Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 8 September 2021

TB2021.68

Title:	**Financial Governance Review**

Status:	**For Discussion**
History:	**TB2021.48**
	IAC2021.42
	TME2021.236

Board Lead:	**Chief Finance Officer**
Author:	**Jason Dorsett, Chief Finance Officer**
Confidential:	**No**
Key Purpose:	**Assurance, Strategy**

Executive Summary

1. In 2019/20 the Trust did not achieve its financial objectives and was required by NHS Improvement to carry out a review of its financial governance.
2. The review was delayed by COVID-19, but has now been completed. While the review concluded that the Trust's financial planning for 2019/20 was reasonable and the result of a reasonable process, it found a number of areas for improvement including:
    a. The approach to delivering productivity;
    b. The control of workforce costs;
    c. Overall understanding of Trust finances and capability to manage budgets among budget holders.
3. The Trust has accepted the report and its recommendations. Delivering financial sustainability is a key part of our strategy ensuring that the interests of all the populations we serve, now and in the future, are protected at the same time as we strive to deliver the best outcomes for the patients under out care today.
4. The Trust has developed a draft action plan and taken feedback from TME and IAC. This plan will be overseen by TME with the IAC testing assurance over the plan on behalf of the Board. As the plan will be finalised before the November Board, it is proposed to delegate approval of the plan to the IAC.

Recommendations

5. The Trust Board is asked to:
    - Note the attached report of the Financial Governance Review which it has previously approved.
    - Note the summary action plan developed in response to the Financial Governance Review;
    - Delegate to the IAC the review and approval of the detailed action plan; and
    - Approve the proposal that programme management be overseen by TME reporting to IAC which will obtain assurance on behalf of the Board.

Contents

Financial Governance Review

1. Purpose

1.1. The purpose of this paper is to receive in public the report of the Financial Governance Review and to agree the process to approve and assure the action plan that the Trust is developing in response.

2. Background

2.1. In 2019/20 the Trust did not achieve either its budgeted or forecast I&E performance. In May 2020 NHS Improvement asked that the Trust commission a financial governance review and that this be done collaboratively with the region.

2.2. The start of the review was delayed by COVID-19 related activities, but Grant Thornton was appointed in Q3 2020/21 with its work commencing in Q4 2020/21. A draft report was circulated in Q1 2021/22 and the final report was approved by the Board in July.

2.3. There have also been presentations of draft findings and more recently draft recommendations at the Integrated Assurance Committee, at a steering group including the regional CFO and ICS Chief Executive, to the executive team, TME and the Governors Performance, Workforce and Finance Committee.

3. Financial Governance Review Report

3.1. The attached final report, which includes its own executive summary of the key findings and recommendations, is attached as Appendix A.

3.2. The report is an independent review and it also draws on a wide range of evidence. The report and its recommendations have been approved by the Board and it has been favourably received by the region and the ICS.

4. Trust Response

4.1. Acceptance of this independent report is an opportunity to reflect and commit to making a series of changes to help to deliver the focus on the financial sustainability of our services under the “Our Populations” section of our agreed Strategic Objectives.

4.3. Our Strategy:

4.4. As part of **Our Populations: "Making the best use of our financial resources to ensure sustainability across the system** – working with other organisations at ICS and ICP level, we will work to develop and maintain a sustainable local and regional health economy and to be a financially sustainable organisation within it. To achieve this, at Trust level we will make the best use of our resources, making investment decisions aligned to our strategic priorities, developing commercial partnerships and making the most of our assets and estates. At team and service level, we will focus on delivering the best value for patients and improving our efficiency and productivity."

4.5. This strategic objective reflects that the potential for tension between delivering for our people and our patients and good financial governance is best resolved, in a cash limited taxpayer funded system, by ensuring that we ensure the medium term sustainability of our services for patients today and in the future.

4.6. The Trust sees the Financial Governance Review, and the actions we propose to take in response, as a key component of delivering our overall strategy for 2020-2025.

5. Status of trust action plan

5.1. A summary of the draft action plan is attached as Appendix B. Earlier versions of this plan were reviewed by TME and IAC in August.

5.2. The scope of the draft plan has been kept aligned to the recommendations of the report. Inevitably there are potential overlaps with other activities in the Trust and ICS, but the draft attempts to keep the plan as narrow as realistically possible to create a focused action plan that can be executed in six to 12 months.

5.3. The key feedback from TME and IAC was as follows:

5.3.1. Ensure the final plan is SMART and outcome focused;

5.3.2. Ensure that the detailed project plan captures milestones and is supported by sufficient detail to provide assurance;

5.3.3. A single executive should be responsible for each workstream; and

5.3.4. Confirm arrangements for programme management, reporting and assurance (see below).

5.4. The detailed project plan is being developed to reflect this feedback and it is proposed that the detailed plan is reviewed at the October IAC. The Board is asked to delegate to the IAC approval of the detailed plan.

6. Programme management and assurance

6.1. Following the discussions at TME and IAC it is proposed that responsibility for management of this programme is held by TME and responsibility for assurance is held by the IAC.

6.2. TME will review the status of the programme monthly and report to IAC which will in turn report to the Board.

6.3. The October IAC will carry out a further review of the detailed action plan and will assure itself on the plan.

7. Recommendations

7.1. The Trust Board is asked to:

- Note the attached report of the Financial Governance Review which it has previously approved.
- Note the summary action plan developed in response to the Financial Governance Review;
- Delegate to the IAC the review and approval of the detailed action plan; and
- Approve the proposal that programme management be overseen by TME reporting to IAC which will obtain assurance on behalf of the Board.

Grant Thornton

Oxford University Hospitals NHS Foundation Trust

External Financial Governance Review

August 2021

FINAL

Oxford University Hospitals NHS Foundation Trust
Trust Headquarters
John Radcliffe Hospital
Headley Way
Headington
Oxford
OX3 9DU

Grant Thornton UK LLP
30 Finsbury Square
London
EC2P 2YU

T +44 (0)20 7383 5100
F +44 (0)20 7383 4715

grantthornton.co.uk

August 2021

FAO Jason Dorset, Chief Financial Officer

Dear Sirs and Madams,

External Financial Governance Review

We have pleasure in enclosing a copy of our final report in accordance with your instructions dated 9 March 2021, with the scope of work reproduced at Appendix A of this report. This document (the **Report**) has been prepared by Grant Thornton UK LLP (**Grant Thornton**) for Oxford University Hospitals NHS Foundation Trust (the **Addressee** or the **Trust**) in connection with an assessment of financial performance and governance arrangements in 2019/20, and to inform and shape future financial governance arrangements (the **Purpose**).

We stress that the Report is confidential and prepared for the Addressee only. We agree that an Addressee may disclose our Report to its professional advisers in relation to the Purpose, or as required by law or regulation, the rules or order of a stock exchange, court or supervisory, regulatory, governmental or judicial authority without our prior written consent but in each case strictly on the basis that prior to disclosure you inform such parties that (i) disclosure by them is not permitted without our prior written consent, and (ii) to the fullest extent permitted by law we accept no responsibility or liability to them or to any person other than the Addressee.

The Report should not be used, reproduced or circulated for any other purpose, in whole or in part, without our prior written consent, such consent will only be given after full consideration of the circumstances at the time. These requirements do not apply to any information, which is, or becomes, publicly available or is shown to have been made so available (otherwise than through a breach of a confidentiality obligation).

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Addressee for our work, our Report and other communications, or for any opinions we have formed. We do not accept any responsibility for any loss or damages arising out of the use of the Report by the Addressee(s) for any purpose other than in relation to the Purpose.

We have discussed all sections of this Report with the Trust's Finance Team who confirmed its factual accuracy in all material respects.

Period of our fieldwork

Our fieldwork was performed in the period between 9 March 2021 and 9 June 2021. We have not performed any fieldwork since 9 June and, in agreement with the addressees of this Report, our Report may not take into account matters that have arisen since then. If you have any concerns in this regard, please do not hesitate to let us know.

Scope of work and limitations

Our work focused on the areas set out in our scope of work, which is reproduced at Appendix A of the Report. Our assessment of the affairs of the Trust does not constitute an audit in accordance with Auditing Standards and no verification work has been carried out by us; consequently, we do not express an opinion on the figures included in the Report.

The scope of our work has been limited both in terms of the areas of the business and operations which we have assessed and the extent to which we have assessed them. There may be matters, other than those noted in the Report, which might be relevant in the context of the Purpose and which a wider scope assessment might uncover.

Forecasts

The responsibility for the Trust's forecasts and the assumptions on which they are based is solely that of the management of the Trust. It must be emphasised that income and expenditure and cash flow forecasts necessarily depend on subjective judgement. They are, to a greater or lesser extent, according to the nature of the businesses and the period covered by the forecasts, subject to inherent uncertainties. In consequence, they are not capable of being audited or substantiated in the same way as financial statements which present the results of completed accounting periods.

Forms of report

For your convenience, the Report may have been made available to you in electronic as well as hard copy format, multiple copies and versions of the Report may therefore exist in different media and in the case of any discrepancy the final signed hard copy should be regarded as definitive.

General

The Report is issued on the understanding that the management of the Trust have drawn our attention to all matters, financial or otherwise, of which they are aware which may have an impact on our Report up to the date of signature of this Report. Events and circumstances occurring after the date of our Report will, in due course, render our Report out of date and, accordingly, we will not accept a duty of care nor assume a responsibility for decisions and actions which are based upon such an out-of-date Report. Additionally, we have no responsibility to update this Report for events and circumstances occurring after this date.

Notwithstanding the scope of this engagement, responsibility for management decisions will remain solely with the directors of the Trust and not Grant Thornton. The directors should perform a credible review of the recommendations and options in order to determine which to implement following our advice.

Contacts

If there are any matters upon which you require clarification or further information, please contact Peter Saunders on 020 7865 2158 or Nick Caley on 01223 225512.

Yours faithfully

Grant Thornton UK LLP

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Executive Summary

Introduction

This report summarises the findings from our external financial governance review at the Oxford University Hospitals NHS Foundation Trust (the Trust).

The agreed scope of our work can be found in Appendix A. The work was delivered during March to June 2021 and included an independent assessment of:

- financial planning, performance and governance arrangements in 2019/20, and
- current financial governance and future financial arrangements.

We did this by:

- reviewing and analysing key financial planning, reporting documents and information
- interviewing key senior staff across the Trust, including Divisional management, clinical and service managers, and the wider Berkshire (West), Oxfordshire and Buckinghamshire Integrated Care System (ICS), including commissioners and system leaders and regional finance staff at NHS England and Improvement (NHSE/I), and
- a survey of budget managers across the Trust.

Our focus has been on the processes and governance arrangements followed by the Trust during 2019/20 and an update on its current arrangements. It is important to note that at the time of the review funding and management were subject to updated national arrangements introduced to support the response to the Covid pandemic. For the majority of 2019/20, the Trust was operating under different arrangements to those which are currently in place.

We have relied on the information provided to us by the Trust to draw our conclusions and have not undertaken our own analysis or deeper review over the accuracy of that information. No warranty or representation as to the accuracy or completeness of any such information is given.

A glossary of terms can be found at the end of the report.

Review of 2019/20 – Summary of Findings

Background and context

Significant organisational leadership changes at the Trust and regulators impacted on the knowledge, understanding and capacity of management to address underlying operational and financial issues leading into and during 2019/20. New governance processes were being developed but these were not yet embedded. The NHS provider financial regime at the time incentivised compliance and acceptance of challenging budgets by the Trust so as not to lose significant funding of approximately £30m and incur contractual financial penalties of a further £20m.

Underlying financial position

As outlined in Table 1, the Trust has had an underlying financial operational deficit for a number of years and entered into 2019/20 with an underlying deficit of approximately £40m. Costs have consistently increased at higher levels than income. Workforce costs in particular have increased significantly. The Trust has relied on non-recurrent, one-off items to deliver its financial targets. Its track record of delivering financial performance, both against its own targets and compared to others, meant that there was an expectation from the wider healthcare system and regulators that financial targets would be delivered.

Table 1: Historic underlying financial performance (excluding non-recurrent items)

£ million	2015/16	2016/17	2017/18	2018/19
Surplus/(deficit)	(23.2)	(25.8)	(34.8)	(39.5)

Source: Trust management information

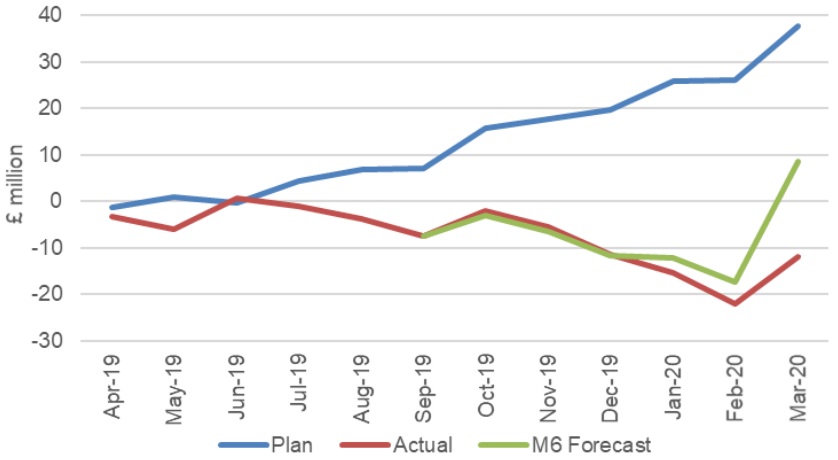
Financial planning

The Trust was set a challenging control total of a £37.9m surplus in 2019/20 by NHSE/I given its underlying financial position and reliance on one-off, non-recurrent transactions to deliver previous years' financial targets. Planning processes, framework and analysis to support assumptions were robust with engagement of Divisional operational management. Despite this there were substantial risks identified in the delivery of the 2019/20 plan. NHSE/I internally rated the perceived risk of delivery as Amber. This was not communicated to the Trust, which perceived the risk to be higher. Greater scrutiny and challenge over the deliverability of workforce assumptions, linked to activity and capacity plans, and more mature plans for delivering and managing productivity and cost efficiencies were needed.

Financial performance

The Trust delivered a £11.9m deficit in 2019/20, £49.8m worse than plan and £20.5m worse than its reforecast completed at month 6. As shown in Chart 1, performance against plan was consistently adverse throughout the year.

Chart 1: Cumulative surplus/(deficit) inc. PSF/MRET in 2019/20

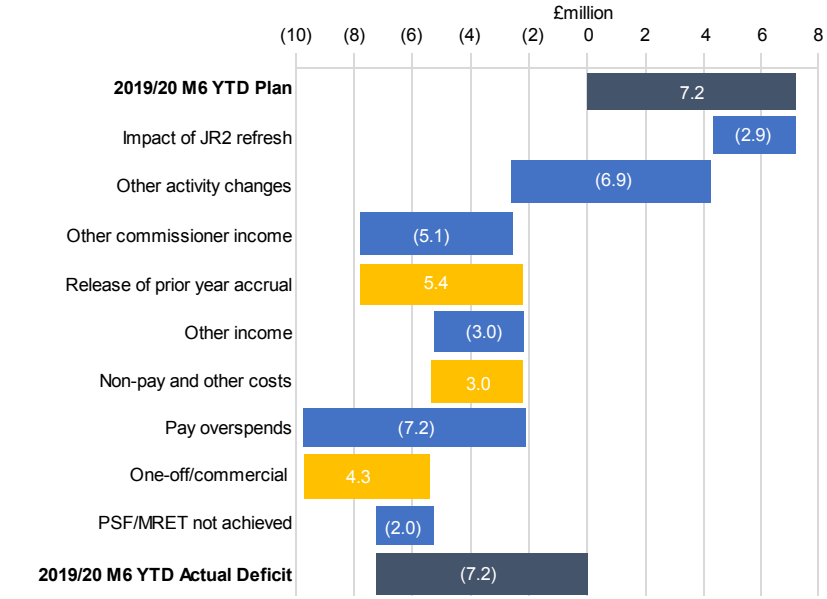


Source: Management working - OUH M12 Finance Reporting Pack

Note: 1. Adjusting out £8.8m unplanned one-off items at M3 relating to NHS Blood and Transplant lease revaluation (£3.7m), release of a PFI risk provision (£0.6m) and £4.5m of prior year income accruals would have resulted in a £15.2m deficit, £8.7m worse than plan at M3. 2. The 2019/20 actual £11.9m deficit includes £0.8m PSF income relating to 2018/19. This was excluded by NHSE/I in reporting so that on a control basis the reported position was a £12.8m deficit, £50.6m worse than plan.

Variances to performance against plan (Chart 2) and forecast (Chart 3) resulted from slower than planned recovery from closure of theatres, substantially higher workforce costs, under delivery of cost efficiencies and undelivered commercial transactions.

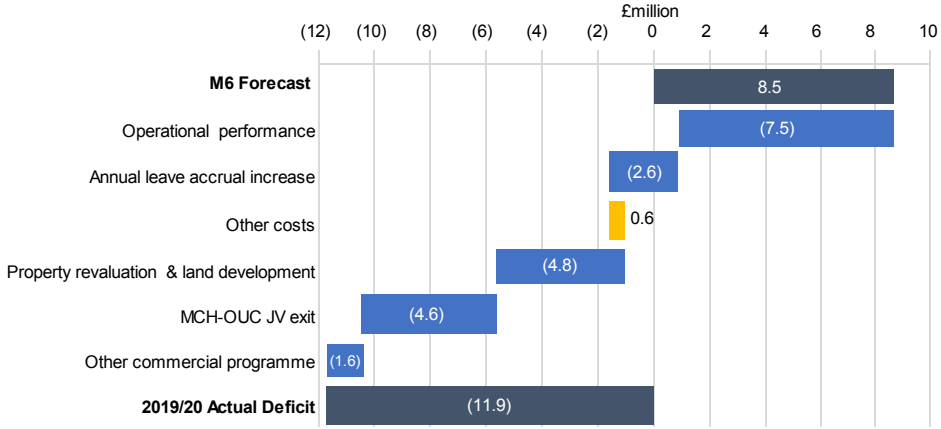
Chart 2: Bridge M6 YTD 2019/20 Plan (Inc PSF/MRET) to M6 YTD F2019/20 actual outturn



Source: OUH Month 6 Finance Report

Note: 1. At month 6 the Trust was reporting delivery of £14.2m operational cost efficiency savings against its M6 YTD target of £17.3m. This under-delivery is primarily reflected in the pay cost overspends. 2. The 2019/20 actual £11.9m deficit includes £0.8m PSF income relating to 2018/19.

Chart 3: Bridge from M6 forecast 2019/20 control total (Inc PSF/MRET) to actual outturn



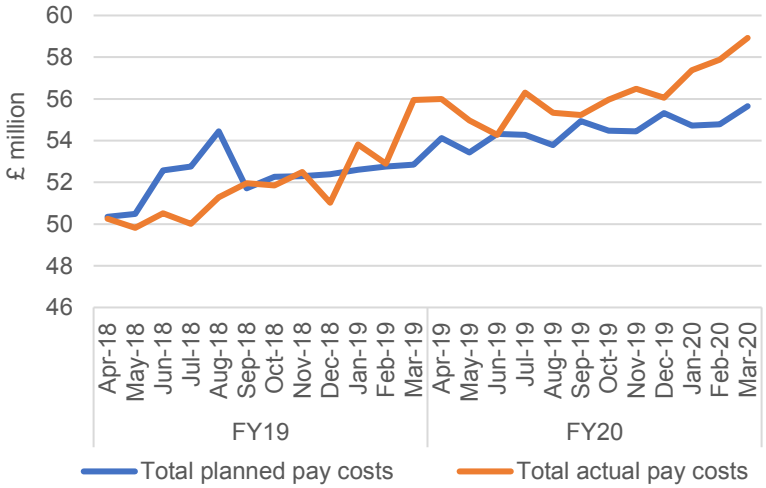
Source: OUH Month 12 IPR Report and Management Information

Note: 1. The 2019/20 actual £11.9m deficit includes £0.8m PSF income relating to 2018/19.

The Trust was proactive in identifying early in the financial year the likely under delivery of the plan and reforecast its position at month 6. There should have however been more challenge from the Trust Board to the ongoing underperformance of operational and workforce costs. Workforce costs continued the trend of overspending against plan (Chart 4). Comparative analysis contained with NHSE/I's model hospital tool (Chart 5) also showed the Trust's costs per Weighted Activity Unit (WAU) in 2019/20 were in the top third quartile (Mid-High) against all NHS Trusts and slightly higher cost than its comparator Shelford Group [1](£3,615 per WAU compared to £3,600).

[1] *The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital Trusts in England.*

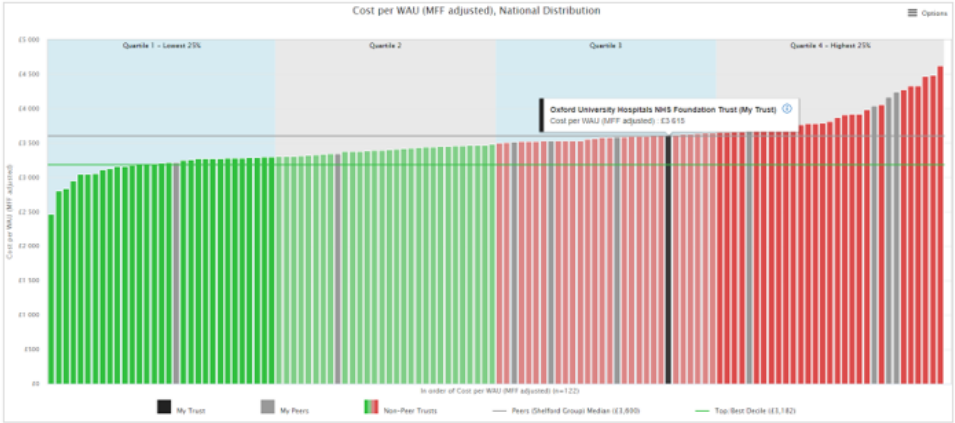
Chart 4: Monthly total pay costs April 2018 to March 2020



Source: Management working - OUH M12 Finance Reporting Pack

Note: Cost of employer's pension uplift (£24.7m), covid costs of £2.9m and the £2.6m increase in the annual leave accrual have been excluded from March 2020.

Chart 5: 2019/20 cost per weighted activity unit (WAU) breakdown



Source: OUH Model Hospital 2019/20

Greater reliance and focus on top-down actions, increasing one-off, commercial transaction delivery and previously unidentified estates and IT costs, led to significant underperformance against the reforecast position. The Trust exited 2019/20 with an increasing underlying financial deficit of £45m.

Financial governance

The governance structures in place during the year to oversee financial performance were appropriate and in line with what we would expect to see at an NHS Trust of this size and complexity. A number of changes to governance processes were developed and introduced during the year, recognising improvements needed in integrating performance, quality and finance processes and involving operational Divisional management in Board governance processes.

The Trust Board was clearly informed and understood the risks with delivering the challenging 2019/20 financial plan. We would, however, have expected to see more challenge on the development and delivery of cost efficiency plans, integration of Commercial Strategy performance and clearer commentary on variances to plans within financial reporting.

Financial risk identification and mitigating actions could also have been improved. The movement to a single detailed Integrated Performance Report meant it was challenging to identify the main messages and operational drivers of financial underperformance in year. A 'line of sight' from Board to Division to Directorate and services using operational, quality and financial information was not always visible.

Divisional financial and performance governance were in development with inconsistencies in quality and granularity of reporting. There was a lack of Divisional understanding and ownership of some of the key assumptions underpinning the plan and forecast with operational and quality issues prioritised without an understanding of the impact on financial plans. This directly contributed to non-delivery of the financial plan in 2019/20.

There was good evidence of communication and collaboration with wider system and regulators on the deteriorating financial position, but the Trust could have managed expectations and actions better by being clearer on the scale of deterioration.

Current governance, reporting and performance

Current Trust arrangements

The Trust has continued to refine and improve its governance arrangements at Committee and Board level since 2019/20. Improvements have been made, for example, through agreeing a new Divisional performance management framework in late-2020 and developing and refining Board integrated performance reporting. However, there is recognition that some of the changes are not yet fully embedded owing to the Covid pandemic and that this is required to fully address some of the issues identified in 2019/20.

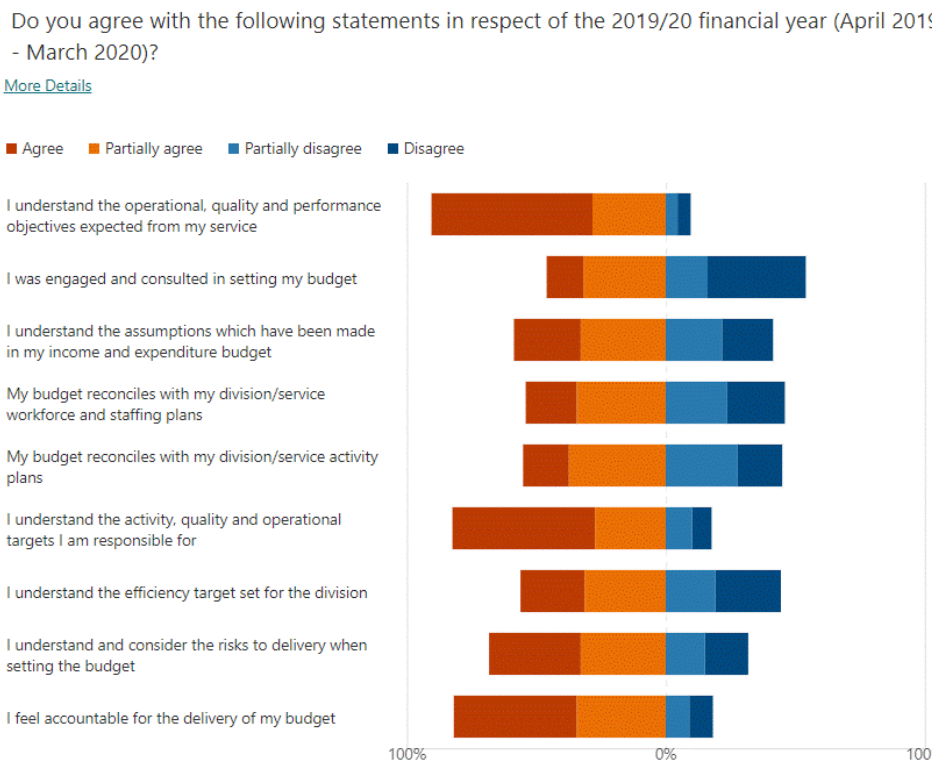
In particular, further work is required to align and understand activity, performance and workforce costs, and to improve the reporting of key messages and risks in the Trust and Divisional finance reports. Progress has been made in developing the Integrated Improvement Programme since 2019/20, however agreeing measures to track the financial impact of the programmes remains an area for further development.

Budget manager survey

The budget manager survey undertaken to explore views on budget setting, financial management and training highlighted a number of messages that largely supported the observations arising from our meetings with clinical budget managers.

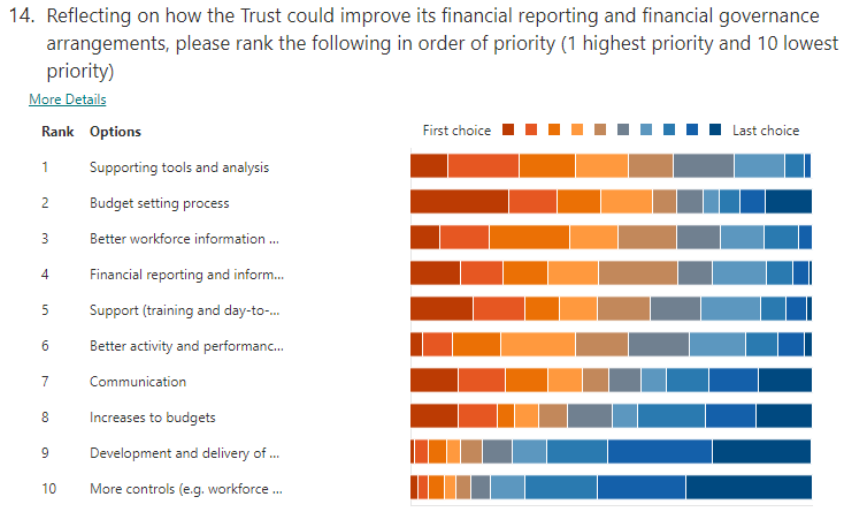
Positive messages were noted regarding budget managers' understanding and engagement with in-year financial performance, with budget managers also feeling supported by Divisional and finance staff. The survey highlighted that a number of budget managers did not feel engaged or consulted on in setting the 2019/20 budget and felt that they lacked control over the activity and resources that drive their income and expenditure budgets (Chart 6).

Chart 6: Budget manager responses 2019/20 financial year



When asked how the Trust could improve finance report and financial governance the top three areas were more supporting tools and analysis, improvements to the budget setting process and better workforce information (Chart 7).

Chart 7: Budget manager responses – improvement areas



Future system and finance arrangements

Funding and finance changes to support the NHS Covid response meant the Trust reported an unaudited position of £3.1m surplus (on a performance basis) in 2020/21. Arrangements for the second half of 2021/22 have not been confirmed. The latest planning position for the first half of 2021/22 is a £10.6m deficit. The Trust's underlying deficit, lack of clarity on financial allocations in the second half of the year and immaturity of system plans present a significant risk to its financial planning and forecasting. The Trust needs to understand its post-Covid cost position so it can be clear in system discussions on its cost and activity baselines for services. It should provide and communicate a clear understanding of the current planning process, assumptions and implications of the underlying financial position to the Board and work within developing system finance arrangements to identify, develop and integrate system delivered efficiencies, productivity and cost savings into its financial planning.

Key improvement areas and recommendations

The review of the historical 2019/20 position and the update of current and future arrangements has identified a number of key improvement areas for the Trust. We have grouped issues into six key areas to enable the Trust and stakeholders to focus on these and implement the proposed recommendations.

Table 2: Improvement areas and recommendations

Improvement area	Key findings & conclusions	Recommendations
STRENGTHENING AND EMBEDDING APPROACH TO PRODUCTIVITY	• **Limited triangulation and co-ordination of corporate cost reduction, Divisional margin targets and improvement programmes.** • **Limited tracking, reporting and realisation of benefits (in particular financial) of productivity plans.** • **Inconsistency of understanding, knowledge and mature worked up plans at Divisional level to deliver the productivity and efficiency assumed in financial plans.**	⇨ Develop a comprehensive, integrated multi-year approach to productivity planning which clearly outlines: ▪ areas (clinical services, back office) ▪ system-wide plans where relevant ▪ engagement plans with clinical and operational staff ▪ quantified benefits (including financial) ▪ accountability, reporting and tracking process to provide assurance of delivery ⇨ Ensure productivity programmes are aligned and converge with wider healthcare system plans and arrangements. ⇨ Equip Divisional, operational, service and clinical leaders to understand comparable performance by developing and sharing analysis of performance, improvement delivered and external benchmarking tools, to develop an understanding and culture of productivity in service delivery.
MANAGEMENT AND CONTROL OF WORKFORCE COSTS	• **Pay costs have been consistently increasing for a number of years – both substantive and temporary – and were significantly higher than planned throughout 2019/20.** • **There was an accepted lack of sufficient controls and management over workforce costs in 2019/20 along with a poor understanding and triangulation of impact of additional workforce on financial plans.**	⇨ Develop workforce management and control plans which: ▪ provide analysis and tools ▪ establish a real-time process for managing variance, setting thresholds and escalation processes ▪ identify and tracks service led workforce efficiency plans ▪ integrate with the long-term workforce strategy

Improvement area	Key findings & conclusions	Recommendations
	• Budget managers highlighted access to better workforce information as one of the key priorities for improvement and difficulties in delivering activity plans without greater than planned temporary staffing levels.	⇨ Work with the system to develop system-wide solutions to efficient workforce management in areas where the system can act more effectively than the Trust, such as the flexible use of staff, development of bank and control of agency.
DIVISIONAL & BUDGET MANAGER UNDERSTANDING, BUY-IN AND DELIVERY	• Operational Divisional and budget managers have limited understanding and buy-in of key assumptions, risks and actions needed to deliver financial plans. • Budget managers perceive financial planning to be top down and do not understand and fully accept targets and control and their implications set on the Trust by national guidance and regulators. • Budget managers do not feel trained on budget management or feel in control of activity and workforce which influence the income and expenditure within budgets or feel empowered to act. • Operational delivery and quality are prioritised, and managers do not understand the impact on financial sustainability or have the analysis to link them.	⇨ Invest in the development and training of Divisional and budget managers to improve and create a shared understanding of the financial requirements of the Trust, in particular: ▪ Budgetary processes and assumptions ▪ Key financial metrics and terms ▪ Impact of operational and workforce plans and issues on finance Cost management, efficiency and productivity ▪ Financial control in the day-to-day operational environment ⇨ Review the budget setting process to engage with clinical Divisions and budget managers to communicate key nationally set targets more effectively and ensure assumptions and their impact are agreed.
UNDERSTANDING AND CAUSES OF THE UNDERLYING FINANCIAL POSITION AND COSTS OF DELIVERING SERVICES	• While securing financial sustainability is one of the Trust's strategic objectives, it has a deteriorating underlying operational financial deficit with costs, in particular workforce, consistently increasing at a higher rate than income. • There is a lack of shared understanding across the operational Divisions and the wider system of the overall position and about how performance is distorted by one-off, non-recurring transactions.	⇨ Create a shared understanding across the Trust and wider system of the underlying and causes of the operational financial position involving: ▪ a service level assessment of the underlying financial position post-Covid involving operational and clinical staff ▪ cover not just operational productivity, cost efficiency and patient acuity analysis and benchmarking comparisons but also wider structural and system issues, such as allocations and service commissioning

Improvement area	Key findings & conclusions	Recommendations
	• **Given its importance to delivering financial performance, the Trust's Commercial Strategy and plans need to be more clearly integrated into financial reporting so that their impact is clear.** • **While some improvements have been made, there continues to be a lack of alignment and understanding of the related impact between activity, performance and costs (particularly workforce).** • **The position is further complicated by the impact of Covid on capacity, activity, productivity and costs. It is likely that a significant underlying operational deficit remains.**	▪ an assessment of financial practice and behaviours in Divisions and clinical Directorates ⇨ Develop and communicate within the Trust and system a medium- to long- term financial plan which integrates improvement and productivity targets, Commercial Strategy and system delivery and efficiency plans. Update service costing processes and information to provide an understanding of the normalised, post-Covid financial position. ⇨ Formally recognise, report and embed the commercial strategy as a key component of the Trust's financial plans and ensure non-recurrent transactions are not used to offset recurring benefits. ⇨ Integrate and align further performance, workforce and financial planning and reporting so that the financial impact of operational and quality issues and decisions are more clearly reported, understood and discussed within Board, Divisional and clinical Directorate governance processes.
REPORTING, ANALYSIS AND TRIANGULATION OF OPERATIONAL PERFORMANCE, WORKFORCE AND FINANCE	• **There have been improvements to the Board's Integrated Performance Report (IPR) since 2019/20 but the level of detailed analysis provided in the IPR mean key messages, actions, support and financial impact are hard to distil.** • **Financial analysis and commentary is not always prominent or clear.** • **'Line of sight' reporting through Board to Division to Directorates on key operational, quality and financial information is not accessible.**	⇨ Streamline and focus reporting within the IPR to ensure that an Executive summary identifies key messages, highlights impact, summarises key metrics performance and improves prominence of financial reporting and commentary. ⇨ Improve the sharing and availability of information and analysis through greater use of dashboards with drill down through Divisions, Directorates and services.

Improvement area	Key findings & conclusions	Recommendations
	• Access to timely, consolidated and drill down analysis on operational (activity, capacity, performance) and workforce information is limited.	
SYSTEM DEVELOPMENT	• System management and governance arrangements are not as mature as other healthcare systems and are in development. • Collaborations on system-wide allocations, delivery and productivity plans are at an early stage. • The immaturity of system development and lack of clarity nationally on allocations and the finance regime presents a significant risk to financial planning and forecasting at the Trust.	⇨ Work with system leaders to develop and embed system financial governance and reporting arrangements. ⇨ Develop a clear understanding of the system-wide financial positions and plans to address them. ⇨ Identify, develop and integrate system-wide efficiency and transformation plans in areas where the system can act more effectively than the Trust.

Introduction

We worked with the Trust to undertake an independent assessment of financial performance and governance arrangements in 2019/20 and to inform and shape future financial governance arrangements in line with the agreed scope of work set out in Appendix A.

This report sets out the findings from our work and has been structured as set out in Table 3.

Table 3: Our report structure

Section	Area	Our observations on:
Review of 2019/20	Background and context	the Trust Board and regulator leadership changes, and financial regime in 2019/20
	Underlying financial position	the underlying financial position of the Trust, including analysis of costs and income
	Financial planning	the 2019/20 budget setting process, key assumptions and risks to the plan
	Financial performance	the drivers of the variance from plan in H1 and from the month 6 reforecast in H2
	Financial governance	the governance arrangements in place in 2019/20 with a focus on financial reporting at Board and Divisional level, and reporting with system leaders and NHSE/I
Current governance, reporting and performance	Current Trust arrangements	the current financial governance arrangements at the Trust
	Budget manager survey	the key messages arising from the responses received from the budget manager survey
	Future system and finance arrangements	the Trust's 2020/21 performance, 2021/22 planning and system development and governance arrangements
Improvement areas and recommendations		The key improvement areas and recommendations arising from our work

In performing our work, we held a series of interviews with a number of Trust staff and external stakeholders, including:

- a number of Executive and Non-Executive directors of the Trust, including the Chair, Chief Executive and Chief Finance Officer.
- Divisional directors, clinical directors and finance business partners
- a number of other finance staff involved in the financial planning and reporting process.
- Chief Finance Officer of Oxfordshire Clinical Commissioning Group (CCG) and finance lead of the Berkshire (West), Oxfordshire and Buckinghamshire STP.
- The Director of Finance and Director of Operational Finance NHSE/I team NHS England and NHS Improvement (South East)

A full list of all the individuals we met is included at Appendix B. In performing our work, we received and considered a significant number of documents provided by Management with key sources of information including:

- Trust Board, committee and Divisional meeting agendas and papers from January 2019 to May 2021
- Documents, workings and analysis prepared as part of the 2019/20 financial planning process
- 2019/20 monthly finance working files
- financial reporting information provided to Divisions and Trust committees in 2019/20, and
- a selection of information reported to NHSE/I, including the monthly financial monitoring returns.

In performing the scope of our work (Appendix A) we:

- Reviewed key 2019/20 financial planning documentation, including workings that supported the 2019/20 financial plan submission
- Analysed Monthly 2019/20 finance working files to inform our commentary on the variance from plan and M6 forecast
- Reviewed minutes and papers of key committees including the Trust Board
- Issued a survey to 528 budget managers at the Trust, to gain a broader view of financial planning and reporting arrangements at the Trust
- Observed a number of Trust meetings, including the Trust Board, Integrated Assurance Committee, Trust Management Executive meeting and two Divisional monthly performance meetings, and
- Considered recommendations for improvement based on our experience of working with similar Trusts.

A glossary of terms used in the report can also be found at the back of the report.

Review of 2019/20

Background and context

Changes at the Trust and NHSE/I

There was a number of significant leadership and governance changes at the Trust and NHSE/I that impacted on the knowledge, understanding and capacity of management at the Trust and the regulator to manage the Trust's financial issues and risks leading into and during 2019/20. These changes included:

- Significant turnover at the Trust across Board, Executive and senior management level, including changes in Medical Director, Chief Operating Officer, Chief Digital Officer, Chief People Officer, Director of Improvement and Culture and a number of Divisional Directors. There was also significant turnover at Non-Executive Director (NED) level during 2019/20, including a change of Chair.
- A number of amendments and developments to governance processes in 2019/20, with these processes not yet fully embedded during the year. Changes included the merging of the Quality and the Finance and Performance Committees into a single Integrated Assurance Committee (IAC) and the development of single Integrated Performance Report (IPR).
- The closer integration of NHS England and NHS Improvement leading into and during 2019/20 led to finance leadership changes in the South East region, with a new Director of Finance in post in 2019/20.

[2] *Including £30.3m PSF and MRET*

Financial Regime

The NHS financial regime in 2019/20, as set out in the NHS Operational Planning and Contracting Guidance 2019/20, meant that the Trust was assigned a control total target of a £37.9m[2] surplus, which was based on past financial performance but significantly higher than the underlying financial position of the Trust coming into 2019/20 (see next section). The control total regime meant many NHS Trusts, including Oxford, agreed challenging budgets for 2019/20 in order to maximise the potential funding of services. In addition to the circa £30m Provider Sustainability Fund (PSF) and Marginal Rate Emergency Rule (MRET) funding the Trust would receive for meeting its control total target in 2019/20, the Trust estimated that not accepting its control total could have led to the enforcement of circa £20m contractual penalties. Although the control total for 2019/20 was in-line with 2018/19 performance, it was challenging given the Trust's underlying financial performance moving into 2019/20.

Underlying financial position

Financial position

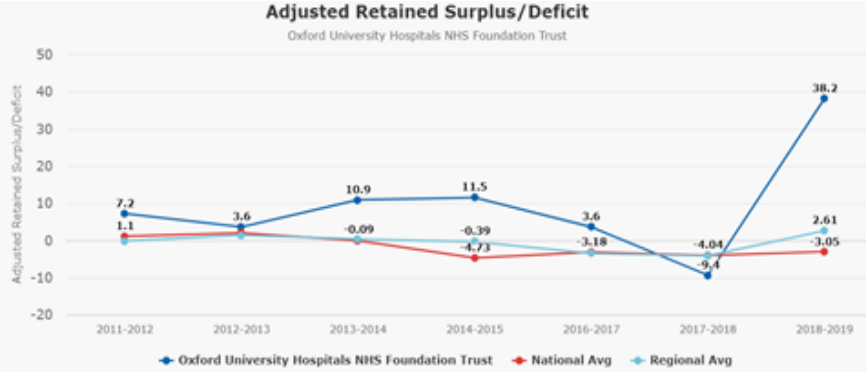
The Trust ended 2018/19 with a reported surplus of £38.2m[3]. This exceeded the control total for year and was significantly higher than both regional and national average out-turn performance (Chart 8).

Financial performance has varied from year to year, and there have also been varying levels of one-off, non-recurrent items which have delivered surplus positions over the last four years. This was particularly the case in 2018/19, where there were several one-off non-recurrent items which supported the

[3] *Included £25.7m of PSF*

delivery of the £38.2m surplus, including profit on disposals, movement in the value of investments, a prior period adjustment and STF/PSF funding. These had a total value of £76.8m, which was significantly higher than in prior years - on average, around £28.0m per annum. The Trust's past financial performance, which compared favourably to both national and regional average (particularly in 2018/19) created an expectation from the wider system and regulators that financial performance would continue to be delivered.

Chart 8: Historic adjusted retained surplus/deficit performance



Source: Grant Thornton benchmarking of national financial accounts

When the financial position is adjusted for the non-recurrent one-off items, such as PSF, in-year commercial transactions, accruals and provisions relating to the previous year, the Trust has an underlying deficit[4] based on management information, which is deteriorating year on year. The underlying deficit has increased from a £23.2m deficit in 2015/16 to a £39.5m deficit in 2018/19 as set out in Table 4.

[4] Information and analysis have been provided by the Trust and while we have reviewed the basis and assumptions of the calculation, we have not reviewed the accuracy of the underpinning information and analysis.

Table 4: Historic underlying financial performance (excluding non-recurrent items)

£ million	2015/16	2016/17	2017/18	2018/19
Surplus/(deficit)	(23.2)	(25.8)	(34.8)	(39.5)

Source: Trust management information

The underlying deficit, and its deterioration over time, resulted from operating costs consistently exceeding income on a recurrent basis. Over the same four-year period, income has grown at 4.1% per annum, whereas operating expenditure has grown at 4.7% per annum, with pay increasing at 5.0% per annum and non-pay at 4.3%. This is set out in Table 5.

Table 5: Historic Summary Income and Expenditure

£ million	2015/16	2016/17	2017/18	2018/19	CAGR 2015/16 - 2018/19
Total Income	951.2	997.4	1,030.0	1,072.5	4.1%
Total Operating Expenditure	895.3	938.6	983.5	1,028.2	4.7%
Pay	538.0	563.7	585.0	622.3	5.0%
Non-Pay	357.3	374.8	398.6	405.9	4.3%

Source: Trust management information

Note: CAGR – Compound Annual Growth Rate. The table above shows the % annual growth between 2015/16 and 2018/19.

Table 6 illustrates that cost growth has ocurred across all types of substantive pay groups. The greatest level of growth is seen in non-clinical pay costs (14.6%). Only nursing and midwifery and scientfific, therapeutic and technical

(STT) pay has been below the level of income growth over the period at 1.0% and 2.7% respectively. Agency costs have been decreasing over the period (-10.6%), although did increase significantly in 2018/19.

Table 5 also shows that whilst pay expenditure has increased by an average of 5.0% per annum over the period, whole time equivalents (WTE) have increased by 1.8%, some of which will be agreed pay increases and pay inflation.

Table 6: Historic Pay Costs

£ million	2015/16	2016/17	2017/18	2018/19	CAGR 2015/16 -2018/19
Consultants	108.1	110.6	118.3	126.7	5.4%
Other medical	75.7	78.4	89.4	91.6	6.6%
Nursing & midwifery	165.8	166.0	161.9	171.0	1.0%
STT	72.5	77.6	72.7	78.5	2.7%
Other clinical	76.3	82.2	87.5	95.1	7.6%
Non-clinical/other	39.5	48.9	55.1	59.4	14.6%
Total Pay	**538.0**	**563.7**	**585.0**	**622.3**	**5.0%**
Of which agency (all staff groups)	25.2	15.3	11.4	18.0	-10.6%
WTEs	11,505	11,740	11,770	12,137	1.8%

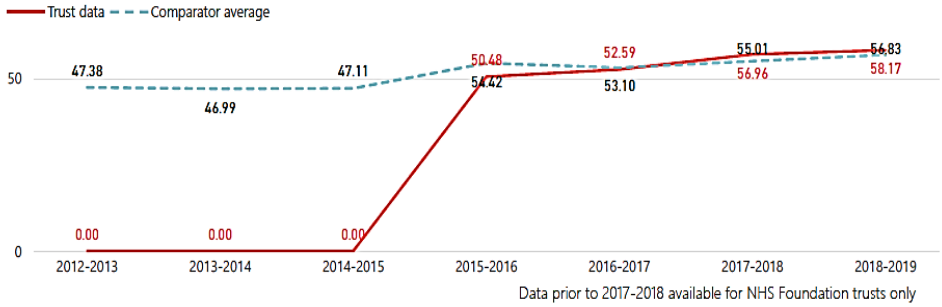
Source: Trust management information

Although the Trust's pay costs have been increasing at a faster rate than income, our analysis indicates that the Trust is not a significant outlier on a number of metrics when compared to other Shelford Group peers.

Analysis of costs and income

Chart 9 shows total staff costs expressed as a percentage of total income. The lower the percentage, the better. This shows that staff costs as a percentage of total income has been increasing and now slightly higher than the Shelford peer group average at 58.17% but not a signficiant outlier.

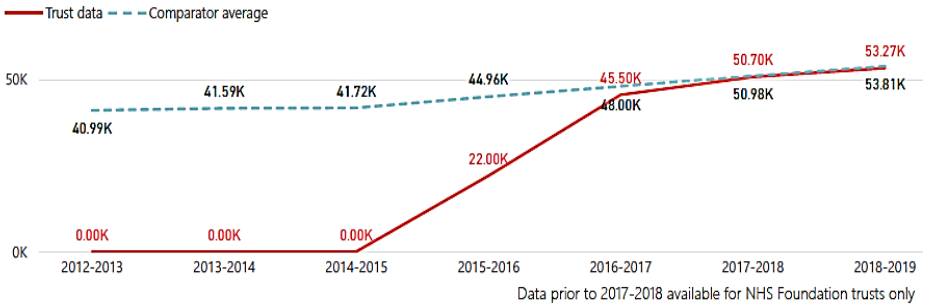
Chart 9: Staff costs as a % of total income



Source: Grant Thornton benchmarking of national financial accounts

Chart 10 shows that staff costs per whole time equivalent member of staff have been increasing from £45.5k in 2016/17 to £53.3k in 2018/19 although this is also in-line with the Shelford Group peer average.

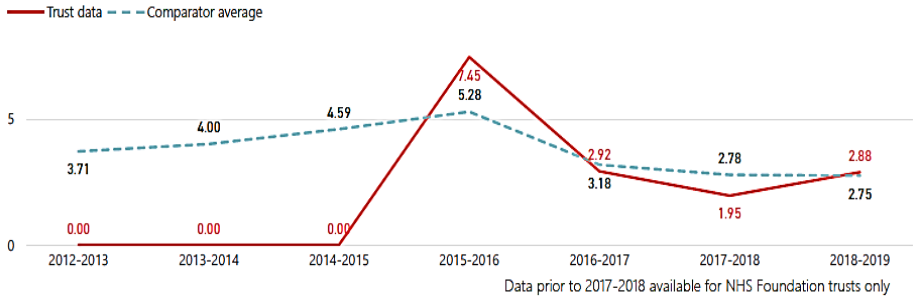
Chart 10: Staff costs per WTE member of staff



Source: Grant Thornton benchmarking of national financial accounts – 2015/16 includes only part year accounts due to Trust moving to Foundation Trust status on 1 October 2016

Chart 11 shows agency spend as a percentage of total staff costs. This shows variable performance with spend reducing between 2015/16 and 2017/18 to below the Shelford Group average but increasing in 2018/19 rising above the peer average.

Chart 11: Agency spend as a % of total staff costs



Source: Grant Thornton benchmarking of national financial accounts

As highlighted in Table 5 previously, non-pay costs have increased by 4.3% between 2015/16 to 2018/19 (compared to income at 4.1%). Table 7 provides a more detailed breakdown of historic non-pay costs.

Table 7: Historic non-pay costs

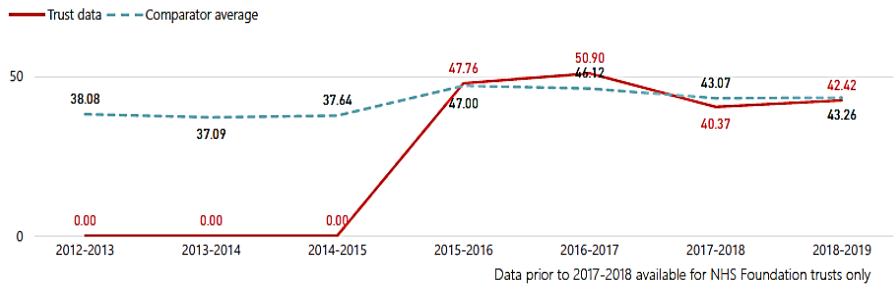
£ million	2015/16	2016/17	2017/18	2018/19	CAGR 2015/16 - 2018/19
Pass-through drugs	82.2	87.0	102.3	101.1	7.2%
Other drugs	25.6	28.7	18.9	14.7	-17.0%
Pass-through devices	20.7	26.6	26.2	24.3	5.4%
Other clinical supplies & services	84.6	87.5	126.0	127.8	14.7%
CNST	30.7	33.7	36.5	31.1	0.5%
Premises (non-PFI)	31.7	35.3	28.5	29.9	-1.9%
Other non-PFI	55.2	47.2	25.4	37.7	-11.9%
PFI OpEx	26.6	28.9	34.7	39.2	13.7%
Total Non-Pay	357.3	374.8	398.6	405.9	4.3%

Source: Trust management information

Historic non-pay costs highlight significant growth in the largest cost areas over the four-year period to 2018/19, including a 14.7% increase in clinical supplies and services, 7.2% increase in pass through drugs and 13.7% increase in PFI operating costs. Over the same period other drugs and other non-PFI costs decreased by 17.0% and 11.9% respectively.

Comparison of the Trust's non-pay costs to Shelford Group peers shows that the Trust is also not an outlier in this area. Chart 12 shows non-staff operating expenses expressed as a percentage of total income. This shows that the Trust was just above average in 2016/17 but has been below peer average in 2017/18 and 2018/19.

Chart 12: Non staff operating expenses as a % of total income



Source: Grant Thornton benchmarking of national financial accounts

In 2018/19, the Trust had a National Cost Collection Index (NCCI) of 98.1, previously known as the Reference Costs Index (RCI). The NCCI is a measure of the relative cost difference between NHS providers and shows the actual cost of a provider's casemix compared with the same casemix delivered at national average cost. An NCCI of 98.1 means that the Trust's costs are 2% lower than national average.

Table 8 shows that the Trust has the third lowest NCCI amongst the 10 Trusts in the Shelford Group in 2018/19, with only The Newcastle Upon Tyne Hospitals and Sheffield Teaching Hospitals having lower cost index.

Table 8: Trust NCCI against Shelford peer group

Organisation name	NCII	NCII MFF adjusted
The Newcastle Upon Tyne Hospitals	91.2	95.8
Sheffield Teaching Hospitals	92.3	97.4
Oxford University Hospitals	**98.9**	**98.1**
Imperial College Healthcare	113.3	100.7
Manchester University	99.0	102.1
University Hospitals Birmingham	99.8	103.6
King's College Hospital	114.4	104.3
Guy's And St Thomas'	121.8	105.7
University College London Hospitals	123.5	106.0
Cambridge University Hospitals	111.8	112.1

Source: National reference costs publication 2018/19

Table 9 shows the Trust performance against several metrics within Model Hospital for 2017/18 and 2018/19. These provide the context for understanding how the Trust has been performing historically and the issues that the Trust was responding to as part of setting the 2019/20 operational and financial plans. Whilst the Trust had areas to improve around clinical performance, it was performing well on finance related metrics such as use of temporary staffing, nursing costs and corporate related costs. It also showed an improving position on medical staffing costs but highlighted improvement opportunities with theatre utilisation.

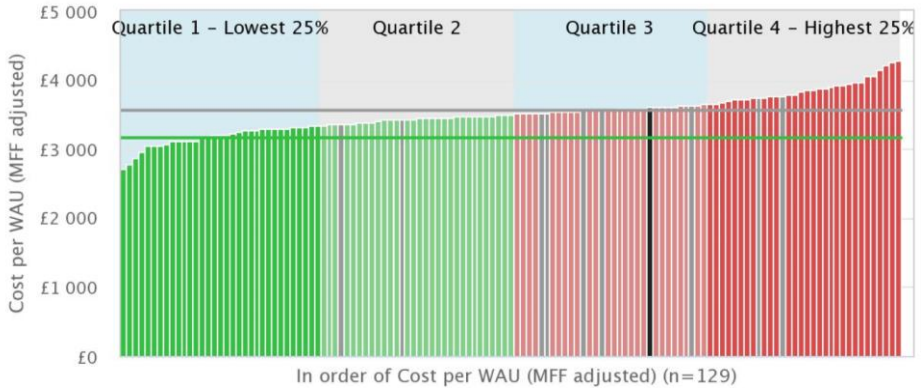
Table 9: Performance on clinical, workforce and corporate metrics

Area	Metric	2017/18	2018/19
Clinical	A&E performance (benchmarked against 95%)		
	RTT 52-week breaches		
	RTT - max 18 weeks incomplete wait		
	Diagnostics- max 6 waits		
	Cancer 62 waits - NHS cancer screening service referrals		
	Cancer 62 waits - urgent GP referral		
Workforce	Staff turnover		
	Staff retention - Doctor		
	Staff retention - Nurses		
	Staff sickness		
	Overall vacancy rate		
	Proportion of temporary staff		
	Surplus/Deficit as % of expenditure		
	Costs per WAU (MFF Adjusted)		
	Medical staff costs per WAU		
	Nursing staff costs per WAU		
Inpatient	Length of stay elective		
	Length of stay emergency		
Outpatients	DNA rate		
Theatres	Touchtime utilisation		
	Finance costs per £100m income		
	HR costs per £100m income		
	IM&T costs per £100m income		
	Payroll costs per £100m income		
	Estates & facilities costs (£ per m2)		
	Critical infrastructure risk (£ per m2)		

Source: Model Hospital 2018/19

Model Hospital shows that in 2018/19 the Trust's cost per WAU was £3,606, which was slightly higher than the Shelford Group peer average of £3,559 and ranking the Trust as the 7th most expensive per WAU out of the 10 Shelford Group Trusts. Model Hospital data for 2019/20 shows that the Trust remains in the top third quartile (Mid-High) against all NHS Trusts and slightly higher cost than the comparator Shelford Group (£3,615 per WAU compared to £3,600).

Chart 13: Cost per weighed activity unit (WAU) breakdown – 2018/19

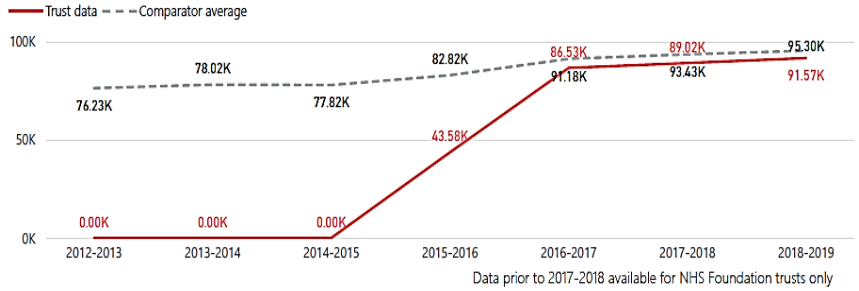


Source: Model Hospital 2018/19

Analysis has shown that whilst the Trust has an underlying deficit, its costs are comparable with its Shelford Group peers, and this is also supported by the 2019/20 Model Hospital data as shown on page 6.

Analysis of income shows that the Trust is below peer average across a number of indicators. Chart 14 shows total income per WTE member of staff and it indicates that the Trust has a lower level of income per WTE than Shelford Group average.

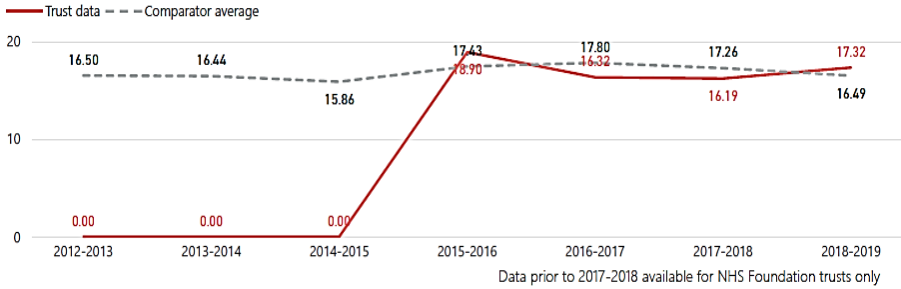
Chart 14: total income per WTE member of staff



Source: Grant Thornton benchmarking of national financial accounts – 2015/16 includes only part year accounts due to Trust moving to Foundation Trust status on 1 October 2016

Chart 15 shows that over the 4-year period to 2018/19 the Trust has generally a comparable level of other operating income as a percentage of total income compared to other Trusts. This includes items such as patient transport services, education and training and research and development.

Chart 15: other operating income % of total income



Source: Grant Thornton benchmarking of national financial accounts

Through our discussions, we have established that Oxfordshire is recognised as having the lowest allocation per patient, running approximately 4% distance from target on current allocation level. This equates to circa £35m. The system financial position, and the need to keep system financial performance in balance, could be impacting on the Trust's income position, and therefore the underlying financial position of the Trust. This apparent shortfall in funding for the system is contributing to the expectation that the Trust can achieve similar financial performance as in previous years through the use of non-recurrent, one-off items, to support the overall system financial position.

Financial planning

Budget setting process

The high-level approach to budget setting in 2019/20 is set out in Table 10. Based on the information provided to us, the planning framework, logic and approach to developing the 2019/20 plan were reasonable. The work undertaken by Divisional and corporate teams was captured at an appropriate level of detail, with a good level of supporting information at Directorate and Divisional level through Excel based workbooks. The key adjustments cover those areas we would expect such as inflation, tariff-based adjustments, non-

recurrent items, known investment or cost pressures and required productivity and cost improvements.

Table 10: Budget setting process

High-level approach
The approach to develop the 2019/20 financial plan can be summarised as: • Starting with the Month 7 2018/19 forecast outturn position • Adjusting the forecast outturn for one-off and non-recurrent items in 2018/19 and the full year impact of recurrent income and expenditure agreed in 2018/19 • Adjusting for inflation, tariff related changes (for example, PSF, CNST and CQUIN moving into tariff) and national efficiency requirement • Adjusting for contract related Tariff changes and pricing rules and local commissioning & contracting risks • Identifying contingency to be retained centrally • Adjusting for previously identified Divisional cost pressures & developments e.g., new business cases • Adjusting for other items such as CNST premium reduction, depreciation and PFI finance costs • Identifying financial improvement savings required including productivity & cost control and one-off transactions

The forecast outturn was reviewed each month and finance staff held regular budget setting meetings with Divisional management teams to identify the recurrent position and agree the baseline. The budget planning was supported by detailed Excel based workbooks as set out in Table 11. The level of information and the approach to triangulating the different sources of information is good and is better than we have seen at many other Trusts.

Table 11: Information used in setting the plan

Key data items	Supporting analysis
• Performance targets such as waiting list position, A&E 4-hour, 62-day cancer and diagnostic waiting time • Activity volumes as reported in SLAM • Capacity (beds) and productivity measures such as bed utilisation, average length of stay, theatre utilisation, commissioning income per WTE medical staff • Workforce data including total WTE, use of temporary staff and support metrics such as sickness and turnover rates • Finance data such as income, pay and non-pay costs	This data is supplemented by graphs and charts to help assimilate the information, as well as financial implications such as EBITDA, EBTDA margin (%), and surplus/deficit position. A Divisional view is provided, along with Directorate specific information.

Review and challenge of Divisional budgets was undertaken during the planning process. At a Divisional level, this included three meetings with finance and Executives across January to March ahead of the final submission. Updates on progress were provided to the Finance and Performance Committee and Trust Board during this process. The engagement and governance over the process was reasonable.

Based on our discussions, Divisional staff appeared engaged in the planning process and there appears to have been an appropriate level of review and challenge at Divisional, Executive and Board level. However, there is a perception that the planning process is top-down and in some cases, budgets and plans were not agreed until several months into the year. For example, NOTTSCaN budget was not agreed until June 2019 due to a difference of £4.5m assessment of risk.

Whilst the planning process will inevitably result in a level of negotiation between corporate and Divisional colleagues, being clear on the basis of any centrally allocated assumptions or targets, including any constraining factors (such as

commissioner affordability) should result in greater buy-in and ownership of plans by Divisional management teams.

Key assumptions

The key assumptions underpinning the plan are set out in Table 12.

Table 12: Key assumptions in 2019/20 plan

Area	Assumptions
Clinical activity & related income	Overall activity growth of 3.3% (varies by point of delivery). In financial terms, growth of £19.2m (2.1%) on prior year before any tariff changes or contractual adjustments.
Workforce	4.4% substantive growth (488 WTE) with a 21% reduction in bank (112.5 WTE) and 39% reduction in agency (77.5%), therefore net growth in WTE of 2.5% (298 WTE). In financial terms, growth of £4.5m (0.7%) on prior year before any cost pressures or efficiency adjustments.
Productivity and cost control	Total efficiency requirement of £60.0m to deliver agreed control total. This was split between £35m productivity and cost control and £25m in one-off items and commercial programme.
Commercial programme and one-off items	

Activity and income

Growth assumptions

At the start of the planning process, the Trust had a different view of demand to commissioners, with the Trust modelling 4-8% growth compared to the CCG at 2-3%. This is set out in Table 13 which shows historic growth based on either IMAS modelling or average growth over the previous 2-3 years. These levels were considered unaffordable for commissioners. Therefore, following discussions and negotiation, the final activity figures were mitigated down to reflect experience of actual activity growth in 2018/19. Assumptions around growth that were agreed are set out in Table 13.

Table 13: Growth in clinical activity by point of delivery

Point of delivery	Historic growth	Growth in 2019/20 plan
ED attendances	2.9%	3.0%
Non-elective admissions	4.0%	1.6%
Elective admissions	6.6%	1.8%
Outpatient attendances	6.0%	1.7%
Specialised activity	-	1.8%

Source: Trust Management Information

When compared with actual performance in 2018/19, the assumptions around clinical income within the plan were reasonable. The level of activity assumed in the 2019/20 was in-line with that delivered in 2018/19 despite IMAS modelling indicating higher levels of historic growth. Overall, the plan represented a 5.4% increase in income from patient care activities (an increase of £48.0m on 2018/19), of which £20.3m (2.3%) was from volume changes. In our view, the assumptions underpinning the planned growth were sensible and in-line with those delivered in 2018/19, including non-elective which saw growth (and casemix change) in 2019/20 (see later section of report) over and above that experienced in 2018/19.

Theatre refresh programme (JR2)

Activity plans were also adjusted for the need to refurbish the eight non-PFI theatres at the John Radcliffe Hospital in the first half of 2019/20 (JR2 theatre refresh). This assumed that four theatres would be closed for a total of 20 weeks (10 weeks for each set of four theatres), thereby reducing capacity available in the first part of the year. The refresh was required following an unannounced CQC core service inspection at the end of 2018, when a formal notice was issued under Section 31 of the Health and Social Care Act 2008 in relation to concerns observed with the JR2 theatres. At the time of submitting the plan, whilst activity reductions were assumed, the recycling of capacity and the potential additional premium cost to deliver the activity (such as evening and weekend payments) were not specifically modelled. The plan assumed that circa 1,264 cases would be lost by the move, of which 306 could be re-provided in

other facilities, and therefore a net loss of circa 958 cases. Our assessment is that the underlying assumptions were reasonable, but better monitoring of actual performance during the refresh should have been established.

Contractual arrangements

Table 14 provides detail on the agreements reached with commissioners. Whilst a block contract was agreed with Oxford CCG, the risks associated with this block were held centrally, with Divisions operating as though a payment for activity contract was in place.

This lack of clarity at Divisional level, and the difference between the SpecComm and CCG block, resulted in a lack of understanding about the actions to be taken to improve financial performance. Clear communication and understanding that the Trust was on a block contract with the CCG may have resulted in Directorates and Divisions taking different decisions which focussed on maintaining or reducing costs, rather than driving activity on the assumption they would receive additional income (although would need to be balanced around other factors such as waiting list priority).

Table 14: Contract income agreed with commissioners

Oxford CCG	NHSE (specialised commissioning)
• Block contract based on a fixed sum contract to deliver specified operational performance (such as zero 52 week waits and A&E performance). • Acknowledgement that due to limiting growth levels and reduced capacity (JR2 refresh) RTT performance would deteriorate. • Contract value set at £366.4m with a commitment that any 'in year headroom' would support any over performance against contract and/or recovery of any agreed premium costs. • Blended payment rules applied to non-elective activity which meant that any over-performance would be funded at 20% tariff value (and ultimately within the overall block contract value).	• Activity-based payment contract (payment by results) • Overall contract value set at £404m (including CQUIN) with smaller values for other services, such as armed forces (£2m) and dental services (£6m). • Level of growth applied was less than assumed by the Trust, however NHSE note the likely impact on waiting time targets. • QIPP applied to the contract (3.4%), although there were no detailed plans to achieve the majority of the QIPP target. • At the time of setting the contract and the operational plan, agreement was outstanding on the local prices to be applied for 2019/20 activity. These were agreed by June 2019 and the contract was signed.

Source: CCG and NHSE 2019/20 contracts

2019/20 was the first year of a blended payment approach to non-elective activity where baseline activity levels were agreed, with any activity levels above the baseline funded at a marginal rate of 20%. Whilst the underlying assumptions were reasonable, and the Trust had commitment from the CCG for any in-year headroom, this change represented an additional risk to the Trust. We would have expected more detailed analysis, such as scenario planning and testing of potential outcomes, to be undertaken as part of the planning process.

This would have modelled the potential impact of changes in demand and activity on workforce, costs and income (to be paid at 20% above the agreed

activity baseline). Additionally, in our view the Trust and CCG should have agreed an in-year 'break glass' clause in line with national guidance[5], if activity was above or below an agreed tolerance, in order trigger a review to understand the driver of any over/under performance. This should have then resulted in agreement of potential options such as demand management initiatives with commissioners or use of an in-year headroom to mitigate the financial impact of any activity change.

Workforce

During the planning process, each service completed a workforce template to forecast any underlying changes required in the workforce, including any changes that might deliver improvements in productivity. The workforce numbers were also aligned to bed numbers and other capacity indicators (such as utilisation) to give a view on overall capacity.

The Trust noted in the final plan submission to NHSE/I that their approach to workforce planning and triangulation of data sources had been improved from 2018/19, including closer integration with business planning, better data, improved methodology and Divisional engagement. Although there was an attempt to triangulate between various sources of information, there is recognition that the approach to workforce planning could have been improved, and, in particular, further corporate support to Divisions in developing workforce plans and the alignment of clinical capacity to activity projections could have been provided. Through our discussions, we have heard that although there were a number of planning meetings which discussed workforce, activity and finance plans, there was a perception that these plans were not joined up to form an integrated plan for 2019/20.

Overall, a 4.4% growth in substantive workforce was agreed which included assumptions around TUPE-transferred staff. This was assumed to be delivered through improving staff turnover (1%), international recruitment of nursing staff (1.5%) and new Nursing Associate role. As a result of increased substantive workforce, the Trust planned for a reduction in the use of bank, agency and overtime so that net growth was assumed to be 1.9%. The reduction in bank and agency spend was assumed at 21% and 39% respectively. Given historic growth around workforce and pay costs, there should have been a greater level of challenge and scepticism about the achievability of these assumptions. Whilst the operational plan highlights a number of workforce initiatives, we have not seen detailed, worked up plans for how some of the assumptions within the plan would be achieved.

We would expect to see more detailed analysis of the baseline capacity of the Trust, covering both physical capacity (such as theatres, beds, diagnostic equipment and outpatient rooms) and clinical workforce capacity (by job role type). This should be undertaken by point of delivery and by speciality. This will provide the Trust with the clearer understanding of the resource (and cost) available to deliver patient activities, which can be used to inform the activity baseline as well as highlighting potential productivity and efficiency opportunities.

Identified cost pressures

During the planning process, Divisions had identified circa £8m of cost pressures and £4m of loss-making business cases. Following a check and challenge process, this was mitigated down to £8m total. These were to support continued investment in key areas of development such as staff recruitment and retention, clinical services strategy, service change, digital and operational productivity improvements. As a result, circa £5m was allocated to Divisional budgets and circa £3m was held in central reserve for business cases that developed in-year.

The approach to identified cost pressures was reasonable, and these areas appeared to be well understood by corporate and Divisional staff and were reflected appropriately within the plan.

[5] *Guidance on blended payment for emergency care – publication by NHS England and NHS Improvement March 2019*

Productivity and cost control

Once all the technical assumptions (such as changes to national tariff and inflation) and activity, workforce and cost pressures had been reflected, it left the Trust with a gap of £60m between the underlying deficit and the 2019/20 control total. In order to submit a control compliant plan, the Trust worked up options for delivering this £60m requirement.

The Trust felt that £60m in productivity and cost control would be a significant risk and would be substantially more than the £31.5m assumed in 2018/19. The Trust therefore agreed to deliver this through £35m in productivity and cost control and £25m in one-off items. The drivers for the £60m efficiency requirement are set out in Table 15.

Table 15: Efficiency requirement

Drivers of efficiency requirement	£m
Underlying deficit	(38.4)
Quality and capacity investments	(8.0)
Contingency	(15.0)
National planning efficiency	(11.0)
PSF funding into tariffs	10.8
Reduction in depreciation and PFI financing costs	3.5
Other	5.7
Efficiency required	**60.0**
Surplus control total (exc. PSF & MRET)	7.6
To be delivered by	
Operational efficiency	35.0
One off items / non-NHS income	25.0

Source: Trust Management Information

The £35m in productivity and cost control was broken down into:

- £10.4m in assumed margin in activity growth, and
- £24.6m in cost control, pharmacy savings and procurement savings

The £10.4m assumed to be delivered from additional margin on activity growth meant that the Trust had assumed that they would be delivering more activity within the existing budgeted cost base, therefore increasing margin. The underpinning assumptions meant that Trust had to deliver the 3.3% activity growth, but also drive through a 2.3% increase in clinical productivity and constrain headcount to 1.0% growth.

Whilst trying to improve margin by delivering more activity and controlling or driving down costs is the right approach, this was ambitious given that this was not assumed in 2018/19 and the number of different actions that were required to deliver this, many of which did not have mature and worked up plans. We also query the extent to which Divisions understood that this additional activity would have to be delivered whilst improving productivity and cost control.

The £24.6m of productivity was made up of centrally identified savings including procurement (£8.6m), pharmacy (£1.2m), GDE/IM&T (£1.6m) and Divisional allocations (£14m) as set out in Table 16. The requirement was allocated to Divisions and Corporate Services on analysis of addressable expenditure (i.e., excluding costs not directly within their control).

Table 16: Efficiency requirement by Division and theme

Division	Total	Procurement	Pharmacy	GDE / IM&T	Margin on growth	Operational*
CSS	6.4	1.6			1.8	2.9
MRC	6.8	0.7	0.2		3.6	2.4
NOTSSCAN	9.2	1.9	0.6		2.7	4.1
SUWON	7.1	1.6	0.5		1.8	3.2
Corporate	5.5	2.6				2.9
Trustwide		0.2		1.6	-0.2	-1.6
Total	**35.0**	**8.6**	**1.2**	**1.6**	**9.7**	**14.0**

Source: Trust Management Information. *operational includes urgent care & stranded patient initiatives, premium staff cost reduction, theatre initiatives and other productivity and cost control

At the time of setting and agreeing the plan, there were varying degrees of development and maturity of the underpinning plans to support delivery of the efficiency assumptions. In April for example, it is noted that the clinical productivity plan assumes a 2.5% improvement in productivity but a plan to deliver that was not worked up at the time of submission.

One-off commercial transactions

Given the delivery of the plan in 2018/19 and the scale of efficiency required to address the underlying deficit, which the Trust felt was too risky and could impact on quality and safety, the Trust set a 2019/20 plan with a £25m assumption around one-off transactions.

This £25m consisted of:

- £19m from transactions, and
- £6m from commercial/private income

At the time of setting the 2019/20 plan, a pipeline of potential one-off transactions had been identified with a range of benefits to the Trust from £12m to £38m. The 2019/20 plan or updates to the Board on the 2019/20 plan did not set out which schemes had been identified to deliver the £25m of transactions included in the 2019/20 plan.

The underlying philosophy and the approach to identifying and using one-off commercial transactions to support the overall financial position of the Trust is sound, especially given the size and relative prestige of the Trust. However, the delivery of such large one-off transactions in 2018/19 has created an expectation from the wider system and regulators that financial performance would be delivered.

In future the Trust should be clearer about the underlying performance of the Trust, by completely separating any one-off commercial transactions from the operational elements of the plan. In addition, developing a pipeline of recurrent, rather than non-recurrent items, will make this approach more sustainable in the longer term.

Appendix C sets out the key movements from the 2018/19 forecast outturn to the 2019/20 £7.6m control total (excluding PSF & MRET) compliant plan, which were presented in reports to the Trust Board and FPC and reflected in the final plan.

Risks to the plan

A number of significant risks to the delivery of the 2019/20 plan were identified at the planning stage. These were considered by Divisional staff and Executives during the planning process, with decisions made on these as part of the development of the assumptions reflected in the 2019/20 plan. The key risks focused around:

- Workforce – level of growth, ability to control agency spend, improving sickness and turnover and driving productivity gains
- Capacity - Capacity available to deliver the expected activity, including the impact of the JR2 theatre refresh
- Efficiencies and productivity – delivery of the £24m in efficiency and £11m in margin on growth
- One off items – delivery of one-off items, including land sales

In our view key assumptions and risks to delivering the 2019/20 plan were clear and understood by the Board and Divisional Management Teams. These are set out in numerous updates to the FPC and Trust Board as well as in the final operational plan. There was documented recognition that the Trust was setting a ‘highly challenging’ financial plan.

The challenging nature of the plan and the risks contained within it also appear to be recognised by NHSE/I. The overall plan was rated internally Amber by NHSE/I and the level of financial efficiencies required through the productivity and cost control is noted as an area of risk. This received an Amber/Red rating. These assessments are not shared so the Trust was not aware of the rating given. The Trust’s perception of the risk within the plan was higher.

The level of risk contained within the plans was recognised by retaining £15m in central contingency. However, there appears to have been limited discussion at Divisional and Board level on the mitigations to address the risks as part of the

planning discussions. There were numerous references to potential opportunities (such as improve late starts in theatres or potential around stranded patients) and indications that plans were under development or already in place, but these appear to be in varying degrees of maturity by the time of the submission of the plan.

For example, non-elective activity and 2019/20 winter was identified as a risk based on elements of the 2018/19 system-wide Winter Plan not being delivered. At the time of the April plan submission, plans were not developed. This was an increased risk given the block contract arrangements, and the blended payment in place for urgent care which meant any overperformance to the contract baseline would only be funded at 20% of tariff. Given the number of assumptions and risks in the plan, we would have expected discussions on other possible avenues to mitigate the risks, including with System colleagues, considering the scale of the financial challenge.

An update to the plan was provided to the June 2019 Board. It noted continuing discussions on the contracting and budget setting for 2019/20 with Divisions at clinical Divisional planning meetings in May, as well as follow up meetings with two Divisions (SuWOn and NOTSSCaN) in June. All Divisions with the exception of NOTSCCaN had agreed their budget by this point. To respond to some of the risk identified by Divisional teams, agreement to move some of the centrally held contingency into Divisional budgets was reached in order to de-risk the plan and incentivise agreement to financial targets. This was to reflect the size of the efficiencies required, the 2018/19 year end position and the risk of the impact of the JR2 theatre refresh.

Financial performance

Overview

The Trust agreed a 2019/20 surplus control total of £37.9m (including £30.3m PSF and MRET). As set out in Table 17, the Trust delivered a £11.9m deficit (including PSF/MRET) in 2019/20, which was £49.8m worse than plan and £20.5m worse than the Month 6 forecast.

The Trust completed and approved a forecast as at M6 which effectively meant the Trust had 2 plans in 2019/20, with performance monitored against the original plan in H1, and against the M6 reforecast for H2.

Table 17: Trust financial performance in 2019/20

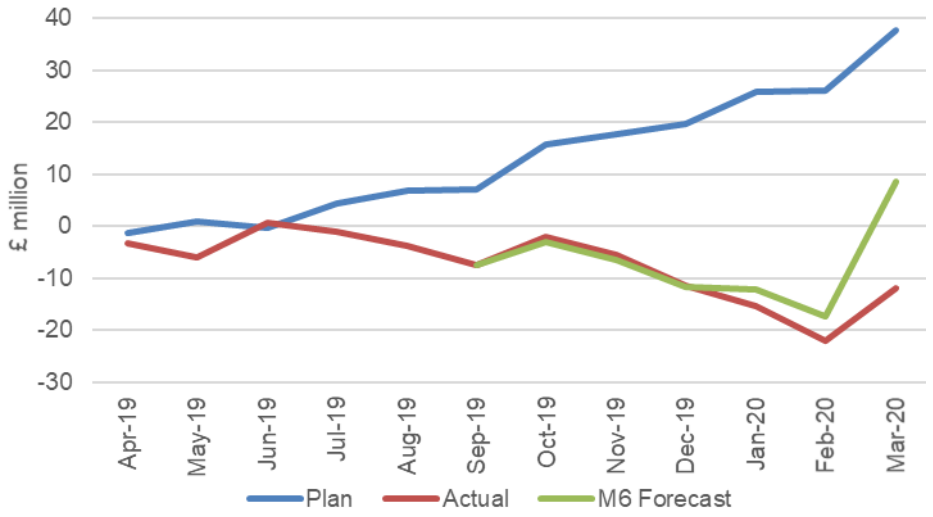
£ million	Plan	Actual	Variance	Forecast	Actual	Variance
Commissioning income	790.2	778.3	(11.9)	776.3	778.3	2.0
Other income	307.0	339.3	32.3	295.3	339.3	44.0
Total Income	**1,097.2**	**1,117.6**	**20.4**	**1,071.6**	**1,117.6**	**46.0**
Pay	(654.2)	(705.0)	(50.8)	(661.9)	(705.0)	(43.1)
Non pay	(400.6)	(410.1)	(9.5)	(397.2)	(410.1)	(12.9)
Underlying EBITDA	**42.4**	**2.5**	**(39.9)**	**12.5**	**2.5**	**(10.0)**
Other costs	(54.8)	(52.4)	2.4	(52.9)	(52.4)	0.6
One-off items	20.0	19.0	(1.0)	30.0	19.0	(11.0)
Surplus/(deficit) (Exc. PSF/MRET)	**7.6**	**(30.9)**	**(38.5)**	**(10.4)**	**(30.9)**	**(20.5)**
PSF/MRET	30.3	18.9	(11.3)	18.9	18.9	0.0
Surplus/(deficit) (Inc. PSF/MRET)	**37.9**	**(11.9)**	**(49.8)**	**8.5**	**(11.9)**	**(20.5)**

Source: OUH Month 12 IPR Report

Note 1. The 2019/20 actual £11.9m deficit includes £0.8m PSF income relating to 2018/19. This was excluded by NHSE/I in reporting so that on a control basis the reported position was a £12.8m deficit, £50.6m worse than plan.

As shown in Chart 16, financial performance in 2019/20 was consistently adverse against plan from M1 (April 2019), and at M6 the Trust had delivered a £7.2m deficit, £14.4m worse than plan. The Trust was only on plan in Q3 of 2019/20 with significant variances from the revised H2 plan in Q4.

Chart 16: Cumulative surplus/(deficit) inc. PSF/MRET in 2019/20



Source: Management working - OUH M12 Finance Reporting Pack

Note: 1. Adjusting out £8.8m unplanned one-off items at M3 relating to NHS Blood and Transplant lease revaluation (£3.7m) and release of a PFI risk provision (£0.6m) and £4.5m of prior year income accruals would have resulted in a £15.2m deficit, £8.7m worse than plan at M3

Performance against plan to Month 6

Significant underperformance in commissioning income, an inability to manage pay costs within budget and failure to deliver against the planned cost efficiency schemes were the key drivers of the variance from plan in the first 6 months of 2019/20. Tables 18 and 19 and Chart 17 and the commentary that follows set out the key themes and variances from plan as at Month 6 (September 2019).

Table 18: Trust financial performance to month 6 (September 2019)

£ million	Plan	Actual	Variance
Commissioning income	461.6	452.2	(9.4)
Other income	83.3	80.3	(3.0)
Total Income	**544.9**	**532.5**	**(12.4)**
Pay	(324.9)	(332.1)	(7.2)
Non pay	(198.4)	(196.5)	1.9
Underlying EBITDA	**21.6**	**3.9**	**(17.7)**
Other costs	(27.4)	(26.4)	0.9
One-off items	0.0	4.3	4.3
Surplus/(deficit) (Exc. PSF/MRET)	**(5.8)**	**(18.2)**	**(12.4)**
PSF/MRET	13.0	11.0	(2.0)
Surplus/(deficit) (Inc. PSF/MRET)	**7.2**	**(7.2)**	**(14.4)**
Other:			
Cost efficiency	17.3	14.2	(3.1)

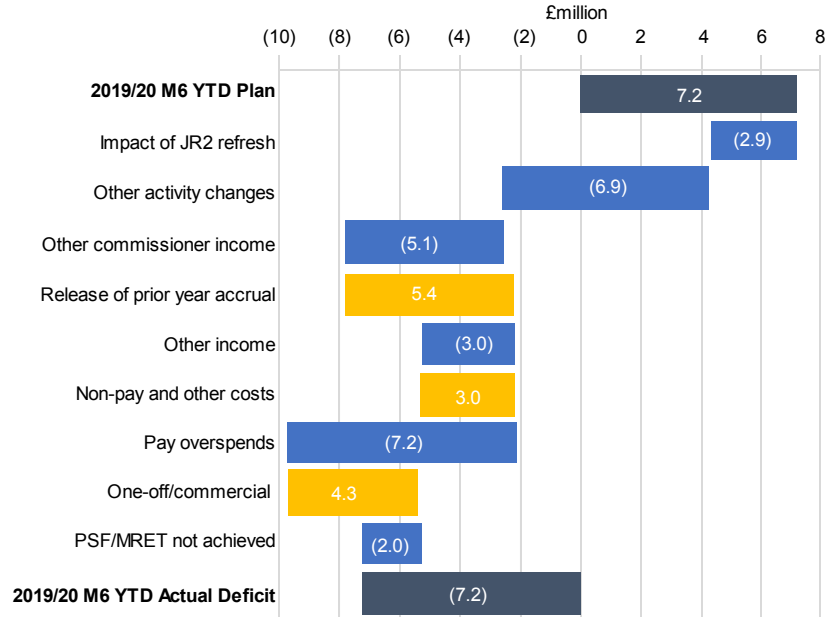
Source: 1. OUH Month 6 Finance Report 2. M6 NHSE/I financial return

Table 19: Divisional overview to month 6 (September 2019)

£ million	Plan	Actual	Variance
CCS	(6.1)	(8.3)	(2.2)
MRC	29.9	25.5	(4.3)
NotSSCaN	32.9	26.1	(6.8)
SuWOn	33.5	27.1	(6.4)
Total Clinical Divisions	**90.1**	**70.4**	**(19.7)**
Corporate	(90.5)	(93.1)	(2.7)
R&D	0.0	0.0	0.0
Central & Technical	21.9	26.6	4.7
Underlying EBITDA	**21.6**	**3.9**	**(17.7)**

Source: OUH Month 6 Finance Report

Chart 17: Bridge M6 YTD 2019/20 Plan (Inc PSF/MRET) to M6 YTD F2019/20 actual outturn



Source: OUH Month 6 Finance Report

Note: 1. At month 6 the Trust was reporting delivery of £14.2m operational cost efficiency savings against its M6 YTD target of £17.3m. This under-delivery is primarily reflected in the pay cost overspends. 2. The 2019/20 actual £11.9m deficit includes £0.8m PSF income relating to 2018/19.

Commissioning Income

The impact of theatre closures was more significant than planned reducing elective activity and income by £2.9m, with the impact more significant for the NOTTSSCaN (£1.8m) and MRC Divisions (£0.8m).

The recovery in theatre activity levels following the completion of the JR2 theatre refresh work was not as quick as expected. Increases in activity were not matched by equal increases in income with reductions in complex elective volumes reported, offset by less complex volumes. Based on discussions with management we understand there were challenges in identifying the root cause of the slower than planned recovery, increasing operational and financial risk.

Elective activity was also impacted by the loss of workforce capacity caused by anaesthetists cutting back additional sessions (due to tax disincentives following the changes in pension contribution rules) and the impact of sickness absence. Based on discussions with management, circa 10-15% of theatre capacity was being created through additional sessions, which was unavailable to deliver planned elective activity. Increases in non-elective activity against plan and compared to 2018/19 also impacted on elective capacity.

As shown in Table 20, elective activity was 3.2% worse than plan at Month 6, having been 3.8% worse than plan in months 4 and 5. Elective income was 5.4% (£4.8m) worse than plan, with this being a key element of the significant underperformance in the specialised commissioning NHSE contract. At Month 6 the impact of changes in activity, including reductions in complex elective volumes, was £6.9m underperformance against plan.

Other commissioning income was £5.1m worse than plan at month 6, driven by:

- Impact of urgent care blended payment (£1.3m)
- £2.0m income shortfall due to pass through drugs
- £0.5m contract penalties
- £1.3m other non-activity related items.

Offsetting the underperformance on commissioning income was the release of £5.4m 2018/19 income accrual.

Table 20: Activity by point of delivery – YTD at Month 6 2019/20

	Plan	Actual	Variance	Variance %
A&E	79,318	81,992	2,674	3.4%
Day Case	40,297	40,313	16	0.0%
Elective	10,637	10,298	(339)	(3.2%)
Non-elective	46,493	47,379	886	1.9%
Outpatient	357,987	361,791	3,804	1.1%
Outpatient procedures	62,704	53,453	(9,251)	(14.8%)
Total commissioning activity	**597,436**	**595,226**	**(2,210)**	**(0.4%)**

Source: OUH Month 6 Finance Report

Table 21: Income by point of delivery and commissioner – YTD at Month 6 2019/20

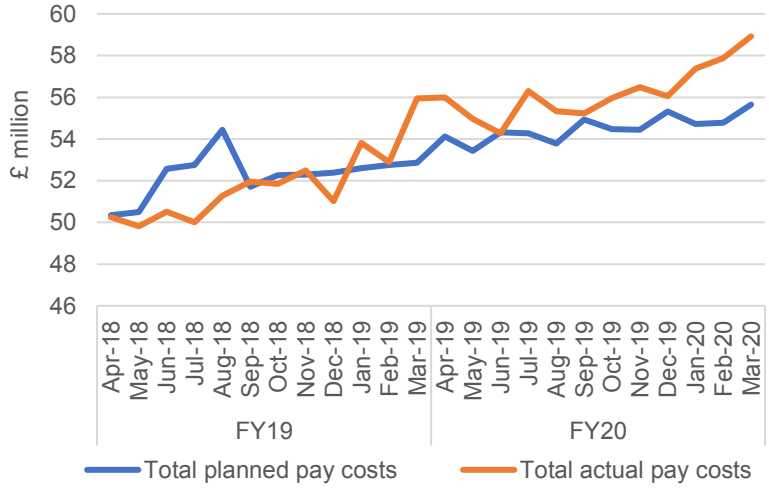
£ million	Plan	Actual	Variance	Variance %
Elective	88.0	83.2	(4.8)	(5.4%)
Non-elective	120.3	121.4	1.1	0.9%
Outpatient	71.5	69.8	(1.7)	-2.4%
Pass-through	69.0	67.6	(1.4)	-2.1%
Other	112.8	110.1	(2.6)	-2.3%
Total commissioning income	**461.6**	**452.2**	**(9.4)**	**-2.0%**
Split by Commissioner:				
NHSE Wessex Contract	210.0	197.5	(12.5)	-5.9%
NHS Oxfordshire CCG	185.8	182.4	(3.4)	-1.8%
Other Commissioners	66.1	65.0	(1.1)	-1.7%
Central adjustments	(0.2)	7.3	7.6	
Total commissioning income	**461.6**	**452.2**	**(9.4)**	**-2.0%**

Source: OUH Month 6 Finance Report

Note: At Month 6 actual elective income per activity (as shown in tables 19 and 20) was £8,100, compared to £2,600 for non-elective activity. The higher value of each unit of elective activity has a greater impact on income than changes in other types of activity.

Pay Cost Overspends

Chart 18: Monthly total pay costs April 2018 to March 2020



Source: Management working - OUH M12 Finance Reporting Pack

Note: Cost of employer's pension uplift £24.7m, covid costs of £2.9m and £2.6m increase in annual leave accrual have been excluded from March 2020.

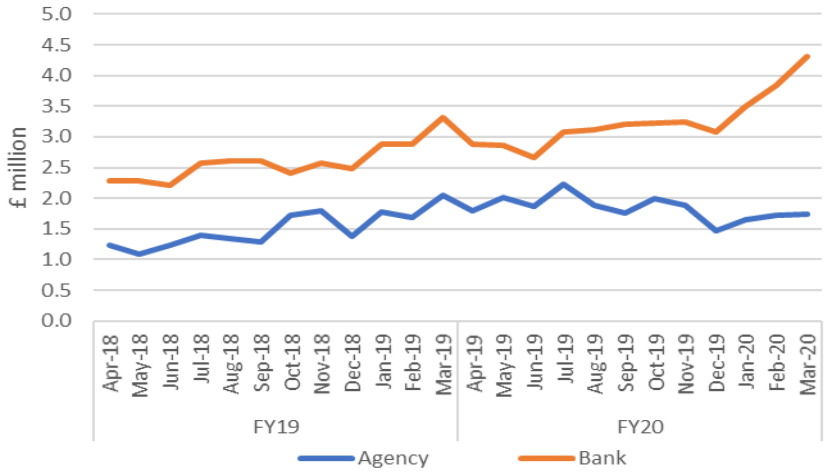
The 2019/20 plan assumed substantive pay cost growth of 4.4%, with significant decreases in agency costs (40%) and bank costs (21%). Pay costs increased each quarter over the period April 2018 to March 2019 and this continued into 2019/20, with quarter 1 and 2 2019/20 total pay costs growing 1.6% and 1% respectively. The £7.2m pay cost variance against plan at Month 6 was reflected in adverse total pay variances across all Divisions and all staff groups apart from the STT staff (£0.7m favourable variances at month 6). At Month 6 substantive pay and temporary pay costs had increased by 7.5% and 33% respectively compared to the same period in 2018/19.

A number of factors contributed to higher pay costs in 2019/20 but based on discussions with management overall there was a lack of robust workforce

planning and pay cost controls in place to keep costs within budget. In particular from our review of Trust documentation and discussions with stakeholders, we understand the controls over the booking and use of bank and agency staff were not effective. Pay areas overspending at Month 6 included:

- Higher premium cost temporary staff were required to keep as much theatre capacity open as possible, and an inability to re-deploy staff impacted by the JR2 theatres work.
- Temporary staff to maintain capacity in areas with vacancy gaps (for example Chemotherapy, Churchill Theatres, Radiology).
- Substantive recruitment to meet safe care standards and which did not necessarily result in increased activity.

Chart 19: Monthly temporary pay costs April 2018 to March 2020



Source: Management working - OUH M12 Finance Reporting Pack

Cost efficiency and one-off items

As noted earlier, the Trust identified a £60m efficiency requirement as part of the 2019/20 planning process which was to be achieved through £35m operational efficiency and £25m one-off/commercial transactions. At M6 the Trust was reporting delivery of £14.2m operational cost efficiency savings against a year-to-date target of £17.3m, which was a key driver of the variance from plan at M6. The YTD performance included £4.3m unplanned one-off benefits from the commercial programme relating to the NHS Blood and Transplant lease revaluation (£3.7m) and release of a PFI risk provision (£0.6m).

Management's M6 Forecast

Excluding non-recurrent items and one-off/commercial items, the M5 YTD deficit was £23.5m including PSF and MRET. As a result of the year-to-date financial performance and in line with approach taken in previous years, the Trust started a review of the forecast outturn at Division and Board level in M5.

The process to review the forecast outturn and the risk of delivery against the 2019/20 plan undertaken with Divisions in M5 failed to identify significant financial improvement compared to the YTD run-rate position. Based on our discussions with Divisions, there was also a perception that commercial/one-off opportunities would be identified to deliver the year end position, as had happened in 2018/19, rather than there needing to be a significant focus on improving the underlying YTD run-rates. This created an expectation and focus on non-recurrent opportunities to deliver financial plans.

As a result, a top-down reforecast was undertaken using high level assumptions and this approach and the resultant revised year end surplus target of £8.5m was approved by the Trust Board at the beginning of October 2019.

Table 22 sets out the high-level approach undertaken to the M6 forecast which was based on:

- Extrapolation of the actual M5 YTD run-rate, adjusted for non-recurrent items in the YTD and planned before year end, for example, release of prior year income accruals and commercial one-off items.
- Mitigations to improve the run-rate in the second half of the year comprising, £1m saving from premium staff cost controls, £6m benefit from the year-end agreement with NHSE Specialised Commissioning and £10m additional commercial opportunities.

Table 22: Approach to M6 reforecast

Ref.	Item	£m	Comment
A	M5 YTD Deficit	(17.5)	Excludes PSF/MRET and one-off items
B	Non-recurrent items in M5 YTD	(6.6)	Remove NR items
C	M5 YTD underlying deficit (A+B)	(24.1)	
D	Monthly underlying deficit to date (C/5)	(4.8)	
E	Sept 19 to Apr 20 run rate (Dx7)	(33.7)	Remaining 7 months of 2019/20 at same run rate as M5 YTD
F	Full year underlying deficit (A+E)	(51.2)	Excludes PSF/MRET and one-off items
G	One-off/commercial items	30.0	£10m increase from £20m in 2019/20 plan
H	Mitigations and NR items	10.8	Includes £6m specialist commissioning, £3m OCCG overperformance & £1m agency pay reduction
I	PSF & MRET	18.9	
	M6 forecast – Full Year Surplus	**8.5**	

Source: Management information

Note 1. The £8.5m full year surplus includes £0.8m PSF income relating to 2018/19.

The Trust was proactive in formally reforecasting at M6 2019/20, with Board approval for the revised target agreed before the quarter 2 submission of financial performance to NHSE/I. The Trust reported performance against the M6 forecast from Month 7 reporting. In our view, setting a revised year-end target at a relatively early stage in the year was an appropriate response given the year-to-date performance and risk to non-delivery of 2019/20 plan. However, we would have expected the Board to challenge Divisions more and agree improvements in the current run-rate.

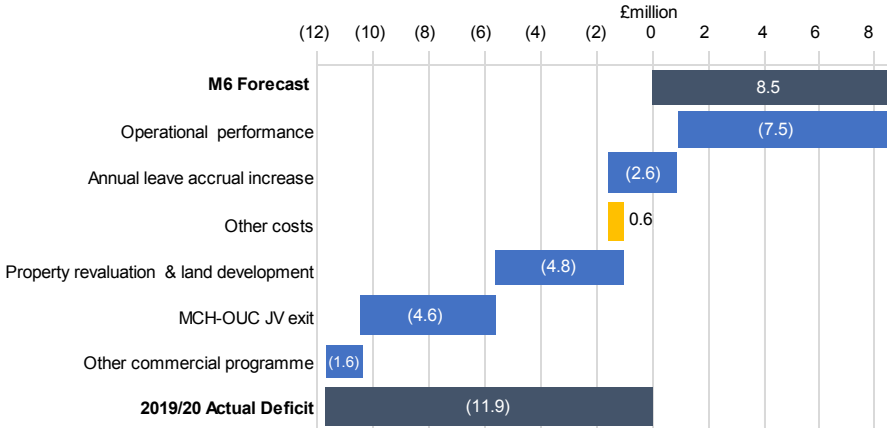
Year-end performance against M6 forecast

Table 23: Trust financial performance in 2019/20

£ million	Plan	Actual	Variance
Commissioning income	913.7	914.6	0.8
Other income	157.9	203.0	45.2
Total Income	**1,071.6**	**1,117.6**	**46.0**
Pay	(661.9)	(705.0)	(43.1)
Non pay	(397.2)	(410.1)	(12.9)
Underlying EBITDA	**12.5**	**2.5**	**(10.0)**
Other costs	(52.9)	(52.4)	0.6
One-off items	30.0	19.0	(11.0)
Surplus/(deficit) (Exc.PSF/MRET)	**(10.4)**	**(30.9)**	**(20.5)**
PSF/MRET	18.9	18.9	(0.0)
Surplus/(deficit) (Inc. PSF/MRET)	8.5	(11.9)	(20.5)
Other:			
Cost efficiency	60.0	45.0	(15.0)

Source: 1. OUH Month 12 IPR Report 2. M12 NHSE/I financial return

Chart 20: Bridge from M6 forecast 2019/20 control total (inc. PSF/MRET) to actual



Source: OUH Month 12 IPR Report and Management Information

Operational performance

As shown in the table above, the Trust was £10m worse than forecast at the underlying EBITDA level at the year end. £2.6m of this related to an increase in the annual leave accrual due to the impact of Covid in March 2020. The remaining £7.5m related to a number of different income, pay and non-pay variances.

Excluding the impact of costs offset by funding in other income, for example the cost of employer's pension uplift (£24.7m), covid costs (£2.9m) R&D costs (£6.6m) and the increase in the annual leave accrual, pay costs were £6.4m above the forecast at the yearend.

The pay cost overspends in H1 continued into H2, with a lack of robust pay cost controls in place to keep costs within the forecast. The pay overspend against forecast predominantly related to the higher cost of temporary staffing to maintain capacity and deliver the activity increases seen in the second half of 2019/20. Excluding £27.7m of pensions and Covid costs in March 2020, total pay costs increased by £55.5m or 9% in 2019/20 (8% substantive, 24% temporary), with all staff groups seeing at least a 5% growth in costs compared to 2018/19. The increases are also reflected in the WTE data as shown in Table 24. Over this period, key workforce indicators moved as set out in Table 25. We note that the growth in substantive staff reduced the Trust vacancy rate from 8.1% in March 2019 to 5.8% at March 2020.

Table 24: WTE at year end (Trust Total)

WTE	2018/19	2019/20	Variance	Variance %
Actual staff in post	10,938	11,707	769	7.0%
Temporary staff	1,000	1,132	132	13.2%
Total staff	**11,938**	**12,839**	**901**	**7.5%**

Source: OUH Workforce dashboard March 2019 and March 2020

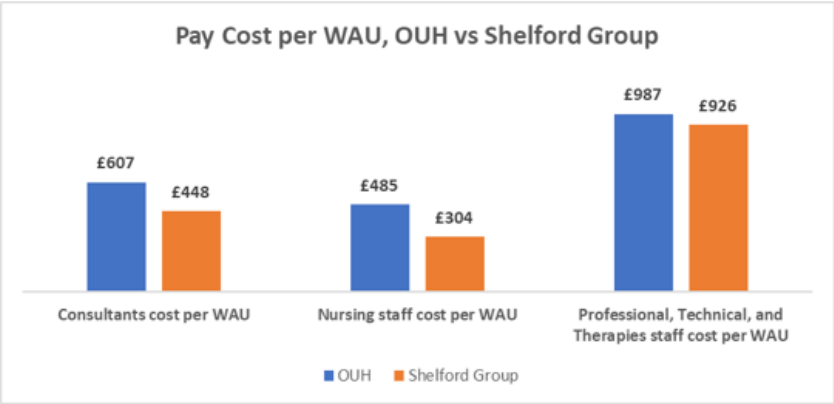
Table 25: Workforce KPIs (Trust Total)

	2018/19	2019/20
Turnover	13.8%	12.7%
Vacancy Rate	8.1%	5.8%
Sickness	3.2%	3.5%

Source: OUH Workforce dashboard March 2019 and March 2020

The updated 2019/20 Model Hospital analysis (released in May 2021) supports conclusions that the Trust has higher pay costs per WAU for key staff groups, in particular medical and nursing costs, compared to its Shelford Group peers (Chart 21), Overall pay costs per WAU for the Trust were however lower (£2,218) than its peers (£2,558).This is likely due to the extent of services the Trust procures via its PFI contract (e.g., portering and other soft facilities management), compared to the peer group and is reflected in the higher non-pay costs per WAU for the Trust (£1,397) compared to its peers (£1,111).

Chart 21: 2019/20 cost per weighed activity unit (WAU) breakdown



Source: OUH Model Hospital Analysis 2019/20

Commissioning income was £0.8m better than forecast at the yearend (Table 26). Year-end agreements were reached in respect of the NHS Wessex Contract and NHS Oxfordshire CCG contract in line with the figures included in the table above. The year-end agreement with Oxfordshire CCG was £5.4m above the M6 forecast.

Increases in urgent care activity, particularly in the final quarter of 2019/20, resulted in actual activity being £8.4m above the Oxfordshire CCG contract plan, but the blended payment adjustment adjusts this down by £6.4m. The higher urgent care activity was delivered through higher pay and non-pay costs.

Table 26: 2019/20 income by point of delivery and commissioner

£ million	Plan	Actual	Variance	
Elective	167.0	168.9	1.9	1.1%
Non-Elective and Births	241.3	248.9	7.6	3.1%
Outpatient	141.5	140.8	(0.7)	(0.5%)
Pass through Drugs and Devices	137.0	142.7	5.7	4.1%
A&E	26.9	27.0	0.1	0.3%
Critical Care	53.0	55.1	2.1	4.0%
Diagnostics	39.3	39.1	(0.3)	(0.7%)
Other	107.7	92.2	(15.5)	(14.4%)
Total commissioning income	**913.7**	**914.6**	**0.8**	**0.1%**
Split by commissioner:				
NHSE Wessex Contract	399.8	407.0	7.2	1.8%
NHS Oxfordshire CCG	364.5	369.9	5.4	1.5%
Other Commissioners	129.1	129.7	0.6	0.5%
Central adjustments	20.4	8.0	(12.3)	
Total commissioning income	**913.7**	**914.6**	**0.8**	**0.1%**

Source: OUH Month 12 IPR Report

Non-pay variances from forecast are driven by year end increases in costs, predominantly relating to IM&T and estates costs and which were unplanned and in part driven by the Trust leadership changes as noted earlier. Additional IM&T costs (£2.0m) related to costs associated with Microsoft Windows 10 migration and costs to meet the compliance requirements of the Healthcare Information and Management Systems Society (HIMSS) level 6. These costs were identified after the Chief Digital and Partnerships Officer joined the Trust in October 2019. Estates cost overspends related to a combination of increased spend at year end to resolve maintenance issues (£1.0m) and additional PFI accrual costs (£1.7m).

Table 27: Commercial/one-off items performance in 2019/20

£ million	Plan	Actual	Variance	Forecast	Actual	Variance
Investment properties & land development activities	19.0	22.3	3.3	26.0	22.3	(3.7)
PFI	2.0	0.0	(2.0)	1.0	0.0	(1.0)
Private patients	3.0	1.3	(1.7)	2.5	1.3	(1.2)
MCH-OUC JV	0.0	(4.6)	(4.6)	0.0	(4.6)	(4.6)
Other	1.0	0.0	(1.0)	0.5	0.0	(0.5)
Contingency	(5.0)	0.0	5.0	0.0	0.0	0.0
Total commercial/one-off	**20.0**	**19.0**	**(1.0)**	**30.0**	**19.0**	**(11.0)**

Source: Management information

The two main drivers of the £11.0m under-performance against the £30m M6 forecast related to:

- £4.6m accumulated losses arising from the Trust's exit from the Joint Venture (JV) with the Mayo Clinic and University of Oxford, which had established a private patient clinic in London in 2019. The clinic had performed below plan since opening and required additional financial support from the JV partners. Turning it around required further financial investment which the Trust was not prepared to make, and so the decision was made late in 2019/20 to exit the agreement.
- £4.8m from the decision to delay the project to develop a care home on surplus land with a third party (Project Indiana). The Trust was in discussions with NHSE/I as part of the development of the business case for the project, planning for the financial benefit to be recognised in 2019/20. The decision by the Trust to delay Project Indiana beyond 2019/20 was driven by the need to consider lessons to be learned from the Mayo Clinic JV experience, to undertake further work to progress the solution for car parking decant on the site and due to staff resourcing pressures.

Underlying financial position exiting 2019/20

As set out in Table 4 earlier, the Trust's underlying deficit has deteriorated from £23.2m in 2015/16 to £39.5m in 2018/19. Management have calculated that the underlying deficit further deteriorated to £45m in 2019/20 as set out in Table 28.

Table 28: Underlying financial position – adjustment for non-recurrent items

Item Ref:		£m
	2019/20 Actual Deficit (Inc. PSF/MRET)	(11.9)
	Operating adjustments	
A	Release of 2018/19 income provision	(5.8)
B	FYE of income and cost changes incurred part-year in 2019/20	(5.1)
C	Other non-recurrent income and cost adjustments	(4.2)
D	Increase in annual leave accrual	2.3
	Other adjustments	
E	Movement in fair value of investment properties and other investments	(10.4)
F	Share of profit of associate/joint ventures	(11.6)
G	PSF funding	(2.9)
H	Other losses on disposal of assets (Mayo JV)	4.6
	2019/20 Underlying Deficit	**(45.0)**

Source: Management information Note: Commercial/one-off items are included as items E, F, H and with the private patients' one-off benefit (£1.3m) included in item C in the above table.

As in previous years, the reported deficit in 2019/20 was supported by significant non-recurrent items, including:

- A net £19m of commercial/one-off items as set out in Table 27. The transactions delivered in 2019/20 were offset by the £4.6m accumulated losses arising from the Trust's JV exit.
- £5.8m benefit from the release of 2018/19 income provision in H1
- £5.1m recurrent full year impact from income and costs incurred partway in 2019/20
- A net £4.2m of other non-recurrent costs and income adjustments. This includes accruals, impact of commissioner yearend agreements, one-off private patient benefits and CNST rebate.

Based on the work we have undertaken, the £45m deficit represents a reasonable estimate of the underlying position of the Trust at the end of 2019/20.

Financial governance

Reporting to Executive Committees and the Board

Overview of the Trust's governance structures

The Trust's main groups and committees with financial monitoring and oversight responsibilities during 2019/20, are set out in Table 29 below:

Table 29: Overview of groups/committees

Group/ Committee	Meeting frequency	Members	Overview of responsibilities	Summary of key reports received in 2019/20
Trust Board	Six times per year	All Executive Directors and all NEDs	• Ensuring financial stewardship • Monitoring of Trust performance, including financial performance, and ensure corrective action is taken • Setting strategic direction, define objectives and agree/approve plans for the Trust	• Updates on 2019/20 plan submission • Draft Trust business plan 2019/20 • Financial performance reports/IPRs for even months of the year • Overview of the M6 reforecast
Trust Management Executive	Monthly	All Executive Directors All Divisional Directors Head of Corporate Governance Head of Communications	• Development and agreement of the annual business plan and detailed capital and revenue plans • Identification and mitigation of risk through Corporate Risk Register (CRR) and the Board Assurance Framework (BAF) • Development and agreement of efficiency, effectiveness and quality plans • Monitoring of delivery of financial objectives • Monitoring delivery of actions agreed by the Board, by the TME and by the sub-committees	• Draft Business Plan updates • Ongoing updates on the JR2 theatre refresh • Financial performance reports/IPRs (for information only) • Overview of the reforecast process
Finance and Performance Committee (FPC)(dissolved	Six times per year	Five NEDs Chief Executive CFO	• Reviewing the integrated performance of the Trust • Monitoring the effectiveness of the Trust's financial and operational performance.	• Draft Business Plan • Approach to 2019/20 budget setting • Contracting arrangements for 2019/20

Group/ Committee	Meeting frequency	Members	Overview of responsibilities	Summary of key reports received in 2019/20
as of February 2020)		Chief Medical Officer Chief Nursing Officer COO	• Monitoring the performance of the Trust's physical estate and non-clinical services. • Designing, developing, delivering, managing and monitoring the Medium-Term Financial Model and the Long-Term Financial Model • Reviewing the in-year delivery of annual efficiency savings programmes	• Update on Divisional budgets • Ongoing updates on the JR2 theatre refresh • Overview of quarterly Divisional performance reviews • Financial performance reports / IPRs for odd months of the year
Integrated Assurance Committee (replaced the FPC from March 2020)	Six times per year	All NEDs CEO CMO Chief Nursing Officer CFO Chief Assurance Officer Chief Digital and Partnerships Officer Chief People Officer All Divisional Directors	• Monitoring the development and delivery of the Trust's annual financial plan. • Monitoring the development and delivery of the Trust's strategy for medium term financial sustainability and ensure adequate clinical involvement. • Monitoring the effectiveness of the Trust's financial and operational performance reporting systems. • Considering any relevant risks and mitigations within the BAF and CRR	• IPRs for odd months of the year • Overview of quarterly Divisional performance reviews
Investment Committee	Six times per year	Four NEDs CFO CMO Chief Assurance Officer	• Reviewing the Trust's approach to making, financing and monitoring investments. • Reviewing capital cases including leases and asset disposals. • Reviewing progress made in implementing larger or higher profile investment cases.	• Trust capital performance reports • Updates on commercial transactions • Updates on the status of the Mayo Healthcare Clinic-OUH JV

To provide better governance and overview of performance of the Trust, the Quality and the Finance and Performance Committees were merged into a single Integrated Assurance Committee (IAC) in February/March 2020. Unlike the FPC, the IAC membership includes the four operational Divisional Directors.

Based on the work undertaken and our observations from elsewhere, we consider the governance structures in place to oversee financial performance appropriate and commensurate with the size of the organisation.

Financial reporting and governance for 2019/20 planning

From our review of committee and Trust Board papers, we note that financial planning was prominent at both FPC and Trust Board meetings coming into 2019/20. This involved descriptions of the process, multiple presentations of the draft plan and obtaining formal approval from the Trust Board for the plan to be submitted.

The reports presented to the FPC and the Trust Board in relation to the plan highlighted the key assumptions and risks to delivery. It is our view that the key assumptions were made clear to the Trust Board and senior management when approving the plan.

From our discussions with Board members, we note that Executives and NEDs felt informed of the financial performance and risks to delivery of the plan both at planning stage and during the year. This is also evidenced in Board and Committee meeting minutes.

Based on the work we have undertaken, we consider financial reporting and governance at planning stage to have been appropriate, as it highlighted relevant key assumptions, risks and issues. As noted earlier, the Trust had a £60m efficiency requirement in 2019/20 which was to be met with £35m in productivity and cost control and £25m in one-off/commercial items. Given the limited progress made coming into 2019/20 and in Q1 to develop worked up plans to support delivery of these targets, we would have expected more detailed reporting to FPC and Board on the progress with these plans and the risk of non-delivery. A detailed breakdown does not appear to have been shared with FPC until June 2019 as part of an update on progress with agreeing Divisional budgets. This also highlighted that there were outstanding risks to Divisional budgets and efficiency savings either not yet identified or at risk across all Divisions.

In-year financial reporting

Frequency of reporting and level of challenge

The table below sets out the dates in 20192/0 that financial performance was reported to the Trust Board and the FPC:

Table 30: Reporting of financial performance

Month	FPC/IAC	Trust Board
M1 – Apr 19	12 Jun 19	-
M2 – May 19	-	10 Jul 19
M3 – Jun 19	14 Aug 19	-
M4 – Jul 19	-	11 Sep 19[6]
M5 – Aug 19[7]	-	-
M6 – Sep 19	-	13 Nov 19
M7 – Oct 19	11 Dec 19	-
M8 – Nov 19	-	15 Jan 20
M9 – Dec 19	12 Feb 20	-
M10 – Jan 20	-	11 Mar 20
M11 – Feb 20	08 April 20	-
M12 – Mar 20	-	13 May 20

[6] *First time as part of an integrated performance report*

[7] *Both the FPC and the Trust Board were cancelled in M5. The financial position was instead reported to the TME on 26 September 2019.*

The staggered frequency of FPC (and IAC from 2020) and Trust Board meetings mean that performance was being reported to the FPC/IAC or the Trust Board monthly. During the Trust Board meetings, the Board regularly received an FPC/IAC update report, setting out the discussion that took place regarding prior month performance.

From our review of meeting minutes and conversations with Board members, we note that the Trust NEDs were questioning at Board and FPC the deterioration of financial position from M2 onwards. The NEDs also requested additional analysis and deep dives to understand the causes of the variance from plan.

Meeting minutes from each FPC/IAC meeting in 2019/20 also indicate that discussions around financial performance were taking place, and attempts taken to understand the key drivers behind the adverse variance against plan.

Our key observations on financial reporting relate to the understanding of the drivers of the variance from plan, including the availability of data to track performance, action tracking and reporting of the commercial programme:

- The JR2 theatre refresh took place in H1 and contributed to the lower levels of activity against plan in this period. However, the focus on the JR2 theatre refresh masked other causes of lower levels of activity and higher pay costs in H1, for example lack of anaesthetist capacity. These other causes were not clearly visible in the reporting of performance to the Board as management struggled to identify or quantify the impact of some of these issues. There appears to not have been a clear line of sight from Board to Divisions to Directorates to help understand the drivers of financial performance. Based on discussions we understand wider issues reporting of operational information and triangulation of this with workforce and finance data may have contributed to the lack of Board visibility.
- We note regular action tracking in the TME meetings during 2019/20 but the tracking of actions to understand and improve financial performance across other committees appears to have been less robust. For example, meeting minutes of the August 2019 FPC evidence a request for the September report to provide clarity on the impact of activity casemix changes in theatres and what actions were being taken. We reviewed the papers and meeting minutes of the September Board 2019 Board and did not observe evidence of this being followed up. We note the Trust commissioned an external review of clinical coding and case mix which reported in November 2019, with the findings reported to Executives but not to the wider Board members.
- Detailed reporting in relation to the Trust's commercial programme was presented to the Investment Committee in 2019/20 and reported by the Committee to the Board. There was limited or no commentary in the monthly finance report. Given the importance of delivering the one-off commercial transactions in order to achieve the 2019/20 financial plan, we would have expected more information and updates on delivery against the commercial transactions plan to the FPC and via that route to the Board.

Financial performance reports

Until month 4 of 2019/20, the financial performance of the Trust was reported in a standalone Financial Performance report to the Trust Board and FPC. The report included a summary I&E position against plan, underlying EBITDA performance, key pay, non-pay and income variances, as well as a balance sheet and cashflow position, with commentary supporting the tables and analysis. Taken in isolation, we consider the tables presented in the finance reports to be sufficient for the Committees and the Board to scrutinise performance, although we would have expected additional commentary and analysis on the key drivers behind the variance from plan in year.

Based on discussions with Trust stakeholders, we understand that integration and triangulation of demand and capacity, workforce and financial data had been identified a weakness in the Trust's reporting for a number of years. This, alongside implementation of recommendations from the external Well-Led review, resulted in the Trust reviewing and changing its reporting arrangements in 2019/20. The format of financial reporting changed to align with the IPR in M4 and was fully integrated into a single IPR document at M9. The IPR was refined and further developed in 2019/20, for example, through the inclusion of an Executive Summary. The development of the IPR in 2019/20 created a single document bringing together key performance information covering quality, operational performance, workforce and finance.

The finance section of the IPR contained similar content to the standalone financial report produced earlier in 2019/20. It included the Trust's summary financial position against the control total, I&E analysis by subjective, income split by point of delivery and commissioner, cash and capital position. There was also an increased focus on pay costs, with additional overall run rate analysis and temporary staffing run rate. The IPR presented to the IAC from March 2020 included all of the above, but with the addition of Divisional summary financial positions.

The IPR was improved during 2019/20, but the version at the end of the year included a significant amount of detail across each of the 4 areas: operational performance, quality, workforce and finance. In our view, there was too much information and insufficient analysis in the report. There was also a lack of standardisation in the presentation and format of data, for example in the use of tables and charts. This meant it was hard to identify the main messages and issues in relation to financial performance and how these were impacted by operational factors. It was also noted that actions identified in the report were often not time bound.

Reporting of cost efficiencies and productivity initiatives

As noted earlier, in 2019/20 there was a cost efficiency programme in place, which included a mix of cost avoidance and productivity cost savings. Based on our discussions there was a significant difference between the Executive team and Divisional managers in their understanding and allocation of responsibility in relation to the delivery of the cost efficiency programme. Discussions with Divisional staff indicated that they considered the programme to be equivalent to a traditional Cost Improvement Programme.

We understand from our discussions that corporate cost avoidance programmes (predominantly related to procurement and drug spend) were underpinned by supporting analysis and were tracked throughout the year. Divisional efficiency and productivity programmes were not tracked or reported throughout the year, either at Divisional or Committee/Board level. We note that Board and IAC IPRs had consistent references to non-delivery of productivity improvements as one of the key cost variances; however, there was no detailed analysis of which initiatives were not being delivered, who was responsible and how remedial action would be taken. Conversations with Divisional staff have also indicated that there was a degree of uncertainty about how the Trust-wide efficiency target was agreed, and how it was allocated down to Divisions, Directorates and below. Many also commented that they would have benefitted from a more open dialogue with the Executive team around the method of allocation of the targets to each Division, and how this was going to be closed.

The cost efficiency exercise was perceived as corporately owned and not deliverable on the scale that was agreed in the plan. This ultimately resulted in £15m worth of efficiencies not being delivered in year,

On the other hand, most individuals we interviewed could articulate the Trust's Integrated Improvement Programme (IIP) in 2019/20, including its workstreams and the progress made in delivering each workstream. Staff were positive about their role in delivering the outcomes and referenced specific improvements that had been achieved. However, the financial implications expected to arise from each of the IIP workstreams were not quantified and tracked. For example, the Urgent Care workstream included a project to reduce the number of patients with an extended Length of Stay (LoS). Based on our experience with similar programmes at other Trusts we would expect the financial benefit arising from the reduced LoS to be quantified and monitored alongside the project's operational KPIs.

Risk identification and management

As mentioned in the planning section, our view is that at Board and Committee level the identification of risks to delivery of the financial plan was clear and key risks were well-understood. However, ongoing risk management in 2019/20 had been identified by the Trust as an area of weakness in its financial governance. This is supported by our observations, interviews and review of papers, and is reflected in the challenges experienced by the Trust in reducing its underlying run-rate in 2019/20.

At the beginning of 2019/20, the Corporate Risk Register (CRR) included three financial risks:

- Failure to deliver the in-year financial plan and NHSE/I Financial Control total plan

- Risk of not hitting financial targets or operational trajectories to access STP funding
- Inability to deliver sustainable level of EBITDA over 3-5 years

The CRR set out an overview of the key controls in place to manage the three risks collectively, e.g., 'centralisation of controls over discretionary spending', however, it did not outline the main drivers behind each financial risk, which may have made it more difficult to implement effective mitigations. For example, we would have expected management of pay costs and delivery of the specialist commissioning income plan to have been highlighted as critical to mitigate the risks.

Reporting and performance management at Divisional level and below

Overview of Divisional governance structures

Divisional governance and performance structures attended by executive directors in place in 2019/20 are set out in Table 31.

Table 31: Divisional governance arrangements

Forum	Meeting frequency	Members	Overview of responsibilities
Performance Management Reviews – Quarterly	Quarterly	All Executive Directors **From Divisional teams:** Divisional Director Divisional General Manager Divisional Nurse Divisional Medical Director	• Monitor and review performance of the Trust's clinical Divisions against their business plan and in delivering the NHS constitutional standards. • Review the Divisional risk register against which to evaluate and improve performance. • Review performance on a regular cycle, provide challenge, get to root cause, request action and follow up where performance falls short of expectation.
Performance Management Reviews - Monthly	Monthly	Chief Financial Officer Chief Operating Officer CMO or Chief Nursing Officer Deputy Medical Director (Quality) or head of Clinical Governance Divisional Team Finance Business Partner HR Business Partner	• As for quarterly, but with a focus on immediate Trust and Divisional priorities and performance concerns, especially quality and productivity.

Within each Division, Divisional Business Management Meetings and Directorate Performance Reviews with the Divisional and Directorate management teams happened on a monthly basis in 2019/20.

Discussions with Board members and Divisional staff indicate that in 2019/20, the performance management arrangements at Divisional level were underdeveloped. There was a lack of formalised structure to the performance

meetings. Whilst Quarterly performance meetings were mandatory for the Executive team and chaired by the CEO, monthly meetings were not – although from discussions we understand that they were attended by a range of Executives which changed from month to month. Based on our discussions, there was, at times, lack of clarity about the agenda for each meeting, what Divisions wanted or needed from the Executive team, and what the Executive team wanted to focus on in any particular meeting.

There was no standard format for reviews across Divisions. Information was produced within each Division, which did not allow for effective challenge, nor for comparison across Divisions. In particular in relation to Finance, multiple stakeholders represented that discussion of some financial issues happened with Finance Business Partners outside of the performance review meetings, rather than in discussions at the performance meeting.

Similarly, there was no consistency in monthly performance reporting across Divisions in 2019/20 – including the format, content and risk management/mitigations. From our review of Divisional finance reports we have observed different levels of detail from Division to Division and quarter to quarter. In particular, the CSS review pack differed significantly from those produced in other Divisions.

Whilst there were attempts to outline interdependencies between activity, workforce and finance, the three parts of the reporting often appeared standalone and difficult to triangulate. From discussions with Divisional staff, we understand that, in most instances, they were produced separately by Ops / HR / Finance and combined into a single report.

Monthly performance reviews typically lasted one hour, with the agenda skewed towards quality and safety issues. They therefore did not provide sufficient time for a comprehensive review of Divisional financial performance. In addition, based on our discussions financial risks were not regularly reviewed by Divisional staff or the Corporate staff at Divisional level.

As part of our work, we reviewed the financial reports and management information received by budget managers outside of the monthly performance review cycle.

These reports and budget statements were Excel-based, outlining the key positive and negative variances and allowing drill down to subjective codes. Budget managers we interviewed commented on the usefulness of the drill down options in identifying, for example, payroll issues where a consultant was not taken off payroll in a timely manner. In our view, the financial information available to staff with budget management responsibilities on an ongoing basis was in line with what we would expect to see.

Divisional engagement

Based on our discussions we have noted varying levels of engagement and buy in from Divisional staff into the financial governance and performance management processes. A number of Divisional staff interviewed highlighted the issues around quality and safety that came to light in 2018/19 relating to the findings from the CQC inspection at the end of 2018. Many connected the organisational focus on rectifying these issues as one of the main drivers behind a less tight grip on financial position. Overall perception that the Trust would be able to recover the financial position through one-off transactions contributed to this.

A significant proportion of Divisional staff we interviewed perceived the 2019/20 budget-setting process as having been top-down and thus resulting in what they deem to be unreasonable expectations in relation to activity growth and workforce required to deliver it. The outcomes of the budget manager survey we conducted (discussed further in the report) support this view.

Divisional staff interviewed also consistently highlighted that, as activity, workforce and finance planning happened separately from each other in 2019/20, they were often faced with a choice to either deliver the activity growth via use of agency, or manage the pay spend by reducing service provision. A third option of improving productivity to deliver the same objective was not consistently highlighted in our interviews.

As outlined earlier, budgets for SuWON and NOTTSCaN were not finalised until several months into the year. From our interviews, we heard that this was not uncommon in previous years and was not limited to these two Divisions. We heard consistent feedback that finalisation of budgets part way through the year

restricted the Division's ability to effectively manage the budget from day 1. Delays in agreeing in agreeing contracts with commissioners means that activity plans and subsequent income and expenditure budgets were not updated and shared until they were finalised.

In our discussions with Divisional staff, the higher pay costs and pay variances from plan were largely attributed to vacancies in difficult to recruit services, such as neonatal ICU. These carried vacancies, that made it impossible to safely provide the service without higher cost temporary staff. Based on discussions with Executives, weak pay controls in 2019/20 allowed some services to use the pay budget associated with vacancies to create new posts which were filled, but which did not necessarily stop or replace the need for temporary staffing.

Reporting and communication with system leaders and regulators

There was documented evidence to suggest that NHSE/I were kept up to date and aware of the Trust's deteriorating financial position, in particular following the reforecasting discussions that commenced in month 5.

From discussions with stakeholders, we note that whilst the deterioration of financial position was known, the scale of this deterioration, in particular in Q4, was not. In a letter dated 12 March 2020, the Trust informed NHSE/I of a range of scenarios for the 2019/20 financial outturn, ranging from best case scenario of £7.7m surplus, to the worst-case scenario of a £32m deficit against the reforecast.

The Trust did not provide the perceived probability of each scenario materialising, which may have been beneficial to enable NHSE/I to assess the risk. The final outturn achieved by the Trust (deficit of £20.5m against reforecast) was within the scenario range, but closer to the worst-case scenario than had been expected.

The financial position was regularly monitored and discussed with commissioners and emerging system leadership groups. There was evidence of good collaboration within commissioners through agreeing risk share arrangements to manage activity and financial challenges.

Support from NHSE/I following the reforecast was focussed on delivering the shorter-term gain through delivery of commercial transactions, rather than on root cause analysis of the deteriorating operational run rate.

Current governance, reporting and performance

Current Trust arrangements

Reporting to Executive Committees and the Board

As part of our work, we have also considered the financial governance and reporting arrangements the Trust now has in place and in the context of the shift in focus as a result of the COVID pandemic.

The Board and Trust's main groups and committees with financial monitoring and oversight responsibilities that were implemented during 2019/20 remain in place. The changes to governance and reporting are now more embedded.

As part of our review, we observed a meeting of the TME in March 2021, the IAC in April 2021, and the Trust Board meeting in May 2021. The meetings we observed were chaired well, and there was a good level of discussion and challenge amongst Board members and other participants at the meetings.

Based on these observations and discussions with staff we have noted that the Trust has continued to refine and improve its governance arrangements at Committee and Board level since 2019/20. This includes for example further development of the improvement programme and plans and further updates to the IPR.

Our key comments on the current arrangements are:

- In the meetings we observed and from discussions with Board members we note that there remains opportunity to improve how the financial position of the Trust is analysed and presented in the IPR. There appears to be a recognition that more commentary is needed to explain financial performance, and to comment on the risks highlighted by the financial analysis presented, and we would agree with this. In our view the IPR content remains voluminous, and it is hard to identify the key messages and risks to the Trust achieving its financial objectives.
- The attendance of the Divisional directors at the IAC has enabled better understanding of operational drivers of performance since 2019/20. Feedback we have received is that further work is required to continue improve the 'line of sight' from Board to Divisions to Directorates to help understand the drivers of financial performance and to triangulate key operational, quality and finance information.
- Finance was covered in each of the meetings we observed, although we believe more focus and prominence could have been given to this and would expect this in future meetings moving into the new financial regime in 2021/22.

Over the last 12 months the focus has understandably been on managing demand/capacity and delivering care, rather than on addressing the underlying financial position. Based on our observations and experience, we consider the current governance structures in place to oversee financial performance appropriate and commensurate with the size of the organisation.

Divisional governance structures and reporting

Divisional performance management had been highlighted as a weakness in previous governance reviews and the Trust has already made a number of changes designed to improve the process since 2019/20.

Since 2019/20 the Trust has recruited to a new Director of Performance and Accountability post and has developed a new Performance Management and Accountability Framework. The new framework sets out an approach to performance management at the Trust for Clinical and Corporate Divisions, and provides focus on Corporate Governance, Risk Management, Accountability and Performance Management.

Other key changes to performance management since 2019/20 include improvements to the monthly and quarterly Divisional performance review meetings between Chief Officers and Divisions. Based on discussions the meetings are now more structured and effective compared to 2019/20, with the meetings focused on reviewing at clinical Division level the performance, risks and progress against agreed actions.

Divisional directors highlighted the drive to provide clinicians with increased training on, and experience of managing budgets to ensure there is better understanding and clearer lines of accountability. From discussions with the Divisional teams, we understand that the level of clinical buy-in is already improving as a result. Within MRC specifically, the Divisional leadership team hold biweekly briefings to discuss performance, including financial performance.

Divisional directors also felt that there had been improvements to budget setting process, and they were consulted on the budgets, albeit acknowledging that tensions still existed around the services that can feasibly be provided with the funding available.

Our interviews highlighted that there are plans to establish corporate performance review meetings later in 2021/22, which will be chaired by the CEO who will hold Chief Officers to account.

After each round of meetings, a summary report of the Divisional performance meetings is written describing the themes and issues discussed relating to the performance challenges, risks or other items covered in the agenda and actions agreed. This is reported to the TME and the IAC on a quarterly basis.

Work is in progress to finalise standardised reporting packs for the monthly and quarterly Divisional performance meetings, to enable more consistency between Divisions, and to improve the quality and effectiveness of the meetings. In line with our observations on reporting at Board and Committee level, in our view further improvements can be made to the performance review reporting pack with improvements in the clearer articulation of actions including what actions are required from Executives, next steps, deadlines and trajectories against the agreed action. We would also expect more commentary on Divisional finance performance to be included in the Divisional packs, and for this to be linked to other performance information in the packs.

Based on our discussions there remains a lack of understanding at Divisional level of the underlying operational financial deficit. In our discussions there was recognition that some progress has been made in developing the improvement programmes, for example theatre productivity and in undertaking analysis to review and right size the workforce based on agreed levels of activity, but progress was not consistent across all Divisions. Pay benchmarking information, for example as included in the Model Hospital, is not used on a consistent basis to review and plan staff resources and pay costs at the Trust.

Whilst recognising some progress has been made both in terms of capacity planning and improved controls, a number of interviewees stated more work was needed to have effective workforce planning in place at the Trust, and to use the information to plan and manage operational activity. Additional pay cost controls had been introduced or strengthened since 2019/20 including the vacancy control review process and the booking and review of temporary staffing controls, job planning and rostering. Based on our discussions there was recognition that a lot more could be done to make these more effective and strengthen arrangements to control pay costs. This includes strengthening processes and controls prior to securing additional staff resources, and in the subsequent review and analysis of pay costs.

During our interviews we also heard about the ‘perverse incentives’ when it comes to the delivery of efficiencies. As budgets have historically been based on

M7 forecast outturn, there was a view amongst a number of budget managers that it is more beneficial to underperform against budget, as this 'secures' more budget for the following year against a budget manager who delivers savings.

In interviews and through the findings of the budget holder survey (see next section) we observed that budget managers value the support of finance staff. The Trust has moved to a new finance system since 2019/20 and a number of individuals commented that the recent move from Excel-based budget statements to PDF limits the ability to analyse/drill down into data, and so are less user-friendly. Similarly in interviews and supported by the findings from the budget holder survey, additional supporting tools and analysis to build on the existing finance information and performance data on Orbit were identified as areas for improvement, which would support budget managers to further understand and manage their services.

Divisional staff interviewed also consistently highlighted that as part of the planning process further work is required to align and ensure a common understanding of activity, workforce and finance plans.

Our findings also indicate that the approach to efficiency/productivity remains a work in progress. The Trust has an established Integrated Improvement Programme with Executive leads assigned to each programme. During our interviews, most individuals interviewed were able to articulate the Integrated Improvement Programme and their contribution to delivering it, however agreed measures to track set robust operational targets for each programme and to track the financial impact of the programmes remains an area for further development.

Budget manager survey

We issued a survey to the Trust's 528 budget managers, with 203 providing responses (38% response rate). The survey was designed to explore views on budget setting, in-year management and delivery and training processes and needs. It also provided an opportunity for budget managers to make recommendations on how processes can be improved. We have prepared a separate reporting pack for the Trust on the detailed responses to the survey and include here only the key points arising from our review of the responses.

As shown in Charts 22 and 23 there were a number of positive points arising from the survey results, particularly related to the in-year management of budgets. Overall budget managers feel accountable for delivery of the budgets and understand the operational, quality and performance objectives expected of their service. There was evidence from the survey of positive engagement with reviews of in-year financial performance with most budget holders feeling supported by Divisional and finance staff and feeling confident that they understand their budgets.

The findings highlighted some mixed messages in respect of 2019/20. Based on the response, 54% of budget managers disagreed or partially disagreed that they were engaged and consulted in setting the 2019/20 budget, and circa 45% disagreed or partially disagreed that their budgets reconciled with workforce and activity plans. 44% of budget managers felt that they didn't understand the efficiency target set for the Division in 2019/20, but in a list of 10 improvement priorities the development and delivery of efficiencies was ranked 9th.

Chart 22: Budget manager responses 2019/20 financial year

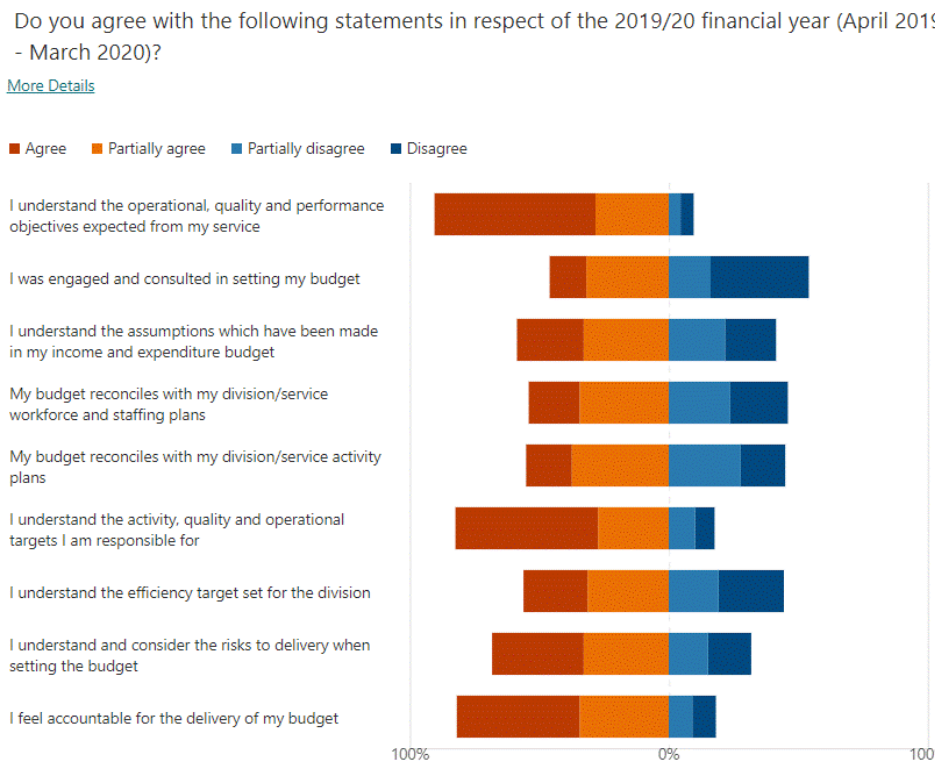
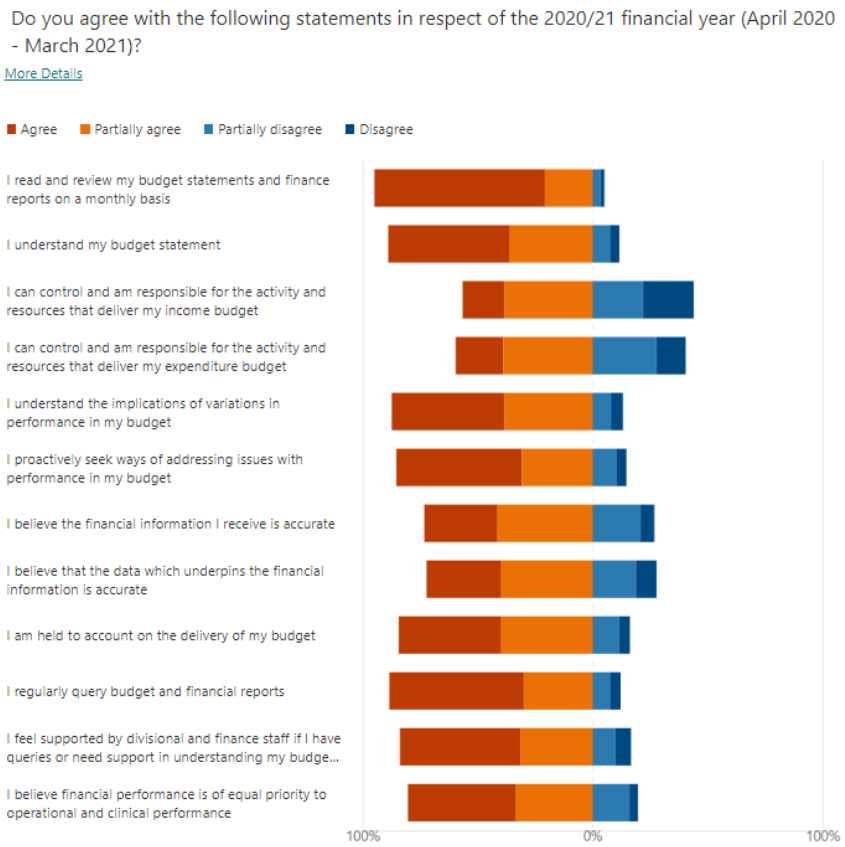
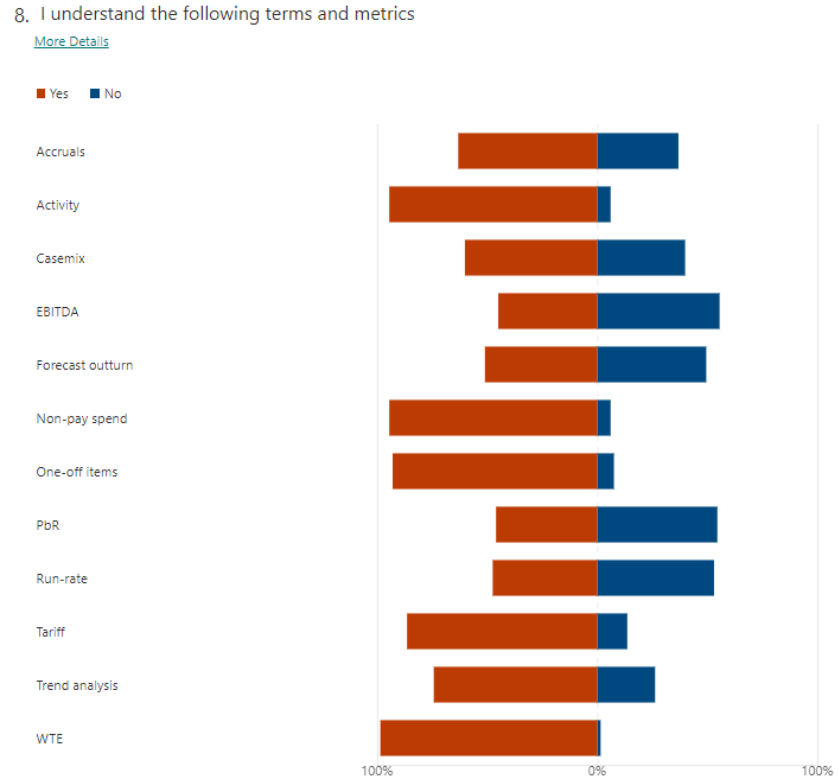


Chart 23: Budget manager responses 2020/21 financial year



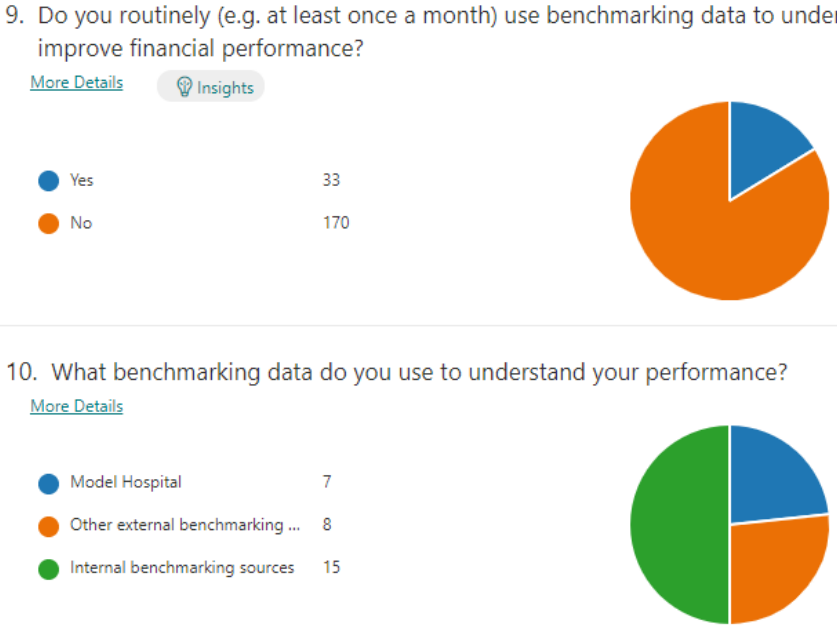
Budget managers felt they understood and trusted the financial information reported to them but over 50% didn't understand key financial terms and metrics such as EBITDA, forecast outturn, PbR and run-rate. Circa 45% also felt they could not control activity and resources required to deliver the budgets.

Chart 24: Budget manager understanding of terms and metrics



Based on the survey responses, it appears that there is limited regular use of benchmarking amongst budget managers. However, given the question is specifically referring to frequency as being at least once a month, there may be more ad hoc use of benchmarking that did not get picked up by the responses.

Chart 25: Budget manager responses - benchmarking



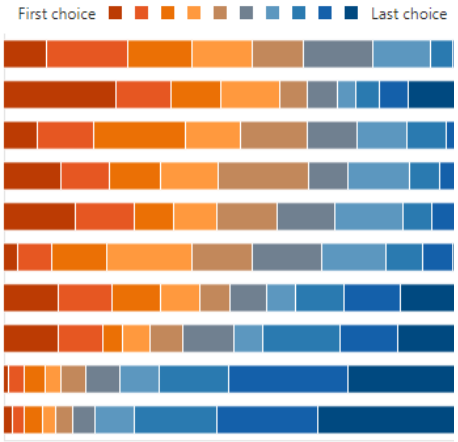
Budget managers felt providing more supporting tools and analysis (including workforce), improving the budget setting process, improving financial information and support were key priority areas for the Trust.

Chart 26: Budget manager responses – improvement areas

14. Reflecting on how the Trust could improve its financial reporting and financial governanc arrangements, please rank the following in order of priority (1 highest priority and 10 lov priority)

More Details

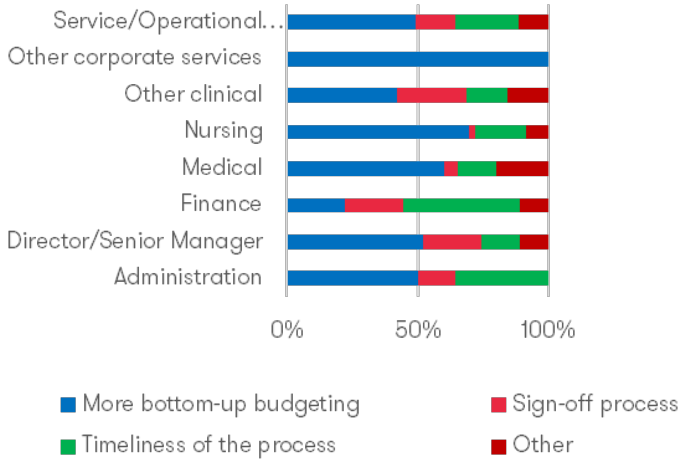
Rank	Options
1	Supporting tools and analysis
2	Budget setting process
3	Better workforce information ...
4	Financial reporting and inform...
5	Support (training and day-to-...
6	Better activity and performanc...
7	Communication
8	Increases to budgets
9	Development and delivery of ...
10	More controls (e.g. workforce ...



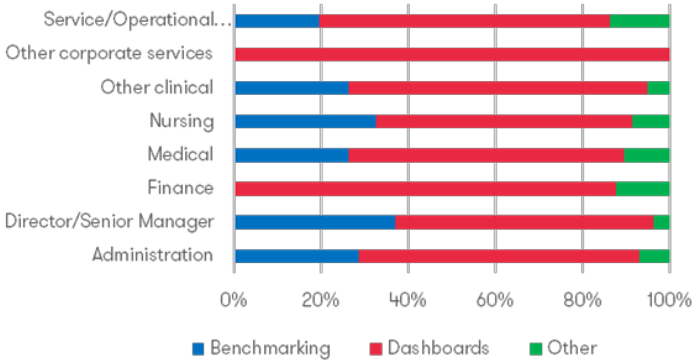
When analysing responses where those priority areas could be improved by staff type, there was a consistent message across all staff that access to dashboards and benchmarking can be improved, operational and front-line staff feel budget setting should be more bottom-up, that financial information and reporting needed greater clarity and support should be strengthened at Divisions. These key messages support many of the findings from our review.

Chart 27: Budget manager responses – Observations by staff

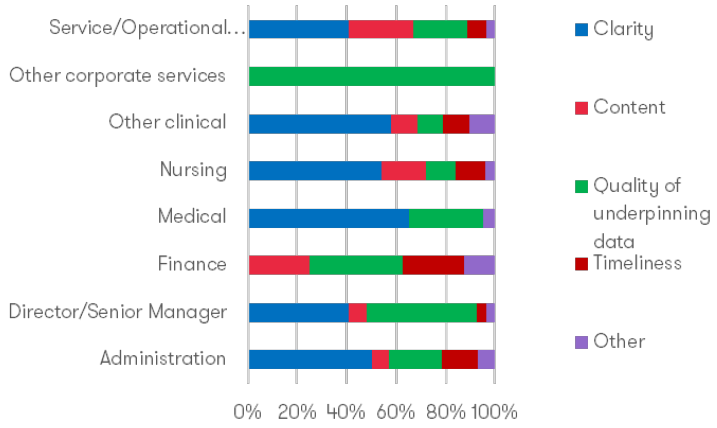
What can be improved within budget-setting?



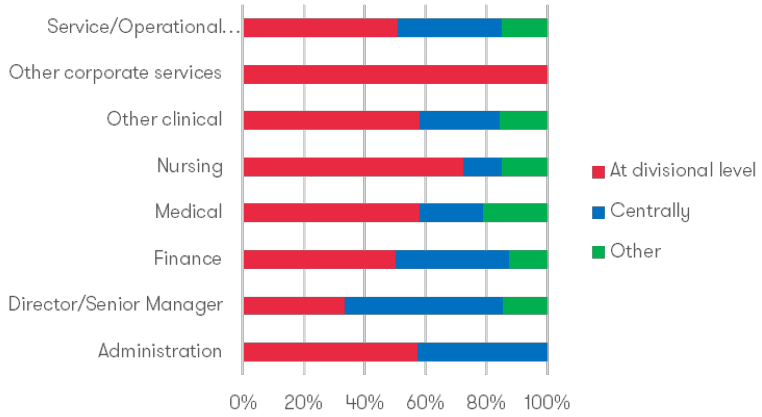
What can be improved in supporting tools and analysis?



What could be improved in financial reporting and information?



How could support be improved?



Future system and finance arrangements

2020/21 performance and 2021/22 planning

Emergency financial measures were introduced at the end of 2019/20 for 2020/21 to support the management of the Covid pandemic. This included the implementation of block contracts and additional funding for dealing with the pandemic.

This support remained in place for the entire financial year. Due to Covid pressures, recovery and restoration plans were only partly implemented during Q3 2020/21. The Trust's final unaudited position for 2020/21 was a £3.1m surplus.

The NHS Operating and Planning Guidance and Guidance on finance and contracting arrangements for H1 2021/22 was published in March 2021. At the time of writing, funding and financial regime for H2 2021/22 has not been confirmed. The current lack of clarity on financial allocations beyond H1 2021/22 presents a significant risk to the Trust in its financial planning and forecasting.

Key components of the H1 planning guidance include:

- Roll over of H2 2020/21 system allocation envelopes and requirements to co-ordinate revenue and capital plans across the system
- Continuation of block funding and Covid top up payments using adjusted Q3 2020/21 as a baseline
- Planning and funding assumptions to support and incentivise the recovery of elective activity
- Clawback/additional efficiency requirement where organisations exiting 2019/20 with underlying deficits
- Development and alignment of activity, workforce and financial plans.

The Trust has been working internally with Divisional teams and in partnership across the Berkshire (West), Oxfordshire and Buckinghamshire (BOB) Integrated Care System (ICS) to develop activity, workforce and finance plans for 2021/22. At the confidential session of the Board meeting in May, the latest

planning position or H1 2021/22 was for a £10.6m deficit for H1 2021/22, which includes £4.2m of efficiencies and the benefit of £2.0m commercial opportunities.

Using planning tools, the Trust has been analysing its 2019/20 closing underlying financial position by reviewing run-rate performance over the last year and removing additional costs and funding. While not conclusive, the tools are useful in attempting to normalise current positions but there are clear inconsistencies in interpretation and completion by organisations. Currently the approach to financial settlements for H2 2021/22 has not been agreed nationally, although the underlying operational deficit for 2019/20 impacts on efficiency requirement for both H1 and H2 in 2021/22 plans. Having a good understanding of costs and activity requirements post Covid will be essential to establish clear reset baseline position for the Trust. The impact of issues that drive the Trust's £45m underlying deficit coming out of 2019/20 and the impact on future financial performance need to be understood, reviewed and discussed at system level.

The latest guidance also suggests future changes to future funding allocations and payments will impact via:

- System determined allocations – systems will determine funding based on population needs, service plans and costs
- Applying aligned payment and incentive system – fixed 'baseline' element based on agreed activity and cost with variable element for elective activity over agreed baseline at marginal rate (currently suggested at 50%)

These proposed changes further strengthen the need for the Trust to understand its post-Covid cost position so that it can be clear in system discussions on its cost and activity baselines for the services it provides. It also needs to provide and communicate a clear understanding of the current planning process and assumptions and underlying financial position to the Board.

System development and governance arrangements

It is recognised that system development and governance arrangements in the BOB ICS are not as mature as other areas. The system does not have a co-terminus, single commissioning group with four CCGs currently operating under a single accountable officer who is also the system leader. Executives meet regularly to discuss issues and co-ordinate plans but system-wide working and governance is at an early stage.

Based on our discussions we note that some initial BOB ICS financial governance arrangements are currently in place, for example the Financial Oversight Group which co-ordinates financial plans and performance (revenue & capital). The group has provided a basis for discussion and challenge and provides a platform to develop broader collaboration through the planned System Finance Group from June.

Planning processes has identified that the ICS has underlying financial deficit exiting 2019/20 but there are not as yet any plans for system productivity, cost reduction or efficiency. The system is accepted as having the lowest per patient funding in Oxfordshire and below distance from target allocation levels across the system, meaning some of the underlying position may be structural. A full understanding of organisational and system underlying financial position is required in order to develop system financial delivery plans.

The Trust will need to ensure that it aligns and converges its own productivity and efficiency plans with that being developed by the system.

Improvement areas and recommendations

The review of the historical 2019/20 position and the update of current and future arrangements has identified a number of key improvement themes as well as specific improvement actions. We have grouped issues into five key improvements areas to enable the Trust and stakeholders to focus on these and implement the proposed recommendations.

Key improvement areas

1. Strengthening and embedding approach to productivity

Key findings and conclusions

- Limited triangulation and co-ordination of corporate cost reduction, Divisional margin targets and improvement programmes.
- Limited tracking, reporting and realisation of benefits (in particular financial) of productivity plans.
- Inconsistency of understanding, knowledge and mature worked up plans at Divisional level to deliver the productivity and efficiency assumed in financial plans.

Recommendations

- Develop a comprehensive, integrated multi-year approach to productivity planning which clearly outlines:
  - areas (clinical services, back office)
  - system-wide plans where relevant
  - engagement plans with clinical and operational staff
  - quantified benefits (including financial)
  - accountability, reporting and tracking process to provide assurance of delivery
- Ensure productivity programmes are aligned and converge with wider system plans and arrangements.
- Equip Divisional, operational, service and clinical leaders to understand comparable performance by developing and sharing analysis of performance, improvement delivered and external benchmarking tools to develop an understanding and culture of productivity in service delivery.

2. Management and control of workforce costs

Key findings and conclusions

- Pay costs have been consistently increasing for a number of years – both substantive and temporary – and were significantly higher than planned throughout 2019/20.
- There was an accepted lack of sufficient controls and management over workforce costs in 2019/20, along with a poor understanding and triangulation of impact of additional workforce on financial plans.
- Budget managers highlighted access to better workforce information as one of the key priorities for improvement and difficulties in delivering activity plans without greater than planned temporary staffing levels.

Recommendations

- Develop workforce management and control plans which:
  - provide analysis and tools
  - establish a real-time process for managing variance setting thresholds and escalation processes
  - identifies and tracks service led workforce efficiency plans
  - integrates with the long-term workforce strategy
- Work with the system to develop system-wide solutions to efficient workforce management in areas where the system can act more effectively than the Trust, such as flexible use of staff, development of bank and control of agency.

3. Divisional & budget manager understanding, buy in and delivery

Key findings and conclusions

- Operational, Divisional and budget managers have limited understanding and buy-in of key assumptions, risks and actions needed to deliver financial plans.
- Budget managers perceive financial planning to be top down and do not understand, accept. nor feel in control of targets set for the Trust by national guidance and regulators, nor fully understand their implications.
- Managers do not feel trained on budget management or feel in control of activity and workforce, which influence the income and expenditure within budgets, nor do they feel empowered to act.
- Operational delivery and quality are prioritised and Divisional and budget managers do not understand the impact on financial sustainability or have the analysis to link them.

Recommendations

- Invest in the development and training of Divisional and budget managers to improve and create a shared understanding the financial requirements of the Trust in particular:
  - Budgetary processes and assumptions
  - Key financial metrics and terms
  - Impact of operational and workforce plans and issues on finance
  - Cost management, efficiency and productivity
  - Financial control in the day-to-day operational environment
- Review the budget setting process to engage with clinical Divisions and budget managers to communicate more effectively key nationally set targets and ensure assumptions and their impact are agreed.

4. Understanding and causes of the underlying financial position and costs of delivering services

Key findings and conclusions

- While ensuring financial sustainability is part of the Trust strategic objectives, the Trust has a deteriorating underlying operational financial deficit with costs consistently, in particular workforce, increasing at a higher rate than income.
- There is a lack of shared understanding across the operational Divisions and the wider system of the overall position and there is a lack of understanding about how performance is distorted by one-off, non-recurring transactions.
- Given its importance to delivering financial performance, the Trust's Commercial Strategy and plans need to be more clearly integrated into financial reporting so that their impact is clear.

- While some improvements have been made, there continues to be a lack of alignment and understanding of the related impact between activity, performance and costs (particularly workforce).
- The position is further complicated by the impact of Covid on capacity, activity, productivity and costs. It is likely that a significant underlying operational deficit remains.

Recommendations

- Create a shared understanding across the Trust and wider system of the underlying and causes of the operational financial position involving:
  - a service level assessment of the underlying financial position post-covid involving operational and clinical staff
  - cover not only operational productivity, cost efficiency and patient acuity analysis and benchmarking comparisons but also wider structural and system issues, such as allocations and service commissioning
  - an assessment of financial practice and behaviours in Divisions and clinical Directorates
- Develop and communicate within the Trust and system a medium- to long-term financial plan which integrates improvement and productivity targets, Commercial Strategy and system delivery and efficiency plans. Update service costing processes and information to provide an understanding of the normalised, post-Covid financial position.
- Formally recognise, report and embed the Commercial Strategy as a key component of the Trust's financial plans and ensure non-recurrent transactions are not used to offset recurring benefits.
- Integrate and align further performance, workforce and financial planning and reporting so that the financial impact of operational and quality issues and decisions are more clearly reported, understood and discussed within Board, Divisional and clinical Directorate governance processes.

5. Reporting, analysis and triangulation of operational performance, workforce and finance

Key findings and conclusions

- There have been improvements to the Board's IPR since the start of 2019/20, but the level of detailed analysis provided in the report mean key messages, actions, support and financial impact are hard to distil from reporting.
- Financial analysis and commentary not always prominent or clear.
- 'Line of sight' reporting through Board to Division to Directorates on key operational, quality and financial information not accessible.
- Access to timely, consolidated and drill down analysis of operational (activity, capacity, performance) and workforce information limited.

Recommendations

- Streamline and focus reporting within the IPR to ensure that an Executive Summary identifies key messages, highlights impact, summarises key metrics performance and improves prominence of financial reporting and commentary.
- Improve the sharing and availability of information and analysis through greater use of dashboards with drill down through Divisions, Directorates and services.

6. System development

Key findings and conclusions

- System management and governance arrangements are not as mature as others and are in development.

- Collaborations on system-wide allocations, delivery and productivity plans are at an early stage.
- The immaturity of system development and lack of clarity nationally on allocations and the finance regime presents a significant risk to financial planning and forecasting at the Trust.

Recommendations

- Work with system leaders to develop and embed system financial governance and reporting arrangements.
- Develop a clear understanding of the system-wide financial positions and plans to address them.
- Identify, develop and integrate system-wide efficiency and transformation plans in areas where the system can act more effectively than the Trust.

Other improvement areas

Other recommendations for specific improvement areas not related to the key improvement areas are summarised below:

Table 32: Other improvement areas

Area	Recommendations
Planning	There needs to be a detailed triangulation of activity, capacity, workforce and financial plans to ensure assumptions made are fully reconciled. A clear and consistent understanding on income levels and management and impact of agreed contractual position needs to be shared and understood with Divisions. The Trust needs to undertake detailed scenario planning to assess the risks with payment and contractual model changes and clearly communicate implications to the Board and Divisions. It also needs to analyse and determine activity and cost baselines for all services to assist system-wide planning and allocations in future years.
Governance	Ensure all actions agreed as being the results of discussions at Board and Committee meetings are tracked and feedback on progress is provided at subsequent meetings. Identify and track any mitigating actions from financial risks identified in reports. Identify, manage and track key drivers for financial risk with risk management arrangements.
Financial reporting	Improve accessibility and clarity on financial reporting tools so budget managers are able to review and interrogate financial analysis in more detail. Ensure consistency and standardisation in use and format of tables and charts in the IPR and finance reports.

Appendix A - Scope of work

Assessment of financial performance and governance in 2019/20

Financial performance

- Understanding of underlying position moving into 2019/20 by reviewing the Trust's analysis and discussions with key staff
- Review, summarise and comment on the key causes and drivers of the financial performance in 2019/20, comparing the income and expenditure actual outturn with the planned control total, and the outturn forecast at Month 6.
- Comment on variances by key income and cost lines and financial performance against plan and forecast at aggregate and Directorate/service level and triangulate our findings using activity and operational key performance information.
- Discuss with Management any significant, unusual or one-off items, including the identification and consideration of nonrecurrent income and expenditure.
- Review and comment on the budget-setting and planning process used to develop the 2019/20 financial plan, including:
    - the extent to which key 2019/20 financial plan assumptions had supporting analysis and the extent to which revenue and capital expenditure plans were consistent with commissioners' expectations;
    - the extent to which the 2019/20 financial plan recognised internal trends, drivers of performance, discussions with NHSE/I and external system plans;
    - the extent to which Divisional management teams appear to own the 2019/20 financial plan, and whether responsibility for achievement of its constituent parts is clearly assigned;
    - the degree of engagement with clinicians and service managers in the preparation of the 2019/20 financial plan, including, for example, initial guidance and context issued; and the nature, format and frequency of meetings to discuss and agree the 2019/20 budget;
- Review and comment on the processes used to consider risks to the 2019/20 financial plan and forecast position, how these were reported and the identification of potential mitigations, including interactions with commissioners, wider system leaders and regulators.
- Assess key areas of judgement used in Management's M6 Forecast and on the process used to consider risks to the forecast, how these we reported and the identification of potential mitigations.

Financial governance

- Review and comment on how financial performance and risks to the delivery of the 2019/20 plan were reported to Executive committees, F&PC and the Trust Board. This will consider the timeliness of reporting, the depth of analysis and quality of any accompanying commentary. We will also comment on what was agreed in terms of subsequent actions to address adverse performance (e.g., additional financial analysis and mitigating actions) and whether or not those actions were acted upon.
- Consider and comment on the Trust's internal financial reporting and budget-monitoring procedures, at a Divisional, committee and Trust Board level, as follows:
    - the timeliness and standardisation of financial reporting, including income and expenditure, balance sheet, capital reporting;
    - the extent of appropriateness and timeliness of financial information made available to the Trust's Board members, F&PC, service managers and clinical leaders in order to allow them to perform their financial

responsibilities effectively and efficiently (considering, for example, the reporting of trends, KPIs, analysis and explanations, of variations against plan and action plans to reverse adverse budget variances, financial risks and the extent of service-line reporting)

- the process used to develop financial reporting and budget management reports and the content of those reports;
- the degree and nature of interaction, support and challenge with respect to financial reporting and budget monitoring that occurs between Divisions, the finance teams and the Trust Board, including how teams and individuals are held to account.

- Review and comment on the degree of engagement with clinicians and service managers in the preparation of the M6 Forecast, including, for example, guidance and context issued.
- Through discussions with the Trust's Senior Finance Team and reading key documentation provided by it, we will:
  - summarise and comment on the appropriateness of the current-year monthly I&E forecasting processes in use at the Trust during 2019/20;
  - consider the methods used by the Senior Finance Team to ensure key I&E reforecasting assumptions have supporting analysis, e.g., the extent to which revenue and capital expenditure plans are consistent with commissioners' expectations, the Trust's financial strategy, run rates and known financial risks;
  - comment on the extent to which Management and the Senior Finance Team appear to own the current-year reforecasts.
- Assess reporting and governance arrangements and the adequacy of monitoring and communication of delivery of the financial plan and forecast with system leaders and regulators.

Informing and shaping future arrangements

Assessment of underlying position impact through 2020/21 and 2021/22 plans

- Review and comment on changes in 2020/21 on the impact of underlying performance and governance issues identified in the review of 2019/20 to provide a clear, independent assessment of the underlying position moving forward.
- Identify and comment on strategic and system plans and structural issues which may impact on the development and delivery of 2021/22 plans
- Triangulate and align analysis with current baseline reset analysis and processes to determine 2021/22 plans.

Current Trust financial governance culture and capability assessment

- Through discussions with Trust Board, wider Divisional management, observations of key governance meetings and survey of budget holders consider the extent to which a sound financial governance culture is currently embedded throughout the Trust, considering:
  - technical competence
  - understanding of requirements
  - clear analysis
  - timely reporting of issues
  - openness and transparency of reporting and discussion
  - clarity of roles, responsibilities and communication lines with respect to financial management; and
  - financial management behaviours that appear to be inconsistent with the Trust's core values and those of recognised good practice.
- Review and comment on the extent to which senior non-finance staff (including Divisional management) are supported to develop their financial skills to an appropriate level for their roles.

Future financial arrangements

- Use insight developed from all components of review and practice from elsewhere to develop future budgeting setting, governance and financial management arrangements which:
    - identify key actions for the Trust with a transition plan to implement them
    - Encompass current policy direction, plans and available guidance on the future finance regime and payment system reform
    - Align with development of plans for system financial governance and reporting.

Appendix B – Principal sources of information

In conducting our work, we held individual meetings and/or exchanged correspondence with the following individuals at Oxford University Hospitals NHS Foundation Trust:

- Jonathan Montgomery, Chair
- Bruno Holthof, Chief Executive Officer
- Anne Tutt, NED
- Paula Hay-Plumb, NED
- Sarah Hordern, NED
- Jason Dorsett, Chief Finance Officer
- Sam Foster, Chief Nursing Officer
- Meghana Pandit, Chief Medical Officer
- Sara Randall, Chief Operating Officer
- Terry Roberts, Chief People Officer
- Eileen Walsh, Chief Assurance Officer
- Jon Evans, Director of Finance
- Jon Westbrook, Divisional Director Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children and Neonates
- Larry Fitton, Divisional Director Medicine, Rehabilitation and Cardiac
- Chris Cunningham, Divisional Director Surgery, Women's and Oncology
- Vivian Addy, Acting Divisional Director for Clinical Support Services
- Karen Barker, Clinical Director of Trauma and Orthopaedics
- Jessica Slater, Operational Services Manager Surgery, Women's and Oncology
- Jay Mistry, Commercial Director
- Mark Currie, Director of Performance and Accountability
- Claire Winch, Deputy Director of Assurance
- Naeem Uddin, Deputy Director of Finance – Performance and Reporting
- Edd Newton, Head of Financial Planning and Reporting
- Richard Gardner, Senior Finance Manager – Governance and Assurance
- Jack Everington, Senior Finance Business Partner - Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children and Neonates
- Andrew Hall, Senior Finance Business Partner – Medicine, Rehabilitation and Cardiac

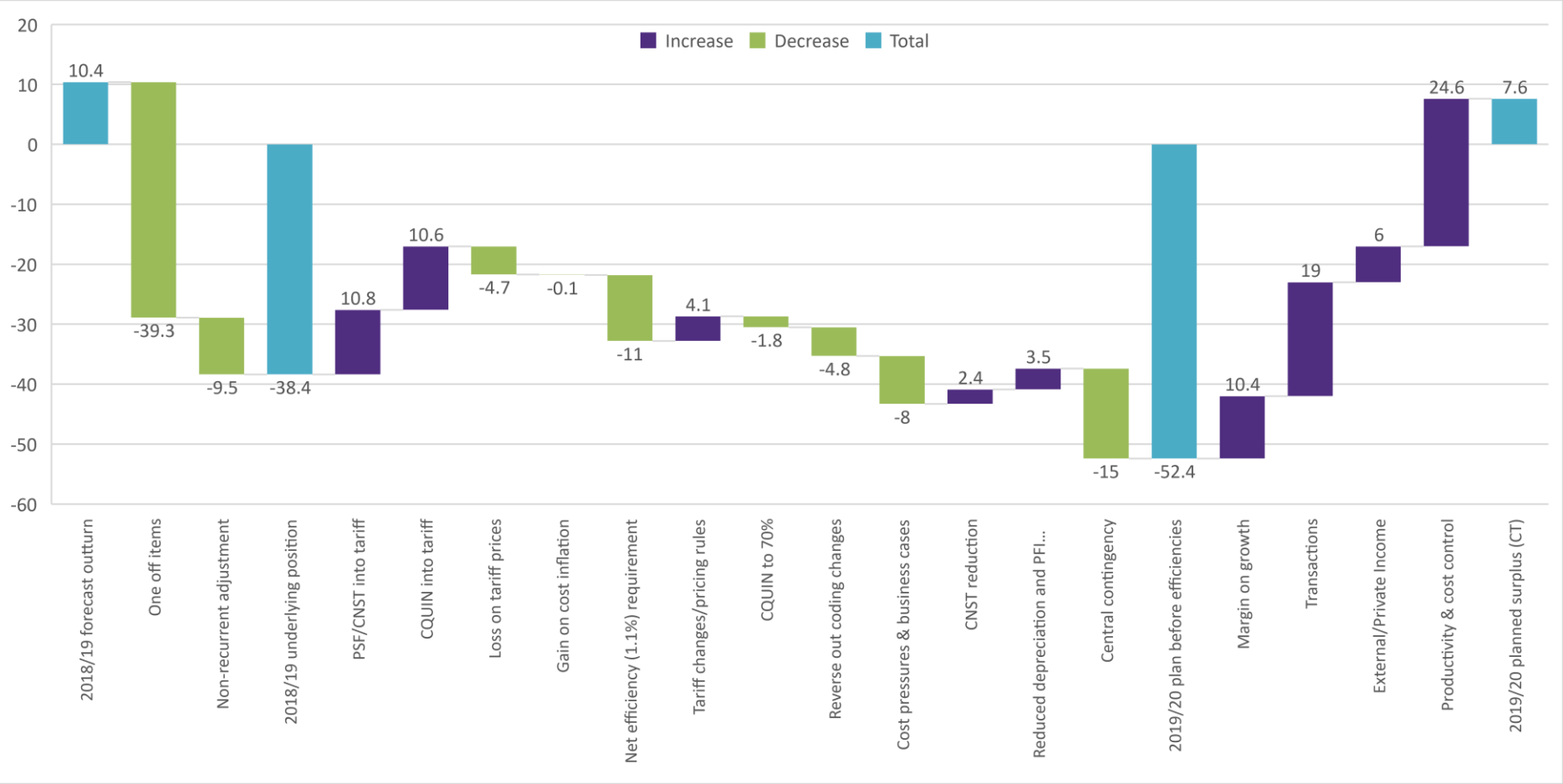
We also held discussions with the following individuals at other organisations:

- Hannah Hamilton, Director of Finance, NHS England and NHS Improvement (South East)
- Steve Gooch, Director of Operational Finance, NHS England and NHS Improvement (South East)
- Jayne Rhodes Deputy Director of Operational Finance, NHS England and NHS Improvement (South East)
- Gareth Kenworthy, Chief Finance Officer Oxfordshire Chief Finance Officer and Berkshire (West), Oxfordshire and Buckinghamshire (BOB) Integrated Care System Finance Lead
- Mark Surridge, External Audit Engagement Lead, Mazars LLP

Appendix C – 2018/19 FOT to 2019/20 control total

The chart below sets out the key movements from the 2018/19 forecast outturn to the 2019/20 £7.6m control total compliant plan, which were presented in reports to the Trust Board and Finance and Performance Committee (FPC) and reflected in the final plan.

Chart 28: 2018/19 forecast outturn to 2019/20 plan



Glossary of Terms

Board, Trust Board	The Board of Directors of Oxford University Hospitals NHS Foundation Trust
CCG	Clinical Commissioning Group
CONTROL TOTAL	The annually agreed financial budget for the Trust with the regulator
CSS	Clinical Support Services Division
CQUIN	Commissioning for Quality and Innovation payment framework
Distance from target	The difference a CCG's funding allocation is from agreed target levels for its population set by NHS England
Model Hospital	NHSE data benchmarking tool
MRC	Medicine, Rehabilitation and Cardiac Division
MRET	Marginal Rate Emergency Rule
NHSE/I	NHS England and Improvement
NOTSSCaN	Neurosciences, Orthopaedics, Trauma, Specialist Surgery, Children's and Neonates Division
PSF	Provider Sustainability Fund, sustainability support funding allocated to Trusts to help reduce or eliminate their deficits
Shelford Group	The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital Trusts in England.
Speccomm	Specialist Commissioning
SuWOn	Surgery, Women's and Oncology Division
System	Wider healthcare system in the Berkshire (West), Oxfordshire and Buckinghamshire region
TME	Trust Management Executive, the senior managerial decision-making body at Oxford University Hospitals NHS Foundation Trust
The Trust, OUH	Oxford University Hospitals NHS Foundation Trust
Underlying position	The financial position for the Trust after adjusting for no-recurrent items

WAU	Weighted Activity Unit – a ‘common currency’ used in Model Hospital benchmarking to describe an amount of clinical activity, with a weighting applied that takes account of casemix and complexity

Public

Improvement Area	Recommendation	Trust action / response	Executive Lead	Corporate Lead / Area Lead	Completion Deadline	Current status
Strengthening and embedding approach to productivity	Develop a comprehensive, integrated multi-year approach to productivity planning which clearly outlines: • areas (clinical services, back office) • system-wide plans where relevant • engagement plans with clinical and operational staff • quantified benefits (including financial) • accountability, reporting and tracking process to provide assurance of delivery.	Develop a structured approach to identifying opportunities for the IIP including the use of internal and external benchmarking and other providers' experiences to supplement current objectives set by OUH stakeholders	COO	CSD	Q3 2021/22	A proposal for an eight week package of external support has been received and is being reviewed by the Executive team prior to consideration by TME in September. Subject to approval by TME this timetable allows for completion of these actions by the deadline
		Develop the tools and capacity to plan and to execute multi-year improvement projects.			Q4 2021/22	
	Equip divisional, operational, service and clinical leaders to understand comparable performance by developing and sharing analysis of performance, improvement delivered and external benchmarking tools, to develop an understanding and culture of productivity in service delivery.	Productivity targets including quantified benefits (including financial) to be established by division and service area for each of the established improvement programmes in H2 2021/22	CFO	DOF	Q3 2021/22	Methodology and data agreed between Information Team and Corporate Finance. The next step is to take feedback from improvement programme sponsors.

Improvement Area	Recommendation	Trust action / response	Executive Lead	Corporate Lead / Area Lead	Completion Deadline	Current status
Management and control of workforce costs	Develop workforce management and control plans which: • provide analysis and tools • establish a real-time process for managing variance setting thresholds and escalation processes • identifies and tracks service led workforce efficiency plans • integrates with the long-term workforce strategy	[Initial set of proposed controls developed by the Chief People Officer, but not currently joined up with other initiatives (e.g. the IIP)]	CPO	DOW	TBC	CPO and DOW are developing a timetable for the introduction of improved controls
		Identify a starting fixed pay budget based on delivery of 'normal' activity volumes – this would inform the productivity targets for each Division	CFO	DOF	[Q1 2022/23]	Outcome of / part of integrated planning project set out below]
		[The Trust will implement a project to improve ESR data so that there is "one person, one post"]	CPO	DOW	[Q4 2021/22]	[Project underway. PID and timetable draft. Pilot data in CSS and Corporate]
	Work with the system to develop system-wide solutions to efficient workforce management in areas where the system can act more effectively than the Trust, such as development of bank and control of agency.	The Trust has signed up to a joint project between the BOB ICS and Frimley ICS to reduce bank and agency staffing.	CPO	DOW	Q4 2021/22 – Q1 2022/23	Project is underway and OUH has met all made requests of it. Timetable and success are dependent on the ICS initiative and is therefore not under OUH control

Improvement Area	Recommendation	Trust action / response	Executive Lead	Corporate Lead / Area Lead	Completion Deadline	Current status
Divisional & Budget manager understanding, buy-in and delivery	Invest in the development and training of divisional and budget managers to improve and create a shared understanding of the financial requirements of the Trust, in particular: • Budgetary processes and assumptions • Key financial metrics and terms • Impact of operational and workforce plans and issues on finance • Cost management, efficiency and productivity	Clinical Director Development programme (1/2 day finance module)	CFO	CFO	Q3 2021/22	Programme has been agreed with Clinical Director Group. Finance module course material under development
		Roll out finance element of programme to wider group of budget managers		DOF	Q4 2021/22	Not started
	Review the budget setting process to engage with clinical divisions and budget managers to communicate more effectively key nationally set targets and ensure assumptions and their impact are agreed.	Initial improved communication programme over core budget assumptions, constraints and process	CFO	DOF	Q3 2021/22	Not started
		Follow up with medium term programme following on from the fundamental review of planning (see below)			Q1 2022/23	Not started

Improvement Area	Recommendation	Trust action / response	Executive Lead	Corporate Lead / Area Lead	Completion Deadline	Current status
Understanding and causes of the underlying financial position and costs of delivering services	Create a shared understanding across the Trust and wider system of the underlying and causes of the operational financial position involving: • a deep dive assessment of the underlying financial position involving operational and clinical staff • cover not just operational productivity, cost efficiency and patient acuity analysis and benchmarking comparisons but also wider structural and system issues, such as allocations and service commissioning • an assessment of financial practice and behaviours in divisions and clinical directorates	Use existing datasets, with an improvement plan where needed, to develop a format to explain the underlying position at Trust, divisional and directorate level	CFO	DOF	Q2 2021/22	Analytical work underway
		Roll out of programme to improve understanding with materials tailored to different audiences (leaders, managers, all staff)			Q4 2021/22	Not started. Completion deadline shifted to Q4 to reflect the fact that the programme will take a longer period to reach all services
	Develop and communicate within the Trust and system a medium to long term financial plan which integrates improvement and productivity targets, commercial strategy and system delivery and efficiency plans. Update service costing processes and information to provide an understanding of the normalised, post-Covid financial position.	Develop medium term financial objectives aligned to external requirements and Trust	CFO	DOF	Q3 2021/22	Draft ready to share with executive team in September
		Develop medium term plan for 2022/23 when post-Covid funding confirmed			[Q1 2022/23]	Not started. Dependent on timing of DHSC & NHSE announcements of medium term funding
	Formally recognise, report and embed the Commercial Strategy as a key component of the Trust's financial plans and ensure transactions are focused on recurring benefits.	Commercial programme plan and actual performance	CFO	CD	Q3 2021/22	Underway. Commercial strategy now reflects recurrent surplus focus.

	Integrate and align further performance, workforce and financial planning and reporting so that the financial impact of operational and quality issues and decisions are more clearly reported, understood and discussed within Board, divisional and clinical directorate governance processes.	Fundamentally change the basis of planning to integrate activity, workforce and financial planning based on improved demand and capacity planning.	CFO	DOP&C	[Q1 2022/23]	Project group has been set up and meeting for set months. The next milestone is to develop a project plan. Completion deadline will be set when that plan is agreed.

Improvement Area	Recommendation	Trust action / response	Executive Lead	Corporate Lead / Area Lead	Completion Deadline	Current status
Reporting analysis and triangulation of operational performance, workforce and finance	Streamline and focus reporting within the IPR to ensure that an executive summary identifies key messages, highlights impact, summarises key metrics performance and improves prominence of financial reporting and commentary. Improve the sharing and availability of information and analysis through greater use of dashboards with drill down through divisions, directorates and services.	Improve finance section of IPR to align with use of trend data and SPC charts as per HR section.	CFO	DOF	Q3 2021/22	Director of Performance has produced a plan for the wider improvement of the IPR and work is underway to deliver this action as part of that wider plan

Improvement Area	Recommendation	Trust action / response	Executive Lead	Corporate Lead / Area Lead	Completion Deadline	Current status
System Development	Work with system leaders to develop and embed system financial governance and reporting arrangements	Progress against this action will be dependent on ICS initiatives and therefore the Trust cannot set out detailed actions at this stage	CFO	DOF	Q4 2021/22	Not started and is dependent on ICS initiatives and therefore not under OUH control. ICS CFO unlikely to be in post until Q4 2021/22
	Develop a clear understanding of the system-wide financial positions and plans to address them.		ICS CFO	N/A	Q2 2022/23	
	Identify and develop system-wide efficiency and transformation plans in areas where the system can act more effectively than the Trust		ICS CFO	N/A	Q2 2022/23	