Oxford University Hospitals

NHS Foundation Trust

Annual Report and Accounts

2022-2023

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Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Table of Contents

Foreword and statement on performance

Welcome to the Annual Report of Oxford University Hospitals NHS Foundation Trust for the period 1 April 2022 to 31 March 2023.

Introduction

On behalf of the Board of Directors of Oxford University Hospitals NHS Foundation Trust (OUH), I would like to thank all our people for working together as OneTeamOneOUH this year to meet the challenges we have faced and to provide the highest quality care for our patients and the populations which we serve. The commitment, dedication and talent of our staff are vital to our organisation. Achieving our vision of delivering compassionate excellence is only possible by supporting each other and working collaboratively to put the patient at the centre of all we do.

Our Council of Governors approved my appointment as the Trust's permanent Chief Executive Officer in February 2023. Having been appointed to the post on a fixed term basis in July 2022, I was delighted to be appointed substantively. I am proud to have the opportunity to lead our OneTeamOneOUH with compassion and respect for others and with a desire for excellence.

Together we make OUH a great place to work where we all feel we belong

In July 2022 the Trust Board approved our People Plan 2022-25, for which hundreds of staff had contributed during listening events between April and June 2022. The three key themes of the People Plan are: *health, wellbeing and belonging for all our people; making OUH a great place to work;* and *more people working differently*.

We started with a focus on the cost of living crisis for our staff. Our Cost of Living Working Group is led by members of our Executive team with other key staff, trade union representatives and Oxford Hospitals Charity. In April 2022, all staff received a one-off £100 cost of living bonus payment. In July 2022, we introduced a transport benefit of £250 off an annual travel pass or a £250 discount when buying a new bike via the Cycle2Work scheme. More than 1,500 staff have accessed this transport benefit scheme by the end of March 2023. Free breakfasts and value for money food offers have been provided on our hospital sites, and in March 2023 we introduced free sanitary product dispensers in staff toilets.

We believe that wellbeing starts with kindness. Evidence shows that kinder cultures improve staff wellbeing and engagement, which in turn leads to safer care and better outcomes for patients. I launched our new Kindness into Action programme in October 2022 with a Leading with Kindness training programme for our leaders and managers.

We also invested £500,000 in new wellbeing equipment for wards and departments, embedded a dedicated psychological health support service which was initially developed with funding from NHS Charities Together via Oxford Hospitals Charity, and worked with the Charity to provide targeted wellbeing support for frontline staff over the winter months.

Our staff networks are key to developing a culture where everyone feels they belong. For example, our Women's Network led the way in raising awareness of the impact of menopause on our people through events and a survey which have helped shape our new policy.

Enabling staff to speak up safely about any concerns they may have, is also central to developing a culture where all staff feel they belong. Our Freedom to Speak Up team was Highly Commended at the *Health Service Journal* (*HSJ*) Awards 2022.

We introduced a values-based appraisal (VBA) window for the first time in 2022 which has had a positive impact. 94.2% of staff completed an appraisal compared to 65% in 2021/22.

We launched our public-facing *No Excuses* campaign in January 2022, following a significant increase in reports of abusive and aggressive behaviour towards staff by patients and visitors, alongside the introduction of body-worn cameras firstly in our Emergency Departments before they were rolled out across other areas of our hospitals.

Our annual Staff Recognition Awards event was held in person in June 2022 for the first time since 2019. The event was a celebration of all that is best about our OneTeamOneOUH. We are grateful to Oxford Hospitals Charity for supporting the Awards.

Ensuring patient safety and staff wellbeing during industrial action

Royal College of Nursing (RCN), Unison and British Medical Association (BMA) junior doctor members working at OUH took part in the national periods of industrial action which impacted on the NHS from December 2022. We worked closely with our people and local union representatives to ensure that patient safety and staff wellbeing were paramount at all times, while supporting the legal right of our people to take industrial action.

I would like to thank all our staff for treating each other with kindness and respect, in line with our Trust values and our OneTeamOneOUH ethos, during these challenging times.

Improving care for our patients

In common with the rest of the NHS, we found it challenging to achieve the national performance target of seeing, treating and either discharging or admitting 95% of Emergency Department patients within four hours. Industrial action, the COVID-19 pandemic, flu and other respiratory conditions and an increase in the volumes of patients accessing our Emergency Departments at the John Radcliffe Hospital in Oxford and the Horton General Hospital in Banbury all contributed to this. We have since made urgent and emergency care as one of the eight key themes of our Trust-wide Quality Improvement Programme.

Enabling more patients to be cared for closer to home is key to improving patient experience and reduces the pressure on our acute hospitals. Our initiatives in this area included our innovative Acute Hospital at Home (AHaH) service which was highlighted by the BBC's Panorama programme in January 2023. The programme showed how the AHaH team has adopted a pioneering approach to support patients who, if medically appropriate, can receive hospital-standard care in their own home.

We also launched the Oxfordshire Rapid Intervention for Palliative and End of Life Care (RIPEL) project, a partnership between OUH, Sobell House Hospice Charity, Macmillan Cancer Support and Social Finance. This project, which was launched in April 2022, enables more people to be cared for at home and avoids unnecessary emergency visits to our hospitals.

We have continued to focus on increasing activity across elective pathways including cancer. We reduced the number of patients waiting over one and a half years for their treatment from 161 in March 2022 to 60 in March 2023. We also reduced the number of patients waiting more than two years from 26 in March 2022 to four in March 2023. However, we were disappointed that the number of patients waiting over a year rose and that too many patients are waiting too long for treatment for cancer. We are committed to reducing the waiting times for elective and cancer treatment in 2023/24.

Sustainable finances

We reported a £5.5m deficit in our Annual Accounts and a break-even performance on the financial measure used by the NHS. We continued to invest in our estates, spending £47m on new buildings and equipment during the year. We continued to find it challenging to regain pre-pandemic levels of productivity, and incurred significant extra staff costs due to higher sickness absences and a general increase in the acuity of our patients. We are applying quality improvement approaches in this area to improve quality and efficiency at the same time. However, a continuation of operational pressures and unfunded inflation increase the risk that the Trust does not break even in 2023/24 and threaten Trust's financial sustainability.

Building a brighter future

2022/23 was another year of ground-breaking developments across the Trust, as we continue to build for the future to improve both patient and staff experience.

- The new Oxford Haemophilia and Thrombosis Centre (OHTC) on our Nuffield Orthopaedic Centre (NOC) site in Oxford was officially opened in October 2022. This service, for people with bleeding and clotting disorders, welcomed its first patients to its new purpose-built home in March 2022.
- Our new Radiotherapy Centre at the Great Western Hospital in Swindon was officially opened in June 2022 and welcomed its first patients in October. It enables patients living in Swindon and the surrounding areas to receive high-quality cancer care closer to home.
- Spencer Court, our new staff accommodation on the Churchill Hospital, was officially opened in November 2022. It is a partnership project between OUH, Oxford Hospitals Charity and A2Dominion which provides homes for 91 staff with more affordable rents.
- The refurbished Acute Multidisciplinary Imaging and Interventional Centre (AMIIC) was officially opened in January 2023 at the John Radcliffe Hospital in Oxford. Located adjacent to the Emergency Department and the Heart Centre, it is a purpose-designed clinical research facility and is the first centre in the UK to provide photon-counting CT imaging.
- The replacement programme for our Linear Accelerator machines at the Churchill Hospital continued with the installation of a Varian True Beam machine in February 2023. We also supported our partner Milton Keynes University Hospitals NHS Foundation Trust which broke ground in December 2022 on a new radiotherapy centre which OUH will operate.
- The Horton General Hospital now benefits from a second CT scanner after a successful funding bid to NHS England. Installation started during the year and the new scanner opened for patients in April 2023.

Working in partnership

Our OneTeamOneOUH is much broader and more inclusive than those people who we employ directly. Working with our partners to improve the health and wellbeing of our populations is one of our strategic objectives as an organisation.

It includes our Governors, volunteers, Oxford Hospitals Charity, medical and nursing students from the University of Oxford and Oxford Brookes University, our palliative care partners Sobell House Hospice Charity and Katharine House Hospice Charity, Maggie's Centre Oxford on the Churchill Hospital site, Ronald McDonald House Charities who provide free accommodation for families of babies and children in hospital, our Private Finance Initiative (PFI) partners, including Mitie and G4S and many more.

The new Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) went live on 1 July 2022. This is an important mechanism for driving forward partnership working with NHS, local authority and other key stakeholders.

In Oxfordshire, we have strengthened the approach to care for our patients and populations, especially during the busy winter months. We signed a Memorandum of Understanding (MoU) with Oxford Health NHS Foundation Trust in May 2022. This partnership between acute, community and mental health services enables more joined-up and seamless care for patients and provides better value for money.

In October 2022, we welcomed the news that our Oxford Biomedical Research Centre (BRC), which is a partnership between OUH and the University of Oxford, will receive £86.6m in Government funding over the next five years to fund 15 research themes. This will enable us to improve diagnosis, treatment and care for NHS patients.

Looking forward

Our Clinical Strategy 2023-28, which was approved by the Trust Board in March 2023, provides a blueprint for our clinical services, our sites, and the role we aim to play as an organisation over the next five years. It sets out our three key roles as a provider of excellent local and specialist care, a leading centre for Quality Improvement, education, innovation and research, and an 'anchor institution' at the heart of our community identifying and tackling health inequalities.

The Clinical Strategy was developed with ideas from our people and from clinical engagement across the Trust. More than 700 strategic ideas and opportunities were submitted from all clinical directorates. I am grateful to all those who took the time to contribute their expertise.

Trust Board changes

On behalf of the Trust Board, I thank my predecessor Professor Bruno Holthof for all he achieved during his seven years as the Chief Executive Officer before stepping down in June 2022. He provided strong and stable leadership, especially during the COVID-19 pandemic.

Clare Winch was Acting Chief Assurance Officer from April to October in 2022 covering a medical absence. Dr Anny Sykes has been the Interim Chief Medical Officer since July 2022, when I was appointed as Chief Executive Officer on a fixed term basis. Rachel Stanfield was appointed as the Joint Chief People Officer from August 2022 to March 2023 working with Terry Roberts. I thank Clare, Anny and Rachel for their contributions as Trust Board members.

Finally, I wish to thank Sam Foster, who left the Trust at the end of March 2023, for her significant contribution during her five years as Chief Nursing Officer. Paula Gardner joined us as Interim Chief Nursing Officer in April 2023 while we recruit a substantive replacement.

Signed:

Professor Meghana Pandit
Chief Executive Officer
28 June 2023

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 2022/23.

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 consists of four hospitals, the John Radcliffe Hospital, the Churchill Hospital and the Nuffield Orthopaedic Centre, all located in Oxford, and the Horton General Hospital in Banbury, North Oxfordshire, and 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 clinical services and specialist 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 normally draws patients from across the country for specialist services and leads networks in areas such as trauma and vascular.

Most of our services are provided in our hospitals, but we also operate from 59 other locations across the region, which include outpatient peripheral clinics in community settings, satellite services in a number of surrounding hospitals and some in patients' homes. The Trust also delivers services from community hospitals in Oxfordshire, including midwifery-led units, and is 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.

Trust Strategy

In August 2020, Oxford University Hospitals NHS Foundation Trust (OUH) launched our 'OUH Strategy 2020-2025' framework, a foundation we use to guide our priorities and decisions.

Our Strategy sets out our focus on three Strategic Objectives.

- We will make OUH a great place to work by delivering the best staff experience and wellbeing for all **Our People**, supported by a sustainable workforce model and a compassionate culture.
- We will improve the access, quality and experience of care for all **Our Patients** by focusing on patient safety and working with patients to improve their health, care and experience.
- We will work with partners to improve the health and wellbeing of **Our Populations**, working collaboratively to provide integrated care close to home, reduce health inequalities, tackle our environmental impact and deliver financially sustainable services.

Our Strategic Objectives are underpinned by Our Values:

Learning, Respect, Delivery, Excellence, Compassion and Improvement

and founded in Our Vision:

Delivering Compassionate Excellence for Our People, Our Patients and Our Populations.

Our Clinical Strategy

In March 2023, the OUH Trust Board approved the OUH Clinical Strategy 2023-2028, which is a blueprint for our clinical services and our sites, and the role we aim to play as an organisation over the next five years. The Strategy is built on a high level of engagement from clinical teams across the Trust.

The Clinical Strategy sets out how we will deliver the highest quality of care for our patients and our population, and our priorities to guide our future decision-making. It also outlines how we plan to meet the needs of our patients in the following services: Cancer, Children and Young People, Critical Care, Enabling Services, Local Services, Long-Term Conditions, Specialised Services, Urgent and Emergency Care, and Women's Health, Maternity and Neonates.

The Strategy sets out our role across three important areas:

- as a provider of excellent local and specialist care
- as a leading centre for Quality Improvement, education, innovation and research
- as an 'anchor institution' at the heart of our community where our sustainability as an organisation is tied to the wellbeing of the population we serve.

Across our services, we commit to:

- be innovative and transformational in providing care for our patients and our populations
- deliver the right services in the right places for our patients
- work with our partners to address shared priorities and tackle health inequalities
- provide high-quality, research and innovation enabled care and treatment.

Our next step is to develop an implementation plan involving all clinical services and corporate teams including Digital, Workforce, Finance, Estates and Capital, and our system partners.

Our Partnerships

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

We work closely with a variety of partners to care for our patients, support our people and make wide scale changes for our populations. 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.

Provider Collaboratives

Provider Collaboratives are a new way for NHS providers to come together 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.

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.

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 collectively influencing national policy.

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.

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.

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 provides extensive support for patients and staff in our hospitals.

A few highlights during 2022/23 include the following.

- £1.2m of funding to create a new staff education centre.
- £796,000 of funding to equip a state-of-the-art Cath Lab in the Oxford Heart Centre.
- Funding of £300,000 for high tech equipment to transform paediatric brain surgery.
- Funding of £108,000 for pioneering endoscopic spinal surgery equipment to help create a leading UK centre.
- Funding of £60,000 for innovative surgical techniques for patients with bone cancer.
- Support for a new nursing research programme.

- Provision of new accommodation for staff.
- Projects to support staff mental health, wellbeing and morale.
- Projects to help patients with dementia as well as toys and technology equipment to entertain children in hospital.

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

Volunteers

Volunteers are key people supporting a large range of services at our four hospital sites, our satellite centres and at the Trust's offices in Cowley. They provide a range of services from wayfinding, delivering donations, obtaining patient feedback and providing non-medical updates to patients' families and next of kin.

The Trust has over 700 volunteers, with 96 joining in the last 12 months.

New areas where volunteers are making a difference include being a listening ear to patients and supporting the Emergency Department with non-medical general duties.

Volunteers are also acting during clinical exams and supporting with the Pets as Therapy (PAT) dogs which are well received in key areas of the Trust.

Last year, our volunteers won the High Sheriff of Oxford Award and were heralded as Oxfordshire's heroes. They received a standing ovation at the OUH Staff Recognition Awards night in recognition of their valuable contribution, and one volunteer won a Gold Award.

Performance Overview

This section summarises the Trust's operational and financial performance and achievements during 2022/23.

The dashboard overleaf provides an overview of the performance against the key indicators from the NHS Oversight Framework (SOF) and the Trust's Quality Priorities. It includes indicators measuring:

- quality of care, access and outcomes
- people
- finance and use of resources.

Further information and additional indicators are included in the Performance Analysis section found later in this report, including comparisons with the pre-COVID-19 period in 2019/20 and references to the national average where possible.

We report on the following objectives.

- ***Elective care and cancer services*** were a key focus in 2022/23 and a requirement of the NHS annual planning guidance. We made progress by increasing inpatient activity by 5.6% compared to the previous financial year and reducing the number of patients waiting over 78 weeks and over 104 weeks. However, the number of patients waiting over 52 weeks increased during 2022/23 compared to 2021/22. This was due to the growth in referrals following the COVID-19 pandemic.
- ***Providing timely urgent and emergency care*** was challenging in the context of continuing high volumes of patient demand in our emergency settings compared to pre-pandemic levels (+5.7%). This put considerable pressure on our ability to see patients quickly. The proportion of patients seen within four hours in our Emergency Departments decreased from 73.3% in 2021/22 to 62.1% in 2022/23. We recorded a higher proportion of patients spending more than 12 hours in an Emergency Department, which increased from 4.4% in 2021/22 to 6.8% in 2022/23.
- ***Delivering safe, high-quality care*** saw the Trust continue to work towards achieving the key indicators in the NHS Oversight Framework and the local Quality Priorities. Despite the rising patient numbers, some indicators improved or continued to demonstrate high-quality performance, including our mortality indicators, harms from pressure ulcers and results endorsement. *Clostridium difficile* cases and E.coli bloodstream infections increased compared to 2021/22.
- ***Our People Plan for 2022/23*** supported improved performance on core skills training, rates of non-medical appraisals and staff turnover, and we continued to grow a diverse senior leadership team. Our sickness rates continued at the higher levels recorded in 2021/22 and we recorded an increase in the incidence of violence and aggression.
- ***Our management of finance and the use of resources*** saw the Trust record a £0.1m surplus as measured by the NHS and achieve our statutory break-even duty. However, this result was less than our £1.3m planned surplus. We invested £46.6m in new buildings and equipment. This was £3.4m below our allocation, and colleagues elsewhere in our Integrated Care System were able to partially use this underspend to offset their overspend.

Performance Dashboard: Quality of care, access and outcomes

Oversight theme and indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
NHS Long Term Plan: Elective care and cancer				
Elective inpatient activity (FCEs[1])	n/a	94,651	89,637	5.6% more inpatient activity
Elective outpatient activity (attendances)	n/a	1,247,056	1,174,818	6.1% more outpatient activity
Patients waiting over 52 weeks (RTT[2])	<950	2,226	971	1,255 more patients waiting
Patients waiting over 78 weeks (RTT[2])	0	60	161	101 fewer patients waiting
Patients waiting over 104 weeks (RTT[2])	0	4	26	22 fewer patients waiting
Cancer referral treatment levels[3]	n/a	3,021	2,918	3.5% more cancer activity
People waiting longer than 62 days[4]	<120	205	226	21 fewer patients waiting
Faster diagnosis standard	≥75%	78.3%	78.8%	0.5 percentage point deterioration but above target
Diagnostic activity levels (elective)	n/a	227,990	202,621	12.5% more diagnostic activity
NHS Long Term Plan: Urgent and emergency care				
Proportion of ambulance arrivals delayed over 30 minutes	n/a	9.8%	7.5%	2.3 percentage point increase (deterioration)
Proportion of patients spending more than 12 hours in an ED[5]	n/a	6.8%	4.4%	2.4 percentage point increase (deterioration)
ED[5] performance within 4 hours (all types)	≥95%	62.1%	73.3%	11.2 percentage point deterioration
NHS Long Term Plan: Safe, high-quality care				
SHMI range[6]	<1	0.96 *(CL[7] 0.90-1.1)*	0.92 *(CL[7] 0.90-1.1)*	Statistically, 'as expected'
HSMR range[8]	<100	93.7 *(CL[7] 89.8-97.8)*	93.1 *(CL[7] 89.1-97.3)*	Statistically 'lower than expected' i.e. fewer deaths than expected
MRSA bacteraemia cases[9]	0	4	4	No change to MRSA cases
Clostridium difficile cases	≤104	141	107	31.8% increase in cases
E.coli[10] bloodstream infection rate	161	208	168	23.8% increase in cases
Local Quality Priorities				
Results endorsed within 7 days	90%	82.2%	78.7%	3.5 percentage point improvement
Hospital Acquired Pressure Ulcers (HAPUs) Category 3 and above per 1,000 admissions	0.035%	0.03%	0.05%	40% reduction (achieved target)
Incident rate[11] of violence and aggression (rate per 10,000 bed days)	n/a	44.61	38.34	16.4% increase in incident rate

Notes:

1. *A finished consultant episode (FCE) is a continuous period of admitted patient care under one consultant within one healthcare provider.*
2. *Referral to Treatment (RTT) pathway.*
3. *Indicator includes all 62 day pathways.*
4. *Indicator includes patients waiting longer than 62 days on a cancer pathway.*
5. *ED - Emergency Department.*
6. *SHMI - Summary Hospital-level Mortality Indicator.*
7. *CL - Confidence Limit.*
8. *HSMR - Hospital Standardised Mortality Ratio.*
9. *MRSA - Methicillin-resistant Staphylococcus Aureus.*
10. *E.coli - Escherichia coli bloodstream Infections.*
11. *Reported rate on Trust's incident management system.*

Performance Dashboard: People, finance and use of resources

Oversight theme and indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
NHS Long Term Plan: Leadership and looking after our people				
Employee Engagement Index (EEI) Staff Survey	n/a	7.0/10	7.0/10	No change
Sickness absence rate	3.1%	4.3%	4.3%	No change
Proportion of BAME[12] staff in senior leadership roles[13]	n/a	4/19[14]	2/18	Increase of 2 BAME staff in senior leadership roles
Proportion of women in senior leadership roles[13]	n/a	12/19[14]	10/18	Increase of 2 female staff in senior leadership
Local people priorities				
Total number of permanent staff (average WTE[15])	n/a	12,854	12,676	1.4% increase
Staff turnover	≤12.0%	11.4%	12.4%	1 percentage point decrease (improvement)
Core Skills Training	≥85.0%	90.2%	88.0%	2.2 percentage point improvement
Appraisals (non-medical)	≥85.0%	94.2%	65.0%	29.2 percentage point improvement
Finance				
Financial performance as measured by the NHS £m	Break-even	0.1	3.3	Break-even target achieved by reduced margin
Capital[16] spend vs ICS[17] plan £m	30.9	-3.4	7.1	10.9% underspend (2021/22 21.4% overspend against a plan of £33.1m)
Local finance priorities				
Turnover £m	1,401	1,512	1,403	7.8% increase (commissioner funding, including enhanced pay awards)
Surplus/(deficit) as measured in the Annual Accounts £m	n/a	-5.5	-17.7[18]	0.8% improvement relative to turnover
Financial performance vs plan £m	n/a	-1.2	8.7	113.8% decrease in performance to under performance
Overall level of capital expenditure £m	60	46.6	67.1	30.6% reduction
Overall level of capital expenditure vs plan £m	60	-13.4	-0.9	£12.5m increase in underspend (plan for 2021/22 £68m)
Cash as of 31 March 2023 £m	n/a	32.6	57.3	43.1% deterioration but 1.5% better than planned
Cash vs plan as of 31 March 2023 £m	31.8	0.8	10.1	2.5% positive variance on plan (plan for 2021/22 £47.2m)

Notes:

12. Black, Asian and Minority Ethnic (BAME) staff.

13. Senior leadership roles defined as Board level roles.

14. Both Joint Chief Officers in post as of 31 March 2023 are included in the total number of Board members.

15. WTE - Whole Time Equivalent.

16. Capital measured as ICS CDEL (ICS Capital Departmental Expenditure Limit). This is capital expenditure as measured by HM Treasury. In effect, a subset of overall capital expenditure by the Trust.

17. ICS - Integrated Care System. The Trust's capital and revenue expenditure were aligned to the plans of the ICS.

18. Updated prior year adjustment.

Performance Analysis

Oxford University Hospitals NHS Foundation Trust's (OUH) 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 for:

- Impact of COVID-19
- Impact of industrial action
- Quality of care, access and outcomes, including elective care, cancer and diagnostic activity and performance
- Urgent and Emergency Care
- Delivering safe, high-quality care
- People, including belonging in the NHS and looking after our people
- Finance and use of resources
- Patient experience, including learning from patient feedback and complaints
- Tackling health inequalities
- Equality of service delivery to different groups.

This is followed by a description of performance and risks for these and related measures.

Impact of COVID-19

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Beds occupied by COVID-19 patients (average per day)	n/a	79	41	92.7% increase in the average daily number of beds occupied by COVID-19 patients
Staff absences related to COVID-19 (average per day)	n/a	168	229	61 fewer COVID-19 related absences

The COVID-19 pandemic continued to have a significant impact on our clinical services and staff in 2022/23. On average, there were 79 patients per day with COVID-19 occupying beds in 2022/23. This corresponded to an increase of 38 patients in beds per day with COVID-19 on average, compared to 2021/22 (+92.7%) where an average of 41 patients per day with COVID-19 were recorded as occupying beds.

Our staff absences were impacted by COVID-19, directly due to the virus and indirectly due to self-isolation requirements. In 2022/23, on average, 168 staff were absent each day due to COVID-19, which although high, corresponded to 61 fewer staff absent per day due to COVID-19 in 2021/22, when the average was 229. In context, during the COVID-19 period in 2020/21, there was an average of 329 staff absent per day.

The average number of inpatients in the hospital per day with COVID-19 in 2022/23 was similar between April to September compared to October to March (82 vs 76). In contrast, the average number of staff absent per day was considerably higher between April to September compared to October to March due to COVID-19 (+88.8% / 219 vs 116).

Impact of industrial action

In late 2022/23, industrial action resulted in the cancellation of 797 patients scheduled for an elective or day case admission to the hospital and 4,401 patients scheduled to attend in an outpatient setting.

The Trust has 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 do so. We worked with colleagues to ensure that staffing was maintained at safe levels and to minimise the rescheduling of planned appointments, procedures and operations.

Quality of care, access and outcomes

Elective care

Elective activity in 2022/23 delivered an increase in the number of services for patients waiting for cancer treatments, patients with a high clinical priority and our longest waiting patients.

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Elective inpatient activity levels (FCEs[1])	n/a	94,651	89,637	5.6% more inpatient activity
Elective outpatient activity levels (attendances)	n/a	1,247,056	1,174,818	6.1% more outpatient activity

Note:

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

In collaboration with system partners within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS), supported by specific elective care funding streams, and using capacity available within the Independent Sector and from insourcing, we were able to increase elective inpatient activity relative to 2021/22 (+5.6% / +5,014) and increase patient services delivered in an outpatient setting (+6.1% / +72,238).

Patients waiting for elective care

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Patients waiting for consultant-led treatment (RTT[1])	<58,256	72,744	57,599	15,145 more patients waiting
Patients waiting over 52 weeks (RTT[1])	<950	2,226	971	1,255 more patients waiting
Patients waiting over 78 weeks (RTT[1])	0	60	161	101 fewer patients waiting
Patients waiting over 104 weeks (RTT[1])	0	4	26	22 fewer patients waiting

Note:

1. *Referral to Treatment (RTT) pathway.*

The targeted approach to focusing treatment for patients, based on their clinical prioritisation and longest waiting patients, enabled a reduction in the number of patients waiting more than 104 weeks (two years) from 26 to four patients, and a reduction in the number of patients wating more than 78 weeks from 161 to 60 patients.

However, there were 1,255 more patients waiting more than 52 weeks at the end of March 2023 compared to March 2022. This was because we followed national requirements to prioritise the patients waiting for over 104 and 78 weeks and due to the impact of industrial action and COVID-19. There is also less capacity than required in our hospitals to meet demand, with activity rising at circa 6% compared to a 26.3% growth in the total number of patients waiting for consultant-led treatment (+15,145 patients), resulting in an increase in the overall size of the waiting list.

OUH elective activity performance compared to national average

Benchmarking data from April to March 2019/20, 2021/22 & 2022/23

2022/23 compared to 2021/22	2022/23 compared to 2019/20
• OUH elective inpatient and day case activity increased in 2022/23 at a rate lower than the national average (5.6% vs 10.1%). • OUH outpatient activity increased in 2022/23 at a rate above the national average (6.1% vs 5.7%).	• OUH provided elective inpatient activity 7.5% below the pre-pandemic level, which was lower than the national average (+1.4%). • OUH outpatient activity was above pre-pandemic levels and higher than the national average (29.1% vs 12.6%). Some of this growth was due to a change in the way in which outpatient activity was classified at OUH.

Notes:

1. *March 2023 data, at the time of reporting, was provisional (did not include final Secondary Uses Services freeze).*

- *Source: Hospital Episode Statistic (HES).*

Patients waiting on a Referral to Treatment (RTT) pathway

Benchmarking data at 31 March 2020, 31 March 2022 and 31 March 2023

2022/23 compared to 2021/22	2022/23 compared to 2019/20
• Patients on an RTT waiting list at OUH increased by 26.3% from March 2021/22 to March 2022/23. This was higher than the 16.6% increase recorded nationally.	• The OUH RTT waiting list remained higher than pre-pandemic levels by 48.0%. This was better than the 75.8% increase recorded nationally.

Source: NHS England.

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

Benchmarking data at 31 March 2020, 31 March 2022 and 31 March 2023

2022/23 compared to 2021/22	2022/23 compared to 2019/20
• Patients waiting over 52 weeks on a RTT waiting list at OUH increased by 129.2% from March 2021/22 to March 2022/23. This increase recorded was higher than the national average which increased by 27.2%.	• There were 2,200 more patients waiting over 52 weeks on a RTT waiting list than at the end of 2019/20 (26 vs 2,226 patients). This was higher than the national average of 1,263 increase in patients waiting over 52 weeks at the end of 2019/20. The number of patients waiting over 52 weeks at OUH was lower than the national average at the end of 2019/20.

Source: NHS England.

Cancer performance

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Cancer referral treatment levels (all 62-day pathways)	n/a	3,021	2,918	3.5% more cancer activity
People waiting longer than 62 days on a cancer pathway	<120	205	226	21 fewer patients waiting
% meeting faster diagnosis standard (28 days)	≥75%	78.3%	78.8%	0.5 percentage point deterioration but above target
2WW[1] for suspected cancer standard	≥93%	74.2%	74.2%	No change
Breast Symptomatic Standard	≥93%	46.6%	31.4%	15.2 percentage point improvement
31-day Decision to First Treatment standard	≥96%	85.1%	90.5%	5.4% percentage point deterioration
31-day Decision to Subsequent Treatment (Radiotherapy) standard	≥94%	93.3%	86.0%	7.3% percentage point improvement
31-day Decision to Subsequent Treatment (Surgery) standard	≥94%	75.9%	80.2%	4.3 percentage point deterioration
31-day Decision to Subsequent Treatment (Drugs) standard	≥98%	97.8%	98.1%	0.3 percentage point deterioration
62-day Screening to First Treatment standard	≥90%	57.7%	70.2%	12.5 percentage point deterioration
62-day GP Referral to Treatment standard	≥85%	57.8%	69.7%	11.9 percentage point deterioration

Note:

1. 2WW - two week wait from referral.

In 2022/23 compared to 2021/22, OUH delivered 3.5% more cancer activity for our patients. On average, OUH achieved one out of the nine national standards. We achieved the 28-day Faster Diagnosis standard (78.3% vs 75%) and national benchmarking to the end of March 2023 and identified that the OUH performance was 8.0 percentage points better than the national average. The achievement of the 28-day Faster Diagnosis standard has been supported by the Trust's investment in increasing diagnostic capacity as well as capacity from the Community Diagnostic Centre.

The number of patients waiting more than 62 days on a cancer pathway for the GP standard reduced from 226 to 205 (21 fewer patients) but remained above the target of fewer than 120 patients by the end of March 2023. This should be seen in the context of a 15.2% increase in cancer referrals to two week wait pathways (including the Breast Symptomatic pathway) in 2022/23 compared to the previous financial year (+3,897 patient referrals).

The remaining Cancer 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 from capacity for some surgical treatments, diagnostics and oncology, late transfers to OUH from other providers and patient choice. We will also review our patient pathways and processes to ensure that these are as efficient as possible.

OUH cancer performance compared to national average

Benchmarking data from April to March 2019/20, 2021/22 & 2022/23

2022/23 compared to 2021/22	2022/23 compared to 2019/20
• OUH cancer performance for the 62-day standard from GP Urgent Referral to First Treatment was below the national average (57.8% vs 61.0%), and decreased by 11.9 percentage points, which was higher than the national decrease of 8.0 percentage points. • OUH cancer activity for all 62-day pathways increased in 2022/23 at a rate lower than the national average (3.5% vs 5.2%).	• Cancer performance for the 62-day standard from GP Urgent Referral to First Treatment fell by 10.9 percentage points, which was a smaller decrease than was recorded nationally (-16.2 percentage points). • OUH cancer activity for 62-day pathways is above pre-pandemic levels and the national average (16.0% vs 12.6%).

Cancer performance

Benchmarking data from April to March 2019/20, 2021/22 & 2022/23

2022/23 compared to 2021/22	2022/23 compared to 2019/20
• OUH 28-day Faster Diagnosis standard performance was 8.0 percentage points better than the national average (78.3% vs 70.3%). National performance decreased compared to 2021/22, by 1.7 percentage points, which was higher than the 0.5 percentage point decrease recorded at OUH between the financial years.	• n/a (the 28-day Faster Diagnosis standard was reported nationally from April 2021).

Source: NHS England.

Diagnostic activity

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Diagnostic activity levels (elective)	n/a	227,990	202,621	12.5% more diagnostic activity
Patients waiting under six weeks (DM01 national standard[1]	≥99%	92.4%	92.7%	0.3 percentage point deterioration

Notes:

1. *DM01 - National standard for Diagnostics Waiting Times and Activity.*

- *Source: NHS England*

An important part of elective treatment for patients includes diagnostic pathways. In 2022/23 compared to 2021/22, OUH provided 12.5% more elective diagnostic activity.

The standard measuring the number of patients waiting no more than six weeks was not achieved in 2022/23. Between the end of March 2021/22 and the end of March 2022/23, performance deteriorated from 92.7% to 92.4%. For the year 2023/24, the Trust has improvement programmes in place to address the performance in the diagnostic modalities not achieving the performance standard.

OUH diagnostic performance compared to national average

Benchmarking data from April to March 2019/20, 2021/22 & 2022/23

2022/23 compared to 2021/22	2022/23 compared to 2019/20
• OUH diagnostic activity increased at a lower rate compared to the national average in 2022/23 (9.8% vs 10.2%), including emergency and elective activity[1]. • Full year diagnostic performance against the standard measuring patients waiting within six weeks was 15.5 percentage points better than the national average (92.4% vs 76.6%).	• OUH diagnostic activity exceeded the volumes achieved in 2019/20 (13.2% higher compared to the national average of 13.8%)

Notes:

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

- *Source: NHS England.*

Urgent and emergency care

Emergency care

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Proportion of ambulance arrivals delayed over 30 minutes	n/a	9.8%	7.5%	2.3 percentage point increase (deterioration)
ED[1] attendances (all types)	n/a	174,479	172,101	1.4% increase in attendances
ED[1] attendances (type 1)	n/a	148,938	149,103	0.1% decrease in attendances
ED[1] performance within 4 hours (all types)	≥95%	62.1%	73.3%	11.2 percentage point deterioration
ED[1] performance within 4 hours (type 1)	≥95%	55.7%	69.2%	13.5 percentage point deterioration
Proportion of patients spending more than 12 hours in an Emergency Department	n/a	6.8%	4.4%	2.4 percentage point increase (deterioration)
Emergency admissions from ED[1]	n/a	90,379	88,551	2.1% increase in admissions
Proportion of patients discharged from hospital to their usual place of residence	n/a	94.6%	94.3%	0.3 percentage point increase

Note:

1. *ED - Emergency Department.*

Elective care is provided alongside non-elective activity, often sharing staff, medical equipment and physical locations. As such, services need to be planned to provide capacity for emergency attendances and admissions in addition to elective services, and therefore increases in emergency activity can create challenges to maximising elective activity and recovery.

In 2022/23, attendances at Emergency Departments and emergency admissions increased by 1.4% and 2.1% respectively, compared to 2021/22. The increase in ED attendances was consistent with the national experience in increasing emergency activity. OUH recorded attendances above pre-pandemic levels and at a level higher than the national average (5.7%

vs -4.1%). Reflecting the higher patient acuity at OUH, the growth in emergency admissions from ED was above pre-pandemic levels and also higher than the national average, which had not returned to pre-pandemic levels (+8.9% vs -7.4%).

In 2022/23, there was an increase in the acuity of patients, as evidenced by a higher number of co-morbidities and corresponding increase in length of stay in the hospital. In addition, the Trust recorded high numbers of patients medically fit in the hospital and whose discharge out of the hospital was delayed.

Performance within the ED, as measured using the national standard for the percentage of patients attending the ED for less than 4 hours from arrival to admission, transfer or discharge, was 62.1% for 'all types', and 55.7% 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 deteriorated compared to the previous year by 11.2 percentage points for 'all types' and by 13.5 percentage points for 'type 1' respectively.

Due to the increases in emergency activity and higher patient acuity, the percentage of patients waiting in the ED for more than 12 hours increased from 4.4% of patients in 2021/22 to 6.8% of patients in 2022/23 (+2.4 percentage points).

OUH Emergency care activity and performance compared to national average

Benchmarking data from April to March 2019/20, 2021/22 & 2022/23

2022/23 compared to 2021/22	2022/23 compared to 2019/20
• OUH ED[1] attendances increased in 2022/23 at a rate lower than the national average (1.4% vs 4.0%). • OUH emergency admissions from ED increased in 2022/23 at a rate higher than the national average (2.1% vs -4.1%). • ED performance was below the national average for 'all types' (62.1% % vs 70.8%), as well as the national average for 'type 1' attendances (55.7% vs 56.7%). • ED performance deteriorated further than the national average for all types of ED attendances (-11.2 percentage points vs -5.9 percentage points), and for 'type 1' attendances -13.5 percentage points vs -9.5 percentage points).	• OUH ED attendances for 'all types' was above pre-pandemic levels and at a level higher than the national average (5.7% vs -4.1%). • OUH recorded emergency admissions from ED above pre-pandemic levels and at a level higher than the national average, which had not returned to pre-pandemic levels (+8.9% vs -7.4%). • ED performance deteriorated further than the national average for all types of ED attendances (-13.8 percentage points vs -13.4 percentage points) and at a level similar to the national average for 'type 1' attendances (-15.6 percentage points vs -18.6 percentage points).

Notes:

1. *ED - Emergency Department*

- *Source: NHS England Emergency Department attendances*

Delivering safe, high-quality care

Mortality Indicators

Indicator	Target	2022/23[1]	2021/22	2022/23 compared to 2021/22
Summary Hospital-level Mortality Indicator (SHMI) range	<1	0.96 *(CL[2] 0.90-1.1)*	0.92 *(CL[2] 0.90-1.1)*	Statistically, 'as expected'
Hospital Standardised Mortality Ratio (HSMR) range	<100	93.7 *(CL[2] 89.8-97.8)*	93.1 *(CL[2] 89.1-97.3)*	Statistically 'Lower than expected' i.e. fewer deaths than expected

Notes:

1. *Data from January 2022- December 2022.*
2. *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 hospital. 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 84.5 (Confidence Limit 81.6 - 89.5), which is lower than expected.

Patient Safety

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
National Patient Safety Alerts not completed by deadline	0	0	0	No change

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 and near misses so that lessons can be learned to improve care.

Infection Prevention and Control

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia cases	0	4	4	No change in MRSA cases
Clostridium difficile cases	≤104	141	107	31.8% increase in cases. Target not achieved.
E.coli[1] bloodstream infection rate	161	208	168	23.8% increase in cases. Target not achieved.
Pseudomonas aeruginosa BSI[2]	57	56	53	5.7% increase in cases. Target achieved.
Klebsiella species BSI[2]	91	81	104	22.1% decrease in cases. Target achieved.

Notes:

1. *E.coli - Escherichia coli bloodstream Infections*
2. *BSI - Blood stream infection.*

The trajectories set for healthcare associated *Clostridium difficile* infection (CDI) and E.coli blood stream infection (BSI) were both exceeded this year. These figures are not adjusted for OUH activity levels. When adjusted by the number of discharges, to account for changes in activity volumes, the number of CDI cases for 2022/23 was 0.0082 cases/discharge, which is very similar to 2020/21 0.0084 cases/discharge, with the number of cases for 2021/22 was lower at 0.0064 cases/discharge. The winter period was especially challenging due to managing SARS-CoV-2 infection, Group A Streptococcus and influenza at the same time, and we saw an increase in sepsis alerts and consequent antimicrobial prescribing, which is the main risk factor for CDI.

A number of interventions designed to improve infection prevention and control and the clinical management of patients with diarrhoea were introduced at the beginning of January 2023, and will take time to produce results. These were communicated to Trust staff via safety messages, guideline updates and updates on MicroGuide. Antimicrobial Stewardship (AMS) rounds at the Churchill Hospital continue to correlate with low CDI rates on its site and AMS rounds are currently being introduced on all other Trust sites.

The national picture is similar. When comparing October to December 2022 with October to December 2019 (prior to the first wave of the COVID-19 pandemic), hospital-onset CDI cases increased by 24.2% from 14.4 to 17.9 cases per 100,000 bed days. The national increase is currently being explained by system pressures, and work is ongoing both across the Integrated Care Board (ICB) and nationally to look at any other possible contributory factors.

There are no clear themes or interventions to reduce the rate of rise of E.coli infections. The changes in patient demographics are likely to contribute to the increase. This is evidenced by an ageing population (18.6% of the total population 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. The nationally-set trajectories for Klebsiella species bloodstream infection (BSI) and Pseudomonas aeruginosa BSI were met.

Falls with harm (moderate and above)

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Number of falls with harm (moderate and above)	n/a	52	49	3 more patient falls with harm
Number of falls with harm (moderate and above) per 10,000 bed days	n/a	1.5	1.5	No change

The number of falls with harm (moderate and above) increased from 49 in 2021/22 to 52 in 2022/23 (+3 falls / +6.1%). Accounting for the increase in bed days recorded in 2022/23, the rate per 10,000 bed days was unchanged.

Reducing patient falls remains a priority for the Trust. This is reflected in a new Quality Priority for 2023/24 which focuses on strengthening training and implementation of the multifactorial falls risk assessment, addressing key areas for improvement identified in the most recent National Audit of Inpatient Falls and strengthening assessments and sharing learning following a fall.

WHO Surgical Safety Checklist compliance

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
WHO[1] Surgical Safety Checklist compliance - Observation	100%	99.8%	99.8%	No change
WHO[1] Surgical Safety Checklist compliance - Documentation	100%	99.9%	n/a *(not collected for full year)*	n/a

Note:

1. WHO - World Health Organization

The compliance against the WHO Surgical Safety Checklist for observation was unchanged in 2022/23 compared to 2021/22 and the WHO compliance achieved over the last three years has been maintained. WHO Checklist audits for documentation were not collected for the full year in 2021/22, therefore a comparison cannot be made to the 2022/23 performance.

Never Events

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Never Events[1]	0	5	4	1 additional Never Event reported

Note:

1. Serious patient safety incidents that are entirely preventable.

There were five Never Events reported in 2022/23 compared to four Never Events reported in 2021/22. All Never Events are investigated, and the report and learning and action plan are presented to the Chief Executive Officer and other Executives. Root cause analysis and learnings are shared with all Divisions and in the Trust's weekly safety messages for all staff.

Results endorsed within 7 days

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Results endorsed within 7 days	90%	82.2%	78.7%	3.5 percentage point improvement

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. Improving timely electronic results endorsement continued to be a Trust Quality Priority during 2022/23 leading to continued steady improvement in the proportion of results endorsed within 7 days. In 2022/23, there was a 3.5 percentage point improvement in results endorsed within 7 days compared to 2021/22 (82.2% vs 78.7%). However, performance fell below the internal target of 90%.

Hospital Acquired Pressure Ulcers (Category 3 and above)

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Hospital Acquired Pressure Ulcers (HAPUs) Category 3 and above per 1,000 admissions	0.035%	0.03%	0.05%	40% reduction (achieved target)
Number of Pressure Ulcers	n/a	1,556	1,751	195 fewer incidents

A strategic and collaborative approach to reducing harms associated with acquired pressure damage has resulted in a marked reduction in the incidents of Hospital Acquired Pressure Ulcers (HAPUs), which was an OUH Quality Priority in 2022/23.

HAPU incidents Category 3 and above were all reviewed, and improvement plans agreed where appropriate. This approach to reducing harms associated with acquired pressure damage (Category 3 and above) has resulted in a 40% decrease in the incidence per 1,000 admissions, from 0.05% in 2021/22 to 0.035% in 2022/23, achieving the Trust Quality Priority target (which was set at a 30% improvement).

Reducing violence and aggression against staff

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Incident rate[1] of violence and aggression (rate per 10,000 bed days)	n/a	44.61	38.34	16.4% increase in incident rate
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[2]	n/a	75.5%	76.1%	0.6 percentage point decrease

Notes:

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

Sadly, the Trust has seen a 16.4% increase in reported violence and aggression incidents against staff recorded within our incident management system. This was also reflected in responses to the question 14a of NHS Staff Survey (as described above) where the percentage decreased from 76.1% in 2021/22 to 75.5% in 2022/23 (0.6 percentage point decrease).

Staff safety and experience are taken very seriously by the Trust. The Trust has taken action to address this issue by launching a 'No Excuses' campaign aimed at patients and the public, introducing body worn body cameras in our Emergency Departments, distributing Lone worker devices and introducing a new Quality Priority focusing on this issue. Trust staff are encouraged to report verbal as well as physical abuse.

People

In 2022/23, our people enabled the delivery of large increases 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	2022/23	2021/22	2022/23 compared to 2021/22
Sickness absence rate	3.1%	4.3%	4.3%	No change
Total number of permanent staff (average WTE)	n/a	12,854	12,676	1.4% increase
Staff turnover	≤12.0%	11.4%	12.4%	1.0 percentage point decrease
Core Skills Training	≥85.0%	90.2%	88.0%	2.2 percentage point improvement
Appraisals (non-medical)	≥85.0%	94.2%	65.0%	29.2 percentage point increase
Employee Engagement Index (EEI) Staff Survey	n/a	7.0/10	7.0/10	No change
Staff morale	n/a	5.8/10	5.9/10	0.1 point decrease

The prevalence of COVID-19 in our community continued in 2022/23. As a result, the sickness absence remained high, with a 4.3% sickness absence rate. Reasons for absence predominately included COVID-19. Other forms of sickness absence included mental health categories, such as stress and anxiety. Throughout 2022/23, the Trust continued to support staff safety and wellbeing through the use of risk assessments and targeted initiatives to assist staff.

The size of the workforce, as measured by average Whole Time Equivalents (WTE) of staff, increased by 1.4% in 2022/23 compared with 2021/22 (12,854 vs 12,676 WTE staff). The increase in the number of staff has been essential to help support the delivery of patient care in response to the challenges created by the emergency demand.

The Trust achieved its target for Core Skills Training, improving by 2.2 percentage points in 2022/23 compared to 2021/22. Core Skills Training is an important marker of compliance in essential modules relating to patient and staff safety, and other essential requirements for staff roles.

In 2022/23 the targets for staff turnover and appraisals (non-medical) were also achieved. Staff turnover, which had been historically low during the early part of the COVID-19 pandemic, had been steadily decreasing in 2022/23. In March 2023, staff turnover was 11.4%, which was a 1.0 percentage point lower compared to 2021/22 and below the 12% target. Staff appraisal (non-medical) compliance was 94.2% in March 2023, achieving the Trust target and improving by 29.2 percentage points from the position in 2021/22. Appraisal compliance has been supported by the introduction of a new online appraisal system and a specific appraisal window to improve compliance alongside providing and supporting patient care.

Staff Survey engagement scores remained unchanged in 2022/23 (7.0 out of a score of 10). This was above the benchmarked national average of 6.8. The staff morale score for 2022/23 was 5.8 out of a score of 10. This was above the benchmarked national average of 5.7 and a

minor decline from the 2021/22 morale score of 5.9. Reductions in staff morale score were also noted nationally in 2022/23.

Belonging in the NHS

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Proportion of BAME[1] staff in senior leadership roles[2]	n/a	4/19[3]	2/18	Increase of 2 BAME staff in senior leadership roles
Proportion of women in senior leadership roles[2]	n/a	12/19[3]	10/18	Increase of 2 female staff 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	55.3%	55.8%	0.5 percentage point decrease

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 have been identified as Board level positions. In 2022/23 compared to 2021/22, the number of staff in senior leadership roles from a BAME (Black, Asian and Minority Ethnic) background increased by two people. Four staff from a 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 increased by two in 2022/23. The majority of senior leadership roles at OUH are held by women (56%), but this is less than the proportion of women in overall workforce (75%). The NHS staff survey response to the question asking whether the organisation 'act(s) fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age', decreased by 0.5 percentage points from 55.8% in 2021/22 to 55.3% in 2022/23.

Finance and use of resources

Income and expenditure

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Turnover £m	1,401	1,512	1,403	7.8% increase (commissioner funding, including enhanced pay awards)
Surplus/(deficit) as measured in the Annual Accounts £m	n/a	-5.5	-17.7[1]	0.8% improvement relative to turnover
Financial performance as measured by the NHS £m	Break-even	0.1	3.3	Break-even target achieved
Financial performance vs plan £m	£1.3	-1.2	8.7	113.8% decrease in performance to under performance
Underlying financial position £m	Break-even	-66.0	-51.7	27.7% deterioration in underlying financial position
Run rate – total expenditure £m	1,361.7	1,483.3	1,387.6[1]	6.9% increase in expenditure and 8.9% above plan

Note:

1. Updated prior year adjustment.

The Trust has a turnover of £1.5bn which is 7.8% higher than in 2021/22 due to inflation linked increases in funding, particularly in respect of the one-off element of the pay deal for staff paid under Agenda for Change and also targeted increases in funding for growth and service development.

In 2022/23, the Trust reported a deficit of £5.5m in its Annual Accounts versus an updated £17.7m deficit in 2021/22. 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. Also adjusted is the impact of Personal Protective Equipment (PPE) donated to the Trust. Adjusting for such items, the Trust made a control total surplus of £0.1m in 2022/23 compared to a control total surplus of £3.3m in 2021/22.

The NHS statutory legislation expects Integrated Care Boards (ICBs) and NHS Trusts to deliver a break-even control total financial performance. This was achieved in 2022/23.

In the last two years, financial performance was favourable to the deficit of £12.8m reported in 2019/20. This was principally because of additional funding made available to the NHS during and since the COVID-19 pandemic. No information is yet available on the financial performance of other NHS providers in 2022/23.

The surplus as measured by the NHS was £0.1m. However, this was £1.2m less than planned for by the Trust. The year 2022/23 was challenging for the Trust as it worked to increase volumes of activity through the Elective Recovery Plan. This was in the context of ongoing high levels of staff sickness due to COVID-19 particularly in the first half of the year and an increase in the average length of stay for non-elective patients. Both of these factors led to higher than planned levels of pay expenditure. Non-pay expenditure remained stable due to robust arrangements in place for procurement of goods and services and a fixed price contract for energy signed in 2020.

The underlying financial position of the Trust, which reflects the position after any one-off income or expenditure has been removed, showed a deterioration of 27.7% to an underlying deficit of £66m. 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.

Total expenditure in 2022/23 was £1,483.3m compared with a planned figure of £1,361.7m. The increase in expenditure was due to the increased costs faced by the Trust as a result of inflation, pay awards, dealing with costs arising from industrial action and increasing capacity for additional activity. The comparable expenditure figures are updated £1,387.6m for 2021/22, £1,296.5m for 2020/21 and £1,142.3m for 2019/20. This is a 6.9% increase in the last year and reflects the financial consequences of the increase in staff numbers, an average of 4.1% pay award with potential lump sum and meeting the costs of increased activity.

Capital spending

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Overall level of capital expenditure £m	60	46.6	67.1	30.6% reduction in year
Capital expenditure charged to ICS[1] CDEL[2] £m	30.9	27.5	40.2	31.6% reduction in year
Overall level of capital expenditure vs plan £m	60	-13.4	-0.9	£12.5m increase in underspend
Capital[3] spend vs ICS[1] plan £m	30.9	-3.4	7.1	(2021/22 21.4% overspend against a plan of £33.1m)

Notes:

1. *ICS - Integrated Care System.*
2. *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.*
3. *Capital measured as ICS CDEL.*

The Trust invested £46.6m in capital expenditure from all funding sources during 2022/23 compared to the investment of £67.1m in 2021/22. The largest items of capital investments were the John Radcliffe Hospital's theatre upgrade work, equipment replacements and digitalisation, together with life-cycling the Private Finance Initiatives (PFIs), including the managed equipment service at the Churchill Hospital. The reduction from 2021/22 reflects fewer large projects. No information is available on the capital investment of other NHS providers in 2022/23.

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 Capital Departmental Expenditure Limit (ICS CDEL). Capital spending against this budget for the year was £27.5m which included the items referred to above with the exception of PFI life-cycling.

Overall capital expenditure for the Trust was £13.4m below plan, with an underspend of £3.4m by the Trust on ICS CDEL projects. The balance of the underspend was due to a shortfall in PFI life-cycle expenditure and less expenditure on IFRS16 (International Financial Reporting Standard) Right of Use Assets. The Trust's spending was aligned with the draft Joint Forward Plan of Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS).

Cash

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Cash as of 31 March 2023 £m	n/a	32.6	57.3	43.1% deterioration but 1.5% better than planned
Cash vs plan as of 31 March 2023 £m	31.8	0.8	10.1	2.5% positive variance on plan (plan for 2021/22 £47.2m)

The cash balance of the Trust on 31 March 2023 was £32.6m compared to £57.3m on 31 March 2022. Cash decreased primarily in the early months of 2022/23 as suppliers were paid for capital spending in the final months of 2021/22.

Patient experience: Learning from patient feedback and complaints

OUH aims to be a learning organisation, and patient feedback is a highly valued source of information about where we have done well and where we can improve. Performance is reported by the Friends and Family Test (FFT), which is a national programme to enable Trusts to seek feedback from patients, their friends and family, and act on it, as well as by local surveys.

Friends and Family Test (FFT): survey results on positive responses

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
Inpatient	>=95%	95.2%	94.6%	0.6 percentage point improvement
Outpatient	>=95%	93.3%	93.6%	0.3 percentage point deterioration
Emergency Department (ED)	>=95%	76.3%	77.2%	0.9 percentage point deterioration
Maternity	>=95%	87.4%	79.4%	8 percentage point improvement

The FFT feedback for positive responses was higher in 2022/23 within inpatient and Maternity Services. Positive themes identified from the FFT included reports of staff attitude, how care was implemented, and themes related to patients' admission to the hospital. Areas for improvement raised via negative themes included waiting times, discharge, cancelled admissions or procedures and car parking. These issues align with complaints and the Trust's operational performance as described in this report. Outpatient and Emergency Department (ED) FFT scores deteriorated in 2022/23 compared to 2021/22.

National benchmarking information, measured from April to February 2022/23, identified that OUH had similar levels of positive response rates to the national average, except for Maternity where the differential was greater. For inpatients, the positive responses were slightly higher than the national average (95.2% vs 95.1%), but lower for outpatients (93.3% vs 93.9%), ED (75.9% vs 77.1%) and Maternity (87.5% vs 92.1%).

Feedback and response rates were reviewed and reported weekly to identify and respond to common themes (or topics). This analysis was distributed to the Incidents, Complaints, Claims, Safeguarding, Inquests and Scrutiny (ICCSIS) triangulation group, as well as to Divisional and corporate leads. A summary and thematic analysis is distributed each month as part of the Integrated Performance Report (IPR), which is reviewed by the Trust Board and Integrated Assurance Committee.

Patient Advice and Liaison Service (PALS) and complaints handling

The Trust's Patient Advice and Liaison Service (PALS) team supports patients, relatives, carers and service users to raise informal concerns and requests for advice in a confidential and impartial manner. The team aims to resolve enquiries as quickly as possible, in the most appropriate manner for the enquirer. PALS works closely with the Trust's Complaints team, enabling issues to be escalated to a formal investigation when required.

The table below shows the last two years' PALS and Complaints teams' performance.

Indicator	Target	2022/23	2021/22	2022/23 compared to 2021/22
PALS cases	n/a	2,365	2,621	9.8% decrease
Complaints	n/a	1,238	1,095	13.1% increase
Complaints upheld by the Parliamentary & Health Services Ombudsman (PHSO)	n/a	nil	nil	n/a
Complaints acknowledged within 3 working days	≥95%	100%	100%	No change
Complaints responded to in 40 working days	≥95%	68.7%	68.0%	0.7 percentage point improvement

PALS cases decreased in 2022/23 by nearly 10% compared to 2021/22, but formal complaints received by the Trust increased by 13% in 2022/23 compared to the previous year.

The Trust responded to 68.7% of complaints received within 40 working days in 2022/23, which was an improvement compared to the previous year by 0.7 percentage points. In the latter part of the financial year, OUH recorded improvements in the timeliness of complaints responded to, and the reported position for March 2023 was 80.0%. This demonstrates the Trust's commitment to addressing formal complaints in a timely manner despite workload pressures.

Tackling health inequalities

The OUH Health Inequalities Programme was set up in June 2022 to systematically identify inequalities of access, experiences and outcomes across our services, and to address these through focused action, both internally and in partnership with other organisations. The work is overseen by a Health Inequalities Steering Group which works towards three main objectives:

- applying 'Core20PLUS5' frameworks for adults and children across our services and key populations (Core20PLUS5 is an NHS England approach to support reduction of health inequalities at both national and system level)
- ensuring that action is taken to address health inequalities in our approach to elective recovery
- building longer-term capability to promote reduction of health inequalities and improving population health through working with partners in our local systems, developing population health management and recognising our role as an 'anchor institution'.

During the year 2022/23, the Trust delivered on actions to facilitate access to standardised data on health inequalities using information from our elective waiting lists, cancer waiting

times, outpatient cancellations and non-attendances, attendances in the Emergency Department and emergency admissions. The Trust also established governance structures that support an aligned programme of work across the Trust. A focused programme of quality improvement work is underway in Maternity Services as a national priority clinical area for long-term impact on health inequalities.

Equality of service delivery to different groups

OUH aims to be inclusive for all patients, their families and carers. OUH has responded by increasing the focus on Equality, Diversity and Inclusion (EDI) to promote the delivery of equality of service further. Updates on the equality of service delivery are provided to the Trust Board via the monthly Trust Integrated Performance Report on complaints and patient experience, and the Annual Report on Patient Engagement, Patient Experience, Patient Advice and Liaison Service, and Complaints.

The Trust's EDI objectives were guided by staff and patient surveys, as well as by analysis conducted on workforce and patient demographic data to reflect the needs of our people, our patients and our populations. The objectives also align with local and national policy, such as the NHS People Plan and other local and national policy drivers, and included in the OUH Strategy 2020-2025 and the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) EDI Strategy.

The Trust seeks to engage its patient population to meet the needs of everyone and undertakes work to mitigate any issues identified. To increase its ability to reach all communities, the Trust has been developing relationships with partners in the local healthcare system, as well as other organisations such as Healthwatch Oxfordshire and the Academic Health Science Network (AHSN), so that a coordinated approach can be taken to engagement across the system.

Key achievements for 2022/23 include improving patient/carer information by collaborating with Carers Oxfordshire to develop an ID card which enables carers to access additional support from the Trust and Carers Oxfordshire. Additionally, we have improved patient information by completing a comprehensive stocktake of the patient information in Maternity Services, ensuring all new information meets the Public Sector Bodies (Websites and Mobile Applications) Accessibility Regulations 2018. The stocktake will continue across the Trust in 2023/24.

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 to different groups,' 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.

Building a Greener OUH

In January 2022, the Trust launched our Green Plan, 'Building a Greener OUH', outlining our commitment to sustainability and putting the Trust on a path to achieving net zero carbon emissions by 2040, for emissions over which we have direct responsibility, in line with NHS England's carbon neutral target.

The Trust is a member of the Zero Carbon Oxford Partnership, working in collaboration with other major organisations and businesses to achieve net zero carbon emissions in the city of Oxford by 2040.

OUH Carbon footprint

In November 2022, NHS England published, for the first time, the estimates of our Trust's emissions contribution to the NHS Carbon Footprint Plus in 2019/20, as shown below:

OUH Carbon Footprint 2019/20	**56,924**	**tCO_2e**
Building energy	45,775	tCO_2e
Waste	940	tCO_2e
Water	477	tCO_2e
Anaesthetic gases	4,362	tCO_2e
Inhalers	157	tCO_2e
Business travel and fleet	5,213	tCO_2e
Personal travel	**24,781**	**tCO_2e**
Staff commuting	9,108	tCO_2e
Patient travel	10,083	tCO_2e
Visitor travel	5,590	tCO_2e
Medicines, medical equipment and other supply chain	**138,966**	**tCO_2e**
Medicines and chemicals	52,681	tCO_2e
Medical equipment	33,893	tCO_2e
Non-medical equipment	9,019	tCO_2e
Other supply chain	43,373	tCO_2e
Commissioned health services outside NHS	**839**	**tCO_2e**
OUH Carbon Footprint Plus	**221,510**	**tCO_2e**

Note:

- *Nationally estimated figures for the Trust provided by NHS England are shown in the table above.*

Decarbonisation initiatives to date

The Trust has implemented the following decarbonisation initiatives to date.

- Installed nearly 24,000 LED lights across our sites that will save 563 tonnes/year of CO_2e and £450,000 a year on energy bills.
- Designed our new Radiotherapy Centre in Swindon to use LED lights throughout and have solar PV panels which generate 30,000kWh annually.
- Worked with partners in primary care to update the Oxfordshire guidelines for Asthma and Chronic Obstructive Pulmonary Disease (COPD) to ensure that patients are offered lower carbon inhalers where appropriate.
- Eliminated desflurane in anaesthetics from our standard practice and across our outpatient services.
- Reduced our use of paper appointment letters sending more than one million appointment letters digitally instead of using paper.
- Established a partnership with a local cycle courier service for delivering patient-specific medicine, such as for chemotherapy and antibiotics, to the John Radcliffe and Churchill hospitals, to reduce supply chain emissions, which has also halved delivery times. We also have an electric van, and electric cycles will be soon introduced with another local courier service.
- Made no use of fossil fuels for primary heating, having installed a combined heat and power plant to heat our hospitals in Oxford, that has been operational since 2017, and our hospital in Banbury does not use fossil fuels.
- Purchased all electricity across Trust sites from 100% renewable sources, as such, backed by Renewable Energy Guarantees Origin (REGO) since 1 April 2021.
- Supported our staff to make sustainable travel choices, either via the Cycle2Work scheme or car salary sacrifice scheme for lower and ultra-low emission vehicles (94% of cars leased via this scheme are ultra-low emission vehicles). We also provide a 30% subsidy for bus passes and in 2022/23, we supplemented this with a further £250 allowance per staff member towards the cost of public transport or a cycle.
- Reduced wastewater and water usage by sourcing a new supplier with contractual access to supplier expertise with developing the Trust Water Policy, an online portal providing real time information from automatic meter reading technology to monitor consumption, reports to assist with operational management, raising queries, viewing historic bills, water audit site surveys, benchmarking and supplier alerts in the event of high consumption.
- Committed to reduce our single use products across our sites and replace them with reusable alternatives, and being transparent where this is not feasible.
- Contracted with a supplier to refurbish and return used equipment such as walking aids and have established community drop-off points for patients.
- Completed an extensive programme of improving data quality on utilities consumption. All fiscal electricity, gas and water supplies now have high-quality data. This means that utilities can be constantly monitored and erroneous data investigated more effectively,

which in turn can lead to a cut in consumption and therefore reduce carbon emissions (CO_2e) and water waste. Accurate data will support the compilation of our greenhouse gases inventory over the coming year.

Future decarbonisation at OUH

During 2022/23, the Trust successfully bid for a significant programme of work that will help us considerably reduce our carbon footprint and deliver financial savings. A total of £37.3m will be invested into installing low-carbon energy and implementing decarbonisation measures at the John Radcliffe and Horton General hospitals' retained estate over the coming three years, reducing the carbon emission of the Trust by an estimated 4,000 tonnes of carbon (tCO_2e) every year.

The project involves the two hospitals being 'de-steamed', with the existing steam network to be decommissioned and replaced with new, cleaner and more efficient pipework that will be heated by substituting heat supplied from gas boilers with low-carbon electric heat pumps.

The Trust will adopt a whole building approach that includes other energy efficiency works such as insulation, solar photovoltaic (PV) panels, reglazing and draught proofing much of the older parts of the John Radcliffe and Horton General hospitals.

In addition, by implementing these measures, we are expecting additional benefits such as:

- significantly improved energy efficiency
- reduced carbon emissions and lower carbon footprint
- easier and more efficient temperature control of buildings
- reduction in water consumption
- lower water treatment costs
- decreased operational and maintenance costs
- reduced backlog maintenance.

This project will be funded by a £29.8m grant as part of the Government's Public Sector Decarbonisation Scheme (PSDS), which supports the aim of reducing emissions from public sector buildings (not Private Finance Initiative (PFI) buildings).

A total of £24.1m has been allocated to the John Radcliffe Hospital and £5.7m allocated to the Horton General Hospital. The Trust will invest £7.5m towards the wider scheme, taking the total expenditure to £37.3m over a three-year period.

Risk Profile of the Trust

As set out in the Annual Governance Statement of this Annual Report, the Board Committees have reviewed the Corporate Risk Register regularly during 2022/23. 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 of the Trust to manage internal bed capacity to sustain waiting list reduction and the impact on patients waiting longer for care (including those waiting longer than 104 weeks)
- the ability to recruit, retain and engage staff and the impact of staff sickness, and the need to use bank and agency staff on service delivery
- the growth in costs, particularly to address operational pressures and staff sickness, 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 limited access to capital funding and the potential impact of the Trust's ability to spend all its capital funding on service delivery, including the digital infrastructure and resilience.

These 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 became more certain and the level of the risk score decreased towards the year end. Conversely, as the outcome of the Trust's operational delivery towards the year end became more certain, particularly in relation to the achievement of the cancer targets, the level of risk remained high.

The following table shows our highest scoring risks, extracted from our Corporate Risk Register.

#	Summary Risk Description	Risk Scores (higher score is higher risk)				
		Q1	Q2	Q3	Q4	Target
1	As a result of costs being greater than planned and greater than total income, there is a risk that there may be a failure to deliver the in-year financial plan that might reduce the funds available for capital expenditure, leading to increased scrutiny by the Integrated Care System (ICS) and NHS England and ultimately requiring emergency cash funding from the Department of Health and Social Care (DHSC) so that the Trust can maintain solvency.	16	16	20	12	8
2	As a result of productivity levels that are insufficient to cover costs-based national average funding levels, there is a risk that there may be an inability to break-even over 3-5 years that might affect the Trust's ability to sustain safe, compliant and effective provision of healthcare.	12	20	20	20	4
3	Due to the introduction of new clinical standards for Emergency Department (ED) waiting times, there could be a	12	15	15	15	9

#	Summary Risk Description	Risk Scores (higher score is higher risk)				
		Q1	Q2	Q3	Q4	Target
	risk to the organisation's performance of the national urgent care targets affecting patient experience.					
4	High bed occupancy and low staffing capacity means there is a risk to our ability to achieve expected delivery levels in line with elective recovery plan that could lead to potential harm for patients.	15	15	15	15	6
5	Due to issues with diagnostic capacity, there is a risk to our ability to reduce the current backlog of patients waiting for cancer diagnosis and treatment that might cause patient harm.	16	16	16	16	6
6	As a result of the reliance on the internal staff bank there is a risk we will not be able to ensure sufficient temporary staffing to sustain services and maintain the wellbeing of our own staff, which affects patient safety.	12	16	16	16	9
7	Due to persistent increased workloads there is a risk that sickness absence levels continue to rise, and that staff will suffer increased levels of mental ill health affecting staff turnover levels.	16	16	16	16	9

The underlying cause of the majority of the principal risks included in the Corporate Risk Register link 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 that have been set out in the Annual Governance Statement that includes the year one implementation of the Trust's People Plan, the development and support of 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, for example the development of the new Integrated Care System arrangements and the changes in the national NHS Contract in relation to 104% and 110% stretch targets.

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

- ***OneTeamOneOUH - Past, Present, Future*:** the Trust published an eBook *OneTeamOneOUH - Past, Present, Future* on 30 June 2022. The eBook is structured around the three key elements of our OUH Strategy – Our People, Our Patients and Our Populations. It has been published at issuu.com/ouhtrust/docs/pastpresentfuture.
- ***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 2023.
- ***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
28 June 2023

Accountability Report

The Accountability Report of Oxford University Hospitals NHS Foundation Trust's Annual Report 2022/23 comprises the following reports.

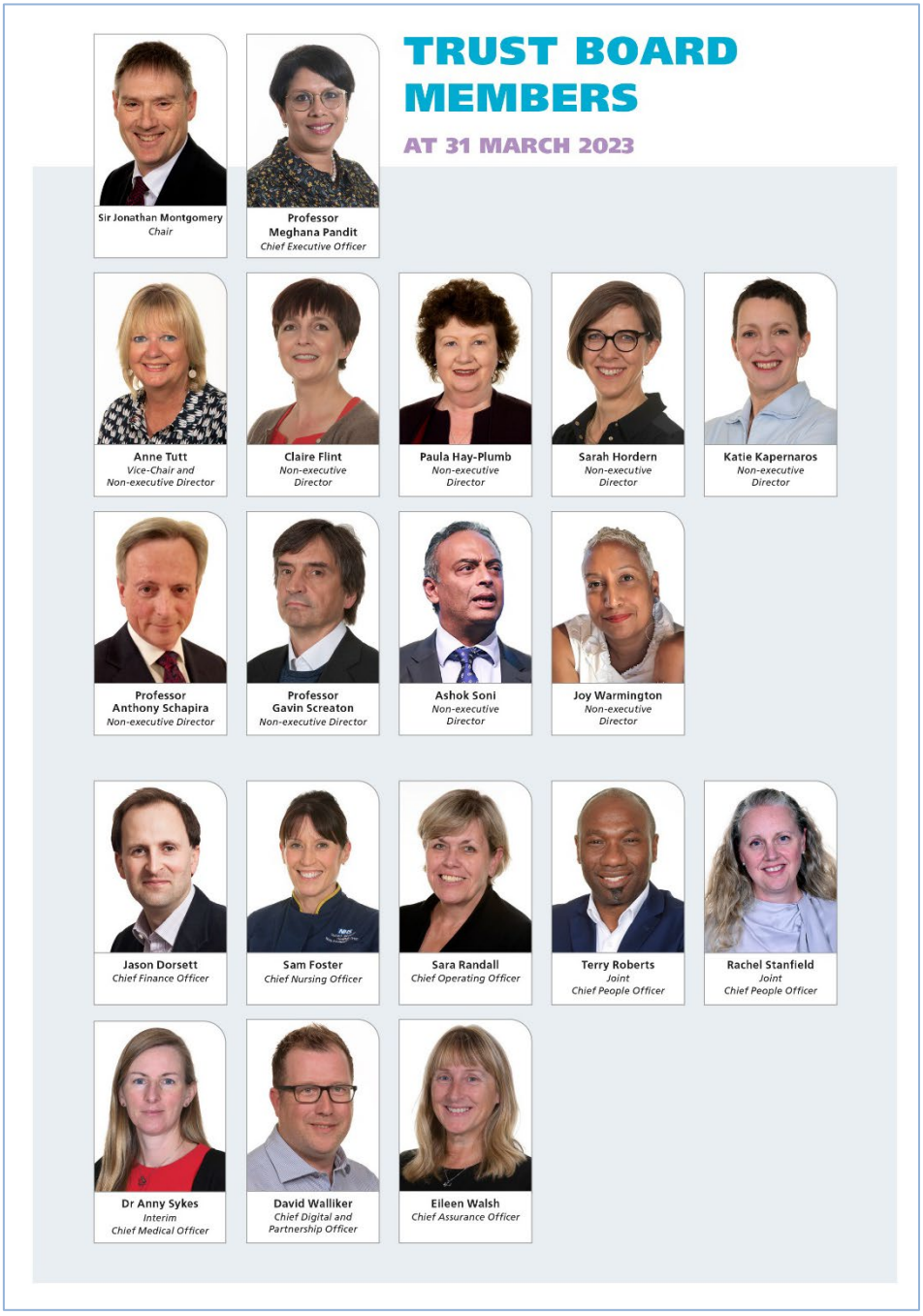
- Directors' Report
- Trust Membership and Council of Governors
- Remuneration Report
- Staff Report
- NHS Foundation Trust Code of Governance Compliance
- NHS Oversight Framework
- Statement of Accounting Officer's Responsibility
- Annual Governance Statement

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 proper 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, NHS England's NHS Foundation Trust Code of Governance, 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 2023.



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

Non-Executive Directors

Professor Sir Jonathan Montgomery, *Trust Chair*
Ms Anne Tutt, *Vice-Chair and Senior Independent Director*
Ms Claire Flint
Ms Paula Hay-Plumb OBE
Ms Sarah Hordern
Ms Katie Kapernaros
Professor Anthony Schapira
Professor Gavin Screaton
Professor Ashok Soni
Ms Joy Warmington

Executive Directors

Professor Bruno Holthof, *Chief Executive Officer (to 30 June 2022)*
Professor Meghana Pandit, *Chief Executive Officer (fixed term from 1 July 2022 to 28 February 2023 and substantive from 1 March 2023)*[1]
Mr Jason Dorsett, *Chief Finance Officer*
Ms Sam Foster, *Chief Nursing Officer (to 31 March 2023)*
Ms Sara Randall, *Chief Operating Officer*
Mr Terry Roberts, *Joint Chief People Officer (from 1 August 2022 to 31 March 2023)*[2]
Ms Rachel Stanfield, *Joint Chief People Officer (from 1 August 2022 to 31 March 2023)*
Dr Anny Sykes, *Interim Chief Medical Officer (from 1 July 2022)*
Mr David Walliker, *Chief Digital and Partnership Officer*
Ms Eileen Walsh, *Chief Assurance Officer*[3]
Ms Clare Winch, *Acting Chief Assurance Officer (from 1 April to 30 October 2022)*[4]

Notes:
1. *Chief Medical Officer to 30 June 2022.*
2. *Chief People Officer to 31 July 2022.*
3. *Medical absence to 31 August 2022 with phased return to 30 October 2022.*
4. *Cover for medical absence and supporting phased return of Chief Assurance Officer.*

All members of the Board are voting members. The two Joint Chief Officers who were in post during the period 1 August 2022 to 31 March 2023, shared one vote between them.

All the Non-Executive Directors of the Board are considered to be independent in accordance with the NHS Foundation Trust Code of Governance 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.

The current periods of office of the Non-Executive Directors and their terms since the Foundation Trust (FT) status are provided below.

Name	Date of initial appointment	Period of office	Term since FT status
Professor Sir Jonathan Montgomery	01/04/2019	01/04/2022 - 31/03/2025	2
Ms Anne Tutt[1]	01/10/2015	01/12/2021 - 30/11/2023	4
Ms Claire Flint	01/05/2019	01/05/2022 - 30/04/2025	2
Ms Paula Hay-Plumb OBE	04/09/2017	04/09/2020 - 03/09/2023	2
Ms Sarah Hordern[2]	28/10/2019	28/10/2022 - 27/10/2025	2
Ms Katie Kapernaros[2]	28/10/2019	28/10/2022 - 27/10/2025	2
Professor Anthony Schapira[2]	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	06/04/2021	06/04/2021 - 05/04/2024	1
Ms Joy Warmington	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.*
2. *Re-appointed for a further three-year term by the Council of Governors on 13 April 2022.*

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

Board development

During 2022/23, the Board continued to participate in a development programme which included seminars providing training and development, as well as opportunities to explore specific issues in more detail than is possible in the context of formal Board meetings. Topics during this year included strategic planning in the context of a changing system landscape, Board development on optimising the use of data and the development of the Clinical Strategy. Seminars were also held on Maternity Services, health inequalities, financial planning and cancer research.

The performance of all Board members has been appraised during the 2022/23 financial year. The Trust Chair was appraised by the Vice-Chair in her capacity as Senior Independent Director, via a process that was agreed with the Governors' Remuneration, Nominations and Appointments Committee, involving a range of key stakeholders.

Board meetings

The Board met six times in public during the year 2022/23. The table below shows the attendance of the Board members at Board meetings.

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

Notes:

1. *Chief Executive Officer to 30 June 2022.*
2. *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).*
3. *Chief Nursing Officer to 31 March 2023.*
4. *Chief People Officer to 31 July 2022 and Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
5. *Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
6. *Interim Chief Medical Officer from 1 July 2022.*
7. *Medical absence to 31 August 2022 with phased return to 30 October 2022.*
8. *Acting Chief Assurance Officer from 1 April 2022 to 30 October 2022, covering medical absence and supporting phased return of Chief Assurance Officer.*
9. *Apologies for absence were given.*
10. *Represented by a nominated deputy, whilst in post as Chief Medical Officer.*
11. *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 2022/23 is included in the Annual Governance Statement of this Annual Report. Attendance at each committee is noted below.

Integrated Assurance Committee

The Integrated Assurance Committee was chaired by Professor Sir Jonathan Montgomery and met six times during 2022/23. The attendance of core members is detailed below.

Committee member	Position	Attendance
Professor Sir Jonathan Montgomery (Chair)	Trust Chair	5/6[10]
Professor Bruno Holthof[1]	Chief Executive Officer	2/2
Professor Meghana Pandit[2]	Chief Executive Officer	5/6[10]
Ms Anne Tutt	Vice-Chair and Non-Executive Director	5/6[10]
Ms Claire Flint	Non-Executive Director	3/6[10]
Ms Paula Hay-Plumb OBE	Non-Executive Director	6/6
Ms Sarah Hordern	Non-Executive Director	6/6
Ms Katie Kapernaros	Non-Executive Director	6/6
Professor Anthony Schapira	Non-Executive Director	5/6[10]
Professor Gavin Screaton	Non-Executive Director	5/6[10]
Professor Ashok Soni	Non-Executive Director	4/6[10]
Ms Joy Warmington	Non-Executive Director	4/6[10]
Mr Jason Dorsett	Chief Finance Officer	6/6
Ms Sam Foster[3]	Chief Nursing Officer	4/6[9]
Ms Sara Randall	Chief Operating Officer	5/6[9]
Mr Terry Roberts[4]	Joint Chief People Officer	3/6[10]
Ms Rachel Stanfield[5]	Joint Chief People Officer	3/4[10]
Dr Anny Sykes[6]	Interim Chief Medical Officer	4/4
Mr David Walliker	Chief Digital and Partnership Officer	5/6[10]
Ms Eileen Walsh[7]	Chief Assurance Officer	3/3
Ms Clare Winch[8]	Acting Chief Assurance Officer	2/3[9]

Notes:

1. *Chief Executive Officer to 30 June 2022.*
2. *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).*
3. *Chief Nursing Officer to 31 March 2023.*

4. *Chief People Officer to 31 July 2022 and Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
5. *Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
6. *Interim Chief Medical Officer from 1 July 2022.*
7. *Medical absence to 31 August 2022 with phased return to 30 October 2022.*
8. *Acting Chief Assurance Officer from 1 April 2022 to 30 October 2022, covering medical absence and supporting phased return of Chief Assurance Officer.*
9. *Represented by a nominated deputy.*
10. *Apologies for absence were given.*

Audit Committee

The Audit Committee was chaired by Ms Paula Hay-Plumb OBE and met five times during 2022/23. The attendance of core members is listed below.

Committee member	Position	Attendance
Ms Paula Hay-Plumb OBE (Chair)	Non-Executive Director	5/5
Ms Anne Tutt	Vice-Chair and Non-Executive Director	5/5
Ms Katie Kapernaros	Non-Executive Director	4/5[1]

Note:

1. *Apologies for absence were given.*

Investment Committee

The Investment Committee was chaired by Ms Anne Tutt and met eight times during 2022/23. The attendance of core members is listed below.

Committee member	Position	Attendance
Ms Anne Tutt (Chair)	Vice-Chair and Non-Executive Director	8/8
Ms Sarah Hordern	Non-Executive Director	7/8[1]
Professor Anthony Schapira	Non-Executive Director	4/8[1]
Mr Jason Dorsett	Chief Finance Officer	8/8
Ms Sam Foster	Chief Nursing Officer	3/8[1]
Mr David Walliker	Chief Digital and Partnership Officer	7/8[1]

Note:

1. *Apologies for absence were given.*

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.

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

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 2022/23, the Trust continued to focus on compliance with the well-led framework. To maintain a well-led organisation and ensure staff and patients remained safe against the context of continuing COVID-19 infections and other respiratory diseases, the Trust Board continued to review all available guidance and advice in managing capacity and maintained responsive Board governance arrangements to support the management of the Trust's operational and strategic planning.

Actions taken during 2022/23 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
- continuing to implement actions identified from the financial governance review, supported by the consultancy firm Grant Thornton
- 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
- developing and monitoring of specific action plans to address the findings of the two reports commissioned by the Trust on culture in Maternity Services and in the neonatal service.

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, the Corporate Governance Statement and 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. The CQC carried out one new inspection on an individual service provided by the Trust during the year 2022/23 and the results were published in April 2023. The issues in the CQC inspection report will result in an action plan that is due to be reported through the governance structures of the Trust.

The monitoring of this action plan will be undertaken through routine reporting to the Divisional Management Committee, Trust Management Executive and Performance Review meetings. The action plan will be the subject of continuous review and focus. In addition, there is a range of wider actions to enhance well-led compliance. These include statutory and mandatory training, appraisal rates, 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 86.6% 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]	2022/23	2021/22	2022/23 compared to 2021/22
Non-NHS Payables				
Total non-NHS trade invoices paid in the period				
Number	n/a	176,275	170,489	3.4% increase
£000	n/a	962,267	920,849	4.5% increase
Total non-NHS trade invoices paid within the target				
Number	n/a	138,557	138,292	0.2% increase
£000	n/a	879,992	838,929	4.9% increase
Percentage of non-NHS trade invoices paid within the target				
Number	95%	78.6%	81.1%	2.5 percentage point deterioration
£000	95%	91.4%	91.1%	0.3 percentage point improvement
NHS Payables				
Total NHS trade invoices paid in the period				
Number	n/a	4,159	4,636	10.3% reduction
£000	n/a	37,176	34,561	7.6% increase
Total NHS trade invoices paid within the target				
Number	n/a	3,280	3,565	8.0% reduction
£000	n/a	27,323	25,958	5.3% increase
Percentage of NHS trade invoices paid within the target				
Number	95%	78.9%	76.9%	2.0 percentage point improvement
£000	95%	73.5%	75.1%	1.6 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 improved in 2022/23 for non-NHS trade invoices improved by value but deteriorated by number. The Trust continues to work to ensure that approved invoices are paid promptly.

During this period, the Trust paid £4,000 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 develop. This supports the Trust in meeting its objectives 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 in 2022/23, it was agreed that more engagement with younger members and people from seldom heard groups is needed 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 to help us shape the way we operate and deliver our health services. We have continued to promote membership via our Governors, members and social media to encourage people to join as members and have attended events, when possible, to undertake active recruitment.

Membership constituencies

The Trust has two membership constituencies: Public and Staff.

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 16,453 members as of 31 March 2023 (15,430 as of 31 March 2022).

Public constituency

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

As of 31 March 2023, the Trust had 7,595 public constituency members, as shown below.

Public constituency	2022/23	2021/22
Cherwell	1,152	1,179
Oxford City	1,729	1,754
South Oxfordshire	746	765
Vale of White Horse	1,062	1,083
West Oxfordshire	856	878
Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	1,020	1,031
Northamptonshire and Warwickshire	417	432
Rest of England and Wales	610	580
Total	**7,592**	**7,702**

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

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 an appointment (by the Non-Executive Directors) of the Chief Executive Officer
- deciding on the remuneration and allowances, and the 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 to the Board when the Board is preparing the document containing information about the Trust's forward planning
- 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 seventh 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.

More information of 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	**Total**	**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	**Total**	**6**
Clinical		4
Non-Clinical		2
Appointed Governors	**Seats**	
Required by statute	**Total**	**2**
Oxfordshire County Council		1
University of Oxford		1
Nominated	**Total**	**6**
Oxford Brookes University		1
Oxford Health NHS Foundation Trust		1
Oxfordshire Clinical Commissioning Group [1]		1
Oxfordshire Local Medical Committee		1
Specialist Commissioner (nominated by NHS Commissioning Board)		1
Young person (nominated by Young People's Executive)		1

Note:

1. *Oxfordshire Clinical Commissioning Group was abolished on 1 July 2022 as part of the Health and Care Act 2022, with their work taken over by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (BOB ICB).*

Members of the Council of Governors

The Governors who were in post during the period 1 April 2022 to 31 March 2023 and their attendance at the five 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	3/5
Anita Higham	Cherwell	01/04/2022-31/03/2025	3	3/5
Mike Gotch	Oxford City	01/04/2021-31/03/2024	1	4/5
Jane Probets	Oxford City	01/04/2022-31/03/2025	1	2/5
Janet Knowles	South Oxfordshire	01/04/2022-31/03/2025	2	4/5
Nina Robinson	South Oxfordshire	01/04/2021-31/03/2024	1	4/5
David Matthews	Vale of White Horse	01/04/2022-31/03/2025	1	5/5
Jill Haynes	Vale of White Horse	01/04/2021-31/03/2024	3	3/5
Robin Carr	West Oxfordshire	01/04/2022-31/03/2025	1	5/5
Graham Shelton	West Oxfordshire	01/04/2021-31/03/2024	2	5/5
Sally-Jane Davidge	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	01/04/2021-31/03/2024	3	5/5
Jeremy Hodge	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	01/04/2022-31/03/2025	1	5/5
Sally-Anne Watts	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	01/04/2021-31/03/2024	1	4/5
Anthony Bagot-Webb	Northamptonshire and Warwickshire	01/04/2021-31/03/2024	2	4/5
Mark Whitley	Northamptonshire and Warwickshire	01/04/2022-31/03/2025	1	3/5
Jonathan Wyatt	Rest of England and Wales	01/04/2022-31/03/2025	2	5/5
Elected Governors – staff constituencies				
Name	**Constituency**	**Tenure**	**Term**	**Attendance**
Giles Bond-Smith	Clinical	01/04/2021-31/03/2024	1	1/5
George Krasopoulos	Clinical	01/04/2022-31/03/2025	1	3/5
Julie Stockbridge	Clinical	01/04/2021-31/03/2024	3	5/5
Pauline Tendayi	Clinical	01/04/2022-31/03/2025	1	3/5
Aliki Kalianou[1]	Non-Clinical	01/04/2022-31/03/2024	1	5/5
Megan Turmezei	Non-Clinical	01/04/2022-31/03/2025	1	5/5

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	Oxford Brookes University	03/07/2020-02/07/2023	2	0/5
Stuart Bell	Oxford Health NHS Foundation Trust	16/10/2020-15/10/2023	1	5/5
Gareth Kenworthy[2]	Oxfordshire Clinical Commissioning Group	05/01/2021-01/07/2022	2	0/1
Vacancy	Oxfordshire County Council	06/05/2021-19/12/2022		
Tim Bearder	Oxfordshire County Council	20/12/2022-19/12/2025	1	0/1
Helen Higham	University of Oxford	16/10/2020-15/10/2023	1	3/5
Ruby[3,4]	Young People's Executive	01/09/2020-31/08/2022	1	1/3
Maryam[3,4]	Young People's Executive	01/09/2021-31/08/2022	1	1/3
Annabelle[4]	Young People's Executive	01/09/2022-31/08/2025	1	0/2
Ishaan[4]	Young People's Executive	01/09/2022-31/08/2025	1	0/2

Notes:

1. *Unexpired term of the previous Governor.*
2. *Stood down due to abolition of Clinical Commissioning Group.*
3. *Resigned during tenure.*
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.*

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

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.

Mr Graham Shelton, a Public Governor for West Oxfordshire, was elected by the Council of Governors as the Lead Governor from 1 April 2022 for a one-year term.

At its October 2022 meeting the Council agreed that Chairs of the Council of Governors' committees could deputise for the Lead Governor when required.

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 2021 and 2022, therefore no elections took place in the spring of 2023. The next set of elections will take place in the spring of 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 five general meetings in 2022/23, with three meetings taking place face-to-face and two meetings taking place virtually. The Trust ensured that all Governors were able to access virtual meetings so that no Governor was disadvantaged by not being able to attend the meetings. The virtual meetings were not open to the public for logistical reasons, however, one meeting was recorded and the video was posted on the Trust's website for the members and the public to observe. The second meeting was held in private and not recorded.

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 2022/23, this event was held face-to-face for the first time since the COVID-19 pandemic. 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.

The electronic version of the Annual Report and Annual Accounts for the year 2021/22 is available online at www.ouh.nhs.uk/about/publications/#accounts.

Board members' attendance at Council of Governors' meetings

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 will be in attendance to comment when issues relevant to their portfolio are on the agenda.

The following table shows the attendance of the Board members at four of the Council of Governors' general meetings that took place during the year. One extraordinary meeting also took place, which no Board members, with the exception of the Chair, were invited to attend.

Board member	Position	Attendance
Professor Sir Jonathan Montgomery	Trust Chair	5
Professor Bruno Holthof[1]	Chief Executive Officer	0
Professor Meghana Pandit[2]	Chief Executive Officer	4
Ms Anne Tutt	Vice-Chair and Non-Executive Director	3
Ms Claire Flint	Non-Executive Director	2
Ms Paula Hay-Plumb OBE	Non-Executive Director	3
Ms Sarah Hordern	Non-Executive Director	3
Ms Katie Kapernaros	Non-Executive Director	1
Professor Anthony Schapira	Non-Executive Director	3
Professor Gavin Screaton	Non-Executive Director	2
Professor Ashok Soni	Non-Executive Director	0
Ms Joy Warmington	Non-Executive Director	1
Mr Jason Dorsett	Chief Finance Officer	4
Ms Sara Randall	Chief Operating Officer	3
Ms Sam Foster[3]	Chief Nursing Officer	0
Mr Terry Roberts[4]	Joint Chief People Officer	2
Ms Rachel Stanfield[5]	Joint Chief People Officer	1
Dr Anny Sykes[6]	Interim Chief Medical Officer	0
Mr David Walliker	Chief Digital and Partnership Officer	3
Ms Eileen Walsh[7]	Chief Assurance Officer	0
Ms Clare Winch[8]	Acting Chief Assurance Officer	2

Notes:

1. *Chief Executive Officer to 30 June 2022.*
2. *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).*
3. *Chief Nursing Officer to 31 March 2023.*
4. *Chief People Officer to 31 July 2022 and Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
5. *Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
6. *Interim Chief Medical Officer from 1 July 2022.*
7. *Medical absence to 31 August 2022 with phased return to 30 October 2022.*
8. *Acting Chief Assurance Officer from 1 April 2022 to 30 October 2022, covering medical absence and supporting phased return of Chief Assurance Officer.*

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.

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. During 2022/23 it was agreed that the Committee should also have a Governor Vice-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 2022/23, the RNAC met three times and the key business undertaken by the Committee included the following.

- Reviewing and updating the Terms of Reference for the Committee to include a Governor Vice-Chair.
- Reviewing the membership of the Committee.
- Receiving assurance regarding the process of appraisal of the Non-Executive Directors and the Trust Chair.
- Reviewing the remuneration received by the Trust Chair and Non-Executive Directors.
- Recommending the need to recruit two new Non-Executive Directors, prompted by the end of terms of office of two existing Non-Executive Directors, and undertaking an open recruitment campaign, supported by a search agency, for the recruitment of those Non-Executive Directors, who will take up their positions in 2023/24.

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 benchmark 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 2022/23 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
- agreeing the cover arrangements for Chief Officers who were absent from work or undertaking a secondment opportunity
- appointing an Interim Chief Nursing Officer to commence in 2023/24 to cover the vacant position
- appointing the substantive Chief Executive Officer.

Signed:

Ms Claire Flint
Chair of Remuneration and Appointments Committee
28 June 2023

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 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 of the component	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 agreed for the Executive Team by the Remuneration and Appointments Committee.
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 of the right calibre to lead the delivery of the Trust's aims and objectives.	Pension is available as a benefit to Executive Directors and follows the national 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 employees who are members.	Not applicable.
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 or lifetime allowance.	The Trust operates an alternative shared payment scheme to support staff who choose to opt out of the NHS Pension Scheme because they are affected by annual or lifetime allowance issues. 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	12.38% of pensionable pay.	Not applicable.

How the component supports the strategic aims of the Trust	How the component operates	Maximum potential value of the component	Description of framework used to assess performance
	the NHS Pension Scheme. The scheme is open to all employees that meet the eligibility criteria laid out in the policy.		
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 the information provided. The process is documented within the Trust's new Very Senior Manager Pay and Reward Policy.	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. For 2022/23, the Trust provided a range of additional benefits to support staff with the cost of living. All members of staff had the option of a £250 green transport incentive that could be used towards the cost of an annual bus/rail season ticket or a new bicycle via the Trust's Cycle2Work scheme.			
Travel expenses			
Appropriate travel expenses are paid for business mileage in line with the Trust's Payment of Expenses Procedure.			

Note:

- *The Trust adapts 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.*
  - *in 2022/23, Dr Anny Sykes was seconded to the Interim Chief Medical Officer position and received a pay uplift that increased their remuneration above £150,000. This salary was unanimously agreed by the Remuneration and Appointments Committee and approved by NHS England.*

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, the Council of Governors' Nominations, Remuneration and Appointments Committee takes into consideration national guidance from NHS England, alongside independently sourced benchmark 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 Executive Directors are subject to an employment contract that stipulates a length of appointment. 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 2022/23 for Executive Directors.

Name	Position	Date of contract as Executive Director	Contract type	Notice period
Professor Bruno Holthof[1]	Chief Executive Officer	01/10/2015 - 30/06/2022	Permanent	Six months
Professor Meghana Pandit[2]	Chief Executive Officer	01/01/2019	Permanent	Six months
Mr Jason Dorsett	Chief Finance Officer	03/10/2016	Permanent	Six months
Ms Sam Foster[3]	Chief Nursing Officer	04/09/2017 - 31/03/2023	Permanent	Six months
Ms Sara Randall	Chief Operating Officer	01/07/2019	Permanent	Six months
Mr Terry Roberts[4]	Joint Chief People Officer	10/02/2020	Permanent	Six months
Ms Rachel Stanfield[5]	Joint Chief People Officer	01/08/2022 - 31/03/2023	Secondment	Three months
Dr Anny Sykes[6]	Interim Chief Medical Officer	01/07/2022	Secondment	Three months
Mr David Walliker	Chief Digital and Partnership Officer	28/10/2019	Permanent	Six months
Ms Eileen Walsh[7]	Chief Assurance Officer	01/05/2011	Permanent	Six months
Ms Clare Winch[8]	Acting Chief Assurance Officer	01/04/2022 - 30/10/2022	Acting up	Three months

Notes:

1. *Chief Executive Officer to 30 June 2022.*
2. *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).*
3. *Chief Nursing Officer to 31 March 2023.*
4. *Chief People Officer to 31 July 2022 and Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
5. *Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
6. *Interim Chief Medical Officer from 1 July 2022.*
7. *Medical absence to 31 August 2022 with phased return to 30 October 2022.*
8. *Acting Chief Assurance Officer from 1 April 2022 to 30 October 2022, covering medical absence and supporting phased return of Chief Assurance 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 six times in 2022/23. The following table contains details of the core membership of the Committee and their attendance at Committee meetings in 2022/23.

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

Note:

1. *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 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 £5000)** £000	**Long-term performance related bonuses (bands of £5000)** £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 Ash Soni	Non-Executive Director		10-15						10-15
Ms Joy Warmington	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 £5000)** **£000**	**Long-term performance related bonuses (bands of £5000)** **£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.*

Salary and Pension Entitlements of Senior Managers 2021/22 *(this information is subject to audit)*

Salary and Pension Entitlements of Senior Managers 2021/22 (12 months to 31 March 2022)									
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 £5000)** £000	**Long-term performance related bonuses (bands of £5000)** £000	**Payment in lieu of pension[1] (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[2,3]									
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						10-15
Professor Gavin Screaton	Non-Executive Director		10-15						10-15
Professor Ash Soni	Non-Executive Director	06/04/2021-31/03/2022	10-15						10-15
Ms Joy Warmington	Non-Executive Director	01/06/2021-31/03/2022	10-15						10-15
Executive Directors[4]									
Professor Bruno Holthof[5,6]	Chief Executive Officer		290-295	8,500			115-120		415-420
Mr Jason Dorsett[5]	Chief Finance Officer		180-185				20-25		200-205

Salary and Pension Entitlements of Senior Managers 2021/22 (12 months to 31 March 2022)									
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 £5000)** **£000**	**Long-term performance related bonuses (bands of £5000)** **£000**	**Payment in lieu of pension[1] (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**
Ms Sam Foster[5, 7]	Chief Nursing Officer		165-170		0-5		20-25		190-195
Professor Meghana Pandit[5]	Chief Medical Officer		235-240				25-30		265-270
Ms Sara Randall[8]	Chief Operating Officer		170-175				10-15	492.5-495	675-680
Mr Terry Roberts[8]	Chief People Officer		155-160						155-160
Mr David Walliker[5]	Chief Digital and Partnership Officer		170-175				20-25		190-195
Ms Eileen Walsh[8]	Chief Assurance Officer		155-160				5-10	517.5-520	680-685

Notes:

1. *Applications for Alternative Shared Payments (ASP) in line with the Pension Contribution Alternative Award Policy were received in 2020/21, however, they were back dated to November and December 2019. The amounts include any back payments that were paid as lump sum amounts and are included in the amounts shown in the column 'Payment in lieu of pension'.*
2. *The basic annual remuneration of Non-Executive Directors (excluding the Trust Chair) is within the band of £10-15,000.*
3. *The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of £15-20,000.*
4. *Following discussion with auditors, the salary figures are shown as the gross amount prior to any salary sacrifice deductions.*
5. *Chose not to be covered by the pension arrangements during the reporting year.*
6. *Received £118,000 in lieu of outstanding pension contributions for the period 1/04/2020 to 31/03/2022 and a £8,500 taxable benefit for the cost a life insurance policy.*
7. *A regular bonus payment has been introduced for achievement of objectives in relation to the Estates and Facilities portfolio from September 2020.*
8. *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.*

Pension Benefits of Senior Managers 2022/23 *(this information is subject to audit)*

Pension Benefits of Senior Managers 2022/23 (12 months to 31 March 2023)									
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 31/03/2023 (bands of £5,000)** **£000**	**Lump sum at pension age related to accrued pension at 31/03/2023 (bands of £5,000)** **£000**	**Cash Equivalent Transfer Value at 01/04/2022** **£000**	**Real increase in Cash Equivalent Transfer Value** **£000**	**Cash Equivalent Transfer Value at 31/03/2023** **£000**	**Employer's contribution to stakeholder pension** **£000**
Mr Terry Roberts[1]	Joint Chief People Officer	2.5-5	5-7.5	50-55	95-100	802	97	923	-
Ms Rachel Stanfield[2]	Joint Chief People Officer	0-2.5	-	20-25	5-10	242	25	287	-
Ms Eileen Walsh[3]	Chief Assurance Officer	-	-	50-55	100-105	1,067	-	1,028	-
Ms Clare Winch[4]	Acting Chief Assurance Officer	0-2.5	-	40-45	70-75	634	25	697	-

Notes:

1. *Chief People Officer to 31 July 2022 and Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
2. *Joint Chief People Officer from 1 August 2022 to 31 March 2023.*
3. *Medical absence to 31 August 2022 with phased return to 30 October 2022.*
4. *Acting Chief Assurance Officer from 1 April 2022 to 30 October 2022, covering medical absence and supporting phased return of Chief Assurance Officer.*

- *Non-Executive Directors do not receive pensionable remuneration (2021/22, nil).*
- *The Trust did not contribute to a stakeholder pension scheme for Directors (2021/22, nil).*
- *Pension details have only been disclosed for those Directors in post during the last 12 months up to 31 March 2023.*
- *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.*
- *Cash Equivalent Transfer Value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023, this guidance will be used in the calculation of 2023/24 CETV figures.*
- *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.

Payment for Loss of Office

No payments for Loss of Office were made to senior managers in 2022/23 (2021/22: 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.

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 past two financial years.

	2022/23	2021/22 updated	2021/22 original
Banded remuneration of the highest-paid Director	£245,000 - £250,000	£295,000 - £300,000	£295,000 - £300,000
Percentage change of remuneration of the highest-paid Director from previous financial year	-16.7%	0%	0%
Range of WTE[1] employee remuneration[2]	£9,400 - £483,000	£9,400 - £419,000	£9,400 - £299,000
Percentage change in average remuneration[3] of employees from previous financial year	6.4%[4]	4.2%	4.2%
WTE[1] employees that received remuneration in excess of the highest-paid Director	7	4	0

Notes:

1. *Whole time equivalent.*
2. *This figure includes Directors and excludes pension benefits of all employees.*
3. *Based on total for all employees divided by full-time equivalent number of employees.*
4. *This figure includes the average 4.1% pay award in 2022/23, an estimate of the additional lump sum in respect of 2022/23 and changes in the composition of the workforce.*

- *The total pay elements for 2021/22 have been updated to include Bank and Agency Staff which were not included in 2021/22 as the information was not available at the time of submission to NHS England.*

Total remuneration includes salary, non-consolidated performance-related pay and 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 £	
	2022/23	2021/22 updated	2022/23	2021/22 updated	2022/23	2021/22 updated
Salary component of pay	28,058	24,882	35,730	32,306	46,816	42,145
Total pay and benefits excluding pension benefits	30,429	26,388	42,001	38,014	54,772	51,443
Pay and benefits excluding pension: pay ratio for highest paid Director	8.191	11.36:1	5.93:1	7.89:1	4.55:1	5.83:1

Note:

- *The total pay elements for 2021/22 have been updated to include Bank and Agency Staff which were not included in 2021/22 as the information was not available at the time of submission to NHS England. The original pay data submitted in 2021/22 are shown in the table below.*

The ratio of the highest-paid Director to the Trust employees has decreased in the last year as the banding of the highest-paid Director has reduced. The average remuneration of the Trust's employees has increased due to the pay award and changes in the composition of the workforce in 2022/23.

Original pay data submitted to NHS England and published in the Annual Report 2021/22

	25th percentile £	Median £	75th percentile £
Salary component of pay	23,651	32,306	42,121
Total pay and benefits excluding pension benefits	25,116	34,738	46,054
Pay and benefits excluding pension: pay ratio for highest paid Director	11.85:1	8.56:1	6.46:1

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.

	2022/23	2021/22
Total number of Governors in office[1]	31	29
Number of Governors who received expenses	8	0
Aggregate sum of expenses paid	£700	0

Note:

1. All members of the Council who were in office during the year 2022/23 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.

	2022/23	2021/22
Total number of Board members in office[1]	21	18
Number of Board members who received expenses	2	1
Aggregate sum of expenses paid	£4,600	£8,500

Note:

1. All members of the Board who were in office during the year 2022/23 have been considered.

Signed:

Professor Meghana Pandit
Chief Executive Officer
28 June 2023

Staff Report

The Staff Report provides information about staffing and staff related matters at Oxford University Hospitals NHS Foundation Trust (OUH), during the year 2022/23.

Our Workforce

The Trust employed over 14,500 people in the year 2022/23 on permanent contracts[1] of employment across both full-time and part-time roles. This equates to a whole time equivalent (WTE) average of 12,854 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 because of the increased number of staff employed by the Trust.

The gender distribution of our workforce as of 31 March 2023 is shown in the table below.

Category	2022/23			2021/22
	Female	Male	Total	Total
Directors[2,3]	12	7	19	18
Senior managers[4]	-	-	-	-
Other staff[5]	10,801	3,712	14,513	14,410
Total[6,7]	**10,813**	**3,719**	**14,532**	**14,428**

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 of 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 2023 ***(this information is subject to audit)***

The average number of staff employed by the Trust as at 31 March 2023 is set out in the table below on a whole time equivalent (WTE) basis.

Staff Category	2022/23 Average WTE			2021/22 Average WTE
	Permanently Employed[1]	Other Staff[2]	Total Number	Total Number
Medical and Dental	2,082	83	2,165	2,070
Ambulance Staff	-	-	-	-
Administration and Estates[3]	2,561	102	2,663	2,719
Healthcare Assistants and Other Support Staff	1,509	301	1,810	1,845
Nursing, Midwifery and Health Visiting Staff	4,247	566	4,813	4,536
Nursing, Midwifery and Health Visiting Learners	-	-	-	-
Scientific, Therapeutic and Technical Staff	1,545	64	1,609	1,574
Healthcare Science Staff	854	10	864	833
Social Care Staff	-	-	-	-
Other	56	-	56	61
Total Average Numbers	12,854	1,126	13,980	13,638
of which				
Number of employees (WTE) engaged on capital projects	5	6	11	12

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 2022/23, split between permanently employed staff and others.

Cost	2022/23			2021/22
	Permanently Employed[1] £000	Other Staff[2] £000	Total £000	Total £000
Salaries and wages	633,263	8,628	641,891	598,603
Social security costs	61,890	-	61,890	54,797
Apprenticeship levy	2,906	-	2,936	2,715
Employer's contributions to NHS pensions	100,915	-	100,915	94,449
Pension cost – other	106	-	106	77
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	190	-	190	33
Temporary staff	-	79,050	79,050	62,515
Total Gross Staff Costs	799,270	87,678	886,948	813,189
Recoveries in respect of seconded staff	-	-	-	-
Total Staff Costs	799,270	87,678	886,948	813,189
of which				
Costs capitalised as part of assets	120	474	594	892

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

Supporting staff with disabilities

Oxford University Hospitals NHS Foundation Trust (OUH) 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 disabled applicants
- 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
- reviewing our plans and activities in support of people with disabilities annually as part of the Workforce Disability Equality Standard (WDES) and ensure disability awareness for all employees.

Practice development and education

As a teaching Trust, patient-centered teaching and education is one of our main activities and is important to the delivery of the Trust's strategic objectives. 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 and there is an in-house continuous professional development (CPD) programme available for them.

OUH is also a collaborative partner in the Oxford School of Nursing and Midwifery alongside Oxford Brookes University and Oxford Health NHS Foundation Trust. In addition, the Trust is a placement partner of choice for a significant range of Allied Health Professions as well as Pharmacy, Healthcare Science and Physician Associates.

The Trust delivers and supports education across all professional groups and services and has a highly competent internal education faculty, delivering and supporting undergraduate and postgraduate academic programmes, professional courses including leadership development and Quality Improvement (QI) methodology as well as clinical skills training and *At The Elbow* mentor support. The provision has been improved by the procurement of a state-of-the-art education centre for all Trust staff with a principal focus on nursing, midwifery and allied health professional education. Access to education and training is being further enhanced through the Continuing Professional Development Hub (CPD Hub) as an addition to our existing My Learning Hub platform which has allowed for greater transparency of training needs and CPD spend.

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 websites where appropriate for further information. A weekly safety message is also sent to all staff. A monthly virtual Staff Briefing is held for all staff with updates from the Executive Team and giving staff the opportunity to ask questions.

The Trust intranet is kept up to date with key campaigns and key information such as policies and procedures and announcements that are updated daily. A project is currently underway to update the intranet to improve its accessibility and also to make it mobile friendly.

The Trust has digital screens across its estate for regular messages for staff and patients and uses a DeskAlerts system that allows key messages to be circulated to Trust computers as a 'ticker'. In addition, the Trust website, posters on staff noticeboards, leaflets and verbal cascading of key messages are used to ensure all staff are kept informed of key safety and priority messages. The Trust actively uses digital networking channels Facebook, LinkedIn, Twitter, Instagram, YouTube and Yammer to communicate with its 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 TAC with membership formed from Workforce and Trade Union colleagues. These sub-groups are:

- Consultation Sub-Group – where all proposed formal consultations under the Trust's Management of Organisational Change Procedure are presented prior to consultation with staff
- Policy Development Group – where all proposed changes to workforce policies affecting our staff are presented prior to formal consultation.

The Trust has been working to promote the voice of our people from protected characteristic groups through the continued development of five staff networks: Black, Asian and Minority Ethnic (BAME) Network, LGBTQ+ Network, Disability and Accessibility Network, Women's Network and Young Apprentices Network.

Encouraging staff involvement in the Trust's performance

The Trust actively encourages staff engagement in enhancing the Trust's performance and is committed to recognising individuals and teams for their delivery of compassionate excellence. There are several ways that staff or teams can be nominated, recognised and thanked. These include the following.

- ***The OUH Staff Recognition Awards*** programme is held annually to give an opportunity for our people and patients to recognise an individual or a team who really lives our Trust values and the great work they do.
- ***Oxford Scheme for Clinical Accreditation (OxSCA)*** is a national initiative that has been adapted locally at OUH, which celebrates the positive impact of strong multidisciplinary practice environments and partnerships through cohesive and proactive team working. It recognises how staff groups work well and effectively together to deliver compassionate and safe care to our patients and our populations.
- ***Reporting Excellence***, a recognition scheme that, through its incident reporting system, helps the Trust to learn and recognise positive events that happen every day in the delivery of excellent care to our patients and service to our staff and improve patient care as a result.
- ***DAISY Foundation® Awards***, an international scheme that allows patients and their families as well as colleagues to nominate a nurse or midwife who has made a real difference through the provision of outstanding clinical care.

Health and Safety

The Trust continued to strengthen its Occupational Health and Safety Management System (OHSMS) throughout 2022/23 and successfully achieved the ISO 45001:2018 (Occupational Health and Safety Management Systems) certification standard at the Churchill Hospital.

The process for strengthening the OHSMS included internal collaboration with the Trust's Estates and Facilities Team that supported monitoring of statutory compliance and risk management, and external collaborations with Private Finance Initiative (PFI) and the University of Oxford that focused on further development of joint processes for workplace inspections and actions to address nonconformities.

During the year the Health and Safety Team supported clinical Divisions to develop Divisional Health and Safety Groups. These groups have implemented a standardised inspection process to identify workplace hazards and to manage risks, and have further strengthened processes to develop and maintain health and safety related risk assessments and other documentation. An internal audit programme has been developed to monitor these processes. The most recent Management Review of the OHSMS concluded that the system remains at a standard consistent with the ISO 45001:2018 certification and that suitable actions are planned for continued improvement.

During the year the Trust updated its Health and Safety training for staff and a new course was also mapped to train large groups of managers.

Health and wellbeing of staff

The Centre for Occupational Health and Wellbeing (COHW) is the Trust's in-house service that provides a full range of occupational health services to Trust staff and external customers in the local area. The COHW promotes and maintains 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 / return to work following sickness absence, workplace assessments, health surveillance and promotion and support for the Trust's health and safety compliance.

The COHW had over 12,000 contact appointments in 2022/23. Key achievements of the service include the following.

- Implementation of a new Occupational Health IT software programme which will support streamlining of the operational aspects of the service and improved data capture for reporting around key metrics and contributing to more accurate monitoring systems for health risks at work.
- Implementation of an Occupational Health Nurse Adviser Link Nurse programme to support directorates and the people function in management of sickness absence.
- Co-ordination of the winter Flu vaccination programme for September 2022 to January 2023. A total of 59% of frontline healthcare workers were vaccinated during this season.
- Successful annual renewal of the service for the Faculty of Occupational Medicine Safe, Effective, Quality, Occupational Health Service (SEQOHS) scheme.

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. They also report regularly to the Audit Committee. The Trust has a Fraud Champion who supports TIAA in their counter fraud work.

The Counter Fraud and Bribery Policy and Procedure of the Trust sets out the approach to countering fraud, bribery and corruption in the NHS and the Trust's role in this. The Declarations of Interests, Gifts, Hospitality and Sponsorship Policy further complies with the NHS requirements for managing conflicts of interest and the requirements of the Bribery Act 2010. The policies are kept under review by TIAA to ensure they remain effective.

The Trust complies with the 12 NHS requirements of NHS Counter Fraud Authority (NHSCFA) which set the standards for countering fraud in adherence with the '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 throughout the year the Trust provides awareness-raising activities for staff on how to raise concerns about fraud and bribery issues. The Trust assesses staff awareness of counter fraud on an annual basis through the use of the Staff Counter Fraud Awareness Survey, the results of which are reported to the Audit Committee.

Equality, Diversity and Inclusion (EDI)

As a responsible employer and provider of healthcare services we actively recognise, value and support the diverse range 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

In September 2022, the Trust Board approved our new EDI Objectives. These four-year objectives 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 levels. Further information on the Trust's EDI Objectives and the activity expected to be delivered against them can be found on the Trust's website at www.ouh.nhs.uk/about/equality/plans.aspx#annual.

Policies and Procedures

The Trust has a Workforce Equality, Diversity and Inclusion Policy in place as well as an Equality Impact Assessment Procedure. All of our policies are equality impact assessed to ensure that no one impacted by a policy receives unjustifiably less favourable treatment on the grounds of protected characteristics such as age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender, and sexual orientation.

Reporting

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are reporting requirements that support the Trust to identify the barriers that Black, Asian and Minority Ethnic (BAME) staff and disabled staff face in terms of their employment within the Trust. The Trust reports on these, as well as its gender pay gap, on an annual basis in our Combined Equality Standards Report. We use these reporting exercises to identify differences in experience between staff groups and plan actions to mitigate them.

The findings from our Combined Equality Standards reporting have been used to inform the refresh of our EDI Objectives with issues to be addressed in the delivery of them. Our most recent WRES, WDES and gender pay gap data can be found on the Trust website: visit www.ouh.nhs.uk and type 'TB2022.72' into the search field on the home page.

The Trust also reports against the Equality Delivery System (EDS). The EDS is an outcomes framework developed by NHS England to support improvement on EDI and Health Inequalities. Starting from 2022/23, the Trust now reports on EDS annually which requires an evidence collation and grading exercise against the outcomes, with actions for improvement developed following this. The findings of this exercise, and associated actions, can be found in this area of the Trust website: www.ouh.nhs.uk/about/equality.

Initiatives

In addition to the initiatives and actions undertaken that are detailed in our Combined Equality Standards Report, further action has been taken in the past year. Many of these have been undertaken in collaboration with our Staff Networks, enabling us to raise the voices of staff from underrepresented groups. Activities include the following.

- Running a programme of activity focusing on the wellbeing of our BAME staff.
- Becoming a Stonewall Diversity Champion, demonstrating our commitment to supporting the LGBTQ+ community.
- Developing a policy to support staff experiencing menopausal symptoms in the workplace.
- Undertaking work to embed EDI into our recruitment processes with an improvement project on values-based interviewing and developing inclusive recruitment training.

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 ensure 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.

	2022/23	2021/22
Number of cases opened	94	116
Number of staff contacts made to raise awareness	4,161	2,072

The FtSU Team's focus in 2022/23 was on:

- holding regular online listening events for staff to ask questions, raise concerns and highlight positive stories
- roadshow events that were held on all four hospital sites and at OUH officers in Cowley during the Speak Up Month in October 2022
- 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 Black, Asian and Minority Ethnic (BAME) Network Team
- a visit to the Trust from the Freedom to Speak Up National Guardian, Dr Jayne Chidgey-Clark, which included a visit to the Maternity Unit at the Women's Centre at the John Radcliffe Hospital
- reviewing the Freedom to Speak Up – Raising Concerns (Whistleblowing) Policy
- presenting six-monthly update reports and an Annual Report to the Trust Board.

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 126 Acute, and Acute and Community Trusts.

From 2021/22 the survey questions align 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.

Our Staff Survey's response rate dropped from 57% in 2021 to 51%. This decline reflected the national trend experienced by most comparable Trusts.

Summary of results in 2022/23 and 2021/22

Scores for each indicator together with that of the Survey Benchmarking Group, 126 Acute, and Acute and Community Trusts, are presented below.

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

Compared to the results in 2021/22, of the 97 questions, we saw 10 of the questions scored better, 62 with no significant difference, and 20 scored less. Five of the questions had no historical data. The Employment Engagement Index (EEI) score, out of a score of 10, remained at 7.0, the same as in 2021. All of the engagement themes scores are above the Picker Institute average.

The results showed that the Trust was slightly above the national average in eight indicators and in line with the average on one indicator. Out of a score of 10, 'We are compassionate and inclusive' was the Trust's highest (7.3 compared to the national average of 7.2). 'We are always learning' was the lowest with 5.6, although it showed the highest growth of 0.4 and was also above the benchmarking group's average.

Within the theme 'We are always learning', the Trust has seen a significant increase of 0.7 in the appraisal sub score. Appraisals have seen a significant improvement, by 19% to a total of 91% (72%, 2021). This is the Trust's most improved score across all questions. This improvement reflects the investment placed upon embedding values-based appraisals, the new appraisal window, and local leadership commitment.

Other improved areas include staff involvement in deciding changes that affect work (54%), last experience of physical violence reported (72%), and not felt pressure from manager to come to work when not feeling well enough (80%). This demonstrates the positive impact that wellbeing initiatives have had on staff.

Areas for improvement where the Trust's results have declined from 2021 include 'would recommend organisation as place to work' (61%, 2022 and 64%, 2021), 'organisation made reasonable adjustment(s) to enable me to carry out work' (75%, 2022 and 79%, 2021) and 'would feel confident that organisation would address concerns about unsafe clinical practice' (57%, 2022 and 61%, 2021).

Summary of results in 2020/21

Scores for each indicator in the 2020/21 Staff Survey, together with that of the Survey Benchmarking Group, 126 Acute, and Acute and Community Trusts, are presented below.

Theme	2020/21	
	Trust	Benchmarking Group
Equality, diversity and inclusion	9.1	9.1
Health and wellbeing	6.3	6.1
Immediate managers	7.0	6.8
Morale	6.3	6.2
Quality of appraisals	*Not collected*	
Quality of care	7.5	7.5
Safe environment - bullying and harassment	8.1	8.1
Safe environment - violence	9.5	9.5
Safety culture	6.9	6.8
Staff engagement	7.2	7.0
Team working	6.6	6.5

Future priorities and targets

In the coming year, the Trust will continue to focus on key areas of staff experience in response to the Staff Survey. The areas of focus will include health and wellbeing, improving the experience of staff with a disability and staff from Black, Asian and Minority Ethnic (BAME) backgrounds, improving the quality of appraisal conversations and embedding a culture of civility and respect.

We will also ensure that we align actions from the Staff Survey with Trust's Equality, Diversity and Inclusion (EDI) objectives and actions.

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, 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 ESR (Electronic Staff Record) Data Warehouse

Period covered: January to December 2022

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

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Published by NHS Digital from ESR Data Warehouse		
Average FTE 2022	**Adjusted FTE days lost to Cabinet Office definitions**	**FTE days available[1]**	**FTE days recorded sickness absence[2]**	**Average sick days per FTE[3]**
12,663	132,683	4,622,004	215,242	10.5

Notes:

1. *The number of FTE (Full-time Equivalent) days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.*
2. *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.*
3. *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

Staff turnover of OUH has steadily decreased over the year as shown in the table below.

Staff group	2022/23	2021/22
Additional Professional Scientific and Technical	9.1%	12.7%
Additional Clinical Services	16.9%	16.3%
Administrative and Clerical	12.2%	13.0%
Allied Health Professional	12.6%	14.5%
Estates and Ancillary	13.3%	16.1%
Healthcare Scientists	10.2%	8.6%
Medical and Dental	5.5%	4.1%
Nursing and Midwifery Registered	9.5%	11.7%
All staff groups	**11.4%**	**12.4%**

Further information on our staff turnover in 2022/23 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.

The Trust is committed to addressing any gender pay gaps within the organisation. Trust's last two years' gender pay gap information, reported to Government Equalities Office, is shown in the table below.

Indicator	2022/23	2021/22	2022/23 compared to 2021/22
Mean Ordinary Pay Gap	29.36%	25.02%	4.34 percentage point increase
Median Ordinary Pay Gap	15.83%	17.22%	1.39 percentage point decrease
Mean Bonus Pay Gap	57.51%	42.83%	14.68 percentage point increase
Median Bonus Pay Gap[1]	62.70%	0.00%	62.70 percentage point increase

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.*

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.

The full Gender Pay Gap Report of the Trust as of 31 March 2022, as reported to the Trust Board in September 2022 can be found on the Trust website: visit www.ouh.nhs.uk and type 'TB2022.72' 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.

Trade Union Facility Time 2022/23

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.

Relevant union officials

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

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
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
0%	18
1-50%	14
51%-99%	0
100%	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?

Total cost of facility time (£000s)	£113
Total pay bill (£000s)	£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%

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?

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	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 at 31 March 2023 earning £245 per day or greater

Number of existing engagements as of 31 March 2023	3
of which…	
Number that have existed for less than one year at time of reporting	-
Number that have existed for between one and two years at time of reporting	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	1

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2023 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2023	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*	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 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
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.	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 2022/23 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 2023. 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	2022/23			2021/22		
	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	2	-	2
£10,000 - £25,000	2	-	2	2	-	2
£25,001 - £50,000	2	-	2	-	-	-
£50,001 - £100,000	1	-	1	-	-	-
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total number of exit packages by type	10	-	10	4	-	4
Total resource cost £k	189	-	189	33	-	33

Exit packages: other non-compulsory departure payments

There were no exit packages in either the year 2022/23 or year 2021/22 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 2022/23 can be found in note 7.1 of the Annual Accounts found later in this document.

NHS Foundation Trust Code of Governance Compliance

Oxford University Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance (updated in 2014) on a comply or explain basis. The Trust considers that it complies with the specific disclosure requirements as set out in the NHS Foundation Trust Code of Governance and NHS Foundation Trust Annual Reporting Manual (FT ARM) issued buy NHS England.

The Code of Governance reference (Code Ref) of the main items 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 requirement of the Code of Governance, but of the NHS Foundation Trust Annual Reporting Manual.

Code Ref	Summary of Requirement	Annual Report Reference/Response
A.1.1	The schedule of matters reserved for the board of directors 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 each of the boards and which are delegated to the executive management of the board of directors.	The Scheme of Delegation, agreed by the Board in May 2021, includes a statement of the roles and responsibilities of the Council of Governors. The Trust's Constitution, initially agreed in October 2015 and revised in July 2021, sets out a dispute resolution procedure, and is available on the Trust website at: www.ouh.nhs.uk/about/foundation-trust/documents/constitution.pdf.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	This information is available in the Directors' Report and the Remuneration Report of this Annual Report.
A.5.3	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 Ref	Summary of Requirement	Annual Report Reference/Response
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	This information is available in the Trust Membership and Council of Governors Report of this Annual Report.
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	All the Non-Executive Directors of the Trust are considered to be independent in accordance with the *NHS Foundation Trust Code of Governance* with the exception of Professor Gavin Screaton who was nominated by the University of Oxford.
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	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.
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	Length of appointments of Non-Executive Directors are available at the Directors' Report of this Annual Report. The Council of Governors at a general meeting of the Council of Governors has the power to appoint or remove the Chair of the Trust and the other Non-Executive Directors. The removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Work of the Council of Governors' Remuneration, Nominations and Appointments Committee is available in the Trust Membership and Council of Governors Report, and the work of the Trust Board's Remuneration and Appointments Committee is available in the Remuneration Report of this Annual Report.
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	During the year an open recruitment campaign supported by a search agency was undertaken to recruit two new Non-Executive Directors who will take up their positions in 2023/24.
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment	Other significant commitments of the Trust Chair have been declared and listed in the

Code Ref	Summary of Requirement	Annual Report Reference/Response
	and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Board of Directors' Register of Interests which is available on the Trust website at: www.ouh.nhs.uk/about/trust-board.
B.5.6	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.
FT ARM	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. 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. * 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). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Not applicable. Except for the Trust Chair, the Board of Directors are 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.
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	The Annual Governance Statement of this Annual Report gives details of all Board committees, their Terms of Reference and the key areas that have been of focus for the year for the committees. Performance evaluation of the Board is discussed in the Remuneration Report and the Trust Membership and Council of Governors Report of this Annual Report.
B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made	Where applicable, this information is available in the Annual Governance Statement of this Annual Report.

Code Ref	Summary of Requirement	Annual Report Reference/Response
	as to whether they have any other connection to the trust.	During 2022/23, there has not been an external evaluation of the Board, with the exception of the Trust's Internal Auditors.
C.1.1	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, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	This has been fulfilled in the Directors' Report and the Annual Governance Statement of this Annual Report.
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	This has been fulfilled in the Annual Governance Statement of this Annual Report.
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	This has been fulfilled in the Annual Governance Statement of this Annual Report.
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable for 2022/23. Tender for award of external audit contract was accepted by the Council of Governors.
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial	This has been fulfilled in the Annual Governance Statement of this Annual Report. Following a competitive tender process, a new External Auditor was appointed in 2022/23.

Code Ref	Summary of Requirement	Annual Report Reference/Response
	statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	The expenditure on external audit services is shown within the Annual Accounts and the effectiveness of the service is monitored by the Audit Committee. The current external audit provides a report of any non-audit services and an independence review conclusion to the Audit Committee.
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Where applicable, such interests would be declared in the Register of Interests, and disclosures related to such earnings are available in the Remuneration Report of this Annual Report. The Board of Directors' Register of Interests is available on the Trust website at: www.ouh.nhs.uk/about/trust-board.
E.1.5	The board of directors should state in the annual report the steps they have 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, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	This has been fulfilled in the Trust Membership and Council of Governors Report of this Annual Report.
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	This has been fulfilled in the Trust Membership and Council of Governors Report of this Annual Report.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	This information is available in the Directors' Report and the Trust Membership and Council of Governors Report of this Annual Report and on the Trust website.

Code Ref	Summary of Requirement	Annual Report Reference/Response
FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	This information is available in the Trust Membership and Council of Governors Report of this Annual Report.
FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	The declaration of interests of the Board members can be found in the Board of Directors' Register of Interests available on the Trust website at: www.ouh.nhs.uk/about/trust-board. The declaration of interests of the members of the Council of Governors can be found in the Council of Governors' Register of Interests available on the Trust website at: www.ouh.nhs.uk/about/governors. Information on how the public can gain access to registers of Governors' and Board of Directors' interests is available in the Directors' Report and 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:

a) 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)
b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

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 2023. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: 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
28 June 2023

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 (OUH) for the year ended 31 March 2023 and up to the date of approval of the Annual Report and the Annual Accounts.

Capacity to handle risk

The Trust has a Risk Management Strategy 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.
- 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.

Risk management training is provided to staff based on the nature of their role and position within the organisation. This includes risk awareness materials which are provided to new staff as part of their corporate induction programme. The Risk Management Policy was refreshed in year, with the change in the electronic risk register system, and describes the roles and responsibilities of all staff in relation to the identification, management and control of risks, and encourages the use of risk management processes as a mechanism to highlight areas they believe require improvement.

The Risk and Control Framework

Approach to risk

The Trust's Risk and Control Framework consists of:

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

The Risk Management Strategy 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 Strategy 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 strategy 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 currently being reviewed and will be reflected in the policy once published. In addition, the strategy describes the reactive mechanisms in place to encourage learning from incidents.

The Risk Management Policy 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 public stakeholder sources such as feedback from the Council of Governors, patient feedback, patient surveys and patient experience groups.

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 Board Assurance Framework was independently reviewed by Internal Auditors. For 2022/23, this was an advisory piece of work, which generated recommendations for improvement that have been completed.

The Trust's risk assessment process covers all of 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. 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 of the Trust to manage internal bed capacity to sustain waiting list reduction and the impact on patients waiting longer for care (including those waiting longer than 104 weeks)
- the ability to recruit, retain and engage staff and the impact of staff sickness, and the need to use bank and agency staff on service delivery
- the growth in costs, particularly to address operational pressures and staff sickness, 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 limited access to capital funding and the potential impact of the Trust's ability to spend all its capital funding on service delivery, including the digital infrastructure and resilience.

These were the principal risks considered to be relevant for 2022/23. The other sections of this Annual Governance Statement describe the key actions taken in relation to these risks.

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 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 following functions 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 2022/23 the Board had five committees: Integrated Assurance, Audit, Remuneration and Appointments, Investment, 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 evidence to enable the Board to make evidence-based unitary decisions
- support the more detailed development of background work that might not otherwise be possible at Board meetings alone.

The Trust has assessed compliance with the NHS Foundation Trust Licence Condition 4 (8) (b) (certification of adequacy of Foundation Trust governance arrangements) and the Board of Directors is able to assure itself of the validity of its Corporate Governance Statement. This assessment included the submission of timely and accurate information to relevant external stakeholders to assess the risks to compliance with the Trust's Provider Licence.

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, effectiveness and constitution, considering the practices set out in the NHS Foundation Trust Code of Governance (the Code). 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 for the reporting period 2022/23, the Board considers the Trust to have complied fully with the Code.

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 conduit 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 and Counter Fraud arrangements.

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 risk registers.

In their Annual Report, TIAA concluded that, in respect of 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:

- 'there were no frauds subject to investigation that met the materiality threshold for referral to the Trust's External Auditors'.
- 'no significant system failures or control weaknesses were identified that impact on the Trust's Annual Governance Statement'.

In addition, TIAA concluded that the Counter Fraud function is embedded well within the Trust and the work undertaken successfully addressed the Trust's Counter Fraud Strategy. In accordance with the 'Government Functional Standards GoVs 013: Counter Fraud', the Trust is required to complete a Counter Fraud Functional Standard Return and has been assessed with an overall rating of 'Green' for 2022/23.

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.

- Cyber Security: Design – Moderate, Effectiveness – Moderate
- Estates Compliance: Design – Moderate, Effectiveness – Moderate
- Payroll Spend Controls: Design – Moderate, Effectiveness – Moderate
- IT Disaster Recovery: Design – Moderate, Effectiveness – Moderate
- Clinical Research Network: Design – Substantial, Effectiveness – Substantial
- Business Continuity: Design – Substantial, Effectiveness – Moderate
- Divisional Governance: Design – Moderate, Effectiveness – Moderate
- Consultant Job Planning: Design – Moderate, Effectiveness – Moderate
- Key Financial Systems Treasury Management: Design – Substantial, Effectiveness – Substantial
- DSP Toolkit: Design – Moderate, Effectiveness – Moderate
- Data Quality – Cancer Wait Standards: Design – Moderate, Effectiveness – Moderate
- Risk Maturity Follow Up (concluded and significant progress noted)

The following audits are currently in progress:

- Direct Award Procurement

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.

In forming their view, BDO (the Internal Auditor of the Trust) took into account the following.

- The financial position reported to the Trust Board in March 2023, which showed Income and Expenditure (I&E) performance in January generated a break-even position, and noted the Board had approved a revised year end reforecast of a £5.3m deficit.
- The majority of audits provided substantial or moderate assurance in the design and operational effectiveness of controls, including the key audits of financial systems and Divisional governance.
- The Trust has seen a continual improvement in implementing audit recommendations in a timely manner. All prior year (2021/22) recommendations have been closed and management is proactive in discussing plans to address the risks identified in the 2022/23 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.

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

- Maternity development programme.
- Plans to ensure patient and staff safety during planned industrial action by the Royal College of Nursing and British Medical Association, whilst supporting the right for staff members to take industrial action.
- Implementation of the new Patient Safety Incident Response Framework (PSIRF) from the current Serious Incident Framework (SIF) aimed at focusing on learning and improvement from patient safety incidents.

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 2022/23, the Committee also reviewed major clinical and non-clinical procurements which are under development, and issues with procurement projects that are delayed and notification of ratifications.

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. These groups 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:

- oversight on risks associated with the recovery from the COVID-19 pandemic and other seasonal respiratory diseases
- supporting members of staff involved with the industrial action and oversight on clinical areas with derogation and reinforcing the need for patient safety during strike action
- assurance received on the progress of the OUH Clinical Strategy programme which was set up to engage with and influence the changing system landscape and shift to statutory Integrated Care Systems
- workforce and organisational development matters such as:
  - forensic analysis of pay costs
  - the Quality Improvement (QI) Education three-year strategy which will enable more staff to access QI training.

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, Board membership consisted of eight Executive Directors, 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 2022/23 year.

The Executive team consists of:

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

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.

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 is 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 to a large extent 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 Trust's five-year strategy) 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. Specific examples of this include:

- development and submission of an agreed annual workforce plan aligned to activity and finance
- ongoing recruitment of overseas staff to ensure an appropriate supply of nursing and other staff to ensure service delivery as well as improve workforce stability by reducing turnover
- deep dive into workforce risks, including sustainable staffing and staff wellbeing, presented to the Risk Committee for assurance and scrutiny
- delivery of year one of the People Plan priorities: supporting staff with the cost of living crisis, improving and streamlining recruitment processes, focusing on basic health and wellbeing needs and introducing more support for managers
- detailed operational planning and communication throughout planned phases of industrial action to ensure patient safety, working closely in partnership with trade unions including the British Medical Association (BMA) and the Royal College of Nursing (RCN)
- continued support of the workforce following the impact of COVID-19, particularly in relation to staff health and wellbeing, by providing a range of supporting interventions for both physical and psychological wellbeing.

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
- Carbon Reduction

Care Quality Commission Compliance

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). 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, with the rating taken from the CQC report published on 7 June 2019.

During 2022/23 there was one unannounced CQC inspection of the Oxford Critical Care Unit at the John Radcliffe Hospital. This was a focused inspection, solely reviewing the Safe and Well-led key lines of enquiry and only in one of the critical care units. Therefore, the service was not rated. The inspection took place in November 2022 and the report was published in April 2023. The Trust is developing an action plan in response to this report, which will be reported through the governance structures of the Trust.

During the year, the Trust has continued engaging the CQC, in accordance with modified approaches to regulation adopted by the CQC during the recovery period from the COVID-19 pandemic. The Trust has maintained routine engagement activity with the CQC and has responded to specific planned and unplanned activities.

During 2022/23, the Trust reported on progress with remaining actions from the CQC maternity inspection published in September 2021, alongside the immediate and essential actions outlined in the Ockenden Report, and evidence requirements to support Maternity Incentive Scheme standards. Findings from CQC inspections, dynamic monitoring activity and surveys have resulted in action plans being produced by the services and monitored by the Trust's 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. In 2022, ECC moved from a monthly to bi-monthly meeting in response to positive feedback that assurance and control measures are in place. These controls include:

- validation of actions proposed for closure by the Authorised Engineer (AE) in advance of them being closed
- Audit Committee review and monitoring of the process and controls
- review of Estates Compliance Controls at the Trust Board Seminar (January 2023)
- development of a recovery plan for any actions that are overdue
- ECC operational sub-group meetings with respective Authorised Persons (AP) to enable focus on targeted actions, in particular the high-risk actions
- uploading all actions on to the action module of Ulysses, the incident reporting system.

Since the 2020/21 Premises Assurance Model (PAM) assessment, there has been a positive improvement in scores, with just 13 of the 343 questions now ranked as 'Requires Improvement' (an improvement from 24 reported in 2020/21). Areas where scores have improved include:

- better analysis of staffing needs
- plans to establish posts and ongoing recruitment (the Estates Resources Business Case was approved at the Trust Board meeting 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 are three 'Inadequate' scores that have emerged from the 2020/21 Premises Assurance Model (PAM) assessment in relation to Fire Safety, and these relate specifically to the Enforcement Notice served on the John Radcliffe Hospital's Private Finance Initiative (PFI), The Hospital Company (THC) in relation to the West Wing and Children's Hospital cladding and with the final two matters being compartmentation and alarm systems within the retained estate.

Cladding works to rectify the fire safety concerns in the West Wing and Children's Hospital commenced in May 2021 and concluded in December 2022. The Trust received confirmation from Oxfordshire Fire and Rescue Services (OFRS) that they were satisfied with the works in December 2022, which resulted in the Enforcement Notice being discharged.

Works to address the highest Fire Safety risks in the retained estate form part of the 2023/24 estates compliance capital infrastructure plan.

Policies for Medical Gas Systems, Pressure Systems, Lift Management and Electrical Safety 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, Asbestos, Waste Management, Pest Control and Control of Contractors Policies.

A full review of the resource requirements across the Estates, Facilities, Capital Development and PFI portfolio took place in 2022 and, with a business case for approximately 120 whole time equivalent posts, was approved at Trust Board in July 2022. This remains an ongoing priority area of focus for 2023/24 and is being supported by a fortnightly task and finish group, and 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.

Carbon Reduction (Greener NHS)

The Foundation Trust has undertaken risk assessments and has developed and published the '*OUH Green Plan' – Building a Greener OUH 2022-2027* in the '*Delivering a Net Zero Health Service*' report under 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 our carbon footprint
- minimise waste
- provide sustainable healthcare to secure better health for future generations.

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

The use of resources in the Trust during 2022/23 continued to be fundamentally altered by the Trust's response to the COVID-19 pandemic and the elective recovery process which commenced in the year 2021/22, which is ongoing. The COVID-19 response and elective recovery process has been built on the Trust's existing well-developed systems and processes for managing its resources.

The national process to develop an Annual Plan for 2022/23 commenced in December 2021 and was informed by the national planning guidance that was published in that month. NHS England continued to publish guidance and provide details of funding arrangements up until May 2022 when a final Annual Plan was submitted. The plan was approved by the Board, and each clinical Division signed off on its contribution. The plan was aligned with the Integrated Care Board's planning activities. As in 2021/22, the focus for the use of resources was the Trust delivering its agreed contribution to the delivery of the Integrated Care System (ICS) activity plan and financial break-even at an ICS level. The Trust planned for a £1.3m surplus on the performance measure used by NHS England.

The planning guidance set out that elective income would have a variable element linked to activity measured as a percentage of value weighted activity in 2019/20. During the year NHS England (NHSE) did not apply this deduction. The majority of clinical income was paid to the Trust on a block basis with only a number of small contracts (for example, for the Community Diagnostic Centre) paid on a variable basis linked to activity.

Achieving the planned financial performance was challenging. Staff costs were above plan from the start of the year due to higher than expected levels of staff sickness, the ongoing impact of the COVID-19 pandemic and an increased average length of stay for non-elective patients. By the end of September 2022, the Trust had reported a £10m deficit for the year to date and was losing approximately £3m a month before accounting for one off items.

The Board put a financial recovery plan in place. The plan aimed to continue to improve underlying productivity via quality improvement processes whilst also looking for one-off income and cost reduction to address the deficit at the end of September 2022. The plan was supported by the ICS and NHSE and resulted in the Board approving a forecast of a £5.3m deficit which was submitted to NHSE in February 2023.

After significant effort by staff, the Trust has reported a surplus on the revenue budget performance measure used by NHSE of £0.1m, and the ICS as a whole has delivered a deficit of £30.6m. The Trust outperformed the forecast due to one-off improvements in its financial performance in March 2023. The Trust has also reported an underspend on the capital budget measure used by NHSE of £3.37m, and the ICS as a whole delivered an underspend of £2.82m.

During the year the Trust continued to implement the findings of the financial governance review carried out in 2021/22 by the consultancy firm Grant Thornton. It also completed a financial governance checklist published by the Healthcare Financial Management Association (HFMA). This work was audited by BDO, the Internal Auditor of the Trust. These reviews have led to an ongoing programme of improvements to financial governance. During 2022/23 these improvements included: the formation of a Productivity Sub-Committee of TME, continuing work on pay controls, the adoption of standardised process control charts for financial analysis and the better use of risk analysis in planning and forecasting.

Information Governance

All incidents related to breaches in the Trust's information security processes are reported on the Trust's incident reporting system Ulysses. 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.

Date reported	Incident description	Actions taken / lessons learned
15/03/2023	Trust laptop was lost.	All Trust computers are encrypted so cannot be accessed without the correct passwords. The Information Management and Technology (IM&T) team implemented their standard operating procedure (SOP) for lost or stolen devices, remotely wiping it and resetting the user's passwords.
13/02/2023	Paper medical records requested as part of Subject Access Request could not be located. Records could also not be found in the tracking system.	Search ongoing. Details passed to ICO.
05/12/2022	Member of staff suspected of accessing patient records inappropriately.	Audit of staff member's Electronic Patient Record (EPR) access undertaken and Trust policies followed.
28/10/2022	A member of staff lost a paper appointment diary.	Diary could not be located. Staff member now uses electronic calendar to manage their appointments.
01/08/2022	Member of staff suspected of accessing patient records inappropriately.	Audit of staff member's EPR access undertaken and Trust policies followed.
16/05/2022	A department that held a local copy of patient contact details was slow to update EPR and incorrectly recorded an email address on EPR that resulted in clinic invitations being sent to a non-patient.	Email address corrected on EPR and the National Spine. Local department improved processes around local storage of patient contact details.

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 as a result 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 and Data Quality Group 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 of these 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 2021/22 DSP Toolkit submission was made on 30 June 2022 and achieved the required standards, and received a grade of 'Standards Met', having received a grade of 'Not met – approaching standards' in 2020/21.

The 2022/23 DSP Toolkit submission is due in June 2023, however the interim submission made in March 2023 indicates that this will be a 'Standards Met' grade. This has been confirmed by the internal audit work.

Data quality is currently being led by the Data Quality team within digital services. This team is responsible for training staff in the usage of key systems, monitoring system usage to ensure accurate administration, sense-checking and correcting data before reporting, and system cleansing to ensure inaccurate and obsolete data are no longer used. The processes described include the monitoring of the quality and accuracy of elective waiting time data and considering the risks to the quality and accuracy of these data.

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 Directors 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.

- Maternity development programme
- Industrial action
- Operational Performance and Operational Pressures Escalation Level (OPEL) 4
- COVID-19 pandemic impact

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 a number of challenges and has continued to focus on the global pandemic recovery over the course of the past year, and has worked to maintain the quality of service provided to its patients during the industrial action impacting ambulance staff, nurses and junior doctors. The Trust continues to maintain a relentless focus on the safety culture of the organisation.

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
28 June 2023

Accountability Report Conclusion

This concludes the Accountability Report of Oxford University Hospitals NHS Foundation Trust for the year 1 April 2022 to 31 March 2023.

Signed:

Professor Meghana Pandit
Chief Executive Officer
28 June 2023

Independent Auditors' Report and Certificate

Oxford University Hospitals NHS Foundation Trust Auditor's Annual Report

Year ended: 31 March 2023

Report date: 7 July 2023

Contents

Introduction

Purpose

The purpose of the auditor's annual report is to bring together all of the auditor's work over the year. A core element of the report is the commentary on value for money (VFM) arrangements, which aims to draw to the attention of the Trust or the wider public relevant issues, recommendations arising from the audit and follow-up of recommendations issued previously, along with the auditor's view as to whether they have been implemented satisfactorily.

Responsibilities of the appointed auditor

We have undertaken our 2022/23 audit work in accordance with the Audit Plan that we issued in October 2022. We have complied with the National Audit Office (NAO) 2020 Code of Audit Practice, other guidance issued by the NAO and International Standards on Auditing (UK).

As auditors we are responsible for:

Expressing an opinion on:

- The 2022/23 financial statements;
- The parts of the remuneration and staff report to be audited;
- The consistency of other information published with the financial statements, including the annual report; and
- Whether the consolidation schedules are consistent with the Trust's financial statements for the relevant reporting period.

Reporting by exception:

- If the governance statement does not comply with relevant guidance or is not consistent with our understanding of the Trust;
- To the Secretary of State for Health and Social Care and NHS England if we have concerns about the legality of transactions of decisions taken by the Trust;
- If we identify a significant weakness in the Trust's arrangements in place to secure economy, efficiency and effectiveness in its use of resources;
- Any significant matters that are in the public interest; and
- Any significant issues or outstanding matters arising from our work which are relevant to the NAO as group auditor.

Responsibilities of the Trust:

The Trust is responsible for preparing and publishing its financial statements, annual report and governance statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Introduction (continued)

2022/23 Conclusions	
Financial statements	Unqualified – the financial statements give a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for the year then ended. We issued our auditor's report on 29 June 2023.
Parts of the remuneration report and staff report subject to audit	We had no matters to report.
Consistency of the other information published with the financial statement	Financial information in the Annual report and published with the financial statements was consistent with the audited accounts.
Value for money (VFM)	We had no matters to report by exception on the Trust's VFM arrangements. We have included our VFM commentary in Section 03.
Consistency of the annual governance statement	We were satisfied that the annual governance statement was consistent with our understanding of the Trust.
Referrals to the Secretary of State and NHS England	We made no such referrals.
Public interest report and other auditor powers	We had no reason to use our auditor powers.
Reporting to the Trust on its consolidation schedules	We concluded that the Trust's consolidation schedules agreed, within a £300,000 tolerance, to the audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	The NAO included the Trust in its sample of Department of Health component bodies. We had no matters to report to the NAO.
Certificate	The final certificate is included in Appendix C.

Audit of the financial statements

Key findings	
The Annual Report and Accounts is an important tool for the Trust to show how it has used public money and how it can demonstrate its financial management and financial health. On 29 June 2023, we issued an unqualified opinion on the financial statements. We reported our detailed findings to the 28 June 2023 Audit Committee meeting. We outline below the key issues identified as part of our audit, reported against the significant risks and other areas of audit focus we included in our Audit Plan. We reported 7 internal control recommendations and no areas for improvement in the control environment in the Audit Results Report.	
Significant risk	**Conclusion**
Misstatements due to fraud or error through management override	Our audit work found no indication of fraud in either revenue or expenditure balances.
Risk of fraud in revenue and expenditure recognition, including the risk of management override	We have not identified any material weaknesses in the recognition of revenue or expenditure. We have not identified any instances of inappropriate judgements or estimates being applied.
Inappropriate capitalisation of revenue expenditure	Our work did not identify any material weaknesses in controls or evidence of material management override concerning the capitalisation of revenue expenditure. Our work did not identify any instances of inappropriate judgements being applied. Our work did not identify any other transactions during our audit which appeared unusual or outside the Trust's normal course of business.
Valuation of land & buildings and investment properties	Our work is complete and we reported the following differences: 1) **Adjusted judgemental difference:** the Trust restated the comparatives for 2021/22 and 2020/21 to include the non-recoverable VAT in the value of non-PFI buildings in a total of £43m as at 31 March 2022 and £39m as at 31 March 2021. The impact as at 31 March 2023 reflected in the first draft of the accounts was an increase of £49m in the value of non-PFI buildings. 2) **Unadjusted factual difference:** reclassification of properties' revaluation gain or loss between surplus and deficit and other comprehensive income of £3.5m. We have also reported a number of control recommendations with regards to the maintenance of the fixed asset register.
Inherent risk	**Conclusion**
New accounting standards – leases	Our testing is complete and we raised an internal control recommendation on documentation retention.
Inventory	Our work is complete and we have no findings to report.
Private Finance Initiative ('PFI')	We engaged our PFI specialist to assist with the review of the accounting models for a number of PFI arrangements of the Trust. Our work is complete and we have no findings to report.
Area of focus	**Conclusion**
Going concern	We reviewed management's going concern assessment and the cash flow forecasts until 30 June 2024. We also reviewed the going concern disclosures in the accounts. We have no findings to report on this area of focus.

Value for Money

We did not identify any risks of significant weaknesses in the Trust's VFM arrangements for 2022/23

Our VFM commentary highlights relevant issues for the Trust and the wider public

We had no matters to report by exception in the audit report

Scope

We are required to report on whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in it use of resources. We have complied with the guidance issued to auditors in respect of their work on value for money arrangements (VFM) in the 2020 Code of Audit Practice (2020 Code) and Auditor Guidance Note 3 (AGN 03). We presented our VFM risk assessment to the 14 June Audit Committee meeting which was based on a combination of our cumulative audit knowledge and experience, our review of Trust committee reports, meetings with the Chief Finance Officer and the Deputy Director of Assurance and evaluation of associated documentation through our regular engagement with Trust management and the finance team.

Reporting

We completed our risk assessment procedures by 14 June 2023 and did not identify any significant weaknesses in the Trust's VFM arrangements. We have also not identified any significant risks during the course of our audit. As a result, we had no matters to report by exception in the audit report on the financial statements.

Our commentary for 2022/23 is set out over pages 7 to 17. The commentary on these pages summarises our conclusions over the arrangements at the Trust in relation to our reporting criteria (see below) throughout 2022/23. Appendix A includes the detailed arrangements and processes underpinning the reporting criteria.

In accordance with the NAO's 2020 Code, we are required to report a commentary against three specified reporting criteria:

Reporting criteria	Risks of significant weaknesses in arrangements identified?	Actual significant weaknesses in arrangements identified?
Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services	No significant risks identified	No significant weaknesses identified
Governance: How the Trust ensures that it makes informed decisions and properly manages its risks	No significant risks identified	No significant weaknesses identified
Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services	No significant risks identified	No significant weaknesses identified

Value for Money (continued)

Financial Sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services

The Trust is part of the wider Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System ('BOB ICS'). ICSs are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. The BOB ICS is under significant financial pressure. A final deficit plan for 2023/24 was produced and submitted to NHS England for the BOB ICS.

The Trust recorded a deficit for the year of £5.5m in 2022/23 on a statutory reporting basis and it has submitted a plan for 2023/24 showing a surplus of £17m on a statutory reporting basis and an adjusted expected deficit of £2.8m, after removing the impact of capital donations, grants and peppercorn leases. It is within this overall context that we comment and make our judgements set out below.

Despite an expected adjusted deficit, the Trust prepared a cash flow forecast which shows a positive closing cash balance through to the end of June 2024. In addition to this, management has assessed a range of scenarios that could present risks to the cash resilience of the Trust. The scenarios considered include the potential for delays to expected cash inflows, the potential for costs to increase and the potential for undelivered efficiencies. These scenarios, individually and collectively, generate the potential for periods of negative cash. The Trust has a Productivity Committee which manages the delivery of efficiencies and productivity improvements, however, the mitigations that management would introduce in any of these scenarios may not sufficiently mitigate the negative cash position, in which circumstance, management would engage with NHS England who have issued their provider revenue support process for 2023/24. This process provides cash support to Trusts facing cash resource issues, either due to a deficit or short term cashflow difficulties and would take the form of Public Dividend Capital rather than a repayable loan facility.

The funding environment for the NHS has been challenging and it is incumbent on services to operate as efficiently as possible to optimize the resources available. Any agreed cost pressures add to the overall efficiency requirement to be made by the divisions and corporate directorates.

Conclusion: The Trust had the arrangements we would expect to see in 2022/23 to enable it to plan and manage its resources to ensure that it can continue to deliver its services.

Value for Money (continued)

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks

The Trust's Board has the overall responsibility for setting the strategic direction for the Trust. It makes sure that the Trust adheres to the principles set out in the NHS Constitution, NHS England's NHS Foundation Trust Code of Governance, and other related publications.

The Audit Committee oversees 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.

Risk is monitored and assessed through a combination of board assurance framework and the Trust risk register and assessment processes. 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. They are required to escalate relevant risks for inclusion in the Corporate Risk Register, which is reviewed by the Board Committees.

The Trust has in place a robust internal audit process implemented by the external provider BDO. For 2022/23, the Head of Internal Audit provided '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'.

The Trust appointed a counter fraud external specialist, TIAA, whose services are underpinned by the Trust's counter fraud policy. TIAA concluded that the Counter Fraud function is embedded well within the Trust and the work undertaken successfully addressed the Trust's Counter Fraud Strategy.

Conclusion: The Trust had the arrangements we would expect to see in 2022/23 to enable it to make informed decisions and properly manage its risks.

Value for Money (continued)

Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

The Trust has a Performance Management and Accountability Framework approved by the Trust Management Executive, which lays out policies for effective and efficient governance processes for accountability and performance management. The purpose of the Framework is to work with partners to collaboratively deliver integrated and sustainable services in order to improve the access, quality, and experience of care for patients.

The Chief Executive Officer has overall responsibility for the management of the Trust with personal responsibility for managing the organisation efficiently and effectively.

An Integrated Performance Report ('IPR') is produced monthly for the Integrated Assurance Committee ('IAC') – this incorporates all aspects of financial performance, activity and workforce as well as quality metrics. The IAC provides detailed scrutiny and challenge of the report at its meetings.

The Trust has an Integrated Quality Improvement Programme for period 2022-2025, which covers KPIs related to improving the quality and efficiency of its service delivery. Following approval at the Integrated Assurance Committee in June 2022, the scope of the Improvement Programme was expanded to include recruitment and avoidable patient harm. The Trust's Productivity Committee receives a monthly update on the impact of the programme on efficiency and effectiveness as well as the financial implications. The Productivity Committee also has the role of reviewing external benchmarking tools, such as GIRFT (Getting It Right First Time), to identify areas for process improvement or cost optimisation.

In addition, the Trust receives quality inspections from the external regulator, Care Quality Commission ('CQC'). At the end of 2022/23, the Trust's overall combined CQC quality rating was 'Requires Improvement'. More details on this can be found in the VFM Appendices that follow.

The Trust's Annual Report sets out its performance against key indicators and how it evaluates and assesses performance and improvement opportunities.

Conclusion: The Trust had the arrangements we would expect to see in 2022/23 to enable it to use information about its costs and performance to improve the way it manages and delivers services.

Appendices

Building a better working world

Appendix A – Summary of arrangements

Financial Sustainability

Reporting Sub-Criteria	Findings
How the body ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them	The Trust is guided by a Performance Management and Accountability Framework, which outlines the processes to identify, monitor and respond to performance against agreed standards, and identifies the roles, functions and responsibilities for Committees and individuals in order to celebrate success, share good practice, oversee continuous improvement, and identify areas in need of performance improvement. There are monthly and quarterly performance reviews within each division attended by Executive Directors, where financial, performance and operational pressures are discussed. There are also Corporate Performance Reviews being performed whereby Chief Officers are being held accountable for the Strategy and Objectives of the Executives. The key issues, pressures and risks are reported either to the Integrated Assurance Committee ('IAC') or Board of Directors, depending on the meeting timetable, to ensure that there is clear oversight of emerging issues and corresponding actions are agreed to respond to those pressures.
How the body plans to bridge its funding gaps and identifies achievable savings	The Trust has a Productivity Committee which manages the delivery of efficiencies and productivity improvements. This committee meets monthly chaired by the Chief Executive Officer. In addition, the Trust continues to progress quality improvements through the Integrated Quality Improvement Team. The Quality improvement programme is focused on key strategic themes. Both the Trust Management Executive ('TME') and the IAC receive a monthly report on the deliverable of the projects, including key metrics, and financial savings, where applicable. This is discussed on a monthly basis at the Productivity Committee. Where the actions engaged by management would not sufficiently mitigate a potential cash negative position, management would engage with NHS England who have issued their provider revenue support process for 2023/24. This process provides cash support to Trusts facing cash resource issues, either due to a deficit or short term cashflow difficulties and would take the form of Public Dividend Capital rather than a repayable loan facility.
How the body plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities	The Trust's strategic and statutory priorities, which are detailed in the Trust's Strategy for 2020-2025, are directed by the NHS national priorities and operational planning guidance. The Trust has a planning oversight group to ensure that all aspects of planning, that is quality, operations, workforce and finance are aligned with the Trust's strategic and statutory priorities. This group reports to TME and through it to the Trust Board. The budgeting process is aligned to commissioning priorities and NHS strategy, as outlined in the budget setting paper and the planning structure.

Appendix A – Summary of arrangements

Financial Sustainability

Reporting Sub-Criteria	Findings
How the body ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system	The overall plans for the Trust are aligned and agreed on an Integrated Care Board ('ICB') basis via the joint Chief Officers forums. Consistency within the Trust is achieved through the oversight group as mentioned in the previous section. Capital planning is aligned to the Trust's needs and regional priorities and the Trust's capital envelope is part of the overall ICB's capital envelope. The capital prioritisation plan is managed by the Capital management group with membership from all clinical and corporate divisions.
How the body identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans	Risks are identified, reported and managed/mitigated in reforecasting or mid-year planning processes. This includes intended use and transparent management of reserves/contingencies. The Trust has a clear business case process when services are faced with changes which impact activity and financials requiring resources via the weekly business planning group, fortnightly TMEs, and a route to Trust Board through the Investment committee when the decisions exceed the TME delegated limit.

Appendix A – Summary of arrangements (continued)

Governance

Reporting Sub-Criteria	Findings
How the body monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud	The Trust has an established Risk Committee which is chaired by the Chief Executive Officer. The committee considers emerging risks, risks highlighted by the divisions and the Trust's risk register and Board Assurance Framework. The Trust has a risk management system, Ulysses, which can be used by any member of staff to alert the Trust to potential or actual risks. The Trust work in tandem with the Trust's internal auditors, BDO, to identify key areas of risk. Based on this risk assessment, an internal audit plan is derived which seeks to provide assurance on the internal controls in key risk areas identified. Management is actively involved in the selection of areas with higher levels of risk and in implementing the recommendations from these reviews in a timely manner, demonstrating an effective loop from findings to implementation. The Trust's anti-crime external provider, TIAA, undertakes a fraud and bribery risk assessment that considers the risk of fraud across all business segments of the Trust. This assessment is undertaken in conjunction with management and it incorporates both internal and external key risks. Where there are areas of high risk, emerging risks across the health economy or within the Trust, remedial work is undertaken by TIAA to mitigate these fraud risks. The fraud and bribery risk assessment is a live document that is regularly reviewed and updated as new risks and issues emerge.
How the body approaches and carries out its annual budget setting process	The Trust is applying an incremental budgeting approach wherein a budget is prepared by taking the current period's budget or actual/forecast financial performance and using it as a base and then adjusting it by incremental amounts. Under the pre-pandemic financial regime, the method was a mix of incremental and activity-based budgeting. There is a reassessment of in-year forecasts and underlying run rate analysis throughout the financial year with bridge analysis to identify key changes. These are included as part of the IAC performance reports.
How the body ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed	There are monthly and quarterly performance reviews within each division, attended by executive directors, where financial, performance and operational pressures are discussed. The key issues, pressures and risks are reported either to the IAC or Board depending on the meeting timetable to ensure that there is clear oversight of emerging issues. An Integrated Performance Report (IPR) is produced monthly for IAC – this incorporates all aspects of financial performance, activity and workforce as well as quality metrics. The IAC provides detailed scrutiny and challenge of the report at its meetings.

Appendix A – Summary of arrangements (continued)

Governance

Reporting Sub-Criteria	Findings
How the body ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency. This includes arrangements for effective challenge from those charged with governance/audit committee	The Trust's Board has the overall responsibility for setting the strategic direction for the Trust. It makes sure that the Trust adheres to the principles set out in the NHS Constitution, NHS England's NHS Foundation Trust Code of Governance, and other related publications. To maintain balanced unitary decision-making, all Board members hold voting positions. The principles of compliance with the NHS Foundation Trust Licence contain processes to support the Non-Executive Directors in their scrutiny and challenge of Executive management actions, as well as processes to support the Board's assessment of evidence to enable the Board to make evidence-based unitary decisions. The Trust has assessed that it is compliant with these conditions. In relation to capital decisions and review, an annual capital plan is developed by the capital management group, which has input for all divisional teams as well as heads of departments. The plan is agreed by the Trust's Board, and performance against the plan is reported to and discussed at the Investment Committee. The Audit Committee meets regularly and challenges the Trust on performance and budgeting reporting.
How the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour (such as gifts and hospitality or declarations/conflicts of interests)	The Trust has a declaration of interest policy, which states that all staff must declare any personal, professional or business interest which may conflict with their official duty, or may be seen to compromise their personal integrity in any way. There is a register of interest maintained for all staff by the company secretariat. Additionally, the Trust maintains a register of interests for all Board members. This is reviewed annually as part of the annual report process to ensure completeness and accuracy of declarations. In addition, the Trust partakes in the National Fraud initiative exercise managed by the Counter Fraud Authority, and the Trust is supported by their anti-crime specialist, TIAA. Part of TIAA's scope of work is to identify any members of staff who also have a beneficial interest in a supplier used by the Trust.

Appendix A – Summary of arrangements (continued)

Improving economy, efficiency and effectiveness

Reporting Sub-Criteria	Findings
How financial and performance information has been used to assess performance to identify areas for improvement	The Chief Finance Officer presents updated financial performance reports at the regular meetings of the Trust Board and the Audit Committee, where the Trust's performance is assessed and management is challenged to identify areas for improvement in the operations of the Trust. The Integrated Quality Improvement Programme led by the Chief Operating Officer uses performance data to identify areas of improvement. The Productivity Committee reviews external benchmarking tools, such as GIRFT (Getting It Right First Time), to identify areas for process improvement or cost optimisation.
How the body evaluates the services it provides to assess performance and identify areas for improvement	Management presents a monthly Integrated Performance Report to the Trust Board, which includes an assessment of the Trust's performance against key quality indicators, both in total and by area. The Trust's internal audit is aligned with the priorities identified in the risk register and it provides insights to management on improvement areas. The Digital Oversight Committee (DOC) has been established to review the digital environment and co-ordinate development. An annual staff survey is conducted by the Trust and the results are analysed overall and by department in order to identify areas of improvement. The Trust also receives quality inspections from the external regulator, Care Quality Commission ('CQC'). At the end of 2022/23, the Trust's overall combined CQC quality rating was 'Requires Improvement', following an inspection performed during 19 - 21 November 2018 with the following domain scores published in June 2019:

Oxford University Hospitals NHS Foundation Trust (Combined ratings from report Issued June 2019)

Theme	Rating
Combined quality and resource rating	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement
Are resources used productively?	Requires improvement

Appendix A – Summary of arrangements (continued)

Improving economy, efficiency and effectiveness

Reporting Sub-Criteria	Findings
How the body evaluates the services it provides to assess performance and identify areas for improvement	During the same inspection, the CQC also rated each of the four hospitals as follows:

Oxford University Hospitals NHS Foundation Trust (Combined ratings from report Issued June 2019)	
Hospital	**Rating**
Nuffield Orthopaedic Centre	Good
Churchill Hospital	Good
Horton General Hospital	Good
John Radcliffe Hospital	Requires improvement

The CQC performed an unannounced inspection in November 2022 on two areas that were identified as requiring improvement in 2018, but it assigned no rating, and only listed areas of good performance and areas of improvement.

In its Annual Governance Statement, the Trust describes its action plan in response to the CQC recommendations, and this is reported through agreed governance processes.

Management has been pro-active and responsive to the CQC findings and recommendations and there is continuous engagement with the CQC in this respect. This demonstrates that the Trust has appropriate arrangements in place to respond to quality improvements requirements. We did not identify a risk of significant weaknesses in arrangements in this respect.

How the body ensures it delivers its role within significant partnerships, engages with stakeholders it has identified, monitors performance against expectations, and ensures action is taken where necessary to improve	The key partners identified by the Trust are: the BOB ICB and other ICB provider Trusts, NHS England regional team, Oxford University, clinical networks. The Trust conducts stakeholder events when developing new services/major changes in service and it conducts Public Trust Board meetings. The Trust has proactively developed strong working relationship with a number of partners over a number of years. This has resulted in strong collaborative working with a focus on delivering the greatest possible outcome across a number of areas. Management proactivity engages with stakeholders either directly (meetings, steering groups, committees etc.) or indirectly via broader communication channels to ensure the Trust's role with any partner or stakeholder is clearly communicated. Expectations are clearly documented at the outset of any engagement, and measured as the engagement progresses.

Appendix A – Summary of arrangements (continued)

Improving economy, efficiency and effectiveness

Reporting Sub-Criteria	Findings
How the body ensures that commissioning and procuring services is done in accordance with relevant legislation, professional standards and internal policies, and how the body assesses whether it is realising the expected benefits	There are rigorous assessments of third party providers to establish whether they have adequate clinical governance arrangements in place, such as CQC licences. The Trust's Procurement teams carry out tender and quotation processes in line with UK Procurement Directives. Such tenders are caried out using procurement best practices techniques and outcomes are reported and ratified by the Director of Procurement and Supply Chain, the Chief Finance Officer and the Trust Board. The Trust uses the NHS approved frameworks to procure good and services using competitions and direct awards to suppliers who provide the best value products and services for the Trust. Where necessary, the team use waivers to ensure the continuity of service or where a competitive process does not deliver any extra value, the waiver process is overseen and approved by the supply Chain Director and the Chief Finance Officer. Benefits from supplier negotiations are captured on the Trust's procurement savings software PAM. The software captures all savings made and projects that are underway. The evidence of savings and efficiencies made are shared with the Trust leads on a monthly basis.

Appendix B – Summary of all recommendations

Recommendations

The table below sets out all the recommendations arising from the financial statements audit in 2022/23. All recommendations have been agreed by management. There were no recommendations raised with regards to our value for money audit.

Issue	Recommendation	Management Response
Financial statements: Record keeping in the fixed asset register	During our property, plant and equipment ('PPE') additions testing, we understood that there was a delay between the capitalisation date of an expense and the date of allocating the new asset in the fixed asset register by asset number. To ensure that the total closing balance of PPE is accurate at the reporting date, an 'asset clearing account' is created that combines the non-allocated assets by project. This poses difficulties in audit testing of in-year additions, thus resulting in additional un-budgeted time spent on the audit. It also creates a risk of misstatement in the closing gross book value by type of PPE, leading to a possible misstatement of depreciation charge in year due to incorrect measurement basis of assets under the clearing account. We recommend that all assets are allocated to the appropriate asset codes before the year-end accounts are prepared for issue and the balance of the 'asset clearing account' in the fixed asset register is reduced to Nil at every year-end reporting date as a minimum.	Management have noted the need for an in depth review of Fixed Asset and will update Audit Committee of progress over the coming financial year.
Financial statements: Plant and machinery asset identification	During our existence testing of plant and machinery, we identified that some assets do not have a unique identification number, thus it is not possible to track which specific asset is selected for testing (such was the case with laptops in our sample) and to determine which assets need to be written off from the fixed asset register once no longer in use. This poses a risk that assets in the closing balance of PPE might not exist as it is impossible for management to demonstrate existence of certain individual assets. This issue also poses difficulties and additional time spent on the audit. We recommend that each asset is assigned an inventory number, which should match the identification number in the accounting records. This will ensure that management is able to identify the assets that exist in the closing balance and gain assurance over the existence assertion at the reporting date of those balances.	Management have noted the need for an in depth review of Fixed Asset and will update Audit Committee of progress over the coming financial year.

Appendix B – Summary of all recommendations (continued)

Recommendations		
Issue	**Recommendation**	**Management Response**
Financial statements: Plant and machinery useful lives	We noted that a large proportion of the plant and machinery gross book value as disclosed in Note 14 for Property, plant and equipment was fully depreciated at the reporting date 31 March 2023 (approximately 50%). Management's assessment indicates that most of the fully depreciated assets were still in use at the reporting date. This indicates that the useful lives of assets applied in calculating their depreciation might not be up to date and proportionate to the usage of the benefits from those assets. Calculating depreciation on understated useful lives could lead to an overstated depreciation expense charge and an understated net book value of assets over time. We recommend that useful lives are revisited by management on a regular basis.	Management have noted the need for an in depth review of Fixed Asset and will update Audit Committee of progress over the coming financial year.
Financial statements: Documentation retention	In relation to the audit difference reported in Audit Differences section on the VAT treatment in non-PFI DRC buildings valuation, we recommend the Trust retains detailed documentation to support their judgment on complex accounting issues. This recommendation also applies to first time implementation of new accounting standards, such as IFRS 16. The documentation should demonstrate that the assumptions and methods used are in line with the requirements of the DHSC GAM. Retention of detailed documentation of management judgments can aid consistency in management practices, it can improve continuity of functions in case of an emergency disruption and it adds efficiencies in the audit process.	Management will review its approach to the retention of key documents.

Appendix B – Summary of all recommendations (continued)

Recommendations		
Issue	**Recommendation**	**Management Response**
Financial statements: Quality of working papers and audit trail	In our first year audit, we noted that the quality of working papers, listings and audit trail evidence provided to the audit team was deficient in multiple areas of the audit. This led to a significant number of iterations in the audit process. Some examples include: incomplete listings that do not reconcile with the trial balance, incomplete working papers with missing audit trail, supporting evidence which does not agree with the sampled amount and/or does not address the assertions tested. We would recommend additional training to support some key accounting personnel in understanding the audit trail quality requirements. Good quality audit evidence is key in delivering a cost efficient and effective audit while enabling the accounting team to tend to ongoing routine duties outside of the audit process. Getting it right first time is also likely to lead to a more rewarding professional experience for individuals involved in the audit process.	Management will carry out a post-audit review, including issues with the working papers which arose during the audit. Changes to processes, including working papers from the review will be actioned.
Financial statements: Good received not invoiced process	During our testing of expenditure related to goods received and not invoiced journal source, we noted that not all estimated expenditure accrued based on a purchase order is adjusted for the actual amount once the invoice is received in the same accounting period. The process described above could lead to an over or under-accrual of expenditure in a certain accounting period, which may be material to the accounts on a cumulative basis. We would recommend to streamline the process to ensure that amounts accrued in the period are reflective of the activity related to that period to the extent that information is available to management at the reporting date.	There is a significant volume of transactions which constitute the automated GRNI accrual, and includes data from procurement and clinical recipients. We will work with both groups to identify structural issues to be resolved in order to improve the accuracy.

Appendix B – Summary of all recommendations (continued)

Recommendations		
Issue	**Recommendation**	**Management Response**
Financial statements: Revaluation gains or losses accounting	We reported an uncorrected audit difference on classification of the properties' revaluation gain or loss between surplus and deficit and other comprehensive income. This audit difference was identified upon our testing of accounting treatment of the revaluation impact in the statement of comprehensive income. We noted that the recalculated amount did not agree with the amounts recorded through the fixed assets system 'RAM', however the root cause of the difference was not explained by management at the time of our procedures. An incorrect accounting treatment of a revaluation movement could lead to a material misstatement in the accounts, which in turn could lead to an incorrect surplus/(deficit) for the year and an incorrect total comprehensive income. Our recommendation is to ensure that figures used in the accounts which are calculated through accounting programmes are verified by management.	Management have noted the need for an in depth review of Fixed Asset and will update Audit Committee of progress over the coming financial year.

Appendix C – Certificate

AUDITORS CERTIFICATE WHERE THE OPINION PREVIOUSLY ISSUED IN ADVANCE OF CLOSURE OF THE AUDIT

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

Issue of audit opinion on the financial statements

In our audit report for the year ended 31 March 2023 issued on 29 June 2023, we reported that, in our opinion, the financial statements:

- gave a true and fair view of the financial position of Oxford University Hospitals NHS Foundation Trust as at 31 March 2023 and of its income and expenditure for the year then ended;
- had been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2022 to 2023; and
- had been properly prepared in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

Certificate

In our report dated 29 June 2023, we explained that we could not formally conclude the audit on that date until we had issued our Auditor's Annual Report for the year ended 31 March 2023. We have now completed our procedures and no matters have come to our attention that would have resulted in a different opinion on the financial statements or additional exception reporting on significant weaknesses in the Foundation Trust's value for money arrangements.

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.

Janet Dawson (Key Audit Partner)

Ernst & Young LLP (Local Auditor)

London

07 July 2023

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ED None

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AUDITORS CERTIFICATE WHERE THE OPINION PREVIOUSLY ISSUED IN ADVANCE OF CLOSURE OF THE AUDIT

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

7 July 2023

Oxford University Hospitals

NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2023

Foreword to the accounts

Oxford University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2023, 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
28 June 2023

Statement of Comprehensive Income

	Note	2022/23 £000	2021/22 (restated)* £000
Operating income from patient care activities	3	1,328,641	1,213,307
Other operating income	4	183,157	189,526
Operating expenses	7, 9	(1,483,312)	(1,387,601)
Operating surplus/(deficit) from continuing operations		**28,486**	**15,232**
Finance income	11	1,586	41
Finance expenses	12	(26,468)	(23,139)
PDC dividends payable		(12,121)	(9,996)
Net finance costs		**(37,003)**	**(33,094)**
Other gains / (losses)	13	2,867	59
Share of profit / (losses) of associates / joint arrangements	19	178	121
Surplus / (deficit) for the year		**(5,472)**	**(17,682)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(1,787)	(784)
Revaluations	16	43,584	31,798
Fair value gains / (losses) on equity instruments designated at fair value through OCI	20	(618)	(9,161)
Total comprehensive income / (expense) for the period		**35,707**	**4,171**

* Throughout the accounts, where opening balances have been restated, please refer to Note 35 for details

Statement of Financial Position

	Note	31 March 2023 £000	31 March 2022 (restated) £000	31 March 2021 (restated) £000
Non-current assets				
Intangible assets	14	14,689	14,155	14,671
Property, plant and equipment	14	730,072	693,628	648,073
Right of use assets	17	13,144		
Investment property	18	34,418	32,030	30,394
Investments in associates and joint ventures	19	13,345	13,166	13,045
Other investments / financial assets	20	676	1,142	10,588
Receivables	23	6,647	7,147	8,600
Total non-current assets		**812,991**	**761,268**	**725,371**
Current assets				
Inventories	22	29,103	28,517	31,939
Receivables	23	82,490	58,888	55,822
Cash and cash equivalents	24	32,604	57,323	83,769
Total current assets		**144,197**	**144,728**	**171,530**
Current liabilities				
Trade and other payables	25	(171,306)	(155,245)	(165,270)
Borrowings	27	(13,869)	(14,095)	(11,443)
Provisions	28	(2,232)	(7,958)	(6,609)
Other liabilities	26	(3,531)	(3,882)	(3,802)
Total current liabilities		**(190,938)**	**(181,180)**	**(187,124)**
Total assets less current liabilities		**766,250**	**724,816**	**709,777**
Non-current liabilities				
Borrowings	27	(232,379)	(236,177)	(239,303)
Provisions	28	(7,659)	(8,460)	(9,033)
Other liabilities	26	(5,066)	(4,628)	(4,072)
Total non-current liabilities		**(245,104)**	**(249,265)**	**(252,408)**
Total assets employed		**521,146**	**475,551**	**457,369**
Financed by				
Public dividend capital		310,808	303,750	289,739
Revaluation reserve		226,276	193,530	170,506
Financial assets reserve		(9,863)	(9,245)	(84)
Other reserves		1,743	1,743	1,743
Income and expenditure reserve		(7,818)	(14,227)	(4,535)
Total taxpayers' equity		**521,146**	**475,551**	**457,369**

The notes on pages 144 to 184 form part of these accounts.

Signed:

Professor Meghana Pandit
Chief Executive Officer
28 June 2023

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

	Note	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	SOCI	-	-	-	-	(5,472)	**(5,472)**
Impairments	8	-	(1,787)	-	-	-	**(1,787)**
Revaluations		-	43,584	-	-	-	**43,584**
Transfer to retained earnings on disposal of assets		-	-	-	-	-	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	20	-	-	(618)	-	-	**(618)**
Public dividend capital received	SoCF	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**

Statement of Changes in Equity for the year ended 31 March 2022 (restated)

	Note	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 2021 - brought forward		**289,739**	**141,648**	**(84)**	**1,743**	**(14,837)**	**418,209**
Prior period adjustment		-	28,859	-	-	10,301	**39,160**
Taxpayers' and others' equity at 1 April 2021 - restated		**289,739**	**170,507**	**(84)**	**1,743**	**(4,536)**	**457,369**
Surplus/(deficit) for the year	SOCI	-	-	-	-	(17,682)	**(17,682)**
Impairments	8	-	(784)	-	-	-	**(784)**
Revaluations		-	31,798	-	-	-	**31,798**
Transfer to retained earnings on disposal of assets		-	(59)	-	-	59	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	20	-	-	(9,161)	-	-	**(9,161)**
Public dividend capital received	SoCF	14,011	-	-	-	-	**14,011**
Other reserve movements		-	(7,932)	-	-	7,932	**-**
Taxpayers' and others' equity at 31 March 2022		**303,750**	**193,530**	**(9,245)**	**1,743**	**(14,227)**	**475,551**

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 expenses. 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	2022/23 £000	2021/22 (restated) £000
Cash flows from operating activities			
Operating surplus / (deficit)		28,486	15,232
Non-cash income and expense:			
Depreciation and amortisation	7.1	49,093	36,257
Net impairments	8	3,289	15,526
Income recognised in respect of capital donations	4	(3,183)	(4,747)
Amortisation of PFI deferred credit		(143)	(86)
(Increase) / decrease in receivables and other assets		(26,949)	(5,955)
(Increase) / decrease in inventories		(586)	3,422
Increase / (decrease) in payables and other liabilities		9,367	11,061
Increase / (decrease) in provisions		(6,499)	804
Net cash flows from / (used in) operating activities		**52,875**	**71,514**
Cash flows from investing activities			
Interest received		1,586	41
Purchase and sale of financial assets / investments		238	-
Purchase of intangible assets		(3,851)	(2,455)
Purchase of PPE and investment property		(28,576)	(81,214)
Sales of PPE and investment property		90	11
Receipt of cash donations to purchase assets		1,903	4,096
Net cash flows from / (used in) investing activities		**(28,610)**	**(79,521)**
Cash flows from financing activities			
Public dividend capital received		7,058	14,011
Movement on loans from DHSC		(662)	10,200
Movement on other loans		(416)	(392)
Capital element of finance lease rental payments		(3,320)	(46)
Capital element of PFI, LIFT and other service concession payments		(12,940)	(11,098)
Interest on loans		(469)	(350)
Interest paid on finance lease liabilities		(120)	(6)
Interest paid on PFI, LIFT and other service concession obligations		(25,904)	(22,741)
PDC dividend (paid) / refunded		(12,211)	(8,017)
Net cash flows from / (used in) financing activities		**(48,984)**	**(18,439)**
Increase / (decrease) in cash and cash equivalents		**(24,719)**	**(26,446)**
Cash and cash equivalents at 1 April - brought forward		**57,323**	**83,769**
Cash and cash equivalents at 31 March	24	**32,604**	**57,323**

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 2022/23 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 2023/24. 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 final 2023/24 plan in May 2023 which indicated that the trajectory breakeven requirement could not be met primarily due to external, excess inflationary pressure leading to a £2.8m plan deficit. As a result of the deficit plan, Management has assessed its cash position through to the end of the going concern period of 30th June 2024 and concluded that, on the basis of the assumptions made in the plan, the Trust will remain cash positive. Therefore, despite the plan 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 for the next 12 months and into the first quarter of 2024/25.

In addition to this, Management has assessed a range of scenarios that could present risks to the cash resilience of the organisation. The scenarios considered include the potential for delays to expected cash inflows, the potential for costs to increase and the potential for undelivered efficiencies. These scenarios, individually and collectively, generate the potential for periods of negative cash. The mitigations that management would introduce in any of these scenarios would not sufficiently mitigate the cash negative position, therefore Management has established where access to further cash would come from, if it were needed.

Management has therefore engaged with NHS England who have issued their Provider revenue support process for 2023/24. This process provides cash support to Trusts facing cash resource issues, either due to a deficit or short term cashflow difficulties and would take the form of Public Dividend Capital rather than a repayable loan facility.

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 income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. These are termed '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 differs from the agreed level set in the fixed payments, the variable element either increases or reduces 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 for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

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 2022/23 payment under these schemes is included in fixed payments from commissioners based on assumed achievement of criteria.

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 grant is used to fund capital expenditure, it is credited to the consolidated 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 Trust 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.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

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.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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.

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.

Gains and losses 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) and Local Improvement Finance Trust (LIFT) 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. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as a finance cost as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

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 Years	Max life Years
Land	Not applicable	
Buildings, excluding dwellings	10	50
Dwellings	10	20
Plant & machinery	5	16
Transport equipment	7	7
Information technology	3	8
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	3	8
Software licences	3	10

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.

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.

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 subsequently measured at amortised cost or fair value through other comprehensive income. Financial liabilities are 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 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

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

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been 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 have only been 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 have not been 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 has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been 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 has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

The Trust as lessor

Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust is an intermediate lessor, classification of all continuing sublease arrangements has been reassessed with reference to the right of use asset.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

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 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.27%	0.47%
Medium-term	After 5 years up to 10 years	3.20%	0.70%
Long-term	After 10 years up to 40 years	3.51%	0.95%
Very long-term	Exceeding 40 years	3.00%	0.66%

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 2023:

	Inflation rate	Prior year rate
Year 1	7.40%	4.00%
Year 2	0.60%	2.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (prior year: minus 1.30%).

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 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 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases - application of liability measurement principles to PFI and other service concession arrangements

From 1 April 2023, the measurement principles of IFRS 16 will also be applied to the Trust’s PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Such remeasurements will be recognised as a financing cost. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred.

Initial application of these principles will be on 1 April 2023 using a modified retrospective approach with the cumulative impact taken to reserves. This is expected to result in an increased PFI liability on the statement of financial position. The effect of this has not yet been quantified.

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 2021. Standard is not yet adopted by the FReM which is expected to be from April 2023: early adoption is not permitted.

Note 1.22 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 section 1.23. 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

The assessment of the optimal site for the modern equivalent asset (MEA) value.

Note 1.23 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 contingent rent. 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 operation assets, the valuation, including movementf from last year, are documented in note 14. The valuation and movement on investment properties is detailed are note 18.

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)	2022/23 £000	2021/22 £000
Acute services		
Income from commissioners under API contracts*	1,051,483	987,728
High cost drugs income from commissioners (excluding pass-through costs)	165,974	157,269
Other NHS clinical income	9,592	9,315
Total acute services income	1,227,049	1,154,312
All services		
Private patient income	7,394	7,457
Elective recovery fund	35,805	20,197
Additional pension contribution central funding**	31,035	28,956
Agenda for change pay offer central funding***	23,839	
Other clinical income	3,519	2,385
Total income from activities	**1,328,641**	**1,213,307**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National Tariff payments system documents.

https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

**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.

*** In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2022/23 £000	2021/22 £000
NHS England	644,565	530,556
Clinical commissioning groups	156,135	665,053
Integrated care boards	508,557	
Department of Health and Social Care	53	-
Local authorities	4,596	7,009
Non-NHS: private patients	7,394	7,457
Non-NHS: overseas patients (chargeable to patient)	2,103	1,127
Injury cost recovery scheme	1,416	1,258
Non NHS: other	3,822	847
Total income from activities	**1,328,641**	**1,213,307**
Of which:		
Related to continuing operations	1,328,641	1,213,307

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2022/23 £000	2021/22 £000
Income recognised this year	2,103	1,127
Cash payments received in-year	587	354
Amounts added to provision for impairment of receivables	2,281	159
Amounts written off in-year	-	(6)

Note 4 Other operating income

	2022/23			2021/22		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	54,298	-	**54,298**	55,315	-	**55,315**
Education and training	47,047	1,560	**48,607**	47,285	1,880	**49,165**
Non-patient care services to other bodies	37,830		**37,830**	43,759		**43,759**
Reimbursement and top up funding	1,964		**1,964**	4,591		**4,591**
Income in respect of employee benefits accounted on a gross basis	15,414		**15,414**	14,535		**14,535**
Receipt of capital grants and donations and peppercorn leases		3,183	**3,183**		4,747	**4,747**
Charitable and other contributions to expenditure		1,803	**1,803**		2,762	**2,762**
Revenue from operating leases		2,060	**2,060**		1,817	**1,817**
Amortisation of PFI deferred income / credits		143	**143**		86	**86**
Other income	17,855	-	**17,855**	12,749	-	**12,749**
Total other operating income	**174,408**	**8,749**	**183,157**	**178,234**	**11,292**	**189,526**
Of which:						
Related to continuing operations			183,157			189,526
The £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

	2022/23	2021/22
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	3,743	1,968

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

Under the terms of its provider licence, 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:

	2022/23	2021/22
	£000	£000
Income from services designated as commissioner requested services	1,319,144	1,204,723
Income from services not designated as commissioner requested services	9,497	8,584
Total	**1,328,641**	**1,213,307**

Note 5.4 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from 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.

	2022/23	2021/22
	£000	£000
Income	12,000	10,073
Full cost	(14,222)	(7,944)
Surplus / (deficit)	**(2,222)**	**2,129**

Note that this relates to private patient income of £7.4m (2021/22: £7.5m), overseas patient income of £2.1m (2021/22: £1.1m) and car parking income of £2.5m (2021/22: £1.1m).

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 applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis. This includes a different maturity analysis of future minimum lease receipts under IAS 17 compared to IFRS 16.

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

	2022/23	2021/22
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	2,060	1,817
Total in-year operating lease income	**2,060**	**1,817**

Note 6.2 Future lease receipts

	31 March 2023	31 March 2022
	£000	£000
Future minimum lease receipts due:		
- not later than one year	2,032	1,859
- later than one year and not later than five years	6,562	6,396
- later than five years	18,089	18,507
Total	**26,683**	**26,762**

Note 7.1 Operating expenses

	2022/23	2021/22 (restated)
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,259	5,563
Purchase of healthcare from non-NHS and non-DHSC bodies	19,639	17,807
Staff and executive directors costs	836,692	761,396
Remuneration of non-executive directors	197	194
Supplies and services - clinical (excluding drugs costs)	161,361	145,280
Supplies and services - general	7,740	8,622
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	186,296	168,114
Inventories written down	110	554
Consultancy costs	2,284	4,552
Establishment	11,328	9,025
Premises	36,324	44,948
Transport (including patient travel)	4,807	10,341
Depreciation on property, plant and equipment	45,095	33,362
Amortisation on intangible assets	3,998	2,895
Net impairments	3,289	15,526
Movement in credit loss allowance: contract receivables / contract assets	1,059	4,759
Change in provisions discount rate(s)	(581)	85
Fees payable to the external auditor		
audit services- statutory audit	320	90
Internal audit costs	188	119
Clinical negligence	31,677	33,217
Legal fees	785	549
Insurance	82	98
Research and development	45,704	48,621
Education and training	12,171	11,553
Operating lease expenditure (comparative only)		1,310
Redundancy	190	33
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	47,229	39,897
Car parking & security	2,101	1,463
Hospitality	6	6
Losses, ex gratia & special payments	29	54
Other services, eg external payroll	8,325	7,892
Other	9,608	9,676
Total	**1,483,312**	**1,387,601**
Of which:		
Related to continuing operations	1,483,312	1,387,601

Note 7.2 Other auditor remuneration

Gross statutory audit fees paid by the Trust were £320k, net of VAT this was £267k. No remuneration was paid 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 £2 million (2021/22: no limit).

Note 8 Impairment of assets

	2022/23	2021/22 (restated)
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	1	289
Changes in market price	3,288	15,237
Total net impairments charged to operating surplus / deficit	**3,289**	**15,526**
Impairments charged to the revaluation reserve	1,787	784
Total net impairments	**5,076**	**16,310**

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

	2022/23 Total £000	2021/22 Total £000
Salaries and wages	641,891	598,603
Social security costs	61,890	54,797
Apprenticeship levy	2,906	2,715
Employer's contributions to NHS pensions	100,915	94,449
Pension cost - other	106	77
Termination benefits	190	33
Temporary staff (including agency)	79,050	62,515
Total gross staff costs	**886,948**	**813,189**
Of which		
Costs capitalised as part of assets	594	892

Further details of staff numbers and directors' remuneration is available in the annual report.

Note 9.1 Retirements due to ill-health

During 2022/23 there were 8 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £959k (£335k in 2021/22).

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 two 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 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

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.

	2022/23	2021/22
	£000	£000
Interest on bank accounts	1,586	41
Total finance income	**1,586**	**41**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2022/23	2021/22
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	188	140
Interest on other loans	284	280
Interest on lease obligations	120	6
Main finance costs on PFI and LIFT schemes obligations	12,708	13,272
Contingent finance costs on PFI and LIFT scheme obligations	13,196	9,469
Total interest expense	**26,496**	**23,167**
Unwinding of discount on provisions	(28)	(28)
Total finance costs	**26,468**	**23,139**

Note 13 Other gains / (losses)

	2022/23	2021/22
	£000	£000
Gains on disposal of assets	90	31
Losses on disposal of assets*	(230)	(1,323)
Total gains / (losses) on disposal of assets	**(140)**	**(1,292)**
Fair value gains / (losses) on investment properties	2,388	1,636
Fair value gains / (losses) on financial assets / investments	619	(285)
Total other gains / (losses)	**2,867**	**59**

* Losses on disposal 2021/22 £1.3m related to assets donated to the Trust during the pandemic which were subsequently returned.

Note 14 Non-current assets - 2022/23

	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 2022 - brought forward (restated)	**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/depreciation at 1 April 2022 - brought forward	**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)**
Historic adjustment					-	-	-	-	(17,124)	(327)	(767)	(259)	**(18,477)**
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)**
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**
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 14.1 Non-current assets - 2021/22

	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 2021 - as previously stated	**3,914**	**28,166**	**5,327**	**37,407**	**36,327**	**438,484**	**820**	**51,991**	**240,771**	**711**	**21,932**	**4,636**	**795,672**
Prior period adjustments	-	-	-	**-**	-	39,017	143	-	-	-	-	-	**39,160**
Valuation / gross cost at 1 April 2021 - restated	**3,914**	**28,166**	**5,327**	**37,407**	**36,327**	**477,501**	**963**	**51,991**	**240,771**	**711**	**21,932**	**4,636**	**834,832**
Additions	1,004	50	1,401	**2,455**	-	7,117	-	23,989	28,126	-	5,424	-	**64,656**
Impairments	-	-	(76)	**(76)**	-	(29,202)	-	(213)	-	-	-	-	**(29,415)**
Reversals of impairments	-	-	-	**-**	2,093	1,383	-	-	-	-	-	-	**3,476**
Revaluations	-	-	-	**-**	6	20,011	46	-	4	-	-	-	**20,067**
Reclassifications	-	2,550	(2,550)	**-**	-	34,705	-	(43,817)	9,074	-	44	(6)	**-**
Disposals / derecognition	-	(6,188)	-	**(6,188)**	-	-	-	-	(3,609)	-	7	-	**(3,602)**
Valuation / gross cost at 31 March 2022	**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**
Amortisation at 1 April 2021 - as previously stated	**2,615**	**20,121**	**-**	**22,736**	**-**	**70**	**-**	**-**	**171,542**	**652**	**10,562**	**3,933**	**186,759**
Provided during the year	530	2,365	-	**2,895**	-	21,313	54	-	8,918	17	2,853	207	**33,362**
Impairments	-	-	-	**-**	-	(3,542)	-	-	-	-	-	-	**(3,542)**
Reversals of impairments	-	-	-	**-**	-	(6,163)	-	-	-	-	-	-	**(6,163)**
Revaluations	-	-	-	**-**	-	(11,677)	(54)	-	-	-	-	-	**(11,731)**
Reclassifications	-	-	-	**-**	-	6	-	-	-	-	-	(6)	**-**
Disposals / derecognition	-	(6,188)	-	**(6,188)**	-	-	-	-	(2,286)	-	(13)	-	**(2,299)**
Amortisation at 31 March 2022	**3,145**	**16,298**	**-**	**19,443**	**-**	**7**	**-**	**-**	**178,174**	**669**	**13,402**	**4,134**	**196,386**
Property, plant and equipment financing - 31 March 2022													
Owned - purchased					34,972	256,429	1,009	29,243	67,986	42	13,706	495	**403,882**
Finance leased					-	-	-	-	429	-	-	-	**429**
On-SoFP PFI contracts and other service concession arrangements					-	204,300	-	-	22,452	-	-	-	**226,752**
Owned - donated/granted					3,454	50,779	-	2,707	5,325	-	299	1	**62,565**
Total net book value at 31 March 2022					**38,426**	**511,508**	**1,009**	**31,950**	**96,192**	**42**	**14,005**	**496**	**693,628**

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

The Trust’s land and buildings were revalued as at 31 March 2023 by the Trust's appointed expert valuer (Richard Waterson, MRICS, 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 thatvaluation 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.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Note 17.1 Right of use assets - 2022/23

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
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**
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 17.2 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.

	2022/23
	£000
Carrying value at 31 March 2022	**388**
IFRS 16 implementation - adjustments for existing operating leases	11,271
Lease additions	2,040
Interest charge arising in year	120
Lease payments (cash outflows)	(3,440)
Carrying value at 31 March 2023	**10,379**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 17.3 Maturity analysis of future lease payments at 31 March 2023

	Total	Of which leased from DHSC group bodies:
	31 March 2023	31 March 2023
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	3,456	901
- later than one year and not later than five years;	7,100	2,757
- later than five years.	67	-
Total gross future lease payments	**10,623**	**3,658**
Finance charges allocated to future periods	(244)	(68)
Net lease liabilities at 31 March 2023	**10,379**	**3,590**
Of which:		
Leased from other NHS providers		3,590

Note 17.4 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the Trust previously determined to be finance leases under IAS 17 at 31 March 2022.

	31 March 2022 £000
Undiscounted future lease payments payable in:	
- not later than one year;	103
- later than one year and not later than five years;	295
- later than five years.	-
Total gross future lease payments	**398**
Finance charges allocated to future periods	(10)
Net finance lease liabilities at 31 March 2022	**388**
of which payable:	
- not later than one year;	98
- later than one year and not later than five years;	290
- later than five years.	-

Note 17.5 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the Trust previously determined to be operating leases under IAS 17.

	2021/22 £000
Operating lease expense	
Minimum lease payments	1,310
Total	**1,310**

	31 March 2022 £000
Future minimum lease payments due:	
- not later than one year;	557
- later than one year and not later than five years;	971
- later than five years.	1,302
Total	**2,830**
Future minimum sublease payments to be received	-

Note 17.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 14.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022
	£000
Operating lease commitments under IAS 17 at 31 March 2022	**2,830**
Impact of discounting at the incremental borrowing rate	
IAS 17 operating lease commitment discounted at incremental borrowing rate	**2,689**
Other adjustments:	
Public sector leases without full documentation previously excluded from operating lease commitments	8,583
Finance lease liabilities under IAS 17 as at 31 March 2022	388
Total lease liabilities under IFRS 16 as at 1 April 2022	**11,660**

Note 18 Investment Property

	2022/23	2021/22
	£000	£000
Carrying value at 1 April - brought forward	**32,030**	**30,394**
Movement in fair value	2,388	1,636
Carrying value at 31 March	**34,418**	**32,030**

Note 18.1 Investment property income and expenses

	2022/23	2021/22
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	(297)	(251)
Total investment property expenses	**(297)**	**(251)**
Investment property income	2,004	1,817

Note 19 Investments in associates and joint ventures

	2022/23	2021/22
	£000	£000
Carrying value at 1 April - brought forward	**13,166**	**13,045**
Share of profit / (loss)	179	121
Carrying value at 31 March	**13,345**	**13,166**

Note 20 Other investments / financial assets (non-current)

	2022/23	2021/22
	£000	£000
Carrying value at 1 April - brought forward	**1,142**	**10,588**
Movement in fair value through income and expenditure	619	(285)
Movement in fair value through OCI	(618)	(9,161)
Disposals	(467)	-
Carrying value at 31 March	**676**	**1,142**

Note 21 Disclosure of interests in other entities

The Trust holds the following interests in key entities, as well as interests in a number of intermediary "shell" companies which are not trading. 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. Oxford University Clinic LLP - 50% voting rights, with 50% share of profits.

Note 22 Inventories

	31 March 2023	31 March 2022
	£000	£000
Drugs	6,258	5,972
Consumables	20,406	20,332
Energy	368	313
Other	2,071	1,900
Total inventories	**29,103**	**28,517**

Inventories recognised in expenses for the year were £149.6m (2021/22: £134.9m). Write-down of inventories recognised as expenses for the year were £0.1m (2021/22: £0.6m).

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 2022/23 the Trust received £1.6m of items purchased by DHSC (2021/22: £2.6m).

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 2023 £000	31 March 2022 £000
Current		
Contract receivables	71,500	48,988
Allowance for impaired contract receivables / assets	(15,386)	(14,346)
Prepayments (non-PFI)	10,181	6,501
PFI prepayments - capital contributions	67	67
PFI lifecycle prepayments	7,499	11,345
VAT receivable	5,543	4,260
Other receivables	3,086	2,073
Total current receivables	**82,490**	**58,888**
Non-current		
Contract receivables	3,604	4,057
Prepayments (non-PFI)	101	127
PFI prepayments - capital contributions	803	870
Other receivables	2,139	2,093
Total non-current receivables	**6,647**	**7,147**
Of which receivable from NHS and DHSC group bodies:		
Current	40,593	11,455
Non-current	2,139	2,093

Note 23.2 Allowances for credit losses

Contract receivables and contract assets	**2022/23 £000**	**2021/22 £000**
Allowances as at 1 April - brought forward	**14,346**	**9,600**
New allowances arising	4,789	5,427
Reversals of allowances	(3,730)	(668)
Utilisation of allowances (write offs)	(19)	(13)
Allowances as at 31 Mar 2023	**15,386**	**14,346**

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. Our receivables exposed to credit risk are £36m. 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.

	2022/23 £000	2021/22 £000
At 1 April	**57,323**	**83,769**
Net change in year	(24,719)	(26,446)
At 31 March	**32,604**	**57,323**
Broken down into:		
Cash at commercial banks and in hand	39	32
Cash with the Government Banking Service	32,565	57,291
Total cash and cash equivalents as in SoFP and as in SoCF	**32,604**	**57,323**

Note 25 Trade and other payables

	31 March 2023 £000	31 March 2022 £000
Current		
Trade payables	52,153	48,669
Capital payables	19,031	12,017
Accruals	63,775	58,684
Social security costs	8,085	8,304
Other taxes payable	8,311	8,441
PDC dividend payable	1,906	1,996
Pension contributions payable	10,049	9,489
Other payables	7,996	7,645
Total current trade and other payables	**171,306**	**155,245**
Of which payables from NHS and DHSC group bodies:		
Current	10,745	9,598

Note 26 Other liabilities

	31 March 2023 £000	31 March 2022 £000
Current		
Deferred income: contract liabilities	3,370	3,796
Deferred PFI credits / income	161	86
Total other current liabilities	**3,531**	**3,882**
Non-current		
Deferred income: contract liabilities	2,169	2,271
Deferred PFI credits / income	2,897	2,357
Total other non-current liabilities	**5,066**	**4,628**

Note 27.1 Borrowings

	31 March 2023 £000	31 March 2022 £000
Current		
Loans from DHSC	733	730
Other loans	443	426
Lease liabilities*	3,419	98
Obligations under PFI, LIFT or other service concession contracts	9,274	12,841
Total current borrowings	**13,869**	**14,095**
Non-current		
Loans from DHSC	14,577	15,239
Other loans	5,662	6,095
Lease liabilities*	6,960	290
Obligations under PFI, LIFT or other service concession contracts	205,180	214,553
Total non-current borrowings	**232,379**	**236,177**

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 17.

Note 27.2 Reconciliation of liabilities arising from financing activities - 2022/23

	Loans from DHSC	Other loans	Lease Liability	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 27.3 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Lease Liability	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2021	**5,700**	**6,913**	**379**	**237,754**	**250,746**
Cash movements:					
Financing cash flows - payments and receipts of principal	10,200	(392)	(46)	(11,098)	**(1,336)**
Financing cash flows - payments of interest	(70)	(280)	(6)	(13,271)	**(13,627)**
Non-cash movements:					
Additions	-	-	55	737	**792**
Application of effective interest rate	139	280	6	13,272	**13,697**
Carrying value at 31 March 2022	**15,969**	**6,521**	**388**	**227,394**	**250,272**

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 2022	**898**	**2,041**	**104**	**13,375**	**16,418**
Change in the discount rate	(107)	(474)	-	(1,926)	**(2,507)**
Arising during the year	-	-	155	2,921	**3,076**
Utilised during the year	(108)	(113)	(125)	(1,772)	**(2,118)**
Reversed unused	(2)	-	(7)	(4,985)	**(4,994)**
Unwinding of discount	(9)	(19)	-	44	**16**
At 31 March 2023	**672**	**1,435**	**127**	**7,657**	**9,891**
Expected timing of cash flows:					
- not later than one year;	108	113	127	1,884	**2,232**
- later than one year and not later than five years;	432	452	-	132	**1,016**
- later than five years.	132	870	-	5,641	**6,643**
Total	**672**	**1,435**	**127**	**7,657**	**9,891**

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 £2.2m 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 2023, £599.7m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Oxford University Hospitals NHS Foundation Trust (31 March 2022: £889.4m).

Changes in the HM Treasury discount rate affect the value of longer term clinical negligence liabilities. The value reported in this note was higher in 2021/22, and lower in 2022/23 reflecting the discount rate fluctuations in each reporting year.

Note 29 Contingent assets and liabilities

	31 March 2023	31 March 2022
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(70)	(53)
Employment tribunal and other employee related litigation	(5,768)	(2,401)
Gross value of contingent liabilities	**(5,838)**	**(2,454)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(5,838)**	**(2,454)**
Net value of contingent assets	**-**	**-**

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 2023	31 March 2022
	£000	£000
Property, plant and equipment	2,711	2,958
Total	**2,711**	**2,958**

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 2023	31 March 2022
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**324,687**	**350,105**
Of which liabilities are due		
- not later than one year;	21,350	25,524
- later than one year and not later than five years;	84,548	83,132
- later than five years.	218,789	241,449
Finance charges allocated to future periods	(110,233)	(122,711)
Net PFI, LIFT or other service concession arrangement obligation	**214,454**	**227,394**
- not later than one year;	9,274	12,841
- later than one year and not later than five years;	41,751	38,211
- later than five years.	163,429	176,342

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 2023	31 March 2022
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,349,720**	**1,339,101**
Of which payments are due:		
- not later than one year;	77,245	70,869
- later than one year and not later than five years;	328,746	301,340
- later than five years.	943,729	966,892

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:

	2022/23	2021/22
	£000	£000
Unitary payment payable to service concession operator	**88,317**	**74,689**
Consisting of:		
- Interest charge	12,708	13,272
- Repayment of balance sheet obligation	12,867	11,138
- Service element and other charges to operating expenditure	46,698	31,656
- Capital lifecycle maintenance	2,473	8,751
- Revenue lifecycle maintenance	375	403
- Contingent rent	13,196	9,469
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	156	7,838
Total amount paid to service concession operator	**88,473**	**82,527**

Note 32 Financial instruments

Note 32.1 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 32.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Held at fair value through OCI	Total book value
	£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**

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	42,865	-	**42,865**
Other investments / financial assets	507	635	**1,142**
Cash and cash equivalents	57,323	-	**57,323**
Total at 31 March 2022	**100,695**	**635**	**101,330**

Note 32.3 Carrying values of financial liabilities

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**
Provisions under contract	4,023	**4,023**
Total at 31 March 2023	**403,275**	**403,275**

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	15,969	**15,969**
Obligations under leases	388	**388**
Obligations under PFI, LIFT and other service concession contracts	227,394	**227,394**
Other borrowings	6,521	**6,521**
Trade and other payables excluding non financial liabilities	136,455	**136,455**
Provisions under contract	9,727	**9,727**
Total at 31 March 2022	**396,454**	**396,454**

Note 32.4 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.

	2023	2022
	£000	£000
In one year or less	180,983	170,992
In more than one year but not more than five years	100,095	91,740
In more than five years	233,995	258,751
Total	**515,073**	**521,483**

Note 32.5 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 33 Losses and special payments

	2022/23		2021/22	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	10	17	15	11
Bad debts and claims abandoned	7	1	11	-
Stores losses and damage to property	2	210	2	327
Total losses	**19**	**228**	**28**	**338**
Special payments				
Ex-gratia payments	50	117	45	29
Total special payments	**50**	**117**	**45**	**29**
Total losses and special payments	**69**	**345**	**73**	**367**

Note 34 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.

Statutory payments were made to NHS Pensions and HMRC in respect of payroll costs and an outstanding payable balance exists as at 31 March in line with normal business.

The Trust made payments to NHS Professionals in respect of temporary staffing and an outstanding payable balance exists as at 31 March in line with normal business.

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 35 Prior period adjustments

The Trust has historically valued the retained estate assets (i.e non-PFI assets) net of VAT. As there was no mechanism in place as at 31 March 2023 or the previous two reporting periods which would enable the VAT to be recovered, the DHSC GAM does not allow this treatment . The correction of this error materially increases the MEA assets and requires a restatement of the opening balance sheet as detailed below:"

The impact on the 2021/22 accounts is as follows:

Item of account	Previously reported	Adjustment	Restated Balance
	£000	£000	£000
SoFP: Property, Plant and Equipment	650,575	43,053	693,628
SoFP: Income and Expenditure Reserve	(23,434)	9,207	(14,227)
SoFP: Revaluation Reserve	159,684	33,846	193,530
SOCI: Operating expenses	(1,386,507)	(1,094)	(1,387,601)
SOCI: Surplus / (deficit) for the year	(16,588)	(1,094)	(17,682)
SOCI: Other comprehensive income (will not be reclassiified to income and expenditure)			
Impairments	(1,127)	343	(784)
Revaluations	27,154	4,643	31,797
SOCF: operating surplus	16,326	(1,093)	15,233
SOCF: Depreciation and amortisation	34,170	2,085	36,255
SOCF: Net Impairments	16,519	(993)	15,526
SOCF: Cash and cash equivalents at 31 March	57,323	-	57,323

The impact on the 2020/21 accounts is as follows:

Item of account	Previously reported	Adjustment	Restated Balance
	£000	£000	£000
SoFP: Property, Plant and Equipment	608,913	39,160	648,073
SoFP: Income and Expenditure Reserve	(14,837)	10,302	(4,535)
SoFP: Revaluation Reserve	141,648	28,858	170,506

Note 36 Adjusted Financial Performance	**2022/23**	**2021/22**
Restated surplus / (deficit) for the prior period		(17,681)
Impact of prior period adjustment		1,093
Surplus / (deficit) for the period	(5,472)	(16,588)
Remove net impairments not scoring to the Departmental expenditure limit	3,288	16,230
Remove I&E impact of capital grants and donations	582	(1,867)
Remove net impact of inventories received from DHSC group bodies for COVID response	1,688	4,154
Remove loss recognised on return of donated COVID assets to DHSC	-	1,323
Adjusted financial performance surplus / (deficit)	**86**	**3,252**

Adjusted financial performance is the measure of financial performance that NHS England holds the Trust accountable for. This note reconciles financial performance under IFRS as adopted by the public sector to adjusted financial performance. This note is not subject to audit