NHS
Oxford Health
NHS Foundation Trust

Annual Report & Accounts

2024-25

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NHS Foundation Trust

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2024/25

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Foreword by the Chair and Chief Executive

The purpose of any Annual Report is to capture and look back on the challenges and successes of the previous twelve months. Once again there have been highlights but none of what has been achieved could have been done without our most valuable asset – our people, who bring skill, experience and commitment to a wide range of roles to provide services to the people we serve. Our colleagues work on wards, in patients' homes, in community hospitals, on IT help desks, in research, and in training seminars. They include people with lived experience, nurses, psychologists, allied health professional, doctors, but also accountants, ward clerks, cleaners, maintenance personnel, drivers.

We have no 'front' and 'back' offices. Staff who see patients depend on a chain of colleagues, equally important. Everyone plays a part. We would like to put on record our thanks to and admiration for all our colleagues and people with lived experience who work in all their different ways towards the goal of looking after patients and serving the public.

We are Oxford Health by name and in Oxfordshire we provide a set of critical services, including specialist dental treatment, podiatry, district nurses, nurses in schools, urgent care and stroke rehabilitation. In both Oxfordshire and Buckinghamshire through our community mental health and our hospitals in Aylesbury and Oxford - we seek to help people who are depressed, anxious, who suffer from schizophrenia and personality disorders. Our efforts focus on getting people back into jobs, back home with their families, back into community living. Finally, through our mental health hubs, we try to prevent people becoming ill.

Across Bath and North East Somerset, Wiltshire and Swindon we help children and young people with mental health problems, including eating disorders. In a still wider geographical area we collaborate in providing more specialist mental health services in prisons and in forensic wards.

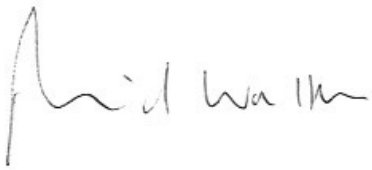
Highlights this year include opening the latest of our high street walk-in mental health hubs in a number of town centres in Oxfordshire, in collaboration with the voluntary sector and local charities, giving people advice and guidance to set them on the pathway to recovery. The past year has also seen continuing progress on redeveloping the Warneford Hospital and its grounds, recycling its buildings which are approaching 200 years old, creating a research campus and the construction of a 21st century unit on site for people with serious mental illness.

Also over this year, to support improvements in same-day urgent and emergency care developments, we launched the Same Day Care Single Point of Access in November to provide central coordination of referrals. Our doctors led a national debate on new therapies and preventing suicide, and to streamline the recording of interviews and meetings we began using artificial intelligence. Lessons learned around a review of workforce skills helped shaped future clinical and medical modelling, while a collaboration with South Central Ambulance Service will help ensure appropriate triage for Urgent Community Response referrals.

To support safe and sustainable service development for Children and Young People's services, the Single Point of Access for 0–19 years services launched in September, alongside growth in Children's Integrated Therapy.

November brought recognition to our Biomedical Research Centre theme leads, named as *Highly Cited Researchers* by Clarivate, placing them among the top 1,000 scientists globally. Our psychiatrists took to the podium at the Royal College of Psychiatry annual awards. We also refurbished the Luther Street Medical Centre - a vital resource providing healthcare to vulnerable and homeless people in the city of Oxford.

These are just some examples of the work undertaken by Oxford Health over the last year. This annual report presents further detail on achievements, activities and areas of focus and we thank you for your interest in our Trust.



David Walker
Chair

Grant Macdonald
Chief Executive

Performance Report

Performance overview

Statement from the Chief Executive

Summarising a year of activity of a Trust as sizeable as Oxford Health can be a challenge. However, it is my perspective as Chief Executive that the Trust performed reasonably well over 2024/25 maintaining and delivering services over a broad service geography. Given the challenges faced by NHS providers – growing demand and complexity, staff recruitment and retention, financial sustainability, and the degree of certainty around the permanence of wider NHS structures – this is no small achievement and is testament to the commitment and professionalism of the Trust's workforce.

The performance analysis section of this report - drawn from a new approach to managing performance across the organisation this year - sets out the Trust's main performance metrics and performance against these. I recommend reading the Trust's Quality Account in tandem with this annual report – it sets well out the Trust's activity, challenges, and achievements in quality improvement.

Areas of good performance include improving access to mental health support for children and young people in Oxfordshire and Buckinghamshire, the number of patients accessing Minor Injury Units seen within four hours, and mental health psychiatric liaison access within 1 hour. Areas to improve include the referral of those with suspected eating disorder starting treatment within 4 weeks.

The Trust is ambitious to be a great place to work and to begin and develop a career - there are good indicators of performance here, in particular reducing agency use rates which both improves the quality of care and also make financial savings. The Trust performed well against national averages in the NHS Staff Survey. There are also areas to improve including reduction in further reducing vacancies and increasing supervision rates.

Financially, the Trust ended the year with an adjusted operating surplus of £2.2m which is £4.9m better than planned and the Trust's cash balance remains in a strong position. The Trust increased internal capital funding investment levels to develop our property and infrastructure. As noted in the going concern statement, the directors have a reasonable expectation that services provided by the Trust will continue to be provided for the foreseeable future. The Trust continues to make progress in reducing its carbon emissions and towards net zero ambitions.

Going into 2025/26 and beyond, I and Oxford Health's senior leaders will continue to focus on maintaining the quality, performance and sustainability of the Trust's services and will seek to continue to work collaboratively with public services partners and the people we service to realise our strategic aims.

Year at a glance

April 2024 - Royal College of Psychiatrists Awards - The success of Oxford Health psychiatrists at the Royal College of Psychiatry Awards demonstrated the strength of

practice and training at the Trust. A total of 12 colleagues won or secured a finalist position across seven categories.

May 2024 - Medical centre for vulnerable people in Oxford refurbished - Luther Street Medical Centre - an award-winning GP surgery which provides healthcare to people experiencing homelessness, or who are vulnerably housed – unveiled new flooring, revamped reception and other improvements. The practice has been part of the NHS since 2001 and Oxford Health since 2013. It opened in 1985 in temporary accommodation with charitable donations funding the building of the current clinic which opened in 1998 and was extended in 2005.

June 2024 – More stars shine at staff awards - Another successful twelve months for Oxford Health packed with exceptional contributions from colleagues across all services was celebrated at the annual staff awards. Presentations were made for 16 awards, covering both individual and team categories. Each award was aligned with an NHS People Promise.

July 2024 – Wantage welcomes new hub - A new Keystone Mental Health & Wellbeing hub opened its doors in Wantage. The hub in Limborough Road was opened by Expert by Experience Leith Greig-Connor who represented all the members of the public who have been involved in co-creating the hubs. She was joined by Wantage Mayor Dr Angela Dunford and Trust chair David Walker

August 2024 **-** *Warneford Park: pre-planning application consultations launched* – A pre-planning consultation aiming to gather valuable insights and feedback on the proposed redevelopment of the Warneford Hospital site began. In partnership with the University of Oxford and a partner, Oxford Health NHS Foundation Trust wants to develop a major brain health research and innovation campus on the existing Warneford Hospital site in Headington.

September 2024 – Annual General Meeting and Annual Members Meeting - The Trust hosted the Annual Members Meeting and Annual General Meeting on Tuesday 10 September at Didcot Town Council Civic Hall. Trust Chair David Walker and Chief Executive Grant Macdonald welcomed stakeholders, acknowledged the continuous dedication, care and efforts from staff. Both recognised the challenges the NHS currently faces and the impacts this may have on the Trust in the future.

October 2024 - Lucy's room opens - After six years of fundraising and development a special facility, named Lucy's Room, opened. The room takes pride of place at Warneford Hospital – bringing a much-needed space for adult mental health patients on both the wards and with community teams to benefit from music therapy. Lucy received care through Oxford Health's adult mental health teams and missed having a space to play and make music during that time. Following her passing, her family wanted to create the space she had been missing for other patients to benefit from in the future. The appeal was created in 2018 and along with donations from the Oxford Health Charity and Oxford Health NHS Foundation Trust, Lucy's family fundraised to take the idea to reality.

November 2024 - Oxford Health Biomedical Research Centre Theme Leads named as highly cited researchers 2024 - Clarivate, a global leader in transformative intelligence, has announced its 2024 Highly Cited Researchers. Of the world's population of scientists and social scientists, Highly Cited Researchers are 1 in 1,000.

December 2024 - Permanent Trust CEO appointed - Grant Macdonald was appointed Chief Executive Officer of Oxford Health after the post was advertised nationally and a selection process conducted involving internal and external stakeholders. Grant had been Interim CEO since July 2023. Previously he was the Executive Managing Director for Mental Health and Learning Disabilities from March 2022.

January 2024 - Chief Nurse Fellows appointed - Following a selection process, seven candidates were successful and began 2025 as Chief Nurse Fellows. The fellowships are designed to boost nursing careers in quality improvement (QI) and research, and to increase diversity in nursing roles. The programme is designed around individual nurses' ambitions and aspirations, and includes mentorship, coaching, formal training and experiential learning. This is a 12-month programme with participants being released for one day per week to take part.

February 2025 - New Executive Director of Corporate Affairs appointed - Taff Gidi joined the Trust from Portsmouth Hospitals University NHS Trust where he was Executive Director of Governance and Risk replacing Georgia Denegri who had been Associate Director of Corporate Affairs in an interim capacity since February 2024.

March 2025 – Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care appointed - Emma Leaver was appointed to fill the role following Dr Ben Riley's departure to BOB ICB.

History of the Trust, purpose, and structure

The principal purpose of Oxford Health NHS Foundation Trust (OHFT) in line with its provider licence is the provision of goods and services for the purposes of the health service in England. OHFT is a community focused public benefit corporation, providing physical (community) and mental health services to approximately two million people across a geographical area that includes Oxfordshire, Buckinghamshire, West Berkshire, Wiltshire, Swindon, Bath and North East Somerset. Services are delivered primarily in community settings, but the Trust also has inpatient facilities. Oxford Health employs approximately 7,500 staff operating from around 150 sites.

The current configuration of the Trust was created through the merger in April 2006 of the Oxfordshire Mental Healthcare NHS Trust (created April 1994) and the Buckinghamshire Mental Health Partnership NHS Trust (created April 2001) to establish the Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust. The Trust became the first NHS organisation in either Oxfordshire or Buckinghamshire to be authorised as an NHS foundation trust when it became Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust on 1 April 2008.

In April 2011, as part of the national Transforming Community Services programme, the Trust began providing community health services in Oxfordshire (previously provided by Community Health Oxfordshire, the provider arm of the Oxfordshire Primary Care Trust). In recognition of this change, the Trust was renamed Oxford Health NHS Foundation Trust.

The Trust is currently structured in the following clinical directorates: Mental Health services for Oxfordshire, Bath & North East Somerset, Swindon and Wiltshire;

Learning Disabilities; Forensic Mental Health; Mental Health Services for Buckinghamshire; and Community Services, Dentistry & Primary Care for Oxfordshire.

Oxford Health's overarching aim is to provide the best possible clinical care and health outcomes for patients, clients, their carers and families – supporting them, wherever possible, to live healthier and independent lives for as long as possible. The Trust works in partnership with many other organisations to that end.

The Trust also leads on several provider collaboratives – partnership arrangements involving Oxford Health, other NHS organisations and non-NHS providers who work at scale across multiple geographies, with a shared purpose and decision-making arrangements. Currently Oxford Health leads on collaboratives in dentistry, Tier 4 Child and Adolescent Mental Health Services (CAMHS), eating disorders and forensic services. The Trust owns the Oxford Pharmacy Store (OPS) a specialist wholesale provider of pharmaceutical products.

OHFT Strategic objectives

Oxford Health has four strategic objectives which have been developed by the Board of Directors to guide the delivery of the Trust's vision of 'Outstanding care delivered by an outstanding team'. Our aim is to provide the best possible clinical care and health outcomes for patients, clients, their carers and families – supporting them, wherever possible, to live healthier and independent lives for as long as possible.

Quality: Deliver the best possible care and health outcomes

- To maintain and continually improve the quality of our mental health and community services to provide the best possible care and health outcomes.
- To promote healthier lifestyles, identify and intervene in ill-health earlier, address health inequalities, and support people's independence, and to collaborate with partner services in this work.

People: Be a great place to work

- To maintain, support and develop a high-quality workforce and compassionate culture where the health, safety and wellbeing of our workforce is paramount.
- To actively promote and enhance our culture of equality, diversity, teamwork and empowerment to provide the best possible staff experience and working environment.

Sustainability: Make the best use of our resources and protect the environment

- To make the best use of our resources and data to maximise efficiency and financial stability and inform decision-making, focusing these on the health needs of the populations we serve, and reduce our environmental impact.

Research & Education: Be a leader in Research & Education

- To be a recognised leader in healthcare research and education by developing a strong research culture across all services and increase opportunities for all staff to become involved in research skills and professional qualifications.

Over the course of the last year, we have introduced four strategic principles that focus on how we operate, to underpin the design and implementation of our key strategic

initiatives. These principles aim to drive significant and impactful changes across the organisation, enhancing patient care and outcomes.

The four principles are:

- We are patient centred
- We empower and support our staff
- We innovate, improve and learn
- We work in partnership and are active players in our ICSs

As part of the 2024/25 strategic delivery plan, we initiated several strategic programmes aimed at achieving improvements aligned with our strategic objectives. Several of these serve as internal 'enablers' focusing on enhancing internal processes and organisational structures to maximise benefits for both patients and staff. The success of strategy delivery is monitored via the strategic dashboard. This is a collection of metrics identified as key strategic outcome measures, which are reviewed twice yearly by the Board of Directors as part of the review of the annual plan.

Principal risks

Oxford Health's approach to risk management is set out within the Trust's Risk Management Strategy & Policy. Over the reported year, the Trust updated this policy as part of a scheduled review and was approved at the February 2025 Audit & Risk Committee. Risks assessed as significant are monitored to ensure mitigating actions are undertaken to reduce risks to an acceptable level where possible.

Significant risks are captured and reported via the Trust Risk Register which is also a source of risk information for the Board Assurance Framework. The Trust Risk Register is reported monthly as a highlight report to the Extended Leadership Team, including reporting on extreme red-rated risks. Risks on the Board Assurance Framework have been reviewed by the Board of Directors, board committees, and Executive over the reporting period.

Over 2024/25, principal risks for the Trust as captured and monitored in the BAF included: unavailability of and demand and capacity for beds (mental health inpatient and learning disability); adequacy of appropriately trained staff (workforce attraction and retention); maintaining financial stability; and capacity for delivery of major programmes. Over Quarter 3 2024/25, a new risk on physical environment, security and health and safety was developed following assessment of these areas. Medium rated risks for the Trust over the reported year included: digital, data & technology; staff retention; business planning; and information governance & cyber security. Individual BAF risks were reviewed and assessed by the relevant Executive director owner and a summary of the BAF reported monthly to the Executive. In the first quarter of 2025/26, the Trust's BAF will be reviewed and refreshed.

Performance analysis

How the Trust manages performance and key performance measures

The Trust manages performance through an integrated performance reporting model that encompasses clinical performance, quality, workforce, and sustainability. The Integrated Performance Report (IPR) was re-designed in early 2024 to better align with the Trust's strategic ambitions and national and local reporting performance

requirements. Following a six-month review in November 2024, further enhancements were identified for implementation in the subsequent financial year where possible.

The Performance Management Framework within the Trust facilitated the implementation of a ward-to-board approach, wherein directorate-specific versions of the IPR fostered a deeper understanding of the performance management framework and enhanced clinical and operational performance management. This approach enabled the initiation of more targeted initiatives aimed at improving work practices and service delivery.

The Key Performance Indicators within the IPR are categorised into four distinct groups: strategic, clinical, quality and people metrics, ensuring a thorough evaluation of the Trust's performance. Performance metrics are derived from nationally reportable metrics, national objectives and locally agreed metrics. A summary of 2024/25 performance is set out in the following tables:

Type of metric	Service area/metric	Target	2024-2025 performance
Child and Adolescent Mental Health Services (CAMHS)			
National measure	Improve access to mental health support for children and young people – Buckinghamshire	5878	6418
National measure	Improve access to mental health support for children and young people – Oxfordshire	6794	8045
National measure	Improve access to mental health support for children and young people - Bath & North East Somerset, Swindon and Wiltshire	-	6401
National Objective *Strategic metric - Quality*	Four (4) week wait (interim metric - one meaningful contact within pathway) – Buckinghamshire	61% National average	65.5% (annual average)
National Objective *Strategic metric - Quality*	Four (4) week wait (interim metric - one meaningful contact within pathway) – Oxfordshire	61% National average	52.2% (annual average)
National Objective *Strategic metric - Quality*	Four (4) week wait (interim metric - one meaningful contact within pathway) - Bath & North East Somerset, Swindon and Wiltshire	61% National average	58.8% (annual average)
National Objective	Waiting time standard for a meaningful contact & outcome measure	In technical development throughout 2024 – 2025.	
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks – Buckinghamshire	95%	89.7%
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks – Oxfordshire	95%	93.3%
National measure	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Bath & North East Somerset, Swindon and Wiltshire	95%	79.5%
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Buckinghamshire	95%	90.48%
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Oxfordshire	95%	85%
National measure	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Bath & North East Somerset, Swindon and Wiltshire	95%	95.5%
Talking Therapies			
National Objective	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Buckinghamshire	597	665

National Objective	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Oxfordshire	617	634
National Objective	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire	-	11.4%
National Objective	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire	-	7.6%
National measure	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire	67%	65.9%
National measure	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	67%	67.3%
National measure	% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire	75%	97.9%
National measure	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	75%	99.7%
National measure	% of people receiving first treatment appointment within 18 weeks of referral - Buckinghamshire	95%	100%
National measure	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	95%	100%
National measure	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Buckinghamshire	10%	2.5%
National measure	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire	10%	3.5%
National measure	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire	48%	50.2%
National measure	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	48%	50.2%
National Objective	Meet and maintain at least 50% Talking Therapies recovery rate (with improvement to 52% by end of Financial Year 24-25) - Buckinghamshire	50%	53.9% (year-end)
National Objective	Meet and maintain at least 50% Talking Therapies recovery rate (with improvement to 52% by end of Financial Year 24-25) - Oxfordshire	50%	62.0% (year-end)
National Objective	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined – Buckinghamshire	50%	51%
National Objective	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire	50%	49%
National Objective	Recovery rate for White British - complete a course of treatment, adult and older adult combined – Buckinghamshire	50%	54%
National Objective	Recovery rate for White British - complete a course of treatment, adult and older adult combined – Oxfordshire	50%	55%
Adult and Older Adult Community Mental Health Services			
National measure	Improve access for Adults and Older Adults to support by community mental health services – Buckinghamshire	4568	5167
National measure	Improve access for Adults and Older Adults to support by community mental health services – Oxfordshire	6737	8683
National Objective	4 week wait (28 days) standard (interim metric - two contacts within pathway) – Buckinghamshire	32% National average	48.8%
National Objective	4 week wait (28 days) standard (interim metric - two contacts within pathway) – Oxfordshire	32% National average	65.7%
National Objective	Waiting time standard, care plan, outcome measure	In technical development throughout 2024 – 2025.	

Strategic metric - Quality			
National measure	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Buckinghamshire)	60%	54.88% (annual average)
National measure	Deliver annual physical health checks to people with Severe Mental Illness (System Measure – Oxfordshire)	60%	32.53% (annual average)
National measure	Improve access to perinatal mental health services - Buckinghamshire	391 per month	416
National measure	Improve access to perinatal mental health services – Oxfordshire	697 per month	514
National measure	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Buckinghamshire	60%	88.3%
National measure	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	60%	90.9%
National measure	Number of people accessing Individual Placement Support (IPS) – Buckinghamshire	466	308
National measure	Number of people accessing Individual Placement Support (IPS) – Oxfordshire	598	380
National measure	Recover dementia diagnosis rate (nationally reported system measure - Buckinghamshire)	63-64%	58.67% (annual average)
National measure	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	63-64%	63.11% (annual average)
Urgent Mental Health Care			
National Objective	Response from Mental Health Psychiatric Liaison within 1 hour – Buckinghamshire	62% National average	90.7%
National Objective	Response from Mental Health Psychiatric Liaison within 1 hour - Oxfordshire	62% National average	84.2%
National Objective	Response from Mental Health Psychiatric Liaison within 24 hours – Buckinghamshire	74% National average	95.5%
National Objective	Response from Mental Health Psychiatric Liaison within 24 hours – Oxfordshire	74% National average	95%
National Objective	Response from Mental Health Crisis Service within 4 hours (Very Urgent) – Buckinghamshire	69% National average	85.7%
National Objective	Response from Mental Health Crisis Service within 4 hours (Very Urgent) – Oxfordshire	69% National average	44.6%
National Objective	Response from Mental Health Crisis Service within 24 hours (Urgent) – Buckinghamshire	57% National average	53.7%
National Objective	Response from Mental Health Crisis Service within 24 hours (Urgent) - Oxfordshire	57% National average	70%
Mental Health Inpatient Services (Adults and Older Adults)			
National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - Adult (acute & Psychiatric Intensive Care Units) - Buckinghamshire	13% National average	18%
National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - Adult (acute & Psychiatric Intensive Care Units) - Oxfordshire	13% National average	17%
National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - Older Adult - Buckinghamshire	13% National average	18%

National Objective	Mental Health acute admissions prior contact with community mental health services in year prior to inpatient admission - % of acute admissions with no prior contact - Older Adult - Oxfordshire	13% National average	15%
National Objective *National Oversight Framework metric*	Rate per 100,000 population in adult acute beds with a length of stay over 60 days - Buckinghamshire	8	2.9
National Objective *National Oversight Framework metric*	Rate per 100,000 population in adult acute beds with a length of stay over 60 days - Oxfordshire	8	7.8
National Objective *National Oversight Framework metric*	Rate per 100,000 population in older adult acute beds with a length of stay over 90 days - Buckinghamshire	8	4.9
National Objective *National Oversight Framework metric*	Rate per 100,000 population in older adult acute beds with a length of stay over 90 days - Oxfordshire	8	5.4
National measure	72 hour follow up for those discharged from mental health wards - Adults - Buckinghamshire	80%	89.5%
National measure	72 hour follow up for those discharged from mental health wards - Adults - Oxfordshire	80%	89.9%
National measure	72 hour follow up for those discharged from mental health wards - Older Adults - Buckinghamshire	80%	95.9%
National measure	72 hour follow up for those discharged from mental health wards - Older Adults - Oxfordshire	80%	93.6%
National measure	Inappropriate adult acute mental health out of area placements - snapshot last day month - Buckinghamshire	2	9 (end of trajectory – March 2025 position)
National measure	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Buckinghamshire		2 (end of trajectory – March 2025 position)
National measure	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Buckinghamshire		0 (end of trajectory – March 2025 position)
National measure	Inappropriate adult acute mental health out of area placements - snapshot last day month – Oxfordshire	3	6 (end of trajectory – March 2025 position)
National measure	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Oxfordshire		0 (end of trajectory – March 2025 position)
National measure	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Oxfordshire		0 (end of trajectory – March 2025 position)
National Oversight Framework metric	Inappropriate adult acute mental health out of area placements - beds days in month – Buckinghamshire	-	1262 (annual total)
	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Buckinghamshire	-	20 (annual total)

	Inappropriate older adult acute mental health out of area placements - beds days in month - Buckinghamshire	-	10 (annual total)
National Oversight Framework metric	Inappropriate adult acute mental health out of area placements - beds days in month - Oxfordshire	-	804 (annual total)
	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Oxfordshire	-	2 (annual total)
	Inappropriate older adult acute mental health out of area placements - beds days in month - Oxfordshire	-	0 (annual total)
National Objective	% adult acute readmission within 30 days for mental health - Buckinghamshire	-	7.2%
National Objective	% adult acute readmission within 30 days for mental health - Oxfordshire	-	5.6%
National Objective	% older adult readmission within 30 days for mental health - Buckinghamshire	-	1.1%
National Objective	% older adult readmission within 30 days for mental health - Oxfordshire	-	2.5%
National Objective	Average number of clinically ready for discharge patients per day - Buckinghamshire	-	8 (annual average)
National Objective	Average number of clinically ready for discharge patients per day - Oxfordshire	-	7 (annual average)
Mental Health Services - other			
National Oversight Framework metric	Mental Health Services Data Set Data Quality Maturity Index (MHSDS DQMI) score – overall assessment of data quality for providers based on a list of key data items	95%	89.9% (December 2024 – latest nationally published position)
Strategic Metric - Quality	% of patients responding that overall care was good or very good	85%	84.8%
Strategic Metric - Quality	% of patients report being involved in their care	80%	83.76%
Community Health Service, Dentistry and Primary Care			
National measure	% of Minor Injury Unit patients seen within 4 hours	78%	90.3%
National measure	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	70%	77.6%
National Oversight Framework metric	Available virtual ward capacity per 100k head of population (nationally reported system measure - Buckinghamshire. Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) level)	40-50	28
National Objective *National Oversight Framework metric*	Virtual ward occupancy (nationally reported system measure - Buckinghamshire. Oxfordshire and Berkshire West Integrated Care Board (BOB ICB) level)	-	87.7%
Strategic Metric - Quality	% of patients responding that overall care was good or very good	85%	93.59%
Strategic Metric - Quality	% of patients report being involved in their care	85%	92.10%
Strategic Metric - Quality	% of out of hours palliative care referrals responded to within 30 minutes: time from receipt of the call from 111 to the start of the telephone consultation was 30 minutes	-	92.7%

Strategic Metric - Quality	% of out of hours palliative care referrals responded to within 60 minutes: the time from completion of that triage call to the start of the home visit consultation was within 60 minutes	-	45.0%
Strategic Metric - Quality	National Early Warning System (NEWS - national tool for detecting clinical deterioration) escalated appropriately	90%	74.6%
Strategic Metric - Quality	National Early Warning System (NEWS - national tool for detecting clinical deterioration) completed where applicable	90%	87.9%
Strategic Metric - Quality	% of breastfeeding prevalence at 6 – 8 weeks old	60%	60.1%
Quality			
	Total number of patient incidents (all levels of harm)	-	15826 (annual total)
	Total number of unexpected deaths report as incidents (by date of death, including natural and unnatural)	-	249 (annual total)
	Number of suspected suicides	-	52 (annual total)
	Total number of incidents involving physical restraint	-	2854 (annual total)
	Total number of complaints and resolutions	-	888 (annual total)
	Total number of violence, physical, non-physical and property damage incidents (patients and staff)	-	3976 (annual total)
Strategic Metric - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint)	188	130
Strategic Metric - Quality	Reduction in the use of seclusion (number of incidents involving seclusion)	575	379
Strategic Metric – Quality National Oversight Framework metric	Response to staff survey question “I would feel secure raising concerns about unsafe clinical practice”	79% (2023 score)	80% (2024 score)
People			
National Oversight Framework metric	NHS staff survey - bullying and harassment score – proportion of staff who say they have not personally experienced harassment, bullying or abuse at work from managers	92.8% (2023 score)	92.7% (2024 score)
National Oversight Framework metric	NHS staff survey - bullying and harassment score – proportion of staff who say they have not personally experienced harassment, bullying or abuse at work from other colleague	86.5% (2023 score)	86.6% (2024 score)
National Oversight Framework metric	NHS staff survey - bullying and harassment score – proportion of staff who say they have not personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	76.4% (2023 score)	77.7% (2024 score)
National Oversight Framework metric	NHS staff survey – people promise score - we are compassionate and inclusive	7.03 (2023 score)	8.14 (2024 score)
National Oversight Framework metric	NHS staff survey – proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	61.4% (2023 score)	62.8% (2024 score)
National Oversight Framework metric	Proportion of staff in senior leadership roles (bands 8a - 8d, 9 and Very Senior Manager) who are women	-	77.8%
National Oversight Framework metric	Reduce staff sickness to 4.5%	4.5%	4.5%
	Personal Development Review (PDR) compliance (PDR season is between April – July; 95% by end of July, not targeted between August and March)	95%	95.5% (July 2024)

	Reduction in vacancies	9%	12%
	% of early turnover	14%	13.9%
	Statutory and mandatory training compliance	95%	90%
	Clinical supervision completion rate	95%	78%
	Management supervision rate	95%	73%
National Oversight Framework metric	Staff leaver rate	-	7%
National Oversight Framework metric	Relative likelihood of white applicant being appointed from shortlisting across all posts compared to Black, Asian and Minority Ethnic (BME) applicants	-	1.77
National Oversight Framework metric	Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants	-	0.94
Strategic Metric - People	Reduce agency usage to meet target (% of agency used)	6.50%	5.68%
Strategic Metric - People	Reduction in % labour turnover	14%	10.57%
Strategic Metric - People	% of staff completing Quality Improvement Training Level 1	-	994 staff
Strategic Metric - People National Oversight Framework metric	Black, Asian and Minority Ethnic (BAME) representation across all pay bands including Board level.	19%	24.55%
Strategic Metric - People National Oversight Framework metric	Black, Asian and Minority Ethnic (BAME) representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Management).	19%	12.99%
Strategic Metric - People National Oversight Framework metric	Staff survey engagement score	7.19 (2023 score)	7.25 (2024 score)

Annual plan 2024/25

Progress against the Trust's annual plan 2024/25 was reported to the board of directors mid-year and at year end; a summary is set out below by strategic objective:

Quality (Deliver the best possible care and health outcomes) - Our ambition is to deliver patient-centred care, effective treatments, timely access, address health inequalities, and ensure safe care. We have achieved 3 out of 4 patient care targets,

with significant improvements in patient involvement and outcome measures. The introduction of the *TrueColours* system in health teams will enable better understanding of patient outcomes. Efforts continue to reduce waiting times and incidents involving physical restraint. We are committed to addressing health inequalities and fostering a safe and learning culture.

People (Be a great place to work) **-** We aim to maintain a sustainable, engaged, well-led, skilled, and just workforce. Turnover rates and agency use have been reduced, and staff engagement has increased. We are developing a comprehensive leadership framework and embedding quality improvement skills across the Trust. Nearly 1,000 staff have completed quality improvement training. Efforts to improve diversity and inclusion are ongoing, with a focus on reducing early turnover among ethnic minority colleagues and increasing representation in senior leadership roles. The Trust has marked various events to demonstrate its commitment to equality, diversity, and inclusion.

Sustainability (Make the best use of our resources and protect the environment) - Our goal is to spend and invest efficiently, achieve net zero carbon emissions by 2045, improve digital systems, and modernise estates. We have developed a revised Green Plan, increased digital maturity, and are modernising our estates with projects like the new Community Health hub in North Oxford and the Warneford Park programme. Our digital systems have seen improvements, with a focus on optimising electronic patient records and supporting the mobilisation of digital tools to enhance patient care.

Research & Education (Be a leader in healthcare research and education) **-** We aim to sustain research leadership, strengthen academic partnerships, and embed research capability. We have expanded clinical research capacity and launched initiatives like the Chief Nurse Fellowships to advance nursing careers in quality improvement and research. The Trust continues to host National Institute for Health and Care Research (NIHR) research infrastructure, allowing us to play a greater role in translating research into practice – for example, our Community Health Services directorate is building stronger links with academic institutions to enable this.

Emergency planning provisions, key incidents and activities

The Civil Contingencies Act (2004) and NHS England Emergency Preparedness, Resilience and Response Framework (2022) establishes a clear set of roles and responsibilities for organisations involved in emergency preparedness and response and these requirements apply to OHFT. The Director of Corporate Affairs is the accountable emergency officer and holds executive responsibility for EPRR on behalf of the organisation. The Trust has an emergency preparedness work programme which is progressed through the emergency preparedness, resilience and response (EPRR) committee. The Trust's EPRR policy, incident response plans and business continuity plans are routinely reviewed and learning from exercises and live incidents is reflected in these plans.

During 2024/25 the Trust participated in several tabletop exercises including a scenario which explored the response to a ransomware cyber attack which affected access to clinical systems and caused a significant reduction in capacity, a scenario which tested the provision of psychosocial support to members of the public and staff members who had been affected by civil unrest and several communications cascade

exercises to test the timely flow of incident response information between NHS organisations. In addition to exercises, learning from live incidents and post-incident review meetings also provide a further opportunity to enhance response plans. During 2024/25 OHFT responded effectively to industrial action, a disruption to the electronic patient record (EMIS) and the e-roster system which impacted access to patient records and access to electronic staff rosters and responded to several periods of high temperatures during 2024 which required the heatwave plan to be activated.

The minimum requirements for EPRR which commissioners and providers of NHS funded services must meet are set out in the NHS England core standards for EPRR. These standards reflect the requirements of guidance issued by NHS England. The accountable emergency officer in each organisation is responsible for ensuring these standards are met. Oxford Health NHS Foundation Trust declared full compliance with all 58 core standards and submitted a statement of compliance to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board which was assessed and accepted. In addition to the core standards, the annual assurance process seeks to review and understand one subject area in greater detail, referred to as a 'deep dive'. The outcome of the deep dive does not contribute to the organisation's assurance rating but is used to help Integrated Care Boards and NHS England identify good practice and emerging themes. The deep dive subject was preparedness for cyber security and IT incidents and, against the eleven deep dive standards, OHFT was assessed as fully compliant.

Quality account and coronial proceedings

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. This definition sets out three dimensions to quality, which must be present in order to provide high quality services: clinical effectiveness; safety; and patient experience.

Oxford Health's 2024/25 Quality Account looks back on the progress made over the past year to achieve the organisations quality improvement goals. The report also looks forward to the year ahead and identifies priority areas for improvement and plans to achieve these. The Quality Account should be read alongside the trust 2024/25 Annual Report. Oxford Health's Quality Accounts are publicly available on the Trust's website by searching '*Oxford Health Quality Account'*.

A duty of coroners is to write what is called a Prevention of Future Deaths (PFD) Report if an issue emerges during the proceedings that give rise to a concern that future deaths may occur. The report is to an organisation who the coroner believes has the means to make a change to systems or processes that would reduce the likelihood of a future death. The coroner cannot state what should be done, simply that the organisation is asked to review the position and state what, if any, action it proposes to take. A report is not a sanction or judgement and coroners state that reports are intended to have utility and be helpful to organisations. Oxford Health had three PFDs over the reported year.

Ahead of an inquest, organisations will already have investigated and reviewed the events leading to a service user's death. They will have identified learning and taken action to improve processes and services. Coroners receive evidence about that

action and often comment that there is no purpose to a PFD report given all that has taken place already. A risk to NHS trusts and foundation trusts exists if the internal review or investigation failed to identify, for example, a gap in services. That risk is potentially greater since the implementation of PSIRF by reason of the Trust completing fewer detailed patient safety incident investigations (PSII). Absent a PSII, there is a higher risk of an issue being identified for the first time at the inquest itself. In such case, a PFD report is more likely to follow.

Financial performance and Capital expenditure statement

In the financial year 2024/25, the Trust ended the year with an adjusted operating surplus of £2.2m (£5.2m in 2023/24), which was £4.9m (£1.8m in 2023/24) better than planned. The Trust also remained within its delegated capital limit[1].

The Trust's turnover increased by £66m to £693m (£627m in 2023/24). Income relating to patient care activities formed £24m of this increase, driven primarily by cost uplift factor funding, which covers the additional cost of NHS pay settlements and expected inflationary changes. Additional funding into new or expansion of existing mental health services totalled £8m.

Significant growth was seen in non-clinical activities, with the Trust's Research and Development growing in 24/25 by £12m to £33m (£21m in 2023/24). Of this increase the largest area of expansion was the Mental Health Mission, grant funding growing by £10m. The Oxford Pharmacy Store service also grew significantly, by £28m, supported by recent investment into new and larger facilities, contributing to the overall sustainability of the Trust.

OHFT is the lead provider for three NHS provider collaboratives, whereby we hold the budgets and commissioner responsibilities for specialised commissioning services. These are in forensics inpatient mental health, CAMHS Tier 4 care and adult eating disorders. The forensics and CAMHS Tier 4 provider collaboratives continue to generate sufficient benefit to facilitate investment into other initiatives.

The Trust's cash balance remains in a strong position, at £97.8m compared to £85.6m in 2023/24, retaining one of the strongest cash positions in the local area.

During 2024/25, the Trust not only maintained but increased internal capital funding investment levels to develop its property and infrastructure. Capital investment in 2024/25 was £24.5m, compared to £15.9m in 2023/24. Public Dividend Capital (PDC) funding of £0.6m was received (£3.7m in 2023/24) relating mostly to the Trust's Frontline Digitalisation infrastructure.

Estates investment in 2024/25 focused on new estate, rationalisation, condition and compliance issues so that properties from which patient services are provided were fit for purpose. The Trust's main estates capital investment areas during 2024/25 were:

- £5.2m on the Jordan Hill Community Health Hub in North Oxford, £0.4m on Community Mental Health Hubs at Kidlington, Wantage and Cowley Road, £0.4m on site & service reconfigurations at Witney, Abingdon and Woodlands

[1] Adjusted operating surplus is the target against which the Trust is managed by NHS England and by the Integrated Care Board. It differs from the reported deficit as it excludes impairments and other costs totalling £0.2m as is set out in note 2 to the accounts.

and £2.1m on other operational estates areas including backlog maintenance and other works to address compliance requirements;

- The Trust also entered contracts with a capital value of £13.1m in new and existing leased properties, predominantly at East Oxford Health Centre and Cotswolds House in Marlborough;
- In IT, the Trust spent £2.5m on devices and equipment, £0.4m on network improvements and £0.4m on clinical systems.

The Trust's gearing ratio (the percentage of capital employed that is financed by debt and long-term financing) is 21.1% (20.0%in 2023/24). Overall, debt liabilities (Department of Health and Social Care loan and lease liabilities) increased by £3.4m to £43.9m in 2024/25 from £40.5m in 2023/24.

Total net assets employed increased by £5.5m in 2024/25 to £207.8m (£202.3m in 2023/24). This reflects a net increase in the value of the Trust's non-current assets of £10.0m to £268.7m (£258.7m in 2023/24) which is largely represented by the capital expenditure referred to above less depreciation and amortisation, and an increase in its current assets of £14.4m to £125.1m (£110.7m in 2023/24) which is largely driven by an increase in the Trust's cash holdings of £12.2m. These increases have been offset by an increase in the Trust's net current and non-current liabilities of £18.9m to £186.0m (£167.1m in 2023/24). Most of the increase in these liabilities relate to £10.9m of deferred income and £3.4m of borrowings.

Going concern disclosure

The Board of Directors is clear about its responsibility for preparing the Annual Report and Accounts. The Board sees the Annual Report and Accounts considered as a whole, as fair, balanced and understandable, and as providing the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. The Board also describes some of the principal risks and uncertainties facing the Trust in the Annual Governance Statement. The Trust has prepared its 2024/25 accounts on a going concern basis.

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Health inequalities

During 2024/25, the Trust has embedded the focus on health inequalities as a "golden thread" in its planning approach, ensuring that all teams prioritise improvements, investments, and service changes to better address these disparities. Specific actions include the implementation of the Patient and Carer Race Equality Framework and an anti-racist approach, which involve improving the collection of ethnicity data, examining and rewriting policies to eliminate implicit racial bias, and establishing governance structures that enable patients, carers, and families to hold the Trust accountable.

Additionally, the Trust has worked alongside the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) to enhance its understanding of

population health and develop long-term solutions for challenges such as Autism and ADHD waits. The Buckinghamshire Mental Health directorate has also initiated health inequalities projects in partnership with the voluntary sector. These efforts collectively aim to improve access, experience, and outcomes for diverse and underserved populations within the Trust's service areas. A health inequalities dashboard is also in development, which will support the Trust in establishing the priority areas for focus.

Information set out in NHS England's Statement on Information Health Inequalities under section 13SA(1) of the NHS Act 2006 (Appendix 1), relevant to the services of the Trust, is captured where available and published in Board reports. Further work is underway to develop the Trust's capture, publication and use of health inequalities data and will be included in work over 2024/25 to develop an integrated performance report across the Trust.

Additional efforts by the Trust to address health inequalities include the establishment of mental health hubs on high streets, and the ongoing implementation of the Community Services Transformation programme. This programme has been set up to evolve the Trust's community-based services to better meet patient needs, and the Trust has begun to deliver its plan of relocating services to where they are easier for patients to access. The Trust also maintains its commitment to working with local system partners to develop and improve access to local services through strategic partnerships and provider collaboratives, for example collaboration with Oxford University Hospitals has led to the implementation of local joint triage and pathway solutions which have reduced community waiting times.

Net zero performance

The Annual Governance Statement section of this report summarises the Trust's net zero and carbon reduction activity and plans. The Trust's *Green Plan* was first signed off by the Board of Directors in 2022. A new three-year plan for 2025-28 (*Green Plan 2*) has now been developed to meet the requirements of the Climate Change Act, Adaption Reporting, and the Trust's approach to achieving net zero by 2040. The Trust produces progress reports against plans.

Equality of service delivery

The Trust has in place an established equality impact assessment process which is used when undertaking service development, transformation, and policy development.

Over the reporting year the Trust has undertaken a number of initiatives to promote equality of service delivery including the establishment of a number of new mental health Keystone hubs on high streets to improve access to mental health support and advice; the continued delivery of the Oliver McGowan e-learning module for staff to improve awareness of and standards for people with a learning disability or Autism; and introduction of the *TrueColours* system in health teams to enable better understanding of patient outcomes.

The Trust has developed new data sets on waiting list analysis to inform improvements in reducing health inequalities and continues to explore how to improve data collection rates. This is one aspect of the Trust's work linked to the implementation of the Patient and Carer Race Equality Framework (known as PCREF) – a national anti-racism

framework enabling the co-production and implementation of actions to reduce racial inequalities within mental health services

Performance Report

Signed: **Date: 25 June 2025**

Grant Macdonald

Chief Executive and Accounting Officer

Accountability Report

Directors' Report

Board composition - the chair, senior independent director, and chief executive

The Board brings a wide range of experience and expertise to its stewardship of the Trust. This report explains the Trust's governance arrangements and how the Board and management team run the Trust for the benefit of the community and its members. The Board of Directors is focused on achieving long-term success for the Trust through the pursuit of sound business strategies, while maintaining high standards of clinical and corporate governance and corporate responsibility. For the reporting year, the chair of the board is David Walker, the chief executive is Grant Macdonald, and the position of senior independent director has been undertaken by Sir Philip Rutnam and Andrea Young.

During the reporting period, the Trust welcomed to the Board:

- Georgia Denegri, as Interim Associate Director of Corporate Affairs from May 2024 to February 2025;
- Taff Gidi, as Executive Director of Corporate Affairs from February 2025;
- Emma Leaver, as Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care, from March 2025; and
- Grant Macdonald, who took up the permanent position as Chief Executive of the Trust, having served as Interim Chief Executive of the Trust from July 2023 to November 2024.

The following Board members left the Trust over 2024/25:

- Dr Nick Broughton, former Chief Executive, who had been seconded as Interim Chief Executive of the Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board at the start of July 2023 and who took up the permanent position as Chief Executive of the Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board in September 2024;

- Professor David M. Clark, Non-Executive Director appointee of the University of Oxford, in December 2024;
- Georgia Denegri, Interim Associate Director of Corporate Affairs, in February 2025;
- Dr Ben Riley, Chief Operating Officer for Community Health Services, Dentistry & Primary Care, in February 2025;
- Kerry Rogers, Director of Corporate Affairs & Company Secretary, in May 2024; and
- Sir Philip Rutnam, Non-Executive Director, in September 2024.

The Chair, David Walker, has throughout the reporting period been responsible for the effective working of the Board, for the balance of its membership, subject to Board and Governor approval, and for ensuring that all directors can play their full part in the strategic direction of the Trust and its performance.

The Chair is also responsible for conducting annual appraisals of the Non-Executive Directors and presenting the outcomes to the Governors' Nominations and Remuneration Committee. Furthermore, the Chair is responsible for carrying out the appraisal of the Chief Executive and reporting to the respective Board committee accordingly.

Grant Macdonald, as Interim Chief Executive and Chief Executive over the reporting period, has been responsible for all aspects of the management of the Trust. This includes developing any appropriate business strategies agreed by the Board, ensuring appropriate objectives and policies are adopted throughout the Trust, appropriate budgets are set within available resources, and that performance is monitored effectively, and risks mitigated.

The Chair, with the support of the Executive Director of Corporate Affairs, ensures that the Directors and Governors receive accurate, timely and clear information, making complex information easier to digest and understand.

Directors are encouraged to update their skills, knowledge and familiarity with the Trust's business through their: induction; ongoing participation at Board and committee meetings; attendance and participation at development events and Board seminars; Board member site visits; and through meetings with Governors. The Board is also updated regularly on governance and regulatory matters.

There is an understanding whereby any Non-Executive Director, wishing to do so in the furtherance of their duties, may take independent professional advice through the Executive Director of Corporate Affairs and at the Trust's expense.

The Non-Executive Directors provide a wide range of skills and experience. They bring an independent judgement on issues of strategy, performance and risk through their contribution at Board and committee meetings. The Board considers that throughout the year, each Non-Executive Director was independent in character and judgement and met the independence criteria set out in NHS England's Code of Governance for NHS provider trusts. Non-Executive Directors continue to declare and manage potential conflicts of interest appropriately, including through declaration on the publicly available Register of Directors' Interests on the Trust's website and at the start of, and during, relevant meetings.

The Non-Executive Directors have ensured that they have sufficient time to carry out their duties. Any term beyond six years is subject to rigorous review by the Governors' Nominations and Remuneration Committee, thus ensuring that the needs of the organisation in the context of the environment within which it operates are considered. The Non-Executive Directors, through the Nominations, Remuneration and Terms of Service Committee, are responsible for reviewing the performance appraisals, conducted by the Chief Executive, of Executive Directors and that of the Chief Executive conducted by the Chair.

During the year, the time spent with the Governors has helped the Board to understand their views of the Trust and its strategies. Board members attend the Council of Governors' meetings, with Governors in return attending public Board meetings routinely as observers. Invitations to observe Board committees have continued to be extended to the Governors during the year to support their wider understanding of the business of the Board and that of the Non-Executive Directors.

Communication with members and service users supports understanding of the areas of interest that matter to patients and the public, and the Board recognises that more can always be done to make membership more meaningful for those involved.

The Board also strives to support patients to be more involved in their own care and service developments via the Trust's Experience and Involvement Strategy and the work of the Experience and Involvement team, progress against which is monitored through the Quality Committee.

Directors of the Foundation Trust over the reporting year

The Board of Directors comprised the following individuals over 2024/25:

Executive Directors

Voting Executive Director Members of the Board:

- Dr Rob Bale, Interim Executive Managing Director of Mental Health & Learning Disabilities
- Charmaine De Souza, Chief People Officer
- Britta Klinck, Chief Nurse
- Emma Leaver, Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care, from March 2025
- Grant Macdonald, Interim Chief Executive and, from November 2024, Chief Executive
- Dr Karl Marlowe, Chief Medical Officer
- Dr Ben Riley, Executive Managing Director for Primary, Community and Dental Care, to February 2025
- Heather Smith, Chief Finance Officer

Non-voting Executive Director Members of the Board:

- Amélie Bages, Executive Director of Strategy and Partnerships (on maternity leave over the reported year)
- Georgia Denegri, Interim Associate Director of Corporate Affairs, to February 2025
- Taff Gidi, Executive Director of Corporate Affairs from February 2025

- Kerry Rogers, Director of Corporate Affairs and Company Secretary, to May 2024

Non-Executive Directors

Voting members of the Board:

- David Walker (Chair)
- Chris Hurst (Vice Chair)
- Professor David M. Clark (to December 2024)
- Geraldine Cumberbatch
- Sir Philip Rutnam (Senior Independent Director to September 2024)
- Mohinder Sawhney
- Professor Sir Rick Trainor
- Lucy Weston
- Andrea Young (Senior Independent Director from December 2024)

The Chair and Non-Executive Directors are appointed for a period of office as decided by the Council of Governors at a general meeting. Their terms of office may be ended by resolution of the Council of Governors in accordance with the Trust's Constitution. The periods of office of each of the Non-Executive Directors and their respective terms are set out below (longest serving first):

Name	Commenced	Term	Current term period	Eligible for re-appt
Chris Hurst	01/04/2017	3rd	01/04/2023 - 31/03/2026	Final term – not eligible post third term
Lucy Weston	01/03/2019	3rd	01/03/2025 - 28/02/2026	Within final term - up to two further years
David Walker	01/04/2019	3rd	01/04/2025 – 31/03/2026	Within final term - up to two further years
Mohinder Sawhney	01/01/2021	2nd	01/01/2024 - 31/12/2026	Up to one further term
Sir Philip Rutnam	01/01/2022	1st	01/01/2022 - 31/12/2024	Left the Trust on 30/09/2024
Andrea Young	01/01/2022	2nd	01/01/2025 - 31/12/2027	Up to one further term
Geraldine Cumberbatch	01/04/2022	2nd	01/04/2025 - 31/03/2028	Up to one further term
Prof. Sir Richard Trainor	01/04/2022	2nd	01/04/2025 - 31/03/2026	Up to one further term
Prof. David M. Clark	17/07/2023	1st	17/07/2023 – 16/07/2026	Left the Trust on 31/12/24

Skills and experience

The Trust considers that the composition of the Board is balanced, complete and appropriate to the requirements of the Trust. Each of the current Directors' experience is outlined on the Trust's website by searching online for '*Oxford Health Board of Directors*'. The biographies of directors who left over the reporting period can be available on request.

Board and board committee meetings and attendances

Directors' attendance at Board of Directors' meetings and Council of Governors' general meetings during the year are shown in the table below.

Name	Board of Directors' meetings	Council of Governors' general meetings
Non-Executive Directors		
David Walker (Chair)	8/8	4/4
Professor David M. Clark	5/5	2/3
Geraldine Cumberbatch	8/8	4/4
Chris Hurst	7/8	4/4
Sir Philip Rutnam	4/4	1/1
Mohinder Sawhney	6/8	3/4
Professor Sir Richard Trainor	8/8	3/4
Lucy Weston	8/8	4/4
Andrea Young	8/8	3/3
Voting Executive Directors		
Dr Nick Broughton	0/0	0/0
Grant Macdonald (Interim Chief Executive and Chief Executive)	8/8	3/4
Dr Rob Bale	7/8	4/4
Charmaine De Souza	7/8	3/4
Britta Klinck	7/8	2/4
Emma Leaver	2/2	1/1
Dr Karl Marlowe	6/8	1/4
Dr Ben Riley	5/6	1/3

Name	Board of Directors' meetings	Council of Governors' general meetings
Heather Smith	8/8	3/4
Non-voting Executive Directors		
Amélie Bages on maternity leave over reported year	5/5	3/4
Georgia Denegri	6/6	2/3
Taff Gidi	2/2	1/1
Kerry Rogers	0/0	0/0

Statutory and non-statutory board committees

The Board has formally constituted committees which support the systematic review of the Trust's risk and control environment and enable a more granular view of its systems of governance. In addition to the statutory Audit and Nomination and Remuneration committees, the other committees of the Board are each chaired by a Non-Executive Director; they are also referenced within the Annual Governance Statement and Remuneration Report, where relevant. The terms of reference of the Board committees reflect the required focus on integrated risk, performance, and quality management. There is a Scheme of Reservation and Delegation that sets out explicitly those decisions that are reserved for the Board, those which may be determined by Board committees and those that are delegated to managers.

Audit and Risk Committee

The Audit & Risk Committee (until January 2025 the Audit Committee), chaired by Non-Executive Director and chartered accountant Chris Hurst, provides an independent and objective review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust and plays a pivotal role in supporting the Board. Its membership is comprised wholly of Non-Executive Directors, with Executives and others in attendance. There were five meetings during the reporting year. Attendance by members is detailed below:

Committee member	Attendance
Chris Hurst (Chair)	5/5
Professor David M. Clark	2/4
Mohinder Sawhney	3/5
Professor Sir Richard Trainor	4/5

Sir Philip Rutnam (deputising for Professor David M. Clark and Professor Sir Richard Trainor)	1/1

Given the skills and experience of Audit Committee members, and through the work of the committee across the year and that of the Auditors reporting to it, the Board of Directors is satisfied that the committee has remained effective and that committee members have recent and relevant financial experience.

The Audit & Risk Committee assists the Board in fulfilling its oversight responsibilities and its primary functions, as outlined in its terms of reference, to monitor the integrity of the financial accounting statements and to independently monitor, review and report to the Board of Directors on the processes of governance and the management of risk.

Key areas of responsibility include corporate and clinical governance, internal control, risk management, internal and external audit, and financial reporting. The Audit & Risk Committee also has a role in relation to whistleblowing, freedom to speak up, and management of concerns arrangements to review the effectiveness of those arrangements through which staff may raise concerns in confidence and ensure measures are in place for proportionate and independent investigation and appropriate follow-up.

In discharging its delegated responsibilities, the Audit & Risk Committee has reviewed the following non-exhaustive range of matters. A review of the Annual Governance Statement within the context of the wider Annual Report, alongside robust scrutiny of the Annual Accounts and Financial Statements, has been undertaken. It has considered the effectiveness of the Board Assurance Framework, to gain on-going assurance of the effectiveness of the Trust's risk and internal control processes and undertaken deep dives into the high rated risks. The Audit & Risk Committee also reviewed and approved the internal and external audit plans and the counter fraud work plan.

The Audit & Risk Committee regularly reviewed internal audit and counter fraud progress reports and review reports. The counter fraud service attends committee meetings to present updates on all counter fraud investigations, fraud prevention and deterrent and awareness-raising activities. The Trust ensures that referrals and allegations of fraud, bribery and corruption are investigated and seeks redress whenever possible so that money recovered can be put back into patient care. The Audit & Risk Committee ensures accountability, and that the Trust does everything in its power to protect the public funds with which it has been entrusted. The Board attaches significant importance to the issue of fraud and corruption. Reported concerns have been investigated by our local counter fraud specialists in liaison with the NHS Counter Fraud Authority (CFA) and the police as necessary, and the Audit & Risk Committee has paid attention to awareness of bribery and corruption obligations.

The Audit & Risk Committee has reviewed whistleblowing arrangements and considered risks around the effective management of concerns. The Freedom to Speak Up Guardian has reported to the Board of Directors on cases of concern and awareness-raising activities which are reviewed by members of the Audit & Risk Committee in their capacity as Board members. Additionally, there has been a regular review of Single Action Tender Waivers and losses and special payments by the committee. The Audit & Risk Committee is informed by assurance work undertaken

by other Board committees, through joint memberships and escalations to the Board. The minutes of the meetings of Board committees are circulated to the Board of Directors and reviewed by members of the Audit & Risk Committee in their capacity as Board members.

In assessing the quality of the Trust's control environment, the committee received reports during the year from the external auditors and the internal auditors on the work they had undertaken in reviewing and auditing the control environment as well as briefing notes on key sector developments. The Non-Executive Directors routinely hold meetings with both internal and external auditors without members of the Executive team present.

Nominations and Remuneration Committees

The Trust has two committees considering nominations and remuneration regarding Executive Directors and Non-Executive Directors: the Board of Directors' Nominations, Remuneration and Terms of Service Committee; and the Council of Governors' Nominations and Remuneration Committee respectively.

The Board of Directors Nominations, Remuneration and Terms of Service Committee is constituted as a standing committee of the Board of Directors and has the statutory responsibility for identifying and appointing suitable candidates to fill Executive Director positions on the Board, ensuring compliance with any mandatory guidance and relevant statutory requirements, and is responsible for succession planning and reviewing Board structure, size, and composition.

The committee was chaired by the Trust's Chair, David Walker, with membership comprising all Non-Executive Directors. At the invitation of the committee, the Chief Executive, Chief People Officer, and Director of Corporate Affairs and Company Secretary attend meetings in an advisory capacity. The Remuneration Report of this Annual Report provides further details.

The Council of Governors' Nominations and Remunerations Committee determines the remuneration of Non-Executive Directors via recommendations from its own Nominations and Remuneration Committee, covered further in the Council of Governors' Report of this Annual Report.

Finance & Investment Committee

The Finance and Investment Committee, chaired by Non-Executive Director and chartered accountant Lucy Weston, has overseen the development and implementation of the Trust's strategic financial plan and overseen management of the principal risks to the achievement of that plan, and associated recovery plan. The committee has also contributed to continued planning regarding the Warneford site development ambitions and Trust annual planning for 2025/26. The committee is made up of both Non-Executive and Executive Directors, with other senior managers in attendance. Attendance is set out below:

Committee member	**Attendance**
Core members	
Lucy Weston (Chair)	6/6
Amélie Bages – *on maternity leave over reported year*	2/6

Dr Rob Bale	3/6
Emma Leaver	1/1
Dr Ben Riley	4/5
Sir Philip Rutnam	2/3
Mohinder Sawhney	2/2
Heather Smith	6/6
Attending Board members	
Grant Macdonald (Interim Chief Executive and Chief Executive)	5/6
Georgia Denegri	5/5
Taff Gidi	1/1
Kerry Rogers	0/0
David Walker	6/6

Quality Committee

The Quality Committee, chaired by Non-Executive Director Andrea Young, enables the Board to obtain assurance regarding standards of care provided by the Trust and that appropriate clinical governance structures, processes and controls are in place.

The Quality Committee provides assurance to the Board of Directors that we are discharging our responsibilities for ensuring service quality and that we are compliant with our registration requirements with the Care Quality Commission (CQC). These responsibilities are defined within the CQC's five key questions and their key lines of enquiry and includes assurance that good and poor practice is recognised, understood and managed through the operational and clinical management structure. The role of Quality Committee and its sub-committee is to:

- provide assurance that we have in place and are implementing appropriate policies, procedures, systems, processes and structures to ensure our services are safe, effective and efficient;
- provide assurance that the organisation is compliant with regulatory frameworks and legislation;
- approve changes in clinical or working practices or the implementation of new clinical or working practices;
- approve new or amended policies and procedures;
- monitor the quality, effectiveness and efficiency of services and identify any associated risks; and
- approve and monitor strategies relating to quality.

Attendance is set out below:

Committee member	**Attendance**
Core members	
Andrea Young (Chair)	5/5
Dr Rob Bale	4/5
Geraldine Cumberbatch	0/5
Georgia Denegri	4/5
Britta Klinck	5/5
Dr Karl Marlowe	4/5
Dr Ben Riley	3/5

Lucy Weston	3/5
Attending Board members	
Amélie Bages - *on maternity leave over reported year*	1/5
Charmaine De Souza	0/5
Grant Macdonald	2/5
Kerry Rogers	0/0
Heather Smith	1/1
David Walker	4/5

People Leadership and Culture Committee

Chaired by Non-Executive Director Mohinder Sawhney, the People Leadership and Culture Committee ensures an appropriate focus on workforce performance, health and wellbeing and assurance that relevant risks and mitigation actions are in place to support the development of innovative enabling strategies for people, leadership and education. Attendance Is set out below:

Committee member	**Attendance**
Mohinder Sawhney (Chair)	4/4
Amélie Bages *on maternity leave over reported year*	0/2
Dr Rob Bale	4/4
Geraldine Cumberbatch	4/4
Georgia Denegri	2/4
Charmaine De Souza	4/4
Britta Klinck	3/4
Emma Leaver	4/4
Grant Macdonald	2/4
Kerry Rogers	0/0
Andrea Young	2/4

The Mental Health and Law Committee

Chaired by Non-Executive Director Geraldine Cumberbatch, the Mental Health and Law Committee is constituted to provide assurance to the Board that the Trust establishes, monitors and maintains appropriate systems, processes and reporting arrangements to ensure compliance with the Mental Health Act and Mental Capacity Act, while protecting the human rights of service users. Attendance is set out below:

Committee member	Attendance
Geraldine Cumberbatch (Chair)	3/4
Georgia Denegri	3/3
Taff Gidi	1/3
Karl Marlowe	4/4
Kerry Rogers	0/4
Mark Underwood	4/4
Rob Bale	1/4
Amy Allen	3/4

The Charity Committee

Chaired by Non-Executive Director Professor Sir Richard Trainor, the Charity Committee is responsible for ensuring the stewardship and effective management of funds which have been donated, bequeathed and/or given to the Oxford Health Charity. Further information on the Charity Committee can be found in the Charity and Community Involvement section of this report. Attendance is set out below:

Committee member	Attendance
Professor Sir Richard Trainor (Chair)	4/4
Georgia Denegri	2/3
Charmaine De Souza	4/4
Taff Gidi	1/1
Chris Hurst	4/4
Britta Klinck	2/4
David Walker	3/4

Conflicts of interest

The Trust has published on its website up-to-date registers of interests for Directors, decision-making staff and the register of gifts and hospitality (as defined by the Trust with reference to the 'Managing Conflicts of Interest in the NHS' guidance within the past twelve months). These can be accessed at the Trust's website by searching online for '*Oxford Health disclosures and declarations'*.

Political donations

No political donations were made or received in the reporting year.

Better payment practice code, payment of suppliers and liability to pay interest

The Better payment code requires the Trust to aim to pay 95% of the value of all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's compliance with the Better Payment Practice Code in respect of invoices received from both NHS and non-NHS trade creditors is shown in the below table.

Measure of compliance	2024/25		2023/24	
	Number	£000	Number	£000

Total Non-NHS trade invoices paid in the year	57,801	364,849	62,849	334,670
Total Non-NHS trade invoices paid within target	52,504	341,093	56,273	313,245
Percentage of Non-NHS trade invoices paid within target	90.8%	93.5%	89.5%	93.6%
Total NHS trade invoices paid in the year	6,350	59,279	5,380	84,510
Total NHS trade invoices paid within target	5,440	51,528	4,972	74,876
Percentage of NHS trade invoices paid within target	85.7%	86.9%	92.4%	88.6%

There was no liability to pay interest accrued by virtue of failing to pay invoices within the 30 day period.

Well-led framework

The Annual Governance Statement of this report provides a statement on Well-led.

Council of Governors

Role of the Council of Governors

The Trust's Council of Governors is a committed group of volunteers and has key role in the governance of the organisation primarily representing the interests of the members of their constituencies and the public and to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. The Council comprises four constituencies – Public, Patient (Service User & Carers), Staff, and Appointed governors.

Composition of the Council of Governors

The composition of the Council of Governors comprises of 28 elected Governors representing Public, Patient and Staff constituencies and 7 appointed Governors from partner organisations as set out in the table below:

Elected Governors		
Constituency	**Class**	**No. of Governors**
Public	Buckinghamshire	3
	Oxfordshire	4
	Rest of England & Wales	1
Patient	Service Users: Buckinghamshire and other Counties	4
	Service Users: Oxfordshire	4
	Carers	3
Staff	Buckinghamshire Mental Health Services	2

	Oxfordshire, Bath & North East Somerset, Swindon & Wiltshire Mental Health Services	2
	Community Services (Primary, Community & Dental Services)	2
	Corporate Services	1
	Specialised Services	2

Appointed Governors	
Partner Organisation	**No of Governors**
Age UK Oxfordshire	1
Buckinghamshire Council	1
Buckinghamshire Healthcare NHS Trust	1
Buckinghamshire Mind	1
Oxford Brookes University	1
Oxfordshire County Council	1
Oxford University Hospital NHS Foundation Trust	1

The Trust's Council of Governors met four times during the year reporting year (June, October, December, and March).

Governor elections were held over Spring 2024 (for new governors to begin on 1 June 2024). There were 18 vacancies, and 11 governors were elected. Eight seats were filled uncontested, and 1 in a contested poll (Oxfordshire public constituency). The Trust used an external elections agency to ensure its independence from the governor election process. 2025 is also a governor election year with elections taking place Spring 2025 for new governors to start on 1 June 2025.

The list of Governors who were in post during the period 1 April 2025 to 31 March 2025 and their participation in the four general meetings are shown in the table below.

Elected Governors				
Name	**Constituency and Class**	**Tenure**	**Term**	**Meeting Attendance**
Evin Abrishami	Staff: Oxfordshire, Banes, Swindon & Wiltshire Mental Health Services	01/06/2022-31/05/2025	1	3/4
Dilshard Alam**	Staff: Mental Health Services Oxfordshire, BaNES, Swindon & Wilts	01/06/2024-31/05/2027	1	0/1

Martyn Bradshaw	Staff: Mental Health Services Buckinghamshire	01/06/2022-31/05/2025	1	0/4
Maud Bvumbe**	Public: Rest of England & Wales	01/06/2024-31/05/2027	1	0/2
James Campbell**	Public: Oxfordshire	01/06/2024-31/05/2027	1	0/1
Kate England	Patient: Carers	01/06/2022-31/05/2025	1	1/4
Gillian Evans*	Patient: Service Users Oxfordshire	01/06/2021-31/05/2024	3	0/0
Julien FitzGerald	Patient: Service Users Buckinghamshire and other Counties	01/06/2024-31/05/2027	2	2/4
Anna Gardner**	Public: Buckinghamshire	01/06/2024-31/05/2027	2	3/3
Benjamin Glass	Patient: Service Users Buckinghamshire and other Counties	01/06/2022-31/05/2025	3	0/4
Bernice Hewson**	Public: Buckinghamshire	01/06/2024-31/05/2027	1	1/3
Nyarai Humba	Patient: Carers	01/06/2024-31/05/2027	2	1/4
Juliet Hunter	Public: Oxfordshire	01/06/2024-31/05/2027	1	4/4
Ekenna Hutchinson*	Staff: Oxfordshire, Banes, Swindon & Wiltshire Mental Health Services	01/06/2021-31/05/2024	1	0/0
Christiana Kolade*	Public: Buckinghamshire	01/06/2021-31/05/2024	1	0/0
Benjamin McCay	Patient: Service Users Oxfordshire	01/06/2024-31/05/2027	2	0/4
Jacqueline-Anne McKenna*	Patient: Service Users Buckinghamshire and other Counties	01/06/2021-31/05/2024	2	0/0
Petr Neckar	Staff: Community Health Services Oxfordshire	01/06/2022-31/05/2025	1	0/4

Vicki Power	Staff: Community Health Services Oxfordshire	01/06/2022-31/05/2025	1	3/4
Srikesavan Sabapathy	Public: Oxfordshire	01/06/2022-31/05/2025	1	2/4
Emma Short	Staff: Specialised Services	01/06/2022-31/05/2025	1	1/4
Jules Timbrell	Staff: Corporate Services	01/06/2024-31/05/2027	1	2/4
Appointed Governors				
Name	**Constituency and Class**	**Tenure**	**Term**	**Meeting Attendance**
Tim Bearder (Cllr)	Oxfordshire County Council	20/12/2022-19/12/2025	1	0/4
Carolyn Llewellyn	Oxford Brookes University	07/09/2023-06/09/2026	1	3/4
Andrea McCubbin**	Buckinghamshire Mind	01/01/2024-31/12/2026	3	2/3
Zahir Mohammed (Cllr)	Buckinghamshire Council	14/03/2024-13/03/2027	1	2/4
Paul Ringer	Age UK Oxfordshire	16/09/2023-15/09/2026	1	4/4
Joel Rose	Buckinghamshire Mind	03/03/2024-02/03/2027	1	1/1
Graham Shelton	Oxford University Hospital Trust	01/08/2022-30/07/2025	1	2/4

Key: * *stood down at end of term*

** *ceased to be a Governor mid-way through tenure*

*** *Non-voting Governor - continued beyond expiry of term*

Lead governor

The Council of Governors has appointed a lead governor in line with the *Code of Governance for NHS provider trusts.* The role description and process for annual appointment for the Lead Governor was reviewed and approved in March 2024.

In January 2025 Vicki Power (Staff governor – Buckinghamshire Mental Health Services), replaced Anna Gardner (Public governor – Buckinghamshire) as lead

governor. The Council of Governors formally noted their thanks and appreciation to Anna Gardner for all her work as lead governor.

Council of Governors register of interests

All Trust Governors are asked to declare any interest on the Register of Governors' interests at the time of their appointment or election and it is reviewed annually thereafter. This register is maintained by the Corporate Affairs directorate. The register is published on the Trust website and available by searching online for '*Oxford Health Disclosures and declarations'* and is available for inspection on request. Any enquiries should be made to the Executive Director of Corporate Affairs at the following address: Oxford Health NHS Foundation Trust, Corporate Services, Littlemore Mental Health Centre, Sandford Road, Littlemore, Oxford, OX4 4XN.

Communication between governors and members

The Council of Governors' public and patient governors allow the Board of Directors to be kept informed about the views of members and public, including via:

- attendance by Non-Executive Directors at Council of Governor meetings;
- attendance by governors at public Board of Directors' meetings;
- attendance and/or presentations at Council of Governor meetings by Board of Directors;
- joint attendance by Non-Executive Directors and governors at Governor and Non-Executive development (private) sessions.

Governors can contact the Senior Independent Director or the Executive Director of Corporate Affairs for concerns regarding any issues which have not been addressed by the Chair, Chief Executive or Executive Directors.

The Council of Governors has discussions focused on member engagement, it comprises members of the Trust and current governors to explore how to continue to best engage with and increase the number of Trust members. Over 2024/25 a membership newsletter was produced and issued electronically approximately every 8 weeks to the Trust's membership with news on the Trust including service news, director appointments, and the discussions of the Council of Governors. In July 2024 a joint member engagement event was held with Oxford University Hospitals NHS Foundation Trust marking the first time the two foundation trusts had worked together on a joint membership and governor event.

As 2025 was a governor election year, from January 2025 there were specific member communications on the governor election process promoting the work of governors and seeking members to stand for and vote for governors. Individual governors undertake member engagement activities and appointed governors are in place to represent the Trust's partner organisations.

As part of the development of the Trust's 2024/25 Annual Plan, emerging plan priorities were discussed with the Council of Governors prior to its sign off by the Board of Directors.

The Chairman, Executive Director of Corporate Affairs, and Deputy Director of Corporate Affairs meet regularly with the Lead Governor. There is an engagement policy which further expands on how the Board and the Council wish to work together.

Both the Board of Directors and the Council of Governors are committed to continuing to promote enhanced joint working so that they can deliver their respective statutory roles and responsibilities in the most effective way possible to improve services.

The Trust's Constitution, Standing Orders of the Board of Directors, and Standing Orders of the Council of Governors set out mechanisms to address any disagreements arising between the Board of Directors and the Council of Governors. There were no such instances within the reporting year.

Council of Governor's Remuneration and Nominations Committee

The Nominations and Remuneration Committee of the Council of Governors makes recommendations to the Council regarding the appointment or removal of the Chair, the Non-Executive Directors, and the Trust's external auditors, and the remuneration arrangements of the Chair and Non-Executive Directors. The Nomination and Remuneration Committee has a terms of reference and meets once a year as a minimum. The Nomination and Remuneration Committee of the Council of Governors met twice over 2024/25 in June and February.

The Committee is chaired by the Trust's Chair with membership comprising the Lead Governor and elected and appointed Governors. When considering the terms and conditions of the Chairman, or if on any occasion the Chairman is unavailable to chair, the Vice Chair or one of the other Non-Executive Directors (who is not standing for re-appointment) would take the Chair. The Lead Governor would chair the meeting if all Non-Executive Directors were conflicted. The Senior Independent Director presents to the committee the outcome of the annual performance review given their role with the Lead Governor in determining the Chairman's appraisal outcome.

Remuneration Report

Scope of the Report

The Remuneration Report summarises the Trust's Remuneration Policy and particularly, its application in connection with the Executive and Non-Executive Directors. It describes how the Trust applies the principles of good corporate governance in relation to Directors' remuneration as defined in the Code of Governance for NHS providers; in Section 420 to 422 of the Companies Act 2006 in so far as they apply to Foundation Trusts; and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations") as interpreted for the context of NHS Foundation Trusts; Parts 2 and 4 of Schedule 8 of the Regulations and elements of the Code of Governance for NHS provider trusts. Details of Executive Directors' remuneration and pension benefits; and non-Executives' remuneration are set out in tables later in this report. They have been subject to audit.

Nominations, Remuneration and Terms of Service Committee

The Board appoints the committee that considers remuneration of the executive directors, which is a single committee considering both nominations and remuneration called the Nominations, Remuneration and Terms of Service Committee and its membership comprises only Non-Executive Directors. The committee that considers remuneration of the non-executive directors is referred to later.

The Committee meets to determine, on behalf of the Board, the remuneration strategy for the organisation including the framework of executive and senior manager remuneration. Its remit includes determining the remuneration and terms and conditions of the executive and their direct reports for any terms outside Agenda for Change, thereby includes the terms and conditions of other senior managers and approving senior manager severance payments where relevant. Employer Based Clinical Excellence Awards have been dealt with by the Board of Directors and allocations were approved during the year.

All Non-Executive Directors are members of the Committee. The Committee has met on 4 occasions over 2024/25. During the year, the following Non-Executive Directors have served on the Committee as voting core members:

Committee Member	Attendance
David Walker	4/4
Geraldine Cumberbatch	2/4
Chris Hurst	2/4
David Clark	2/3
Sir Philip Rutnam	1/2
Mohinder Sawhney	4/4
Professor Sir Rick Trainor	2/4
Lucy Weston	4/4
Andrea Young	2/4

The Committee also invited the assistance of the Chief Executive, the Chief People Officer, the Director of Corporate Affairs and Company Secretary and the Interim Associate Director of Corporate Affairs. None of these individuals or any other Executive or senior manager participated in any decision relating to their own remuneration.

Senior Managers' Remuneration Policy

The Trust is committed to the governing objective of maximising value over time. To achieve its goals, the Trust must attract and retain a high calibre senior management team to ensure it is well positioned to deliver its business plans. The remuneration policy is to ensure remuneration is consistent with market rates for equivalent roles in

other Trusts of comparable size and complexity taking account of benchmarking information. Account is also taken of the performance of the Trust as well as the skills, knowledge and experience required on the Board to meet current and future business needs and succession planning as well as the structure, size, diversity and composition of the Board.

The Trust defines its senior managers as those managers who have the authority or responsibility for directing or controlling the major activity of the Trust - those who influence the Trust as a whole. For the purposes of this report, 'senior managers' are defined as the voting and non-voting members of the Board of Directors.

During the year the Trust adhered to the principles of the agreed pay framework that remunerated the performance of the Executive Directors and their direct reports based on the delivery of objectives as defined within the Trust's plans.

There are no contractual provisions for performance related pay for executive and direct reports and as such no payments were made in 2024/25. The approach to remuneration is intended to provide the rigour necessary to deliver assurance and the flexibility needed to adapt to the dynamics of a changing NHS. It is fundamental to business success and is modelled upon the guidance in the Code of Governance and the Pay Framework for Very Senior Managers in the NHS (Department of Health and Social Care). The key principles of the approach are that pay and reward are assessed relative to the performance of the whole Trust and in line with available benchmarks.

The remuneration policy for 2024/25 continued to not include any performance related pay elements, and all directors' performance will continue to be assessed against delivery of objectives and kept in line with recognised benchmarks (e.g. NHS Providers and the wider pay policies of the NHS).

Executive appointments to the Board of Directors continue under permanent contracts and over 2024/25, no substantive director held a fixed term employment contract. The Chief Executive and all other executive directors (voting and non-voting) hold office under notice periods of six months except when related to conduct or capability. This information is detailed later in this report.

With regard to interim appointments on the Board, there were four interim members of the Board of Directors during 2024/25. From July 2023, the substantive Chief Executive commenced a secondment with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board (ICB) as their interim Chief Executive. Following an internal recruitment process, the Managing Director of Mental Health Services - Grant Macdonald - was successful in being appointed to the interim Chief Executive position from July 2023. Following the permanent appointment of the BOB ICB Chief Executive in September 2024, the Trust undertook a recruitment process to appoint a permanent Chief Executive. Grant Macdonald was appointed as the Trust's substantive Chief Executive from November 2024.

Following the departure in April 2024 of the substantive Director of Corporate Affairs and Company Secretary, an interim Associate Director of Corporate Affairs was in post from May 2024 to February 2025.

Following the departure of the Chief Operating Officer for Community, Primary & Dental Services in February 2025, an interim Chief Operating Officer for Community

Primary & Dental Services was appointed from 1 March 2025 for a period of 6 months to allow for a substantive recruitment process.

Equality and Inclusion

The Trust uses the NHS Equality Delivery System assessment to develop its equalities work. This framework has helped us to identify our equality priorities and to consolidate the progress we have made to date which can be attributed to a variety of relationships, practices and initiatives involving a diverse range of stakeholders, sector agencies and partnerships.

The Board and the People Leadership and Culture (PLC) Committee receive reports which include matters of equality, diversity and inclusion, including progress against the Trust's People Plan along with oversight of the annual submissions concerning Workforce Race Equalities Standards (WRES) and the Workforce Disability Equality Standards (WDES) and associated action plans. The PLC Committee is responsible for overseeing progress with closing gender and race pay gaps.

Further detail regarding the Trust's strategy and objectives in terms of diversity and inclusion can be found in the Staff Report of this Annual Report, and on the Trust's website by searching online for '*Oxford Health equality, diversity and inclusion'*.

Annual Statement on Remuneration

There are no additional elements that constitute any senior managers' remuneration, including executive and non-executive directors, in addition to those specified in the table of salaries and allowances which feature later in the report. The amounts that are designated salary in the table represent a single contracted annual salary and there are no particular remuneration arrangements which are specific to any senior manager. There were no changes made in the period to existing components of the remuneration policy and no components were added.

The majority of staff employed by the Trust are contracted on Agenda for Change terms and conditions and the general policy on remuneration contained within these terms and conditions is applied to senior managers' remuneration (and all other staff employed on non-Agenda for Change contracts), with the exception of the Chief Medical officer and the Interim Managing Director of Mental Health Services, to whom Medical and Dental terms and conditions apply.

The list of Board members who are each not on Agenda for Change contracts is available later in this report (their contracts are permanent, with no unexpired terms).

Remuneration for senior managers is set on appointment or following benchmark comparison with reference to reports on NHS senior manager pay from NHS England and NHS benchmarking data collected by organisations such as NHS Providers. The main consideration for annual pay increases for senior managers has been the inflationary uplift award made under Agenda for Change and the Very Senior Manager guidance from regulators and against benchmark comparators.

The Code of Governance for NHS providers submits that the Board of Directors should not agree to a full-time Executive Director taking on more than one Non-Executive Directorship of an NHS Foundation Trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation. The Declarations of

Interest Register highlights those occupying Trustee/Non-Executive roles outside the organisation for which none were remunerated in 2024/25.

Non-Executive Directors' Remuneration

The remuneration for Non-Executive Directors has been determined by the Council of Governors following recommendations from its Nominations and Remuneration Committee and is set at a level to recognise the significant responsibilities of Non-Executive Directors in Foundation Trusts, and to attract individuals with the necessary experience and ability to make an important contribution to the Trust's affairs.

They each have terms of no more than three years and are able to serve two consecutive terms dependent on formal assessment, confirmation of satisfactory on-going performance and the needs of the organisation. The Council of Governors is mindful of the need to ensure independence and progressive refreshing of the Board and consider this when making decisions concerning reappointments. A third term of three years may be served, subject to ongoing assessment of independence and positive appraisals and a broader review considering the needs of the Board and the Trust and the ongoing independence of the individual under consideration. The maximum period of office of any Non-Executive Director shall not exceed nine years.

The Non-Executive Directors' Remuneration, as agreed by the Council of Governors, is consistent with best practice and external benchmarking, and remuneration over 2024/25 has been consistent with that framework. The annual standard rate (excluding supplementary payments) of existing Non-Executive Directors was consistent with issued guidance. Over 2024/25 the Trust's council of governors awarded the Non-Executive Directors and Chair a 5% inflationary increase.

All trusts also have local discretion to award limited supplementary payments depending on organisational size in recognition of designated extra responsibilities. Foundation trusts are expected to explain their rationale for divergence from the recommended structure. The responsibility allowance (for chairing Board committees/ extra responsibilities) will not be increased during the tenure of existing Non-Executive Directors while the guidance sets the responsibility allowance at £2,000 given that currently the payment received by those who joined the Trust prior to 2021/22 is £3169.

The disparity between the current payment and that in the guidance (to be phased over several years) is to ensure that no Director receives a reduction in their remuneration. Current Non-Executive Directors' total remuneration (regarding the £2,000 responsibility cap) will not reduce until their terms at the Trust expire. New appointments or new responsibilities attracting payments will be in accordance with the guidance. While the guidance limits the number of Non-Executives in receipt of such an allowance, in recognition of the responsibilities involved in chairing the committees of the Board all chairs - excluding the Mental Health and Law and Charity Committees, receive the allowance.

None of the Non-Executive Directors are employees of the Trust; they receive no benefits or entitlements other than fees and are not entitled to any termination payments. The entire Council of Governors determine the Terms and Conditions of the Non-Executive Directors. The Trust does not make any contribution to the pension arrangements of Non-Executive Directors. Fees reflect individual responsibilities

including as stated, higher rates for chairing the core committees of the Board, with all Non-Executive Directors otherwise subject to the same terms and conditions.

Annual Report on Remuneration

Termination Payments

Notice periods under senior managers' contracts are determined and agreed taking into consideration the need to protect the Trust from extended vacancies on the one hand and the needs of the employee and financial risks to the Trust on the other. The maximum notice period is six months.

Payments to senior managers for loss of office are governed by and compliant with the NHS standard conditions and regulations; where relevant, payments are submitted to NHS England for Treasury approval. All payments made in the period to any senior manager for loss of office are outlined in the tables detailing Staff Exit Packages below.

Fair Pay Disclosures

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

The banded remuneration of the highest-paid director in the organisation in the financial year 2024/25 was £235,000 to £240,000 (2023-24 £190,000 to £195,000). This is a change between years of 21.2%.

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

For employees of the Trust as a whole (excluding the highest paid director), the range of remuneration in 2024/25 was from £209,368 to £23,615 (2023/24 £201,395 to £22,383). The percentage change in average employee remuneration (based on the total for all employees on an annualised basis divided by the full-time equivalent number of employees, excluding agency staff) between years is 7.3% (2023/24 5.51%).

No employees received remuneration in excess of the highest-paid director in 2024/25 (two in 2023/24).

The relationship between the remuneration of the highest paid director against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce are set out below and also show the pay ratio 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.

2024/25	**25th percentile**	**Median**	**75th percentile**
Staff remuneration by percentile	£26,530	£36,485	£48,225
Remuneration pay ratio with the highest paid director	10:1	7:1	6:1

Staff salary by percentile	£26,530	£36,485	£48,225
Staff pay ratio with the highest paid director	9:1	6:1	5:1

2023/24	**25th percentile**	**Median**	**75th percentile**
Staff remuneration by percentile	£25,147	£34,588	£45,987
Remuneration pay ratio with the highest paid director	10:1	7:1	5:1
Staff salary by percentile	£25,147	£34,588	£45,987
Staff pay ratio with the highest paid director	8:1	6:1	4:1

To achieve its goals, the Trust must attract and retain high calibre and experienced members of the Executive Team to ensure the Trust is best positioned to succeed. As referenced within this Remuneration Report, the Trust applies the principles of the Code of Governance and NHS guidance on remuneration, in addition to a regular review of available benchmark information, and consideration of pay and conditions across the wider Trust and the associated pay increases each year.

The Governors' Nomination and Remuneration Committee includes Staff Governor representation in addition to patient, carer and partner governors, and the Committee is consulted prior to recommendations to the Council with regard to any changes in Non-Executive Director remuneration.

The Non-Executive Directors' Nominations, Remuneration and Terms of Service Committee is satisfied that it has taken appropriate steps to ensure where any senior manager is paid more than £150,000, that the level of remuneration is reasonable and proportionate, including benchmarking of job content, responsibility and salary across similar sized organisations. There are currently four senior managers who have been paid above this level for more than three years and there have been no additions to this group in 2024/25.

Expenses

There were 21 directors who served in office during the financial year 2024/25 (2023/24, 22), of which, 13 (2023/24, 12) received expenses with a total value of £7,090 (2023/24, £7,473).

During 2024/25, the Trust had 36 governor seats available (2023/24, 36). Full details of the governors in post through the year can be found in the Council of Governors report of this Annual Report. While the role is voluntary, governors are entitled to claim reasonable expenses. In 2024/25, two governors (2023/24, two) expenses were reimbursed for £266.20 (total value of £336, 2023/24).

Salaries and Allowances

Details of Executive Directors' remuneration and pension benefits and Non-Executive Directors' remuneration are set out in the tables available next. Remuneration, cash

equivalent transfer values (CETV), exit packages, staff costs and staff numbers are all subject to audit.

Salaries and allowances 2024/25								
Name	**Title**	**Effective dates if not in post full year**	**Salary (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (rounded to nearest £00)**	**Total salary and other remuneration (bands of £5,000)***	**Pension-related benefits (bands of £2,500)****	**Total including pension-related benefits (bands of £5,000)**
			£000	**£000**	**£00**	**£000**	**£000**	**£000**
Grant Macdonald	Chief Executive (Appointed substantive Chief Executive in November 2024)		215-220	0-5	0	215-220	0	215-220
Dr Karl Marlowe	Chief Medical Officer		140-145	90-95	0	230-235	97.5-100	330-335
Kerry Rogers	Director of Corporate Affairs and Company Secretary	To 03/05/2024	10-15	0-5	0	10-15	0-2.5	10-15
Britta Klinck	Chief Nurse		145-150	0-5	0	145-150	280-282.5	425-430
Dr Ben Riley	Executive Managing Director – Primary, Community and Dental Care	To 28/02/2025	135-140	0-5	0	135-140	165-167.5	300-305
Charmaine De Souza	Chief People Officer		145-150	0-5	0	145-150	37.5-40.0	185-190
Heather Smith	Chief Finance Officer		170-175	0-5	0	170-175	42.5-45.0	215-220

Amelie Bages	Executive Director of Strategy		115-120	0-5	0	115-120	40.0-42.5	160-165
Rob Bale	Interim Executive Managing Director for Mental Health and Learning Disabilities		140-145	95-100	0	235-240	32.5-35.0	270-275
Taff Gidi	Executive Director of Corporate Affairs	From 17/02/2025	15-20	0-5	0	15-20	45.0-47.5	60-65
Emma Leaver	Interim Chief Operating Officer for Community Health, Dentistry & Primary Care	From 01/03/2025	10-15	0-5	0	10-15	25.0-27.5	35-40
Georgia Denegri ***	Interim Associate Director of Corporate Affairs	To 05/03/2025	150-155	0-5	0	150-155	0	150-155
David Walker	Chairman		55-60	0-5	0	55-60	0	55-60
Chris Hurst	Non-Executive Director		15-20	0-5	0	15-20	0	15-20
Lucy Weston	Non-Executive Director		15-20	0-5	0	15-20	0	15-20
Mohinder Sawhney	Non-Executive Director		15-20	0-5	0	15-20	0	15-20
Sir Philip Rutnam	Non-Executive Director	To 30/09/2024	5-10	0-5	0	5-10	0	5-10
Andrea Young	Non-Executive Director		15-20	0-5	0	15-20	0	15-20
Geraldine Cumberbatch	Non-Executive Director		10-15	0-5	0	10-15	0	10-15

Professor Sir Rick Trainor	Non-Executive Director		10-15	0-5	0	10-15	0	10-15
Professor David Clark	Non-Executive Director	To 01/01/2025	10-15	0-5	0	10-15	0	10-15

**Total salary and other remuneration' include salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.*

***The 'pension-related benefits' presented in the table above represent the annual increase in pension entitlement determined in accordance with the 'HMRC' method. This is calculated as the inflation adjusted in year movement in the lump sum plus the movement in twenty times the annual rate of pension payable to the Director if they became entitled to it at the end of the financial year. The 'HMRC' method used above differs from the real increase/(decrease) in cash equivalent transfer value presented in the pension benefits disclosure available later in the report.*

**** Georgia Denegri was an interim member of staff, the figure shows salary only and does not include agency rate (20%) or VAT*

Salaries and allowances 2023/24								
Name	**Title**	**Effective dates if not in post full year**	**Salary (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Benefits in kind (rounded to nearest £00)**	**Total salary and other remuneration (bands of £5,000)***	**Pension-related benefits (bands of £2,500)****	**Total including pension-related benefits (bands of £5,000)**
			£000	**£000**	**£00**	**£000**	**£000**	**£000**
Dr Nick Broughton	Chief Executive	01/04/2023 to 30/06/2023	60-65	5-10	0	65-70	0	65-70

Grant Macdonald	Chief Executive (Formerly Managing Director of Mental Health and Learning Disabilities)	From 01/07/2023	180-185	0	0	180-185	0	180-185
Dr Karl Marlowe	Chief Medical Officer		125-130	100-105	0	225-230	5.0-7.5	230-235
Kerry Rogers***	Director of Corporate Affairs and Company Secretary		130-135	0	0	130-135	0	130-135
Marie Crofts	Chief Nurse	To 08/12/23	105-110	40-45	0	150-155	0	150-155
Britta Klinck	Chief Nurse	From 08/12/23	45-50	0		45-50	0	45-50
Dr Ben Riley***	Executive Managing Director – Primary, Community and Dental Care		140-145	0	0	140-145	0	140-145
Charmaine De Souza	Director of Human Resources		135-140	0	0	135-140	32.5-35.0	170-175
Heather Smith	Chief Finance Officer		155-160	0	0	155-160	37.5-40.0	190-195
Amelie Bages	Director of Strategy and Partnerships		135-140	0	0	135-140	32.5-35.0	170-175
Rob Bale	Executive Managing Director for Mental Health and Learning Disabilities	From 01/10/23	60-65	50-55	0	115-120	0	115-120
David Walker	Chairman		55-60	0-5	0	55-60	0	55-60
Chris Hurst	Non-Executive Director		15-20	0	0	15-20	0	15-20

Lucy Weston	Non-Executive Director		15-20	0	0	15-20	0	15-20
Mohinder Sawhney	Non-Executive Director		15-20	0	0	15-20	0	15-20
Kia Nobre	Non-Executive Director		0-5	0	0	0-5	0	0-5
Sir Philip Rutnam	Non-Executive Director		15-20	0	0	15-20	0	15-20
Andrea Young	Non-Executive Director		15-20	0	0	15-20	0	15-20
Geraldine Cumberbatch	Non-Executive Director		10-15	0	0	10-15	0	10-15
Professor Sir Rick Trainor	Non-Executive Director		10-15	0	0	10-15	0	10-15
Professor David Clark	Non-Executive Director		10-15	0	0	10-15	0	10-15

**Total salary and other remuneration' include salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.*

***The 'pension-related benefits' presented in the table above represent the annual increase in pension entitlement determined in accordance with the 'HMRC' method. This is calculated as the inflation adjusted in year movement in the lump sum plus the movement in twenty times the annual rate of pension payable to the Director if they became entitled to it at the end of the financial year. The 'HMRC' method used above differs from the real increase/(decrease) in cash equivalent transfer value presented in the pension benefits disclosure available later in the report.*

**** Executive directors affected by the Public Service Pensions Remedy. Their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero."*

Pension benefits 2024/25								
Name, Title	Real increase/ (decrease) in pension at pension age (bands of £2,500)	Real increase/ (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31/03/2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31/03/2025 (bands of £5,000)	Cash equivalent transfer value at 01/04/2024	Real increase/ (decrease) in cash equivalent transfer value	Cash equivalent transfer value at 31/03/2025	Employer's contribution to stakeholder pension
	£'000	***£'000***	***£'000***	***£'000***	***£'000***	***£'000***	***£'000***	***£'000***
Grant Macdonald, Chief Executive	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Kerry Rogers, Director of Corporate Affairs and Company Secretary (to May 2024)	0.0-2.5	0.0-2.5	30-35	80-85	808	0	782	n/a
Britta Klinck, Chief Nurse	12.5-15.0	30.0-32.5	45-50	115-120	754	298	1,070	n/a
Dr Ben Riley, Executive Managing Director – Primary, Community and Dental Care (to Feb 2025)	7.5-10.0	0.0-2.5	25-30	20-25	290	103	421	n/a
Dr Karl Marlowe, Chief Medical Officer	5.0-7.5	0.0-2.5	60-65	160-165	1,373	0	1302	n/a
Charmaine De Souza, Chief People Officer	2.5-5.0	n/a	10-15	n/a	106	26	151	n/a

Heather Smith – Chief Finance Officer	2.5-5.0	n/a	5-10	n/a	77	25	124	n/a
Amelie Bages	2.5-5.0	n/a	20-25	n/a	193	20	227	n/a
Taff Gidi (from Feb 2025)	0.0-2.5	n/a	15-20	n/a	183	2	215	n/a
Emma Leaver (from Mar 2025)	0.0-2.5	0.0-2.5	50-55	135-140	1,171	3	1,221	n/a

Notes: The benefits and related cash equivalent transfer values (CETVs) reflect the Public Service Pensions Remedy. Membership for applicable Executives between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.

Contract Type and Notice Period

Name	Start Date as Senior Manager	Contract Type	Notice Period by Employee	Notice Period by Employer
Nick Broughton	15/06/2020	Permanent	6 months	6 months
Kerry Rogers	01/09/2015	Permanent	6 months	6 months
Charmaine De Souza	04/10/2021	Permanent	6 months	6 months
Grant Macdonald	21/03/2022	Permanent	6 months	6 months
Karl Marlowe	10/05/2021	Permanent	6 months	6 months
Ben Riley	02/04/2020	Permanent	6 months	6 months
Amélie Bages	25/04/2022	Permanent	6 months	6 months
Heather Smith	11/07/2022	Permanent	6 months	6 months
Rob Bale *	01/10/2023	Permanent	6 months	6 months
Taff Gidi	17/02/2025	Permanent	6 months	6 months
Emma Leaver**	01/03/2025	Permanent	6 months	6 months
Britta Klink	18/12/2023	Permanent	6 months	6 months

Notes: No senior manager has a contract of employment with a notice period greater than six months.

**Rob Bale has a permanent contract of employment with the Trust and has been acting up to the role of Interim Managing Director for Mental Health and Learning Disabilities since 1 October 2023.*

***Emma Leaver has a permanent contract of employment with the Trust and has been acting up to the role of Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care since 1 March 2025.*

Analysis of Staff Costs

			2024/25	2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	270,708	13,174	283,882	247,925
Social security costs	27,910	1,284	29,193	26,613
Apprenticeship levy	1,379	-	1,379	1,265
Employer's contributions to NHS pension scheme	57,861	1,804	59,665	45,188
Pension cost – other	-	41	41	62

Temporary staff	-	45,950	45,950	57,892
Total gross staff costs	357,875	62,235	420,110	378,946
Recoveries in respect of seconded staff	(2,312)	-	(2,312)	(2,096)
Total staff costs	355,564	62,235	417,798	376,850
Of which				
Costs capitalised as part of assets	-	-	-	499

Analysis of Average Staff Numbers (WTE Basis)

			2024/25	2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	347	39	386	351
Administration and estates	1,496	62	1,559	1,518
Healthcare assistants and other support staff	1,163	311	1,474	1,500
Nursing, midwifery and health visiting staff	1,562	267	1,829	1,718
Nursing, midwifery and health visiting learners	28	-	28	37
Scientific, therapeutic and technical staff	1,444	67	1,511	1,380
Social care staff	192	4	196	174
Total average numbers	6,232	751	6,983	6,678

**WTE - Whole Time Equivalent. WTE shown is an average throughout the year*

Exit Packages

Reporting of Compensation Schemes - Exit Packages 2024/25

	Number of Compulsory redundancies *	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000 *		12	12
£10,000 - £25,000	1	3	4
£25,001 - £50,000	1		1
£50,001 - £100,000			
£100,001 - £150,000			
£150,001 - £200,000			
>£200,000			
Total number of exit packages by type	2	15	17
Total cost (£)	£61,000	£88,000	£149,000

**contractual compulsory redundancy*

Reporting of Compensation Schemes - Exit Packages 2023/24

	Number of compulsory redundancies	Number of other departures agreed [Restated]**	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000 *	1	12	13
£10,000 - £25,000	-	1	1
£25,001 - £50,000	1	1	2
£50,001 - £100,000	1	-	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit	3	14	17

Total cost (£)	£90,000	£99,000	£189,000

**contractual compulsory redundancy*

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. 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 in the table. This disclosure reports the number and value of exit packages taken by staff leaving in the year.

Exit packages: other (non-compulsory) departure payments

	2024/25		2023/24	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**Total value of agreements**
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	14	76	14	99
Secondment paid by Trust	-	-	-	-
Exit payments following Employment Tribunals or court orders	1	12	-	-
Non-contractual payments requiring HMT approval	-	-	-	-

Total	15	88	14	99
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number above will not necessarily match the total number in the exit packages note which will be the number of individuals.

Service Contracts Obligations

There are no obligations contained within senior managers' service contracts that could give rise to or impact upon remuneration payments which are not disclosed elsewhere in the remuneration report.

Remuneration Report

Signed: **Date: 25 June 2025**

Grant Macdonald

Chief Executive and Accounting Officer

Accountability Report

Signed: **Date: 25 June 2025**

Grant Macdonald

Chief Executive and Accounting Officer

Staff Report

Introduction

2024/25 has seen several improvements in relation to workforce and people metrics. Building on work already done in recent years to embed corporate induction, secure annual appraisals compliance, and implement accurate matrices for staff to access statutory and mandatory training, the focus for 2024/25 has been a programme of work to further reduce agency spending and new ways of attracting talent to the Trust.

In relation to agency costs, service directorates and the central temporary staffing team worked closely in partnership to improve controls, implement a 'Bank First' approach, create incentives for agency staff to join OHFT substantively and bring down unit costs. To do this the Trust worked in partnership with the South East Temporary Staffing Collaboratives resulting in a significant reduction in agency spend of £11.6m across both the Agenda for Change and Medical workforces.

Coupled with this there has been an ongoing focus to innovate how we attract new joiners to the Trust. This work has been led by the resourcing team who have delivered roadshows targeted at the local workforce. Vacancy rates have fallen as we have attracted new staff and retention rates have also improved considerably. The improvement in the overall NHS Staff Survey Results for the Trust in 2024 provides a initial indication that we are attracting, retaining, and providing a positive staff experience.

Analysis of staff costs

An analysis of average staff numbers is available in the remuneration report section of this annual report.

Analysis of average staff numbers

At 31 March 2025, the Trust employed 7,507 staff with a contracted whole time equivalent (WTE) of 6,672. The following table shows the breakdown of the Trust's workforce based upon NHS staff groups. This is the average WTE of employee headcount (HC) contracted throughout the year split by permanent employees and other staff (in separate table).

The latter includes employees on short-term contracts of employment, bank and agency workers (agency WTE in separate table), and inwards secondments of staff where they are recorded on the Trust's electronic staff record (ESR) system.

Staff Group	Permanent 12m Avg. WTE	%
Additional Professional Scientific and Technical	944.77	14.16%
Additional Clinical Services	1576.53	23.63%
Administrative and Clerical	1450.16	21.73%
Allied Health Professionals	427.49	6.41%

Estates and Ancillary	219.52	3.29%
Medical and Dental	365.92	5.48%
Nursing and Midwifery Registered	1677.94	25.15%
Students	10.00	0.15%
Grand Total	**6672.33**	**100.00%**

Other staff includes employees on short-term contracts of employment, bank and agency workers and inwards secondments of staff where they are recorded on the Trust's electronic staff record system. The table below shows WTE for all cost centres.

Role Group	OTHER 12m Avg WTE	12m Avg WTE %
Support to Clinical Staff (Bank & Overtime)	229.91	16.13%
Qualified Nursing - Registered (Bank & Overtime)	133.33	9.36%
Admin & Estates (Bank & Overtime)	54.27	3.81%
Other	53.10	3.73%
Hotel Property & Estates	32.60	2.29%
ST&T (Bank & Overtime)	13.98	0.98%
AHPs (Bank & Overtime)	7.88	0.55%
Qualified Nursing - HV,DN SHN (Bank & Overtime)	1.68	0.12%
Admin & Estates	94.01	6.60%
Admin & Estates (Agency)	2.89	0.20%
Managers and Infrastructure Support (Agency)	0.00	0.00%
Managers and Senior Managers	21.98	1.54%
AHPs (Agency)	7.61	0.53%
Medics - Career /Staff Grade	16.84	1.18%
AHPs	10.85	0.76%
Qualified Nursing - HV,DN SHN	4.92	0.35%
Qualified Nursing - Registered	26.23	1.84%
Medics - Career /Staff Grade (Locum)	1.58	0.11%
Qualified Nursing - Registered (Agency)	108.19	7.59%
Medics – Consultants	2.62	0.18%
ST&T	43.17	3.03%
ST&T (Agency)	5.17	0.36%
Support to Clinical staff	6.93	0.49%
Medics - Consultants (Locum)	32.39	2.27%
Support to Clinical Staff (Agency)	60.04	4.21%
Support to ST&T incl AHP	269.30	18.90%
Support to Doctors & Nursing	33.84	2.37%
Medics - Other Substantive	1.37	0.10%
Medics - Training Grades	139.18	9.77%

Medics - Other Non Substantive	9.21	0.65%
Grand Total	**1425.08**	**100.00%**

Gender breakdown

As of 31 March 2025, the breakdown of male and female staff was as set out below. This data is taken from the Trust's electronic staff record (ESR) which currently has only the capacity to record male and female characteristics at birth and not other gender identities. Respondents do have the choice of not declaring either.

- Board directors (executive and non-executive, voting and non-voting) – 7 male and 9 female;
- Other senior managers – 18 male and 29 female;
- Employees (excluding the above) – 1,427 male and 6,002 female.

Sickness absence data

In November 2024 the Trust moved away from an external absence management system to managing absence internally. Considerable planning and training went into ensuring that the changeover was successful and that prompts for line managers and guidance for reporting of absence continued to be clearly accessible.

Throughout 2024/25 there has been a continued focus on proactively supporting line managers to use the Sickness absence policy and processes. A focus has also continued to ensure return to work interviews are taking place after every absence. There has been an emphasis on communicating the benefits of conducting return to work interviews and supporting staff returning to work particularly after a long period of absence.

Occupational Health continue to support and advise staff members and line managers in assisting staff back into work. A new Occupational Health system was introduced in January 2025 providing a more automated process of line managers making referrals for their staff members.

Work is undertaken monthly to identify services with higher volumes of absence and to understand the drivers for this, including HR reports into operational meetings identifying higher areas of absence and reasons for absence. Analysis of data is undertaken and direct contact made with line managers to provide advice on applying the Trust Sickness absence policy. There is also additional guidance, training and support for managers on the management of absence.

During 2024/25, overall sickness absence increased by 0.3% (from March 2024). The top three reasons for sickness absence in 2024/25 based on hours lost were: anxiety/stress, cold/cough/flu symptoms and other musculoskeletal. Sickness absence figures for 2024/25 are shown in the table below.

	2024/25	2023/24
Total days lost in period (sick FTE)	106,148	97,744
12m Average Staff in Post (headcount)	7,219	6,704
12m Avg WTE in post	6,406	5,930
Average working days lost (WTE)	16.57	16.48

Gender pay gap

Gender Pay Gap reporting is a requirement under the Equality Act 2010 and is based on data from the previous year. The Gender Pay Gap is the difference between the average pay of men and women in an organisation. The Trust's Gender Pay Gap Report 2024/25 shows that the mean gender pay gap is 20.5% in favour of men, and that the median gender pay gap is 5.8% in favour of men.

The Trust is committed to continuously reviewing its systems, practices and processes to ensure that it is reducing the Gender Pay Gap where practically possible and will work closely with relevant stakeholders to develop a Gender Equality Work Programme that will address the gender pay gap effectively. Oxford Health's information on Gender Pay Gap can be found at the Trust's page on the Cabinet Office's website by searching online for '*Cabinet Office Gender Pay Gap Oxford Health 2024/25*'.

Staff policies

The development of Trust policies relating to workforce reflect best practice and legislative requirements. There is a robust process of review in partnership with Trade Union colleagues, management representatives and HR professionals.

During 2024/25, progress was been made in reviewing key HR policies with a full suite of HR policies being reviewed to confirm their ongoing compliance with legislation. Notably, a revised disciplinary procedure, reframed as 'promoting respect, civility and resolution', and based within the principles of a restorative, just and learning framework, was launched, and will be accompanied by a revised grievance procedure, focused on resolution. These policy changes are a key to the Trust's goal of embedding a just and restorative learning culture.

The Trust's approach to employee relations is informed by organisational workforce policies and supported by trained HR professionals and managers, in partnership with Trade Union colleagues.

For countering fraud and corruption, the Trust has in place a Code of Conduct and Freedom to Speak Up and whistleblowing procedures and guidance as well as a Counter Fraud function. See the following section for information relating to equality, diversity and inclusion policies.

Diversity and inclusion policies and initiatives

The Trust has been extensively using the NHSE Equality, Diversity & Inclusion (EDI) Improvement Plan to develop its equalities work. Against the 18 elements of the NHS England high impact actions (HIAs), 14 are complete and 4 remain in progress. Progress is tracked by the Trust's EDI Steering Group and escalated as necessary to the People, Leadership and Culture (PLC) Committee. Achievements over 2024/25 have included:

- Inclusion of EDI objectives in Board and Executive Team members' annual appraisals;
- Regular use of organisational data and staff feedback to drive EDI improvements;
- Board-level oversight and risk monitoring for EDI through the People, Leadership and Culture Committee;
- Steps taken to eliminate gender and ethnicity pay gaps, including implementing NHS 'Mend the Gap' recommendations;
- Efforts to address workforce health inequalities through wellbeing conversations and manager support'
- Promotion of a culture of speaking up and raising concerns;
- Provision of comprehensive psychological and well-being support for staff.

Staff turnover and retention

Staff turnover for the year 2024/25 was 10.56%, against a target of 14%. In 2023/24 a new Retention team was created within the Organisational Development team. This team has continued to lead change programmes to support the Trust to deliver retention initiatives, including a project focused on new starter experience and a number of initiatives focused on the retention of specific staff groups. Workstreams included: a new induction checklist to support managers with new staff in their teams; development of a Healthcare worker champion role and network group; a celebratory event for Healthcare workers, held in November 2024

The Trust qualified for Cohort 2 of the National NHS England Retention Programme and recruited a 'People Promise Manager' to drive turnover and retention work. This work has included a number of initiatives:

- creation of dedicated intranet pages on the People Promise elements;
- creation of 'People Promise in action' bite-size videos, launched on Employee Appreciation Day;
- continued work on Flexible Working, launch of a Flex intranet, improving awareness of the options that are being accessed and that are available; and
- promoting how flexible working can support gender equality for an International Women's Day Event.

Freedom to Speak Up

Oxford Health has in place a fully implemented Freedom to Speak Up programme. The Trust has a Freedom to Speak Up (FTSU) Policy and two FTSU Guardians following the guidance and remit of the National Guardian's Office who contribute to meeting the key objectives set out by the People Promise and the delivery of the Trust's strategic objectives. The Guardians report to the Chief People Officer and report quarterly and annually to the Board of Directors.

The FTSU Guardians have worked with senior leaders at Board level to assess FTSU arrangements and completed the board Self-Assessment Tool for the Trust. A further board assessment will take place in Spring 2025 which will form a new two-year programme of work which will be developed by the Guardians and approved by the Board. We have successfully embedded the new FTSU policy and launched the Detriment guidance in line with National Guardians office. FTSU e-learning modules (Speak up, Listen Up and Follow up) are now essential on staff training matrices to support positive speak up culture change and help to tackle barriers such as futility and incivility. Since launched in 2024, 92% of staff have completed the Speak up module and there has also seen an increase in completion rates for Listen up and follow up.

Overall, the National staff survey results show a positive trend in speaking up. Staff feel able to speak up and that their concerns would be addressed. There is an increase in the category Oxford health would address concerns raised 61.7% and this is above the national average of 52.5%. In addition, Freedom to Speak Up questions in the pulse survey has allowed benchmarking comparisons with January 2024 highlighting improvements of between 1-7% in 4 out of the 5 questions, staff feel able to speak up and that action would be taken as a result. Guardians will use the results to identify gaps and work with directors for further improvement.

During this reporting period, 307 cases were raised with the FTSU Guardians. This is compared to 290 cases raised the previous year, showing a minor increase in the volume of cases raised. This trend is observed for the last few years whereby the number of cases continue to rise year over year. This is a direct result of increase in Guardians capacity and proactive work that they carry out trust wide.

Registered Nurses and clinical staff are the Trust's highest reporting group, indicating the issues coming from clinical areas, not necessarily about patient safety but rather worker safety elements and quality of care. 77% of cases raised contained elements of worker safety or wellbeing and this consistently remains the highest thematic issue raised via reporting to the Guardians. '*Other inappropriate attitudes or behaviours*' (28.6%) is the second most common category of concerns raised, followed by *patient safety* (18%). Guardians are now also collecting and analysing data on those who seek support by protected characteristics. 82% of concerns are raised by female staff, 64% are white, 25% are Black and Minority Ethnic. This is in proportion with the Trust's overall workforce.

Throughout the year, the Guardians have continued to work proactively to empower staff to create and promote a positive speak up culture. Speak Up month in October 2024 focused on the power of listening and the importance of staff being listened to and action taken as a result. based on the imminent board assessment the guardians will be formulated two year programme to support the trusts key priorities.

Staff engagement and Staff survey results

Staff engagement remains a priority for Oxford Health, the Trust recognising that organisations that have higher levels of staff engagement are in stronger positions to deliver quality patient care. Staff engagement enables the Trust to deliver higher quality services, achieve financial plans and support future organisational change and transformation programmes. Oxford Health's approach to staff engagement includes measuring staff engagement, satisfaction and experience of work through the methods set out in the following paragraphs.

National quarterly pulse survey

This much shorter survey is undertaken electronically in January, April and July. It provides an opportunity for colleagues to share their feedback at more regular times throughout the year as opposed to a one-off survey. The response rate for this engagement method is lower than the national staff survey. While this is not unique to the Trust, the Communications Team has developed a trust-wide plan to increase engagement with the pulse survey.

Local engagement

As well as national methods of engagement, the Trust also provides opportunities for staff to have their say through fortnightly online Leadership / Team Briefings, monthly Open Door Executive Team sessions, and local less formal listening events run by directorate senior management teams – these events enable staff to discuss local challenges they are facing and often lead to early and swift solutions being found.

2024/25 NHS Staff Survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions have aligned to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. These replaced the ten indicator themes used in 2020/21 and earlier years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2024/25 survey among Trust staff was 53.2% which equates to 3,667 respondents. Results are also shared through the Directorate Senior Management Teams and discussed at the Trust's Equality Network Groups. Results are reported to the Trust Executive and relevant board committees. Managers and teams are able to access 1:1 coaching and supported in identifying areas they might take action upon.

Scores for each indicator together with that of the survey benchmarking group Mental Health, Learning Disability and Mental Health, Learning Disability and Community Trusts (comparison is to the average score for this group) are presented below.

Indicators ('People Promise' elements and themes)	**2024/2025**		**2023/2024**		**2022/2023**	
	Trust Score	Bench-marking group score	Trust Score	Bench-marking group score	Trust Score	Bench-marking group score
We are Compassionate & Inclusive	7.75	7.55	7.72	7.58	7.6	7.5
We are recognised and rewarded	6.52	6.35	6.52	6.41	6.3	6.3
We each have a voice that counts	7.09	6.94	7.08	7.01	7.0	7.0
We are safe and healthy	6.42	6.40	6.38	6.38	6.2	6.2
We are always learning	6.1	5.93	6.00	5.93	5.5	5.7
We work flexibly	6.83	6.83	6.75	6.84	6.5	6.7
We are a team	7.27	7.15	7.22	7.18	7.1	7.1
Staff Engagement	7.24	7.07	7.19	7.11	7.1	7.0
Morale	6.26	6.0	6.16	6.17	5.9	6.0

The Trust scores increased compared with 2023/24 on all reported People Promise Indicators. The Trust is also currently ranked above the benchmarked average in 7 out of the 8 published indicators. The 'We work flexibly' element is equal to the benchmark average, however we have seen an improvement over the past three years. Over 2025/26, the Trust will also continue its improvement journey and focus on workforce priorities:

- Developing and empowering our people and teams so we can ensure that decisions are made by teams of people working at the closest possible point to our patients and carers and better address their needs;
- Developing our approach to becoming an anti-discriminatory organisation improving equality, diversity and inclusion to improve the experience of our staff and teams and the experience and outcomes of our patients, families and carers;
- Enhancing staff safety & minimising violence and aggression to ensure colleagues feel supported, safe and secure at work and can operate at their best to support patients, families and carers.

The above, alongside ongoing work from the Wellbeing and Equality, Diversity & Inclusion Team, continue to support staff with their wellbeing at work through staff networks and support groups and a dedicated wellbeing offer including physical, spiritual and psychological resources.

Health & Safety

The Trust is supported by a SEQOHS (Safe, Effective, Quality Occupational Health Service) accredited Occupational Health team. The team has a pivotal role in helping to create these environments for healthier employees by:

- Continuing to provide independent advice when staff health (psychological and/or physical) results in short or longer-term absence or it impacts their ability to fulfil their roles and activities. The Occupational Health team will promote proactive approaches aimed at improved lifestyle and general wellbeing;
- Protecting employees from risks identified by the employer through statutory health surveillance, new starter and periodic fitness work assessments and immunisation programmes. Risks have been highlighted to the Trust when identified to ensure appropriate mitigation. Improvements to new starter immunisation compliance are being developed with partners within the Trust;
- Advising the Trust, employees and managers on the assessment and management of risks including compliance with regard to health and safety regulations, where employees' fitness for work and their health may be of concern in line with current UK and European legislation and best practice;
- Offering interventions to support rehabilitation such as physiotherapy and psychological support in cases of work-related injuries and trauma.
- Contributing to policy development, review, and implementation throughout the Trust; and

- Working closely in partnership with the wider organisational development, infection prevention and control, health and safety and HR teams.

The Trust recognises the importance of ensuring the health, safety and wellbeing of its patients, visitors, employees, and contractors as enshrined within the NHS Constitution and statutory legislation. It strives to provide to all who use our facilities a healthy and safe environment where all practicable steps are taken to ensure the workplace is free from verbal or physical violence from patients, the public or staff. The Trust continues to grow and enhance the Health, Safety, Fire and Security team to support the Trust in all areas, which includes:

- Liaison with relevant areas to support communication around roles and responsibilities relating to stress management across all disciplines in the Trust;
- Regular review and update of relevant Health, Safety, Fire and Security policies and procedures;
- Continuing to develop a wider Lone Working management approach which will assist the Trust to mitigate Lone Working risks; and
- Work with Estates colleagues to reduce health, safety, security, and fire risks;

The team will continue to offer both a proactive as well as reactive safety service provision and advice, through working in collaboration with the multidisciplinary teams to ensure and maintain a safe and secure work environment.

Trade union facility time

The Trust's Staff Partnership, Negotiation and Consultation Committee (SPNCC) exists to promote understanding and co-operation between management and staff in the planning and operation of Trust services. It provides a regular forum for consultation and negotiation between management and staff on strategic decisions (principally those that may have staffing implications) and operational decisions. The Joint Local Negotiating Committee provides a forum for consultation and negotiation specifically with our medical and dental staff groups.

Sub-committees of SPNCC (HR Policy Group, and the Organisational Change Group) focus on the ongoing development of the Trust's HR policy framework, and individual proposals of organisational change. The SPNCC provides one of the formal channels of communication between management and recognised Trade Unions on Trust issues.

The SPNCC agenda is co-created, and the chair of the committee rotates between staff side and management. Details on the number of union officials and facility time and costs are provided in the tables below.

Relevant union officials	Number
Number of employees who were relevant union officials during the relevant period	11

Full-time equivalent employee number	8.5

Percentage of time spent on facility time	Number of employees
0%	0
1-50%	9
51%-99%	1
100%	1

Percentage of pay bill spent on facility time	Figures
Provide the total cost of facility time	£71,351
Provide the total pay bill	£417,981,717
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Paid Trade Union activities	%
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	2.00%

Expenditure of consultancy

Trust expenditure on consultancy in 2024/25 was £0.5m (2023/24 £1.24m). This included the following suppliers and contractors over a spend of £10k – Hunter Healthcare Resourcing, Realm IT Partners, KPMG, Venn Group, CapGemini UK, RSK Environment, Cherwell Consulting Ltd, Ethical Healthcare Ltd, Dionach Limited, Arrimo Limited, Kevin Murray Associates and other contractors engaged in the Warneford site development.

Off payroll engagements

There were no off payroll engagements over the reporting period.

Exit packages

Details on exit packages are covered in the Remuneration Report.

Charity and volunteering

The Trust's Charity and Involvement team The Trust's Charity and Involvement team have continued to provide support to enhance the experience of patients, carers and staff throughout 2024/25 through volunteering, the Oxford Health Charity (OHC), the Oxford Health Arts Partnership, and informal community group engagement for the Trust.

Oxford Health Charity

The Oxford Health Charity (OHC) has continued to provide valuable funding support to teams across the Trust, thanks to the generous donations, fundraising efforts, grants, and legacies received. The charity is working towards the 2023-2028 strategy, focusing on the development of 'Positive Spaces.' These spaces aim to increase meaningful impact, engagement, and support for innovation. 'Positive Spaces' encompass both physical areas like gardens, rooms, and buildings, as well as mental spaces dedicated to wellbeing, innovation, research, and development.

Highlights from the year include further development of our fundraising events calendar, which saw the highest number of participants for the Oxford Half marathon and the introduction of several Brush Party events across Oxfordshire. As well as the official opening of Lucy's Room, our new onsite music room for adult mental health patients at the Warneford Hospital, which is now fully equipped with outdoor and indoor furniture and musical instruments. The largest appeal for OHC continues to be ROSY (Respite for Oxfordshire's Sick Youngsters) which delivers additional respite care to Oxfordshire's terminally ill, acute and chronically sick children in their own homes.

The charity continued to support a wide range of initiatives across the Trust to enhance patient care, through the provision of therapy aids and patient activities. These include various Oxford Health Arts Partnership projects, such as support for AiM (Arts Impact Measured) Home Community Research Project, large scale murals at Townlands Hospital, Henley and Wallingford Community Hospitals and public art for Didcot Community Hospital.

For more detailed information, the Oxford Health Charity Annual Impact and Finance Report for each year can be found on the charity website by searching online for '*Oxford Health Charity Annual Report and Statements*'.

Volunteering

The Volunteering Programme has continued to grow across Oxford Health with this past year seeing an increase in interest across the organisation in developing new roles and Volunteering being a key element to the AiM Home research project. With Volunteer to Career being built into the Volunteer Programme, every new Volunteer recruited has an

informal conversation about careers, learning or development interests. This conversation aims to capture those Volunteers joining Oxford Health with a view to gaining career experience whilst Volunteering and potential support and signposting towards substantive opportunities in the trust.

All new Volunteers now have in place formal training induction once they are cleared through recruitment. This introduces Volunteers to the NHS England Volunteer training (formally National Volunteer Certificate) which is essential for all Volunteers to complete.

The Volunteer Policy and Toolkit has been renewed and published - this included some changes around the introduction of training, the new Volunteer Management system and team structure. The volunteer management system was officially rolled-out to all Volunteers during 2024/25 and is now in full operational. This software allows us to advertise, recruit, onboard and manage all Oxford Health Volunteers in one system and store and report on Volunteering data throughout the year.

The Volunteer Programme team have also built strong links with recruitment and have joined various recruitment events and roadshows over the year to promote the value of Volunteering as a stepping stone into careers and promote our current roles. Ongoing aims for the Volunteer Programme are to:

- continue to grow awareness of Volunteering in Oxford Health
- support services to develop new roles for Volunteers
- celebrate, share stories, assessments and impact of Volunteering in Oxford Health
- grow the Volunteer to Career pathway further
- collaborative working with BOB ICB Volunteer Service Managers to develop opportunities within all our organisations

Oxford Health Arts Partnership

The Oxford Health Arts Partnership (OHAP) continued to deliver successfully against its strategy with the overall vision of ‘Inspiring recovery, wellbeing and growth through creativity’. The green spaces co-ordinator has added a huge amount to the team, literally growing the impact across the trust. Well over 1000 trees have been planted and ward gardens have benefited from increased service users, staff and volunteer involvement. OHAP received funding towards the Warneford 200 project which will see a new garden created with service users, staff and the wider community following workshops looking at the history and archives of the hospital.

OHAP published its Music Development Programme Plans after consultation with a range of staff and patients across the trust. The document outlines the role of music in enhancing patient care, improving staff well-being, and creating a healing environment, as well as the positive effects on physical, emotional, and psychological well-being. The plan will enable the OHAP team to build capacity and increase access to music. Over the year OHAP have facilitated 69 mini-concerts or bedside serenading sessions at 17 different community and mental health wards that have been enjoyed by 670 participants.

OHAP continues to evaluate the effects of arts-based activities for patients and in December our research study AiM Home gained ethical approval and trust sponsorship to start recruitment in January 2025. This project is in partnership with University of Oxford's Nuffield Primary Care Health Sciences Department and The University of Southampton.

Over 62 unique art workshops were delivered in the community, on wards and in museums and galleries across Oxfordshire for people with long term mental health difficulties. Over 4000 people have benefited from the work OHAP deliver to increase wellbeing and support recovery in all areas of the trust.

Team member, Angela Conlan, received a special medal from the British Geriatrics Society for her creative work with older people.

Code of governance for NHS provider trusts – Disclosures

The following statements set out applicable Trust disclosures with reference to the *Code of Governance for NHS provider Trusts* (April 2023) Schedule A, or as otherwise stated:

A.2.1. The Annual Governance Statement within this report sets out the Trust's effectiveness, efficiency and economy. The Trust's contribution to collaborative working and the work of the integrated care board is set out in the Performance Report section of this report. The Trust's principal risks are described in the Performance Report.

A.2.3 The Trust's Board of Directors monitor culture. The Trust's Board Assurance Framework has a specific risk on culture. The Staff Report section of this report sets out work to promote workforce wellbeing.

A.2.8 The Trust's Annual Report sets out how the interests of stakeholders are taken into account and consideration and contributions to partnerships and collaborations.

B.2.6 The Board of Directors considers all of its Non-Executive Directors to be independent against the potential impairments to independence set out in Schedule A B.2.6. The Trust discloses that one Non-Executive Director has been a member of the board since 2017 and that their third term will expire in March 2026. Over 2024/25, two Non-Executive Directors that commenced on the board in 2019 and whose second three-year terms were due to end in February and March 2025 had their terms and performance reviewed by the Council of Governor's Nominations and Remuneration Committee, with their third and final terms commencing in February and March 2025 respectively. Over 2024/25, one Non-Executive Director that commenced on the board in January 2022 and whose first three-year term was due to end in December 2024 had their term and performance reviewed by the Council of Governor's Nominations and Remuneration Committee, with their second term commencing in January 2025.

B.2.13 The Directors' Report within this report sets out number of times the Board of Directors and its committees met and individual director attendance.

B.2.17 The Council of Governors section of this report sets out the role of the Council of Governors, how disagreements between the Board and the Council are to be resolved, the types of decisions taken and reserved to Board and those delegated.

C 2.5 The Staff Report sets out information on expenditure on consultancy.

C.2.8 The Council of Governors and Remuneration Report sections of this report sets out the process followed by the Council of Governors to appoint the Chair and Non-Executive Directors (Nomination and Remuneration Committee).

C.4.2 The Directors' Report sets out the experience and expertise of directors. This is also available on the Trust's webpages by searching online for '*Oxford Health – Board of Directors*'

C.4.7 An externally facilitated Well-led review was last undertaken in Autumn 2022 – details of this review were presented in the Trust's 2022/23 Annual Report & Accounts. Information and plans on Well-led reviews for 2024/25 and into 2025/26 can be found in the Annual Governance Statement.

C.4.13 The Remuneration Report section of this report sets out the work of the nominations committee (Nominations, Remuneration and Terms of Service Committee).

C.5.15 The Council of Governors section of this report provides information on governor and member communication and engagement for example in relation to Trust forward planning.

D.2.4 The Audit Committee section of the Directors' Report sets out information in relation to the Trust's auditors.

D.2.6. The Board of Directors are responsible for the preparation of the annual report and accounts and consider these, as a whole, fair, balanced and understandable.

D.2.7. and D.2.8 The Performance Report section of this report sets out the Trust's principal risks and approach to monitoring and managing risks.

D.2.9 The Performance Report section of this report includes a Going Concern statement.

Appendix B 2.3 The Council of Governors section of this report sets out the members of the Council of Governors for the reported year, constituencies, duration of appointments and the lead governor(s).

Appendix B 2.14 and B 2.15 The Council of Governors section of this report sets out communication mechanisms between governors and members and how members of the Board of Directors develop and understanding of the views of governors.

NHS Oversight Framework

NHS England's NHS Oversight Framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities),
b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions. As of March 2025, NHS England has placed Oxford Health NHS Foundation Trust in segment two (2) of the NHS Oversight Framework as published in the NHS Oversight Framework Provider segmentation.

Statement of Chief Executive's responsibilities as the Accounting Officer of Oxford Health 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 Health 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 Health 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 Manua*l (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 and
- 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.*

Statement of Chief Executive's responsibilities as Accounting Officer

Signed: **Date: 25 June 2025**

Chief Executive and Accounting Officer

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 Health 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 Health NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk and the risk and control framework

Arrangements for and leadership of risk management are detailed in the Trust's Risk Management Strategy & Policy, this document was last updated in February 2025. The document sets out how risks are identified, evaluated, transferred, controlled and treated. Operational risks are identified through risk assessments, incidents, observation and acknowledgement of local, regional and national alerts. Leadership from managers at all levels of the Trust ensures that effective risk management is a core part of an integrated approach to quality, corporate and clinical governance, performance management and assurance.

Overarching leadership of risk management within the Trust is through the Executive Leadership Team. Risks are collated, escalated and transferred through local, directorate (where a risk is more readily addressed within the skill set of an alternate directorate) and trust risk registers. The Extended Leadership Team receives monthly reports on risk activity, escalations and de-escalations.

The Executive Management Team manages the strategic risks to the Trust on and ongoing basis through the Board Assurance Framework (BAF). Through these risk management processes, along with guidance and support offered via the Risk

Management Strategy & Policy and the corporate governance team, risk management is an embedded activity across the organisation.

An internal audit of the Trust's operational risk management processes took place over February 2024. The internal audit reviewed the design of controls established to support effective local risk management and returned an overall rating of 'Significant assurance with minor improvement opportunities'. The minor improvement recommendations, reflecting auditor assessments of sector good practice, were addressed over 2024/25 reporting to the Audit and Risk Committee to provide assurance and identify where the Trust might continue to improve.

The Board of Directors and board committees receive regular updates on the Board Assurance Framework including 'deep dives' into BAF risks specific to the terms of reference of a board committee. Through regular strategy meetings of the Board over 2024/25, threats and weaknesses alongside opportunities have been reviewed. The Trust uses a risk appetite matrix as a mechanism for setting appetite statements in relation to risks under consideration. Over the first quarter of 2025/26 the Board will review and refresh its Board Assurance Framework and, as a part of this, its risk profile and appetite.

Over 2024/25, significant strategic risks for the Trust (those with a high likelihood and impact) as captured and monitored in the BAF included: unavailability of and demand and capacity for beds (mental health inpatient and learning disability); adequacy of appropriately trained staff (workforce attraction and retention); maintaining financial stability; and capacity for delivery of major programmes. Over Quarter 3 2024/25, a new risk on physical environment, security and health and safety was developed following assessment of these areas. Medium rated risks for the Trust over the reported year included: digital, data & technology; staff retention; business planning; and information governance & cyber security. Individual BAF risks are reviewed and assessed by the relevant Executive director owner and a summary of the BAF is reported monthly to the Executive Leadership Team.

Quality governance, incident management and learning from incidents

The Trust is registered with the Care Quality Commission (CQC) and systems are in place to ensure compliance with the registration requirements, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009. The Board of Directors is responsible for ensuring compliance with these regulations. The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust's Executive Leadership Team and Directorate leaders proactively manage and seek assurance that the quality and safety of clinical services are robust and managed effectively. The Executive Leadership Team receives a weekly report from the Weekly Review Meeting chaired by the Chief Nurse. The Chief Nurse chairs the Quality & Clinical Governance Sub-Group and the Chief Medical Officers chairs the Clinical Effectiveness Group. The Trust's Board of Directors actively seek assurance on the quality and safety

of clinical services, including reviewing the Trust's Integrated Performance Report at each board meeting.

The Quality Committee (chaired by a Non-Executive Director) takes a comprehensive oversight of the quality and safety of care provided by the Trust. The committee is responsible for monitoring the Trust's arrangements for ensuring the delivery of safe, effective, patient-focused care and services on behalf of the Trust Board. The Quality Committee chair's report provides assurance to Trust's Board of Directors as well as alerting it to areas of ongoing improvement focus.

The Trust uses a web-based incident management system to report and manage local incidents, significant near misses and deaths. Every incident is reviewed by multiple staff members and information from the system is embedded into weekly and monthly forums which are part of the Trust's quality governance framework.

The Trust also identifies incidents that require a review with other external agencies and will actively engage partners to learn and identify changes together. The Trust's web-based incident management system is linked automatically to the national *Learn From Patient Safety Events* service (LFPSE) to share all patient incidents in 'real-time' with NHS England and the Care Quality Commission to support national learning. Further detail on how incidents are handled is included in the Trust's policy on Reporting and Learning from Deaths.

Oxford Health has a positive incident reporting culture with high numbers of incidents and near misses reported, the majority of which result in no harm to patients. When an incident is reported this is used as an opportunity to learn through established safety forums and quality governance arrangements as well as regular data analysis to identify trends and emerging themes. The 2024 national staff survey results showed 92% of staff feel that the Trust encourages them to report errors, near misses and incidents, this is above the national average for other NHS Trusts.

The Trust aims to always be curious and to work with patients and families to identify and make improvements from patient safety incidents. The Trust has an employed role for Patient Safety Partners bringing people with lived experiences of using services to work alongside staff to further develop and ensure that patient and family voices are central to decision-making and quality improvement initiatives.

NHS Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. The Trust's annual Quality Account brings an overview and summary of the successes and challenges experienced across the year while working towards achieving the quality priorities set by the Trust to deliver during 2024/25 and beyond to improve the quality of care and services provided.

Patient safety

As a part of the national Patient Safety Strategy around developing a safer culture, safer systems, and safer patient care was the development of the *Patient Safety Incident*

Response Framework (PSIRF). This is a significant change in how NHS providers consider and act in relation to responding, learning and improving from patient safety incidents. The Trust transitioned and started working under PSIRF from 4 December 2023. A summary of our approach under the PSIRF as well as our local incident response plan is published on the Trust's website and can be found by searching for '*Oxford Health Patient Safety Incident Response Framework'.*

The four key PSIRF aims the Trust has implemented are:

1. Compassionate engagement and involvement of those affected by patient safety incidents;
2. Application of a range of system-based methodologies to learning from patient safety incidents;
3. Considered and proportionate responses to patient safety incidents; and
4. Supportive oversight focused on strengthening how we learn and apply improvements.

The Trust's Quality Account published annually sets out key information on the quality, safety, effectiveness and experience of services. The published Quality Account includes updates on improvements undertaken throughout the year, any inspection findings, areas of challenge, incidents and learning from incidents and shares key achievements and identifies priority areas for future development. Once published, Oxford Health's 2024/25 Quality Account is available on the Trust's website by searching '*Oxford Health Quality Account'*.

In coronial proceedings, one duty on coroners is to write what is called a Prevention of Future Deaths (PFD) Report if an issue emerges during the proceedings that give rise to a concern that future deaths may occur. The coroner cannot state what should be done, simply that the organisation is asked to review the position and state what, if any, action it proposes to take. A report is not a sanction or judgement and coroners state that reports are intended to have utility and be helpful to organisations. Oxford Health received three PFD reports over the reported year. Having reviewed these, no significant control issues have been identified.

Workforce and workforce systems

At 31 March 2025, the Trust employed 7,507 staff with a contracted WTE (whole time equivalent) of 6672. Over 2024/25, the Trust recruited 1,548 substantive staff (1,418.35 WTE). I am required to describe the key ways in which the Trust ensures that short, medium, and long-term workforce strategies and staffing systems are in place and how the Trust complies with the '*Developing Workforce Safeguards'* recommendations.

The Trust is investing in skill mix work to make sure that the blend of skills in its services is safe, appropriate, affordable and available. We have expanded our Education Centre and continue to innovate to bring onboard new learning opportunities.

The Trust continues to take an active approach to grow the nursing and allied healthcare professional (AHP) workforce for both current and future demand working closely with partners within the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care System to improve workforce planning capabilities. The Trust has a variety of initiatives in place to attract, develop and retain the nursing and AHP workforce which includes collaborative working with local universities to advance existing staff and recruit students, the development of attractive new clinical roles and improving our bank offer so that new hires can use this as springboard to joining us substantively.

The Trust has been particularly successful in supporting alternative routes to registration through apprenticeship programmes and this is particularly effective for recruiting staff who live in the local area.

Creative methods of recruitment attraction have been implemented over 2024/25 including developing digital marketing, such as social media and radio, and offline marketing such as careers events, conferences, and visual brand advertising on local busses and service stations. The Resourcing team have used local recruitment fairs as a way to attract staff to hard to fill roles as these have been particularly successful.

The Trust uses a recruitment management system to improve its ability to control, manage and report on recruitment activity. The Trust measures 'time to hire' monthly and is working to reduce this by streamlining processes and continuing to upskill both the recruitment team and hiring managers. The Trust has made significant progress over 2024/25 to reduce the number of vacancies and speed-up time to hire both having a positive impact on frontline services.

Over 2024/25 the Trust has reduced its use of agency staff which has reduced agency costs and had a positive impact on the care provided to patients.

The Trust has run a series of initiatives to improve retention. Oxford Health is one of NHS England's twenty-three *People Promise* exemplar Trusts working with national and regional retention teams alongside other teams at NHS England to deliver high impact interventions set out in the *People Promise* to achieve improved outcomes and optimum staff satisfaction and retention. Staff turnover for the 2024/25 was 10.56% against a target of 14% which has improved the stability and effectiveness of the services offered.

The Trust is working collaboratively with staff side partners to address stress which is a significant issue in staff health and wellbeing and, as such, a major cause in sickness absence and a significant factor in retention. The Trust continues to fund psychological services which are available to staff to access via Occupational Health.

The Board and its sub-committee - the People, Leadership and Culture Committee - monitors recruitment, staff turnover, sickness levels, staff engagement data and agency spend. Safer staffing reports are reviewed at ward, directorate and board committee level and received at Board on a six-monthly basis to review workforce metrics, quality and outcome indicators, and productivity.

Register 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 with reference to the guidance) within the past twelve months as required by the *Managing Conflicts of Interest in the NHS*[2]. Further information can be found by searching online for '*Oxford Health disclosures and declarations'*.

Well-led

Over the reporting year, the Trust undertook a comprehensive review of its governance structures - including reference to the Well-led framework - leading to the development of a new Operating Framework which will be implemented over 2025/26. The Trust did not undertake a Well-led self-assessment over the reporting period. The Trust receives independent governance expertise from the Good Governance Institute, including advice given at board workshop discussions. A Well-led self-assessment will be undertaken over 2025/26 and is scheduled on the board work plan.

Pension scheme

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

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

Climate change

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Over 2024/25, the Trust developed its second Green Plan for 2025-2028 and updated its Environmental Sustainability Policy, which was approved by the relevant board committee in May and March 2025, respectively. The Trust has also created a comprehensive Green Action Plan to achieve Net Zero Carbon emissions by 2040. This action plan includes key initiatives such as reducing energy consumption, increasing the use of renewable energy sources, minimising waste, promoting sustainable travel, and enhancing biodiversity

[2] www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/ guidance

across the Estate. These measures aim to foster a culture of sustainability, support the adoption of green technologies, and ensure the NHS positively contributes to the environment. In terms of governance , the Trust ensures compliance with the Climate Change Act and Adaptation Reporting requirements.

Provider Licence condition compliance

As an NHS Foundation Trust, the Trust is required by its Provider Licence conditions to apply relevant principles, systems and standards of good corporate governance (section 4 governance). In order to discharge this responsibility, the Trust has an established, clear and effective Board and standing committee structure. This structure allows for monitoring, scrutiny, challenge and assurance of the systems of internal control. The responsibilities of the committees are set out in formal terms of reference that include clear lines of accountability and each has a forward plan of agenda items.

The Board has not identified any principal risks to compliance with Provider Licence condition (governance) over 2024/25 and is satisfied with the timeliness and accuracy of information to assess risks to compliance with the provider licence and degree of rigour of oversight it has over performance.

The Board receives finance, performance, quality and compliance reports at each meeting. Individual reports address elements of risk, such as reports on safe staffing levels or adherence to infection prevention and control policy enabling the Board to have oversight over Trust performance. The Board also receives regular assurance reports (3A reports) from the chairs of board committees following each committee meeting.

There are clear reporting lines and accountabilities throughout the organisation that ensure quality and performance reporting requirements are mirrored from a Board committee level to local level with information flowing both ways to include re-established lines of accountability to the Executive Management Team.

The Governance risk in the Trust's Board Assurance Framework over the reported year - which is owned by the Audit Committee with the Executive Director of Corporate Affairs as executive lead – allows for oversight of the ongoing effectiveness of controls that assure compliance. The Trust also has a comprehensive programme of internal audit in place aligned to key areas of potential financial and operational risk.

Modern slavery

The Trust publishes annually a Modern Slavery statement as required by the Modern Slavery Act 2015. The Trust's statements can be accessed by searching online for '*Oxford Health Modern Slavery Act statements*'.

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

As Accounting Officer, I have responsibility for ensuring economy, efficiency and effectiveness of the use of resources and I am supported by my executive team that has responsibility for overseeing the day-to-day operations of the Trust. Performance in this

area is monitored by the Board on a regular basis as well as through assurance reports from its standing committees. The Board discusses and approves the Trust's strategic and annual plans and budgets taking into account the views of the Council of Governors.

The Trust's Audit and Risk Committee supports the Board and me as Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management and the control environment. The scope of the Audit and Risk Committee's work is defined in its terms of reference and encompasses all the assurance needs of the Board and the Accounting Officer. The Audit Committee has engagement with the work of internal audit and external audit and is chaired by a Non-Executive Director.

Internal audit services support the Trust's system of internal control by providing an objective and independent opinion on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. The Trust's internal audit plan which is agreed by the Board sets out the full range of audits across the Trust, and includes reviews of the economy, efficiency and effectiveness of the use of resources.

The internal audit annual report, presented to the Audit and Risk Committee in June 2025, notes the Head of Internal Audit opinion is one of 'significant assurance with minor improvement opportunities'. Over the reported year internal audit reviews included patient experience, cyber security, core financial controls, and provider collaboratives.

Information governance and data security management

The Trust's Integrated Information Governance Policy outlines the management and assurance framework, including key roles and committees responsible, for managing and monitoring confidentiality and data security. The Information Management Group, chaired by the Senior Information Risk Owner (SIRO), is responsible for: fidelity to the policy; provides management focus and analysis of data security threats; and delivers improved data security through the review of incidents, policy development, education of users, highlighting risks, and developing risk mitigation action plans.

The Caldicott Guardian (held by the Chief Medical Officer) is a member of the Information Management Group, as is the Data Protection Officer (DPO). The group oversees compliance with the Freedom of Information Act and receives assurance with respect to subject access requests under the Data Protection Act and progress with the completion of the Data Security and Protection Toolkit (DSPT).

The DSPT is a national annual online national self-assessment process, which enables the Trust to measure its compliance against the National Data Guardian security standards and information governance management, confidentiality and data protection, information security, clinical information, secondary uses, and corporate information. The DSPT now incorporates the National Cyber Security Organisation's Cyber Assessment Framework (CAF). The Trust met all standards and assertions in the DSPT over 2023/24.

The DSPT/CAF year is from July to June and the Trust's baseline submission was completed as required by 31 December 2024. The Trust has provided evidence to the Trust's internal auditors to demonstrate compliance with each of the assessment criteria selected for internal audit verification during 2024/25. The field work for the internal audit review of this evidence was completed in March 2025. The internal audit report will be reviewed and, following sign-off by the Trust's Information Management Group and then by the Board of Directors, the DSPT/CAF will be submitted by 30 June 2025.

The Trust requires all information incidents to be reported. Each incident is recorded on the Trust Incident Reporting System and all incidents of Level 1 or less are summarised, reported, analysed, and considered by the Information Management Group quarterly.

There were two serious confidentiality incidents (Level 2) over 2024/25. Two incidents met the criteria for escalation to the Information Commissioner's Office (ICO) these being:

1. A data breach where a patient assessment was sent in error to the wrong recipient resulting in reported patient distress and loss of confidence in the service. The ICO took no further action. They were satisfied with the action taken by the Trust, and provided generic guidance about accuracy;
2. Employee witness details, name and interview, were included as appendices in a whistleblowing report. The incident was reported to the ICO, who have acknowledged receipt but have not yet taken any further action.

The Trust is acutely aware of the ongoing threat from cybercrime i.e. malicious attempts to damage, disrupt or steal the Trust's IT related resources and data. To combat this, the Trust's Information Management & Technology (IM&T) department continues to step-up efforts in all areas to monitor for suspicious activity, with a programme that includes providing awareness education to staff, analysing infrastructure for potential weaknesses, and remediating any issues.

In July 2024, the Trust – like a number of other organisations worldwide – was affected by the systems outage caused by a faulty update in the cybersecurity software *Crowdstrike*. The Trust declared an incident and controls put in place were effective in managing the impact of the outage and timely recovery with no patient harms or data losses recorded.

An internal audit review of cyber security in December 2024 was received at the Audit & Risk Committee in February 2025 with an overall rating of 'Significant assurance'. All audit recommendations were completed by the end of April 2025.

The Trust is operating in accordance with the General Data Protection Regulation (GDPR) and Data Protection Act (2018) and policy - procedures and mandatory information governance training reflect this legal framework.

Data quality and governance

The Trust has a Data Quality Strategy and framework to support the management of data quality. Data quality risks are managed and controlled via the risk management systems within the Trust. These risks and associated actions are continually assessed and updated as appropriate in the risk register.

Over 2024/25 the Trust embedded a new performance management framework. Areas of focus for data quality improvements and monitoring of progress are managed as a part of this framework, with routine reports being shared and reviewed in collaboration with services. Information is also available at a ward/team level to self-serve via the Trust Online Business Intelligence platform (TOBI). The Trust reports regularly on nationally mandated data sets.

Assurance in relation to data submissions and quality is overseen by the Information Management Group (IMG) which has delegated responsibility from the Trust's Quality Committee. Activities and progress in relation to data and digital are overseen by the Trust's Digital and Data Strategy Board - chaired by the Chief Digital Information Officer - and associated workstreams.

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 quality committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The system of internal control is designed to manage risk to an acceptable 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 the 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 Audit Committee - which became the Audit & Risk Committee in December 2024 with its revised Terms of Reference being approved by the Board in January 2025 - comprises Non-Executive Directors (excluding the Chairman as a core member) and has reviewed throughout the year the effectiveness of the system of internal control and overall assurance processes associated with managing risk. The system of internal control has

been in place in Oxford Health NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Conclusion

No significant internal control issues have been identified over 2024/25 and, as Accounting Officer, I am reassured that the Trust's system of internal control is sound and supports progress towards our aims and objectives and the safeguarding and prudent management of financial resources. The Board of Directors, its delegated committees and relevant audit processes have remained vigilant to identify risks and to learn from service developments, major projects, and incidents. Over the reporting period, improvements have begun to be made in our approach to major estates projects and to our processes for risk identification and mitigation in our physical environment, health and safety and security. As a Trust we continue to seek learning from experience and from best practice and to continuously improve our control processes.

Annual Governance Statement

Signed: **Date: 25 June 2025**

Chief Executive and Accounting Officer

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

Opinion

We have audited the financial statements of Oxford Health NHS Foundation Trust for the year ended 31 March 2025 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity 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: 2024-25 as contained in the Department of Health and Social Care Group Accounting Manual 2024 to 2025 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 Health NHS Foundation Trust as at 31 March 2025 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 2024 to 2025; 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 31st July 2026.

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

Other information

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

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

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

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

- the parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25.

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 2024/25 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 Health NHS Foundation Trust' set out on pages 76 to 77 the chief executive is the accounting officer of Oxford Health 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.

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 Health NHS Foundation Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, 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 review of 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. We identified one instance of non-compliance with laws and regulations and completed a programme of work to obtain assurance that this matter did not have a material impact on the financial statements.

- 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 and the omission of expenditure) and management override of controls to be our fraud risks.

- To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue and omission of expenditure, we reviewed transactions recorded in the ledger and payments received into the bank account post year-end, to confirm that expenditure had been recognised in the correct period, we reviewed research and development transactions, agreeing these back to research agreements and bank statements, to ensure research and development income was being recognised correctly in line with terms and conditions, and we reviewed accrued income transactions relating to contract and pharmacy sales, agreeing these back to source documentation and post year-end bank statement where possible, to ensure accrued income was not being inappropriately recognised.

- 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 as unusual following our analysis of the Foundation Trust's data and testing significant manual adjustments made outside of the ledger as part of the accounts preparation process. 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 November 2024, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

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.

Certificate

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 Health NHS Foundation Trust

Use of our report

This report is made solely to the Council of Governors of Oxford Health 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.

Claire Mellons (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Newcastle upon Tyne
27 June 2025

Oxford Health NHS Foundation Trust

Annual accounts for the year ended 31 March 2025

Foreword to the accounts

Oxford Health NHS Foundation Trust

These accounts, for the year ended 31 March 2025, have been prepared by Oxford Health NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Grant Macdonald**
Job title **Chief Executive**
Date **25 June 2025**

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	550,831	525,907
Other operating income	4	142,393	101,152
Operating expenses	6,8	(692,388)	(640,891)
Operating surplus/(deficit) from continuing operations		**836**	**(13,832)**
Finance income	10	5,852	5,414
Finance expenses	11	(1,649)	(2,444)
PDC dividends payable		(3,043)	(2,905)
Net finance costs		**1,160**	**65**
Other gains / (losses)	12	-	354
Surplus / (deficit) for the year from continuing operations		**1,996**	**(13,413)**
Surplus / (deficit) for the year		**1,996**	**(13,413)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(5,978)	(3,888)
Revaluations	15	8,790	5,099
Remeasurements of the net defined benefit pension scheme liability / asset	30	123	153
Other reserve movements		-	10
Total comprehensive income / (expense) for the period		**4,931**	**(12,039)**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	13	5,410	7,012
Property, plant and equipment	14	221,715	216,329
Right of use assets	16	39,301	33,133
Other investments / financial assets	17	1,125	1,125
Receivables	20	366	412
Other assets	21	799	651
Total non-current assets		**268,716**	**258,662**
Current assets			
Inventories	19	6,463	3,184
Receivables	20	19,599	21,722
Non-current assets for sale and assets in disposal groups	22.1	1,185	200
Cash and cash equivalents	23	97,818	85,628
Total current assets		**125,065**	**110,734**
Current liabilities			
Trade and other payables	24	(81,457)	(77,857)
Borrowings	26	(8,002)	(6,633)
Provisions	27	(14,804)	(16,518)
Other liabilities	25	(35,101)	(24,222)
Total current liabilities		**(139,364)**	**(125,230)**
Total assets less current liabilities		**254,417**	**244,166**
Non-current liabilities			
Trade and other payables	24	(1,500)	(1,500)
Borrowings	26	(35,873)	(33,863)
Provisions	27	(9,226)	(6,545)
Total non-current liabilities		**(46,599)**	**(41,908)**
Total assets employed		**207,818**	**202,258**
Financed by			
Public dividend capital		113,965	113,336
Revaluation reserve		85,893	83,359
Financial assets reserve		1,125	1,125
Income and expenditure reserve		6,835	4,438
Total taxpayers' equity		**207,818**	**202,258**

The notes on pages 102 to 153 form part of these accounts.

Name Grant Macdonald
Position Chief Executive
Date 25 June 2025

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**113,336**	**83,359**	**1,125**	**4,438**	**202,258**
Surplus/(deficit) for the year	-	-	-	1,996	**1,996**
Impairments	-	(5,978)	-	-	**(5,978)**
Revaluations	-	8,790	-	-	**8,790**
Transfer to retained earnings on disposal of assets	-	(278)	-	278	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	123	**123**
Public dividend capital received	629	-	-	-	**629**
Taxpayers' and others' equity at 31 March 2025	**113,965**	**85,893**	**1,125**	**6,835**	**207,818**

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**109,631**	**82,587**	**1,125**	**17,249**	**210,591**
Surplus/(deficit) for the year	-	-	-	(13,413)	**(13,413)**
Impairments	-	(3,888)	-	-	**(3,888)**
Revaluations	-	5,099	-	-	**5,099**
Transfer to retained earnings on disposal of assets	-	(439)	-	439	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	153	**153**
Public dividend capital received	3,705	-	-	-	**3,705**
Other reserve movements	-	-	-	10	**10**
Taxpayers' and others' equity at 31 March 2024	**113,336**	**83,359**	**1,125**	**4,438**	**202,258**

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.

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

Statement of Cash Flows

	Note	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		836	(13,832)
Non-cash income and expense:			
Depreciation and amortisation	6.1	16,261	15,161
Net impairments	7	140	5,116
Non-cash movements in on-SoFP pension liability		(20)	(12)
Decrease in receivables and other assets		1,285	13,734
(Increase) in inventories		(3,279)	(252)
Increase / (decrease) in payables and other liabilities		15,676	(5,564)
Increase in provisions		104	12,966
Net cash flows from / (used in) operating activities		**31,003**	**27,316**
Cash flows from investing activities			
Interest received		5,852	5,414
Purchase of intangible assets		(385)	(4,664)
Purchase of PPE and investment property		(11,480)	(8,592)
Sales of PPE and investment property		-	1,200
Net cash flows from / (used in) investing activities		**(6,013)**	**(6,642)**
Cash flows from financing activities			
Public dividend capital received		629	3,705
Movement on loans from DHSC		(1,338)	(1,338)
Movement on other loans		(850)	-
Capital element of lease rental payments		(6,347)	(6,035)
Capital element of PFI service concession payments		(403)	(657)
Interest on loans		(515)	(566)
Other interest		(113)	(121)
Interest paid on lease liability repayments		(437)	(204)
Interest paid on PFI obligations		(521)	(1,481)
PDC dividend paid		(2,905)	(2,959)
Net cash flows from / (used in) financing activities		**(12,800)**	**(9,656)**
Increase / (decrease) in cash and cash equivalents		**12,190**	**11,018**
Cash and cash equivalents at 1 April - brought forward		**85,628**	**74,610**
Cash and cash equivalents at 31 March	23.1	**97,818**	**85,628**

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 2024/25 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

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.

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future and until 31st July 2026 i.e. 12 months after the publication of the annual report and accounts for 2024/25. Management's enquiries covered planning, allocations, capital planning, policy on NHS structures and Trust strategy. The following points support the adoption of the going concern basis:

• There are no local or national policy decisions that are likely to affect that continued funding and provision of services by the Trust.

• The Trust's adjusted financial performance in 2024/25 was a £2.2m surplus, £2.3m better than plan. The Trust is expecting to report in line with plan in 2025/26.

• In 2024/25 the Trust has continued to benefit from the block contract arrangements which were put in place during the covid pandemic.

•The Trust Board has approved a plan for 2025/26 and this has been submitted to NHSE by the Trust and as part of the submission made by Buckinghamshire, Oxfordshire and Berkshire West ICS, of which the Trust is a member. The plan is for a £4.75m surplus and income is based on planning guidance assumptions and agreements with the Trust's main NHS and non-NHS commissioners.

• The Trust ended 2024/25 with £97.8m of cash. The Trust maintains a rolling cash flow forecast based on expectations for funding and this extends to the end of July 2026. This indicates that the Trust would be able to continue to operate with good levels of liquidity for revenue and capital purposes, with no requirement to undertake borrowing. The Trust is forecasting a cash balance of £87m at the end of July 2026.

Note 1.3 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.

Consideration should be received within the Trust's credit terms once performance obligations have been satisfied. Contract receivable balances are recognised when consideration has not been received.

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. 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. 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 covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and 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.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Mental health provider collaboratives

NHS led provider collaboratives for specialised mental health, learning disability and autism services involve a lead NHS provider taking responsibility for managing services, care pathways and specialised commissioning budgets for a population. As lead provider for the 'For Me', 'Thames Valley CAMHS T4' and 'HOPE AED' Provider Collaboratives, the Trust is accountable to NHS England and as such recognises the income and expenditure associated with the commissioning of services from other providers in these accounts. Where the trust is the provider of commissioned services, this element of income is recognised in respect of the provision of services, after eliminating internal transactions.

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 1.4 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the 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 1.5 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust’s accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Note 1.6 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 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

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.

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)

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	**Max life**
	Years	**Years**
Land	Not applicable	Not applicable
Buildings, excluding dwellings	1	60
Plant & machinery	1	15
Transport equipment	7	7
Information technology	1	5
Furniture & fittings	4	10

Note 1.8 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.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	**Max life Years**
Software licences	1	5

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.10 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 1.11 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 at fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities classified as 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: Its investment in Cristal health Limited, trading as Akrivia Health.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

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 1.12 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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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.

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 1.13 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 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

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 27.2 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 1.14 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 28 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 28, 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 1.15 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 1.16 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 1.17 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 1.18 Third party assets

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

Note 1.19 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 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

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

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

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:

The Trust's provider collaborative activity has been accounted for on a gross accounting basis in accordance with the relevant standards and the Trust acting as a principal and not an agent.This judgement has been reached on the basis that the Trust has determined it is the lead commissioner, accountable and responsible for the service delivery of the contracts under these arrangements. On these grounds, the Trust is recognising £131,032k (2023/24 £133,139k) income relating to the provider collaborative, which is split between income for commissioning services in a mental health collaborative of £59,434k (2023/24 £65,947k) and services the Trust delivers under the mental health collaborative of £71,598k (2023/24 £67,191k) as shown in Note 3.1.If the Trust was accounting for this on an agency basis, the amounts collected would not be treated as income but would pass through and be accounted for on a net basis.

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:

Property assets were valued by Carter Jonas as at 31 March 2025. These valuations are based on Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health and Social Care . There will be a degree of estimation uncertainty in these valuations as they are based on indexation and location factors.

The Trust's PFI Provision is based on the book value of the asset. This value is subject to the outcome of a due diligence exercise, a compliance review, specialist condition surveys, commercial checks and negotiation.

Note 2 Operating Segments and Adjusted Financial Performance

All of the Trust's activities relate to the provision of healthcare, which is an aggregate of all the individual specialty components included therein. Similarly, the majority of the Trust's income originates with UK Whole-of-Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the provision or support of healthcare activities generally across the Trust together with the related supplies and overheads necessary. The business activities which earn revenue and incur expenses are therefore of one broad combined nature.

The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board, which includes non-executive directors. The finance report considered by the Board contains only total balance sheet positions and cash flow forecasts for the Trust as a whole. The Board as chief operating decision maker therefore only considers one segment of healthcare in its decision making process.

The single segment of 'healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities in which the Trust engages and economic environments in which it operates.

Adjusted financial performance (control total basis):	**2024/25**	**2023/24**
	£000	**£000**
Surplus / (deficit) for the period	1,996	(13,413)
Remove net impairments not scoring to the Departmental expenditure limit	100	5,116
Remove I&E impact of capital grants and donations	66	72
Remove non-cash element of on-SoFP pension costs	(20)	(12)
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis and add back I&E impact of IFRIC 12 schemes on a UK GAAP basis	52	52
Other control total adjustments	-	13,336
Adjusted financial performance surplus / (deficit)	**2,194**	**5,151**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	2024/25 £000	2023/24 £000
Mental health services		
Income from commissioners under API contracts*	255,712	242,933
Services delivered under a mental health collaborative	71,598	67,191
Income for commissioning services in a mental health collaborative	59,434	65,947
Clinical partnerships providing mandatory services (including S75 agreements)	3,111	2,818
Clinical income for the secondary commissioning of mandatory services	4,274	4,221
Other clinical income from mandatory services	1,941	1,530
Community services		
Income from commissioners under API contracts*	117,133	115,426
Income from other sources (e.g. local authorities)	12,595	11,604
All services		
Private patient income	302	441
National pay award central funding***	269	104
Additional pension contribution central funding**	23,496	13,692
Other clinical income	966	-
Total income from activities	**550,831**	**525,908**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023-25 NHS Payment Scheme documentation.

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 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the 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)	2024/25 £000	2023/24 £000
Income from patient care activities received from:		
NHS England	157,879	156,810
Integrated care boards	371,587	347,730
Other NHS providers	2,396	2,207
Local authorities	16,137	15,135
Non-NHS: private patients	302	306
Injury cost recovery scheme	149	89
Non NHS: other	2,381	3,629
Total income from activities	**550,831**	**525,907**
Of which:		
Related to continuing operations	550,831	525,907

Note 4 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	33,081	-	**33,081**	20,776	-	**20,776**
Education and training	24,725	-	**24,725**	23,099	-	**23,099**
Non-patient care services to other bodies	2,309		**2,309**	2,720		**2,720**
Charitable and other contributions to expenditure		181	**181**		324	**324**
Other income*	82,097	-	**82,097**	54,232	-	**54,232**
Total other operating income	**142,212**	**181**	**142,393**	**100,827**	**324**	**101,152**
Of which:						
Related to continuing operations			142,393			101,152

* Other income includes £78.7m (2023/24 £50.1m) of pharmacy sales generated by the Oxford Pharmacy Store.

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

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	4,955	12,117

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2025	31 March 2024
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	33,023	20,159
after one year, not later than five years	2,078	4,063
after five years		
Total revenue allocated to remaining performance obligations	**35,101**	**24,222**

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:

	2024/25	2023/24
	£000	£000
Income from services designated as commissioner requested services	529,465	504,541
Income from services not designated as commissioner requested services	21,366	21,366
Total	**550,831**	**525,907**

Note 6.1 Operating expenses

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	42,452	39,954
Purchase of healthcare from non-NHS and non-DHSC bodies	32,634	37,810
Staff and executive directors costs *	417,798	376,351
Remuneration of non-executive directors	184	200
Supplies and services - clinical (excluding drugs costs)	21,097	26,369
Supplies and services - general	5,362	4,147
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	79,467	52,056
Inventories written down	88	67
Consultancy costs	542	1,240
Establishment	14,738	14,116
Premises	15,007	17,429
Transport (including patient travel)	6,130	6,285
Depreciation on property, plant and equipment	14,274	12,533
Amortisation on intangible assets	1,987	2,628
Net impairments	140	5,116
Movement in credit loss allowance: contract receivables / contract assets	147	142
Increase/(decrease) in other provisions	549	302
Change in provisions discount rate(s)	14	(149)
Fees payable to the external auditor		
audit services- statutory audit	254	228
Internal audit costs	63	220
Clinical negligence	1,531	1,313
Legal fees	560	892
Insurance	540	563
Research and development	27,350	11,844
Education and training	2,581	3,262
Expenditure on short term leases	76	125
Expenditure on low value leases	194	181
Variable lease payments not included in the liability	1,133	2,246
Redundancy	61	49
Charges to operating expenditure for on-SoFP IFRIC 12 PFI schemes	553	822
Car parking & security	18	15
Losses, ex gratia & special payments	56	36
Other services, eg external payroll	699	675
Other	4,109	21,824
Total	**692,388**	**640,891**
Of which:		
Related to continuing operations	692,388	640,891

* Increase due to national pay awards of £17.1m, additional pension costs of £9.8m and 4.5% increase in staff numbers across services.

Note 6.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2,000k (2023/24: £2,000k).

Note 7 Impairment of assets

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	40	-
Changes in market price	100	5,116
Total net impairments charged to operating surplus / deficit	**140**	**5,116**
Impairments charged to the revaluation reserve	5,978	3,888
Total net impairments	**6,118**	**9,004**

Note 8 Employee benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	283,882	247,925
Social security costs	29,193	26,613
Apprenticeship levy	1,379	1,265
Employer's contributions to NHS pensions	59,665	45,188
Pension cost - other	41	62
Temporary staff (including agency)	45,950	57,892
Total gross staff costs	**420,110**	**378,945**
Recoveries in respect of seconded staff	(2,312)	(2,096)
Total staff costs	**417,798**	**376,850**
Of which		
Costs capitalised as part of assets	-	499

Note 8.1 Retirements due to ill-health

During 2024/25 there were 6 early retirements from the trust agreed on the grounds of ill-health (13 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £1,034k (£1,384k in 2023/24).

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

Note 9 Pension costs

Past and present employees are covered by the provisions of the 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 to 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.

Note 10 Finance income

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	5,779	5,358
Other finance income	73	55
Total finance income	**5,852**	**5,414**

Note 11.1 Finance expenditure

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	510	565
Interest on lease obligations	436	204
Finance costs on PFI arrangements:		
Main finance costs	33	97
Contingent finance costs	488	1,384
Total interest expense	**1,467**	**2,249**
Unwinding of discount on provisions	69	75
Other finance costs	113	119
Total finance costs	**1,649**	**2,444**

Note 12 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	-	360
Losses on disposal of assets	-	(6)
Total gains / (losses) on disposal of assets	**-**	**354**
Total other gains / (losses)	**-**	**354**

Note 13.1 Intangible assets - 2024/25

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**12,251**	**12,251**
Additions	384	**384**
Disposals / derecognition	(557)	**(557)**
Valuation / gross cost at 31 March 2025	**12,078**	**12,078**
Amortisation at 1 April 2024 - brought forward	**5,239**	**5,239**
Provided during the year	1,987	**1,987**
Disposals / derecognition	(557)	**(557)**
Amortisation at 31 March 2025	**6,668**	**6,668**
Net book value at 31 March 2025	**5,410**	**5,410**
Net book value at 1 April 2024	**7,012**	**7,012**

Note 13.2 Intangible assets - 2023/24

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**9,900**	**9,900**
Additions	4,664	**4,664**
Disposals / derecognition	(2,313)	**(2,313)**
Valuation / gross cost at 31 March 2024	**12,251**	**12,251**
Amortisation at 1 April 2023 - as previously stated	**4,924**	**4,924**
Provided during the year	2,628	**2,628**
Disposals / derecognition	(2,313)	**(2,313)**
Amortisation at 31 March 2024	**5,239**	**5,239**
Net book value at 31 March 2024	**7,012**	**7,012**
Net book value at 1 April 2023	**4,977**	**4,977**

Note 14.1 Property, plant and equipment - 2024/25

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2024 - brought forward	**44,811**	**160,948**	**6,604**	**7,371**	**104**	**4,420**	**2,639**	**226,897**
Additions	-	242	8,318	9	-	2,125	332	**11,026**
Impairments	(67)	(6,051)	-	-	-	-	-	**(6,118)**
Revaluations	3,556	206	-	-	-	-	-	**3,762**
Reclassifications	-	4,995	(5,665)	35	-	552	83	**0**
Transfers to / from assets held for sale	(360)	(625)	-	-	-	-	-	**(985)**
Disposals / derecognition	-	(254)	-	(53)	-	(1)	(621)	**(929)**
Valuation/gross cost at 31 March 2025	**47,940**	**159,461**	**9,257**	**7,362**	**104**	**7,096**	**2,433**	**233,653**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**2,450**	**-**	**4,435**	**104**	**1,652**	**1,927**	**10,568**
Provided during the year	-	5,325	-	575	-	1,126	188	**7,214**
Impairments	-	0	-	-	-	-	-	**0**
Revaluations	-	(4,915)	-	-	-	-	-	**(4,915)**
Disposals / derecognition	-	(254)	-	(53)	-	(1)	(621)	**(929)**
Accumulated depreciation at 31 March 2025	**-**	**2,606**	**-**	**4,957**	**104**	**2,777**	**1,494**	**11,938**
Net book value at 31 March 2025	**47,940**	**156,855**	**9,257**	**2,405**	**-**	**4,318**	**940**	**221,715**
Net book value at 1 April 2024	**44,811**	**158,499**	**6,604**	**2,936**	**-**	**2,767**	**712**	**216,329**

Note 14.2 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**45,011**	**153,772**	**12,777**	**6,939**	**104**	**5,547**	**2,663**	**226,813**
Additions	0	4,136	6,393	275	-	443	-	**11,247**
Impairments	-	(8,933)	-	-	-	-	-	**(8,933)**
Revaluations	-	583	-	-	-	-	-	**583**
Reclassifications	-	12,296	(12,566)	181	-	89	-	**0**
Transfers to / from assets held for sale	(200)	-	-	-	-	-	-	**(200)**
Disposals / derecognition	-	(907)	-	(24)	-	(1,659)	(24)	**(2,614)**
Valuation/gross cost at 31 March 2024	**44,811**	**160,948**	**6,604**	**7,371**	**104**	**4,420**	**2,639**	**226,897**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**3,082**	**-**	**3,900**	**104**	**2,231**	**1,700**	**11,018**
Provided during the year	-	4,789	-	558	-	1,081	246	**6,673**
Revaluations	-	(4,516)	-	-	-	-	-	**(4,516)**
Disposals / derecognition	-	(906)	-	(23)	-	(1,659)	(19)	**(2,608)**
Accumulated depreciation at 31 March 2024	**-**	**2,450**	**-**	**4,435**	**104**	**1,652**	**1,927**	**10,568**
Net book value at 31 March 2024	**44,811**	**158,499**	**6,604**	**2,936**	**-**	**2,768**	**712**	**216,330**
Net book value at 1 April 2023	**45,011**	**150,690**	**12,777**	**3,038**	**-**	**3,316**	**964**	**215,796**

Note 14.3 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	47,940	155,905	9,257	2,405	4,317	940	**220,765**
Owned - donated/granted	-	950	-	-	-	-	**950**
Total net book value at 31 March 2025	**47,940**	**156,855**	**9,257**	**2,405**	**4,317**	**940**	**221,715**

Note 14.4 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	44,811	143,949	6,604	2,936	2,766	712	**201,778**
On-SoFP PFI contracts and other service concession arrangements	-	13,547	-	-	-	-	**13,547**
Owned - donated/granted	-	1,004	-	-	-	-	**1,004**
Total net book value at 31 March 2024	**44,811**	**158,499**	**6,604**	**2,936**	**2,766**	**712**	**216,329**

Note 15 Revaluations of property, plant and equipment

Valuations are carried out by Carter Jonas, an independent commercial valuation provider. All work is completed by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuation was performed for a 31st March 2025 valuation date.

Note 16 Leases - Oxford Health NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

At 31 March 2025, the Trust was a lessee in 77 arrangements that were classified as right of use assets under IFR16. These leases were made up of the following:

Lease type	Number
Property	56
Pool cars	16
Land	4
Equipment	1

29 of these building leases are held with other NHS providers and DHSC bodies while the remainder are held with local authorities and other bodies external to the DHSC.

Note 16.1 Right of use assets - 2024/25

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	**44,422**	**34**	**162**	**44,618**	**22,291**
Additions	962	24	199	**1,185**	-
Remeasurements of the lease liability	11,137	-	-	**11,137**	9,700
Movements in provisions for restoration / removal costs	794	-	-	**794**	(5)
Revaluations	112	-	-	**112**	90
Reclassifications	(9)	-	-	**(9)**	3,298
Disposals / derecognition	(61)	(34)	(43)	**(138)**	-
Valuation/gross cost at 31 March 2025	**57,357**	**24**	**318**	**57,699**	**35,374**
Accumulated depreciation at 1 April 2024 - brought forward	**11,371**	**26**	**88**	**11,485**	**8,086**
Provided during the year	6,981	11	69	**7,061**	4,301
Reclassifications	(9)	-	-	**(9)**	(5)
Disposals / derecognition	(61)	(34)	(43)	**(138)**	-
Accumulated depreciation at 31 March 2025	**18,281**	**3**	**114**	**18,398**	**12,382**
Net book value at 31 March 2025	**39,076**	**21**	**204**	**39,301**	**22,992**
Net book value at 1 April 2024	**33,051**	**8**	**74**	**33,133**	**14,206**

Net book value of right of use assets leased from other NHS providers	11,410
Net book value of right of use assets leased from other DHSC group bodies	11,582

Note 16.2 Right of use assets - 2023/24

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2023 - brought forward	**36,476**	**34**	**74**	**36,584**	**21,300**
Additions	5,732	-	88	**5,820**	-
Remeasurements of the lease liability	693	-	-	**693**	715
Movements in provisions for restoration / removal costs	1,700	-	-	**1,700**	353
Impairments	(72)	-	-	**(72)**	(53)
Disposals / derecognition	(108)	-	-	**(108)**	(23)
Valuation/gross cost at 31 March 2024	**44,422**	**34**	**162**	**44,618**	**22,291**
Accumulated depreciation at 1 April 2023 - brought forward	5,667	13	54	**5,734**	4,247
Provided during the year	5,812	13	35	**5,859**	3,862
Impairments	(1)	-	-	**(1)**	(0)
Disposals / derecognition	(108)	-	-	**(108)**	(23)
Accumulated depreciation at 31 March 2024	**11,371**	**26**	**88**	**11,485**	**8,086**
Net book value at 31 March 2024	**33,051**	**8**	**74**	**33,133**	**14,206**
Net book value at 1 April 2023	**30,809**	**21**	**20**	**30,850**	**17,053**

Net book value of right of use assets leased from other NHS providers	8,594
Net book value of right of use assets leased from other DHSC group bodies	5,611

Note 16.3 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 26.1.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**25,833**	**25,356**
Lease additions	1,185	5,820
Lease liability remeasurements	11,137	693
Interest charge arising in year	436	204
Lease payments (cash outflows)	(6,784)	(6,239)
Carrying value at 31 March	**31,807**	**25,833**

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 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2024	31 March 2024
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	6,645	4,195	4,019	2,024
- later than one year and not later than five years;	14,691	8,268	11,405	5,753
- later than five years.	10,471	5,643	10,409	5,277
Total gross future lease payments	**31,807**	**18,106**	**25,833**	**13,054**
Finance charges allocated to future periods	-	-	-	-
Net lease liabilities at 31 March 2025	**31,807**	**18,106**	**25,833**	**13,054**
Of which:				
Leased from other NHS providers		7,729		8,349
Leased from other DHSC group bodies		10,377		4,705

Note 17 Other investments / financial assets (non-current)

	2024/25	2023/24
	£000	£000
Carrying value at 1 April - brought forward	**1,125**	**1,125**
Carrying value at 31 March	**1,125**	**1,125**

The Trust has a £1,125k investment and 5.31% shareholding in Cristal Health Ltd (trading as Akrivia Health) , a research development software company

Note 18 Disclosure of interests in other entities

The Trust is a corporate trustee of the Oxford Health Charity. The Trust's interest in the charity is not material, therefore they have not been consolidated into these financial statements.

Note 19 Inventories

	31 March 2025	31 March 2024
	£000	£000
Drugs *	6,390	3,111
Energy	60	55
Other	13	19
Total inventories	**6,463**	**3,184**

* 95% of drug inventories are held by Oxford Pharmacy Stores (OPS) and end of year inventories reflect the growth of OPS in year (Income up 57%) . Inventories are expected to be maintained at this level going forward.

Inventories recognised in expenses for the year were £79,814k (2023/24: £52,694k). Write-down of inventories recognised as expenses for the year were £91k (2023/24: £68k).

Note 20.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	14,795	16,592
Allowance for impaired contract receivables / assets	(1,548)	(1,437)
Prepayments (non-PFI)	3,412	2,670
PFI lifecycle prepayments	-	742
PDC dividend receivable	35	173
VAT receivable	2,670	2,799
Other receivables	235	181
Total current receivables	**19,599**	**21,722**
Non-current		
Other receivables	366	412
Total non-current receivables	**366**	**412**
Of which receivable from NHS and DHSC group bodies:		
Current	11,892	12,108
Non-current	336	382

Note 20.2 Allowances for credit losses

	2024/25	2023/24
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**1,437**	**1,303**
New allowances arising	1,244	1,369
Reversals of allowances	(1,097)	(1,226)
Utilisation of allowances (write offs)	(36)	(9)
Allowances as at 31 Mar 2025	**1,548**	**1,437**

Note 21 Other assets

	31 March 2025	31 March 2024
	£000	£000
Non-current		
Net defined benefit pension scheme asset	577	433
Other assets	222	218
Total other non-current assets	**799**	**651**

Note 22.1 Non-current assets held for sale and assets in disposal groups

	2024/25	2023/24
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**200**	**840**
Assets classified as available for sale in the year	985	200
Assets sold in year	-	(840)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**1,185**	**200**

Shrublands (£200k) remains as an asset held for sale in 2024/25. It has been joined by St Barnabas and South Parade in 2024/25. These assets relate to land and buildings and are surplus to operational requirements.
Harlow House (£840k) was sold during the course of 2023/24.

Note 23.1 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.

	2024/25	2023/24
	£000	£000
At 1 April	**85,628**	**74,610**
Net change in year	12,190	11,018
At 31 March	**97,818**	**85,628**
Broken down into:		
Cash at commercial banks and in hand	48	47
Cash with the Government Banking Service	97,770	85,581
Total cash and cash equivalents as in SoFP	**97,818**	**85,628**
Total cash and cash equivalents as in SoCF	**97,818**	**85,628**

Note 23.2 Third party assets held by the trust

Oxford Health NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2025	31 March 2024
	£000	£000
Bank balances	494	452
Total third party assets	**494**	**452**

Note 24.1 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables *	22,031	10,608
Capital payables *	3,427	4,623
Accruals *	43,309	51,613
Social security costs	3,830	3,440
Other taxes payable	3,490	2,903
Pension contributions payable	5,204	4,523
Other payables	166	148
Total current trade and other payables	**81,457**	**77,857**
Non-current		
Trade payables	1,500	1,500
Total non-current trade and other payables	**1,500**	**1,500**
Of which payables from NHS and DHSC group bodies:		
Current	12,593	8,943

* Combined payable and accruals balances in 2024/25 are £68.8m (2023/24 £66.8m). These balances represent different stages of the Purchase to Pay (P2P) process.

Note 25 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	35,101	24,222
Total other current liabilities	**35,101**	**24,222**

Deferred income relates to consideration received from commissioners, where the performance obligation has not been satisfied at 31 March. These performance obligations will be satisfied in a future period.

Of the £35.1m income deferred at 31 March 2025, £29.0m (2023/24 £20.2m) relates to the Trust's Provider Collaborative.

Note 26.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Loans from DHSC	1,356	1,361
Other loans	-	850
Lease liabilities	6,646	4,019
Obligations under PFI arrangements	-	403
Total current borrowings	**8,002**	**6,633**
Non-current		
Loans from DHSC	10,712	12,049
Lease liabilities	25,161	21,814
Total non-current borrowings	**35,873**	**33,863**

Note 26.2 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 2024	**13,410**	**850**	**25,833**	**403**	**40,496**
Cash movements:					
Financing cash flows - payments and receipts of principal	(1,338)	(850)	(6,347)	(403)	**(8,938)**
Financing cash flows - payments of interest	(515)	-	(437)	(32)	**(984)**
Non-cash movements:					
Additions	-	-	1,185	-	**1,185**
Lease liability remeasurements	-	-	11,137	-	**11,137**
Application of effective interest rate	511	-	436	32	**979**
Carrying value at 31 March 2025	**12,068**	**-**	**31,807**	**0**	**43,875**

	Loans from DHSC	Other loans	Lease Liabilities	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2023	**14,749**	**850**	**25,356**	**1,060**	**42,014**
Cash movements:					
Financing cash flows - payments and receipts of principal	(1,338)	-	(6,035)	(657)	**(8,030)**
Financing cash flows - payments of interest	(566)	-	(204)	(97)	**(867)**
Non-cash movements:					
Additions	-	-	5,820	-	**5,820**
Lease liability remeasurements	-	-	693	-	**693**
Application of effective interest rate	565	-	204	97	**866**
Carrying value at 31 March 2024	**13,410**	**850**	**25,833**	**403**	**40,496**

Note 27.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2024	**625**	**2,249**	**286**	**72**	**19,832**	**23,064**
Change in the discount rate	1	13	-	-	(3)	**11**
Arising during the year	54	204	204	316	870	**1,648**
Utilised during the year	(90)	(147)	(29)	-	(168)	**(434)**
Reversed unused	(23)	-	(154)	-	(168)	**(345)**
Unwinding of discount	15	54	-	-	17	**86**
At 31 March 2025	**582**	**2,373**	**307**	**388**	**20,380**	**24,030**
Expected timing of cash flows:						
- not later than one year;	89	148	307	388	13,872	**14,804**
- later than one year and not later than five years;	357	591	-	-	5,457	**6,405**
- later than five years.	136	1,634	(0)	(0)	1,051	**2,821**
Total	**582**	**2,373**	**307**	**388**	**20,380**	**24,030**

Pension provisions relate to early staff retirements where the Trust is liable. The timing and value of the cash flows are based on known costs and individual demographics.

Injury benefit provisions relate to injury benefit awards where the Trust is liable. The timing and value of the cash flows are based on current costs and individual demographics.

Legal claims relate to outstanding public and employer liability cases. These cases are managed by NHS Resolution on behalf of the Trust.

Other includes dilapidations provisions for the Trust's leasehold premises and a provision against the Trust's exit from its PFI arrangements.

There are no material uncertainties around the timing of these cash flows.

Note 27.2 Clinical negligence liabilities

At 31 March 2025, £3,534k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Oxford Health NHS Foundation Trust (31 March 2024: £6,522k).

Note 28 Contingent assets and liabilities

	31 March 2025	31 March 2024
	£000	£000
Value of contingent liabilities		
Other	(4,175)	(4,175)
Gross value of contingent liabilities	**(4,175)**	**(4,175)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(4,175)**	**(4,175)**

In the event of the Trust not proceeding with the Warneford Redevelopment project once planning permission has been achieved and when funding for the programme has been identified, the Trust will have to reimburse in full the costs that have been jointly incurred through Warneford Park LLP in relation to the planning application and the preparatory work done for this. At the 31st March this figure was capped at £4,175k.

In the event of the Warneford Park LLP withdrawing from the project, the Trust will retain the £1.5m premium paid to the Trust.

Note 29 Contractual capital commitments

	31 March 2025	31 March 2024
	£000	£000
Property, plant and equipment	698	984
Intangible assets	73	548
Total	**771**	**1,533**

Note 30.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2024/25	2023/24
	£000	£000
Present value of the defined benefit obligation at 1 April	**(2,561)**	**(2,614)**
Current service cost	(12)	(20)
Interest cost	(113)	(121)
Contribution by plan participants	(4)	(7)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	235	21
Benefits paid	551	180
Present value of the defined benefit obligation at 31 March	**(1,904)**	**(2,561)**
Plan assets at fair value at 1 April	**2,994**	**2,883**
Interest income	135	135
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial gain / (losses)	(113)	132
Contributions by the employer	11	18
Contributions by the plan participants	4	7
Benefits paid	(551)	(180)
Plan assets at fair value at 31 March	**2,480**	**2,994**
Plan surplus/(deficit) at 31 March	**576**	**433**

Note 30.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2025	31 March 2024
	£000	£000
Present value of the defined benefit obligation	(1,904)	(2,561)
Plan assets at fair value	2,480	2,994
Net defined benefit (obligation) / asset recognised in the SoFP	**577**	**433**
Net (liability) / asset after the impact of reimbursement rights	**577**	**433**

Note 30.3 Amounts recognised in the SoCI

	2024/25	2023/24
	£000	£000
Current service cost	(12)	(20)
Interest expense / income	22	14
Total net (charge) / gain recognised in SOCI	**10**	**(6)**

Note 31 On-SoFP PFI

Description of the scheme

The Oxford Health PFI scheme provides a centre in Oxford for the secure care of 30 clients with mental health problems and 10 clients with learning disabilities. Many of the clients are offenders who have been referred for treatment through the Courts. The scheme also provides a staff accommodation block.

Community Health Facilities (Oxford) Limited have designed, built, financed, maintained and operated the new facility. They are a special purpose company established through three main sponsors:

The Miller Group Limited

Mitie FM Limited (formerly Interserve (Facilities Management) Ltd)

Uberior Infrastructure Investments Limited (formerly British Linen Investments Limited)

Contract Start Date: 06 September 1999

Contract End Date: 05 September 2024*

*** 04 September 2023 was the date the Trust has exercised its break clause. From 05 September 2024, the Trust has legal ownership of the asset.**

The inflation of the PFI scheme is linked directly to RPI.

The contract involved the lease of Trust land to the operator for nil consideration. The substance of this transaction was that it would result in lower annual payments over the life of the contract, i.e. an implicit reduction in the unitary charge since the operator has not had to lease the land on the open market. Consequently the value of the land is recorded within the Trust's total land value.

Note 31.1 On-SoFP PFI obligations

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	31 March 2025 £000	31 March 2024 £000
Gross PFI liabilities	**-**	**440**
Of which liabilities are due		
- not later than one year;	-	440
Finance charges allocated to future periods	-	(37)
Net PFI obligation	**-**	**403**
- not later than one year;	-	403

Note 31.2 Total on-SoFP PFI commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2025 £000	31 March 2024 £000
Total future payments committed in respect of the PFI arrangements	**-**	**1,445**
Of which payments are due:		
- not later than one year;	-	1,445

Note 31.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2024/25 £000	2023/24 £000
Unitary payment payable to service concession operator	**1,349**	**2,969**
Consisting of:		
- Interest charge	32	97
- Repayment of balance sheet obligation	403	657
- Service element and other charges to operating expenditure	426	822
- Capital lifecycle maintenance	-	10
- Contingent rent	488	1,384
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	128	-
Total amount paid to service concession operator	**1,477**	**2,969**

Note 32 Financial instruments

Note 32.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Integrated Care Boards (ICB's) and the way those organisations are financed, the 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. The Trust has limited powers to borrow or invest surplus funds. 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 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.

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 regulator review. The borrowings are for 1 – 20 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 therefore has low exposure to interest rate fluctuations.

Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2025 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 Integrated Care Boards and NHS England, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Note 32.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	13,360	-	**13,360**
Other investments / financial assets	-	1,125	**1,125**
Cash and cash equivalents	97,818	-	**97,818**
Total at 31 March 2025	**111,178**	**1,125**	**112,303**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through OCI	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	15,226	-	**15,226**
Other investments / financial assets	-	1,125	**1,125**
Cash and cash equivalents	85,628	-	**85,628**
Total at 31 March 2024	**100,854**	**1,125**	**101,979**

Note 32.3 Carrying values of financial liabilities

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	12,068	**12,068**
Obligations under leases	31,807	**31,807**
Trade and other payables excluding non financial liabilities	67,608	**67,608**
Total at 31 March 2025	**111,483**	**111,483**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	13,410	**13,410**
Obligations under leases	25,833	**25,833**
Obligations under PFI, LIFT and other service concession contracts	403	**403**
Other borrowings	850	**850**
Trade and other payables excluding non financial liabilities	64,611	**64,611**
Total at 31 March 2024	**105,107**	**105,107**

Note 32.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2025	31 March 2024
	£000	£000
In one year or less	76,075	69,444
In more than one year but not more than five years	21,437	20,716
In more than five years	16,370	17,915
Total	**113,882**	**108,075**

Note 32.5 Fair values of financial assets and liabilities

The book value (carrying value) is a reasonable approximation of fair value.

Note 33 Losses and special payments

	2024/25		2023/24	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	-	-	6	1
Bad debts and claims abandoned	82	29	-	-
Stores losses and damage to property	3	89	3	68
Total losses	**85**	**118**	**9**	**69**
Special payments				
Compensation under court order or legally binding arbitration award	3	22	1	2
Ex-gratia payments	32	40	23	32
Total special payments	**35**	**62**	**24**	**34**
Total losses and special payments	**120**	**180**	**33**	**104**

Note 34 Related parties

Oxford Health NHS Foundation Trust is a body corporately established by order of the Secretary of State for Health. The Department of Health and Social Care is regarded as a related party. During the year the Trust had a number of material transactions with the department, and with other entities for which the department is regarded as the parent department. These entities are listed below in order of significance and represent 83% of the Trusts total income.

- NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
- NHS England
- Department of Health and Social Care
- NHS Bath and North East Somerset, Swindon and Wiltshire ICB
- University Hospital Southampton NHS Foundation Trust
- Royal Berkshire NHS Foundation Trust
- Hampshire Hospitals NHS Foundation Trust
- University Hospitals Dorset NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust

Other bodies that the Trust has had material transactions with are:

- NHS Pension Scheme
- HM Revenue and Customs
- Oxfordshire County Council
- NHS Property Services
- Community Health Partnerships
- Buckinghamshire Council
- NHS Resolution
- The University of Oxford

The Trust has also received payments from the Oxford Health Charity, the trustees for which are also members of the Oxford Health NHS Foundation Trust Board.

The individuals and entities that the Department of Health and Social Care identifies as meeting the definition of Related Parties set out in IAS 24 (Related Party Transactions) are also deemed to be related parties of entities within the Departmental Group.

This note therefore sets out the individuals and entities which we have assessed as meeting the IAS 24 definition of Related Parties for the year ending 31 March 2025 to assist group bodies in preparing disclosures compliant with IAS 24.

Ministers

The Rt Hon Victoria Atkins MP
Andrew Stephenson CBE MP
Andrea Leadsom MP
Helen Whately MP
Maria Caulfield MP
The Lord Markham CBE
The Rt Hon Wes Streeting MP
Karin Smyth MP
Stephen Kinnock MP
Ashley Dalton MP
Andrew Gwynne
Baroness Gillian Merron

Senior Officials

Sir Chris Wormald KCB
Professor Sir Christopher Whitty KCB
Shona Dunn
Clara Swinson CB
Jonathan Marron CB
Matthew Style
Michelle Dyson
Andrew Brittain
Professor Lucy Chappell
Jenny Richardson
Zoe Bishop
Hugh Harris
Lorraine Jackson
Sally Warren
Catherine Frances CB
Tom Riordan

Non-executive Directors

Gerry Murphy
Doug Gurr
Steve Rowe
Samantha Jones
Sir Roy Stone
Will Harris
The Rt Hon Alan Milburn
Richard Douglas
Naomi Eisenstadt CB
Baroness Camilla Cavendish
Phil Jordan

	Categorisation of body added by NHS England	
Listing provided by DHSC	Bodies within government control (see GAM para 5.252: fewer disclosures required for these entities as part of the public sector)	Other bodies
ABF Energy Ltd		ABF Energy Ltd
AB Sugar China North Ltd		AB Sugar China North Ltd
AB Sugar China Ltd		AB Sugar China Ltd
AB Sugar China Holdings Ltd		AB Sugar China Holdings Ltd
Accurx Ltd		Accurx Ltd
Advantage Mentoring C.I.C		Advantage Mentoring C.I.C
Alzheimer's Society		Alzheimer's Society
AM Strategy Ltd		AM Strategy Ltd
Andigital Ltd		Andigital Ltd
Anglofive Ltd		Anglofive Ltd
Apax Partners UK Ltd		Apax Partners UK Ltd
Bridge Consulting London Limited		Bridge Consulting London Limited
Capital & Regional PLC		Capital & Regional PLC
Chock Professional Services Ltd		Chock Professional Services Ltd
CommentSold		CommentSold
Competition & Markets Authority	Competition & Markets Authority	
CRN Thames Valley and South Midlands Partnership	CRN Thames Valley and South Midlands Partnership	
Currys Plc		Currys Plc
Demelza Hospice Care for Children		Demelza Hospice Care for Children
Estover Energy Ltd		Estover Energy Ltd
Extra Time Partners Ltd		Extra Time Partners Ltd
Fareshare		Fareshare
Farnborough Park Consulting Ltd		Farnborough Park Consulting Ltd
Forton Firewood and Sawmill Ltd		Forton Firewood and Sawmill Ltd
GrowUp Group Ltd		GrowUp Group Ltd
Hope Enterprises (Northampton) CIC		Hope Enterprises (Northampton) CIC
Island Research LLP		Island Research LLP
IVC Evidensia		IVC Evidensia
Keys Group Limited		Keys Group Limited
Kindling Transformative Interventions		Kindling Transformative Interventions Ltd
Macmillan Cancer Support		Macmillan Cancer Support
Natural History Museum	Natural History Museum	
Newhaven Fishing Community Interest Company		Newhaven Fishing Community Interest Company
NHS Confederation		NHS Confederation
NHS Employers Policy Board		NHS Employers Policy Board
Nichols and Harris LLP		Nichols and Harris LLP
Northampton Hope Centre		Northampton Hope Centre
Norwood Ravenswood		Norwood Ravenswood
@PVJCIO Ltd		@PVJCIO Ltd
Penneys XI Ltd		Penneys XI Ltd
Place2Be		Place2Be
R2B H Ltd		R2B H Ltd
Samantha Jones Limited		Samantha Jones Limited
Seed Developments Ltd		Seed Developments Ltd
Seed Invesco Ltd		Seed Invesco Ltd

Sightsavers (registered in the UK as Royal Commonwealth Society for the Blind)		Sightsavers (registered in the UK as Royal Commonwealth Society for the Blind)
Social Mobility Foundation		Social Mobility Foundation
South East Medical Services Ltd		South East Medical Services Ltd
Smith Whitty International Consultants Ltd		Smith Whitty International Consultants Ltd
The Alan Turing Institute		The Alan Turing Institute
Top Up TV 2 Ltd		Top Up TV 2 Ltd
Top Up TV Europe Ltd		Top Up TV Europe Ltd
Top Up TV Holdings Ltd		Top Up TV Holdings Ltd
UK Biobank Ltd		UK Biobank Ltd
Unbiased EC1 Ltd		Unbiased EC1 Ltd
XLinks Ltd		XLinks Ltd
Yorkshire Sculpture Park		Yorkshire Sculpture Park

Note 35 Events after the reporting date

None

Note 36 Buckinghamshire and Oxfordshire Pooled Budget

Oxford Health NHS Foundation Trust host two pooled budgets with Buckinghamshire Council and one pooled budget with Oxfordshire County Council.

These are treated as agency transactions and only Oxford Health's proportion of expenditure is recognised in the Trust's accounts.

1 April 2024 to 31 March 2025

Oxfordshire			
Adults of Working Age	£000's	£000's	£000's
Delegated Budgets	**Total**	**Oxford Health Contribution**	**Oxfordshire County Council**
Expenditure			
Pay	11,789	10,021	1,768
Non-pay	447	413	34
	12,236	10,434	1,802
Income	-47	-47	0
Total Delegated Budgets	12,189	10,387	1,802
Overhead Contribution	0	0	0
Contribution to the Pool	**12,189**	**10,387**	**1,802**

Buckinghamshire			
Adults of Working Age	£000's	£000's	£000's
Delegated Budgets	**Total**	**Oxford Health Contribution**	**Buckinghamshire County Council**
Expenditure			
Pay	2,919	0	2,919
Non-pay	146	0	146
	3,065	0	3,065
Income	0	0	0
Total Delegated Budgets	3,065	0	3,065
Overhead Contribution	215	0	215
Contribution to the Pool	**3,280**	**0**	**3,280**

Glossary of Terms

Abbreviation	Term
OCI	Other Comprehensive Income
IFRS	International Financial Reporting Standards
SoCI	Statement of Comprehensive Income
SoFP	Statement of Financial Position
PFI	Private Finance Initiative
GAM	Group Accounting Manual
ICS	Intergrated Care System
ICB	Intergrated Care Board
CQUIN	Commissioning for Quality Innovation
CAMHS	Child and Adolescent Mental Health Services
AED	Adult Eating Disorders
IAS	International Accounting Standards
DHSC	Department of Health and Social Care
API	Aligned Payment and Incentive
BPT	Best Practice Tariffs
PDC	Public Dividend Capital