage points). | • OUH diagnostic activity exceeded the volumes achieved in 2019/20, but at a rate lower than the national average (10.8% higher compared to the national average of 25.0% higher)<br>• Performance in 2023/24 was 12.2 percentage points lower than 2019/20. This was lower than the change nationally, which remained 9.8 percentage points below the performance in 2019/20. |

*Notes:*

1. *Activity benchmarking includes both elective and emergency diagnostic activity.*

- *Source: NHS England.*

## Urgent and emergency care

### *Emergency care*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| General and acute bed occupancy | <92% | 94.6% | 95.9% | 1.3 percentage point improvement |
| Proportion of ambulance arrivals delayed over 30 minutes | n/a | 9.6% | 9.8% | 0.2 percentage point improvement |
| ED[1] attendances (all types[2]) | n/a | 182,212 | 174,479 | 4.4% increase in activity |
| ED[1] performance within 4 hours (all types[2]) | ≥95% | 65.1% | 62.1% | 3.0 percentage point improvement |
| ED[1] attendances (type 1[3]) | n/a | 155,776 | 148,938 | 4.6% increase in activity |
| ED[1] performance within 4 hours (type 1[3]) | ≥95% | 58.8% | 55.7% | 3.1 percentage point (with rounding) improvement |
| Proportion of patients spending more than 12 hours in an Emergency Department | n/a | 4.4% | 6.8% | 2.4 percentage point improvement |
| Emergency admissions from ED[1] | n/a | 48,644 | 43,465 | 11.9% increase in activity |
| Proportion of patients discharged from hospital to their usual place of residence | n/a | 95.2% | 94.6% | 0.6 percentage point improvement |
| Patients medically fit to discharge[4] | n/a | 11.7% | 9.9% | 1.8 percentage point deterioration |

*Note:*

1. *ED - Emergency Department.*
2. *All types - Includes type 1 (see below), type 2 and type 3 departments. A type 2 department is a single specialty ED service (e.g. ophthalmology and dentistry) and a type 3 department includes other ED/minor injury unit/walk-in centre, treating minor injuries and illnesses.*
3. *Type 1 - type 1 departments are major EDs that provide a consultant-led 24-hour service with full facilities for resuscitating patients.*
4. *Patients medically fit to discharge refers to patients assessed as no longer needing medical treatment in hospital and are ready for discharge.*

In 2023/24, full year attendances at Emergency Departments (EDs) and emergency admissions increased by 4.4% and 11.9% respectively, compared to 2022/23. These increases were higher than the growth seen nationally, which increased by 3.6% for ED attendances and 7.1% for emergency admissions from ED.

In the context of the higher growth in emergency admissions, it should be noted that elective care is provided alongside non-elective activity, often sharing staff, medical equipment and physical locations. As such, these increases in emergency activity create challenges to maximising elective activity and recovery since services need to be planned to provide capacity for emergency attendances and admissions in addition to elective services.

In 2023/24, bed capacity was also restricted by the increase in the percentage of patients medically fit in the hospital and whose discharge out of the hospital was delayed (+1.8 percentage points). This curtailed available bed capacity, and created challenges in admitting

patients within four hours from our ED departments as well as limiting capacity for patients requiring an admission for elective operations and an overnight stay in hospital.

Performance within the ED, as measured across the full year using the national standard for the percentage of patients attending the ED for less than four hours from arrival to admission, transfer or discharge, was 65.1% for 'all types', and 58.8% for 'type 1' attendances. 'Type 1' activity accounts for approximately 85% of patients at OUH and covers the Emergency Departments at the John Radcliffe and Horton General hospitals. 'All types' includes activity outside these settings that incorporate 'type 2' single specialty departments and 'type 3' Minor Injury Units.

ED performance improved compared to the previous year by 3.0 percentage points for 'all types' and by 3.1 percentage points for 'type 1'. ED performance was below the national average for 'all types', which was 72.1% nationally in 2023/24 but better than the national average for 'type 1' attendances, which was 58.1% nationally in 2023/24.

Notwithstanding the increases in emergency activity and higher patient acuity, in addition to the improvement in 4-hour performance, we recorded a lower proportion of patients spending more than 12 hours in an Emergency Department, which decreased from 6.8% in 2022/23 to 4.4% in 2023/24. We also increased the proportion of patients discharged from hospital to their usual place of residence in 2023/24.

### ***OUH emergency care activity and performance compared to national average***

*Benchmarking data from April to March 2019/20, 2022/23, and 2023/24*

| 2023/24 compared to 2022/23 | 2023/24 compared to 2019/20 |
|---|---|
| • In 2023/24, attendances at Emergency Departments and emergency admissions from ED[1] increased by 4.4% and 11.9% respectively at OUH, compared to 2022/23. The increase in ED attendances was higher than the growth seen nationally, which increased by 3.6% for attendances and 7.1% for emergency admissions from ED.<br>• ED performance was below the national average for 'all types' (65.1% vs 72.2%), but above the national average for 'type 1' attendances (58.8% vs 58.6%). | • OUH ED attendances for 'all types' was above pre-pandemic levels and at a level higher than the national average (5.9% vs 4.9%).<br>• OUH recorded emergency admissions from ED above pre-pandemic levels and at a level much higher than the national average, which was slightly below pandemic levels (+19.8% vs -0.9%). However, this is likely to be skewed by differences in recording practices of same day emergency care.<br>• Related to the challenges of higher attendances and emergency admissions, ED performance deteriorated further than the national average for all types of ED attendances (-17.3 percentage points vs -12.1 percentage points) and at a level similar to the national average for 'type 1' attendances (-21.9 percentage points vs -17.3 percentage points). |

*Notes:*

1. *ED - Emergency Department.*

- *Source: NHS England Emergency Department attendances.*

## Delivering safe, high-quality care

### *Mortality Indicators*

| Indicator | Target | 2023/24[1] | 2022/23[2] | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Summary Hospital-level Mortality Indicator (SHMI) range | <1 | 0.86 *CL[3] 0.89-1.12* | 0.96 *CL[3] 0.90-1.1* | Statistically 'lower than expected' (fewer deaths than expected) |
| Hospital Standardised Mortality Ratio (HSMR) range | <100 | 90.3 *CL[3] 85.3- 92.9* | 93.7 *CL[3] 89.8-97.8* | Statistically 'lower than expected' (fewer deaths than expected) |

*Notes:*

1. *Data from January to December 2023.*
2. *Data from January to December 2022.*
3. *CL - Confidence Limit.*

The Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) confirmed that the Trust continued to compare favourably with national mortality benchmarks. The performance for both the SHMI and HSMR was below 1.0 and 100 respectively, meaning that there were fewer deaths than expected using the rate predicted for the hospitals. As OUH is one of a small minority of acute Trusts that includes hospice data, the HSMR has also been calculated for the Trust excluding the Sobell House and Katharine House hospices to facilitate comparison with most other acute hospital Trusts. The HSMR excluding both hospices is 80.4 (Confidence Limit 76.7 - 84.2), which is lower than expected.

### *Patient Safety*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| National Patient Safety Alerts not completed by deadline | 0 | 0 | 0 | No change |
| Medication incidents causing moderate harm, major harm or death | n/a | 26 | 24 | Increase of two incidents |

OUH continued to manage risks proactively, identified through the Central Alerting System (CAS). All National Patient Safety Alerts were actioned and closed within CAS timescales. OUH actively encourages staff to report clinical incidents so that lessons can be learned to improve care.

***Maternity***

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Neonatal deaths per 1,000 live births | <3.2 | 4.5 | 3.8 | Deterioration in the rate per 1,000 by 0.7 (target not achieved) |
| Stillbirths per 1,000 total births | <4.0 | 3.6 | 4.7 | Improvement in the rate per 1,000 by 1.1 (target achieved) |
| Midwife to birth ratio (birthrate plus ratio) analysis | 1:28 | 1:24 | 1:27 | Improvement in ratio by 0.03 (target achieved) |
| Postpartum haemorrhage (PPH) | n/a | 3.0% | 3.5% | 0.5 percentage point improvement |
| 3rd and 4th degree tear rate | n/a | 2.9% | 3.5% | 0.6 percentage point improvement |

In 2023/24, targets were achieved for the stillbirth ratio per 1,000 births and improvement recorded compared to the previous financial year (3.6 vs 4.7). The target for the midwife to birth ratio was also achieved and improved compared to 2022/23.

Postpartum haemorrhages and the rate per 1,000 births improved in 2023/24 to 3.0% from 3.5% in 2022/23.

The target for neonatal deaths per 1,000 births was not achieved, and against this indicator there was an increase in the ratio of stillbirths in 2023/24 to 4.5, from 3.8 in 2023/24.

***Infection Prevention and Control***

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| *Methicillin-resistant Staphylococcus Aureus (MRSA)* bacteraemia cases | 0 | 6 | 4 | Increase of two cases (deterioration) |
| *C. difficile*[1] cases | 103 | 130 | 124 | Increase of six cases (deterioration) |
| *Escherichia coli (E. coli)* bacteraemia cases | 153 | 173 | 208 | Reduction of 35 cases (improvement) |
| *Pseudomonas aeruginosa* bacteraemia cases | 47 | 63 | 56 | Increase of 7 cases (deterioration) |
| *Klebsiella species* bacteraemia cases | 86 | 94 | 81 | Increase of 13 cases (deterioration) |
| *MSSA*[2] cases (HOHA[3] and COHA[4]) | n/a | 70 | 66 | Increase of four cases (deterioration) |

*Notes:*
1. *C. difficile - Clostridioides difficile*
2. *MSSA - Methicillin-sensitive Staphylococcus Aureus*
3. *HOHA - hospital onset, healthcare associated*
4. *COHA - community onset, healthcare associated*

Each year NHS England (NHSE) assigns the Trust a threshold for healthcare associated *Clostridioides difficile* (*C. difficile*) cases, and *Escherichia coli (E. coli)*, *Klebsiella species* and *Pseudomonas aeruginosa* bacteraemia cases. There is no threshold for *MSSA*, and there remains zero tolerance for *MRSA*. These figures are not corrected for OUH activity. OUH reports the total number of healthcare associated *MRSA* and *MSSA* bacteraemia cases to UK Health Security Agency (UKHSA).

The trajectories set for healthcare associated *C. difficile* infection cases and *E. coli*, *Pseudomonas aeruginosa* and *Klebsiella species* bacteraemia have all been exceeded this year.

The threshold for OUH apportioned cases of *C. difficile* for 2023/24 was set by NHSE at 103 cases (one case less than previous year's target). The threshold does not consider any changes in casemix or Trust activity. At the end of March 2024, the Trust reported a total of 130 healthcare associated *C. difficile* cases (hospital onset, healthcare associated (HOHA), and community onset healthcare associated (COHA)). Rates of *C. difficile* across England have been steadily rising for the last four years.

In relation to *Pseudomonas aeruginosa* and *Klebsiella species* bacteraemia, there are no clear themes or interventions to reduce the rate of Gram-negative bacteraemia. This year we reported fewer cases of *E. coli* bacteraemia. The majority of cases were associated with urinary tract infection. Changes in patient demographics are likely to contribute to the challenge of reducing case numbers. This is evidenced by an ageing population (18.6% of the total population in England and Wales were aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011) and more people at risk because of comorbidity or treatment such as immunosuppression.

***Benchmarking: hospital infections. Rolling 12-month average of cases per occupied bed days expressed per 100,000 beds***

*Benchmarking data rolling 12 months as at December 2019, 2023 and 2024*

| 2023/24 compared to 2022/23 | 2023/24 compared to 2020/21 |
| --- | --- |
| • *C. difficile* cases increased by 1.5%, which was lower than the 5.2% increase observed nationally, however the rate was higher at OUH (47.6 vs 43.5).<br>• Hospital onset *E. Coli* bacteraemia cases decreased by 18.2%, which was lower than the 2.4% increase observed nationally. The rate of cases at OUH was above the national average (23.8 vs 19.9).<br>• *Pseudomonas aeruginosa* bacteraemia cases increased by 29.1%, which was higher than the 2.7% decrease observed nationally. The rate of cases at OUH was above the national average (25.4 vs 11.5).<br>• *Klebsiella species* bacteraemia cases increased by 3.7%, which was lower than the 11.7% increase observed nationally. The rate of cases at OUH was above the national average (49.5 vs 35.5).<br>• *MSSA* cases decreased by 7.4%, which was lower than the 1.4% decrease observed nationally. The rate of cases at OUH was above the national average (41.5 vs 35.7). | • *C. difficile* cases increased by 54.5%, which was a larger rise than the 20.9% increase observed nationally.<br>• Hospital onset *E. Coli* bacteraemia cases decreased by 19.1%, which was a larger reduction than the 5.8% decrease observed nationally.<br>• *Pseudomonas aeruginosa* bacteraemia cases decreased by 10.2%, which was a larger reduction than the 4.5% decrease observed nationally.<br>• *Klebsiella species* bacteraemia cases decreased by 3.0%, compared to the 15.4% increase observed nationally.<br>• *MSSA* cases decreased by 7.0%, compared to the 3.9% increase observed nationally. |

*Note:*

- *Source: Office for Health Improvement and Disparities - Public Health Data.*

*Falls with harm (moderate and above)*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Number of falls with harm (moderate and above) | n/a | 47 | 52 | Five fewer falls with harm (improvement) |
| Number of falls with harm (moderate and above) per 10,000 bed days | n/a | 1.3 | 1.8 | 0.5 fewer falls per 10,000 bed days (improvement) |

The number of falls with harm (moderate and above) has decreased from 52 in 2022/23 to 47 in 2023/24 (5 fewer falls). Accounting for the increase in bed days recorded in 2022/23, the number of falls with harm (moderate and above) per 10,000 bed days decreased by 0.5 per 10,000 bed days from 1.8 in 2022/23 to 1.3 in 2023/24.

Reducing patient falls remains a priority for the Trust. This is reflected in the continuation of the Trust's Quality Priority for 2024/25 which focuses on strengthening and embedding the work from 2023/24.

*WHO Surgical Safety Checklist compliance*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| WHO[1] Surgical Safety Checklist compliance - Observation | 100% | 99.4% | 99.8% | 0.4 percentage point deterioration |
| WHO[1] Surgical Safety Checklist compliance - Documentation | 100% | 97.9% | 99.9% | 2.0 percentage point deterioration |

*Note:*

*1. WHO - World Health Organization.*

In 2023/24, compliance for the WHO Surgical Safety Checklist was 99.4% for Observation and 97.9% for Documentation. Both indicators deteriorated marginally compared to 2022/23 where Observation compliance decreased by 0.4 percentage points and Documentation compliance decreased by two percentage points.

*Never Events*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Never Events[1] | 0 | 2 | 5 | Three fewer Never Events |

*Note:*

*1. Serious patient safety incidents that are entirely preventable.*

There were two Never Events reported in 2023/24 compared to five Never Events reported in 2022/23. All Never Events are investigated, and the report, learning and action plan are presented to the Chief Executive Officer and other Chief Officers. Root cause analysis and learnings are shared with all Divisions and included in the Trust's weekly safety messages for all staff.

***Results endorsed within seven days***

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Results endorsed within seven days | 85% | 82.5% | 82.2% | 0.3 percentage point improvement |

There was a 0.3 percentage point improvement in results endorsed within seven days, from 82.2% in 2022/23 to 82.5% in 2023/24.

Ensuring that the results of requested tests / investigations are seen and acted upon is important to avoid serious findings being missed and patients coming to harm. Results endorsement is part of a working group under the Patient Safety Incident Response Framework (PSIRF) which is led by the Director of Clinical Informatics. Incidents and trends are reviewed, and an improvement plan is developed to address any issues.

***Hospital Acquired Pressure Ulcers (HAPUs) (Category 3 and above)***

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Pressure ulceration incidents per 10,000 bed days (Hospital Acquired Category 3 and 4) | <3.0 | 2.5 | 2.2 | Deterioration in rate per 10,000 bed days by 0.3 (achieved target) |
| Number of pressure ulcers | n/a | 1,468 | 1,556 | 88 fewer incidents (improvement) |

Although there was an increase in instance of Category 3 and 4 HAPUs per 10,000 bed days, it is noted that there was an overall decrease in the number of HAPU incidents reported, with a 50% reduction in the number of patients who acquired a Category 4 pressure ulcer (the most severe). Despite the increase by 0.3 per 10,000 bed days, the Trust achieved its target to record fewer than 3.0 per 10,000 bed days. There was also a decrease in the overall number of pressure ulcers reported.

HAPU incidents are reviewed to identify areas for learning and improvement where appropriate, and learning shared across clinical Divisions through a central forum. This approach to reducing harms associated with acquired pressure damage aligns to the PSIRF approach. Targets for reduction have been agreed for 2024/25.

***Reducing violence and aggression against staff***

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Incident rate[1] of violence and aggression (rate per 10,000 bed days) | n/a | 51.5 | 40.7 | Deterioration in rate per 10,000 bed days by 10.8 |
| NHS Staff Survey: (Staff) Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public within the last 12 months[1] | n/a | 76.8% | 75.5% | 1.3 percentage point improvement |

*Notes:*

1. *Reported rate on Incident Management System.*
2. *Source: Question 14a from NHS Staff Survey.*

The Trust has seen an increase in the incident rate of reported violence and aggression incidents against staff recorded within our incident management system. This was also reflected in responses to question 14a of the NHS Staff Survey (as described above) where the percentage increased from 75.5% in 2022/23 to 76.8% in 2023/24 (+1.3 percentage points).

Staff safety and experience continued to be a focus for the Trust with the launch of 'No Excuses' campaign which is aimed at patients and the public. Trust staff are encouraged to report verbal as well as physical abuse.

**People**

In 2023/24, our people, supported by an overall increase in the number of permanent staff by 4.3%, continued to enable the Trust to increase the delivery in both elective and emergency activity, and underpinned the achievements in the quality improvements provided for our patients.

In addition to the summary of key measures described below, further information on our workforce is available within the Staff Report of this Annual Report.

***Looking after our people***

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Employee Engagement Index (EEI) Staff Survey | n/a | 7.1/10 | 7.0/10 | 0.1/10 improvement |
| Sickness absence rate | 3.1% | 3.8% | 4.3% | 0.5 percentage point improvement |
| Total number of permanent staff (average WTE) | n/a | 13,410 | 12,854 | 4.3% increase |
| Staff turnover | ≤12% | 10.2% | 11.4% | 1.2 percentage point improvement |
| Core Skills Training | ≥85% | 88.7% | 90.2% | 1.5 percentage point deterioration |
| Appraisals (non-medical) | ≥85% | 94.1% | 94.2% | 0.1 percentage point deterioration |
| Staff morale | n/a | 6.0/10 | 5.8/10 | 0.2/10 improvement |

The Staff Survey engagement scores (EEI) increased by 0.1 point out of a score of 10 (7.1/10) compared to 2022/23. This was above the benchmarked national average of 6.91. The staff morale score also improved by 0.2 points out of a score of 10 (6.0/10) against last year. This was also above the benchmarked national average of 5.91.

There has also been an improvement in our people's perceptions around the NHS Staff Survey response to the question 'organisation acting fairly with regards to career progression / promotion', achieving 56.9% in 2023/24 against 55.3% in 2022/2023.

The Trust continued to exceed its target for Core Skills Training, with a compliance level of 88.7% as of March 2024 across the Trust, although it is a 1.5 percentage point decrease compared to 2022/23. Core Skills Training is an important indicator of compliance in essential modules relating to patient and staff safety, and other essential requirements for our staff.

Since the introduction of the new appraisal window in 2022, compliance levels on appraisals have continued to increase across the Trust. The 2023/24 appraisals (non-medical) had a compliance percentage of 94.1%, which is broadly similar to 2022/23 levels.

### *Belonging in the NHS*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Proportion of BAME[1] staff in senior leadership roles[2] | n/a | 4/19 | 4/19[3] | No change |
| Proportion of women in senior leadership roles[2] | n/a | 9/19 | 12/19[3] | Reduction of three women in senior leadership |
| NHS Staff Survey: Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age[4] | n/a | 56.9% | 55.3% | 1.6 percentage point improvement |

*Notes:*

1. *Black, Asian and Minority Ethnic (BAME) staff.*
2. *Senior leadership roles defined as Board level roles.*
3. *Both Joint Chief Officers in post as of 31 March 2023 are included in the total number of Board members.*
4. *Source: Question 15 from NHS Staff Survey.*

Senior leadership roles in the Trust have been identified as Board level positions. In 2023/24, the number of staff in senior leadership roles from a BAME (Black, Asian and Minority Ethnic) background remained the same as in 2022/23. Four personnel from a Black, Asian and Minority Ethnic (BAME) background held a senior leadership role out of 19 senior leadership roles identified within the Trust.

The number of women in senior leadership roles decreased in 2023/24 by three compared to 2022/23. Although 47% of senior leadership roles in the Trust were held by women, this was less than the proportion of women in the overall workforce, which was approximately 74%.

The NHS Staff Survey response to the question whether the organisation 'act(s) fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age', increased by 1.6 percentage points from 55.3% in 2022/23.

## Finance and use of resources

### *Income and expenditure*

| Indicator | Target | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| Financial performance surplus/(deficit) £m | n/a | -28.2 | -5.5 | £22.7m adverse compared to 2022/23 |
| Adjusted financial performance surplus/(deficit) £m | -2.8 | -10.7 | 0.1 | £7.9m adverse to plan 2023/24 |
| Value-weighted activity % of 2019/20 | 103.0% | 102.4% | 94.5% | 7.9 percentage point improvement but below target |

In 2023/24, the Trust reported a deficit of £28.2m in its Annual Accounts versus £5.5m deficit in 2022/23. The NHS measures financial performance by adjusting for some transactions outside the Trust's control, such as impairments arising from changes to the valuation of land and buildings. This is known as adjusted financial performance or the control total. Adjusting for such items, the Trust made a deficit of £10.7m in 2023/24 compared to a surplus of £0.1m in 2022/23.

The NHS statutory legislation expects Integrated Care Systems and NHS Trusts to deliver a break-even control total financial performance. Integrated Care Systems are made up of the local Integrated Care Board and the provider Trusts in that area. This was not achieved in 2023/24 with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) reporting a deficit of £53.4m.

The deficit was £7.9m worse than the Trust's original plan for the year. The plan for 2023/24 was a challenging one with the Trust having to offset excess inflation from utilities and the Private Finance Initiatives (PFIs) with an ambitious efficiency plan. The year then saw significant additional staff costs as substantive workforce increased with no compensating reductions in temporary staffing, the impact of industrial action and a significant planned land sale not being achieved.

The underlying financial position of the Trust, which reflects the position after any one-off income or expenditure has been removed, showed an improvement of 7.6% to an underlying deficit of £61.3m. Measuring underlying turnover is an area of significant judgement. While underlying costs are reasonably clear, there is uncertainty over which funding sources are recurrent and which are non-recurrent. Value-weighted activity (VWA), a measure of the volume and relative complexity of planned (elective) procedures and outpatient appointments undertaken by the Trust, was 102.4% compared to the baseline VWA from 2019/20. This was 0.6 percentage point lower than the target of 103% for 2023/24, but an improvement compared to 2022/23 when this measure was 94.5% (compared to a target of 104%).

### *Capital spending*

| Indicator | Target | 2023/24 | 2022/23 | 2022/23 compared to 2021/22 |
|---|---|---|---|---|
| Overall level of capital expenditure £m | 90.5 | 80.0 | 46.6 | 71.6% increase |
| Overall level of capital expenditure vs plan £m | 0 | -10.5 | -13.4 | 21.6% decrease in underspend |
| ICS[1] CDEL[3] capital expenditure £m | 28.5 | 31.6 | 27.5 | 10.8% agreed overspend |
| Capital[1] spend vs ICS[2] plan £m | 0 | 3.0 | -3.4 | 10% overspend compared to 11% underspend in 2022/23 |

*Notes:*

1. *Capital measured as ICS[2] CDEL[3].*
2. *ICS - Integrated Care System.*
3. *CDEL - Capital Departmental Expenditure Limit. This is capital expenditure as measured by HM Treasury. In effect, a subset of overall capital expenditure by the Trust.*

The Trust invested £80.0m in capital expenditure from all funding sources during 2023/24 compared to the investment of £46.6m in 2022/23. The largest items of capital investments were the installation of plant related to the Public Sector Decarbonisation Scheme (PSDS), replacements and digitalisation, together with life-cycling the Private Finance Initiatives (PFIs), including the managed equipment service at the Churchill Hospital. The increase in capital expenditure, due to the PSDS scheme and other additional projects, were funded externally during the year. No information is available on the capital investment of other NHS providers in 2023/24.

NHS England does not set the Trust a limit for overall capital expenditure, but it requires the Trust to agree a limit for projects within the allocated budget of the Integrated Care System (ICS) Capital Departmental Expenditure Limit (CDEL). Capital spending against this budget for the year was £31.6m which included the items referred to above with the exception of PFI life-cycling. The overspend against the ICS CDEL plan was agreed by the ICS to offset underspends at other Trusts in the local system.

Overall capital expenditure for the Trust was £10.5m below plan. The underspend was due to a shortfall in PFI life-cycle expenditure, less expenditure on IFRS16 (International Financial Reporting Standard) Right of Use Assets and delays on the new theatres build project. The Trust's spending was aligned with the draft Forward Plan of BOB ICS.

### *Cash*

| Indicator | Target | 2023/24 | 2022/23 | 2022/23 compared to 2021/22 |
|---|---|---|---|---|
| Cash as of 31 March 2024 £m | n/a | 46.8 | 32.6 | 43.5% improvement |
| Cash vs plan as of 31 March 2024 £m | 12.0 | 34.8 | 0.8 | 190% positive variance on plan |

The cash balance of the Trust on 31 March 2024 was £46.8m compared to £32.6m on 31 March 2023. The improvement in cash balance was driven in part by the timing of payments for capital expenditure at the end of 2023/24 where the invoices were settled early in 2024/25 rather than in March as had been expected. Another reason for the improved cash position was the timing of year-end over a bank holiday weekend with some payments to

creditors delayed as a result. Despite the increase in closing cash, the draft financial plan for 2024/25 has increased the risk of the Trust needing cash support early in the year.

**Risk Profile of the Trust**

The Board Committees of the Trust have reviewed the Corporate Risk Register regularly during 2023/24, as set out in the Annual Governance Statement of this Annual Report. This included high-scoring (principal) risks relating to:

- the delivery of key national access targets (including 18 weeks referral to treatment times and the waiting list target, diagnostic waiting target, cancer waiting targets and Emergency Department waiting time targets)
- the ability to recruit, retain and engage staff, and the need to use bank and agency staff on service delivery
- the growth in costs, particularly to address operational pressures and the impact of industrial action, and also considering unfunded inflation for 2023/24 which may be beyond the ability of internal cost efficiency programmes to mitigate, and which threaten the financial sustainability of the Trust.

The risks have been tracked over time with changes in risk scores, and changes to controls being updated and agreed by the Risk Committee. For example, the financial outturn position has been actively monitored during the year and a revised forecast submitted led to an increase in the likelihood of this risk materialising, with a range of scenario-based risk outcomes reported. Conversely, as the impact of the Trust’s delivery against the People Plan initiatives was seen on the workforce metrics, the level of risk in relation to staff sickness was reduced.

The underlying cause of the majority of the principal risks included in the Corporate Risk Register links back to the capacity of the Trust’s workforce to deliver the objectives of the Trust. These risks have in part been mitigated by actions as set out in the Annual Governance Statement, which includes the continued implementation of the Trust’s People Plan, the development and supporting business plans and related business cases for investment opportunities, and the development of workforce plans.

The Board Committees have identified emerging risks that may affect future performance, such as the development of the new Integrated Care System arrangements and the changes in the national elective payment regime in relation to targets to deliver 104% and 110% of 2019/20 elective activity on a value-weighted basis.

## Green Plan

In January 2022, the Trust launched our three-year Green Plan, 'Building a Greener OUH', outlining our commitment to sustainability and putting the Trust on a path to achieving net zero carbon emissions. For this, the Trust has two targets to meet, net zero by 2040 for emissions over which we have direct responsibility, and net zero by 2045 for the emissions over which we have indirect responsibility, namely our supply chain.

During the year, the Trust has been calculating its carbon emissions for those activities over which we have direct responsibility, such as energy, water, waste and business miles. We have improved our data reporting and removed the emissions of our tenants, so that they are not included within our footprint.

### *Carbon footprint*

The carbon footprint data for the year 2019/20 was undertaken for the Trust by NHS England and the Trust calculated our footprint for 2022/23 and 2023/24. The table below shows our carbon emissions in the areas where data are available.

| OUH Carbon Footprint | OUH 2019/20[1] $tCO_2e$ | OUH 2023/24 $tCO_2e$ | OUH 2022/23[2] $tCO_2e$ |
|---|---|---|---|
| Building energy[3] | 45,775 | 37,225 | 40,551 |
| Waste | 940 | 968 | 1,174 |
| Water | 477 | 220 | 264 |
| Anaesthetic gases | 4,362 | 3,335 | 3,619 |
| Inhalers | 157 | 1,167 | 1,140 |
| Business travel and fleet[4] | 5,213 | 714 | 780 |
| NHS Facilities[5] | - | 388 | 388 |
| **Total Emission Direct Control** | **56,924** | **44,017** | **47,916** |

*Notes:*

1. *Nationally estimated figures for the Trust provided by NHS England.*
2. *OUH base year.*
3. *Scope 1 fuels combustion at site and Scope 2 grid electricity and includes 'Well-to-Tank' emissions. The Trust buys Renewable Energy Guarantees of Origin (REGO) backed electricity but reports this as location-based emissions.*
4. *Includes travel 'Well-to-Tank' emissions.*
5. *Fugitive emissions from fluorinated gases (leaked refrigerants).*

- *The Trust uses the carbon factors for the years in which the majority of our financial year fell. For example, for data in 2022/23 the Trust used the 2022 carbon factors.*

### *Our decarbonisation initiatives*

During the year, the Trust has galvanised its approach to managing the environmental impacts of our activities.

The Trust created two new roles in Sustainability and Carbon Management. The post holders will be tasked with developing an overarching strategy for achieving net zero targets for our carbon footprint and footprint PLUS to mitigate our impact on climate change.

Three of our greatest sources of direct emissions for the Trust are energy, travel and anaesthetic gases. Our Anaesthetists have worked hard to reduce the emissions associated with anaesthetic gases, including storing anaesthetics locally in smaller cannisters and eliminating Desflurane completely.

We have undertaken a Travel Survey of our staff and volunteers. The data gathered from the survey have not only allowed us to calculate the emissions from commuting but also gain insights into how our staff travel now and how we could support more sustainable travel options. We have installed new and improved covered and secure bike parking facilities across our sites to encourage staff cycling to site.

The Trust continues to purchase electricity from renewable sources, which supports investment in solar and wind energy reducing emissions across the grid. This also allows us to separately report a lower carbon tonnage once this green electricity is taken into account.

The Trust has participated in a new carbon accounting methodology trial called E-liability. We are the first healthcare setting to have joined the trial. This work will inform global carbon accounting improvements.

## Task force on climate-related financial disclosures (TCFD)

NHS England's NHS Foundation Trust Annual Reporting Manual (FT ARM) has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD-aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD-aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance pillar for the year 2023/24 which are provided below.

### *Board's oversight of climate-related issues*

The Trust is committed to environmental sustainability and has appropriate governance and the support of the Trust Board, with the Chief Estates and Facilities Officer being responsible for approving and delivering Trust's net zero targets and Green Plan. These targets are also represented in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board's Green Plan.

Sustainability and carbon management is a regular agenda item of the Delivery Committee, which is chaired by the Chief Executive Officer. The Committee monitors the progress of

strategically important projects within the Trust. Its membership includes some of the Executive Directors and the senior management of the clinical Divisions. In addition, the Board members are briefed on climate change mitigation issues at Board Development sessions.

***Management's role in assessing and managing climate-related issues***

Reporting to the Chief Estates and Facilities Officer is the Head of Sustainability and Carbon Management. This role will oversee the Trust's strategic response to climate change mitigation, resilience and adaptation.

The Trust has been working to make its workforce and suppliers aware of their role and impact on the calculated carbon footprint. Some of the work includes:

- presentations on carbon management to staff groups such as the Sustainability Network and Specialty and Specialist Doctors Group, as well as staff question and answer sessions
- procurement and sustainability colleagues meeting with suppliers to discuss products and services with lower carbon emissions.

### Tackling health inequalities and equality of service delivery

During the year 2023/24, the Trust's Health Inequalities Programme advanced its understanding of health inequalities across its services through use of data and integrated consideration of health inequalities in its Clinical Strategy Implementation Plan. The Trust worked with system partners to develop a shared understanding and programme of work on health inequalities. A focused programme of quality improvement work in Cancer Services is underway to understand and seek to address health inequalities. This supports the Trust's commitment to the National Healthcare Inequalities Improvement Programme.

As part of the Trust's health inequalities approach, and in consideration of data and intelligence about our local communities, work has been undertaken by the Trust to develop an approach to being an 'Anchor Institution'. Anchor Institutions have an important presence at local level (Oxfordshire) and within communities and have the potential to influence the social and economic conditions in a local area. In 2023/24, the Trust held a community-focused event to explore a vision for its Anchor role within a wider system, by listening to a range of perspectives that will inform this work that will align the efforts of other Oxfordshire Anchor Institutions to make the greatest positive contribution to our local communities.

The Trust has responded to the challenges of providing equitable services by increasing its commitment and focus on Equality, Diversity and Inclusion (EDI) as outlined in the Trust EDI Objectives for 2022-2026, guided by staff and patient surveys, as well as by analysis conducted on workforce and patient demographic data. The objectives also align with local and national policy, such as the NHS People Plan, the OUH Strategy and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) EDI Strategy.

To increase its ability to reach all communities and coordination of engagement across the system to undertake work to mitigate issues identified, the Trust has developed partnerships with the local healthcare system and other organisations such as Healthwatch Oxfordshire and the Academic Health Science Network (AHSN),

Key achievements for 2023/24 include improving interpreting and translation services and development of patient safety partner roles, to ensure the voices of patients are heard through the Trust's safety approach. The Friends and Family Test (FFT) which captures feedback from patients on our services has also been developed to give online access to many languages.

### Human rights policies

Understanding of human rights, and responsibilities of staff under the Human Rights Act 1998, are covered within the Trust's Core Skills training on Equality, Diversity and Human Rights. All staff are required to complete this training and refresh themselves on it every three years. The training is regularly reviewed in line with best practice and any changes to legislation.

*Note: Social and community policies are discussed earlier in this report under 'Tackling health inequalities and equality of service delivery,' and the anti-bribery policies and their effectives are discussed under 'Policy on Counter Fraud and Corruption' in the Staff Report of this Annual Report.*

## Disclosures

The Trust is required to make the following disclosures.

### Overseas operations

The Trust has no overseas operations.

### Important events since balance sheet date

There have been no material events after the reporting dates which require disclosure.

### Going concern disclosure

The Directors have considered the application of the going concern concept to the Trust, based upon the continuation of services provided by the Trust. The required disclosure that the Trust is a going concern can be found in note 1.2 of the Annual Accounts found later in this document.

### Further reading

- ***OUH Quality Account***: the Quality Account of the Trust incorporates all the requirements of the Quality Account Regulations (which include detailed reporting on a number of Quality Indicators) as well as a number of additional reporting requirements set by NHS England. The Quality Account is expected to be published on the Trust website at www.ouh.nhs.uk/about/publications/#accounts in July 2024.
- ***Glossary***: a list of NHS terms and abbreviations has been published on the Trust website at www.ouh.nhs.uk/about/publications/documents/annual-report-glossary.pdf.

Signed: Professor Meghana Pandit
Chief Executive Officer
26 June 2024

# Accountability Report

The Accountability Report of Oxford University Hospitals NHS Foundation Trust's Annual Report 2023/24 comprises the following reports.

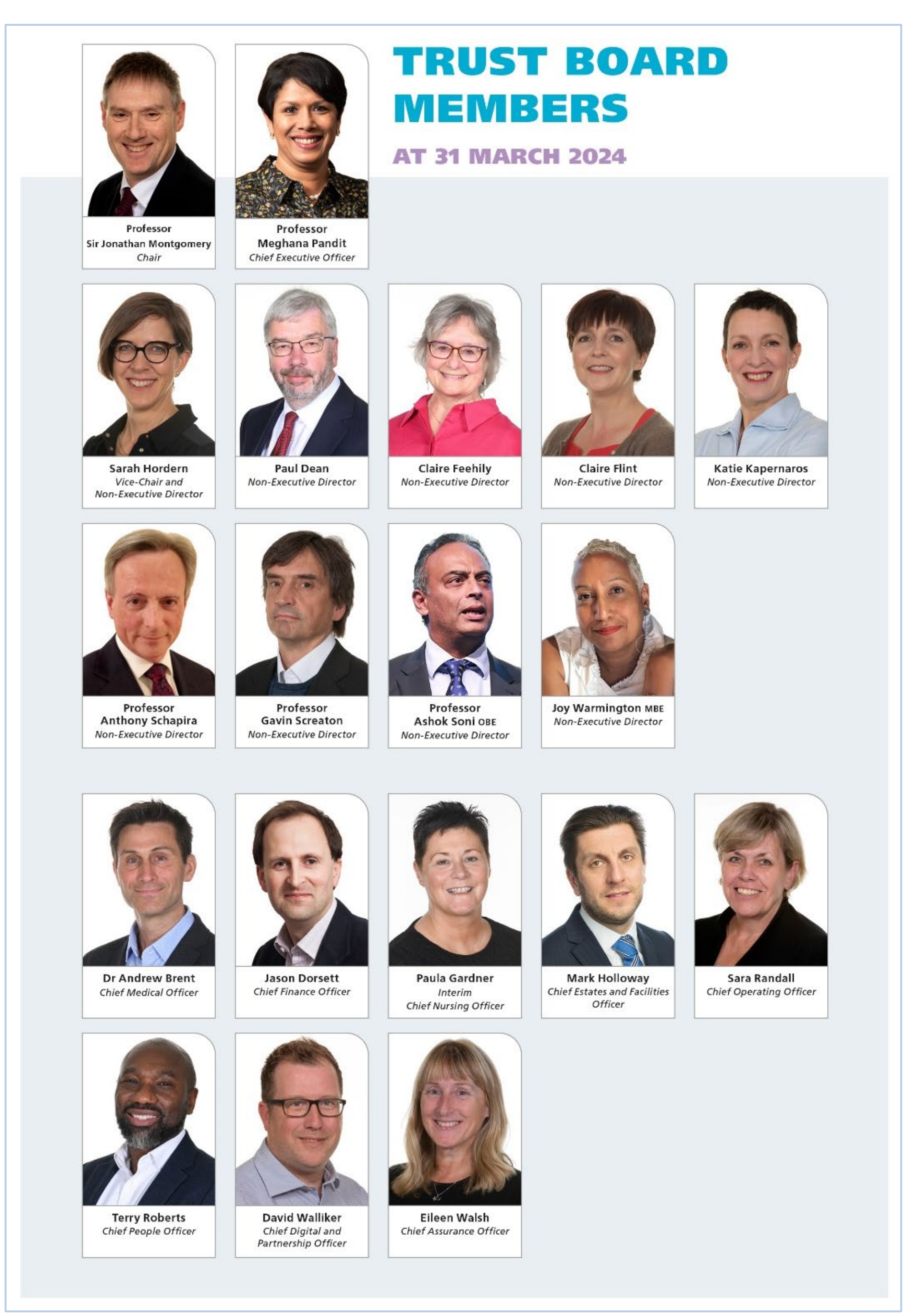
- Directors' Report
- Trust Membership and Council of Governors
- Remuneration Report
- Staff Report
- Code of Governance Compliance
- NHS Oversight Framework
- Statement of Accounting Officer's Responsibility
- Annual Governance Statement

# Directors' Report

Oxford University Hospitals NHS Foundation Trust's Board has the overall responsibility for the vision, strategy and performance of the Trust and ensuring that good standards of corporate governance are maintained. It attaches great importance to making sure that the Trust adheres to the principles set out in the NHS Constitution, the Code of Governance for NHS Provider Trusts, and other related publications. The Trust is working hard to ensure that it operates to high ethical and compliance standards.

## Board Membership

The Board of Directors of Oxford University Hospitals NHS Foundation Trust comprised the following individuals as at 31 March 2024.



During the reporting period, the following members served in the Trust Board.

**Non-Executive Directors**

Professor Sir Jonathan Montgomery, *Trust Chair*
Ms Sarah Hordern, *Vice-Chair*[1]
Ms Anne Tutt, *Vice-Chair and Senior Independent Director (to 30 November 2023)*[2]
Mr Paul Dean *(from 4 September 2023)*
Ms Claire Feehily *(from 1 December 2023)*
Ms Claire Flint, *Senior Independent Director*[3]
Ms Paula Hay-Plumb OBE *(to 3 September 2023)*[2]
Ms Katie Kapernaros
Professor Anthony Schapira
Professor Gavin Screaton
Professor Ashok Soni OBE
Ms Joy Warmington MBE

**Executive Directors**

Professor Meghana Pandit, *Chief Executive Officer*
Dr Andrew Brent, *Chief Medical Officer (from 9 October 2023)*
Mr Jason Dorsett, *Chief Finance Officer*
Ms Paula Gardner, *Interim Chief Nursing Officer (fixed term from 1 April 2023 to 30 April 2024)*
Mr Mark Holloway, *Chief Estates and Facilities Officer (from 11 September 2023)*
Ms Sara Randall, *Chief Operating Officer*
Mr Terry Roberts, *Chief People Officer*[4]
Ms Rachel Stanfield, *Acting Chief People Officer (from 1 April 2023 to 31 July 2023)*[5]
Dr Anny Sykes, *Interim Chief Medical Officer (to 8 October 2023)*
Mr David Walliker, *Chief Digital and Partnership Officer*
Ms Eileen Walsh, *Chief Assurance Officer*

*Notes:*
1. *Vice-Chair from 1 December 2023.*
2. *Stepped down at end of term.*
3. *Senior Independent Director from 1 December 2023.*
4. *Medical absence to 2 June 2023 with phased return to 31 July 2023.*
5. *Cover for medical absence and supporting phased return of Chief People Officer.*

The Board took the decision to create a new Chief Estates and Facilities Officer position in the Trust Board, subsequent to a recommendation by the Remuneration and Appointments Committee. The first Chief Officer for this post was appointed in 2023/24. The Board already contained sufficient Non-Executive Directors to retain Board balance after this appointment.

All members of the Board are voting members. All the Non-Executive Directors of the Board are considered to be independent in accordance with the Code of Governance for NHS Provider Trusts with the exception of Professor Gavin Screaton who was nominated by the University of Oxford.

The biographies of the members of the Trust Board are available on the Trust website at www.ouh.nhs.uk/about/trust-board/directors.

**Period of office of Non-Executive Directors**

The current periods of office of the Non-Executive Directors who served on the Board during the reporting year and their terms since Foundation Trust (FT) status commenced are provided below.

| Name | Date of initial appointment | Current period of office | Term since FT status |
|---|---|---|---|
| Professor Sir Jonathan Montgomery | 01/04/2019 | 01/04/2022 - 31/03/2025 | 2 |
| Ms Sarah Hordern | 28/10/2019 | 28/10/2022 - 27/10/2025 | 2 |
| Ms Anne Tutt[1] | 01/10/2015 | 01/12/2021 - 30/11/2023 | 4 |
| Mr Paul Dean | 04/09/2023 | 04/09/2023 - 03/09/2026 | 1 |
| Ms Claire Feehily | 01/12/2023 | 01/12/2023 - 30/11/2026 | 1 |
| Ms Claire Flint | 01/05/2019 | 01/05/2022 - 30/04/2025 | 2 |
| Ms Paula Hay-Plumb OBE[2] | 04/09/2017 | 04/09/2020 - 03/09/2023 | 2 |
| Ms Katie Kapernaros | 28/10/2019 | 28/10/2022 - 27/10/2025 | 2 |
| Professor Anthony Schapira | 01/12/2019 | 01/12/2022 - 30/11/2025 | 2 |
| Professor Gavin Screaton | 01/09/2018 | 01/09/2021 - 31/08/2024 | 2 |
| Professor Ashok Soni OBE[3] | 06/04/2021 | 06/04/2021 - 05/04/2024 | 1 |
| Ms Joy Warmington MBE[3] | 01/06/2021 | 01/06/2021 - 31/05/2024 | 1 |

*Notes:*

1. *Held office as a Non-Executive Director of Oxford University Hospitals NHS Trust when the Trust became a Foundation Trust. Stepped down at end of term.*
2. *Stepped down at end of term.*
3. *Re-appointed for a further three-year term by the Council of Governors on 17 January 2024.*

Terms of office of the Executive Directors of the Board are available in the Remuneration Report of this Annual Report.

**Board meetings**

The Board met six times in public during the year 2023/24. The table below shows the attendance of the Board members at Board meetings.

| Board member | Position | Attendance |
|---|---|---|
| Professor Sir Jonathan Montgomery | Trust Chair | 6/6 |
| Professor Meghana Pandit | Chief Executive Officer | 6/6 |
| Ms Sarah Hordern[1] | Vice-Chair and Non-Executive Director | 6/6 |
| Ms Anne Tutt[2] | Vice-Chair and Non-Executive Director | 4/4 |
| Mr Paul Dean[3] | Non-Executive Director | 4/4 |
| Ms Claire Feehily[4] | Non-Executive Director | 2/2 |
| Ms Claire Flint | Non-Executive Director | 3/6[11] |
| Ms Paula Hay-Plumb OBE[5] | Non-Executive Director | 2/2 |
| Ms Katie Kapernaros | Non-Executive Director | 5/6[11] |
| Professor Anthony Schapira | Non-Executive Director | 5/6[11] |
| Professor Gavin Screaton | Non-Executive Director | 3/6[11] |
| Professor Ashok Soni OBE | Non-Executive Director | 3/6[11] |
| Ms Joy Warmington MBE | Non-Executive Director | 5/6[11] |
| Dr Andrew Brent[6] | Chief Medical Officer | 3/3 |
| Mr Jason Dorsett | Chief Finance Officer | 6/6 |
| Ms Paula Gardner | Interim Chief Nursing Officer | 5/6[11] |
| Mr Mark Holloway[7] | Chief Estates and Facilities Officer | 4/4 |
| Ms Sara Randall | Chief Operating Officer | 6/6 |
| Mr Terry Roberts[8] | Chief People Officer | 4/4 |
| Ms Rachel Stanfield[9] | Acting Chief People Officer | 2/2 |
| Dr Anny Sykes[10] | Interim Chief Medical Officer | 3/3 |
| Mr David Walliker | Chief Digital and Partnership Officer | 6/6 |
| Ms Eileen Walsh | Chief Assurance Officer | 4/6[12] |

*Notes:*

1. *Vice-Chair from 1 December 2023.*
2. *Vice-Chair and Non-Executive Director to 30 November 2023. Stepped down at end of term.*
3. *Non-Executive Director from 4 September 2023.*
4. *Non-Executive Director from 1 December 2023.*
5. *Non-Executive Director to 3 September 2023. Stepped down at end of term.*
6. *Chief Medical Officer from 9 October 2023.*
7. *Chief Estates and Facilities Officer from 11 September 2023.*
8. *Medical absence to 2 June 2023 with phased return to 31 July 2023.*
9. *Acting Chief People Officer from 1 April 2023 to 31 July 2023, covering medical absence and supporting phased return of Chief People Officer.*
10. *Interim Chief Medical Officer to 8 October 2023.*
11. *Apologies for absence were given.*
12. *Represented by a nominated deputy.*

## Board Committees

In order to discharge the Board's duties effectively, the Trust is required to have Board Committees in place. The Terms of Reference define the purpose, duties and membership of each committee. All Board Committees are chaired by a Non-Executive Director.

A description of each of the Board Committees and their activities during 2023/24 is included in the Annual Governance Statement of this Annual Report.

Further details of the Trust Board and Board Committees are available on the Trust website at www.ouh.nhs.uk/about/trust-board.

The core membership of each committee and their attendance at committee meetings are noted below.

### Investment Committee

The Investment Committee met seven times during 2023/24. The Committee was chaired by Ms Anne Tutt until 30 November 2023 and by Ms Sarah Hordern thereafter. The attendance of the core membership at the Committee meetings is listed below.

| Board member | Position | Attendance |
|---|---|---|
| Ms Sarah Hordern (Chair)[1] | Vice-Chair and Non-Executive Director | 7/7 |
| Ms Anne Tutt (Chair)[2] | Vice-Chair and Non-Executive Director | 4/4 |
| Ms Claire Feehily[3] | Non-Executive Director | 2/2 |
| Ms Katie Kapernaros[4] | Non-Executive Director | 0/1[6] |
| Professor Anthony Schapira | Non-Executive Director | 4/7[6] |
| Mr Jason Dorsett | Chief Finance Officer | 6/7[7] |
| Ms Sara Randall[5] | Chief Operating Officer | 7/7 |
| Mr David Walliker | Chief Digital and Partnership Officer | 6/7[6] |

*Notes:*
1. *Vice-Chair and Investment Committee Chair from 1 December 2023.*
2. *Vice-Chair, Non-Executive Director and Investment Committee Chair to 30 November 2023. Stepped down at end of term.*
3. *Non-Executive Director from 1 December 2023 and committee member from January 2024.*
4. *Committee member from 23 February 2024.*
5. *Committee member from 1 April 2023.*
6. *Apologies for absence were given.*
7. *Represented by a nominated deputy.*

### Integrated Assurance Committee

The Integrated Assurance Committee was chaired by Professor Sir Jonathan Montgomery and met six times during 2023/24. The attendance of the core membership is listed below.

| Board member | Position | Attendance |
|---|---|---|
| Professor Sir Jonathan Montgomery (Chair) | Trust Chair | 5/6[11] |
| Professor Meghana Pandit | Chief Executive Officer | 5/6[11] |
| Ms Sarah Hordern[1] | Vice-Chair and Non-Executive Director | 5/6[11] |
| Ms Anne Tutt[2] | Vice-Chair and Non-Executive Director | 3/4 |
| Mr Paul Dean[3] | Non-Executive Director | 3/3 |
| Ms Claire Feehily[4] | Non-Executive Director | 2/2 |
| Ms Claire Flint | Non-Executive Director | 4/6[11] |
| Ms Paula Hay-Plumb OBE[5] | Non-Executive Director | 3/3 |
| Ms Katie Kapernaros | Non-Executive Director | 6/6 |
| Professor Anthony Schapira | Non-Executive Director | 4/6[11] |
| Professor Gavin Screaton | Non-Executive Director | 2/6[11] |
| Professor Ashok Soni OBE | Non-Executive Director | 2/6[11] |
| Ms Joy Warmington MBE | Non-Executive Director | 4/6[11] |
| Dr Andrew Brent[6] | Chief Medical Officer | 2/3[12] |
| Mr Jason Dorsett | Chief Finance Officer | 6/6 |
| Ms Paula Gardner | Interim Chief Nursing Officer | 5/6[12] |
| Mr Mark Holloway[7] | Chief Estates and Facilities Officer | 3/3 |
| Ms Sara Randall | Chief Operating Officer | 6/6 |
| Mr Terry Roberts[8] | Chief People Officer | 4/4 |
| Ms Rachel Stanfield[9] | Acting Chief People Officer | 2/2 |
| Dr Anny Sykes[10] | Interim Chief Medical Officer | 3/3 |
| Mr David Walliker | Chief Digital and Partnership Officer | 4/6[11] |
| Ms Eileen Walsh | Chief Assurance Officer | 2/6[12] |

*Notes:*

1. *Vice-Chair from 1 December 2023.*
2. *Vice-Chair and Non-Executive Director to 30 November 2023. Stepped down at end of term.*
3. *Non-Executive Director from 4 September 2023.*
4. *Non-Executive Director from 1 December 2023.*
5. *Non-Executive Director to 3 September 2023. Stepped down at end of term.*
6. *Chief Medical Officer from 9 October 2023.*
7. *Chief Estates and Facilities Officer from 11 September 2023.*
8. *Medical absence to 2 June 2023 with phased return to 31 July 2023.*
9. *Acting Chief People Officer from 1 April 2023 to 31 July 2023, covering medical absence and supporting phased return of Chief People Officer.*
10. *Interim Chief Medical Officer to 8 October 2023.*
11. *Apologies for absence were given.*
12. *Represented by a nominated deputy.*

### Audit Committee

The Audit Committee met five times during 2023/24. The Committee was chaired by Ms Paula Hay-Plumb OBE until 3 September 2023 and by Mr Paul Dean thereafter. The attendance of the core membership at the Committee meetings is listed below.

| Board member | Position | Attendance |
|---|---|---|
| Mr Paul Dean (Chair)[1] | Non-Executive Director | 2/2 |
| Ms Paula Hay-Plumb OBE (Chair)[2] | Non-Executive Director | 3/3 |
| Ms Anne Tutt[3] | Vice-Chair and Non-Executive Director | 4/4 |
| Ms Claire Feehily[4] | Non-Executive Director | 1/1 |
| Ms Katie Kapernaros | Non-Executive Director | 5/5 |

*Notes:*

1. *Non-Executive Director and Audit Committee Chair from 4 September 2023.*
2. *Non-Executive Director and Audit Committee Chair to 3 September 2023. Stepped down at end of term.*
3. *Vice-Chair and Non-Executive Director to 30 November 2023. Stepped down at end of term.*
4. *Non-Executive Director from 1 December 2023.*

### Remuneration and Appointments Committee

The membership of the Remuneration and Appointments Committee and their attendance at the Committee meetings can be found in the Remuneration Report of this Annual Report.

### Board Registers

#### *Board of Directors' Register of Interests*

Any declarations of interests made by members of the Trust Board are confirmed at each meeting of the Board and its committees and recorded in the minutes of the relevant meetings. The Board of Directors' Register of Interests is open to the public and is published on the Trust website at www.ouh.nhs.uk/about/trust-board.

Any enquiries on the Board of Directors' Register of Interests should be made in writing to the Head of Corporate Governance, Level 3, Academic Corridor, John Radcliffe Hospital, Headington, Oxford OX3 9DU or by email to company.secretary@ouh.nhs.uk.

#### *Board of Directors' Register of Gifts, Hospitality and Sponsorship*

The Register of Gifts, Hospitality and Sponsorship is open to the public and is published on the Trust website at www.ouh.nhs.uk/about/trust-board. Any enquiries on the Board of Directors' Register of Gifts, Hospitality and Sponsorship should be made in writing to the Head of Corporate Governance, Level 3, Academic Corridor, John Radcliffe Hospital, Headington, Oxford OX3 9DU or by email to company.secretary@ouh.nhs.uk.

#### *Contacting the Board of Directors*

The public or members of the Trust can contact the Board of Directors through the Corporate Governance Department by writing to the Head of Corporate Governance, Level 3, Academic Corridor, John Radcliffe Hospital, Headington, Oxford OX3 9DU or by email to company.secretary@ouh.nhs.uk.

## NHS England's well-led framework disclosures

Throughout the year 2023/24, the Trust continued to focus on compliance with the well-led framework.

Actions taken during the year included, but were not limited to:

- reviewing and updating the Trust's Quality Priorities
- continuing to focus on staff wellbeing, with forums and initiatives to enable staff to discuss concerns, and with specific actions to address certain estate-related issues raised by staff
- improving the use of local audit results to identify areas of focus and to enable more effective monitoring of performance
- continuing to develop the Integrated Performance Report to make more use of statistical process control charts.

Further information on the governance structure that supports the organisation can be found in the Annual Governance Statement of this Annual Report.

There were no material inconsistencies between the Annual Governance Statement and other reports of the Annual Report.

### Regulatory Rating

As of 31 March 2023, the Trust had an overall rating of 'Requires Improvement' (RI) from the Care Quality Commission (CQC). This was consistent with the rating disclosed in the previous Annual Report and reflected the well-led activities undertaken by the CQC during the year 2019/20 and the results of the inspection of the Horton General Hospital Midwifery Led Unit. The Annual Governance Statement, found later in this Annual Report, describes the full activities carried out by CQC during the year.

The issues in the CQC inspection reports received during 2023/24, in relation to Oxford Critical Care unit at the John Radcliffe Hospital and the Midwife Led Unit at the Horton General Hospital resulted in specific action plans that were reported through the governance structures of the Trust. The monitoring of the action plans have been undertaken through routine reporting to the respective Divisional Management Committees, Trust Management Executive and Performance Review meetings. The action plans are subject to continuous review and focus.

In addition, there is a range of wider actions to enhance well-led compliance. These include a continued focus on statutory and mandatory training, consistent appraisal completion, medicines management and infection control. Moreover, the Trust has continued to work on actions in relation to the national waiting time standards that relate to the current RI rating in the 'responsive' category, including the Integrated Quality Improvement Programme.

Further information on the plans and actions taken in response to the CQC inspections can be found in the Annual Governance Statement of this Annual Report.

## Disclosures

The Trust is required to make the following disclosures.

### Directors' responsibility for the Annual Report and Accounts

The Board of Directors takes the responsibility for preparing the Annual Report and Accounts of the Trust. The Directors consider that the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, public, regulators and other stakeholders to assess the Trust's performance and strategy.

### Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

### Income disclosures as required by section 43(2A) of the NHS Act 2006

NHS legislation states that the Trust should primarily deliver NHS-funded healthcare, which is measured by testing that non-NHS activity (including research and development, and education and training) is no more than 49% of total income. Our analysis shows that the Trust has met this requirement with NHS healthcare activities comprising 85.6% of total income.

NHS legislation also requires that the Trust tests that this activity does not significantly interfere with NHS activity. The Trust has concluded that there is no significant interference based on the surpluses generated and the lack of any direct conflicts between commercial activities and NHS activities.

### Political donations

The Trust made no political donations during the financial year.

### Investments

The Trust has a number of investments in associates and joint venture entities. Further information is available in notes 19 to 21 of the Annual Accounts found later in this document.

**Better Payment Practice Code Performance**

| Indicator | Target[1] | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| **Total non-NHS trade invoices paid in the period** | | | | |
| Number | n/a | 167,829 | 176,275 | 4.8% reduction |
| £000 | n/a | 1,041,111 | 962,267 | 8.2% increase |
| **Total non-NHS trade invoices paid within the target** | | | | |
| Number | n/a | 119,364 | 138,557 | 13.9% reduction |
| £000 | n/a | 890,719 | 879,992 | 1.2% increase |
| **Percentage of non-NHS trade invoices paid within the target** | | | | |
| Number | 95% | 71.1% | 78.6% | 7.5 percentage point deterioration |
| £000 | 95% | 85.6% | 91.4% | 5.8 percentage point deterioration |
| **NHS Payables** | | | | |
| **Total NHS trade invoices paid in the period** | | | | |
| Number | n/a | 3,965 | 4,159 | 4.7% reduction |
| £000 | n/a | 36,283 | 37,176 | 2.4% reduction |
| **Total NHS trade invoices paid within the target** | | | | |
| Number | n/a | 2,896 | 3,280 | 11.7% reduction |
| £000 | n/a | 23,348 | 27,323 | 14.5% reduction |
| **Percentage of NHS trade invoices paid within the target** | | | | |
| Number | 95% | 73.0% | 78.9% | 5.9 percentage point deterioration |
| £000 | 95% | 64.3% | 73.5% | 9.2 percentage point deterioration |

*Note:*

1. *Under the Better Payment Practice Code, NHS providers have a responsibility to pay 95% of invoices by volume and by value within 30 days of the date of invoice.*

The Trust has a responsibility to pay its suppliers in line with the payment terms agreed at the time of purchase. Failure to do this would harm the reputation of the Trust and the wider NHS, as well as damaging supply sources and straining relationships with suppliers.

Performance against the Better Payment Practice Code deteriorated in 2023/24. The Trust continues to work to ensure that approved invoices are paid promptly.

During this period, the Trust paid £48,232 arising from claims made under The Late Payment of Commercial Debts (Interest) Act 1998.

# Trust Membership and Council of Governors

This report provides information on the membership of Oxford University Hospitals NHS Foundation Trust and its Council of Governors.

## Trust membership

All NHS Foundation Trusts have a statutory duty to engage with their local communities and staff to encourage people who use their services to become members of their Trust.

The Trust aims to recruit and develop a membership which fairly represents people living in the communities served by the Trust. This includes patients, former patients, carers and members of the public, not only in Oxfordshire but also from the surrounding counties of Berkshire, Buckinghamshire, Northamptonshire, Warwickshire, Gloucestershire and Wiltshire, as well as the rest of England and Wales.

Our Membership Strategy aims to build an engaged and representative membership to support our members to be well-informed, and motivated and to provide them with opportunities to help shape how our services are developed and delivered. This supports the Trust in meeting its objectives and priorities by being a responsive organisation with a good understanding of the needs of its patients and the communities it serves.

Our public membership is broadly in line with the ethnic breakdown of the population of Oxfordshire and the geographic reach of our patient base, and is disproportionately balanced towards older age groups, with the majority of our members aged over 50. Following a review of the Membership Strategy, more engagement with younger members and people from seldom heard groups was pursued to encourage them to become members of the Trust.

The Membership Team works actively with colleagues to maximise recruitment opportunities. During the year, we continued to invite our patients and the public to become members of the Trust. We promoted membership via our Governors, members and social media. We attended events, when possible, to undertake active recruitment, and held membership recruitment activities at apprenticeship and careers events, as well as Older People’s Day events and the Hong Kongers’ Lunar New Year Celebration in Oxford.

More information about the Trust’s membership and Membership Strategy is available on the Trust website at www.ouh.nhs.uk/ft.

## Membership constituencies

The Trust has two membership constituencies: Public and Staff.

### *Public constituency*

Anyone aged 16 or over and living in England or Wales can become a member of the Trust. Our Public membership is divided into eight constituencies.

As at 31 March 2024, the Trust had 7,573 Public constituency members (7,592 as at 31 March 2023).

| Public constituency | 2023/24 | 2022/23 |
|---|---|---|
| Cherwell | 1147 | 1,152 |
| Oxford City | 1740 | 1,729 |
| South Oxfordshire | 742 | 746 |
| Vale of White Horse | 1053 | 1,062 |
| West Oxfordshire | 837 | 856 |
| Buckinghamshire, Berkshire, Gloucestershire and Wiltshire | 1005 | 1,020 |
| Northamptonshire and Warwickshire | 404 | 417 |
| Rest of England and Wales | 645 | 610 |
| **Total** | **7,573** | **7,592** |

### *Staff constituency*

The Staff constituencies are made up of individuals employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months, or who have been continuously employed by the Trust under a contract of employment for at least 12 months (for instance, the honorary contract holders). This also includes people who undertake functions for the Trust but have a contract of employment with the University of Oxford within its Medical Sciences Division or are employed by a Private Finance Initiative (PFI) organisation to provide services at any of the Trust's premises.

There are two Staff constituencies, Clinical and Non-Clinical. The Staff constituencies had 17,050 members as at 31 March 2024 (16,453 as at 31 March 2023).

## Council of Governors

As a Foundation Trust, we have a Council of Governors elected by the Public and Staff members, as well as appointed representatives from local organisations that we work with. The Trust is accountable through our membership and Council of Governors to our local communities.

The Governors play a valuable role by holding the Trust's Non-Executive Directors to account for the performance of the Board of Directors. They also ensure that the interests of the Trust's members (staff, patients and the wider public) and the views of the organisations that the appointed Governors represent, are considered, when shaping the Trust's forward plans.

In addition to holding the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors, the Council of Governors is responsible for:

- appointing or removing the Trust Chair and the other Non-Executive Directors
- approving the appointment (by the Non-Executive Directors) of the Chief Executive Officer
- deciding on the remuneration and allowances, and other terms and conditions of office, of the Trust Chair and the other Non-Executive Directors
- appointing or removing the Trust's External Auditor
- approving significant transactions
- approving any changes to the Trust's Constitution.

To allow the Governors to exercise their statutory duties, the Trust Board is responsible, among other things, for ensuring the Council of Governors:

- receives the Annual Report and Annual Accounts of the Trust
- is presented with other management reports detailing the Trust's performance
- provides its views when the Board is preparing the Trust's forward plan
- is able to engage with their members, or in the case of an appointed Governor, to engage with members of the representing organisation.

Our Council of Governors has now completed its eighth full year of operation following our authorisation as a Foundation Trust. Over that time, there has been regular and increasing engagement with the Board, within the context of which concerns may be raised by the Council as a whole, or by individual Governors.

The Chair of the Trust is also the Chair of the Council of Governors and has the responsibility of updating the Board regularly on matters arising from the Council of Governors, Trust members and the Membership Strategy. The Governors are encouraged to canvass opinions and concerns of the members they represent, and to this effect, constituency meetings take place throughout the year around Oxfordshire for Governors to seek people's views of the Trust and the services provided.

More information about our Council of Governors is available on the Trust website at www.ouh.nhs.uk/about/governors.

**Composition of the Council of Governors**

The Council is made up of 16 elected Governors representing the Public constituencies, six elected Governors from the Staff constituencies, and a total of eight appointed Governors from partner organisations, as shown in the table below. All elected and appointed Governors hold a term of office of up to three years.

| Elected Governors | Seats |
|---|---|
| **Public constituencies** | **16** |
| Cherwell | 2 |
| Oxford City | 2 |
| South Oxfordshire | 2 |
| Vale of White Horse | 2 |
| West Oxfordshire | 2 |
| Buckinghamshire, Berkshire, Gloucestershire and Wiltshire | 3 |
| Northamptonshire and Warwickshire | 2 |
| Rest of England and Wales | 1 |
| **Staff constituencies** | **6** |
| Clinical | 4 |
| Non-Clinical | 2 |
| **Appointed Governors** | **Seats** |
| **Required by statute** | **2** |
| Oxfordshire County Council | 1 |
| University of Oxford | 1 |
| **Nominated** | **6** |
| Oxford Brookes University | 1 |
| Oxford Health NHS Foundation Trust | 1 |
| Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) | 1 |
| Oxfordshire Local Medical Committee | 1 |
| Specialist Commissioner (nominated by NHS Commissioning Board) | 1 |
| Young person (nominated by Young People’s Executive) | 1 |

**Members of the Council of Governors**

The Governors who were in post during the period 1 April 2023 to 31 March 2024 and their attendance at the four general meetings held during the year are shown below.

| Elected Governors – Public constituencies | | | | |
|---|---|---|---|---|
| **Name** | **Constituency** | **Tenure** | **Term** | **Attendance** |
| Gemma Davison | Cherwell | 01/04/2021 - 31/03/2024 | 1 | 2/4 |
| Anita Higham[1] | Cherwell | 01/04/2022 - 19/09/2023 | 3 | 0/2 |
| Mike Gotch | Oxford City | 01/04/2021 - 31/03/2024 | 1 | 4/4 |
| Jane Probets | Oxford City | 01/04/2022 - 31/03/2025 | 1 | 0/4 |
| Janet Knowles | South Oxfordshire | 01/04/2022 - 31/03/2025 | 2 | 4/4 |
| Nina Robinson | South Oxfordshire | 01/04/2021 - 31/03/2024 | 1 | 3/4 |
| David Matthews | Vale of White Horse | 01/04/2022 - 31/03/2025 | 1 | 3/4 |
| Jill Haynes | Vale of White Horse | 01/04/2021 - 31/03/2024 | 3 | 2/4 |
| Robin Carr | West Oxfordshire | 01/04/2022 - 31/03/2025 | 1 | 2/4 |
| Graham Shelton | West Oxfordshire | 01/04/2021 - 31/03/2024 | 2 | 4/4 |
| Sally-Jane Davidge | Buckinghamshire, Berkshire, Gloucestershire and Wiltshire | 01/04/2021 - 31/03/2024 | 3 | 4/4 |
| Jeremy Hodge | Buckinghamshire, Berkshire, Gloucestershire and Wiltshire | 01/04/2022 - 31/03/2025 | 1 | 4/4 |
| Sally-Anne Watts | Buckinghamshire, Berkshire, Gloucestershire and Wiltshire | 01/04/2021 - 31/03/2024 | 1 | 1/4 |
| Anthony Bagot-Webb | Northamptonshire and Warwickshire | 01/04/2021 - 31/03/2024 | 2 | 3/4 |
| Mark Whitley | Northamptonshire and Warwickshire | 01/04/2022 - 31/03/2025 | 1 | 0/4 |
| Jonathan Wyatt | Rest of England and Wales | 01/04/2022 - 31/03/2025 | 2 | 4/4 |
| **Elected Governors – Staff constituencies** | | | | |
| **Name** | **Constituency** | **Tenure** | **Term** | **Attendance** |
| Giles Bond-Smith | Clinical | 01/04/2021 - 31/03/2024 | 1 | 0/4 |
| George Krasopoulos | Clinical | 01/04/2022 - 31/03/2025 | 1 | 4/4 |
| Julie Stockbridge | Clinical | 01/04/2021 - 31/03/2024 | 3 | 4/4 |
| Pauline Tendayi | Clinical | 01/04/2022 - 31/03/2025 | 1 | 0/4 |
| Aliki Kalianou[2] | Non-Clinical | 01/04/2022 - 31/03/2024 | 1 | 4/4 |
| Megan Turmezei | Non-Clinical | 01/04/2022 - 31/03/2025 | 1 | 4/4 |

| Appointed Governors | | | | |
|---|---|---|---|---|
| **Name** | **Constituency** | **Tenure** | **Term** | **Attendance** |
| Vacancy | Berkshire, Buckinghamshire and Oxfordshire Local Medical Committees | Since 05/07/2017 | | |
| Vacancy | NHS England | Since 05/01/2021 | | |
| Astrid Schloerscheidt [3] | Oxford Brookes University | 03/07/2020 - 02/07/2023 | 2 | 0/3 |
| Lorraine Dixon | Oxford Brookes University | 02/10/2023 - 01/10/2026 | 1 | 1/1 |
| Stuart Bell CBE | Oxford Health NHS Foundation Trust | 16/10/2023 - 15/10/2026 | 2 | 3/4 |
| Tim Bearder | Oxfordshire County Council | 20/12/2022 - 19/12/2025 | 1 | 0/4 |
| Helen Higham | University of Oxford | 16/10/2023 - 15/10/2026 | 2 | 0/4 |
| Annabelle[4] | Young People's Executive | 01/09/2022 - 31/08/2025 | 1 | 2/4 |
| Ishaan[4] | Young People's Executive | 01/09/2022 - 31/08/2025 | 1 | 0/4 |

*Notes:*

1. *Resigned during tenure.*
2. *Unexpired term of the previous Governor.*
3. *Stepped down at end of term.*
4. *The Council agreed that, due to the age of the Young People's Executive members, two young Governors could share this seat. However, only a single vote is associated with the post.*

### ***Lead Governor***

In line with the requirement of NHS England, the Council of Governors nominates a Lead Governor. The selection of the Lead Governor takes place on an annual basis by an electronic secret ballot following self-nomination, seconded by one other Governor. The Chairs of the Council of Governors' committees can deputise for the Lead Governor when required.

Mr Graham Shelton, a Public Governor for West Oxfordshire, was re-elected by the Council of Governors as the Lead Governor for a one-year term from 1 April 2023.

The current list of members of the Council of Governors is available on the Trust website at www.ouh.nhs.uk/about/governors.

### *Council of Governors' election*

The Trust operates a three-yearly cycle for elections to the Council of Governors, with half of the seats elected in year one for the vacant seats of the Public and Staff constituencies and the other half of the vacant seats elected in year two, and no elections held in the third year.

Elections were held in the spring of 2024 for all constituencies, except for the Rest of England and Wales constituency, and its election will take place next year. Those elected started their term of office on 1 April 2024.

### *Council of Governors' meetings*

The Council of Governors holds a minimum of four general meetings a year, at which the Board of Directors is invited to observe, and, at the request of Governors, speak on particular matters. The general meetings are open to the public for observation.

The Council held four general meetings in 2023/24, with all meetings taking place face-to-face. Meetings were held in Wantage, Oxford, Witney and Bicester to enable members of the public to attend.

### *Annual Public Meeting and Annual Members' Meeting*

The Trust holds an Annual Public Meeting and Annual Members' Meeting for the Council of Governors and members of the Trust which is also open to the public. In 2023/24, this event was held face-to-face. The Board delivered a review of the last year along with the Annual Accounts and the Trust's plans for the future.

The Annual Report of the Trust was presented to the Council of Governors at a general meeting of the Council.

### *Council of Governors' Register of Interests*

The Council of Governors' Register of Interests is maintained by the Trust and reviewed throughout the year. It is available on the Trust website at www.ouh.nhs.uk/about/governors. Any enquiries about the Council of Governors' Register of Interests can be made in writing to the Head of Corporate Governance, Level 3, Academic Corridor, John Radcliffe Hospital, Headington, Oxford OX3 9DU or by email to governors@ouh.nhs.uk.

### *Contacting the members of the Council of Governors*

The public can contact a member of the Council of Governors through the Corporate Governance Department by writing to the Head of Corporate Governance, Level 3, Academic Corridor, John Radcliffe Hospital, Headington, Oxford OX3 9DU or by email to governors@ouh.nhs.uk.

### Board engagement with the Council of Governors

Board members, with the exception of the Trust Chair, are not members of the Council of Governors and are not formally required to attend the Council's general meetings. However, Non-Executive Directors regularly attend the Council of Governors' meetings, and Executive Directors attend to comment when issues relevant to their portfolio are on the agenda.

In addition, Non-Executive Directors attend meetings of the two Council of Governors' Committees, the Performance, Workforce and Finance Committee (PWF), and the Patient Experience, Membership and Quality Committee (PEMQ). This enables Governors to hold the Non-Executive Directors to account and to ask questions related to particular portfolios.

Joint Board and Governors seminars are held to enable the Governors to be kept up to date with Trust activities and developments, and to seek answers from the Board. A number of Board meetings and Council of Governors meetings are also organised to take place on the same day and location to enable Governors to have informal discussions with the Board members.

### Remuneration, Nominations and Appointments Committee

The Council of Governors' Remuneration, Nominations and Appointments Committee (RNAC) is constituted as a standing committee of the Council of Governors and is authorised by the Council to act within its Terms of Reference. The Committee consists of Governors appointed by the Council and is chaired by the Trust Chair. Only the members of the Committee have the right to attend its meetings.

The Committee's role includes coordinating the process of recruitment of Non-Executive Directors, including the Trust Chair, on behalf of the Council of Governors and receiving assurance regarding the appraisal of the Non-Executive Directors and the Trust Chair. Appraisal of the Trust Chair is undertaken by the Senior Independent Director with Governors contributing to the process and the Committee receiving the outcome. Appraisals of other Non-Executive Directors are undertaken by the Trust Chair and outcomes reported to the Committee.

During the year 2023/24, the RNAC met four times and the key business undertaken by the Committee included the following.

- Reviewing the Trust Chair's role description and person specification and agreeing amendments to reflect the Trust's needs for the next three to five years and its position within the developing Integrated Care System.
- Reviewing the process for appointing the Trust Chair and Non-Executive Directors.
- Reviewing and agreeing revised Terms of Reference for the Committee including term limits for the Vice-Chair.
- Agreeing the process for the Trust Chair's appraisal and receiving the outcome of the appraisal.
- Reviewing the remuneration of the Trust Chair.
- Receiving reports on Non-Executive Director appraisals and their remuneration.
- Recommending the appointment of the Trust Vice-Chair.
- Recommending the reappointment of two Non-Executive Directors.
- Receiving changes to the Trust's Fit and Proper Persons Test process.

# Remuneration Report

## Annual Statement on Remuneration from the Chair of the Committee

In discharging its responsibility for setting the remuneration and conditions of service for the Trust's most senior managers, the Remuneration and Appointments Committee's main objectives are to approve contracts of employment for the Chief Executive Officer, Executive Directors, who are defined as members of the Trust Board, and Divisional Directors, and to ensure that the remuneration packages are sufficient to recruit and retain individuals of the calibre required for the successful operation of the Trust.

To do so, the Committee:

- ensures an objective evaluation of all relevant job roles
- makes decisions in the context of the current market
- considers independently-sourced benchmarking data and analysis of pay within relevant NHS, private health and non-healthcare markets
- compares pay with other staff on nationally agreed Agenda for Change and Medical Consultant terms and conditions of service
- considers issues of equal pay, utilising appropriate available data to make decisions and recommendations
- ensures appropriate approvals for proposals are obtained from NHS England and the Department of Health and Social Care where required.

The Remuneration and Appointments Committee is composed of all the Non-Executive Directors and, on behalf of the Trust Board, is responsible for determining policies for the remuneration and terms and conditions of service for all very senior managers (VSMs) consisting of the Executive Directors and other managers on VSM contracts, and for the four Divisional Directors. Where a very senior manager is on nationally agreed terms and conditions of service, the Committee determines any local elements of their contractual arrangements.

The Committee's workload in 2023/24 included:

- agreeing objectives and reviewing performance appraisals for the Chief Executive Officer, Executive Directors and Divisional Directors
- reviewing remuneration and agreeing cost of living increases for staff within its remit
- appointing the substantive Chief Medical Officer and Chief Estates and Facilities Officer
- appointing the substantive Chief Nursing Officer and Deputy Chief Executive Officer to commence in 2024/25
- appointing an Interim Chief Digital and Partnership Officer and Interim Chief Operating Officer to commence in 2024/25 to cover vacant positions.

Signed: Claire Flint
Chair of Remuneration and Appointments Committee
26 June 2024

## Senior Managers’ Remuneration Policy

The senior managers of the Trust are defined as the Trust Chair, Chief Executive Officer, Non-Executive Directors and Executive Directors, who are the members of the Trust Board and have the authority and responsibility to direct or control major activities and influence the Trust as a whole.

The Trust applies a rigorous approach when setting and reviewing the remuneration of the Trust’s senior managers. In doing so, the Trust aims to ensure a balance between the appropriate use of public money, fair and proportionate remuneration packages which reflect the responsibilities of leading and working in a complex environment, and the application of pay levels which promote the long-term success of the organisation by recruiting and retaining high calibre individuals in a competitive marketplace.

The Non-Executive Directors of the Board, including the Trust Chair, are considered ‘office holders’ and not employees. Their remuneration and terms and conditions are determined by the Council of Governors’ Nominations, Remuneration and Appointments Committee. Non-Executive Directors’ pay is composed of an annual allowance, and they can claim appropriate expenses in line with Trust policies.

An additional responsibility allowance is paid to the Vice-Chair, Senior Independent Director and some Chairs of the Board Committees. Non-Executive Directors are eligible for a maximum of one responsibility allowance. Information on Non-Executive Directors’ performance appraisals is available in the Trust Membership and Council of Governors Report of this Annual Report.

The Remuneration and Appointments Committee of the Trust Board determines the remuneration for the Trust’s Executive Directors, including the Chief Executive Officer. Their remuneration comprises a base pay, pension-related benefits and any taxable benefits. The Committee is also responsible for agreeing on any elements of performance-related pay and evaluating performance against set objectives. The Trust complies with guidance from NHS England and on pay for senior managers including an earn-back clause for Executive Directors which places up to 10% of salary at risk depending on performance.

Performance appraisals for the Executive Directors are conducted annually by the Chief Executive Officer using the Trust’s values-based appraisal system. The Trust Chair undertakes the annual performance appraisal of the Chief Executive Officer. The Remuneration and Appointments Committee reviews the individual and team performance reports and conducts earn-back assessments.

**Future Policy Table**

The Future Policy Table below gives a description of each of the components of the remuneration package for senior managers, which comprise the senior managers' Remuneration Policy.

| How the component supports the strategic aims of the Trust | How the component operates | Maximum potential value | Description of framework used to assess performance |
|---|---|---|---|
| **Base pay** | | | |
| Base pay is determined using benchmarked data in order to attract, reward and retain individuals of the right calibre to lead the delivery of the Trust's aims and objectives. | Determined by the Remuneration and Appointments Committee using a range of data and external job evaluation as set out in the Very Senior Managers Pay and Reward Policy. Salaries are reviewed annually to account for the cost of living, and any changes are normally effective from 1 April each year. | As set out in the Salary and Pension Entitlements of Senior Managers table found later in this report. | The Trust's values-based appraisal and objective setting process is used for all staff, including Executive Directors. Additional measures are proposed by the Chief Executive Officer and / or Chair and agreed by the Remuneration and Appointments Committee. |
| **Performance-related pay** | | | |
| Performance-related pay is used to reward Executive Directors for achieving specific objectives, beyond the scope of their core role. | Determined by the Remuneration and Appointments Committee following a request by the Chief Executive Officer and / or Chair. | As set out in the Salary and Pension Entitlements of Senior Managers table found later in this report. | Specific objectives which are linked to performance-related pay are reviewed regularly by the Remuneration and Appointments Committee. |
| **Awards for clinical excellence/impact** | | | |
| As a practising clinician, the Chief Medical Officer is also eligible for national / local clinical excellence / impact awards. | The Chief Medical Officer receives a national clinical impact award, which is coordinated by the Advisory Committee for Clinical Impact Awards and funded from a central pot. | In accordance with the terms and conditions of the clinical excellence / impact award schemes. | The National Clinical Impact Awards scheme is assessed by a panel of senior clinicians at a national level. |
| **Pension-related benefits** | | | |
| Pension benefits (which may be opted out of) are part of the total remuneration of Executive Directors to attract, reward and retain individuals | Pension is available as a benefit to Executive Directors and follows the NHS Pension Scheme contribution rules. See also Pension Contribution Alternative Award Policy below. | Contributions and entitlements are in accordance with the NHS Pension Scheme for all | Not applicable. |

| How the component supports the strategic aims of the Trust | How the component operates | Maximum potential value | Description of framework used to assess performance |
|---|---|---|---|
| of the right calibre to lead the delivery of the Trust's aims and objectives. | | employees who are members. | |
| **Pension Contribution Alternative Award Policy** | | | |
| Supports the retention of staff who may otherwise consider leaving the organisation or reducing their hours to avoid being adversely impacted by the annual allowance. | The Trust operates a scheme to support staff who choose to opt out of the NHS Pension Scheme because they are affected by annual allowance taxation. The scheme restructures the total reward package of an employee by paying a figure broadly equivalent to the employer pension contributions that the Trust would otherwise pay if they remained a member of the NHS Pension Scheme. The scheme is open to all employees that meet the policy's eligibility criteria. | 12.38% of pensionable pay. | Not applicable. |
| **Earn-back scheme** | | | |
| Promotes individual and team high performance within the Executive Team. | The Remuneration and Appointments Committee agrees the objectives for the Executive Directors and monitors this through mid-year and end-of-year reviews (including the annual performance appraisal). The Committee reviews the individual and team performance and conducts earn-back reviews based on this. | No payments are made, but up to 10% of annual salary is placed at risk. | Assessment of achievement of Executive Team objectives. |
| **Benefits** | | | |
| To support the Trust's total reward package to attract, reward and retain staff at all levels, the Trust operates several salary sacrifice schemes including for childcare vouchers, bicycles and lease cars. These are optional and available to all staff members. | | | |
| **Travel expenses** | | | |
| Appropriate travel expenses are paid for business mileage in line with the Trust's Payment of Expenses Procedure. | | | |

*Note:*

- *The Trust adopts the following steps to satisfy itself that the remuneration paid in excess of the threshold of £150,000 for senior managers is reasonable:*
  - *The Remuneration and Appointments Committee comprising all the Non-Executive Directors sets the pay for senior managers and provides objective scrutiny of pay.*
  - *As outlined in guidance issued by the Cabinet Office, regard is paid to remuneration benchmarking data, market conditions and the individual employee's level of experience and development of the role.*

**Service contracts obligations**

There are no special contractual compensation issues for the early termination of Executive Director contracts or any obligations that would give rise to, or impact on, remuneration payments or payments for loss of office.

**Policy on Payment for Loss of Office**

Senior managers' contracts primarily stipulate a minimum notice period of six months. As detailed above, there are no special contractual compensation issues for the early termination of Executive Director contracts. However, payment in lieu of notice, as a lump sum payment, may be made at the Trust's discretion, subject to approval from the Remuneration and Appointments Committee and in line with governance limits.

Early termination by reason of redundancy is subject to the normal provisions of the NHS Terms and Conditions of Service Handbook. For staff above the minimum retirement age, early termination by reason of redundancy or in the interests of efficiency of the service is in accordance with the NHS Pension Scheme. Employees above the minimum retirement age, who themselves request termination by reason of early retirement, are subject to the normal provisions of the NHS Pension Scheme.

**Consideration of employment conditions elsewhere in the Trust**

When determining the appropriate remuneration for Non-Executive Directors, including the Trust Chair, the Council of Governors' Nominations, Remuneration and Appointments Committee takes into consideration national guidance from NHS England, alongside independently sourced benchmarking data from a range of comparator organisations.

In determining the pay and conditions of employment for Executive Directors and other very senior managers, the Remuneration and Appointments Committee takes into consideration prevailing market rates assessed against benchmarking data, responsibilities and duties of the post, objective job evaluation, and national guidance including VSM pay guidelines from NHS England.

The remuneration for all other members of staff, both medical and non-medical, is determined by national terms and conditions such as the Medical and Dental Terms and Conditions and NHS Terms and Conditions of Service (Agenda for Change).

**Policy on Diversity and Inclusion**

The Trust Board recognises that diversity and inclusion are a vital part of the continued assessment and enhancement of the Board and is committed to fostering diversity within Board composition. Prior to any appointment made to the Executive team, the Remuneration and Appointments Committee evaluates the balance of skills, knowledge, experience and diversity of the team and, in the light of the evaluation, the Committee reviews a description of the role and capabilities required for a particular appointment. The Committee ensures that the appointment process is designed to attract the best candidates, using a range of open advertising and / or using the services of external advisers to facilitate the search, and also ensures that appointments to the Board of Directors are subject to a formal, rigorous and transparent procedure.

## Annual Report on Remuneration

### Service contracts

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment. The Interim Chief Nursing Officer had a fixed term contract which ended on 30 April 2024.

The Chief Executive Officer and other Executive Directors have permanent employment contracts with appropriate notice periods in line with employment legislation, rather than a fixed term. This is in line with similar contracts in the sector. Acting up arrangements and secondments are usually made for a fixed period.

The following table contains details of the service contracts in place during 2023/24 for Executive Directors.

| Name | Position | Date of contract as Executive Director | Contract type | Notice period |
|---|---|---|---|---|
| Professor Meghana Pandit[1] | Chief Executive Officer | 01/01/2019 | Permanent | Six months |
| Dr Andrew Brent | Chief Medical Officer | 09/10/2023 | Permanent | Six months |
| Mr Jason Dorsett | Chief Finance Officer | 03/10/2016 | Permanent | Six months |
| Ms Paula Gardner | Interim Chief Nursing Officer | 01/04/2023 | Fixed term contract | Three months |
| Mr Mark Holloway | Chief Estates and Facilities Officer | 11/09/2023 | Permanent | Six months |
| Ms Sara Randall | Chief Operating Officer | 01/07/2019 | Permanent | Six months |
| Mr Terry Roberts[2] | Chief People Officer | 10/02/2020 | Permanent | Six months |
| Ms Rachel Stanfield[3] | Acting Chief People Officer | 01/04/2023 - 31/07/2023 | Acting up | Three months |
| Dr Anny Sykes | Interim Chief Medical Officer | 01/07/2022 - 08/10/2023 | Secondment | Three months |
| Mr David Walliker | Chief Digital and Partnership Officer | 28/10/2019 | Permanent | Six months |
| Ms Eileen Walsh | Chief Assurance Officer | 01/05/2011 | Permanent | Six months |

*Notes:*

1. *Chief Medical Officer from 1 January 2019 to 30 June 2022 and Chief Executive Officer from 1 July 2022 (fixed term contract from 1 July 2022 to 28 February 2023 and substantive from 1 March 2023).*
2. *Medical absence to 2 June 2023 with phased return to 31 July 2023.*
3. *Acting Chief People Officer from 1 April 2023 to 31 July 2023, covering medical absence and supporting phased return of Chief People Officer.*

The details of terms of office for Non-Executive Directors are available in the Directors' Report of this Annual Report.

**Remuneration and Appointments Committee**

The Remuneration and Appointments Committee is constituted as a standing committee of the Trust Board. The Committee is a Non-Executive Committee and has no executive powers, other than those specifically delegated in the Terms of Reference. The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference.

For the purpose of assisting with its business and informing its decision-making, the Committee may commission external expert advice, as necessary, from specialist agencies.

The Committee was chaired by Ms Claire Flint and met twice in 2023/24. The following table contains details of the core membership of the Committee and their attendance at Committee meetings in 2023/24.

| Committee Member | Title | Attendance |
|---|---|---|
| Ms Claire Flint (Chair) | Non-Executive Director | 2/2 |
| Professor Sir Jonathan Montgomery | Trust Chair | 2/2 |
| Ms Sarah Hordern[1] | Vice-Chair and Non-Executive Director | 2/2 |
| Ms Anne Tutt[2] | Vice-Chair and Non-Executive Director | 1/2[6] |
| Mr Paul Dean[3] | Non-Executive Director | 1/1 |
| Ms Claire Feehily[4] | Non-Executive Director | 0/0 |
| Ms Paula Hay-Plumb OBE[5] | Non-Executive Director | 0/1[6] |
| Ms Katie Kapernaros | Non-Executive Director | 2/2 |
| Professor Anthony Schapira | Non-Executive Director | 2/2 |
| Professor Gavin Screaton | Non-Executive Director | 1/2[6] |
| Professor Ashok Soni OBE | Non-Executive Director | 0/2[6] |
| Ms Joy Warmington MBE | Non-Executive Director | 1/2[6] |

*Notes:*

1. *Vice-Chair from 1 December 2023.*
2. *Vice-Chair and Non-Executive Director to 30 November 2023. Stepped down at end of term.*
3. *Non-Executive Director from 4 September 2023.*
4. *Non-Executive Director from 1 December 2023.*
5. *Non-Executive Director to 3 September 2023. Stepped down at end of term.*
6. *Apologies for absence were given.*

In addition to the members of the Committee, the Chief Executive Officer and the Chief People Officer are in attendance at the meetings to provide relevant advice to the Committee to support decision-making. Neither of them is involved in any discussions regarding their own remuneration.

## Salary and Pension Entitlements of Senior Managers 2023/24 *(this information is subject to audit)*

| Salary and Pension Entitlements of Senior Managers 2023/24 (12 months to 31 March 2024) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Name** | **Title** | **Effective dates if not in post full year** | **Salary (bands of £5,000) £000** | **Taxable benefits (£s to the nearest £100) £** | **Annual performance related bonuses[4] (bands of £5,000) £000** | **Long-term performance related bonuses (bands of £5,000) £000** | **Payment in lieu of pension (bands of £5,000) £000** | **All pension related benefits (bands of £2,500) £000** | **Total including all pension related benefits (bands of £5,000) £000** |
| ***Non-Executive Directors[1,2]*** | | | | | | | | | |
| Professor Sir Jonathan Montgomery[3] | Trust Chair | | 70-75 | | | | | | 70-75 |
| Ms Sarah Hordern[5] | Vice-Chair and Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Ms Anne Tutt[6] | Vice-Chair and Non-Executive Director | 01/04/2023-30/11/2023 | 5-10 | 200 | | | | | 5-10 |
| Mr Paul Dean[7] | Non-Executive Director | 04/09/2023-31/03/2024 | 5-10 | | | | | | 5-10 |
| Ms Claire Feehily[8] | Non-Executive Director | 01/12/2023-31/03/2024 | 0-5 | | | | | | 0-5 |
| Ms Claire Flint | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Ms Paula Hay-Plumb OBE[9] | Non-Executive Director | 01/04/2023-03/09/2023 | 5-10 | 100 | | | | | 5-10 |
| Ms Katie Kapernaros | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Professor Anthony Schapira | Non-Executive Director | | 10-15 | 100 | | | | | 10-15 |
| Professor Gavin Screaton | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Professor Ashok Soni OBE | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Ms Joy Warmington MBE | Non-Executive Director | | 10-15 | | | | | | 10-15 |

| Salary and Pension Entitlements of Senior Managers 2023/24 (12 months to 31 March 2024) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Name** | **Title** | **Effective dates if not in post full year** | **Salary (bands of £5,000) £000** | **Taxable benefits (£s to the nearest £100) £** | **Annual performance related bonuses[4] (bands of £5,000) £000** | **Long-term performance related bonuses (bands of £5,000) £000** | **Payment in lieu of pension (bands of £5,000) £000** | **All pension related benefits (bands of £2,500) £000** | **Total including all pension related benefits (bands of £5,000) £000** |
| ***Executive Directors[10]*** | | | | | | | | | |
| Professor Meghana Pandit[11] | Chief Executive Officer | | 260-265 | | 25-30 | | 30-35 | | 320-325 |
| Dr Andrew Brent[12,13] | Chief Medical Officer | 09/10/2023-31/03/2024 | 75-80 | | | 5-10 | 0-5 | 2.5-5 | 105-110 |
| Mr Jason Dorsett[11] | Chief Finance Officer | | 195-200 | | 5-10 | | 20-25 | | 225-230 |
| Ms Paula Gardner[11,14] | Interim Chief Nursing Officer | | 125-130 | | 15-20 | | | | 145-150 |
| Mr Mark Holloway[13,15] | Chief Estates and Facilities Officer | 11/09/2023-31/03/2024 | 80-85 | | 5-10 | | | 40-42.5 | 130-135 |
| Ms Sara Randall[11] | Chief Operating Officer | | 195-200 | | | | 20-25 | | 220-225 |
| Mr Terry Roberts[13,16] | Chief People Officer | | 170-175 | | | | | 0 | 170-175 |
| Ms Rachel Stanfield[17] | Acting Chief People Officer | 01/04/2023-31/07/2023 | 45-50 | | | | 0 | | 45-50 |
| Dr Anny Sykes[13,18] | Interim Chief Medical Officer | 01/04/2023-08/10/2023 | 90-95 | | | | 10-15 | 5-7.5 | 105-110 |
| Mr David Walliker[11] | Chief Digital and Partnership Officer | | 185-190 | | | | 20-25 | | 205-210 |
| Ms Eileen Walsh[13] | Chief Assurance Officer | | 170-175 | | | | | 75-77.5 | 245-250 |

*Notes:*

1. *The basic annual remuneration of Non-Executive Directors (excluding the Trust Chair) is within the band of £10-15,000.*
2. *The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of £15-20,000.*

3. *The annual remuneration of the Trust Chair is within the band of £60-£65,000. A pay increase was agreed for the Trust Chair and was back dated to 01 April 2022, and the salary amount includes the back payment made as a lump sum amount.*
4. *Directors have received performance related bonuses where specific objectives have been set by the Remuneration and Appointments Committee and have been achieved.*
5. *Vice-Chair from 1 December 2023.*
6. *Vice-Chair and Non-Executive Director to 30 November 2023, stepped down at end of term.*
7. *Non-Executive Director from 4 September 2023.*
8. *Non-Executive Director from 1 December 2023.*
9. *Non-Executive Director to 3 September 2023, stepped down at end of term.*
10. *Following discussion with auditors, the salary figures for Executive Directors are shown as the gross amount prior to any salary sacrifice deductions.*
11. *Chose not to be covered by the pension arrangements during the reporting year.*
12. *Chief Medical Officer from 9 October 2023. Paid as Deputy Chief Medical Officer (former position) throughout 2023/24 while awaiting ministerial approval.*
13. *The 'All pension related benefits' figure is calculated including the cash value of payments (whether in cash or otherwise) in lieu of retirement benefits and all benefits in year from participating in pension schemes. As mandated in the guidance produced by the NHS Business Services Authority – Disclosure of Senior Managers' Remuneration (Greenbury) 2015, the annual pension figure is calculated using legislated relevant valuation factor of 20 on annual pension at pension age, plus lump sum at pension age. These are the aggregate input amounts calculated using the method set out in section 229 of the Finance Act 2004 and any employee contributions are excluded from the figure arrived at to reach the amount which is disclosed. This does not reflect an increase in remuneration during 2022/23 but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. The pension benefit table sets out the Cash Equivalent Transfer Values.*
14. *Interim Chief Nursing Officer on part-time basis.*
15. *Chief Estates and Facilities Officer from 11 September 2023.*
16. *Medical absence to 2 June 2023 with phased return to 31 July 2023.*
17. *Acting Chief People Officer from 1 April 2023 to 31 July 2023, covering medical absence and supporting phased return of Chief People Officer.*
18. *Interim Chief Medical Officer to 8 October 2023.*

## Salary and Pension Entitlements of Senior Managers 2022/23 *(this information is subject to audit)*

| Salary and Pension Entitlements of Senior Managers 2022/23 (12 months to 31 March 2023) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Name** | **Title** | **Effective dates if not in post full year** | **Salary (bands of £5,000) £000** | **Taxable benefits (£s to the nearest £100) £** | **Annual performance related bonuses (bands of £5,000) £000** | **Long-term performance related bonuses (bands of £5,000) £000** | **Payment in lieu of pension (bands of £5,000) £000** | **All pension related benefits (bands of £2,500) £000** | **Total including all pension related benefits (bands of £5,000) £000** |
| ***Non-Executive Directors[1,2]*** | | | | | | | | | |
| Professor Sir Jonathan Montgomery | Trust Chair | | 50-55 | | | | | | 50-55 |
| Ms Anne Tutt | Vice-Chair and Non-Executive Director | | 15-20 | | | | | | 15-20 |
| Ms Claire Flint | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Ms Paula Hay-Plumb OBE | Non-Executive Director | | 15-20 | | | | | | 15-20 |
| Ms Sarah Hordern | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Ms Katie Kapernaros | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Professor Anthony Schapira | Non-Executive Director | | 10-15 | 100 | | | | | 10-15 |
| Professor Gavin Screaton | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Professor Ashok Soni OBE | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| Ms Joy Warmington MBE | Non-Executive Director | | 10-15 | | | | | | 10-15 |
| ***Executive Directors[3]*** | | | | | | | | | |
| Professor Bruno Holthof[4,5] | Chief Executive Officer | 01/04/2022-30/06/2022 | 70-75 | 4,500 | | | 15-20 | | 90-95 |

**Salary and Pension Entitlements of Senior Managers 2022/23 (12 months to 31 March 2023)**

| Name | Title | Effective dates if not in post full year | Salary (bands of £5,000) £000 | Taxable benefits (£s to the nearest £100) £ | Annual performance related bonuses (bands of £5,000) £000 | Long-term performance related bonuses (bands of £5,000) £000 | Payment in lieu of pension (bands of £5,000) £000 | All pension related benefits (bands of £2,500) £000 | Total including all pension related benefits (bands of £5,000) £000 |
|---|---|---|---|---|---|---|---|---|---|
| Professor Meghana Pandit[5,6] | Chief Executive Officer | | 245-250 | | | | 30-35 | | 275-280 |
| Mr Jason Dorsett[5] | Chief Finance Officer | | 185-190 | | | | 20-25 | | 210-215 |
| Ms Sam Foster[5,7,8] | Chief Nursing Officer | | 190-195 | | | | 20-25 | | 215-220 |
| Ms Sara Randall[5,9] | Chief Operating Officer | | 185-190 | | | | 20-25 | | 250-255 |
| Mr Terry Roberts[9,10,11,12] | Joint Chief People Officer | | 165-170 | | | | | 85-87.5 | 250-255 |
| Ms Rachel Stanfield[12,13,14] | Joint Chief People Officer | 01/08/2022-31/03/2023 | 80-85 | | | | | 17.5-20 | 100-105 |
| Dr Anny Sykes[5] | Interim Chief Medical Officer | 01/07/2022-31/03/2023 | 135-140 | | | | 10-15 | | 150-155 |
| Mr David Walliker[5] | Chief Digital and Partnership Officer | | 175-180 | | | | 20-25 | | 195-200 |
| Ms Eileen Walsh[12,15,16] | Chief Assurance Officer | | 165-170 | | | | 0-5 | | 170-175 |
| Ms Clare Winch[12,17] | Acting Chief Assurance Officer | 01/04/2022-30/10/2022 | 70-75 | | | | | 7.5-10 | 80-85 |

*Notes:*

1. *The basic annual remuneration of Non-Executive Directors (excluding the Trust Chair) is within the band of £10-15,000.*
2. *The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of £15-20,000.*
3. *Following discussion with auditors, the salary figures for Executive Directors are shown as the gross amount prior to any salary sacrifice deductions.*
4. *Chief Executive Officer to 30 June 2022. Received a taxable benefit of £4,500 (pro-rata to part year) for the cost of a life insurance policy.*
5. *Chose not to be covered by the pension arrangements during the reporting year.*
6. *Chief Medical Officer to 30 June 2022 and Chief Executive Officer from 1 July 2022 (fixed term from 1 July 2022 to 28 February 2023 and substantive from 1 March 2023).*
7. *Chief Nursing Officer to 31 March 2023.*

8. *Includes back pay for a salary increase from 1 September 2020.*
9. *Includes back pay for a salary increase from 1 April 2021.*
10. *Chief People Officer to 31 July 2022 and Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
11. *Seconded to NHS England 50% from 1 August 2022 to 31 March 2023.*
12. *The 'All pension related benefits' figure is calculated including the cash value of payments (whether in cash or otherwise) in lieu of retirement benefits and all benefits in year from participating in pension schemes. As mandated in the guidance produced by the NHS Business Services Authority – Disclosure of Senior Managers' Remuneration (Greenbury) 2015, the annual pension figure is calculated using legislated relevant valuation factor of 20 on annual pension at pension age, plus lump sum at pension age. These are the aggregate input amounts calculated using the method set out in section 229 of the Finance Act 2004 and any employee contributions are excluded from the figure arrived at to reach the amount which is disclosed. This does not reflect an increase in remuneration during 2021/22 but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. The pension benefit table sets out the Cash Equivalent Transfer Values.*
13. *Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
14. *Retained 50% of substantive role as Joint Director of Workforce.*
15. *Medical absence to 31 August 2022 with phased return to 30 October 2022.*
16. *Chose not to be covered by the pension arrangements for part of the reporting year.*
17. *Cover for medical absence and supporting phased return of Chief Assurance Officer.*

## Pension Benefits of Senior Managers 2023/24 *(this information is subject to audit)*

| Pension Benefits of Senior Managers 2023/24 (12 months to 31 March 2024) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Name** | **Title** | **Real increase in pension at pension age (bands of £2,500) £000** | **Real increase in pension lump sum at pension age (bands of £2,500) £000** | **Total accrued pension at pension age at 31/03/2024 (bands of £5,000) £000** | **Lump sum at pension age related to accrued pension at 31/03/2024 (bands of £5,000) £000** | **Cash Equivalent Transfer Value at 01/04/2023 £000** | **Real increase in Cash Equivalent Transfer Value £000** | **Cash Equivalent Transfer Value at 31/03/2024 £000** | **Employer's contribution to stakeholder pension £000** |
| Dr Andrew Brent | Chief Medical Officer | 0-2.5 | 0 | 35-40 | 90-95 | 678 | 1 | 771 | - |
| Mr Mark Holloway | Chief Estates and Facilities Officer | 0-2.5 | 22.5-25 | 35-40 | 90-95 | 424 | 123 | 707 | - |
| Mr Terry Roberts | Chief People Officer | 0 | 35-37.5 | 50-55 | 140-145 | 923 | 179 | 1,216 | - |
| Dr Anny Sykes | Interim Chief Medical Officer | 0-2.5 | 0-2.5 | 40-45 | 115-120 | 766 | 8 | 878 | - |
| Ms Eileen Walsh | Chief Assurance Officer | 0-2.5 | 50-52.5 | 55-60 | 160-165 | 1,028 | 300 | 1,454 | - |

*Notes:*

- *Non-Executive Directors do not receive pensionable remuneration (2022/23, nil).*
- *The Trust did not contribute to a stakeholder pension scheme for Directors (2022/23, nil).*
- *Pension details have only been disclosed for those Directors in post during the last 12 months up to 31 March 2024.*
- *A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. These figures do not include any potential impact from the McCloud judgment.*
- *Real increase in CETV reflects the increase in CETV funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).*

## Disclosures

The Trust is required to make the following disclosures.

### Fair Pay Multiple *(this information is subject to audit)*

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest-paid Director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The table below shows the change in remuneration of the Trust over last two financial years.

| | 2023/24 | 2022/23 |
|---|---|---|
| Banded remuneration of the highest-paid Director | £285,000-£290,000 | £245,000-£250,000 |
| Percentage change of remuneration of the highest-paid Director from previous financial year[1] | 15.9% | -16.7% |
| Range of WTE[2] employee remuneration[3] | £10,300-£322,000 | £9,400-£483,000 |
| Percentage change in average remuneration[4] of employees from previous financial year | 2.5% | 6.4% |
| WTE[1] employees that received remuneration in excess of the highest-paid Director | 2 | 7 |

*Notes:*

1. *Following the departure of the former Chief Executive Officer (CEO) on 30 June 2022, an interim CEO was appointed until 28 February 2023 on fixed term basis. Subsequently, the post holder, who is the current CEO, was appointed substantively on 1 March 2023. Once substantiated, the CEO was awarded the full entitlement of the role. This accounts for the downward change in renumeration in 2022/23 and the upward movement in 2023/24.*
2. *Whole time equivalent.*
3. *This figure includes Directors and excludes pension benefits of all employees. It also includes the WTE salary cost for bank and agency staff.*
4. *Based on total for all employees divided by full-time equivalent number of employees. The 2022/23 figures included the additional lump sum pay award which was accrued in 2022/23 and paid in 2023/24.*

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions or payments in lieu of employer contributions and the cash equivalent transfer value of pensions.

The whole time equivalent remuneration of the employee at the 25th percentile, median and 75th percentile excluding the highest-paid Director is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest-paid Director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

| | 25th percentile £ | | Median £ | | 75th percentile £ | |
|---|---|---|---|---|---|---|
| | 2023/24 | 2022/23 | 2023/24 | 2022/23 | 2023/24 | 2022/23 |
| Salary Component of pay | 27,596 | 28,058 | 35,392 | 35,730 | 45,996 | 46,816 |
| Total pay and benefits excluding pension benefits | 30,937 | 30,429 | 42,559 | 42,001 | 55,792 | 54,772 |
| Pay and benefits excluding pension: pay ratio for highest-paid Director | 9.33:1 | 8.19:1 | 6.78:1 | 5.93:1 | 5.18:1 | 4.55:1 |

**Payment for Loss of Office**

No payments for Loss of Office were made to senior managers in 2023/24 (2022/23: nil).

**Payments to past Senior Managers**

The Trust has not made any payment to any person who was not a Director at the time the payment was made, but who had been a Director of the Trust previously. This excludes any payments of regular pension benefits which commenced in previous years, payments in respect of employment for the Trust other than as a Director, and sums disclosed in the single total remuneration disclosure or the disclosure of compensation for early retirement or loss of office.

**Expenses**

***Expenses of the Council of Governors***

Governors are not remunerated but are entitled to claim expenses for costs incurred while undertaking duties for the Trust as a Governor. Governor expenses information for the last two years are shown below.

| | 2023/24 | 2022/23 |
|---|---|---|
| Total number of Governors in office[1] | 29 | 31 |
| Number of Governors who received expenses | 6 | 8 |
| Aggregate sum of expenses paid | £700 | £700 |

*Note:*

1. *All members of the Council who were in office during the year 2023/24 have been considered.*

***Expenses of the Board of Directors***

Members of the Board can claim appropriate expenses in line with Trust policies. Board expenses information for the last two years are shown below.

| | 2023/24 | 2022/23 |
|---|---|---|
| Total number of Board members in office[1] | 23 | 21 |
| Number of Board members who received expenses | 3 | 2 |
| Aggregate sum of expenses paid | £400 | £4,600 |

*Note:*

1. *All members of the Board who were in office during the year 2023/24 have been considered.*

Signed: Professor Meghana Pandit
Chief Executive Officer
26 June 2024

# Staff Report

The Staff Report provides information about staffing and staff related matters at Oxford University Hospitals NHS Foundation Trust (OUH) during the year 2023/24.

## Our Workforce

The Trust employed over 15,500 people in the year 2023/24 on permanent contracts[1] of employment across both full-time and part-time roles. This equates to a whole time equivalent (WTE) average of 13,410 WTE. Workforce numbers have increased during the year as turnover during the COVID-19 pandemic has decreased and recruitment has taken place to help assist with unprecedented demands. Likewise, pay costs have also risen due to the increased number of staff employed by the Trust.

The gender distribution of our workforce as at 31 March 2024 is shown in the table below.

| Category | 2023/24 | | | 2022/23 |
|---|---|---|---|---|
| | Female | Male | Total | Total |
| Directors[2] | 9 | 10 | 19 | 19[3] |
| Senior managers[4] | - | - | - | - |
| Other staff[5] | 11,463 | 4,040 | 15,503 | 14,513 |
| **Total[6,7]** | **11,472** | **4,050** | **15,522** | **14,532** |

*Notes:*

1. *Permanent contract holders are those staff with contracts of employment including fixed term contracts but excluding honorary contract holders.*
2. *Defined as all members of the Board.*
3. *For the purpose of reporting the gender distribution of the Board, both Joint Chief Officers in post as at 31 March 2023 are included in the number of Directors.*
4. *Defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. Within OUH, all such staff are members of the Board.*
5. *Everyone else in the organisation.*
6. *Everyone in the organisation including the Board.*
7. *Workforce numbers disclosed above are as per reporting requirement.*

In addition to the permanent workforce, the Trust is supported by a flexible, temporary workforce working either directly through our Temporary Staffing Bank or through appropriate use of external agencies.

**Analysis of Average Staff Numbers as at 31 March 2024** ***(this information is subject to audit)***

The average number of staff employed by the Trust as at 31 March 2024 is set out in the table below on a whole time equivalent (WTE) basis.

| Staff Category | 2023/24 Average WTE | | | 2022/23 Average WTE |
|---|---|---|---|---|
| | Permanently Employed[1] | Other Staff[2] | Total Number | Total Number |
| Medical and Dental | 2,166 | 72 | 2,238 | 2,165 |
| Ambulance Staff | - | - | - | - |
| Administration and Estates[3] | 2,681 | 87 | 2,768 | 2,663 |
| Healthcare Assistants and Other Support Staff | 1,553 | 336 | 1,889 | 1,810 |
| Nursing, Midwifery and Health Visiting Staff | 4,435 | 625 | 5,060 | 4,813 |
| Nursing, Midwifery and Health Visiting Learners | - | - | - | - |
| Scientific, Therapeutic and Technical Staff | 1,640 | 72 | 1,712 | 1,609 |
| Healthcare Science Staff | 884 | 17 | 901 | 864 |
| Social Care Staff | - | - | - | - |
| Other | 51 | - | 51 | 56 |
| **Total Average Numbers** | 13,410 | 1,209 | 14,619 | 13,980 |
| **of which** | | | | |
| Number of employees (WTE) engaged on capital projects | 45 | 7 | 52 | 11 |

*Notes:*

1. *Staff with a permanent (UK) employment contract directly with the Trust (this includes Executive Directors but excludes Non-Executive Directors). The fixed term contracts are also included as the Trust's system does not allow the fixed term contracts to be separated from permanent contracts.*
2. *Staff engaged on the objectives of the Trust that do not have a permanent (UK) contract directly with the Trust. This includes employees on short-term contracts of employment, agency/temporary staff, locally engaged staff overseas and inward secondments from other Trusts.*
3. *Includes all Corporate Support Services.*

**Analysis of Staff Costs** ***(this information is subject to audit)***

The table below sets out an analysis of staff costs during the year 2023/24, split between permanently employed staff and others.

| Cost | 2023/24 | | | 2022/23 |
|---|---|---|---|---|
| | Permanently Employed[1] £000 | Other Staff[2] £000 | Total £000 | Total £000 |
| Salaries and wages | 674,187 | 8,902 | 683,089 | 641,891 |
| Social security costs | 68,478 | - | 68,478 | 61,890 |
| Apprenticeship levy | 3,292 | - | 3,292 | 2,936 |
| Employer's contributions to NHS pensions | 108,136 | - | 108,136 | 100,915 |
| Pension cost – other | 92 | - | 92 | 106 |
| Other post-employment benefits | - | - | - | - |
| Other employment benefits | - | - | - | - |
| Termination benefits | 430 | - | 430 | 190 |
| Temporary staff | - | 87,170 | 87,170 | 79,050 |
| **Total Gross Staff Costs** | 854,615 | 96,072 | 950,687 | 886,948 |
| Recoveries in respect of seconded staff | - | - | - | - |
| **Total Staff Costs** | 854,615 | 96,072 | 950,687 | 886,948 |
| **of which** | | | | |
| Costs capitalised as part of assets | 1,291 | 292 | 1,583 | 594 |

*Notes:*

1. *Staff with a permanent (UK) employment contract directly with the Trust (this includes Executive Directors but excludes Non-Executive Directors). The fixed term contracts are also included as the Trust's system does not allow the fixed term contracts to be separated from permanent contracts.*
2. *Staff engaged on the objectives of the Trust that do not have a permanent (UK) contract directly with the Trust. This includes employees on short-term contracts of employment, agency/temporary staff, locally engaged staff overseas and inward secondments from other Trusts.*

## Staff Policies and Actions Applied during the Financial Year

### Equality, Diversity and Inclusion (EDI)

As a responsible employer and healthcare services provider, we actively recognise, value and support the diversity of staff we employ and patients we care for. Our aim is to treat all patients, visitors and staff with dignity and respect and ensure that as an organisation we learn from occasions when our actions have fallen short of our high expectations.

Through adherence to the requirements of the Equality Act 2010, the public sector equality duty and the NHS Constitution provisions, the Trust strives to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different groups
- foster good relations between people.

#### *EDI Objectives*

The four-year EDI Objectives, agreed in September 2022, aim to position the Trust to meet the increasing challenges in the EDI space and support delivery against the overall strategy by focusing on developing EDI capability at individual, service and organisational level. Further information on the Trust's EDI Objectives and the activity expected to be delivered against them can be found on the Trust website at www.ouh.nhs.uk/about/equality/plans.aspx.

#### *Policies and Procedures*

The Trust has a Workforce Equality, Diversity and Inclusion Policy in place as well as an Equality Impact Assessment Procedure. All our policies are equality impact assessed to ensure that no one impacted by a policy receives unjustifiably less favourable treatment on the grounds of their protected characteristics.

#### *Reporting*

The Trust reports annually on progress against EDI through various mechanisms, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and Equality Delivery System (EDS).

These reports summarise the analysis undertaken on workforce diversity data, performance against key diversity metrics, barriers that have been identified for different staff groups, and the actions that have or will be taken to address those barriers. Reports are published on the Trust website at www.ouh.nhs.uk/about/equality/plans.aspx.

#### *Initiatives*

Initiatives undertaken in the past year to progress against the Trust's EDI Objectives and the NHS EDI Workforce Improvement Plan include:

- approval and implementation of protected time for those leading our staff networks
- introducing a requirement for all our people to identify and action their own individual EDI objective as part of the Values Based Appraisal process
- development and implementation of an EDI Dashboard that provides meaningful EDI data disaggregated by Division and Directorate to facilitate local action planning

- introducing a range of support for internationally educated staff, including welcome information packs, informal buddying schemes and other pastoral support
- delivering a programme to eradicate bullying and harassment, which consists of eight workstreams including the Kindness into Action programme to promote civility and respect.

**Supporting Disabled Staff**

As part of its work on EDI, the Trust has an ongoing commitment to the employment of people with disabilities and to support our disabled employees through:

- our participation in the Department for Work and Pensions' Disability Confident Scheme, and as a Level 2 'Disability Confident Employer', we take positive action to ensure that our recruitment processes do not disadvantage applicants with disabilities
- our dedicated Occupational Health Service with a range of support options
- a Disability Passport Procedure which facilitates employees and their managers to have meaningful discussions about how their health and impairments may impact them in the workplace and identify appropriate adjustments to enable them to thrive at work
- the Disability and Accessibility Staff Network which provides an opportunity for employees with disabilities to access peer support while supporting the Trust to deliver disability equality.

**Practice Development and Education**

As a teaching Trust, patient-centred teaching and education is one of our main activities and is important to the delivery of the Trust's strategic objectives. In April 2023, we opened our new Oxford Hospitals Education Centre (OxHEC), the Trust-wide training centre for professional education and training, with support from Oxford Hospitals Charity. OxHEC hosts a range of training and educational events throughout the Trust to ensure all needs are met.

The Trust comprises the teaching hospitals for the University of Oxford through the School of Clinical Medicine and the Postgraduate Medical and Dental Education (PGMDE) Centre and is the largest placement provider for approximately 450 medical students in the clinical years. We provide clinical placements for around 900 postgraduate doctors and dentists in training (PGDDiTs) from several Deaneries. We also have a small number of dental trainees and physician associate students on placement with us. There are approximately 400 locally employed and specialty and specialist (SAS) doctors and around 1200 consultants who are also continuously learning with us. Almost 650 of our consultants and senior doctors are General Medical Council (GMC) recognised medical educators.

The Trust comprises the teaching hospitals for the University of Oxford through the School of Clinical Medicine and the Postgraduate Medical and Dental Education (PGMDE) Centre. Approximately 75% of the Trust's junior doctors are in one of the University of Oxford's recognised training programmes. More than a third of the Trust's consultants and senior doctors are recognised General Medical Council (GMC) trainers.

We have a comprehensive Simulation-Based Education (SBE) programme, which is run in partnership with Oxford Simulation, Teaching and Research Centre (OxSTaR) based at the John Radcliffe Hospital. All foundation doctors have access to the OUH Quality Improvement

(QI) programme run in conjunction with OxSTaR. The QI programme supports trainee doctors, other grades of doctors and professional groups in QI projects.

We continue to work in collaboration with our Oxfordshire partners to offer and increase placement capacity for nurses, midwives and allied health professionals (AHPs). We have commenced a direct entry Nursing Degree Programme with the Open University that aims to provide a flexible route into nursing for students who do not meet traditional higher education academic entry requirements. We also offer a bridging programme for internationally recruited nurses, midwives and AHPs.

In partnership with Oxford Brookes University and Oxford Health NHS Foundation Trust, the Trust supports students (nurses, midwives and AHPs) who have neuro diverse characteristics. A further supportive measure we have in place is the Professional Nurse Advocate (PNA) Lead, who is available to promote restorative clinical supervision across the Trust.

**Staff communications**

The Trust is committed to timely and transparent internal communications with staff so that all our people have the information they need to do their jobs, and we use a wide variety of channels to communicate important messages to staff.

We circulate a Staff Bulletin by email to all staff three times a week, with short messages of relevance to most staff with links to the Trust intranet or external website where appropriate for further information. A Weekly Safety Message is also sent to all staff by the Chief Medical Officer and Chief Nursing Officer.

The Chief Executive Officer and Chief Officers hold a monthly Virtual Staff Briefing for all staff. A summary of key messages from the Staff Briefing is then cascaded to managers to use in their team meetings and safety huddles.

As part of our wider Board Visibility Programme, ‘Meet the Chief Executive and Chief Officers’ face-to-face staff engagement events are held quarterly on our four main hospital sites and at the OUH offices in Cowley. Quarterly OUH People Plan Update virtual listening events are hosted by the Chief People Officer. Weekly Medical Grand Rounds and fortnightly virtual Quality Improvement (QI) Stand Up events are also held.

The Trust intranet is a central source of information for staff. In 2023/24 we redeveloped our intranet to improve its accessibility and to make it mobile friendly. The Trust has digital screens on all four main hospital sites to communicate key messages to staff, patients and the public. The Trust website, posters on staff noticeboards, leaflets and verbal cascading of key messages are also used to ensure all staff are kept informed and engaged. The Trust uses its social media channels including Facebook, LinkedIn, X, Instagram, YouTube and Viva Engage to communicate with patients, public and staff.

### Consulting staff and representatives

The Trust works in partnership with staff through a number of mechanisms on matters of concern to staff and the performance of the organisation. The Trust Alliance Committee (TAC) and Joint Local Negotiation Committee (JLNC) are the two formal bodies for Trust-wide negotiation and consultation with union partners. The Committees include representation from staff-side (Trade Union) representatives and senior management. The Committees meet bi-monthly to foster partnership working and to deliver a positive impact on staff experience.

In addition, there are two formal sub-groups of the Trust Alliance Committee with membership formed from Workforce and Trade Union colleagues.

- Consultation Sub-Group – all proposed formal consultations under the Trust's Management of Organisational Change Procedure are presented to this sub-group prior to formal consultation with staff. During 2023/24, more than 20 organisational change proposals were reviewed by the group prior to formal consultation with affected staff.
- Policy Development Group – all proposed changes to workforce policies affecting our staff are presented to this sub-group prior to formal consultation. 2023/24 has seen significant activity to review our workforce procedures with changes introduced following consultation to support our commitments set out in the Trust's People Plan. We have reviewed the Respect and Dignity at Work Procedure and the Conduct and Expected Behaviour Procedure. Both procedures now address managing concerns relating to sexual safety and sexual misconduct, which is aligned with the Trust becoming a signatory to NHS England's Sexual Safety in Healthcare Organisational Charter.

The Trust has continued to promote the voice of our people from protected characteristic groups through the ongoing development of, and commitment to, five staff networks: Black, Asian and Minority Ethnic (BAME) Network, LGBTQ+ Network, Disability and Accessibility Network, Women's Network and Young Apprentices Network. Each network feeds into the Trust's Equality, Diversity and Inclusion (EDI) Steering Group to inform decision-making and Trust Strategy aligned to our EDI Objectives.

### Encouraging staff involvement in the Trust's performance

The Trust actively encourages staff engagement in enhancing the Trust's performance, and in line with the OUH People Plan 2022-2025, our vision is to make OUH a great place to work where we all feel we belong.

To help us achieve this vision, we consult with our employees regularly to monitor and learn from staff feedback. We do this through our quarterly People Plan Listening Events, where all staff are invited to provide us with feedback on our progress against our People Plan priorities as well as inform and shape our commitments for the year ahead. The Trust also responds to staff feedback from the annual Staff Survey by providing leaders and managers with their local survey results together with a 'Time to Talk' methodology which includes guidance and resources to our central initiatives to support local action plans in response to staff feedback.

The Trust provides a safe and supportive space for our staff networks to promote voices of the under-represented staff groups and drive positive change within the workplace. They play a vital role in shaping and delivering the Trust's EDI agenda and influencing Trust priorities.

The Trust is also committed to recognising individuals and teams for their delivery of compassionate excellence. Some of its recognition schemes include the following.

- ***The OUH Staff Recognition Awards*** recognise individuals or teams who really live the Trust values and acknowledge the great work they do.
- ***An instant note of appreciation*** allows staff to recognise a colleague for going above and beyond to help or support, or a job well done, aligned to the Trust values.
- ***Reporting Excellence*** is a way to recognise positive experiences and moments of excellent care and service through the Trust's real time incident reporting system.
- ***DAISY Foundation® Awards*** allow patients and their families to nominate a nurse or midwife who has made a real difference through outstanding clinical care.

**Promoting the wellbeing of our workforce**

The Trust has a range of initiatives and governance processes in place to ensure the wellbeing of our workforce is promoted. Our People Plan 2022-25 includes the strategic theme of 'Health Wellbeing and Belonging for all Our People', which has a range of sub-themes focusing on creating a physical and psychological environment that enhances the wellbeing of our workforce.

We have an established governance route via our monthly People Governance Meeting chaired by the Chief People Officer, where we report on progress, including the triangulation of absence and sickness metrics. We then ensure that our wellbeing initiatives can be tailored to help support any areas of focus. All of this information is shared alongside the Integrated Performance Report that is presented at Trust Management Executive and Board meetings.

Our staff network leads are invited over the course of the year to present their network priorities to the Board, including sharing progress and challenges that their members face. These meetings have also included individual stories which we have then shared more widely through Trust blogs to emphasise the importance of wellbeing and creating a culture of kindness across the Trust. These stories have then helped form improvements to our people, policies, processes and Trust-wide initiatives.

The Trust has appointed a Non-Executive Director as the Wellbeing Guardian, whose role is to meet with relevant senior stakeholders to review progress on all our wellbeing initiatives.

Key wellbeing achievements in 2023/24 included the following.

- The installation of rest and relaxation equipment across our main sites, using £450,000 provided by the Trust. Nine 'energy pods', nine 'sleep tubes', 15 'wellbeing nooks' and three sets of outdoor gym equipment have been installed across the Trust.
- The Staff Support Service was fully relaunched after a successful bid for permanent funding following a trial. There is now a group of clinical psychologists and one psychiatrist with dedicated time to helping staff with any work-based psychological or emotional issues.
- The launch of the Creating a Suitable Estates and Environments Enabling Group, a forum for discussing our cross-Trust capital wellbeing projects and putting them to the Capital Management Group and Trust Management Executive (TME) for approval.

## Occupational Health

The Centre for Occupational Health and Wellbeing (COHWB) is the Trust's in-house occupational health service, providing a full range of services to Trust staff as well as other organisations in the local area. The core business of COHWB is the promotion and maintenance of the health and wellbeing of employees of the Trust and its principal contractors. Key areas of work include health risk management; advice on reasonable adjustments and rehabilitation following absence from work; workplace assessments and health surveillance and health and safety compliance, as well as policy development.

Working as part of a multidisciplinary team, COHWB has worked closely with the Staff Psychology Service and Staff Physiotherapy Service to treat and support Trust staff with a wide range of mental health conditions and musculoskeletal conditions.

During the year, COHWB had over 14,000 contact appointments (in 2022/23 over 12,000) and the key achievements of the service included the following.

- Annual renewal of accreditation for the Faculty of Occupational Medicine Safe Effective Quality Occupational Health (SEQOHS) scheme.
- Launching the OUH Stress Management in the Workplace Policy and training for managers on managing employees with work related stress.
- Co-ordination of the Winter Flu and COVID-19 Staff Vaccination Programme from September 2023 to January 2024. A total of 54% (Flu) and 48% (COVID-19) of frontline healthcare workers were vaccinated during this season. (In the September 2022 to January 2023 season this was 59% (Flu); COVID-19 vaccinations were not delivered during this season).
- Developing the newly upgraded software system to streamline operational aspects and improve reporting around key metrics and contribute to more accurate monitoring systems for health risks at work.

## Health and Safety

The Trust continued to implement its Occupational Health and Safety Management Systems at all sites throughout the year, supported by the Health and Safety Committee and Divisional Health and Safety Groups.

We successfully re-certified to ISO 45001:2018 (Occupational Health and Safety Management Systems [OHSMS]) standard at the Churchill Hospital, providing independent, external assurance for the robust health and safety processes in place.

The Trust simplified its annual Health and Safety Audit as a series of six smaller audits and revised the audit content. At the completion of the first three parts of the audit, compliance averaged at 91.4% for requirements linked to health and safety legislation and Trust policies and procedures.

Throughout the reporting period, compliance with the Trust's Health, Safety and Welfare Training, which is mandatory for over 15,000 staff, stayed consistent around 93%. The Health and Safety Team provided training to 117 staff during the year for the role of 'Health and Safety Champions'. This training enables the Champions to support department managers with local health and safety arrangements.

## Freedom to Speak Up

The Freedom to Speak Up (FtSU) Team provides support for staff to raise concerns which may affect the safety of our patients, and ensures that appropriate action is taken by the Trust.

The number of cases opened, and the contacts that the team had with staff to raise awareness and remove barriers to speaking up, over the last two years, are shown below.

| | 2023/24 | 2022/23 |
|---|---|---|
| Number of cases opened | 97 | 94 |
| Number of staff contacts made to raise awareness | 4,241 | 4,161 |

The FtSU Team's focus in 2023/24 was on the following.

- Holding regular online listening events for staff to ask questions, discuss topical issues impacting staff, raise concerns and highlight positive stories. Following the Trust signing up to NHS England's Sexual Safety in Healthcare Organisational Charter, one of the sessions also covered sexual safety in the workplace.
- Holding roadshow events on all four hospital sites and at the OUH offices in Cowley during Speak Up Month in October 2023, which focused on 'breaking down barriers' to speaking up.
- Developing a business case to support investment in an external platform for the anonymous and confidential reporting of concerns from staff at OUH, to overcome one of the main barriers to speaking up. This initiative forms a key part of Trust's Eradicating Bullying and Harassment Strategy.
- Encouraging collaborative working with other key stakeholders across the Trust, including the Occupational Health and Wellbeing Team, Culture and Leadership and Workforce teams, Communications Team, Patient Safety teams, and the staff networks.
- Building the Freedom to Speak Up network of Champions to improve visibility and access FtSU and providing support to more of our people.
- Presenting six-monthly update reports and an Annual Report to the Trust Board.
- Promoting access to online Freedom to Speak Up training for staff and managers on 'speaking up', 'listening up' and 'following up'.

**Policy on Counter Fraud and Corruption**

Oxford University Hospitals NHS Foundation Trust is committed to providing a zero-tolerance culture to fraud, bribery and corruption. The counter fraud service provider for the Trust is TIAA and is accountable to the Chief Finance Officer under statutory regulations. TIAA also reports regularly to the Audit Committee. The Trust has a Fraud Champion who supports TIAA with counter fraud work.

TIAA provides a Lead Local Counter Fraud Specialist (LCFS) which undertakes activities to understand the Trust's fraud risks, and works to prevent and detect fraudulent activity. Fraud Prevention Notices are shared with the Trust to raise awareness on fraud risks and to take action where necessary. The LCFS works closely with Internal Auditors to identify fraud risks and improve controls where necessary. Focus in 2023/24 has been on finance mandate fraud, staff dual employment and the verification of pre-employment checks.

Throughout the year the LCFS raises staff awareness of NHS fraud and how to raise concerns. LCFS presented a counter fraud training session to the quarterly Finance team in February 2024.

The Counter Fraud and Bribery Policy and Procedure of the Trust sets out the approach to countering fraud, bribery and corruption. The Declarations of Interests, Gifts, Hospitality and Sponsorship Policy complies with the NHS requirements for managing conflicts of interest and the requirements of the Bribery Act 2010.

The Trust complies with the 12 NHS requirements of the NHS Counter Fraud Authority (NHSCFA) which sets out the standards for countering fraud in adherence with Government Functional Standards GoVs 013: Counter Fraud. An annual assessment against the Government Functional Standards is undertaken in conjunction with TIAA on behalf of the Trust, reporting on the work conducted during the year. It is anticipated that the Trust will meet the NHS requirements as set by the NHSCFA.

All matters relating to fraud are investigated by our Counter Fraud Team and appropriate action is taken including disciplinary and possible criminal proceedings, and the Trust will seek to recover any monies lost to fraudulent activity.

## NHS Staff Survey

The mandatory annual NHS Staff Survey for all NHS Trusts provides an opportunity for organisations to survey their staff in a consistent and systematic way. Obtaining feedback from staff, and considering their views and priorities, enables the co-creation of better ways of working, which are vital for improving the employee experience, and are key contributing factors to driving real service improvements in the NHS.

The Trust commissioned the Picker Institute to manage its Staff Survey. The national Survey Coordination Centre provided the Trust with valuable benchmarking data against 122 Acute, and Acute and Community Trusts.

Since 2021/22 the survey questions have aligned to the seven elements of the NHS 'People Promise' and retain the two previous themes of engagement and morale. These replaced the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2023/24 survey among Trust staff was 46% (2022/23: 51%).

### *Summary of results*

Scores for each indicator together with that of the Survey Benchmarking Group, 122 Acute, and Acute and Community Trusts, are presented below.

| Indicators | 2023/24 | | 2022/23 | | 2021/22 | |
|---|---|---|---|---|---|---|
| **People Promise elements and themes** | **Trust** | **Benchmarking Group** | **Trust** | **Benchmarking Group** | **Trust** | **Benchmarking Group** |
| People Promise: | | | | | | |
| We are compassionate and inclusive | 7.3 | 7.0 | 7.3 | 7.2 | 7.3 | 7.2 |
| We are recognised and rewarded | 6.0 | 6.0 | 5.8 | 5.8 | 5.9 | 5.8 |
| We each have a voice that counts | 6.8 | 6.7 | 6.8 | 6.7 | 6.8 | 6.7 |
| We are safe and healthy | 6.2 | 6.1 | 6.0 | 5.9 | 6.1 | 5.9 |
| We are always learning | 5.9 | 5.6 | 5.6 | 5.4 | 5.2 | 5.2 |
| We work flexibly | 6.3 | 6.3 | 6.1 | 6.0 | 6.2 | 5.9 |
| We are a team | 6.9 | 6.8 | 6.8 | 6.6 | 6.7 | 6.6 |
| Staff engagement | 7.1 | 6.9 | 7.0 | 6.8 | 7.0 | 6.8 |
| Morale | 6.0 | 5.9 | 5.8 | 5.7 | 5.9 | 5.7 |

*Note:*

- *Above indicators have been prescribed by NHS England.*

The Trust performed better than the national average across all People Promise elements and themes and made improvements on 90% of the scored questions in the survey.

The Trust scored well on questions within the 'Advocacy' sub-score, with improvements across all three questions, and scored above the national average for two of the questions. These included, 'if a friend or relative needed treatment I would be happy with the standard

of care provided by this organisation', which scored 11.52 percentage points above the national average of 63.32%, and 'Care of patients / service users is my organisation's top priority', which scored 4.52 percentage points above the national average.

The Trust saw a trend of sustained improvement in Line Management Capability, seen on questions that make up the 'Compassionate Leadership and Line Management' sub-scores. Five questions across these sub-scores were significantly higher than the national average.

The Trust also scored above the national average on the Appraisal sub-score, with further improvement on the proportion of staff having an appraisal. Whilst we improved on questions relating to appraisal quality, we have fallen below the national average on two questions, identifying this as an area for improvement.

Discrimination was identified as an area for improvement, where we saw increases in experiences of discrimination from 'patients and the public', and 'managers and colleagues', as well as falling below the national average for both questions. The Trust also saw an increase in experiences of bullying and harassment from colleagues which, combined with declines or below average scores for questions such as 'the people I work with are polite and treat each other with respect' and 'relationships at work are strained', identifies bullying, harassment and incivility as another area for improvement.

**Future priorities and targets**

Following the survey, we aim to build on our successes as well as take action to address areas for improvement.

- Appraisals. We aim to capitalise on the large increases in proportion of staff having appraisals by ensuring they are of good quality and leave staff feeling valued.
- Line Management Capability. We wish to continue the trend of year-on-year improvements through expanding the rollout of our leadership development programme.
- Discrimination, Bullying, Harassment, and Incivility. We will work to reduce instances of bullying, harassment and discrimination through delivery of our Eradicating Bullying and Harassment Programme.

## Disclosures

The Trust is required to make the following disclosures.

### Staff sickness absence

The Trust is required to disclose details of staff sickness absences in a centrally prescribed format. Data is supplied by the Department of Health and Social Care (DHSC), and can be found on the NHS Digital website: visit digital.nhs.uk and search for 'NHS Sickness Absence Rates'.

***Source:*** NHS Digital Sickness Absence and Workforce Publications, based on data from the Electronic Staff Record (ESR) Data Warehouse.

***Periods covered:*** January to December 2023 and January to December 2022.

***Data Items:*** ESR does not hold details of the planned working / non-working days for employees, therefore days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used.

| Period | Figures Converted by DHSC[1] to Best Estimates of Required Data Items | | Statistics Published by NHS Digital from ESR Data Warehouse | | |
|---|---|---|---|---|---|
| Jan - Dec | Average FTE | Adjusted FTE days lost to Cabinet Office definitions | FTE days available[2] | FTE days recorded sickness absence[3] | Average sick days per FTE[4] |
| 2023 | 13,060 | 112,361 | 4,767,047 | 182,274 | 8.6 |
| 2022 | 12,663 | 132,683 | 4,622,004 | 215,242 | 10.5 |

*Notes:*

1. *DHSC - Department of Health and Social Care.*
2. *The number of Full-time Equivalent (FTE) days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.*
3. *The number of FTE days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.*
4. *The average number of sick days per FTE has been estimated by dividing the FTE days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by average FTE.*

### Staff turnover

The Trust saw a steady decrease of staff turnover over the year as shown in the table below.

| Staff group | 2023/24 | 2022/23 |
|---|---|---|
| Additional Professional Scientific and Technical | 9.42% | 9.12% |
| Additional Clinical Services | 13.22% | 16.88% |
| Administrative and Clerical | 10.61% | 12.22% |
| Allied Health Professional | 12.62% | 12.57% |
| Estates and Ancillary | 14.52% | 13.30% |
| Healthcare Scientists | 9.45% | 10.18% |
| Medical and Dental | 5.10% | 5.52% |
| Nursing and Midwifery Registered | 9.04% | 9.52% |
| **All staff groups** | **10.19%** | **11.38%** |
| **Trust target** | **12.00%** | **12.00%** |

Further information on our staff turnover in 2023/24 can be found on the NHS Digital website: visit digital.nhs.uk and search for 'NHS workforce statistics'.

### Gender pay gap

Gender pay gap reporting legislation requires organisations to publish figures relating to their gender pay gap on an annual basis, and against a prescribed methodology which looks at mean and median gender pay gaps. The gender pay gap is different to equal pay, which is a legal requirement. The gender pay gap is the percentage difference between average (mean and median) hourly earnings for men and women.

For each reporting year, the gender pay gap is calculated using a snapshot date at the end of the previous financial year as required by the gender pay gap reporting legislation (2023/24 reporting year uses data as of 31 March 2023). Trust's last two years' gender pay gap information, reported to Government Equalities Office, is shown in the table below.

| Indicator | 2023/24 | 2022/23 | 2023/24 compared to 2022/23 |
|---|---|---|---|
| Mean Ordinary Pay Gap | 28.71% | 29.36% | 0.65 percentage point decrease |
| Median Ordinary Pay Gap | 13.62% | 15.83% | 2.21 percentage point decrease |
| Mean Bonus Pay Gap | 47.17% | 57.51% | 10.34 percentage point decrease |
| Median Bonus Pay Gap[1] | 4.17% | 62.70% | 58.53 percentage point decrease |

*Note:*

1. *The Median Bonus Pay Gap fluctuates depending on whether bonus payments, such as winter incentives or onwards payments, are made to nursing staff.*

The full Gender Pay Gap Report of the Trust as of 31 March 2023, as reported to the Trust Board in September 2023 can be found on the Trust website: visit www.ouh.nhs.uk and type 'TB2023.84' into the search field on the home page. During the year, the Trust Board considered the key matters and most up to date data relating to the Trust's gender pay gap.

Further information on Trust's gender pay gap, including the distribution of men and women in each pay quartile, is available online at gender-pay-gap.service.gov.uk.

## Trade Union Facility Time

*The Trade Union (Facility Time Publication Requirements) Regulations 2017* came into effect on 1 April 2017. Under the Regulations Oxford University Hospitals NHS Foundation Trust is legally required to publish the following information annually.

Facility time is the provision of paid or unpaid time off from an employee's normal role, granted to the employees who are trade union representatives to carry out their Trade Union role.

### *Relevant union officials*

*What was the total number of your employees who were relevant union officials during the relevant period?*

| Year | Number of employees who were relevant union officials during the relevant period | Full-time equivalent employee number |
|---|---|---|
| 2023/24 | 35 | 29.47 |
| 2022/23 | 34 | 30.08 |

### *Percentage of time spent on facility time*

*How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?*

| Percentage of time | Number of employees 2023/24 | Number of employees 2022/23 |
|---|---|---|
| 0% | 21 | 18 |
| 1-50% | 13 | 14 |
| 51%-99% | 0 | 0 |
| 100% | 1 | 2 |

### *Percentage of pay bill spent on facility time*

*What was the percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period?*

| | 2023/24 | 2022/23 |
|---|---|---|
| Total cost of facility time (£000s) | £122 | £113 |
| Total pay bill (£000s) | £949,104 | £886,858 |
| Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100 | 0.01% | 0.01% |

***Paid Trade Union activities***

*As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid Trade Union activities?*

| | 2023/24 | 2022/23 |
|---|---|---|
| Time spent on paid Trade Union activities as a percentage of total paid facility time, hours calculated as: (total hours spent on paid Trade Union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100 | 0.17% | 4.9% |

## Off-payroll arrangements

In accordance with the HM Treasury annual reporting guidance, the Trust is required to report the number of off-payroll engagements where an individual is paid £245 or more per day. From April 2017, the Government has reformed the legislation associated with off-payroll payments so that public sector bodies are responsible for deducting and paying all employment taxes and National Insurance contributions from the individuals concerned. The Trust has worked hard to eliminate the off-payroll arrangements that were in place in previous years and has implemented a policy that no individuals are paid off-payroll unless the employing manager submits evidence from HM Revenue and Customs (HMRC) that they are certified as self-employed.

***Table 1: Highly-paid off-payroll worker engagements as of 31 March earning £245 per day or greater***

| | 31 March 2024 | 31 March 2023 |
|---|---|---|
| Number of existing engagements as of… | 4 | 3 |
| of which… | | |
| Number that have existed for less than one year at time of reporting | 1 | - |
| Number that have existed for between one and two years at time of reporting | 1 | 1 |
| Number that have existed for between two and three years at time of reporting | - | - |
| Number that have existed for between three and four years at time of reporting | - | 1 |
| Number that have existed for four or more years at time of reporting | 2 | 1 |

***Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March earning £245 per day or greater***

| | **31 March 2024** | **31 March 2024** |
|---|---|---|
| Number of off-payroll workers engaged during the year ended... | 5 | 3 |
| of which… | | |
| Not subject to off-payroll legislation* | - | - |
| Subject to off-payroll legislation and determined as in-scope of IR35* | - | - |
| Subject to off-payroll legislation and determined as out-of-scope of IR35* | 5 | 3 |
| Number of engagements reassessed for compliance or assurance purposes during the year | - | - |
| of which… | | |
| Number of engagements that saw a change to IR35 status following review | - | - |

**A worker who provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.*

***Table 3: For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility***

| | **Between 1 April 2023 and 31 March 2024** | **Between 1 April 2022 and 31 March 2023** |
|---|---|---|
| Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year. | 0 | 0 |
| Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements. | 23[1] | 21[1] |

*Note:*

1. *For the purpose of reporting off-payroll engagements of the Board, all members of the Board who were in office during the year have been considered.*

### Staff exit packages *(this information is subject to audit)*

The table below discloses the total of all staff exit packages agreed in the 12 months to 31 March 2024. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the accounting period of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included within this table.

#### *Exit packages*

| Exit package cost band | 2023/24 | | | 2022/23 | | |
|---|---|---|---|---|---|---|
| | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages |
| <£10,000 | - | - | - | 5 | - | 5 |
| £10,000 - £25,000[1] | 1 | - | 1 | 2 | - | 2 |
| £25,001 - £50,000 | 1 | - | 1 | 2 | - | 2 |
| £50,001 - £100,000 | 1 | - | 1 | 1 | - | 1 |
| £100,001 - £150,000 | 2 | - | 2 | - | - | - |
| £150,001 - £200,000 | - | - | - | - | - | - |
| >£200,000 | - | - | - | - | - | - |
| Total number of exit packages by type | 5 | - | 5 | 10 | - | 10 |
| Total resource cost £k | 355 | - | 355 | 189 | - | 189 |

*Note:*

1. *One exit package disclosed in the banding £10,000 - £25,000 for 2023/24 was agreed in late March 2023, thus it relates to the 2022/23 accounting period. This would reduce the 'Total resource cost' from £355k to £330k for 2023/24 and increase it from £189k to £214k for 2022/23.*

During 2023/24, the funding provided to the Trust by the National Institute for Health and Care Research (NIHR) for hosting the UK Cochrane Centre ended on 31 March 2024, as the contract ended a year early. This resulted in the redundancy of a small number of long serving staff and increased the overall cost of exit packages.

#### *Exit packages: other non-compulsory departure payments*

There were no exit packages in either the year 2023/24 or year 2022/23 which were classed as non-compulsory departure payments.

### Expenditure on consultancy

Reporting bodies are required to disclose the expenditure on consultancy. The consultancy expenditure incurred by the Trust in 2023/24 can be found in note 7.1 of the Annual Accounts found later in this document.

# Code of Governance Compliance

NHS Foundation Trusts are required to provide certain disclosures in their Annual Report to meet the requirements of the Code of Governance for NHS Provider Trusts (updated in October 2022). Oxford University Hospitals NHS Foundation Trust has applied the principles of the Code of Governance and considers that it complies with the specific disclosure requirements as set out in the Code of Governance for NHS Provider Trusts and NHS Foundation Trust Annual Reporting Manual (FT ARM) issued by NHS England.

The Code of Governance reference (Code Section in table below) of the main provisions that are required to be disclosed, summary of its requirement, and the location of the Annual Report where the disclosure has been made or any responses are shown in the table below. 'FT ARM' indicates a requirement that is not a disclosure requirement of the Code of Governance, but of the NHS Foundation Trust Annual Reporting Manual.

| Code Section | Summary of Requirement | Annual Report References/Response |
|---|---|---|
| A 2.1 | The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy. | This information is available in the Annual Governance Statement of this Annual Report. |
| A 2.3 | The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce. | This information is available in the Staff Report of this Annual Report. |
| A 2.8 | The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its | This information is available in the Performance Report and the Annual Governance Statement of this Annual Report. |

| Code Section | Summary of Requirement | Annual Report References/Response |
|---|---|---|
| | collaboration with other organisations and any associated risk management arrangements. | |
| B 2.6 | The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:<br>• has been an employee of the trust within the last two years<br>• has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust<br>• has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme<br>• has close family ties with any of the trust's advisers, directors or senior employees<br>• holds cross-directorships or has significant links with other directors through involvement with other companies or bodies<br>• has served on the trust board for more than six years from the date of their first appointment<br>• is an appointed representative of the trust's university medical or dental school.<br><br>Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why. | This information is available in the Directors' Report of this Annual Report.<br><br>Where applicable, such circumstances which are likely to impair, or could appear to impair a Non-Executive Directors' independence would be declared in the Board of Directors' Register of Interests.<br><br>The Board of Directors' Register of Interests is available on the Trust website at: www.ouh.nhs.uk/about/trust-board. |
| B 2.13 | The annual report should give the number of times the board and its committees met, and individual director attendance. | This information is available in the Directors' Report and the Remuneration Report of this Annual Report. |
| B 2.17 | For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees | This information is available in the Trust Membership and Council of Governors Report of this Annual Report. |

| Code Section | Summary of Requirement | Annual Report References/Response |
|---|---|---|
| | and the types of decisions which are delegated to the executive management of the board of directors. | |
| C 2.5 | If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors. | The Trust, through a compliant procurement process, has contracted Odgers Berndtson for all Board recruitment. One of their staff members is related to a Governor of the Trust. |
| C 2.8 | The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference. | This information is available in the Trust Membership and Council of Governors Report of this Annual Report.<br><br>The Terms of Reference of the Council of Governors' Remuneration, Nominations and Appointment Committee is available on the Trust website at www.ouh.nhs.uk/about/governors/#committees |
| 4.2 | The board of directors should include in the annual report a description of each director's skills, expertise and experience. | The Directors' Report refers to the Trust website for details of the skills, expertise and experience of each of our Board members, and are available at: www.ouh.nhs.uk/about/trust-board/directors. |
| C 4.7 | All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors. | It is the Trust's intention to consider the commissioning of an external review during 2024/25, subject to the ongoing application of controls over non-essential non-pay expenditure across the Integrated Care System. |
| C 4.13 | The annual report should describe the work of the nominations committee(s), including:<br>• the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline | Work of the Council of Governors' Remuneration, Nominations and Appointments Committee is available in the Trust Membership and Council of Governors Report.<br>The work of the Trust Board's Remuneration and Appointments Committee is available in the Remuneration Report of this Annual Report. |

| Code Section | Summary of Requirement | Annual Report References/Response |
|---|---|---|
| | • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition<br><br>• the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives<br>• the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served<br>• the gender balance of senior management and their direct reports. | During 2023/24, there has not been an external evaluation of the Board. This was due to the number of changes in the Board membership that took place during the year. It was agreed that the Board membership needs to be fully established and in place before undertaking any external evaluation.<br><br>This information is available in the Staff Report of this Annual Report. |
| C 5.15 | Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. | This information is available in the Trust Membership and Council of Governors Report of this Annual Report. |
| D 2.4 | The annual report should include:<br>• the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed<br>• an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans<br>• where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit | This information is available in the Annual Governance Statement (AGS) of this Annual Report.<br><br>The independence of the external audit function is reviewed as part of the Annual Review of Effectiveness of the Audit Committee and is confirmed annually.<br><br>There have been no changes to the current External Auditor in year, and the AGS sets out that there is an internal audit function in place, outsourced to BDO. |

| Code Section | Summary of Requirement | Annual Report References/Response |
|---|---|---|
| | • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services. | |
| D 2.6 | The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy. | This information is available in the Directors' Report of this Annual Report. |
| D 2.7 | The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report. | This information is available in the Performance Report and the Annual Governance Statement of this Annual Report. |
| D 2.8 | The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report. | This information is available in the Annual Governance Statement of this Annual Report. |
| D 2.9 | In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare. | The Performance Report refers to the Trust Annual Accounts for this disclosure.<br><br>The going concern disclosure can be found in note 1.2 of the Annual Accounts found later in this document. |
| E 2.3 | Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings. | Not applicable for the reporting year. |
| Appendix B, para 2.3 (not in Schedule A) | The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. | This information is available in the Trust Membership and Council of Governors Report of this Annual Report. |

| Code Section | Summary of Requirement | Annual Report References/Response |
|---|---|---|
| Appendix B, para 2.14 (not in Schedule A) | The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report. | This information is available in the Trust Membership and Council of Governors Report of this Annual Report. |
| Appendix B, para 2.15 (not in Schedule A) | The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. | This information is available in the Trust Membership and Council of Governors Report of this Annual Report. |
| Additional requirement of FT ARM resulting from legislation | If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.<br>This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012.<br>* Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance).<br>** As inserted by section 151 (6) of the Health and Social Care Act 2012) | Not applicable.<br><br>Except for the Trust Chair, the Board of Directors is not formally required to attend the Council meetings. Board members attend the Council of Governors meetings by choice or at the request of the Governors. More information is available in the Trust Membership and Council of Governors Report of this Annual Report. |

# NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)

a) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.
b) An NHS Foundation Trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

## Segmentation

Oxford University Hospitals NHS Foundation Trust has been segmented into category 2 and is not in breach of licence and no formal action is needed, but with the potential for support in one or more of the five themes. There are no enforcement actions from NHS England currently in place.

This segmentation information is the Trust's position as at 31 March 2024. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

# Statement of Accounting Officer’s Responsibilities

***Statement of the Chief Executive Officer's responsibilities as the Accounting Officer of Oxford University Hospitals NHS Foundation Trust.***

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Oxford University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Oxford University Hospitals NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust’s performance, business model and strategy
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the Foundation Trust’s auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity’s auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Signed: Professor Meghana Pandit
Chief Executive Officer
26 June 2024

# Annual Governance Statement

## Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Oxford University Hospitals NHS Foundation Trust for the year ended 31 March 2024 and up to the date of approval of the Annual Report and Annual Accounts.

## Capacity to handle risk

The Trust has a Risk Management Policy which sets out the agreed protocol for the management of risk and the individual responsibilities and accountabilities for risk.

Operationally, responsibility for the implementation of risk management has been delegated to Executive Directors as follows.

- The Chief Assurance Officer has delegated authority for the Risk and Control Framework and is the Executive Lead for maintaining the Board Assurance Framework and its supporting processes.
- The Chief Finance Officer has responsibility for financial risk and control.
- The Chief Medical Officer has responsibility for quality, clinical governance and clinical risk, including incident management, and joint responsibility with the Chief Nursing Officer for patient safety.
- The Chief Nursing Officer has responsibility for patient experience and joint responsibility with the Chief Medical Officer for patient safety.
- The Chief Digital and Partnership Officer is the Senior Information Risk Owner (SIRO) and has responsibility for the assessment and management of information risk.
- The Chief Estates and Facilities Officer has responsibility for the oversight and advice on estates and facilities risk.

- The Chief Operating Officer has responsibility for the clinical operational arrangements in the Trust and for oversight of the clinical Divisions.
- All Executive Directors have responsibility for the management of strategic and operational risk within their individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their Directorates.

During the year, efforts have been made to train additional staff on their responsibilities towards risk management. Risk management training has been delivered during quarter one to quarter three of the year to over 120 additional staff with functional responsibility for risk management through a series of ad-hoc training sessions. In quarter four, a regular programme of risk training was adopted offering both an Introduction to the Management of Risk and more functional training on the Trust's risk management software system. This training programme is linked to the Trust's induction programme and to the emerging leaders' scheme and will continue monthly for the foreseeable future.

## The Risk and Control Framework

### Approach to risk

The Trust's Risk and Control Framework consists of:

- Risk Management Policy
- Board Assurance Framework
- risk registers and assessment processes
- Trust's governance structure
- Risk Management Strategy.

The Risk Management Policy currently sets out an integrated approach to the management of risk across the organisation. The aim is to encourage considered risk-taking within authorised limits, and in line with the Board's risk appetite, but to reduce those risks that impact on patient and staff safety or have an adverse effect on the Trust's reputation as well as its financial and operational performance.

The Risk Management Policy also describes how risks are linked to one or more of the Trust's strategic themes or operational objectives. It provides the framework for the proactive risk identification and management of risks, through risk registers, risk assessment and the Board Assurance Framework. The Policy describes how the Board develops its risk appetite statement. The Board's risk appetite statement has been included in the Risk Management Policy and is being revisited and will be reflected in the Risk Management Policy when that is next reviewed.

The Risk Management Policy also describes how to consider a full range of risks, including the assessment and consideration of risks to our patients, our people and our populations. The policy provides information on the range of sources used to inform risk assessment and identification, including risk assessments, public stakeholder sources such as feedback from the Council of Governors, patient feedback, patient surveys and patient experience groups.

In addition, the Risk Strategy is currently being comprehensively reviewed, with the aim of replacing it with a long-term plan for future risk management within the Trust.

The Board Assurance Framework provides the mechanism for the Board to monitor risks, controls and the outputs of its assurance processes. During the year, the content and use of the Board Assurance Framework has been reviewed with a view to improving the assurance derived from it.

The Trust's risk assessment process covers all its activities across clinical services, clinical support services and business support functions. Each Division and Directorate is responsible for maintaining its own risk register in accordance with the Risk Management Policy. These risk registers are reviewed regularly by Divisional and Directorate forums, and they are required to escalate risks, where their ratings warrant this, for Corporate Risk Register inclusion. During the year, the Board committees have reviewed the Corporate Risk Register, including the following high-scoring (principal) risks.

- Due to some unsupported hardware or software, there was a risk identified that some systems might not be recovered or could be susceptible to cyber security vulnerability, or that some systems could have become incompatible with supported systems.
- As a result of costs being greater than planned and greater than total income, the risk identified was that there could have been a failure to deliver the in-year financial plan potentially reducing the funds available for capital expenditure, leading to increased scrutiny by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) and NHS England.
- As a result of productivity levels that are insufficient to cover costs based on national average funding levels, there was a risk identified around the inability of the Trust to break even over the next three to five years which might affect the Trust's ability to sustain safe, compliant and effective provision of healthcare.
- Changes in demand and acuity led to a risk to the achievement of national standards for Emergency Department (ED) waiting times that might affect patient experience.
- Due to high bed occupancy and changes to staffing capacity, a risk to our ability to achieve expected delivery levels in line with our elective recovery plan was identified that could lead to potential harm for patients.
- The lack of capacity in beds and staffing, and the impact of industrial action, led to a risk to meeting the elective care delivery plan for patients waiting 78 weeks and a risk to delivery of 65 week wait trajectory that might affect patient outcomes and experience.
- Due to issues with diagnostic capacity and industrial action, a risk to our ability to reduce the current backlog of patients waiting for cancer diagnosis and treatment was identified that might cause patient harm.

The details of the key actions taken in relation to the above risks can be found later in this Annual Governance Statement.

Risk management is embedded within the organisation in a variety of ways. The Risk Committee, a sub-committee of the Trust Management Executive, meets bi-monthly ensuring the Trust operates an effective risk management system through monitoring and oversight of Divisional and the Corporate Risk Registers. The Committee also conducts deep dives of selected risk registers, reviewing the consistency of risk scoring and risk recording. All members of staff have a duty to report incidents, hazards, complaints and near misses in accordance with the relevant policies. Information on incident management, serious

incidents and 'never events' is reported to the Clinical Governance Committee and is presented to the Integrated Assurance Committee of the Board as a standing agenda item.

The Trust Board has overall responsibility for the performance of the Trust and is accountable to members of the Trust and Council of Governors, through its Chair. The Board's role is largely supervisory and strategic, and it has the responsibility to:

- set strategic direction, define objectives and agree plans for the Trust
- delegate the achievement of objectives and planned outcomes to the Chief Executive Officer
- monitor performance and ensure appropriate corrective action is taken
- ensure financial probity and stewardship
- ensure high standards of corporate and clinical governance
- appoint, appraise and remunerate Executive Directors
- ensure dialogue with external stakeholders such as statutory bodies and the local community.

In 2023/24, the Board had five committees: Integrated Assurance Committee, Audit, Remuneration and Appointments Committee, Investment Committee, and the Trust Management Executive. These committees were established to mitigate the principal risks to compliance with the NHS Foundation Trust Licence. The Licence sets out conditions that healthcare providers must meet to help ensure that the health sector works for the benefit of patients. Condition 4 of the Licence, relating to Foundation Trust Governance, has governance processes to:

- enable the Board to discharge its duties and to govern the Trust effectively, including extending its ability to monitor, review and revise its strategic direction and the achievement of agreed outcomes
- support the Non-Executive Directors in their scrutiny and challenge of Executive management action
- maximise the value of Non-Executive Directors' time
- support the Board's assessment of information to enable evidence-based unitary decisions
- support the more detailed development of background work that might not otherwise be possible at Board meetings alone.

The Chairs of the Board committees present written reports to the Board after each meeting, highlighting significant issues of interest to the Board, including key risks identified, other matters considered, and decisions made at their meetings. In addition, the Board and each of its committees undertake an annual review of their performance and effectiveness, considering the practices set out in the Code of Governance for NHS Provider Trusts (the Code) and the constitution. These reviews are used to produce an annual committee report to the Board, including a summary of the activities of the committee in terms of the risks and assurances considered. These annual reports have been used to provide additional evidence in formulating the Board's consideration of its compliance with the Code.

The Trust applies the principles of the Code on a 'comply or explain' basis, and the Board considers the Trust to have complied fully with the Code for the reporting period 2023/24.

## Work of the Board Committees

The ***Audit Committee*** exists to oversee the establishment and maintenance of an effective system of internal control throughout the organisation, by means of independent and objective review of financial and corporate governance, and risk management arrangements including compliance with law, guidance and regulations governing the NHS. It ensures there are effective Internal Audit arrangements in place that meet mandatory NHS Internal Audit Standards and provide independent assurance to the Board.

The Committee reviews the work and findings of External Audit and provides a route through which their findings can be considered by the Board. It also reviews the Trust's annual statutory accounts before they are presented to the Board, ensuring that the significance of figures, notes and important changes are understood. The Committee maintains oversight of the Trust's Internal Audit, carried out by the external agency BDO and Counter Fraud arrangements, managed by TIAA. During the year, the Committee reviewed and considered:

- a mid-year review of judgements and estimates
- the Going Concern assumption, accounting policy for Going Concern
- cashflow projections
- financial statements, update on Management Representations
- an update to the use of costing data.

The Audit Committee has received regular reports from the Trust's Local Counter Fraud Specialist (LCFS) TIAA. The Counter Fraud Progress Report has focused on highlighting key fraud, bribery and corruption risks and trends, receiving intelligence from Trust management, staff, the police, the NHS Counter Fraud Authority (NHSCFA) and external third parties. This intelligence has allowed the LCFS to create a profile of risks for the Trust and illustrate the level of risk, and recommending the Trust to add these risks to relevant Trust risk registers.

TIAA has assessed the Trust's exposure to key fraud risks and developed key deliverables for the year which were reviewed at each meeting of the Audit Committee.

- Workforce controls, for example dual employment
- Fraud awareness, for example finance mandate fraud

The Audit Committee receives a range of assurance from Executive Directors during the year. This has included detailed reviews of Counter Fraud, progress against the Internal Audit programme, insurance arrangements, and assurance on various aspects of financial governance. In addition, the Audit Committee was regularly updated on progress with the development of the Board Assurance Framework and Corporate Risk Register, and the review of the compliance with accreditation, legislation and regulation.

The Audit Committee received Internal Audit opinions as follows.

- Getting It Right First Time (GIRFT): Design – Moderate, Effectiveness – Moderate
- Performance Framework: Design – Substantial, Effectiveness – Moderate
- Data Quality – ED Access Standards: Design – Moderate, Effectiveness – Moderate
- DSP Toolkit: Design – Substantial, Effectiveness – Moderate
- Financial Governance Review / Healthcare Financial Management Association (HFMA): Action Plan Implementation: Design – Moderate, Effectiveness – Moderate
- Medicines Security: Design – Moderate, Effectiveness – Moderate
- Outpatient Management: Advisory Review

- Environmental Sustainability: Maturity Review
- Corporate Governance: Advisory Review
- Key Financial Systems: Design – Substantial, Effectiveness - Moderate

The following audits are currently in progress:

- Overpayments (Draft Report)
- Direct Awards Procurement (Work in Progress): Advisory Review
- Research and Development (Work in Progress): Advisory Review

The Trust Management Executive (TME) retains the responsibility for ensuring all actions from Internal Audit reports are complete and provides assurance to the Board on matters arising from the actions. The Audit Committee has maintained oversight of overdue recommendations and timeliness of management responses to audit reports. Any concerns are escalated to TME for further focus and expeditious resolution. No concerns were noted as part of this process during the year.

The Trust's Internal Auditors provide an annual Head of Internal Audit Opinion based on the work conducted throughout the year. This year, the Head of Internal Audit Opinion provided the Trust with a rating of Moderate Assurance that there is a sound system of internal control, designed to meet the Trust's objectives, and that controls are being applied consistently across various services.

In forming their view, Trust's Internal Auditor BDO considered the following.

- The Trust's unaudited 2023/24 financial performance was reported as £10.7m income and expenditure deficit, £8m adverse to 2023/24 plan. The £10.7m deficit is £4.5m better than the re-forecast of £15.3m deficit and in line with the subsequently submitted forecast to NHSE, which included a revision for deficit and industrial action funding.

- All audit reports provided substantial or moderate assurance in the design and operational effectiveness of controls, including the key audits of Key Financial Systems, Data Security and Protection Toolkit and ED Access Standards Data Quality.

- Internal Audit have closed all prior year (2022/23) recommendations. Management are proactive in discussing plans to address the risks identified in the 2023/24 audits.

The ***Integrated Assurance Committee*** is responsible for receiving, scrutinising and triangulating the main sources of evidence across the Trust to enable the Board to assess its level of confidence in the assurances provided regarding:

- the Trust's values and culture
- the organisation's financial and operational performance
- the quality of services (including clinical effectiveness, patient experience and safety) across the organisation
- the appropriate identification, assessment and management of risks.

The Committee has a standing agenda on the review of emerging risks and has received regular reports as part of its cycle of business on the Board Assurance Framework and Corporate Risk Register.

During the year, the Committee has received assurance on the following.

- The reinvigoration of the 'No Excuses' campaign and training to combat the increase in assault, aggression and violence towards staff, attributed to patient capacity and staffing issues.
- Financial performance and recovery, assurances on pay controls, forecast year-end position and capital expenditure.
- The impact of industrial action on the pace of waiting list recovery pertaining to cancer and elective care performance.
- The Newborn Care Development Programme, a scheme facilitating the transition to an enhanced dynamic care culture that nurtures assistance for childbearing people and their families.

The ***Investment Committee*** is responsible for advising the Board in relation to investments. The Committee advises on the annual capital investment plan, reviews capital cases prior to Board consideration, and ensures that there are appropriate monitoring arrangements in place for investments. The Committee also monitors the Trust's commercial activities including significant leases, joint ventures and asset disposals. During 2023/24, the Committee also reviewed investments into staff wellbeing projects, and major clinical and non-clinical procurements which are under development.

The ***Remuneration and Appointments Committee*** is responsible for determining the policy on executive remuneration, approving contracts of employment for Executive Directors, senior managers on VSM (very senior managers) contracts and for the four Divisional Directors, and agreeing arrangements for termination of contracts. The Committee ensures that appropriate performance management arrangements are in place for Executive Directors.

On behalf of the Board, the ***Trust Management Executive (TME)*** is responsible for the achievement of the outcomes set out in the Trust's Annual Business Plan, and for ensuring compliance with regulatory and legislative requirements. TME is supported to fulfil this function by its management groups, which are constituted with clear Terms of Reference and are required to report to TME regularly.

Key areas discussed by TME and reported to the Board for information included:

- the rollout of the Patient Safety Incident Response Framework (PSIRF) and Policy aimed at improving support for staff, families and patients affected by patient safety incidents
- support for colleagues taking industrial action, including their rights and respect, whilst maintaining patient safety and staff wellbeing
- the significant reduction in patients waiting 65 weeks or longer and the active tracking of the relevant waiting lists to 31 March 2024
- workforce and organisational development matters such as:
  - delivery of the Year 2 People Plan
  - Staff Network resource and time investment to enable and support the delivery of the Equality, Diversity and Inclusion (EDI) agenda as part of the OUH People Plan.

### Trust Board membership

The Trust Constitution states that the Board shall comprise between five and nine members from both the Executive Directors and the Non-Executive Directors. To maintain balanced unitary decision-making, all Board members hold voting positions.

During the reporting year, the Board membership consisted of nine Executive Director roles, including the Chief Executive Officer, and ten Non-Executive Directors, including the Trust Chair. It was considered that the membership of the Board was fully compliant with the terms of the Trust Constitution for the 2023/24 year.

Trusts Executive team consists of:

- Chief Executive Officer
- Chief Medical Officer
- Chief Finance Officer
- Chief Nursing Officer
- Chief Estates and Facilities Officer
- Chief Operating Officer
- Chief People Officer
- Chief Digital and Partnership Officer
- Chief Assurance Officer

Further information of the Board membership during the year 2023/24 is available in the Directors' Report of this Annual Report.

Working alongside the Board of Directors is the Council of Governors, which is composed of governors elected by public and staff members as well as appointed representatives from local organisations with which the Trust works. The Non-Executive Directors are accountable to the local community for the performance of the Board through the Council of Governors. The Council of Governors appoints the Non-Executive Directors.

Details of the Trust Constitution and the purpose and role of the Council of Governors are available on the Trust website at www.ouh.nhs.uk/about/governors. Further information on the Council of Governors' membership during the year 2023/24 is available in the Trust Membership and Council of Governors' Report of this Annual Report.

### Discharging statutory functions

The Trust has arrangements to ensure that it discharges its statutory functions and complies with legislative requirements. These include, but are not limited to:

- use of Internal Audit to consider the systems and processes which support the management of the Trust's functions
- monitoring compliance with Care Quality Commission (CQC) requirements and reporting this to the Board and its committees
- monitoring compliance with quality, operational and financial performance standards, including the standards set out in the NHS Foundation Trust Constitution
- consideration of the implication of any proposed service changes and taking legal advice as required

- access to external, independent legal and audit advice to all Board members, should they require this in line with undertaking their role
- oversight of the internal control systems within the Trust by the Audit Committee, with a particular focus on the management of risk
- assurance provided to the Board by the work of the Board Committees
- use of external, independent reviewers to provide assurance of the Trust's systems where possible issues have been identified.

**Developing workforce safeguards**

The overall workforce plan for the Trust is developed on an annual basis, approved by the Trust Board, and aligned to activity and financial plans. The Trust also has established daily operational processes in place to ensure the ongoing monitoring of safe staffing levels. This is supported largely by workforce deployment systems including the e-rostering system.

The People and Communications Committee, a sub-committee of the Trust Management Executive, monitors and provides strategic assurance on workforce plans, controls and systems that are financially sustainable, while providing high quality and compassionate care to patients, both short-term and long-term.

NHS England (NHSE) has identified staffing as one of the key risks impacting NHS Trusts. The OUH Strategy 2020-2025, the five-year strategy of the Trust, refocused resources on our patients, our people and our populations. The Trust Board also recognises that workforce is a key priority to underpin the achievement of clinical and financial performance and approved the OUH People Plan 2022-25 in July 2022. This has three strategic themes: *health, wellbeing and belonging for all our people*, *making OUH a great place to work* and *more people working differently*.

The Trust has engaged in activities throughout the year to ensure compliance with the 'developing workforce safeguards' objective. Some of which are:

- development and submission of an agreed annual workforce plan aligned to activity and finance
- ongoing recruitment of overseas staff to maintain an appropriate supply of nursing and other staff, to ensure service delivery as well as improve workforce stability by reducing turnover
- focused support for filling vacancies in hotspot areas such as Healthcare Support Workers, Estates and Facilities, and Administration and Clerical
- deep dive into workforce risks, including bullying and harassment, sexual safety and violence and aggression plus staff wellbeing, presented to the People and Communications Committee and Risk Committee for assurance and scrutiny
- delivery of Year 2 People Plan priorities: supporting staff with their psychological wellbeing and stress management, continuing to improve our recruitment processes, focusing on supporting new starters joining the Trust to have an improved welcome experience, and introducing leadership and management training

- developing, delivering and monitoring the Eradication of Bullying and Harassment Strategy, working collaboratively on tackling violence and aggression plus signing up to and progressing the Sexual Safety in Healthcare Organisational Charter.
- detailed operational planning and communication throughout planned phases of industrial action to ensure patient safety, working closely in partnership with the British Medical Association (BMA) and the Local Negotiating Committee.

**Compliance with key mandated statements**

The Trust is required to make the following mandatory statements each year.

- Care Quality Commission Compliance
- Estates Compliance
- Conflicts of Interests
- Pension Scheme
- Equality and Diversity
- Greener NHS

***Care Quality Commission Compliance***

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). As of 31 March 2024, the Trust had an overall rating of 'Requires Improvement' (RI) from the CQC. This was consistent with the rating disclosed in the previous Annual Report and reflected the activities undertaken by the CQC during the year 2023/24.

In April 2023, the Trust received the report from the November 2022 unannounced inspection of Oxford Critical Care services at the John Radcliffe Hospital. Services were inspected, but not rated under the domains of Safe and Well-led. The state-of-the-art facilities, which are spacious and designed using proven modern practices for improving infection prevention and control standards and reducing patient risk of contamination, were commended as examples of outstanding practice. The 'should do actions' that the Trust was advised to undertake, were integrated into the work of the Oxford Critical Care Development Programme, the outputs of which continue to be reported by the service and Division through key committees and existing governance processes.

During 2023/24, there was one short-notice CQC inspection of the Midwifery-led Unit at the Horton General Hospital. This inspection was part of the national maternity inspection programme, solely reviewing the Safe and Well-led key lines of enquiry. The inspection took place in October 2023 and the report was published in March 2024. The service was rated as 'Requires Improvement' for both Safe and Well-led. This outcome resulted in a change to the CQC rating of the Horton General Hospital to 'Requires Improvement'.

The Trust takes every opportunity to use feedback in a proactive and positive way; whenever a report is received an action plan is developed with the service and executive leadership to celebrate successes and address opportunities for improvement. The Trust developed an action plan in response to the March 2024 report, which was submitted to the CQC in April 2024, and will be reported through the governance structures of the Trust.

During the year, the Trust has continued engaging the CQC, which recommenced engagement meetings following the launch of its new approach to regulation, continuing with engagement

activities, such as responding to specific enquiries and information requests for the purpose of assurance.

The Trust continued to report on progress with the two remaining actions from the CQC maternity inspection published in September 2021, alongside progress with the ‘should do actions’ identified in the November 2022 inspection of the Oxford Critical Care Unit at the John Radcliffe Hospital. In addition, the Trust has continued to report on progress with any actions aligned to the immediate and essential actions outlined in the Ockenden Report, NHS England three-year plan for maternity and neonatal services and evidence requirements to support Maternity Incentive Scheme standards.

The Trust has engaged with a range of CQC stakeholder surveys during 2023/24, results of which have been published on the CQC website. Findings from CQC inspections, ongoing monitoring activity and surveys have resulted in action plans being produced by the services and monitored by the Clinical Governance Committee and Maternity Safety Champions.

***Estates Compliance***

Further to the implementation of an Estates Compliance Action Plan in May 2020, ongoing monitoring and updates continue via the Estates Compliance Committee (ECC), the Health and Safety Committee, the Executive Risk Committee and the Trust Management Executive. ECC moved from a monthly to a bi-monthly meeting in response to positive feedback that assurance and control measures are in place. These controls include the following.

- Validation of actions proposed for closure by the Authorised Engineer (AE) in advance of them being closed.
- ECC Operational Sub-group meetings with respective authorised persons (AP) to enable focus on targeted actions, particularly the high-risk actions.
- Risk assessment of the Trust’s 5 x 5 risk matrix.
- Presenting a summary of closed actions at the relevant safety groups to ensure this information is communicated to all stakeholders.
- Development of a recovery plan for any actions that are overdue.
- Tracking and managing all actions on the Ulysses action module. This improves transparency and reporting.

The Premises Assurance Model (PAM) assessment, carried out in August 2023, saw a positive improvement in scores, with only eight of the 343 questions ranked as ‘Requires Moderate Improvement’ (an improvement from 29 reported in initial 2020/21 PAM). Areas where scores have improved include:

- better analysis of staffing needs
- plans to establish new posts and ongoing recruitment following the Estates Resources Business Case approval by the Trust Board in July 2022
- strengthened governance and understanding around prioritisation of future ventilation investment
- more robust arrangements to manage asbestos
- implementation of plans to reduce water risks.

There was one ‘Inadequate’ score (an improvement of two reported in 2022/23) that emerged from the 2020/21 PAM assessment in relation to fire safety. This single inadequate

score is in the area of fire safety compartmentation and alarm systems within the retained estate.

Works to address the highest fire safety risks in the retained estate form part of the 2024/25 Estates Compliance capital infrastructure plan.

Policies for Asbestos and Pest Control have all been progressed in year and recommended for approval via the respective safety groups, Health and Safety Committee and Trust Management Executive. Further work is ongoing to update the Staff Travel and Car Parking, Waste Management, Ventilation Gas Safety and Control of Contractors policies.

A full review of the resource requirements across the Estates, Facilities, Capital Development and Private Finance Initiative (PFI) portfolio took place in 2022, and this has remained a priority area 2024/25 supported by a fortnightly task and finish group Chaired by the Chief Estates and Facilities Officer, with oversight via the Productivity Committee.

***Conflicts of Interests***

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust's updated policy and with reference to the guidance) within the past 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

***Pension Scheme***

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

***Equality and Diversity***

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

***Greener NHS***

The Foundation Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust aims to achieve net zero carbon emissions by 2040 in line with NHS England's carbon neutral target, and is looking forward to implementing plans to:

- reduce its carbon footprint
- minimise waste
- provide sustainable healthcare to secure better health for future generations.

Further information on the Trust's Green Plan and its progress are available in the Performance Report of this Annual Report.

## Review of economy, efficiency and effectiveness of the use of resources

The national process to develop an Annual Plan for 2023/24 commenced in December 2022 and was informed by the national planning guidance that was published in that month. NHS England (NHSE) continued to publish guidance and provide further details during January 2023. Final plans were submitted to NHSE at the end of March however, there were a limited number of systems that were required to resubmit their plans during May 2023 due to their deficit positions. This included the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS). Following the resubmission, the BOB ICS planned for a £20.4m deficit, which included a planned deficit of £2.8m for OUH.

The Annual Plan of the Trust for 2023/24 was approved by the Board, and each clinical Division approved their contribution. The Annual Plan was aligned with the Integrated Care System's planning activities.

Achieving the planned financial performance was challenging and staff costs continued to be the main driver of overspend. Regardless of significant increases in substantive whole-time equivalents (WTEs) staff during the year, temporary staffing, particularly bank staffing, did not see any corresponding reductions. In addition, industrial action taken throughout the year disrupted the delivery of plans.

Notwithstanding the significant effort by staff, the Trust has reported a deficit on the revenue budget performance measure used by NHSE of £10.7m, and the BOB ICS as a whole has delivered a deficit of £53.4m. Although the Trust's deficit of £10.7m for the year was worse than plan, it did meet the forecast for the year-end that had been submitted to NHSE in year. The Trust outperformed its efficiency plan for the year delivering an additional £18.4m of savings. The Trust has also reported an underspend on the capital budget measure used by NHSE of £10.5m, and the ICS as a whole delivered an underspend of £57.3m.

The result of the deficit position has increased pressure on the Trust's cash reserves which have come close to being exhausted in the year. There is now a significant risk that the Trust will require cash support early in 2024/25.

The Trust engaged external specialists to provide a detailed review of cash processes and develop a forecasting tool. As a result of this review, some short-term improvements were made in cash balances during the year. However, we recognise that there is additional work to do in 2024/25 to improve cash management and cash forecasting.

The Trust experienced a decline in its productivity in the second half of the year when measured against an unpublished NHSE analysis, where real terms costs are tracked against cost weighted activity. This followed the first five months of the year when the Trust had made good progress against this measure. The main drivers of the decline have been the continuation of industrial action and the increased level of overall staffing costs. This decline in productivity was less pronounced for OUH than seen in other national benchmarks.

The Trust has established a Productivity Committee to provide the Board with assurance that the Trust is successful in delivering sustainable services and making the best use of their resources by improving efficiency and productivity. The Trust also forms part of the ICS Efficiencies Collaboration Group (IECG) with the Trust's Chief Financial Officer being the group chair.

**Partnerships**

The Trust has active participation in, and contributes to, the long-term plans of the Oxfordshire place-based partnership through its contribution to the BOB ICB Place Board, Oxfordshire County Council's Health and Wellbeing Board and its close working relationships with Public Health England and other Oxfordshire County Council Directorates.

The Trust Board has endorsed the BOB ICS Integrated Care Strategy, and the BOB Joint Forward Plan and Board members and senior leaders within the Trust participate in the Integrated Care Board's wide strategic and operational meetings, such as the Primary Care Strategy System Workshop in March 2024 and BOB Health Inequality and Prevention Board.

The Trust works closely with Oxford Health NHS Foundation Trust as part of the Oxfordshire Provider Collaborative for Integrated Care. This collaboration initially focuses on urgent care in the home and the community. This is supported by the development of a Memorandum of Understanding with Oxford Health NHS Foundation Trust and joint executive meetings. The Executive-to-Executive meetings provide opportunities for consideration of operational and strategic challenges, for example in response to current system financial challenges.

The Trust runs the NIHR (National Institute for Health and Care Research) Oxford Biomedical Research Centre (BRC) in partnership with the University of Oxford, and quarterly meetings are held with the University of Oxford via the Strategic Partnership Board with a specific focus on the Oxford Biomedical Research Centre.

The Board is provided with information about collaborations with key partners and key work included as part of the routine Chief Executive Officer reports and the Integrated Performance Report (IPR), for example the work of the Acute Provider Collaborative and the Elective Care Board. The Integrated Assurance Committee also receives the IPR and has received specific updates on the place-based Integrated Improvement Programme, Health Inequalities and the Urgent and Emergency Quality Improvement Programme, which are developed in collaboration with the ICS / ICB, where relevant, these would include reference to any associated risk management arrangements.

## Information Governance

All incidents related to breaches in the Trust's information security processes are reported on the Trust's incident reporting system. These are then assessed against the NHS Digital reporting matrix and are reported via the Data Security Protection Toolkit (DSPT).

Not all incidents meet the threshold for onward reporting to the Department of Health and Social Care and the Information Commissioner. Those that do not meet this threshold are investigated and reviewed locally. Incidents within the cohort that meet the threshold of causing harm or distress to patients are reported to the Integrated Care System (ICS) as Serious Incidents Requiring Investigation (SIRI).

The table below provides information in relation to serious incidents that met the threshold for onward reporting via the DSPT and the status of the incident. This is a reduction in ICO reported incidents of 50% compared to 2022/23.

| Date reported | Incident description | Actions taken / lessons learned |
|---|---|---|
| 12/01/2024 | Appointment form for one job applicant sent to another applicant via the TRAC recruitment system. | Both applicants were apologised to. The ICO considered the matter is closed. |
| 20/07/2023 | Occupational Health System auto populated the employee address field on management referral reports and a member of staff who was referred was provided with a manager's personal home address. | Occupational Health System templates checked and corrected to avoid repetition of this error. |
| 20/07/2023 | Maternity patient scan report sheet filed in wrong patient's notes, and the patient was given incorrect information about their pregnancy. | Scan report returned to correct patient notes. Patient contacted to advise of error and offered new appointment with consultant to provide them with reassurance. New electronic patient record went live in Maternity in February 2024, which will remove this risk in the future. |

## Data Quality and Governance

Under data protection legislation, the Trust is a Data Controller and holds responsibility for the confidentiality, integrity and availability of data provided by patients and staff and data generated because of the administration of the services provided.

The Chief Digital and Partnership Officer is the Trust's Lead Executive for digital technology, which includes the provision of hardware, software and digital systems, examples being the Trust's Electronic Patient Record (EPR) system. The Chief Digital and Partnership Officer also acts as the Trust's Senior Information Risk Owner (SIRO) and accepts organisational responsibility for the assessment and management of information risk.

The Caldicott Guardian is the organisational lead responsible for protecting the confidentiality of health and care information and making sure it is used properly, i.e. it is used lawfully, ethically and appropriately. The Trust also has a Data Protection Officer (DPO) who acts as an independent advisor ensuring that the organisation is aware of, and meets, its data protection responsibilities. They both report directly to senior management.

The Trust's Information Governance is overseen by the Caldicott Guardian and has delegated responsibility for ensuring the Trust complies with its legal obligations for information governance and data quality. Both aspects are subject to Internal Audit reviews.

Each year, the organisation makes an annual submission, via the Data Security Protection Toolkit, to demonstrate that it is achieving compliance with the National Data Guardian's 10 data security standards set out in the National Data Guardian's Review of Data Security, Consent and Opt-Outs published in 2016. The Trust's 2022/23 DSP Toolkit submission was made on 30 June 2023 and achieved the required standards and received a grade of 'Standards Met'.

The 2023/24 DSP Toolkit submission is due in June 2024, however the interim submission made in March 2024 indicated that this will be a 'Standards Met' grade.

Maintaining high levels of data quality and completeness supports delivering safe, high quality and efficient care to patients and a positive experience for Trust staff. The Trust incorporates data quality measures to guide the assessment and improvement of data quality, which is a core principle within the Trust's Performance Management and Accountability Framework. Evidence of data quality reports is embedded within the Trust's Integrated Performance Report, which is scrutinised by the Trust Management Executive and Trust Board.

Additionally, the Trust publishes specific data quality and completeness reports via the central Trust Information Repository System ORBIT. This includes information on admission timeliness, ethnicity data completeness and elective waiting lists. Specifically for waiting lists, data quality lists are automated to highlight specific cohorts of patients with possible data quality errors. With over 50 data quality filters, these lists identify pathways for immediate review and correction prior to monthly statutory returns. These lists are reviewed by the Referral to Treatment Access Team and clinical services and are accessible within the Referral to Treatment Patient List.

The Digital team provides support to improve data quality by educating staff in the use of key systems and monitoring system usage, to ensure accurate administration, quality-checking, and system cleansing to ensure inaccurate and obsolete data are no longer used.

## Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Integrated Assurance Committee, and informed by various operational plans to address weaknesses and ensure continuous improvement of the system is in place.

The effectiveness of the system of internal control has been reviewed by the Board via its committees and by officers and managers at Executive and Divisional Director level.

Regular reports have been received from the Board committees and senior managers in relation to key risks. Annual reports of the committees have been received by the Board relating to all important areas of activity, and ad-hoc reports in year wherever these were required. As mentioned previously in this Annual Governance Statement, the annual review of effectiveness of the Board committees has resulted in comprehensive reports on compliance to the Board. The reports demonstrated assurance that they have operated effectively in relation to their Terms of Reference.

The following issues were noted as sufficient to highlight within the statement as specific areas of note with focused actions that had to be taken within the year.

- Oxford Critical Care – CQC inspection and report
- Midwife-led Unit at Horton General Hospital – CQC inspection and report
- Moving to Tier 2 oversight for elective care and cancer care performance
- The impact of missing our financial plan on the financial control environment
- The impact of the increases in our staffing numbers on the workforce control environment

However, it was concluded that these areas, once reviewed, did not constitute a significant gap in control in relation to the delivery of the Trust's strategic objectives.

Based on national guidance, the Trust Management Executive and the Audit Committee have reviewed several issues in advising myself and the Board as to the content of this Annual Governance Statement.

It is my view as Accounting Officer, as supported by the Board and Audit Committee, that the issues reviewed did not constitute significant gaps in control.

## Conclusion

The Trust has faced numerous challenges mostly around staffing, impacted by industrial action and a rise in costs which has affected both patients and staff. Many projects and programmes have been implemented to support staff wellbeing while they face many challenges, both in and out of work. The implementation of the Patient Safety Incident Response Framework (PSIRF) and learning from patient safety events (LFPSE) has also been embraced well within the Trust and will continue to drive a culture of safety, learning and improvement.

Subject to the areas highlighted above, the Trust has concluded that no significant control issues have been identified.

Signed: Professor Meghana Pandit
Chief Executive Officer
26 June 2024

# Accountability Report Conclusion

This concludes the Accountability Report of Oxford University Hospitals NHS Foundation Trust for the year 1 April 2023 to 31 March 2024.

Signed: Professor Meghana Pandit
Chief Executive Officer
26 June 2024

# Independent Auditor’s Report and Certificate

# INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

## Opinion

We have audited the financial statements of Oxford University Hospitals NHS Foundation Trust for the year ended 31 March 2024 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and the related notes 1 to 35, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2023-24 as contained in the Department of Health and Social Care Group Accounting Manual 2023 to 2024 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

In our opinion the financial statements:

- give a true and fair view of the financial position of Oxford University Hospitals NHS Foundation Trust as at 31 March 2024 and of Foundation Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023 to 2024; and
- have been properly prepared in accordance with the National Health Service Act 2006.

## Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

## Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Foundation Trust's ability to continue as a going concern for a period to 30 June 2025.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Foundation Trust's ability to continue as a going concern.

## Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

## Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and

- the parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2023/24.

## Matters on which we are required to report by exception

The Code of Audit Practice requires us to report to you if:

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources;
- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2023/34 and is not misleading or inconsistent with other information forthcoming from the audit; or
- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

## Responsibilities of the Accounting Officer

As explained more fully in the 'Statement of the chief executive's responsibilities as the accounting officer of Oxford University Hospitals NHS Foundation Trust' set out on page 97 the chief executive is the accounting officer of Oxford University Hospitals NHS Foundation Trust. The accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to

going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations of the Foundation Trust, or have no realistic alternative but to do so.

As explained in the Governance Statement, the accounting officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

## Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

### Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, as well as relevant employment laws of the United Kingdom. In addition, the Foundation Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

- We understood how Oxford University Hospitals NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the internal audit provider and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Foundation Trust's board minutes, through enquiry of employees to verify Foundation Trust policies, and through the inspection of other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation. Oxford University Hospitals NHS Foundation Trust has robust policies and processes in place to mitigate the potential for override of controls, and there is a culture of honesty and ethical behaviour, supported by a number of policies in respect of human resources and counter fraud, bribery and corruption.

- We assessed the susceptibility of the Foundation Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance through understatement of accrued liabilities, and inappropriate capitalisation of revenue expenditure and management override of controls to be our fraud risks.

- To address our fraud risk around the manipulation of reported financial performance through understatement of accrued liabilities, we reviewed the Foundation Trust's accruals policies, tested payables for cut-off issues and searched for unrecorded liabilities, challenged assumptions and corroborated information provided by management to appropriate evidence. This was done in conjunction with our review of Department of Health and Social Care (DHSC) agreement of balances data, investigating and challenging differences which we considered to be significant.
- To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.
- To address the presumed fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

## Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in May 2024, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Foundation Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under schedule 10(1)(d) of the National Health Service Act 2006 to be satisfied that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Under the Code of Audit Practice, we are required to report to you if the Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

## Certificate

We certify that we have completed the audit of the accounts of Oxford University Hospitals NHS Foundation Trust in accordance with the requirements of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General.

## Use of our report

This report is made solely to the Council of Governors of Oxford University Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.

Janet Dawson
Ernst & Young LLP

Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
27 June 2024

# Oxford University Hospitals NHS Foundation Trust

# Annual Accounts

## for the year ended 31 March 2024

## Foreword to the accounts

**Oxford University Hospitals NHS Foundation Trust**

These accounts, for the year ended 31 March 2024, have been prepared by Oxford University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed:

Professor Meghana Pandit
Chief Executive Officer
26 June 2024

# Statement of Comprehensive Income

| | Note | 2023/24 £000 | 2022/23 £000 |
|---|---|---|---|
| Operating income from patient care activities | 3 | 1,440,258 | 1,328,641 |
| Other operating income | 4 | 211,732 | 183,157 |
| Operating expenses | 7, 9 | (1,643,504) | (1,483,312) |
| **Operating surplus/(deficit)** | | **8,486** | **28,486** |
| Finance income | 11 | 3,852 | 1,586 |
| Finance expenses | 12 | (40,751) | (26,468) |
| PDC dividends payable | | (5,697) | (12,121) |
| **Net finance costs** | | **(42,596)** | **(37,003)** |
| Other gains / (losses) | 13 | 6,205 | 2,867 |
| Share of profit / (losses) of associates / joint arrangements | 19 | (272) | 178 |
| **Surplus / (deficit) for the year** | | **(28,177)** | **(5,472)** |
| **Other comprehensive income** | | | |
| **Will not be reclassified to income and expenditure:** | | | |
| Impairments | 8 | (78,579) | (1,787) |
| Revaluations | 16 | 75,309 | 43,584 |
| Fair value gains / (losses) on equity instruments designated at fair value through OCI | 20 | 28 | (618) |
| **Total comprehensive income / (expense) for the period** | | **(31,419)** | **35,707** |

## Statement of Financial Position

| | Note | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 14 | 16,559 | 14,689 |
| Property, plant and equipment | 15 | 723,928 | 730,072 |
| Right of use assets | 17 | 15,859 | 13,144 |
| Investment property | 18 | 44,778 | 34,418 |
| Investments in associates and joint ventures | 19 | 12,939 | 13,345 |
| Other investments / financial assets | 20 | 1,110 | 676 |
| Receivables | 23 | 8,711 | 6,647 |
| **Total non-current assets** | | **823,884** | **812,991** |
| **Current assets** | | | |
| Inventories | 22 | 32,241 | 29,103 |
| Receivables | 23 | 69,415 | 82,490 |
| Cash and cash equivalents | 24 | 46,813 | 32,604 |
| **Total current assets** | | **148,469** | **144,197** |
| **Current liabilities** | | | |
| Trade and other payables | 25 | (198,126) | (171,306) |
| Borrowings | 27 | (15,318) | (13,869) |
| Provisions | 28 | (1,274) | (2,232) |
| Other liabilities | 26 | (2,696) | (3,531) |
| **Total current liabilities** | | **(217,414)** | **(190,938)** |
| **Total assets less current liabilities** | | **754,939** | **766,250** |
| **Non-current liabilities** | | | |
| Trade and other payables | 25 | - | - |
| Borrowings | 27 | (379,131) | (232,379) |
| Provisions | 28 | (6,176) | (7,659) |
| Other liabilities | 26 | (5,546) | (5,066) |
| **Total non-current liabilities** | | **(390,853)** | **(245,104)** |
| **Total assets employed** | | **364,086** | **521,146** |
| **Financed by** | | | |
| Public dividend capital | | 329,198 | 310,808 |
| Revaluation reserve | | 212,618 | 226,276 |
| Financial assets reserve | | (9,835) | (9,863) |
| Other reserves | | 1,743 | 1,743 |
| Income and expenditure reserve | | (169,638) | (7,818) |
| **Total taxpayers' equity** | | **364,086** | **521,146** |

The notes on pages 129 to 168 form part of these accounts.

Signed:

Professor Meghana Pandit
Chief Executive Officer
26 June 2024

## Statement of Changes in Equity for the year ended 31 March 2024

| | Public dividend capital | Revaluation reserve | Financial assets reserve | Other reserves | Income and expenditure reserve | Total |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2023 - brought forward** | **310,808** | **226,276** | **(9,863)** | **1,743** | **(7,818)** | **521,146** |
| Application of IFRS 16 measurement principles to PFI liability on 1 April 2023 | - | - | - | - | (144,031) | **(144,031)** |
| Surplus/(deficit) for the year | - | - | - | - | (28,177) | **(28,177)** |
| Impairments | - | (78,579) | - | - | - | **(78,579)** |
| Revaluations | - | 75,309 | - | - | - | **75,309** |
| Fair value gains/(losses) on equity instruments designated at fair value through OCI | - | - | 28 | - | - | **28** |
| Public dividend capital received | 18,390 | - | - | - | - | **18,390** |
| Other reserve movements | - | (10,388) | - | - | 10,388 | **-** |
| **Taxpayers' and others' equity at 31 March 2024** | **329,198** | **212,618** | **(9,835)** | **1,743** | **(169,638)** | **364,086** |

## Statement of Changes in Equity for the year ended 31 March 2023

| | Public dividend capital | Revaluation reserve | Financial assets reserve | Other reserves | Income and expenditure reserve | Total |
|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' and others' equity at 1 April 2022 - brought forward** | **303,750** | **193,530** | **(9,245)** | **1,743** | **(14,227)** | **475,551** |
| Implementation of IFRS 16 on 1 April 2022 | - | - | - | - | 2,830 | **2,830** |
| Surplus/(deficit) for the year | - | - | - | - | (5,472) | **(5,472)** |
| Impairments | - | (1,787) | - | - | - | **(1,787)** |
| Revaluations | - | 43,584 | - | - | - | **43,584** |
| Fair value gains/(losses) on equity instruments designated at fair value through OCI | - | - | (618) | - | - | **(618)** |
| Public dividend capital received | 7,058 | - | - | - | - | **7,058** |
| Other reserve movements | - | (9,051) | - | - | 9,051 | **-** |
| **Taxpayers' and others' equity at 31 March 2023** | **310,808** | **226,276** | **(9,863)** | **1,743** | **(7,818)** | **521,146** |

**Information on reserves**

**Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

**Revaluation reserve**
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

**Financial assets reserve**
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

**Other reserves**
This reserve reflects historical balances formed when the Horton General Hospital became a part of the Trust.

**Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

## Statement of Cash Flows

| | Note | 2023/24 £000 | 2022/23 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus / (deficit) | | 8,486 | 28,486 |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 7.1 | 44,943 | 49,093 |
| Net impairments | 8 | 28,903 | 3,289 |
| Income recognised in respect of capital donations | 4 | (22,356) | (3,183) |
| Amortisation of PFI deferred credit | | (209) | (143) |
| (Increase) / decrease in receivables and other assets | | 10,606 | (26,949) |
| (Increase) / decrease in inventories | | (3,138) | (586) |
| Increase / (decrease) in payables and other liabilities | | 23,842 | 9,367 |
| Increase / (decrease) in provisions | | (2,471) | (6,499) |
| **Net cash flows from / (used in) operating activities** | | **88,606** | **52,875** |
| **Cash flows from investing activities** | | | |
| Interest received | | 3,852 | 1,586 |
| Purchase and sale of financial assets / investments | | - | 238 |
| Purchase of intangible assets | | (4,286) | (3,851) |
| Purchase of PPE and investment property | | (61,281) | (28,576) |
| Sales of PPE and investment property | | 31 | 90 |
| Initial direct costs or up front payments in respect of new right of use assets | | (796) | - |
| Receipt of cash donations to purchase assets | | 21,384 | 1,903 |
| Cash from acquisitions / disposals of subsidiaries | | 23 | - |
| **Net cash flows from / (used in) investing activities** | | **(41,073)** | **(28,610)** |
| **Cash flows from financing activities** | | | |
| Public dividend capital received | | 18,390 | 7,058 |
| Movement on loans from DHSC | | (661) | (662) |
| Movement on other loans | | (452) | (416) |
| Capital element of finance lease rental payments | | (3,560) | (3,320) |
| Capital element of PFI, LIFT and other service concession payments | | (16,670) | (12,940) |
| Interest on loans | | (447) | (469) |
| Other interest | | (50) | - |
| Interest paid on finance lease liabilities | | (191) | (120) |
| Interest paid on PFI, LIFT and other service concession obligations | | (20,077) | (25,904) |
| PDC dividend (paid) / refunded | | (9,606) | (12,211) |
| **Net cash flows from / (used in) financing activities** | | **(33,324)** | **(48,984)** |
| **Increase / (decrease) in cash and cash equivalents** | | **14,209** | **(24,719)** |
| **Cash and cash equivalents at 1 April - brought forward** | | **32,604** | **57,323** |
| **Cash and cash equivalents at 31 March** | 24 | **46,813** | **32,604** |

**Notes to the Accounts**

**Note 1 Accounting policies and other information**

**Note 1.1 Basis of preparation**

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2023/24 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

**Accounting convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

**Note 1.2 Going concern**

Under International Accounting Standard 1, organisations are required to report that they are able to continue for the foreseeable future in broadly the same form as at present. Doing so means that, in accounting terms, the organisation is a ‘going concern’.

The Board has reported that the Trust is a going concern, with no plans for any substantial changes to its portfolio of services, even though the Trust is not planning to achieve financial balance in 2024/25. Since the Trust has neither been notified that its services are no longer required nor received notice of material closure of NHS services currently run by the Trust, and services continue to be commissioned from the Trust by local and specialist commissioners. The Trust therefore expects to operate for the foreseeable future. The Trust Board has considered the advice in the DHSC’s GAM that the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. The Trust has therefore adopted this approach in preparing these accounts.

The Trust submitted a 2024/25 plan in June 2024 which reflected an £8.1m deficit. Although Management will aim to deliver improved financial performance during the course of the year the plan identifies a requirement for external cash support in and from September 2024.

Despite the deficit, Management has the reasonable expectation that the Trust will continue to have access to adequate cash resources to service its operational activities in cash terms through to the end of the going concern period 30 June 2025 through DHSC’s cash support facilities.

NHS England have issued their Provider revenue support process for 2024/25 which provides cash support to Trusts facing cash resource issues, either due to a deficit or short term cashflow difficulties. This takes the form of Public Dividend Capital rather than a repayable loan facility.

Management has already notified DHSC of the potential need for cash support in 2024/25 and its application for cash has been acknowledged by NHSE and is in the approval process according to the quarterly cash application dates.

The Trust will endeavour to mitigate the cash risk by careful management of resources. The deficit plan also includes an assumption of a challenging efficiency programme which the Trust will closely monitor to ensure delivery in line with expectations.

As a result of Management actions identified to mitigate the cash risk and the availability of cash support from DHSC, Management has the reasonable expectation that the Trust will continue to have access to adequate cash resources to service its operational activities in for the next 12 months.

These factors have been considered in assessing the Trust’s ability to continue as a going concern and The Trust Board is in regular contact with its Regulator, and as such, should any of these circumstances arise that create the potential for deteriorating cash flow, has a reasonable expectation that funding would be provided, although this funding is not yet committed. Therefore, no adjustments have been made to the financial statements as a result of this potential uncertainty.

**Note 1.3 Interests in other entities**

The Trust holds interests in a number of other entities. These are accounted for using equity accounting to update the fair value of the Trust's Investment.

**Associates**

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses (eg revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, eg, share dividends are received by the Trust from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and "fair value less costs to sell".

**Joint ventures**

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

**Note 1.4 Revenue from contracts with customers**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

**Revenue from NHS contracts**

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to Trusts for NHS-funded secondary healthcare.

In 2023-24, the Aligned Payment and Incentive (API) payment mechanism was introduced in full for all contractual relationships between NHS Commissioners and NHS Providers, where the Expected Annual Contract Value (EACV) is over £500k. The API mechanism is made up of a variable element and a fixed element. The majority of the elective activity delivered by the Trust is paid for on a variable basis. Where the actual elective activity delivered differs from the level set in the agreed plan, additional activity is paid for at 100% of the National Tariff price; underperformance is clawed back at 100% of the National Tariff price. The elective plan value (target) is set at a level prescribed by NHSE for each Commissioner. All other activity delivered by NHS providers, including urgent and emergency care and maternity services, are paid for by the fixed element i.e. there is no adjustment for activity delivered above or below the agreed plan. There are some other elements of service delivery, including High-Cost Drugs and Devices, and Diagnostic Imaging, which can be negotiated and paid for either on a variable basis, or as part of the fixed element. The allocations made to Commissioners to fund the elective activity is called Elective Recovery Funding (ERF). ERF funding is passed to providers via the API mechanism.

For relationships with an EACV below £500k, the payment is made under the Low Value Activity (LVA) mechanism, which is a block payment covering all activity delivered, and is based on historic activity levels.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner. In 2023-24 payment for BPTs is included in the fixed payment element from commissioners; CQUIN income is included in the fixed payment element for contracts with an EACV less than £10m but is variable where the EACV is greater than £10m. The variable payment is based on performance against agreed criteria.

In 2022/23 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments are accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at a rate of 75% of the tariff price. Due to nation-wide operational pressures, this payment scheme was not implemented in full as described. The majority of the Trust’s commissioning income continued to be paid on a block/fixed basis. A very small proportion of additional income was awarded to the Trust based on actual performance against the elective activity targets set.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. In 2023/24, Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust’s commissioners. In 2022/23 elective recovery funding for providers was separately identified within the aligned payment and incentive contracts.

**Revenue from research contracts**

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust’s interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

**NHS injury cost recovery scheme**

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

## Note 1.5 Other forms of income

### Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

### Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

## Note 1.6 Expenditure on employee benefits

### Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

### Pension costs

*NHS Pension Scheme*

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

## Note 1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

**Note 1.8 Property, plant and equipment**

**Recognition**

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

*Subsequent expenditure*

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

**Measurement**

*Valuation*

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

In agreement with the Trust's property valuation experts, where appropriate, the Trust has applied an 'optimal site' valuation which recognises any efficiencies that could be obtained if the site were to be rebuilt, whilst allowing the current level of service provision to be maintained. This valuation approach is based on a detailed review by qualified valuation staff of the land and buildings on the Trust’s John Radcliffe, Churchill and Nuffield Orthopaedic Centre sites and Horton General Hospital site. This approach is consistent with the concepts provided under Depreciated Replacement Cost valuation based on modern equivalent assets. For non-operational buildings, including surplus land, the valuations are carried out at open market value

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust’s Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

*Depreciation*

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Assets in the course of construction are not depreciated until the asset is brought into use.

*Revaluation gains and losses*

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure as an impairment.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses as an impairment.

Gains and losses (impairments) recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

*Impairments*

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

**De-recognition**

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**Donated and grant funded assets**

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the Trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

**Private Finance Initiative (PFI) transactions**

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

*Initial recognition*

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

*Subsequent measurement*

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.
*Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities*

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis has been applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

Comparatives for PFI and other service concession arrangement liabilities have not been restated on an IFRS 16 basis, as required by the DHSC Group Accounting Manual. Under IAS 17 measurement principles which applied in 2022/23 and earlier, movements in the liability were limited to repayments of the liability and the annual finance cost arising from application of the implicit interest rate. The cumulative impact of indexation on payments for the asset was charged to finance costs as contingent rent as incurred.

**Useful lives of property, plant and equipment**

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

| | **Min life** | **Max life** |
|---|---|---|
| | **Years** | **Years** |
| Land | Not applicable | |
| Buildings, excluding dwellings | 10 | 49 |
| Dwellings | 10 | 24 |
| Plant & machinery | 5 | 16 |
| Transport equipment | 7 | 7 |
| Information technology | 3 | 10 |
| Furniture & fittings | 5 | 10 |

## Note 1.9 Intangible assets

### Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

*Internally generated intangible assets*

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

*Software*

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

### Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

*Amortisation*

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

### Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset.  The range of useful lives are shown in the table below:

| | Min life Years | Max life Years |
|---|---|---|
| Information technology | 5 | 13 |
| Software licences | 1 | 11 |

**Note 1.10 Inventories**

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method, or, for pharmacy items, the weighted average cost method.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

**Note 1.11 Investment properties**

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure. The Trust engages valuation experts to calculate the fair value of investment properties capitalising the passing rent at an appropriate yield having regard to Market Rent, the nature of the building, the strength of the tenant covenant, comparable evidence and general market conditions.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

**Note 1.12 Cash and cash equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

**Note 1.13 Financial assets and financial liabilities**

**Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

**Classification and measurement**

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

**Financial assets and financial liabilities at amortised cost**

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

**Financial assets measured at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income: Equity investment in one private company obtained by the Trust in recognition of its part in establishing the company – this is held as a strategic asset and the Trust is not able to liquidise the asset.

**Impairment of financial assets**

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined by reference to past experience within separate categories of debt, classified by level of risk. Judgement is also applied, where the expectation of future credit losses is expected to impact upon the recoverable amount of the asset. The age of a receivable is taken into account and the more overdue a receivable becomes, the higher the value of expected credit loss. A separate model has been determined for the private patient income project.
HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

**Derecognition**

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

**Note 1.14 Leases**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

**The Trust as a lessee**

*Recognition and initial measurement*

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust’s incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT.  Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

*Subsequent measurement*

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

**The Trust as a lessor**

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

*Finance leases*

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust’s net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust’s net investment outstanding in respect of the leases.

*Operating leases*

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

**Initial application of IFRS 16 in 2022/23**

*IFRS 16 Leases* as adapted and interpreted for the public sector by HM Treasury was applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaced *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard was applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 were only applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments were not revisited.

*The Trust as lessee*

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust’s incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the Statement of Financial Position immediately prior to initial application. Hindsight was used in determining the lease term where lease arrangements contained options for extension or earlier termination.

No adjustments were made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets had a value below £5,000. No adjustments were made in respect of leases previously classified as finance leases.

*The Trust as lessor*

Leases of owned assets where the Trust was lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust was an intermediate lessor, classification of all continuing sublease arrangements was been reassessed with reference to the right of use asset.

**Note 1.15 Provisions**

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2024:

| | | Nominal rate | Prior year rate |
|---|---|---|---|
| Short-term | Up to 5 years | 4.26% | 3.27% |
| Medium-term | After 5 years up to 10 years | 4.03% | 3.20% |
| Long-term | After 10 years up to 40 years | 4.72% | 3.51% |
| Very long-term | Exceeding 40 years | 4.40% | 3.00% |

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2024:

| | Inflation rate | Prior year rate |
|---|---|---|
| Year 1 | 3.60% | 7.40% |
| Year 2 | 1.80% | 0.60% |
| Into perpetuity | 2.00% | 2.00% |

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.70%).

**Clinical negligence costs**

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 28.2 but is not recognised in the Trust’s accounts.

**Non-clinical risk pooling**

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

**Note 1.16 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity’s control) are not recognised as assets, but are disclosed in Note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity’s control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

**Note 1.17 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

**Note 1.18 Value added tax**

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

**Note 1.19 Climate change levy**

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

**Note 1.20 Third party assets**

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s *FReM* .

**Note 1.21 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

**Note 1.22 Early adoption of standards, amendments and interpretations**

No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

**Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted**

**IFRS 14 Regulatory Deferral Accounts**

Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

**IFRS 17 Insurance Contracts**

Application required for accounting periods beginning on or after 1 January 2023. Standard is not yet adopted by the FReM which is expected to be from April 2025: early adoption is not permitted.
The impact of applying IFRS 17 is not yet known and is inestimable.

**Note 1.24 Critical judgements in applying accounting policies**
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

**PFI and service concessions classification**
The Trust has assessed the three PFI schemes, Welcome Centre, and Carbon Energy Scheme against the international financial reporting standards and relevant NHS accounting guidance and judges that all are capitalised under the IFRIC 12 criteria. Estimates for the assets, liabilities and amounts chargeable to the SOCI are determined as per the estimation paragraph in the next section. The Welcome Centre has no economic outflow from the Trust so is reported under deferred income following the guidance.

**Capitalisation of staff costs**
The Trust makes judgements about which of its staff costs are related to capital improvements that meet the definitions in 1.8. These judgements are based on timesheets and the Trust's understanding of what is being achieved by the individuals carrying out the work.

**Valuation of Estate**

Revaluation of estate as at 1.4.23 has been considered in relation to IAS8 and the Trust has determined it is a change in accounting estimate rather than a prior period adjustment. The principle on which the MEA is based, that of a theoretical modern asset, is unchanged and the valuation method employed by the Trust's professional valuers remains the same.
**Note 1.25 Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

**Estimation of contract income**
Achieving early closure of accounts means that the accounts must be prepared before the normal cycle for contract income is complete. Contract income includes some estimated values and assessment of income risk based on actual activity for the first 10 months of the Financial Year. Actual amounts may differ from the estimate depending on actual activity levels, but not materially so.

**Estimation of payments for the PFI and service concession assets, including finance costs**

The assets and liabilities relating to the three PFI schemes have been brought onto the statement of financial position based on estimations from the DH financial model as required by the Department of Health guidance. The models also provide estimates for interest payable and lease remeasurement. A similar model has been developed to estimate the accounting entries for the Trust's Carbon Energy Scheme which is capitalised under IFRIC12 as a service concession. A liability also exists for future commitments and the model estimates the interest payable.

**Estimation of asset lives as the basis for depreciation calculations**
Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Managers have adjusted estimated lives at the end of the accounting period, where their estimate of useful life is significantly different to the original. The estimate of asset lives may differ to the actual period the Trust utilises the asset but any difference would not be material.

**Estimation of Asset values**

The valuation approach for Property Plant and Equipment are detailed in Note 16. For operational assets, the valuation, including movement from last year, are documented in note 14. The valuation and movement on investment properties is detailed in note 18. The assessment of the optimal site for the modern equivalent asset (MEA) value including judgements about the amount of space required, location, and relevant costs.

**Impairment of receivables**

The Trust is required to judge when there is sufficient evidence to impair individual receivables. It does this based on the aged profile and class of the receivables. Different classes of receivables attract different rates of impairment depending on the Trust's assessment of the level of risk associated with the collection of the debt. The Trust adopts a prudent policy of increasing the expected credit loss the older the debt is. The Trust makes every effort to collect the debt, even when it has been impaired, and only writes off the debt as a final course of action after all possible collection efforts have been made. The actual level of debt written off may be different to that which had been judged as impaired, but not materially so.

**Accruals and prepayments**

Each year the Trust sets detailed guidance for its managers in order to assist them in calculating accruals and prepayments including de minimis levels. The Trust uses a number of techniques to calculate its best estimate for accruals. Techniques that are used include:-
Trend analysis
Expert judgement of Finance Managers
Supplier statements
Formulaic approach based on historical cost information
Prepayments are not normally sensitive to future events, and they can be reliably estimated. Accruals are a matter of judgement, based on past experience and information available at the time. Once realised, accruals can be different to the original estimate, but not materially so.

**Note 2 Operating Segments**

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across all locations and the appropriate policies, procedures and governance arrangements are Trust wide. As an NHS Foundation Trust, all services are subject to the same regulatory environment and standards set by external performance managers. The Trust operates one segment and in the period to 31 March reported to the Board in this format. No discrete activities of the business have individual revenue exceeding 10% of the total combined revenue or assets.

## Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

| **Note 3.1 Income from patient care activities (by nature)** | **2023/24** | **2022/23** |
|---|---|---|
| | **£000** | **£000** |
| **Acute services** | | |
| Income from commissioners under API contracts - variable element* | 323,623 | - |
| Income from commissioners under API contracts - fixed element* | 867,672 | 1,051,483 |
| High cost drugs income from commissioners | 185,188 | 165,974 |
| Other NHS clinical income | 14,196 | 9,592 |
| **All services** | | |
| Private patient income | 9,030 | 7,394 |
| Elective recovery fund | - | 35,805 |
| National pay award central funding*** | 731 | 23,839 |
| Additional pension contribution central funding** | 33,161 | 31,035 |
| Other clinical income | 6,657 | 3,519 |
| **Total income from activities** | **1,440,258** | **1,328,641** |

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation. This was effective from 1 April 2023, thus no comparatives are available. Variable element includes all items paid for on an activity basis, all other items are fixed.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

***Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

### Note 3.2 Income from patient care activities (by source)

| | **2023/24** | **2022/23** |
|---|---|---|
| **Income from patient care activities received from:** | **£000** | **£000** |
| NHS England | 694,537 | 644,565 |
| Clinical commissioning groups | - | 156,135 |
| Integrated care boards | 720,039 | 508,557 |
| Department of Health and Social Care | - | 53 |
| Local authorities | 5,282 | 4,596 |
| Non-NHS: private patients | 9,030 | 7,394 |
| Non-NHS: overseas patients (chargeable to patient) | 1,355 | 2,103 |
| Injury cost recovery scheme | 5,302 | 1,416 |
| Non NHS: other | 4,713 | 3,822 |
| **Total income from activities** | **1,440,258** | **1,328,641** |

**Note 3.3 Overseas visitors (relating to patients charged directly by the provider)**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Income recognised this year | 1,355 | 2,103 |
| Cash payments received in-year | 1,534 | 587 |
| Amounts added to provision for impairment of receivables | 137 | 2,281 |
| Amounts written off in-year | - | - |

**Note 4 Other operating income**

| | 2023/24 | | | 2022/23 | | |
|---|---|---|---|---|---|---|
| | Contract income | Non-contract income | Total | Contract income | Non-contract income | Total |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| Research and development | 57,498 | - | **57,498** | 54,298 | - | **54,298** |
| Education and training | 50,371 | 1,439 | **51,810** | 47,047 | 1,560 | **48,607** |
| Non-patient care services to other bodies | 44,640 | - | **44,640** | 37,830 | - | **37,830** |
| Reimbursement and top up funding | - | - | **-** | 1,964 | - | **1,964** |
| Income in respect of employee benefits accounted on a gross basis | 16,363 | - | **16,363** | 15,414 | - | **15,414** |
| Receipt of capital grants and donations and peppercorn leases | - | 22,356 | **22,356** | - | 3,183 | **3,183** |
| Charitable and other contributions to expenditure | - | 302 | **302** | - | 1,803 | **1,803** |
| Revenue from operating leases | - | 1,879 | **1,879** | - | 2,060 | **2,060** |
| Amortisation of PFI deferred income / credits | - | 209 | **209** | - | 143 | **143** |
| Other income | 16,675 | - | **16,675** | 17,855 | - | **17,855** |
| **Total other operating income** | **185,547** | **26,185** | **211,732** | **174,408** | **8,749** | **183,157** |

**Of which:**

The £16.7m other income includes £10m with other public sector bodies (2022/23: £17.9m other income includes £8m with other public sector bodies)

**Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Revenue recognised in the reporting period that was included within contract liabilities at the previous period end | 3,478 | 3,743 |

**Note 5.2 Transaction price allocated to remaining performance obligations**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

**Note 5.3 Income from activities arising from commissioner requested services**

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Income from services designated as commissioner requested services | 1,429,873 | 1,319,144 |
| Income from services not designated as commissioner requested services | 10,385 | 9,497 |
| **Total** | **1,440,258** | **1,328,641** |

**Note 5.4 Fees and charges**

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Income | 13,285 | 12,000 |
| Full cost | (12,861) | (14,222) |
| **Surplus / (deficit)** | **424** | **(2,222)** |

Note that this relates to private patient income of £9m (2022/23: £7.4m), overseas patient income of £1.4m (2022/23: £2.1m) and car parking income of £2.9m (2022/23: £2.5m).

**Note 6 Operating leases - Oxford University Hospitals NHS Foundation Trust as lessor**

This note discloses income generated in operating lease agreements where Oxford University Hospitals NHS Foundation Trust is the lessor.

The Trust has a number of areas within properties where it acts as a lessor. These are generally buildings or areas within buildings on the various hospital sites where space has been let to universities, charities or other organisations.

**Note 6.1 Operating lease income**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Lease receipts recognised as income in year:** | | |
| Minimum lease receipts | 1,879 | 2,060 |
| **Total in-year operating lease income** | **1,879** | **2,060** |

**Note 6.2 Future lease receipts**

| | 31 March 2024 | 31 March 2023 |
|---|---|---|
| | £000 | £000 |
| **Future minimum lease receipts due in:** | | |
| - not later than one year | 2,487 | 2,032 |
| - later than one year and not later than five years | 7,541 | 6,562 |
| - later than five years | 18,251 | 18,089 |
| **Total** | **28,279** | **26,683** |

## Note 7.1 Operating expenses

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Purchase of healthcare from NHS and DHSC bodies | 7,116 | 5,259 |
| Purchase of healthcare from non-NHS and non-DHSC bodies | 18,791 | 19,639 |
| Staff and executive directors costs | 896,600 | 836,692 |
| Remuneration of non-executive directors | 212 | 197 |
| Supplies and services - clinical (excluding drugs costs) | 177,774 | 161,361 |
| Supplies and services - general | 9,904 | 7,740 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | 206,885 | 186,296 |
| Inventories written down | 1 | 110 |
| Consultancy costs | 1,391 | 2,284 |
| Establishment | 12,382 | 11,328 |
| Premises | 52,999 | 36,324 |
| Transport (including patient travel) | 8,035 | 4,807 |
| Depreciation on property, plant and equipment | 42,502 | 45,095 |
| Amortisation on intangible assets | 2,441 | 3,998 |
| Net impairments | 28,903 | 3,289 |
| Movement in credit loss allowance: contract receivables / contract assets | 2,551 | 1,059 |
| Change in provisions discount rate(s) | (106) | (581) |
| Fees payable to the external auditor | | |
| audit services- statutory audit | 379 | 320 |
| Internal audit costs | 217 | 188 |
| Clinical negligence | 33,889 | 31,677 |
| Legal fees | 570 | 785 |
| Insurance | 553 | 82 |
| Research and development | 49,559 | 45,704 |
| Education and training | 13,033 | 12,171 |
| Redundancy | 430 | 190 |
| Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) | 60,640 | 47,229 |
| Car parking & security | 2,107 | 2,101 |
| Hospitality | 33 | 6 |
| Losses, ex gratia & special payments | 83 | 29 |
| Other services, eg external payroll | 8,421 | 8,325 |
| Other | 5,209 | 9,608 |
| **Total** | **1,643,504** | **1,483,312** |

**Of which:**

**Note 7.2 Other auditor remuneration**

Gross statutory audit fees were £379k, net of VAT this was £316k (2022/23 £320k including VAT, £267k excluding VAT). No remuneration was accrued to the auditors other than for statutory audit services.

**Note 7.3 Limitation on auditor's liability**

The limitation on auditor's liability for external audit work is £2m (2022/23: £2m).

**Note 8 Impairment of assets**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Net impairments charged to operating surplus / deficit resulting from:** | | |
| Abandonment of assets in course of construction | 25 | 1 |
| Unforeseen obsolescence | 336 | - |
| Changes in market price | 28,542 | 3,288 |
| **Total net impairments charged to operating surplus / deficit** | **28,903** | **3,289** |
| Impairments charged to the revaluation reserve | 78,579 | 1,787 |
| **Total net impairments** | **107,482** | **5,076** |

There are two reasons for the impairments above:
i. impairment on revaluation to a modern equivalent asset basis when a new building or enhancement to an existing building is first brought into use
ii. changes in market price arising from the annual revaluation exercise which results in impairments and reverse impairments

**Note 9 Employee benefits**

| | 2023/24 | 2022/23 |
|---|---|---|
| | Total | Total |
| | £000 | £000 |
| Salaries and wages | 683,089 | 641,891 |
| Social security costs | 68,478 | 61,890 |
| Apprenticeship levy | 3,292 | 2,906 |
| Employer's contributions to NHS pensions | 108,136 | 100,915 |
| Pension cost - other | 92 | 106 |
| Other post employment benefits | - | - |
| Other employment benefits | - | - |
| Termination benefits | 430 | 190 |
| Temporary staff (including agency) | 87,170 | 79,050 |
| **Total staff costs*** | **950,687** | **886,948** |
| **Of which** | | |
| Costs capitalised as part of assets | 1,583 | 594 |

Further details of staff numbers and directors' remuneration is available in the annual report.

* Note that staff costs include elements of Research and Development and Education and Training costs from note 7.1

**Note 9.1 Retirements due to ill-health**

During 2023/24 there were 4 early retirements from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £138k (£959k in 2022/23).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

**Note 10 Pension costs**

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

**a) Accounting valuation**

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

**b) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

**Non-NHS Pension Scheme**

By law all employers are required to automatically enrol certain workers in a pension scheme. If employees meet the scheme's eligibility criteria they will be enrolled in the NHS Pension Scheme. If an employee cannot be enrolled in the NHS Pension Scheme for whatever reason, they are automatically enrolled in an alternative qualifying pension scheme. For OUH employees this scheme is the National Employee's Savings Trust (NEST). At the present time there are very few employees (<1%) in this scheme.

**Note 11 Finance income**

Finance income represents interest received on assets and investments in the period.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Interest on bank accounts | 3,852 | 1,586 |
| **Total finance income** | **3,852** | **1,586** |

**Note 12.1 Finance expenditure**

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Interest expense:** | | |
| Interest on loans from the Department of Health and Social Care | 181 | 188 |
| Interest on other loans | 457 | 284 |
| Interest on lease obligations | 191 | 120 |
| Interest on late payment of commercial debt | 48 | - |
| **Finance costs on PFI, LIFT and other service concession arrangements:** | | |
| Main finance costs | 20,077 | 12,708 |
| Contingent finance costs* | - | 13,196 |
| Remeasurement of the liability resulting from change in index or rate* | 19,767 | - |
| **Total interest expense** | **40,721** | **26,496** |
| Unwinding of discount on provisions | 30 | (28) |
| **Total finance costs** | **40,751** | **26,468** |

* From 1 April 2023, IFRS 16 liability measurement principles are applied to PFI, LIFT and other service concession liabilities. Increases to imputed lease payments arising from inflationary uplifts are now included in the liability, and contingent rent no longer arises. More information is provided in Note 32.

**Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Amounts included within interest payable arising from claims made under this legislation | 48 | - |

**Note 13 Other gains / (losses)**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Gains on disposal of assets | 8 | 90 |
| Losses on disposal of assets | (114) | (230) |
| **Total gains / (losses) on disposal of assets** | **(106)** | **(140)** |
| Fair value gains / (losses) on investment properties | 5,905 | 2,388 |
| Fair value gains / (losses) on financial assets / investments | 406 | 619 |
| **Total other gains / (losses)** | **6,205** | **2,867** |

**Note 14.1 Non current assets - 2023/24**

| | Intangible assets | | | | Property, plant and equipment | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Software licences | Internally generated information technology | Intangible assets under construction | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation / gross cost at 1 April 2023 - brought forward** | **8,139** | **19,294** | **4,419** | **31,852** | **41,681** | **580,256** | **1,125** | **10,832** | **244,888** | **605** | **27,451** | **4,738** | **911,576** |
| Additions | 972 | 2,256 | 1,083 | **4,311** | - | 9,605 | - | 36,146 | 19,706 | 81 | 3,320 | 516 | **69,374** |
| Impairments | - | - | - | **-** | (20,094) | (136,947) | - | - | - | - | - | - | **(157,041)** |
| Reversals of impairments | - | - | - | **-** | 2,575 | 31,039 | - | - | - | - | - | - | **33,614** |
| Revaluations | - | - | - | **-** | - | 69,033 | 1,076 | - | - | - | - | - | **70,109** |
| Reclassifications* | - | 405 | (405) | **-** | (2,878) | (6,317) | (27) | (10,091) | 12,995 | - | 1,899 | (36) | **(4,455)** |
| Disposals / derecognition | - | - | - | **-** | - | - | - | (25) | (20,092) | - | - | (67) | **(20,184)** |
| **Valuation / gross cost at 31 March 2024** | **9,111** | **21,955** | **5,097** | **36,163** | **21,284** | **546,669** | **2,174** | **36,862** | **257,497** | **686** | **32,670** | **5,151** | **902,993** |
| **Amortisation/depreciation at 1 April 2023 - brought forward** | **2,467** | **14,696** | **-** | **17,163** | **-** | **-** | **-** | **-** | **165,663** | **422** | **11,354** | **4,065** | **181,504** |
| Provided during the year | 1,673 | 768 | - | **2,441** | - | 21,383 | 117 | - | 11,815 | 67 | 5,246 | 236 | **38,864** |
| Impairments | - | - | - | **-** | 2,575 | (52,504) | - | 25 | 345 | - | - | - | **(49,559)** |
| Reversals of impairments | - | - | - | **-** | (2,575) | 36,198 | - | - | (9) | - | - | - | **33,614** |
| Revaluations | - | - | - | **-** | - | (5,083) | (117) | - | - | - | - | - | **(5,200)** |
| Reclassifications | - | - | - | **-** | - | 6 | - | - | 3 | - | (2) | (7) | **-** |
| Disposals / derecognition | - | - | - | **-** | - | - | - | (25) | (20,066) | - | - | (67) | **(20,158)** |
| **Amortisation at 31 March 2024** | **4,140** | **15,464** | **-** | **19,604** | **-** | **-** | **-** | **-** | **157,751** | **489** | **16,598** | **4,227** | **179,065** |
| **Net book value at 31 March 2024** | **4,971** | **6,491** | **5,097** | **16,559** | **21,284** | **546,669** | **2,174** | **36,862** | **99,746** | **197** | **16,072** | **924** | **723,928** |
| **Net book value at 1 April 2023**** | **5,672** | **4,598** | **4,419** | **14,689** | **41,681** | **580,256** | **1,125** | **10,832** | **79,225** | **183** | **16,097** | **673** | **730,072** |

* Note the net reclassifications of £4,455k are a transfer to investment properties - see note 18

| **Property, plant and equipment financing - 31 March 2024** | | | | | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Owned - purchased | | | | | 19,894 | 276,170 | 2,174 | 21,629 | 63,649 | 197 | 16,066 | 919 | **400,698** |
| On-SoFP PFI contracts and other service concession arrangements | | | | | - | 209,769 | - | - | 27,510 | - | - | - | **237,279** |
| Owned - donated/granted | | | | | 1,390 | 60,730 | - | 15,233 | 8,587 | - | 6 | 5 | **85,951** |
| **Total net book value at 31 March 2024** | | | | | **21,284** | **546,669** | **2,174** | **36,862** | **99,746** | **197** | **16,072** | **924** | **723,928** |

** The Trust carried out a revaluation on 1 April 2023 of land and buildings excluding dwellings, the effect of this was a reduction of £92m and is included in the revaluations/impairment rows in the above note. Please see note 1.8.

| **Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024** | | | | | Land | Buildings excluding dwellings | Dwellings | Assets under construction | Plant & machinery | Transport equipment | Information technology | Furniture & fittings | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Subject to an operating lease | | | | | 3,246 | 2,285 | - | - | - | - | - | - | **5,531** |
| Not subject to an operating lease | | | | | 18,038 | 544,384 | 2,174 | 36,862 | 99,746 | 197 | 16,072 | 924 | **718,397** |
| **Total net book value at 31 March 2024** | | | | | **21,284** | **546,669** | **2,174** | **36,862** | **99,746** | **197** | **16,072** | **924** | **723,928** |

**Note 14.2 Non current assets - 2022/23**

| | Software licences £000 | Internally generated information technology £000 | Intangible assets under construction £000 | Total £000 | Land £000 | Buildings excluding dwellings £000 | Dwellings £000 | Assets under construction £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Furniture & fittings £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2022 - as previously stated** | **4,918** | **24,578** | **4,102** | **33,598** | **38,426** | **511,515** | **1,009** | **31,950** | **274,366** | **711** | **27,407** | **4,630** | **890,014** |
| IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets | - | - | - | **-** | - | - | - | - | (2,732) | - | - | - | **(2,732)** |
| Historic adjustment | | | | | | | | | (17,124) | (327) | (767) | (259) | **(18,477)** |
| Additions | 3,534 | - | 317 | **3,851** | - | 19,343 | - | 10,435 | 3,351 | 221 | 6,997 | 368 | **40,715** |
| Impairments | - | - | - | **-** | - | (38,701) | - | - | (1) | - | - | - | **(38,702)** |
| Reversals of impairments | - | - | - | **-** | 3,242 | 8,364 | - | - | - | - | - | - | **11,606** |
| Revaluations | - | - | - | **-** | 13 | 41,898 | 116 | - | - | - | - | - | **42,027** |
| Reclassifications | 1,790 | (1,093) | - | **697** | - | 37,837 | - | (31,553) | (8,423) | - | 1,443 | (1) | **(697)** |
| Disposals / derecognition | (2,103) | (4,191) | - | **(6,294)** | - | - | - | - | (4,549) | - | (7,629) | - | **(12,178)** |
| **Valuation / gross cost at 31 March 2023** | **8,139** | **19,294** | **4,419** | **31,852** | **41,681** | **580,256** | **1,125** | **10,832** | **244,888** | **605** | **27,451** | **4,738** | **911,576** |
| | | | | | | | | | | | | | |
| **Amortisation at 1 April 2022 - as previously stated** | **3,145** | **16,298** | **-** | **19,443** | **-** | **7** | **-** | **-** | **178,174** | **669** | **13,402** | **4,134** | **196,386** |
| IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets | - | - | - | **-** | - | - | - | - | (2,303) | - | - | - | **(2,303)** |
| Provided during the year | 1,425 | 2,573 | - | **3,998** | - | 23,514 | 57 | - | 11,480 | 80 | 6,348 | 190 | **41,669** |
| Impairments | - | - | - | **-** | (3,242) | (5,254) | - | - | 1 | - | - | - | **(8,495)** |
| Reversals of impairments | - | - | - | **-** | 3,242 | (16,767) | - | - | - | - | - | - | **(13,525)** |
| Revaluations | - | - | - | **-** | - | (1,500) | (57) | - | - | - | - | - | **(1,557)** |
| Reclassifications | - | - | - | **-** | - | - | - | - | (17,124) | (327) | (767) | (259) | **(18,477)** |
| Disposals / derecognition | (2,103) | (4,175) | - | **(6,278)** | - | - | - | - | (4,565) | - | (7,629) | - | **(12,194)** |
| **Amortisation at 31 March 2023** | **2,467** | **14,696** | **-** | **17,163** | **-** | **-** | **-** | **-** | **165,663** | **422** | **11,354** | **4,065** | **181,504** |
| | | | | | | | | | | | | | |
| **Net book value at 31 March 2023** | **5,672** | **4,598** | **4,419** | **14,689** | **41,681** | **580,256** | **1,125** | **10,832** | **79,225** | **183** | **16,097** | **673** | **730,072** |
| **Net book value at 1 April 2022** | **1,773** | **8,280** | **4,102** | **14,155** | **38,426** | **511,508** | **1,009** | **31,950** | **96,192** | **42** | **14,005** | **496** | **693,628** |
| | | | | | | | | | | | | | |
| **Property, plant and equipment financing - 31 March 2023** | | | | | | | | | | | | | |
| Owned - purchased | | | | | 37,922 | 313,044 | 1,125 | 10,832 | 46,262 | 183 | 16,090 | 665 | **426,123** |
| On-SoFP PFI contracts and other service concession arrangements | | | | | - | 215,882 | - | - | 24,255 | - | - | - | **240,137** |
| Owned - donated/granted | | | | | 3,759 | 51,330 | - | - | 8,708 | - | 7 | 8 | **63,812** |
| **Total net book value at 31 March 2023** | | | | | **41,681** | **580,256** | **1,125** | **10,832** | **79,225** | **183** | **16,097** | **673** | **730,072** |
| | | | | | | | | | | | | | |
| **Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023** | | | | | | | | | | | | | |
| Subject to an operating lease | | | | | - | 2,060 | - | - | - | - | - | - | **2,060** |
| Not subject to an operating lease | | | | | 41,681 | 578,196 | 1,125 | 10,832 | 79,225 | 183 | 16,097 | 673 | **728,012** |
| **Total net book value at 31 March 2023** | | | | | **41,681** | **580,256** | **1,125** | **10,832** | **79,225** | **183** | **16,097** | **673** | **730,072** |

**Note 15 Donations of property, plant and equipment**

The donated assets acquired in the year were mostly donated by Oxford Hospitals Charity, and other trust funds associated with Oxford University Hospitals NHS Foundation Trust. There were no restrictions or conditions imposed by the donor on the use of the donated assets.

**Note 16 Revaluations of property, plant and equipment and investment properties**

The Trust’s land and buildings were revalued as at 31 March 2024 by the Trust's appointed independent expert valuer (a MRICS qualified valuer from Carter Jonas LLP). The full movements as a result of revaluations are disclosed at note 8.

The valuation was an open market value using the modern equivalent asset basis of valuation. In assessing the value of the Trust’s land it was assumed that should the existing buildings be replaced by a modern equivalent asset, certain buildings would be rebuilt on a more intensive basis, on an alternative 'optimal site'. Therefore a smaller landholding and buildings footprint is required while still maintaining the current level of service provision.

Asset lives of buildings are updated at the end of each statutory reporting period on the expert advice of the Trust's appointed expert valuer. The update does not affect depreciation in the current period of accounts and does not have a material impact on future accounting periods.

Investment assets are assessed to Fair value under IFRS 13 which equates to market value. For reference the RICS definition of Market Value is as follows.

*The estimated amount for which an asset or liability should exchange on the valuation date between a willing buyer and a willing seller in an arm’s length transaction, after proper marketing and where the parties had each acted knowledgeably, prudently and without compulsion*

Where an asset is valued to Fair Value, IFRS 13 it requires the valuer to make additional disclosures regarding the valuation technique applied to measure the Fair Value and the nature of the inputs to that valuation technique, having regard to the fair value hierarchy.

It is confirmed that the valuation technique applied constitute Level 2 inputs in each instance. Level 2 inputs are inputs that are observable for the asset, either directly or indirectly. The inputs used took the form of analysed and weighted market evidence such as sales, rentals and yields in respect of comparable properties in the same or similar locations at or around the valuation date

**Note 17 Leases - Oxford University Hospitals NHS Foundation Trust as a lessee**

This note details information about leases for which the Trust is a lessee.

The Trust's leases fall into two main categories:
a) Leases of items of plant and equipment. These are predominantly items of medical equipment, office equipment or motor vehicles. There is no material contingent rental, and the leases are usually for fixed terms. There are no restrictions in these leases other than those which would commonly be found in commercial leases of this kind.
b) Leases of property. Typically these are leases of space in other NHS facilities. These leases are usually negotiated for fixed terms.

**Note 17.1 Right of use assets - 2023/24**

| | Property (land and buildings) £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2023 - brought forward** | **9,687** | **8,461** | **725** | **-** | **18,873** | **4,452** |
| Additions | 4,297 | 820 | - | 1,236 | **6,353** | - |
| Reclassifications | - | - | (59) | 59 | **-** | - |
| **Valuation/gross cost at 31 March 2024** | **13,984** | **9,281** | **666** | **1,295** | **25,226** | **4,452** |
| | | | | | | |
| **Accumulated depreciation at 1 April 2023 - brought forward** | **1,549** | **4,001** | **179** | **-** | **5,729** | **880** |
| Provided during the year | 1,543 | 1,916 | 159 | 20 | **3,638** | 879 |
| Reclassifications | - | - | (20) | 20 | **-** | - |
| **Accumulated depreciation at 31 March 2024** | **3,092** | **5,917** | **318** | **40** | **9,367** | **1,759** |
| | | | | | | |
| **Net book value at 31 March 2024** | **10,892** | **3,364** | **348** | **1,255** | **15,859** | **2,693** |
| **Net book value at 1 April 2023** | **8,138** | **4,460** | **546** | **-** | **13,144** | **3,572** |
| | | | | | | |
| Net book value of right of use assets leased from other NHS providers | | | | | | 2,693 |

**Note 17.2 Right of use assets - 2022/23**

| | Property (land and buildings) £000 | Plant & machinery £000 | Transport equipment £000 | Information technology £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|---|
| **Valuation / gross cost at 1 April 2022 - brought forward** | **-** | **-** | **-** | **-** | **-** | **-** |
| IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets | - | 2,732 | - | - | **2,732** | - |
| IFRS 16 implementation - adjustments for existing operating leases / subleases | 9,687 | 3,689 | 725 | - | **14,101** | 4,452 |
| Additions | - | 2,040 | - | - | **2,040** | - |
| **Valuation/gross cost at 31 March 2023** | **9,687** | **8,461** | **725** | **-** | **18,873** | **4,452** |
| | | | | | | |
| **Accumulated depreciation at 1 April 2022 - brought forward** | - | - | - | - | **-** | - |
| IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets | - | 2,303 | - | - | **2,303** | - |
| Provided during the year | 1,549 | 1,698 | 179 | - | **3,426** | 880 |
| **Accumulated depreciation at 31 March 2023** | **1,549** | **4,001** | **179** | **-** | **5,729** | **880** |
| | | | | | | |
| **Net book value at 31 March 2023** | **8,138** | **4,460** | **546** | **-** | **13,144** | **3,572** |
| | | | | | | |
| Net book value of right of use assets leased from other NHS providers | | | | | | 3,572 |

**Note 17.4 Reconciliation of the carrying value of lease liabilities**

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 27.1.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Carrying value at 31 March** | **10,379** | **388** |
| IFRS 16 implementation - adjustments for existing operating leases | - | 11,271 |
| Lease additions | 5,557 | 2,040 |
| Interest charge arising in year | 191 | 120 |
| Lease payments (cash outflows) | (3,751) | (3,440) |
| **Carrying value at 31 March** | **12,376** | **10,379** |

**Note 17.5 Maturity analysis of future lease payments**

| | Total | Of which leased from DHSC group bodies: | Total | Of which leased from DHSC group bodies: |
|---|---|---|---|---|
| | 31 March 2024 | 31 March 2024 | 31 March 2023 | 31 March 2023 |
| | £000 | £000 | £000 | £000 |
| **Undiscounted future lease payments payable in:** | | | | |
| - not later than one year; | 3,462 | 901 | 3,456 | 901 |
| - later than one year and not later than five years; | 6,963 | 1,857 | 7,100 | 2,757 |
| - later than five years. | 3,162 | - | 67 | - |
| **Total gross future lease payments** | **13,587** | **2,758** | **10,623** | **3,658** |
| Finance charges allocated to future periods | (1,211) | (39) | (244) | (68) |
| **Net lease liabilities at 31 March 2024** | **12,376** | **2,719** | **10,379** | **3,590** |
| **Of which:** | | | | |
| Leased from other NHS providers | | 2,719 | | 3,590 |

**Note 18 Investment Property**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Carrying value at 1 April - brought forward** | **34,418** | **32,030** |
| Movement in fair value | 5,905 | 2,388 |
| Reclassifications to/from PPE | 4,455 | - |
| **Carrying value at 31 March** | **44,778** | **34,418** |

**Note 18.1 Investment property income and expenses**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| Direct operating expense arising from investment property which generated rental income in the period | (862) | (297) |
| **Total investment property expenses** | **(862)** | **(297)** |
| Investment property income | 2,247 | 2,004 |

**Note 19 Investments in associates and joint ventures**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Carrying value at 1 April - brought forward** | **13,345** | **13,166** |
| Share of profit / (loss) | (272) | 179 |
| Disposals | (134) | - |
| **Carrying value at 31 March** | **12,939** | **13,345** |

**Note 20 Other investments / financial assets (non-current)**

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Carrying value at 1 April - brought forward** | **676** | **1,142** |
| Movement in fair value through income and expenditure | 406 | 619 |
| Movement in fair value through OCI | 28 | (618) |
| Disposals | - | (467) |
| **Carrying value at 31 March** | **1,110** | **676** |

**Note 21 Disclosure of interests in other entities**

The Trust holds the interests in the following key entity. Further detail on financial performance is contained within the preceding notes. Oxford Headington Holdings LLP - 50% voting rights, with priority access to the first £12m of profits, thereafter 75% profit/loss share.
The Trust disposed of its interests in the following entity during 2023/24 as the organisation was dissolved:
Oxford University Clinic LLP - 50% voting rights, with 50% share of profits.

**Note 22 Inventories**

| | 31 March 2024 | 31 March 2023 |
|---|---|---|
| | £000 | £000 |
| Drugs | 8,246 | 6,258 |
| Consumables | 21,497 | 20,406 |
| Energy | 440 | 368 |
| Other | 2,058 | 2,071 |
| **Total inventories** | **32,241** | **29,103** |

Inventories recognised in expenses for the year were £185.2m (2022/23: £149.6m). Write-down of inventories recognised as expenses for the year were £0.0m (2022/23: £0.1m).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £0.2m of items purchased by DHSC (2022/23: £1.6m).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

**Note 23.1 Receivables**

| | 31 March 2024 | 31 March 2023 |
|---|---|---|
| | £000 | £000 |
| **Current** | | |
| Contract receivables | 60,289 | 71,500 |
| Allowance for impaired contract receivables / assets | (17,915) | (15,386) |
| Prepayments (non-PFI) | 12,000 | 10,181 |
| PFI prepayments - capital contributions | 67 | 67 |
| PFI lifecycle prepayments | 5,091 | 7,499 |
| PDC dividend receivable | 2,003 | - |
| VAT receivable | 3,892 | 5,543 |
| Other receivables | 3,988 | 3,086 |
| **Total current receivables** | **69,415** | **82,490** |
| **Non-current** | | |
| Contract receivables | 6,154 | 3,604 |
| Prepayments (non-PFI) | 78 | 101 |
| PFI prepayments - capital contributions | 736 | 803 |
| Other receivables | 1,743 | 2,139 |
| **Total non-current receivables** | **8,711** | **6,647** |
| | | |
| **Of which receivable from NHS and DHSC group bodies:** | | |
| Current | 29,900 | 40,593 |
| Non-current | 1,743 | 2,139 |

**Note 23.2 Allowances for credit losses**

| **Contract receivables and contract assets** | 31 March 2024 | 31 March 2023 |
|---|---|---|
| | £000 | £000 |
| **Allowances as at 1 April - brought forward** | **15,386** | **14,346** |
| New allowances arising | 7,571 | 4,789 |
| Changes in existing allowances | 415 | - |
| Reversals of allowances | (5,435) | (3,730) |
| Utilisation of allowances (write offs) | (22) | (19) |
| **Allowances as at 31 Mar 2024** | **17,915** | **15,386** |

**Note 23.3 Exposure to credit risk**

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the receivables note above. We actively manage the debt and have made a provision to reflect a probability-weighted estimate for expected credit loss which has been determined by evaluating the range of possible outcomes

**Note 24 Cash and cash equivalents movements**

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **At 1 April** | **32,604** | **57,323** |
| Net change in year | 14,209 | (24,719) |
| **At 31 March** | **46,813** | **32,604** |
| **Broken down into:** | | |
| Cash at commercial banks and in hand | 35 | 39 |
| Cash with the Government Banking Service | 46,778 | 32,565 |
| **Total cash and cash equivalents as in SoFP and SoCF** | **46,813** | **32,604** |

**Note 25 Trade and other payables**

| | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|
| **Current** | | |
| Trade payables | 89,815 | 52,153 |
| Capital payables and accruals | 23,769 | 19,031 |
| Accruals | 44,764 | 63,775 |
| Social security costs | 9,172 | 8,085 |
| Other taxes payable | 10,855 | 8,311 |
| PDC dividend payable | - | 1,906 |
| Pension contributions payable | 10,906 | 10,049 |
| Other payables | 8,845 | 7,996 |
| **Total current trade and other payables** | **198,126** | **171,306** |
| **Of which payables from NHS and DHSC group bodies:** | | |
| Current | 12,618 | 10,745 |

**Note 26 Other liabilities**

| | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|
| **Current** | | |
| Deferred income: contract liabilities | 2,470 | 3,370 |
| Deferred PFI credits / income | 226 | 161 |
| **Total other current liabilities** | **2,696** | **3,531** |
| **Non-current** | | |
| Deferred income: contract liabilities | 2,272 | 2,169 |
| Deferred PFI credits / income | 3,274 | 2,897 |
| **Total other non-current liabilities** | **5,546** | **5,066** |

**Note 27.1 Borrowings**

| | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|
| **Current** | | |
| Loans from DHSC | 731 | 733 |
| Other loans | 718 | 443 |
| Lease liabilities | 3,133 | 3,419 |
| Obligations under PFI, LIFT or other service concession contracts* | 10,736 | 9,274 |
| **Total current borrowings** | **15,318** | **13,869** |
| **Non-current** | | |
| Loans from DHSC | 13,916 | 14,577 |
| Other loans | 5,128 | 5,662 |
| Lease liabilities | 9,243 | 6,960 |
| Obligations under PFI, LIFT or other service concession contracts* | 350,844 | 205,180 |
| **Total non-current borrowings** | **379,131** | **232,379** |

* The Trust has applied IFRS 16 to PFI liabilities within these accounts from 1 April 2023 without restatement of comparatives.

**Note 27.2 Reconciliation of liabilities arising from financing activities**

| | Loans from DHSC | Other loans | Lease Liabilities | PFI and LIFT schemes | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April 2023** | **15,310** | **6,105** | **10,379** | **214,454** | **246,248** |
| **Cash movements:** | | | | | |
| Financing cash flows - payments and receipts of principal | (661) | (452) | (3,560) | (16,670) | **(21,343)** |
| Financing cash flows - payments of interest | (184) | (263) | (191) | (20,079) | **(20,717)** |
| **Non-cash movements:** | | | | | |
| Application of IFRS 16 measurement principles to PFI liability on 1 April 2023 | - | - | - | 144,031 | **144,031** |
| Additions | - | - | 5,557 | - | **5,557** |
| Remeasurement of PFI / other service concession liability resulting from change in index or rate | - | - | - | 19,767 | **19,767** |
| Application of effective interest rate | 182 | 456 | 191 | 20,077 | **20,906** |
| **Carrying value at 31 March 2024** | **14,647** | **5,846** | **12,376** | **361,580** | **394,449** |

| | Loans from DHSC | Other loans | Lease Liabilities | PFI and LIFT schemes | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **Carrying value at 1 April 2022** | **15,969** | **6,521** | **388** | **227,394** | **250,272** |
| **Cash movements:** | | | | | |
| Financing cash flows - payments and receipts of principal | (662) | (416) | (3,320) | (12,940) | **(17,338)** |
| Financing cash flows - payments of interest | (185) | (284) | (120) | (12,708) | **(13,297)** |
| **Non-cash movements:** | | | | | |
| Impact of implementing IFRS 16 on 1 April 2022 | - | - | 11,271 | - | **11,271** |
| Additions | - | - | 2,040 | - | **2,040** |
| Application of effective interest rate | 188 | 284 | 120 | 12,708 | **13,300** |
| **Carrying value at 31 March 2023** | **15,310** | **6,105** | **10,379** | **214,454** | **246,248** |

**Note 28.1 Provisions for liabilities and charges analysis**

| | Pensions: early departure costs | Pensions: injury benefits | Legal claims | Other | Total |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| **At 1 April 2023** | **672** | **1,435** | **127** | **7,657** | **9,891** |
| Change in the discount rate | (20) | (86) | - | (383) | **(489)** |
| Arising during the year | - | - | 50 | 399 | **449** |
| Utilised during the year | (116) | (123) | (1) | (972) | **(1,212)** |
| Reversed unused | (1) | - | (69) | (1,265) | **(1,335)** |
| Unwinding of discount | 9 | 21 | - | 116 | **146** |
| **At 31 March 2024** | **544** | **1,247** | **107** | **5,552** | **7,450** |
| **Expected timing of cash flows:** | | | | | |
| - not later than one year; | 118 | 125 | 107 | 924 | **1,274** |
| - later than one year and not later than five years; | 426 | 500 | - | 3,023 | **3,949** |
| - later than five years. | - | 622 | - | 1,605 | **2,227** |
| **Total** | **544** | **1,247** | **107** | **5,552** | **7,450** |

The Trust is reasonably certain about the amounts and timings of Pensions relating to staff and former Directors as the calculation is based on NHS Pension Agency payments and determined nationally on an actuarial basis.

The Trust is reasonably certain about the amounts and timings of legal claims as the information is provided by NHS Resolution.

Included within other provisions is a £1.8m back-to-back (i.e. fully funded and not a cost to the Trust) provision in respect of consultants who may take up the option to have their additional tax charge, due as a result of work undertaken during 2019/20, paid for by the NHS Pension Scheme. This is known as a "Scheme Pays" arrangement. It has been estimated using headcount data and applying an average figure calculated by the Government Actuary's Department, the Business Services Authority and the Department of Health and Social Care.

Other provisions reflect commercial claims for which the value carries some uncertainty and the timing is dependent on final resolution.

**Note 28.2 Clinical negligence liabilities**

At 31 March 2024, £465.9m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Oxford University Hospitals NHS Foundation Trust (31 March 2023: £599.7m).

**Note 29 Contingent assets and liabilities**

| | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|
| **Value of contingent liabilities** | | |
| NHS Resolution legal claims | (40) | (70) |
| Employment tribunal and other employee related litigation | (7,538) | (5,768) |
| **Net value of contingent liabilities** | **(7,578)** | **(5,838)** |

Contingent liabilities are the legal claims under the liability to third parties and property expenses schemes administered by NHS Resolution (formerly NHS Litigation Authority) and any ongoing Employment Tribunal claims where the chance of economic outflow from the Trust is possible, but not probable.

**Note 30 Contractual capital commitments**

| | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|
| Property, plant and equipment | 15,597 | 2,711 |
| **Total** | **15,597** | **2,711** |

**Note 31 On-SoFP PFI, LIFT or other service concession arrangements**

The Trust has three PFI schemes being the John Radcliffe West Wing, the Churchill Cancer Centre and the Nuffield Orthopaedic Centre. In addition the Trust has two service concession arrangements in respect of the John Radcliffe Welcome Centre and the Trust's Carbon Energy Scheme.

The West Wing and Children's Hospital was built in 2006 at an overall cost of approximately £160m as part of a 30 year contract with The Hospital Company (Oxford John Radcliffe) Ltd who built these buildings and operate across most of the site. The West Wing and Children's Hospital are located on the John Radcliffe site and will revert to Trust ownership at the end of the contract period.

The Cancer Centre was completed in 2008 at an overall cost of approximately £150m at part of a 30 year contract with Ochre Solutions Limited who built and operate across most of the site. The Cancer Centre is located on the Churchill site and will revert to Trust ownership at the end of the contract period.

The Nuffield Orthopaedic Centre was built in 2006 at an overall cost of approximately £35m as part of a 30 year contract with Albion Healthcare (Oxford) Ltd who built and operate across most of the site. The Nuffield Orthopaedic Centre will revert to Trust ownership at the end of the contract period.

The John Radcliffe Welcome Centre opened in 2015 following an approximate build project of £3m as part of a 35 year lease with Larkstoke Properties Limited. It is recognised as an asset with no liability as there are no payments being made by the Trust, instead a deferred income balance is recognised. The arrangement includes sub-leases where tenants pay rent to Larkstoke and a profit share element that entitles the Trust to an element of surpluses over and above a defined level.

The Trust's Carbon Energy Scheme which was built in 2017 as part of a 25 year lease with Vital Energi Solutions Limited is recognised as an IFRIC12 asset with corresponding liability. The overall cost was approximately £18m. The equipment reverts to Trust ownership at the end of the contract period.

**Note 31.1 On-SoFP PFI, LIFT or other service concession arrangement obligations**

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

| | 31 March 2024 | 31 March 2023 |
|---|---|---|
| | £000 | £000 |
| **Gross PFI, LIFT or other service concession liabilities** | **542,150** | **324,687** |
| **Of which liabilities are due** | | |
| - not later than one year; | 30,491 | 21,350 |
| - later than one year and not later than five years; | 131,616 | 84,548 |
| - later than five years. | 380,043 | 218,789 |
| Finance charges allocated to future periods | (180,570) | (110,233) |
| **Net PFI, LIFT or other service concession arrangement obligation** | **361,580** | **214,454** |
| - not later than one year; | 10,736 | 9,274 |
| - later than one year and not later than five years; | 58,306 | 41,751 |
| - later than five years. | 292,538 | 163,429 |

**Note 31.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments**

Total future commitments under these on-SoFP schemes are as follows:

| | 31 March 2024 | 31 March 2023 |
|---|---|---|
| | £000 | £000 |
| **Total future payments committed in respect of the PFI, LIFT or other service concession arrangements** | **1,433,062** | **1,349,720** |
| **Of which payments are due:** | | |
| - not later than one year; | 89,058 | 77,245 |
| - later than one year and not later than five years; | 380,805 | 328,746 |
| - later than five years. | 963,199 | 943,729 |

**Note 31.3 Analysis of amounts payable to service concession operator**

This note provides an analysis of the unitary payments made to the service concession operator:

| | 2023/24 | 2022/23 |
|---|---|---|
| | £000 | £000 |
| **Unitary payment payable to service concession operator** | **104,654** | **88,317** |
| **Consisting of:** | | |
| - Interest charge | 20,077 | 12,708 |
| - Repayment of balance sheet obligation | 16,563 | 12,867 |
| - Service element and other charges to operating expenditure | 60,640 | 46,698 |
| - Capital lifecycle maintenance | 7,374 | 2,473 |
| - Revenue lifecycle maintenance | - | 375 |
| - Contingent rent | - | 13,196 |
| Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment | - | 156 |
| **Total amount paid to service concession operator** | **104,654** | **88,473** |

**Note 32 Impact of change in accounting policy for on-SoFP PFI, LIFT and other service concession liabilities**

IFRS 16 liability measurement principles have been applied to PFI, LIFT and other service concession arrangement liabilities from 1 April 2023. When payments for the asset are uplifted for inflation, the imputed lease liability recognised on the SoFP is remeasured to reflect the increase in future payments. Such increases were previously recognised as contingent rent as incurred.

The change in measurement basis has been applied retrospectively without restatement of comparatives and with the cumulative impact on 1 April 2023 recognised in the income and expenditure reserve. The incremental impact of applying the new accounting policy on (a) the allocation of the unitary charge in 2023/24 and (b) the primary statements in 2023/24 is set out in the disclosures below.

**Note 32.1 Impact of change in accounting policy on the allocation of unitary payment**

| | IFRS 16 basis (new basis) 2023/24 | IAS 17 basis (old basis) 2023/24 | Impact of change 2023/24 |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Unitary payment payable to service concession operator** | **104,654** | **104,654** | **-** |
| **Consisting of:** | | | |
| - Interest charge | 20,077 | 12,049 | **8,028** |
| - Repayment of balance sheet obligation | 16,563 | 9,344 | **7,219** |
| - Service element | 60,640 | 60,640 | **-** |
| - Lifecycle maintenance | 7,374 | 7,374 | **-** |
| - Contingent rent | - | 15,247 | **(15,247)** |

**Note 32.2 Impact of change in accounting policy on primary statements**

| **Impact of change in PFI accounting policy on 31 March 2024 Statement of Financial Position:** | **£000** |
|---|---|
| Increase in PFI / LIFT and other service concession liabilities | (156,579) |
| Decrease in PDC dividend payable / increase in PDC dividend receivable | - |
| Increase in cash and cash equivalents (impact of PDC dividend only) | 5,238 |
| **Impact on net assets as at 31 March 2024** | **(151,341)** |

| **Impact of change in PFI accounting policy on 2023/24 Statement of Comprehensive Income:** | **£000** |
|---|---|
| PFI liability remeasurement charged to finance costs | (19,767) |
| Increase in interest arising on PFI liability | (8,028) |
| Reduction in contingent rent | 15,247 |
| Reduction in PDC dividend charge | 5,238 |
| **Net impact on surplus / (deficit)** | **(7,310)** |

| **Impact of change in PFI accounting policy on 2023/24 Statement of Changes in Equity:** | **£000** |
|---|---|
| Adjustment to reserves for the cumulative retrospective impact on 1 April 2023 | (144,031) |
| Net impact on 2023/24 surplus / deficit | (7,310) |
| **Impact on equity as at 31 March 2024** | **(151,341)** |

| **Impact of change in PFI accounting policy on 2023/24 Statement of Cash Flows:** | **£000** |
|---|---|
| Increase in cash outflows for capital element of PFI / LIFT | (7,219) |
| Decrease in cash outflows for financing element of PFI / LIFT | 7,219 |
| Decrease in cash outflows for PDC dividend | 5,238 |
| **Net impact on cash flows from financing activities** | **5,238** |

## Note 33 Financial instruments

### Note 33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust’s treasury management operations are carried out by the finance department, within parameters defined formally within the Trust’s standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust’s internal auditors.

**Currency risk**
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

**Interest rate risk**
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust's regulators. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust's loan to support commercial activities has an interest rate linked to RPI. The Trust therefore has low exposure to interest rate fluctuations.

**Credit risk**
Because the majority of the Trust’s revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the trade and other receivables note.

**Liquidity risk**
The Trust’s operating costs are incurred under contracts with Commissioners, which are financed from resources voted on annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

**Note 33.2 Carrying values of financial assets**

| Carrying values of financial assets as at 31 March 2024 | Held at amortised cost | Held at fair value through OCI | Held at fair value through I&E | Total book value |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Trade and other receivables excluding non financial assets | 54,259 | - | - | **54,259** |
| Other investments / financial assets | - | 45 | 1,065 | **1,110** |
| Cash and cash equivalents | 46,813 | - | - | **46,813** |
| **Total at 31 March 2024** | **101,072** | **45** | **1,065** | **102,182** |

| Carrying values of financial assets as at 31 March 2023 | Held at amortised cost | Held at fair value through OCI | Held at fair value through I&E | Total book value |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Trade and other receivables excluding non financial assets | 64,916 | - | - | **64,916** |
| Other investments / financial assets | 659 | 17 | - | **676** |
| Cash and cash equivalents | 32,604 | - | - | **32,604** |
| **Total at 31 March 2023** | **98,179** | **17** | **-** | **98,196** |

**Note 33.3 Carrying values of financial liabilities**

| Carrying values of financial liabilities as at 31 March 2024 | Held at amortised cost | Total book value |
|---|---|---|
| | £000 | £000 |
| Loans from the Department of Health and Social Care | 14,647 | **14,647** |
| Obligations under leases | 12,376 | **12,376** |
| Obligations under PFI, LIFT and other service concession contracts | 361,580 | **361,580** |
| Other borrowings | 5,846 | **5,846** |
| Trade and other payables excluding non financial liabilities | 173,242 | **173,242** |
| Other financial liabilities | - | **-** |
| Provisions under contract | 3,687 | **3,687** |
| **Total at 31 March 2024** | **571,378** | **571,378** |

| Carrying values of financial liabilities as at 31 March 2023 | Held at amortised cost | Total book value |
|---|---|---|
| | £000 | £000 |
| Loans from the Department of Health and Social Care | 15,310 | **15,310** |
| Obligations under leases | 10,379 | **10,379** |
| Obligations under PFI, LIFT and other service concession contracts | 214,454 | **214,454** |
| Other borrowings | 6,105 | **6,105** |
| Trade and other payables excluding non financial liabilities | 153,004 | **153,004** |
| Other financial liabilities | - | **-** |
| Provisions under contract | 4,023 | **4,023** |
| **Total at 31 March 2023** | **403,275** | **403,275** |

**Note 33.4 Maturity of financial liabilities**

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

| | 31 March 2024 | 31 March 2023 |
|---|---|---|
| | £000 | £000 |
| In one year or less | 209,412 | 180,983 |
| In more than one year but not more than five years | 145,969 | 100,095 |
| In more than five years | 400,781 | 233,995 |
| **Total** | **756,162** | **515,073** |

**Note 33.5 Fair values of financial assets and liabilities**

The book value (carrying value) is considered to be a reasonable approximation of fair value of the financial assets and liabilities the Trust has disclosed.

**Note 34 Losses and special payments**

| | 2023/24 | | 2022/23 | |
|---|---|---|---|---|
| | Total number of cases | Total value of cases | number of cases | Total value of cases |
| | Number | £000 | Number | £000 |
| **Losses** | | | | |
| Cash losses | 22 | 22 | 10 | 17 |
| Bad debts and claims abandoned | - | - | 7 | 1 |
| Stores losses and damage to property | 2 | 337 | 2 | 210 |
| **Total losses** | **24** | **359** | **19** | **228** |
| **Special payments** | | | | |
| Ex-gratia payments | 45 | 45 | 50 | 117 |
| **Total special payments** | **45** | **45** | **50** | **117** |
| **Total losses and special payments** | **69** | **404** | **69** | **345** |

**Note 35 Related parties**

During the accounting period none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Oxford University Hospitals NHS Foundation Trust. The Department of Health is regarded as a related party. During the accounting period Oxford University Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

Related parties may include but are not limited to:
- Department of Health and Social Care ministers
- Board members of the Trust
- The Department of Health and Social Care
- Other NHS providers
- CCGs and NHS England
- Integrated Care Boards
- Other health bodies
- Other Government departments
- Local authorities
- NHS charities and other charitable organisations

Material transactions in the year have been with local CCGs/ICBs, NHS Resolution, NHS England, Health Education England, and the Department of Health and Social Care.

In addition, the Trust had a number of material transactions with other government departments and other central and local government bodies as set out below.

Most of the trading-type transactions have been with Oxfordshire County Council and are for various services including Genito-Urinary Medicine services, salary recharges associated with social services and supported hospital discharges as well as sub-lease arrangements for rental of property space.

The Trust has also received revenue and capital payments from a number of charitable funds. None of these are material and certain charitable fund trustees are also members of the Trust board. Details of donations from OUH Charity can be found in the Our Partnerships section of the Annual Report.

Consolidated accounts to include Oxford Hospitals Charity are not prepared as this entity is a company limited by guarantee, independent from Oxford University Hospitals NHS Foundation Trust and therefore the charity is not controlled by the Trust.

Please see notes 19 to 21 for details of the Trust's joint ventures in partnership with a number of other entities and their corresponding accounting treatments. This includes details of the arrangements and key financial information related to OUH's joint ventures.

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Oxford University Hospitals NHS Foundation Trust.

**Note 36 Adjusted financial performance (control total basis):**

| | **2023/24** | **2022/23** |
|---|---|---|
| Surplus / (deficit) for the period | (28,177) | (5,472) |
| Remove net impairments not scoring to the Departmental expenditure limit | 28,878 | 3,288 |
| Remove I&E impact of capital grants and donations | (18,496) | 582 |
| Remove impact of IFRS 16 on IFRIC 12 schemes | 6,480 | - |
| Remove net impact of inventories received from DHSC group bodies for COVID response | 567 | 1,688 |
| **Adjusted financial performance surplus / (deficit)** | **(10,748)** | **86** |