Introduction

Welcome to the Annual Report 2012/13 of the Oxford University Hospitals NHS Trust. This report describes how the Trust has performed over the last year and how we account for the public money spent by the Trust over this period. It also includes an overview to outline our activities and priorities to improve quality of care and outcomes for patients who use our services. This work is described in full in a separate Quality Account.

Message from the Chairman and Chief Executive

Over the past year, we have set ourselves clear goals as part of our Integrated Business Plan which outlines how we will develop the services we provide over a five year period to 2018.

Our vision is rightly ambitious to ensure that we always deliver optimum treatment outcomes and meet our promise to deliver excellent care with compassion – the healthcare that we all want and expect for ourselves, our friends and families. This remains a key focus and you will read in this report about our achievements in meeting performance standards, delivering local and specialist healthcare of high value, and a commitment to innovation and transformation.

The process we are going through to achieve Foundation Trust status is a rigorous one, and requires the demonstration that quality is a top priority at every level of the organisation. It provides the assurance that clinical practices, governance arrangements and financial management are of high quality. We are working with the Trust Development Authority (TDA) which acts on behalf of the Secretary of State for Health in the assessment of the Trust’s Foundation Trust application. Our application will then be passed on to Monitor for the final stage of assessment in the latter months of the financial year 2013/14, which we hope will be followed by authorisation later in 2014.

Becoming a Foundation Trust and a membership organisation will enable us to work more effectively in partnership with our patients and our local community to provide high quality healthcare. The most important thing is that we are able to meet the expectations of our local community and our patients and receive their support and involvement in return.
In the summer of 2012, Board members and staff visited 14 different towns as part of a three month roadshow to consult with the public on our plans to become a Foundation Trust. The NHS attracts a high level of goodwill, but we know that we don’t always get it right. Through our roadshows, we listened to public views and one area where you told us we could do better was in preventing fragmentation of care when treatment crosses organisational boundaries. This is particularly important for some of our most vulnerable patients, such as the frail elderly, who rely on all the organisations involved in their care working together seamlessly. You will read in this report how we are working closely with local GPs and social care partners to better integrate patient pathways and improve discharge procedures and reduce delays in moving patients on to the next stage of their care.

We hope that the 6,500 people who have so far signed up to become a member of our Foundation Trust will help us to build on our achievements and keep our focus on what matters most to you.

Francis report and quality care

The publication of the Report of the Public Inquiry into events at Mid Staffordshire NHS Foundation Trust by Robert Francis QC in February 2013 served as a stark reminder of the importance of maintaining an unrelenting focus on quality and compassion when delivering healthcare. The Francis Report has provided an important opportunity for reflection and has reinforced for us the vital importance of our ongoing work around the Trust’s values.

We are confident that we in the Oxford University Hospitals have the values and approach to culture and behaviours across the Trust that will ensure that we deliver compassionate excellence in care to all our patients. Our ongoing focus on high quality patient care reflects our commitment, and while we must never be over confident or complacent, the majority of our patients are very satisfied with the care they receive.

During 2012/13 we have reviewed our strategy for delivering continuous quality improvements and have developed a vision and programme of work focusing on three key areas of patient safety; patient experience; and effectiveness and outcomes. We are focusing on leadership, education and training, robust systems and processes, and ongoing monitoring and assessment to ensure we deliver year on year improvements in the quality of our services. The Quality Account section in this report includes some of the activities which we undertook during 2012/13 to improve all aspects of quality and outlines our priorities for quality improvements in 2013/14.

Working in partnership

In Oxfordshire, the NHS, social care and our university partners have formed an academic health consortium to help us tackle the challenges we face. We have agreed that one of our first priorities is to improve the way we look after people with dementia. You will read in this report how we are working with the Dementia Action Alliance, our partner organisations and charities to provide seamless and patient-centred care for people with dementia.

We are proud of our achievements in 2012/13 and look forward to delivering further benefits to our patients through better integration of services delivered by hospitals and GPs in the community and innovative network agreements with academic and commercial institutions to help bring research opportunities to fruition in the form of new models of care and treatment.

The end of March 2013 brought the formal change in the structures of the NHS, but our work in doing the very best for all patients under our care continues as we work with the newly created GP-led clinical commissioning groups. We, and all NHS Trusts, continue to face tough savings targets alongside projected increases in demand for our services. It is more important than ever that we collaborate with our health and social care partners to jointly address the challenges we face in delivering affordable and sustainable services to our local communities.

Sir Jonathan Michael
Chief Executive

Dame Fiona Caldicott
Chairman
The well being of every patient and member of staff is central to our work and our intent is to deliver compassionate excellence in everything we do.
The Oxford University Hospitals NHS Trust (OUH) is one of the largest acute teaching trusts in the UK, with a national and international reputation for the excellence of its services and its role in teaching and research.

The Trust provides services from four hospital sites: the John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Centre in Oxford, and the Horton General Hospital in Banbury.

We have around one million patient contacts each year and, in addition to providing general hospital services, we treat patients from across the country for specialist services not routinely available elsewhere.

Most services are provided in our hospitals, but over 6% are delivered from 44 other locations across the region and some in patients’ homes. In 2012/13 we provided care for people through:
- **835,448** outpatient appointments in the Trust’s hospitals;
- **186,587** emergency and elective inpatient admissions;
- **8,777** babies.

We employ around **11,000** people and our turnover in 2012/13 was **£822 million**.

**University partnerships**

We have a close partnership with the University of Oxford's Medical Sciences Division and Oxford Brookes University’s Faculty of Health and Life Sciences, which both provide renowned teaching and education for doctors, nurses and other healthcare professionals.

Joint Working Agreements between the Trust, Oxford Brookes University and the University of Oxford provide the ability to share ideas and activities in the pursuit of excellence in patient care, research and education.

Our existing university collaborations include the ambitious research programmes, funded by the National Institute for Health Research (NIHR), and established through the Oxford Biomedical Research Centre (BRC) and at the Biomedical Research Unit in musculoskeletal disease at the Nuffield Orthopaedic Centre. These set the standard in translating science and research into new and better NHS clinical care.

One of our strategic objectives is to develop both clinical and academic networks. The formation of the Oxfordshire Academic Health Consortium and the Oxford Academic Health Science Network will assist in the translation of research into innovative practice. Our partnerships with the University of Oxford and Oxford Brookes University complement and enhance the services we offer, supporting the delivery of teaching, education, training and research.

Two noteworthy developments over the past year include:
- The Acute Vascular Imaging Centre (AVIC) officially opened alongside the Oxford Heart Centre and the Emergency Department at the John Radcliffe Hospital as a unique, research-funded facility to develop faster and safer treatment for arterial blockages;
- The Nuffield Orthopaedic Centre has been designated as a Centre of Excellence by Arthritis UK to reduce the risk of osteoarthritis in sports people and to facilitate safe sport in the wider population.

**About us**

The Oxford University Hospitals NHS Trust (OUH) is one of the largest acute teaching trusts in the UK, with a national and international reputation for the excellence of its services and its role in teaching and research.

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Our hospitals

The John Radcliffe Hospital in Oxford is the largest of the Trust’s hospitals and the home of many departments, including the majority of the Trust’s corporate functions. It is the site of the county’s main accident and emergency service, the Major Trauma Centre for the Thames Valley region, and also provides acute medical and surgical services, intensive care and women’s services. The Oxford Children’s Hospital, the Oxford Eye Hospital and the Oxford Heart Centre are also part of the John Radcliffe Hospital.

The site has a major role in teaching and research and hosts many of the University of Oxford’s departments, including those of the Medical Sciences Division.

The Churchill Hospital in Oxford is the centre for the Trust’s cancer services and a range of other medical and surgical specialties. These include: renal services and transplant, clinical and medical oncology, dermatology, haemophilia, infectious diseases, chest medicine, medical genetics, palliative care and sexual health. It also incorporates OCDEM (the Oxford Centre for Diabetes, Endocrinology and Metabolic Medicine).

The hospital, and the adjacent Old Road campus, are major centres for healthcare research, and host some of the departments of the University’s Medical Sciences Division and other major research centres such as the Oxford Cancer Research Centre, a partnership between Cancer Research UK, Oxford University Hospitals and the University of Oxford.

The Nuffield Orthopaedic Centre forms the Musculoskeletal and Rehabilitation Services division of the Trust. It has been treating patients with bone and joint problems for more than 80 years and has an international reputation for excellence in orthopaedics, rheumatology and rehabilitation. The hospital also undertakes specialist services such as children’s rheumatology, the treatment of bone infection and bone tumours, and limb reconstruction. The renowned Oxford Centre for Enablement is based on the hospital site and provides rehabilitation to those with limb amputation or complex neurological or neuromuscular disabilities suffered, for example, through stroke or head injury.

The site also houses the University of Oxford’s Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences and is home to the NIHR’s Oxford Biomedical Research Unit in Musculoskeletal Disease.

The Horton General Hospital in Banbury serves the people of north Oxfordshire and surrounding counties. Services include an emergency department, acute general medicine and general surgery, trauma, obstetrics and gynaecology, paediatrics, critical care and the newly expanded Brodey Centre offering treatment for cancer.

The outpatient department runs clinics with specialist consultants from Oxford in dermatology, neurology, ophthalmology, oral surgery, paediatric cardiology, radiotherapy, rheumatology, oncology, pain rehabilitation, ear nose and throat (ENT) and plastic surgery. Acute general medicine also includes a medical assessment unit, a day hospital as part of specialised elderly care rehabilitation services, and a cardiology service. Other clinical services include dietetics, occupational therapy, pathology, physiotherapy and radiology.
Our clinical services

Acute services are provided from our four main hospital sites, with outpatient peripheral clinics in a range of community settings and satellite outreach services in a number of surrounding hospitals. This includes:
- a satellite paediatric surgical centre at Milton Keynes General Hospital;
- specialist radiotherapy services for patients in Swindon via a satellite clinic at the Great Western Hospital.

The Trust delivers services from community hospitals in Oxfordshire and from district general hospitals in surrounding counties. The Trust runs midwifery-led units in community settings across the county. It is responsible for a number of screening programmes, including those for bowel cancer, breast cancer, diabetic retinopathy, cervical cancer and Chlamydia.

Putting more services in more places, for more people

We are committed to bringing clinical care closer to our patients’ homes and we are working closely with the providers of community services, including Oxfordshire County Council social care teams, to reduce fragmentation of care across organisational boundaries.

We already deliver supported care packages for people discharged from hospital and we are looking at how we can further deliver our medical care and clinical expertise outside our acute hospitals and in collaboration with community-based clinical teams.

The key themes of our clinical services strategy are:
- to provide more integrated models of care that enable provision of care from the acute hospital to the community where appropriate;
- to expand specialist services through the strengthening and expansion of clinical networks.

Clinical networks

As a large tertiary acute centre, the Trust provides specialist treatment for patients from a wide regional area. New partnerships have been developed with colleagues across hospitals in the Thames Valley area and beyond, enabling all hospitals to work together to improve care for patients across the region.

We have been designated as the regional hubs for the following clinical networks:
- vascular surgery
- critical care for newborn babies
- major trauma

We are establishing selected specialist services at designated partner hospitals. This enables more specialist care to be provided at regional hospitals and to improve outcomes for local populations beyond the Thames Valley region. We have already agreed some developments including:
- Surgical hubs at partner sites for the treatment of children – South of England Children’s Services Network (see page 22 for details)
- The provision of satellite radiotherapy units in other hospitals outside Oxford.

The number of patients seen

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<th>FINANCIAL YEAR</th>
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<th>Daycase admissions</th>
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Our healthcare market

The Trust's hospitals in Oxford serve the Oxfordshire population of 655,000 and the Horton General Hospital in Banbury has a catchment population of around 150,000 people in north Oxfordshire and neighbouring communities in south Northamptonshire and south east Warwickshire.

We have strong partnerships with our local NHS and social care organisations, and also with a wider network of district general hospitals, universities and research institutions. Our role as a university teaching centre and focus on research and innovation is a defining feature and as such attracts patients from beyond our surrounding counties.

The Trust provides services to two markets: a local market for general hospital services and a wider market for more specialist care. From April 2013.

- Just over 40% of the Trust's income for the delivery of patient services comes from the GP-led Oxfordshire Clinical Commissioning Group.
- 49% of income comes from specialist commissioners
- 11% comes from other GP-led clinical commissioning groups outside Oxfordshire.

The Trust provides the majority of acute services for Oxfordshire with a small volume of activity going to neighbouring District General Hospitals and private providers which have contracts for a limited range of orthopaedic and other planned care.

The wider population served by the Trust’s specialist services is one of approximately 2.5 million within the local authority areas of Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Gloucestershire, Northamptonshire and Warwickshire. Some specialist services serve an even larger catchment population, with national and international elements. In 2012/13, South Central Specialised Commissioning Group (SCSCG) accounted for over 61% of the total Trust specialist income amounting to around £193m annually.

Specialised commissioning

Clinical networks have an important input into specialist commissioning. The networks develop responses to the recommendations of national service improvement programmes with a common feature being recommendations to centralise specialist resources and expertise. In close collaboration with academic and clinical research, the networks work reciprocally with providers across a region to ensure the best outcomes for patients by providing seamless access to specialist healthcare when needed. Clinical networks involving Oxford University Hospitals are:

- Cancer
- Cardiovascular (including cardiac surgery, cardiology, vascular and stroke services)
- Critical care
- Maternity
- Neonatal
- Pathology
- Renal
- Trauma
Working with our commissioners and partners

New NHS landscape

April 2013 brought changes to the overall structure of the NHS in England, with the establishment of the NHS England Commissioning Board, new GP-led clinical commissioning groups, and local councils having a greater role in tackling public health issues.

Locally, clinical commissioning groups – made up of doctors, nurses and other professionals – will buy services for patients, while local councils formally take on their new roles in promoting public health. Health and Wellbeing Boards will bring together local organisations to work in partnership and Healthwatch will provide a powerful voice for patients and local communities.

Most people won’t notice any immediate difference to how they get the care they need – they will still contact their GP when unwell, or their local council for social care needs, and they will continue to receive healthcare free at the point of delivery just as before. However, in the long term, the way we deliver care should be different with greater integration between providers of care.

Integrated care

A key feature locally is the rising demand from an ageing population with increasingly complex health and social care needs. Our response is to work with local partners and commissioners to develop appropriate care pathways to meet this demand in a way that reflects the needs of patients within the constraints of the current economic climate.

As a local health economy we are working with the Oxfordshire Clinical Commissioning Group, the Oxfordshire County Council and Oxford Health NHS Foundation Trust which provides community-based care including the county’s community hospitals. Our joint aim is to improve integration of care and reduce the number of patients waiting to leave our hospitals for ongoing care in the community. A range of initiatives have been piloted to provide care closer to home for elderly patients and those with long-term conditions. Examples include the provision of stroke rehabilitation services in Abingdon and Witney, and the establishment of a joint health and social care team to speed up decisions around patient discharge to enable patients to either go home sooner or on to the next stage of their care in the community.

Oxford Academic Health Consortium

Trust Chief Executive Sir Jonathan Michael and Chair Dame Fiona Caldicott (front) with Consortium partners

The Trust has established a partnership between health, social care, academic and education providers in Oxfordshire to strengthen collaboration and to tackle some of the major issues facing our local communities including dementia and care of the elderly; stroke; and end of life care. The Trust has signed up to a National Dementia Declaration to improve the care of people with dementia.

Oxford’s NHS Trusts and Universities are also preparing an application to become the Oxford Academic Health Science Centre (AHSC).

Oxford Academic Health Science Network

The Trust has successfully collaborated with health and social care providers, commissioners, universities, the voluntary sector, the life sciences industry, and business organisations to set up the Oxford Academic Health Science Network which was designated in May 2013. The purpose of the Network is to achieve tangible improvement in outcomes for patients and in the health of the local population. The aim is to support research and innovation and to deliver new opportunities through the UK life sciences industry.

The Network will focus on delivering these improvements by enabling greater access to research projects and clinical trials, and also supporting the direction of future research and by drawing on the skills, expertise and knowledge of all partners to increase the speed of dissemination, adoption and development of innovation in treatment and care pathways.

The Network covers the Thames Valley and represents a group of health economies and providers who share common challenges and opportunities as outlined below:

- the need to support comprehensive and sustainable healthcare provision, with the right care in the right place, locally and increasingly based in the community rather than in an acute hospital;
- demographic pressures in relatively affluent populations where high health and social care demand is compounded by an aging population, intermingled with pockets of significant deprivation;
- the need to create service solutions without the benefits that large population centres offer for the configuration and viability of services.

The population served will be around 3.3 million.
Our ambition and vision for success

Building on our foundations as an organisation with a clinically-led structure, we have developed a strategy and a five-year business plan to deliver the Trust’s vision. The Trust’s vision is to put the Trust:

- at the heart of a sustainable and outstanding, innovative academic health science system;
- working in partnership and through networks locally, nationally and internationally;
- to deliver excellence and value in patient care, teaching and research within a culture of compassion and integrity.

Underpinning this vision is our strategy built on six pillars – our strategic objectives – which shape our annual plans and business priorities.

Improving quality of care and treatment

Supporting all our plans is a clear focus on the quality of care that we offer in terms of patient safety, patient experience and the outcomes of care. We are committed to being amongst the best in the country in all the elements of quality.

Our vision and strategic objectives remain the framework against which we have set our quality priorities for 2013/14 and in the next section of this report you will read about the quality improvements we plan to make over the financial year 2013/14.

The Trust’s strategic objectives are to deliver:

1. Compassionate excellence – the kind of healthcare we would all expect for ourselves and our families
2. A well-governed and adaptable organisation
3. Better value health care
4. Integrated local healthcare
5. Excellent secondary and specialist care through sustainable clinical networks
6. The benefits of research and innovation to patients
Delivering compassionate excellence

As always, our focus is on our patients’ experience and we strive to capture patients’ feedback and views consistently to ensure that the organisation delivers optimum treatment outcomes, and compassionate excellence – the healthcare that we all want and expect for ourselves, our friends and families.

Our values reflect what is important to staff and patients in terms of not only standards of care and treatment, but also in how we behave and the decisions we take to deliver the best possible healthcare. They reflect the principles, values and pledges of the NHS Constitution and play a key part in describing how we deliver compassionate excellence.

The Trust Values:

Learning | Respect | Delivery | Excellence | Compassion | Improvement

These values underpin our drive for continuous improvement in delivering high quality services that exceed our patients’ expectations. We actively support the development of engaged and informed staff who understand how their efforts contribute to the success of the organisation. This helps us to deliver effective change, service improvements and innovative ways of delivering care.

Our vision and core values ensure that we operate with a common purpose and achieve our shared aspirations.

Our Integrated Business Plan and future priorities

The Trust’s Board has agreed an Integrated Business Plan (IBP) that sets out the organisation’s plans over a five year period until 2018. It describes the services we provide, our plans for developing our services for the future, the money we spend and the people we employ.

A summary can be downloaded from the Trust’s website at: www.ouh.nhs.uk/about/publications

There is an immediate focus on improving care for older, vulnerable patients, with plans to reduce delays in transfer from hospital care and to improve the psychological support and care given to this significant and growing group of patients.

We expect to make important changes in how care is provided across many of our services in the next few years, including:

- better access to services including diagnostic tests and surgery at weekends and over extended days;
- work with local NHS and social care providers to develop care for people at home and to reduce the need for hospital-based care;
- providing specialised care as locally as possible with a network of hospitals in an area from Swindon to Milton Keynes while concentrating some services to deliver the best standards of care;
- better use of our newest hospital buildings and withdrawal from outdated buildings, especially at the Churchill Hospital.

We are focusing on working with our patients, staff and partners in care to do what we describe as ‘Delivering Compassionate Excellence.’
Becoming a Foundation Trust

Oxford University Hospitals NHS Trust is applying to become a Foundation Trust (FT). As an NHS Foundation Trust we must meet the same standards of care and principles that guide other NHS organisations, but we will be more accountable to our local communities through public membership. We are committed to building a substantial and representative membership to help us to become a more responsive organisation with an improved understanding of the needs of our patients, partners and local communities.

Becoming a Foundation Trust means we can involve many people as members and elect a Council of Governors that will work alongside the Trust’s Board of Directors and collectively hold it to account for the Trust’s performance. The governors are elected by the Trust’s membership body to represent the interests of patients and service users, staff and the general public, giving them a greater voice in our future. We currently have around 6,500 public members in addition to our staff membership of around 11,000.

As a Foundation Trust we will have greater freedom to decide locally how best to meet the Government’s national policies and performance targets. We will also have more financial flexibility and will be able to retain savings and invest, with a degree of autonomy, to respond to opportunities for innovation and improvement.

During the summer of 2012 we consulted widely on our strategy and governance arrangements as a Foundation Trust. We expect the Trust Development Authority acting on behalf of the Secretary of State for Health to review our application in 2013 and following a detailed assessment by Monitor, the Parliamentary regulator of NHS Foundation Trusts, we hope to achieve authorisation as a Foundation Trust in 2014.

We have achieved much over the past 12 months as we prepare to operate as a Foundation Trust. There are continuing challenges for the NHS locally and nationally which require innovation and effective partnership working to provide the best possible care for the people we look after now and in the future.

Our ambition is to listen to our patients, staff and members and build a strong partnership that enhances our ability to be a successful Foundation Trust.
We aim to provide the best healthcare outcomes. An important part of this is to monitor and measure what we do to ensure that high quality care is maintained.

Equally important are the priorities of our patients. We hold regular events to listen to the views of our patients and other stakeholders to deliver improvements and provide the best experience.

The Oxford University Hospitals NHS Trust continues to be registered without conditions by the Care Quality Commission to provide health services.

Care Quality Commission

The Trust is governed by a regulatory framework set by the Care Quality Commission (CQC) which has a statutory duty to assess the performance of healthcare organisations. The CQC requires that hospital trusts are registered with the CQC and therefore licensed to provide health services.

The CQC provides assurance to the public and commissioners about the quality of care through a system of monitoring a trust’s performance across a broad range of areas to ensure it meets essential standards. The CQC assessors and inspectors frequently review all available information and intelligence they hold about a hospital.

The regulations are grouped into six key areas, each of which has a number of expected outcomes against which the organisation is measured.

Essential standards:
- Involvement and information on services
- Personalised care, treatment and support
- Safeguarding and safety
- Suitability of staffing
- Quality and management
- Suitability of management

The CQC expects compliance across all these standards and focuses on outcomes to measure how well these standards are being met, with particular emphasis on the views and experiences of people who use the services.

You can find out more about the standards here: www.cqc.org.uk

Care Quality Commission inspections

During 2012/13 the Care Quality Commission (CQC) undertook two reviews within the Trust. In October 2012 an inspection on the Dignity and Nutrition standard for Older People was undertaken at the Horton General Hospital. The CQC found that the Horton General Hospital meets all of the essential standards of quality and safety inspected which included: outcome 1 (Respecting and involving people who use services), outcome 5 (Meeting nutritional needs), outcome 7 (Safeguarding people who use services from abuse), outcome 13 (Staffing) and outcome 21 (Records).

In February 2013 a planned review of compliance was undertaken by the CQC at the John Radcliffe Hospital. The inspection focused on the following four outcomes:
- Care and welfare of people who use services
- Cleanliness and infection control
- Staffing
- Supporting workers

Our Quality Account

You can read more about the activities we undertook over the past year to improve all aspects of quality in our Quality Account. This details our achievements in delivering patient safety, clinical effectiveness and improving the patient experience, and highlights our priorities and focus for 2013/14.

The Trust’s Quality Account is available to read on our website at: www.ouh.nhs.uk/about/publications
Inspectors visited one surgical and one medical ward in the main hospital as well as the Women’s Centre. They looked at treatment records, observed how people were being cared for; spoke to 29 inpatients, spoke to relatives and a range of staff including doctors, nurses, midwives and managers. In all four areas reviewed the hospital met the required standards.

Patients were complimentary about the care they received and said the environment was very clean. A few areas required some improvement and inspectors noted that early consideration and development of discharge plans was not in place for all patients.

“...The CQC inspection helps to inform the training of our staff and provides evidence of good practice as well as constructive feedback of areas that could improve our patients’ experience of care.”

Eileen Walsh, Director of Assurance

Our vision for quality is to be:

Recognised as one of the UK’s highest quality healthcare providers. All our clinical services will provide high quality healthcare; some will provide care that is internationally outstanding.

Our quality domains apply to all staff and departments. We strive for excellence in healthcare by encouraging a culture of support, respect, integrity and teamwork; by monitoring and assessing our performance against national and international standards of care; by learning from our successes and setbacks; by striving to improve what we do through innovation and change; and by ensuring we work in partnership and collaboration with all local agencies of health and social care.

Our Quality Strategy has also been informed by patients through a number of workshops. We need to understand not only what quality means to us as healthcare professionals, but also what matters to our members, patients and their families.

Our aim is to deliver continuous improvement at all levels in the quality of our services in the pursuit of the best patient-centred care.

New quality strategy

Each year we work with our patients, staff and commissioners to agree a number of priorities for development. During 2012, the Trust agreed a new Quality Strategy aimed at building high quality healthcare based on national and international comparisons and to improve our performance in three key domains:

- Patient Safety
- Patient Experience
- Clinical Effectiveness and Outcomes

We also consult with our commissioners to determine local goals in terms of quality and innovation projects. These are known as CQUINs (Commissioning for Quality and Innovation) and are aimed at supporting shared priorities for improvement.

During 2012/13, our priorities included:

**Patient Safety**

Safe medicines delivered on time – we have:
- Introduced a review of patients’ medication when they are admitted to hospital.
- Improved the speed at which patients receive their medication to take home at discharge.
- Improved audit processes for medicines storage and security.

**Clinical Effectiveness**

Innovation to support better care – we have:
- Put in place an electronic early warning system to better record vital sign data and help highlight deterioration in a patient’s condition.
- Developed a smart phone ‘app’ to remotely monitor blood sugar levels for pregnant women with diabetes.

**Patient Experience**

Improving end of life care – we have:
- Introduced a process that better supports patients discharged for end of life care through improved communication between the patient/ family and other professionals in the community who will be involved in providing care.
- Piloted a clinical tool to support staff in identifying and delivering care to patients nearing the end of their lives.
- Implemented the Oxfordshire Advance Care Planning documentation for seamless care for patients across the county.
Delivering compassionate excellence – we have:

- launched the Care Support Worker (CSW) Academy to provide training and develop competencies of healthcare support staff;
- developed a leadership programme for our clinical sisters and charge nurses;
- established a developmental programme for Practice Development Nurses and Clinical Educators in partnership with Oxford Brookes University.

Looking forward, in 2013/14, our quality improvement priorities are:

**Patient Safety**

- Safer care associated with surgery including reducing infection rates, preventing avoidable readmissions, and preventing patient safety incidents.

**Clinical Effectiveness**

- Use of technology to improve care including telemedicine and virtual assessment by hospital doctors of patients in community care settings.

**Patient Experience**

- Improving the way we listen and act on feedback.
- Improving care for people with cognitive impairment and the environment in which patients with dementia are cared for.

**Venous Thromboembolism Assessment (VTE)**

VTE (the formation of blood clots within the veins) is a condition that contributes to an estimated 25,000 deaths amongst patients in hospital each year, some of which could be avoided. National guidance by the National Institute for Health and Clinical Excellence (NICE) states that 90% of all patients should be assessed for their risk of suffering from a VTE on admission at hospital.

We are pleased with the progress made to increase our assessment rate. During 2012/13 we achieved 92.43% against the national target of 90% which was a significant increase on our assessment rate of 78.35% for the previous year. The Trust received third prize for the most improved VTE CQUIN results by the Lifeblood Charity and the All Party Parliamentary annual awards for NHS Trusts.

**Smartphone app to help prevent clots**

Senior nurse Penney Clarke and her team at the Churchill Hospital helped develop an award-winning mobile phone application which could help prevent potentially fatal venous thromboembolisms (VTE), more commonly known as blood clots. The application won first prize in the charity Lifebloods’ national VTE awards 2012 for the best delivery of patient information on VTE.

Dr David Keeling and Senior Nurse Penney Clarke who helped develop the app which patients can download onto mobile devices.
Quality assurance

The Trust uses a variety of nationally recognised indicators to ensure quality of care throughout the Trust. Commissioning for Quality and Innovation (CQUINS) indicators, as well as measures required by our contract with our local commissioner, Oxfordshire Clinical Commissioning Group, along with CQC registration and NHS Litigation Authority (NHSLA) standards, have all become important frameworks for measuring, achieving and ensuring quality within the organisation. Learning from adverse events has continued to be an important part of ensuring organisational cultural change.

Patient Safety Thermometer

Since July 2012, all adult inpatient wards (excluding the short-stay Emergency Assessment Units) in the Trust have completed the NHS Patient Safety Thermometer on a given day every month. The tool identifies patients who receive ‘harm free’ care by collecting data in relation to four ‘harm’s:

- Pressure Ulcers
- Falls causing harm
- Catheter related urinary tract infections
- New venous thromboembolisms

We now have data for over 8,000 patients giving us a reliable baseline from which to inform and monitor our improvements over the next 12 months and beyond. We are keen to do more to reduce the numbers of avoidable pressure ulcers and continue to work with our colleagues in the community to improve preventative measures.

Quality inspection visits

The Trust has established a rolling programme of unannounced compliance inspections on all clinical wards and departments. Since April 2012, 63 quality walk rounds have also taken place, led by members of the executive team – including non-executive directors – the Chief Nurse, senior nurses, divisional directors and clinical leads. There is an emphasis on the patient experience as well as patient and staff safety.

The multi-professional inspection teams focus on compliance with national standards covering quality of care, competence and behaviour of staff and quality and cleanliness of the environment. Inspections are followed by feedback and corrective actions where necessary. During 2013/14, walk rounds will also take place ‘out of hours’ to enable the Trust to have a round-the-clock view of issues affecting our ability to deliver safe care and a positive patient experience.

Clinical effectiveness and audit

We constantly monitor the quality of our services by auditing our clinical practice. In 2012/13 the Trust participated in 43 national clinical audits and other major studies including on cancer, heart disease, diabetes, trauma and neonatal intensive and special care. The Trust also participates in a Department of Health initiative known as Patient Recorded Outcome Measures (PROMs). Patients undergoing surgery for hip and knee joint replacement, and surgery for varicose veins or inguinal hernias, are asked to complete a questionnaire both immediately prior to, and some months after, their treatment. The purpose is to assess the success of the operation from the patient’s viewpoint. Surgical success is measured by the patient’s feedback on the impact the operation has had on their quality of life.

Audit development

In 2013/14 the Trust will develop and implement an annual audit programme that looks at our performance against national, regional and local standards. This will provide a framework that helps us identify where we are doing well and where we need to make improvements. The programme will be based on national priorities such as infection control, patient safety, clinical effectiveness and the priorities agreed with our commissioners.
Our operational and financial performance

Our clinical services are assessed against a wide range of targets and other performance measures. We continue to work hard to ensure we diagnose and treat all patients without delay and have achieved waiting time targets in most areas. There have been challenges around delayed transfers of care which has made it more difficult for the Trust to treat patients as quickly as we would like and we have experienced unprecedented demand for emergency services.

Meeting our access targets

<table>
<thead>
<tr>
<th>COMMITMENT</th>
<th>Standard</th>
<th>Trust achievement 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to treatment waiting times for non-urgent consultant-led treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>90%</td>
<td>91.92%</td>
</tr>
<tr>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>95%</td>
<td>97.56%</td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>92%</td>
<td>95.02%</td>
</tr>
<tr>
<td>Diagnostic test waiting times</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral</td>
<td>99%</td>
<td>92.5%*</td>
</tr>
<tr>
<td>Emergency Department waits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within four hours of their arrival at an accident and emergency department</td>
<td>95%</td>
<td>92.9%*</td>
</tr>
<tr>
<td>Cancer waits – two week waits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>95.43%</td>
</tr>
<tr>
<td>Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>95.24%</td>
</tr>
<tr>
<td>Cancer waits – 31 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>96%</td>
<td>96.91%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>94%</td>
<td>96.31%</td>
</tr>
</tbody>
</table>

* See page 17 for more details
Increased demand and Emergency Department performance

In the period June to December 2012 the Trust consistently met or exceeded the national target of 95% of patients admitted, transferred or discharged within four hours. But the demand on our health services has been higher than ever during the winter of 2012/13, with unprecedented numbers of patients attending our Emergency Departments and being treated in our hospitals. During January, February and March, we were below target with 89.9% of patients attending our Emergency Departments admitted, transferred or discharged within four hours. There have been similar pressures at Trusts across our region and more widely across the country.

Oxfordshire’s health and social care organisations have worked hard to cope with the ongoing pressures of winter-related illnesses in the community and the associated high demand for emergency care. In the first quarter of 2013/14 (April, May and June), the Trust returned to delivering at least 95% of its patients attending the Emergency Departments seen and treated within four hours.

Meeting the financial challenges ahead

The Trust has an integrated business plan which sets out the Trust’s business strategy for the future. As with all other NHS trusts we are required to make significant savings and efficiencies. This is part of the national NHS drive to save £20 billion by 2015.

In the last financial year (to March 2013), we successfully delivered a challenging savings plan and achieved savings of £45.5m and a surplus of 0.44% of turnover of £822m. This is a significant achievement and thanks go to all our staff who continue to work hard to improve the quality of care while reducing costs.

In 2013/14, the challenge is just as great with a further £44m worth of savings to be made. We are doing everything we can to be more efficient behind the scenes. This includes internal efficiencies such as better theatre utilisation, and service moves to improve clinical adjacencies and to make better use of our estate and hospitals.

Over the next five years we plan to reduce our operating costs significantly with average annual savings over these five years (2013/14 to 2017/18) of over 5% of our total costs.

Our integrated business plan sets out our ambition to be among the best in the UK delivering the care we provide. As we prepare to operate as a Foundation Trust we must work together to meet key performance targets, notably in emergency care and delays in transfers of care, and support system change to run services across our local healthcare system as efficiently as possible.

In Section 2 of this report, the Financial Review provides our summary financial statements with the full annual accounts available on the website at www.ouh.nhs.uk
Leaving hospital and delayed transfers of care

Progress in reducing the number of patients remaining in our hospitals beyond their clinical need remains challenging. Over the winter months, we opened more than 100 additional beds as the number of patients who were delayed in moving on to the next stage of their care remained significantly higher than our target of 3.5%. We have made positive developments working with our colleagues in community and social care and we are optimistic that the joint initiatives will help to reduce these delays in transferring patients.

Over the past year we have worked as part of a multi-agency group with our NHS partners and Oxfordshire County Council social care teams to tackle the problem of delays in transferring patients to community and social care. New discharge procedures have been introduced, to include:

- establishing an estimated discharge date for patients on their admission to hospital;
- a bureau to act as a single point of contact for community health and social care teams to receive referrals and develop individually tailored care packages;
- the introduction of assessment teams across the John Radcliffe Hospital, Horton General Hospital and Oxfordshire community hospitals. The assessment teams include acute nurses, community nurses, therapists and social workers and are empowered to make final decisions regarding plans with patients.

The main objective is for the partners to operate as a single entity in ensuring patients move seamlessly across organisational boundaries as their care and treatment requires. Using common ways of working, the partnership is streamlining assessment processes and jointly runs schemes to manage patients’ acute and community bed-based care alongside reablement packages and short-term social care. The programme is also working to increase the timeliness of assessments for people requiring residential nursing home placements but who are delayed in community and acute hospital beds.

Infection prevention and control

Throughout 2012/13 the Infection Prevention and Control Team in partnership with staff has driven forward safer practices in order to minimise ‘preventable infections’. Teamwork and a constant focus by staff on cleaning, disinfection of surfaces and equipment and hand hygiene audits and training have all contributed to reducing infection rates.

The table below indicates the number of cases over the past three years and shows that the Trust has met its national objectives for reducing the number of cases of MRSA in its hospitals. It is a significant achievement to have reduced MRSA and Clostridium difficile infections to their current levels. However, there is more work to do in reducing the number of cases of Clostridium difficile to further meet these very challenging targets.

<table>
<thead>
<tr>
<th></th>
<th>Annual limit 2010/11</th>
<th>Cases in 2010/11</th>
<th>Annual limit 2011/12</th>
<th>Cases in 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>John Radcliffe, Churchill, Horton</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>12</td>
<td>9</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>205</td>
<td>150</td>
<td>137</td>
<td>103</td>
</tr>
<tr>
<td><strong>Nuffield Orthopaedic Centre</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>9</td>
<td>6</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Oxford University Hospitals (cases across all four hospital sites)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRSA</td>
<td>7</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>88</td>
<td>85</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Successful flu vaccination campaign

The Trust again participated in the national NHS staff seasonal flu vaccination campaign which seeks to vaccinate frontline staff. All frontline staff, those in direct contact with patients, were asked to protect themselves, their patients and their families by having the flu jab. During October, November and December 2012 the Trust ran flu clinics across all of its four hospital sites.

By December 2012, the campaign had successfully vaccinated 58.6% (5,259) of frontline staff. In total, 6,500 staff received the vaccine.
Information governance

The Trust takes its responsibilities for maintaining patient and staff confidentiality seriously. Trust employees operate within a comprehensive information governance framework that covers data protection compliance, information security, data quality, confidentiality, records management, IT system security and Freedom of Information compliance. This framework includes procedures for the management of information risks and the reporting of information incidents.

All NHS organisations must include details of incidents involving loss of confidential information in their annual reports. The Oxford University Hospitals NHS Trust reviews and maps its information flows to ensure they are secure and all staff are provided with guidance and training about their responsibilities.

During 2012/13 there was one Serious Incident Requiring Investigation (SIRI) relating to a breach of confidentiality. A set of patient handover notes were found by a member of the public on a coach. The incident was reported to the Information Commissioner’s Office, fully investigated and all patients, or their families, notified.

Trust-wide reminders of information governance responsibilities have since been revised and reissued, including revision of corporate and local induction processes. System changes have been made to force partial de-identification of printed patient lists. New guidance on the creation, printing and handling of patient lists has been written and circulated.

A copy of these guidelines is included in the Medical Staff Manual. Information Governance training is a mandatory element of training for all staff and there continues to be a great emphasis on ensuring this is completed by all staff every year.

The Trust is committed to observing the Caldicott Principles for patient confidentiality. Dr Christopher Bunch is the Trust’s Caldicott Guardian.

The Trust is leading the way in health technology and sees investment in IT systems and processes as key to improving the delivery of patient care. Our vision is to have our patients’ medical history and care requirements available online in real time and easily shared between health professionals.

The implementation of an electronic system to store and manage patient information is the biggest operational change that the Trust has ever undertaken and is being delivered in phases over a number of years. Known as the Electronic Patient Record (EPR) system, it promises to provide a modern and comprehensive set of tools to support the Trust in achieving its strategic goals to be a provider of high quality and efficient patient care and treatment. The aim is to hold patient records electronically, identifying their medical history and ongoing treatment and care requirements, which can be easily shared between health professionals. This includes a picture archiving system for x-ray images.

Over 1.5 million patient records have so far been migrated from paper to the new electronic system. Over the past year we have implemented the system for patient administration and over the coming year will improve the mechanisms used within the system to record data. We are also working to improve access to the system so that all clinical staff are able to use it routinely.

Major changes in working practice are in the process of becoming embedded and our focus is now on developing clinical use of the system. Components of the clinical functions of the system are being used at the Nuffield Orthopaedic Centre, in the Emergency Department and in our maternity service. This currently involves the ordering of diagnostic tests and viewing of results. Nurses on medical wards are now electronically recording patient admissions, discharges and transfers and doctors are able to order laboratory and radiology investigations, complete VTE assessments, view and endorse results.
Freedom of Information

The Trust operates a transparent and open system of access to information about its services, whilst recognising and adhering to best practice on protecting the confidentiality of certain types of information.

During 2012/13 the Trust received 347 Freedom of Information requests.

The majority of requests contain multiple questions that require input across the Trust’s divisions. The Trust endeavours to respond to all requests within 20 working days. However, on occasions, answers to more complex requests do take longer.

During 2012/13, most requests resulted in full disclosure and of those closed during the period, 79% were responded to within 20 working days.

Preparing for an emergency

The Trust has a Major Incident Plan that details how it will respond to an emergency or internal incident. The plan aims to bring co-ordination and professionalism to the often unpredictable and complicated events of a major incident such as one involving multiple casualties requiring extraordinary mobilisation of the emergency services.

The purpose of planning for emergencies is to ensure that we can provide an effective response to any major incident or emergency and to ensure the Trust returns to normal services as quickly as possible.

The plan has been put together in collaboration with partner organisations across Oxfordshire including other NHS Trusts, the emergency services, local councils and emergency planning experts.

Improving our environment

Sustainability update

The trust incurs an annual expenditure of around £13 million on energy and utilities.

The NHS has pledged, as part of its Carbon Reduction Strategy, to be more efficient with resources and also to take a lead in addressing sustainability issues. The NHS Sustainable Development Unit (SDU) has set out the size of the challenge in terms of carbon reduction and has set a target of a 10% reduction on baseline figures by 2015. For the Trust, this means an annual reduction in carbon emissions of 7,000 Tonnes CO₂e.

For the Trust to meet the challenges and realise the benefits it must set out a strategic approach to governance, monitoring and reporting, with an action plan to reduce carbon emissions. In the first instance the Trust will concentrate its efforts on reducing carbon emissions arising from scope 1 and scope 2 activities. This will involve reducing the use of electricity, gas and oil used within the Trust’s buildings.

To achieve the required carbon savings, the Trust has elected to take part in the Carbon and Energy Fund (CEF) initiative to assist in delivering energy asset improvement works at the John Radcliffe and Churchill Hospitals. The Trust has successfully applied to be included in Tranche 3 of the CEF’s programme. The Trust has commissioned feasibility studies at both sites. A summary of the potential for carbon reductions is provided below.

1. John Radcliffe
   a. Circa 5,000 tonnes CO₂ annual reduction
   b. Circa £700,000 annual guaranteed savings
   c. Required capital investment of circa £4.3 million
   d. Delivered NPV of circa £1.8 million over a 15 year term

2. Churchill
   a. Circa 2,400 tonnes CO₂ annual reduction
   b. Circa £550,000 annual guaranteed savings
   c. Required capital investment of circa £3.7 million
   d. Delivered NPV of circa £1.2 million over a 15 year term

This would require significant investment in improvements to the energy infrastructure at both hospitals. Core schemes would include replacement of boilers with modern efficient equivalents, the installation of combined heat and power sets, upgrading existing controls and reduction on the demand side by measures such as replacement lighting fittings.

The Trust is moving forward at pace with this initiative and is aiming to sign contracts this calendar year with a view to work starting on site in January 2014. It is estimated that the scheme would take 12 to 18 months to complete dependent on preferred bid options.

Energy efficiency

We purchase 10% of our total electricity from renewable, carbon efficient sources.

There are further challenges ahead to reduce our waste, water consumption and energy consumption. On our John Radcliffe, Churchill, Horton General and NOC hospital sites:

- Electricity consumption has increased in 2012/13 by 1%
- Gas consumption has increased in 2012/13 by 6%
- Water consumption has increased in 2012/13 by 5%

For a full report on our sustainability activities visit: www.ouh.nhs.uk/publications
The Trust is investigating a self-funding Carbon and Energy Fund Contract to obtain third party funding to replace major boiler plant and provide improved energy efficiency across the John Radcliffe and Churchill sites.

Recycling

In the last year we have recycled approximately 1,010 tonnes of waste – an increase of around 262 tonnes.

Hospital Environment

Each year, the Trust receives a Patient Environment Action Team (PEAT) inspection. The PEAT programme was set up in 2000 to assess NHS hospitals and has been overseen by the National Patient Safety Agency since 2006.

The inspections involve assessments of hospital cleanliness, food and food service, infection control, privacy and dignity and environmental standards, along with other related matters. The assessments are undertaken by a team made up of panel members from the Oxford University Hospitals Patient and Public Panel and accompanied by members of the estates and facilities, nursing and infection control teams.

There are five possible scores, ranging from excellent to unacceptable. In 2012/13:

The Churchill Hospital achieved:
- ‘good’ score for food
- ‘good’ for privacy and dignity
- ‘good’ score for environment

The John Radcliffe Hospital achieved:
- ‘good’ for food,
- ‘good’ for privacy and dignity
- ‘good’ for environment

The Horton General Hospital achieved:
- ‘good’ in food and privacy and dignity
- ‘good’ for environment

The Nuffield Orthopaedic Centre achieved:
- ‘excellent’ for food,
- ‘good’ for privacy and dignity
- ‘good’ for environment

From 1st April 2013 the Department of Health introduced a new annual assessment process for assessing the quality of the patient environment known as Patient Led Assessments of the Care Environment (PLACE) which replaces PEAT.

The focus of the revised process will continue to be how the environment supports patients’ privacy and dignity, food, cleanliness and general building maintenance. The process will see increased representation of local people going into the Trust’s four hospitals as part of the assessment teams; 50% of these teams will be patient assessors.

In March 2013, staff were joined by pupils from Longfields Primary and Bardwell School in Bicester to plant trees in the woodland area on the hospital site.

The children were able to put their own names on the trees as part of the NHS Forest project aimed at supporting and raising awareness of sustainability issues.
New developments and innovation

We aim to provide excellent care to our patients. We strive for continuous improvement and here we highlight some of the changes and developments to services that we have made over the past year.

**Major Trauma Centre and specialist acute rehabilitation**

As a large Trust providing specialist treatment for patients from across the region, the John Radcliffe Hospital has been designated a Major Trauma Centre. This means that the most seriously injured and complex patients from across the Thames Valley region are brought to the John Radcliffe Hospital where they have access to specialist teams 24 hours a day, seven days a week.

Major trauma is the main cause of death for people under the age of 45 and is a major cause of debilitating long term injuries. More than half of major trauma is caused by road traffic accidents. After being designated in April 2012, the John Radcliffe Hospital became fully operational as a Major Trauma Centre in October 2012.

The John Radcliffe Trauma Centre is supported by a network of smaller trauma units at other hospitals which provide stabilisation and ongoing treatment and rehabilitation for local patients as required following major trauma injury.

The Trust has invested in the delivery of acute rehabilitation for major trauma patients. Patients are provided with one-to-one and group therapy sessions in the physiotherapy gym helping our therapists to react as early as possible to the recovery needs of patients with serious injury.

The John Radcliffe trauma service currently sees approximately 26,700 outpatients each year and operates on over 2,400 inpatients.

**Regional vascular centre expands**

Our expanded vascular centre includes a 20-bed vascular ward, dedicated vascular theatres and radiological intervention suite. Patients requiring specialist vascular treatment are transferred from hospitals across the Thames Valley region for treatment of severe conditions of the vascular system including life-threatening emergencies such as aortic aneurysms, an abnormal dilation of an artery caused by the pressure of blood flowing through the area.

In February 2013, we opened a new state-of-the-art interventional radiology suite at the Oxford Regional Vascular Centre in the John Radcliffe Hospital.

Interventional Radiology is a speciality which uses minimally invasive image-guided procedures to diagnose and treat conditions which in many cases would previously have required major open surgery. These procedures reduce not only the length of time spent in hospital but also recovery periods for patients.

The new suite strengthens the John Radcliffe Hospital’s position as the hub hospital at the centre of the Thames Valley Vascular Network created in 2010 following a review which recommended a single vascular centre based in Oxford. All patients requiring major vascular surgery in Buckinghamshire and Berkshire will be transferred to the John Radcliffe for their operation whilst remaining under the care of their local clinical team.
**Integrated spinal service improves patient pathway**

The Trust’s spinal service has been reconfigured to streamline both neurosurgical and orthopaedic surgery and to establish a single referral route and clinical programme for non-emergency spinal referrals. Spinal surgeons are benefitting from improved access to theatres and support services and the better management of workload between the Nuffield Orthopaedic Centre and the West Wing at the John Radcliffe Hospital, where more complex spinal work is undertaken.

We are able to provide a more flexible and responsive spinal service with improved access times for surgery by running this joint service across two hospital sites with an integrated clinical team.

We have been able to achieve greater integration with closer working and sharing of resources between spinal surgeons, particularly as a result of the integration of the Nuffield Orthopaedic Centre as a division of the Trust, bringing improvements in our healthcare delivery, greater patient satisfaction and improved patient outcomes.

**Specialist kidney surgery wins funding**

Patients with difficult tumours on a solitary kidney can now benefit from a surgical technique which preserves the kidney and prevents them from going on to long term dialysis.

Doctors and surgeons at the Churchill Hospital have received the first case of specialist funding, from NHS Specialised Services, for urological surgery in the UK. This innovative procedure involves removing the diseased kidney, cooling it to 4°, removing the tumour(s) and then reattaching it via an incision in the groin.

The only options in the past for patients with this condition would have been to have the solitary kidney removed and then go on to dialysis and wait for a suitable donor kidney. This surgical option now has the potential to save around 20 patients in the UK from going on to dialysis every year. The surgical option offers a much better outcome and quality of life for the patient as dialysis can be time consuming and costly compared to the one off cost of the operation.

“We are delighted to be the only centre in the UK to have received funding for this procedure and can now offer it as a treatment option to more patients each year.”

Mr David Cranston, Consultant Urological Surgeon

**Extension to Newborn Intensive Care Unit**

A £5.5 million extension to the Newborn Intensive Care Unit has provided twice as many intensive care cots for the very sickest babies in the Thames Valley. The extension is built on to the existing unit and will house 16 of the intensive care cots. It will allow the unit to double the intensive care cots from 10 to 20.

**Following the expansion, the unit will:**

- Care for all babies in the Thames Valley Region born before 27 weeks gestation;
- Improve services for babies with complex needs;
- Provide the right facilities for babies who need specialised care;
- Improve care for local families and babies delivered at the John Radcliffe Hospital;
- Improve privacy for families within the unit as a whole.

**Generation games!**

An innovative initiative from the Nuffield Orthopaedic Centre’s Sport and Exercise Medicine Department to encourage the over-50s to become more active was launched in January 2013.

Called Generation Games, the service is being run jointly with Age UK Oxfordshire, initially as a three-year project.

Developed by Dr Julia Newton and Dr Natasha Jones, the new service is designed to offer a network of exercise opportunities to promote increased participation in regular physical activity by older people in the county. The programme is linked to a number of research projects in collaboration with the Universities of Oxford and Bath to evaluate the effectiveness of Generation Games and its potential to be rolled out at a national level.

The Sports and Exercise Medicine Department at the Nuffield Orthopaedic Centre spent a year working with Age UK Oxfordshire to identify areas of need. The team at the hospital developed software which can measure a patient’s current level of activity, their co-mobility, motivation to change and safety to exercise, then streamlining the data into exercise opportunities based on the patient’s preferences.
New test to detect cell mutations helps doctors determine course of treatment

The first multi-gene DNA sequencing test that can help predict cancer patients’ responses to treatment has been launched in the NHS, thanks to a partnership between scientists at the University of Oxford and our doctors.

The test uses the latest DNA sequencing techniques to detect mutations across 46 genes that may be driving cancer growth in patients with solid tumours. The presence of a mutation in a gene can potentially determine which treatment a patient should receive. It has been launched through the National Institute for Health Research (NIHR) Oxford Biomedical Research Centre (BRC), a collaboration between Oxford University Hospitals and the University of Oxford to accelerate healthcare innovation.

Tests are carried out at the BRC Molecular Diagnostics Centre, based at Oxford University Hospitals, for all cancer patients in the Thames Valley area. The new £300 test could save significantly more in drug costs by putting patients on to the right treatments immediately, reducing harm from side effects as well as the time lost before arriving at an effective treatment.

Dr Anna Schuh, who heads the BRC Molecular Diagnostics Centre and is a consultant haematologist at Oxford University Hospitals, said: ‘Patients like the idea of a test that can predict and say up front whether they will respond to an otherwise toxic treatment. A biopsy is taken from the patient’s tumour for genetic testing with a consultant talking through the results a few days later. It is part of the normal diagnostic process.’

The collaboration between the Oxford University Hospitals NHS Trust and Southampton University Hospitals NHS Foundation Trust as a Partnership to develop the South of England Children’s Services Network continues to progress very well. The Network currently includes Cardiac, Neurosciences and Critical Care Services for children with senior clinicians and managers from both Trusts working together. Networks are an effective way of developing long term solutions and ensuring increased standards of care and governance on a collaborative footing rather than a competitive basis. The partnership will also provide increased opportunities for research into future treatments and clinical development.

Cardiac – A national Safe and Sustainable review of paediatric services suggested that the number of centres undertaking children’s heart surgery should be reduced from 11 to a smaller number of larger specialist centres, each carrying out at least 300 operations per year in order to ensure quality of care. This partnership has enabled cardiac surgery services to increase operation numbers carried out in Southampton, whilst utilising team members and resources across the regional network. Patients benefit by receiving their care in a specialist centre, receiving a multi-disciplinary team approach.

Critical Care – A Southampton and Oxford Retrieval Team (SORT) was implemented in September 2012 and has enabled the network to provide a 24/7 retrieval service across a large geographical region. Further information can be viewed at: www.sort.nhs.uk/home.aspx

Neurosciences – This partnership is working collaboratively to provide a Safe and Sustainable Paediatric Neurosciences Service which will deliver a robust pathway for patients with complex conditions requiring expert multi-disciplinary professional skills. The service will enable a balance between the need for convenient treatment locations for patients and their families, and the need for specialist high quality surgery. One of the key elements to improving this service is that there is 24/7 advice and support to all children with an urgent neurosurgical condition from a children’s neurosurgeon.
OUH teams in the news!

Award for improving patient safety

A system that enables clinicians to identify patients at the bedside by barcode scanning of their wristband has won three national awards for improving patient safety.

Our clinicians use a small hand-held scanning device which generates an instant test request label for specimen samples. With laboratories at the Trust being sent up to 1,500 requests a day, this award-winning system reduces the risk of samples being mis-labelled and allows clinicians to track the status of their test requests. It also reduces the amount of time laboratory staff spend querying incomplete information.

Excellence in oncology care

Congratulations to our oncology team working with head and neck cancer patients. They were commended in the 2012 Quality in Care Programme’s ‘Excellence Oncology’ awards. Our staff were recognised for their good practice and collaboration between themselves and patient groups on appropriate post-operative enteral tube feeding following head and neck cancer surgery.

Midwife of the year!

We are very proud that one of our community midwives has been named as ‘Midwife of the Year’ for the south and midlands region. Pauline Ellaway, a community midwife based at Wallingford Community Hospital’s midwifery-led unit, was nominated for delivering exceptional care by a local mother.

The award is presented as part of the Royal College of Midwives annual midwifery awards aimed at recognising the work carried out by midwives across the country.

Baby Café – a UK first

The John Radcliffe Hospital broke new ground in June 2012 with the launch of the UK’s first hospital based, teaching Baby Café. The café is a place where new parents and midwifery students have the opportunity to come together and learn invaluable breastfeeding skills from trained practitioners.

BRAIN DOCTORS ON TV

A team of film makers spent the better part of nine months researching and filming a three-part documentary for BBC 2 at the John Radcliffe Hospital. They wanted to capture on film the daily emotional challenges faced by patients and their families having to make life changing decisions about surgery and treatment for injuries and diseases of the brain. Viewers were also given an insight into the inner workings and daily lives of the medical and surgical teams who look after patients with injuries and diseases of the brain at the John Radcliffe Hospital.

The result was a new three-part series Brain Doctors which was aired on BBC 2 for three weeks in February, 2013. More than five million people tuned in to watch the unfolding drama of patients and their families facing life-changing decisions and the trust they put into the hands of our amazing colleagues. The series seems to have hit an emotional chord with members of the public who sent twitter into a frenzy recommending it to others and filled our facebook page and website with overwhelmingly glowing praise and positive comments.

Brain Doctors was watched by more than five million people and follows on from the highly acclaimed Craniofacial Surgery series produced by a local production company, Landmark Films, in 2010.
Prime Minister praises nursing practice

Oxford Children’s Hospital hosted a very special visitor in October 2012. Prime Minister David Cameron’s visit was timed to coincide with the announcement of a £140m funding package for new technology for nurses and midwives, designed to allow them to spend more time with patients.

Mr Cameron was welcomed by the Chief Executive of the Trust, Sir Jonathan Michael and Non-executive Director Sir John Bell. The Prime Minister was taken to meet staff and patients at Melanie’s Ward, where he spent nearly an hour. Mr Cameron went behind the nurses’ station, and was interested to learn more about technology currently being used by nurses and understand the difference between the colours of the nurses uniforms.

Country’s top nurses see how Trust is ‘Delivering Compassionate Excellence’

Two of the country’s most senior nurses visited the Trust in February, 2013, as part of a visit to see ‘How Oxford is Delivering Compassionate Excellence’.

Jane Cummings, NHS Commissioning Board Chief Nursing Officer (pictured here talking to one of the Trust’s nurses) and Viv Bennett, Director of Nursing at the Department of Health spent a morning visiting clinical areas at the John Radcliffe Hospital, before attending a presentation on the subject of Dignity In Care.

Cardiology team undertake 100th life-saving TAVI procedure

In March, 2013, the cardiology team at the John Radcliffe Hospital performed their 100th transcatheter aortic valve implantation (TAVI).

TAVI is the most significant development in interventional cardiology in the past decade and has the ability to transform the lives of patients with severe aortic valve disease who are too frail or ill to undergo open heart surgery. In time, it may even replace conventional valve replacement.

Dr Bernard Prendergast, Consultant Cardiologist and Cardiology Clinical Director at the John Radcliffe Hospital, said: “The success of the Oxford programme depends strongly on the excellence of the whole team and we are very proud to reach this milestone.”

The procedure is normally performed by a team of five specialists supported by an expert team in a cardiac catheterisation laboratory under general anaesthesia. Depending on the rate of their recovery, patients can expect to be in hospital anywhere from 3-8 days. Recovery after discharge from hospital is much more rapid than after open heart surgery and the procedure produces short and long term relief of a patient’s symptoms with increased life expectancy and improved quality of life.

The John Radcliffe Hospital is just one of 25 accredited centres with highly trained, specialist multi-disciplinary heart teams, which perform this technique in the United Kingdom.
Our aim is that every patient’s experience is an excellent one and understanding what matters most for our patients and their families is a key factor in achieving this.
Building a culture of compassionate care – the friends and family ‘test’

Seeking and acting on patient feedback is key to improving the quality of healthcare services and putting patients at the centre of everything we do. From 1 April 2013, all patients in acute inpatient hospital wards and emergency departments across the country must be offered the opportunity to complete a Friends and Family Test (FFT). The test supports the six ‘C’s of ‘Compassionate Care’ – the three-year vision and strategy for nursing, midwifery and care staff.

The Trust introduced the new scheme early in January 2013 and patients are given a comment card at the point of being discharged and asked to answer the simple question – “How likely are you to recommend our ward/department to friends and family if they needed similar care or treatment?”

Our Friends and Family Test score for February and March 2013 is 66. The score can range from -100 to +100 and comprises the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.

The percentage of patients who are extremely likely or likely to recommend is 93%. This is based on 1,044 responses (it was not possible to determine a rating for a further 17 responses).
Learning from you

Patient views are invaluable to help us improve service delivery. The Trust routinely seeks patient feedback on its services and the quality of care. We recognise the importance of listening to patients and their families to ensure we provide responsive care. During 2012/13 we introduced a number of initiatives to improve our approach to involving people in decisions about their care. These include:

- Filming ‘Patient stories’: asking patients to tell us about their experiences in detail. These stories are viewed by clinical teams to help them better understand what they do well and what needs to be improved. The stories and plans to address issues are shared at Trust Board meetings. The action plan is also discussed and agreed with the patients.
- New quality improvement and medical education project: twice a year, medical students interview patients on acute general medicine wards to highlight what is working well and what needs to change, and to enable students to engage with patients’ views and preferences about their care.
- Inviting patients and the public to help shape our priorities for developing our services through public meetings including a ‘Let us know your views’ event in March 2013 with a further meeting in October 2013.
- Improving waiting times for outpatient appointments by running additional clinics (for example, on Saturdays and Bank Holidays), and increasing the number of appointments at each clinic session.
- Establishing Patient and Public Involvement groups in all Trust divisions to improve communication and engage patients in service development.
- Established a Care Support Worker Academy.

National patient surveys

There were two national surveys in 2012: the inpatient survey and the Accident and Emergency survey. The results from both were very positive with 82% of patients rating their care overall at 7 or above on a scale of 0-10.

More than half (55%) of patients who were sent a questionnaire responded to the national Inpatient Survey for 2012. Responses highlighted delays in discharge as an issue for patients, with 39% of patients who responded to the survey saying their discharge was delayed by one hour or more. The main reason for this was ‘waiting for medicines’ (67%). The Pharmacy is working to address this by:

- seeing patients within 24 hours of arrival and ensuring wards have predicted discharge medicines in stock;
- asking doctors to confirm discharge medications the night before;
- introducing a 90 minute turnaround time target for pharmacy.

Improvements to the discharge process are also being addressed by working with local health and social care organisations, Oxford Health NHS Foundation Trust and Oxfordshire County Council. A new policy has been developed with these organisations and was launched in December 2012. An important part of this process is to ensure advance notice of an early discharge date (EDD) and to pre-empt patient requirements for discharge, and ensuring onward services have appropriate provision in place. This work is focused on support and timely discharge of elderly frail patients with complex health and/or social care needs.

The results also showed that the Trust performed well in respect of:

- Staff introducing themselves (76% said “all staff”, 21% said “some”).
- Being offered a choice of food (81% said “always”, 10.6% said “sometimes”).
- Doctors giving clear answers to questions (73% said “always”; 21% said “sometimes”).
- Risks and benefits of surgery being fully explained (86% said the risks and benefits were explained “completely”, 11% said “to some extent”).
- Results of surgery being explained in a clear way (71% “completely”, 17% “to some extent”).
- Being fully told about side-effects of medications at discharge (46% “completely”, 22% “to some extent”).
- Receiving copies of letters sent between hospital doctors and GP (77% did).

The Accident and Emergency Department Survey for 2012 showed that 48% of patients waited more than 15 minutes to speak to a doctor. This was partly due to unfamiliarity with a new IT system which contributed to an increase in process times. A training programme has been introduced for new doctors. The department holds a daily meeting to discuss any cases where a patient has waited more than four hours so the reasons can be identified and steps can be taken to improve waiting times.
The survey also showed positive results on the following questions:

- 76% of respondents had complete confidence and trust in doctors and nurses.
- 90% of respondents felt doctors and nurses worked well together.
- 87% of respondents rated reception staff as good, very good or excellent.

**Patient Advice and Liaison Service (PALS)**

PALS is a first stop service for patients, their families and carers who have a query or concern about our hospitals or services. The team provides an impartial and confidential service and aims to help resolve issues by addressing them as quickly as possible. Where PALS is unable to help, the enquirer is directed to a more appropriate person or organisation.

The majority of PALS contacts relate to requests for information about hospital processes or putting people in touch with the correct department or individual who can help them.

The service collates comments, suggestions and concerns made either directly to the service or through the patient experience feedback mechanisms available throughout the hospitals. A monthly report is prepared for the Trust Board on key themes for patient concerns and positive/negative feedback.

For full contact details, visit: [www.ouh.nhs.uk/contact](http://www.ouh.nhs.uk/contact).

**During 2012/13, PALS dealt with 3,514 requests, compliments and concerns. The main categories related to patient care, communication and cancellations or delays in appointments.**

**Your privacy and dignity**

The Trust is committed to delivering patient-centred care via our clinical teams who understand the principles of privacy, dignity and respect for everybody. Problems concerning privacy and dignity are taken very seriously and the Trust wants to ensure that patients feel confident, comfortable and supported when in hospital.

**Dementia Action Alliance**

The Trust has signed up to a National Dementia Declaration to improve the quality of life for people with dementia and the care of sufferers in hospitals. The Declaration, set up by the Dementia Action Alliance, explains the huge challenges presented to our society by dementia and some of the outcomes we are seeking to achieve for people with dementia. The Trust’s action plan has been created in partnership with our service users, people with dementia and their carers and with other providers such as social services, primary care, community hospitals, and mental health services across Oxfordshire to provide seamless and patient-centred care for people with dementia. We will also work closely with charitable organisations such as Age UK, Dementia Action Alliance, Alzheimer’s Society and others to maximise expertise and resources.

**Our commitment:**

- We will involve patients and relatives in decision making about their health care.
- We will plan discharge with patients and relatives to make sure their return home is safe and well supported.
- The majority of our patients over 75 will have a memory screening test to support early diagnosis and help to plan their care in hospital and when they return home.
- We will work in partnership with our Palliative Care Team to ensure better end of life care that focuses on a patient’s wishes and protects their privacy and dignity.
The Trust will appoint three consultants specifically to support patients with dementia, delirium and to provide educational support for medical, nursing and allied health professionals.

The Oxford Academic Health Science Consortium has made dementia one of its exemplar projects. This will enable an investment in research into the early diagnosis and treatment of dementia to be put into practice across the region with the support of its partners.

**Mencap Charter**

The Trust has signed up to the Mencap charter *Getting it right* which shows our commitment to improving healthcare and treatment for people with a learning disability. Mencap has worked in partnership with a number of organisations to produce a charter for healthcare professionals, to help them work towards better health, wellbeing and quality of life for people with a learning disability.

A number of projects are underway across the Trust to illustrate our commitment to this charter including:

- the creation of a hospital passport for patients with learning disabilities to ensure that medical and nursing staff are aware of the patient’s wishes and needs;
- we have employed an acute liaison nurse to act as a point of advice on the Trust-wide policy and protocol for patients with learning disabilities as well as providing training for other staff;
- we provide easy read format leaflets and information on the Trust website and we work with users and other organisations to get patient feedback and continually improve our services.

**Patients** from the John Radcliffe’s geratology wards are feeling the benefits from the sensory garden.

A £100,000 fundraising campaign has helped to transform an outdoor terrace into a Sensory Garden providing patients with an area where they can relax and enjoy some time away from the wards.

Trust Chairman Dame Fiona Caldicott opened Annie’s Garden, named in recognition of the work of Sister Ann Readhead MBE and other key supporters who launched and managed the project.

**Neurosciences staff** held a third Dignity In Care Day, to launch a new Dignity in Care Charter. The Charter, which has been produced jointly by the Neuroscience Ward, Neuro Intensive Care Unit and Outpatient service, is intended as a clear statement of what people can expect when they receive care from the department, and sets out how staff intend to implement the 10 Point Dignity Challenge.

Staff are currently gathering feedback about the Charter from patients and relatives in order to fine tune it. The first draft Charter sets out standards patients can expect to be met in aspects of their care such as how they are addressed, and the support they should receive to maintain their appearance and hygiene.

As in previous Dignity in Care days, the event was marked with tea and cake and was part of a larger national campaign which will also see members of staff signed up to become Dignity in Care champions. The department already has a notice board, on which patients can leave feedback notes about those aspects of their care that they did – and did not – like.

*“Dignity Action Day is about recognising how important it is to treat patients and colleagues with dignity and respect. Most of us do this without thinking but it doesn’t hurt to stop and think about how we behave and the impact it can have on others.***

*Senior Staff Nurse Kat Cane*
Picture power to help calm young patients

A unique photographic installation by the German artist Jan von Holleben hopes to make the journey to an operating theatre for surgery less traumatic for young patients at the Oxford Children’s Hospital.

New artwork, funded through charitable donations, has been installed along two long corridors leading from wards in the Children’s Hospital to the operating theatres, and also on the ceilings of 14 anaesthetic rooms and eight recovery bays. In May 2012, Jan spent a week as artist in residence in the hospital, speaking to doctors, therapists, play specialists, nurses, anaesthetists, porters, patients and their parents to understand the experience of a patient’s journey to theatre and to capture ideas from young patients.

The artwork features 315 individual photographs, creating more than 40 composite panels which depict the adventures of two friends, Lily and Jonathan, who go on two fantastic journeys into space and into a magical undersea world.

The project has been entirely funded through charitable donations for art projects from Firefly Tonics, the Fund for Children and the League of Friends, and supported by Kwickscreen.
The Trust has an excellent reputation for research and teaching activities in partnership with the University of Oxford’s Medical Sciences Division and with Oxford Brookes University’s Faculty of Health and Life Sciences. Our hospitals offer a range of integrated treatments and skills which would be impossible to deliver without research and teaching input.

Research as a strategic priority

Pioneering research at Oxford University Hospitals is tackling the major healthcare challenges of the 21st Century and ensuring our patients benefit from discovery and innovation. Our broad portfolio is addressing major conditions including cancer, dementia and stroke. It is developing new technologies to enhance surgery and harnessing the latest genetic techniques to increase understanding of disease and inform treatment.

The research and teaching carried out in our partnerships combines clinical excellence with academic expertise. This is providing new diagnosis and treatment services today and creating the research infrastructure and outstanding leaders capable of tackling tomorrow’s challenges.

Research underpins improvements in healthcare. Our internationally renowned research and clinical facilities are co-located on our hospital sites to foster a culture of collaboration and innovation that has patient treatment and care at its heart.

Our goal is to take innovation “from bench to bedside” and our translational research is supported by two major National Institute for Health (NIHR) awards. The NIHR Oxford Biomedical Research Centre is a £100m partnership between Oxford University Hospitals and the University of Oxford. Its aim is to support patient-centred research, accelerate innovation and improve health services by pioneering new treatments, services and diagnostic tools. Its 14 research themes include cancer, dementia, cardiovascular, functional neuroscience, genomic medicine, vaccines and infection.

The Trust also leads an NIHR Biomedical Research Unit in Musculoskeletal Research, where teams based at the Nuffield Orthopaedic Centre (NOC) are advancing orthopaedic surgery and developing new understanding of osteoarthritis, osteoporosis and inflammatory arthritis.
Our research also supports growth in the UK’s significant healthcare and life sciences sector. Trust and University of Oxford research support services are based at the Joint Research Office at the Churchill Hospital, including our business development team which has built significant links with industry and removed barriers to collaboration.

Public involvement in research

Each year the Trust and Biomedical research teams stage an open day to showcase the work going on behind the scenes. Local people and interested groups are invited to meet our scientists and clinicians developing new and innovative treatments and techniques, and to tour some of the facilities housing our research.

Centre expansion strengthens musculoskeletal research

The expansion of the Botnar Research Centre facilities on the Nuffield Orthopaedic Centre site will help enhance the treatment of musculoskeletal injuries, strengthen the fight against bone cancer and improve arthritis care.

Research teams moved into the £6m second phase of the centre in January 2013.

It makes the University of Oxford research facility one of the largest musculoskeletal research centres in Europe, doubling its size to ensure it continues to compete with leading institutions on the world stage, with 4,000sqm of custom built research facilities including state-of-the-art laboratories, and flexible office accommodation to house up to 250 scientists and clinicians working on genetics and cell biology, orthopaedic engineering and surgery, clinical research and epidemiological studies.

Phase 2 is the culmination of a seven year fundraising campaign by the NOC Appeal, the same independent charity that previously raised more than £5m to build the original Botnar Research Centre.

Professor Andrew Carr, Divisional Director at the NOC, Director of the Botnar Research Centre and the NIHR Oxford BRU said: “Since it opened in 2002, the Botnar Research Centre has established itself as a world leading centre for musculoskeletal research. This extension will strengthen our efforts and provide our researchers and clinicians with the best possible facilities”.

“Our work started back in the early 1990s when we set a target of raising £1m towards building the first phase of the Botnar. That became £5m and the centre opened its doors in 2002. Our vision always included a second phase and it is wonderful to see research teams moved in.”

NOC Appeal Director Jeanette Franklin

Kennedy Institute

In autumn 2013, the Kennedy Institute of Rheumatology will open its new building at the University’s Old Road campus. The institute, founded in 1965, transferred to the University of Oxford in 2011. The Kennedy Institute, the Botnar Research Centre, and the Nuffield Orthopaedic Centre, will bring together world class basic research, translational research and NHS treatment.
World first in liver transplant technique

An Oxford surgeon and medical engineer have contributed to a world first whereby a donated human liver has been ‘kept alive’ outside a human being and then successfully transplanted into a patient in need of a new liver. So far the procedure has been performed on two patients and both are making excellent recoveries.

Currently transplantation depends on preserving donor organs by putting them ‘on ice’ – cooling them to slow their metabolism. But this often leads to organs becoming damaged. Professor Peter Friend, a consultant surgeon who is Director of the Oxford Transplant Centre at the Churchill Hospital and Professor of Transplantation at Oxford University, has jointly developed a new device that enables the donor liver potentially to be preserved at body temperature outside the human body for up to 24 hours.

He has been researching the technology since 1994 alongside Professor Constantin Coussios of Oxford University’s Department of Engineering Science, one of the machine’s inventors and Technical Director of OrganOx, the University spin-out created to bring the device from bench to bedside.

The results from the first two transplants, carried out at King’s College Hospital in February 2013, suggest that the device could be useful for all patients needing liver transplants.

Developing new therapies for Parkinson’s disease

A new brain stimulation therapy could help suppress tremors in people with Parkinson’s disease.

The non-invasive technique has been pioneered by Oxford researchers supported by the Oxford Biomedical Research Centre. The research shows that transcranial alternating current stimulation (TACS) is effective in tremor suppression. TACS works through electrode pads placed on the surface of the patient’s head and an electrical current cancels out the brain signal causing the tremor. This does not carry the risks associated with deep brain stimulation which is currently used to treat physical tremors.

This preliminary study was conducted with 15 patients with Parkinson’s disease at Oxford’s John Radcliffe Hospital. Professor Peter Brown who led the study, said: “We are very hopeful this research may, in time, lead to a therapy that is both successful and is safer for patients.”

State-of-the-art lung imaging techniques move a step closer

A pioneering lung imaging technique that could improve diagnosis and treatment of conditions such as asthma is being developed in Oxford. Researchers led by Professor Fergus Gleeson have started the first UK patient trials of xenon imaging.

Xenon imaging provides greater detail on how the lung is functioning, as well as its structure. Hyperpolarized xenon gas – an inert gas inhaled by patients prior to a scan – fills the lung space and can be imaged by specially adapted MRI equipment. Unlike imaging techniques such as CT scans, xenon imaging does not use ionising radiation so poses less risk to patients undergoing repeated monitoring for long-term conditions.

It is hoped the technique will help clinicians select the most effective treatment programme for individual patients based on their responsiveness.
Our people

The Trust has remained committed to delivering on the key pledges in the NHS Constitution. It has continued its focus on staff engagement through its strategy of ‘Delivering Compassionate Excellence’.

We are supporting ongoing improvements in the quality of patient care through a process of engaging staff in ensuring that the aspect of quality of care, patient safety, clinical effectiveness and patient experience are embedded in the practice and behaviours of our Trust.

Our strategy to deliver compassionate excellence includes:

- Recruitment, reward and internal recognition schemes.
- Expectations and standards of behaviours.
- Actively listening and involving staff through regular listening events.
- Embedding a shared set of values and behaviours that have been developed by staff.
- Learning and development through leadership programmes.

Our Workforce

The Trust is one of the largest employers in Oxfordshire with a workforce of around 11,000. This is a slight increase from 2011/12.

The Human Resources and Organisational Development teams have been leading work to develop and engage our staff to deliver compassionate excellence, and to recruit a workforce that shares our values.

Nurses and midwives are the largest staff group and make up approximately 33% of the workforce. Over 38% of staff work flexibly – either part-time or under one of our varied flexible contracts, e.g. term-time working.

In addition to the staff in the table below, we have approximately 560 medical staff who hold honorary contracts with the Trust. These include University medical staff who provide clinical services and doctors from other UK trusts and from overseas who wish to expand their knowledge and experience. We also employ over 600 staff to provide facilities services at the John Radcliffe Hospital, Nuffield Orthopaedic Centre and Churchill Hospital sites who are managed by our Private Finance Initiative (PFI) partners. Staff turnover levels remained fairly constant at 11% for 2012/13.

<table>
<thead>
<tr>
<th>Category</th>
<th>Headcount</th>
<th>Total WTE</th>
<th>Full time</th>
<th>Male</th>
<th>Full time</th>
<th>Male</th>
<th>Part time</th>
<th>Female</th>
<th>Part time</th>
<th>Female</th>
<th>TOTAL</th>
<th>Male</th>
<th>Female</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and Clerical staff</td>
<td>2,218</td>
<td>1,868.6</td>
<td>429</td>
<td>65</td>
<td>494</td>
<td></td>
<td></td>
<td>970</td>
<td>754</td>
<td>1,724</td>
<td></td>
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<tr>
<td>Healthcare assistants</td>
<td>1,757</td>
<td>1,339.9</td>
<td>293</td>
<td>190</td>
<td>393</td>
<td></td>
<td></td>
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<td>110</td>
<td>357</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Healthcare scientists</td>
<td>567</td>
<td>513.2</td>
<td>190</td>
<td>190</td>
<td>210</td>
<td></td>
<td></td>
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<td>110</td>
<td>357</td>
<td></td>
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<tr>
<td>Medical staff</td>
<td>1,822</td>
<td>1,540.3</td>
<td>815</td>
<td>194</td>
<td>1,009</td>
<td></td>
<td></td>
<td>542</td>
<td>271</td>
<td>813</td>
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<tr>
<td>Nurses and midwives</td>
<td>3,620</td>
<td>2,996.3</td>
<td>227</td>
<td>52</td>
<td>279</td>
<td></td>
<td></td>
<td>1,962</td>
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<td>3,341</td>
<td></td>
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</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>1,009</td>
<td>806.2</td>
<td>156</td>
<td>29</td>
<td>185</td>
<td></td>
<td></td>
<td>448</td>
<td>376</td>
<td>824</td>
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<tr>
<td>Externally funded staff</td>
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<td>89.7</td>
<td>12</td>
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<td>24</td>
<td></td>
<td></td>
<td>56</td>
<td>67</td>
<td>123</td>
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<tr>
<td>Total</td>
<td>11,140</td>
<td>9,154.2</td>
<td>2,122</td>
<td>472</td>
<td>2,594</td>
<td></td>
<td></td>
<td>4,794</td>
<td>3,752</td>
<td>8,546</td>
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<td></td>
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</tbody>
</table>

Number of directly employed staff on 31 March, 2013.
Consulting and engaging with our staff

Each year our staff are given the opportunity to tell us what they think through an annual survey. During October and November 2012, the Care Quality Commission ran the national NHS survey which provides the Trust with direct feedback from its staff on the effectiveness of its employment and management policies and practices. Simultaneously, the Trust ran a local survey inviting all 11,000 employees to provide feedback on their experience of working for the Trust.

The 2012 NHS Staff Survey highlighted a number of improvements in our results compared to 2011. More staff who responded to the survey in 2012 said they would recommend the Trust as a place to work, with an increase in the number of staff saying that they feel able to carry out their role to a standard they are pleased with.

More staff also said they felt recognised for the work they do, with support from their managers and that they were involved in deciding changes that affect their work. This reflects the Trust’s efforts to interact and engage with its workforce and the introduction of an annual awards event to acknowledge and thank staff who have gone that extra mile.

Where areas have been identified as needing improvement, a number of actions have been implemented, including developing a five-year strategy which focuses on leadership, education and training and monitoring to ensure that we deliver year on year improvements in the quality of our services.

Listening into Action

As part of the ‘Delivering Compassionate Excellence’ programme, the Trust has been engaging staff in discussions about how to improve outcomes and experiences for patients.

In particular, the Trust has participated in an initiative called ‘Listening into Action’, as an approach to engaging and empowering all staff around priority outcomes for patients. The programme builds on the Trust’s values development and offers executive-led ‘big conversations’ with staff groups to help shape a participative culture.

The aim is to engage staff to think about how we can all improve the experiences of the patients we care for and the colleagues we work with. Hundreds of staff joined in the ‘conversation’ events and teams are now taking forward pieces of work broadly grouped into themes around:

- delivering the best patient experience
- keeping our staff informed
- working better together
- environment and infrastructure
- effective processes that support patient care

Eleven pioneering teams are involved and are working on a range of projects including:

- reviewing the role of therapy services in reducing the 48 hours emergency pathway;
- addressing waiting times and patient experience at the Eye Hospital;
- shaping the future of day care services at the Horton General Hospital.

Value Based Interviewing

With the development of new Trust values, the organisation commenced a pilot on ‘Value Based Interviewing’ (VBI). The VBI Project seeks to ensure that the Trust’s organisational values are reflected in the day-to-day care it provides, through designing and delivering value-based interviewing as part of its recruitment process. The pilot aims to prove that VBI:

- enables recruitment decision-making aligned with the Trust values;
- provides a process for evidence-based decisions;
- helps obtain more information about candidates’ suitability;
- contributes to ‘Safer Recruitment and Selection’ practice.

Key Findings from 2012 NHS Staff Survey for OUH

<table>
<thead>
<tr>
<th>2012 Score</th>
<th>2012 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>% staff feeling satisfied with the quality of work and patient care they are able to deliver</td>
<td>77%</td>
</tr>
<tr>
<td>Levels of Staff Engagement (score out of 5)</td>
<td>3.73</td>
</tr>
<tr>
<td>Staff recommendation of the Trust as a place to work or receive treatment (score out of 5)</td>
<td>3.62</td>
</tr>
<tr>
<td>% staff appraised</td>
<td>77%</td>
</tr>
<tr>
<td>% staff receiving job relevant training, learning and development</td>
<td>81%</td>
</tr>
<tr>
<td>% staff able to contribute to improvements at work</td>
<td>72%</td>
</tr>
<tr>
<td>Staff motivation (score out of 5)</td>
<td>3.86</td>
</tr>
<tr>
<td>Job satisfaction</td>
<td>3.64</td>
</tr>
</tbody>
</table>
Employee reward and recognition

The Trust recognises the importance of acknowledging the work of our staff in delivering compassionate excellence. A number of our staff and volunteers who have been recognised as going the extra mile for patients and the organisation were celebrated in our first Staff Recognition Scheme held in December 2012. The categories of awards included Excellence, Compassion, Good Thinking, Leader, Innovator and Volunteer. The Trust received over 240 nominations, of which there were 33 finalists.

During the year we have introduced a number of new benefits for staff, including salary sacrifice schemes for bicycle and car leases. There is a range of ongoing benefits designed to have broad appeal to staff, including recognition and long service awards, retirement vouchers, subsidised restaurants, discounts from local and national retailers, staff lottery, on-site accommodation, on-site staff hotel rooms and support through the Key Worker Living Scheme.

Flexibility is important for employees and therefore the Trust offers a range of options to enable better management of work life balance, including part time and term time working, job shares and flexi-time. In addition, for parents there are enhanced leave options for parents and carers, childcare vouchers, reduced cost on-site nurseries and discounts for breakfast, after school and holiday clubs.

Learning, education and workforce development

The Trust continues to strengthen learning and education for staff in order to deliver the best possible care for patients.

A new Trust induction programme has been launched. The emphasis on the Trust induction is about introducing new staff to the Trust values and effective team working to deliver the highest standards of patients care. This is achieved by putting the patient at the heart of the programme using real patient stories throughout the learning.

Building on the induction, staff will continue to be supported through a new electronic appraisal system which has been developed and tested with our staff and managers. The new system gives an open and transparent process to objective setting and personal development which is aligned to the Trusts values and will be rolled out over the next 12 months.

This year also saw the successful launch of the competence based approach to statutory and mandatory training providing on-line learning modules. The on-line assessment of competencies is now embedded in the organisation’s training processes. This approach has been welcomed by our external regulators and staff alike.

Staff health and wellbeing

Sickness levels in the Trust fell to 3.1% in 2012/13 from 3.4% in the previous three years. This reflects the Trust’s commitment, in line with expectations for the wider NHS, to maintain sickness absence at a Trust-wide average of 3% or below.

The Trust is participating in the Department of Health funded project which examines best practice approaches to improving sickness absence across 60 hospitals and will provide useful insights for the Trust to use to inform further action plans.

Staff health and wellbeing continues to be a major focus for the Trust. NHS Employers and the Health and Work Development Unit, at the Royal College of Physicians, have been working with the Trust to assist with the implementation of the NICE public health guidance for the workplace.

This also includes work to implement the 5 High Impact Changes identified in the 2009 Boorman report.

Several initiatives have been introduced, such as menopause support groups, stress busting workshops for junior doctors and managers, health checks for staff and organised exercise classes.

NHS Constitution Pledge 1:
Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

The Annual Staff Survey included some key indicators on staff’s perception of their roles and ability to make a difference to patients. Staff felt able to contribute towards improvements at work and agreed that their role made a difference to patients. However, we need to make continued improvements in work life balance and work pressure felt by staff.

NHS Constitution Pledge 2:
To provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed.

The staff survey indicated that there was:

- An increase in support from immediate managers
- An increase in staff receiving job related training, learning and development
- An increase in staff receiving both infection control and equality and diversity training
Equality and Diversity Commitment

As part of the Trust’s assessment against the NHS Equality Delivery System undertaken in March 2012, some objectives were identified for development in our ongoing commitment to equality and diversity. A summary of actions against each of these is outlined below:

**To reduce, year on year, the level of bullying, harassment or abuse at work, experienced by staff from other staff (as reported in the staff survey).**

- **Bullying & Harassment support colleagues** – These are volunteers who have been trained to provide initial support to individuals who approach them with concerns of bullying and harassment. The Trust has been recruiting and training volunteers in 2012-3 and details are published on the Trust intranet for staff to access.
- **Bullying and Harassment Procedure** – This has been revised and updated to reflect Trust Values.
- **Bullying and Harassment intranet site** – This has been developed to provide staff with information on support and guidance available.
- **Poster campaign** – New poster displayed in staff areas.
- **Communications** – Articles featured in staff and patient newsletter OUH News

**To improve the capture and analysis of workforce and patient information**

An Equality and Diversity monitoring exercise in 2012 has greatly improved the reliability of diversity data held in the Electronic Staff Record (Personnel/Payroll system). The most significant increase in data, due to the monitoring exercise, was for disabled staff, where previously this has been reported as 0.5% and it is now 3%. This Equality Objective for staff records is being achieved with 98.7% of disability, religion and sexual orientation data being recorded.

**To increase awareness of equality and diversity across the Trust by reviewing and improving equality and diversity training and ensuring that at least 90% of staff have completed equality and diversity training by 2013**

The Equality and Diversity training material was reviewed in 2012. This included the production of revised training presentation, a workbook (available online) and an on-line competency assessment. Training events are available for new staff and for staff who prefer or need the direct input of a trainer.

As at the beginning of March 2013, the Trust’s compliance with Equality and Diversity Training was 74.3% and there is a concerted drive to increase compliance.

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**New health and wellbeing centre**

Sir Roger Bannister, distinguished neurologist and the first person to run the sub-four-minute-mile in 1954, was guest of honour at the opening of the new Centre for Occupational Health and Wellbeing.

The new centre brings together the occupational health team, back care team, and physiotherapy teams under one roof providing a range of general occupational health services, physiotherapy assessments and clinics, counselling, and a variety of health and wellbeing initiatives.

The Occupational Health Department plays a key role in supporting the Trust’s workforce and works collaboratively in developing the Health and Wellbeing Programme.

**Healthy hospitals**

A group of doctors at the Trust have joined together to launch a ‘healthy’ network of healthcare professionals who share the vision of creating a healthier hospital by having healthy food in canteens and shops, exercise and relaxation opportunities for staff or smoke-free worksites.

Part of their work has seen the development of a ‘free fruit scheme’ where the Headington branch of Waitrose donated fruit to patients, staff and visitors on ward 7B at the John Radcliffe Hospital.

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**NHS Constitution Pledge 3:**

To provide support and opportunities for staff to maintain their health, well-being and safety.

The Staff Survey indicated that there was an increase in staff receiving health and safety training. Staff felt that the incident reporting procedures were fair and effective. A low number of staff had experienced errors or near misses, or physical violence. Staff working additional hours and experiencing workplace stress are areas for improvement.
To support the University of Oxford Medical Sciences Division in achieving the Athena Swan Silver Award by 2015. This award recognises good employment practice for women working in science in higher education and research.

The Trust continues to offer support to the University of Oxford’s Medical Sciences Division with respect to Athena Swan. Progress is monitored at partnership meetings and the University’s Athena Swan Steering Group meetings. The Medical Sciences Division has recently made an appointment to a dedicated role to progress Athena Swan within the Division.

To provide more accessible communication to patients who have specific communication needs.

- Interpreting services have been promoted within training sessions. The combined Trust spend on these services (including British Sign Language) was £109,981.52 for the year 2012-2013. The most frequently requested languages are Polish, Portuguese, Urdu and Mandarin.
- Twenty eight deaf awareness training sessions have been delivered so far across the Trust since June 2012.
- Key documents such as the patient hospital booklets, PALS leaflet, feedback form and Complaints leaflet are being produced in ‘easy read’ format and will be available on the Trust website.

To improve the patient experience, year on year, for patients across all nine protected characteristics (under the Equality Act 2010) and additional marginalised groups, through feedback obtained from patients and outreach activities.

- Liaison between the Christian Chaplaincy service and members of other faiths to enable a rapid response following the death of Jewish and Muslim patients.
- Funding has been obtained for a multi-faith room at the Cancer Centre. Both a chapel and multi-faith room are required on each site for use by patients, visitors and staff.
- Community involvement and feedback activity – individual issues are referred to PALS, wider systems issues are raised with appropriate departments. Some examples of improvements include improved signage to toilets on level 2 of the John Radcliffe Hospital, and funding of deaf awareness training.

Positive about Disabled People

The Trust is positive about the employment of disabled people and continues to promote this through the use of the ‘two tick’ disability symbol. In doing so the Trust demonstrates its commitment in terms of recruitment of disabled applicants; ensuring there is regular consultation with employees with a disability; helping people who become disabled to stay in employment; developing disability awareness for all employees; and reviewing our plans and activities in support of disabled people.

NHS Constitution Pledge 4:

To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.

The annual staff survey indicated that there has been an increase in staff job satisfaction and staff felt able to contribute towards improvements at work.
We involve service users and seek the views of our Patient and Public Panel on a range of issues. We also work in partnership with other NHS, social care and charitable organisations to support community engagement and to share knowledge and expertise.

Be part of our future

As we prepare to work as a Foundation Trust, we hope that many of the patients and public we serve will join our 11,000 staff as members to help us shape the way we operate and deliver our health services. Foundation Trusts are different from other NHS Trusts in that they have a membership, like a building society or co-operative, drawn from the communities they serve and the staff who work for them. This membership is involved in setting the future direction for the Trust.

Anyone living in our catchment area can become a member and get involved in the Trust. Those aged over 16 can become a member, eligible to elect and be elected to our Council of Governors. Children and young people can get involved through our Young People’s Executive (YiPpEe).

Consultation

Between June and October 2012, we consulted with staff, service users, carers, the public and stakeholder organisations on our plans for the future and how we will work as a Foundation Trust. During the consultation period we held 17 public meetings across the county and organised staff roadshows at each of our four hospital sites. Hundreds of people attended these events and we received much valuable feedback to help us shape our plans.

The next stage involves arranging elections for the Council of Governors which will form part of the Trust’s governing body as a Foundation Trust.

The Council of Governors will comprise:

- 15 elected public governors,
- six elected staff governors, and
- seven governors appointed by stakeholder bodies.

All members are eligible to vote for the governors and elections will be conducted by an independent electoral organisation.
Community Partnership Network for Banbury

Over the last few years, the Trust has worked closely with local GPs, our commissioners, local councils and local people in Banbury and the surrounding areas on the provision of services at the Horton General Hospital.

The work initially started when concerns were raised about the long term stability of maternity and paediatric services at the Horton, which led to the Better Healthcare Programme (BHP) for Banbury. That programme saw the development of an integrated model of care for pediatrics across the Horton General Hospital and the John Radcliffe Hospital in Oxford. The Community Partnership Network (CPN) now continues that excellent engagement work between local people, local councils and the Trust.

Vision for the Horton General Hospital

The CPN, the Trust and the Oxfordshire Clinical Commissioning Group are now discussing a vision for the Horton General Hospital. As part of its plans to build a strong future for the hospital, the Trust has reviewed the provision of abdominal surgery at the Horton.

A reduction in the number of surgeons available for the rota at the Horton has meant that abdominal surgery has been moved to the John Radcliffe Hospital in Oxford.

It is important to ensure that all patients are treated by a surgeon with the relevant specialist skills and therefore the decision has been taken to centralise emergency abdominal services at the John Radcliffe Hospital where there is a critical mass of patients requiring emergency abdominal surgery to warrant a full range of specialist emergency surgical staff rotas.

Working together to make a difference

The Trust’s ‘Charitable Funds’ unit supports around 600 unique funds, covering almost every corner of our hospitals – from major campaigns for new facilities, to help for individual hospital wards, purchasing state of the art medical equipment and funding innovative medical research. The money raised and donated is put to effective use in our hospitals, making a difference to thousands of patients every day.

In 2012/13, abseils alone raised over £80,000 and the ever popular Oxford Mail OX5RUN in aid of the Children’s Hospital and children’s causes across the Trust, broke all records in March 2013 when 1,150 runners signed up for the five mile fun run, raising over £70,000 – that’s £10,000 more than in previous years.

Dr Betts took part in the Thames 100 – a 100 mile run along the Thames, non stop – through day and night, raising nearly £8,000. The Appeal was also boosted by a fundraising dinner and auction at Merton College in June.

A further fundraising dinner took place in October thanks to the generosity of Raymond Blanc and Le Manoir aux Quat’Saisons. This unique event raised £22,000 for the Oxford Children’s Hospital, the Heartfelt Appeal and the Cancer Care Fund and recruited regular and new supporters.

The business community showed their support; with Darbys Solicitors exceeding their £50,000 pledge for the Cancer Care Fund after staff took part in an Oxford to Paris bike ride. Legacies also are fundamental to the charity and this year we are fortunate to have received over £1.3 million through gifts in wills supporting many areas across our hospitals.

“We are committed to providing the best possible services for our patients. In particular we will expand the number of outpatient clinics, day cases and short stay elective operations available at the Horton. The vision we are proposing is designed to build a strong future for that hospital.”

Paul Brennan, Director of Clinical Services
Thanks to the generosity of our supporters, hospital wards and departments across the Trust have benefited from additional equipment, research and improved facilities including:

- a paediatric 3D head scanner, costing £15,000;
- a chill out room for teenage cancer patients at the Children’s Hospital;
- first aid training for year six primary children via the IMPS programme;
- a £79,000 retinal scanner for use on newborn babies and children;
- £40,000 towards ECG recording devices to enable cardiac patients to be monitored whilst mobile;
- £100,000 towards the latest 3D ultrasound equipment for the echocardiography unit and equipment for use in a ground-breaking cleft lip and palate research project.

We are very grateful to everyone who supports their hospital causes with such generosity and enthusiasm. To find out how you can get involved with fundraising for the OUH hospitals visit www.ouh.nhs.uk/charity email: charity@ouh.nhs.uk, or telephone 01865 743444.

Working with our patient groups

You tell us what matters to you…

We held two successful patient and public engagement events in 2012/13 aimed at better understanding patients’ priorities in terms of their hospital experience and to gather views on areas on which to focus on going forward.

Involving children and our young patients

The Young People’s Executive (YiPpEe) is a group of children and young people who meet and work with staff in the Children’s Hospital to discuss improving services for young patients in hospital. The group is facilitated and supported by the Trust’s Children’s Rights Lead Nurse, the Play Specialist team, and the Hospital School staff.

YiPpEe members have also supported the children’s services team by reviewing and commenting on policy development, providing challenging and constructive feedback that has influenced service development and professional practice.

The Trust is part of the Oxfordshire Children’s Participation Network. This brings together all the key organisations in Oxfordshire from schools and children’s services to health providers and young offenders’ centres. The aims of the Network are to improve and develop the involvement of young people across all these services and to co-ordinate involvement more effectively.

Posters for Promises

Children and young patients from the Oxfordshire Hospital School, based within the Children’s Hospital, have been directly involved in the creation of posters to illustrate the newly re-launched Nursing and Midwifery standards.

These standards are a set of 12 statements outlining the kind of care we aim to provide for all patients in delivering compassionate excellence. Currently, these standards are written for adult patients. It is hoped that this project will help young patients to communicate their understanding and interpretation of our promises to them, through a range of different mediums including painting, drawing, audiovisual tools and verbal feedback.

The project, which is a joint collaboration between the Trust, Oxfordshire Hospital School and local artist Dionne Barber, aims to ensure that all young patients understand about the care they receive. By translating this through a range of artwork, it is hoped that children will be reassured about and understand better the roles of the nurses and those who care for them while in hospital.
Our volunteers and supporters

Volunteers play an invaluable part in allowing staff to offer an enhanced service to patients. The Trust has a Voluntary Services Department that manages volunteers, other volunteer organisations and the work experience programme. Volunteers help in various departments, talking to patients, helping at mealtimes on wards, taking the library trolley around wards, providing a friendly welcome and giving directions on help desks, working with the Chaplaincy, and supporting staff with administrative duties.

Our supporters always go that extra mile for their local hospitals and we very much appreciate all that they do.

The Trust now has around 250 directly authorised volunteers and there are plans to increase numbers by 50 additional volunteers by March 2014.

The Trust continues to work closely with the hospital-based Leagues of Friends, Radio Cherwell and Radio Horton and charities such as the British Red Cross and SSNAP (Support for the Sick Newborn and their Parents).

Our friends are in a league of their own!

The Leagues of Friends are voluntary organisations that support the Trust by donating equipment and the small extras that enhance the environment for patients, through fundraising and income raised running cafeterias and tea bars in our Oxford hospitals, and small shops at the Horton General Hospital and Nuffield Orthopaedic Centre.

The Trust has over 600 hundred Leagues of Friends volunteers, some of whom have been supporting us for over 20 years. They provide invaluable support and services to our patients and our staff. Every day, the Leagues of Friends groups working across the Trust serve over 1,500 people and raise around £350,000 annually for the Trust. They are managed by Trustees, who meet every month to make decisions about how best to spend the money they raise.

In September 2012, Oxford’s Children’s Hospital played host to three life-sized Olympic Statues in Gold, Silver and Bronze and Olympic medal making workshops. The statues were made in The Ashmolean Museum in family drop-in workshops as part of Artweeks and involved over 200 families over two days. Since then the statues had been on display in different locations around Oxford before arriving at the Children’s Hospital.

The project was run by local artist Francesca Shakespeare with the statues created by using a body mould from Madame Tussauds. They were then gilded and decorated with children’s drawings before being mounted on plinths made by students from d’Overbroeck’s College.

During the time that the statues were based at the Children’s Hospital, Francesca held workshops, available to children on the wards, where they could design and make their own Olympic medals in their own boxes to take home with them.
Trust Board

The Board is responsible for the management of the Trust and ensuring proper standards of corporate governance are maintained. It attaches great importance to making sure the Trust adheres to the principles set out in the NHS Constitution and the Monitor NHS Foundation Trust Code of Governance as an aspiring Foundation Trust, and other related publications such as Quality Governance in the NHS, and works hard to ensure it operates to high ethical and compliance standards.

Board membership comprises:

**Non-executive Directors (NED)**
- Dame Fiona Caldicott, Chairman*
- Professor Sir John Bell*
- Mr Alisdair Cameron*
- Mr Christopher Goard*
- Professor David Mant (Associate Non-executive Director)
- Mr Geoffrey Salt (Vice-chairman)*
- Mrs Anne Tutt*
- Mr Peter Ward*

**Executive Directors**
- Sir Jonathan Michael, Chief Executive*
- Professor Edward Baker, Medical Director*
- Mr Paul Brennan, Director of Clinical Services*
- Mr Mark Mansfield, Director of Finance and Procurement*
- Mr Andrew Stevens, Director of Planning and Information
- Mrs Elaine Strachan-Hall, Chief Nurse*
- Mr Mark Trumper, Director of Development and the Estate
- Ms Eileen Walsh, Director of Assurance

The asterisk* indicates those members holding voting positions, in line with The Health Service Trusts (Membership and Procedure) Regulations 1990.

The Board met seven times in public during the year:

**Board Committee Membership 2012/13**

**AUDIT COMMITTEE**

The Audit Committee is responsible for providing assurance to the Board on the Trust's system of internal control by means of independent and objective review of financial and corporate governance, and risk management arrangements, including compliance with laws, guidance and regulations governing the NHS. It also reviews the Trust's annual statutory accounts before they are signed off by the Trust Board, and monitors the Trust's Counter Fraud arrangements.

The Audit Committee is made up exclusively of independent, Non-executive Directors:
- Mr Alisdair Cameron (Chairman to 31 October 2012)
- Mrs Anne Tutt (Chairman from 1 November 2012)
- Mr Christopher Goard (Vice-chairman from 1 November 2012)

The Chief Executive, Director of Finance and Procurement, and Director of Assurance normally attend the meetings of the Committee. The Chairman of the Board, and any other Board member or senior executive may also attend these meetings, at the invitation of the Audit Committee Chairman.

Representatives from Internal Audit and External Audit and Counter Fraud Services normally attend meetings to deal with audit issues, and they also hold private meetings with the Audit Committee Chairman to discuss confidential matters.

The Committee met a total of six times in the year:

**FINANCE AND PERFORMANCE COMMITTEE**

The Finance and Performance Committee is responsible for reviewing the Trust's financial and operational performance against annual plans and budgets and for overseeing the development of the Trust's medium and long term financial plans. It also monitors performance of the Trust's physical estate and non-clinical services. In addition, the Committee is responsible for reviewing the delivery of annual efficiency savings programmes, and monitoring the effectiveness of the Trust's financial and operational performance reporting systems.

The Committee's core membership comprises Non-executive Directors:
- Mr Christopher Goard (Chairman)
- Mrs Anne Tutt (Vice-chairman)
- Mr Geoff Salt

and the following Executive Directors:
- Sir Jonathan Michael, Chief Executive
- Mr Mark Mansfield, Director of Finance and Procurement
- Professor Edward Baker, Medical Director
- Mr Mark Trumper, Director of Development and the Estate
- Mr Paul Brennan, Director of Clinical Services

The Committee met a total of four times during the year:
QUALITY COMMITTEE
The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care, governance systems, including the management of risk for clinical, corporate, human resources, information and research and development issues and regulatory standards of quality and safety.

The Committee core membership comprises Non-executive Directors:

Mr Geoffrey Salt (Chairman)
Mr Peter Ward (Vice-chairman)
Dame Fiona Caldicott
Mr Christopher Goard (to provide cross membership with the Audit and Finance and Performance Committees)
Professor David Mant

with the following Executive Directors as members:

Professor Edward Baker, Medical Director
Mr Paul Brennan, Director of Clinical Services
Ms Sue Donaldson, Director of Workforce
Sir Jonathan Michael, Chief Executive
Mrs Elaine Strachan-Hall, Chief Nurse
Ms Eileen Walsh, Director of Assurance

Mr Andrew Stevens, Director of Planning and Information is invited to attend the Quality Committee as requested to do so by the Chairman.

The Committee met a total of four times during the year.

REMUNERATION AND APPOINTMENTS COMMITTEE
The Remuneration Committee comprises all Non-executive Directors and is chaired by Professor Sir John Bell. The Committee is established in accordance with good practice and with the requirements of NHS Codes and the Monitor Code of Governance (as an aspiring Foundation Trust).

The Board delegates to the Committee the responsibility for determining the organisation of appraisal of the Chief Executive and Executive Directors; all aspects of salary (including any performance-related elements or bonuses); provisions for other benefits (including pensions and cars); and the arrangements for terminating employment and other contractual terms.

The Remuneration Committee met a total of three times during the year. Full details of the Executive Directors’ remuneration can be found in the Annual Accounts.

Members:
Professor Sir John Bell (Chairman)
Dame Fiona Caldicott
Mr Alisdair Cameron
Mr Christopher Goard
Mr Geoffrey Salt (Vice-chairman)
Mrs Anne Tutt
Mr Peter Ward

In Attendance
The Chief Executive and the Director of Workforce may be asked to attend meetings (or parts of meetings) at which the appointment, remuneration and terms of service of Executive Directors, other than their own, are under consideration.

Declaration of Interests and Register of Interests of members of the Trust Board for the year 2012/13
Declarations of interests by members of the Trust Board are sought at each meeting of the Board and its Committees, and recorded in the minutes of the relevant meetings. The Register of Interests of Board Members is published each year in the Annual Report, and includes those interests recorded during the preceding twelve months for Directors whose appointments have terminated in year.

The interests for the year 2012/13 are given below. Guidance to the codes defines ‘relevant and material’ interests as:

a) Directorships, including Non-executive Directorships held in private companies or PLCs (with the exception of those for dormant companies);
b) ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
c) majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
d) a position of authority in a charity or voluntary organisation in the field of health and social care;
e) any connection with a voluntary or other organisation contracting for NHS services;
f) research funding/grants that may be received by an individual or department;
g) interests in pooled funds that are under separate management.

Full table detailing Register of interests overleaf.

Further details and biographies of the Board of Directors are available from the Trust’s website at www.ouh.nhs.uk/aboutus
<table>
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<th>BOARD MEMBER</th>
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<th>Majority or controlling share holdings</th>
<th>Charity or voluntary organisation</th>
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<th>Research funding/grants</th>
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<td>Dame Fiona Caldicott Chairman</td>
<td>Non-executive Director and Company Secretary Waters 1802 Ltd</td>
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<td>Professor Sir John Bell Regius Professor of Medicine, NED</td>
<td>Chairman: Oxford Health Alliance; GMEC, NED: Roche AG (pharma); Genentech; Oxagen Ltd (biotech); 459-Plus (biotech); Gray Laboratory Cancer Research Trust; The Edward Jenner Institute for Vaccine Research; ISIS Innovation Ltd</td>
<td>None</td>
<td>None</td>
<td>Trustee, Rhodes Trust and Ewelme Almshouse Charity Oxford Lotus Fund; UK Life Sciences Champion (Department of Health) Advisor; Bill and Melinda Gates Foundation; Robertson Foundation</td>
<td>Chairman, Office for Strategic Coordination of Health Research; Human Genome Strategy Group</td>
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<td>Professor Edward Baker Medical Director</td>
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<td>Mr Paul Brennan Director of Clinical Services</td>
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<td>Mr Alisdair Cameron NED</td>
<td>Non-executive Director of the E-Learning Foundation; executive Director/Trustee of various British Gas/Centrica companies</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Mrs Cameron, member of Fundraising Committee for Children’s Hospital</td>
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<td>Ms Sue Donaldson Director of Workforce</td>
<td>Governor of Oxford and Cherwell Valley College with effect from 14 December 2010 to 13 December 2012</td>
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<td>Mr Chris Goard, NED</td>
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<td>Trustee of the Genetic Alliance UK, (an organisation that cooperates with and lobbies both the NHS and the Government here and in Brussels) Non-executive Director of the Patient Safety Federation</td>
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<td>Mr Mark Mansfield Director of Finance &amp; Procurement</td>
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<td>Professor David Mant, NED</td>
<td>Member of the Oxford University Department of Primary Health Care Honorary Consultant with Oxfordshire Primary Care Trust</td>
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<td>Research grant holder from medical charities, EU, Department of Health and NIHR</td>
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<td>Mrs Elaine Strachan-Hall</td>
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<td>None</td>
</tr>
<tr>
<td>Director of Development and the Estate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs Anne Tutt, NED</td>
<td>Section 11 Trustee Oxford Radcliffe Hospitals Charitable Funds and Chairman Audit Committee NED of the Adventure Capital Fund Ltd; NED of the Social Investment Business Ltd*; NED of Bamboo Innovations Ltd**; NED of HM Passport Office, Member of Audit Committee of the Home Office, member of DEFRA Audit Committee</td>
<td>Ownership of private business A Tutt Associates Ltd</td>
<td>None</td>
<td>Consultant to a subsidiary of the Cochrane Collaboration</td>
<td>Section 11 Trustee Oxford Radcliffe Hospitals Charitable Fund and Chairman Audit Committee</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Ms Eileen Walsh</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Director of Assurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Peter Ward, NED</td>
<td>Director of John Laing Projects and Developments</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The Adventure Capital Fund Ltd and the Social Investment Business Ltd are companies in a group that makes grants and loans to third sector organisations who may contract for NHS services. They also manage the following funds: Future Builders England, Community Builders and SEIF (on behalf of the Department of Health).

** Bamboo Innovations is in liquidation.
Four hospitals, one Trust, one vision
Financial Review and outlook

Summary
This is the second report produced by the Oxford University Hospitals NHS Trust which came into existence on the 1st November 2011 with the merger of the Oxford Radcliffe Hospitals NHS Trust and the Nuffield Orthopaedic Centre NHS Trust. The accounts have been prepared under IFRS on a going concern basis, reflecting the cash-flow forecasts of the Trust over the 15 months subsequent to the balance sheet date.

The Trust ended with a surplus of £3,646,000 before the technical adjustments due to impairments and IFRIC 12, against an original plan to produce a surplus of £3.6m. If this figure is then adjusted for impairments and IFRIC 12, a technical deficit under the IFRS regime of £1,316,000 results.

A glossary of technical financial terms used in this report is shown later in this report.

Summary financial statements are included on pages 54-57. Details of how to obtain a full set of accounts are set out on page 54.

Review of 2012/13 and outlook for future years
The Trust had planned to make a surplus of £3.6m in 2012/13 after removing technical adjustments and the accounts indicate that the Trust achieved a surplus of £3.646m. The Trust also had a target to achieve savings of £49.5M and the outcome was that savings of £45.5M (or 92% of the target) were achieved.

For 2013/14 the Trust is planning to make a surplus on Income and expenditure of (1%) £8.1m. Within this plan is an assumption that the Trust will deliver further cost improvements and it has plans to find at least £44.7m. The continuing need for significant savings reflects the financial constraints facing the whole public sector. Within the Oxfordshire Health economy, the Trust is working with the Clinical Commissioning Group (CCG), NHS England Area Team and our partners in Social Services to deliver a plan for Oxfordshire which seeks to find the best solution for the whole health economy. This means that the Trust needs to continue to reduce its costs and seek alternative ways to deliver services if it is to remain in financial good health.

Vital to the continued success of the Trust is the management of risks which could affect service delivery. The Quality Committee is key to the timely and robust identification of risks, the formulation of mitigation plans / action plans and the monitoring of risks. The principal risks to the Trust are managed through two key mechanisms – the Corporate Risk Register and the Trust Assurance Framework. The Corporate Risk Register is used to identify risks relating to trust-wide priorities and corporate issues – for example, it identifies risks relating to delivery of Trust objectives such as access targets and how these will be managed.

The Trust Assurance Framework builds on the Risk Register in that it assesses the effectiveness of the controls in place to ensure delivery against each of the Trust’s objectives. Gaps in controls and assurance are identified in the document and, where required, action plans are put in place to address identified weaknesses.

The highest organisational risks, as identified within the Assurance Framework and which may impact on the Trust’s strategies and development, were reported to the Trust Board and are recorded in the Annual Governance Statement.

Income from Commissioners and other sources
The Trust’s income increased by £33.5m (4.2%) over the previous year and the main components of the Trust’s income for 2012/13 of £822m are shown in the table below. As can be seen from this table, over 80% of the Trust’s resources came directly from Primary Care Trusts. The increase in income from PCTs arose because the Trust was able to meet the demand for more patient care services.

On the 1st April 2013, the responsibility for commissioning services transferred from Primary Care Trusts to the Clinical Commissioning Groups, NHS England, (whom assumed responsibility for commissioning a range of specialist services) and local authorities. From April just over 40% of the Trust’s income came from PCTs. The other 60% of the Trust’s resources came from a range of other bodies including NHS Trusts and FTs, Strategic Health Authorities, the Department of Health, NHS Trusts and FTs, Clinical Commissioning Groups, NHS England, (whom assumed responsibility for commissioning a range of specialist services) and local authorities. From April just over 40% of the Trust’s income came from PCTs. The other 60% of the Trust’s resources came from a range of other bodies including NHS Trusts and FTs, Strategic Health Authorities, the Department of Health, NHS Trusts and FTs, Clinical Commissioning Groups, NHS England, (whom assumed responsibility for commissioning a range of specialist services) and local authorities.

For further financial information please refer to the Accounts section at the end of this report.
Operating expenses (see Fig.3)

The Trust spends on average just under £2.2m each and every day. The largest item of expenditure is staff costs and the next most significant is clinical supplies and services. Fig. 3 shows an analysis of how much of each pound spent is attributable to staff costs and the other main expenditure headings.

Looking ahead, the cost base of the Trust will alter as the Trust continues to use a number of external benchmarks to identify the potential for further efficiencies and introduces further changes as a result.

Capital resources

The capital programme is a key resource of funding to enable modernisation and to ensure that our services are delivered in a safe and well maintained environment. In general, the Trust has to generate sufficient surplus cash flow to finance capital investment by the retention of cash generated through operations (principally depreciation) for reinvestment.

Over £24.7m was spent in 2012/13 and Fig. 4 provides an indication of the areas of investment the Trust pursued in the year. The Plan for 2013/14 can be summarised as Fig. 5 (see right).

Summary of financial duties

The Trust’s performance measured against its statutory financial duties is summarised as follows.

Break-even on income and expenditure (a measure of financial stability)

The Trust reported a surplus of income over expenditure of £3,646,000 for 2012/13, after Department of Health agreed exclusions of £4,962,000 arising from the technical treatment associated with Private Finance Initiative schemes, the elimination of the donated asset / government grant reserves and the revaluation of assets. Although this expenditure is included in the Trust’s Accounts, it is the position excluding these items which forms the basis of the break-even requirement and against which the Trust’s financial performance is judged by the Department of Health.

External Financing Limit

(An overall cash management control)

The Trust was set a target not to increase its level of external finance by more than £5.094 million in 2012/13. The Trust achieved this target by reducing its level of external financing requirement by £37.024 million.

Capital Resource Limit

(a measure of balance sheet management)

NHS trusts are targeted to absorb the cost of capital at a rate of 3.5% of average net assets (as reflected in their opening and closing balance sheets for the year). However since 2009/10 the dividend payable on public dividend capital has been based upon the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

The Trust was set a limit of £24.775m which it could spend on capital and during the year it spent £24.735M, thus undershooting it’s control limit by £0.04m.

<table>
<thead>
<tr>
<th>Scheme</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Intensive Care</td>
<td>1,200</td>
</tr>
<tr>
<td>Vascular Business Case</td>
<td>400</td>
</tr>
<tr>
<td>Medical and Surgical Equipment</td>
<td>3100</td>
</tr>
<tr>
<td>Radiotherapy satellite units</td>
<td>510</td>
</tr>
<tr>
<td>IT/ EPR</td>
<td>200</td>
</tr>
<tr>
<td>Ward Relocations</td>
<td>275</td>
</tr>
<tr>
<td>Estates Maintenance</td>
<td>160</td>
</tr>
<tr>
<td>IMRT – Rapid Arc</td>
<td>291</td>
</tr>
<tr>
<td>Molecular Diagnostic Centre</td>
<td>243</td>
</tr>
<tr>
<td>Out-Patient (Mobile) HH</td>
<td>100</td>
</tr>
<tr>
<td>Other Schemes</td>
<td>410</td>
</tr>
<tr>
<td>Total</td>
<td>25,394</td>
</tr>
</tbody>
</table>

(SourceMonth 12 Trust Board Report TB2013.66)
Performance over the last five years

This table summarises the performance of the Oxford University Hospital Trust and its predecessors over the last five years.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Turnover £000</th>
<th>Retained surplus / (deficit) £000</th>
<th>Break-even cumulative position surplus / (deficit) £000</th>
<th>CCA rate % (target 3.5% from 2003/4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>821,705</td>
<td>3,646</td>
<td>(4,218)</td>
<td>3.5%</td>
</tr>
<tr>
<td>2011/12</td>
<td>788,220</td>
<td>7,157</td>
<td>(7,864)</td>
<td>3.5%</td>
</tr>
<tr>
<td>2010/11</td>
<td>745,957</td>
<td>2,171</td>
<td>(15,021)</td>
<td>3.5%</td>
</tr>
<tr>
<td>2009/10</td>
<td>714,827</td>
<td>417</td>
<td>(17,192)</td>
<td>3.5%</td>
</tr>
<tr>
<td>2008/09</td>
<td>686,836</td>
<td>2,464</td>
<td>(17,609)</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

(Source note 43.1 Annual Accounts 2012/13)

Note 2008/09 - 2010/11 refers only to the former Oxford Radcliffe Hospitals NHS Trust.

The figures given for years before 2008/9 are on the basis of UK Generally Accepted Accounting Principles as that is the basis on which the Trust reported its performance and on which its targets were set for those years. The figures for 2009/10 and subsequently are on the basis of the International Financial Reporting Standards (IFRS).

For break-even performance, impairments and IFRIC 12 adjustments are excluded.
Summary financial statements

These accounts for the year ended 31st March 2013 have been prepared by the Oxford University Hospitals NHS Trust under section 232 (schedule 15) of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

The financial statements that follow are only a summary of the information contained in the Trust’s annual accounts. Full copies of the accounts are available from the Publications page in the About us section of the Trust’s website (www.ouh.nhs.uk) or by contacting the Finance Department at the Oxford University Hospitals NHS Trust. The Trust is required to include an Annual Governance Statement, which is shown at the end of this document.

Signed: ……………………………………….
Mark Mansfield, Director of Finance and Procurement

Foreword to the Accounts

The Trust made a surplus of £3,646,000 against the break-even duty for 2012/13. The accounts record a deficit of £1,316,000; the difference of £4,962,000 relates to technical treatments associated with accounting for Private Finance Initiatives’ schemes, elimination of the donated asset / government grant reserve and revaluations of assets which are each excluded by the Department of Health when considering the performance of the Trust.

Statement of comprehensive income for year ended

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus /</td>
<td></td>
<td></td>
</tr>
<tr>
<td>deficit for the year</td>
<td>(1,316)</td>
<td>7,603</td>
</tr>
<tr>
<td>IFRIC*12 Adjustment</td>
<td>1</td>
<td>440</td>
</tr>
<tr>
<td>Impairments</td>
<td>4,568</td>
<td>(2,328)</td>
</tr>
<tr>
<td>Adjustments into</td>
<td></td>
<td></td>
</tr>
<tr>
<td>donated asset/gov’t</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grant reserve</td>
<td>393</td>
<td>1,442</td>
</tr>
<tr>
<td>elimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported NHS finance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(adjusted retained</td>
<td>3,646</td>
<td>7,157</td>
</tr>
<tr>
<td>surplus)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*IFRIC stands for the International Financial Reporting Interpretations Committee. It is the Interpretations Committee for the International Accounting Standards Board (IASB).
## Statement of financial position as at 31 March 2013

<table>
<thead>
<tr>
<th></th>
<th>31 March 2013 £000</th>
<th>31 March 2012 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>681,746</td>
<td>696,398</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>7,745</td>
<td>7,301</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>3,774</td>
<td>3,742</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>693,265</td>
<td>707,441</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>11,353</td>
<td>12,761</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>27,054</td>
<td>36,392</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other current assets</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>65,657</td>
<td>43,884</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>104,064</td>
<td>93,107</td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>104,064</td>
<td>93,107</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>797,329</td>
<td>800,548</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2013 £000</th>
<th>31 March 2012 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(109,203)</td>
<td>(100,141)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(2,902)</td>
<td>(8,421)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(10,054)</td>
<td>(12,626)</td>
</tr>
<tr>
<td>Working capital loan from Department</td>
<td>0</td>
<td>(3,326)</td>
</tr>
<tr>
<td>Capital loan from Department</td>
<td>(1,404)</td>
<td>(1,404)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>(123,563)</td>
<td>(125,918)</td>
</tr>
<tr>
<td><strong>Non-current assets plus/ less current assets/liabilities</strong></td>
<td>673,766</td>
<td>674,630</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2013 £000</th>
<th>31 March 2012 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td>(302,380)</td>
<td>(302,670)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>371,386</td>
<td>371,960</td>
</tr>
</tbody>
</table>

**Financed by taxpayers’ equity:**

- Public dividend capital: 207,673
- Retained earnings: 14,608
- Revaluation reserve: 147,362
- Other reserves: 1,743

**Total taxpayers’ equity:**

- 371,386
## Statement of changes in taxpayers’ equity for the year ended 31 March 2013

<table>
<thead>
<tr>
<th>Public dividend capital (PDC) £000</th>
<th>Retained earnings £000</th>
<th>Revaluation reserve £000</th>
<th>Other reserves £000</th>
<th>Total reserves £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2012</strong></td>
<td><strong>206,873</strong></td>
<td><strong>15,600</strong></td>
<td><strong>147,744</strong></td>
<td><strong>1,743</strong></td>
</tr>
<tr>
<td><strong>Changes in taxpayers’ equity for 2012/13</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>(1,316)</td>
<td>(1,316)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net gain on revaluation of property, plant, equipment</td>
<td>4,592</td>
<td>4,592</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>(4,650)</td>
<td>(4,650)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>324</td>
<td>(324)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Release of reserves to SOCI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New PDC received</td>
<td>800</td>
<td></td>
<td></td>
<td>800</td>
</tr>
<tr>
<td>PDC repaid in year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDC written off</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net recognised revenue/(expense) for the year</td>
<td>800</td>
<td>(992)</td>
<td>(382)</td>
<td>(574)</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2013</strong></td>
<td><strong>207,673</strong></td>
<td><strong>14,608</strong></td>
<td><strong>147,362</strong></td>
<td><strong>1,743</strong></td>
</tr>
</tbody>
</table>

*Included above:*
- Transfer from revaluation reserve to retained earnings in respect of impairments 0 0 0

## Statement of changes in taxpayers’ equity for 2011/12

<table>
<thead>
<tr>
<th>Public dividend capital (PDC) £000</th>
<th>Retained earnings £000</th>
<th>Revaluation reserve £000</th>
<th>Other reserves £000</th>
<th>Total reserves £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2011</strong></td>
<td><strong>203,912</strong></td>
<td><strong>7,913</strong></td>
<td><strong>140,091</strong></td>
<td><strong>1,743</strong></td>
</tr>
<tr>
<td><strong>Changes in taxpayers’ equity for 2011/12</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td><strong>7,603</strong></td>
<td></td>
<td></td>
<td>7,603</td>
</tr>
<tr>
<td>Net gain on revaluation of property, plant, equipment</td>
<td>7,737</td>
<td></td>
<td></td>
<td>7,737</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>84</td>
<td>(84)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New PDC received</td>
<td>2,961</td>
<td></td>
<td></td>
<td>2,961</td>
</tr>
<tr>
<td>PDC repaid in year</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>PDC written off</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net recognised revenue/(expense) for the year</td>
<td>2,961</td>
<td>7,687</td>
<td>7,653</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2012</strong></td>
<td><strong>206,873</strong></td>
<td><strong>15,600</strong></td>
<td><strong>147,744</strong></td>
<td><strong>1,743</strong></td>
</tr>
</tbody>
</table>

*Included above:*
- Transfer from revaluation reserve to retained earnings in respect of impairments 0 0 0
Statement of cash flows for the year ended 31 March 2013

<table>
<thead>
<tr>
<th>Cash flows from operating activities</th>
<th>2012/13 £000</th>
<th>2011/12 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating surplus / (deficit)</td>
<td>27,491</td>
<td>36,992</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>36,758</td>
<td>34,850</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>4,568</td>
<td>(2,328)</td>
</tr>
<tr>
<td>Donated asset received credited to revenue but non-cash</td>
<td>(923)</td>
<td>(45)</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(20,697)</td>
<td>(20,436)</td>
</tr>
<tr>
<td>Dividends paid</td>
<td>(9,374)</td>
<td>(8,983)</td>
</tr>
<tr>
<td>(Increase) / decrease in inventories</td>
<td>1,408</td>
<td>253</td>
</tr>
<tr>
<td>(Increase) / decrease in trade and other receivables</td>
<td>10,331</td>
<td>(7,139)</td>
</tr>
<tr>
<td>(Increase) / decrease in other current assets</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Increase / (decrease) in trade and other payables</td>
<td>18,858</td>
<td>13,448</td>
</tr>
<tr>
<td>Increase / (decrease) in other current liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>(3,152)</td>
<td>(1,171)</td>
</tr>
<tr>
<td>Increase / (decrease) in provisions</td>
<td>(2,184)</td>
<td>5,770</td>
</tr>
</tbody>
</table>

Net cash inflow / (outflow) from operating activities | 63,084       | 51,212       |

Cash flows from investing activities

| Interest received | 179 | 145     |
| Payments for property, plant and equipment (PPE) | (23,499) | (14,018) |
| Payments for intangible assets | (2,740) | (3,420) |
| Payments for investments with DH | 0 | 0 |
| Proceeds from disposal of assets held for sale (PPE) | 0 | 0 |
| Proceeds from disposal of assets held for sale (intangible) | 0 | 0 |
| Proceeds from disposal of investments with DH | 0 | 0 |
| Proceeds from disposal of other financial assets | 0 | 0 |
| Rental revenue | 0 | 0 |

Net cash inflow/(outflow) from investing activities | (26,060) | (17,293) |

Net cash inflow/(outflow) before financing | 37,024 | 33,919 |

Cash flows from financing activities

| Public dividend capital received | 800 | 2,961 |
| Public dividend capital repaid | 0 | 0 |
| Loans received from DH-new capital investment loans | 0 | 0 |
| Loans received from DH-new working capital loans | 0 | 0 |
| Loans repaid to DH-capital | 0 | 0 |
| Investment loans repayment of principal | (1,404) | (1,404) |
| Loans repaid to DH-working | 0 | 0 |
| Capital Loans repayment of principal | (3,326) | (3,332) |
| Capital element of finance leases and On-SoFP PFI | (11,321) | (14,059) |
| Capital grants and other capital receipts | 0 | 0 |

Net cash inflow/(outflow) from financing | (15,251) | (15,834) |

Net increase/(decrease) in cash and cash equivalents | 21,773 | 18,085 |

Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year | 43,884 | 25,799 |

Effect of exchange rate changes on the balance of cash held in foreign currencies | 0 | 0 |

Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year | 65,657 | 43,884 |
Public interest and other reports

1 Better payment practice Code
In accordance with the CBI prompt payment code, the Trust’s payment policy is to pay all creditors within 30 days of receipt of goods or a valid invoice unless other payment terms are agreed. The performance for 2012/13 is set out opposite (see Fig 6 and 7). The Trust has signed up to the Prompt Payment Code which is a payment initiative developed by Government, and which was referenced in a letter from the NHS Chief Executive on 18th May 2009.

2 Audit disclosure
The Trust’s external auditors are appointed by the Audit Commission and following the outsourcing of the Commission’s in-house Audit Practice, all auditor appointments are of private firms. The Trust’s external auditors are Ernst & Young. The statutory audit fee for the year ended 31st March 2013 was £189,700 (plus VAT). In addition, Ernst & Young undertook additional work on the Board Governance Assurance Framework (BGAF) assessment to support the Trust’s foundation trust application process and received a further £30,000. The external auditors report to the Audit Committee, which is a sub committee of the Trust Board chaired by a non-executive director and whose membership is limited to the non-executive directors of the Trust. Under the governance arrangements of the Audit Commission, the contracts for the provision of external audit services are subject to periodic market testing.

In line with current guidance, each director has given a statement that as far as they are aware, there is no relevant audit information of which the external auditors are unaware. They have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that Ernst & Young are aware of that information.

3 Land values
The carrying values for land and buildings in the Trust’s accounts are based upon the valuations by the Valuation Office Agency.

4 Charging for information
The Trust has complied with Treasury’s guidance on setting charges for information as specified within the Treasury guidance set out in appendix 6.3 of Managing Public Money.

5 Pension liabilities
Oxford University Hospitals NHS Trust staff are members of the National NHS Pension scheme. Further details about the scheme are available in Note 10.5 to the full accounts and in the remuneration report.

6 Contingent liabilities
The notes to the Accounts (note 36) disclose that at the year end the Trust had contingent liabilities of £10,868,000.

7 Exit packages for staff leaving 2012/13
Redundancy costs have been paid in accordance with the provisions of the NHS Scheme and other departures are under a Mutually Agreed Resignation Scheme. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table (see Fig 8).

---

### Fig 6

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Value</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Total non-NHS trade invoices paid</td>
<td>112,981</td>
<td>277,612</td>
</tr>
<tr>
<td>Total non-NHS trade invoices within target</td>
<td>97,445</td>
<td>235,241</td>
</tr>
<tr>
<td>% non-NHS trade invoices paid within target</td>
<td>86.25%</td>
<td>84.74%</td>
</tr>
</tbody>
</table>

### Fig 7

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Value</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Total NHS trade invoices paid</td>
<td>4,923</td>
<td>74,063</td>
</tr>
<tr>
<td>Total NHS trade invoices within target</td>
<td>3,636</td>
<td>62,565</td>
</tr>
<tr>
<td>% NHS trade invoices paid within target</td>
<td>73.86%</td>
<td>84.48%</td>
</tr>
</tbody>
</table>

(Source note 11 to Annual Accounts 2012/13)

---

### Fig 8

<table>
<thead>
<tr>
<th>Exit package cost band (including any special payment element)</th>
<th>Number of compulsory redundancies</th>
<th>Number of other departures agreed</th>
<th>Total number of exit packages by cost band</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>b</td>
<td>c</td>
<td>d</td>
</tr>
<tr>
<td>&lt;£10,001</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>£10,001 - £25,000</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>£25,001 - £50,000</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>£50,001 - £100,000</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>£100,001 - £150,000</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>£150,001 - £200,000</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>&gt;£200,000</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Total number of exit packages by type (total cost): £767,000  £2,082,000  £2,849,000

(Source note 10.4 Annual Accounts 2012/13)
8 Sickness Absence Data

It is a Treasury requirement that public bodies must report sickness absence data and the data must be consistent to permit aggregation across the NHS and with similar data from the Department of Health. The table below lists the data for January 2012 – December 2012 which has been provided centrally for this purpose and is included within the Annual Accounts at note 10.3 (see Fig. 9).

<table>
<thead>
<tr>
<th></th>
<th>2012/13 Number</th>
<th>2011/12 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days lost</td>
<td>58,725</td>
<td>62,794</td>
</tr>
<tr>
<td>Average number of staff (wte)</td>
<td>8,180</td>
<td>8,035</td>
</tr>
<tr>
<td>Average working days lost</td>
<td>7.2</td>
<td>7.8</td>
</tr>
</tbody>
</table>
# Remuneration report

The table below discloses the remuneration provided to Directors within the Oxford University Hospitals NHS Trust during 2012/13.

## Salary and pension entitlements of senior managers

<table>
<thead>
<tr>
<th>Name and title</th>
<th>2012/13</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary (Bands of £5,000) £000</td>
<td>Other remuneration (Bands of £5,000) £000</td>
</tr>
<tr>
<td>----------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Dame Fiona Caldicott</td>
<td>Chairman</td>
<td>20-25</td>
</tr>
<tr>
<td>Mr Geoffrey Salt</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Alisdair Cameron</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Professor Sir John Bell</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Mrs Anne Tutt</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Peter Ward</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Chris Goard</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Mark Mansfield</td>
<td>Director of Finance and Procurement</td>
<td>140-145</td>
</tr>
<tr>
<td>Mrs Elaine Strachan-Hall</td>
<td>Chief Nurse</td>
<td>110-115</td>
</tr>
<tr>
<td>Mr Andrew Stevens</td>
<td>Director of Planning and Information</td>
<td>110-115</td>
</tr>
<tr>
<td>Mr Paul Brennan</td>
<td>Director of Clinical Services</td>
<td>140-145</td>
</tr>
<tr>
<td>Ms Sue Donaldson</td>
<td>Director of Human Resources</td>
<td>105-110</td>
</tr>
<tr>
<td>Professor Edward Baker¹</td>
<td>Medical Director</td>
<td>160-165</td>
</tr>
<tr>
<td>Mr Mark Trumper²</td>
<td>Director of Development and the Estate</td>
<td>125-130</td>
</tr>
<tr>
<td>Ms Eileen Walsh³</td>
<td>Director of Assurance</td>
<td>115-120</td>
</tr>
</tbody>
</table>

**NOTES**

1. Other Remuneration relates to clinical excellence awards.
2. Part year effect due to appointment to the Trust from May 2011.
3. Part year effect due to appointment to the Trust from May 2011.

*SEE PAGE 62 for further information relating to performance related payments
### b) Pension benefits

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60 (Bands of £2,500) £000</th>
<th>Real increase in pension lump sum at age 60 (Bands of £2,500) £000</th>
<th>Total accrued pension at age 60 at 31 March 2013 (Bands of £5,000) £000</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2013 (Bands of £5,000) £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2013 (Bands of £2,500) £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2012 (Bands of £2,500) £000</th>
<th>Real increase in Cash Equivalent Transfer Value (To nearest £100)</th>
<th>Employer’s contribution to Stakeholder Pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Elaine Strachan-Hall Chief Nurse</td>
<td>-2.5 -0.25</td>
<td>40-45</td>
<td>130-135</td>
<td>792</td>
<td>744</td>
<td>10</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Andrew Stevens Director of Planning and Information</td>
<td>-2.5 -0.25</td>
<td>45-50</td>
<td>135-140</td>
<td>862</td>
<td>810</td>
<td>10</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Mark Mansfield Director of Finance and Procurement</td>
<td>-2.5 -0.25</td>
<td>45-50</td>
<td>145-150</td>
<td>899</td>
<td>835</td>
<td>21</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Paul Brennan Director of Clinical Services</td>
<td>-2.5 -5-2.5</td>
<td>50-55</td>
<td>155-160</td>
<td>987</td>
<td>928</td>
<td>21</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Professor Edward Baker Medical Director</td>
<td>-2.5 -7.5-5</td>
<td>100-105</td>
<td>300-305</td>
<td>2,166</td>
<td>2,042</td>
<td>18</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ms Sue Donaldson Director of Human Resources</td>
<td>0-2.5 2.5-5</td>
<td>10-15</td>
<td>35-40</td>
<td>210</td>
<td>172</td>
<td>29</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Mark Trumper Director of Development and the Estate</td>
<td>0-2.5</td>
<td>0</td>
<td>35-40</td>
<td>373</td>
<td>341</td>
<td>14</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ms Eileen Walsh Director of Assurance</td>
<td>0-2.5 0-2.5</td>
<td>25-30</td>
<td>80-85</td>
<td>440</td>
<td>403</td>
<td>16</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

**NOTES**

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV’s are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV – this reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

**Terms of office**

The Executive Directors are employed within a standard employment contract which provides for a three month notice period. The exceptions to this are Chief Executive (six months) and Director of Planning and Information and Chief Nurse (six months). On termination of employment the director may be entitled to contractual severance terms and redundancy. Any payments above normal contractual levels would have to be approved by HM Treasury as an economic use of public funds before they were made.

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Date of appointment</th>
<th>End of term of office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dame Fiona Caldicott</td>
<td>09/03/2009</td>
<td>08/03/2017</td>
</tr>
<tr>
<td>Mr Geoffrey Salt</td>
<td>01/05/2009</td>
<td>15/04/2017</td>
</tr>
<tr>
<td>Mr Alisdair Cameron</td>
<td>01/05/2009</td>
<td>30/04/2015</td>
</tr>
<tr>
<td>Professor Sir John Bell</td>
<td>01/11/2009</td>
<td>31/10/2013</td>
</tr>
<tr>
<td>Mrs Anne Tutt</td>
<td>01/12/2009</td>
<td>30/11/2013</td>
</tr>
<tr>
<td>Mr Peter Ward</td>
<td>01/12/2009</td>
<td>30/11/2013</td>
</tr>
<tr>
<td>Mr Chris Goard</td>
<td>01/11/2012</td>
<td>31/03/2015</td>
</tr>
</tbody>
</table>
Overview of Executive Director Remuneration

Executive Directors (excluding the Medical Director*) are not paid according to national terms and conditions for NHS staff. Arrangements are determined locally by the Remuneration and Appointments (R&A) Committee which is constituted solely by Non-executive Directors.

Executive Directors’ contracts of employment include:

- A fixed annual salary payment, which is disclosed in the Annual Report and Accounts, and;
- Eligibility for a variable performance related payment (PRP) linked to Corporate Objectives, as set out in the Annual Business Plan.

The PRP Scheme recognises both team and individual performance. The maximum potential payment through the scheme is 20% of annual salary for the Chief Executive and 10% of annual salary for other Executive Directors.

75% of the potential payment is linked to team objectives and 25% to individual objectives. PRP is paid via a single annual ‘lump sum’ payment which does not attract pension benefits.

<table>
<thead>
<tr>
<th>Corporate Objective</th>
<th>Comment</th>
<th>Potential PRP</th>
<th>PRP Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivering Compassionate Excellence</strong></td>
<td>Achieved</td>
<td>30%</td>
<td>25%</td>
</tr>
<tr>
<td>• Embed the Trust’s new values into everyday action</td>
<td>Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintain a focus on patient safety</td>
<td>Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Improve/Maintain national standards for access to services</td>
<td>Achieved with exception of: – A&amp;E waiting times Q4 – Diagnostic waiting times Q3</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Becoming a Resilient, Flexible and Successful Organisation</strong></td>
<td>Achieved</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>• Improve the quality of services, achieving the objectives set out in the Quality Account</td>
<td>Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Achieve NHS Foundation Trust milestones</td>
<td>Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Continue to develop financial regimes and systems that meet FT requirements</td>
<td>Achieved</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delivering Better Value Healthcare</strong></td>
<td>Achieved</td>
<td>7.5%</td>
<td>7.5%</td>
</tr>
<tr>
<td>• Increase productivity and delivery of CIPS year on year in line with the agreed financial strategy and within the agreed performance framework/compacts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delivering Integrated Healthcare</strong></td>
<td>Not achieved</td>
<td>7.5%</td>
<td>0%</td>
</tr>
<tr>
<td>• Work with partners to reduce the number of system wide delayed transfers of care (DTOC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Delivering Sustainable Clinical Networks</strong></td>
<td>Achieved</td>
<td>7.5%</td>
<td>7.5%</td>
</tr>
<tr>
<td>• Delivery of outcomes from business cases for Trauma, Vascular, Stroke and Neonatal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A Robust Academic Health Science Network</strong></td>
<td>Achieved</td>
<td>7.5%</td>
<td>7.5%</td>
</tr>
<tr>
<td>• With partners bid to achieve designation as one of the new Academic Health Science Networks, with the OUH at its heart</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PRP allocation and the assessment of performance against Corporate Objectives to determine and agree PRP is undertaken by the R&A Committee.

Details of the PRP scheme and payments arising from the team’s performance against Corporate Objectives during 2012/2013 are set out in the table below. Personal objectives are agreed with the Chairman for the Chief Executive and with the Chief Executive for Executive Directors. Performance in respect of personal objectives is managed via individual annual appraisals.

* The Medical Director (MD) is employed on the nationally determined Consultant Contract which includes a basic salary from agreed pay-scales plus a responsibility allowance. It also includes eligibility for Clinical Excellence Awards which are paid to consultant medical staff in recognition of outstanding clinical, teaching or academic achievement. The MD is not eligible for the Executive PRP Scheme.
Reporting bodies are expected to disclose, in addition, the relationship between the remuneration of the highest-paid director in the organisation and the median average remuneration for the whole of the workforce. Organisations are also required to publish the year on year change in this ratio from the previous accounting period.

The remuneration of the highest paid director in the Oxford University Hospitals NHS Trust in the financial year 2012/2013 was £285,000 - £290,000. This was nine times the median remuneration of the workforce, which was £30,183, (2011/12 median £30,471).

No employees received remuneration in excess of the highest paid director during 2012-2013. Remuneration ranged from £14,153 - £285,480.

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

The total full time equivalent number of staff employed by the Oxford University Hospitals at 31st March 2013 is 9,026 (31 March 2012 8,772).

All employees, with the exception of medical staff, very senior managers and executive directors are subject to NHS ‘Agenda for Change’ Terms and Conditions of Service which include nationally agreed salary scales.

Similarly the pay and contractual arrangements of medical staff are determined by nationally agreed terms and conditions of service.

There are a small number of employees that are on very senior manager contracts. Their pay levels are determined by the Trust on the basis of the relative size and complexity of the role and take account, as far as possible, of benchmarking for comparable jobs across the NHS. The pay point for these individuals is fixed. Other terms and conditions of service are in line with Agenda for Change.

The remuneration arrangements of executive directors are determined by the Remuneration and Appointments Committee of the Board, which comprises all of the Trust’s Non-executive Directors. Remuneration packages are determined by the relative size and complexity of the role and take account, as far as possible, of benchmarking for comparable jobs across the NHS.

The remuneration arrangements for executive directors include an eligibility for unconsolidated annual bonus payment that is dependent on performance against targets determined by the Remuneration and Appointments Committee of the Board.

In accordance with the HM Treasury annual reporting guidance the Trust is required to report the number of “off-payroll engagements”. At 31 January 2012 there were six “off payroll engagements”. There were no new engagements in the period between 23 August 2012 and 31 March 2013. During the period 31 January 2012 and 31 March 2013 one engagement transferred onto the payroll and two came to an end.
Independent Auditor’s Report to the Directors of Oxford University Hospitals NHS Trust

We have examined the summary financial statement for the year ended 31 March 2013 which comprises Section 2: Financial Review.

This report is made solely to the Board of Directors of Oxford University Hospitals NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

We conducted my work in accordance with Bulletin 2008/03 “The auditor’s statement on the summary financial statement in the United Kingdom” issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the Oxford University Hospitals NHS Trust for the year ended 31 March 2013.

Maria Grindley
for and on behalf of Ernst & Young LLP, Statutory Auditor
Apex Plaza, Fordbury Road, Reading, RG1 1YE
6 June 2013
### Explanation of financial terminology

The format of the accounts is specified by the Department of Health and reflects the adoption of the International Financial Reporting Standards (IFRS) by the NHS. A glossary of the terms used in the Annual Report is outlined below. This covers the terms used in the financial statements and in the Financial Review.

The four primary statements as specified by the NHS Trust Manual for accounts are:

- Statement of Comprehensive Income
- Statement of Financial Position (previously known as the Balance Sheet)
- Statement of Changes in Taxpayers Equity
- Statement of Cash Flows

The annual accounts also include:

- A foreword
- Notes to the accounts
- The directors Statement of Responsibilities
- The Annual Governance Statement
- The auditors report.

The full Annual Report for 2013 including:

- The Primary Financial Statements and notes
- The Annual Governance Statement
- The Statement of the Accounting Officer’s responsibilities
- The Audit opinion and report

Is available from the Publications page in the About us section of the Trust’s website (www.ouh.nhs.uk) or by contacting the Finance Department at the Oxford University Hospitals NHS Trust or the Media and Communications Unit on 01865 231471.

The Statement of Comprehensive Income records the Trust’s income and expenditure for the year, together with any other recognised gains and losses in summary form. It includes cash-related items such as expenditure on staff and supplies as well as non-cash items such as a change in value of the Trust’s assets. If income exceeds expenditure, the Trust has a surplus for the year and if expenditure exceeds income, there is a deficit.

#### Terms used within the Statement of Comprehensive Income:

- **Revenue for patient care activities:** This includes all income from patient care, the largest element of which is from the Primary Care Trusts (PCTs). Other sources of income include private patient income and overseas patients.
- **Other operating revenue:** includes non-patient related income including education, training and research funding.
- **Operating expenses:** this includes the costs of staff, supplies, premises and services received from other organisations.
- **Investment revenue:** This shows the interest received from bank accounts.
- **Other gains & losses:** This shows the gain or (loss) on the sale of an asset compared with the asset’s value as recorded in the Statement of Financial position.
- **Impairments & reversals:** This shows reductions (or impairments) compared to asset values previously recorded in the Statement of Financial Position.
- **Gains on revaluation:** This shows increases compared to asset values previously recorded in the Statement of Financial Position.
- **Provisions:** are liabilities where the amount and / or timing are uncertain. Whilst there has been no cash payment, the trust anticipates making a payment at a future date and so its net assets are reduced accordingly.
- **Non current assets:** These are assets which the Trust expects to keep for more than one year.
- **Intangible assets:** are assets such as computer software licences and patents which, although they have a continuing value to the Trust, do not have a physical existence.
- **Trade & other receivables:** are amounts owed to the NHS Trust and are analysed between those due over 12 months (non current) and those due within 12 months (current)
- **Current assets:** These are assets which the Trust expects to keep for less than one year.
- **Inventories:** are stock such as theatre consumables
- **Non-current assets held for sale:** are long term assets (such as land) which the Trust expects to sell shortly.
- **Current Liabilities:** reflect monies the Trust owes, including invoices it has not yet paid but which it expects to pay within a year.
- **Trade & other payables:** are amounts which the NHS Trust owes and are analysed between those due to be paid within 12 months (current) and those due to be paid after more than 12 months (non-current)
- **Borrowings:** are amounts which the NHS Trust owes and are analysed between those due to be paid within 12 months (current) and those due to be paid after more than 12 months (non-current), they include items such as bank overdrafts, loans and the loan element of PFI schemes.
- **Provisions:** are liabilities where the amount and / or timing are uncertain.

#### Terms used in the statement of Financial Position:

- **Non current assets:** These are assets which the Trust expects to keep for more than one year.
- **Intangible assets:** are assets such as computer software licences and patents which, although they have a continuing value to the Trust, do not have a physical existence.
- **Trade & other receivables:** are amounts owed to the NHS Trust and are analysed between those due over 12 months (non current) and those due within 12 months (current)
- **Current assets:** These are assets which the Trust expects to keep for less than one year.
- **Inventories:** are stock such as theatre consumables
- **Non-current assets held for sale:** are long term assets (such as land) which the Trust expects to sell shortly.
- **Current Liabilities:** reflect monies the Trust owes, including invoices it has not yet paid but which it expects to pay within a year.
- **Trade & other payables:** are amounts which the NHS Trust owes and are analysed between those due to be paid within 12 months (current) and those due to be paid after more than 12 months (non-current)
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- **Provisions:** are liabilities where the amount and / or timing are uncertain.

**Note:**

The Statement of Financial Position which was formally known as the balance sheet provides a snapshot of the Trust’s financial position at a specific date, which in this case is the end of the financial year. It lists assets (what the trust owns or is owed), liabilities (what the Trust owes) and taxpayers equity (the amount of public funds invested in the Trust). At any given time, the trust’s total assets less its total liabilities must equal the taxpayer’s equity.
The Statement of changes in Taxpayers’ Equity essentially shows the movement from the previous year on reserves and public dividend capital. It represents the taxpayer’s investment in the Trust.

- Prior Period Adjustment: reflects adjustments made in an accounting period prior to that to which the statement refers.
- Impairments & reversals: reflects reductions in asset values compared to asset values previously recorded in the Statement of Financial Position.

The Statement of Cash Flows summarises the cash flows of the Trust during the year. It analyses the cash flows under the headings of operating, investing, and financing cash flows.

Terms used in the statement of Cash Flows

- **Depreciation & amortisation**: These are the non-cash items included within the operating surplus and they need to be removed to give the movement in cash during the year. As an example, depreciation is an accounting charge to reflect the use of capital assets and does not involve cash; hence it is added back to the operating surplus/deficit.
- **Impairments & reversals**: reflects reductions in asset values compared to asset values previously recorded in the Statement of Financial Position. These are the non-cash items included within the operating surplus and they need to be removed to give the movement in cash during the year.
- **Increase / (decrease) in provisions**: Provisions are liabilities where the amount and/or timing are uncertain. Whilst there has been no cash payment, a change in the amount set aside for provisions impacts on the operating surplus and hence needs to be adjusted for to calculate the movement in cash during the year.
- **Net cash inflow from operating activities**: reflects the amount of cash received resulting from the Trust’s normal operating activities.
- **Net cash inflow / (outflow) from investing activities**: reflects the amount of cash received / (paid) as a result of cash transactions that are not directly related to operating activities, for example, purchasing new assets.
- **Capital element of Finance leases and PFI**: Where an asset is financed through PFI or a finance lease, a liability is shown on the Statement of Financial Position. This is the annual repayment of the capital part of that loan which is part of the unitary payment but not recorded as an expense in the statement of Comprehensive Income.
- **Net cash inflow / (outflow) from financing**: reflects the amount of cash received / (paid) as a result of cash transactions that are related to the financing of the Trust. The Department of Health sets a limit on the amount of external finance a trust can obtain. This is known as the External financing Limit (EFL).
Annual governance statement 2012/13

1.0 Scope of responsibility

1.1. As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Oxford University Hospitals NHS 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.

1.2. I am also responsible for ensuring that the Trust is administered prudently and economically, and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum, including recording the stewardship of the organisation to supplement the annual accounts.

2.0 Accountability

2.1. In the delivery of my responsibilities and objectives, I am accountable to the Board and my performance is reviewed regularly and formally by the Chairman on behalf of the Board. Until 31 March 2013, the organisation routinely reported on financial, operational and strategic matters to the Strategic Health Authority (SHA). Meetings were held with senior officers at the SHA and the PCT cluster in relation to performance and the Trust’s trajectory towards achieving foundation trust status during 2013/14. With effect from 1 April, the Trust reports to the Trust Development Authority under the auspices of the Accountability Framework.

3.0 The purpose of the system of internal control and governance framework of the organisation

3.1. 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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford University Hospitals NHS 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.

3.2. The system of internal control has been in place at the Oxford University Hospitals NHS Trust for the year ended 31 March 2013 and up to the date of approval of the Annual Report and Accounts. In July 2012, the Trust Board approved a new Assurance Strategy which established a clear system to enable the Trust Board and senior managers to review the corporate governance, risk management and internal control framework, and address any weaknesses identified. The strategy set out the types, levels and sources of assurance and established how assurance tools, such as the Board Assurance Framework and Internal Audit, individually and collectively assure the Board of the effectiveness of the system of internal control and what is being done to address any weaknesses.

3.3. The system of internal control is underpinned by the existence of a number of individual controls that are in place: senior management/executive review, policies and procedures covering important activities, the Standing Orders, Standing Financial Instructions and Scheme of Delegation, the checks and balances inherent in internal and external audit reviews and Board oversight.

4.0 The governance framework of the organisation

4.1. The Trust Board has overall responsibility for the activity, integrity and strategy of the Trust and is accountable, through its Chairman, to the SHA and the Secretary of State for Health. Its role is largely supervisory and strategic, and it has six key functions:

- to set strategic direction, define objectives and agree plans for the Trust
- to monitor performance and ensure corrective action
- to ensure financial stewardship
- to ensure high standards of corporate and clinical governance
- to appoint, appraise and remunerate executives
- to ensure dialogue with external bodies and the local community

4.2. The Trust Board operates with the support of four committees: Audit, Finance & Performance, Quality and Remunerations & Appointments. These committees have been established on the basis of the following principles:

- the need for committees to strengthen the Trust’s overall governance arrangements and support the Board in the achievement of the Trust’s strategic aims and objectives,
- the requirement for a committee structure that strengthens the Board’s role in strategic decision making and supports the non-executive directors in scrutiny and challenge of executive management actions,
- maximising the value of the input from non-executive directors, given their limited time, and providing clarity around their role, and
- supporting the Board in fulfilling its role, given the nature and magnitude of the Trust’s wider agenda, to support background development work and to perform scrutiny in more detail than is possible at Board meetings.

4.3. In May 2012, the Trust Board approved a proposal to split the functions that had previously been undertaken by the Audit & Finance Committee, leading to the establishment of a dedicated Audit Committee and a new Finance & Performance Committee.

4.4. The Audit Committee exists to oversee the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the Board. The committee reviews the work and findings of External Audit and provides a conduit through which their findings can be considered by the Board. It also reviews the Trust’s annual statutory accounts before they are presented to the Trust Board, ensuring that the significance of figures, notes and important changes are understood. The committee maintains oversight of the Trust’s Counter Fraud arrangements.
4.5. The Finance & Performance Committee’s main responsibilities are to review the Trust’s financial and operational performance against annual plans and budgets, and to provide overview of the development of the Trust’s medium and long term financial models. It also monitors performance of the Trust’s physical estate and non-clinical services. Other responsibilities include reviewing in-year delivery of annual efficiency savings programmes, and monitoring the effectiveness of the Trust’s financial and operational performance reporting systems.

4.6. The Quality Committee is responsible for providing the Board with assurance on all aspects of the quality of clinical care; on governance systems, including the management of risk, for clinical, corporate, HR, Information Governance, Research & Development issues; and on standards of quality and safety. The committee oversees the Trust’s ongoing compliance with Care Quality Commission Essential Standards of Quality & Safety, and the management of risk through the NHS Litigation Authority’s Risk Management Standards. It works closely with the Audit Committee through joint membership and joint management support provided by the Director of Assurance.

4.7. The Remuneration & Appointments Committee is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for termination of contracts. The committee ensures that appropriate performance management arrangements are in place for Executive Directors and work with the Chief Executive to relate performance judgements to pay. In determining remuneration policy and packages, the committee has regard to the Trust’s overarching reward and benefit strategy for all staff, the arrangements in the wider NHS and any relevant guidance from the Treasury.

Record of attendance at committee meetings

4.8. Fig. 10 (top right) shows how many of the core members of each of the Board Committees attended meetings during 2012/13.

4.9. All meetings were quorate during the year.

<table>
<thead>
<tr>
<th>Committee</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Committee</td>
<td>3/3</td>
</tr>
<tr>
<td>Quality Committee</td>
<td>10/11</td>
</tr>
<tr>
<td>Finance &amp; Performance Committee</td>
<td>7/9</td>
</tr>
<tr>
<td>Remuneration and Appointments Committee</td>
<td>6/7</td>
</tr>
</tbody>
</table>

*Deputies were nominated to attend on behalf of both Executive and Non Executive members.

4.10. Following the creation of the Finance & Performance Committee, the Trust undertook a review of the Board and its sub-committees. This confirmed changes to the Audit and Quality Committees’ terms of reference.

4.11. The chairs of each of the sub-committees routinely present written and verbal reports to the Board, highlighting key issues and decisions at their meetings. Approved minutes of each sub-committee meeting are also presented at public Board meetings. During the course of the year, the Audit Committee commenced a programme of risk “deep dives”, consisting of an in-depth review of a selection of the Trust’s principal risks, their key controls, and the whether the Board could be assured of the effectiveness of those controls.

4.12. The Board met a total of seven times in public in 2012/13: May, July, September, November 2012, and January, February and March 2013. Attendance was monitored throughout the year, and there was only one authorised absence by a non-executive director during the period.

4.13. As part of its Foundation Trust application, the Trust completed a Board Governance Memorandum for submission to the Strategic Health Authority in July 2012. This assessment highlighted outcomes of an evaluation of the Board’s effectiveness, and referred to the Board’s development programme, which had been informed in the main by these outcomes. In September 2012, a 360 degree assessment process was introduced to enable staff, commissioners and other key stakeholders to participate in evaluations of the Board.

4.14. In September 2012, all Board members signed a declaration of compliance with the NHS Codes of Conduct, Accountability and Openness, and the Trust has not reported any breach of these Codes. The Trust’s Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions were updated in January 2013 to take account of changes to the Trust’s governance arrangements and legislation. The Standing Orders were adhered to over the course of the year and no suspensions were recorded.

4.15. The Board’s Register of Interests was updated throughout the year, and it was formally received at the Trust Board meeting in September 2012. The Register of Gifts, Hospitality, Consultancies, Sponsorship and support for travel education and training covering Board members and Divisional Directors was presented to the Board in November 2012.

4.16. In December 2012, the Trust’s Local Counter Fraud Specialists undertook a Bribery Act Risk Assessment. The Trust was found to be meeting the requirements of the Act, but it was recommended that requirement to declare interests be extended to wider groups of staff. This recommendation has been implemented.

5.0 Capacity to handle risk

5.1. The Trust implemented a revised Risk Management Strategy in September 2012 which sets out the Trust’s philosophy for the management of risk and individual responsibilities and accountabilities in this regard. Operationally, responsibility for the implementation of risk management has been delegated to Executive Directors as follows:
6.0 Risk Assessment

6.1. The Risk Management Strategy sets out an integrated approach to the management of risk across the organisation. The aim is to encourage considered risk taking, including experimentation and innovation within authorised limits, but to reduce those risks that impact on patient and staff safety, and have an adverse effect on the Trust’s reputation as well as its financial and operational performance.

6.2. The Risk Management Strategy also defines how risks are linked to one or more of the Trust’s strategic or operational objectives. Once the risk has been identified, it is then described, and it is assigned an owner. At this stage, key controls that are to be taken to reduce the likelihood of the risk happening, or reducing its impact, are identified. If it has been identified as a severe risk, a contingency action plan would be considered.

6.3. The Trust’s risk assessment process covers all of its activities – clinical services, clinical support services and business support functions. Each Division and Directorate is responsible for maintaining its own detailed risk register in accordance with the procedures described in the Risk Management Strategy. These risk registers are reviewed regularly by directorate and divisional forums, and risks are escalated, where their ratings warrant this, for inclusion on the Corporate Risk Register.

6.4. As part of its immediate response to the recommendations from the final report of the Mid-Staffordshire NHS Foundation Trust Inquiry, the Trust undertook a series of briefings, providing all staff with an opportunity to comment on what it meant for their practice. A summary of the feedback from these sessions was presented to the Trust Board in March 2013, and a process has been implemented by which concerns about the quality of services can be conveyed directly for discussion at Board meetings.

6.5. The Board Assurance Framework provides the mechanism for the Board to monitor risks, controls, and the outputs of its assurances processes. It is monitored regularly by the Trust Management Executive, the Audit, Finance and Performance and Quality Committees and the Trust Board, and it is used as a strategic tool to provide assurance that controls are in place and effective.

6.6. In March 2013, the Trust’s Bed and Mattress Task Group identified a number of risks in relation to the replacement, disposal and maintenance of static foam mattresses, the change in regulations to do with bed frames, and the suitability of the Trust’s current bed stores and repair sites. The ratings of these risks were such that they were escalated to the Corporate Risk Register; and dedicated projects have been set up to address them.

6.7. As part of its immediate response to the recommendations from the final report of the Mid-Staffordshire NHS Foundation Trust Inquiry, the Trust undertook a series of briefings, providing all staff with an opportunity to comment on what it meant for their practice. A summary of the feedback from these sessions was presented to the Trust Board in March 2013, and a process has been implemented by which concerns about the quality of services can be conveyed directly for discussion at Board meetings.

6.8. Throughout the year, the Trust has monitored its compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 against the 16 Care Quality Commission (CQC) Essential Standards of quality and safety. The Quality and Risk Profile tool, which aggregates a wide range of information on each provider of health and social care registered with the CQC, indicated an overall improvement in the Trust’s compliance during the year; and no areas of serious concern. Regular updates on the risk estimates reported within the tool, and the drivers behind any changes, are provided to the Quality Committee.

6.9. In October 2012, the CQC carried out an inspection at the Horton General Hospital as part of its routine schedule of planned reviews. Compliance against 5 of the essential standards was tested and the hospital was found to be meeting all the standards. Identified areas for improvement have been addressed. In February 2013, a further routine inspection was carried out at the John Radcliffe Hospital. This covered 4 of the essential standards including cleanliness and the care and welfare of patients. Again, the Trust was found to be compliant in respect of the requirements of the standards.

6.10. All new staff are provided with Information Governance (IG) training at corporate induction. This includes an outline of the relevant legal position, NHS guidance and the Trust’s policies relating to the safe and appropriate processing of data.

6.11. Additionally, in line with the requirements of the IG toolkit, all existing staff are required to undergo IG training on an annual basis. This is carried out mainly via a series of e-learning modules on the Department of Health’s Connecting for Health E-Learning portal. As at March 2013, 76% of staff had completed this training. This was an improvement on 2011/12, but was short of the 95% target set out within the toolkit.
6.12. Data security incidents are reported via the Trust's incident reporting system. Incidents are reviewed by the Information Governance Group, which is chaired by the Trust's Caldicott Guardian. Where an ongoing information risk is identified, this is recorded on the Corporate Risk Register; along with a note of actions to be taken to minimise the chances of occurrence and impact.

6.13. In December 2012, a list containing names and limited clinical details of 23 Trust patients was found on a bus and subsequently reported to the BBC by the person who had found it. An internal investigation was conducted and the matter reported to the Information Commissioner's Office (ICO). The guidance around the use and management of paper-based patient lists has been tightened, and revisions made to the Information Protection Policy. A number of other less serious information security-related incidents were reported during the year but none of them required referral to the ICO.

6.14. In January 2013, as part of the 2012/13 plan, internal audit conducted a review of the Trust's IG Toolkit self-assessment. The Trust had determined that it would achieve an overall Level 2 rating by March 2013, but the audit reflected an overall conclusion of limited assurance and therefore did not support the self-assessment. A number of medium and low risk recommendations were made with a view to developing the self-assessment.

7.0 The risk and control framework

7.1. Risk management is embedded within the organisation in a variety of ways. All staff have a duty to report on incidents, hazards, complaints and near misses in accordance with the relevant policies. From 1 June 2012, responsibility for collating and benchmarking the number of incidents reported by all Trusts passed from the National Patient Safety Agency to the NHS Commissioning Board, who provide information on how incident reporting rates at this Trust compare to others. During the course of the year, the Trust introduced the Datix web-based incident reporting system, providing staff with a simpler method for reporting incidents in real time. This has led to a rise in the number of incidents reported, providing all staff with more learning opportunities.

7.2. The Trust has retained its Level 1 accreditation status against the NHS Litigation Authority Risk Management Standards for Trusts. Risk processes are monitored and reviewed by the Clinical Governance Committee, which is a sub-committee of the Trust Management Executive, and the Quality and Audit Committees.

7.3. 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.

7.4. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are met with updated objectives forming part of the Trust’s Equality Delivery Scheme for 2012/16.

7.5. Control measures are in place to ensure that patients, the public and staff with physical and sensory impairments are able to access buildings on all the Trust's sites. All new estates schemes, as well as refurbishments or ad hoc improvements, are assessed to ensure that they meet the requirements of the Disability Discrimination Act. Issues identified through patient feedback, complaints or PALS contacts are used to inform priorities for estates improvements.

7.6. The Trust has reviewed and continues to monitor the systems in place to care for people with learning disabilities. One of the requirements of Monitor’s Compliance Framework is that Trusts are compliant with the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008). Initially, the Trust had self-assessed itself as amber, but by the end of March 2013, it had taken a number of actions and was able to re-assess itself as fully compliant.

7.7. The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projections, to ensure that this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

8.1. The Trust has well developed systems and processes for managing its resources. The annual budget setting process for 2012/13 was approved by the Board before the start of the financial year and was communicated to all managers in the organisation. The Director of Finance and Procurement and his team have worked closely with divisional and corporate managers throughout the year to ensure that a robust annual budget was prepared and delivered. In 2013/14, the Trust achieved 90% of its agreed Cost Improvement Programme target, and it generated its planned surplus for the year.

8.2. Monthly financial and operational performance reports are presented to the Finance & Performance Committee, the Trust Management Executive and to the Board. The Trust makes use of both internal and external audit functions to ensure that controls are operating effectively and to advise on areas for improvement. In addition to financially related audits, the internal audit programme covers governance and risk issues. Individual recommendations and overall conclusions are risk assessed, such that action plan priorities are agreed with Trust management for implementation. All action plans are monitored and implementation is reviewed regularly and reported to the Audit Committee as appropriate.

8.3. As part of their annual audit, the Trust’s external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They do this by examining documentary evidence and through discussions with senior managers. The audit working papers in relation to this work are made available to the Trust and presented to the Audit Committee.
9.0 Annual Quality Report

9.1. The Trust Board is required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare a Quality Account for each financial year. Guidance has been issued to Trusts on the form and content of the annual Quality Account which incorporates the above legal requirements and requisite external assurance arrangements.

9.2. The Medical Director leads on the quality account, and for 2012/13, the decision was made to align the Trust’s Quality Account priorities with four of the Commissioning for Quality and Innovation (CQUIN) schemes. These priorities were agreed between the Trust and its commissioners. For the future, the Trust will work closely with commissioners and other stakeholders to ensure that such priorities are in line with the Quality Strategy. A public engagement event was held in March 2013, during which local people worked with trust staff to agree the organisations quality priorities for the coming year. This feedback was combined with guidance contained within the NHS Outcomes Framework as well as nationally and locally mandated CQUINs to arrive at a list of priorities subsequently agreed by the Trust Board. These include reducing preventable harm and providing safer care during surgery.

9.3. In terms of monitoring, regular updates of the Trust’s progress against its Quality Account priorities and the CQUIN payment framework programme are provided both to the Quality Committee and the Trust Board.

10.0 Review of effectiveness of risk management and internal control

10.1. As accountable officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed by the work of the internal auditors, clinical audit and the Executive and Divisional Directors within the Trust that have responsibility for the development and maintenance of the internal control framework. I have also relied on the content of the Quality Account accompanying this Annual Report and other available performance information. This review is also informed by comments made by the external auditors in their management letter; the Head of Internal Audit Opinion and other reports.

10.2. 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, the Finance & Performance Committee and the Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

10.3. The effectiveness of the system of internal control has been reviewed by the Trust Board via its sub-committees and individual management responsibilities at Executive and Divisional Director level. I am satisfied that this Annual Governance Statement describes a system and approach which remained robust for the period from 1 April 2012 to 31 March 2013 and supports preparation of the annual accounts on a going concern basis.

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

11.0 Significant issues

11.1. As identified through the Trust’s risk management processes, the significant issues to report and corresponding actions taken to address key risk issues are outlined below:

11.2. The Trust continues to work with colleagues across the local health and social care network to reduce the high number of patients whose discharge from hospital is delayed, and to improve performance against thresholds. Detailed workstreams addressing the various aspects of this issue are being implemented, and the Trust, with its partners, are on track to achieve reductions in the numbers of delays.

11.3. The Trust reported 3 Never Events during 2012/13. All were avoidable incidents of swabs being retained within patients’ bodies following surgery, and although none of the patients involved suffered harm, it was evident that all the cases related to failures to follow established systems and processes. A number of actions were taken following the events, including sessions arranged to remind all surgical staff of the requirements of the WHO Surgical Checklist, and putting in place systems to ensure that these are consistently followed.

11.4. Two surgical site infection deaths were reported in September and October 2012 following cardiac surgery. Both deaths were investigated as Serious Incidents Requiring Investigation (SIRI), and it was concluded that both infections had been hospital acquired. A retrospective audit covering the period from July 2010 to August 2012 was carried out, as a result of which the requirement to undertake surgical site surveillance as recommended by NICE guidance was reiterated, and Trust guidelines for the prevention of such infections were updated.

11.5. In January 2013, as a result of a shortage of sufficiently skilled clinical staff to enable safe delivery of the service, the Trust decided to suspend, with immediate effect, the performance of emergency abdominal surgery at the Horton General Hospital. Revised arrangements for patients to be treated at the John Radcliffe Hospital remain in place.

12.0 Conclusion

12.1. With the exception of the internal control issues that I have outlined in this statement, my review confirms that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Signed .........................................................

Sir Jonathan Michael
Chief Executive
Date: 6 June 2013
Glossary of NHS terms and abbreviations

Academic Health Science Centre / Network (AHSC / AHSN)
Academic Health Science Centres (AHSC) or Academic Health Science Networks (AHSN) are partnerships between one or more universities and healthcare providers focusing on research, clinical services, education and training. AHSCs are intended to ensure that medical research breakthroughs lead to direct clinical benefits for patients.

Acute services
Medical and surgical interventions provided in hospitals.

Acute trust
A legal entity / organisation formed to provide health services in a secondary care setting, usually a hospital.

Annual Governance Statement
This has replaced the Statement of Internal Control (SIC) and is the mechanism by which the NHS Trust’s Accountable officer (in our case the Chief Executive) provides assurance about the stewardship of the organisation to the NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health.

The governance statement records the stewardship of the organisation to supplement the accounts. It will give a sense of how successfully it has coped with the challenges it faces and of how vulnerable the organisation’s performance is or might be. This statement will draw together position statements and evidence on governance, risk management and control, to provide a more coherent and consistent reporting mechanism.

Assurance Framework
The Assurance Framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the Annual Governance Statement.

Audit Commission
They are an independent public body responsible for ensuring that public money is spent economically, efficiently, and effectively in the areas of local government, housing, health, criminal justice and fire and rescue services. They appoint the External Auditors for NHS Trusts.

Better Payment Practice Code
The Better Payment Practice Code requires the Trust to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Break-even (duty)
A financial target. In its simplest form it requires the Trust to match income and expenditure.

Capital
Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if its costs exceed £5000 and it’s useful life expectancy is greater than one year.

Capital Absorption Rate
The Capital Absorption rate is determined by dividing the PDC dividend (from the Statement of Comprehensive Income) by the average net relevant assets (owned assets of the trust at the beginning and end of the year less current liabilities & cash). The trust achieves the target if it achieves a rate of return of 3.5 per cent.

Capital Resource Limit (CRL)
NHS Trusts are given a Capital Resource Limit (CRL) each year. They must not make capital expenditure in excess of this limit.

Care Quality Commission (CQC)
The Care Quality Commission was set up in April 2009 and it replaced the Healthcare Commission. It is an independent regulator to help improve the quality of healthcare. It does this by providing an independent assessment of the standards of services, whether provided by the NHS, the private sector or voluntary organisations.

Clinical Commissioning Groups (CCGs)
Clinical commissioning groups are groups of GPs that from April 2013 are responsible for designing local health services in England. They will do this by commissioning or buying health and care services working with patients and healthcare professionals and in partnership with local communities and local authorities. On their governing body, Groups will have, in addition to GPs, a least one registered nurse and a doctor who is a secondary care specialist. Groups will have boundaries that will not normally cross those of local authorities. All GP practices will have to belong to a Clinical Commissioning Group.

Clostridium difficile (C.difficile)
Clostridium difficile is a bacterium that can cause an infection of the gut and is the major infectious cause of diarrhoea that is acquired in hospitals in the UK.

Current assets
Debtors, stocks, cash or similar whose value is, or can be converted into, cash within the next 12 months.

Depreciation
The measure of the wearing out, consumption or other loss of value of a fixed asset whether arising from use, passage of time or obsolescence through technology and market changes. The process of charging the cost of an asset over its useful life as opposed to recording its cost as a single entry in the income & expenditure records.

Elective inpatient activity
Elective activity is where the decision to admit to hospital could be separated in time from the actual admission, i.e. planned. This covers waiting list, booked and planned admissions.

Electronic Patient Record (EPR)
A new system of recording patient notes on computer rather than paper.

Emergency inpatient activity
Emergency activity is where admission is unpredictable and at short notice because of clinical need.

External Financing Limit (EFL)
NHS trusts are subject to public expenditure controls on their use of cash. The control is an external financing limit (EFL) issued to each NHS trust by the Department of Health. The EFL represents the difference between the cash resources a trust can generate internally (principally retained surpluses and depreciation) and its approved capital spending. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference.

Fixed assets
Land, buildings, equipment and other long term assets that are expected to have a life of more than one year.

Foundation Trust (FT)
NHS Foundation Trusts have been created to devolve decision-making from central Government control to local organizations and communities so they are more responsive to the needs and wishes of their local people. Foundation Trusts have a membership drawn from the community which they serve and an elected Governors’ Council. They also enjoy some financial freedoms not available to NHS Trusts.
Health Innovation and Education Cluster
A local partnership hosted by Oxford Health NHS Foundation Trust.

Health Overview and Scrutiny Committee (HOSC)
An Oxfordshire County Council committee; the NHS is obliged to consult HOSC on any substantial changes it wants to make to local health services.

Inpatient
A patient whose care involves an overnight stay in hospital.

International Financial Reporting Interpretations Committee (IFRIC) 12
The International Financial Reporting Interpretations Committee issued an interpretation – IFRIC 12 – on Service Concession Arrangements. These are arrangements whereby a government (or the NHS) grants a contract for the supply of public services to private operators. Hence for the Trust, the PFI is an example of a scheme that is subject to IFRIC 12.

International Financial Reporting Standards (IFRS)
The International Financial Reporting Standards provide a framework of accounting policies which the NHS has adopted since April 2009 and which replace the UK Generally Accepted Accounting Practice (UK GAAP) which was the basis of accounting in the UK before international standards were adopted.

Investors in People
The Investors in People Standard provides a framework that helps organizations to improve performance and realize objectives through the effective management and development of their people.

Local Involvement Networks (LINks)
Oxfordshire LINks is made up of individuals and community groups who care about our health and social care services and work together to improve them.

Market Forces Factor
An index used in resource allocation to adjust for unavoidable variation in input costs. It consists of components to take account of staff costs, regional weighting, land, buildings and equipment.

Methicillin resistant staphylococcus aureus (MRSA)
This is a strain of a common bacterium, which is resistant to an antibiotic called methicillin.

Monitor
Monitor authorises and regulates NHS foundation trusts, making sure they are well-managed and financially strong so that they can deliver excellent healthcare for patients. It was established in 2004.

National Institute for Health and Clinical Excellence (NICE)
A body which evaluates drugs and treatments. NICE’s role was set out in the 2004 White Paper ‘Choosing health: making healthier choices easier’. In it the government set out key principles for helping people make healthier and more informed choices about their health. The government wants NICE to bring together knowledge and experience on ways of promoting good health and treating ill health.

National Institute for Health Research (NIHR)
NIHR provides the framework through which the research staff and research infrastructure of the NHS in England is positioned, maintained and managed as a national research facility.

National Service Frameworks
National standards for the best way of providing particular services.

NHS England (NHSCB)
The NHS England (formally the NHS Commissioning Board) is the body which oversees the day-to-day operation of the NHS from April 2013 as set out in the Health and Social Care Act 2012. It oversees the Clinical Commissioning Groups and commissions certain specialist services directly.

NHS Trust Development Agency (NHSTDA)
From April 2013, the role of the NHS Trust Development Authority (NHS TDA) is to provide governance and accountability for NHS trusts in England and delivery of the foundation trust pipeline. The NHS TDA will help each NHS trust secure sustainable, high quality services for the patients and communities they serve.

NHS Trusts
NHS Trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as commissioned by PCTs.

Non-executive Directors
Non-executive directors, including the Chairman, are Trust Board members but they are not full-time NHS employees. They are people from other backgrounds who have shown a keen interest in helping to improve the health of local people. They have a majority on the Board and their role is to bring a range of varied perspectives and experiences to strategy development and decision-making, ensure effective management arrangements and an effective management team is in place and hold the executive directors to account for organizational performance.

Outpatient attendance
An outpatient attendance is when a patient visits a consultant or other medical outpatient clinic. The attendance can be a ‘first’ or ‘follow up’.

Oxford Biomedical Research Centre (OxBRC)
A partnership between the University of Oxford and the Oxford University Hospitals funded by the National Institute for Health Research.

Patient Advice and Liaison Service (PALS)
A service providing support to patients, carers and relatives.

Private Finance Initiative (PFI)
The Private Finance Initiative (PFI) provides a way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases, manage new projects.

Primary care
Family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners.

Prudential Borrowing Code (PBC)
This is the code provided by Monitor to determine the limit on the total amount of borrowing of an NHSTDA and the same principles are applied by the Department of Health to NHS trusts.
Prudential Borrowing Limit (PBL)
This is the maximum cumulative borrowing a trust may have outstanding at any time and is set based on prudential borrowing code.

Risk Register
A register of all the risks identified by the organization, each of which is assessed to determine the likelihood of the risk occurring and the impact on the organization if it does occur.

Secondary Care
Services provided by medical specialists. Usually they do not have first contact with patients. Secondary care is mostly provided in hospitals or clinics and patients are generally referred to secondary care by their primary care provider (usually their GP).

Service Level Agreements
A Service Level Agreements (SLA) is the main mechanism for service provision between NHS Trusts and the commissioners (CCG’s and NHS Commissioning Board) for NHS services. An SLA is an agreement that sets out formally the relationship between service providers and customers for the supply of a service by one or another.

Thames Valley Local Education & Training Board (Thames Valley LETB)
From 1 April 2013 Local Education and Training Boards (LETBs) will take on responsibility for workforce planning and development and education and training of the healthcare and Public Health workforce.
Useful websites

For further information on all our services please visit www.ouh.nhs.uk or follow developments at Oxford University Hospitals Trust on Twitter: http://twitter.com/OxfordUniversityHospitals

Other useful websites

AirMed (air ambulances) www.airmed.co.uk
Audit Commission www.audit-commission.gov.uk
Care Quality Commission www.cqc.org.uk
Cherwell District Council www.cherwell.gov.uk
Department of Health www.gov.uk/dh
Foundation Trust Network www.foundationtrustnetwork.org
General Medical Council (GMC) www.gmc-uk.org
Health and Social Care Information Centre www.hscic.gov.uk
Health Education England www.hee.nhs.uk
Medical Sciences at Oxford University www.medsci.ox.ac.uk
Monitor www.monitor-nhsft.gov.uk
National Institute for Health and Clinical Excellence (NICE) www.nice.org.uk
National Institute for Health Research www.nihr.ac.uk
NHS Choices www.nhs.uk
NHS Confederation www.nhsconfed.org
NHS Direct www.nhsdirect.nhs.uk
NHS England www.england.nhs.uk
NHS Health at Work -- occupational health provider www.nhshealthatwork.co.uk
NHS Improving Quality www.england.nhs.uk/ourwork/qual-clin-lead/nhsiq
NHS Protect -- Counter Fraud and Security Services www.nhsbapublishing.nhs.uk/protect
NHS Trust Development Authority www.ntda.nhs.uk

Oxford Academic Health Science network www.Oxfordahsn.org
Oxford Biomedical Research Centre www.oxfordbrc.org
Oxford Brookes Faculty of Health and Life Sciences www.hls.brookes.ac.uk
Oxford Brookes University www.brookes.ac.uk
Oxford City Council www.oxford.gov.uk
Oxford Health NHS Foundation Trust www.oxfordhealth.nhs.uk
Oxfordshire Clinical Commissioning Group www.Oxfordshireccg.nhs.uk
Oxfordshire County Council www.oxfordshire.gov.uk
Oxfordshire Link www.oxfordshirelink.org.uk
Patients Association www.patients-association.com
Patient Safety Federation www.patientsafetyfederation.nhs.uk
Royal College of Midwives www.rcm.org.uk
Royal College of Nurses www.rcn.org.uk
Royal College of Pathologists www.rcpath.org
Royal College of Paediatrics and Child Health www.rcpch.ac.uk
Royal College of Physicians www.rcplondon.ac.uk
Royal College of Surgeons www.rcseng.ac.uk
South Oxfordshire District Council www.southoxon.gov.uk
Southern Health www.southernhealth.nhs.uk
Thames Valley Health Innovation & Education Cluster www.tvhiec.org.uk
Thames Valley Local Education and Training Board www.workforce.southcentral.nhs.uk/thames_valley_letb.aspx
University of Oxford www.ox.ac.uk
Vale of White Horse District Council www.whitehorse.gov.uk
West Oxfordshire District Council www.westoxon.gov.uk
Every year we produce an Annual Report, which summarises what we have done over the year and includes our accounts.

We publish it on our website and make some printer versions available, on request.

We also produce a CD of all key documents, including the full accounts.

We aim to ensure that the Report is accessible and we can arrange to have it translated into different languages, and produced in large print if required.

We are keen to have more feedback on both the content and format of the Report, so that we can take your comments into account next year.

To make a comment, please use the following contact information:

Email us:
media.office@ouh.nhs.uk

Write to us:
Media and Communications Unit, Level 3, John Radcliffe Hospital, Headley Way Headington, Oxford OX3 9DU

See our website:
www.ouh.nhs.uk
Four hospitals, one Trust, one vision