Oxford University Hospitals NHS Foundation Trust

Annual Report and Accounts 2025/26

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

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Foreword and Statement on Performance

Welcome to the Annual Report of Oxford University Hospitals NHS Foundation Trust for the period 1 April 2025 to 31 March 2026.

On behalf of the Board of Directors of Oxford University Hospitals (OUH) NHS Foundation Trust, I would like to thank all our people for working together as OneTeamOneOUH to provide high quality and compassionate care for patients.

I am proud to have led our organisation as Interim Chief Executive Officer (CEO) since April 2025 when Professor Meghana Pandit, our substantive CEO, began her 18-month secondment as Co-National Medical Director – Secondary Care with NHS England. Meghana will continue her secondment until October 2026 following her appointment to a new role as a Deputy CEO of NHS England. From 1 April 2026 she is spending 50% of her time as CEO at OUH.

I would also like to take this opportunity to thank Professor Sir Jonathan Montgomery for his significant contribution to OUH before he stepped down from his role as Trust Chair on 31 March 2026, following his appointment as Regional Chair of NHS England's South East region. Recruitment of a new substantive Chair for the Trust is underway and, in the interim period, Sarah Hordern, Vice-Chair, is undertaking the role of Acting Chair.

This Foreword and Statement of Performance is structured around our four strategic pillars – Patient Care, People, Performance and Partnerships – which underpin everything that we do.

Patient Care

In 2025/26, our teams continued working hard to improve care for our patients, with the list below representing just a handful of the highlights:

- Following a successful pilot scheme, we launched Martha's Rule, a national patient safety initiative that enables patients, families, carers and staff to request an urgent clinical review if concerns about a patient's deteriorating condition remain unresolved. Martha's Rule is now in place across all inpatient areas in the Trust, strengthening the culture of asking, listening and acting when patients or those close to them report worrying changes.
- Brain tumour patients being treated at the Churchill Hospital in Oxford were the first in the UK to benefit from a new way of carrying out MRI scans to plan specialist radiotherapy treatment. We are now able to provide faster, more precise, and targeted radiotherapy in a more efficient way for our patients. An electromagnetic coil ensures patients' heads can be kept in the same place during both CT and MRI scans. With the new coil, the images can now be lined up without the need for manual adjustment in order to plan treatment.
- OUH has been recognised as the top performing NHS centre for adult living kidney transplants in the UK. According to the latest NHS Blood and Transplant annual report on kidney transplants, OUH clinicians performed 68 living donor kidney transplants out of a total of 201 in the UK. This reflects the unwavering commitment of OUH's Living Donor and Kidney Recipient Transplant team to excellence, innovation, and patient-centred care.

We are also investing into building for the future to improve patient care and experience:

- The new Surgical Elective Centre (SEC) at the John Radcliffe Hospital is due to welcome its first patients in Autumn 2026. This is the Trust's most significant capital project for many years. It will provide additional operating theatres to reduce elective waiting times and improve patient pathways to meet the demands of the growing population across the Thames Valley.
- Work has been completed to redevelop the Maternity outpatient clinic at the Horton General Hospital in Banbury. The project represents a significant investment in facilities for expectant mothers and their families in order to enhance clinical capacity to deliver safe, high quality care. Three new weekly high-risk obstetric clinics will be introduced at the Horton General.
- The trial of several Ambient Voice Technology (AVT) solutions began in July 2025. The evaluation report was published in February 2026. It shows clear benefits for reducing administrative workload and improving the working lives of clinical staff, while maintaining high levels of patient satisfaction. AVT uses a microphone and secure Artificial Intelligence (AI) software to document patient consultations in real time.

People

Our new OUH People Plan 2025-28 was approved by the Trust Board in May 2025. Hundreds of colleagues working at OUH took part in virtual and in-person listening events to ensure that it was co-created with staff for staff.

It outlines our People Plan vision, ***'Together we make OUH a great place to work where we all feel we belong***', and sets out the three key themes which we will focus on to deliver this vision – Health, wellbeing and belonging for all our people; Making OUH a great place to work; More people working differently.

A summary and an animation are available on the Trust website.

The introduction of a Values-Based Appraisal (VBA) window at OUH continues to have a positive effect. 95.2% of OUH staff who took part in the annual NHS Staff Survey 2025 reported that they had an appraisal in the previous 12 months - the highest appraisal rate achieved to date and also the best of any NHS trust nationally. Our focus going forward is to ensure that the quality of these appraisal conversations matches the quantity.

Thanks to all colleagues who played a part in our 2025 staff flu vaccination programme, a total of 6,342 frontline healthcare workers at OUH were vaccinated. This represented a significant year-on-year improvement with an increase of 2,000 colleagues being vaccinated in 2025 and was significantly better than the national average.

We have continued to focus on the Eradication of Bullying & Harassment Programme which this year led to a small, but promising, improvement in our annual NHS Staff Survey scores relating to this important issue.

Our No Excuses for Sexual Harassment campaign was launched in March 2025, followed by Active Bystander training for all staff in November 2025. A Trust Board 'deep dive' session was held at the Integrated Assurance Committee in February 2026 before a refreshed programme of work was finalised.

Performance

Delivery of safe, timely and high-quality care for patients, provided in a compassionate way, and aligned to Trust values and OneTeamOneOUH ethos, is our top priority.

Patient safety and staff wellbeing have been prioritised during several periods of industrial action by resident doctors over the past 12 months. I would like to thank all colleagues who have enabled us to minimise disruption to our patients, while ensuring that all care was safe and appropriate, including teams who postponed and rebooked patient appointments. I would also like to apologise to any patients whose care was impacted as a result of industrial action.

Despite the increasing demand for Urgent and Emergency Care, we worked exceptionally hard to improve our performance in our Emergency Departments at the John Radcliffe Hospital and the Horton General Hospital. We delivered significant improvement on the previous year's performance, with 78% of patients seen, treated, and discharged or admitted within four hours in 2025/26, compared with 72% in 2024/25. This was the fourth equal most improved performance of any NHS trust nationally.

The Trust's overall Cancer performance against 62-day treatment standard remained below target. Improvement in this area remains a key priority for 2026/27.

We continued to focus on improving cancer care through a Quality Improvement (QI) approach. More than 100 staff across six tumour sites and related services attended collaborative workshops which resulted in 100-day plans which are monitored at the Cancer Improvement Programme Group.

Cancer patients rated the level of care which they received at OUH as 9 out of 10 for the fourth year in a row, according to the results of the national Cancer Patient Experience Survey which were published in July 2025. They particularly praised the dignity and respect with which they were treated by staff.

Reducing elective waiting lists has remained a key focus. Several 'Super Surgery' days have been held in specialties including breast cancer surgery at the Churchill Hospital in Oxford and day case hernia surgery at the Horton General Hospital in Banbury.

There continues to be a focus on Maternity Services both locally and nationally. OUH is one of 12 trusts included in the Independent Investigation into Maternity and Neonatal Services in England which was commissioned by the Department of Health and Social Care. We have engaged with Baroness Amos and her team in an open and transparent manner, and we welcome the opportunity to reflect, improve, and ensure that every voice is heard.

An interim report was published in February 2026, and the final report is expected to be published in Summer 2026. This report will be reviewed carefully to identify key learnings and actions that we can take to improve patient experience within our services.

In March 2026 MBRRACE-UK published its latest national report on perinatal mortality, relating to babies born in 2024. The report showed that OUH's stillbirth rate was in line with the average for comparable services, while neonatal mortality and overall perinatal mortality rates were better than average for similar specialist maternity units.

The Care Quality Commission (CQC) carried out unannounced inspections of both Maternity and Newborn Care Services at OUH in Autumn 2025. Thank you to all

colleagues who welcomed the CQC inspectors. The final report was published in June 2026 and rated Maternity services at both the John Radcliffe and Horton General Hospitals as 'Good'. We remain committed to working on all areas for improvement which the CQC has identified in the inspection report.

Partnerships

Working in partnership for the benefit of our patients and populations is one of our six strategic objectives.

Approval of our Quality Priorities for the next 12 months at the Trust Board meeting in March 2026 was the culmination of a cycle of engagement and involvement with a wide range of external stakeholders, including at our annual Quality Conversation event in December 2025. The Quality Priorities have been published on the Trust website.

We also worked closely with our partners and with our patients this year during the Shaping our Future engagement phase of the development of our new OUH Strategy for 2026-31, building on our ambition to deliver compassionate, research-enabled care of the highest quality.

The insights which we have gained will play a key role in shaping our new Strategy which will be aligned with the three key shifts set out in the Government's 10 Year Plan for the NHS – from hospital to community; from analogue to digital; and from treatment to prevention.

We are grateful to Oxford Hospitals Charity for working in partnership with us to support both patients and staff at OUH. For example, the Charity has funded a series of improvements to the waiting area of the Oxford Eye Hospital and enabled us to purchase new equipment. New seating, artwork and colour-coded designs have created a more welcoming, accessible space that is easier for patients with eye conditions to navigate while the new equipment has speeded up diagnosis and treatment.

Also thanks to the generous support of the Charity, a new OUH Quality Improvement Fund has been established to drive improvements in patient care. In Autumn 2025 staff were invited to submit bids for projects up to a value of £5,000. A total of 10 projects which demonstrated how they would benefit patient care were successful.

We are extremely proud of everything our colleagues have been able to achieve in what has been an extremely challenging year for the NHS. This Annual Report captures a small part of the dedication they show every day. We extend a heartfelt thank you to them, to our partners, and to our patients, who are at the heart of everything we do.

Signed: 

Simon Crowther
Interim Chief Executive Officer
25 June 2026

Performance Report

The Performance Report provides information about Oxford University Hospitals NHS Foundation Trust and its main objectives and outlines how the Trust performed during the year 2025/26.

About Oxford University Hospitals NHS Foundation Trust

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

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

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

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

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

More information on Oxford University Hospitals NHS Foundation Trust and its services is available on the Trust website at www.ouh.nhs.uk.

Trust Strategy

During 2025/26, OUH commenced a formal refresh of its Strategic Framework, building on the foundations established through the Trust Strategy 2020–2025. This work takes into account changing external environment but maintains focus on high-quality patient care and effective collaboration across the health and care system. The four strategic pillars — Patient Care, People, Performance and Partnerships — continue to provide a consistent framework for our decision-making.

The strategy refresh will be shaped by national direction, including NHS England's 10 Year Plan and the NHS Cancer Plan. It will integrate national priorities - such as accelerating personalised cancer pathways, digital and data driven transformation, and delivering efficient and timely patient access. The establishment of the SEC, alongside complementary projects (for example, improvements to the supply chain for surgical kits and consumables) are key to the Trust's delivery of a number of these strategic priorities.

The Trust's vision — ***to be an exemplar in healthcare delivery that is compassionate and enabled by the highest levels of research and innovation*** — guides the refresh. It is grounded in our values of Learning, Respect, Delivery, Excellence, Compassion and Improvement, which underpin OUH's leadership, culture and priorities.

Our Partnerships

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

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS) works closely with health, social care and voluntary sector partners to deliver integrated care for our populations. OUH involvement in the BOB ICS is primarily through their strategic commissioning function, provider collaboratives and the Oxfordshire Place-Based Partnership. The footprint of the ICB has increased to include East Berkshire as the Thames Valley ICB from 1st April 2026.

Provider Collaboratives

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

OUH works closely with Oxford Health NHS FT as part of the Oxfordshire NHS Provider Collaborative for Integrated Care. The Acute Provider Collaborative, focussed on collaboration on pathway redesign and shared corporate services, includes Royal Berkshire Hospitals NHS FT and Buckinghamshire Healthcare NHS Trust.

The Primary Care and Community Board was established in 2025 with the Trust represented. Collaboration between Primary and Secondary Care is supported through the Interface Group, delivering solutions-focused interface working in local areas to improve pathways and experience for patients and colleagues.

Oxfordshire Place-Based Partnership

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

Productive partnerships have arisen from the Local Policy Lab, an alliance between the University of Oxford, Oxford Brookes University and Oxfordshire County Council which aims to promote relationships and bridge the gap between research and local policy by connecting university researchers' capacity with Oxfordshire challenges.

Oxfordshire's 'Marmot' county programme, with OUH as co-chair of the steering group brings together the City, District and County Councils together with local community, voluntary sector organisations and our universities. This supports our work on Health Inequalities and delivery as an anchor institution.

Networks and collaborations

The Trust hosts and contributes to multiple regional and national clinical networks, delivering and improving specialist clinical services. These include the Thames Valley Cancer Alliance, Thames Valley Trauma Network, Southeast, Secure Data Environment (SDE) and a variety of Operational Delivery Networks. The Trust is an active participant in the Oxfordshire Inclusive Economy Partnership and Oxfordshire Anchor Network.

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

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

We are a member of the Shelford Group, a collaboration of 10 of the largest teaching and research Trusts in England, learning from each other.

World-class universities

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

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

Charitable Partnerships

The Trust continues to benefit from a strong network of charitable partnerships.

Our principal charitable partner is Oxford Hospitals Charity (OHC), with whom we have a long established and productive relationship. OHC supports the work of the Trust by funding state-of-the-art medical equipment and major enhancements to the hospital

environment, such as improving wards, waiting rooms, play spaces and staff areas. The Charity also funds research, specialist staff training and extensive support for patients and staff across our hospitals.

A few highlights during 2025/26 include:

- Funding of £170,000 for a digital transformation of the Maxillofacial team, improving outcomes for patients and making environmental and financial savings
- A new way to help patients and visitors with accessibility needs navigate the Horton General and the Nuffield Orthopaedic Centre.
- A continuation of our Music on Wards programme for older patients being cared for across the Trust.
- A 'kitten' scanner miniature MRI machine to reassure young patients having diagnostic scans, alongside new artwork throughout children's radiology
- A series of improvements for the Horton General Children's Ward outdoor play area, including new bouncy flooring, planting and play equipment
- Medical-grade breast pumps to support breastfeeding in the Women's Centre

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

Alongside OHC, the Trust works in partnership with several other charities that contribute directly to patient care pathways and specialist services. Katharine House Hospice (KHH) and Sobell House Hospice Charity are longstanding partners, supporting the delivery of palliative and end of life care across Oxfordshire.

The Trust continues to strengthen its coordination with all charitable partners to maximise opportunities for joint working, strategic alignment and shared impact.

Volunteers

Our volunteers are essential to patient care and staff support across the Trust. Nearly 800 volunteers now contribute, with 130 new members joining last year.

We have expanded roles in maternity, specialist surgery, and sustainability, offering meaningful opportunities alongside clinical and non-clinical teams.

The snack and newspaper trolley will soon launch at the Complex Medicine Unit with the League of Friends, while new positions at the SEC are being explored.

Training, wellbeing, and engagement events throughout 2026 aim to recognise and support volunteers.

Thanks to the Chaplaincy Team and Oxford Hospitals Charity for funding Coffee Mornings, Tea Parties, and Christmas Lunches.

We deeply appreciate our volunteers' dedication in strengthening our community.

Performance Overview

The Performance Overview summarises the Trust's performance during 2025/26. The dashboard overleaf provides an overview of performance against key indicators. Further information is included in the Performance Analysis section of this report.

Access, Quality, and Productivity in Elective Care and Cancer Services:

Access within our elective pathways improved for patients waiting within 18 and above 52 weeks, with OUH meeting the operating plan target and national expectations for both. The Trust's average annual performance against the 28-day cancer standard was just below operating plan target; the target for 62-day cancer pathway however was not achieved. The operating plan target for the percentage of diagnostic tests conducted within six weeks was also not achieved.

Access to urgent and emergency care:

We improved the proportion of patients seen within four hours in our Emergency Departments to 78.5% from 72.2% in 2024/25. This was also better than the operating plan target of 78.0% and national expectations. The percentage of patients waiting in A&E over 12-hours was 2.1% - improvement on 4.6% in 2024/25 and better than the operating plan target of 4.4%. This was delivered in the context of further year-on-year growth in patient demand in our emergency settings.

Delivery of safe and high-quality care:

We remained a hospital with lower-than-expected mortality. Hospital acquired infections reduced as did hospital acquired pressure ulcers following a sustained quality improvement process. Still birth numbers fell, but neonatal deaths and measures of harm to women during labour increased creating a mixed picture during a year when our maternity services have been under significant scrutiny.

Enhancing leadership and supporting staff:

The NHS operates in an increasingly difficult environment, and this impacts on how our staff feel when they come to work. This is reflected in the 2025 NHS Staff Survey, which has seen deterioration across several domains, although overall performance remains above national average. Our Leadership Development and Better People Leaders programmes supported managers by promoting inclusive leadership skills aligned with EDI. A slight increase in sickness absence is being addressed through proactive work with Occupational Health and managers requiring support.

Improving patient experience:

Patient experience data suggested a slight deterioration in the general patient experience and an improvement for maternity patients. We are preparing a new approach to the patient experience to support improvements in the future.

Our management of finance and the use of resources:

In 2025/26, the Trust delivered an adjusted financial surplus of £7.0m against a planned target of a £2.0m surplus. This is the measure used by NHS England to assess providers' financial performance. This was achieved through improved Trust productivity and efficiency, redistribution of Deficit Support Funding by NHS England from systems that failed to deliver against their financial plan, and in-year non-recurrent measures.

Performance Dashboard[1]

Domain and indicator	Target	2025/26	2024/25	2025/26 compared to 2024/25
Elective Care, Cancer and Diagnostics				
Patients waiting over 18 weeks (RTT[2])	63.0%	63.0%	57.1%	5.9 percentage point improvement
Patients waiting over 52 weeks (RTT)	2.0%	1.8%	3.0%	1.2 percentage point improvement
Patients waiting over 18 weeks (OP FA[3])	69.1%	68.0%	63.6%	4.4 percentage point improvement
28-day Faster Diagnosis Standard	80.0%	79.5%	77.9%	1.6 percentage point improvement
62-day general cancer standard	71.1%	60.2%	60.6%	0.4 percentage point deterioration
Percentage of people waiting within 6 weeks for a diagnostic procedure / test	95.1%	79.1%	76.3%	2.8 percentage point improvement
Number of days from discharge ready date to actual discharge date	n/a	0.6	0.6	No change
Urgent and Emergency care				
4-hour A&E[4] performance (all types)	78.0%	78.5%	72.2%	6.3 percentage point improvement
12-hour A&E performance	4.4%	2.1%	4.6%	2.5 percentage point improvement
Quality and Safety				
SHMI[5] range	<1	0.89 (CL[6] 0.85-1.17)	0.91 (CL 0.88-1.14)	Remains as expected
HSMR[5] range	1	92.0 (CL 87.7-96.5)	92.0 (CL 88.3-95.9)	Remains as expected
MRSA[7] bacteraemia cases	0	6	9	Reduction of 3 cases - improvement
C-Difficile[8] cases	123	109	164	Reduction of 55 cases – improvement
E-Coli[9] bloodstream infection cases	165	220	220	No change
Midwife ratios (birth rate / staffing level)	1:22.9	1:23.91	1:25	Increase in ratio by 1.09 – target met
Neonatal deaths per 1,000 live births	<3.2	3.4	2.1	Deterioration in the rate per 1,000 by 1.3 – target not met
Stillbirths per 1,000 births	<4.0	2.8	3.2	Improvement in the rate per 1,000 by 0.4 – target met
Postpartum haemorrhage >1500mls	n/a	3.18%	3.0%	0.18 percentage point deterioration
3rd and 4th degree tear rate	n/a	2.98%	2.2%	0.78 percentage point deterioration
Pressure ulceration incidents per 1,000 bed days (category 2) [10]	<1.9	1.96	2.05	4.4 percentage improvement
Pressure ulceration incidents per 1,000 bed days (category 3) [10]	<0.2	0.27	0.22	22.7 percentage deterioration
Pressure ulceration incidents – total number (category 4) [10]	0	1	3	Reduction of two incidents - improvement
Patient Experience				
CQC inpatient survey[11] – 'Overall experience' score	n/a	8.4/10	8.5/10	Deterioration in score by 0.1/10
CQC maternity survey score[12,13]:				
'Labour and birth' aggregate score	n/a	8.2/10	8.0/10	Improvement in score by 0.2/10
'Staff caring for you' aggregate score	n/a	8.4/10	Not scored	Not applicable

Domain and indicator	Target	2025/26	2024/25	2025/26 compared to 2024/25
'Care in hospital after the birth' aggregate score	n/a	6.7/10	Not scored	Not applicable
Number of inpatients referred to stop smoking services	n/a	4,174	2,416	73 percentage point increase
Our People				
Sickness absence rate	3.1%	4.22%	4.16%	0.06 percentage point deterioration
NHS Staff Survey – 'Engagement' theme score	n/a	6.83	6.96	Deterioration in score by 0.13/10
NHS Staff Survey – 'Raising Concerns' sub-score	n/a	6.30	6.45	Deterioration in score by 0.15/10
Proportion of BAME[14] staff in senior leadership roles[15]	n/a	4 out of 19	4 out of 19	No change
Proportion of women in senior leadership roles[15]	n/a	9 out of 19	8 out of 18	Increase of 1 woman in senior leadership role
National Education and Training Survey 'Overall Satisfaction' sub-score	n/a	77.18	75.00	Improvement in score by 2.18
Finance				
Planned adjusted / control total surplus / (deficit)[16]	n/a	2.0	(0.3)	£2.3m improvement on 2024/25
Actual adjusted / control total surplus / (deficit)	n/a	7.0	(6.8)	£13.8m improvement on 2024/25
Implied productivity[16] change since previous year	n/a	+2.4%	Not reported	Not applicable
Gross capital expenditure	91.9	137.7	82.1	Increase of £55.6m on 2024/25
Closing cash balance[17]	14.7	75.4	12.5	£62.9m improvement on 2024/25
Sustainability				
Annual reduction of Carbon direct control emissions tCO2e (CORE)	5.56%	37,419	41,818	10.5 percentage point improvement

Notes:

1. *All figures represent the full year position, unless indicated otherwise.*
2. *Referral To Treatment pathway*
3. *Outpatient First Attendances*
4. *Accident & Emergency department*
5. *Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio, mortality indicators in use by OUH*
6. *Confidence Limit*
7. *Methicillin-resistant Staphylococcus Aureus*
8. *Clostridioides difficile*
9. *Escherichia coli bloodstream infections*
10. *Hospital-acquired pressure ulceration incidents*
11. *Latest survey data available for 2024 (published 2025), compared to 2023 (published 2024)*
12. *Survey looked at experiences of woman who gave birth between 1 and 28 February 2025*
13. *Scoring domains have changed between 2024 and 2025 and therefore no comparable information is available for some domains*
14. *Black, Asian and Minority Ethnic (BAME) staff, as self-reported by staff on ESR*
15. *'Senior leadership' roles are defined as Board-level roles*
16. *Compares cost weighted activity growth and real terms resource growth between 2025 and 2024; latest available data is as of M9 2025/26*
17. *Circa £50m relates to capital invoices falling due in Quarter 1 of 2026/27, therefore artificially inflating the position.*

Performance Analysis

The Performance Management and Accountability Framework of OUH governs the oversight and delivery of the Trust's strategic and performance objectives. This Framework encompasses both strategic and routine ('business as usual') goals, as well as National Oversight Framework and contractual indicators within the organisation, including those with multi-year targets.

The Framework ensures a comprehensive focus from the Board to ward level on Corporate Governance, Risk Management, Accountability and Performance Management, seamlessly integrated across the Trust's Clinical and Corporate Divisions.

The Performance Analysis section provides an analysis of performance and associated risks for the principal metrics in the Performance Overview section. These are the key metrics within the NHS Oversight Framework that pertain to the NHS Long Term Plan, the 2025/26 priorities and operational planning guidance, and local priorities.

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

Elective Care, Cancer and Diagnostics

Patients waiting for elective care

Access within our elective pathways improved for patients waiting within 18 weeks and long waiters above 52 weeks.

At the end of March 2026, 63.0% of patients on a Referral to Treatment (RTT) pathway were waiting for under 18 weeks, which met the operating plan target and national expectation (63.0%). There were 1,590 patients waiting over 52 weeks (1.8% of the total waiting list), better than the target (1,650 or 2.0% of the total waiting list) and an improvement on 2,711 as of March 2025. This was due to a sustained effort by thousands of Trust staff overseen by the Chief Operating Officer and supported by our internal Delivery Fund funding increases in capacity and insourcing across a range of services.

Under the National Oversight Framework, OUH ranked 77th of 131 providers for patients waiting under 18 weeks (Segment 2) and 101st of 131 for patients waiting over 52 weeks (Segment 3), based on Quarter 3 - latest position available at the time of writing.

OUH did not meet the operating plan target for first outpatient appointments (68.0% vs plan of 69.10%), which will remain a focus for 2026/27.

Cancer performance

The Trust's operating plan was targeting gradual improvement against the 28-day Faster Diagnosis Standard (FDS) in-year, with a planned weighted average of 80%. OUH delivered a sustained improvement trajectory and achieved 82.9% in March, exceeding the 80% target. However, actual average annual performance over the course of 2025/26 was slightly below target at 79.5%.

The 62-day cancer standard was not achieved, recording 60.2% against the operating plan target of 71.1%. OUH has been working to address our longest waiting patients

waiting over 62 days for cancer care, and this has reduced from 428 patients as of April 2025 to 262 as of March 2026.

Under the National Oversight Framework, OUH ranked 36th out of 118 providers for the 28-day FDS (Segment 1), and 91st for the 62-day cancer standard (Segment 3), based on Quarter 3 - latest position available at the time of writing.

OUH cancer demand is significantly above pre-pandemic levels and continues to grow year-on-year. The achievement of the 28-day FDS has been supported by the Trust's investment in increasing diagnostic capacity as well as capacity from the Community Diagnostic Centre. Improvement in performance is the focus of specific initiatives within the Trust's Cancer Improvement Programme.

Diagnostic performance

Diagnostic waiting time performance is a fundamental aspect of delivering elective treatment for patients within timeframes set in the Trust's operating plan, as well as the national standards.

The operating plan target for the percentage of diagnostic tests conducted within six weeks was not achieved. Performance at the end of March 2026 was 79.1% (an improvement on last year's 76.3%) but below the operating plan target of 95.0%.

Challenges to performance were noted in the modalities of Audiology and Endoscopy and these are the subject of improvement plans for 2026/27. Additional internal funding and resourcing have been put in place to partially mitigate this.

Urgent and Emergency care

A&E performance

A&E performance improved during 2025/26 and exceeded the operating plan target for the percentage of patients attending the ED for less than four hours from arrival to admission, transfer or discharge. Performance for 'all types' was 78.5% against the target of 78.0%, while 'type 1' performance was 70.7%.

'Type 1' activity, which accounts for around 72% of attendances, relates to the Emergency Departments at the John Radcliffe and Horton General hospitals. 'All types' also includes 'type 2' single specialty departments and 'type 3' Minor Injury Units. Compared to 2024/25, performance improved by 6.3% for 'all types' and by 6.8% for 'type 1' attendances.

The percentage of patients waiting over 12 hours in A&E reduced to 2.1%, better than the operating plan target of 4.4% and improved from 4.6% in 2024/25. Nationally, OUH ranked in Segment 1 for both indicators, placing 21st of 123 providers for the four-hour standard and 12th of 123 providers for 12-hour waits, based on Quarter 3 data.

This was achieved in the context of further increases in patient demand. Attendances were 5.5% higher at the Horton and 0.9% higher at the John Radcliffe Hospitals. The total increase in 'type 1' attendances at the OUH was 2.2% compared to 2024/25.

Quality and Safety

Mortality

The Trust references two mortality indicators: the SHMI, which is produced by NHS Digital, and the HSMR+ produced by Dr Foster Intelligence. Both are standardised mortality indicators, expressed as a ratio of the observed number of deaths compared to the expected number of deaths adjusted for the characteristics of patients treated at a Trust.

While both mortality indicators use slightly different methodology to arrive at the indicator value, both aim to provide a risk adjusted comparison to a national benchmark (1 for SHMI or 100 for HSMR+) to ascertain whether a Trust's mortality is 'as expected', 'lower than expected' or 'higher than expected'.

The SHMI and HSMR confirm that the Trust continued to compare favourably with national mortality benchmarks.

Maternity

Our maternity services have been under significant patient, family and media scrutiny during the year, and we have continued to place significant focus on measures of performance.

Stillbirths per 1,000 achieved the national threshold and demonstrated continuing improvement over three years (2.8 per 1,000 compared to 3.2 in 2024/25 and 3.7 in 2023/24), indicating sustained effectiveness of interventions. Regular pathway reviews ensure our care remains of the highest standard. The birth-to-midwife ratio also demonstrates ongoing improvement (1:23.9 vs 1:25), with strategies in place for recruitment, retention, and roster optimisation aimed at achieving the target of 1:22.9.

There has been slight increase in neonatal deaths per 1,000 live births, postpartum haemorrhage and 3rd and 4th degree rate tears. Enhanced monitoring for at-risk pregnancies, robust clinical protocols, and advanced neonatal resuscitation training is embedded within current practice. Active collaboration with regional networks and frequent audits facilitates timely identification and resolution of issues, while antenatal education and parental engagement initiatives offer comprehensive support throughout the care journey.

Dedicated panels with independent external representation systematically review each neonatal death to determine causes, any local learning and actions, and outcomes are reported regularly to the Trust Board. Risk adjusted perinatal mortality rates benchmarked against similar organisations are published by MBBRACE-UK.

Infection Prevention and Control

Each year NHS England assigns the Trust a threshold for healthcare-associated *Clostridioides difficile* (*C. difficile*) infection and *Escherichia coli (E. coli*) bacteraemia cases. This data is reported to the UK Health Security Agency (UKHSA).

There has been a reduction in healthcare-associated *C. difficile* this year with the number below the NHSE target value. All *C. difficile* and MRSA cases are investigated using Trust's Patient Safety Incident Response Framework (PSIRF) for the purpose of learning

and improving patient safety. The reduction in *C. difficile* is especially positive and follows the successful work of the antimicrobial stewardship team and the Trust in reducing antibiotic use in general, and certain antibiotics in particular.

There has also been a reduction in MRSA cases from 9 cases to 6 cases. Last year 11 cases of MRSA were reported but this was revised to 9 cases on review. The thresholds set for healthcare-associated MRSA and *E. coli* for 2025/26 were not achieved this year.

These figures are in the context of a national increase in E. coli, and a small decrease in hospital onset cases of both *C. difficile* infection and MRSA bacteraemia in the last year.

Hospital-Acquired Pressure Ulcers (HAPUs)

During 2025/26, the Trust delivered a comprehensive Quality Improvement Programme (QIP) aimed at reducing HAPUs through targeted interventions and workforce education.

This programme has delivered sustained improvement, achieving a 4.4% reduction in Category 2 pressure ulcers per 1,000 bed days, building on the 24.6% reduction achieved in the previous year. The QIP will be reviewed and refreshed for 2026/27 to build on this improvement, incorporating the learning and progress achieved during the year.

Patient Experience

Patient Feedback

Results of national CQC surveys for Adult Inpatients and Maternity Services have been published in 2025/26 – both surveys were conducted in 2024/25. The results of these were mixed, indicating minor improvements in some areas, and deterioration in others.

Findings from both surveys informed action plans produced by the services - these will be monitored by the Clinical Governance Committee and Maternity Safety Champions.

Promoting Smoking Cessation

In December 2024, a planned EPR change meant that the questions related to smoking were removed from the clerking template into a standalone smart update. This has meant that the reported number of service users referred to both Inpatient and Outpatient Tobacco Dependency support has increased substantially in the last 12 months.

This has since stabilised for the Inpatient services, whereas Outpatient support referrals are continuing to grow. In Maternity, services continued to strengthen support for smoking cessation in pregnancy, recognising its importance for improving outcomes for women and babies. A total of 374 referrals were received during the year for women who met the criteria and were offered specialist smoking cessation support. Of these, 147 women took up the offer, demonstrating meaningful engagement with the service.

Our People

Looking After Our People

Sickness absence rates have increased marginally on 2024/25, from 4.16% to 4.22%, or a 0.06% increase.

NHS Staff Survey 2025 and other survey results presented a mixed picture. The Trust's scores deteriorated on average from prior year, although they remain above national average. Staff engagement theme score decreased from 6.98/10 to 6.85/10 but remains above the national benchmarked average score of 6.74. On the other hand, for our doctors in training, the overall satisfaction score measured through the National Education and Training Survey has improved from 75.00 to 77.18.

The 'raising concerns' sub-score decreased from 6.46/10 to 6.31/10. This deterioration reflects the national decline in this domain, indicating that staff are feeling less confident in speaking up about concerns. Positively, however, the Freedom to Speak Up cases at OUH have increased on 2024/25 in the same period. The People and Communications Directorate has continued to support staff wellbeing. Key initiatives are described further in the Staff Report section of the Annual Report.

Belonging in the NHS

Although there has been little change to gender or ethnicity make up of our most senior workforce, we are continuing to put in place improvements to ensure our staff feel safe and appreciated, irrespective of their background.

We have held conference events for Black History Month, International Day for Persons with Disabilities, and International Women's Day, as well as working with our Staff Networks to implement initiatives that advance equality. Our new Reasonable Adjustments Policy is in operation to better support our disabled staff in the workplace.

We implemented an accountability intervention for recruitment of consultants to mitigate against bias and enable equality of opportunity for candidates. This involves panels having to provide clear justifications for their recruitment decisions, with those justifications being regularly reviewed by the Chief People Officer.

Finance

Income and expenditure

NHS legislation expects ICSs and provider trusts to deliver a break-even control total financial performance. The Trust belongs to BOB ICS made up of the local ICB and the NHS Trusts in that area. From the 1st of April 2026, BOB ICB has merged with Frimley ICB to form the Thames Valley ICB.

The NHS measures financial performance of trusts by adjusting for some transactions outside of the Trust's control. This is known as adjusted performance or the control total.

There has been an increased focus on finance across all NHS providers, driven by NHS England and the Department of Health and Social Care. The Trust's performance against its control total improved significantly from a £6.8m deficit in 2024/25 to a £7.0m surplus in 2025/26.

This improvement is attributed to Trust's own efforts through its productivity and efficiency programme, but also to receipt of in-year deficit support funding from NHS England totalling approximately £19.3m. The Trust remains committed to reducing its agency expenditure, with further reduction of £4.7m against 2025/26. Agency costs now represent only 0.3% of Trust's total staff cost.

The £5.0m over delivery against the planned surplus of £2.0m in year was the result of a Quarter 4 national redistribution of additional deficit support funding from ICSs that failed to deliver their planned financial performance for 2025/26.

Capital Expenditure

In total, the Trust invested a total of £137.7m in capital expenditure from all funding sources in 2025/26, compared to the investment of £82.2m in 2024/25. This was £45.8m higher than the capital plan agreed at the start of the year.

The variance against plan was due to a number of additional national PDC funded capital awards made to the Trust in year, and transfers of capital allocation from the region to the Trust to offset underspends elsewhere.

Some of the largest capital schemes progressed in-year included:

- Circa £25.7m spend Surgical Elective Centre build on the John Radcliffe site;
- Circa £4.6m on associated Surgical Elective Centre equipment costs;
- Circa £18.2m spend on Private Finance Initiative (PFI) life-cycling costs.

NHS England requires the Trust to agree a limit for projects within the allocated budget of the ICS Capital Departmental Expenditure Limit (CDEL). The 2024/25 ICS CDEL allocation for the Trust, excluding the impact of IFRS16, was £16.3m. The in-year £11.9m overspend against this allocation was agreed with the ICS to absorb underspends by other system providers.

Cash

The Trust's cash balance on 31 March 2026 was £75.4m, compared to £12.5m on 31 March 2025. Circa £50m of this cash balance relates to capital invoices that are falling due in April and May of 2026. The Trust has continued to manage cash carefully over the course of the financial year and drew down £11.3m of working capital support from NHS England to address deferred supplier payments.

Proactive management will continue to be a focus for the year ahead. However, at this stage, the Trust does not anticipate requiring further NHS England cash drawdowns in 2026/27. Enhanced oversight will be provided by the Trust Board and its Committees.

Productivity

The latest available productivity data released by NHS England is as of Month 9 of 2025/26. Based on this, the Trust has seen implied productivity growth of 2.4% against 2024/25, which exceeds the national improvement target of 2%. However, this has reduced from 4.7% recorded in Month 1 of the year.

Overall, costs have remained flat in real terms, but corresponding increases in activity have slowed over the course of 2025/26. The Trust has been particularly successful in controlling workforce costs, but non-pay cost growth remains a challenge and a focus moving into 2026/27.

Looking to 2026/27

Long-term financial sustainability remains a key strategic objective for the Trust and nationally, with a focus on medium-term planning and returning to balance. For 2026/27,

we expect the focus to be on improving financial and operational performance through delivery of additional elective activity following the opening of the Surgical Elective Centre on the John Radcliffe site, alongside implementing more robust non-pay cost control measures.

Risk Profile of the Trust

The Board Committees of the Trust have reviewed the Corporate Risk Register regularly during 2025/26, as set out in the Annual Governance Statement of this Annual Report.

This high-scoring (principal) risks were:

1. As a result of lack of capacity in beds and staffing, there was a risk to the delivery of our elective care delivery plan that might affect patient outcomes and experience.
2. Due to issues with diagnostic capacity, there was a risk to our ability to reduce the current backlog of patients waiting for cancer diagnosis and treatment that might cause patient harm.
3. Due to increased demands for services, there was a risk in relation to the failure to effectively control pay and non-pay costs which may lead to the inability to achieve in year financial targets and break-even position. In addition, this had a further impact on the Trust's cash position.
4. Due to local interest groups and other external factors, there is a risk of poor public and patient confidence and reduced staff morale.
5. Due to increases in workload, there is a risk that sickness levels may increase linked to work related stress.
6. As a result of productivity levels that were insufficient to cover costs based on national average funding levels, there was a risk around the potential inability of the Trust to break even over the next three to five years which might affect the Trust's ability to sustain safe, compliant and effective provision of healthcare.

The risks have been tracked over time with changes in risk scores, and changes to controls being updated and agreed by the Risk Committee. For example, the financial position has been monitored during the year at Board and Committee level, as well as additional briefings held with Non-Executive Directors outside of Committee cycle.

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

Green Plan and Decarbonisation

In October 2025, in line with NHS England guidance, the Trust launched its Green Plan 2025-2028. The plan (available on our website) has 32 actions ranging from upskilling our staff on sustainability to sustainable procurement and enhanced reporting and tracking the impacts of carbon reduction projects.

Decarbonisation initiatives

The Trust's decarbonisation initiatives for 2025/26 included the following:

- Securing a range of grants to support energy management and facilitate carbon reduction, including:
    - £100,000 to fund sub metering for energy
    - £4.5 million grant was to fund LED lighting across the four hospitals, with installation already commenced and likely to save over 2,000 tonnes of CO2e per annum as well as cutting annual energy costs
    - £24,000 of Heat Network Efficiency Scheme (HNES) revenue funding from the Department for Energy Security and Net Zero to support a heat network optimisation study across our hospital sites
- Development of greener inhaler guidance and training for clinicians to support patients in switching to dry power inhalers (DPIs) where safe and effective to do so, resulting in a reduction of 200 tonnes CO2e in 2025/26
- 13% (or 212,000 miles) reduction in business miles from continued use of tele-medicine and tele-conference
- Solar panels at the Horton General Hospital and Swindon Radiotherapy Centre generating 233 MWh this year, avoiding over 40 tonnes of carbon from grid electricity
- Use of Hydrotreated Vegetable Oil (HVO) for dual-fuel boilers at the Horton Hospital, avoiding 20 tonnes of CO2e compared to gas oil previously used.

Taskforce on Climate-related Financial Disclosures (TCFD)

NHS England's NHS Foundation Trust Annual Reporting Manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis. All four pillars require to be disclosed from 2025/26 onwards.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. However, OUH goes beyond the NHS GHG methodology, ensuring compliance to the GHG Protocol and therefore reports emissions associated with in-year activities.

Governance Pillar

The OUH Green Plan 2025-28 sets out the governance structure, wider accountability and board visibility of climate-related issues. The plan was approved at Public Board in the year, with TME approving the Terms of Reference of a cross-divisional Sustainability Steering Group (SSG) who will monitor the progress of Green Plan actions. A Sustainability Working Group replaces the Staff Sustainability Network with a more structured approach to developing carbon reduction projects from all areas of the workforce.

A six-monthly progress update is presented to Delivery Committee on environmental aspects of OUH as an anchor institution and wider sustainability themes including Social Value and green spaces. The Head of Sustainability and Carbon Management is responsible for updating the climate-related risks on the Corporate Services Risk Register and has commenced completing the NHS Climate Change Risk Assessment Tool (CCRA). A development session on TCFD will further inform Board about climate-related issues and the required action from business strategy planning and objectives.

Strategy pillar

The Green Plan outlines OUH's objectives, initiatives and activities in reducing the Trust's carbon footprint. It both acts as a strategy for the Trust's activities and aligns to other complementary OUH strategies – such as the Digital Strategy and the Clinical Services Strategy.

Completion of the CCRA in 2026/27 will further support planning over the short-, medium- and long-term, and work has begun to gather the data for this Green Plan action. OUH actively participates in research to understand the long-term impact of extremes of weather specifically heatwaves on our built estates, service demand and vulnerable patients.

The completion of a carbon reduction plan for the Trust in 2026/27 with costed projects will also support the Trust's financial planning to address climate related issues.

Risk Management pillar

The Trust has a twofold approach to managing climate-related risks:

- Physical risks (both acute e.g. flooding and chronic e.g. heatwaves) to the assets, service delivery, workforce and supply chain are recorded by the Emergency Planning Officer
- Climate-related issues, such as heat waves and flooding, have been captured on the Corporate Services Risk Register. Following the upcoming Board development session, the Climate risk will be discussed and escalated to the Corporate Risk Register for monitoring by Risk Committee.

Metrics and target pillar

The Trust has a legally binding target to achieve net zero by 2040 over core emissions which it directly controls and by 2045 for footprint plus. Tonnage (including a wider subset of scope 3) and progress against targets is captured below. Historic GHG emissions for the Trust from Base Year to date are included.

In 2026/27, OUH will publish its GHG accounting methodology, including accounting boundary approach, and report relative, as well as absolute, emissions to strengthen our work in this area.

	Base Year	Year 1	Year 2	Year 3
	OUH 2022/23 tCO_2e	**OUH 2023/24 tCO_2e**	**OUH 2024/25 tCO_2e**	**OUH 2025/26 tCO_2e**
OUH Carbon Footprint				
Scope 1				
Anaesthetic gases	3,619	2,997	2,456	2,170
Fossil fuels	26,839	22,925	20,900	19,671
NHS Facilities[1]	388	388	273	112
Fleet & leased vehicles[2]	38	78	93	96
Scope 2				
Electricity (Grid)[3]	6,768	7,906	9,118	7,125
Scope 3 Carbon Footprint CORE				
Business Travel[4]	582	518	585	475
Well-to-Tank[5]	7,098	6,550	6,611	6,179
Inhalers	1,140	1,167	1,093	892
Waste	613	968	523	500
Water	264	220	152	185
Total Emissions Direct Control	**47,349**	**43,817**	**41,804**	**37,419**
OUH Carbon Footprint PLUS				
Staff Commuting[6]	16,367	16,569	18,009	17,866
Business Services (Logistics/couriers) captured currently[7]	313.68	313	337	344
Non – Emergency Patient Transport (Taxi)[8]	30	23	23	25
Total Emissions	**64,059**	**60,721**	**60,173**	**55,653**

Notes:

1. Fugitive emissions from fluorinated gases (leaked refrigerants) have been reported previously as OUH followed the GHG Protocol prior to recent inclusion in the NHS methodology and footprint.
2. This includes owned fleet and pool vehicles; data quality and capture have improved this year.
3. Previously purchased Renewable Energy Guarantees of Origin (REGO) backed electricity was reported as location-based emissions. We also generate electricity on site from solar PV which is zero carbon
4.For business travel we include flights, train journeys, overnight hotel stays (from Year 2), reclaimed business miles (grey fleet), the inter-site shuttle buses and staff taxi data.
5.Emissions associated with the supply of natural gas, transmission and distribution of electricity, and the supply of fuel for use by NHS Fleet, business-use only leased vehicles, and business travel vehicles. Calculated using UK Government greenhouse gas conversion factors applied to Trust fuel, energy and travel activity data. Includes WTT on all fuels, business travel and fleet and leased vehicles.
6. The figure was calculated using a recognition estimation methodology based on latest staff numbers, staff travel patterns established via a comprehensive staff travel survey in 2024, and relevant carbon factors. A single figure is reported and includes Well-to-Tank
7. A single figure is reported and includes well-to-Tank
8. A single figure is reported and includes well-to-tank

The Trust continually expands its GHG Inventory as and when better data is available and will adjust previously reported data if material. The Trust uses the BEIS carbon factors for the years in which most of its financial year fell in line with the GHG protocol.

Tackling health inequalities and equality of service delivery

The Trust's Health Inequalities (HI) Programme was developed in response to the NHS Long Term Plan and supports the NHS Ten Year Plan ambitions. The programme focuses on HI systematically and working with local partners to develop population health management approaches.

In 2025/26, OUH strengthened the integration of HI inequalities considerations into service planning and transformation programmes, and continued development and use of HI dashboards. Improved access to timely and relevant data has enabled teams to identify unwarranted variation, review performance and target action more effectively.

OUH has continued to support Oxfordshire's ambitions to achieve 'Marmot Place' status through the Oxfordshire Inclusive Economy Partnerships Charter and a focus on inclusive recruitment, procurement of goods and services, estate use and reducing environmental impact.

The Trust also strengthened its approach to inclusion and fairness across patient care and the workforce, using demographic data, feedback and quality intelligence to identify inequalities and support more inclusive decision-making. This work aligns with the NHS People Plan, the OUH Strategy and BOB ICS priorities.

Partnership working has remained central to delivery. The Trust has continued to work closely with system partners, including local authorities, Healthwatch Oxfordshire and the Health Innovation Network, to strengthen community engagement, improve access and experience, and respond to identified needs.

Key additional achievements in 2025/26 included further improvements to interpreting and translation services, enhanced focus on equitable access initiatives, and continued expansion of patient safety partner roles. These partners now play a more visible role in shaping safety, patient experience and Quality Improvement work, ensuring patient voices inform decision-making. The Friends and Family Test (FFT) has also been further developed, with expanded multilingual access supporting more inclusive patient feedback.

Human rights policies

Understanding of human rights, and responsibilities of staff under the Human Rights Act 1998, are covered within the Trust's Core Skills training on Equality, Diversity and Human Rights. All staff are required to complete this training and refresh themselves on it every three years.

Compliance rate for 2025/26 with this training is 94.6%. The training is regularly reviewed in line with best practice and any changes to legislation.

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

Disclosures

The Trust is required to make the following disclosures.

Overseas operations

The Trust has no overseas operations.

Important events since balance sheet date

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

Going concern disclosure

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

Further reading

OUH Quality Account

The Quality Account of the Trust incorporates all the requirements of the Quality Account Regulations (which include detailed reporting on a number of Quality Indicators) as well as a number of additional reporting requirements set by NHS England. The Quality Account is expected to be published on the Trust website at www.ouh.nhs.uk/about/publications/#accounts in July 2026.

Glossary

A list of NHS terms and abbreviations has been published on the Trust website at www.ouh.nhs.uk/about/publications/documents/annual-report-glossary.pdf.

Signed: 

Simon Crowther
Interim Chief Executive Officer
25 June 2026

Accountability Report

The Accountability Report of Oxford University Hospitals NHS Foundation Trust's Annual Report 2025/26 comprises the following reports.

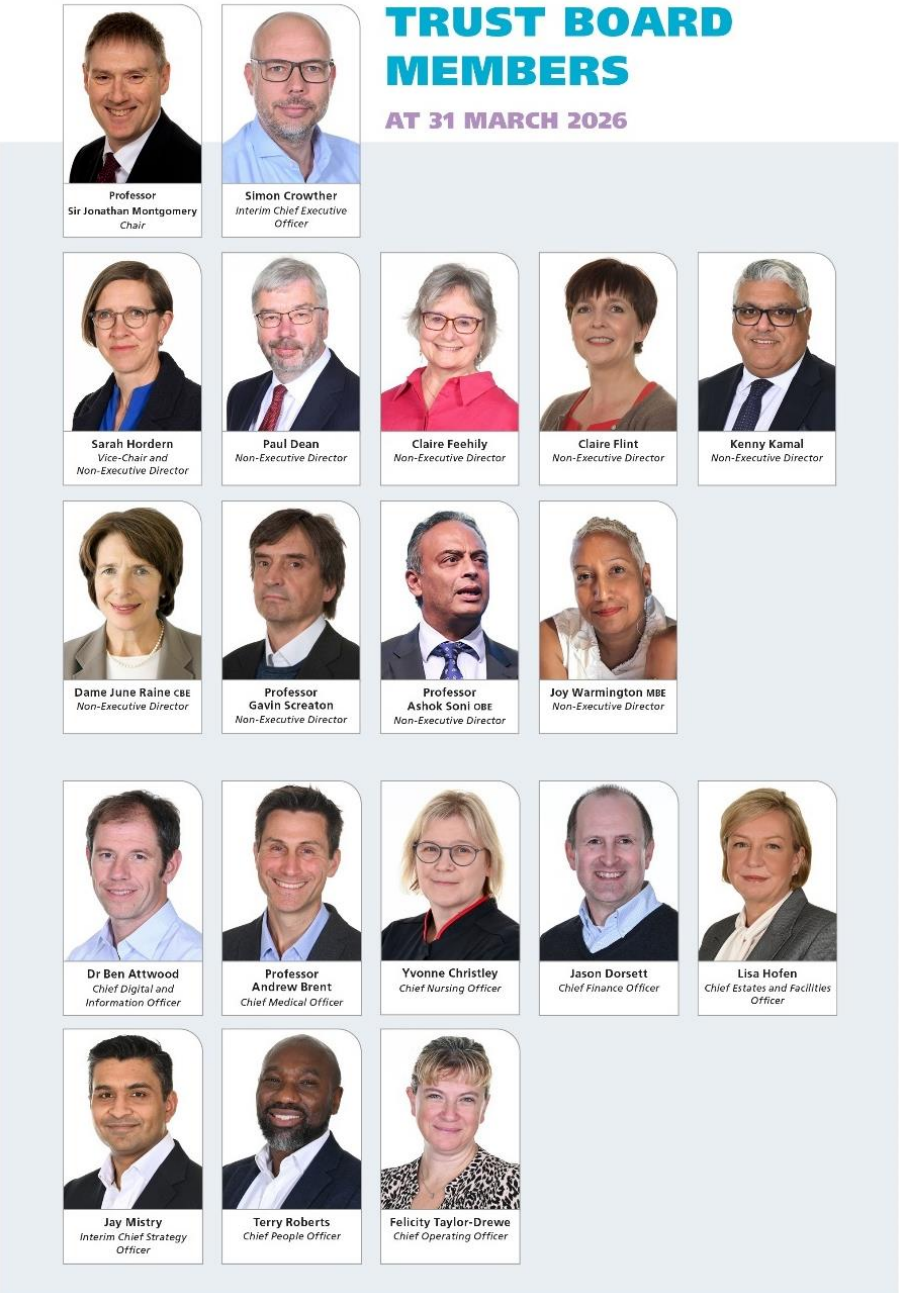
- Directors' Report
- Trust Membership and Council of Governors
- Remuneration Report
- Staff Report
- Code of Governance Compliance
- NHS Oversight Framework
- Statement of Accounting Officer's Responsibility
- Annual Governance Statement

Directors' Report

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

Board Membership

The Board of Directors of Oxford University Hospitals NHS Foundation Trust comprised the following individuals as at 31 March 2026.



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

Non-Executive Directors

Professor Sir Jonathan Montgomery, *Trust Chair (until 31 March 2026)*
Ms Sarah Hordern, *Vice-Chair*
Mr Paul Dean
Ms Claire Feehily
Ms Claire Flint, *Senior Independent Director (until 31 March 2026)*
Mr Kanwaljit Kamal *(from 1 January 2026)*
Ms Katie Kapernaros *(until 31December 2025)*
Dame June Raine CBE *(from 1 December 2025)*
Professor Anthony Schapira *(until 30 November 2025)*
Professor Gavin Screaton
Professor Ashok Soni OBE
Ms Joy Warmington MBE

Executive Directors

Professor Meghana Pandit, *Chief Executive Officer (on secondment as Co-National Medical Director – Secondary Care from 1 April 2025) (not pictured)*
Mr Simon Crowther, *Acting Chief Executive Officer (from 1 April to September 2025), Interim Chief Executive Officer (from September 2025)*
Dr Ben Attwood, *Chief Digital and Information Officer*
Professor Andrew Brent, *Chief Medical Officer*
Ms Yvonne Christley, *Chief Nursing Officer*
Mr Jason Dorsett, *Chief Finance Officer*
Ms Lisa Hofen, *Chief Estates & Facilities Officer (from 27 October 2025)*
Mr Mark Holloway, *Chief Estates & Facilities Officer (until 31 August 2025)*
Mr Terry Roberts, *Chief People Officer*
Ms Felicity Taylor-Drewe, *Chief Operating Officer*
Mr Jay Mistry, *Interim Chief Strategy Officer (from 23 March 2026)*

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

During the year the Trust's substantive Chief Executive, Professor Meghana Pandit, was on a full-time secondment to NHS England as Co-National Medical Director – Secondary Care from 1 April 2025 to 31 March 2026. Professor Pandit did not attend any meetings of the Trust Board or its committees during year. We have therefore followed the requirements of the NHS Foundation Trust Reporting Manual and excluded Professor Pandit from all disclosures in the report relating to members of the Board of Directors.

Biographies of Board members

The biographies of the Board members who served in the Trust Board during the reporting period are given below. The biographies of the current members of the Trust Board can be found on the Trust website at www.ouh.nhs.uk/about/trust-board/directors.

Professor Sir Jonathan Montgomery, Trust Chair

Jonathan is a Professor of Healthcare Law at University College London and Chair of the Ethics Advisory Committee of Genomics England.

He has served on local NHS boards in Hampshire and the Isle of Wight for more than 20 years up to March 2013, including being the Chair of a group of Primary Care Trusts, a Strategic Health Authority and two provider Trusts, and was a member of the panel of advisers to the Morecambe Bay Investigation, which was reported in 2015. He is also a past Chair of the Health Research Authority, the Advisory Committee on Clinical Excellence Awards and the Nuffield Council on Bioethics and the Human Genetics Commission.

During the COVID-19 pandemic, he was the Co-Chair of the Moral and Ethical Advisory Group in the Department of Health and Social Care (DHSC). In 2020, he chaired the Ethics Advisory Board to NHSX, a join unit of the NHS and DHSC that focused on digital transformation, on the development of a COVID-19 contact tracing app. In 2021 he co-chaired the independent review into the legal, clinical and ethical aspects of the cosmetic procedure hymenoplasty. In 2024, Professor Sir Jonathan was appointed as the Chair of the expert group advising the Cabinet Office on responding to the Infected Blood Inquiry's recommendations on compensation.

Jonathan was awarded a Knighthood in the 2019 New Year Honours List for Services to Bioethics and Healthcare Law.

Mr Simon Crowther, Acting Chief Executive Officer *(1 April 2025 – September 2025)* ***and Interim Chief Executive Officer*** *(from September 2025)*

Simon worked as the Chief Finance Officer and Deputy Chief Executive at University Hospitals of Derby and Burton (UHDB) NHS Foundation Trust before joining the Trust.

Simon formerly held roles at Board level in a number of NHS organisations and has worked across different sectors and health communities within the NHS throughout his career. Prior to his role at UHDB, Simon spent over five years as the Executive Director of Finance, Information and Estates at a large mental health, community and specialised services provider.

In his role as Deputy Chief Executive Officer for the Trust, Simon focused on strategy, planning, improvement, innovation and delivery. He is currently Vice President of the Healthcare Financial Management Association and Vice-Chair of the National Finance Academy.

Simon was appointed as Acting Chief Executive Officer on 1 April 2025 when Professor Meghana Pandit was appointed as Co-National Medical Director – Secondary Care in the NHS Transformation Executive Team.

Simon was appointed as Interim Chief Executive Officer in September 2025 to cover the remaining period of Meghana's secondment.

Ms Sarah Hordern, Vice-Chair and Non-Executive Director

Sarah has extensive Board experience in public limited company (plc), private and mutual entities focusing on operational property management and real estate development.

Her current portfolio combines a mix of Non-Executive, consulting and Executive roles. Her advisory business supports landowners to deliver long-term value by creating visionary places which enhance their operating activities.

Sarah is a Chartered Accountant and was Joint Chief Executive and Finance Director at Newbury Racecourse PLC for 15 years. She led the redevelopment of the racecourse, creating a new community of 1,500 homes with the racecourse at its core. She was subsequently Chief Operating Officer for the Meyrick Group, a complex multi-site private property group with commercial, leisure and residential interests.

She was a Non-Executive Director at Newbury Building Society, one of the largest shared ownership lenders in the UK.

Mr Paul Dean, Non-Executive Director

Paul lives in West Oxfordshire and is a chartered management accountant with extensive Audit Chair and Chief Finance Officer experience gained in a range of multi-national companies.

He has worked in both private equity and PLC environments, including FTSE 100 and FTSE 250 companies. He also has extensive experience as a Trustee of various charities.

Ms Claire Feehily, Non-Executive Director

Claire lives in Gloucestershire and is Vice-Chair of the Brandon Trust, which provides learning disability services in Oxfordshire and throughout the southwest of England.

She is a qualified accountant with extensive experience gained in a range of executive, non-executive and trustee board positions in government, NHS and charitable settings.

Claire is the Chair of the Audit and Risk Committee and Senior Independent Director at the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (a role that will continue until the ICB is reorganised in June 2026); a former Chair of Healthwatch Gloucestershire; and also a Non-Executive Director and Audit Committee Chair at Gloucestershire Hospitals NHS Foundation Trust until Summer 2023 before she joined the Oxford University Hospitals NHS Foundation Trust Board.

Ms Claire Flint, Senior Independent Director and Non-Executive Director *(until 31 March 2026)*

Claire has a portfolio career consisting of a number of Non-Executive roles. She is a Non-Executive Director and Remuneration Committee Chair at Atomic Weapons Establishment.

Claire was previously the Group Human Resources and Brand Director at Oxford Instruments PLC, a leading international provider of hi-tech tools, systems and products, where she served on the Management Board for more than ten years. She was also the Senior Independent Director at National Nuclear Laboratory and chaired their

Remuneration Committee. Prior to this, she held several senior roles in Human Resources including Diageo, Bass and NatWest.

Mr Kanwaljit Kamal, Non-Executive Director *(from 1 January 2026)*

Kanwaljit is Global Chief Information Officer at Open Society Foundations.

He has more than 30 years of global IT and digital leadership experience in large, complex organisations where strong governance, clear strategy and practical delivery make a direct difference to frontline services, including as Global Chief Information Officer at Oxfam and Director of UK Cyber Security at Microsoft.

Ms Katie Kapernaros, Non-Executive Director *(until 31 December 2025)*

Katie is an experienced IT professional who has spent 30 years in the industry, managing large teams across the world. She is a Fellow of the British Computer Society.

She holds Non-Executive roles at the Property Ombudsman, the Pensions Regulator and Manx Care, sitting on various committees.

Katie has been a Charity Trustee and is heavily involved in sport, both participating and volunteering.

Dame June Raine CBE *(from 1 December 2025)*

June is the former Chief Executive of the Medicines and Healthcare products Regulatory Agency (MHRA), where she led the organisation through the UK's regulatory response to the COVID-19 pandemic.

A medical doctor trained in Oxford, with a background in pharmacology and drug safety, June has spent more than four decades in public health and medicines regulation, championing patient involvement and evidence-based innovation.

Professor Anthony Schapira, Non-Executive Director *(until 30 November 2025)*

Anthony was appointed as a Consultant Neurologist at the Royal Free Hospital and the National Hospital for Neurology and Neurosurgery in 1988, and as the Chair of the Department of Clinical Neurosciences at the University College London (UCL) Institute of Neurology in 1990.

His research interests focus on neurodegenerative disease, particularly Parkinson's and other movement disorders. He is the Principal Investigator on several UK and US funded research programmes for neurodegenerative diseases and the Chief Investigator of the Parkinson's and Ambroxol study. During his career he has won a number of awards for his research and was elected a Fellow of the Academy of Medical Sciences in 1999.

He was a Non-Executive Director of Royal Free London NHS Foundation Trust from 2009 to 2020 and chaired the Trust's Clinical Standards and Innovation Committee and was a member of the Remuneration Committee.

He also has extensive Board experience in the broader public sector including as a Non-Executive Director on the Board of the Ministry of Justice, Office of the Public Guardian from 2012 to 2018 and as a current member of the NHS Independent Reconfiguration Panel.

Professor Gavin Screaton, Non-Executive Director

Gavin is a Professor of Medicine and Head of the Medical Sciences Division at the University of Oxford.

He received his first degree from Cambridge in 1984 before moving to Oxford to complete his medical studies in 1987. He then completed training in general internal medicine and obtained a DPhil from Oxford University in 1998.

In 2004, he was appointed to the Chair of Medicine at Hammersmith Hospital, Imperial College and became Dean of the Faculty of Medicine in 2015. He returned to the University of Oxford as Head of the Medical Sciences Division in October 2017.

His research concerns the immunology of infectious diseases with an interest in dengue and Zika virus infections. He is a Fellow of both the Academy of Medical Sciences and the Royal College of Physicians and was a Senior Investigator in the National Institute for Health Research.

Professor Ashok Soni OBE, Non-Executive Director

Ashok studied Pharmacy at Portsmouth School of Pharmacy and, after graduating in 1983, he began his Pharmacy career in Central London and opened the first of his three pharmacies in 1986.

In early 2004, he was one of the first pharmacists to qualify as a supplementary prescriber and he qualified as an independent prescriber in June 2007.

He has been Chair of the National Pharmacy Association's Board, is a past President, Assembly and English Pharmacy Board Member of the Royal Pharmaceutical Society, and is a former Vice President of the International Pharmacy Federation.

He is currently Chair of Pharm@Sea, a wholly owned subsidiary of University Hospitals Sussex and a clinical advisor to the National Association of Primary Care.

He has held a number of roles with Lambeth Clinical Commissioning Group, including Clinical Network Lead and Professional Executive Committee Chair, and has received an OBE for Services to Pharmacy and the NHS.

Ms Joy Warmington MBE, Non-Executive Director

Joy is Non-Executive Champion for Freedom to Speak Up.

As CEO of brap, Joy also spearheads their work on learning and change. Joy's area of expertise is leadership and organisational development, and she applies this lens to the work that brap does with organisations, boards, and leadership teams.

Recently, Joy led on the design and delivery allyship programmes for white leaders in partnership with the King's Fund and has created clear paradigm shifting work about the implementation of anti-racism. Joy works with many NHS organisations and nationally across health and social care systems.

As a lifelong learner, Joy has an MSc in Organisational Development and Learning, a Certificate in Education PGCE, a Postgraduate Diploma in Multicultural Education, and a Certificate in Process Work (from the Deep Democracy Institute - Oregon). She is currently qualifying as a psychotherapist.

Joy was awarded an MBE in 2019 for services to healthcare and the community in the West Midlands and is a Visiting Professor for Middlesex University Business School.

Dr Ben Attwood, Chief Digital and Information Officer

Ben has spent 25 years in clinical training and practice with 10 years of experience as a Consultant in Intensive Care and Anaesthesia. He first joined the Trust as Divisional Director for Clinical Support Services in March 2022.

During his career, he has developed expertise in not only the use of digital technology to transform patient care but also senior medical management and leadership. Before joining the Trust, he was the Chief Clinical Informatics Officer and Associate Medical Director for Technology and Transformation at South Warwickshire NHS Foundation Trust.

Professor Andrew Brent, Chief Medical Officer

Andrew trained in medicine at the University of Cambridge and University of Oxford followed by postgraduate medical training in London and Oxford.

He was first appointed as a Consultant in Infectious Diseases and Medicine at the Trust in 2015. From 2018 to 2021 he was Clinical Lead for Infectious Diseases, and the Deputy Chief Medical Officer and Director of Clinical Improvement from 2021 to 2023.

A clinical academic by background, Andrew was a Wellcome Trust Fellow at the KEMRI-Wellcome Trust Research Programme in Kenya from 2002 to 2003 and from 2008 to 2012, where his research focused on invasive bacterial disease and tuberculosis. He was regional clinical lead for sepsis and deterioration for the Oxford Academic Health Sciences Network from 2016 to 2023 and has contributed to national studies and task and finish groups for both sepsis and COVID-19.

Andrew has a Masters in Epidemiology and a Postgraduate Diploma in Learning and Teaching in Higher Education and has been an examiner for the University of Oxford and the Royal College of Physicians. He is a Visiting Professor of Infectious Diseases & Medicine at the University of Oxford.

Ms Yvonne Christley, Chief Nursing Officer

Yvonne has more than 25 years of experience in clinical leadership, education, and research. Throughout her career, Yvonne has played a crucial role in developing and implementing strategies to improve the quality and safety of clinical services. She has a proven track record of leading clinical teams, enhancing patient care, and introducing innovative practices to meet the evolving needs of patients, families and staff.

Before joining the Trust, Yvonne was the Chief Nursing Officer (CNO) at Milton Keynes University Hospital NHS Foundation Trust. During her tenure as CNO, Yvonne led several initiatives to improve clinical care and operational efficiency. Under her leadership, she significantly reduced vacancies and turnover rates while strengthening the nursing, midwifery and Allied Health Professional workforce. Additionally, she played a crucial role in launching and embedding improvement programmes that enhanced patient outcomes, integrated digital innovation and improved care coordination.

Yvonne is dedicated to fostering a culture of continuous improvement and professional development. She actively supports initiatives that promote staff wellbeing and enhance clinical skills.

Mr Jason Dorsett, Chief Finance Officer

Jason worked as the Director of Finance, Reporting and Risk at the Foundation Trust regulator, Monitor, prior to joining the Trust.

He is a graduate of the University of Oxford, where he completed a Doctorate in Modern History.

His extensive career experience includes three years as the Deputy Finance Director at University College London Hospitals NHS Foundation Trust, and roles within HM Treasury and major audit and professional services companies.

Ms Lisa Hofen, Chief Estates & Facilities Officer *(from 27 October 2025)*

Lisa joined the Trust from Coventry University where she was Director of Infrastructure Delivery.

She is an experienced Estates and Facilities professional whose other roles have included Director of Estates at Coventry University.

Lisa, who lives locally in Oxford, previously spent 20 years working for the University of Oxford in a variety of senior roles including Head of Strategic Facilities Management.

Mr Mark Holloway, Chief Estates & Facilities Officer *(until 31 August 2025)*

Mark joined the Trust in 2023 from Bradford Teaching Hospitals NHS Foundation Trust, where he was the Executive Director of Estates and Facilities. His previous roles include Director of Estates and Facilities at Birmingham Community Healthcare NHS Foundation Trust.

Mark is a qualified building services engineer and has a track record of leading transformational programmes to create the best possible environments to improve both patient and staff experience.

Mr Jay Mistry, Interim Chief Strategy Officer *(from 23 March 2026)*

Jay joined the Trust in 2017. In his previous role as Commercial Director, he established the Trust's Commercial Function, which has grown since 2019 to lead strategically aligned commercial activities across areas including private patients, innovation, property development, investments and high value transactions.

Jay has played a key role in developments including the new Surgical Elective Centre, which will open on the John Radcliffe Hospital site in 2026, the development of high quality and affordable staff accommodation, and the Oxford Hospitals Education Centre (OxHEC).

Jay is a qualified Chartered Accountant who has both private sector experience with Deloitte, Ernst and Young and within industry, and public sector experience with NHS Improvement and the Department of Health.

Mr Terry Roberts, Chief People Officer

Terry joined the Trust in February 2020 from the Hillingdon Hospitals NHS Foundation Trust, where he was the Director of People and Organisational Development. Prior to this role, he was the Director of Workforce at Kingston Hospital NHS Foundation Trust and Associate Director of Human Resources at Barts Health NHS Trust, and has held a number of other senior HR positions in NHS Trusts. In 2022, he was seconded to NHS England as Joint Director of Equality and Inclusion. He is the Vice Chair of the Shelford CPO network.

Terry is a Fellow of the Chartered Institute of Personnel and Development (CIPD) and has completed the Harvard Senior Executive Programme, King's Fund Top Manager Programme. He is a certified Coach and Mediator.

Ms Felicity Taylor-Drewe, Chief Operating Officer

Felicity joined the Trust from Great Western Hospitals NHS Foundation Trust where she was the Chief Operating Officer from 2021. She was previously the Deputy Chief Operating Officer and Divisional Director for Surgery at Gloucestershire Hospitals NHS Foundation Trust.

Felicity has a strong track record of leading teams in delivering clinical services and access standards, so that patients receive high-quality treatment in the most appropriate care setting in a timely way. She has a clear passion for integration of services across organisational barriers, in order to improve care pathways for patients.

Period of office of Non-Executive Directors

The periods of office of the Non-Executive Directors who served on the Board during the reporting year, and their terms, are listed below.

Name	Date of initial appointment	Period of office	Term
Professor Sir Jonathan Montgomery[1]	01/04/2019	01/04/2025 - 31/03/2026	3
Ms Sarah Hordern	28/10/2019	28/10/2025 - 27/10/2028	3
Mr Paul Dean	04/09/2023	04/09/2023 - 03/09/2026	1
Ms Claire Feehily	01/12/2023	01/12/2023 - 30/11/2026	1
Ms Claire Flint	01/05/2019	01/05/2022 - 31/03/2025	2
Mr Kanwaljit Kamal	01/01/2026	01/01/2026 – 31/12/2028	1
Ms Katie Kapernaros	28/10/2019	28/10/2022 – 31/12/2025	2
Dame June Raine CBE	01/12/2025	01/12/2025 – 30/11/2028	1
Professor Anthony Schapira	01/12/2019	01/12/2022 - 30/11/2025	2
Professor Gavin Screaton	01/09/2018	01/09/2024 - 31/08/2027	3
Professor Ashok Soni OBE	06/04/2021	06/04/2024 - 05/04/2027	2
Ms Joy Warmington MBE	01/06/2021	01/06/2024 - 31/05/2027	2

Notes:

1. Left the Trust on 31 March 2026.

Service Contract details of the Executive Directors of the Board are available in the Remuneration Report of this Annual Report.

Board meetings

The Board met six times in public during the year 2025/26. The table below shows the attendance of the Board members at Board meetings.

Board member	Position	Attendance
Professor Sir Jonathan Montgomery	Trust Chair	6/6
Mr Simon Crowther[1]	Deputy CEO, Interim CEO	6/6
Ms Sarah Hordern	Vice-Chair and Non-Executive Director	4/6[9]
Mr Paul Dean	Non-Executive Director	4/6[9]
Ms Claire Feehily	Non-Executive Director	5/6[9]
Ms Claire Flint	Non-Executive Director	4/6[9]
Mr Kanwaljit Kamal[2]	Non-Executive Director	2/2
Ms Katie Kapernaros[3]	Non-Executive Director	1/4[9]
Dame June Raine CBE[4]	Non-Executive Director	1/2[9]
Professor Anthony Schapira[5]	Non-Executive Director	3/4[9]
Professor Gavin Screaton	Non-Executive Director	6/6
Professor Ashok Soni OBE	Non-Executive Director	5/6[9]
Ms Joy Warmington MBE	Non-Executive Director	6/6
Mr Ben Attwood	Chief Digital and Information Officer	6/6
Professor Andrew Brent	Chief Medical Officer	6/6
Ms Yvonne Christley	Chief Nursing Officer	6/6
Mr Jason Dorsett	Chief Finance Officer	6/6
Ms Lisa Hofen[6]	Chief Estates & Facilities Officer	3/3
Mr Mark Holloway[7]	Chief Estates & Facilities Officer	2/2
Mr Jay Mistry[8]	Interim Chief Strategy Officer	0/0
Mr Terry Roberts	Chief People Officer	5/6[10]
Ms Felicity Taylor-Drewe	Chief Operating Officer	6/6

Notes:

1. *Acting CEO (from 1 April to September 2025), Interim CEO (from September 2025)*
2. *Non-Executive Director from 1 January 2026*
3. *Non-Executive Director until 27 October 2025*
4. *Non-Executive Director from 1 December 2025*
5. *Non-Executive Director until 30 November 2025*
6. *Chief Estates and Facilities Officer from 27 October 2025*
7. *Chief Estates and Facilities Officer until 31 August 2025*
8. *Interim Chief Strategy Officer from 23 March 2026*
9. *Apologies for absence were given*
10. *Represented by a nominated deputy*

Board Committees

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

A description of each of the Board Committees and their activities during 2025/26 is included in the Annual Governance Statement of this Annual Report.

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

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

Investment Committee

The Investment Committee met seven times during 2025/26. The Committee was chaired by Ms Sarah Hordern. The attendance of the core membership at the Committee meetings is listed below.

Board member	Position	Attendance
Ms Sarah Hordern (Chair)	Vice-Chair and Non-Executive Director	7/7
Ms Claire Feehily	Non-Executive Director	7/7
Mr Kanwaljit Kamal[1]	Non-Executive Director	1/1
Ms Katie Kapernaros [2]	Non-Executive Director	5/6[6]
Professor Anthony Schapira[3]	Non-Executive Director	1/5[6]
Mr Ben Attwood	Chief Digital and Information Officer	6/7[6]
Mr Jason Dorsett	Chief Finance Officer	7/7
Ms Felicity Taylor-Drewe	Chief Operating Officer	6/7[7]
Mr Mark Holloway[4]	Chief Estates and Facilities Officer	2/3[6]
Ms Lisa Hofen[5]	Chief Estates and Facilities Officer	3/3

Notes:

1. *Committee member from 1 January 2026.*
2. *Committee member until 27 October 2025.*
3. *Committee member until 30 November 2025.*
4. *Committee member until 31 August 2025*
5. *Committee member from 27 October 2025*
6. *Apologies for absence were given*
7. *Represented by a nominated deputy*

Integrated Assurance Committee

The Integrated Assurance Committee was chaired by Professor Sir Jonathan Montgomery and met six times during 2025/26. The attendance of the core membership is listed below.

Board member	Position	Attendance
Professor Sir Jonathan Montgomery (Chair)	Trust Chair	6/6
Mr Simon Crowther[1]	Deputy CEO, Interim CEO	6/6
Ms Sarah Hordern	Vice-Chair and Non-Executive Director	6/6
Mr Paul Dean	Non-Executive Director	6/6
Ms Claire Feehily	Non-Executive Director	4/6[9]
Ms Claire Flint	Non-Executive Director	0/6[9]
Mr Kanwaljit Kamal[2]	Non-Executive Director	1/1
Ms Katie Kapernaros[3]	Non-Executive Director	4/5[9]
Dame June Raine CBE[4]	Non-Executive Director	2/2
Professor Anthony Schapira[5]	Non-Executive Director	4/4
Professor Gavin Screaton	Non-Executive Director	4/6[9]
Professor Ashok Soni OBE	Non-Executive Director	4/6[9]
Ms Joy Warmington MBE	Non-Executive Director	2/6[9]
Mr Ben Attwood	Chief Digital and Information Officer	5/6[10]
Professor Andrew Brent	Chief Medical Officer	5/6[10]
Ms Yvonne Christley	Chief Nursing Officer	6/6
Mr Jason Dorsett	Chief Finance Officer	5/6[10]
Ms Lisa Hofen[6]	Chief Estates & Facilities Officer	2/2
Mr Mark Holloway[7]	Chief Estates & Facilities Officer	0/3[11]
Mr Jay Mistry[8]	Interim Chief Strategy Officer	0/0
Mr Terry Roberts	Chief People Officer	5/6[10]
Ms Felicity Taylor-Drewe	Chief Operating Officer	5/6[10]

Notes:

1. *Acting CEO (from 1 April to September 2025), Interim CEO (from September 2025)*
2. *Committee member from 1 January 2026*
3. *Committee member until 27 October 2025*
4. *Committee member from 1 December 2025*
5. *Committee member until 30 November 2025*
6. *Committee member from 27 October 2025*
7. *Committee member until 31 August 2025*
8. *Committee member from 23 March 2026*
9. *Apologies for absence were received*
10. *Represented by a nominated deputy*
11. *Apologies for absence received for two meetings and represented by a nominated deputy for a third.*

Audit Committee

The Audit Committee met five times during 2025/26. The Committee was chaired by Mr Paul Dean. The attendance of the core membership at the Committee meetings is listed below.

Board member	Position	Attendance
Mr Paul Dean (Chair)	Non-Executive Director	5/5
Ms Claire Feehily	Non-Executive Director	5/5
Mr Kanwaljit Kamal[1]	Non-Executive Director	1/1
Ms Katie Kapernaros[2,3]	Non-Executive Director	3/4[3]

1. *Committee member from 1 December 2025.*
2. *Apologies for absence were received.*
3. *Committee member until 31 December 2025.*

Remuneration and Appointments Committee

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

Board Registers

Board of Directors' Register of Interests

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

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

Board of Directors' Register of Gifts, Hospitality and Sponsorship

The Register of Gifts, Hospitality and Sponsorship is open to the public and is published on the Trust website at www.ouh.nhs.uk/about/trust-board.

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

Contacting the Board of Directors

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

NHS England's well-led framework disclosures

Throughout the year 2025/26, the Trust continued to focus on compliance with the well-led framework.

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

- continuing to focus on staff wellbeing, bullying and harassment and sexual safety, informed by the staff survey results linked to the People Plan
- improving the use of local compliance, through our Care Assure and OxSCA process to identify areas of focus and improvement
- Carrying out a Board development programme facilitated by NHS Providers
- The commissioning of a Trust wide Well-Led gap analysis against the CQC well led key questions by an external provider (Grant Thornton) to support the development of a related action plan.

Further information on the governance structure that supports the organisation can be found in the Annual Governance Statement of this Annual Report. There were no material inconsistencies between the Annual Governance Statement and other reports of the Annual Report.

Regulatory Rating

As of 31 March 2026, the Trust had an overall rating of 'Requires Improvement' (RI) from the Care Quality Commission (CQC). This was consistent with the rating disclosed in the previous Annual Report and reflected the well-led activities undertaken by the CQC during the year 2019/20. The Annual Governance Statement, found later in this Annual Report, describes the full activities carried out by the CQC during the year.

There were three new CQC inspections during 2025/26. These comprised maternity services at the Horton General Hospital and the John Radcliffe Hospital and the neonatal services at the John Radcliffe Hospital. The results of the Maternity inspections were published in June 2026, with both sites rated 'Good' overall. The results of the neonatal services inspection were not yet published at the time of this report. The findings and associated actions will be reported to the Trust Board and Integrated Assurance Committee, and assurance evidence to support completion and embedding of actions will be considered by the relevant governance meetings within the Trust.

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

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

Disclosures

The Trust is required to make the following disclosures.

Directors' responsibility for the Annual Report and Accounts

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

Cost allocation and charging requirements

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

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

NHS legislation states that the Trust should primarily deliver NHS-funded healthcare, which is measured by testing that non-NHS activity (including research and development, and education and training) is no more than 49% of total income. Our analysis shows that the Trust has met this requirement with NHS healthcare activities comprising 89% of total income.

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

Political donations

The Trust made no political donations during the financial year.

Investments

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

Better Payment Practice Code Performance

Indicator	Target[1]	2025/26	2024/25	2025/26 compared to 2024/25
Non-NHS Payables				
Total non-NHS trade invoices paid in the period				
Number	n/a	179,778	171,700	4.7% increase
£000	n/a	1,180,849	1,076,541	9.7% increase
Total non-NHS trade invoices paid within the target				
Number	n/a	52,143	78,334	33.4% deterioration
£000	n/a	699,933	737,905	5.1% deterioration
Percentage of non-NHS trade invoices paid within the target				
Number	95%	29.0%	45.7%	16.7 percentage points deterioration
£000	95%	59.3%	67.6%	8.3 percentage points deterioration
NHS Payables				
Total NHS trade invoices paid in the period				
Number	n/a	4,233	4,448	4.7% reduction
£000	n/a	41,290	46,272	10.8% reduction
Total NHS trade invoices paid within the target				
Number	n/a	1,780	2,181	18.4% deterioration
£000	n/a	16,679	20,794	19.8% deterioration
Percentage of NHS trade invoices paid within the target				
Number	95%	42.1%	45.7%	3.6 percentage points deterioration
£000	95%	40.4%	67.6%	27.2 percentage points deterioration

Note:

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

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

Performance against the Better Payment Practice Code deteriorated in 2025/26 due to the requirement to carefully manage the cash position. The Trust continues to work to ensure that approved invoices are paid promptly.

During this period, the Trust paid £27,921 (£15,182 in 2024/25) arising from claims made under The Late Payment of Commercial Debts (Interest) Act 1998.

Trust Membership and Council of Governors

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

Trust membership

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

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

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

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

The Membership Team works actively with colleagues to maximise recruitment opportunities. During the year, we continued to invite patients and the public to become members of the Trust. We promoted membership via our Governors, members and social media. We attended events to undertake active recruitment and held membership recruitment activities at apprenticeship, careers and volunteers' events, as well as Older People's Day events, Oxford City Council health promotion events, OUH health open days and events at Oxford Brookes University. We held constituency meetings in the West Oxfordshire and Cherwell constituencies, chaired by Governors. A joint constituency meeting was also held in South Oxfordshire along with Governors from Oxford Health NHS Foundation Trust. A joint event with the South Central Ambulance Service also took place.

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

Membership constituencies

The Trust has two membership constituencies: Public and Staff.

Public constituency

Anyone aged 16 or over and living in England or Wales can become a member of the Trust. The Public membership is divided into eight constituencies: Cherwell, Oxford City, South Oxfordshire, Vale of White Horse, West Oxfordshire, Buckinghamshire, Berkshire, Gloucestershire and Wiltshire, Northamptonshire and Warwickshire, and Rest of England and Wales.

Staff constituency

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

Council of Governors

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

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

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

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

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

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

The Council of Governors has regular engagement with the Board, within the context of which concerns may be raised by the Council as a whole, or by individual Governors. The Chair of the Trust is also the Chair of the Council of Governors and has the responsibility of updating the Board regularly on matters arising from the Council of Governors, Trust members and the Membership Strategy.

The Governors are encouraged to canvass opinions and concerns of the members they represent, and to this effect, constituency meetings take place throughout the year around Oxfordshire for Governors to seek people's views of the Trust and the services provided.

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

Composition of the Council of Governors

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

All elected and appointed Governors hold a term of office of up to three years.

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

Members of the Council of Governors

The Governors who were in post during the period 1 April 2025 to 31 March 2026 and their attendance at the four general meetings held during the year are shown below.

Elected Governors - Public constituencies				
Name	**Constituency**	**Tenure**	**Term**	**Attendance**
Gemma Davison [1]	Cherwell	01/04/2024 - 31/03/2027	2	0/5
Christine Montague-Johnson	Cherwell	01/04/2025 - 31/03/2028	2	4/5
Fiona Morrison [2]	Cherwell	01/04/2025 - 31/03/2027	1	3/5
Ariana Adjani	Oxford City	01/04/2024 - 31/03/2027	2	4/5
Damian Haywood	Oxford City	01/04/2025 - 31/03/2028	1	5/5
Hannah Watkins	South Oxfordshire	01/04/2025 - 31/03/2028	1	5/5
Nina Robinson	South Oxfordshire	01/04/2024 - 31/03/2027	2	5/5
Alastair Harding	Vale of White Horse	01/04/2024 - 31/03/2027	1	4/5
David Matthews	Vale of White Horse	01/04/2025 - 31/03/2028	2	4/5
Robin Carr	West Oxfordshire	01/04/2025 - 31/03/2028	2	5/5
Graham Shelton	West Oxfordshire	01/04/2024 - 31/03/2027	3	5/5
Jeremy Hodge	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	01/04/2025 - 31/03/2028	2	5/5
Anthony Lloyd	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	01/04/2024 - 31/03/2027	1	4/5
Charles Adomah-Boadi	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	01/04/2025 - 31/03/2028	1	2/5
Anthony Bagot-Webb	Northamptonshire and Warwickshire	01/04/2024 - 31/03/2027	3	3/5
Andrew Lawrie	Northamptonshire and Warwickshire	01/04/2025 - 31/03/2028	1	5/5
Ascanio Tridente	Rest of England and Wales	01/04/2025 - 31/03/2028	1	3/5
Elected Governors - Staff constituencies				
Name	**Constituency**	**Tenure**	**Term**	**Attendance**
George Krasopoulos	Clinical	01/04/2025 - 31/03/2028	2	4/5
Claire Litchfield	Clinical	01/04/2024 - 31/03/2027	1	2/5
Sneha Sunny	Clinical	01/04/2024 - 31/03/2027	1	3/5
Jacqueline Palace	Clinical	01/04/2025 - 31/03/2028	1	5/5
Aliki Kalianou	Non-Clinical	01/04/2024 - 31/03/2027	2	5/5
Megan Turmezei	Non-Clinical	01/04/2025 - 31/03/2028	2	5/5
Appointed Governors				
Name	**Constituency**	**Tenure**	**Term**	**Attendance**
Tim Bearder	Oxfordshire County Council	20/12/2025 - 19/12/2028	2	1/5

Helen Higham	University of Oxford	16/10/2023 - 15/10/2026	2	2/5
Lorraine Dixon	Oxford Brookes University	02/10/2023 - 01/10/2026	1	4/5
Stuart Bell CBE	Oxford Health NHS FT	16/10/2023 - 15/10/2026	2	3/5
Vacancy	BOB ICB	Since 01/07/2022		
Gareth Evans	Berkshire, Buckinghamshire and Oxfordshire Local Medical Committee	25/01/2025 - 24/01/2028	1	1/5
Vacancy	Specialist Commissioner	Since 05/01/2021		
Benjamin[3]	Young People's Executive	01/09/2024 - 31/08/2027	1	0/5
Niamh[3]	Young People's Executive	01/09/2024 - 31/08/2027	1	4/5

Notes:

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

Lead Governor

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

Mr Graham Shelton, a Public Governor for West Oxfordshire, was re-elected for a third term by the Council of Governors as the Lead Governor for a one-year term from 1 April 2025.

During the year, the Council of Governors agreed that a Deputy Lead Governor should be appointed and an electronic secret ballot following self-nomination, seconded by one other Governor took place. George Krasopoulos was announced as Deputy Lead Governor until 31 March 2026.

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

Council of Governors' election

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

Elections were held in the spring of 2024 and 2025, therefore no elections took place in the spring of 2026. The next set of elections will take place in the spring of 2027.

Council of Governors' meetings

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

The Council held five general meetings in 2025/26, with all but one meeting taking place face-to-face. Meetings were held in Oxford to enable members of the public to attend.

Annual Public Meeting and Annual Members' Meeting

The Trust holds an Annual Public Meeting and Annual Members' Meeting for the Council of Governors and members of the Trust which is also open to the public. In 2025/26, this event was held face-to-face. The Board delivered a review of the last year along with the Annual Accounts and the Trust's plans for the future.

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

Council of Governors' Register of Interests

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

Contacting the members of the Council of Governors

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

Board engagement with the Council of Governors

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

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

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

Some members of the Council of Governors attend the Integrated Assurance Committee meeting to hear the Board scrutinise and triangulate sources of evidence across the Trust to enable the Board assess its level of confidence in the assurances provided.

Remuneration, Nominations and Appointments Committee

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

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

During the year 2025/26, the RNAC met four times and the key business undertaken by the Committee included the following:

- Approval of the process for the Chair's appraisal and review of the Chair's appraisal report for 2024/25, including the Chair's objectives
- Review of the remuneration for the Chair and the Non-Executive Directors
- Receipt of the Non-Executive Directors appraisal report from the Chair
- Recommendation of the re-appointment of two Non-Executive Directors
- Recommendation of a recruitment exercise for three Non-Executive Directors
- Recommendation of a recruitment process for the Trust Chair
- Annual review of the Terms of Reference for the Committee, including provision for the selection of a Committee Vice-Chair-elect.

Remuneration Report

Annual Statement on Remuneration from the Chair of the Committee

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

To do so, the Committee:

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

The Remuneration and Appointments Committee is composed of all the Non-Executive Directors and, on behalf of the Trust Board, is responsible for determining policies for the remuneration and terms and conditions of service for all very senior managers (VSMs) consisting of the Executive Directors and other managers on VSM contracts, and for the four Divisional Directors.

Where a very senior manager is on nationally agreed terms and conditions of service, the Committee determines any local elements of their contractual arrangements.

The Committee's workload in 2025/26 included:

- Agreeing objectives and reviewing performance appraisals for the Chief Executive Officer, Executive Directors and Divisional Directors
- Reviewing remuneration and agreeing annual pay uplifts for staff within its remit
- Succession planning for the CEO, Chief Officer and Divisional Director roles
- Approving contracts of employment for the Chief Estates and Facilities Officer.

Signed:

Lynne Graham
Chair of Remuneration and Appointments Committee
25 June 2026

Senior Managers' Remuneration Policy

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

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

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

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

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

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

Future Policy Table

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

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

How the component supports the strategic aims of the Trust	How the component operates	Maximum potential value	Description of framework used to assess performance
Pension Contribution Alternative Award Policy			
Supports the retention of staff who may otherwise consider leaving the organisation or reducing their hours to avoid being adversely impacted by the annual allowance.	The Trust operates a scheme to support staff who choose to opt out of the NHS Pension Scheme because they are affected by annual allowance taxation. The scheme restructures the total reward package of an employee by paying a figure broadly equivalent to the employer pension contributions that the Trust would otherwise pay if they remained a member of the NHS Pension Scheme. The scheme is open to all employees that meet the policy's eligibility criteria until 31 March 2026, at which time it will be withdrawn following agreement by the Committee in November 2025.	12.38% of pensionable pay.	Not applicable.
Earn-back scheme			
Promotes individual and team high performance within the Executive Team.	The Remuneration and Appointments Committee agrees objectives for the Executive Directors and monitors this through mid-year and end-of-year reviews (including the annual performance appraisal). The Committee reviews the individual and team performance and conducts earn-back reviews based on this.	No payments are made, but up to 10% of annual salary is placed at risk.	Assessment of achievement of Executive Team objectives.
Benefits			
To support the Trust's total reward package to attract, reward and retain staff at all levels, the Trust operates several salary sacrifice schemes including for childcare vouchers, bicycles, home and electronic goods and lease cars. These are optional and available to all staff members.			
Travel expenses			
Appropriate travel expenses are paid for business mileage in line with the Trust's Payment of Expenses Procedure.			

Note:

- *The Trust adopts the following to ensure that the remuneration more than the threshold of £170,000 for senior managers is reasonable:*
  - *The Remuneration and Appointments Committee comprising all the Non-Executive Directors sets the pay for senior managers and provides objective scrutiny of pay.*
  - *As outlined in VSM Pay Framework issued by NHS England, regard is paid to remuneration benchmarking data, market conditions and the individual employee's level of experience and development of the role.*

Service contracts obligations

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

Policy on Payment for Loss of Office

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

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

Consideration of employment conditions elsewhere in the Trust

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

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

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

Policy on Diversity and Inclusion

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

Annual Report on Remuneration

Service contracts

None of the current substantive Executive Directors are subject to an employment contract that stipulates a length of appointment.

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

The following table contains details of the service contracts in place during 2025/26 for Executive Directors.

Name	Position	Date of contract as Executive Director	Contract type	Notice period
Mr Simon Crowther	Deputy Chief Executive Officer, Interim Chief Executive Officer	30/09/2024	Permanent	Six months
Dr Ben Attwood	Chief Digital and Information Officer	16/10/2024	Permanent	Six months
Professor Andrew Brent	Chief Medical Officer	09/10/2023	Permanent	Six months
Ms Yvonne Christley	Chief Nursing Officer	01/05/2024	Permanent	Six months
Mr Jason Dorsett	Chief Finance Officer	03/10/2016	Permanent	Six months
Mrs Lisa Hofen	Chief Estates & Facilities Officer	27/10/2025	Permanent	Six months
Mr Mark Holloway	Chief Estates & Facilities Officer	01/09/2023	Permanent	Six months
Mr Jay Mistry	Interim Chief Strategy Officer	23/03/2026	7-month secondment agreement	Six months
Mr Terry Roberts	Chief People Officer	10/02/2020	Permanent	Six months
Ms Felicity Taylor-Drewe	Chief Operating Officer	28/10/2024	Permanent	Six months

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

Remuneration and Appointments Committee

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

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

The Committee was chaired by Ms Claire Flint and met 4 times in 2025/26. The following table contains details of the core membership of the Committee and their attendance at Committee meetings in 2025/26.

Committee Member	Title	Attendance
Ms Claire Flint (Chair)[1]	Non-Executive Director	4/4
Lynne Graham (Chair) [1]	Non-Executive Director	1/1
Professor Sir Jonathan Montgomery[3]	Trust Chair	3/4
Ms Sarah Hordern	Vice-Chair and Non-Executive Director	4/4
Mr Paul Dean[2, 3, 5]	Non-Executive Director	1/4
Ms Claire Feehily	Non-Executive Director	4/4
Mr Kanwaljit Kamal[5]	Non-Executive Director	0/1
Ms Katie Kapernaros	Non-Executive Director	3/3
Dame June Raine CBE[5]	Non-Executive Director	0/1
Professor Anthony Schapira[4]	Non-Executive Director	2/3
Professor Gavin Screaton[3,4]	Non-Executive Director	2/4
Professor Ashok Soni OBE[4]	Non-Executive Director	3/4
Ms Joy Warmington MBE[2, 4, 5]	Non-Executive Director	1/4

Note:

1. *Lynne Graham attended 30 March 2026 as incoming Chair. Clair Flint attended their last Committee meeting as Chair on 30 March 2026.*
2. *Apologies for Paul Dean and Joy Warmington were received for 19 May 2025.*
3. *Apologies for Professor Sir Jonathan Montgomery, Professor Gavin Screaton and Paul Dean were received for 27 August 2025.*
4. *Apologies for Professor Gavin Screaton, Professor Ashok Soni OBE, Joy Warmington MBE and Professor Anthony Schapira were received for 26 November 2025.*
5. *Apologies for Joy Warmington MBE, Kanwaljit Kamal, Dame June Raine CBE and Paul Dean were received for 30 March 2026.*

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

Salary and Pension Entitlements of Senior Managers 2025/26 *(this information is subject to audit)*

Salary and Pension Entitlements of Senior Managers 2025/26 (12 months to 31 March 2026)									
Name	**Title**	**Effective dates if not in post full year**	**Salary (bands of £5,000) [1, 2] £000**	**Taxable benefits (£s to the nearest £100) £**	**Annual performance related bonuses[3] (bands of £5,000) £000**	**Long-term performance related bonuses (bands of £5,000) £000**	**Payment in lieu of pension (bands of £5,000) £000**	**All pension related benefits (bands of £2,500) £000**	**Total including all pension related benefits (bands of £5,000)[4] £000**
Non-Executive Directors									
Professor Sir Jonathan Montgomery	Trust Chair		60-65						60-65
Ms Sarah Hordern	Vice-Chair and Non-Executive Director		15-20						15-20
Mr Paul Dean	Non-Executive Director		15-20						15-20
Ms Claire Feehily	Non-Executive Director		10-15	600					10-15
Ms Claire Flint	Non-Executive Director		15-20						15-20
Ms Katie Kapernaros	Non-Executive Director	01/04/2025-31/12/2025	10-15						10-15
Professor Anthony Schapira	Non-Executive Director	01/04/2025-30/11/2025	5-10	1,200					10-15
Professor Gavin Screaton	Non-Executive Director		10-15						10-15
Professor Ashok Soni OBE	Non-Executive Director		10-15						10-15
Ms Joy Warmington MBE	Non-Executive Director		10-15						10-15
Mr Kanwaljit Kamal	Non-Executive Director	01/01/2026-31/03/2026	0-5						0-5

Salary and Pension Entitlements of Senior Managers 2025/26 (12 months to 31 March 2026)									
Name	**Title**	**Effective dates if not in post full year**	**Salary (bands of £5,000) [1, 2] £000**	**Taxable benefits (£s to the nearest £100) £**	**Annual performance related bonuses[3] (bands of £5,000) £000**	**Long-term performance related bonuses (bands of £5,000) £000**	**Payment in lieu of pension (bands of £5,000) £000**	**All pension related benefits (bands of £2,500) £000**	**Total including all pension related benefits (bands of £5,000)[4] £000**
Dame June Raine CBA	Non-Executive Director	01/12/2025-31/03/2026	0-5						0-5
Executive Directors[5]									
Mr Simon Crowther	Deputy CEO / Interim CEO		235-240		15-20			517.5-520	765-770
Dr Benjamin Attwood	Chief Digital & Information Officer		175-180		15-20			62.5-65	260-265
Professor Andrew Brent[6]	Chief Medical Officer		205-210		20-25		10-15	252.5-255	495-500
Ms Yvonne Christley	Chief Nursing Officer		175-180		15-20			47.5-50	240-245
Mr Jason Dorsett[7]	Chief Finance Officer		210-215				25-30		235-240
Ms Lisa Hofen	Chief Estates & Facilities Officer	27/10/2025-31/03/2026	65-70					15-17.5	80-85
Mr Mark Holloway	Chief Estates & Facilities Officer	01/04/2025-31/08/2025	60-65		5-10			25-27.5	95-100
Mr Jay Mistry	Interim Chief Strategy Officer	23/03/2026-31/03/2026	0-5		0-5			32.5-35	35-40
Mr Terry Roberts	Chief People Officer		185-190					67.5-70	255-260
Ms Felicity Taylor-Drewe[8]	Chief Operating Officer		175-180		15-20			137.5-140	330-335

Notes:

1. *The basic annual remuneration of Non-Executive Directors (excluding the Trust Chair) is within the band of £10-15,000.*
2. *The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of £15-20,000.*
3. *Directors have received performance-related bonuses where specific objectives were set by the Remuneration and Appointments Committee and achieved.*

4. *The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.*
5. *Following discussion with auditors, the salary figures for Executive Directors are shown as the gross amount prior to any salary sacrifice deductions.*
6. *Opted into pension arrangements partway through the year. Deferred pension figures provided by NHSBSA were used in calculating the figure for all pension related benefits.*
7. *Chose not to be covered by the pension arrangements during the reporting year.*
8. *Opted out of the pension arrangements partway through the year.*

Pension Benefits of Senior Managers 2025/26 *(this information is subject to audit)*

Pension Benefits of Senior Managers 2025/26 (12 months to 31 March 2026) [1,2,3]									
Name	**Title**	**Real increase in pension at pension age (bands of £2,500) £000**	**Real increase in pension lump sum at pension age (bands of £2,500) £000**	**Total accrued pension at pension age at 31/03/2026 (bands of £5,000) £000**	**Lump sum at pension age related to accrued pension at 31/03/2026 (bands of £5,000) £000**	**Cash Equivalent Transfer Value at 01/04/2025 [4] £000**	**Real increase in Cash Equivalent Transfer Value [5] £000**	**Cash Equivalent Transfer Value at 31/03/2026 £000**	**Employer's contribution to stakeholder pension £000**
Dr Benjamin Attwood	Chief Digital & Information Officer	2.5-5	2.5-5	40-45	85-90	734	56	824	-
Professor Andrew Brent[6]	Chief Medical Officer	2.5-5	10-12.5	45-50	125-130	782	100	1,064	-
Ms Yvonne Christley	Chief Nursing Officer	2.5-5	-	20-25	-	246	33	305	-
Mr Simon Crowther	Deputy Chief Executive officer / Interim Chief Executive Officer	22.5-25	55-57.5	100-105	265-270	1,698	518	2,275	-
Ms Lisa Hofen	Chief Estates & Facilities Officer	0-2.5	-	0-5	-	-	-	19	-
Mr Mark Holloway	Chief Estates & Facilities Officer	0-2.5	-	45-50	105-110	872	5	919	-
Mr Jay Mistry	Interim Chief Strategy Officer	0-2.5	-	15-20	-	197	-	233	
Mr Terry Roberts	Chief People Officer	2.5-5	2.5-5	65-70	160-165	1,364	76	1,484	-
Ms Felicity Taylor-Drewe	Chief Operating Officer	5-7.5	-	45-50	-	585	62	707	-

Notes:

1. *Non-Executive Directors do not receive pensionable remuneration (2024/25, nil).*
2. *The Trust did not contribute to a stakeholder pension scheme for Directors (2024/25, nil).*
3. *Pension details have only been disclosed for those Directors in post during the last 12 months up to 31 March 2025.*

4. *A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.*
5. *Real increase in CETV reflects the increase in CETV funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).*
6. *Opted into pension arrangements partway through the year. Deferred pension figures provided by NHSBSA were used in calculating the figure for all pension related benefits.*

Salary and Pension Entitlements of Senior Managers 2024/25 *(this information is subject to audit)*

Salary and Pension Entitlements of Senior Managers 2024/25 (12 months to 31 March 2025)									
Name	**Title**	**Effective dates if not in post full year**	**Salary (bands of £5,000) £000**	**Taxable benefits (£s to the nearest £100) £**	**Annual performance related bonuses[3] (bands of £5,000) £000**	**Long-term performance related bonuses (bands of £5,000) £000**	**Payment in lieu of pension (bands of £5,000) £000**	**All pension related benefits (bands of £2,500) £000**	**Total including all pension related benefits (bands of £5,000) £000**
Non-Executive Directors[1,2]									
Professor Sir Jonathan Montgomery	Trust Chair		60-65						60-65
Ms Sarah Hordern	Vice-Chair and Non-Executive Director		15-20	700					15-20
Mr Paul Dean	Non-Executive Director		15-20						15-20
Ms Claire Feehily	Non-Executive Director		10-15	1,100					15-20
Ms Claire Flint	Non-Executive Director		15-20						15-20
Ms Katie Kapernaros	Non-Executive Director		10-15						10-15
Professor Anthony Schapira	Non-Executive Director		10-15	100					10-15
Professor Gavin Screaton	Non-Executive Director		10-15						10-15
Professor Ashok Soni OBE	Non-Executive Director		10-15						10-15
Ms Joy Warmington MBE	Non-Executive Director		10-15						10-15
Executive Directors[4]									
Professor Meghana Pandit[5]	Chief Executive Officer		275-280	1500	25-30		30-35		335-340

Salary and Pension Entitlements of Senior Managers 2024/25 (12 months to 31 March 2025)									
Name	**Title**	**Effective dates if not in post full year**	**Salary (bands of £5,000) £000**	**Taxable benefits (£s to the nearest £100) £**	**Annual performance related bonuses[3] (bands of £5,000) £000**	**Long-term performance related bonuses (bands of £5,000) £000**	**Payment in lieu of pension (bands of £5,000) £000**	**All pension related benefits (bands of £2,500) £000**	**Total including all pension related benefits (bands of £5,000) £000**
Dr Ben Attwood[6]	Chief Digital and Information Officer	16/10/2024-31/03/2024	70-75		5-10			57.5-60	135-140
Dr Andrew Brent[5,7]	Chief Medical Officer		195-200	900	20-25		20-25		240-245
Ms Yvonne Christley[8]	Chief Nursing Officer	01/05/2024-31/03/2025	155-160		15-20			47.5-50	220-225
Mr Simon Crowther[9]	Deputy Chief Executive Officer	30/09/2024-31/03/2025	110-115					265-267.5	375-380
Mr Jason Dorsett[5]	Chief Finance Officer		205-210				25-30		230-235
Ms Paula Gardner[5,10]	Interim Chief Nursing Officer	01/04/2024-30/04/2024	10-15		0-5				10-15
Ms Lisa Glynn[5,11]	Acting Chief Operating Officer	22/07/2024-10/11/2024	45-50		0-5				50-55
Mr Matt Harris[12]	Acting Chief Digital and Partnerships Officer	01/05/2024-11/10/2024	65-70		0-5			20-22.5	90-95
Mr Mark Holloway[7]	Chief Estates and Facilities Officer		155-160		15-20			110-112.5	280-285
Ms Sara Randall[5,13]	Chief Operating Officer	01/04/2024-21/07/2024	60-65				5-10		65-70
Mr Terry Roberts[7]	Chief People Officer		180-185					40-42.5	220-225
Ms Felicity Taylor-Drewe[14]	Chief Operating Officer	28/10/2024-31/03/2025	70-75		5-10			110-112.5	185-190
Mr David Walliker[5,15]	Chief Digital and Partnership Officer	01/04/2024-28/04/2024	10-15				0-5		15-20

Salary and Pension Entitlements of Senior Managers 2024/25 (12 months to 31 March 2025)									
Name	**Title**	**Effective dates if not in post full year**	**Salary (bands of £5,000) £000**	**Taxable benefits (£s to the nearest £100) £**	**Annual performance related bonuses[3] (bands of £5,000) £000**	**Long-term performance related bonuses (bands of £5,000) £000**	**Payment in lieu of pension (bands of £5,000) £000**	**All pension related benefits (bands of £2,500) £000**	**Total including all pension related benefits (bands of £5,000) £000**
Ms Eileen Walsh[7,16]	Chief Assurance Officer	01/04/2024-31/10/2024	75-80					5-7.5	80-85

Notes:

1. *The basic annual remuneration of Non-Executive Directors (excluding the Trust Chair) is within the band of £10-15,000.*
2. *The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of £15-20,000.*
3. *Directors have received performance related bonuses where specific objectives have been set by the Remuneration and Appointments Committee and have been achieved.*
4. *Following discussion with auditors, the salary figures for Executive Directors are shown as the gross amount prior to any salary sacrifice deductions.*
5. *Chose not to be covered by the pension arrangements during the reporting year.*
6. *Chief Digital and Information Officer from 16 October 2024.*
7. *The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.*
8. *Chief Nursing Officer from 1 May 2024.*
9. *Deputy Chief Executive Officer from 30 September 2024.*
10. *Interim Chief Nursing Officer to 30 April 2024 on part-time basis.*
11. *Acting Chief Operating Officer from 22 July 2024 to 10 November 2024, provided a two-week handover period to the new Chief Operating Officer.*
12. *Acting Chief Digital and Partnerships Officer from 1 May 2024 to 11 October 2024.*
13. *Chief Operating Officer to 21 July 2024.*
14. *Chief Operating Officer from 28 October 2024.*
15. *Chief Digital and Partnership Officer to 28 April 2024.*
16. *Chief Assurance Officer to 31 October 2024.*

Pension Benefits of Senior Managers 2024/25 *(this information is subject to audit)*

Pension Benefits of Senior Managers 2024/25 (12 months to 31 March 2025)									
Name	**Title**	**Real increase in pension at pension age (bands of £2,500)** **£000**	**Real increase in pension lump sum at pension age (bands of £2,500)** **£000**	**Total accrued pension at pension age at 31/03/2025 (bands of £5,000)** **£000**	**Lump sum at pension age related to accrued pension at 31/03/2025 (bands of £5,000)** **£000**	**Cash Equivalent Transfer Value at 01/04/2024** **£000**	**Real increase in Cash Equivalent Transfer Value** **£000**	**Cash Equivalent Transfer Value at 31/03/2025** **£000**	**Employer's contribution to stakeholder pension** **£000**
Dr Ben Attwood	Chief Digital and Information Officer	0-2.5	0-2.5	35-40	80-85	635	18	734	-
Ms Yvonne Christley	Chief Nursing Officer	2.5-5		15-20		182	28	246	-
Mr Simon Crowther	Deputy Chief Executive Officer	5-7.5	15-17.5	75-80	205-210	1,319	133	1,698	-
Mr Matt Harris	Acting Chief Digital and Partnerships Officer	0-2.5		5-10		111	2	141	-
Mr Mark Holloway	Chief Estates and Facilities Officer	5-7.5	7.5-10	40-45	105-110	707	98	872	-
Mr Terry Roberts	Chief People Officer	2.5-5		60-65	150-155	1,216	46	1,364	-
Ms Felicity Taylor-Drewe	Chief Operating Officer	2.5-5		40-45		466	29	585	-
Ms Eileen Walsh	Chief Assurance Officer	0-2.5		60-65	165-170	1,454	5	1,575	-

Notes:

- *Non-Executive Directors do not receive pensionable remuneration (2023/24, nil).*
- *The Trust did not contribute to a stakeholder pension scheme for Directors (2023/24, nil).*
- *Pension details have only been disclosed for those Directors in post during the last 12 months up to 31 March 2025.*
- *A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. These figures do not include any potential impact from the McCloud judgment. Real increase in CETV reflects the increase in CETV funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).*

Disclosures

The Trust is required to make the following disclosures.

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

NHS Foundation Trusts are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation and the 25th percentile, median and 75th percentile remuneration of the organisation's workforce.

There has been a significant change in all metrics calculated using compensation of OUH's highest-paid Director. This is due to the OUH substantive Chief Executive Officer's, Professor Meghana Pandit's, secondment to NHS England over the course of the year.

For the purposes of annual reporting, she was a member of NHS England Board in 2025/26 and is therefore excluded from OUH's calculations this year. She is, however, included in the 2024/25 figures used as a comparator. The highest paid Director in 2025/26 is the Chief Medical Officer, whose compensation package is different to that of Professor Pandit.

As a result, the banded remuneration of the highest paid director in 2025/26 was £240,000-£245,000 (£300,000-£305,000 in 2024/25). Based on the midpoint of the banded remuneration, this represents a reduction of 19.8%.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £14,762 to £325,528 (£12,513 to £384,038 in 2024/25). The percentage increase in average employee remuneration from prior year 5.5%. The calculation is based on the total for all employees, on an annualised basis, divided by full time equivalent number of employees. Remuneration includes overtime, additional hours worked and selling of annual leave. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The general increase in remuneration results from the national pay uplift across Agenda for Change bands.

20 employees (19.9 WTE) received remuneration in excess of the highest-paid director in 2025/26 (compared to one employee in 2024/25).

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

	25th percentile £		Median £		75th percentile £	
	2025/26	2024/25	2025/26	2024/25	2025/26	2024/25
Salary component of pay	26,598	25,674	37,264	34,068	47,810	46,148
Total pay and benefits excl. pension	34,043	31,799	46,580	44,337	58,804	55,293
Pay and benefits excl. pension: pay ratio for highest-paid Director	7.12:1	9.53:1	5.21:1	6.84:1	4.12:1	5.49:1

Payment for Loss of Office

No payments for Loss of Office were made to senior managers in 2025/26 (2024/25: nil).

Payments to past Senior Managers

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

Expenses

Expenses of the Council of Governors

Governors are not remunerated but can claim expenses for costs incurred while undertaking Governor duties. Expenses information for the last two years are shown below.

	2025/26	2024/25
Total number of Governors in office during year 2025/26	29	30
Number of Governors who received expenses	5	4
Aggregate sum of expenses paid	£1,050	£600

Expenses of the Board of Directors

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

	2025/26	2024/25
Total number of Board members in office during year 2025/26	22	25
Number of Board members who received expenses	5	5
Aggregate sum of expenses paid	£1,965	£4,300

Signed: 

Simon Crowther
Interim Chief Executive Officer
25 June 2026

Staff Report

The Staff Report provides information about staffing and staff related matters at Oxford University Hospitals (OUH) NHS Foundation Trust during the year 2025/26.

Our Workforce

The Trust employed over 16,000 people in the year 2025/26 on permanent contracts[1] of employment across both full-time and part-time roles. This equates to a whole-time equivalent (WTE) average of 13,840 WTE.

The gender distribution of our workforce as at 31 March 2026 is shown in the table below.

Category	2025/26			2024/25
	Female	Male	Total	Total
Directors[2]	8	11	19	19
Senior managers[3]	-	-	-	-
Other staff[4]	11,750	4,578	16,328	16,111
Total[5,6]	**11,759**	**4,588**	**16,347**	**16,130**

Notes:

1. *Permanent contract holders are those staff with contracts of employment including fixed term contracts but excluding honorary contract holders.*
2. *Defined as all members of the Trust Board.*
3. *Defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. Within OUH, all such staff are the Trust Board.*
4. *Everyone else in the organisation.*
5. *Everyone in the organisation including the members of the Trust Board.*
6. *Workforce numbers disclosed above are as per reporting requirement.*

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

Analysis of average staff numbers as at 31 March 2026 ***(this information is subject to audit)***

The average number of staff employed by the Trust as at 31 March 2026 is set out in the table below on a whole-time equivalent (WTE) basis.

Staff category	2025/26 Average WTE			2024/25 Average WTE
	Permanently employed[1]	Other staff[2]	Total number	Total number
Medical and dental	2,330	66	**2,396**	2,366
Ambulance staff			**0**	-
Administration and estates[3]	2,659	30	**2,689**	2,753
Healthcare assistants and other support staff	1,624	190	**1,814**	1,850
Nursing, midwifery and health visiting staff	4,676	324	**5,000**	5,060
Nursing, midwifery and health visiting learners			**0**	-
Scientific, therapeutic and technical staff	1,723	41	**1,764**	1,775
Healthcare science staff	933	13	**946**	925
Social care staff			**0**	-
Other	11		**11**	22
Total average numbers	**13,956**	**664**	**14,620**	14,751
of which				
Number of employees (WTE) engaged on capital projects	28	3	**31**	59

Notes:

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

Analysis of staff costs ***(this information is subject to audit)***

The table below sets out an analysis of staff costs during the year 2025/26, split between permanently employed staff and others.

Cost	2025/26			2024/25
	Permanently employed[1] £000	Other staff[2] £000	Total £000	Total £000
Salaries and wages	762,892	3,125	766,017	739,625
Social security costs	96,563	-	96,563	73,838
Apprenticeship levy	3,680	-	3,680	3,533
Employer's contributions to NHS pensions	144,905	-	144,905	137,644
Pension cost – other	82	-	82	103
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	146	-	146	92
Temporary staff	-	47,283	47,283	57,251
Total gross staff costs	**1,008,268**	**50,408**	**1,058,676**	**1,012,086**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**1,008,268**	**50,408**	**1,058,676**	**1,012,086**
of which		-	-	-
Costs capitalised as part of assets	1,600	-	1,600	2,960

Notes:

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

Staff Policies and Actions Applied during the Financial Year

Equality, Diversity and Inclusion (EDI)

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

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

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between people.

EDI Objectives

The Trust's EDI Objectives 2022-2026 aim to support delivery against the overall strategy by focusing on developing EDI capability at individual, service and organisational level. The Trust also aligns its EDI activity to the NHS EDI Improvement Plan which sets out six High Impact Actions that will address inequalities within the workforce. Further information on the Trust's EDI Objectives and the activity expected to be delivered against them can be found on the Trust website at www.ouh.nhs.uk/about/equality/plans.

Policies and Procedures

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

Reporting

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

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

Initiatives

Initiatives undertaken in 2025/26 to progress against the Trust's EDI Objectives include:

- Implementation of a 'comply or explain' accountability intervention for consultant recruitment to support gender and racial equity
- Continued delivery of the Eradication of Bullying and Harassment Programme – some interventions within the Divisions have already led to cultural transformation
- Rolling out sexual safety and active bystander training throughout the Trust

- Development of a rapid access pathway for staff to access healthcare, supporting us to reduce health inequalities in our workforce, to be fully implemented in 2026/27
- Delivery of Divisional EDI action plans aligned to the six High Impact Actions
- Refreshed our approach to the provision of reasonable adjustments.

Supporting disabled staff

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

- Our participation in the Department for Work and Pensions' Disability Confident Scheme, and as a Level 2 'Disability Confident Employer', and taking positive action to ensure that our recruitment processes do not disadvantage applicants with disabilities
- Our dedicated Occupational Health Service with a range of support options
- Our comprehensive staff wellbeing offer, including our Staff Support Service
- A Reasonable Adjustments Procedure which outlines a clear process for ensuring disabled staff have access to appropriate adjustments to enable them to thrive at work. It is accompanied by a wealth of resources to support managers in the application of the procedure.
- The Disability and Accessibility Staff Network which provides an opportunity for employees with disabilities to access peer support while supporting the Trust to deliver disability equality. This includes a newly created Neuro-inclusion Sub-Group that aims to support neuro-divergent colleagues.

Education and development

The Trust comprises the teaching hospitals for the University of Oxford through the School of Clinical Medicine and Postgraduate Medical and Dental Education. We are the largest placement provider in the Thames Valley Deanery for 5,540 medical students from year four to year six, and 1,022 postgraduate resident doctors on General Medical Council (GMC) recognised training programmes in 2025/26. There are approximately 400 locally employed and specialty and specialist (SAS) doctors and around 1,200 consultants who are also continuously learning with us. Approximately 650 of our consultants and senior doctors are GMC recognised medical educators providing clinical and educational supervision to doctors in training.

Over the past year, the Practice Development and Education Department has collaborated with partners in Oxfordshire, including Oxford Brookes University, to expand placement opportunities for 494 nurses, 131 midwives, and allied health professionals (AHPs). This objective has been accomplished through the implementation of innovative supervisory strategies designed to enhance learning in practice.

We are committed to improving learner experiences across departments through a phased introduction of the Safe Learning Environment Charter, initially implemented at smaller sites and subsequently extended to the John Radcliffe Hospital.

Career pathways have also been expanded by promoting 430 apprentices and supporting a variety of programmes and placements. Additionally, the induction programme for Health Care Support Workers has been revised to integrate theoretical knowledge with practical skills essential for quality care delivery.

Staff communications

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

A Staff Bulletin is sent by email to all staff twice a week, with short messages of relevance to most staff. A Weekly Safety Message is sent to all staff by the Chief Medical Officer and Chief Nursing Officer. We have also introduced a weekly Senior Leaders' Safety Huddle which is followed by a cascade email focused on important messages for the Trust.

The Chief Executive Officer and Chief Officers hold a monthly Virtual Staff Briefing for all staff. A recording and a note of the meeting are then circulated to all staff in the following week's Staff Bulletin.

As part of our wider Board Visibility Programme, 'Meet the Chief Executive and Chief Officers', face-to-face staff engagement events are held quarterly on our four main hospital sites and at the OUH offices in Cowley. Weekly Medical and Surgical Grand Rounds and fortnightly virtual Quality Improvement events are also held.

The Communications team carry out an annual Internal Communications Survey and take actions in response to staff feedback including launching a new monthly NEWS@OUH ebulletin of positive developments within the Trust.

The Trust intranet is a central source of information for staff. The Trust has digital screens on all four main hospital sites to communicate key messages to staff, patients and the public. The Trust also uses its social media channels to communicate with patients, public and staff.

Freedom to Speak Up

The Freedom to Speak Up (FTSU) service provides independent, confidential support for staff to raise concerns that may impact patient safety, staff wellbeing or organisational culture, and ensures that appropriate action is taken by the Trust.

In 2025/26, engagement with the FTSU service continued to increase, reflecting improved visibility, accessibility and confidence to speak up. During the year, 290 cases were opened (197 in 2024/25) and the FTSU team recorded 2,113 staff contacts through listening events, roadshows, induction sessions and awareness-raising activity across the Trust.

A key focus during 2025/26 was reducing barriers to speaking up. Staff engagement with Work in Confidence, an independent external platform providing guaranteed anonymity, remained high and has enabled concerns to be raised by colleagues who may not otherwise have felt able to speak up. This sat alongside continued promotion of direct access to FTSU Guardians, ensuring staff have a choice of routes to raise concerns.

Regular online listening events and Trust-wide roadshows, including during national Speak Up Month, supported organisational listening and reinforced the Trust's #SpeakUpListenUpFollowUp approach. The FTSU team continued to work closely with Divisional teams, Patient Safety, Workforce, Culture and Leadership, Occupational Health and staff networks to support learning and improvement.

Concerns raised during the year most frequently related to staff wellbeing, workplace culture and behaviours, alongside patient safety. This intelligence has informed wider Trust priorities, including work to address bullying and harassment and to strengthen leadership and management practice. The Trust also strengthened its approach to preventing detriment, with the refreshed Freedom to Speak Up Policy reinforcing protections for staff who raise concerns in good faith.

The Trust recognises that sustaining confidence to speak up depends on clear follow-up and visible learning. The FTSU team will continue to work in partnership across the organisation to support a positive speaking up culture, aligned to the Trust's Strategy and People Plan.

Consulting staff and representatives

The Trust collaborates closely with staff through the Trust Alliance Committee and Joint Local Negotiation Committee to tackle issues related to staff and organisational performance. These committees, which include Trade Union representatives and senior management, meet bi-monthly to foster partnership working and enhance staff experience.

The Trust Alliance Committee is supported by two formal sub-groups consisting of Workforce and Trade Union colleagues. The Consultation Sub-Group reviews and approves all proposed formal consultations under the Trust's Management of Organisational Change Procedure before they are formally presented to staff. In 2025/26, they reviewed 33 organisational change proposals. The Policy Development Sub-Group examines all proposed changes to workforce policies affecting staff prior to formal consultation. Throughout 2025/26, they continued to review workforce procedures to support our commitments outlined in our People Plan.

OUH has remained dedicated to amplifying the voices of staff from protected characteristic groups through the ongoing development of, and commitment to, our staff networks: Black, Asian and Minority Ethnic (BAME) Network, LGBTQ+ Network, Disability and Accessibility Network, Women's Network, and Young Apprentice Network. Each network contributes to the Trust's Equality, Diversity and Inclusion (EDI) Steering Group, ensuring informed decision-making and alignment of the Trust Strategy with our EDI Objectives.

Encouraging staff involvement in the Trust's performance

The Trust is committed to creating a culture that actively seeks collaboration and inclusion of our people to enhance our performance in line with our People Plan 2025-2028.

We consult our staff regularly through People Plan Listening Events, hosted by the Chief People Officer, where our staff provide feedback on progress against priorities to inform and help shape our commitments for the year ahead. We rolled out the *Growing Stronger Together* staff engagement process to ensure that all employees have opportunities to co-design and co-implement improvements to the services through regular team meetings

We provide a safe space for our staff networks to promote voices from under-represented staff groups and drive positive change. These networks deliver events across the year to engage staff involvement in shaping Trust priorities. We foster a culture of staff recognition and appreciation for the great work our people do through a range of schemes.

- ***Instant appreciation*** allows colleague-to-colleague recognition for a job well done
- ***'Stars' of the month*** allows local appreciation of those who make positive impact
- ***Quarterly Staff Recognition Awards*** are shortlisted from local nominations and selected by Trust Executives. These finalists and 25+ Long Service employees attend an afternoon tea
- ***Annual Recognition Awards*** recognises an individual or a team who live the Trust values in the way they work
- ***Reporting Excellence*** recognises moments of excellent care through the Trust's incident reporting system
- ***DAISY Foundation® Awards*** allow patients and their families to nominate a nurse or midwife who made a real difference through outstanding clinical care.

Promoting the wellbeing of our workforce

Staff Health and Wellbeing is one of the three key strategic themes of refreshed Our People Plan 2025-2028. Our wellbeing activities and initiatives are tailored to support areas that are identified through our local people metrics and are reported at Trust Management Executive and Board meetings. The Trust has a Non-Executive Director as the Health and Wellbeing Guardian, who meets with senior stakeholders to review progress on all our wellbeing initiatives. Highlights of our wellbeing activity in 2025/26 include the following:

- The launch of a new Wellbeing and Occupational Health Programme of Support intranet site. This provides a 'one stop shop' where all our staff can find the health and wellbeing support that they require, quickly and easily.
- A series of lunchtime financial wellbeing webinars showcasing all the financial organisations we have partnered with to support our staff.
- The creation of new changing rooms on our Horton site which will also encourage staff to use more sustainable forms of transport to work such as cycling.

- Creation of bespoke support programmes for our Emergency Department and Maternity & Neonatal Departments.
- Our Wellbeing Service Leads (Occupational Health, Staff Support Service, Here for Health, Wellbeing Team, Oxford Hospitals Charity and Freedom to Speak Up) met quarterly to ensure a connected, holistic wellbeing offer is available to our people.
- Our team of 350+ Wellbeing Champions at OUH continued to promote and identify ways to support our colleagues. They share wellbeing information at local level and organise team meetings to share all the support available and monthly forums to share excellent practices. Wellbeing Champions are connected to Divisional Programme Leads of our Eradication of Bullying and Harassment Programme to help support their work.
- Our Creating a Suitable Estates and Environments Enabling Group met quarterly to provide a forum for staff feedback on our estates and to escalate any issues directly impacting staff wellbeing to the Trust's senior management.

Occupational Health

The Centre for Occupational Health and Wellbeing (COHWB) is the Trust's in-house occupational health service, providing a full range of services to Trust staff and external organisations. The core business of COHWB is the promotion and maintenance of the health and wellbeing of employees of the Trust and its principal contractors. This includes prevention of work-related ill health, advice on reasonable adjustments, rehabilitation advice following absence from work, workplace assessments, health surveillance, health and safety compliance, and policy development.

COHWB works closely with the Staff Psychology Service and Staff Physiotherapy Service to treat and support Trust staff with a wide range of mental health conditions and musculoskeletal conditions.

In 2025/26, COHW had 11,226 appointments in 2025-2026 (2024/25, over 13,500).

Key achievements of the service include the following.

- Annual renewal of accreditation for the Faculty of Occupational Medicine, Safe Effective Quality Occupational Health Scheme (SEQOHS)
- Training and guidance for managers on making a good referral to occupational health and a wellbeing and occupational health toolkit for staff to access a one stop approach to resources and signposting.

Health and Safety

Over the past year, the Health and Safety team completed workplace health and safety inspections in 114 departments across all main sites. All annual Health and Safety objectives have been met or are making progress toward long-term goals. The annual Health and Safety Audit was issued as 6 bi-monthly audits covering current requirements related to Health and Safety legislation, as well as Trust policies and procedures, resulting in an average compliance rate of 93%.

The Trust achieved a consistent compliance rate of 92% for mandatory Health, Safety, and Welfare training for the past year. In addition, the Health and Safety team trained another 40 staff members to become 'Health and Safety Champions.' This brings the current number of staff trained to this role to 254, enabling them to assist department managers in implementing local health and safety measures.

For the fifth consecutive year, the Trust achieved ISO 45001:2018 certification for Occupational Health and Safety Management Systems at the Churchill Hospital.

Policy on Counter Fraud and Corruption

The Trust is committed to providing a zero-tolerance culture to fraud, bribery and corruption. The Trust commissions a counter fraud service provider, TIAA, who is accountable to the Chief Finance Officer under statutory regulations. TIAA reports regularly to the Audit Committee. The Trust has a Fraud Champion who supports the counter fraud agenda.

TIAA provides a Lead Local Counter Fraud Specialist (LCFS) who undertakes activities to understand the Trust's fraud risks, and to prevent and detect fraudulent activity. They share Fraud Prevention Notices with the Trust and raise awareness of NHS fraud and raising concerns and take action where necessary. The LCFS works closely with Internal Auditors to identify risks and improve controls.

The Trust complies with the 12 NHS requirements of the NHS Counter Fraud Authority (NHSCFA), which sets out the standards for countering fraud in adherence with Government Functional Standards GoVs 013: Counter Fraud. This includes compliance of the Trust's Counter Fraud and Bribery Policy and the Declarations of Interests, Gifts, Hospitality and Sponsorship Policy with the NHS requirements and the Bribery Act 2010. An annual assessment against the Standards is undertaken. It is anticipated that the Trust will meet the requirements set by the NHSCFA.

All matters relating to fraud are investigated and appropriate action is taken including disciplinary and possible criminal proceedings. The Trust seeks to recover any monies lost to fraudulent activity.

NHS Staff Survey

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

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

From 2021/22, the survey questions have aligned to the seven elements of the NHS 'People Promise' and retained the two previous themes of staff engagement and morale. All indicators are based on a score out of ten for specific questions with the indicator score being the average of those.

The response rate to the 2025/26 survey among Trust staff was 40.2% (2024/25: 48.2%).

Summary of results

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

Indicators	2025/26		2024/25		2023/24	
People Promise elements and themes	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
People Promise:						
We are compassionate and inclusive	7.34	7.28	7.3	7.2	7.3	7.0
We are recognised and rewarded	5.93	5.87	6.0	5.9	6.0	6.0
We each have a voice that counts	6.65	6.60	6.8	6.7	6.8	6.7
We are safe and healthy	6.14	6.07	6.2	6.1	6.2	6.1
We are always learning	5.73	5.57	5.9	5.6	5.9	5.6
We work flexibly	6.27	6.22	6.3	6.2	6.3	6.3
We are a team	6.84	6.75	6.9	6.7	6.9	6.8
Staff engagement	6.85	6.74	7.0	6.8	7.1	6.9
Morale	5.83	5.84	5.9	5.9	6.0	5.9

Note:

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

The Trust performed better than the national average across all People Promise elements and the staff engagement theme, and the morale theme was in line with the national average.

The Trust also scored above the national average (5.17) on the 'Appraisal' sub-score (4.89), with further improvement on the self-reported 'Proportion of staff having an

appraisal', which achieved the highest appraisal rates within the Acute Sector in the NHS.

In 2023/24, bullying, harassment and incivility was identified as an area for improvement. This year, we saw a further decrease in experiences of bullying and harassment from patients, managers and colleagues, and the scores for these three questions were better than the national average.

Future priorities and targets

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

Appraisals

We aim to capitalise on the large increase in the proportion of our staff having an appraisal and provide a greater focus on personal development plans, career development and supporting managers to give feedback to help staff to feel valued, and to build training / learning needs analysis into our appraisal process.

Line management capability

We wish to continue the trend of year-on-year improvements by focusing on leadership and management training for all line managers, helping them deliver their role and responsibilities, upskilling managers on core people practices and corporate governance, and empowering them to make a difference.

Discrimination, bullying, harassment and incivility

We will continue to work on reducing instances of bullying, harassment and discrimination through delivery of our Eradicating Bullying and Harassment Programme that includes the development of our Sexual Safety Action Plan. Active Bystander training has been launched, and this training is available to all staff.

Wellbeing

We will continue to work on supporting our people's wellbeing as outlined above (in Promoting the Wellbeing of Our Workforce). We will focus on early / proactive education around managing mental health, increasing the support available for staff experiencing violence and aggression at work, and addressing estates and facilities issues impacting wellbeing.

Disclosures

The Trust is required to make the following disclosures.

Staff sickness absence

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

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

Periods covered: January to December 2025 and January to December 2024.

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

Period	Figures converted by DHSC[1] to best estimates of required data			Statistics published by NHS Digital	
Jan - Dec	Average FTE	Adjusted FTE days lost to Cabinet Office definitions	Average sick days per FTE[2]	FTE days available[3]	FTE days recorded sickness absence[4]
2025	13,904	130,531	9.4	5,101,251	211,751
2024	13,697	128,761	9.4	4,999,497	208,879

Notes:

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

Staff turnover

The Trust saw a steady decrease of staff turnover over the year as shown in the table below. During 2025/26, the Trust saw a continued improvement across most staff groups, with the overall rate reducing from 9.5% in 2024/25 to 7.8%, remaining well below the Trust target of 12.0%. This reflects sustained progress in workforce stability and the impact of targeted interventions across a number of areas.

Staff group	2025/26	2024/25
Additional professional scientific and technical	11.6%	8.3%
Additional clinical services	10.5%	11.9%
Administrative and clerical	7.6%	11.3%
Allied health professional	10.5%	11.9%
Estates and ancillary	8.6%	12.0%
Healthcare scientists	7.4%	8.9%
Medical and dental	2.1%	2.9%
Nursing and midwifery registered	7.0%	8.3%
All staff groups	**7.8%**	**9.5%**
Trust target	**12.0%**	**12.0%**

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

Gender pay gap

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

For each reporting year, the gender pay gap is calculated using a snapshot date at the end of the previous financial year as required by the gender pay gap reporting legislation (2025/26 reporting year uses data as of 31 March 2025). The Trust's last two years' gender pay gap information, reported to Government Equalities Office, is shown in the table below.

Indicator	2025/26	2024/25	2025/26 compared to 2024/25
Mean Ordinary Pay Gap	24.2%	25.5%	1.3 percentage point decrease
Median Ordinary Pay Gap	10.9%	9.0%	1.9 percentage point increase
Mean Bonus Pay Gap	11.3%	51.9%	40.6 percentage point decrease
Median Bonus Pay Gap[1]	-0.2%[2]	87.6%	87.8 percentage point decrease

Note:

1. *The Median Bonus Pay Gap fluctuates depending on whether bonus payments, such as winter incentives or onwards payments, are made to nursing staff. Onwards payments were incentive payments provided to Band 5 nurses first introduced in 2020. They were provided to nurses who stayed with OUH as Band 5s to support retention of this workforce group.*

2. *A negative pay gap means a pay gap in favour of women. In this case, the median bonus pay for women is 0.2% higher than it is for men. A negative pay gap is not necessarily a good thing as a large negative pay gap would still indicate inequity, just in favour of women rather than men. An ideal situation would be for the figure to be close to zero, which in this case it is.*

The full Gender Pay Gap Report of the Trust as of 31 March 2025, as reported to the Trust Board in September 2025 can be found on the Trust website: visit www.ouh.nhs.uk and type 'TB2025.78' into the search field on the home page. During the year, the Trust Board considered the key matters and most up to date data relating to the Trust's gender pay gap.

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

Off-payroll arrangements

In accordance with the HM Treasury annual reporting guidance, the Trust is required to report the number of off-payroll engagements where an individual is paid £245 or more per day. From April 2017, the Government has reformed the legislation associated with off-payroll payments so that public sector bodies are responsible for deducting and paying all employment taxes and National Insurance contributions from the individuals concerned.

The Trust has worked hard to eliminate the off-payroll arrangements that were in place in previous years and has implemented a policy that no individuals are paid off-payroll unless the employing manager submits evidence from HM Revenue and Customs (HMRC) that they are certified as self-employed.

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

	31 March 2026	31 March 2025
Number of existing engagements as of...	3	4
of which...		
Number that have existed for less than one year at time of reporting	-	1
Number that have existed for between one and two years at time of reporting	-	-
Number that have existed for between two and three years at time of reporting	1	1
Number that have existed for between three and four years at time of reporting	-	-
Number that have existed for four or more years at time of reporting	2	2

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

	31 March 2026	31 March 2025
Number of off-payroll workers engaged during the year ended…	3	5
of which…		
Not subject to off-payroll legislation*	-	-
Subject to off-payroll legislation and determined as in-scope of IR35*	-	-
Subject to off-payroll legislation and determined as out-of-scope of IR35*	3	5
Number of engagements reassessed for compliance or assurance purposes during the year	-	-
of which…		
Number of engagements that saw a change to IR35 status following review	-	-

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

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

	Between 1 April 2025 and 31 March 2026	Between 1 April 2024 and 31 March 2025
Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0	0
Number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility'[1] during the financial year. This figure must include both off-payroll and on-payroll engagements.	22	25

Note:

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

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

The table below discloses the total of all staff exit packages agreed in the 12 months to 31 March 206. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the accounting period of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included within this table.

Exit packages

Exit package cost band	2025/26			2024/25		
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	1	-	1	1	-	1
£10,000 - £25,000	1	-	1	1	-	1
£25,001 - £50,000	-	-	-	0	-	0
£50,001 - £100,000	-	-	-	1	-	1
£100,001 - £150,000	1	-	1	0	-	0
£150,001 - £200,000	-	-	-	0	-	0
>£200,000	-	-	-	0	-	0
Total number of exit packages by type	3	-	3	3	-	3
Total resource cost £k	134	0	134	77	0	77

Exit packages: other non-compulsory departure payments

There were no exit packages in either the year 2025/26 or 2024/26 which were classed as non-compulsory departure payments.

Expenditure on consultancy

Reporting bodies are required to disclose the expenditure on consultancy. The consultancy expenditure incurred by the Trust in 2025/26 can be found in note 7.1 of the Annual Accounts found later in this document.

Code of Governance Compliance

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

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

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

Code Section	Summary of Requirement	Annual Report References/Response
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	This information is available in the Directors' Report of this Annual Report. Where applicable, such circumstances which are likely to impair, or could appear to impair a Non-Executive Directors' independence would be declared in the Board of Directors' Register of Interests. The Board of Directors' Register of Interests is available on the Trust website at: http://www.ouh.nhs.uk/about/trust-board
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	This information is available in the Directors' Report and the Remuneration Report of this Annual Report.
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	This information is available in the Trust Membership and Council of Governors Report of this Annual Report.
C 2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	The Trust, through a compliant procurement process, has contracted Odgers Berndtson for all Board recruitment. One of their staff members is related to a Governor of the Trust.

Code Section	Summary of Requirement	Annual Report References/Response
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	This information is available in the Trust Membership and Council of Governors Report of this Annual Report. The Terms of Reference of the Council of Governors' Remuneration, Nominations and Appointment Committee is available on the Trust website at www.ouh.nhs.uk/about/governors/#committees
4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	This information is available in the Directors' Report of this Annual Report. The biographies of the current members of the Trust Board can be found on the Trist website at www.ouh.nhs.uk/about/trust-board/directors.
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	The Trust Management Executive approved the commissioning of an external review during 2025/26, was put on hold due to three CQC inspections. The trust subsequently commissioned at Trust wide Well-led gap analysis by an external provider (Grant Thornton).

Code Section	Summary of Requirement	Annual Report References/Response
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline. • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition. • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	Work of the Council of Governors' Remuneration, Nominations and Appointments Committee is available in the Trust Membership and Council of Governors Report of this Annual Report. The work of the Trust Board's Remuneration and Appointments Committee is available in the Remuneration Report of this Annual Report. During 2025/26, there has not been an external evaluation of the Board. This was due to the number of changes in the Board membership that took place during the year. It was agreed that the Board membership needs to be fully established and in place prior undertaking any external evaluation. Gender balance information is available in the Staff Report of this Annual Report.
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	This information is available in the Trust Membership and Council of Governors Report of this Annual Report.

Code Section	Summary of Requirement	Annual Report References/Response
D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	This information is available in the Annual Governance Statement of this Annual Report. The independence of the external audit function is reviewed as part of the Annual Review of Effectiveness of the Audit Committee and is confirmed annually. The Trust adopted a policy for the provision of non-audit services by the External Auditor Ernst & Young LLP. There have been no changes to the current External Auditor in year, and the Annual Governance Statement sets out that there is an internal audit function in place, outsourced to BDO.
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	This information is available in the Directors' Report of this Annual Report.
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	This information is available in the Performance Report and the Annual Governance Statement of this Annual Report.
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	This information is available in the Annual Governance Statement of this Annual Report.
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	The Performance Report refers to the Trust Annual Accounts for this disclosure. The going concern disclosure can be found in note 1.2 of the Annual Accounts found later in this document.

Code Section	Summary of Requirement	Annual Report References/Response
E 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Not applicable for the reporting year.
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	This information is available in the Trust Membership and Council of Governors Report of this Annual Report.
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	This information is available in the Trust Membership and Council of Governors Report of this Annual Report.
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	This information is available in the Trust Membership and Council of Governors Report of this Annual Report.
Additional req't of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	Not applicable. Except for the Trust Chair, the Board of Directors is not formally required to attend the Council meetings. Board members attend the Council of Governors meetings by choice or at the request of the Governors. More information is available in the Trust Membership and Council of Governors Report of this Annual Report.

NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/2627 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five 'segments'.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

- Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
- Considering financial override which may limit a segment to be no better than three
- Contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality) and
- Capability assessments which consider the organisation's leadership and governance.

Segmentation

Based on Quarter 3 2025/26 data (latest available at the time of publication), the Trust was allocated to Segment 3.

The Trust's unadjusted average score was 2.18, ranking it 44th out of 134 acute Trusts in the country. This would normally result in Segment 2 allocation; however, financial override was applied due to receipt of Deficit Support Funding.

The Trust's unadjusted segmentation was driven by lower scores against the following key areas:

- Patient Safety domain – number of MRSA bacteraemia cases and proportion of E. coli bacteraemia;
- Access to Services domain – percentage of patients waiting over 52 weeks for elective treatment, percentage of cases where a patient is waiting 18 weeks or less for elective treatment; percentage of patients treated for cancer within 62 days of referral.

This segmentation information is the Trust's position as at 31 March 2026. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England website: https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/. The Trust is included on the acute Trust dashboard.

Statement of Accounting Officer's Responsibilities

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

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

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

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

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

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

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

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

Signed: Simon Crowther
Interim Chief Executive Officer
25 June 2026

Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Oxford University Hospitals NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the Annual Report and Annual Accounts.

Capacity to handle risk

The Trust has a Risk Management Policy which sets out the agreed protocol for the management of risk and the individual responsibilities and accountabilities for risk. Operationally, responsibility for the implementation of risk management has been delegated to Executive Directors as follows:

- The Interim Chief Executive Officer has delegated authority for the Risk and Control Framework and is the Executive Lead for maintaining the Board Assurance Framework and its supporting processes
- The Chief Finance Officer has responsibility for financial risk and control
- The Chief Medical Officer has responsibility for quality, clinical governance and clinical risk, including incident management, and joint responsibility with the Chief Nursing Officer for patient safety
- The Chief Nursing Officer has responsibility for patient experience and joint responsibility with the Chief Medical Officer for patient safety

- The Chief Digital and Information Officer is the Senior Information Risk Owner (SIRO) and has responsibility for the assessment and management of information risk
- The Chief Estates and Facilities Officer has responsibility for the oversight and advice on estates and facilities risk
- The Chief Operating Officer has responsibility for the clinical operational arrangements in the Trust and for oversight of the clinical Divisions
- All Executive Directors have responsibility for the management of strategic and operational risk within their individual portfolios.

These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their Directorates. During the year, the Trust delivered risk management training to over 340 staff with functional responsibility for risk management through a series of planned training sessions. This training programme is linked to the Trust's induction process and is delivered monthly.

The Risk and Control Framework

Approach to risk

The Trust's Risk and Control Framework consist of:

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

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

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

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

In addition, the Trust has developed a long-term plan for improvement of future risk management within the Trust.

The Board Assurance Framework provides the mechanism for the Board to monitor risks, controls and the outputs of its assurance processes. The Trust's risk assessment process covers all its activities across clinical services, clinical support services and business support functions. Each Division and Directorate is responsible for maintaining its own risk register in accordance with the Risk Management Policy.

These risk registers are reviewed regularly by Divisional and Directorate forums, and they are required to escalate risks, where their ratings warrant this, for Corporate Risk Register inclusion. During the year, the Board Committees have reviewed the Corporate Risk Register, including the following high-scoring (principal) risks:

1. As a result of lack of capacity in beds and staffing, there was a risk to the delivery of our elective care delivery plan that might affect patient outcomes and experience.
2. Due to issues with diagnostic capacity, there was a risk to our ability to reduce the current backlog of patients waiting for cancer diagnosis and treatment that might cause patient harm.
3. Due to increased demands for services, there was a risk in relation to the failure to effectively control pay and non-pay costs which may lead to the inability to achieve in year financial targets and break-even position. In addition, this had a further impact on the Trust's cash position.
4. Due to local interest groups and other external factors, there is a risk of poor public and patient confidence and reduced staff morale.
5. Due to increases in workload, there is a risk that sickness levels may increase linked to work related stress.
6. As a result of productivity levels that were insufficient to cover costs based on national average funding levels, there was a risk around the potential inability of the Trust to break even over the next three to five years which might affect the Trust's ability to sustain safe, compliant and effective provision of healthcare.

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

Risk management is embedded within the organisation in a variety of ways. The Risk Committee, a sub-committee of the Trust Management Executive, meets bi-monthly ensuring the Trust operates an effective risk management system through monitoring and overseeing Divisional and the Corporate Risk Registers. The Committee also conducts deep dives of selected Corporate Risk Registers, reviewing the consistency of risk scoring and risk recording.

All members of staff have a duty to report incidents, hazards, complaints and near misses in accordance with the relevant policies. Information on incident management, serious incidents and never events is reported to the Clinical Governance Committee and is presented to the Integrated Assurance Committee of the Board as a standing agenda item.

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

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

In 2025/26, the Board had five committees: Integrated Assurance Committee, Audit Committee, Remuneration and Appointments Committee, Investment Committee, and the Trust Management Executive. These committees were established to mitigate the principal risks to compliance with the NHS Provider Licence. The Licence sets out conditions that healthcare providers must meet to help ensure that the health sector works for the benefit of patients.

The Trust has governance processes to:

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

The Chairs of the Board Committees present written reports to the Board, highlighting significant issues of interest to the Board, including key risks identified, other matters considered, and decisions made at their meetings. In addition, the Board and each of its committees undertake an annual review of their performance and effectiveness, considering the practices set out in the Code of Governance for NHS Provider Trusts (the Code) and the constitution.

These reviews are used to produce an annual committee report to the Board, including a summary of the activities of the committee in terms of the risks and assurances considered. These annual reports have been used to provide additional evidence in formulating the Board's consideration of its compliance with the Code.

The Trust applies the principles of the Code on a 'comply or explain' basis, and the Board considers the Trust to have complied fully with the Code for the reporting period 2025/26.

Work of the Board Committees

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

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

During the year, the Committee reviewed and considered:

- a mid-year review of judgements and estimates including the Going Concern assumption
- the cash improvement and cash forecasting programme
- Clinical Audit planning processes and the Clinical Audit plan
- The update to Standing Financial Instructions and Scheme of Delegation.

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

TIAA assesses the Trust's exposure to key fraud risks and develops key deliverables for the year which are reviewed as part of the LCFS reports at each meeting of the Audit Committee. Some of the deliverables for the year included the following.

- The Counter Fraud Bribery and Corruption policy
- Continued focus on fraud awareness for staff, for example, training as part of budget holder training sessions.

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

The Audit Committee received Internal Audit Opinions as follows:

- Stock control: Design - Moderate, Effectiveness – Limited
- Waiting list management: Design – Substantial, Effectiveness - Moderate
- Divisional finance controls: Design – Moderate, Effectiveness – Limited
- IT asset management: Design – Moderate, Effectiveness – Limited
- Medical device management: Design – Moderate, Effectiveness – Moderate
- Key financial controls: Design - Moderate, Effectiveness - Moderate
- E-Rostering: Design – Substantial, Effectiveness – Moderate
- Data quality DM01: Design – Substantial, Effectiveness – Substantial
- Directorate risk management: Design – Moderate, Effectiveness - Moderate
- DSP Toolkit: unrated Advisory

The Audit Committee has maintained oversight of overdue recommendations and timeliness of management responses to audit reports. Where reports resulted in limited assurance or significant scope for improvement was identified, recommendations were followed up on and reported to the Committee until it obtained sufficient assurance that the relevant risks had been addressed.

The Trust's Internal Auditors provide an annual Head of Internal Audit Opinion based on the work conducted throughout the year. This year, the Head of Internal Audit Opinion provided the Trust with an overall opinion of "generally satisfactory with improvements required in some areas."

In forming this view, the Trust's Internal Auditor BDO considered the following:

- Their assessment of the design and operation of the underpinning risk management framework and supporting processes, including whether risk appetite has been established and embedded within the activities, limits and reporting of the organisation
- The range of individual opinions arising from risk-based audit assignments that have been reported throughout the year; including the relative materiality of these areas
- Any significant recommendations not accepted by management and the consequent risks (if any)
- Management's progress in respect of addressing control weaknesses and implementing recommendations
- Any limitations which may have been placed on the scope of internal audit.

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

- the Trust's values and culture
- the organisation's financial and operational performance

- the quality of services (including clinical effectiveness, patient experience and safety) across the organisation
- the appropriate identification, assessment and management of risks.

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

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

- Improvement activities from specific action plans across the Trust's Maternity Services, developed in the context of a shifting pattern of demand for services and due regulatory inspections, and media interest
- Financial performance and assurances on cash flow forecast, and the forecast year-end position
- Key workforce updates, including annual workforce plan changes and the development of medical workforce project
- The management of estates and infrastructure risks on a day to day and strategic basis.

The ***Investment Committee*** is responsible for advising the Board in relation to investments. The Committee advises on the annual capital investment plan, reviews capital cases prior to Board consideration, and ensures that there are appropriate monitoring arrangements in place for investments. The Committee also monitors the Trust's commercial activities including significant leases, joint ventures and asset disposals. During 2025/26, the Committee continued to review progress on the Surgical Elective Centre project, PFI strategy, and work on travel and transport initiatives.

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

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

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

- the review and update of the Trust's financial control environment, including the establishment controls and nursing establishment reviews
- workforce and organisational development matters such as the continued delivery of the People Plan, and information of the eradicating bullying and harassment programme of work.

Trust Board membership

The Trust Constitution states that the Board shall comprise between five and nine members from each of the Executive Directors and the Non-Executive Directors. To maintain balanced unitary decision-making, all Board members hold voting positions, except for the Interim Chief Strategy Officer.

During the reporting year, the Board membership consisted of nine Executive Director roles, including the Chief Executive Officer, and ten Non-Executive Directors, including the Trust Chair. It was considered that the membership of the Board was fully compliant with the terms of the Trust Constitution for the 2025/26 year.

During 2025/26, the Trust Executive team consisted of the following roles.

- Interim Chief Executive Officer
- Chief Medical Officer
- Chief Finance Officer
- Chief Nursing Officer
- Chief Estates and Facilities Officer
- Chief Operating Officer
- Chief People Officer
- Chief Digital and Information Officer
- Interim Chief Strategy Officer (part year)

Further information of the Board membership during the year 2025/26 is available in the Directors' Report of this Annual Report.

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

Details of the Trust Constitution and the purpose and role of the Council of Governors are available on the Trust website at www.ouh.nhs.uk/about/governors. Further information on the Council of Governors' membership during the year 2025/26 is available in the Trust Membership and Council of Governors Report of this Annual Report.

Discharging statutory functions

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

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

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

Developing workforce safeguards

The workforce plan for the Trust is developed on an annual basis, approved by the Trust Board, and aligned to operational and financial plans, taking quality and safety into account. For its nursing workforce, the Trust also has established daily monitoring of safe staffing levels and conducts twice yearly establishment reviews and monthly 'check and challenge' e-rostering meetings. These all support our People Plan theme of having the right skills in place to deliver our services.

The People and Communications Committee, a sub-committee of Trust Management Executive, monitors and provides strategic assurance on workforce plans, governance and systems that they are financially sustainable, while providing compassionate excellence for our people, our patients and our populations.

The UK Government, through NHS England, has identified staffing and the pay bill as one of the key risks impacting NHS Trusts. The Trust Board also recognises that workforce is a key priority to underpin the achievement of operational and financial performance. The Trust has engaged with our people, listening to their feedback to ensure our compliance with the 'developing workforce safeguards' objective, whilst keeping wellbeing at the heart of our decision-making. Some of the safeguard measures in place are listed below.

- Enhanced controls for temporary staffing, ensuring pay parity and increased reporting. Performance against the temporary staffing targets and the pay rates are monitored at Divisional performance reviews, the Productivity Committee and at Trust Management Executive.
- Implementing one person, one post, delivering improved establishment controls, giving increased governance around whole-time equivalent (WTE).
- Delivering the Year 1 People Plan priorities, supporting staff with their financial wellbeing, improving our new starters induction and enhancing leadership capabilities. Performance against the plan is monitored at the People and Communications Committee, Trust Management Executive and the Delivery Committee.
- Continued work to eliminate bullying and harassment, encouraging staff to speak up, which is communicated through our 'No-Excuses' campaign, and through the launch of our Work in Confidence platform which is managed by the Freedom to Speak Up Team.

- Working on tackling violence and aggression and signing up to and progressing the actions against the Sexual Safety in Healthcare Organisational Charter.
- Roll out of the Establishment Control policy to support the organisation in consistently and transparently managing the responsibilities, processes and requirements aligned with the organisational workforce planning principles.

Compliance with key mandated statements

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

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

Care Quality Commission Compliance

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). As of 31 March 2025, the Trust had an overall rating of 'Requires Improvement' (RI) from the CQC. This was consistent with the rating disclosed in the previous Annual Report and reflected the activities undertaken by the CQC during the year 2024/25.

The Trust continued engagement with the CQC is reported to the Clinical Governance Committee. Activities reported involved but were not limited to the following.

- The management of new enquiries from or notifications to CQC and the maintenance of quarterly engagement meetings. This includes the maintenance of regular notifications covering: Deprivation of Liberty Standards (DoLS) applications, section 42 activities, and other incidents requiring notification to the CQC.
- There were three new CQC inspections during 2025/26. These comprised maternity services at the Horton General Hospital and the John Radcliffe Hospital and the neonatal services at the John Radcliffe Hospital.
- The commissioning of a Trust wide Well-Led gap analysis against the CQC well led key questions by an external provider (Grant Thornton) to support the development of a related action plan.
- The launch of phase 2 Perinatal Improvement Programme and the continuing focus on staff wellbeing aligned to the OUH People Plan 2025/28, with forums and initiatives to enable staff to discuss concerns and make recommendations for future focus.
- Engagement with national CQC surveys for Children and Young People (published May 25), Adult Inpatients (results published September 25), and Maternity Services (results published December 25). Findings from surveys have resulted in action plans

being produced by the services and will be monitored by the Clinical Governance Committee and Maternity Safety Champions.

There are a range of areas that remain the subject of continuous review and focus for the Trust. These include statutory and mandatory training, appraisal rates, medicines management and infection control, for example, areas that relate to the current 'Requires Improvement' (RI) rating in the 'Safe' category. In addition, the Trust has continued to work on actions in relation to the national waiting time standards that relate to the current RI rating in the 'Responsive' category.

Estates Compliance

The Premises Assurance Model (PAM) assessment undertaken in August 2025 identified eight areas requiring 'Moderate Improvement', compared to nineteen reported in the previous year.

The Trust continues to prioritise estates and fire compliance and is demonstrating increased maturity in its approach, including strengthening assurance processes, and embedding greater rigour to align with regulatory expectations. This is supported by a structured, risk-based capital investment programme.

The Trust will continue to strengthen its estates compliance position through a programme of ongoing internal and external audits, routine physical inspections, and the delivery of a prioritised programme of works within a robust governance framework.

Conflicts of Interests

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

Pension Scheme

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

Equality and Diversity

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

Greener NHS

The Foundation Trust has included Climate Change and the impacts to the organisation of extreme weather events, deteriorating air quality and frequency of events, particularly on human health, in the Corporate Risk Register. The risk is currently scored as 'High' with the Severity 'Extreme' and the Likelihood 'Almost Certain'.

The risk of heatwaves, flooding, increased atmospheric CO_2, spread of diseases and poor air quality is likely to impact the Trust in multiple ways from disruption of critical

infrastructure and service delivery, to supply chain shortages and increased financial costs of cooling during heatwaves and drying during flooding, as well as negatively impacting staff and patients.

As part of addressing the risk, the Trust updated our Green Plan following the 2025 guidance of the Greener NHS programme. There are 32 actions in the 2025-2028 Green Plan looking at both mitigation by reducing our emissions, and adaptation and resilience of the Trust estate buildings and infrastructure to Climate Change. Completing the NHS Climate Change Risk Assessment (CCRA) will help to identify risks, understand the potential impact to the delivery of healthcare and maintain service continuity during climate disruption. Extreme and adverse weather events to date and other data currently collected by the Emergency Planning and Estates teams at the Trust will support the completion of the tool.

The resulting Climate Change Adaptation Plan will be developed following completion of the CCRA. The Trust ensures that its obligations under the Climate Change Act, Health and Care Act and the Adaptation Reporting requirements are complied with.

The Trust is working collaboratively with Oxfordshire County Council on Climate Change Adaptation and Resilience. The Trust took part in the Climate Adaptation in Oxfordshire summit to co-develop the Oxfordshire Climate Change Adaptation Route Map. The Green Plan sets out an ongoing action to collaborate with key local stakeholders.

The Trust is also working on two National Institute for Health and Care Research (NIHR) projects with academic institutions, local authorities, Met Office and other NHS Trusts. The projects are centred around building knowledge, metrics and toolkits to support NHS estates teams to deliver climate adaptation and reduce the risk of overheating in hospital buildings.

The Trust is working to the Taskforce on Climate-related Financial Disclosures (TCFD) recommendations to take into account the social and economic impacts associated with a 2°C warming scenario.

To mitigate Climate Change the Trust aims to achieve net zero in the carbon emissions it can control by 2040 (scope 1, 2 and a subset of 3) and net zero by 2045 for the emissions in the wider supply chain by 2045, in line with NHS England's net zero target, and is looking to build on the measurement of the core footprint by extending measurement to the whole value chain.

Further information on the Trust's Green Plan 2025-28, our response to and progress against TCFD including our carbon footprint and progress toward reductions is available in the Performance Report of this Annual Report.

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

The Trust has a well-established set of arrangements to ensure its resources are used economically, efficiently and effectively. These include providing the Trust Board with regular assurance over affordability of the Trust's cost base, ongoing scrutiny of Cost Improvement Plans, and regular integrated performance monitoring at all levels of the organisation.

As part of its annual business cycle, the Trust assures itself over its use of resources through the following.

- The Integrated Assurance Committee, Trust Board and Divisional approval of the Trust's Annual Plan, which reflects national and local service and operational requirements and financial targets and incorporates required efficiency savings.
- Regular reporting to the Trust Board and the Integrated Assurance Committee of key performance indicators, aiming to triangulate financial performance with operational, workforce, quality, safety and other factors.
- Standardised processes for service developments, ensuring an appraisal of Return on Investment is undertaken and scrutinised by the Business Planning Group, Investment Committee and Trust Management Executive, prior to spend being committed. Strategic decisions are always considered at Trust Management Executive and Trust Board level.
- Governance structures below Executive level, including monthly Divisional Performance Reviews, which provide an opportunity for Divisions and individual services to be challenged on their use of resources. In 2025/26, the Trust has continued to supplement its performance management processes with regular budget manager training, alongside bespoke training on other finance related topics on request, to better enable budget holders to use resources economically, efficiently and effectively.
- Use of national, regional and peer benchmarking to identify opportunities to improve value for money in delivery of services, including Model Health System, NHS England Getting It Right First Time (GIRFT) Programme and ad-hoc data provided by NHS England and other regulatory bodies.
- Participation in Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System-level (Thames Valley ICS from 1 April 2026) projects and programmes, aiming to reduce duplication and make better use of system-wide resources.

The Trust has a well-established Productivity Committee, chaired by the Chief Executive Officer, that provides the Trust Board with assurance that the organisation is successful in delivering sustainable services and making the best use of resources by improving efficiency and productivity. Where risks or issues in relation to the Trust's productivity or use of resources are identified, the Committee will instruct the relevant service to undertake a deep dive to get better understanding of the issues and implement remedial actions.

Alongside the Productivity Committee, the Delivery Committee monitors large-scale programmes of strategic importance to the Trust including delivery of the operational plan, the people plan and large-scale programmes such as the Stock Control Programme.

The Audit Committee continues to play a key role in overseeing the Trust's financial governance arrangements and management of financial risks and controls. In its work, the Audit Committee draws on assurance provided by the external and internal audit functions. The emphasis of the 2025/26 internal audit plan was predominantly on core

financial controls, with work undertaken on stock management, Divisional finance controls, and Accounts Payable and Receivable.

Where reports resulted in limited assurance or significant scope for improvement was identified, recommendations were followed up on and reported to the Committee until it obtained sufficient assurance that the relevant risks had been addressed.

As a result, over the course of 2025/26, the Committee received a standalone report on progress made in addressing the findings of stock control, divisional finance controls and IT asset management audits.

Alongside its review of external sources of assurance, the Audit Committee continues to receive, as standing items on its agenda, reports regarding losses, special payments and compensations, write-off bad debts and contingent liabilities.

Information Governance

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

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

The table below provides information in relation to serious incidents that met the threshold for onward reporting via the DSPT and the status of the incident. There were three such incidents in 2025/26.

Date reported	Incident description	Actions taken / lessons learned
05/05/2025	Medical HR staff sent an email to 32 consultant anaesthetists with an attached spreadsheet containing names of those 32 consultants along with details of pay progression including their current and expected salaries at next pay point.	Email was recalled, removing it from the inboxes of staff who had not opened it. Those staff members impacted received direct communication. All staff in the relevant division were contacted with recommendations on safe sending of sensitive data. **The ICO consider the matter closed.**
09/05/2025	An email containing a link to a post-surgery survey for patients who had had a LICAP (Lateral Intercostal Artery Perforation, a form of partial breast reconstruction) was sent to 95 patients via email, using CC not BCC thereby disclosing the names and email addresses of all recipients of the survey.	All recipients were contacted with an apology and requested to delete the email and confirm that they have done so. Review of processes in place for sending out questionnaires within the general surgery department underway, with recommendations to circulated trust-wide. **The ICO consider the matter closed.**
25/05/2025	The fact that a vulnerable patient was having surgery was disclosed to a family member who should not have been informed due to safeguarding concerns.	A recording of the call was available, and reviewed which confirmed that the only detail disclosed was that the patient needed to book an appointment with the surgery team. An investigation around the use of an out-of-date phone number showed that the system used by the team treating this patient was not connected to the National Spine. Changes to the system have been made to enable updates to be received. **The ICO consider the matter closed.**

The previous Annual Governance statement made reference to an Enforcement Notice issued by the Information Commissioner about the Trust's performance in relation to duties under the Freedom of Information Act, this Enforcement Notice was formerly closed by the ICO during 25/26.

Data Quality and Governance

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

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

The Caldicott Guardian is the organisational lead responsible for protecting the confidentiality of health and care information and making sure it is used properly, i.e. it is used lawfully, ethically, and appropriately. This role is also responsible for the oversight of Trust compliance with legal obligations for Information Governance and data quality. The Trust also has a Data Protection Officer (DPO) who acts as an independent advisor ensuring that the organisation is aware of, and meets, its data protection responsibilities. Both roles report directly to senior management, and both aspects are subject to Internal Audit reviews.

Each year, the organisation makes an annual submission, via the Data Security Protection Toolkit (DSPT), to demonstrate that it is achieving compliance with a set of standards defined by the NHS.

The 2025/26 DSPT assessed the same areas using the same scoring as the 2024/25 toolkit. The Trust made its required interim submission in December 2025, scoring as "Standards Not Met" which was expected as not all the annual work required to achieve "Standards Met" has been completed. This work is in train to be completed by the 31 June 2026 deadline, and the Trust is expecting to achieve "Standards Met" for 2025/26.

In January and February 2026, the Trust underwent its annual external audit of its DSPT responses – this resulted in high confidence in the quality of the Trust's responses and an overall score of 'low risk', with two minor findings related to policies due for review before June 2026.

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

Additionally, the Trust publishes specific data quality and completeness reports via the central Trust Information Repository System, ORBIT. This includes information on admission timeliness, ethnicity data completeness and elective waiting lists. Specifically for waiting lists, data quality lists are created using programmatic rules to highlight specific cohorts of patients with possible data quality errors. These lists are reviewed by the Referral to Treatment Access Team and clinical services and are accessible within the Referral to Treatment Patient List.

The Digital Team provides support to improve data quality by educating staff in the use of key systems, and monitoring system usage to ensure accurate administration, quality-checking, and system cleansing to prevent inaccurate and obsolete data from being used.

Review of effectiveness

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

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

Regular reports have been received from the Board Committees and senior managers in relation to key risks. Annual reports of the committees have been received by the Board relating to all important areas of activity, and ad-hoc reports in year wherever these were required.

As mentioned previously in this Annual Governance Statement, the annual review of effectiveness of the Board Committees has resulted in comprehensive reports on compliance to the Board. The reports demonstrated assurance that they have operated effectively in relation to their Terms of Reference.

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

- Oxford Fire and Rescue Service Enforcement Notice, following a fire in the Women's Centre, actions related to the remedial works are being monitored by Delivery Committee.
- Issues identified from CQC inspections during the year, final results awaited.

However, it was concluded that these areas, once reviewed, did not constitute a significant gap in control in relation to the delivery of the Trust's strategic objectives. Based on national guidance, the Trust Management Executive and the Audit Committee have reviewed several issues in advising myself and the Board as to the content of this Annual Governance Statement.

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

Conclusion

As with previous years, the Trust continued to face challenges around staffing and the financial control environment, which have affected both patients and staff. Our People Plan continued to provide focus programmes of work to support staff wellbeing, retention and recruitment. Our four strategic pillars have enabled us to maintain a wide range of actions that support our People, Patient Care, Performance and Partnerships, and helped with the delivery of our vision to be an exemplar in healthcare delivery that is compassionate and enabled by the highest levels of research and innovation.

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

Signed:

Simon Crowther

Interim Chief Executive Officer

25 June 2026

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

Opinion

We have audited the financial statements of Oxford University Hospitals NHS Foundation Trust for the year ended 31 March 2026 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and the related notes 1 to 36, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted International Financial Reporting Standards as interpreted and adapted by the HM Treasury's Financial Reporting Manual: 2025-26 as contained in the Department of Health and Social Care Group Accounting Manual 2025 to 2026 and the Accounts Direction issued by NHS England with the approval of the Secretary of State as relevant to the National Health Service in England.

In our opinion the financial statements:

- give a true and fair view of the financial position of Oxford University Hospitals NHS Foundation Trust as at 31 March 2026 and of Foundation Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025 to 2026; and
- have been properly prepared in accordance with the National Health Service Act 2006.

Basis for opinion

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

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

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on Foundation Trust's ability to continue as a going concern for a period to 30 June 2027**.**

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

In evaluating the Accounting Officer's conclusions, we have considered the requirement of the DHSC Group Accounting Manual for entities to adopt the going concern basis of accounting in the

preparation of the financial statements where it is anticipated that the services they provide will continue into the future, and had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) regarding the application of ISA (UK) 570 Going Concern to public sector entities.

Other information

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

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

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

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

- the parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Matters on which we are required to report by exception

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

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Foundation Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources;
- We have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2025/26 and is not misleading or inconsistent with other information forthcoming from the audit; or
- We have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

Responsibilities of the Accounting Officer

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

In preparing the financial statements, the accounting officer is responsible for assessing the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations of the Foundation Trust, or have no realistic alternative but to do so.

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

Auditor's responsibility for the audit of the financial statements

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

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

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

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

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

- of controls, and there is a culture of honesty and ethical behaviour, supported by a number of policies in respect of human resources and counter fraud, bribery and corruption.

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

- To address our fraud risk around the manipulation of reported financial performance through understatement of accrued liabilities, we reviewed the Foundation Trust's accruals policies, tested payables for cut-off issues and searched for unrecorded liabilities, challenged assumptions and corroborated information provided by management to appropriate evidence. This was done in conjunction with our review of Department of Health and Social Care (DHSC) agreement of balances data, investigating and challenging differences which we considered to be significant.

- To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.

- To address the presumed fraud risk of management override of controls, we implemented a journal entry testing strategy, assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions. This included testing specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were authorised and accounted for appropriately.

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

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

We have undertaken our review in accordance with the Code of Audit Practice 2024, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in March 2026, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

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

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

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

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of Oxford University Hospitals NHS Foundation Trust.

Use of our report

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

Ben Lazarus (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London
25 June 2026

Oxford University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Oxford University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Oxford University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Simon Crowther
Interim Chief Executive Officer
25 June 2026

Statement of Comprehensive Income

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	3	1,635,195	1,538,907
Other operating income	4	209,003	213,548
Operating expenses	7,9	(1,802,598)	(1,723,734)
Operating surplus/(deficit) from continuing operations		**41,600**	**28,721**
Finance income	11	2,820	3,033
Finance expenses	12	(33,341)	(22,816)
PDC dividends payable		(9,470)	(8,345)
Net finance costs		**(39,991)**	**(28,128)**
Other gains / (losses)	13	3,967	3,309
Share of profit / (losses) of associates / joint arrangements	20	(9)	(49)
Surplus / (deficit) for the year		**5,567**	**3,853**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(15,849)	(21,980)
Revaluations	17	15,067	15,862
Fair value gains / (losses) on equity instruments designated at fair value through OCI	21	-	(45)
Total comprehensive income / (expense) for the period		**4,785**	**(2,310)**

Statement of Financial Position

	Note	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Intangible assets	14	38,234	28,105
Property, plant and equipment	15	725,336	716,140
Right of use assets	18	77,503	24,924
Investment property	19	49,709	47,767
Investments in associates and joint ventures	20	12,881	12,890
Other investments / financial assets	21	1,582	1,404
Receivables	24	25,686	13,984
Total non-current assets		**930,931**	**845,214**
Current assets			
Inventories	23	32,859	32,893
Receivables	24	91,156	93,100
Cash and cash equivalents	25	75,906	12,456
Total current assets		**199,921**	**138,449**
Current liabilities			
Trade and other payables	26	(219,237)	(197,560)
Borrowings	28	(12,985)	(9,371)
Provisions	29	(837)	(905)
Other liabilities	27	(3,327)	(1,572)
Total current liabilities		**(236,386)**	**(209,408)**
Total assets less current liabilities		**894,466**	**774,255**
Non-current liabilities			
Borrowings	28	(415,751)	(374,371)
Provisions	29	(6,905)	(6,407)
Other liabilities	27	(7,686)	(5,864)
Total non-current liabilities		**(430,342)**	**(386,642)**
Total assets employed		**464,124**	**387,613**
Financed by			
Public dividend capital		426,761	355,035
Revaluation reserve		183,592	195,269
Financial assets reserve		(9,880)	(9,880)
Other reserves		1,743	1,743
Income and expenditure reserve		(138,092)	(154,554)
Total taxpayers' equity		**464,124**	**387,613**

The notes on pages 122 to 161 form part of these accounts.

Simon Crowther
Interim Chief Executive Officer
25 June 2026

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	**355,035**	**195,269**	**(9,880)**	**1,743**	**(154,554)**	**387,613**
Surplus/(deficit) for the year	-	-	-	-	5,567	**5,567**
Impairments	-	(15,849)	-	-	-	**(15,849)**
Revaluations	-	15,067	-	-	-	**15,067**
Public dividend capital received	71,726	-	-	-	-	**71,726**
Other reserve movements	-	(10,895)	-	-	10,895	**-**
Taxpayers' equity at 31 March 2026	**426,761**	**183,592**	**(9,880)**	**1,743**	**(138,092)**	**464,124**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Financial assets reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	**329,198**	**212,618**	**(9,835)**	**1,743**	**(169,638)**	**364,086**
Surplus/(deficit) for the year	-	-	-	-	3,853	**3,853**
Impairments	-	(21,980)	-	-	-	**(21,980)**
Revaluations	-	15,862	-	-	-	**15,862**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	(45)	-	-	**(45)**
Public dividend capital received	25,837	-	-	-	-	**25,837**
Other reserve movements	-	(11,231)	-	-	11,231	**-**
Taxpayers' equity at 31 March 2025	**355,035**	**195,269**	**(9,880)**	**1,743**	**(154,554)**	**387,613**

Information on reserves

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

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

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

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

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

Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		41,600	28,721
Non-cash income and expense:			
Depreciation and amortisation	7.1	54,184	50,971
Net impairments	8	3,323	12,144
Income recognised in respect of capital donations	4	(1,677)	(13,044)
Amortisation of PFI deferred credit		(303)	(272)
(Increase) / decrease in receivables and other assets		(10,879)	(30,363)
(Increase) / decrease in inventories		34	(652)
Increase / (decrease) in payables and other liabilities		6,049	(2,616)
Increase / (decrease) in provisions		409	(164)
Net cash flows from / (used in) operating activities		**92,740**	**44,725**
Cash flows from investing activities			
Interest received		2,820	3,033
Purchase of intangible assets		(13,945)	(10,778)
Purchase of PPE and investment property		(44,768)	(55,490)
Sales of PPE and investment property		9,104	16
Receipt of cash donations to purchase assets		1,026	12,213
Net cash flows from / (used in) investing activities		**(45,763)**	**(51,006)**
Cash flows from financing activities			
Public dividend capital received		71,726	25,837
Movement on loans from DHSC		(661)	(661)
Movement on other loans		(568)	(575)
Capital element of lease rental payments		(7,919)	(3,972)
Capital element of PFI and other service concession payments		(15,462)	(20,806)
Interest on loans		(253)	(286)
Other interest		(30)	(15)
Interest paid on lease liability repayments		(1,106)	(615)
Interest paid on PFI and other service concession obligations		(19,591)	(19,936)
PDC dividend (paid) / refunded		(9,663)	(7,047)
Net cash flows from / (used in) financing activities		**16,473**	**(28,076)**
Increase / (decrease) in cash and cash equivalents		**63,450**	**(34,357)**
Cash and cash equivalents at 1 April - brought forward		**12,456**	**46,813**
Cash and cash equivalents at 31 March	25.1	**75,906**	**12,456**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

The Board has reported that the Trust is a going concern, with no plans for any substantial changes to its portfolio of services. Since the Trust has neither been notified that its services are no longer required nor received notice of material closure of NHS services currently run by the Trust, and services continue to be commissioned from the Trust by local and specialist commissioners. The Trust therefore expects to operate as a going concern through to the end of the going concern period of 30 June 2027. The Trust Board has considered the advice in the DHSC's GAM that the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. The Trust has therefore adopted this approach in preparing these accounts.

Therefore, these accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

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

Associates

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

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

Joint ventures

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

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. The Aligned Payment and Incentive (API) payment mechanism applies to all contractual relationships between NHS Commissioners and NHS Providers, where the Expected Annual Contract Value (EACV), taking into account both core ICB commissioned activity and delegated specialised activity, is over £1.5m. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear
medicine, and chemotherapy delivery activity, where there is a National Tariff set for the activity within the NHSPS. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services delivered by NHS providers, including urgent and emergency and maternity services i.e. there is no adjustment for activity delivered above or below the agreed plan. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

For relationships with an EACV below £1.5m, the payment is made under the Low Value Activity (LVA) mechanism, which is a block payment covering all activity delivered, and is based on historic activity levels. High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.5 Other forms of income

Grants and donations

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

Apprenticeship service income

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Pension costs

NHS Pension Scheme

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

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

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

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

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

Depreciation

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

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

Revaluation gains and losses

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

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

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

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

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

De-recognition

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

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

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

Donated and grant funded assets

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

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

Private Finance Initiative (PFI) transactions

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

Initial recognition

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

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	Not applicable	
Buildings, excluding dwellings	8	48
Dwellings	8	22
Plant & machinery	5	25
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	5	10

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as ‘deemed cost’ and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

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

	Min life Years	Max life Years
Information technology	3	13
Software licences	1	11

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method or the weighted average cost method.

Note 1.11 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income: Equity investment in one private company obtained by the Trust in recognition of its part in establishing the company – this is held as a strategic asset and the Trust is not able to liquidise the asset.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined by reference to past experience within separate categories of debt, classified by level of risk. Judgement is also applied, where the expectation of future credit losses is expected to impact upon the recoverable amount of the asset. The age of a receivable is taken into account and the more overdue a receivable becomes, the higher the value of expected credit loss. A separate model has been determined for the private patient income project.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 29.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 30 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in Note 30, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-Trusts-and-foundation-Trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

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

IFRS 14 Regulatory Deferral Accounts

Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.

IFRS18 Presentation and Disclosure in Financial Statements

Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.

IFRS19 Subsidiaries without Public Accountability: Disclosures

Application required for accounting periods beginning on or after 1 January 2027. Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted.

Note 1.22 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

PFI and service concessions classification

The Trust has assessed the three PFI schemes, Welcome Centre, and Carbon Energy Scheme against the international financial reporting standards and relevant NHS accounting guidance and judges that all are capitalised under the IFRIC 12 criteria. Estimates for the assets, liabilities and amounts chargeable to the SOCI are determined as per the estimation paragraph in section 1.23. The Welcome Centre has no economic outflow from the Trust so is reported under deferred income following the guidance.

Capitalisation of staff costs
The Trust makes judgements about which of its staff costs are related to capital improvements that meet the definitions in 1.8. These judgements are based on timesheets and the Trust's understanding of what is being achieved by the individuals carrying out the work.

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

Note 1.23 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Estimation of contract income
Achieving early closure of accounts means that the accounts must be prepared before the normal cycle for contract income is complete. Contract income includes some estimated values and assessment of income risk based on actual activity for the first 10 months of the Financial Year. Actual amounts may differ from the estimate depending on actual activity levels, but not materially so.

Estimation of payments for the PFI and service concession assets, including finance costs
The assets and liabilities relating to the three PFI schemes have been brought onto the statement of financial position based on estimations from the Department of Health financial model as required by the Department of Health guidance. The models also provide estimates for interest payable and lease remeasurement. A similar model has been developed to estimate the accounting entries for the Trust's Carbon Energy Scheme which is capitalised under IFRIC12 as a service concession. A liability also exists for future commitments and the model estimates the interest payable.

Estimation of asset lives as the basis for depreciation calculations
Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Managers have adjusted estimated lives at the end of the accounting period, where their estimate of useful life is significantly different to the original. The estimate of asset lives may differ to the actual period the Trust utilises the asset but any difference would not be material.

Estimation of Asset values
The valuation approach for Property Plant and Equipment are detailed in Note 17. For operational assets, the valuation, including movement from last year, are documented in Note 15. The valuation and movement on investment properties is detailed in Note 19.

Impairment of receivables
The Trust is required to judge when there is sufficient evidence to impair individual receivables. It does this based on the aged profile and class of the receivables. Different classes of receivables attract different rates of impairment depending on the Trust's assessment of the level of risk associated with the collection of the debt. The Trust adopts a prudent policy of increasing the expected credit loss the older the debt is. The Trust makes every effort to collect the debt, even when it has been impaired, and only writes off the debt as a final course of action after all possible collection efforts have been made. The actual level of debt written off may be different to that which had been judged as impaired, but not materially so.

Accruals and prepayments
Each year the Trust sets detailed guidance for its managers in order to assist them in calculating accruals and prepayments including de minimis levels. The Trust uses a number of techniques to calculate its best estimate for accruals. Techniques that are used include:-

Trend analysis
Expert judgement of Finance Managers
Supplier statements
Formulaic approach based on historical cost information

Prepayments are not normally sensitive to future events, and they can be reliably estimated. Accruals are a matter of judgement, based on past experience and information available at the time. Once realised, accruals can be different to the original estimate, but not materially so.

Note 2 Operating Segments

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across all locations and the appropriate policies, procedures and governance arrangements are Trust wide. As an NHS Foundation Trust, all services are subject to the same regulatory environment and standards set by external performance managers. The Trust operates one segment and in the period to 31 March reported to the Board in this format. No discrete activities of the business have individual revenue exceeding 10% of the total combined revenue or assets.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2025/26 £000	2024/25 £000
Acute services		
Income from commissioners under API contracts - variable element*	359,654	363,040
Income from commissioners under API contracts - fixed element*	860,543	860,395
High cost drugs income from commissioners	295,722	214,567
Other NHS clinical income	44,814	27,627
Private patient income	9,601	7,232
National pay award central funding***		3,601
Additional pension contribution central funding**	57,897	54,890
Other clinical income	6,964	7,555
Total income from activities	**1,635,195**	**1,538,907**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2025/26 £000	2024/25 £000
NHS England	359,106	678,651
Integrated care boards	1,231,478	821,709
Other NHS providers	16,781	16,636
Local authorities	5,384	5,472
Non-NHS: private patients	9,601	7,232
Non-NHS: overseas patients (chargeable to patient)	3,139	2,722
Injury cost recovery scheme	3,825	4,833
Non NHS: other	5,881	1,652
Total income from activities	**1,635,195**	**1,538,907**

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

	2025/26	2024/25
	£000	£000
Income recognised this year	3,139	2,722
Cash payments received in-year	1,715	1,144
Amounts added to provision for impairment of receivables	743	1,320

Note 4 Other operating income

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	52,903	-	**52,903**	55,265	-	**55,265**
Education and training	60,395	1,640	**62,035**	55,752	1,547	**57,299**
Non-patient care services to other bodies	51,432		**51,432**	47,116		**47,116**
Income in respect of employee benefits accounted on a gross basis	19,089		**19,089**	17,805		**17,805**
Receipt of capital grants and donations and peppercorn leases		1,677	**1,677**		13,044	**13,044**
Charitable and other contributions to expenditure		188	**188**		285	**285**
Revenue from operating leases		2,340	**2,340**		2,184	**2,184**
Amortisation of PFI deferred income / credits		303	**303**		272	**272**
Other income	19,036	-	**19,036**	20,278	-	**20,278**
Total other operating income	**202,855**	**6,148**	**209,003**	**196,216**	**17,332**	**213,548**

Other income includes £12.6m with other public sector bodies (2024/25: £10.1m with other public sector bodies)

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

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,135	2,554

Note 5.2 Transaction price allocated to remaining performance obligations

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	1,622,455	1,528,953
Income from services not designated as commissioner requested services	12,740	9,954
Total	**1,635,195**	**1,538,907**

Note 5.4 Fees and charges

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2025/26	2024/25
	£000	£000
Income	16,667	14,001
Full cost	(16,551)	(14,598)
Surplus / (deficit)	**116**	**(597)**

Note that this relates to private patient income of £9.6m (2024/25: £7.2m), overseas patient income of £3.1m (2024/25: £2.7m) and car parking income of £3.9m (2024/25: £4.0m).

Note 6 Operating leases - Oxford University Hospitals NHS Foundation Trust as lessor

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

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

Note 6.1 Operating lease income

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	2,340	2,184
Total in-year operating lease income	**2,340**	**2,184**

Note 6.2 Future lease receipts

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	3,453	5,172
- later than one year and not later than five years	13,492	20,246
- later than five years	32,708	25,688
Total	**49,653**	**51,106**

Note 7.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,540	6,903
Purchase of healthcare from non-NHS and non-DHSC bodies	26,099	20,429
Staff and executive directors costs	1,012,812	962,063
Remuneration of non-executive directors	231	222
Supplies and services - clinical (excluding drugs costs)	226,657	210,123
Supplies and services - general	10,787	10,708
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	233,192	225,817
Inventories written down	422	883
Consultancy costs	1,991	1,902
Establishment	9,490	9,135
Premises	48,334	40,921
Transport (including patient travel)	9,866	9,560
Depreciation on property, plant and equipment	49,522	47,395
Amortisation on intangible assets	4,662	3,576
Net impairments	3,323	12,144
Movement in credit loss allowance: contract receivables / contract assets	(2,185)	(1,883)
Change in provisions discount rate(s)	(77)	7
Fees payable to the external auditor		
audit services- statutory audit	417	385
Internal audit costs	119	111
Clinical negligence	37,605	36,982
Legal fees	1,057	1,428
Insurance (as a policy holder)	514	511
Research and development	42,515	44,940
Education and training	11,958	11,798
Expenditure on low value leases	35	51
Redundancy	146	92
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	45,460	51,041
Car parking & security	2,126	2,265
Hospitality	39	26
Losses, ex gratia & special payments	92	82
Other services, eg external payroll	9,281	9,389
Other	11,568	4,728
Total	**1,802,598**	**1,723,734**

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2024/25: £2m).

Note 8 Impairment of assets

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	470
Abandonment of assets in course of construction	644	47
Unforeseen obsolescence	107	-
Changes in market price	2,572	11,627
Total net impairments charged to operating surplus / deficit	**3,323**	**12,144**
Impairments charged to the revaluation reserve	15,849	21,980
Total net impairments	**19,172**	**34,124**

There are two reasons for the impairments above:
i. impairment on revaluation to a modern equivalent asset basis when a new building or enhancement to an existing building is first brought into use
ii. changes in market price arising from the annual revaluation exercise which results in impairments and reverse impairments

Note 9 Employee benefits

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	766,017	739,625
Social security costs	96,563	73,838
Apprenticeship levy	3,680	3,533
Employer's contributions to NHS pensions	144,905	137,644
Pension cost - other	82	103
Termination benefits	146	92
Temporary staff (including agency)	47,283	57,251
Total staff costs	**1,058,676**	**1,012,086**
Of which		
Costs capitalised as part of assets	1,600	2,960

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

* Note that staff costs include elements of Research and Development and Education and Training costs from note 7.1

Note 9.1 Retirements due to ill-health

During 2025/26 there were 9 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £997k (£249k in 2024/25).

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

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Non-NHS Pension Scheme

By law all employers are required to automatically enrol certain workers in a pension scheme. If employees meet the scheme's eligibility criteria they will be enrolled in the NHS Pension Scheme. If an employee cannot be enrolled in the NHS Pension Scheme for whatever reason, they are automatically enrolled in an alternative qualifying pension scheme. For OUH employees this scheme is the National Employee's Savings Trust (NEST). At the present time there are very few employees (<1%) in this scheme.

Note 11 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,820	3,033
Total finance income	**2,820**	**3,033**

Note 12.1 Finance expenditure

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	165	171
Interest on other loans	86	(84)
Interest on lease obligations	1,106	614
Interest on late payment of commercial debt	28	15
Finance costs on PFI and other service concession arrangements:		
Main finance costs	19,592	19,937
Remeasurement of the liability resulting from change in index or rate	12,343	2,137
Total interest expense	**33,320**	**22,790**
Unwinding of discount on provisions	21	26
Total finance costs	**33,341**	**22,816**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	28	15

Note 13 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	1,847	10
Losses on disposal of assets	-	(29)
Total gains / (losses) on disposal of assets	**1,847**	**(19)**
Fair value gains / (losses) on investment properties	1,942	2,989
Fair value gains / (losses) on financial assets / investments	178	339
Total other gains / (losses)	**3,967**	**3,309**

Note 14.1 Intangible assets - 2025/26

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**13,743**	**25,469**	**12,075**	**51,287**
Additions	8,373	271	5,301	**13,945**
Reclassifications	2,341	(1,676)	1,013	**1,678**
Disposals / derecognition	(950)	(212)	(644)	**(1,806)**
Cost at 31 March 2026	**23,507**	**23,852**	**17,745**	**65,104**
Amortisation at 1 April 2025 - brought forward	**6,577**	**16,605**	**-**	**23,182**
Provided during the year	2,603	2,059	-	**4,662**
Impairments	-	-	644	**644**
Reclassifications	188	-	-	**188**
Disposals / derecognition	(950)	(212)	(644)	**(1,806)**
Amortisation at 31 March 2026	**8,418**	**18,452**	**-**	**26,870**
Net book value at 31 March 2026	**15,089**	**5,400**	**17,745**	**38,234**
Net book value at 1 April 2025	**7,166**	**8,864**	**12,075**	**28,105**

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 14.2 Intangible assets - 2024/25

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**9,111**	**21,955**	**5,097**	**36,163**
Additions	486	214	10,078	**10,778**
Reclassifications	4,146	3,300	(3,100)	**4,346**
Valuation / gross cost at 31 March 2025	**13,743**	**25,469**	**12,075**	**51,287**
Amortisation at 1 April 2024 - as previously stated	**4,140**	**15,464**	**-**	**19,604**
Provided during the year	2,435	1,141	-	**3,576**
Reclassifications	2	-	-	**2**
Amortisation at 31 March 2025	**6,577**	**16,605**	**-**	**23,182**
Net book value at 31 March 2025	**7,166**	**8,864**	**12,075**	**28,105**
Net book value at 1 April 2024	**4,971**	**6,491**	**5,097**	**16,559**

Note 15.1 Property, plant and equipment - 2025/26

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2025 - brought forward	**20,540**	**554,271**	**1,454**	**30,146**	**265,261**	**686**	**30,351**	**5,116**	**907,825**
Additions	1,540	19,364	-	17,711	22,239	197	5,189	-	**66,240**
Impairments	(506)	(42,789)	-	-	-	-	-	-	**(43,295)**
Reversals of impairments	723	7,494	-	-	-	-	-	-	**8,217**
Revaluations	43	5,258	(6)	-	-	-	-	-	**5,295**
Reclassifications	-	1,882	-	1,908	(2,448)	(180)	(2,849)	9	**(1,678)**
Disposals / derecognition	-	-	-	(7,250)	(5,918)	-	(9,078)	(3,940)	**(26,186)**
Valuation/gross cost at 31 March 2026	**22,340**	**545,480**	**1,448**	**42,515**	**279,134**	**703**	**23,613**	**1,185**	**916,418**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**-**	**165,582**	**541**	**21,129**	**4,433**	**191,685**
Provided during the year	-	26,355	74	-	14,313	49	3,861	183	**44,835**
Impairments	-	(11,290)	-	-	107	-	-	-	**(11,183)**
Reversals of impairments	-	(5,367)	-	-	-	-	-	-	**(5,367)**
Revaluations	-	(9,698)	(74)	-	-	-	-	-	**(9,772)**
Reclassifications	-	-	-	-	(188)	-	-	-	**(188)**
Disposals / derecognition	-	-	-	-	(5,910)	-	(9,078)	(3,940)	**(18,928)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**173,904**	**590**	**15,912**	**676**	**191,082**
Net book value at 31 March 2026	**22,340**	**545,480**	**1,448**	**42,515**	**105,230**	**113**	**7,701**	**509**	**725,336**
Net book value at 1 April 2025	**20,540**	**554,271**	**1,454**	**30,146**	**99,679**	**145**	**9,222**	**683**	**716,140**

Note 15.2 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**21,284**	**546,669**	**2,174**	**36,862**	**257,497**	**686**	**32,670**	**5,151**	**902,993**
Additions	-	22,162	-	23,800	10,610	-	1,373	-	**57,945**
Impairments	(744)	(47,733)	(720)	-	-	-	-	-	**(49,197)**
Reversals of impairments	-	(233)	-	-	-	-	-	-	**(233)**
Revaluations	-	7,312	-	-	-	-	-	-	**7,312**
Reclassifications	-	26,094	-	(30,469)	3,957	-	(3,692)	(35)	**(4,145)**
Disposals / derecognition	-	-	-	(47)	(6,803)	-	-	-	**(6,850)**
Valuation/gross cost at 31 March 2025	**20,540**	**554,271**	**1,454**	**30,146**	**265,261**	**686**	**30,351**	**5,116**	**907,825**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**-**	**-**	**-**	**157,751**	**489**	**16,598**	**4,227**	**179,065**
Provided during the year	-	24,308	129	-	13,862	52	4,531	209	**43,091**
Impairments	-	(8,429)	(129)	47	534	-	-	-	**(7,977)**
Reversals of impairments	-	(7,329)	-	-	-	-	-	-	**(7,329)**
Revaluations	-	(8,550)	-	-	-	-	-	-	**(8,550)**
Reclassifications	-	-	-	-	202	-	-	(3)	**199**
Disposals / derecognition	-	-	-	(47)	(6,767)	-	-	-	**(6,814)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**165,582**	**541**	**21,129**	**4,433**	**191,685**
Net book value at 31 March 2025	**20,540**	**554,271**	**1,454**	**30,146**	**99,679**	**145**	**9,222**	**683**	**716,140**
Net book value at 1 April 2024	**21,284**	**546,669**	**2,174**	**36,862**	**99,746**	**197**	**16,072**	**924**	**723,928**

Note 15.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	21,296	259,657	1,448	41,231	66,779	113	7,699	507	**398,730**
On-SoFP PFI contracts and other service concession arrangements	-	213,649	-	-	29,910	-	-	-	**243,559**
Owned - donated/granted	1,044	72,174	-	1,284	8,541	-	2	2	**83,047**
Total net book value at 31 March 2026	**22,340**	**545,480**	**1,448**	**42,515**	**105,230**	**113**	**7,701**	**509**	**725,336**

Note 15.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	19,357	273,148	1,454	28,160	62,013	145	9,218	679	**394,174**
On-SoFP PFI contracts and other service concession arrangements	-	210,733	-	-	28,776	-	-	-	**239,509**
Owned - donated/granted	1,183	70,390	-	1,986	8,890	-	4	4	**82,457**
Total net book value at 31 March 2025	**20,540**	**554,271**	**1,454**	**30,146**	**99,679**	**145**	**9,222**	**683**	**716,140**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	5,059	2,276	-	-	-	-	-	-	**7,335**
Not subject to an operating lease	17,281	543,204	1,448	42,515	105,230	113	7,701	509	**718,001**
Total net book value at 31 March 2026	**22,340**	**545,480**	**1,448**	**42,515**	**105,230**	**113**	**7,701**	**509**	**725,336**

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	3,246	2,285	-	-	-	-	-	-	**5,531**
Not subject to an operating lease	17,294	551,986	1,454	30,146	99,679	145	9,222	683	**710,609**
Total net book value at 31 March 2025	**20,540**	**554,271**	**1,454**	**30,146**	**99,679**	**145**	**9,222**	**683**	**716,140**

Note 16 Donations of property, plant and equipment

The donated assets acquired in the year were mostly donated by Oxford Hospitals Charity, and other charities associated with Oxford University Hospitals NHS Foundation Trust. There were no restrictions or conditions imposed by the donor on the use of the donated assets.

Note 17 Revaluations of property, plant and equipment

The Trust's land and buildings were revalued as at 31 March 2026 by the Trust's appointed independent expert valuer (a MRICS qualified valuer from Carter Jonas LLP). The full movements as a result of revaluations are disclosed at note 15.

The valuation was an open market value using the modern equivalent asset basis of valuation. In assessing the value of the Trust's land it was assumed that should the existing buildings be replaced by a modern equivalent asset, certain buildings would be rebuilt on a more intensive basis, on an alternative 'optimal site'. Therefore a smaller landholding and buildings footprint is required while still maintaining the current level of service provision.

Asset lives of buildings are updated at the end of each statutory reporting period on the expert advice of the Trust's appointed expert valuer. The update does not affect depreciation in the current period of accounts and does not have a material impact on future accounting periods.

Investment assets are assessed to Fair value under IFRS 13 which equates to market value. For reference the RICS definition of Market Value is as follows. *The estimated amount for which an asset or liability should exchange on the valuation date between a willing buyer and a willing seller in an arm's length transaction, after proper marketing and where the parties had each acted knowledgeably, prudently and without compulsion*

Where an asset is valued to Fair Value, IFRS 13 it requires the valuer to make additional disclosures regarding the valuation technique applied to measure the Fair Value and the nature of the inputs to that valuation technique, having regard to the fair value hierarchy.

It is confirmed that the valuation technique applied constitute Level 2 inputs in each instance. Level 2 inputs are inputs that are observable for the asset, either directly or indirectly. The inputs used took the form of analysed and weighted market evidence such as sales, rentals and yields in respect of comparable properties in the same or similar locations at or around the valuation date

Note 18 Leases - Oxford University Hospitals NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust's leases fall into three main categories:
a) Lease of the five-storey Surgical Elective Centre building located on the John Radcliffe Hospital site incorporating seven operating theatres.
b) Leases of items of plant and equipment. These are predominantly items of medical equipment, office equipment or motor vehicles. There is no material contingent rental, and the leases are usually for fixed terms. There are no restrictions in these leases other than those which would commonly be found in commercial leases of this kind.
c) Leases of property. Typically these are leases of space in other NHS facilities. These leases are usually negotiated for fixed terms.

Note 18.1 Right of use assets - 2025/26

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**19,691**	**13,869**	**666**	**2,563**	**36,789**	**10,159**
Additions	50,823	6,295	-	-	**57,118**	-
Remeasurements of the lease liability	-	399	-	-	**399**	-
Reclassifications	-	67	-	(67)	**-**	-
Disposals / derecognition	(829)	(1,256)	-	-	**(2,085)**	-
Valuation/gross cost at 31 March 2026	**69,685**	**19,374**	**666**	**2,496**	**92,221**	**10,159**
Accumulated depreciation at 1 April 2025 - brought forward	**4,884**	**6,185**	**477**	**319**	**11,865**	**2,693**
Provided during the year	1,900	2,265	80	442	**4,687**	1,205
Reclassifications	-	-	-	-	**-**	-
Disposals / derecognition	(578)	(1,256)	-	-	**(1,834)**	-
Accumulated depreciation at 31 March 2026	**6,206**	**7,194**	**557**	**761**	**14,718**	**3,898**
Net book value at 31 March 2026	**63,479**	**12,180**	**109**	**1,735**	**77,503**	**6,261**
Net book value at 1 April 2025	**14,807**	**7,684**	**189**	**2,244**	**24,924**	**7,466**
Net book value of right of use assets leased from other NHS providers						6,261
Net book value of right of use assets leased from other DHSC group bodies						-

Note 18.2 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**13,984**	**9,281**	**666**	**1,295**	**25,226**	**4,452**
Additions	5,707	6,352	-	1,327	**13,386**	5,707
Reclassifications	-	(201)	-	-	**(201)**	-
Disposals / derecognition	-	(1,563)	-	(59)	**(1,622)**	-
Valuation/gross cost at 31 March 2025	**19,691**	**13,869**	**666**	**2,563**	**36,789**	**10,159**
Accumulated depreciation at 1 April 2024 - brought forward	3,092	5,917	318	40	**9,367**	1,759
Provided during the year	1,792	2,019	159	334	**4,304**	934
Reclassifications	-	(195)	-	(6)	**(201)**	-
Disposals / derecognition	-	(1,556)	-	(49)	**(1,605)**	-
Accumulated depreciation at 31 March 2025	**4,884**	**6,185**	**477**	**319**	**11,865**	**2,693**
Net book value at 31 March 2025	**14,807**	**7,684**	**189**	**2,244**	**24,924**	**7,466**
Net book value at 1 April 2024	**10,892**	**3,364**	**348**	**1,255**	**15,859**	**2,693**
Net book value of right of use assets leased from other NHS providers						7,466

Note 18.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 28.1.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**21,772**	**12,376**
Lease additions	57,118	13,386
Lease liability remeasurements	399	-
Interest charge arising in year	1,106	614
Early terminations	(255)	(17)
Lease payments (cash outflows)	(9,025)	(4,587)
Other changes	-	-
Carrying value at 31 March	**71,115**	**21,772**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.
These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.4 Maturity analysis of future lease payments

	Total 31 March 2026	Of which leased from DHSC group bodies: 31 March 2026	Total 31 March 2025	Of which leased from DHSC group bodies: 31 March 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	10,635	1,351	4,968	1,724
- later than one year and not later than five years;	54,753	2,135	12,216	3,114
- later than five years.	35,649	5,495	9,793	5,495
Total gross future lease payments	**101,037**	**8,981**	**26,977**	**10,333**
Finance charges allocated to future periods	(29,922)	(2,640)	(5,205)	(2,892)
Net lease liabilities at 31 March 2026	**71,115**	**6,341**	**21,772**	**7,441**
Of which:				
Leased from other NHS providers		6,341		7,441

Note 19 Investment Property

	2025/26	2024/25
	£000	£000
Carrying value at 1 April - brought forward	**47,767**	**44,778**
Movement in fair value	1,942	2,989
Carrying value at 31 March	**49,709**	**47,767**

Note 19.1 Investment property income and expenses

	2025/26	2024/25
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	(1,103)	(1,095)
Total investment property expenses	**(1,103)**	**(1,095)**
Investment property income	2,597	2,579

Note 20 Investments in associates and joint ventures

	2025/26	2024/25
	£000	£000
Carrying value at 1 April - brought forward	**12,890**	**12,939**
Share of profit / (loss)	(9)	(49)
Carrying value at 31 March	**12,881**	**12,890**

Note 21 Other investments / financial assets (non-current)

	2025/26	2024/25
	£000	£000
Carrying value at 1 April - brought forward	**1,404**	**1,110**
Movement in fair value through income and expenditure	178	339
Movement in fair value through OCI	-	(45)
Carrying value at 31 March	**1,582**	**1,404**

Note 22 Disclosure of interests in other entities

The Trust holds interests in the following entity. Further detail on financial performance is contained within the preceding notes. Oxford Headington Holdings LLP - 50% voting rights, with priority access to the first £12m of profits, thereafter 75% profit/loss share.

Note 23 Inventories

	31 March 2026	31 March 2025
	£000	£000
Drugs	8,857	9,315
Consumables	22,985	22,349
Energy	238	314
Other	779	915
Total inventories	**32,859**	**32,893**

Inventories recognised in expenses for the year were £206.5m (2024/25: £253.2m). Write-down of inventories recognised as expenses for the year were £0.4m (2024/25: £0.9m).

Note 24.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	69,910	77,095
Allowance for impaired contract receivables / assets	(13,822)	(15,994)
Prepayments (non-PFI)	13,986	13,871
PFI prepayments - capital contributions	67	67
PFI lifecycle prepayments	3,670	4,984
PDC dividend receivable	898	705
VAT receivable	5,272	4,690
Other receivables	11,175	7,682
Total current receivables	**91,156**	**93,100**
Non-current		
Contract receivables	7,637	7,303
Prepayments (non-PFI)	62	44
PFI prepayments - capital contributions	602	669
Other receivables	17,385	5,968
Total non-current receivables	**25,686**	**13,984**
Of which receivable from NHS and DHSC group bodies:		
Current	16,938	45,431
Non-current	1,607	1,768

Note 24.2 Allowances for credit losses

	2025/26 £000	2024/25 £000
Allowances as at 1 April - brought forward	**15,994**	**17,915**
New allowances arising	7,574	8,487
Changes in existing allowances	(3,578)	(2,538)
Reversals of allowances	(6,181)	(7,832)
Utilisation of allowances (write offs)	13	(38)
Allowances as at 31 Mar 2026	**13,822**	**15,994**

Note 24.3 Exposure to credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the receivables note above. We actively manage the debt and have made a provision to reflect a probability-weighted estimate for expected credit loss which has been determined by evaluating the range of possible outcomes.

Note 25.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2025/26 £000	2024/25 £000
At 1 April	**12,456**	**46,813**
Net change in year	63,450	(34,357)
At 31 March	**75,906**	**12,456**
Broken down into:		
Cash at commercial banks and in hand	22	28
Cash with the Government Banking Service	75,884	12,428
Total cash and cash equivalents as in SoFP and SoCF	**75,906**	**12,456**

Note 26.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables	91,867	92,804
Capital payables	44,793	25,285
Accruals	41,482	38,763
Receipts in advance and payments on account	1,886	-
Social security costs	10,453	8,696
Other taxes payable	11,426	10,781
Pension contributions payable	12,206	11,795
Other payables	5,124	9,436
Total current trade and other payables	**219,237**	**197,560**

The annual leave accrual £nil is included within the "accruals" row (2024/25: £1.1m), all other payroll associated accruals are included within "other payables".

Of which payables from NHS and DHSC group bodies:		
Current	10,776	9,639

Note 27 Other liabilities

	2026 £000	2025 £000
Current		
Deferred income: contract liabilities	2,911	1,277
Deferred PFI credits / income	416	295
Total other current liabilities	**3,327**	**1,572**
Non-current		
Deferred income: contract liabilities	3,654	2,301
Deferred PFI credits / income	4,032	3,563
Total other non-current liabilities	**7,686**	**5,864**

Note 28.1 Borrowings

	2026 £000	2025 £000
Current		
Loans from DHSC	724	726
Other loans	634	522
Lease liabilities	4,715	3,824
Obligations under PFI or other service concession contracts	6,912	4,299
Total current borrowings	**12,985**	**9,371**
Non-current		
Loans from DHSC	12,593	13,254
Other loans	3,876	4,556
Lease liabilities	66,400	17,948
Obligations under PFI or other service concession contracts	332,882	338,613
Total non-current borrowings	**415,751**	**374,371**

Note 28.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Lease Liabilities	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2025	**13,980**	**5,078**	**21,772**	**342,912**	**383,742**
Cash movements:					
Financing cash flows - payments and receipts of principal	(661)	(568)	(7,919)	(15,462)	**(24,610)**
Financing cash flows - payments of interest	(167)	(86)	(1,106)	(19,591)	**(20,950)**
Non-cash movements:					
Additions	-	-	57,118	-	**57,118**
Lease liability remeasurements	-	-	399	-	**399**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				12,343	**12,343**
Application of effective interest rate	165	86	1,106	19,592	**20,949**
Early terminations	-	-	(255)	-	**(255)**
Carrying value at 31 March 2026	**13,317**	**4,510**	**71,115**	**339,794**	**428,736**

	Loans from DHSC	Other loans	Lease Liabilities	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2024	**14,647**	**5,846**	**12,376**	**361,580**	**394,449**
Cash movements:					
Financing cash flows - payments and receipts of principal	(661)	(575)	(3,972)	(20,806)	**(26,014)**
Financing cash flows - payments of interest	(177)	(109)	(615)	(19,936)	**(20,837)**
Non-cash movements:					
Additions	-	-	13,386	-	**13,386**
Remeasurement of PFI / other service concession liability resulting from change in index or rate				2,137	**2,137**
Application of effective interest rate	171	(84)	614	19,937	**20,638**
Early terminations	-	-	(17)	-	**(17)**
Carrying value at 31 March 2025	**13,980**	**5,078**	**21,772**	**342,912**	**383,742**

Note 29.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**429**	**1,140**	**150**	**5,593**	**7,312**
Change in the discount rate	(14)	(63)	-	(127)	**(204)**
Arising during the year	-	-	50	1,131	**1,181**
Utilised during the year	(120)	(135)	(11)	(287)	**(553)**
Reversed unused	(15)	-	(13)	(93)	**(121)**
Unwinding of discount	5	16	-	106	**127**
At 31 March 2026	**285**	**958**	**176**	**6,323**	**7,742**
Expected timing of cash flows:					
- not later than one year;	120	135	176	406	**837**
- later than one year and not later than five years;	165	540	-	1,162	**1,867**
- later than five years.	-	283	-	4,755	**5,038**
Total	**285**	**958**	**176**	**6,323**	**7,742**

The Trust is reasonably certain about the amounts and timings of Pensions relating to staff and former Directors as the calculation is based on NHS Pension Agency payments and determined nationally on an actuarial basis.

The Trust is reasonably certain about the amounts and timings of legal claims as the information is provided by NHS Resolution.

Included within other provisions is a £1.7m back-to-back (i.e. fully funded and not a cost to the Trust) provision in respect of consultants who may take up the option to have their additional tax charge, due as a result of work undertaken during 2019/20, paid for by the NHS Pension Scheme. This is known as a "Scheme Pays" arrangement. It has been estimated using headcount data and applying an average figure calculated by the Government Actuary's Department, the Business Services Authority and the Department of Health and Social Care.

Other provisions reflect commercial claims for which the value carries some uncertainty and the timing is dependent on final resolution.

Note 29.2 Clinical negligence liabilities

At 31 March 2026, £540.8m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Oxford University Hospitals NHS Foundation Trust (31 March 2025: £526.8m).

Note 30 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(68)	(58)
Employment tribunal and other employee related litigation	(7,166)	(8,055)
Net value of contingent liabilities	**(7,234)**	**(8,113)**

Contingent liabilities are the legal claims under the liability to third parties and property expenses schemes administered by NHS Resolution (formerly NHS Litigation Authority) and any ongoing Employment Tribunal claims where the chance of economic outflow from the Trust is possible, but not probable.

Note 31 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	13,643	2,340
Intangible assets	1,062	700
Total	**14,705**	**3,040**

Note 32 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has three PFI schemes being the John Radcliffe West Wing, the Churchill Cancer Centre and the Nuffield Orthopaedic Centre. In addition the Trust has two service concession arrangements in respect of the John Radcliffe Welcome Centre and the Trust's Carbon Energy Scheme.

The West Wing and Children's Hospital was built in 2006 at an overall cost of approximately £160m as part of a 30 year contract with The Hospital Company (Oxford John Radcliffe) Ltd who built these buildings and operate across most of the site. The West Wing and Children's Hospital are located on the John Radcliffe site and will revert to Trust ownership at the end of the contract period.

The Cancer Centre was completed in 2008 at an overall cost of approximately £150m at part of a 30 year contract with Ochre Solutions Limited who built and operate across most of the site. The Cancer Centre is located on the Churchill site and will revert to Trust ownership at the end of the contract period.

The Nuffield Orthopaedic Centre was built in 2006 at an overall cost of approximately £35m as part of a 30 year contract with Albion Healthcare (Oxford) Ltd who built and operate across most of the site. The Nuffield Orthopaedic Centre will revert to Trust ownership at the end of the contract period.

The John Radcliffe Welcome Centre opened in 2015 following an approximate build project of £3m as part of a 35 year lease with Larkstoke Properties Limited. It is recognised as an asset with no liability as there are no payments being made by the Trust, instead a deferred income balance is recognised. The arrangement includes sub-leases where tenants pay rent to Larkstoke and a profit share element that entitles the Trust to an element of surpluses over and above a defined level.

The Trust's Carbon Energy Scheme which was built in 2017 as part of a 25 year lease with Vital Energi Solutions Limited is recognised as an IFRIC12 asset with corresponding liability. The overall cost was approximately £18m. The equipment reverts to Trust ownership at the end of the contract period.

Note 32.1 On-SoFP PFI or other service concession arrangement obligations

The following obligations in respect of the PFI or other service concession arrangements are recognised in the statement of financial position:

	31 March 2026 £000	31 March 2025 £000
Gross PFI or other service concession liabilities	**486,464**	**507,634**
Of which liabilities are due		
- not later than one year;	26,317	23,811
- later than one year and not later than five years;	149,638	141,687
- later than five years.	310,509	342,136
Finance charges allocated to future periods	(146,670)	(164,722)
Net PFI or other service concession arrangement obligation	**339,794**	**342,912**
- not later than one year;	6,912	4,299
- later than one year and not later than five years;	81,104	69,583
- later than five years.	251,778	269,030

Note 32.2 Total on-SoFP PFI and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI or other service concession arrangements	**1,312,655**	**1,394,942**
Of which payments are due:		
- not later than one year;	96,652	92,980
- later than one year and not later than five years;	415,893	401,715
- later than five years.	800,110	900,247

Note 32.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	**93,777**	**96,942**
Consisting of:		
- Interest charge	19,592	19,937
- Repayment of balance sheet obligation	15,462	18,948
- Service element and other charges to operating expenditure	45,336	50,765
- Capital lifecycle maintenance	11,103	7,016
- Revenue lifecycle maintenance	124	276
- Addition to lifecycle prepayment	2,160	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	4,366	4,026
Total amount paid to service concession operator	**98,143**	**100,968**

Note 33 Financial instruments

Note 33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust's regulators. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust's loan to support commercial activities has an interest rate linked to RPI. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted on annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 33.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	92,285	-	**92,285**
Other investments / financial assets	-	1,582	**1,582**
Cash and cash equivalents	75,906	-	**75,906**
Total at 31 March 2026	**168,191**	**1,582**	**169,773**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	82,054	-	**82,054**
Other investments / financial assets	-	1,404	**1,404**
Cash and cash equivalents	12,456	-	**12,456**
Total at 31 March 2025	**94,510**	**1,404**	**95,914**

Note 33.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	13,317	**13,317**
Obligations under leases	71,115	**71,115**
Obligations under PFI and other service concession contracts	339,794	**339,794**
Other borrowings	4,510	**4,510**
Trade and other payables excluding non financial liabilities	183,266	**183,266**
Provisions under contract	3,027	**3,027**
Total at 31 March 2026	**615,029**	**615,029**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	13,980	**13,980**
Obligations under leases	21,772	**21,772**
Obligations under PFI and other service concession contracts	342,912	**342,912**
Other borrowings	5,078	**5,078**
Trade and other payables excluding non financial liabilities	165,206	**165,206**
Provisions under contract	3,519	**3,519**
Total at 31 March 2025	**552,467**	**552,467**

Note 33.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2026	31 March 2025
	£000	£000
In one year or less	222,191	195,971
In more than one year but not more than five years	211,281	160,930
In more than five years	359,855	367,566
Total	**793,327**	**724,467**

Note 33.5 Fair values of financial assets and liabilities

The book value (carrying value) is considered to be a reasonable approximation of fair value of the financial assets and liabilities the Trust has disclosed.

Note 34 Losses and special payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	23	34
Bad debts and claims abandoned	-	-	3	3
Stores losses and damage to property	2	310	3	677
Total losses	**2**	**310**	**29**	**714**
Special payments				
Ex-gratia payments	39	76	40	47
Total special payments	**39**	**76**	**40**	**47**
Total losses and special payments	**41**	**386**	**69**	**761**
Compensation payments received				

Note 35 Related parties

During the accounting period none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Oxford University Hospitals NHS Foundation Trust. The Department of Health is regarded as a related party. During the accounting period Oxford University Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

Related parties may include but are not limited to:
- Department of Health and Social Care ministers
- Board members of the Trust
- The Department of Health and Social Care
- Other NHS providers
- ICBs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- NHS charitable funds

Material transactions in the year have been with local NHS organisations/ICBs, NHS Resolution, NHS England, Health Education England, and the Department of Health and Social Care.

In addition, the Trust had a number of material transactions with other government departments and other central and local government bodies as set out below.

Most of the trading-type transactions have been with Oxfordshire County Council and are for various services including Genito-Urinary Medicine services, salary recharges associated with social services and supported hospital discharges as well as sub-lease arrangements for rental of property space.

The Trust has also received revenue and capital payments from a number of charities. None of these are material. Details of donations from OUH Charity can be found in the Our Partnerships section of the Annual Report.

Consolidated accounts to include Oxford Hospitals Charity are not prepared as this entity is a company limited by guarantee, independent from Oxford University Hospitals NHS Foundation Trust and therefore the charity is not controlled by the Trust.

The Trust shares a number of key decision makers with the Oxford Academic Health Partners (OAHP). These transactions are not material to the Trust but are likely to be material to OAHP.

Please see notes 19 to 21 for details of the Trust's joint venture in partnership with a number of other entities and the corresponding accounting treatment. This includes details of the arrangement and key financial information related to OUH's joint venture.

Professor Meghana Pandit (Executive Director) was seconded on a full-time basis to NHS England throughout 2025/26. During the period of secondment, she undertook no duties in relation to the governance or management of Oxford University Hospitals NHS Foundation Trust and accordingly has not been included within the Trust’s remuneration disclosures.

During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Oxford University Hospitals NHS Foundation Trust.

Note 36 Adjusted financial performance (control total basis):

	2025/26	2024/25
Surplus / (deficit) for the period	5,567	3,853
Remove net impairments not scoring to the Departmental expenditure limit	2,679	12,097
Remove I&E impact of capital grants and donations	4,745	(8,043)
Report IFRIC12 schemes on a UK GAAP basis	(6,026)	(14,908)
Remove net impact of inventories received from DHSC group bodies for COVID response	-	207
Adjusted financial performance surplus / (deficit)	**6,965**	**(6,794)**