Oxford University Hospitals

NHS Foundation Trust

Annual Report and Accounts

2021-2022

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Foreword and statement on performance

Welcome to the Annual Report of Oxford University Hospitals NHS Foundation Trust for the period 1 April 2021 to 31 March 2022.

OneTeamOneOUH

This has been another year of unprecedented challenges for the NHS, both locally and nationally, as we continued to respond to the COVID-19 pandemic. On behalf of the Trust Board, I would like to thank all staff at Oxford University Hospitals NHS Foundation Trust (OUH) for working together as OneTeamOneOUH in order to demonstrate compassionate excellence in caring for the communities which we serve. We can be proud of everything that we have achieved together, despite the many and varied challenges which we have faced, and this OneTeamOneOUH philosophy remains at the heart of our approach as we look forward to the next 12 months.

Our people are at the centre of everything we do. In recognition of the need to support our staff, we launched our *Growing Stronger Together – Rest, Reflect, Recover* programme as well as introducing an agile working policy. This allows the maximum possible remote and flexible working that every role can accommodate. *Growing Stronger Together* has been key to our emphasis on staff health and wellbeing in 2021/22 including the launch of Wellbeing Check-ins for every member of staff, a new online Staff Wellbeing Hub developed with colleagues across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS), and the introduction of Healthcare Needs Assessment kiosks on our sites where staff can get an interactive 'wellbeing MOT'.

It also includes a network of 280 Wellbeing Leads in teams, a post-traumatic growth workshop called R3P which nearly 300 staff have participated in, and a dedicated psychological health support service which has been developed with funding from NHS Charities Together via our own Oxford Hospitals Charity. This wide-ranging programme of work to support every single member of our OneTeamOneOUH workforce led to a 25% increase in staff reporting that the Trust is taking positive action on the health and wellbeing of our people in the NHS Staff Survey, which was open to all OUH staff from September to November 2021.

Growing Stronger Together has also been recognised nationally as an example of best practice by winning the 'Most Promising Organisational Development and People' category of Skills for Health's Our Health Heroes Awards in March 2022.

The COVID-19 Pandemic

The second year of the pandemic has been less eventful than the first. We were prepared for the surge in cases caused by the Omicron variant. The programme of second vaccinations and boosters protected our people and our patients from the worst consequences of the disease. Meanwhile our dedicated respiratory wards which opened earlier in the year at the John Radcliffe Hospital have reduced the impact of COVID-19 on other services.

We are tackling Long COVID, working with Oxford Health NHS Foundation Trust through a joint service which includes doctors, nurses, psychologists, physiotherapists and occupational therapists. Our teams offer both physical and psychological assessments of patients, so they can be referred to the most appropriate treatment and rehabilitation services. This is a

comprehensive service to give people living with Long COVID the longer-term care, support and rehabilitation they need.
As we emerge from the pandemic, we have encouraged our people to reflect on and share their experiences of working through the COVID-19 pandemic by submitting their stories and photographs for inclusion in our e-Book '*Stories from the COVID-19 Pandemic*', published in April 2021, and our book '*Beyond Words . . . Images from the COVID-19 Pandemic*', published in January 2022 – available to read online and download at www.ouh.nhs.uk/about/publications/books.aspx. We thank Oxford Hospitals Charity whose funding made both projects possible.

Reducing waiting times for patients

It has been an often challenging 12 months as, in common with the rest of the NHS, we have seen high volumes of patients accessing our urgent and emergency care services through our Emergency Departments at both the John Radcliffe Hospital in Oxford and the Horton General Hospital in Banbury. However, during the year 2021/22, services from across our clinical divisions developed ambitious Recovery plans which focused on increasing activity across elective and cancer pathways, reducing the length of time patients were waiting and ensuring patients were seen according to clinical priority.

The Elective Recovery Plan brought together a range of initiatives including working with partners across BOB ICS, as well as with independent sector partners and insourcing additional capacity for challenged specialties.

Through this work, the Trust was able to reduce the number of patients waiting over one year for their treatment from 4,934 to 971 between March 2021 and March 2022 (80.3% reduction). We also reduced the number of patients waiting more than two years from a peak of 101 in October 2021 to 26 patients in March 2022 (74.3% reduction). However, we are disappointed that waiting times are longer than before pre-pandemic levels and are committed to reducing further the number of patients waiting in 2022/23.

New developments

2021/22 was a year of groundbreaking developments across the Trust, as we continued 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 has opened its doors to patients with bleeding and clotting disorders, following a £4m investment by the Trust. The service has relocated to its new home from our Churchill Hospital site.

- Oxford Critical Care, our brand-new Critical Care Building at the John Radcliffe Hospital, opened in March 2022. This £29m development, supported by Department of Health and Social Care financing, is part of a regional approach for managing critical care demand.

- Trauma inpatients returned to the Trauma Building at the John Radcliffe Hospital, also in March 2022, following an extensive refurbishment project. This means that our clinical teams can care for their patients in a purpose-built environment under one roof after a number of years when Trauma inpatients were cared for in different areas of the main hospital building.

- In February 2022 the National Institute for Health Research (NIHR) announced funding for its Clinical Research Facilities (CRFs). The hub of the new Oxford Experimental Medical Clinical Research Facility will be on our Churchill Hospital site in Oxford, which will enable us to significantly expand early phase clinical trials which can have life-changing benefits for patients.

- Patients across Oxfordshire will benefit from earlier diagnostic tests in a convenient location following the opening of our new Oxford Community Diagnostic Centre (CDC) in January 2022. Early diagnosis is key to successful treatment and the development of the Oxford CDC in partnership with Perspectum will help us achieve this goal.

- Our new Swindon Radiotherapy Centre at the Great Western Hospital is due to open in Summer 2022. This will enable cancer patients in Wiltshire and surrounding counties to receive radiotherapy treatment and high-quality care closer to home and without the need to travel into central Oxford.

Our partnerships

Our OneTeamOneOUH includes those with whom we have worked closely and those who have supported our staff. It includes our 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, our Private Finance Initiative (PFI) partners, including Mitie at the John Radcliffe Hospital, and many more.

Our unique partnership with the University of Oxford has never been more important than during the COVID-19 pandemic, and it has continued to deepen and strengthen in 2021/22. Our staff and patients have played a key role in Oxford's place at the heart of global research into COVID-19, and this is just one example of how the close relationship between the Trust and the University directly benefits our patients and our staff.

Looking ahead, in 2022/23 the new BOB ICS will go live on 1 July 2022. This will be an important mechanism for driving forward partnership working with NHS, local authority and other key stakeholders.

A personal reflection

In January 2022, I announced that I would be stepping down as Chief Executive Officer on 30 June 2022, after almost seven years in the role. While the Trust appoints my substantive successor, I am very pleased that Professor Meghana Pandit, our Chief Medical Officer, will act as Chief Executive Officer from 1 July 2022.

I have decided that I want to be able to travel more to see friends and family around the world and that is not compatible with my role leading a busy hospital trust. I am going to carry on living in Oxford and I will be pursuing a portfolio of interests including research and teaching at the University of Oxford and Non-Executive roles in health innovation and social impact. I look forward to seeing OneTeamOneOUH continue to grow and develop after I step down this summer.

I have very much enjoyed leading the Trust since 2015. I would like to take this opportunity to thank every member of staff for delivering compassionate excellence to the populations

and patients we serve, especially during the difficult circumstances of the pandemic. In particular, I would like to recognise the support I have received from the whole Board of Directors, from the current Chair Professor Sir Jonathan Montgomery, our former Chair Dame Fiona Caldicott who sadly passed away in 2021, and from our former Lead Governor Dr Cecilia Gould who stepped down in March 2022 at the end of her term of office.

Signed:

Dr Bruno Holthof
Chief Executive Officer
15 June 2022

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 2021/22.

About Oxford University Hospitals NHS Foundation Trust

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 revised formal Joint Working Agreement between the Trust and the University of Oxford came into effect. 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 Improvement.

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

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.

Most of our services are provided in our hospitals, but some are delivered from 44 other locations across the region, which include which include outpatient peripheral clinics in community settings, satellite services in several 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. More than 2,000 of our staff, patients and partners worked together to develop this new strategic vision, to best serve our people, our patients and our populations.

The COVID-19 pandemic significantly changed the way we work and the OUH Strategy Framework captured the change in our context and recognised how we put into place many of the longer-term strategic shifts to safely care for our patients.

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 Future Ambitions

We continue to take forward our OUH Strategy 2020-2025, embedding and translating our objectives into our:

- Clinical Strategy
- partnership working with our Integrated Care System
- formation of provider collaboratives.

OUH Clinical Strategy Programme

In April 2022, a new Health and Care Act received royal assent and is expected to lead to significant changes in the organisation of the NHS and its integration with adult social care. In light of this, along with the ongoing challenges posed by the early waves of the COVID-19 pandemic and the opportunities to transform how we work, we have commenced the OUH Clinical Strategy Programme.

The OUH Clinical Strategy Programme will allow us to work through each of our services, identifying key strategic choices and opportunities to work differently within our system and our priorities. It will help us identify where we can add the most value for our patients and populations, and ensure that we are prioritising our people and resources effectively.

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.

Networks and Collaboration

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 (for which the John Radcliffe Hospital is the dedicated Major Trauma Centre), and a variety of paediatric 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.

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.

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 Oxford University Hospitals NHS Foundation Trust by funding the very latest medical equipment, innovative research and specialist training, as well as important staff and patient support. It also helps to enhance the hospital environment by improving wards, waiting rooms, play spaces and staff areas. The Trust is very grateful for the support of the Charity and to the many thoughtful and generous individuals, families, groups and companies for their kind donations, fundraising and gifts in wills. During the year the Charity has continued its important programme of COVID-19 support, working closely with the Trust volunteers. A few other highlights during 2021/22 include:

- funding of £262,000 for a robotic digital microscope for use in brain and spinal surgery
- funding of more than £50,000 to help create a dedicated Children's Emergency area at the Horton General Hospital
- funding of £62,000 for a new Radiology Play Specialist role for two years, to help young patients having magnetic resonance imaging (MRI) scans
- the creation of a Reminiscence Room to help patients with dementia at the Horton General Hospital

- more than £100,000 of funding for specialist equipment in Children's Critical Care areas.

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

Volunteers

Volunteers provide support in numerous ways across our four hospital sites and the OUH offices in Cowley, and work with managers and departments to deliver compassionate excellence to patients, staff and carers. The Trust's Voluntary Services Department continues to identify volunteering opportunities across the hospital sites, recruit new volunteers and provide an induction for new starters joining the Trust. In 2021/22, an additional 55 volunteers joined the volunteering family and we currently have more than 1,100 dedicated volunteers. In the last 12 months, volunteers have provided support by:

- delivering charitable donations to ward areas for staff and other services
- obtaining patient feedback in clinic areas
- providing non-medical updates to patients' families and next of kin
- helping patients with low mobility get to treatment centres
- wayfinding at the hospital entrances
- providing general administration support to departments.

Performance Overview

This section summarises operational and financial performance and achievements against the Trust's Quality Priorities during 2021/22.

The dashboard overleaf provides an overview of the performance against the key indicators from the NHS System Oversight Framework (SOF) and OUH local priorities. It includes:

- 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 provides a reference to the national average where possible.

We report on the following objectives.

- ***Maximising elective activity and restoring all cancer services*** which was a key focus in 2021/22 and a requirement of the NHS annual planning guidance. We made progress by increasing inpatient activity by 31.1% and reducing the number of patients waiting over 52 weeks from 4,934 in 2020/21 to 971 in 2021/22. However, the overall size of the waiting list rose from 42,999 to 57,599 as referrals for treatment rose faster than activity.
- ***Providing timely non-elective care*** where increasing capacity for emergency attendances and admissions affected capacity for elective services. Attendances rose by 36.3% in our Emergency Departments and emergency admissions rose by 19.5%. These increases were above the national averages and put considerable pressure on our ability to see patients quickly. The proportion of patients waiting within four hours in our Emergency Departments decreased from 85.5% in 2020/21 to 73.3% in 2021/22.
- ***Delivering safe, high-quality care*** saw the Trust continued to work towards achieving the key indicators in the NHS System Oversight Framework and the local Quality Priorities. Despite the rising patient numbers, some indicators improved with reductions in Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia cases, Clostridium difficile infections and in pressure ulcers. However, falls where a patient was harmed, and Never Events increased.
- ***Our People Plan for 2021/22*** saw action to support the health and wellbeing of staff and on recruitment and retention. We improved performance on training rates and continued to grow a diverse senior leadership team. However, sickness rates and staff turnover rose as the COVID-19 pandemic continued, and a difficult implementation of a new IT system reduced the appraisal rates, which are now a focus for improvement in 2022/23.
- ***Our management of finance and the use of resources*** saw a £3.3m surplus as measured by the NHS, which was better than our plan. We invested £67.1m in new buildings and equipment. However, this was £7.1m over our plan and we relied on underspends elsewhere in our Integrated Care System (ICS) to offset this overspend.

This performance was achieved while monitoring the risk of non-delivery, with a focus on the risks that continued COVID-19 infections levels posed to achieving waiting times for elective and non-elective care and to staff sickness levels. The emergency funding arrangements during the pandemic also made income uncertain, which affected our ability to forecast the delivery of a break-even financial performance for the whole year.

Performance Dashboard: Quality of care, access and outcomes

Oversight theme and indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
NHS Long Term Plan: Restoration of elective and cancer services				
Elective inpatient activity	n/a	68,395	89,637	31.1% more inpatient activity
Elective outpatient activity	n/a	1,007,971	1,174,818	16.6% more outpatient activity
Size of the RTT[1] waiting list	<53,550	42,999	57,599	34% more patients waiting
Patients waiting over 52 weeks (RTT[1])	<1,693	4,934	971	80.3% improvement
Cancer referral treatment levels[2]	n/a	2,531	2,918	15.3% more cancer activity
People waiting longer than 62 days[3]	<175	172	226	31.4% deterioration
Faster diagnosis standard	≥75%	81.3%	78.8%	2.5 percentage point deterioration but above target
Diagnostic activity levels (elective)	n/a	162,033	204,792	26.4% more diagnostic activity
NHS Long Term Plan: Implementation of agreed waiting times				
Outpatient activity (remotely)	n/a	18.9%	29.3%	10.4 percentage point improvement
NHS Long Term Plan: Maternal and children's health				
% of women on continuity of care pathway[4]	≥90%	99.6%	99.2%	0.4 percentage point deterioration but above target
NHS Long Term Plan: Emergency care				
% of zero-day length of stay[5]	n/a	42.0%	43.5%	1.5 percentage point improvement
Local priorities				
ED[6] performance within 4 hours (all types)	≥95%	85.5%	73.3%	12.2 percentage point deterioration
Beds occupied by COVID-19 patients (average per day)	n/a	63	41	22 fewer COVID-19 patients in beds per day
Adult Critical Care beds occupied by COVID-19 patients (average per day)	n/a	9	2	7 fewer COVID-19 patients in Critical Care beds per day
Staff absences related to COVID-19 (average per day)	n/a	329	229	100 fewer staff absent per day due to COVID-19
NHS Long Term Plan: Delivering safe, high-quality care overall				
SHMI range[7]	<1	0.90-0.92	0.91-0.92	'As expected'
HSMR range[8]	<100	85.7-92.4	85.5-93.5	'Lower than expected' i.e. fewer deaths than expected
MRSA bacteraemia cases[9]	0	8	4	Halving of MRSA (-4 cases)
Clostridium difficile cases	≤83	114	107	7 (6.1%) decrease in cases
VTE risk assessment[10]	≥95%	98.3%	98.2%	0.1 percentage point decrease
Number of falls with harm[11]	n/a	30	49	+19 (63.3%) increase
WHO Surgical Safety Checklist compliance[12]	100%	99.3%	99.7%	0.4 percentage point improvement
Local Quality Priorities				
Hospital Acquired Thrombosis (HAT)	0	4	12	+8 cases with moderate or above harm
Never Events	0	2	4	+2 increase in Never Events
Hospital Acquired Pressure Ulcers Grade 3 & 4	0	108	103	4.6% decrease in Grade 3 & 4
Incidents of violence and aggression to staff	0	214	363	69.6% increase
NHS Staff Survey score - safe environment (violence)	n/a	9.5	9.5	No change

Performance Dashboard: People, Finance and use of resources

Oversight theme and indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
NHS Long Term Plan: Looking after our people and belonging in the NHS				
Sickness absence (working days lost)	n/a	116,988	145,162	24.1% increase
Proportion of BAME[13] staff in senior leadership roles[14]	n/a	2/16	4/18	Increase of two BAME staff members in senior leadership roles
Proportion of women in senior leadership roles[14]	n/a	9/16	10/18	Increase of one female staff member in senior leadership
Local people priorities				
Total number of staff (WTE)[15]	n/a	12,246	12,676	3.5% increase
Staff turnover	≤12.0%	9.4%	12.4%	3.0 percentage point increase
Core Skills Training	≥85.0%	82.4%	88.0%	5.6 percentage point improvement
Appraisals	≥85.0%	71.3%	65.0%	6.3 percentage point deterioration
Staff engagement	n/a	7.2	7.0	0.2 decline
Staff morale	n/a	6.3	5.9	0.4 decline
NHS Long Term Plan: The NHS will return to financial balance & NHS in overall financial balance each year				
Surplus/(deficit) £m	n/a	-1.6	-16.6	1.2% movement on turnover
Financial performance as measured by the NHS £m	Break-even	3.1	3.3	6.5% improvement
Financial performance versus plan £m	n/a	19.6	8.7	55.6% decrease in surplus
Underlying financial position £m	Break-even	-57.8	-51.7	10.6% improvement
Run rate - total expenditure £m	1,273.5	1,296.5	1,386.5	6.9% increase
Local finance priorities				
Overall level of capital expenditure £m	n/a	84.2	67.1	20.3% reduction
Capital expenditure charged to ICS[16] CDEL[17] £m	33.8	27.8	40.2	44.6% increase
Overall level of capital expenditure versus plan £m	n/a	-2.9	-0.9	69% reduction in underspend
ICS[16] CDEL[17] versus plan £m	n/a	-	7.1	21.0% overspend on plan
Cash as of 31 March 2022 £m	n/a	83.8	57.3	31.6% deterioration
Cash versus plan as of 31 March 2022 £m	n/a	63.0	10.1	21.4% positive variance on plan

Notes:

1. *Referral to Treatment (RTT) pathway*
2. *Indicator includes all 62 day pathways*
3. *Indicator includes patients waiting longer than 62 days on a cancer pathway*
4. *% of women on continuity of care pathway. This indicator was first reported from Dec 2020 and the measurement criteria changed in Oct 2021*
5. *% of zero-day length of stay admissions (as a proportion of total)*
6. *ED - Emergency Department*
7. *SHMI - Summary Hospital-level Mortality Indicator*
8. *Hospital Standardised Mortality Ratio*
9. *Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia cases*
10. *Venous Thromboembolism (VTE) risk assessment*
11. *Number of falls with harm (moderate and above)*
12. *World Health Organization (WHO) Surgical Safety Checklist*
13. *Black, Asian and Minority Ethnic (BAME) staff*
14. *Senior leadership roles defined as Board level roles*
15. *WTE - Whole Time Equivalent*
16. *ICS - Integrated Care System*
17. *CDEL - Capital Department Expenditure Limit - capital expenditure as measured by HM Treasury. In effect, a subset of overall capital expenditure by the Trust*

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 System Oversight Framework relating to the NHS Long Term Plan for:

- restoring elective and cancer services
- implementing agreed waiting times
- maternal and children's health
- emergency care
- delivering safe, high-quality care overall
- looking after our people
- belonging in the NHS
- returning to financial balance.

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

Impact of COVID-19

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Beds occupied by COVID-19 patients (average per day)	n/a	63	41	22 fewer COVID-19 patients in beds per day
Adult Critical Care beds occupied by COVID-19 patients (average per day)	n/a	9	2	7 fewer COVID-19 patients in Critical Care beds per day
Staff absences related to COVID-19 (average per day)	n/a	329	229	100 fewer staff absent per day due to COVID-19

COVID-19 had a significant impact on our clinical services and staff in 2021/22. On average, there were 41 patients per day with COVID-19 occupying beds in 2021/22. This corresponded to a reduction of 22 patients in beds per day with COVID-19, on average, compared to 2020/21 where an average of 63 patients per day with COVID-19 were recorded as occupying beds.

The number of patients in hospital reflected the peaks experienced during the successive waves of the pandemic and resulted in periods of much higher numbers of patients than the average recorded. In 2021/22 the peak of patients with COVID-19 occupying beds was 149, compared to 327 patients in 2020/21.

In 2021/22, there was a daily average of two patients in Adult Critical Care beds with COVID-19, compared to a daily average of nine patients in 2020/21. This corresponded to a reduction in the daily average by seven patients. The daily peak in the number of patients in Adult Critical Care with COVID-19 decreased from 45 patients in 2020/21 compared to seven patients in 2021/22.

Our staff absences were impacted by COVID-19, directly due to the virus and indirectly due to self-isolation requirements. In 2021/22, on average, 229 staff were absent each day due to COVID-19, which although high, corresponded to 100 fewer staff absent per day due to COVID-19 in 2020/21, when the average was 329.

Quality of care, access and outcomes

Elective activity

The Elective Recovery Plan in 2021/22 included a coordinated approach to increase elective services for patients waiting for cancer treatments and long-waiting patients, and was set out according to clinical priority. We also followed the specific guidance issued for the first and second half of the financial year.

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Elective inpatient activity levels (FCEs[1])	n/a	68,395	89,637	31.1% more inpatient activity
Elective outpatient activity levels (attendances)	n/a	1,007,971	1,174,818	16.6% 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 2021/22, working 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 by nearly one-third (31.1% / +21,242) and increase patient services delivered in an outpatient setting by approximately one-sixth (+16.6% / +166,847).

Outpatient activity delivered remotely

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
% of outpatient activity delivered remotely via telephone or video	n/a	18.9%	29.3%	10.4 percentage point improvement in delivery of outpatient activity remotely

The increase in activity provided in an outpatient setting included a 10.4 percentage point improvement in the amount of activity delivered remotely, either via telephone or video consultation.

Patients waiting for elective care

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Patients waiting for consultant-led treatment (RTT[1])	<53,550	42,999	57,599	34.0% increase in patients waiting
Patients waiting more than 52 weeks to start consultant-led treatment (RTT[1])	<1,693	4,934	971	80.3% reduction in patients waiting over 52 weeks
Patients waiting more than 104 weeks to start consultant-led treatment (RTT[1])	<75	7	26	19 additional patients waiting

Note:
1. Referral to Treatment (RTT) pathway

The targeted approach to focusing treatment for patients, based on their clinical prioritisation and long-waiting patients, enabled a reduction in the number of patients waiting more than 12 months on RTT waiting lists by 80.3% from 4,934 to 971. However, due to growth in patient referrals, the number of patients waiting for treatment increased by approximately one-third (34.0% / +14,600 patients) at the beginning of clinical pathways.

There were 26 patients waiting more than 104 weeks at the end of March 2022. Although this was above the number of patients waiting in March 2021, it is important to note that, due to the COVID-19 pandemic, patients waiting were forecast to increase and the number of patients waiting at the end of the year was lower than the original forecast of 75 and better than the peak recorded in October 2021, when 101 patients were reported as waiting more than 104 weeks.

OUH performance compared to national average

Elective activity

2021/22 compared to 2020/21	2021/22 compared to 2019/20
• OUH elective inpatient and day case activity increased in 2021/22 at a rate lower than the national average (36.2% vs 42.0%). • OUH outpatient activity increased in 2021/22 at a rate above the national average (25.2% vs 22.6%).	• OUH provided elective inpatient activity 13.8% below the pre-pandemic level, which was the same as the national average (i.e. also 13.8% below 2019/20 levels). • OUH outpatient activity was above pre-pandemic levels and higher than the national average (18.7% vs 3.1%).

Source: Hospital Episode Statistic (HES) data reported by Dr Foster, April to January 2019/20, 2020/21 and 2021/22

Patients waiting over one year on a RTT pathway

2021/22 compared to 2020/21	2021/22 compared to 2019/20
• Patients waiting over 52 weeks on a RTT waiting list at OUH reduced by 80.3% from March 2020/21 to March 2021/22. • OUH's improvement was better than the national average which reduced by 29.8%.	• Patients waiting over 52 weeks remained approximately 37 times higher than in 2019/20 (971 vs 26), but the scale of the difference was lower than the national level to the end of March 2022, which was nearly 99 times higher than number of patients recorded as waiting over one year in March 2019/20.

Source: NHS England. March 2020 vs 2021 vs 2022

Patients waiting on a RTT pathway

2021/22 compared to 2020/21	2021/22 compared to 2019/20
• Patients on a RTT waiting list at OUH increased by 34.2% from March 2020/21 to March 2021/22. This was higher than the 28.5% increase recorded nationally, measured to March 2022.	• The OUH waiting list remained higher than pre-pandemic levels by 16.7%. This was better than the 50.0% increase recorded nationally in the number of patients recorded waiting, measured to March 2022. • Notwithstanding the higher levels of activity provided at OUH since 2019/20, the waiting list change will have been affected by the temporary closure to routine referrals during the pandemic which would have meant the growth in the waiting list was lower.

Source: NHS England. March 2020 vs 2021 vs 2022

Cancer performance

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Cancer referral treatment levels (all 62 day pathways)	n/a	2,531	2,918	15.3% more cancer activity
People waiting longer than 62 days on a cancer pathway	<175	172	226	31.4% increase in patients waiting over 62 days on a cancer pathway
% meeting faster diagnosis standard (28 days)	≥75%	81.3%	78.8%	2.5 percentage point deterioration but above target
2WW for suspected cancer standard	≥93%	74.9%	74.2%	0.7 percentage point deterioration
Breast Symptomatic Standard	≥93%	24.6%	31.4%	6.8 percentage point improvement
31 day Decision to First Treatment standard	≥96%	94.9%	90.5%	4.4 percentage point deterioration
31 day Decision to Subsequent Treatment (Radiotherapy) standard	≥94%	98.1%	86.0%	12.1 percentage point deterioration
31 day Decision to Subsequent Treatment (Surgery) standard	≥94%	90.0%	80.2%	9.8 percentage point deterioration
31 day Decision to Subsequent Treatment (Drugs) standard	≥98%	99.5%	98.1%	1.4 percentage point deterioration
62 day Screening to First Treatment standard	≥90%	81.6%	70.2%	11.4 percentage point deterioration
62 day GP Referral to Treatment standard	≥85%	75.7%	69.7%	6.0 percentage point deterioration

Note:

1. *2WW - two week wait from referral*

In 2021/22 compared to 2020/21, OUH delivered 15.3% more cancer activity for our patients and continued the successful Cancer Prioritisation Panel established during the COVID-19 pandemic to maintain surgery. On average across 2021/22, OUH achieved two out of the nine national standards. We achieved the 28 day Faster Diagnosis standard (78.8% vs 75%) and the 31 day Decision to Subsequent Treatment (Drugs) standard (98.1% vs 98%). The remaining standards were not achieved and are the focus of specific initiatives within the Trust's Improvement Programme.

Although meeting the standard when measured on an average across the 12 months, compared to 2020/21, there was a two and a half percentage point deterioration in patients meeting the cancer faster diagnosis standard (28 days). The Trust has invested in increasing diagnostic capacity and will be supported by a new Community Diagnostic Centre which opened in early 2022 and has plans to strengthen the workforce to enable additional services to be provided to patients and shorten waiting times. The number of patients waiting more than 62 days on a cancer pathway for the GP, screening and upgrade standards increased to 226 from 172 in 2021/22 (+54 patients). During this period, an increase of 27.5% cancer referrals to two week wait pathways (including the Breast Symptomatic pathway) were recorded compared to the previous financial year (+6,121 patient referrals).

OUH performance compared to national average

Cancer treatment levels

2021/22 compared to 2020/21	2021/22 compared to 2019/20
• OUH cancer activity for 62 day pathways increased in 2021/22 at a rate lower than the national average (15.3% vs 20.4%).	• OUH cancer activity is above pre-pandemic levels and the national average (9.2% vs 5.3%), illustrating the success of OUH in continuing to provide cancer treatments at the highest level possible during the pandemic.

Cancer performance

2021/22 compared to 2020/21	2021/22 compared to 2019/20
• The Faster Diagnosis standard (28 days) was reported nationally from April 2021. OUH performance was 6.7 percentage points better than the national average (78.8% vs 72.1%).	• N/A - the Faster Diagnosis standard was reported nationally from April 2021.

Source: NHS England. April to March 2019 vs 2020 vs 2021

Diagnostic activity

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Diagnostic activity levels (elective)	n/a	162,033	204,792	26.4% more elective diagnostic activity
Patients waiting under six weeks (DM01 national standard[1])	≥99%	92.2%	92.7%	0.5 percentage point improvement

Note:
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 2021/22 compared to 2020/21 OUH provided 26.4% more elective diagnostic activity.

The standard measuring the number of patients waiting no more than six weeks was not achieved in 2021/22. Between the end of March 2020/21 to the end of March 2021/22, performance improved from 92.2% to 92.7%.

OUH performance compared to national average

Diagnostic activity and performance

2021/22 compared to 2020/21	2021/22 compared to 2019/20
• OUH activity increased at a lower rate compared to the national average in 2021/22 (26.4% vs 30.4%). • Diagnostic performance against the standard measuring patients waiting within six weeks was 17.5 percentage points better than the national average (92.7% vs 75.2%).	• OUH activity remained closer to the volumes achieved in 2019/20 (3.8% lower compared to the national average of 6.1%), demonstrating that activity volumes were maintained at higher levels during the pandemic.

Source: NHS England. April to March 2019 vs 2020 vs 2021

Emergency care

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
ED[1] attendances (all types)	n/a	126,306	172,101	36.3% increase in activity
ED attendances (type 1)	n/a	109,133	149,103	36.6% increase in activity
ED performance within 4 hours (all types)	≥95%	85.5%	73.3%	12.2 percentage point deterioration
ED performance within 4 hours (type 1)	≥95%	83.2%	69.2%	14.0 percentage point deterioration
Emergency Spells[2]	n/a	58,425	70,363	19.5% increase in activity
% of zero-day length of stay admissions (as a proportion of total)	n/a	42.0%	43.5%	1.5 percentage point improvement in zero-day length of stay admissions

Notes:

1. *ED - Emergency Department*
2. *Measured from April 2020 to February 2021 and April 2021 to February 2022*

Elective care performance 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 2021/22, attendances at Emergency Departments (type 1) and emergency admissions increased by 36.6% and 19.5% respectively, compared to 2020/21, and this was 6.3% and 2.2% higher than 2019/20. Although there was an increase in the bed capacity at OUH in 2021/22 to accommodate some of the emergency pressures, the additional demand has placed pressure on providing elective care capacity.

Performance within the Emergency Department, as measured using the national standard for the percentage of patients attending the Emergency Department for less than 4 hours from arrival to admission, transfer or discharge, was 73.3% for 'all types', and 69.2% 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.

Performance deteriorated compared to the previous year by 12.3 percentage points for 'all types' and 14.0 percentage points for 'type 1', respectively. This was a larger decrease than recorded in 2019/20 and related to the lower activity seen during the peak of the pandemic during 2020/21 when emergency attendances were lower.

Same day emergency care services (zero day length of stay admissions) have supported an increase in same day emergency care and played a significant role in helping to see and treat patients as quickly as possible, increasing from 42.0% of all emergency admissions in 2020/21 to 43.5% in 2021/22. This prevented unnecessary overnight stays in hospital and enabled this capacity to be used for patients who needed an overnight bed.

In the context of the increases in emergency care at OUH, the achievements in increasing elective care treatments for patients, including cancer services, and reducing waiting times for long-waiting patients, are particularly noteworthy. These operational highlights should also be seen in the context of the Quality Priorities and achievements detailed in the section below, as well as within the context of the financial management of OUH. The Trust has successfully deployed additional resources and capital for the current financial year, but also invested in capacity for a sustainable future for patients and staff at OUH.

OUH performance compared to national average

Emergency care activity and performance

2021/22 compared to 2020/21	2021/22 compared to 2019/20
• OUH ED[1] attendances increased in 2021/22 at a rate higher than the national average (36.6% vs 31.3%). • OUH emergency admissions increased in 2021/22 at a rate higher than the national average (19.5% vs 15.1%). • ED performance was below the national average for all types (73.3% vs 76.7%), but better than the national average for type 1 attendances (major ED departments) (69.2% vs 66.0%). • ED performance deteriorated further than the national average for all types of ED attendances (-12.3 percentage points vs -10.3 percentage points), but at a rate that was lower than the national average for type 1 attendances (-14.0 percentage points vs -15.5 percentage points).	• OUH is recording attendances above pre-pandemic levels and higher than the national average (6.3% vs 2.1%). • OUH is recording emergency admissions above pre-pandemic levels and higher than the national average, which had not returned to pre-pandemic levels (+2.2% vs -6.3%). • ED performance deteriorated further than the national average for all types of ED attendances (-9.1 percentage points vs -7.4 percentage points), and also for type 1 attendances (-11.5 percentage points vs -9.3 percentage points).

Note:

1. ED - Emergency Department

Emergency Department attendances: source: NHS England April to March 2019/20, 2020/21 and 2021/22
Emergency Admissions: Hospital Episode Statistics (HES) data reported by Dr Foster April to February 2019/20, 2020/21 and 2021/22

Maternity – continuity of care

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
% women on continuity of care pathway	≥90%	99.6%	99.2%	0.4 percentage point deterioration

In 2021/22, 99.2% of women had continuity of care recorded on their maternity pathway, which was better than the target of 90%.

Although performance in 2020/21 deteriorated slightly, there was a change in the criteria for recording this indicator in October 2021, which clarified that all women need to be booked by 28 weeks and be receiving all aspects of antenatal, labour and postnatal care within Oxfordshire. As a result, the change in performance between financial years, and prior to October 2021, is not directly comparable. Notwithstanding this change, performance achieved the standard (>90%) in each month of reporting.

Mortality Indicators

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Summary Hospital-level Mortality Indicator (SHMI) range	<1	0.90-0.92	0.91-0.92	SHMI remains banded 'as expected'
Hospital Standardised Mortality Ratio (HSMR) range	<100	85.7-92.4	85.5-93.5	HSMR remains 'lower than expected' meaning fewer deaths than expected

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. This means that there were fewer deaths than expected using the rate predicted for the hospital.

Patient Safety Alerts

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
National Patient Safety Alerts	0	0	0	No change

OUH continued proactively to manage risks identified through the Central Alerting System (CAS). All National Patient Safety Alerts were actioned and closed within CAS timescales.

Infection Prevention and Control metrics

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia cases	0	8	4	Halving of MRSA cases (-4 cases)
Clostridium difficile infection cases	≤83	114	107	7 (6.1%) decrease in Clostridium difficile cases

There was a decrease in OUH-apportioned cases of Clostridium difficile, based on the most recent data available, despite an increase in cases nationally. In March 2021 we launched the '7 Key Steps Safety Checklist to remember' for Preventing Healthcare Associated Infection.

Regular Antimicrobial Stewardship (AMS) ward rounds are also now conducted at the Churchill Hospital.

Falls with harm (moderate and above)

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Number of falls with harm (moderate and above)	n/a	30	49	+19 (63.3%) increase in falls reported with a moderate or greater harm

The apparent increase in reported falls with moderate or above harm is against the background of low bed occupancy during 2020/21 due to the COVID-19 pandemic. The number of 49 incidents in 2021/22 is more comparable with the 40 incidents reported pre-pandemic in 2019/20.

WHO Surgical Safety Checklist compliance

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
WHO[1] Surgical Safety Checklist compliance	100%	99.3%	99.7%	0.4 percentage point improvement

Note:

1. *WHO - World Health Organization*

There has been consistent improvement in WHO compliance over the last three years (2019/20 - 98%). This includes observed as well as documented WHO checklist audits.

Venous thromboembolism (VTE) risk assessment

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Venous thromboembolism (VTE) risk assessment	≥95%	98.3%	98.2%	0.1 percentage point decrease but above target
Hospital Acquired Thrombosis (HAT)	0	4	12	+8 increase in reporting of moderate or greater impact HATs

The Trust has met and exceeded the 95% target for VTE risk assessment of patients for the last three consecutive years. All identified Hospital Acquired Thrombosis (HAT) incidents were reported and investigated, and learning is disseminated.

Never Events

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Never Events[1]	0	2	4	+2 increase in number of Never Events

Note:

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

Four Never Events were reported during the year compared with two in 2020/21 and seven in 2019/20. Root cause analysis and learning were shared with all Divisions and in the Trust's weekly safety messages for all staff.

Hospital Acquired Pressure Ulcers (Grade 3 & Grade 4)

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Hospital Acquired Pressure Ulcers (HAPUs) Grade 3 & 4	0	108	103	4.6% decrease in Grade 3 & 4 HAPUs (NB. G4 HAPUs reduced from 2 to 1)

Hospital Acquired Pressure Ulcer (HAPU) incidents were all reviewed, and action plans agreed. In 2021/22 there was a 4.6% decrease in Grade 3 & 4 HAPUs. Grade 4 HAPUs reduced from 2 to 1.

Reducing violence and aggression against staff

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Reported incidents of violence and aggression against staff	0	214	363	69.6% increase in reported violence and aggression incidents against staff
NHS Staff Survey score - safe environment (violence)	n/a	9.5	9.5	No change

The Trust has unfortunately seen a 69.6% increase in reported violence and aggression incidents against staff which are taken very seriously. The Trust has taken action to address this, including launching a 'No Excuses' campaign aimed at patients and the public, piloting body cameras in our Emergency Departments, and a new Quality Priority focusing on this issue.

People

In 2021/22, 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, additional information on our workforce is available within the Staff Report of this Annual Report.

Belonging in the NHS

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Sickness absence (working days lost)	n/a	116,988	145,162	24.1% increase in sickness absence
Proportion of BAME staff in senior leadership roles	n/a	2/16	4/18	Increase of two BAME staff members in senior leadership roles
Proportion of women in senior leadership roles	n/a	9/16	10/18	Increase of one female staff member in senior leadership

The prevalence of COVID-19 in our community increased in 2021/22 while the Trust continued to ask staff to test for COVID-19 twice each week and self-isolate after a positive test. As a result, the sickness absence rate increased by 24.1% in 2021/22 compared with the number of working days lost in 2020/21 (145,162 vs 116,988). Reasons for absence predominately included COVID-19. Other forms of sickness absence included mental health categories, such as stress and anxiety. Throughout 2021/22 the Trust supported staff safety and wellbeing through the use of risk assessments and targeted initiatives to assist staff.

Senior leadership roles have been identified as Board level positions. In 2021/22 compared to 2020/21, 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 hold a senior leadership role out of 18 senior leadership roles identified within the Trust. The number of women in senior leadership roles increased by one in 2021/22. 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%).

Looking after our people

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Total number of staff (WTE)	n/a	12,246	12,676	3.5% increase in total number of staff
Staff turnover	≤12.0%	9.4%	12.4%	3.0 percentage point increase
Core Skills Training	≥85.0%	82.4%	88.0%	5.6 percentage point improvement
Appraisals	≥85.0%	71.3%	65.0%	6.3 percentage point deterioration
Staff engagement	n/a	7.2	7.0	0.2 point decline
Staff morale	n/a	6.3	5.9	0.4 point decline

The size of the workforce, as measured by staff Whole Time Equivalents (WTE) increased by 3.5% in 2021/22 compared with 2020/21 (12,676 vs 12,246 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 COVID-19 pandemic.

The Trust achieved its target for Core Skills Training, improving by 5.6 percentage points in 2021/22 compared to 2020/21. In March 2022, 88.0% of staff were compliant with Core Skills Training, which is an important marker of compliance in essential modules relating to patient and staff safety, and other essential requirements for staff roles.

In 2021/22 the targets for staff turnover and appraisals were not achieved. Staff turnover, which had been historically low during the early part of the COVID-19 pandemic, has been steadily increasing in 2021/22. In March 2022, staff turnover was 12.4%, which was a 3.0 percentage point increase compared to 2021/22 and above the 12% target.

Staff appraisal compliance was 65.0% in 2021/22, a decrease of 6.3 percentage points compared to 2021/22. Appraisal compliance has been challenging during the pandemic and the introduction of a new online appraisals system initially reduced compliance. This is now improving, and a specific appraisal window has been introduced to improve compliance alongside providing and supporting patient care.

Staff Survey scores deteriorated across the NHS in 2021/22. The Trust's employee engagement index (EEI) score for 2021 was 7.0 out of a score of 10. This was above the national average of 6.9, but was a decline from the 2020/21 EEI score of 7.2. The staff morale score for 2021 was 5.9 out of a score of 10. This was above the national average of 5.7, but was a decline from the 2020/21 morale score of 6.3. Reductions were also noted nationally in 2021/22.

Finance and use of resources

Income and expenditure

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Surplus/(deficit) £m	n/a	-1.6	-16.6	1.2% variance on turnover
Financial performance as measured by the NHS £m	Break-even	3.1	3.3	6.5% improvement
Financial performance versus plan £m	n/a	19.6	8.7	55.6% decrease in over-performance
Underlying financial position £m	Break-even	-57.8	-51.7	10.6% improvement
Run rate - total expenditure £m	1,273.5	1,296.5	1,386.5	6.9% increase in expenditure

In 2021/22 the Trust reported a deficit of £16.6m in its accounts versus a £1.6m deficit in 2020/21. The NHS measures financial performance by adjusting for some transactions outside the Trust's control, such as changes to the valuation of land and buildings, and also the impact of Personal Protective Equipment (PPE) donated to the Trust. Adjusting for such items, the Trust made a surplus of £3.3m in 2021/22 compared to a surplus of £3.1m in 2020/21.

The NHS expects the Trust to deliver a break-even financial performance. The small surplus generated was due to funding for the costs of COVID-19 and elective recovery was not confirmed until the final months of the year. In these circumstances, the Trust was unable to spend all of these resources to deliver its objectives while maintaining value for money.

In both 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 the COVID-19 pandemic. No information is available on the financial performance of other NHS providers in 2021/22.

The surplus as measured by the NHS of £3.3m was £8.7m better than planned for by the Trust. The 2021/22 financial year was split into two halves with a different funding regime in each. A separate plan was submitted for each six-month period and the financial performance versus plan is measured as the difference between the sum of those two plans and the actual financial performance. This changing and uncertain funding environment led the Trust to plan cautiously. The Trust planned to deliver increased volumes of elective care even if this resulted in a planned deficit. As the year progressed, additional funding was made available for elective care. In addition, the Trust spent less than planned on COVID-19 activities.

The underlying financial position of the Trust, which reflects the position after any one-off income or expenditure (such as income and expenditure on COVID-19) has been removed, showed an improvement of 10.6% to an underlying deficit of £51.7m.

Total expenditure in 2021/22 was £1,386.5m compared with a planned figure of £1,273.5m. The increase in expenditure was due to higher levels of activity than originally planned which resulted in increased income compared to the plan. The comparable expenditure figures for 2020/21 are £1,296.5m and £1,142.3m for 2019/20. This is a 6.9% increase in the last year and reflects the financial consequences of a 3.5% increase in staff numbers, a 3% pay award and increased activity.

Capital spending

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Overall level of capital expenditure £m	n/a	84.2	67.1	20.3% reduction in year
Capital expenditure charged to ICS[1] CDEL[2] £m	33.8	27.8	40.2	44.6% increase in expenditure
Overall level of capital expenditure versus plan £m	n/a	-2.9	-0.9	69% reduction in underspend
ICS[1] CDEL[2] versus plan £m	n/a	-	7.1	21.0% overspend on plan

Notes:

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

The Trust invested £67.1m in capital expenditure from all funding sources during 2021/22 compared to the investment of £84.2m in 2020/21. The largest items of capital investments were the new Critical Care Building at the John Radcliffe Hospital in Oxford (£20.9m) and the new Swindon Radiotherapy Centre at the Great Western Hospital (£13.4m). In both years, the capital investment was more than the £45.9m invested in 2019/20 when there were fewer large projects. No information is available on capital investment of other NHS providers in 2021/22.

NHS England and NHS Improvement does not set the Trust a limit for overall capital expenditure, but it does require the Trust to agree a limit for projects within the allocated

budget of the Integrated Care System (ICS). Capital spending against this budget was £40.2m which included completing the new Critical Care Building

Overall capital expenditure was £0.9m below plan with an overspend on ICS projects and successful bids for unplanned projects largely offsetting a shortfall in Private Finance Initiative (PFI) life-cycle expenditure. However, against the ICS budgeted projects, the Trust overspent by £7.1m due to locally funded expenditure on the new Critical Care Building, which the plan assumed would be funded from other sources. This was offset by underspending on capital elsewhere in the ICS.

Cash

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Cash as of 31 March 2022 £m	n/a	83.8	57.3	31.6% deterioration
Cash versus plan as of 31 March 2022 £m	n/a	63.0	10.1	21.4% positive variance on plan

The cash balance on 31 March 2022 was £57.3m compared to £83.8m on 31 March 2021. Cash decreased primarily in the early months of 2021/22 as suppliers were paid for capital spending in the final months of 2020/21.

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) [1]

Positive score	Target	2020/21	2021/22	2021/22 compared to 2020/21
Inpatient	≥95%	95.6%	94.6%	1 percentage point deterioration
Outpatient	≥95%	94.1%	93.6%	0.5 percentage point deterioration
Emergency Department (ED)	≥95%	87.8%	77.2%	10.6 percentage point deterioration
Maternity	≥95%	96.6%	79.4%	17.2 percentage point deterioration
Children's Department	≥95%	n/a	93.9%	Not measured in 2020/21[2]

Notes:

1. *FFT response rate includes eligible responses. Responses in 2020/21 relate to January to March 2021 only due to the national suspension of the FFT between April 2020 and December 2020.*
2. *The Children's Department's FFT was recorded from September 2021 and a full year result and comparison to 2020/21 is not available.*

The FFT feedback for positive themes was lower across all areas in 2021/22 compared to 2020/21. Positive themes identified from the FFT included reports of kind and helpful staff, personalised care and efficient service. Areas for improvement raised via negative themes

included waiting times, discharge and communication. These issues align with complaints and the Trust's operational performance as described in this report. These are key areas for planned improvement in 2022/23.

Benchmarking information within the Shelford Group of Hospitals shows that the combination of positive feedback at OUH for all FFT areas was 91% in 2021/22. This was equal to the Shelford Group average and was an increase compared to 2019/20 where the positive feedback across all FFT areas was 90%.

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.

In 2021/22 the combined FFT response rates declined compared to the periods that the FFT was reported in 2020/21 for Inpatients (24.5% vs 25.6%) and ED (25.1% vs 29.4%). The response rate for Maternity remained at low levels in both years (0.3% in 2021/22 and 0.2% in 2020/21). Compared to the pre-COVID-19 period in 2019/20, FFT response rates were higher in 2021/22 for inpatients (24.5% vs 19.5%) and ED (25.1% vs 20.1%), but lower in Maternity FFT response rate (0.3% vs 16.9%).

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.

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
PALS cases	n/a	789	2,621	Increase of 1,832 cases
Complaints	n/a	757	1,095	Increase of 338 complaints
Complaints upheld by the Parliamentary & Health Services Ombudsman (PHSO),	n/a	nil	nil	No change
Complaints acknowledged within 3 working days	≥95%	100%	100%	No change
Complaints responded to in 40 working days	≥95%	60%	68%	8 percentage point improvement

Both PALS cases and complaints increased in 2021/22 compared to 2020/21, which the Trust believes is broadly in line with the increase in overall activity. The number of PALS cases were higher than the 1,720 cases in 2019/20, however, the formal complaints received remained below the 1,139 complaints received in 2019/20. The complaints responded to within 40 working days continued to remain at a low level over the last two years since the clinical teams were unable to respond as per expectation due to COVID-19 work pressures.

Equality of service delivery to different groups

OUH aims to be inclusive for all patients, their families and carers. The COVID-19 pandemic has had a significant impact on the NHS and has highlighted a range of health and workplace inequalities.

OUH has responded by increasing the focus on Equality, Diversity and Inclusion (EDI) with the ongoing refresh of the EDI objectives for 2022-2026 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 the OUH Strategy 2020-2025 and the 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.

In 2021/22, ways in which the Trust supported our diverse patient population included the following.

- **Keep in Touch scheme**: During the COVID-19 pandemic, when restrictions on visits to hospitals were introduced, the Keep in Touch scheme was set up in May 2020 to enable family and friends to write to inpatients at the Trust, and continued in 2021/22.
- **Support for patients with hidden disabilities**: A need was identified to help support patients who have hidden disabilities and are unable to wear masks, and a single-use sticker was developed to be given on arrival. The sticker was approved by Carers Oxfordshire and supported by clear communications to advertise the appropriate use of the stickers alongside the key messages of hand washing, social distancing and mask wearing (for those who can).
- **Patient survey launched to understand access to healthcare during COVID-19**: Two Trust-wide patient questionnaires to explore experience of receiving health services during the COVID-19 pandemic were developed, relating to remote outpatient appointments (telephone/video) and face-to-face appointments / day case treatment. Findings demonstrated that patients had a positive experience of remote outpatient appointments and would like, where appropriate, for these to continue, as they alleviate some stresses that can be associated with coming into hospital.
- **Interpreting and Translation services:** Improvements to the accessibility of interpreters to support patients continued to be made in 2021/22. The simplification of the booking process led to an increase in the use of interpreting services. The Trust produced communications cards available in 28 languages for patients to convey their needs. Patient leaflets were also produced in other languages.

- **Learning Disability Liaison Team:** The team continued to provide support to patients with learning disabilities. During 2021/22 there has been an increase in patient complexity, declining health and challenging circumstances at discharge. To enable further improvements, development of support across the county is being led by the Oxon Learning Disability and Autism system wide implementation group.
- **EDI Visioning workshops:** A series of engagement workshops were held with our people and patients over the Summer of 2021, engaging approximately 130 people in total. These workshops sought to understand what 'good' looked like in relation to EDI and what the priorities are for our people and patients.

In addition, the Trust is launching a programme of work to identify and take action to reduce health inequalities. This focuses on three objectives.

- ***Addressing 'Core20PLUS5'*** across our services to support the reduction of health inequalities at both national and system level (Core20PLUS5 is a national NHS England and NHS Improvement approach to support reducing health inequalities at both national and system level).
- ***Planning elective recovery*** following the COVID-19 pandemic while being mindful of the need to address health inequalities that worsened during the pandemic. We will measure health inequalities within our elective waiting lists and incorporate a Clinical Priority Tool to guide patient scheduling to help to reduce inequalities.
- ***Building longer-term capability*** to promote the reduction of health inequalities and improve population health through population health management and recognising our role as an anchor institution.

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, in line with NHS England's carbon neutral target. It sets out actions that will be taken across key areas, including procurement and supply chains, medicines, digital transformation, estates and facilities, and travel and transport. We report below on our progress under the requirements of Service Condition 18 of the NHS Standard contract.

Service Condition 18 indicator	Statement of progress by the Trust
Overall Green Plan (18.2)	
Deliver a Green Plan, approved by its Governing Body	In January 2022, we launched our Green Plan, 'Building a Greener OUH', which is available on the Trust website at: www.ouh.nhs.uk/about/sustainability/documents/building-a-greener-ouh.pdf.
Provide an annual summary of progress on delivery of that plan to the Co-ordinating Commissioner	The Co-ordinating Commissioner has been provided with a copy of the progress report.
Nominate a Net Zero Lead	The Trust has nominated the Chief Digital and Partnerships Officer.
Environmental impacts (18.3)	
Greenhouse gas emission in tonnes	The Trust is not currently able to estimate its greenhouse gas emissions and is working on estimation in 2022/23. The

Service Condition 18 indicator	Statement of progress by the Trust
	Trust's Chief Finance Officer is leading a regional group to introduce robust CO2 reporting into Annual Reports.
Minimum emissions reduction projections	As above.
An overview of the Provider's strategy to deliver those reductions.	The Trust cannot currently estimate the reduction in greenhouse gas emissions from each initiative in its Building a Greener OUH Plan.
Air Pollution (18.4.1)	
Take action to reduce air pollution from fleet vehicles, transitioning as quickly as reasonably practicable to the exclusive use of low and ultra-low emission vehicles	We have 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 also halved delivery times.
Take action to phase out oil and coal for primary heating and replace them with less polluting alternatives.	We make no use of oil or coal 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 these fuels.
Develop and operate expenses policies for staff which promote sustainable travel choices	We support 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.
Ensure that any car leasing schemes restrict high-emission vehicles and promote ultra-low emission vehicles	We have restricted access to our car salary sacrifice scheme to lower and ultra-low emission vehicles. 94% of cars leased via this scheme are ultra-low emission vehicles.
Climate Change (18.4.2)	
Reduce greenhouse gas emissions from the Provider's Premises in line with targets in Delivering a 'Net Zero' National Health Service	During 2020/21 and 2021/22, we have installed nearly 24,000 LED lights across our sites that will save 563 tonnes/year of CO2 and £450,000 a year on energy bills.
Reduce the carbon impacts from the use, or atmospheric release, of environmentally damaging gases such as nitrous oxide and fluorinated gases used as anaesthetic agents and as propellants in inhalers, including by appropriately reducing the proportion of desflurane to sevoflurane used in surgery to less than 10% by volume, through clinically appropriate prescribing of lower greenhouse gas emitting inhalers, by encouraging service users to return their inhalers to pharmacies for appropriate disposal	We have committed to map our anaesthetic carbon footprint and reducing the proportion of desflurane to sevoflurane used in surgery. We will also review our transportation, use, and explore the disposal of nitrous oxide across the Trust. This year we worked with partners in primary care to update the Oxfordshire guidelines for Asthma and Chronic Obstructive Pulmonary Disease to ensure that patients are offered lower carbon inhalers where appropriate.
Adapt the Provider's Premises and the manner in which services are delivered to mitigate risks associated	We have not yet developed a plan to adapt our premises for the effects of climate change which will be a focus of work in the future.

Service Condition 18 indicator	Statement of progress by the Trust
with climate change and severe weather	
Single use plastics and waste (18.4.3)	
Reduce waste and water usage through best practice efficiency standards and adoption of new innovations	We have sourced a new supplier for water and wastewater during 2021/22 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. We will use these new tools to develop a plan for efficient water usage during 2022/23.
Reduce avoidable use of single use plastic products, including by signing up to and observing the Plastics Pledge	Where possible we have committed to reduce our single use products across our sites and replace them with reusable alternatives, and being transparent where this is not feasible.
As clinically appropriate, to cease use at the Provider's Premises of single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo- degradable plastics	We are working with our contracted catering services to switch to chemical-free cleaning products wherever possible and remove all single-use plastics from our contracted catering services. We are also working with our catering suppliers to reduce the amount of packaging coming into the hospital in the first instance, as well as committing to sourcing more fresh produce from local businesses.
Reduce the use at the Provider's Premises of single-use plastic food and beverage containers, cups, covers and lids	We are working to reduce avoidable use of single-use plastic products and working with providers to reduce single-use cutlery, plates and cups across our sites.
Make provision with a view to maximising the rate of return of walking aids for re-use or recycling	Alongside Oxford Health NHS Foundation Trust and Oxfordshire County Council, we hold a contract with a supplier to send used equipment for refurbishment and return to us, including community drop-off points for patients.
Use of renewable sources (18.5)	
Ensure that all electricity it purchases is from renewable sources	All electricity purchased across Trust sites has been purchased from 100% renewable sources since 1 April 2021.

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 2021/22. This included high-scoring (principal) risks relating to:

- the delivery of key national access targets (including 18-week 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 post COVID-19 waiting list delivery and the impact on patients waiting longer for care (including those waiting longer than 52 weeks)
- the ability to recruit, retain and engage staff and the impact of staff sickness on service delivery
- the tracking of financial activity and financial risk, including the access to capital funding and the potential impact of the lack of capital funding on service delivery, including the digital infrastructure and resilience
- the effective use of capital funding and ability to address a range of existing estates issues including fire safety, electrical infrastructure, ventilation and equipment replacement.

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 has been increased.

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 development of the People Plan, review and update of related policies (for example the Agile Working Policy) 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.

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 'equality of service delivery to different groups' and the anti-bribery policies and their effectives are discussed in the Staff Report of this Annual Report.

Disclosures

The Trust is required to make the following disclosures.

Overseas operations

The Trust has no overseas operations.

Important events since balance sheet date

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

Going concern disclosure

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

Further reading

- **OUH Quality Report:** the Quality Report 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 and NHS Improvement. It is expected to be published on the Trust website at www.ouh.nhs.uk/about/publications/#accounts in July 2022.
- **Our COVID-19 story:** the Trust's response to the COVID-19 pandemic, including the experiences of staff and their achievements, have been published in two e-Books, 'Beyond Words... Images from the COVID-19 Pandemic' and 'Stories from the COVID-19 pandemic - #OneTeamOneOUH'. They are both available to read online on the Trust website at www.ouh.nhs.uk/about/publications/books.aspx.
- **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:

Dr Bruno Holthof
Chief Executive Officer
15 June 2022

Accountability Report

The Accountability Report of Oxford University Hospitals NHS Foundation Trust's Annual Report 2021/22 comprises the following reports.

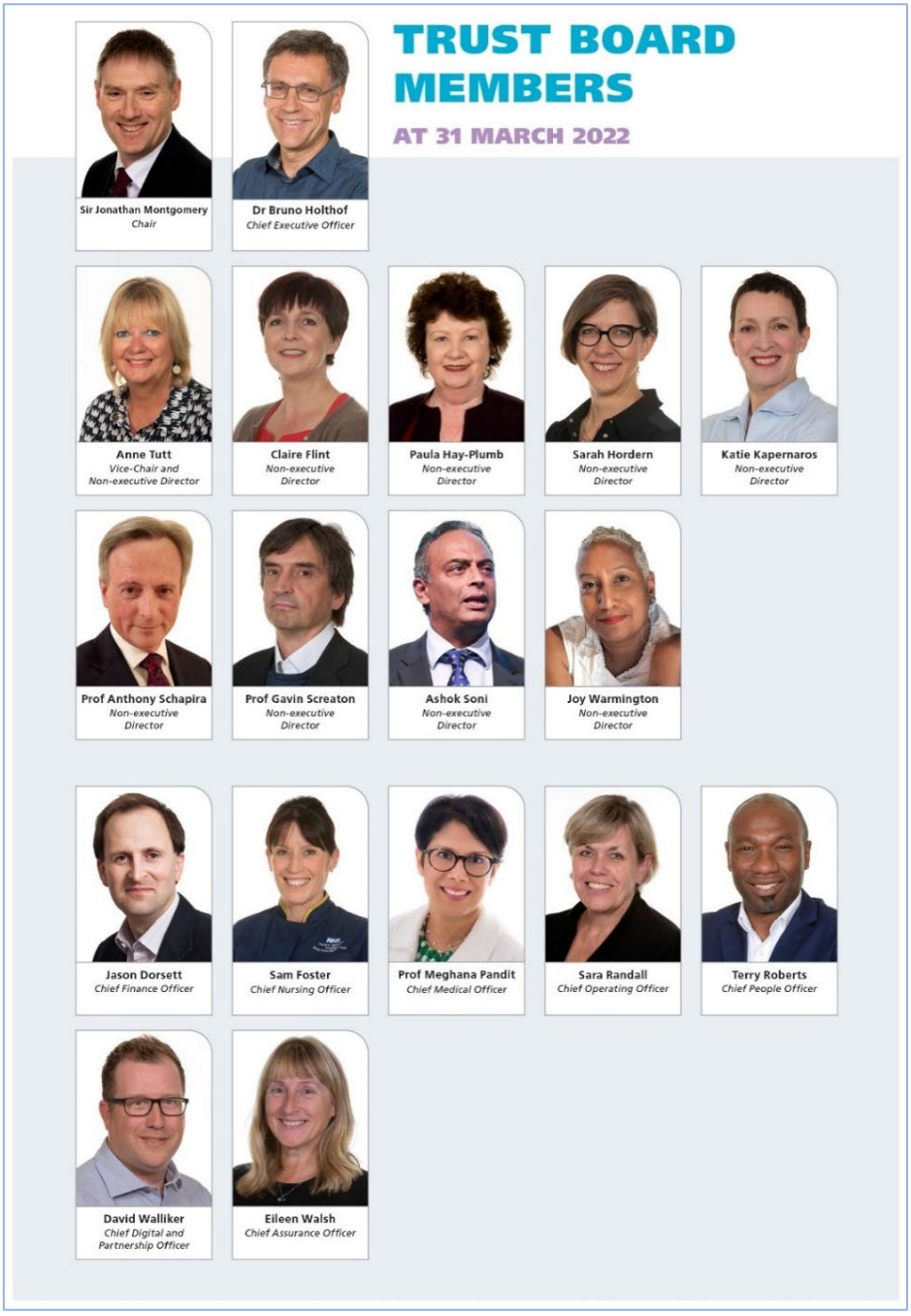
- Directors' Report
- Trust Membership and Council of Governors
- Remuneration Report
- Staff Report
- NHS Foundation Trust Code of Governance Compliance
- NHS System Oversight Framework
- Statement of Accounting Officer's Responsibility
- Annual Governance Statement

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 Improvement'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 during the year 2021/22. All members of the Board are voting members.



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
Ms Sarah Hordern
Ms Katie Kapernaros
Professor Anthony Schapira
Professor Gavin Screaton
Professor Ashok Soni
Ms Joy Warmington

Executive Directors

Dr Bruno Holthof, *Chief Executive Officer*
Mr Jason Dorsett, *Chief Finance Officer*
Ms Sam Foster, *Chief Nursing Officer*
Professor Meghana Pandit, *Chief Medical Officer*
Ms Sara Randall, *Chief Operating Officer*
Mr Terry Roberts, *Chief People Officer*
Mr David Walliker, *Chief Digital and Partnership Officer*
Ms Eileen Walsh, *Chief Assurance Officer*

The Trust welcomed two new Non-Executive Directors to the Board in 2021/22, following a rigorous recruitment process during 2020/21. All the Non-Executive Directors 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 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[1]	01/04/2019	01/04/2019 to 31/03/2022	1
Ms Anne Tutt[2]	01/10/2015	01/12/2021 to 30/11/2023	4
Ms Claire Flint[3]	01/05/2019	01/05/2019 to 30/04/2022	1
Ms Paula Hay-Plumb	04/09/2017	04/09/2020 to 03/09/2023	2
Ms Sarah Hordern	28/10/2019	28/10/2019 to 27/10/2022	1
Ms Katie Kapernaros	28/10/2019	28/10/2019 to 27/10/2022	1
Professor Anthony Schapira	01/12/2019	01/12/2019 to 30/11/2022	1
Professor Gavin Screaton[4]	01/09/2018	01/09/2021 to 31/08/2024	2
Professor Ashok Soni	06/04/2021	06/04/2021 to 05/04/2024	1
Ms Joy Warmington	01/06/2021	01/06/2021 to 31/05/2024	1

Notes:

1. *Re-appointed for a further three-year term by the Council of Governors on 31 March 2021.*
2. *Held office as a Non-Executive Director of Oxford University Hospitals NHS Trust when the Trust became a Foundation Trust.*
3. *Re-appointed for a further three-year term by the Council of Governors on 19 January 2022.*
4. *Re-appointed for a further three-year term by the Council of Governors on 14 July 2021.*

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

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

Board development

During 2021/22, the Board continued to participate in Board Seminars which include the provision of Board training and development, as well as opportunities to explore specific issues in more detail than is possible in the context of formal Board meetings. The level of development activities has been adjusted to reflect the need for the enhanced Board focus on the pandemic response. The Board has completed the Affina Programme, a development programme that aims to improve performance through team-based working.

The performance of all Board members has been appraised during the 2021/22 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 wide range of key stakeholders.

Board meetings

The Board met six times in public during the year 2021/22 and all meetings were held virtually, following government guidelines due to the COVID-19 pandemic. The table below shows the attendance of the Board members at Board meetings.

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

Notes:

1. *Represented by a nominated deputy.*
2. *Apologies for absence were given.*

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 2021/22 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 2021/22. The attendance of core members is detailed below.

Committee Member	Title	Attendance
Professor Sir Jonathan Montgomery (Chair)	Trust Chair	6/6
Dr Bruno Holthof	Chief Executive Officer	5/6[1]
Ms Anne Tutt	Vice-Chair and Non-Executive Director	6/6
Ms Claire Flint	Non-Executive Director	5/6[1]
Ms Paula Hay-Plumb	Non-Executive Director	6/6
Ms Sarah Hordern	Non-Executive Director	5/6[1]
Ms Katie Kapernaros	Non-Executive Director	5/6[1]
Professor Anthony Schapira	Non-Executive Director	6/6
Professor Gavin Screaton	Non-Executive Director	6/6
Professor Ashok Soni	Non-Executive Director	4/6[1]
Ms Joy Warmington	Non-Executive Director	3/5[1]
Mr Jason Dorsett	Chief Finance Officer	6/6
Ms Sam Foster	Chief Nursing Officer	6/6
Professor Meghana Pandit	Chief Medical Officer	6/6
Ms Sara Randall	Chief Operating Officer	6/6
Mr Terry Roberts	Chief People Officer	6/6
Mr David Walliker	Chief Digital and Partnership Officer	6/6
Ms Eileen Walsh	Chief Assurance Officer	6/6

Note:

1. *Apologies for absence were given.*

Audit Committee

The Audit Committee was chaired by Ms Paula Hay-Plumb and met six times during 2021/22. The attendance of core members is listed below.

Committee Member	Title	Attendance
Ms Paula Hay-Plumb (Chair)	Non-Executive Director	6/6
Ms Anne Tutt	Vice-Chair and Non-Executive Director	6/6
Ms Katie Kapernaros	Non-Executive Director	6/6

Investment Committee

The Investment Committee was chaired by Ms Anne Tutt and met seven times during 2021/22. The attendance of core members is listed below.

Committee Member	Title	Attendance
Ms Anne Tutt (Chair)	Vice-Chair and Non-Executive Director	7/7
Ms Sarah Hordern	Non-Executive Director	7/7
Professor Anthony Schapira	Non-Executive Director	5/7[1]
Mr Jason Dorsett	Chief Finance Officer	7/7
Ms Sam Foster	Chief Nursing Officer	5/7[1]
Mr David Walliker	Chief Digital and Partnership Officer	5/7[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.

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.

NHS Improvement's well-led framework disclosures

Throughout the year 2021/22, the Trust continued to build on the actions taken in 2020/21 to strengthen compliance with the well-led framework. To maintain a well-led organisation and ensure staff and patients remained safe during the COVID-19 pandemic, 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 response and recovery planning.

Actions taken during 2021/22 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
- the completion of a 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
- the development and monitoring of specific action plans to address the findings of the two reports received from the Care Quality Commission on Infection Control and Maternity Services in the Trust.

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 2022, the Trust had an overall rating of 'Requires Improvement' (RI) from the Care Quality Commission (CQC), this was consistent to the rating disclosed in the previous Annual Report and reflected the activities undertaken by the CQC during the year 2021/22. The CQC carried out two new inspections on individual services provided by the Trust during the year 2021/22 and the results were published in July 2021 and September 2021. The issues in the CQC inspection reports resulted in detailed action plans that have been monitored during 2021/22.

The Trust took several actions to address the conclusions reported by the CQC, for example:

- continued focus on the completion of core skills training and maternity staff appraisal rates
- reviewed and refreshed specific maternity guidelines and a process for keeping such guidelines in date
- developed a specific maternity performance report and dashboard
- commissioned an external culture review across maternity and neonatal services
- reviewed estate's issues within maternity services, with a view to develop a longer-term plan
- began a search for an electronic patient record (EPR) system for maternity services.

We have completed many of these actions, but other areas remain the subject of continuous review and focus. These include statutory and mandatory training, appraisal rates, medicines management and infection control. In addition, 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.

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 86.5% 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 18 to 20 of the Annual Accounts section.

Better Payment Practice Code Performance

Indicator	Target	2020/21	2021/22	2021/22 compared to 2020/21
Non-NHS Payables				
Total non-NHS trade invoices paid in the period				
Number	n/a	154,656	170,489	10.2% increase
£000	n/a	765,944	920,849	20.2% increase
Total non-NHS trade invoices paid within the target				
Number	n/a	93,039	138,292	48.6% increase
£000	n/a	449,790	838,929	86.5% increase
Percentage of non-NHS trade invoices paid within the target				
Number	95%	60.2%	81.1%	20.9 percentage point improvement
£000	95%	58.7%	91.1%	32.4 percentage point improvement
NHS Payables				
Total NHS trade invoices paid in the period				
Number	n/a	4,728	4,636	1.9% decrease
£000	n/a	68,823	34,561	49.8% decrease
Total NHS trade invoices paid within the target				
Number	n/a	2,352	3,565	51.6% increase
£000	n/a	51,512	25,958	49.6% decrease
Percentage of NHS trade invoices paid within the target				
Number	95%	49.7%	76.9%	27.2 percentage point increase
£000	95%	74.8%	75.1%	0.3 percentage point increase

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 2021/22 following the implementation of a new financial system in 2020/21. Adjusting to the new system and associated processes took some time, and a backlog in invoice processing arose which delayed processing and payment. This backlog has now been addressed.

During this period, the Trust did not pay any money 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 our 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, supporting 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. The Membership Team works with colleagues to maximise opportunities to recruit from hard-to-reach groups and actively encourages younger people to become members of the Trust.

During 2021/22, 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. However, due to the COVID-19 pandemic, we have not been able to undertake any face-to-face recruitment. We have continued to promote membership via our Governors, members and social media to encourage people to join as members. A review of the Trust's Membership Strategy, led by the Trust's Governors, is currently underway.

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 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 organisation to provide services at any of the Trust's premises.

There are two Staff constituencies: Clinical and Non-Clinical. The Staff constituencies had 15,430 members as at 31 March 2022 (15,277 as at 31 March 2021).

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. During 2021/22, we saw a small drop in the membership due to the challenges of recruiting members, owing to the COVID-19 pandemic.

As at 31 March 2022, we had 7,702 public members, as shown below.

Public Constituency	2020/21	2021/22
Cherwell	1,190	1,179
Oxford City	1,781	1,754
South Oxfordshire	781	765
Vale of White Horse	1,088	1,083
West Oxfordshire	888	878
Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	1,046	1,031
Northamptonshire and Warwickshire	426	432
Rest of England and Wales	541	580
Total	**7,741**	**7,702**

More information on Oxford University Hospitals NHS Foundation Trust's membership is available at www.ouh.nhs.uk/ft.

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 auditor
- approving significant transactions
- approving any changes to the Trust's Constitution.

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

- receives the Annual Report and Accounts of the Trust
- is presented with other management reports detailing the Trust's performance
- provides its views to the Board of Directors when the Board of Directors 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 do so with members of the representing organisation.

Our Council of Governors has now completed its sixth 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
Oxfordshire Local Medical Committee		1
Specialist Commissioner (nominated by NHS Commissioning Board)		1
Young person (nominated by Young People's Executive)		1

Members of the Council of Governors

The Governors who were in post during the period 1 April 2021 to 31 March 2022 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	4/5
Anita Higham[1]	Cherwell	01/10/2018-30/09/2021	2	3/5
Mike Gotch	Oxford City	01/04/2021-31/03/2024	1	5/5
Cecilia Gould[1]	Oxford City	01/10/2018-30/09/2021	2	5/5
Janet Knowles[1]	South Oxfordshire	01/10/2018-30/09/2021	1	5/5
Nina Robinson	South Oxfordshire	01/04/2021-31/03/2024	1	4/5
Martin Havelock[1]	Vale of White Horse	01/10/2018-30/09/2021	2	5/5
Jill Haynes	Vale of White Horse	01/04/2021-31/03/2024	3	4/5
David Heyes[1,2]	West Oxfordshire	22/10/2019-30/09/2021	1	4/5
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
Sally-Anne Watts	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	01/04/2021-31/03/2024	1	4/5
Sue Woollacott[1]	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	01/10/2018-30/09/2021	2	2/5
Anthony Bagot-Webb	Northamptonshire and Warwickshire	01/04/2021-31/03/2024	2	5/5
Rosemary Herring[3]	Northamptonshire and Warwickshire	01/10/2018-30/09/2021	2	1/3
Vacancy	Northamptonshire and Warwickshire	Since 01/10/2021		
Jonathan Wyatt[1]	Rest of England and Wales	01/10/2018-30/09/2021	1	4/5
Elected Governors - Staff Constituencies				
Name	**Constituency**	**Tenure**	**Term**	**Attendance**
Giles Bond-Smith	Clinical	01/04/2021-31/03/2024	1	3/5
Shahab Khan[1]	Clinical	01/10/2018-30/09/2021	1	4/5
Shing Law[1,2]	Clinical	23/10/2019-30/09/2021	1	4/5
Julie Stockbridge	Clinical	01/04/2021-31/03/2024	3	5/5
Rebecca Cullen[1]	Non-Clinical	01/10/2018-30/09/2021	1	5/5
Samantha Parker[4]	Non-Clinical	01/04/2021-11/05/2021	1	0/0
Vacancy	Non-Clinical	Since 12/05/2021		

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	5/5
Stuart Bell	Oxford Health NHS Foundation Trust	16/10/2020-15/10/2023	1	4/5
Gareth Kenworthy	Oxfordshire Clinical Commissioning Group	05/01/2021-04/01/2024	2	1/5
Lawrie Stratford[4]	Oxfordshire County Council	01/11/2020-05/05/2021	2	0/0
Vacancy	Oxfordshire County Council	Since 06/05/2021		
Helen Higham	University of Oxford	16/10/2020-15/10/2023	1	3/5
Ruby	Young People's Executive	01/09/2020-31/08/2023	1	4/5
Maryam	Young People's Executive	01/09/2021-31/08/2024	1	1/5

Notes:

1. *Co-opted as a non-voting member of the Council until 31 March 2022, following the deferral of the Governor Elections in the summer of 2021 in order to align the election cycles (explained further in the Council of Governors' election section in the next page).*
2. *Unexpired term of the previous Governor.*
3. *Stood down at end of term.*
4. *Resigned during tenure.*

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

As requested by NHS Improvement, the Council of Governors nominates a Lead Governor, and the selection of the Lead Governor takes place on an annual basis by an electronic secret ballot following self-nomination and is seconded by one other Governor.

Dr Cecilia Gould, a Public Governor for the Oxford City constituency, was re-elected by the Council of Governors as the Lead Governor on 1 December 2019 for a further one-year term. Since the Governor election in 2020 was deferred until early 2021, the Council approved a six-month extension to Dr Gould's Lead Governor term of office until 1 June 2021. The Council subsequently agreed that Dr Gould would remain the Lead Governor until 31 March 2022 in order to align the election of the Lead Governor with the Governor elections in early 2022.

Dr Gould stood down from the Council of Governors on 31 March 2022 at the end of her term. Graham Shelton was elected as the new Lead Governor on 1 April 2022.

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.

Due to the COVID-19 pandemic, the year one election which was due to take place in summer 2020 was deferred to early 2021, and the candidates who were successful in the election commenced their term of office on 1 April 2021. In order to bring the elections into alignment, the Council of Governors agreed to defer the year two election which was due to take place in summer 2021 until early 2022. Governors whose terms of office ended on 30 September 2021 were co-opted back on to the Council of Governors until 31 March 2022 as non-voting members of the Council.

The Trust commenced the Council of Governors' election process by publication of the Notice of Election on 6 January 2022 for 11 seats from all Public and Staff constituencies. The results of the election were publicised on 4 March 2022. All 11 seats were successfully filled, and the newly elected and re-elected Governors commenced their term of office on 1 April 2022.

Council of Governors' meetings

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

The Council held five general meetings in 2021/22 and all the meetings took place virtually due to the COVID-19 pandemic. 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. These virtual meetings, however, were not open to the public for logistical reasons but were recorded and posted on the Trust's website so that any member of the public wishing to do so was able to observe them.

Annual Public Meeting

The Trust holds an Annual Public Meeting for the Council of Governors and members of the Trust which is also open to the public. In 2021/22, this event was held virtually. In addition, the Annual Report and Annual Accounts of the Trust were formally presented to the Council of Governors at its September meeting. At this meeting, the external auditors also presented their Audit Report to the Governors including the audit of financial statements and value for money conclusion. The electronic version of the Annual Report and 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 the Council of Governors' general meetings that took place during the year.

Board Member	Position	Attendance
Professor Sir Jonathan Montgomery	Trust Chair	5
Dr Bruno Holthof	Chief Executive Officer	2
Ms Anne Tutt	Vice-Chair and Non-Executive Director	5
Ms Claire Flint	Non-Executive Director	3
Ms Paula Hay-Plumb	Non-Executive Director	4
Ms Sarah Hordern	Non-Executive Director	3
Ms Katie Kapernaros	Non-Executive Director	5
Professor Anthony Schapira	Non-Executive Director	4
Professor Gavin Screaton	Non-Executive Director	2
Mr Jason Dorsett	Chief Finance Officer	3
Ms Sam Foster	Chief Nursing Officer	1
Professor Meghana Pandit	Chief Medical Officer	1
Ms Sara Randall	Chief Operating Officer	2
Mr Terry Roberts	Chief People Officer	2
Professor Ash Soni	Non-Executive Director	3
Mr David Walliker	Chief Digital and Partnership Officer	1
Ms Eileen Walsh	Chief Assurance Officer	2
Ms Joy Warmington	Non-Executive Director	4

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 of Governors to act within its Terms of Reference. The Committee consists of Governors appointed by the Council of Governors and is chaired by the Trust Chair. Where the Chair has a conflict of interest, the Committee is chaired by the Senior Independent Director. 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 2021/22, the RNAC met three times and the key business undertaken by the Committee included the following.

- Receiving assurance regarding the process of appraisal of the Non-Executive Directors and the Trust Chair.
- Recommending to the Council of Governors the re-appointment of Professor Gavin Screaton as a Non-Executive Director for a second three-year term of office, concluding on 31 August 2024.
- Recommending to the Council of Governors the re-appointment of Ms Claire Flint as a Non-Executive Director for a second three-year term of office, concluding on 30 April 2025.

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 objective is 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
- ensures appropriate approvals for proposals are obtained from NHS England and NHS Improvement and 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 2021/22 included:

- setting 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 a new pay and reward policy for very senior managers, including an objective and transparent job evaluation system
- reviewing the succession plans and talent management for the Chief Executive Officer, Executive Directors and Divisional Directors
- reviewing and agreeing the process to appoint a new Chief Executive Officer.

There were no substantial changes relating to senior managers' remuneration during the year.

Signed:

Ms Claire Flint
Chair of Remuneration and Appointments Committee
15 June 2022

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 the 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 NHS Improvement 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	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
	broadly equivalent to the employer pension contributions that the Trust would otherwise pay if they remained a member of the NHS Pension Scheme. The scheme is open to all employees that meet the 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 members of staff.			
Travel expenses			
Appropriate travel expenses are paid for business mileage in line with the Trust's Payment of Expenses Procedure.			

Note:

1. *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 of 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 2021/22, no new employees were recruited with remuneration greater than £150,000 per annum, and no employee received a pay uplift that increased their remuneration above £150,000.*

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. 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. 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 and NHS Improvement, 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 and NHS Improvement.

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

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.

In 2021/22, the Remuneration and Appointments Committee undertook a detailed review of gender diversity in the recruitment process for very senior managers and discussed the findings in relation to wider work overseen by the Trust's Equality, Diversity and Inclusion (EDI) Steering Group. The Committee also strengthened its approach to its remuneration policy by implementing an objective external job evaluation system for very senior manager posts. This job evaluation system ensures that there is a clear rationale for the remuneration of staff that is defendable and justifies any salary differentials. The new process is documented in the Trust's new Very Senior Manager Pay and Reward Policy.

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.

The following table contains details of the service contracts in place during 2021/22 for Executive Directors.

Name	Post	Date of Contract as Executive Director	Contract Type	Notice Period
Dr Bruno Holthof	Chief Executive Officer	01/10/2015	Permanent	Six months
Mr Jason Dorsett	Chief Finance Officer	03/10/2016	Permanent	Six months
Ms Sam Foster	Chief Nursing Officer	04/09/2017	Permanent	Six months
Professor Meghana Pandit	Chief Medical Officer	01/01/2019	Permanent	Six months
Ms Sara Randall	Chief Operating Officer	01/07/2019	Permanent	Six months
Mr Terry Roberts	Chief People Officer	10/02/2020	Permanent	Six months
Mr David Walliker	Chief Digital and Partnership Officer	28/10/2019	Permanent	Six months
Ms Eileen Walsh	Chief Assurance Officer	01/05/2011	Permanent	Six months

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. In 2021/22, the Committee received advice from the specialist consulting firm Korn Ferry to support the implementation of an objective and transparent job evaluation system for VSM staff.

The Committee was chaired by Ms Claire Flint and met four times in 2021/22. The following table contains details of the core membership of the Committee and their attendance at Committee meetings in 2021/22.

Committee Member	Title	Attendance
Ms Claire Flint (Chair)	Non-Executive Director	4/4
Prof Sir Jonathan Montgomery	Trust Chair	4/4
Ms Anne Tutt	Trust Vice Chair and Non-Executive Director	4/4
Ms Paula Hay-Plumb	Non-Executive Director	4/4
Ms Sarah Hordern	Non-Executive Director	4/4
Ms Katie Kapernaros	Non-Executive Director	4/4
Prof Anthony Schapira	Non-Executive Director	4/4
Prof Gavin Screaton	Non-Executive Director	2/4[1]
Prof Ashok Soni	Non-Executive Director	3/4[1]
Ms Joy Warmington	Non-Executive Director	2/4[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 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	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]									
Dr 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. *In 2021-22 Dr Holthof received a payment of £118,000 in lieu of outstanding pension contributions covering the period 1 April 2020 to 31 March 2022.*
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.*

Salary and Pension Entitlements of Senior Managers 2020/21 *(this information is subject to audit)*

Salary and Pension Entitlements of Senior Managers 2020/21 (12 months to 31 March 2021)									
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	100					15-20
Ms Claire Flint	Non-Executive Director		10-15						10-15
Ms Paula Hay-Plumb	Non-Executive Director		15-20	1,600					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
Executive Directors[4]									
Dr Bruno Holthof[5]	Chief Executive Officer		285-290	8,300					295-300
Mr Jason Dorsett[6]	Chief Finance Officer		185-190				30-35		215-220
Ms Sam Foster[7,8,]	Chief Nursing Officer		160-165		5-10		20-25	15-17.5	205-210
Professor Meghana Pandit	Chief Medical Officer		235-240				40-45		275-280

Salary and Pension Entitlements of Senior Managers 2020/21 (12 months to 31 March 2021)									
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 Sara Randall[8]	Chief Operating Officer		165-170				15-20	265-267.5	450-455
Mr Terry Roberts[8]	Chief People Officer		150-155					212.5-215	360-365
Mr David Walliker	Chief Digital and Partnership Officer		165-170				25-30		195-200
Ms Eileen Walsh	Chief Assurance Officer		150-155				20-25		170-175

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. *A life assurance and income protection premium are also paid in respect of the CEO, as shown in the 'Taxable benefits column'.*
6. *Received a non-consolidated additional responsibility payment until August 2020 in relation to additional responsibilities in respect of the Estates function (this is shown under the salary column), as agreed by the Remuneration and Appointments Committee.*
7. *A one-off cash bonus for the achievement of objectives in 2019/20 was paid in 2020/21, and 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 2020/21 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 2021/22 *(this information is subject to audit)*

Pension Benefits of Senior Managers 2021/22 (12 months to 31 March 2022)									
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 31/03/2022 (bands of £5,000)** **£000**	**Lump sum at pension age related to accrued pension at 31/03/2022 (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 31/03/2021** **£000**	**Employer's contribution to stakeholder pension** **£000**
Ms Sara Randall	Chief Operating Officer	20-22.5	65-67.5	95-100	295-300	-	-	-	-
Mr Terry Roberts	Chief People Officer	0-2.5	-	45-50	90-95	802	-	798	-
Ms Eileen Walsh	Chief Assurance Officer	25-27.5	-	50-55	110-115	1,067	26	1,026	-

Notes:

- *Non-Executive Directors do not receive pensionable remuneration (2020/21, nil).*
- *The Trust did not contribute to a Director's stakeholder pension scheme (2020/21, nil).*
- *Pension details have only been disclosed for those Directors in post during the last 12 months up to 31 March 2022. Balances for those in post during 2020/21 are available in the 2020/21 Annual Report.*
- *A number of Executive Directors opted out of the NHS Pension Scheme in 2019/20 due to the pension taxation issues described in the 2019/20 Annual Report and requested the alternative payment in lieu of the employer contribution.*
- *During 2021/22, one Director re-joined the NHS pension scheme and relevant details are shown in the table above.*
- *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. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.*
- *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.

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.

	2021/22	2020/21
Total number of Governors in office	29	30
Number of Governors who received expenses	0	0
Aggregate sum of expenses paid	0	0

Expenses of the Board of Directors

	2021/22	2020/21
Total number of Board members in office	18	16
Number of Board members who received expenses	1	3
Aggregate sum of expenses paid	8,500	£10,000

Payment for Loss of Office

No payments for Loss of Office were made to senior managers in 2021/22 (2020/21: 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 banded remuneration of the highest-paid Director in the organisation in the financial year 2021/22 was £295,000-300,000 (2020/21, £295,000-£300,000). The percentage change between years is 0.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The median and ratio include locum staff but do not include bank or agency staff.

For employees of the Trust as a whole, the range of remuneration in 2021/22 was from £9,400 to £299,000 (2020/21 £1,000 to £297,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full-time equivalent number of employees) between years is 4.2%. This figure will include the 3% pay award in 2021/22 and changes in the composition of the workforce. No employees received remuneration in excess of the highest-paid Director in 2021/22.

The remuneration of the employee at the 25th percentile, median and 75th percentile 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.

2021/2022	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 [2020/21; £33,394]	46,054
Pay and benefits excluding pension: pay ratio for highest paid director	11.85:1	8.56:1 [2020/21, 8.9:1]	6.46:1

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 not changed between years but the average remuneration of the Trust's employees has increased due to the 3% pay award and changes in the composition of the workforce in 2021/22.

Signed:

Dr Bruno Holthof
Chief Executive Officer
15 June 2022

Staff Report

The Staff Report provides information about staffing and staff related issues at Oxford University Hospitals NHS Foundation Trust (OUH), during the year 2021/22.

One of the three strategic objectives in the Trust Strategy for 2020-2025 is to '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. The Trust will deliver this objective by looking after our people, supporting personal and professional development, and growing our team and developing new ways of working.

Our Workforce

The Trust employed over 14,428 people in the year 2021/22 on permanent contracts[1] of employment across both full-time and part-time roles. This equates to a whole time equivalent (WTE) average of 12,676 WTE. Workforce numbers have increased during the year as turnover during the pandemic has decreased and recruitment has taken place to help assist with unprecedented demands. Likewise, pay costs have also risen as a result of the increased number of staff employed by the Trust.

The gender distribution of our workforce as at 31 March 2022 is shown in the table below.

Category	Female	Male	Total
Directors[2]	10	8	18
Senior Managers[3]	-	-	-
Other Staff[4]	10,811	3,599	14,410
Total[5, 6]	10,821	3,607	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. *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.*
4. *Everyone else in the organisation.*
5. *Everyone in the organisation including the Board.*
6. *Workforce numbers disclosed above are as per reporting requirement.*

The actual number of staff employed by the Trust is greater than the staff numbers disclosed above, since the honorary contract holders who do not carry out clinical work for the Trust are also considered as staff members of the Trust.

In addition to the above-mentioned workforce, the Trust is supported by a flexible temporary workforce working either directly for us on our Staff Bank or through appropriate use of external agencies.

Analysis of Average Staff Numbers as at 31 March 2022 *(this information is subject to audit)*

The average number of staff employed by the Trust as at 31 March 2022 is set out in the table below on a whole time equivalent (WTE) basis (the number for Administrative and Estates Staff includes all Corporate Support Services).

Staff Category	2021/22 Average WTE			2020/21 Average WTE
	Permanent Contract	Other Staff	Total Number	Total Number
Medical and Dental	2,032	38	2,070	1,993
Ambulance Staff	-	-	-	-
Administration and Estates	2,627	92	2,719	2,707
Healthcare Assistants and Other Support Staff	1,588	257	1,845	1,761
Nursing, Midwifery and Health Visiting Staff	4,030	506	4,536	4,378
Nursing, Midwifery and Health Visiting Learners	-	-	-	-
Scientific, Therapeutic and Technical Staff	1,511	63	1,574	1,529
Healthcare Science Staff	827	6	833	801
Social Care Staff	-	-	-	-
Other	61	-	61	60
Total Average Numbers	12,676	962	13,638	13,229
Of which				
Number of employees (WTE) engaged on capital projects	5	7	12	23

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

The table below sets out an analysis of staff costs during the year 2021/22, split between permanently employed staff and others.

Cost	2021/22			2020/21
	Permanently Employed[1] £000	Other Staff[2] £000	Total £000	Total £000
Salaries and wages	581,466	17,137	598,603	572,879
Social security costs	54,797	-	54,797	50,913
Apprenticeship levy	2,715	-	2,715	2,529
Employer's contributions to NHS pensions	94,449	-	94,449	87,789
Pension cost – other	77	-	77	60
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	33	-	33	4
Temporary staff	-	62,515	62,515	65,862
Total Gross Staff Costs	733,537	79,652	813,189	780,036
Recoveries in respect of seconded staff	-	-	-	-
Total Staff Costs	733,537	79,652	813,189	780,036
Of which				
Costs capitalised as part of assets	182	710	892	785

Notes:

1. *Staff with a permanent (UK) employment contract directly with the Trust (this includes Executive Directors but excludes Non-Executive Directors).*
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 supporting our disabled employees. The Trust participates in the Department for Work and Pensions' Disability Confident Scheme. As a Level 2 'Disability Confident Employer', the Trust takes positive action to ensure that our recruitment processes do not disadvantage disabled applicants. This includes operating a guaranteed interview scheme for those who meet the minimum criteria for a role. The Trust's commitment to this scheme was renewed for a further three years in November 2020.

The Trust actively supports employees who have a disability and helps employees who become disabled to stay in employment. We do this by supporting staff with disabilities in the workplace via our dedicated Occupational Health Service with a range of support options. The Trust has 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 provides an opportunity for employees with disabilities to access peer support while supporting the Trust to deliver disability equality. We review 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

OUH is 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 is the teaching hospital 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 programme available for them.

OUH is also a partner in the University of Oxford's School of Nursing and Midwifery alongside Oxford Health NHS Foundation Trust and Oxford Brookes University, as part of the Oxford School of Nursing and Midwifery. In addition, the Trust is a placement partner of choice for a significant range of allied health professions as well as pharmacy and healthcare science.

The Trust delivers and supports education across all professional groups and services and has a highly competent internal education faculty. In 2021/22, the faculty continued to provide critical support to staff to enable them to deliver the quality of services and patient care the Trust is recognised for. Access to education and training is being further enhanced through the rollout of our new Continuing Professional Development Hub (CPD Hub) as an addition to our existing My Learning Hub platform.

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. These include the following.

- Monthly virtual staff briefings led by the Chief Executive Officer and the rest of the Executive team.
- Our 'OUHStaffText' initiative, which is an internal communications channel providing OUH news and information updates via SMS messages for staff who sign up to receive these alerts.
- Twice weekly Staff Bulletin emails sent to all staff with a range of news, events and other information.
- Monthly, themed Freedom to Speak Up virtual listening events led by the Freedom to Speak Up Guardian with other key Trust staff depending on the theme.
- Posters for those staff who do not have regular access to email.
- Regularly updated messages on digital screens on all OUH hospital sites.
- Posts on the official OUH social media platforms, including Yammer, which many staff follow.
- The Trust intranet, OUHi and the Trust's external website, www.ouh.nhs.uk.
- Our Guide to Health and Wellbeing for staff, hosted on the Trust website so it is accessible to all staff.

Consulting staff and representatives

Oxford University Hospitals NHS Foundation 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. All proposed formal consultations under the Trust's Management of Organisational Change Procedure should be presented to the consultation sub-group, prior to consultation with staff.

The Trust has been working to promote the voice of our people from protected characteristic groups through the development of five staff networks as follows:

- Black, Asian and Minority Ethnic (BAME) Network
- LGBT+ Network
- Disability and Accessibility Network
- Women's Network
- Young Apprentices Network.

The aim of these networks is to promote equality for, and provide support to, its members.

Each network feeds into the Trust's Equality, Diversity and Inclusion Steering Group to inform decision-making and Trust Strategy. Each network has an Executive Sponsor who supports the development of the network and champions the network's voice at a senior level.

Encouraging staff involvement in the Trust's performance

We recognise that our workforce is one of the key assets that contributes to the operations and performance of the Trust, allowing us to achieve our objectives in delivering high-quality and efficient healthcare services to our populations. In addition to encouraging and supporting our staff in personal development to enhance their 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.

- *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.
- *Reporting Excellence*, a recognition scheme that helps the Trust to learn from 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.
- *Oxford Scheme for Clinical Accreditation (OxSCA)*, a national initiative that has been adapted locally at OUH. It 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 for the benefit of our patients, our staff and our populations.
- *OUH Staff Recognition Awards,* an opportunity for our people and patients to recognise an individual or a team who really lives our Trust values as part of our OneTeamOneOUH response to the COVID-19 pandemic. 1,482 nominations were received throughout December 2021 and the awards celebration will take place in June 2022.

In 2021/22, to appreciate and thank staff for their remarkable response to the COVID-19 pandemic and encourage the importance of taking a break for good mental and physical health, our staff received an extra day's annual leave as a 'recognition day'.

Health and Safety

The Trust continued to develop its management system for health and safety throughout 2021/22 towards meeting the requirements for certification to the ISO 45001:2018 standard (Occupational Health and Safety Management Systems) and to ensure workplace risks were identified, assessed and addressed. During 2021/22, significant risks continued to include the risk from COVID-19 infection in addition to general workplace health and safety risks. To support staff to assess and address these risks, the Health and Safety team collaborated with teams across the Trust to monitor national guidance and respond to any changes required to existing practice. Where necessary, changes in policy and guidance were reflected in revised risk assessments.

In September 2021, the Trust was included in a national programme of inspections of healthcare establishments carried out by the Health and Safety Executive (HSE) to examine the management arrangements for violence and aggression, musculoskeletal disorders and COVID-19 control at care providers in the public sector. The Trust performed extremely well in the inspection with only a small number of verbal feedback points from the HSE and no formal follow-up actions required.

Health and wellbeing of staff

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

COHWB had over 12,000 contact appointments in 2021/22. Achievements include successful re-accreditation at five years for the Faculty of Occupational Medicine Safe Effective Quality Occupational Health (SEQOHS) scheme in October 2021 and after a period of transition a new Head of Occupational Health was appointed at the end of January 2022. The team continued to be at the forefront of the Trust's response to COVID-19 in 2021/22 providing support to our staff and their managers, including over 4,210 symptomatic COVID-19 nasal/throat swabs; support for contact tracing and outbreak management; specific advice for those suffering from long-term effects of COVID-19 (Long COVID); and ongoing support for COVID-19 vulnerability scoring and workplace risk assessments as part of the system in place to ensure that staff are protected from the risks of contracting COVID-19 at work.

Policy on Counter Fraud and Corruption

OUH is committed to providing a zero-tolerance culture to fraud, bribery and corruption while maintaining an absolute standard of honesty and integrity in dealing with our assets. We are committed to eliminating fraud and illegal acts within the Trust. We ensure the rigorous investigation of reported matters of fraud, bribery or corruption and the pursuance of redress for financial losses stemming from such acts. The Trust will consider the application of all appropriate sanctions including disciplinary, criminal or civil sanctions. In April 2020, TIAA was appointed as the Counter Fraud Service provider of the Trust. TIAA is accountable to the Chief Finance Officer and the Audit Committee.

To tackle fraud, bribery and corruption, the Trust complies with the NHS Counter Fraud Authority (NHSCFA) Requirement 12, which sets the standards for countering fraud in adherence with the 'Government Functional Standards GoVs 013: Counter Fraud'. The Counter Fraud and Bribery Policy of the Trust sets out the approach to countering fraud, bribery and corruption in the NHS and the Trust's role in this. In March 2022, the policy was updated and approved by the Board to reflect the revised NHSCFA Strategy.

To comply with the NHS requirements for managing conflicts of interest and the requirements of the Bribery Act 2010, the Declarations of Interests, Gifts, Hospitality and Sponsorship Policy of the Trust is in place. The policy was revised and approved by the Trust Board in September 2021.

The policies are kept under review by our Counter Fraud service provider TIAA, to ensure they remain effective. Their effectiveness is tested through an annual staff survey. All matters relating to fraud and anti-bribery are investigated by TIAA, throughout the year the Trust provides advice to staff on how to raise concerns about fraud and bribery issues.

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.

Policies and Procedures

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 also undertakes reporting on its gender pay gap on an annual basis. We use this exercise to enable us to identify differences in the experience of men and women working within the Trust and plan actions to mitigate them.

Our 2021 Combined Equality Standards Report contained the following key findings.

- There are variations in the metrics when looking at them by Division, highlighting that local approaches are required to make further progress against the metrics.
- Reporting of bullying and harassment experienced is higher for BAME and disabled staff. However, there needs to be a focus on how issues are addressed once reported.
- Specific analysis and interventions are required for the Medical and Dental Workforce, especially with the introduction of the Medical Workforce Race Equality Standard.

The findings from our Combined Equality Standards Report have been used to support our EDI Objective refresh and Delivery Plan. This will incorporate a four-year approach to addressing WRES, WDES and the gender pay gap. Our most recent WRES, WDES and gender pay gap data can be found on the Trust website: visit www.ouh.nhs.uk and type 'TB2021.69' into the search field on the home page.

Initiatives

The primary focus during 2021/22 has been on the refresh of the Trust's EDI Objectives which will be launched next year. These objectives aim to accelerate progress on improving EDI as well as the Trust's position to effectively meet current and future EDI challenges. To develop the Objectives, several approaches, including engagement activities involving staff, patients and system partners, analysis of internal data sources, as well as review of local and national policy and strategy, were taken.

The Trust developed and launched an EDI Peer Review, which is an assurance and service improvement tool that aims to understand how EDI is being delivered at a service level. The tool is aligned to EDS2 to enable us to meet reporting requirements whilst also providing a holistic review of EDI. This tool is now part of the Trust's regular peer review cycle and will enable continuous improvement on EDI.

Work has continued to develop and strengthen staff networks and support their activities. Each staff network has an identified Executive Sponsor with whom the networks can engage and escalate issues to. Staff Network Leads are also supported with development activities to enable them to drive forward and lead their respective networks. Consultation with our staff networks ensures that the Trust develops actions that address barriers to improve the experience of our diverse workforce.

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 FtSU team played a key role in supporting staff dealing with ongoing consequences of COVID-19, including support for those concerned about the prospect of government-mandated vaccination. In 2021/22, 116 cases were opened, and the team had contact with 2,072 staff to raise awareness and remove barriers to speaking up.

The team, in collaboration with Executive and Non-Executive Directors, held regular online listening events for staff to ask questions, raise concerns and highlight positive stories. In addition, e-Learning modules on Speaking Up and Listening Up were launched for all staff and six face-to-face roadshow events were held (compliant with COVID-19 restrictions) on all four hospital sites and the OUH offices in Cowley during Speak Up Month in October 2021.

The team keeps the Trust Board informed by presenting six-monthly update reports and an Annual Report. With the support of the Board, the FtSU team undertook a service review and developed a comprehensive Action Plan including proposals for a revised operational model to optimise service delivery. Progress has already been made to establish a network of volunteer FtSU Champions and further events and activities are planned in 2022/23 to continue to promote, create and sustain an open and honest culture where staff feel safe to speak up if they have a concern.

NHS Staff Survey

Recognised as being an important intervention in supporting the delivery of the NHS Constitution, the annual NHS Staff Survey is a mandatory undertaking for all NHS Trusts in England. NHS England sets the framework and questions for the survey. Oxford University Hospitals NHS Foundation Trust (OUH) commissioned the Picker Institute to manage the Staff Survey. The National Coordination Centre provided the Trust with valuable benchmarking data against 126 Acute, and Acute and Community Trusts.

The survey results are primarily intended for use by local organisations to help them review and improve staff experience, which is accepted as having a direct impact on the quality of care and the patient experience.

The NHS Staff Survey is conducted annually. 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 replace 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.

Summary of results 2021/22

The Trust's NHS Staff Survey 2021 response rate of 57% was its best ever, increasing from 53.1% in 2020. This is also 11% higher than the average for Acute, and Acute and Community Trusts of 46% in 2021. Compared with 2020, the Trust scored significantly better on 11% of the questions in 2021, 39% remained similar and 50% of the questions scored less. This decline from the 2020 results reflected the national trend in results experienced by the majority of comparable Trusts in the previous year.

Scores for each indicator together with that of the survey benchmarking group, 126 Acute, and Acute and Community Trusts, are presented below.

Indicators (People Promise elements and themes)	2021/22	
	Trust Score	Benchmarking Group Score
People Promise:		
We are compassionate and inclusive	7.3	7.2
We are recognised and rewarded	5.9	5.8
We each have a voice that counts	6.8	6.7
We are safe and healthy	6.1	5.9
We are always learning	5.2	5.2
We work flexibly	6.2	5.9
We are a team	6.7	6.6
Staff engagement	7.0	6.8
Morale	5.9	5.7

These results show the Trust was slightly above the national average in eight indicators and was in line with the average on one indicator. From the seven new People Promise elements in 2021, 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), and 'we are always learning' was the lowest (5.2 – the same as the national average). 'We work flexibly' with a score of 6.2 was the element that scored most positively when compared to the national average of 5.9.

Within the element 'we are safe and healthy' the Trust has seen a 25% increase in staff reporting that it is taking positive action on the health and wellbeing of its people. This has been a focus of the Trust's award-winning *Growing Stronger Together – Rest, Reflect, Recover* programme. Other improved areas include staff reporting that their immediate line manager asks their opinion, and staff not experiencing harassment, bullying or abuse from colleagues.

Areas for improvement where the Trust's results have declined in 2021 include staff coming to work when feeling unwell, staff not feeling valued for the work that they do, and the percentage of staff who would recommend OUH as a place to work to their friends and family.

Summary of results of the staff surveys in 2020/21 and 2019/20

The Trust's last two years' staff survey scores for the previous 11 themes, together with that of the survey benchmarking group, 126 Acute, and Acute and Community Trusts, are presented in the table below.

Theme	2020/21		2019/20	
	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.1	9.1	9.0	9.0
Health and wellbeing	6.3	6.1	5.9	5.9
Immediate managers	7.0	6.8	6.9	6.8
Morale	6.3	6.2	6.2	6.1
Quality of appraisals	*Not collected*		5.6	5.6
Quality of care	7.5	7.5	7.5	7.5
Safe environment - bullying and harassment	8.1	8.1	8.0	7.9
Safe environment - violence	9.5	9.5	9.5	9.4
Safety culture	6.9	6.8	6.8	6.7
Staff engagement	7.2	7.0	7.1	7.0
Team working	6.6	6.5	6.5	6.6

Future priorities and targets

The Trust aims to build on the journey of improvement over the last four years and continue to develop an inclusive culture that makes the Trust a great place to work. With the 2021 staff survey results, the Trust has launched its 'Engagement Promise' which is underpinned by all Divisional leaders being responsible for cascading the results, and Team Leads undertaking 'Time to Talk' conversations with their teams to co-design, embed and own local action plans.

The Trust will also continue to focus on four key organisational areas for action in 2022/23.

- Build on its award-winning *Growing Stronger Together – Rest, Reflect, Recover* programme to continually improve the wellbeing of its people.

- Refresh its Equality, Diversity and Inclusion four-year objectives and commence delivery.
- Implement a values-based leadership framework within Trust leadership programmes, and roll out specific training to enable a culture of civility and respect.
- Lead forward a Quality Priority to tackle physical and verbal violence and aggression towards its people.

These priorities will be integrated into the Trust's new People Plan 2022-2025 and monitored through its performance governance arrangements.

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 2021

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2021[1]	**Adjusted FTE days lost to Cabinet Office definitions[2]**	**FTE days available**	**FTE days recorded sickness absence**	**Average sick days per FTE[3]**
12,431	111,209[4]	4,537,423	180,406	8.9

Notes:

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.

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.*
4. *Data shown here is the estimate mandated by the Department of Health and Social Care and is for the period January and December 2021, this is different to the actual data provided in the Performance Report of this Annual Report, which is for the period April 2021 to March 2022.*

Staff turnover

Staff turnover has steadily increased throughout the year. In April 2021 turnover was at 9.5% and in March 2022 it was 12.4%. In March 2022, turnover was highest within the Additional Clinical Services staff group (clinical support staff), where turnover was 16.3%. Nursing and Midwifery is the largest staff group within the Trust and the turnover was 11.7%. Out of all the Clinical Divisions, SuWON (Surgery, Women's and Oncology) division had the highest turnover rate at 14.2%. Further information on our staff turnover in 2021/22 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. Further information on gender pay gap is available online at gender-pay-gap.service.gov.uk.

The gender pay gap is the percentage difference between average hourly earnings for men and women. The Trust is committed to addressing this issue. The key points relating to the Trust's gender pay gap as of 31 March 2021, as reported to the Trust Board in September 2021, included the following.

- Ordinary pay – there has been little change in the mean and median pay gap from the previous year with the mean decreasing by 0.13% and the median increasing by 0.62%.
- There has been a significant decrease in both the mean and median bonus pay gap, with the mean bonus pay gap reducing by 20.94% and the median bonus pay gap closing. This is largely attributed to changes in the way Clinical Excellence Awards were allocated.
- The proportion of women in each quartile of the pay structure has increased in all but the upper middle quartile. Despite an increased proportion in the top quartile, there was a larger increase of the proportion of women in the lower quartiles, contributing to the increased median pay gap.

The Trust's full Gender Pay Gap Report can be found on the Trust website as part of the Combined Equality Standards Report for 2021: visit www.ouh.nhs.uk and type 'TB2021.69' into the website's search field. This provides an analysis of the Trust's position along with a summary of initiatives that were either being undertaken or planned to be undertaken to reduce the gender pay gap.

Trade Union Facility Time 2021/22

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	30.97

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%	20
1-50%	12
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)	£104
Total pay bill (£000s)	£813,189
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	100%

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 2022 earning £245 per day or greater

Number of existing engagements as of 31 March 2022	2
of which…	
Number that have existed for less than one year at time of reporting	0
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	1
Number that have existed for between three and four years at time of reporting	-
Number that have existed for four or more years at time of reporting	-

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2022 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2022	2
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*	2
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 2021 and 31 March 2022

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.	18

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 2022. 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

	2021/22			2020/21		
Exit package cost band	**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	2	-	2	1	-	1
£10,000 - £25,000	2	-	2	-	-	-
£25,001 - £50,000	-	-	-	-	-	-
£50,001 - £100,000	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-
Total number of exit packages by type	4	-	4	1	-	1
Total resource cost £k	33	0	33	4	0	4

Exit packages: other non-compulsory departure payments

There were no exit packages in either 2021/22 or 2020/21 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 2021/22 can be found within our Annual Accounts in note 6.1.

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 on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. 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).

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 of the Code of Governance, but of the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

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 January 2020 and updated in April 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.
FT ARM	The annual report should include a statement about the number of meetings of the council of	This information is available in the Trust Membership and Council of

Code Ref	Summary of Requirement	Annual Report Reference/Response
	governors and individual attendance by governors and directors.	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.
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.	This information is available in the Remuneration Report of this Annual Report.
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors	Other significant commitments of the Trust Chair have been declared and

Code Ref	Summary of Requirement	Annual Report Reference/Response
	before appointment 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.	listed in the 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. Board members attend the Council of Governors meetings by choice and have not been required to attend by 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 as to	Where applicable, this information is available in the Annual Governance Statement of this Annual Report. During 2021/22, there has not been an external evaluation of the Board, with

Code Ref	Summary of Requirement	Annual Report Reference/Response
	whether they have any other connection to the trust.	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 2021/22.
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 statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process	This has been fulfilled in the Annual Governance Statement of this Annual Report. The three-year contract of the Trust's External Audit Provider was extended by a further year for the 2021/22 financial year. Following a competitive tender process, a new auditor has been appointed for 2022/23.

Code Ref	Summary of Requirement	Annual Report Reference/Response
	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.
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.	The Chief Executive Officer holds Non-Executive appointments, as declared in the Register of Interests, and it is confirmed that he is entitled to retain the earnings under his contract. 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.
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;	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
	• 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.	
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.

NHS System Oversight Framework

NHS England and NHS Improvement's NHS System Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. The framework looks at five national themes:

- quality of care, access and outcomes
- preventing ill health and reducing inequalities
- finance and use of resources
- people
- leadership and capability.

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

Oxford University Hospitals NHS Foundation Trust has been segmented into category 3 – mandated and targeted support.

From 1 April 2021 until 1 December 2021 the Trust continued to be under an enforcement notice from NHS England and NHS Improvement which has been in place from 2018. The enforcement notice was lifted following the completion of an independent review of financial governance which highlighted areas of potential learning. The Trust accepted the recommendations and is in the process of implementing them.

The Trust remains in category 3 while NHS England and NHS Improvement carries out a process of assurance to determine whether or not any areas of operational performance require ongoing support.

This segmentation information is the Trust's position as at 31 March 2022. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England and Improvement website at www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation.

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive'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 Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, 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 Improvement, 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:

Dr Bruno Holthof
Chief Executive Officer
15 June 2022

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Oxford University Hospitals NHS Foundation Trust for the year ended 31 March 2022 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
- 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 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
- 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 - this has progressed but has yet to be published. The delay is partly due to the COVID-19 pandemic and the introduction of a new electronic risk management system in 2022. The Board's risk appetite statement has been included in the Risk Management Policy, which is currently out for consultation within the Trust. 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 the following public stakeholder sources: 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 and the Corporate Risk Register are independently reviewed annually by Internal Audit. This year, this was an advisory piece of work, which generated recommendations for improvement.

The Trust's risk assessment process covers all of its activities – 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 Strategy. These risk registers are reviewed regularly by Divisional and Directorate forums, and they are required to escalate risks, where their ratings warrant this, for inclusion on the Corporate Risk Register.

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-week referral to treatment waiting list target, diagnostic wait target, cancer waiting targets and Emergency Department waiting time targets)
- the ability of the Trust to manage post COVID-19 waiting list delivery and the impact on patients waiting longer for care
- the ability to recruit, retain and engage staff and the impact of staff sickness on service delivery
- the tracking of financial activity and financial risk, including the access to capital funding and the potential impact of the lack of capital funding on service delivery, including the digital infrastructure and resilience.

These were the principal risks considered to be relevant for 2021/22. 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. 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. To embed risk management further, the Risk Committee was introduced in 2020/21 as a sub-committee to the Trust Management Executive and has continued to evolve during 2021/22.

The Board has overall responsibility for the performance of the Trust and is accountable to its NHS Foundation Trust members and 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 Executives
- ensure dialogue with external stakeholders such as statutory bodies and the local community.

In 2021/22 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, 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 reviewing the submission of timely and accurate information to relevant external stakeholders.

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 2021/22, 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, also recommending the Trust to add these risks to relevant Trust risk registers.

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

TIAA concluded that:

- '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'.

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.

2021/22 was the first year of service of the new Internal Auditors (BDO). The Audit Committee noted the change in the definition of the audit opinion ratings for each audit assignment. The new definitions provide separate ratings on the design of the controls and the effectiveness of these controls. In addition, BDO uses a different scale (substantial assurance, moderate assurance, limited assurance and no assurance) to that used by the previous internal auditors. The Audit Committee mapped these two scales to each other and confirmed with BDO that the change in terminology did not have an impact on the assurance conclusions.

The Audit Committee received Internal Audit opinions as follows:

- Clinical Validation of Waiting Lists: Design: Moderate, Effectiveness: Moderate
- Infection Prevention and Control – 7 key steps to preventing HCAIs (Healthcare Associated Infections): Design: Moderate, Effectiveness: Moderate
- Key financial systems: Design: Substantial, Effectiveness: Moderate
- Technologies Advisory Group: Design: Substantial, Effectiveness: Moderate
- DSP Toolkit: Design: Substantial, Effectiveness: Moderate

Currently in draft:

- Cyber Security
- Estates Compliance
- 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. The change in the scale of ratings also applied to the overall opinion and the Audit Committee is satisfied that the change in terminology does not represent a reduction in assurance.

In forming this opinion, the internal auditor took the following into account.

- The NHS Improvement (NHSI) and NHS England (NHSE) forecast submitted to NHSI in Month 10 was a surplus of £3.0m, an £8.5m improvement to the £5.5m deficit previously planned.
- 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 DSP Toolkit.
- The Trust has a good record in implementing audit recommendations. Internal Audit noted that the Trust has closed all prior year (2020/21) recommendations and management is proactive in discussing plans to address the risks identified in the 2021/22 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.

- COVID-19 response and recovery, specifically the vaccination programme, and the fulfilment of safe and timely use of resources as part of the national vaccination programme
- The results of the Financial Governance Review and associated action plan
- Estates and Health and Safety Compliance
- Serious Incidents Requiring Investigation (SIRI) and Never Events which have occurred during the year, levels of investigation and impact on the patients
- The continued improvements on patients waiting in excess of 52 and 104 weeks due to the elective recovery programme and specific actions taken in relation to the management of the overall waiting list size (additional information is provided in the performance section of the Annual Report)

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 2021/22, the Committee also considered the lessons learned from previous projects and investment activity.

The ***Remuneration and Appointments Committee*** is responsible for determining the policy on executive remuneration, approving contracts of employment for executives 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:

- workforce and organisational development matters, such as:
  - policies to support agile working during the pandemic
  - review of consultant recruitment
  - supporting programmes such as Rest, Reflect, Recover and Integrated Care System (ICS)-wide initiatives promoting staff wellbeing
- approval of Divisional Business Planning and ongoing alignment of Divisional Directors' objectives and national planning requirements
- risks and opportunities to maintain productivity through workforce and the oversight of risks related to COVID-19 response and recovery
- supporting key investment opportunities such as:
  - the proposal to restructure and expand Infection Prevention and Control services

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's Constitution for the 2021/22 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. Governors appoint the Non-Executive Directors.

Details of the Constitution, 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 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, 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 Board Committees review and challenge all workforce plans undertaken in different work streams to align workforce planning to the triangulated approach defined by the National Quality Board (NQB) and escalate any risks associated with staffing to the Board for consideration.

The People and Communications Committee, a sub-committee of TME, has been in place for the whole year. It monitors and provides assurance on the delivery of safe staffing that is financially sustainable, while providing high-quality and compassionate care to patients, both short-term and long-term.

The Trust's five-year Strategy (2020-2025) refocused resources on Our Patients, Our People and Our Populations. NHS England and NHS Improvement (NHSE&I) have identified staffing as one of the key risks impacting NHS Trusts. The Trust recognises that workforce is a key priority to underpin the achievement of clinical and financial performance. Workforce planning and making the Trust a great place to work are at the heart of the revised People Plan.

The Trust has engaged in activities throughout the year to ensure compliance with the 'developing workforce safeguards' objective through the following actions:

- the use of virtual monthly staff briefing sessions, led by Executive Directors and involving staff, in providing updates on ongoing workforce matters and staff support during the pandemic
- changes in communications by the production of regular TME and Board blogs which aim to improve the link between the Board and staff by sharing information about what was discussed and decided during meetings
- promoting staff wellbeing, through the Employee Assistance Programme (EAP) for all staff, and providing risk assessments and bespoke guidance for key groups e.g. those with

conditions and Black, Asian and Minority Ethnic (BAME) staff. A health and wellbeing guardian from a BAME background was appointed by the Trust, and this position is co-funded by Oxford Hospitals Charity.
- Staff being awarded a recognition day for their efforts during the pandemic as an extra annual leave day on or near their birthday.

COVID-19

The COVID-19 pandemic impact on the Trust over the year has remained significant. The Trust has followed government guidance in dealing with the evolving pandemic and the variants of the virus that have occurred. To maintain a well-led organisation, ensuring staff and patients remained safe, the Board continued to identify risks and issues associated with the pandemic and developed mitigations to tackle the risks as and when identified.

Some key risks that were identified relating to the pandemic were:

- potential harm to patients, staff and public from nosocomial COVID-19 exposure
- having sufficient resources to drive the recovery programme
- high levels of staff absence due to COVID-19 related mental health issues.

The Board developed programmes and activities to support staff during 2021/22, such as:

- staff vaccination programme, including winter vaccination for boosters
- comprehensive staff testing and wellness/wellbeing checks
- availability of lateral flow tests
- psychological support from EAP and Occupational Health.

Regular activities, communication and training resources on Personal Protective Equipment (PPE) and Infection Prevention and Control have been made available and accessible to all staff and regularly updated on the Trust's intranet and external website pages.

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). The Trust is currently registered with the CQC without restrictions and has an overall 'Requires Improvement' rating based on inspections conducted during 2021/22.

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

The CQC conducted two onsite inspections over the year, one planned Infection Prevention and Control inspection and an unplanned inspection in Maternity Services. The Trust has reported progress against emerging actions through agreed governance processes. Concurrent to the CQC maternity inspection action plan the Trust has reported progress in relation to the immediate and essential actions outlined in the Ockenden Report, in conjunction with 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 have continued throughout 2021 and into 2022 via the Estates Compliance Committee, the Health and Safety Committee, the Executive Risk Committee and the Trust Management Executive. A key step forwards to support this work has been the appointment of an Estates Compliance Manager in November 2021, with responsibility for Estates Compliance reporting.

The Trust commissioned consultancy firm GK Transformation to update the Trust's Estates and Facilities Premises Assurance Model (PAM) assessment and gap analysis of the evidence required Trust-wide. Since the 2019/20 assessment, all 14 'Inadequate' scores have improved and there are no remaining 'Inadequate' scores. Of the 340 questions in the assessment, there are 24 that 'Require Moderate Improvement' and the remaining scores are 'Require Minimal Improvement', 'Good' and 'Outstanding'. The PAM assessment has improved significantly since the last assessment during 2019/20, with the most significant areas of improvement being implementation of:

- better information systems such as the Computer Aided Facilities Management (CAFM) software for the retained estate
- regular review and Assurance Committee meetings
- the two-facet survey of the retained estate
- updates to Trust-wide Estates and Facilities policies ratified by TME
- establishment of future capital investment action plans.

Key areas identified for further improvement are focused on:

- updating risk assessments
- ratifying updated policies
- training and appointments
- tendered action plans
- additional ongoing revenue funded maintenance
- future capital replacement and upgrades for safety and resilience.

Following these improvements, the Trust Estates team has moved on to the following areas identified for further improvement: the updating of certain risk assessments, continual improvements with the ratifying of updated policies, training and appointments of remaining Authorising Engineers, having tendered action plans ready for more immediate use of available capital funds, having additional ongoing revenue funded maintenance and future capital replacement and upgrades identified for safety and resilience.

In response to Executive feedback, the Estates team has focused efforts and resources to progress improvements in these areas. The Ventilation Systems Policy, Gas Safety Policy and Asbestos Policy have all now been ratified at TME following updates. The Water Safety Plan has been updated, pending final ratification as recommended by the Water Safety Group, and further updates are currently underway for Electrical, Pressure Systems, Planned & Reactive Maintenance, Lifts, Staff Travel & Car Parking and Waste Management Policies.

In addition to the status of various capital and Private Finance Initiative (PFI) works, the team has undertaken a review of resources requirements across the Estates, Facilities, Capital Development and PFI portfolio. A business case is currently under development, with a proposal for investment in additional resources for the team. This will be a priority area of focus throughout 2022 and into 2023.

During the last year, the PFI portfolio has transitioned to the responsibility of the Chief Nursing Officer under the direction of the Director of Nursing. As part of this transition the PFI team has been restructured and several areas for development have been identified. These are covered mainly under the domains of people and processes, as well as specific initiatives planned to improve services and provide transparency for assurance purposes. This will be achieved by evolving the contractual management of the three Trust PFIs away from penalty notices to improving patient safety and the overall experience of patients and staff. These objectives will be met by enabling a greater level of partnership working with Clinical Divisions and the PFI service provider teams.

To demonstrate the new approach to governance and assurance, a performance dashboard has been created, covering the key areas of performance, compliance, commercial, contract and people management. The dashboard has been developed with the support of the Trust Director of Performance and Accountability, with performance indicators and measurements agreed with the Director of Nursing. In addition to the dashboard, a new risk register is being developed that identifies the PFI risks. This will ensure that relevant risks are identified, registered and managed effectively by the PFI team. The identification of risk in this manner will allow ownership of risks to be consistently achieved and ensure responsibility is in accordance with the contractual obligations that the PFIs operate under.

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 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 '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 2021/22 continues to be fundamentally altered by the Trust's response to the COVID-19 pandemic and the elective recovery process which commenced in the year. 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 Business Plan for 2021/22 was paused in December 2020 following the COVID-19 surge caused by the Alpha variant. Instead, the Trust, working to a revised national process, prepared a six-month plan for April to September 2021 (H1 2021/22) followed by a second six-month plan for October 2021 to March 2022 (H2 2021/22).

NHS England (NHSE) also instituted a decisive step towards planning on an ICS basis in 2021/22. The primary focus of planning was the operational and financial performance of the ICS and not the Trust. As a result, the focus for the use of resources was the Trust delivering its agreed contribution to the delivery of the ICS activity plan and financial break-even at an ICS level.

The challenges of a changing backdrop of COVID-19 infection levels also led to an unusual degree of change to national financial guidance during the year. In H1 2021/22 the Elective Recovery Fund (ERF) mechanism was initially very generous to the Trust which shared benefits with the wider ICS. However, NHSE changed the rules for July to September 2021 (Q2 2021/22) making the scheme less generous. The payment system for elective recovery was changed for H2 2021/22 and was initially less generous than in H1 2021/22 however, for January to March 2022 (Q4 2021/22) NHSE made substantial additional resources available.

The requirements of the national funding system and the ICS were complied with including the requirement to achieve a break-even or better financial performance. The volume of change in the funding arrangements has required frequent adjustments to the Trust's forecast and has required a degree of caution to manage the risks associated with these changing requirements.

The Trust has reported a surplus on the revenue budget performance measure used by NHSE&I of £3.3, and the ICS as a whole has delivered a surplus of £9.4m. The Trust has also reported an overspend on the capital budget measure used by NHSE&I of £7.1m, and the ICS as a whole delivered an underspend of £2.2m. From January 2022 onwards, the Trust submitted monthly forecasts of revenue and capital to NHSE&I on the year-end financial performance. These forecasts were discussed in advance of each month at the relevant Board and Board Committee meetings and with NHSE&I and the ICS. The Trust does not regard either the revenue underspend or capital overspend as significant control issues given the regular scrutiny of forecasts and the risks to achieving these forecasts.

During the year the Trust also carried out a review of its financial governance supported by the consultancy firm Grant Thornton. The review concluded that overall financial governance was robust, but with opportunities for improvement. The Trust published the review, and the actions it proposed to take as a result, in September. Early actions have been delivered improving reporting with work continuing on pay controls, quality improvement and efficiency, planning and work with the ICS.

Partly as a result of financial governance review, NHSE&I lifted its enforcement undertakings in respect of finance in December 2021 and as a result the Trust is no longer in breach of its provider licence.

Information Governance

Serious incidents related to breaches in the Trust's information security processes are 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 locally. Incidents that do meet the threshold are reported to the Oxfordshire Clinical Commissioning Group as Serious Incidents Requiring Investigation (SIRI). All incidents are discussed at the Information Governance and Data Quality Group, which is chaired by the Trust's Caldicott Guardian / Data Protection Officer.

The following table provides information in relation to serious incidents that met the threshold for onward reporting via the DSPT and the status of the incident.

Incident Date	Detail	Investigation Type	Status	Lessons Learned
04/06/2021	Patient health records required for subject access request made via a Solicitor were lost and could not be found.	Department of Health and Social Care / NHS England and Information Commissioner's Office (ICO).	Closed	Process changed to ensure incidents where notes are reported missing are followed up and updated with the final outcome of the search.
11/10/2021	Maternity records of another patient were disclosed, instead of their own, to a patient who requested their records.	ICO	Closed	New systems around Positive Patient Identification and avoiding handling of multiple record sets introduced within relevant team.
30/03/2022	Unauthorised access attempt to a Trust IT system.	Internal – submitted via DSPT but no further reporting required.	Closed (after 31/03/2022)	Strengthened security access by implementing multi factor authentication on all access points.

Data Quality and Governance

Under Data Protection legislation, the Trust is a Data Controller, and the organisation holds responsibility for the confidentiality, integrity and availability of data provided by patients and staff and 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 digital 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., that it is used lawfully, ethically and appropriately. The Trust currently has an Acting Caldicott Guardian and a Deputy

Caldicott Guardian. A formal recruitment process for a permanent Caldicott Guardian is underway. 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 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 2020/21 DSP Toolkit submission was made on 30 June 2021 and was initially rated as "Standards not met". On 9 July 2021, an improvement plan was submitted, and the rating was adjusted to "Approaching standards – improvement plan in place".

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

- The receipt of the Maternity CQC Report containing a 'Requires Improvement' judgement
- The ongoing assurance over Estates Compliance

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 during the global pandemic and over the course of the past year and has worked to maintain the quality of service provided to its patients and to continue to focus on developing 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:

Dr Bruno Holthof
Chief Executive Officer
15 June 2022

Accountability Report Conclusion

This concludes the Accountability Report of Oxford University Hospitals NHS Foundation Trust for the year 1 April 2021 to 31 March 2022.

Signed:

Dr Bruno Holthof
Chief Executive Officer
15 June 2022

Independent Auditor’s Report and Certificate

Independent auditor's report to the Council of Governors of Oxford University Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Qualified opinion on the financial statements

We have audited the financial statements of Oxford University Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2022 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, except for the possible effects of the matter described in the 'Basis for qualified opinion' section of our report, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2022 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

We were unable to obtain sufficient appropriate audit evidence about the existence and condition of the inventory balance held by the Trust at 31 March 2021 of £31.9m because we were unable to attend the year-end physical inventory counts due to COVID-19-related travel restrictions. Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2021 was necessary, or whether there was any consequential effect on operating expenses in relation to inventory expenditure for the year ended 31 March 2022.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our qualified opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

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

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2021/22 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accounting Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in April 2021.

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

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2022.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accounting Officer
The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice
We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2021/22; or
- the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report
This report is made solely to the Council of Governors of Oxford University Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

Suresh Patel, Key Audit Partner
For and on behalf of Mazars LLP

30 Old Bailey, London, EC4M 7AU

16 June 2022

Audit Completion Certificate issued to the Council of Governors of Oxford University Hospitals NHS Foundation Trust for the year ended 31 March 2022

In our auditor's report dated 16 June 2022 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 16 June 2022 that would have a material impact on the financial statements on which we gave our qualified opinion.

The Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in this respect.

Certificate

We certify that we have completed the audit of Oxford University Hospitals NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Suresh Patel, Key Audit Partner
For and on behalf of Mazars LLP

30 Old Bailey, London, EC4 7AU

21 June 2022

Oxford University Hospitals

NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2022

Foreword to the accounts

Oxford University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2022, 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:

Dr Bruno Holthof
Chief Executive Officer
15 June 2022

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	1,213,307	1,054,113
Other operating income	4	189,526	269,847
Operating expenses	6, 8	(1,386,507)	(1,296,545)
Operating surplus/(deficit) from continuing operations		**16,326**	**27,415**
Finance income	11	41	22
Finance expenses	12	(23,139)	(21,324)
PDC dividends payable		(9,996)	(6,575)
Net finance costs		**(33,094)**	**(27,877)**
Other gains / (losses)	13	59	(1,118)
Share of profit / (losses) of associates / joint arrangements	18	121	(61)
Surplus / (deficit) for the year		**(16,588)**	**(1,641)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,127)	5,341
Revaluations	16	27,154	-
Fair value gains / (losses) on equity instruments designated at fair value through OCI	19	(9,161)	7,256
Total comprehensive income / (expense) for the period		**278**	**10,956**
Adjusted financial performance* (control total basis):			
Surplus / (deficit) for the period		(16,588)	(1,641)
Remove net impairments not scoring to the Departmental expenditure limit		16,230	14,379
Remove I&E impact of capital grants and donations		(1,867)	(3,017)
Remove net impact of inventories received from DHSC group bodies for COVID response		4,154	(6,616)
Remove loss recognised on return of donated COVID assets to DHSC		1,323	-
Adjusted financial performance surplus / (deficit)		**3,252**	**3,105**

* Note this table is additional information for readers of the accounts and doesn't form part of the primary statement

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	14	14,155	14,671
Property, plant and equipment	14	650,575	608,913
Investment property	17	32,030	30,394
Investments in associates and joint ventures	18	13,166	13,045
Other investments / financial assets	19	1,142	10,588
Receivables	22	7,147	8,600
Total non-current assets		**718,215**	**686,211**
Current assets			
Inventories	21	28,517	31,939
Receivables	22	58,888	55,822
Cash and cash equivalents	23	57,323	83,769
Total current assets		**144,728**	**171,530**
Current liabilities			
Trade and other payables	24	(155,245)	(165,270)
Borrowings	26	(14,095)	(11,443)
Provisions	28	(7,958)	(6,609)
Other liabilities	25	(3,882)	(3,802)
Total current liabilities		**(181,180)**	**(187,124)**
Total assets less current liabilities		**681,763**	**670,617**
Non-current liabilities			
Borrowings	26	(236,177)	(239,303)
Provisions	28	(8,460)	(9,033)
Other liabilities	25	(4,628)	(4,072)
Total non-current liabilities		**(249,265)**	**(252,408)**
Total assets employed		**432,498**	**418,209**
Financed by			
Public dividend capital		303,750	289,739
Revaluation reserve		159,684	141,648
Financial assets reserve		(9,245)	(84)
Other reserves		1,743	1,743
Income and expenditure reserve		(23,434)	(14,837)
Total taxpayers' equity		**432,498**	**418,209**

The notes on pages 120 to 149 form part of these accounts.

Signed:

Dr Bruno Holthof
Chief Executive Officer
15 June 2022

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2022

	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**
Surplus/(deficit) for the year	-	-	-	-	(16,588)	**(16,588)**
Impairments	-	(1,127)	-	-	-	**(1,127)**
Revaluations	-	27,154	-	-	-	**27,154**
Transfer to retained earnings on disposal of assets	-	(59)	-	-	59	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	(9,161)	-	-	**(9,161)**
Public dividend capital received	14,011	-	-	-	-	**14,011**
Other reserve movements	-	(7,932)	-	-	7,932	**-**
Taxpayers' and others' equity at 31 March 2022	**303,750**	**159,684**	**(9,245)**	**1,743**	**(23,434)**	**432,498**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

	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 2020 - brought forward	**241,445**	**148,235**	**(7,340)**	**1,743**	**(25,124)**	**358,959**
Surplus/(deficit) for the year	-	-	-	-	(1,641)	**(1,641)**
Impairments	-	5,341	-	-	-	**5,341**
Transfer to retained earnings on disposal of assets	-	(91)	-	-	91	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	7,256	-	-	**7,256**
Public dividend capital received	48,294	-	-	-	-	**48,294**
Other reserve movements	-	(11,837)	-	-	11,837	**-**
Taxpayers' and others' equity at 31 March 2021	**289,739**	**141,648**	**(84)**	**1,743**	**(14,837)**	**418,209**

Information on reserves

Public dividend capital

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

Revaluation reserve

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

Financial assets reserve

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

Other reserves

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

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		16,326	27,415
Non-cash income and expense:			
Depreciation and amortisation	6.1	34,170	31,665
Net impairments	7	16,519	15,322
Income recognised in respect of capital donations	4	(4,747)	(5,485)
Amortisation of PFI deferred credit		(86)	(86)
(Increase) / decrease in receivables and other assets		(5,955)	24,715
(Increase) / decrease in inventories		3,422	(9,314)
Increase / (decrease) in payables and other liabilities		11,061	9,012
Increase / (decrease) in provisions		804	5,950
Net cash flows from / (used in) operating activities		**71,514**	**99,194**
Cash flows from investing activities			
Interest received		41	22
Purchase and sale of financial assets / investments		-	(176)
Purchase of intangible assets		(2,455)	(4,941)
Purchase of PPE and investment property		(81,214)	(68,025)
Sales of PPE and investment property		11	393
Receipt of cash donations to purchase assets		4,096	1,031
Cash from acquisitions / disposals of subsidiaries		-	100
Net cash flows from / (used in) investing activities		**(79,521)**	**(71,596)**
Cash flows from financing activities			
Public dividend capital received		14,011	48,294
Movement on loans from DHSC		10,200	5,700
Movement on other loans		(392)	(360)
Capital element of finance lease rental payments		(46)	(179)
Capital element of PFI, LIFT and other service concession payments		(11,098)	(5,973)
Interest on loans		(350)	(296)
Interest paid on finance lease liabilities		(6)	(7)
Interest paid on PFI, LIFT and other service concession obligations		(22,741)	(21,035)
PDC dividend (paid) / refunded		(8,017)	(6,321)
Net cash flows from / (used in) financing activities		**(18,439)**	**19,823**
Increase / (decrease) in cash and cash equivalents		**(26,446)**	**47,421**
Cash and cash equivalents at 1 April - brought forward		**83,769**	**36,348**
Cash and cash equivalents at 31 March	23	**57,323**	**83,769**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, 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 2021/22 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

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System/Sustainability and Transformation Partnership level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

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

Measurement

Valuation

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

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

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

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

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.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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.

Derecognition

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

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

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

Donated and grant funded assets

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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.
This includes assets donated to the Trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the Trust. 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 incurred.

Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life	Max life
	Years	Years
Land	Not applicable	
Buildings, excluding dwellings	10	50
Dwellings	10	25
Plant & machinery	5	25
Transport equipment	7	7
Information technology	3	8
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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.

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
•the technical feasibility of completing the intangible asset so that it will be available for use
•the intention to complete the intangible asset and use it
•the ability to sell or use the intangible asset
•how the intangible asset will generate probable future economic benefits or service potential
•the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and;
•the ability to measure reliably the expenditure attributable to the intangible asset during its development.

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	Max life
	Years	Years
Information technology	3	8
Software licences	3	8

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.

In 2020/21 and 2021/22, 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 the profit and loss.

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 profit and loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

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, 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

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.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Operating leases

Rental income from operating leases is recognised on a straight-line 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.

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 2022:

	Nominal rate	Prior year rate
		Minus
Short-term: Up to 5 years	0.47%	0.02%
Medium-term: After 5 years up to 10 years	0.70%	0.18%
Long-term: After 10 years up to 40 years	0.95%	1.99%
Very long-term: Exceeding 40 years	0.66%	1.99%

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 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

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 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 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 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	19,246
Additional lease obligations recognised for existing operating leases	(19,246)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(3,665)
Additional finance costs on lease liabilities	(181)
Lease rentals no longer charged to operating expenditure	3,682
Estimated impact on surplus / deficit in 2022/23	**(164)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,375**

From 1 April 2022, the 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. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified due to detailed guidance not yet being available.

The estimates above have been calculated at a point in time during 2021/22 in preparation for IFRS16. The values may be subject to change, for example if the Trust enters into new lease arrangements near the end of 2021/22, or if arrangements or assumptions change.

Other standards, amendments and interpretations

The following is a list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM, and are therefore not applicable to DHSC group accounts in 2021-22.

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 1.23 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 1.24. The Welcome Centre has no economic outflow from the Trust so is reported under deferred income following the guidance.

Leases

New operating leases are considered against the criteria to determine whether substantially all the risks and rewards of ownership have been transferred to the Trust. More detail is contained in 1.14.

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 1.24 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.

Impairment of receivables

The Trust applies the IFRS9 Expected Credit Loss approach in determining impairment in its receivables. This requires an assessment of future expected credit loss associated with these assets and impairment if required. The Trust also takes into account additional factors such as 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)	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income	987,728	856,221
High cost drugs income from commissioners (excluding pass-through costs)	157,269	148,682
Other NHS clinical income	9,315	11,585
Total acute services income	1,154,312	1,016,488
All services		
Private patient income	7,457	6,753
Elective recovery fund	20,197	-
Additional pension contribution central funding*	28,956	26,944
Other clinical income	2,385	3,928
Total income from activities	**1,213,307**	**1,054,113**

*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.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2021/22 £000	2020/21 £000
NHS England	530,556	492,613
Clinical commissioning groups	665,053	543,291
NHS other	-	161
Local authorities	7,009	6,654
Non-NHS: private patients	7,457	6,753
Non-NHS: overseas patients (chargeable to patient)	1,127	835
Injury cost recovery scheme	1,258	1,913
Non NHS: other	847	1,893
Total income from activities	**1,213,307**	**1,054,113**

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

	2021/22 £000	2020/21 £000
Income recognised this year	1,127	835
Cash payments received in-year	354	654
Amounts added to provision for impairment of receivables	159	182
Amounts written off in-year	(6)	-

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	55,315	-	**55,315**	51,619	-	**51,619**
Education and training	47,285	1,880	**49,165**	44,192	1,250	**45,442**
Non-patient care services to other bodies	43,759	-	**43,759**	28,733	-	**28,733**
Reimbursement and top up funding	4,591	-	**4,591**	101,053	-	**101,053**
Income in respect of employee benefits accounted on a gross basis	14,535	-	**14,535**	9,378	-	**9,378**
Receipt of capital grants and donations	-	4,747	**4,747**	-	5,485	**5,485**
Charitable and other contributions to expenditure	-	2,762	**2,762**	-	13,267	**13,267**
Rental revenue from operating leases	-	1,817	**1,817**	-	1,909	**1,909**
Amortisation of PFI deferred income / credits	-	86	**86**	-	86	**86**
Other income	12,749	-	**12,749**	12,875	-	**12,875**
Total other operating income	**178,234**	**11,292**	**189,526**	**247,850**	**21,997**	**269,847**

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,968	2,829
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

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:

	2021/22	2020/21
	£000	£000
Income from services designated as commissioner requested services	1,204,723	1,046,525
Income from services not designated as commissioner requested services	8,584	7,588
Total	**1,213,307**	**1,054,113**

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.

	2021/22	2020/21
	£000	£000
Income	10,073	7,956
Full cost	(7,944)	(5,012)
Surplus / (deficit)	**2,129**	**2,944**

Note that this relates to private patient income of £7.5m (2020/21: £6.8m), car parking income of £1.5m (2020/21: £1.2m) and overseas patient income of £1.1m (2020/21: £0.8m). Overseas patient income is not required to be included in the prior year figures because it generated less than £1m of income.

Note 6.1 Operating expenses

	2021/22	2020/21
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,563	6,163
Purchase of healthcare from non-NHS and non-DHSC bodies	17,807	5,465
Staff and executive directors costs	761,396	730,685
Remuneration of non-executive directors	194	168
Supplies and services - clinical (excluding drugs costs)	145,280	118,697
Supplies and services - general	8,622	13,626
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	168,114	143,938
Inventories written down	554	2,806
Consultancy costs	4,552	2,671
Establishment	9,025	7,709
Premises	44,948	40,095
Transport (including patient travel)	10,341	6,351
Depreciation on property, plant and equipment	31,275	29,638
Amortisation on intangible assets	2,895	2,027
Net impairments	16,519	15,322
Movement in credit loss allowance: contract receivables / contract assets	4,759	2,043
Change in provisions discount rate(s)	85	115
Fees payable to the external auditor audit services - statutory audit	90	90
Internal audit costs	119	229
Clinical negligence	33,217	32,483
Legal fees	549	946
Insurance	98	70
Research and development	48,621	46,753
Education and training	11,553	10,240
Rentals under operating leases	1,310	1,490
Redundancy	33	4
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	39,897	46,099
Car parking & security	1,463	1,437
Hospitality	6	158
Losses, ex gratia & special payments	54	153
Other services, eg external payroll	7,892	7,485
Other	9,676	21,389
Total	**1,386,507**	**1,296,545**

Other expenditure in 2020/21 includes a grant to Oxford University £11.5m.

Note 6.2 Statutory and other auditor remuneration

Gross statutory audit fees were £90k, net of VAT this was £75k. There was no remuneration paid to the auditors other than for statutory audit services.

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2021/22 or 2020/21.

Note 7 Impairment of assets

	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	289	943
Changes in market price	16,230	14,379
Total net impairments charged / credited to operating surplus / deficit	**16,519**	**15,322**
Impairments charged to the revaluation reserve	1,127	(5,341)
Total net impairments	**17,646**	**9,981**

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 8 Employee benefits

	2021/22 Total £000	2020/21 Total £000
Salaries and wages	598,603	572,879
Social security costs	54,797	50,913
Apprenticeship levy	2,715	2,529
Employer's contributions to NHS pensions	94,449	87,789
Pension cost - other	77	60
Termination benefits	33	4
Temporary staff (including agency)	62,515	65,862
Total gross staff costs	**813,189**	**780,036**
Recoveries in respect of seconded staff	-	-
Total staff costs	**813,189**	**780,036**
Of which		
Costs capitalised as part of assets	892	785

Note 8.1 Retirements due to ill-health

During 2021/22 there were 4 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £335k (£25k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

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 10 Operating leases

Note 10.1 Oxford University Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Oxford University Hospitals NHS Foundation Trust is the lessor.

The Trust has a number of areas within properties where it acts as a lessor. These are generally buildings or areas within buildings on the various hospital sites where space has been let to universities, charities or other organisations.

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	1,817	1,909
Total	**1,817**	**1,909**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due:		
- not later than one year;	1,859	1,906
- later than one year and not later than five years;	6,396	6,907
- later than five years.	18,507	19,863
Total	**26,762**	**28,676**

Note 10.2 Oxford University Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Oxford University Hospitals NHS Foundation Trust is the lessee.

The Trust's operating leases fall into two categories:
a) Leases of items of plant and equipment which are not treated as finance leases. These are predominantly items of office equipment or motor vehicles. There is no material contingent rental, and the leases are 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 negotiated for fixed terms.

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	1,310	1,490
Total	**1,310**	**1,490**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	557	955
- later than one year and not later than five years;	971	8
- later than five years.	1,302	-
Total	**2,830**	**963**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2021/22	2020/21
	£000	£000
Interest on bank accounts	41	18
Other finance income	-	4
Total finance income	**41**	**22**

Note 12.1 Finance expenditure

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

	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	140	-
Other loans	280	296
Finance leases	6	7
Main finance costs on PFI and LIFT schemes' obligations	13,272	13,666
Contingent finance costs on PFI and LIFT schemes' obligations	9,469	7,370
Total interest expense	**23,167**	**21,339**
Unwinding of discount on provisions	(28)	(15)
Total finance costs	**23,139**	**21,324**

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	31	143
Losses on disposal of assets *	(1,323)	-
Total gains / (losses) on disposal of assets	**(1,292)**	**143**
Fair value gains / (losses) on investment properties	1,636	(1,711)
Fair value gains / (losses) on financial assets / investments	(285)	450
Total other gains / (losses)	**59**	**(1,118)**

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

Note 14 Non-current assets

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 - brought forward	**3,914**	**28,166**	**5,327**	**37,407**	**36,327**	**438,484**	**820**	**51,991**	**240,771**	**711**	**21,932**	**4,636**	**795,672**
Additions	1,004	50	1,401	**2,455**	-	7,117	-	23,989	28,126	-	5,424	-	**64,656**
Impairments	-	-	(76)	**(76)**	-	(31,021)	-	(213)	-	-	-	-	**(31,234)**
Reversals of impairments	-	-	-	**-**	2,093	3,655	-	-	-	-	-	-	**5,748**
Revaluations	-	-	-	**-**	6	15,679	32	-	4	-	-	-	**15,721**
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**	**468,619**	**852**	**31,950**	**274,366**	**711**	**27,407**	**4,630**	**846,961**
Amortisation / depreciation at 1 April 2021 - brought forward	**2,615**	**20,121**	**-**	**22,736**	**-**	**70**	**-**	**-**	**171,542**	**652**	**10,562**	**3,933**	**186,759**
Transfers by absorption	530	2,365	-	**2,895**	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	-	-	**-**	-	19,229	51	-	8,918	17	2,853	207	**31,275**
Impairments	-	-	-	**-**	-	(3,542)	-	-	-	-	-	-	**(3,542)**
Reversals of impairments	-	-	-	**-**	-	(4,374)	-	-	-	-	-	-	**(4,374)**
Revaluations	-	-	-	**-**	-	(11,382)	(51)	-	-	-	-	-	**(11,433)**
Reclassifications	-	-	-	**-**	-	6	-	-	-	-	-	(6)	**-**
Disposals / derecognition	-	(6,188)	-	**(6,188)**	-	-	-	-	(2,286)	-	(13)	-	**(2,299)**
Amortisation / depreciation at 31 March 2022	**3,145**	**16,298**	**-**	**19,443**	**-**	**7**	**-**	**-**	**178,174**	**669**	**13,402**	**4,134**	**196,386**
Net book value at 31 March 2022													
Owned - purchased					34,972	218,586	852	29,243	67,986	42	13,706	495	**365,882**
Finance leased					-	-	-	-	429	-	-	-	**429**
On-SoFP PFI contracts and other service concession arrangements					-	204,300	-	-	22,452	-	-	-	**226,752**
Owned - donated/granted					3,454	45,726	-	2,707	5,325	-	299	1	**57,512**
NBV total at 31 March 2022					**38,426**	**468,612**	**852**	**31,950**	**96,192**	**42**	**14,005**	**496**	**650,575**

Note 14.2 Non-current assets -2020/21

	Software licences	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 2020 - brought forward	**3,985**	**25,467**	**3,144**	**32,596**	**34,800**	**442,388**	**857**	**29,312**	**221,141**	**711**	**14,932**	**4,636**	**748,777**
Transfers by absorption	-	-	-	**-**	-	-	-	-	-	-	-	-	**-**
Additions	12	1,138	3,791	**4,941**	-	13,872	-	38,593	19,627	-	7,192	-	**79,284**
Impairments	-	-	-	**-**	(188)	(27,899)	-	(943)	-	-	-	-	**(29,030)**
Reversals of impairments	-	-	-	**-**	1,540	(1,758)	(37)	-	-	-	-	-	**(255)**
Revaluations	-	-	-	**-**	-	-	-	-	-	-	-	-	**-**
Reclassifications	98	1,561	(1,608)	**51**	175	11,881	-	(14,971)	3,037	-	2	-	**124**
Disposals / derecognition	(181)	-	-	**(181)**	-	-	-	-	(3,034)	-	(194)	-	**(3,228)**
Valuation / gross cost at 31 March 2021	**3,914**	**28,166**	**5,327**	**37,407**	**36,327**	**438,484**	**820**	**51,991**	**240,771**	**711**	**21,932**	**4,636**	**795,672**
Amortisation / depreciation at 1 April 2020 - brought forward	**2,095**	**18,795**	**-**	**20,890**	**-**	**-**	**-**	**-**	**167,140**	**635**	**7,922**	**3,706**	**179,403**
Provided during the year	701	1,326	-	**2,027**	-	19,321	53	-	7,380	17	2,640	227	**29,638**
Impairments	-	-	-	**-**	-	(5,526)	-	-	-	-	-	-	**(5,526)**
Reversals of impairments	-	-	-	**-**	-	(13,725)	(53)	-	-	-	-	-	**(13,778)**
Revaluations	-	-	-	**-**	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	**-**	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	(181)	-	-	**(181)**	-	-	-	-	(2,978)	-	-	-	**(2,978)**
Amortisation / depreciation at 31 March 2021	**2,615**	**20,121**	**-**	**22,736**	**-**	**70**	**-**	**-**	**171,542**	**652**	**10,562**	**3,933**	**186,759**
Net book value at 31 March 2021													
Owned - purchased					33,096	199,253	820	50,961	43,252	59	11,365	691	**339,497**
Finance leased					-	-	-	-	491	-	-	-	**491**
On-SoFP PFI contracts and other service concession arrangements					-	195,866	-	-	18,813	-	-	-	**214,679**
Owned - donated/granted					3,231	43,295	-	1,030	6,673	-	5	12	**54,246**
NBV total at 31 March 2021					**36,327**	**438,414**	**820**	**51,991**	**69,229**	**59**	**11,370**	**703**	**608,913**

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 2022 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 7.

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.

Note 17.1 Investment Property

	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**30,394**	**32,280**
Acquisitions in year	-	-
Movement in fair value	1,636	(1,711)
Reclassifications to/from PPE	-	(175)
Carrying value at 31 March	**32,030**	**30,394**

Note 17.2 Investment property income and expenses

	2021/22	2020/21
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	(251)	(250)
Total investment property expenses	**(251)**	**(250)**
Investment property income	1,817	1,697

Note 18 Investments in associates and joint ventures

	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**13,045**	**13,206**
Share of profit / (loss)	121	(61)
Disbursements / dividends received	-	(100)
Carrying value at 31 March	**13,166**	**13,045**

Note 19 Other investments / financial assets (non-current)

	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**10,588**	**2,707**
Acquisitions in year	-	-
Movement in fair value through profit and loss	-	625
Movement in fair value through OCI	(285)	-
Net impairments *	(9,161)	7,256
Carrying value at 31 March	**1,142**	**10,588**

* Revaluation of a shareholding in Sensyne Health PLC, due to falling share price over the year

Note 20 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 21 Inventories

	31 March 2022	31 March 2021
	£000	£000
Drugs	5,972	5,416
Consumables	20,332	24,957
Energy	313	377
Other	1,900	1,189
Total inventories	**28,517**	**31,939**

Inventories recognised in expenses for the year were £134.9m (2020/21: £103.5m). Write-down of inventories recognised as expenses for the year were £0.6m (2020/21: £2.8m).

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 2021/22 the Trust received £2.6m of items purchased by DHSC (2020/21: £12.3m).

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 22.1 Receivables

	31 March 2022	31 March 2021
	£000	£000
Current		
Contract receivables	48,988	34,156
Allowance for impaired contract receivables / assets	(14,346)	(9,600)
Prepayments (non-PFI)	6,501	5,911
PFI prepayments - capital contributions	67	67
PFI lifecycle prepayments	11,345	15,687
VAT receivable	4,260	8,503
Other receivables	2,073	1,098
Total current receivables	**58,888**	**55,822**
Non-current		
Contract receivables	4,057	4,387
Prepayments (non-PFI)	127	6
PFI prepayments - capital contributions	870	936
Other receivables	2,093	3,271
Total non-current receivables	**7,147**	**8,600**
Of which receivable from NHS and DHSC group bodies:		
Current	11,455	13,774
Non-current	2,093	3,271

Note 22.2 Allowances for credit losses

	2021/22	2020/21
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**9,600**	**7,466**
New allowances arising	5,427	6,877
Reversals of allowances	(668)	(4,834)
Utilisation of allowances (write offs)	(13)	91
Allowances as at 31 Mar 2022	**14,346**	**9,600**

Note 22.3 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 trade and other receivables note.

Note 23 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.

	2021/22	2020/21
	£000	£000
At 1 April	**83,769**	**36,348**
Net change in year	(26,446)	47,421
At 31 March	**57,323**	**83,769**
Broken down into:		
Cash at commercial banks and in hand	32	33
Cash with the Government Banking Service	57,291	83,736
Total cash and cash equivalents as in SoFP	**57,323**	**83,769**

Note 24 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	48,669	46,911
Capital payables	12,017	34,360
Accruals	58,684	55,194
Social security costs	8,304	7,418
Other taxes payable	8,441	7,044
PDC dividend payable	1,996	17
Other payables	17,134	14,326
Total current trade and other payables	**155,245**	**165,270**
Of which payables to NHS and DHSC group bodies:		
Current	9,598	8,318

Note 25 Other liabilities

	31 March 2022 £000	31 March 2021 £000
Current		
Deferred income: contract liabilities	3,796	3,716
Deferred PFI credits / income	86	86
Total other current liabilities	**3,882**	**3,802**
Non-current		
Deferred income: contract liabilities	2,271	1,629
Deferred PFI credits / income	2,357	2,443
Total other non-current liabilities	**4,628**	**4,072**

Note 26.1 Borrowings

	31 March 2022 £000	31 March 2021 £000
Current		
Loans from DHSC	730	-
Other loans	426	391
Obligations under finance leases	98	24
Obligations under PFI, LIFT or other service concession contracts	12,841	11,028
Total current borrowings	**14,095**	**11,443**
Non-current		
Loans from DHSC	15,239	5,700
Other loans	6,095	6,522
Obligations under finance leases	290	355
Obligations under PFI, LIFT or other service concession contracts	214,553	226,726
Total non-current borrowings	**236,177**	**239,303**

Note 26.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Finance leases	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 26.3 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**-**	**7,273**	**537**	**243,725**	**251,535**
Cash movements:					
Financing cash flows - payments and receipts of principal	5,700	(360)	(179)	(5,973)	**(812)**
Financing cash flows - payments of interest	-	(296)	(7)	(13,664)	**(13,967)**
Non-cash movements:					
Additions	-	-	21	-	**21**
Application of effective interest rate	-	296	7	13,666	**13,969**
Carrying value at 31 March 2021	**5,700**	**6,913**	**379**	**237,754**	**250,746**

Note 27 Finance leases

Note 27.1 Oxford University Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	**398**	**395**
of which liabilities are due:		
- not later than one year;	103	30
- later than one year and not later than five years;	295	365
- later than five years.	-	-
Finance charges allocated to future periods	(10)	(16)
Net lease liabilities	**388**	**379**
of which payable:		
- not later than one year;	98	24
- later than one year and not later than five years;	290	355
- later than five years.	-	-

The Trust has a number of finance lease arrangements which have been typically used to acquire items of medical equipment. Often, these leases provide for an option to purchase at the end of the primary term. The leases do not include any escalation clauses, nor do they include any restrictions other than those which would be expected to apply in a normal lease contract on normal commercial terms.

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 2021	**956**	**2,022**	**90**	**12,574**	**15,642**
Change in the discount rate	15	70	-	-	**85**
Arising during the year	40	74	47	4,626	**4,787**
Utilised during the year	(105)	(105)	(28)	(2,694)	**(2,932)**
Reversed unused	-	-	(5)	(1,131)	**(1,136)**
Unwinding of discount	(8)	(20)	-	-	**(28)**
At 31 March 2022	**898**	**2,041**	**104**	**13,375**	**16,418**
Expected timing of cash flows:					
- not later than one year;	105	110	104	7,639	**7,958**
- later than one year and not later than five years;	420	440	-	3,763	**4,623**
- later than five years.	373	1,491	-	1,973	**3,837**
Total	**898**	**2,041**	**104**	**13,375**	**16,418**

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 £2.1m 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 addditional 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 2022, £889.4m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Oxford University Hospitals NHS Foundation Trust (31 March 2021: £593.4m).

Note 29 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
NHS Resolution legal claims	(53)	(53)
Employment tribunal and other employee related litigation	(2,401)	-
Gross value of contingent liabilities	**(2,454)**	**(53)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(2,454)**	**(53)**
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 2022 £000	31 March 2021 £000
Property, plant and equipment	2,958	41,470
Intangible assets	-	-
Total	**2,958**	**41,470**

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 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 2022 £000	31 March 2021 £000
Gross PFI, LIFT or other service concession liabilities	**350,105**	**373,386**
Of which liabilities are due		
- not later than one year;	25,524	24,259
- later than one year and not later than five years;	83,132	87,811
- later than five years.	241,449	261,316
Finance charges allocated to future periods	(122,711)	(135,632)
Net PFI, LIFT or other service concession arrangement obligation	**227,394**	**237,754**
- not later than one year;	12,841	11,028
- later than one year and not later than five years;	38,211	40,759
- later than five years.	176,342	185,967

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 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**1,339,101**	**1,420,547**
Of which payments are due:		
- not later than one year;	70,869	69,740
- later than one year and not later than five years;	301,340	296,580
- later than five years.	966,892	1,054,227

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:

	2021/22 £000	2020/21 £000
Unitary payment payable to service concession operator	**74,689**	**68,223**
Consisting of:		
- Interest charge	13,272	13,666
- Repayment of balance sheet obligation	11,138	5,973
- Service element and other charges to operating expenditure	31,656	31,245
- Capital lifecycle maintenance	8,751	4,854
- Revenue lifecycle maintenance	403	258
- Contingent rent	9,469	7,370
- Addition to lifecycle prepayment	-	4,857
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	7,838	14,596
Total amount paid to service concession operator	**82,527**	**82,819**

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 NHS 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 NHS 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 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**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	33,312	-	**33,312**
Other investments / financial assets	792	9,796	**10,588**
Cash and cash equivalents	83,769	-	**83,769**
Total at 31 March 2021	**117,873**	**9,796**	**127,669**

Note 32.3 Carrying values of financial liabilities

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 finance 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**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	5,700	**5,700**
Obligations under finance leases	379	**379**
Obligations under PFI, LIFT and other service concession contracts	237,754	**237,754**
Other borrowings	6,913	**6,913**
Trade and other payables excluding non financial liabilities	150,791	**150,791**
Provisions under contract	9,457	**9,457**
Total at 31 March 2021	**410,994**	**410,994**

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.

	31 March 2022	31 March 2021
	£000	£000
In one year or less	170,992	181,657
In more than one year but not more than five years	91,740	94,911
In more than five years	258,751	270,972
Total	**521,483**	**547,540**

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

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	15	11	-	-
Bad debts and claims abandoned	11	-	4	(5)
Stores losses and damage to property	2	327	2	247
Total losses	**28**	**338**	**6**	**242**
Special payments				
Ex-gratia payments	45	29	50	1,232
Total special payments	**45**	**29**	**50**	**1,232**
Total losses and special payments	**73**	**367**	**56**	**1,474**
Compensation payments received		-		-

2020/21 Special Payments has been restated to include the £1.2m overtime corrective payments that were accrued for and funded in 2020/21 and should have been classified as special payments in 2020/21.

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
- Other health bodies
- Other Government departments
- Local authorities
- NHS charitable funds

Material transactions in the year have been with NHS Oxfordshire CCG, NHS Resolution, NHS England, Health Education England, Department of Health and Social Care and NHS Buckinghamshire CCG.

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.

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 18 to 20 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.