



Annual Report & Accounts 2025-26

Oxford Health
NHS Foundation Trust

Annual Report and Accounts
2025/26

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Foreword by the Chair and Chief Executive

Over the past year, staff at Oxford Health NHS Foundation Trust have worked hard to deliver high-quality, compassionate care. It is always a privilege to serve and care for people who are at their most vulnerable and we don't take that responsibility lightly.

Our focus on strengthening teams and ensuring we recruit, retain and develop people who work for us is showing results in staff engagement, with capable and well led teams, who in turn are making improvements and innovating to meet the growing demand for all our services. We have also put in place support for people and their families while they wait for care. There is always more to do, but we are proud of what has been achieved over the past 12 months. It provides a strong foundation to move forward.

Although this is a look back, you will notice that this is the first Annual Report for the Trust's new chair, Andrea Young. It is also the last for chief executive Grant Macdonald, who is stepping down later in 2026.

In the last year we saw the publication of the Government's 'Fit for the Future: A 10 Year Health Plan for England' which aims to reform the NHS through three main shifts: moving care from hospital to community, analogue to digital, and from sickness to prevention. These are changes we wholeheartedly support, specifically caring for people closer to home, enabling recovery, is core to what we do.

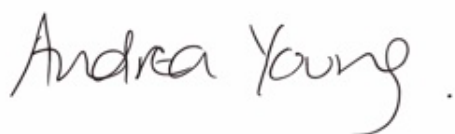
As a Trust we strongly believe in putting people at the centre of their care and are focused on care planning. Over this year we have seen how the rollout of a new patient-first mental health care planning approach across adult services is helping people who use our services to shape their own goals and be more actively involved in decisions about their care. Alongside this, the opening of Murray House in north Oxford marked a significant investment in community-based services, providing a modern base for a wide range of outreach and on-site care for people of all ages.

The work of colleagues at the Trust is recognised throughout the year through a range of awards. Whether it is our own Exceptional People, BEE, Daisy, annual Staff Awards or a range of external prizes, marking and recognising achievement and commitment is a part of our Trust culture.

A strong theme throughout the year has been our commitment to sustainability, innovation and responsible stewardship of public resources. In April, we secured funding to install solar panels at Littlemore Mental Health Centre, supporting our ambition to reduce energy costs and environmental impact. This was followed by the launch of our Green Plan 2025–2028, setting out a clear and practical roadmap to support the NHS's ambition to become the world's first net zero health system.

Research and innovation remain central to our mission. This year saw the submission of plans for the Warneford Park development, a unique partnership that will transform the Warneford Hospital site into a major mental health and medical research campus.

We were also delighted to secure £16.3 million in NIHR funding to support the new Applied Research Collaboration Thames Valley, with Oxford Health as the NHS host. Together with the launch of our Count Me In initiative, these developments will help ensure research makes a difference to patients today and for tomorrow.



Andrea Young
Chair



Grant Macdonald
Chief Executive

Performance Report

Performance overview

Statement from the Chief Executive

Oxford Health NHS Foundation Trust is a sizeable organisation, with a wide geographical spread, meaning that summarising a year of activity can be a challenge. Nevertheless, it is my view as Chief Executive that the Trust performed reasonably well over 2025/26 delivering a wide range of community and mental health services over a broad service geography. Given, the challenges faced by NHS providers – sustained high demand, complexity of need, financial sustainability, and changes to wider NHS structures – our performance underlines the passion and professionalism of the Trust's staff.

My view of Trust performance is supported by examples such as areas of good performance against key metrics set-out in the performance analysis section, NHS England's support for the board's positive provider capability assessment, the Trust's segmentation rating in the National Oversight Framework, feedback from staff as part of the national NHS staff survey, and assurance from auditors on governance controls in place. We remain focused however on areas for improvement, acting on requirements from regulator inspections and against key national metrics.

The performance analysis section of this report sets out the Trust's main metrics and performance against these, and progress against our annual plan and strategic objectives. I recommend reading the Trust's Quality Account alongside this annual report – it sets out well the Trust's activity, challenges, and achievements in quality improvement.

Over the year, the Trust made good progress against our 2025/26 annual plan focusing on service quality improvement, neighbourhood health, waiting times, improving staff experience, digital maturity and strengthening our research capacity. Risk management has been strengthened over the year with the board refreshing its Board Assurance Framework focusing on eleven principal risks. A major focus has been on health inequalities with work underway to improve data quality and insight on a population level to better inform work to reduce health inequalities in access and outcomes.

Areas of good performance to highlight over the year include urgent community response rates, improved performance in the mental health crisis service compared to last year, and consistently good performance in talking therapy services. Performance reporting also identifies areas for focus and improvement including waits for community services, and mental health inpatient lengths of stay. Fuller details on performance can be found later in this report.

Over October 2025, the Trust undertook NHS England's provider capability self-assessment providing an evaluation against key areas such as leadership, quality of care, access to services and financial performance. Following the self-assessment process, the board was satisfied to confirm a positive self-assessment. The Trust's self-assessment was supported by NHS England's South East regional team following its review. Over the year the Trust was placed in 'segment 1' (highest of four) of the

NHS oversight framework segmentation for two quarters, and concluded the reported year in 'segment 2'¹.

The Trust wants to be a great place to work and to begin a career – and there are areas of performance in these areas, in particular continuing to reduce agency use rates and in recruitment and retention rates. The Trust also performed well against national averages in the 2025/26 NHS Staff Survey but also identified some areas to focus on.

Financially, the Trust is in a good position at year end with a surplus above plan, a strong cash position, and remaining within our delegated capital limits. 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 as set out in our Green Plan.

Going into 2026/27 and beyond, the board of directors and other senior leaders will continue to focus on maintaining the quality, performance and sustainability of the Trust's services and will continue to work collaboratively with public services partners and the people we service to realise our strategic ambitions.

This will be my last annual report at the Trust as I will be retiring over September 2026. I believe that I leave the Trust in a good position with the stability needed to realise the ambitions set out in the imminent new Trust strategy, work towards the NHS 10 year plan and, most importantly, to continue to deliver good quality care for the people we serve.

[Year at a glance](#)

April 2025 - *New solar panel funding awarded to Oxford Health – The Trust was awarded £343,000 to install solar panels at Littlemore Mental Health Centre, Oxford as part of a nationwide £100 million Department for Energy Security and Net Zero package aimed at increasing installation of solar power and battery storage solutions.*

May - *Patient-first mental health care planning rolling out across adult services* - A new mental health care planning process was introduced to improve involvement and choice, strengthening the Trust's continued commitment to care planning. Adults who use community mental health services are now invited to work with their Mental Health Practitioner to set out how their care will be delivered and the goals they want to achieve for their own lives.

June - *New Trust facility in Oxford sees first patients* - Murray House in Jordan Hill Business Park, North Oxford, was opened as a new base for a range of community healthcare services provided by Oxford Health. The refurbished venue now offers both outreach and on-site care — from district nurses and health visitors to podiatry and specialist therapy services for all ages.

¹ Quarter 4 (published in June 2026) was reported nationally that the Trust was in *segment 3*, however this was due to an error in the Trust's submitted data. The NHS regional team confirmed that, although the NOF position could not be amended, the true performance of the Trust was in *segment 2* and should be recognised.

July – *Launch of the Green Plan 2025 – 2028* - The Trust officially launched its Green Plan 2025–2028, setting out a practical roadmap to reduce the Trust’s environmental impact and support the NHS’s national ambition to become the world’s first net zero health system.

August - *Planning application submitted for a major mental health and medical research campus* - Plans to transform the Warneford Hospital site in Headington into a major mental health and medical research campus were submitted this month to Oxford City Council by the Trust. The Warneford Park project is a unique collaboration between the Trust, the University of Oxford and a benefactor that would see the creation of brand-new facilities that will benefit patients and support the advancement of medical research and mental health and brain science.

September - *Our next steps – shaping Oxford Health together* - The Trust invited patients, carers, members of the local communities and partner organisations to take part in a short survey that will help shape its plans for the next five years. With the publication of the government’s 10 Year Health Plan, and the Trust’s strategy coming to an end, patients, partners and local communities were invited to give their views on about how the Trust can improve and make Oxford Health’s services fit for the future.

October - *£16.3m boost for health research across the Thames Valley* -Oxford Health, the University of Oxford and Aston University secured £16.3 million to strengthen health and care research aimed at improving people’s health across the Thames Valley and beyond. The funding, awarded by the National Institute for Health and Care Research, will support the new NIHR Applied Research Collaboration (ARC) Thames Valley from April 2026, with Oxford Health confirmed as the NHS host organisation.

The collaboration will focus on prevention, reducing health inequalities and accelerating the use of research evidence in everyday health and social care. It will work with more than 40 partners, including NHS organisations, local authorities, universities, businesses and voluntary sector groups.

November - *Count Me In launches* - Count Me In, Oxford Health’s approach to make research participation easier, fairer and more inclusive. Patients who use the Trust’s services and haven’t opted out, may be contacted about studies that are relevant to them. Participation is always voluntary. This new approach means more people will hear about research, participants will be recruited more quickly, research will reflect the diversity of our communities and patients will help shape future studies

December - *New chair announced* - The Trust announced that Andrea Young will become Chair of Oxford Health NHS Foundation Trust from 1 April 2026, following the completion of David Walker’s term at the end of March. Andrea has been a valued non-executive director at the Trust since 2022 and brings a wealth of experience and leadership to this role. She began her NHS career in 1977 as a student nurse and later trained and practiced as a midwife. Andrea went on to hold a range of CEO roles in the NHS at regional and local level, culminating in her appointment as chief executive of North Bristol NHS Trust, a position she held until her retirement in 2020.

January 2026 - *Chief executive to retire later this year* - Grant Macdonald, Chief Executive of Oxford Health NHS Foundation Trust, announced his intention to retire from the NHS later this year. Grant has worked for the NHS for nearly four decades, training as a mental health nurse in the late 1980s and later holding senior executive

positions across London and the South East for over two decades. His extensive clinical and leadership expertise has been instrumental in advancing care for patients and local communities.

February - *TUNE-UP service boosts access to clozapine* - A new study shows that Oxford Health's TUNEUP clinic has had a significant impact by enabling many more patients to start clozapine safely in the community showing a dramatic increase in the number of patients able to start clozapine safely in the community. Clozapine remains the only evidence-based pharmacological treatment for people with treatment-resistant schizophrenia, yet many patients face long delays in accessing it, often because initiation typically requires an inpatient stay.

March - *Changes to the Trust board* - Oxford Health welcomed Harjit Sandhu to its board as a new Non-Executive Director and Chair of the Audit and Risk Committee. Trust Chair, David Walker, stepped down to be replaced by Andrea Young.

History of Oxford Health NHS FT, 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 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 Health Services, Dentistry and 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 specialist mental health 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. 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.

Our current strategy will shortly be coming to an end. Over 2026, we have been engaging with staff; patients, families and carers; communities; partner organisations and the Oxford Health Board and Governors to develop the Trust's new strategy (2026-2031). This will be published in later 2026. Until then, 2025-26 is the second of two 'bridging' years in which we continue to focus on our existing strategic objectives:

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.

Our refreshed strategy delivery plan for 2025/26 and 2026/27 bridges the transition between our current and future strategy, and is structured as follows:

Our six strategic priorities are:

1. Developing our neighbourhood health contribution to improve the health of the populations we serve
2. Improving access and waiting times
3. Listening and responding to the voice of patients, families and carers
4. Supporting our people and teams (developing our culture in Oxford Health)
5. Building an anti-discriminatory organisation
6. Prioritising staff safety and minimising violence and aggression

Our Trust-wide supporting work:

1. Continuing to improve the quality and safety of the care we provide through embedding quality improvement (in development)
2. Develop and provide innovative clinical services, and support world-class research (in development)
3. Improving how we use insights and deliver value (in development)
4. Improving our central support and corporate services
5. Measuring and improving outcomes for our patients
6. Rolling out our Frontline Digitisation programme
7. Building our workforce planning approach (in development)
8. Implementing our Operating Framework and building our Well-led Assurance
9. Improving our estates, including delivering the Warneford Park programme
10. Delivering our Green Plan

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 in the Trust's Risk Management Strategy & Policy which was reviewed and updated over the reported year with approval from the Audit & Risk Committee (February 2026). Risks assessed as significant are monitored to ensure mitigating actions are undertaken to reduce risks to an acceptable level where possible.

Strategic organisational risks are captured and monitored in the Trust's Board Assurance Framework (BAF). From early 2025/26, the BAF was reviewed and refreshed, including focused board workshop discussions. The refreshed BAF was approved by the Board in July 2025 and is structured around eleven strategic risks. Individual BAF risks are owned and maintained by the relevant Executive director and overseen by a board committee. BAF updates are reported to each Board meeting and once a quarter to the Executive Management Team.

Operational 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 and seeking approvals for escalation and de-escalations where required.

Over 2025/26, principal risks for the Trust as captured and monitored in the BAF were: timely access to services; quality & safety of clinical services; financial sustainability; recruitment and retention; staff experience and culture; improvement, research and innovation; environmental sustainability; information and data; partnerships and system working; digital transformation; and infrastructure.

Over quarter 4 2025/26, the Trust's internal auditors undertook an audit of the Trust's BAF and reported 'significant assurance with minor improvement opportunities'. Recommended actions will be completed over 2026/27 and will be reported to the Audit & Risk Committee.

Performance analysis

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, national and local reporting performance requirements; it also contains NHS Oversight Framework (NOF) reporting overview. The report continued to be developed further to provide comprehensive oversight of Trust performance measures with further improvement identified to be implemented over the next financial year (2026/27).

The Performance Management Framework within the Trust facilitated the implementation of a ward-to-board approach, wherein directorate-specific versions of the IPR continued fostering a deeper understanding of the performance management framework and enhanced clinical and operational performance management. This approach further 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 groups: strategic, clinical, quality and people metrics, ensuring a thorough evaluation of the Trust's performance. Performance against strategic objectives and metrics can be found in the following section. An overview of NHS Oversight Framework (NOF) performance can be found in the Accountability Report. Performance metrics are derived from nationally reportable metrics, national objectives and locally agreed metrics. A summary of 2025/26 performance can be found in *appendix 1*.

Annual plan 2025/26

Progress against the Trust's Annual Plan 2025/26 was reported to the Board of Directors mid-year and at year end. A summary of progress against our strategic objectives and strategic priorities is set out below:

Strategic objectives

1. 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. In 2025/26 over 80% of patients responded to say that their care was good or very good, and that they were involved in their care. We have worked with system partners to develop neighbourhood health and care approaches to strengthen prevention, access and population health management across Oxfordshire, Buckinghamshire and Bath, Swindon and Wiltshire.

A focus on waiting lists has improved governance and performance, reducing long waits in children's community services and strengthening harm-minimisation in mental health. Patient engagement and co-production have become more consistent across the Trust, with improvements enabling people to more easily use their lived experience to influence care. Focused work is taking place to reduce use of restrictive practice.

2. Be a great place to work

We aim to maintain a sustainable, engaged, well-led, skilled, and just workforce. A culture plan is being developed to align with the new Strategy and strengthen our work to be a great place to work. Violence prevention and reduction was strengthened through a new policy, improved governance, formal joint working with Thames Valley Police. We have delivered improvement on retention and vacancy-filling while doing better than our target on reduction of the use of agency staff. The trust achieved its highest response rate since 2009 in the annual staff survey and score above average for our sector across all people plan themes. A focus remains on improving the staff experience for those colleagues who are from ethnic minority backgrounds.

3. Make 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. The Trust has met financial targets in FY26 and set balanced plans for FY27, FY28 and FY29. The Board approved Oxford Health's new Green Plan, including expanding green social prescribing and other nature-based approaches. Increased business mileage has meant milestones to meet the required direct carbon emission reduction have been missed and work is ongoing to strengthen our approach, notably the development of a sustainable transport strategy to enable lower-carbon travel. Digital work has progressed to strengthen our digital maturity with the Trust benchmarking 2nd in its sector in the 2025 survey. Work is ongoing with all clinical directorates to support the development of our Estates and Facilities Strategy.

4. 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 Nurses, Midwives, Allied Health Professionals, Healthcare Scientists, Pharmacists, and Psychologists Research Capacity and Capability programme to strengthen research skills across these key professional groups. A £16.3m award was secured to host the National Institute for Health and Care Research Applied Research Collaboration Thames Valley from April 2026 with the University of Oxford and Aston University. The work will focus on improving the health of people living in the Thames Valley region and beyond, through prevention and innovations.

Strategic priorities

1. Developing our neighbourhood health contribution to improve the health of the populations we serve

During 2025/26, Oxford Health began developing a neighbourhood health and care approach focused on prevention, accessibility and population health management, while also strengthening its Trust-wide approach to tackling health inequalities. The

year has focused on establishing governance, system alignment and early foundations for delivery, alongside improving visibility of variation in access and waiting times to identify more equitable approaches. Progress of neighbourhood health and care approaches has progressed at different stages across systems:

- Buckinghamshire: supporting the first wave of the national Neighbourhood Health Improvement Programme, with Integrated Neighbourhood Teams established across six localities, strong multi-agency engagement, and strengthened governance linked to the Buckinghamshire Executive Partnership.
- Oxfordshire: establishing core foundations for delivery, including agreed governance arrangements, fifteen working-draft neighbourhood geographies, a shared neighbourhood vision and early neighbourhood-level engagement to shape future priorities.
- BSW: aligning system models and infrastructure, initially focused on adult services, progressing neighbourhood approaches for children and young people, and supporting system-wide capital bids

Across all areas, clinical and community teams are increasingly working within neighbourhood models, including closer alignment of primary care mental health services, school-based support for children and young people, and specialist services contributing to integrated care pathways. Work is also underway to strengthen the use of population health data to better understand inequalities and target support to underserved groups.

2025/26 has focused on creating the conditions for more integrated, neighbourhood-based delivery, with stronger implementation and more sophisticated use of insight expected to develop further in 2026/27.

2. Improving access and waiting times

Oxford Health made progress in strengthening its approach to improving access and waiting times across services. The focus was on establishing more consistent governance, improving data quality and embedding systematic oversight to support delivery against local and national expectations. Key progress included:

- More consistent governance and oversight of waiting times, with regular review through pathway-level, directorate-level and Trust-level forums across community and mental health services.
- Standardised approaches to triage, safety-netting and pathway management, supported by clearer KPIs, reporting timelines and routine performance review.
- Improved understanding of demand and capacity, with modelling completed across priority pathways and agreed trajectories and implementation plans signed off through directorate boards.
- Stronger operational grip and harm-minimisation, including targeted scrutiny of longest waiters, routine review in mental health service and performance meetings, and wellbeing and mitigation calls for people waiting for services.

- Targeted pathway improvement and partnership working where waits were highest, alongside increasing use of an ethnicity and deprivation lens to identify potential health inequalities.
- Reductions in the longest waits, including the elimination of all 104-week waiters in Children and Young People's services, no 52-week waiters in most adult community services by March 2026, and services broadly on track to deliver agreed performance trajectories.

2025/26 has been a year of strengthening grip, consistency and forward planning in the management of waiting times across services.

3. Listening and responding to the voice of patients, families and carers

Oxford Health made progress in strengthening how it listens to, involves and responds to the voices of patients, families and carers, moving toward a more consistent Trust-wide approach. The focus was on building the infrastructure, capability and governance needed to embed lived experience more routinely. Progress included:

- Strengthening co-production and involvement through a new Trust-wide training offer, refreshed resources and clearer support for Experts by Experience.
- Increasing the visibility of lived experience within governance, including changes to induction, Board development and the introduction of lived experience representation at Trust Board from May 2026.
- Improving consistency in how patient and carer feedback is gathered, used and reflected in decision-making, with alignment to PCREF and wider quality improvement work. A dashboard pulling together patient feedback and experience is in development.
- Expanding opportunities for patients, families and carers to shape services, including forums, "Have Your Say" events, and carer engagement activities.

2025/26 has focused on putting the foundations in place to embed lived experience more consistently across the Trust, with further maturity and impact expected to develop in 2026/27.

4. Supporting our people and our teams (developing our culture in Oxford Health)

Progress focused on understanding current culture activity and putting the foundations in place for a more coherent Trust-wide approach. The appointment of a Deputy People Director towards the end of Q3 provided leadership and momentum for this work, which was primarily diagnostic and design-led. Progress included:

- A Trust-wide stocktake of existing activity against the culture framework, identifying strengths, duplication and gaps. Five "asks" for all teams have been identified.

- Recognition of the need for a more joined-up and consistent approach to culture, leadership and development activity.
- Establishment of a small cross-functional working group, led by the Deputy People Director, to co-design priority culture workstreams and develop proposals for Executive consideration.
- Embedding trauma-informed and compassionate leadership approaches, including strengthened supervision, Trauma Risk Management (TRiM) support, and a focus on supportive team culture.
- Using staff survey feedback to inform local action planning.

2025/26 has laid the groundwork for a more coherent and focused approach to culture, with delivery expected to progress in 2026/27.

5. Building an anti-discriminatory organisation

An anti-racist statement has been drafted following consultation with colleagues and will be taken to governance groups in the Trust for discussion and agreement. A programme of work will be scoped to support this statement which will join up with the work already underway on our EDI Plan and more broadly on staff engagement.

6. Prioritising staff safety and minimising violence and aggression

Oxford Health strengthened its approach to staff safety and Violence Prevention and Reduction (VPR), moving beyond a narrow zero-tolerance approach toward a more trauma-informed and preventative framework. The year focused on policy refresh, clearer governance and improved assurance, alongside strengthening staff support and partnership working. Progress included:

- Establishing a task force with engagement from all directorates to prioritise work streams and identify actions needed.
- Implementation of a new Violence Prevention and Reduction Policy, replacing the previous Zero Tolerance Policy and clarifying expectations around risk, reporting and support.
- Strengthened governance and assurance arrangements, aligned to the NHS England VPR Standard, with improved oversight through Quality, Health and Safety and VPR forums.
- Ensuring that all inpatient areas have appropriate health and safety risk assessments and plans in place.
- Enhanced partnership working, including the introduction of Operation Cavell in Oxfordshire to support staff affected by criminal assaults.
- Improved data quality and visibility of trends, supporting better understanding of risks across inpatient and community services.
- Strengthening of de-escalation, trauma-informed care.
- Introduction and rollout of measures to improve staff safety in community settings, including enhanced lone worker support.
- Ongoing use of incident review processes and governance forums to identify trends, share learning and implement targeted action

2025/26 has established a stronger and more consistent framework for preventing and responding to violence and aggression, with remaining risks and gaps clearly identified to inform priorities for 2026/27.

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 Executive 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, chaired by the Executive Director of Corporate Affairs and comprising representatives from service directorates, Communications, Information Management and Technology, Human Resources, and Estates and Facilities. 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 2025/26 the Trust participated in the following tabletop exercises: Adastra clinical system outages, a cyber incident affecting pathology services across the South East, a hostage situation within a forensic mental health setting, and a psychosocial response scenario involving convening a humanitarian assistance centre management group meeting, followed by a live exercise to test the psychosocial response at a humanitarian assistance centre. A multi-agency communications cascade exercise also took place to test the timely flow of incident response information between NHS organisations.

The following live events required the implementation of incident response plans and business continuity plans. Learning from live events is captured by the emergency planning lead and debrief reports are presented to the Trust's EPRR committee. OHFT responded effectively to industrial action by BMA Resident Doctors, which required activation of the Trust's industrial action response plan and set up of the incident coordination centre to manage the impact of the industrial action. The Trust also responded periods of high temperatures during summer 2025 which required the heatwave plan to be activated (including five yellow and three amber alerts), a mains water outage affecting OX3, OX4 and OX33 areas including Warneford Hospital, and a supply chain disruption affecting inpatient meal provision across the Trust's inpatient services.

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. The Trust declared full compliance with all 58 core standards and submitted a statement of compliance to Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board following review of the self-assessment by the accountable emergency officer and the EPRR committee, which was assessed and

accepted at a confirm and challenge meeting on 28 October 2025. In addition to the core standards, the annual assurance process ordinarily seeks to review and understand one subject area in greater detail, referred to as a 'deep dive'. A deep dive was not conducted this year owing to organisational changes within NHS England.

Quality account

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 setting 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 Quality Accounts can be found on the Trust's website by searching online for: *Oxford Health Quality Account*.

Financial performance and Capital expenditure statement

In the financial year 2025/26, the Trust ended the year with an adjusted operating surplus of £9.7m² (£2.2m in 2024/25), which was £4.9m better than planned due to additional NHSE funding received in month 12 of £4.9m as part of an NHS wide reallocation. The Trust also remained within its delegated capital limits.

The Trust's turnover increased by £59m to £752m (£693m in 2024/25). Income relating to patient care activities formed £45m 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 £7m, with further investment into community services of £3.3m. Other targeted investment through NHSE's strategic development fund was received into talking therapies and individual placement support services.

Non-clinical income has increased by £13m from £82m in 24/25 to £95m in 25/26, primarily driven by Oxford Pharmacy Store sales growth. Other non-clinical areas have largely remained static with Research and Development seeing funding reduced marginally from £33m in 24/25 to £32.2m in 25/26.

OHFT remains the lead provider for three NHS provider collaboratives, whereby we hold the budgets and commissioner responsibilities for specialised commissioning services. These are Forensics Inpatient Mental Health, CAMHS Tier 4 care and Adult Eating Disorders. All three provider collaboratives underspent against annual planned budget, generating savings to be reinvested in the future. Both the Forensics and CAMHS provider collaboratives have developed plans for reinvestment.

The Trust's cash balance remains in a strong position, at £98.8m compared to £97.8m in 2024/25, retaining one of the strongest cash positions in the local area.

During 2025/26 the Trust's capital investment into estates and ICT totalled £14.3m. ICT investment focused on clinical systems development work and devices. Estates investment had no one significant in year scheme, focussing on smaller upgrades and urgent works.

² Adjusted operating surplus is the target against which the Trust is managed by NHS England and our local Integrated Care Board. It differs from the reported deficit as it excludes impairments and other costs totalling £0.1m as is set out in note 2 to the accounts.

The Trust's gearing ratio (the percentage of capital employed that is financed by debt and long-term financing) is 16.5% (21.1% in 2024/25). Overall, debt liabilities (Department of Health and Social Care loan and lease liabilities) decreased by £6.4m to £37.5m in 2025/26 from £43.9m in 2024/25.

Total assets employed increased by £19.7m in 2025/26 to £227.5m (£207.8m in 2024/25). This reflects an increase in the value of the Trust's current assets of £8.2m to £133.2m (£125m in 2024/25), driven by increased inventories (£1.1m), receivables (£6.3m) and cash balances (£1m). Current liabilities reduced in 2025/26 to £135.9m from £139.4m in 2024/25. Non-current liabilities also reduced, from £46.6m in 2024/25 to £38.3m in 2025/26 due to reduced 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 & 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, principal risks, and strategy.

The Trust has prepared its 2025/26 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

Health inequalities are systemic, unfair and avoidable differences in health status between different groups of people which are often determined by the social and economic conditions and circumstances in which they are born, grow, work, live and age. These conditions also affect the way in which people are able to look after their own health and use NHS services throughout their life.

NHS trusts must have regard to all likely effects of decisions in relation to the health and wellbeing of people and the quality of services provided to individuals including in relation to inequalities. Trusts must also include a description in their Annual Report of the extent to which NHS England's Statement on information about inequalities (updated November 2025) have been met.

NHS England expects NHS bodies to collect, analyse and publish data to:

- understand population health need by drawing on local analysis, demographic insight and population health outcomes data to identify the risk factors for health inequalities and Core20PLUS population groups;
- disaggregate data (at a minimum by deprivation, ethnicity, age, and sex) and analyse performance data and local service insight to identify unwarranted variation in access and outcomes across population groups and geographies;
- improve data quality, collection and analysis by identifying gaps in datasets (including where key demographic data is recorded as unknown or not stated) and identifying practical steps to make improvements;

- use information on health inequalities to take action across commissioning and service delivery, and evaluate impact on reducing health inequalities;
- publish information on health inequalities as part of annual reports, and embed health inequalities data into other data publications throughout the financial year, such as public board papers, through any relevant channels.

Reducing health inequalities is a central element of Oxford Health's strategy. The Trust's Quality strategic objective commits us to reducing unwarranted variation and improving outcomes. Work is ongoing to improve data quality and reporting. Our strategic priority "Developing our neighbourhood health contribution to improve the health of the populations we serve" places population need, local context and partnership working at the centre of service planning.

We are using information on deprivation, local demographics and Core20PLUS principles to identify priority neighbourhoods and cohorts. Our strategic priority '*Building an anti-discriminatory organisation*' aims to create an equitable and inclusive workplace. In particular, this work builds on our existing Equality, Diversity and Inclusion (EDI) and our Patient and Carer Race Equality Framework (PCREF) programmes of work. The aim is to build an organisational framework for being an anti-discriminatory organisation with key measures and outcomes to monitor implementation throughout the organisation.

During 2025/26, the Trust strengthened its Trust-wide approach to health inequalities. Our Executive and Board discussions have emphasised the need for consistent understanding, use of data and clear governance with oversight of health inequalities being embedded in quality, performance and assurance processes.

In October 2025, the Trust agreed a three-step approach to tackling health inequalities: strengthening understanding and visibility of inequalities; supporting targeted action through directorate governance; and tracking progress over time.

- The focus of 2025/26 has been on building the foundations for this approach, including improving data quality and consistency, developing a Health Inequalities dashboard within the Trust's Online Business Intelligence (TOBI) system, and working to produce Health Inequalities data packs aligned with the Core20PLUS approach to support directorates to use aligned information within their existing performance and governance meetings.
- The Trust also began early work to develop population-level insight, including linking Trust data with system partner data through Connected Care, recognising this remains at an early stage.
- Next steps will explore how the Trust can develop a patient lens view of Health inequalities across its services.

In line with NHS England's statement of information on health inequalities (duty under section 13 of the NHS Act 2006), this work puts the Trust in good stead to fulfil its health inequalities legal duties and inform an evidence-led improvement approach to healthcare inequalities, in line with Core20PLUS5.

The Trust works with system partners to strengthen prevention, improve population health and reduce health inequalities, including through developing

neighbourhood-based approaches informed by Core20PLUS5, contributing to Health and Wellbeing Partnerships, supporting ICB-led prevention priorities, and engaging with the Oxfordshire Marmot Place Advisory Group.

Net zero performance

The Annual Governance Statement section of this report summarises the Trust's net zero and carbon reduction activity and plans.

Equality of service delivery

As a provider of mental health, community healthcare, and learning disability services, Oxford Health is committed to providing equality of opportunity, access, and treatment to the communities we serve. The Trust has policies in place to work to eliminate unlawful discrimination and harassment and has a quality impact assessment process and policy in line with the 2010 Public Sector Equality Duty to actively consider equality in decision-making in service development, transformation and policy development.

Over the reported year, the Trust has strengthened governance, made improvements in ethnicity data, enhanced staff network activity, and made commitments to anti-racist practice to demonstrate our determination to deliver equitable care, and foster a workplace where every colleague feels valued and able to fully contribute. The national Patient and Carer Race Equality Framework (referred to as PCREF), implemented last year at the Trust, enables co-production and implementation of actions to reduce racial inequalities. Continuing to enhance equality data is an area of focus to support improved monitoring and assurance.

As noted, over the reported year the Trust strengthened its approach to health inequalities focusing on consistent use of data to better understand, act on, and continue to address health inequalities in line with NHS England's statement on information on health inequalities. This work will be a key focus going into 2026/27.

Performance Report

Signed:

Date: 25 June 2026



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 was David Walker, the chief executive was Grant Macdonald, and the position of senior independent director was undertaken by Andrea Young.

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

- Dr Rob Bale, who took up the permanent position as Chief Operating Officer for Mental Health and Learning Disability, having served as Interim Chief Operating Officer for Mental Health and Learning Disability from October 2023 to November 2025;
- Emma Leaver, who took up the permanent position as Chief Operating Officer for Community Health Services, Dentistry & Primary Care, having served as Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care from March 2025 to December 2025; and
- Professor Kamal Mahtani, as Non-Executive Director Nominee of the University of Oxford from April 2026.

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 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 2025/26:

Executive Directors

Voting Executive Director Members of the Board:

- Dr Rob Bale, Chief Operating Officer of Mental Health & Learning Disabilities
- Charmaine De Souza, Chief People Officer
- Britta Klinck, Chief Nurse
- Emma Leaver, Chief Operating Officer for Community Health Services, Dentistry & Primary Care
- Grant Macdonald, Chief Executive
- Dr Karl Marlowe, Chief Medical Officer
- Heather Smith, Chief Finance Officer

Non-voting Executive Director Members of the Board:

- Amélie Bages, Executive Director of Strategy
- Taff Gidi, Executive Director of Corporate Affairs

Non-Executive Directors

Voting members of the Board:

- David Walker (Chair)
- Chris Hurst (Vice Chair)
- Geraldine Cumberbatch
- Kamal Mahtani
- Mohinder Sawhney
- Professor Sir Rick Trainor
- Lucy Weston
- Andrea Young (Senior Independent Director)

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 in the table below (longest serving first). Harjit Sandhu is included in the table as served 5 days as Non-Executive Director within the reported period.

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	01/03/2026 - 31/03/2027	Within final term - up to one further year
David Walker	01/04/2019	3rd	01/04/2025 – 31/03/2026	Final term
Mohinder Sawhney	01/01/2021	2nd	01/01/2024 - 31/12/2026	Up to one further term
Andrea Young	01/01/2022	2nd	01/01/2025 - 31/12/2027	First term as Trust Chair 01/04/2026 - 31/03/2029
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	01/04/2026 - 31/03/2028	Up to one further term
Prof. Kamal Mahtani	01/04/2025	1st	01/04/2025-31/03/2028	Up to two further terms
Harjit Sandhu	27/03/2026	1st	27/03/2026-31/03/2029	Up to two further terms

Skills and experience

The Trust considers that the composition of the Board is balanced, complete and appropriate to the requirements of the Trust. Assessments of skills needs are taken into account during recruitment exercises for Non-Executive Directors and discussed

at Council of Governors' Nomination and Remuneration Committee meetings. 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
<i>Non-Executive Directors</i>		
David Walker (Chair)	10/10	3/4
Geraldine Cumberbatch	5/10	3/4
Chris Hurst	10/10	4/4
Prof. Kamal Mahtani	8/10	0/4
Mohinder Sawhney	9/10	3/4
Professor Sir Richard Trainor	9/10	4/4
Lucy Weston	10/10	4/4
Andrea Young	10/10	3/4
<i>Voting Executive Directors</i>		
Grant Macdonald (Chief Executive)	10/10	4/4
Dr Rob Bale	10/10	2/4
Charmaine De Souza	10/10	2/4
Britta Klinck	9/10	1/4
Emma Leaver	9/10	2/4
Dr Karl Marlowe	9/10	0/4
Heather Smith	9/10	3/4
<i>Non-voting Executive Directors</i>		
Amélie Bages	10/10	3/4
Taff Gidi	9/10	4/4

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, 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
Geraldine Cumberbatch (deputising)	1/5
Professor Kamal Mahtani (deputising)	1/5
Professor Sir Richard Trainor	5/5

Given the skills and experience of Audit & Risk 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
<i>Core members</i>	
Lucy Weston (Chair)	6/6
Amélie Bages	5/6
Dr Rob Bale	6/6
Taff Gidi	4/6
Emma Leaver	4/6
Mohinder Sawhney	6/6
Heather Smith	6/6
David Walker	6/6
<i>Attending Board members</i>	
Grant Macdonald (Chief Executive)	4/6

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 it is discharging its 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
<i>Core members</i>	
Andrea Young (Chair)	5/5
Dr Rob Bale	5/5
Geraldine Cumberbatch	0/5
Taff Gidi	5/5
Britta Klinck	5/5
Dr Karl Marlowe	4/5
Dr Emma Leaver	3/5
Lucy Weston	5/5
<i>Attending Board members</i>	
Amélie Bages	1/5
Charmaine De Souza	0/5
Grant Macdonald	2/5
Heather Smith	1/5
David Walker	5/5

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	0/4
Dr Rob Bale	3/4
Geraldine Cumberbatch	3/4
Charmaine De Souza	3/4
Taff Gidi	3/4
Britta Klinck	4/4
Emma Leaver	4/4
Andrea Young	4/4
<i>Attending Board members</i>	
Grant Macdonald	3/4
Karl Marlowe	1/4
Heather Smith	1/4

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)	4/4
Taff Gidi	3/4
Karl Marlowe	4/4
David Walker	4/4
Rob Bale	4/4
<i>Previous members prior to change in membership</i>	
Mark Underwood	4/4
Amy Allen	4/4

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
Charmaine De Souza	3/4
Taff Gidi	4/4
Chris Hurst	4/4
Britta Klinck	2/4
<i>Attending Board members</i>	
Emma Leaver	3/4
Grant Macdonald	3/4
David Walker	4/4

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	2025/26		2024/25	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	59,162	355,993	57,801	364,849
Total Non-NHS trade invoices paid within target	53,762	338,150	52,504	341,093
Percentage of Non-NHS trade invoices paid within target	90.9%	95.0%	90.8%	93.5%
Total NHS trade invoices paid in the year	6,877	85,556	6,350	59,279
Total NHS trade invoices paid within target	5,632	81,935	5,440	51,528
Percentage of NHS trade invoices paid within target	81.9%	95.8%	85.7%	86.9%

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 has key role in the governance of the organisation meeting provisions of foundation trust status 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 8 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
Buckinghamshire, Oxfordshire & Berkshire West Integrated Care System		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, September, December, and March).

Governor elections were held over Spring 2025 (for new governors to begin terms on 1 June 2025). Eleven governors were elected. The Trust used an external elections agency to ensure its independence from the governor election process. Since the 2025 election, two governors have replaced those originally elected. The next governor elections are scheduled to take place in 2027.

The table below shows the governors in post within the period 1 April 2025 to 31 March 2026 and their attendance at the available general meetings of the Council in June

2025, September 2025, December 2025, and March 2026. This table does not include governors who ceased to be governors within three months of their term start date. The table does not include governors who stood down at the end of their terms in May 2025 – these being Emma Short, Martyn Bradshaw and Petr Neckar (all Staff governors) and Cllr Zahir Mohammed (Appointed governor – Buckinghamshire Council).

Elected Governors				
Name	Constituency and Class	Term period	Term	Meeting Attendance
Evin Abrishami	Staff: Oxfordshire, Banes, Swindon & Wiltshire Mental Health Services	01/06/2025-31/05/2028	2	3/4
Jan Churchill	Public: Rest of England & Wales	01/06/2025-31/05/2028	1	0/4
Kate England	Patient: Carers	01/06/2025-31/05/2028	2	1/4
Julien FitzGerald	Patient: Service Users Buckinghamshire and other Counties	01/06/2024-31/05/2027	2	3/4
Nyarai Humba*	Patient: Carers	01/06/2024-31/05/2027	2	0/2
Juliet Hunter	Public: Oxfordshire	01/06/2024-31/05/2027	1	3/4
Colleen Jones	Public: Buckinghamshire	01/06/2025-31/05/2028	1	4/4
Benjamin McCay	Patient: Service Users Oxfordshire	01/06/2024-31/05/2027	2	0/4
Nicky Miller*	Staff: Oxfordshire Mental Health Services	01/06/2025-31/08/2025	1	0/1
Pete Logan**	Staff: Oxfordshire Mental Health Services	01/09/2025-31/05/2028	1	0/3
Vicki Power	Staff: Buckinghamshire Mental Health Services	01/06/2024-31/05/2027	2	3/4
Tichakunda Rusike	Staff: Specialised Services	01/06/2025-31/05/2028	1	3/4
Srikesavan Sabapathy	Public: Oxfordshire	01/06/2025-31/05/2028	2	3/4

Anu Saproo**	Public: Oxfordshire	22/08/2025-31/05/2028	1	0/3
Tanveer Siyan	Patient: Carers	01/06/2025-31/05/2028	1	2/4
Marc Smith	Public: Buckinghamshire	01/06/2025-31/05/2028	1	4/4
Jules Timbrell	Staff: Corporate Services	01/06/2024-31/05/2027	1	0/4
Appointed Governors				
Name	Constituency and Class	Tenure	Term	Meeting Attendance
Kate Gregory (Cllr)	Oxfordshire County Council	06/06/2025-05/06/2028	1	1/4
Carolyn Llewellyn	Oxford Brookes University	07/09/2023-06/09/2026	1	2/4
Paul Ringer	Age UK Oxfordshire	16/09/2023-15/09/2026	1	3/4
Joel Rose	Buckinghamshire Mind	03/03/2024-02/03/2027	1	3/4
Graham Shelton	Oxford University Hospitals Trust	01/08/2023-30/07/2026	1	2/4

**ceased to be a governor during term*

***replacement governor of originally elected governor*

Lead governor

The Council of Governors has appointed a lead governor in line with the *Code of Governance for NHS provider trusts*. Vicki Power (Staff governor – Buckinghamshire Mental Health Services) was first appointed as lead governor in January 2025 and re-appointed for another calendar year in December 2025 to the end of 2026.

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 and, with permission, observation of board committee meetings;
- attendance and/or presentations at Council of Governor meetings by Board of Directors including individual Non-Executive Director updates on their recent work and 3As reports on committees chaired;
- joint attendance by Non-Executive Directors and governors at Governor and Non-Executive private informal 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.

Over 2025/26 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 October 2025, a joint member engagement event was held with Oxford University Hospitals NHS Foundation Trust, following the first joint member event the two foundation trusts held in July 2024.

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 can 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 2025/26 Annual Plan, emerging plan priorities were discussed with the Council of Governors prior to its sign off by the Board of Directors. Governors have also been involved in and engagement with development of the Trust's new strategy (intended for launch in Autumn 2026) including a presentation by the Executive Director of Strategy at the March 2026 Council of Governors meeting.

The Chair, 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 – this document was updated over the reporting year being approved by the Council of Governors at its December 2025 meeting. 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 Committee is chaired by the Trust's chair with membership comprising the lead governor and public, service user and appointed Governors. When considering the terms and conditions of the chair, or if on any occasion the chair is unavailable to chair, the vice chair or one of the other Non-Executive Directors (who is not standing for re-appointment) would chair the committee. 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 appraisal of the chair working with the lead governor.

The Nomination and Remuneration Committee of the Council of Governors met five times over 2025/26 to discuss and approve proposals and make recommendations to the Council of Governors for the appointment of Andrea Young as the new chair (from April 2026), a number of Non-Executive Director appointments, and the appointment of a new Vice Chair and Senior Independent Director required following David Walker standing down as chair at the end of March 2026.

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 a committee that considers remuneration and terms of service of the executive directors, which is a single committee considering both nominations and remuneration called the Nominations, Remuneration and Terms of Service Committee

- its membership comprises of the Chair, Chief Executive and all other Non-Executive Directors. For any decisions relating to the remuneration and terms of service of all other the executive directors, membership of the Committee will include the Chief Executive, as required under Schedule 7 of the National Health Service Act 2006, who will count in the quorum for the meeting. The Chief Executive will not participate when the Committee is dealing with matters concerning their own remuneration or terms of service. 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 (but excluding medical and dental remuneration terms and conditions), and 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 5 occasions over 2025/26. During the year, the following Non-Executive Directors have served on the Committee as voting core members:

Committee Member	Attendance
David Walker	5/5
Geraldine Cumberbatch	5/5
Chris Hurst	5/5
Professor Kamal Mahtani	5/5
Mohinder Sawhney	4/5
Professor Sir Rick Trainor	5/5
Lucy Weston	5/5
Andrea Young	5/5
Grant Macdonald	5/5
<i>Attending Board members</i>	
Charmaine De Souza	4/5
Taff Gidi	4/5

The committee also invited the assistance of the Chief People Officer, and the Executive 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 2025/26. The approach to remuneration is intended to provide the rigour necessary to deliver assurance and the flexibility needed to adapt to the dynamics of the 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.

In light of the Trust's financial situation, the remuneration policy for 2025/26 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 2025/26, 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 two interim members of the Board of Directors for periods during 2025/26, these being: the Interim Chief Operating Officer for Mental Health & Learning Disability; and the Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care. Later in the reporting year, both of these positions were recruited to substantively.

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 & 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 Chief Operating Officer of Mental Health & Learning Disability (substantive position from October 2025), 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 provider trusts 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 Executive Directors occupying Trustee/Non-Executive roles outside the organisation in 2025/26.

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 ongoing 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 2025/26 has been consistent with that framework. The annual standard rate (excluding supplementary payments) of existing Non-Executive Directors was consistent with issued guidance.

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 Trust's responsibility allowance (for chairing board committees / extra responsibilities) is the standard £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 2025/26 was £240,000 to £245,000 (2024/25 £235,000 to £240,000). This is a change between years of 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, the range of remuneration in 2025/26 was from £248,965 to £23,874 (2024/25 £255,713 to £22,368 restated). 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, including agency staff) between years is 4.47% (2024/25 6.83% restated).

1 employee received remuneration in excess of the highest-paid director in 2025/26 (2 in 2024/25 restated).

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.

2025/26	25th percentile	Median	75th percentile
Staff remuneration by percentile	£30,162	£38,682	£50,273
Remuneration pay ratio with the highest paid director	8:1	6:1	5:1
Staff salary by percentile	£30,162	£38,682	£50,273
Staff pay ratio with the highest paid director	8:1	6:1	5:1

2024/25	25th percentile (restated)	Median (restated)	75th percentile (restated)
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Staff remuneration by percentile	£29,114	£36,907	£48,526
Remuneration pay ratio with the highest paid director	8:1	6:1	5:1
Staff salary by percentile	£29,114	£36,907	£48,526
Staff pay ratio with the highest paid director	8:1	6:1	5:1

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 for NHS provider trusts 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 Council of Governors' Nomination and Remuneration Committee includes Staff Governor representation in addition to public, 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 2025/26.

Expenses

There were 18 directors who served in office during the financial year 2025/26 (2024/25, 21), of which, 9 (2024/25, 13) received expenses with a total value of £7,718 (2024/25, £7,090).

During 2025/26, the Trust had 36 governor seats available (2024/25, 36). Full details of the governors in post through the year can be found in the Council of Governors section of this Annual Report. While the role is voluntary, governors are entitled to claim reasonable expenses. In 2025/26, One governor (2024/25, two) expenses were reimbursed for £90.20 (total value of £266, 2024/25).

Salaries and Allowances

Details of Executive Directors' remuneration and pension benefits and Non-Executive Directors' remuneration are set out in the tables available below. Remuneration, cash equivalent transfer values (CETV), exit packages, staff costs and staff numbers are all subject to audit.

**The restatement of the 2024/25 fair pay figures is due to prior year data incorrectly reflecting total remuneration excluding pensions and incorrectly excluding agency staff as well as changes to the data sets upon which the calculation is performed to ensure staff data used is in line with the reporting framework.*

The table below shows the restatements made.

Figure	2024/25 Original	2024/25 Restated
<i>Range of remuneration</i>	£209,368 to £23,615	£255,713 to £22,368
<i>Percentage change in average employee remuneration between years</i>	7.3%	6.83%
<i>Employees receiving remuneration in excess of the highest paid director</i>	0	2
<i>Staff remuneration as a ratio of the highest paid director – 25th percentile</i>	£26,350 10:1	£30,162 8:1
<i>Staff salary as a ratio of the highest paid director – 25th percentile</i>	£26,350 9:1	£30,162 8:1
<i>Staff remuneration as a ratio of the highest paid director – median</i>	£36,485 7:1	£38,682 6:1
<i>Staff salary as a ratio of the highest paid director – median</i>	£36,485 6:1	£38,682 6:1
<i>Staff remuneration as a ratio of the highest paid director – 75th percentile</i>	£48,225 6:1	£50,273 5:1
<i>Staff salary as a ratio of the highest paid director – 75th percentile</i>	£48,225 5:1	£50,273 5:1

Salaries and allowances 2025/26								
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		240-245	0-5	14	240-245	0	240-245
Dr Karl Marlowe	Chief Medical Officer		145-150	90-95	16	240-245	15-17.5	255-260
Britta Klink	Chief Nurse		150-155	0-5	0	150-155	52.5-55.0	205-210
Charmaine De Souza	Chief People Officer		150-155	0-5	0	150-155	30.0-32.5	180-185
Heather Smith	Chief Finance Officer		175-180	0-5	0	175-180	45.0-47.5	220-225
Amelie Bages	Executive Director of Strategy		145-150	0-5	44	150-155	40.0-42.5	195-200
Rob Bale	Interim Executive Managing Director for Mental Health and Learning Disabilities		145-150	80-85	0	225-230	25-27.5	250-255

Taff Gidi	Executive Director of Corporate Affairs		140-145	0-5	21	140-145	40.0-42.5	185-190
Emma Leaver	Interim Chief Operating Officer for Community Health, Dentistry & Primary Care		150-155	0-5	0	150-155	250.0-252.5	405-410
David Walker	Chairman		60-65	0-5	0	60-65	0	60-65
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
Andrea Young	Non-Executive Director		15-20	0-5	0	15-20	0	15-20
Geraldine Cumberbatch	Non-Executive Director		15-20	0-5	0	15-20	0	15-20
Kamal Mahtani	Non-Executive Director		10-15	0-5	0	10-15	0	10-15
Professor Sir Rick Trainor	Non-Executive Director		15-20	0-5	0	15-20	0	15-20
Harjit Sandhu	Non-Executive Director	From 27/03/2026	0-5	0-5	0	0-5	0	0-5

Notes: Total salary for Non-Executive Directors for 2025/26 includes any back pay for inflationary increment.

**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. No performance-related pay was made. The benefits in kind disclosed for Grant Macdonald, Dr Karl Marlowe, Amelie Bages and Taff Gidi relate solely to leased vehicles provided by the Trust.*

***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.*

Dr Karl Marlowe and Rob Bale remuneration includes elements that relates to their clinical role.

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 Klink	Chief Nurse		145-150	0-5	0	145-150	280-282.5	425-430
Dr Ben Riley	Executive Managing Director – Primary,	To 28/02/2025	135-140	0-5	0	135-140	165-167.5	300-305

	Community and Dental Care							
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 Executive 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. No performance-related pay was made.*

***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 salary includes agency fees and VAT.*

***** Amelie Bages was on maternity leave over reported year*

Pension benefits 2025/26								
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 31/03/2026 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31/03/2026 (bands of £5,000)	Cash equivalent transfer value at 01/04/2025	Real increase/ (decrease) in cash equivalent transfer value	Cash equivalent transfer value at 31/03/2026	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
Britta Klinck, Chief Nurse	2.5-5.0	0-2.5	50-55	115-120	1,070	61	1,168	n/a
Dr Karl Marlowe, Chief Medical Officer	0-2.5	0.0-2.5	50-55	135-140	1,302	0	1,109	n/a
Charmaine De Souza, Chief People Officer	2.5-5.0	n/a	10-15	n/a	151	18	201	n/a
Heather Smith – Chief Finance Officer	2.5-5.0	n/a	10-15	n/a	124	29	177	n/a
Amelie Bages	2.5-5.0	n/a	20-25	n/a	227	19	268	n/a
Taff Gidi	2.5-5.0	n/a	20-25	n/a	215	22	257	n/a
Rob Bale	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Emma Leaver	10.0-12.5	27.5-30.0	65-70	165-170	1,221	276	1,537	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.

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 February 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 February 2025)	0.0-2.5	n/a	15-20	n/a	183	2	215	n/a
Emma Leaver (from March 2025)	0.0-2.5	0.0-2.5	50-55	135-140	1,171	3	1,221	n/a

Contract Type and Notice Period

Name	Start Date as Senior Manager	Contract Type	Notice Period by Employee	Notice Period by Employer
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
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 Klinck	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 over 2025/26 was acting up to the role of Interim Managing Director for Mental Health and Learning Disabilities (since 1 October 2023) – position now substantive.*

***Emma Leaver has a permanent contract of employment with the Trust and over 2025/25 was acting up to the role of Interim Chief Operating Officer for Community Health Services, Dentistry & Primary Care since 1 March 2025 – position now substantive*

Analysis of Staff Costs – Subject to Audit

	Permanent	Other	2025/26	2024/25
			Total	Total
	£000	£000	£000	£000
Salaries and wages	299,562	12,545	312,108	283,882
Social security costs	38,618	1,373	39,991	29,193
Apprenticeship levy	1,515	0	1,515	1,379
Employer's contributions to NHS pension scheme	39,080	960	40,039	59,665
Pension cost – other	25,516	662	26,178	41
Temporary staff	0	38,528	38,528	45,950

Total gross staff costs	404,290	54,068	458,358	420,110
Recoveries in respect of seconded staff	(2,269)	0	(2,269)	(2,312)
Total staff costs	402,022	54,068	456,089	417,798
Of which				
Costs capitalised as part of assets	423	-	423	-

Analysis of Average Staff Numbers (WTE Basis) – Subject to Audit

			2025/26	2024/25
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	361	29	390	386
Administration and estates	1542	55	1597	1,559
Healthcare assistants and other support staff	1169	290	1459	1,474
Nursing, midwifery and health visiting staff	1734	190	1925	1,829
Nursing, midwifery and health visiting learners	16	0	16	28
Scientific, therapeutic and technical staff	1593	55	1647	1,511
Social care staff	206	0	206	196
Total average numbers	6619	620	7239	6,983

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

Exit Packages – Subject to Audit

Reporting of Compensation Schemes - Exit Packages 2025/26

	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 *		13	13
£10,000 - £25,000	1	3	4
£25,001 - £50,000			
£50,001 - £100,000			
£100,001 - £150,000	1		1
£150,001 - £200,000			
>£200,000			
Total number of exit packages by type	2	16	18
Total cost (£)	£157,000	£91,000	£248,000

**contractual compulsory redundancy*

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	2	15	17
Total cost (£)	£61,000	£88,000	£149,000

**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

	2025/26		2024/25	
	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	16	91	14	76
Secondment paid by Trust	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	1	12
Non-contractual payments requiring HMT approval	-	-	-	-
Total	16	91	15	88
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 2026**



Grant Macdonald

Chief Executive and Accounting Officer

Accountability Report

Signed: **Date: 25 June 2026**



Grant Macdonald

Chief Executive and Accounting Officer

Staff Report

Introduction

There have been a number of further improvements in relation to the workforce across the 2025/26 year. The changes in relation to resourcing which embedded a more proactive talent acquisition approach to hard to fill roles has contributed to a decrease in overall vacancy rates and towards the second half of the year the resourcing team also piloted centralised recruitment in relation to high volume vacancies such as Healthcare Assistants.

Considerable work continues to be done to attract locum medics and agency staff to join us substantively, which has also contributed to reduction in vacancies. The Trust was able to achieve better than target savings for agency for the 2025/26 year and more savings are planned for the coming financial year. The Bank First approach has been fully embedded, allowing substantive staff to undertake bank shifts with the Trust.

We continue to prioritise the health and wellbeing of our staff and staff are encouraged to speak up through a range of channels including via our Freedom to Speak up Guardians, staff side colleagues and Executive Open Door sessions. We have launched a new Raising Concerns policy which brings together speaking up and Whistleblowing and also a new Sexual Misconduct Policy.

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 2026, the Trust employed 7,706 staff with a contracted whole time equivalent (WTE) of 6,845. The table below shows the breakdown of the Trust's workforce based upon NHS digital's occupation codes. This is the average WTE of employee headcount (HC) contracted throughout the year split by permanent employees. The second table shows "other staff".

Staff Group	Permanent 12m Avg FTE	%
Add Prof Scientific and Technic	760.78	12.49%
Additional Clinical Services	1429.33	23.47%
Administrative and Clerical	1350.97	22.18%
Allied Health Professionals	425.36	6.98%
Estates and Ancillary	211.28	3.47%
Healthcare Scientists	0.17	0.00%

Medical and Dental	182.98	3.00%
Nursing and Midwifery Registered	1726.74	28.35%
Students	3.55	0.06%
Grand Total	6091.15	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)	266.94	19.71%
Qualified Nursing - Registered (Bank & Overtime)	143.66	10.61%
Admin & Estates (Bank & Overtime)	53.35	3.94%
Other	56.17	4.15%
Hotel Property & Estates	32.55	2.40%
ST&T (Bank & Overtime)	14.82	1.09%
AHPs (Bank & Overtime)	6.88	0.51%
Qualified Nursing - HV,DN SHN (Bank & Overtime)	0.99	0.07%
Admin & Estates	84.72	6.25%
Admin & Estates (Agency)	2.00	0.15%
Managers and Senior Managers	25.00	1.85%
Medics	0.82	0.06%
AHPs (Agency)	4.00	0.30%
Medics - Career /Staff Grade	40.65	3.00%
AHPs	9.51	0.70%
Qualified Nursing - HV,DN SHN	4.37	0.32%
Qualified Nursing - Registered	28.24	2.09%
Medics - Career /Staff Grade (Locum)	1.33	0.10%
Qualified Nursing - Registered (Agency)	52.56	3.88%
Medics - Consultants	4.03	0.30%
ST&T	35.81	2.64%
ST&T (Agency)	0.20	0.01%
Support to Clinical staff	5.58	0.41%
Medics - Consultants (Locum)	25.43	1.88%
Support to Clinical Staff (Agency)	33.04	2.44%
Support to ST&T incl AHP	276.37	20.40%
Support to Doctors & Nursing	21.58	1.59%
Medics - Other Substantive	0.25	0.02%
Medics - Training Grades	116.91	8.63%
Medics - Other Non Substantive	6.71	0.50%
Grand Total	1354.43	100.00%

Gender breakdown

As of 31 March 2026, 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) – 8 male and 9 female;
- Other senior managers – 15 male and 27 female;
- Employees (excluding the above) – 1,520 male and 6,128 female.

Sickness absence data

Throughout 2025/26 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. The new Occupational Health system has now been in place for over a year and is providing a more automated and consistent process for line managers who need to be make a referral.

Work is undertaken monthly to identify services with higher volumes of absence and to understand the drivers for this, including HR input 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 including HR modules in the Management Toolkit.

During 2025/26, overall sickness absence increased by 0.51% (from March 2025). The top three reasons for sickness absence in 2025/26 based on hours lost were: Anxiety/stress/depression/psychological - Psychological Non-Work Related, cold/cough/flu symptoms and Anxiety/stress/depression/psychological – Psychological Work Related. Sickness absence figures for 2025/26 are shown in the table below.

	2025/26	2024/25
Total days lost in period (sick FTE)	120,519	106,148
12m Average Staff in Post (headcount)	7,605	7,219
12m Avg WTE in post	6,751	6,406
Average working days lost (WTE)	17.85	16.57

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 2025/26 shows that the mean gender pay gap is 16% in favour of men a decrease overall of 4.5%, when compared with 2024/25. The median gender pay gap is 5.2% in favour of men a reduction of 0.6% when compared with 2024/25.

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*'.

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 2025/26, progress has been made in reviewing key HR policies with a full suite of HR policies being reviewed to confirm their ongoing compliance with legislation. Notable is a revised Grievance policy which was fully reviewed in line with our work to review HR policies from a restorative, just learning culture approach moving to an approach more focussed on resolution at the earliest point. A Raising Concerns policy has also been developed which brings together in one policy clearer guidance for staff on how they raise a concern and the approach the Trust will take where this is a protected disclosure. We continue our shift towards adopting the National NHSE Framework policies with the introduction of the Sexual Misconduct Policy. The Trust will continue to review policies particularly in light of the new Employment Rights Act 2025.

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, Counter Fraud, Bribery and Corruption Policy 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 made sustained progress in advancing its Equality, Diversity and Inclusion (EDI) work, building on the NHS England EDI Improvement Plan and now bringing this activity together within a single, integrated EDI plan. Of the 18 NHS England high impact

actions, 15 are complete and the remaining three are progressing well, with delivery and impact overseen by the Trust's EDI Steering Group and escalated through established governance to the People, Leadership and Culture Committee. During 2025/26, EDI has been included as part of Board and Executive appraisal objectives, supported by regular use of organisational and intersectional workforce data and staff feedback to inform improvement activity. The Trust has also strengthened its focus on workforce health inequalities through wellbeing conversations, continued its work with Inclusion Representatives to help embed fair and inclusive recruitment practices, and continued to promote a culture where staff feel confident to speak up and raise concerns.

Staff turnover and retention

Staff turnover for the year 2025/26 was 9.35%%, against a target of 14%. In 2025/26 the team focused on Staff Recognition and improving data collection from our leavers. The work that was completed in July 2025 relating to our 'people promise' continues to inform our approach to improving staff experience such as:

- Updated wellbeing pages that support all parts of the 'People Promise';
- An updated Induction programme aligned with the People Promise (due for launch in April 2026).

Freedom to Speak Up

Oxford Health has in place a fully implemented Freedom to Speak Up (FTSU) service. Two FTSU Guardians (1.6WTE) following the guidance and remit of the National Guardian's Office 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, quarterly to the Extended Leadership Team and annually to the Board of Directors. The Guardians have worked with senior leaders at Board level to formulate a new two-year (2025/27) programme of work.

The Trust continues to embed a positive speak up culture. The Freedom to Speak Up (FTSU) Policy is being revised to incorporate the whistleblowing and detriment process in line with national guidance.

Throughout the year, the Guardians have continued to work proactively to empower staff to create and promote a positive speak up culture. Speak Up week in October 2025 focused on the importance of Following up.

There is a consistent uptake of FTSU e-learning modules (Speak up, Listen Up and Follow up) since these were launched in 2024.

Overall, the People Promise score for "we have a voice that counts" remains at 7.1 compared to national average 6.9. The National staff survey 2025 results continue to show a positive trend in speaking up. We use these results to identify gaps and work with directors for further improvement.

- Staff feel safe to speak up remains consistent at 72%, which is higher than the national average, 63.9%.
- Oxford health would address concerns raised at 60.7% (slight decrease from 2024, 61.7%) however this is above the national average of 51.6%.

During this reporting period 2025/26, 300 cases were raised with the FTSU Guardians.

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 below.

National quarterly pulse survey

This short 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.

2025/26 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 2025/26 survey among Trust staff was 61.3% which equates to 4,541 respondents, 900 more than in 2024 and well above the 52% average of the survey benchmarking group Mental Health and Learning Disability and Community Trusts. Results are shared through the Directorate Senior Management Teams and discussed at the Trust's Equality Network Groups. They are also reported to the Trust Executive and

relevant board committees. Managers and teams can access coaching and support 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)	2025/2026		2024/2025		2023/2024	
	Trust Score	Bench-marking group score	Trust Score	Bench-marking group score	Trust Score	Bench-marking group score
We are Compassionate & Inclusive	7.81	7.61	7.75	7.55	7.72	7.58
We are recognised and rewarded	6.51	6.37	6.52	6.35	6.52	6.41
We each have a voice that counts	7.05	6.89	7.09	6.94	7.08	7.01
We are safe and healthy	6.47	6.34	6.42	6.4	6.38	6.38
We are always learning	6.11	5.83	6.1	5.93	6	5.93
We work flexibly	6.88	6.84	6.83	6.83	6.75	6.84
We are a team	7.29	7.17	7.27	7.15	7.22	7.18
Staff Engagement	7.21	7.02	7.24	7.07	7.19	7.11
Morale	6.29	6.12	6.26	6	6.16	6.17

The Trust scores increased compared with 2024/25 on all but three reported People Promise Indicators. However, the Trust is currently ranked above the benchmarked average in all of the 8 published indicators. Over 2026/27, the Trust will 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 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 all Health, Safety, Fire, Security 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;
- Work with Estates colleagues to reduce health, safety, security, and fire risks;
- Provide training, information and instruction to all Trust colleagues to ensure the organisation meets statutory and regulatory requirements;

- Collaborate effectively with Estates colleagues and site contractors to ensure a proactive approach that aligns with statutory and regulatory obligations;
- Establish and monitor realistic objectives aimed at reducing manual handling injuries across the Trust;
- Maintain a proactive and structured approach to Health and Safety management in accordance with HSG65 guidance;
- Enhance the Health and Safety culture of the Trust.

Expenditure of consultancy

Trust expenditure on consultancy in 2025/26 was £40k (2024/25 £0.5m). This included contractors engaged in the review of the pay of Executive Directors.

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 2025/26 through volunteering, the Oxford Health Charity (OHC), the Oxford Health Arts Partnership, and informal community group engagement for the Trust. Over the reporting year, a significant project the Trust's charity has been commemorating the bicentenary of one of the Trust's sites, the Warneford Hospital in Oxford.

Oxford Health Charity

The Oxford Health Charity (OHC) has continued to provide valuable funding support to teams across the Trust, made possible through the generosity of our donors, fundraisers, grant makers and legacy supporters.

This year marks an important point in our journey as we move into the next phase of our 2023-2028 Strategy, with a refreshed focus on delivering greater impact, clarity and sustainability through our **Strategy Roadmap 2026-2028**.

Building on our earlier work around 'Positive Spaces', the charity is evolving towards a more structured and strategic model of funding and engagement. Our new roadmap sets out three core priorities:

- *Charitable Funding* - ensuring funding is directed towards clear, impact-led priorities across four key pillars: *Our Spaces and Environments, Our Patients, Carers and Families, Our People, and Our Future Care*

- *Internal Growth, Structure and Capability* - strengthening our systems, governance and financial planning to enable scalable and sustainable growth
- *Engagement and Involvement* - creating clearer and more accessible ways for staff, patients, volunteers, and communities to connect with and support the charity

This transition represents a shift from more localised and reactive fundraising towards a coordinated, Trust-wide approach that maximises impact and aligns with the Trust's strategic priorities.

Highlights from the year include the continued growth in our fundraising events programme, with strong participation in the Oxford Half Marathon and the expansion of community-led events such as Brush Party sessions, community concerts and fundraisers taking on their own challenges and raising money for Oxford Health Charity. This coming year we are introducing a Golf Day event, as well as expanding our portfolio of sporting events across our regions.

The charity has continued to support a wide range of initiatives that enhance care and wellbeing across the Trust. This includes investment in therapeutic environments, patient activities, and arts programmes. Our largest appeal, ROSY (Respite for Oxfordshire's Sick Youngsters), continues to provide vital respite for children with life-limiting and complex conditions, supporting families across Oxfordshire in their own homes.

As we look ahead, the charity is strengthening its foundations to enable future growth, including readiness for larger-scale fundraising opportunities and capital developments. Our focus remains on delivering meaningful, measurable impact for patients, carers and staff, while building a modern, inclusive and sustainable charity.

For more detailed information, the Oxford Health Charity Annual Impact and Finance Report for each year can be found on the Oxford Health Charity website.

Volunteering

The Trust's Volunteering Programme has continued to develop across Oxford Health, with growing recognition of the value volunteers bring in enhancing patient experience, supporting staff, and strengthening connections with our communities. Volunteering is increasingly being embedded within service as a complementary offer- working alongside staff, not replacing employed roles-with dedicated supervisors supporting volunteers in their placement.

We currently have over 140 active volunteers supporting a diverse range of roles across the Trust. These include administrative support, befriending, community service support, family and carers support, lived experience roles, research support, and ward-based patient liaison services. Over the past year, there has been increased interest from services in developing new volunteer opportunities, and we are now actively looking to expand both the number and range of roles available.

This year has also seen a stronger alignment with the wider NHS ambition for volunteering. Work is underway to improve how we collect and use data on volunteering activity, enabling us to better understand impact, support service integration and inform future planning. Volunteers are recognised as an important part of the Oxford Health community, reflected within the Trust's *Our People* approach, with a focus on ensuring they have a positive, supported and meaningful experience.

A key area of development this year is the introduction of supported volunteering pathways, designed to widen access and remove barriers to participation. This includes creating more structured and supported opportunities for individuals who may face additional challenges in accessing volunteering, such as people with disabilities, those experiencing homelessness and individuals supported through asylum welcome programmes. These pathways provide tailored support, clearer role structures and closer supervision, ensuring volunteering is accessible, inclusive and beneficial for all involved.

People come to volunteering for a variety of reasons. For many, it provides a valuable pathway into employment, with our Volunteer to Career approach continuing to support individuals seeking experience and development opportunities within the NHS. Others volunteer to give their time, contribute to their local community, or use their lived experience to influence and improve services for patients and carers.

The Volunteering Team continues to play a key role in recruiting, training and supporting volunteers, as well as working with services to embed volunteering effectively. This includes ensuring appropriate induction, ongoing training and support, and clear role design - alongside strengthening relationships with service leads to maximise the benefits volunteers bring.

Looking ahead, we have a clear ambition to significantly grow our volunteer base, with a target to increase numbers towards 500 volunteers, positioning Oxford Health within the higher percentile of NHS Trusts of a similar size and specialism. Alongside this growth, we will continue to focus on developing high-quality roles, improving data and insight and ensuring volunteering remains a rewarding and impactful experience for all involved.

Our ongoing priorities are to:

- Expand the number and diversity of volunteer roles across services
- Increase awareness and accessibility of volunteering opportunities
- Develop and scale supported volunteering pathways
- Strengthen the Volunteer to Career pathway
- Improve data collection and reporting to demonstrate impact
- Continue collaborative working with partners, including ICB Volunteer Service Managers

Through this approach, volunteering will continue to play an integral role in supporting Oxford Health's services, patients and communities.

Code of governance for NHS provider trusts – Disclosures

The following statements set out applicable Trust disclosures requiring a supporting statement with reference to the *Code of Governance for NHS provider Trusts* (April 2023) Schedule A, or as otherwise stated with full disclosures. The Trust complies with those disclosures requiring a comply or explain disclosure (set out in appendix 2).

A.2.1 The Annual Governance Statement within this report sets out the Trust's approach to ensuring effectiveness, efficiency and economy.

A.2.3 The Trust's Board of Directors actively monitor culture. The Trust's Board Assurance Framework has a specific risk on culture. The Trust has clear procedures for promoting staff wellbeing as set out in the Staff Report section of the Annual Report.

A.2.8 The Trust's Board of Directors considers the interests of stakeholders are taken into account and consideration in decision-making and actively collaborates with partners as set out in the Performance Report section of the Annual Report.

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. Over the reporting period three Non-Executive Directors had their terms extended following review of performance and approval by the Council of Governors. The Trust discloses that one Non-Executive Director over the reporting period had been a member of the board since 2017 and that their third expired at the end of March 2026.

B.2.13 The Directors' Report within the Annual 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 the Annual 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 the Annual Report sets out the process followed by the Council of Governors to appoint the Chair and Non-Executive Directors (Nomination and Remuneration Committee) in accordance with written terms of reference.

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 is being undertaken over Q1 2026/27 and will report to board in late June 2026. Further information on Well-led is set out in the Annual Governance Statement.

C.4.13 The Remuneration Report and Staff Report sections of the Annual Report set out the work of the nominations committee (Nominations, Remuneration and Terms of Service Committee) and on diversity and inclusion, ethnicity of board members and senior managers, and gender balance of senior managers.

C.5.15 The Council of Governors section of the Annual Report provides information on governor and member communication and engagement for example in relation to Trust strategy development.

D.2.4 The Audit & Risk Committee section of the Directors' Report sets out information in relation to the Trust's auditors, financial statements audited, and how auditor independence and objectivity are ensured.

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. The Annual Governance Statement will set out this disclosure.

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 the Annual 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.

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

The NHS National Oversight Framework (NOF) 2025/26, published by NHS England in summer 2025, set out a revised and more focused approach to assessing the performance of NHS providers. The framework is designed to provide a clear, consistent, and transparent view of organisational performance across key domains, including financial sustainability, operational delivery, quality of care, and leadership capability. It also establishes how NHS England will tailor its oversight and support, ensuring that interventions are proportionate to both performance and organisational capability.

Under the NOF, NHS Foundation Trusts are assessed against a defined set of metrics grouped into six domains: 1) access to services; 2) effectiveness and experience of care; 3) patient safety; 4) people and workforce; 5) finance and productivity; and 6) improving health and reducing inequalities. The first five domains contribute directly to an overall organisational delivery score, while the sixth domain is contextual and used to inform oversight and planning rather than formal scoring.

A key feature of the new framework is the segmentation of providers into one of five oversight categories, reflecting the level of autonomy or support required. The Oversight Segments for NHS Foundation Trusts are: Segment 1 – maximum autonomy; Segment 2 – targeted support; Segment 3 – mandated support; Segment 4 – significant support needs; and Segment 5 – Provider Improvement Programme (PIP). The framework includes a financial override, meaning that trusts operating in deficit or reliant on financial support cannot be placed in the highest segments, regardless of performance in other areas. In addition to performance metrics, NHS England undertakes a provider capability assessment, considering factors such as leadership, governance, and operational resilience to ensure a balanced and proportionate approach to oversight.

Oxford Health NHS Foundation Trust was assessed as *Segment 1* for Quarter 1 of 2025/25, reflecting a strong overall performance and organisational capability. This position was sustained in Quarter 2, as confirmed in December 2025. In Quarter 3, the Trust's segmentation moved to *Segment 2*, in line with the Trust's internal forecast, indicating a requirement for targeted support in specific areas while maintaining a generally stable performance profile.

Overall, Quarter 3 reflects a stable performance position, with clear strengths in workforce, finance, and access, alongside consistent delivery in urgent care response. Targeted improvement is required in reducing long waits, improving length of stay and mental health crisis response metrics. Quarter 4 (published June 2026) reported that the Trust was in *Segment 3*, however this was due to an error in the Trust's submitted data. The NHS regional team confirmed that, although the NOF position could not be amended, the true performance of the Trust was in *Segment 2* and should be recognised.

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 Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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 2026**



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 2026 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 2026. The document sets out and provides guidance on how risks are identified, evaluated, transferred, controlled and treated. Operational risks can be 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 a monthly highlight report on risk performance, escalations and de-escalations. Directorates also report and escalate risks through the Executive Performance Review Meeting. The Executive Management Team manages the strategic risks to the Trust 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.

The Board of Directors and board committees receive regular updates on the BAF including 'deep dives' into BAF risks relevant to their terms of reference. Each board committee is assigned specific BAF risks by the Board. The Audit & Risk Committee receives an update on all BAF risks and reviews each BAF risk at least once over its meetings per year. The Trust uses a risk appetite approach – set out in the Risk Management Strategy & Policy as a structured approach to assessing and monitoring the risk appetite for strategic risks.

Over 2025/26, principal risks for the Trust as captured and monitored in the BAF were: timely access to services; quality & safety of clinical services; financial sustainability; recruitment and retention; staff experience and culture; improvement, research and innovation; environmental sustainability; information and data; partnerships and system working; digital transformation; and infrastructure. The BAF was revised over July 2025 and approved by the Board of Directors. Over Q4 2025/26, an internal audit of the BAF was undertaken with a finding of 'significant assurance with minor improvements' which are being progressed. A summary of principal operational risks managed over the reporting period is set out in the Performance Report.

At the June 2026 Audit & Risk Committee, the Trust's head of internal audit presented their annual report with conclusions over four components, as set out in the table below:

Component	Overall finding	Rating
Governance	Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed some control to be operating effectively, and others could be more consistently applied.	Amber-Green
Risk management	Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed some control to be operating effectively, and others could be more consistently applied.	Amber-Green
Financial reporting and management	Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed some control to be operating effectively, and others could be more consistently applied.	Amber-Green
Data captured and used by the organisation	Overall findings on design showed controls are effectively designed and our testing showed controls are operating effectively.	Green

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 2014, as amended (most recently in 2025), and the Care Quality Commission (Registration) Regulations 2009. The Board of Directors is responsible for ensuring compliance with these regulations. The Trust is fully compliant with the registration requirements of the Care Quality Commission; the Trust current overall rating is 'Good' as of December 2019. In April 2026, the Trust's inpatient child and adolescent mental health (CAMHS) wards were inspected by the CQC. While the 'effective' and 'caring' domains were rated as 'good', the overall rating was 'inadequate'; engagement with the CQC on the report findings has been effective and an action plan is in place to address areas of improvement.

The Trust continues to develop its systematic approach to managing quality through a Quality Management System (QMS) approach. A QMS provides a balanced and integrated framework for managing quality through four interrelated functions: Quality Planning; Quality Maintaining (or Quality Control); Quality Assurance; and Quality Improvement.

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. Through embedding of a QMS approach, leaders are moving from position of monitoring quality indicators and responding to incidents, audit outcomes, or external feedback, towards a proactive, data-driven, and learning-oriented system that anticipates quality challenges and continuously improves and enhances outcomes for service users.

The Executive Team Meeting receives a weekly report from the Weekly Review Meeting chaired by the Deputy Chief Nurse. The Weekly Review Meeting is mirrored in each of the Clinical Directorates. The Chief Nurse chairs the monthly Quality & Clinical Governance Sub-Group and the Chief Medical Officers chairs the Clinical Effectiveness Group with both reporting into the Quality Committee. 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 and Quality and Safety Dashboard at each board meeting.

The Quality Committee (chaired by a Non-Executive Director) takes 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 safety 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. Patient Safety Incidents (PSIs) are reported to Board. 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 about how the Trust learns from incidents is included in the Trust's policy on Reporting and Learning from Incidents and 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 2025 national staff survey results showed 92.44% 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, and we have seen incremental improvements each year for the last 4 years

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 employed Patient Safety Partners since September 2023, 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.

Reducing health inequalities is a central element of Oxford Health's strategy with the Trust's quality strategic objective focused on reducing unwarranted variation and improving outcomes. During 2025/26, the Trust strengthened its approach to health inequalities with an emphasis on consistent use of data and oversight of health inequalities being embedded in quality, performance and assurance processes, and the Trust works with system partners to strengthen prevention, and to improve population health. In line with NHS England's Statement of Information, this work puts the Trust in good stead to fulfil its health inequalities legal duties and inform an evidence-led improvement approach to healthcare inequalities, in line with Core20PLUS5.

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 2025/26 and beyond to improve the quality of care and services provided. The Quality Account is published each year available by searching online for '*Oxford Health Quality Account*'

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

Patient Safety

To support the continual improvement of the safety of care the Trust has embedded the standards and principles of the national Patient Safety Incident Response Framework (PSIRF). A summary of what this means, the Trust approach and local incident response plan is published on the Trust's website and is available by searching online for '*Oxford Health Patient Safety Incident Response Framework*'. The Trust reports publicly on patient safety incidents, our learning and changes being made at each of the Board of Directors meetings. The four key PSIRF principles the Trust has implemented are:

- Compassionate engagement and support for all affected by a significant incident
- Application of a range of system-based approaches to learning
- Considered and proportionate responses to incidents
- More attention to learning and identifying the right actions to take
- Continually making changes to improve the safety of systems

The trust has compassionate support mechanisms to help patients, families and staff affected by incidents. These mechanisms are invaluable and enable those affected to be involved and engaged in patient safety reviews.

The Trust is committed to supporting the national suicide prevention strategy as well as the local authority action plans and the Trust actively contributes to multi-agency suicide prevention groups to strengthen collaboration and joint working. The Trust has embedded the 2025 national Staying Safe from Suicide Best Practice Guidance focused on a patient-centred collaborative approach to assessments and safety plans. Information and progress with embedding this is published in the 6-monthly mortality and suicide prevention report to the Board of Directors.

In coronial proceedings, one duty a Coroner considers is whether 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, we have carefully reviewed and reflected on each report received for the emergence of any new information shared within the Coronial process to look at how this may contribute to learning and further improving the system and process changes that we use.

Workforce and workforce systems

At 31 March 2026, the Trust employed 7,706 staff with a contracted WTE (whole time equivalent) of 6845. Over 2025/26, the Trust recruited 1,209 substantive staff (1,123.52 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 continues to invest in skill mix work to make sure that the blend of skills in its services is safe, appropriate, affordable and available.

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 which is important to wider economic goals for the local community such as increasing employment and career paths for those entering the workforce.

During 2025/2026, the Trust continued to strengthen its approach to attracting talent, building on the foundations established in previous years and moving towards a more targeted, digitally led and candidate-focused model.

Our digital attraction strategy has significantly evolved, with a continued expansion of our social media presence to reach wider and more diverse candidate groups. This has enabled more proactive and engaging promotion of opportunities across the Trust, supporting both volume recruitment and harder-to-fill roles.

A key development this year has been the enhancement of the Trust's careers website, creating a more user-friendly and accessible experience for candidates. New functionality has been introduced, including improved job search tools, job alerts, and a chatbot to support candidate queries, alongside clearer insight into roles and locations. These developments help guide candidates through the application process and improve both engagement and conversion.

Alongside this, we have strengthened our focus on internal mobility, making it easier for existing staff to access opportunities within the organisation. This includes the introduction of a dedicated internal job search page, complementing our internal vacancy bulletin, which is distributed to all employees on a weekly basis, supporting our existing employees to stay within the Trust.

We introduced a centralised recruitment model for areas of high-volume hiring. This has enabled a more consistent, robust, efficient and candidate-focused process, improving the quality of applicants, reducing time to hire, and supporting services to fill vacancies more effectively.

Underpinning this work is the Trust's recruitment management system, which continues to support improved oversight, control and reporting of recruitment activity. The Trust

monitors 'time to hire' on a monthly basis and has made further progress this year in streamlining and simplifying the onboarding process, including the introduction of an online form filling tool and a digital ID checking platform. We have further upskilled both the recruitment team and hiring managers which has contributed to a reduction in vacancy levels and faster hiring timelines, positively impacting service delivery.

We have continued to complement our digital approach with targeted in-person activity, including recruitment events and careers fairs, particularly where these support engagement with local communities, underrepresented areas, early careers and pipelines into hard-to-fill roles.

Overall, our approach has shifted from largely reactive advertising to a more proactive, insight-driven model, strengthening the Trust's employer brand and improving our ability to attract the right people into the organisation. This approach has contributed to improved recruitment outcomes, including reduced reliance on repeat advertising and stronger candidate pipelines across key staff groups.

Over 2025/26 the Trust has further reduced its use of agency staff which has reduced agency costs and had a positive impact on the care provided to patients. We have been particularly successful at filling medical vacancies in the last 12 months and hope to further improve our position in the coming period.

In 2025/26 the Trust has built upon the work undertaken in the previous year when it was one of NHS England's *People Promise* exemplar Trusts working alongside other teams at NHS England to deliver high impact interventions set out in the *People Promise* to achieve improve staff satisfaction and retention. Staff turnover improved from 11.85% in January 2025 to 9.16% in January 2026 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.

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

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 NHS30 guidance.

Well-led

Over the reporting year, the Trust undertook a range of activities contributing to an ongoing assessment of whether services are well-led under the relevant Care Quality

Commission and NHS England frameworks. These included completion of the Trust's Well-led self-assessment process against the CQC Well-led framework in February 2026; and completion of the NHS England *Provider Capability Assessment* which was accepted by the NHS region - the Trust is currently placed in *Segment 2* of the NHS Oversight Framework (see NOF section for further information on segmentation).

The Trust rated itself 'Amber/Green' in its Well-led self-assessment which was agreed by the Board in February 2026. This means that the Trust meets the majority of requirements against the Well Led Framework, with some areas requiring improvement, but no material concerns. An externally facilitated independent Well-led review will be undertaken over Q1 of 2026/27 culminating in a June 2026 board workshop to discuss the findings and a final report with recommendations being issued in early July 2026.

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.

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.

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 set out in the Standing Orders and Scheme of Reservation and Delegation for the Board of Directors. 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 receives quality, safety, finance, performance, risk and compliance information at each meeting. Individual board committee 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 receives updates on the Board Assurance Framework (BAF) and each board committee has oversight of specific strategic risks within the BAF. The Board also receives regular

assurance reports (3As reports) from each board committee 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.

Over the reporting period the Trust has developed an operating framework setting out governance arrangements – this document was published for internal information and reference in April 2026.

The Trust also has a comprehensive programme of internal audit in place aligned to key areas of potential financial and operational risk.

The Board has not identified any principal risks to compliance with Provider Licence condition (governance) over 2025/26 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.

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 the 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 conclusion 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.

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 2024/25.

The DSPT/CAF year is from July to June and the Trust's baseline submission was completed as required by 31 December 2025. The Trust's internal auditors have conducted a review to assess compliance with each of the assessment criteria selected for internal audit verification in March 2026. Following sign-off by the Trust's Information Management Group and then by the Finance & Investment Committee, the next DSPT/CAF will be submitted by 30 June 2026.

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 was one serious confidentiality incident (Level 2) over 2025/26, which met the criteria for escalation to the Information Commissioner's Office (ICO) relating to human error resulting from a 'phishing' email. The matter was investigated by an approved Cyber expert and the ICO contacted the Trust in early March 2026 for further information on the incident.

The Trust prioritises the implementation of systems and processes to combat cybercrime which poses a significant threat to the Trust's IT related resources and data.

Throughout 2025/26, several new cybercrime prevention systems have been implemented, replacing older systems, to enhance the protection of the Trust's IM&T resources and data. Controls on existing IT systems have been reviewed and further controls implemented. In July 2025 an independent cyber audit was conducted with all

recommendations identified subsequently addressed and reported to the December 2025 Audit & Risk Committee by the Head of IT. All recommendations were addressed.

Staff awareness campaigns and Trust wide phishing simulations are conducted to highlight to Staff the importance of their role in keeping the systems and information safe.

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. The Trust's performance management framework monitors progress in relation of areas of data quality focus, with routine reports being shared and reviewed in collaboration with services. These reports are taken from information 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. Areas of focus for 2025/26 have included improvements in data quality associated with waits reporting (by cleansing of caseloads and improvements in recording of appointment information which were identified as an area of focus) and improving recording of ethnicity information via a clinically led campaign.

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 Trust's 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 & Risk Committee comprises Non-Executive Directors and has reviewed throughout the year the effectiveness of the system of internal control and overall assurance processes associated with managing risk. Over the reported year the committee received items and recommendations from internal audit and external audit including internal audit annual report and reviews on provider collaboratives and quality systems, and external audit results and key audit areas of fraud, valuations and disclosures. The committee also covered the counter fraud annual report and work plan, revision to the Risk Management Policy & Strategy, financial planning, cyber security, digitisation, health & safety, and regular updates on the Board Assurance Framework.

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 2025/26 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. As a Trust we continue to seek learning from experience and from best practice and to continuously improve our control processes.

A handwritten signature in black ink, appearing to read 'G. Macdonald', is displayed within a rectangular border.

Grant Macdonald, Chief Executive

25 June 2026

Appendix 1 – Performance summary 2025/26

Type of metric	Service area/metric	Target	2025 - 2026 performance
Child and Adolescent Mental Health Services (CAMHS)			
<i>National measure</i> NOF (scored)	Improve access to mental health support for children and young people – Buckinghamshire (12 rolling months)	7848	7768 end of March 2026
<i>National measure</i> NOF (scored)	Improve access to mental health support for children and young people – Oxfordshire (12 rolling months)	10612	9086 end of March 2026
<i>National measure</i> NOF (scored)	Improve access to mental health support for children and young people - Bath & North East Somerset, Swindon and Wiltshire (12 rolling months)	-	7066 end of March 2026
<i>National measure</i> Strategic metric - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Buckinghamshire	62% National average	75.75% annual average 86.99% March 2026
<i>National measure</i> Strategic metric - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Oxfordshire	62% National average	61.22% annual average 61.59% March 2026
<i>National measure</i> Strategic metric - Quality	Four (4) week wait (interim metric - one meaningful contact within pathway) - Bath & North East Somerset, Swindon and Wiltshire	62% National average	52.96% annual average 61.26% March 2026
<i>National measure</i>	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks – Buckinghamshire	95%	92.50% annual average
<i>National measure</i>	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks – Oxfordshire	95%	83.19% annual average
<i>National measure</i>	% referred (routine cases) with suspected Eating Disorder that start treatment within 4 weeks - Bath & North East Somerset, Swindon and Wiltshire	95%	88.34% annual average
<i>National measure</i>	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days – Buckinghamshire	95%	96.43% annual average
<i>National measure</i>	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days – Oxfordshire	95%	95% annual average
<i>National measure</i>	% referred (urgent cases) with suspected Eating Disorder that start treatment within 7 days - Bath & North East Somerset, Swindon and Wiltshire	95%	91.84% annual average
Talking Therapies			
<i>National measure</i>	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Buckinghamshire	515 monthly	655 annual average
<i>National measure</i>	Increase the number of adults and older adults completing a course of treatment for anxiety and depression - Oxfordshire	687 monthly	723 annual average
<i>National measure</i>	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Buckinghamshire	-	10.89% annual average 9.97% March 2026
<i>National measure</i>	% of those completing a course of treatment for anxiety and depression who are older adults (65 and over) - Oxfordshire	-	6.67% annual average 5.89% March 2026
<i>National measure</i>	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Buckinghamshire	68% by March 2026	70.53% end of March 2026
<i>National measure</i>	Reliable improvement rate for those completed a course of treatment adult and older adults combined - Oxfordshire	68% by March 2026	70.67% end of March 2026
<i>National measure</i>	% of people receiving first treatment appointment within 6 weeks of referral - Buckinghamshire	75%	98.17% annual average 98.09% March 2026
<i>National measure</i>	% of people receiving first treatment appointment within 6 weeks of referral - Oxfordshire	75%	99% annual average 99.54% March 2026

<i>National measure</i>	% of people receiving first treatment appointment within 18 weeks of referral - Buckinghamshire	95%	99.97% annual average 100% March 2026
<i>National measure</i>	% of people receiving first treatment appointment within 18 weeks of referral - Oxfordshire	95%	99.97% annual average 99.88% March 2026
<i>National measure</i>	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Buckinghamshire	10%	2.01% annual average 1.72% March 2026
<i>National measure</i>	Meet and maintain Talking Therapies standards 1st to 2nd treatment waiting times (less than 10% waiting more than 90 days between treatments) - Oxfordshire	10%	6.68% annual average 7.25% March 2026
<i>National measure</i> NOF (contextual)	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Buckinghamshire	50% by March 2026	53.53% end of March 2026
<i>National measure</i> NOF (contextual)	Reliable recovery rate for those completed a course of treatment adults and older adults combined - Oxfordshire	50% by March 2026	53.37% end of March 2026
<i>National measure</i>	Meet and maintain at least 52% Talking Therapies recovery rate - Buckinghamshire	52%	56.09% March 2026
<i>National measure</i>	Meet and maintain at least 52% Talking Therapies recovery rate - Oxfordshire	52%	53.37% March 2026
<i>National measure</i>	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Buckinghamshire	50%	50.32% annual average 54.26% March 2026
<i>National measure</i>	Recovery rate for Ethnically and Culturally Diverse Communities (ECDC) - completed a course of treatment, adult and older adult combined - Oxfordshire	50%	47.15% annual average 52.24% March 2026
<i>National measure</i>	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Buckinghamshire	50%	55.85% annual average 56.43 March 2026
<i>National measure</i>	Recovery rate for White British - complete a course of treatment, adult and older adult combined - Oxfordshire	50%	54.65% annual average 56.69% March 2026
Adult and Older Adult Community Mental Health Services			
<i>National measure</i> NOF (contextual)	Improve access for Adults and Older Adults to support by community mental health services – Buckinghamshire (12 rolling months)	4568	5500 end of March 2026
<i>National measure</i> NOF (contextual)	Improve access for Adults and Older Adults to support by community mental health services – Oxfordshire (12 rolling months)	6737	9536 end of March 2026
<i>National measure</i>	Four (4) week wait standard (interim metric - two contacts within pathway) - Buckinghamshire	36% National average	52.98% annual average 52.35% March 2026
<i>National measure</i>	Four (4) week wait standard (interim metric - two contacts within pathway) - Oxfordshire	36% National average	65.98% annual average 73.77% March 2026
<i>National measure</i>	Deliver annual physical health checks to people with Severe Mental Illness (System Measure - Buckinghamshire)	60%	Q4 data not yet published nationally Q1 – Q3 average 50.87%
<i>National measure</i>	Deliver annual physical health checks to people with Severe Mental Illness (System Measure – Oxfordshire)	60%	Q4 data not yet published nationally Q1 – Q3 average 41.06%
<i>National measure</i>	Improve access to perinatal mental health services – Buckinghamshire (rolling 12 months)	422	390 end of March 2026
<i>National measure</i>	Improve access to perinatal mental health services – Oxfordshire (rolling 12 months)	501	680 end of March 2026

<i>National measure</i>	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Buckinghamshire	60%	81.61% annual average 75% March 2026
<i>National measure</i>	% of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral - Oxfordshire	60%	94.39% annual average 87.50% March 2026
<i>National measure</i>	Number of people accessing Individual Placement Support (IPS) – Buckinghamshire (rolling 12 months)	286	325 end of March 2026
<i>National measure</i>	Number of people accessing Individual Placement Support (IPS) – Oxfordshire (rolling 12 months)	440	572 end of March 2026
<i>National measure</i>	Recover dementia diagnosis rate (nationally reported system measure - Buckinghamshire)	63%	March 2026 data not yet published nationally 58.56% annual average (to Feb-26)
<i>National measure</i>	Recover dementia diagnosis rate (nationally reported system measure - Oxfordshire)	63%	March 2026 data not yet published nationally 64.27% annual average (to Feb-26)
Urgent Mental Health Care			
<i>National measure</i>	Response from Mental Health Psychiatric Liaison within 1 hour - Buckinghamshire	66% National average	93.28% annual average 90.72% March 2026
<i>National measure</i>	Response from Mental Health Psychiatric Liaison within 1 hour - Oxfordshire	66% National average	90.45% annual average 89.26% March 2026
<i>National measure</i>	Response from Mental Health Psychiatric Liaison within 24 hours - Buckinghamshire	81% National average	98.97% annual average 100% March 2026
<i>National measure</i>	Response from Mental Health Psychiatric Liaison within 24 hours - Oxfordshire	81% National average	100% annual average 100% March 2026
<i>National measure</i>	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Buckinghamshire	61% National average	81.82% annual average 100% March 2026
<i>National measure</i>	Response from Mental Health Crisis Service within 4 hours (Very Urgent) - Oxfordshire	61% National average	39.18% annual average 100% March 2026
<i>National measure</i> NOF (scored)	Response from Mental Health Crisis Service within 24 hours (Urgent) - Buckinghamshire	58% National average	65.12% annual average 82.96% March 2026
<i>National measure</i> NOF (scored)	Response from Mental Health Crisis Service within 24 hours (Urgent) - Oxfordshire	58% National average	67.79% annual average 76.19% March 2026
Mental Health Inpatient Services (Adults and Older Adults)			
<i>National measure</i>	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 (rolling quarter)	12% National average	11.18% March 2026
<i>National measure</i>	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 (rolling quarter)	12% National average	16% March 2026
<i>National measure</i>	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 (rolling quarter)	12% National average	5.9% March 2026
<i>National measure</i>	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 (rolling quarter)	12% National average	5% March 2026

<i>National measure</i>	Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care Unit (PICU) discharges (combined, rolling 3 months) - Buckinghamshire	49 days by March 2026	46 days March 2026
<i>National measure</i>	Mean Length of Stay Mental Health acute, older adult acute and Psychiatric Intensive Care Unit (PICU) discharges (combined, rolling 3 months) - Oxfordshire	49 days by March 2026	69 days March 2026
<i>National measure</i> NOF (scored)	Percentage of adult inpatients with a length of stay over 60 days (discharged patients) - Buckinghamshire	-	23.93% annual average 21.05% March 2026
<i>National measure</i> NOF (scored)	Percentage of adult inpatients with a length of stay over 60 days (discharged patients) - Oxfordshire	-	27.78% annual average 40.35% March 2026
<i>National measure</i> NOF (contextual)	Percentage of older adult inpatients (over 65) with a length of stay over 90 days (discharged patients) - Buckinghamshire	-	27.39% annual average 36.84% March 2026
<i>National measure</i> NOF (contextual)	Percentage of older adult inpatients (over 65) with a length of stay over 90 days (discharged patients) - Oxfordshire	-	21.82% annual average 20.59% March 2026
<i>National measure</i>	72 hour follow up for those discharged from mental health wards - Adults - Buckinghamshire	80%	92.19% annual average 93.90% March 2026
<i>National measure</i>	72 hour follow up for those discharged from mental health wards - Adults - Oxfordshire	80%	91.94% annual average 90.20% March 2026
<i>National measure</i>	72 hour follow up for those discharged from mental health wards - Older Adults - Buckinghamshire	80%	96.84% annual average 100% March 2026
<i>National measure</i>	72 hour follow up for those discharged from mental health wards - Older Adults - Oxfordshire	80%	97.63% annual average 100% March 2026
<i>National measure</i>	Inappropriate adult acute mental health out of area placements - snapshot last day month - Buckinghamshire	1	3 (end of trajectory – March 2026 position)
<i>National measure</i>	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Buckinghamshire		0 (end of trajectory – March 2026 position)
<i>National measure</i>	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Buckinghamshire		0 (end of trajectory – March 2026 position)
<i>National measure</i>	Inappropriate adult acute mental health out of area placements - snapshot last day month - Oxfordshire	1	6 (end of trajectory – March 2026 position)
<i>National measure</i>	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - snapshot last day month - Oxfordshire		0 (end of trajectory – March 2026 position)
<i>National measure</i>	Inappropriate older adult acute mental health out of area placements - snapshot last day month - Oxfordshire		0 (end of trajectory – March 2026 position)
Local measure	Inappropriate adult acute mental health out of area placements - beds days in month - Buckinghamshire	-	1483 (annual total)
Local measure	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Buckinghamshire	-	39 (annual total)
Local measure	Inappropriate older adult acute mental health out of area placements - beds days in month - Buckinghamshire	-	10 (annual total)
Local measure	Inappropriate adult acute mental health out of area placements - beds days in month - Oxfordshire	-	1697 (annual total)

Local measure	Inappropriate Psychiatric Intensive Care Unit (PICU) out of area placements - beds days in month - Oxfordshire	-	31 (annual total)
Local measure	Inappropriate older adult acute mental health out of area placements - beds days in month - Oxfordshire	-	0 (annual total)
Local measure	% adult acute readmission within 30 days for mental health - Buckinghamshire	-	9.92% annual average 3% March 2026
Local measure	% adult acute readmission within 30 days for mental health - Oxfordshire	-	8.71% annual average 3% March 2026
Local measure	% older adult readmission within 30 days for mental health - Buckinghamshire	-	2.78% annual average 0% March 2026
Local measure	% older adult readmission within 30 days for mental health - Oxfordshire	-	3.23% annual average 0% in March 2026
Local measure	Average number of clinically ready for discharge patients per day - Buckinghamshire	-	8 annual average
Local measure	Average number of clinically ready for discharge patients per day - Oxfordshire	-	7 annual average
Mental Health Services - other			
Strategic Metric - Quality	% of patients responding that overall care was good or very good	85%	85.94% annual average 87.17% March 2026
Strategic Metric - Quality	% of patients report being involved in their care	80%	85.57% annual average 82.16% March 2026
Community Health Service, Dentistry and Primary Care			
<i>National measure</i>	% of Minor Injury Unit patients seen within 4 hours	78%	95.78% annual average 95.61% March 2026
<i>National measure</i> NOF (scored)	Consistently meet or exceed the 70% 2-hour Urgent Community Response (UCR) standard	70%	84.45% annual average 98.03% March 2026
Local measure	Average Length of Stay in Community Hospitals by basket of care - Rehab	-	30 days annual average 28 days end of March 2026
Local measure	Average Length of Stay in Community Hospitals by basket of care - Stroke	-	42 days annual average 36 days end of March 2026
Local measure	Average Length of Stay in Community Hospitals by basket of care - End of Life	-	15 days annual average 15 days end of March 2026
Local measure	Average Length of Stay in Community Hospitals by basket of care - EMU	-	12 days annual average 12 days end of March 2026
Local measure	Average number of Medically Optimised For Discharge (MOFD) patients per night	-	22.4 annual average 18.2 March 2026
Strategic Metric - Quality	% of patients responding that overall care was good or very good	85%	94.26% annual average 94.57 March 2026
Strategic Metric - Quality	% of patients report being involved in their care	85%	92.46% annual average 93.24% March 2026
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	90%	94.59% annual average 96.0% March 2026
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	90%	50.27% annual average 65.89% March 2026
Local measure	% of out of hours palliative care referrals responded to within 120 minutes: the time from completion of that triage call to the start of the	90%	85.68% annual average (Aug-25 to Mar-26) 92.25% March 2026

	home visit consultation was within 120 minutes (new from August 2025)		
Strategic Metric - Quality	National Early Warning System (NEWS - national tool for detecting clinical deterioration) escalated appropriately (quarterly metric)	90%	87.60% annual average 86.62% in Q4
Strategic Metric - Quality	National Early Warning System (NEWS - national tool for detecting clinical deterioration) completed where applicable (quarterly metric)	90%	81.18% annual average 78.68% in Q4
National measure Strategic Metric - Quality	% of breastfeeding prevalence at 6 – 8 weeks old	60%	62.73% annual average 65.60% March 2026
National measure	Percentage of Children notified by Local Authority to the Children Looked After team as new to care to be offered a health assessment within 20 working days (measured from notification to offered)	100%	54% annual average 80% March 2026
National measure	Healthy Child Programme - No. and % of families receiving a new birth visit within 14 days of birth (quarterly metric)	90%	82% annual average 84.6% in Q4
National measure	Healthy Child Programme - % of 6 - 8-week reviews completed (quarterly metric)	93%	84.2% annual average 85.4% in Q4
National measure	Healthy Child Programme - % of 12-month development reviews completed by the time the child turned 12 months (quarterly metric)	90%	85.1% annual average 87.4% in Q4
National measure	Healthy Child Programme - % of 2-to-2.5-year reviews completed (quarterly metric)	90%	81.7% annual average 83.9% in Q4
National measure	Community Dentistry - Proportion of patients accepted for care who are seen for an assessment within 12 weeks (Of those treated in period)	90%	97.45% annual average 97.78% in March 2026
National measure	Community Dentistry - Special Care - Core Units of Activity (UDA)	24085 per year	16216 year end
National measure	Community Dentistry - Urgent Care - Out of Hours Units of Activity (UDA) combined with main out of hours dental service	4000 per year	2756 year end
National measure	Emergency Dental Service Waiting times to triage - % Patients triaged within 6 hours	-	98.06% annual average 99.4% in March 2026
National measure NOF (scored)	Percentage of patients waiting over 52 weeks for community services (CYP and Adults combined)	-	18.50% annual average 18.03% end of March 2026
Local measure	Number of patients waiting over 52 weeks for community services (CYP and Adults combined)	-	1375 annual average 1232 end of March 2026
Quality			
Local measure	Total number of patient incidents (all levels of harm excluding inherited pressure damage)	-	18623 annual total
Local measure	Total number of unexpected deaths report as incidents (by date of death, including natural and unnatural)	-	286 annual total
Local measure	Number of suspected suicides	-	57 annual total
Local measure	Total number of incidents involving physical restraint	-	4386 annual total
Local measure	Total number of complaints and resolutions	-	1030 annual total
Local measure	Total number of violence, physical, non-physical and property damage incidents (patients and staff)	-	4925 annual total
Local measure Strategic Metric - Quality	Reduction in the use of prone restraints (number of incidents involving prone restraint)	97	208 year end
Local measure Strategic Metric - Quality	Reduction in the use of seclusion (number of incidents involving seclusion)	303	457 year end
Local measure Strategic Metric – Quality	Response to staff survey question “I would feel secure raising concerns about unsafe clinical practice”	80% (2024 score)	79% (2025 score)
Local measure Strategic Metric – Quality	Rate of meaningful data completeness in the domain of 'ethnicity/ethnic group' on electronic health records for the trust's core mental health services, as defined in the Mental Health Minimum Dataset.	90%	82.39% end of March 2026
People			
National measure NOF (scored)	NHS Staff survey "raising concerns" sub-score	6.99	6.96 (2025 score)

		(2024 score)	
National measure	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	92.7% (2024 score)	93.2% (2025 score)
National measure	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	86.6% (2024 score)	87.6% (2025 score)
National measure	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	77.7% (2024 score)	78.0% (2025 score)
National measure	NHS staff survey – people promise score - we are compassionate and inclusive	7.81 (2024 score)	7.81 (2025 score)
National measure	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation *Metric definition updated for 2025 hence no target	-*	59.50% (2025 score)
Local measure	Proportion of staff in senior leadership roles (bands 8a - 8d, 9 and Very Senior Manager) who are women	-	77.81% annual average 78.08% March 2026
National measure NOF (scored)	Reduce staff sickness to 4.5%	4.5%	4.89% annual average 4.74% March 2026
Local measure	Personal Development Review (PDR) compliance (PDR season is between April – July; target - 95% by end of July)	95%	96.68% end of July 2025 92.93% end of March 2026
Local measure	Reduction in vacancies	9%	8.35% annual average 7.45% March 2026
Local measure	% of early turnover	14%	11.51% annual average 11.78% March 2026
Local measure	Statutory and mandatory training compliance	95%	92.31% annual average 92.68% March 2026
Local measure	Overall supervision rate (metric introduced October 2025)	95%	80.17% annual (Oct-25 – Mar-26) 81.39% March 2026
Local measure	Staff leaver rate	-	6.29% annual average 6.9% March 2026
Local measure	Relative likelihood of white applicant being appointed from shortlisting across all posts compared to Black, Asian and Minority Ethnic (BME) applicants	1	1.8 annual average 1.4 March 2026
Local measure	Relative likelihood of non-disabled applicant being appointed from shortlisting compared to disabled applicants	1	1.1 annual average 1.3 March 2026
National measure Strategic Metric - People	Reduce agency usage to meet target (% of agency used)	4.23%	3.11% annual average 1.06% March 2026
Local measure Strategic Metric - People	Reduction in % labour turnover	14%	9.63% annual average 9.35% March 2026
Local measure Strategic Metric – People	Number of people who have completed Quality Improvement Training Level 1	-	1314 end of March 2026
Local measure Strategic Metric - People	Black, Asian and Minority Ethnic (BAME) representation across all pay bands including Board level.	19%	26.96% annual average 27.97% March 2026

Local measure Strategic Metric – People	Black, Asian and Minority Ethnic (BAME) representation in senior leadership roles (Bands 8a-8d, Band 9, Very Senior Management).	19%	14.07% annual average 14.20% March 2026
National measure Strategic Metric – People NOF (scored)	Staff survey engagement score	7.25 (2024 score)	7.21 (2025 score)

Appendix 2 – Disclosures, comply or explain

Ref	Section - headline	
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives.	Comply
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively.	Comply
Section A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance.	Comply
Section A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	Comply
Section A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually.	Comply
Section A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously.	Comply
Section A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	Comply

Section A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes.	Comply
Section B, 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Comply
Section B, 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively.	Comply
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Comply
Section B, 2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	Comply
Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual.	Comply
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	Comply
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	Comply
Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees.	Comply
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Comply
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director	Comply
Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives.	Comply
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time.	Comply
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters	Comply
Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	Comply

Section B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.	Comply
Section B, 2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.	Comply
Section B, 2.17	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	Comply
Section C, 2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	Comply
Section C, 2.2	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair).	Comply
Section C, 2.3	The chair or an independent non-executive director should chair the nominations committee(s).	Comply
Section C, 2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	Comply
Section C, 2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.	Comply
Section C, 2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority.	NA
Section C, 2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	Comply
Section C, 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence.	Comply
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review.	Comply
Section C, 4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.	Comply
Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors.	Comply

Section C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors.	Comply
Section C, 4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance	Comply
Section C, 4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust.	Comply
Section C, 4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	Comply
Section C, 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment	Comply
Section C, 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge.	Comply
Section C, 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities.	Comply
Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff.	Comply
Section C, 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors.	Comply
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Comply
Section C, 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information.	Comply
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees	Comply
Section C, 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	Comply
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management.	Comply

Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors.	Comply
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties.	Comply
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations	Comply
Section C, 5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan	Comply
Section C, 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Comply
Section D, 2.1 And Section D, 2.2	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts.	Comply
Section D, 2.3	A trust should change its external audit firm at least every 20 years.	Comply
Section D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	Comply
Section E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Comply
Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Comply
Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance.	Comply
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Comply
Section E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Comply
Section C, 4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and	Comply

	unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	
Section C, 5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties.	Comply
Section C, 2.9 Section B, 2.13	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing.	Comply
Section C, 4.2	The board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Comply
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three.	Comply

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 2026 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 36, including a summary of significant accounting policies.

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

In our opinion the financial statements:

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

Basis for opinion

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

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

Conclusions relating to going concern

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

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on Foundation Trust's ability to continue as a going concern for a period to 31 July 2027.

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

In evaluating the Accounting Officer's conclusions, we have considered the requirement of the DHSC Group Accounting Manual for entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services they provide will continue into the future, and had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) regarding the application of ISA (UK) 570 Going Concern to public sector entities.

Other information

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

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

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

We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration Report and Staff Report identified as subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Matters on which we are required to report by exception

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

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

We have nothing to report in respect of these matters.

Responsibilities of the Accounting Officer

As explained more fully in the 'Statement of the Chief Executive's responsibilities as the accounting officer of Oxford Health NHS Foundation Trust' set out on page 72 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.

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

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Foundation 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, head of internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Foundation Trust's board minutes, through enquiry of employees to verify Foundation Trust policies, and through the inspection of 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. Management have procedures in place which ensure that those charged with governance have appropriate oversight of the legal and regulatory frameworks,

supplemented through the reports taken to the Audit and Risk Committee, and they promote a culture of honesty and ethical behaviour at the Foundation Trust, where a strong emphasis is placed on fraud prevention, which may reduce opportunities for fraud to take place, and fraud deterrence, which could persuade individuals not to commit fraud because of the likelihood of detection and punishment.

- 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 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, we focused on the testing on three areas, being the understatement of receivables, the understatement of research and development (R&D) income and the overstatement of deferred income. To address the understatement of receivables we reviewed transactions recorded in the ledger and cash receipts received into the bank account post year-end to confirm that income had been recognised in the correct period, we performed a reconciliation of income recognised against a sample of signed contracts, we reviewed the output of the NHS agreement of balance and confirmed that there were no variances where the Foundation Trust's income was reported lower than that reported by the counterparty above our testing threshold, and we reviewed minutes of Board and committee meetings to identify any potential income that been omitted from the financial statements. To address the understatement of R&D income we tested a sample of R&D agreements to check that income was recognised in line with any terms and conditions included within the agreement, where income was recognised in line with expenditure we tested a sample of expenditure to check that the income was recognised in the correct period, and we agreed R&D income to the cash receipts in the bank statement. To address the overstatement of deferred income we tested a sample of deferred income balances to confirm performance obligations in the contract had not been met, to check that it was appropriate to defer the income and, for the same sample, we reviewed the contracts due to expire to confirm that continued deferral of income was appropriate.
- 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 which had been identified as unusual following our analysis of the Foundation Trust's data and confirmed that there were no 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 March 2026, as to whether the Foundation Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

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

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

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

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of Oxford 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
25 June 2026

Oxford Health NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Oxford Health NHS Foundation Trust

These accounts, for the year ended 31 March 2026, 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

A handwritten signature in black ink, appearing to read 'G. Macdonald', enclosed within a thin black rectangular border.

Name Grant Macdonald

Job title Chief Executive

Date 25 June 2026

Statement of Comprehensive Income

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	595,887	550,831
Other operating income	4	156,386	142,393
Operating expenses	6,8	(742,814)	(692,388)
Operating surplus/(deficit) from continuing operations		9,459	836
Finance income	10	4,994	5,852
Finance expenses	11	(1,508)	(1,649)
PDC dividends payable		(3,423)	(3,043)
Net finance costs		63	1,160
Other gains / (losses)	12	344	-
Surplus / (deficit) for the year from continuing operations		9,866	1,996
Surplus / (deficit) for the year		9,866	1,996
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(1,982)	(5,978)
Revaluations	15	4,354	8,790
Remeasurements of the net defined benefit pension scheme asset	31	78	123
Total other comprehensive income for the period		2,450	2,935
Total comprehensive income / (expense) for the period		12,316	4,931

Statement of Financial Position

		31 March 2026	31 March 2025
	Note	£000	£000
Non-current assets			
Intangible assets	13	4,617	5,410
Property, plant and equipment	14	228,302	221,715
Right of use assets	16	33,170	39,301
Other investments / financial assets	18	1,125	1,125
Receivables	20	367	366
Other assets	21	915	799
Total non-current assets		268,496	268,716
Current assets			
Inventories	19	7,569	6,463
Receivables	20	25,856	19,599
Non-current assets for sale and assets in disposal groups	22	985	1,185
Cash and cash equivalents	23	98,832	97,818
Total current assets		133,242	125,065
Current liabilities			
Trade and other payables	24	(72,668)	(81,457)
Borrowings	26	(9,134)	(8,002)
Provisions	27	(15,677)	(14,804)
Other liabilities	25	(38,455)	(35,101)
Total current liabilities		(135,934)	(139,364)
Total assets less current liabilities		265,804	254,417
Non-current liabilities			
Trade and other payables	24	(1,500)	(1,500)
Borrowings	26	(28,387)	(35,873)
Provisions	27	(8,426)	(9,226)
Total non-current liabilities		(38,313)	(46,599)
Total assets employed		227,491	207,818
Financed by			
Public dividend capital		121,322	113,965
Revaluation reserve		88,166	85,893
Financial assets reserve		1,125	1,125
Income and expenditure reserve		16,878	6,835
Total taxpayers' equity		227,491	207,818

The notes on pages 111 to 160 form part of these accounts.



Name Grant Macdonald
Position Chief Executive
Date 25 June 2026

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

	Public dividend capital	Revaluation reserve	Financial assets reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	113,965	85,893	1,125	6,835	207,818
Surplus/(deficit) for the year	-	-	-	9,866	9,866
Impairments	-	(1,982)	-	-	(1,982)
Revaluations	-	4,354	-	-	4,354
Transfer to retained earnings on disposal of assets	-	(99)	-	99	-
Remeasurements of the defined net benefit pension scheme asset	-	-	-	78	78
Public dividend capital received	7,357	-	-	-	7,357
Taxpayers' equity at 31 March 2026	121,322	88,166	1,125	16,878	227,491

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' 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' equity at 31 March 2025	113,965	85,893	1,125	6,835	207,818

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

		2025/26	2024/25
	Note	£000	£000
Cash flows from operating activities			
Operating surplus / (deficit)		9,459	836
Non-cash income and expense:			
Depreciation and amortisation	6.1	17,591	16,261
Net impairments	7	292	140
Income recognised in respect of capital donations	4	(180)	-
Non-cash movements in on-SoFP pension liability		(36)	(20)
(Increase) / decrease in receivables and other assets		(6,296)	1,285
(Increase) / decrease in inventories		(1,106)	(3,279)
Increase / (decrease) in payables and other liabilities		(5,792)	15,676
Increase / (decrease) in provisions		(713)	104
Net cash flows from / (used in) operating activities		13,219	31,003
Cash flows from investing activities			
Interest received		4,994	5,852
Purchase of intangible assets		(1,026)	(385)
Purchase of PPE		(12,239)	(11,480)
Sales of PPE		504	-
Net cash flows from / (used in) investing activities		(7,767)	(6,013)
Cash flows from financing activities			
Public dividend capital received		7,357	629
Movement on loans from DHSC		(1,338)	(1,338)
Movement on other loans		-	(850)
Capital element of lease rental payments		(6,072)	(6,347)
Capital element of PFI, LIFT and other service concession payments		-	(403)
Interest on loans		(458)	(515)
Other interest		(102)	(113)
Interest paid on lease liability repayments		(860)	(437)
Interest paid on PFI, LIFT and other service concession obligations		-	(521)
PDC dividend (paid) / refunded		(2,965)	(2,905)
Net cash flows from / (used in) financing activities		(4,438)	(12,800)
Increase / (decrease) in cash and cash equivalents		1,014	12,190
Cash and cash equivalents at 1 April - brought forward		97,818	85,628
Cash and cash equivalents at 31 March	23.1	98,832	97,818

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

Accounting convention

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

Note 1.2 Going concern

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

The directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future and until 31st July 2027 i.e. 12 months after the publication of the annual report and accounts for 2025/26. 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 2025/26 was a £9.7m surplus, in line with plan.
- In 2025/26 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 2026/27 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 breakeven position and income is based on planning guidance assumptions and agreements with the Trust's main NHS and non-NHS commissioners. The changes to ICB boundaries into Thames Valley ICB/ICS does not impact the Trust funding.
- The Trust ended 2025/26 with £98.8m of cash. The Trust maintains a rolling cash flow forecast based on expectations for funding and this extends to the end of July 2027. 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 £90.5m at the end of July 2027.

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

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 For Me Adult Secure, Healthy Outcomes of People with Eating Disorders (HOPE) Adult Eating Disorders, Thames Valley Child and Adolescent Mental Health (CAMH) Provider Collaborative, 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 grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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

Note 1.5 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 value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

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) and Local Improvement Finance Trust (LIFT) transactions

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

Initial recognition

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

Subsequent measurement

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

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

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

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	Not applicable	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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

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

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

Impairments

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
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 weighted average cost method.

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 as 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 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.

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 2025/26.

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 2025/26:

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.

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 £138,866k (2024/25 £131,032k) income relating to the provider collaborative, which is split between income for commissioning services in a mental health collaborative of £66,872k (2024/25 £59,434k) and services the Trust delivers under the mental health collaborative of £71,994k (2024/25 £71,598k) 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 2026. 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):	2025/26	2024/25
	£000	£000
Surplus / (deficit) for the period	9,866	1,996
Remove net impairments not scoring to the Departmental expenditure limit	2	100
Remove I&E impact of capital grants and donations	(92)	66
Remove non-cash element of on-SoFP pension costs	(35)	(20)
Remove impact of IFRS 16 on IFRIC 12 schemes and add back PFI revenue costs on a UK GAAP basis	-	52
Adjusted financial performance surplus / (deficit)	9,741	2,194

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)	2025/26	2024/25
	£000	£000
Mental health services		
Income from commissioners under API contracts*	276,666	255,712
Services delivered under a mental health collaborative	71,994	71,598
Income for commissioning services in a mental health collaborative	66,872	59,434
Clinical partnerships providing mandatory services (including S75 agreements)	3,434	3,111
Clinical income for the secondary commissioning of mandatory services	4,207	4,274
Other clinical income from mandatory services	2,033	1,941
Community services		
Income from commissioners under API contracts*	130,720	117,133
Income from other sources (e.g. local authorities)	13,305	12,595
All services		
Private patient income	310	302
National pay award central funding***	-	269
Additional pension contribution central funding**	26,142	23,496
Other clinical income	204	966
Total income from activities	595,887	550,831

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2024/25: 23.7%) and related NHS England funding (9.4%, 2024/25: 9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2025/26 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2024/25 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)

	2025/26	2024/25
	£000	£000
Income from patient care activities received from:		
NHS England	29,835	157,879
Integrated care boards	543,126	371,587
Other NHS providers	2,470	2,396
Local authorities	17,477	16,137
Non-NHS: private patients	309	302
Injury cost recovery scheme	127	149
Non NHS: other	2,543	2,381
Total income from activities	595,887	550,831
Of which:		
Related to continuing operations	595,887	550,831

Note 4 Other operating income

	2025/26			2024/25		
	Contract	Non-contract	Total	Contract	Non-contract	Total
	income	income		income	income	
	£000	£000	£000	£000	£000	£000
Research and development	32,210	-	32,210	33,081	-	33,081
Education and training	27,739	-	27,739	24,725	-	24,725
Non-patient care services to other bodies	932		932	2,309		2,309
Receipt of capital grants and donations and peppercorn leases		180	180		-	-
Charitable and other contributions to expenditure		0	0		181	181
Other income	95,325	-	95,325	82,097	-	82,097
Total other operating income	156,206	180	156,386	142,212	181	142,393
Of which:						
Related to continuing operations			156,386			142,393

* Other income includes £91.5m (2024/25 £78.7m) of pharmacy sales generated by the Oxford Pharmacy Store.

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

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	7,099	4,955

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2026	31 March 2025
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	38,455	33,023
after one year, not later than five years	-	2,078
after five years	-	-
Total revenue allocated to remaining performance obligations	38,455	35,101

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

The trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	572,961	529,465
Income from services not designated as commissioner requested services	22,926	21,366
Total	595,887	550,831

Note 5.4 Profits and losses on disposal of property, plant and equipment

	2025/26	2024/25
	£000	£000
Profit on disposal of property, plant and equipment	304	-
Profit on termination of leases	40	-
Total	344	-

Note 6.1 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	47,313	42,452
Purchase of healthcare from non-NHS and non-DHSC bodies	33,775	32,634
*Staff and executive directors costs	455,667	417,798
Remuneration of non-executive directors	202	184
Supplies and services - clinical (excluding drugs costs)	17,488	21,097
Supplies and services - general	5,352	5,362
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	92,178	79,467
Inventories written down	139	88
Consultancy costs	40	542
Establishment	14,669	14,738
Premises	13,294	15,007
Transport (including patient travel)	6,684	6,130
Depreciation on property, plant and equipment	15,772	14,274
Amortisation on intangible assets	1,820	1,987
Net impairments	292	140
Movement in credit loss allowance: contract receivables / contract assets	18	147
Increase/(decrease) in other provisions	(1,031)	549
Change in provisions discount rate(s)	144	14
Fees payable to the external auditor		
audit services- statutory audit	220	254
Internal audit costs	97	63
Clinical negligence	1,778	1,531
Legal fees	696	560
Insurance (as a policy holder)	685	540
Research and development	23,876	27,350
Education and training	2,858	2,581
Expenditure on short term leases	31	76
Expenditure on low value leases	187	194
Variable lease payments not included in the liability	2,213	1,133
Redundancy	15	61
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	-	553
Car parking & security	13	18
Losses, ex gratia & special payments	57	56
Other services, eg external payroll	940	699
Other	5,332	4,109
Total	742,814	692,388
Of which:		
Related to continuing operations	742,814	692,388

* Increase due to national pay awards of £14.3m, additional pension costs of £2.6m and 3.7% 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 (2024/25: £2,000k).

Note 7 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	290	40
Changes in market price	2	100
Total net impairments charged to operating surplus / deficit	292	140
Impairments charged to the revaluation reserve	1,982	5,978
Total net impairments	2,274	6,118

Note 8 Employee benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	312,108	283,882
Social security costs	39,991	29,193
Apprenticeship levy	1,514	1,379
Employer's contributions to NHS pensions	66,182	59,665
Pension cost - other	35	41
Temporary staff (including agency)	38,528	45,950
Total gross staff costs	458,358	420,110
Recoveries in respect of seconded staff	(2,269)	(2,312)
Total staff costs	456,089	417,798
Of which		
Costs capitalised as part of assets	423	-

Note 8.1 Retirements due to ill-health

During 2025/26 there were 10 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £639k (£1,034k in 2024/25).

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 2026, is based on valuation data as at 31 March 2023, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

Note 10 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	4,917	5,779
Other finance income	77	73
Total finance income	4,994	5,852

Note 11.1 Finance expenditure

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	457	510
Interest on lease obligations	860	436
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	-	33
Contingent finance costs	-	488
Total interest expense	1,317	1,467
Unwinding of discount on provisions	88	69
Other finance costs	103	113
Total finance costs	1,508	1,649

Note 12 Other gains / (losses)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	344	-
Total gains / (losses) on disposal of assets	344	-
Total other gains / (losses)	344	-

Note 13.1 Intangible assets - 2025/26

	Software licences £000	Total £000
Cost at 1 April 2025 - brought forward *	12,078	12,078
Additions	1,026	1,026
Disposals / derecognition	(370)	(370)
Cost at 31 March 2026	12,734	12,734
Amortisation at 1 April 2025 - brought forward	6,668	6,668
Provided during the year	1,820	1,820
Disposals / derecognition	(370)	(370)
Amortisation at 31 March 2026	8,118	8,118
Net book value at 31 March 2026	4,616	4,616
Net book value at 1 April 2025	5,410	5,410

Note 13.2 Intangible assets - 2024/25

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	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 - as previously stated	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 14.1 Property, plant and equipment - 2025/26

	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 2025 - brought forward	47,940	159,461	9,257	7,362	104	7,096	2,433	233,654
Additions	-	1,590	8,667	123	-	1,885	88	12,353
Impairments	(1,001)	(1,221)	-	-	-	-	-	(2,222)
Revaluations	1,297	(1,685)	-	-	-	-	-	(388)
Reclassifications	-	6,903	(8,178)	318	-	940	17	0
Disposals / derecognition	-	(13)	-	(30)	-	(166)	(70)	(279)
Valuation/gross cost at 31 March 2026	48,236	165,035	9,746	7,773	104	9,755	2,468	243,117
Accumulated depreciation at 1 April 2025 - brought forward	-	2,606	-	4,957	104	2,777	1,494	11,938
Provided during the year	-	5,404	-	562	-	1,702	230	7,898
Revaluations	-	(4,742)	-	-	-	-	-	(4,742)
Disposals / derecognition	-	(13)	-	(30)	-	(166)	(70)	(279)
Accumulated depreciation at 31 March 2026	-	3,255	-	5,489	104	4,313	1,654	14,815
Net book value at 31 March 2026	48,236	161,780	9,746	2,284	-	5,442	814	228,302
Net book value at 1 April 2025	47,940	156,855	9,257	2,405	-	4,318	940	221,715

Note 14.2 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 - as previously stated	44,811	160,948	6,604	7,371	104	4,420	2,639	226,897
Valuation / gross cost at start of period as FT	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-
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 - as previously stated	-	2,450	-	4,435	104	1,652	1,927	10,568
Depreciation at start of period as FT	-	-	-	-	-	-	-	-
Transfers by absorption	-	-	-	-	-	-	-	-
Provided during the year	-	5,325	-	575	-	1,126	188	7,214
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 14.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	48,236	160,801	-	9,746	2,240	-	5,441	768	227,232
Owned - donated/granted	-	979	-	-	44	-	-	47	1,070
Total net book value at 31 March 2026	48,236	161,780	-	9,746	2,284	-	5,441	815	228,302

Note 14.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	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 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 2026 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 2026, the Trust was a lessee in 85 (2024/25-77) arrangements that were classified as right of use assets under IFR16. These leases were made up of the following:

Lease type	Number
Property	57
Pool cars	23
Land	4
Equipment	1

25 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 - 2025/26

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	57,357	24	318	57,699	35,374
Additions	631	-	186	817	-
Remeasurements of the lease liability	280	-	-	280	346
Movements in provisions for restoration / removal costs	698	-	-	698	(139)
Impairments	(52)	-	-	(52)	(28)
Disposals / derecognition	(82)	-	(40)	(122)	(82)
Valuation/gross cost at 31 March 2026	58,832	24	464	59,320	35,471
Accumulated depreciation at 1 April 2025 - brought forward	18,281	3	114	18,398	12,382
Provided during the year	7,746	12	116	7,874	4,915
Disposals / derecognition	(82)	-	(40)	(122)	(82)
Accumulated depreciation at 31 March 2026	25,945	15	190	26,151	17,215
Net book value at 31 March 2026	32,887	9	274	33,169	18,256
Net book value at 1 April 2025	39,076	21	204	39,300	22,992
Net book value of right of use assets leased from other NHS providers					8,682
Net book value of right of use assets leased from other DHSC group bodies					9,575

Note 16.2 Right of use assets - 2024/25

	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£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 16.3 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.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	31,807	25,833
Lease additions	817	1,185
Lease liability remeasurements	280	11,137
Interest charge arising in year	860	436
Early terminations	(40)	-
Lease payments (cash outflows)	(6,932)	(6,784)
Carrying value at 31 March	26,792	31,807

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

	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2026	2026	2025	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	7,779	5,007	6,645	4,195
- later than one year and not later than five years;	10,936	5,575	14,691	8,268
- later than five years.	8,077	3,573	10,471	5,643
Total gross future lease payments	26,792	14,155	31,807	18,106
Finance charges allocated to future periods	-	-	-	-
Net lease liabilities at 31 March 2026	26,792	14,155	31,807	18,106
Of which:				
Leased from other NHS providers		5,012		7,729
Leased from other DHSC group bodies		9,143		10,377

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

	2025/26	2024/25
	£000	£000
Carrying value at 1 April - brought forward	1,125	1,125
Carrying value at 31 March	<u>1,125</u>	<u>1,125</u>

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 2026 £000	31 March 2025 £000
Drugs*	7,485	6,390
Consumables	(0)	-
Energy	63	60
Other	21	13
Total inventories	7,569	6,463
of which:		

* 95% of drug inventories are held by Oxford Pharmacy Stores (OPS) and end of year inventories reflect the growth of OPS in year (Income has increased by 16%) . Inventories are expected to be maintained at this level going forward.

Inventories recognised in expenses for the year were £92,181k (2024/25: £79,814k). Write-down of inventories recognised as expenses for the year were £140k (2024/25: £91k).

Note 20.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	20,071	14,795
Allowance for impaired contract receivables / assets	(1,555)	(1,548)
Prepayments (non-PFI)	5,685	3,412
PDC dividend receivable	-	35
VAT receivable	1,480	2,670
Other receivables	175	235
Total current receivables	25,856	19,599
Non-current		
Other receivables	367	366
Total non-current receivables	367	366
Of which receivable from NHS and DHSC group bodies:		
Current	17,579	11,892
Non-current	337	336

Note 20.2 Allowances for credit losses

	2025/26	2024/25
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	1,548	1,437
New allowances arising	1,054	1,244
Reversals of allowances	(1,037)	(1,097)
Utilisation of allowances (write offs)	(10)	(36)
Allowances as at 31 Mar 2026	1,555	1,548

Note 21 Other assets

	31 March 2026 £000	31 March 2025 £000
Non-current		
Net defined benefit pension scheme asset	690	577
Other assets	225	222
Total other non-current assets	915	799

Note 22 Non-current assets held for sale and assets in disposal groups

	2025/26 £000	2024/25 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	1,185	200
Assets classified as available for sale in the year	-	985
Assets sold in year	(200)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	985	1,185

Asset held for sale is St Barnabas and South Parade in 2025/26. These assets relate to land and buildings and are surplus to operational requirements.

Shrublands (£200k) was sold during the course of 2025/26.

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.

	2025/26	2024/25
	£000	£000
At 1 April	97,818	85,628
Net change in year	1,014	12,190
At 31 March	98,832	97,818
Broken down into:		
Cash at commercial banks and in hand	46	48
Cash with the Government Banking Service	98,786	97,770
Total cash and cash equivalents as in SoFP	98,832	97,818
Total cash and cash equivalents as in SoCF	98,832	97,818

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	31 March
	2026	2025
	£000	£000
Bank balances	505	494
Total third party assets	505	494

Note 24.1 Trade and other payables

	31 March 2026 £000	31 March 2025 £000
Current		
Trade payables *	10,866	22,031
Capital payables *	3,361	3,427
Accruals *	43,533	43,309
Social security costs	5,001	3,830
Other taxes payable	3,811	3,490
PDC dividend payable	423	-
Pension contributions payable	5,543	5,204
Other payables	130	166
Total current trade and other payables	72,668	81,457
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	8,204	12,593
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* Combined payable and accruals balances in 2025/26 are £57.8m (2024/25 £68.8m). These balances represent different stages of the Purchase to Pay (P2P) process.

Note 25 Other liabilities

	31 March 2026 £000	31 March 2025 £000
Current		
Deferred income: contract liabilities	38,455	35,101
Total other current liabilities	38,455	35,101

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 £38.4m income deferred at 31 March 2026, £32.1m (2024/25 £29.0m) relates to the Trust's Provider Collaboratives, for which the Trust is lead provider. The Provider Collaboratives contracts state that underspends should be deferred for future investment in the services that they cover.

Note 26.1 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Loans from DHSC	1,355	1,356
Lease liabilities	7,779	6,646
Total current borrowings	9,134	8,002
Non-current		
Loans from DHSC	9,374	10,712
Lease liabilities	19,013	25,161
Total non-current borrowings	28,387	35,873

Note 26.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	12,068	-	31,807	0	43,875
Cash movements:					
Financing cash flows - payments and receipts of principal	(1,338)	-	(6,072)	-	(7,410)
Financing cash flows - payments of interest	(458)	-	(860)	-	(1,318)
Non-cash movements:					
Additions	-	-	817	-	817
Lease liability remeasurements	-	-	280	-	280
Application of effective interest rate	457	-	860	-	1,317
Early terminations	-	-	(40)	-	(40)
Carrying value at 31 March 2026	10,729	-	26,792	0	37,521

	Loans from DHSC £000	Other loans £000	Lease Liabilities £000	PFI and LIFT schemes £000	Total £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

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 2025	582	2,373	307	388	20,380	24,030
Change in the discount rate	12	132	-	-	(27)	117
Arising during the year	28	7	159	68	1,818	2,080
Utilised during the year	(91)	(150)	(44)	(10)	(545)	(840)
Reversed unused	(9)	(201)	(171)	(137)	(877)	(1,395)
Unwinding of discount	18	70	-	-	23	111
At 31 March 2026	540	2,231	251	309	20,772	24,103
Expected timing of cash flows:						
- not later than one year;	91	146	251	309	14,881	15,678
- later than one year and not later than five years;	362	543	-	-	3,801	4,706
- later than five years.	87	1,542	(0)	-	2,090	3,719
Total	540	2,231	251	309	20,772	24,103

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 2026, £3,277k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Oxford Health NHS Foundation Trust (31 March 2025: £3,534k).

Note 28 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £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)
Net value of contingent assets	-	-

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 2026 £000	31 March 2025 £000
Property, plant and equipment	5,407	698
Intangible assets	-	73
Total	5,407	771

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

	2025/26	2024/25
	£000	£000
Present value of the defined benefit obligation at 1 April	(1,904)	(2,561)
Current service cost	(7)	(12)
Interest cost	(103)	(113)
Contribution by plan participants	-	(4)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	(84)	235
Benefits paid	117	551
Present value of the defined benefit obligation at 31 March	(1,981)	(1,904)
Plan assets at fair value at 1 April	2,480	2,994
Interest income	135	135
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial gain / (losses)	162	(113)
Contributions by the employer	11	11
Contributions by the plan participants	-	4
Benefits paid	(117)	(551)
Plan assets at fair value at 31 March	2,671	2,480
Plan surplus/(deficit) at 31 March	690	576

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	31 March
	2026	2025
	£000	£000
Present value of the defined benefit obligation	(1,981)	(1,904)
Plan assets at fair value	2,671	2,480
Net defined benefit (obligation) / asset recognised in the SoFP	690	577
Net (liability) / asset after the impact of reimbursement rights	690	577

Note 30.3 Amounts recognised in the SoCI

	2025/26	2024/25
	£000	£000
Current service cost	(7)	(12)
Interest expense / income	32	22
Total net (charge) / gain recognised in SOCI	25	10

This note relates to the LGPS pension scheme.

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 Analysis of amounts payable to service concession operator

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

	2025/26	2024/25
	£000	£000
Unitary payment payable to service concession operator	-	1,349
Consisting of:		
- Interest charge	-	32
- Repayment of balance sheet obligation	-	403
- Service element and other charges to operating expenditure	-	426
- Contingent rent	-	488
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

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 2026 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

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2026				
Trade and other receivables excluding non financial assets	18,705	-	-	18,705
Other investments / financial assets	-	-	1,125	1,125
Cash and cash equivalents	98,832	-	-	98,832
Total at 31 March 2026	117,537	-	1,125	118,662

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2025				
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

Note 32.3 Carrying values of financial liabilities

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2026			
Loans from the Department of Health and Social Care	10,729	-	10,729
Obligations under leases	26,792	-	26,792
Trade and other payables excluding non financial liabilities	56,167	-	56,167
Total at 31 March 2026	93,688	-	93,688

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025			
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

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 2026 £000	31 March 2025 £000
In one year or less	65,713	76,075
In more than one year but not more than five years	17,468	21,437
In more than five years	12,424	16,370
Total	95,605	113,882

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

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Fruitless payments and constructive losses	1	6	-	-
Bad debts and claims abandoned	3	141	82	29
Stores losses and damage to property	-	-	3	89
Total losses	4	147	85	118
Special payments				
Compensation under court order or legally binding arbitration award	2	2	3	22
Ex-gratia payments	26	67	32	40
Total special payments	28	69	35	62
Total losses and special payments	32	216	120	180
Compensation payments received				

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 76% 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
 Hampshire & Isle of Wight ICB

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
 Response

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 2026 to assist group bodies in preparing disclosures compliant with IAS 24.

Ministers

The Rt Hon Wes Streeting MP
 Karin Smyth MP
 Stephen Kinnock MP
 Ashley Dalton MP
 Baroness Gillian Merron
 Sharon Hodgson MP
 Zubir Ahmed MP

Senior Officials

Professor Sir Christopher Whitty KCB
 Samantha Jones OBE (from 16 June 2025)
 Jonathan Marron CB
 Matthew Style
 Michelle Dyson
 Andrew Brittain
 Professor Lucy Chappell
 Jenny Richardson
 Lorraine Jackson
 Sally Warren
 Catherine Frances CB
 Tom Riordan
 Paul Macnaught
 Danny Mortimer
 Jules Hunt
 Gila Sacks
 Sir Jim Mackey
 David Probert
 Fiona Bride
 Duncan Burton
 Dr Claire Fuller
 Professor Meghana Pandit
 Jo Lenaghan
 Elizabeth O'Mahoney
 Paul Dinkin

Non-executive Directors

Samantha Jones OBE (until 16 June 2025)
 The Rt Hon Alan Milburn
 Sir Richard Douglas
 Naomi Eisenstadt CB
 Baroness Camilla Cavendish
 Phil Jordan

Entities linked to the individuals above

Accurx Ltd (ended early June 2025)
Advantage Mentoring C.I.C (until 1 August 2025)
AM Strategy Ltd
ANDIGITAL Ltd
Apax Partners UK Ltd (until June 2025)
Bryn and Cwmavon Events
Carsøe Group A/S
Cole Close Management Company
Demelza Hospice Care for Children
DJE Holdings operating as DJE Consulting Ltd
Education Endowment Foundation
EN-Projects Ltd
Extra Time Partners Ltd
Financial Fairness Trust (until June 2025)
Health Consultants International Ltd
Intergenerational Music Making (from 29 October 2025)
JJ Pandit Ltd (from 29 October 2025)
Juganu (from May 2025)
Keys Group Limited (until June 2025)
Kindling Transformative Interventions Ltd
Lancaster University
Macmillan Cancer Support
Middlesbrough Football Club Foundation (until February 2026)
Neurons Inc ApS
NHS Confederation
NHS Employers Policy Board
Norwood Ravenswood (until 1 August 2025)
@PVJCIO Ltd
Palo Alto Networks
Place2Be
Princess Alice Hospice, Esher (from 29 October 2025)
Safelane Global International Ltd
Samantha Jones Limited
Sightsavers (registered in the UK as Royal Commonwealth Society for the Blind)
Social Mobility Foundation
South East Medical Services Ltd
XLinks (until June 2025)
Vestas Wind Systems LLP
Yorkshire Sculpture Park

Note 35 Events after the reporting date

No event after reporting date.

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 2025 to 31 March 2026

Oxfordshire			
Adults of Working Age	£000's	£000's	£000's
	Total	Oxford Health Contribution	Oxfordshire County Council
Delegated Budgets			
Expenditure			
Pay	12,467	10,699	1,768
Non-pay	423	389	34
	12,890	11,088	1,802
Income	-47	-47	0
Total Delegated Budgets	12,843	11,041	1,802
Overhead Contribution	0	0	0
Contribution to the Pool	12,843	11,041	1,802

Buckinghamshire			
Adults of Working Age	£000's	£000's	£000's
	Total	Oxford Health Contribution	Buckinghamshire County Council
Delegated Budgets			
Expenditure			
Pay	3,242	0	3,242
Non-pay	162	0	162
	3,404	0	3,404
Income	0	0	0
Total Delegated Budgets	3,404	0	3,404
Overhead Contribution	238	0	238
Contribution to the Pool	3,642	0	3,642

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

