This report describes how the Oxford University Hospitals NHS 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 our Quality Account, a report to outline our activities and priorities to improve quality of care and outcomes for patients who use our services.

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Message from the Chairman and Chief Executive

In last year’s annual report we told you of our plans and ambition to become a Foundation Trust. We have made considerable progress on that front but, along with a number of other Trusts, our application was temporarily delayed due to major changes in the way NHS organisations are monitored and assessed. As an aspirant Foundation Trust we underwent a detailed inspection by the Care Quality Commission in February 2014 resulting in an overall rating of ‘good’ for the Trust. Our updated Foundation Trust application will next be formally considered by the Trust Development Authority and by Monitor, the Parliamentary Regulator of NHS Foundation Trusts, and we hope to achieve authorisation in the first half of 2015.

The CQC undertook a comprehensive and thorough review of the way we conduct ourselves, the way we communicate with patients and their families and the way we treat hundreds of thousands of patients each year. A team of 51 inspectors visited all four hospital sites for two days, followed by unannounced spot checks in the first week of March, 2014.

We are extremely pleased with the rating of ‘good’ for the Trust and a rating of ‘good’ across all five of the standards or ‘domains’ upon which the CQC judges the services and care that we provide for patients. The detailed inspection report offers a clear endorsement of the hard work of our 11,500 staff on a daily basis to make sure we provide compassionate and excellent care for our patients, the kind of care we would want for our friends and families. We are particularly pleased that the inspectors observed caring and compassionate staff throughout the four hospitals and noted that they worked well between teams and valued the benefits of working across different disciplines. You can read more about the detail of the report on page 34.
Our aim is to provide high quality care consistently for our patients...

Our overall vision remains the same; to be amongst the best providers of quality healthcare in the NHS through releasing the skills, talents and knowledge of our staff and those of our teaching and research partners. Our ambition is to continue to be financially viable and well governed so that we can provide high quality care consistently for our patients both locally and nationally irrespective of age, disability, religion, race, gender and sexual orientation, ensuring that our services are accessible to all and tailored to the individual.

Although the year presented a number of regulatory and financial challenges for the Trust there was much to celebrate as well. We continue to recruit excellent and committed staff who, in a recent survey, gave an overwhelmingly positive response when asked if they would recommend the Trust as a place to work or receive treatment. We continue to be impressed by our workforce, many of whom go beyond the call of duty and run marathons, abseil down buildings and raise money for great causes in their spare time. Those who stand out among their peers as providing exceptionally good care for patients were recognised at our annual staff recognition awards ceremony in November. Hundreds of nominations were received and, for the first time, there was an additional category of ‘Hospital Heroes’ — individuals and teams nominated by the public, and sponsored by the Oxford Mail.

The Trust has been recognised for its health and academic partnership working by being designated by the Department of Health as one of only six Academic Health Science Centres. This acknowledges our formal collaboration with Oxford Brookes University, the University of Oxford, and Oxford Health NHS Foundation Trust, which draws on our world-class research and health education to improve patient care and healthcare delivery.

An increasing older population and the rise of chronic disease is forcing all healthcare providers to think about delivering services in a more flexible, cost effective and innovative way. We have secured a grant of £600,000 to provide mobile computers for nurses and midwives. This allows us to buy computers on wheels, tablets, and wall-mounted computers in drug dispensing rooms to assist pharmacy prescribing and replace paper-based systems to cut drug errors and make patient care safer.

Putting even more comfort and convenience into consideration of service around service delivery is demonstrated by a new facility for transplant patients at the Churchill Hospital’s Haematology Ward. The Ambulatory Care Project provides outpatient rather than inpatient care, enabling patients to go home more quickly following transplant. It allows ‘relatively well’ patients the chance to remain at home for the first part of their treatment, for which historically they would have been admitted. The aim is to encourage a better dietary intake and an improved psychological state, which should speed up recovery following bone marrow transplant.

Our five year integrated business plan has been revised recently as we prepare to become a Foundation Trust. It helps us to stay focused on what we need to deliver for our patients in an increasingly challenging financial climate and at a time when the NHS is under considerable scrutiny. It acts as our strategy in setting ambitious targets and a framework of improvement to ensure that we are financially viable and well governed in the future so we can continue to provide high quality care for our patients.

Dame Fiona Caldicott
Chairman

Sir Jonathan Michael
Chief Executive
About us

**Our ambition** is to listen to our patients and members, build on our strong academic partnerships, combining our talents and expertise to enhance our ability to become a successful Foundation Trust.

The Oxford University Hospitals NHS Trust (OUH) is one of the largest NHS teaching trusts in the UK, employing over 11,500 staff across four hospital sites: the John Radcliffe Hospital, the Churchill Hospital and the Nuffield Orthopaedic Centre are all located in Oxford, and the Horton General Hospital is in the north of Oxfordshire in Banbury.

We have around one million patient contacts each year and, in addition to providing general hospital services, we draw 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. These include outpatient peripheral clinics in community settings and satellite services in a number of surrounding hospitals such as:**

- A satellite children’s surgical centre at Milton Keynes General Hospital
- A specialist radiotherapy clinic at the Great Western Hospital in Swindon
- Renal dialysis units at Stoke Mandeville Hospital and at the Great Western Hospital in Swindon

The Trust delivers services from community hospitals in Oxfordshire, including midwifery-led units. It is also responsible for a number of screening programmes, including those for bowel cancer, breast cancer, diabetic retinopathy, cervical cancer and Chlamydia.

**During 2013/14 we provided:**

- 1 million patient contacts
- 108,000 planned admissions
- 90,000 emergency admission
- 130,000 emergency department attendances
- 1.4 million meals for patients

**The Trust has:**

- 1,300 beds, including 100 for children
- 67 wards
- 44 operating theatres
- 11,598 staff
- 3,600 nurses
- 1,800 doctors
- 1,300 healthcare support workers

- Our turnover in 2013/14 was £868 million
- In May 2014 we received CQC ‘good’ rating
Our clinical services

We offer a wide range of local and specialist services, including:

- Accident and Emergency
- Trauma and Orthopaedic Services
- General Surgery
- Cardiac Services
- Critical Care
- Maternity, Obstetrics and Gynaecology
- Renal and Transplant Services
- Neurosurgery and Maxillofacial Surgery
- Infectious Diseases and Blood Disorders
- Cancer Services
- General Surgery
- Renal and Transplant Services
- Neurosurgery and Maxillofacial Surgery
- Critical Care
- Infectious Diseases and Blood Disorders
- Cancer Services
- General Surgery
- Renal and Transplant Services
- Neurosurgery and Maxillofacial Surgery

Financial performance overview

The Trust has an integrated business plan which sets out the Trust's business strategy for the future. Like 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 over the coming years.

In the last financial year (to March 2014), we successfully delivered a challenging savings plan and achieved savings of £42.7m and a surplus of 1.25% of turnover of £868m. 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 this financial year, the challenge is just as great with a further £46m worth of savings to be made.

Over the next five years we plan to make savings averaging £38.9m per annum (in nominal terms). This represents an average annual saving over these five years (2015/16 to 2019/20) of 4.3% each year.

As we prepare to operate as a Foundation Trust we are working 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

Number of patients seen

<table>
<thead>
<tr>
<th>FINANCIAL YEAR</th>
<th>Emergency inpatient admissions</th>
<th>Elective inpatient admissions</th>
<th>Daycase admissions</th>
<th>Outpatient attendances</th>
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<tbody>
<tr>
<td>2010/11</td>
<td>80,163</td>
<td>20,188</td>
<td>68,265</td>
<td>805,895</td>
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<tr>
<td>2011/12</td>
<td>83,778</td>
<td>19,477</td>
<td>73,266</td>
<td>825,958</td>
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<tr>
<td>2012/13</td>
<td>88,316</td>
<td>22,312</td>
<td>75,959</td>
<td>835,448</td>
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<tr>
<td>2013/14</td>
<td>87,741</td>
<td>24,015</td>
<td>84,533</td>
<td>906,513</td>
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</table>
Our Hospitals

The John Radcliffe Hospital in Oxford is the largest of the Trust’s hospitals. It is the site of the county’s main accident and emergency service, the Major Trauma Centre for the Thames Valley region, and 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, is a major centre for healthcare research, and hosts 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 has been treating patients with bone and joint problems for more than 80 years and has a world-wide 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 for 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 National Institute for Health Research’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 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 healthcare market

The Trust’s hospitals in Oxford serve an 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 the 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 with a 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 2014:

- **37.6%** of the Trust’s income for the delivery of patient services comes from the Oxfordshire Clinical Commissioning Group.
- **47.7%** of income comes from specialist commissioners
- **14.7%** comes from other commissioners outside Oxfordshire.

<table>
<thead>
<tr>
<th>COMMISSIONER</th>
<th>Service Level Agreement income (£ million)</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS England (Wessex Area Team)</td>
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<td>46.2</td>
</tr>
<tr>
<td>Oxfordshire Clinical Commissioning Group (CCG)</td>
<td>263.4</td>
<td>37.6</td>
</tr>
<tr>
<td>Buckinghamshire CCGs (Aylesbury Vale and Chiltern)</td>
<td>16.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Northamptonshire CCGs (Nene and Corby)</td>
<td>14.8</td>
<td>2.1</td>
</tr>
<tr>
<td>NHS England (Thames Valley Area Team)</td>
<td>10.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Other NHS Commissioners (&lt;1% share)</td>
<td>71.8</td>
<td>10.3</td>
</tr>
</tbody>
</table>
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 2013/14, NHS England’s Wessex Area Team, which commissions specialist services from NHS providers, accounted for over 46% of the Trust’s specialist income amounting to around £327m annually. A separate agreement for 2013/14 with the Thames Valley Area Team amounted to £10.6m to cover dentistry, offender health services and some screening services.

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 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 the Oxford University Hospitals are:

- Cancer
- Cardiovascular (including cardiac surgery, cardiology, vascular and stroke services)
- Critical care
- Maternity
- Neonatal
- Pathology
- Renal
- Trauma
The year following April 2013 brought changes to the structure of the NHS in England. We have worked closely with the GP-led Oxfordshire Clinical Commissioning Group (OCCG), and with the local authority-led Health and Wellbeing Boards, which were introduced to understand local community needs and priorities and to help health and social care services to work in a more joined-up way.

Clinical commissioning groups (made up of doctors, nurses and other professionals) buy health services for patients, while local councils are responsible for promoting public health, reducing health inequalities and ensuring social care needs are met. The aim is for Health and Wellbeing Boards to bring together local organisations to work in partnership and support greater integration of services.

We have productive relationships with our local community health and social care partners and we work together to deliver solutions to improve patient care across organisational boundaries.

Providing better pathways of care through partnership working

Integration of care – as an acute healthcare provider, we are experiencing a greater demand from an ageing population with increasingly complex health and social care needs. We are working with GPs, health and social care colleagues and the voluntary sector to develop integrated pathways of care that meet the needs of patients in a more holistic and joined-up manner.

Better support for frail, elderly patients – our joint aim is to improve integration of care and a reduction in delayed transfers of care – ensuring our patients are able to go home or move on to the next stage of their care in the community.

A range of initiatives have been introduced to provide care closer to home for elderly patients and those with long-term conditions and to help them leave hospital sooner. Examples include:

- the establishment of a joint health and social care team to speed up decisions about patient discharge to enable patients to either go home sooner or on to the next stage of their care in the community,
- developing the Supported Hospital Discharge Service and becoming an authorised provider of domiciliary care in Oxfordshire to support patients in their own homes in the first two weeks after discharge while appropriate social care packages are put in place,
- the provision of stroke rehabilitation services in Abingdon and Witney,
- Emergency Multi-disciplinary Units (EMUs) – in partnership with local GPs and Oxford Health NHS Foundation Trust we have jointly created Emergency Multi-disciplinary Units in Abingdon and Witney with a further unit planned for Banbury at the Horton General Hospital (see page 9).

As a large tertiary acute centre, the Trust provides specialist treatment for patients from a wide geographical area. We are designated as regional centres for major trauma, vascular surgery, and critical care for newborn babies. We also have multi-disciplinary teams working jointly with teams at Southampton General Hospital as part of the South of England Children’s Services Network. This involves senior clinicians and surgeons from both Trusts working together to deliver specialist children’s heart services to patients from across the region.

The development of specialist clinical network collaborations – we participate in collaborative networks to help reduce fragmentation of care and ensure better outcomes for patients by providing seamless access to regional and specialist healthcare when needed. Our collaborations include:

- Burns treatment with Stoke Mandeville Hospital, of Buckinghamshire Healthcare NHS Trust
- Paediatric cardiac services, paediatric neurosurgery and paediatric critical care with Southampton General Hospital of University Hospital Southampton NHS Foundation Trust (See page 9).
**EMUs**

The Emergency Multi-disciplinary Unit is designed to meet the urgent assessment and treatment needs of patients with multiple, often complex problems, many of whom are frail and elderly. The EMU’s multi-disciplinary teams consist of doctors, nurses, occupational therapists, physiotherapists and social workers.

In partnership with local GPs and Oxford Health NHS Foundation Trust, we have established EMUs in Abingdon and Witney with a further unit planned for Banbury.

EMUs act as a halfway house between GPs and hospital Emergency Departments. They aim to avoid unnecessary admission to hospital by early intervention and supporting an individual’s ability to self-care. They can treat any serious medical emergencies, except for heart attacks and strokes. The units only provide treatment to patients following a referral from a GP or other healthcare professional.

Dr James Price, Clinical Director of Acute Medicine and Rehabilitation, said:

“When expert teams assess patients promptly and tailor care to individual needs, the results are great quality of care and best value for money. The EMU ‘emergency team’ approach does exactly that, and is being rolled out county-wide. Alongside other important changes that strengthen the county’s emergency health and social services, this will ensure that care remains safe and accessible throughout the periods of exceptional patient need that we expect this winter.”

**Pioneering Network**

The Oxford and Southampton Children’s Hospitals Network is a pioneering model which was developed following a national Safe and Sustainable review of specialist paediatric services which recommended such work should be carried out in larger specialist centres. The Oxford and Southampton network provides partnership working across two specialist centres at the John Radcliffe Hospital in Oxford and Southampton General Hospital. It is recognised as a leading model in delivering an integrated service for children with complex requirements in cardiac, neurosciences, critical care and rehabilitation. The clinical teams work across both hospital sites to ensure that children from a large geographical area receive the benefits of shared medical and surgical expertise. Many young patients are referred from more than 20 district general hospitals across a region stretching from Northamptonshire in the north and as far south as Cornwall and the Channel Islands.
Academic and research partnerships

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

A Joint Working Agreement between the Trust and the University of Oxford provides the formal structure 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 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.

The Trust is also part of a network involving local health and social care providers, commissioners, universities, business and life sciences industry called the Oxford Academic Health Science Network. It supports collaboration, research and innovation across the NHS, universities and business, designed to tackle some of the biggest healthcare challenges through the support of the life sciences industry.

Academic Health Science Centre designation

Oxford’s NHS Trusts and universities have formed a health sciences partnership to combine basic science, translational research, training and clinical expertise enabling scientific discoveries to move rapidly from the laboratory to the hospital ward. In November 2013, Oxford was formally designated an Academic Health Science Centre (AHSC) – a prestigious designation, placing the Trust and its partners within a health sciences model that will attract increased funding for biomedical and clinical research of international standing.

Through these partnerships the Trust seeks to deliver measurably better outcomes for patients through innovative new treatments.

The vision for the Oxford AHSC is that the partnership will create the environment where the best research can be immediately translated, appraised and evaluated for patient benefit.

It will deliver six themes:

- **Big Data:** *delivering the digital medicine revolution*
- **Building novel NHS, University and Industry Relationships**
- **Cognitive health:** *maintaining cognitive function in health and disease*
- **Managing the epidemic of chronic disease**
- **Emerging infections and antimicrobial resistance**
- **Modulating immune response for patient benefit**

You can read more about the benefits to patients of our health science partnerships in the section Research and Development on page 39.
Our ambition and future priorities

Our MISSION is the improvement of health and the alleviation of suffering and sickness for the people we serve. We will achieve this through providing high quality, cost-effective and integrated healthcare.

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.

The Trust’s strategic objectives are to deliver:

1. Compassionate excellence – the kind of healthcare we 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 2019. 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/trust-strategy-integrated-business-plan.aspx

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.

There is a continuing focus on integrating care pathways so that more seamless care is provided across many of our services and also across organisational boundaries, including:

- better access to care such as 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 where needed to deliver the safest and best standards of care;
- better use of our newest hospital buildings and withdrawal from outdated buildings, especially at the Churchill Hospital.

The Trust is working with our partners in health and social care to do what we describe as ‘Delivering Compassionate Excellence’ with a focus on the following key themes:

- **Better integration of care** between local community based services run by GPs, the Oxfordshire County Council’s social care teams, and acute hospital based services.

- **Re-organisation and configuration of specialist services** that will see the Trust provide more specialist treatment which smaller district general hospitals are not able to provide.

- **The development of clinical networks** will help to reduce fragmentation of care and ensure better outcomes for patients by providing seamless access to regional and specialist healthcare when needed.

- With our academic partners we will **support collaboration** with other NHS and social care bodies to develop services that benefit from research and innovation.

- **Achieve Foundation Trust status** enabling us to be more accountable to our local communities through our public membership.
Our primary strategic focus is the redesign of care pathways to integrate care across community and hospital-based services and primary care. We are working closely with Oxford Health NHS Foundation Trust which provides locally based services in our community hospitals and health centres, and with Oxfordshire County Council Social Services.

**Key priorities are to:**

- Develop greater integration of the urgent care pathway by supporting community health and social care teams with enhanced medical assessment and diagnostic capacity and capability, for example, through strengthening services in selected community hospitals.
- Develop services for patients with long-term conditions through the use of technology to streamline care and treatment.
- Strengthen the interface between the Trust’s specialty services and general acute medicine and surgery services.
- Deliver the vision for the Horton General Hospital in Banbury to enable it to serve as a modern local hospital.
- Develop satellite services – the Trust’s strategy for specialist services involves a portfolio of interconnected clinical networks to help partner trusts deliver acute services locally. For example, the populations served by Milton Keynes Hospital and the Great Western Hospital in Swindon will benefit from satellite radiotherapy units sited at each of these hospitals. These units will be run and managed by our clinical teams. They will reduce the journeys for patients having radiotherapy treatment. Developing a local radiotherapy service for the populations of Swindon and Wiltshire will mean significant reductions in time for over 13,000 patient journeys to Oxford’s Churchill Hospital for radiotherapy treatment each year.
- The Trust will continue to extend six and seven day working to provide additional capacity. In 2013/14, additional radiotherapy capacity was achieved in Oxford by extending the service to be run for seven days a week.
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 of 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.

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.

We have made good progress towards being able to operate as a Foundation Trust, with all milestones having been met on time. However, there has been a delay for all NHS trusts which are applying for Foundation Trust status following a new requirement to have a full Care Quality Commission (CQC) inspection before approval can be granted. The CQC undertook its inspection of the Trust’s four hospital sites in February 2014 and the report and outcomes are detailed later in this report (see page 50).

Our updated FT application will be considered by the Trust Development Agency and, following a detailed assessment by Monitor, the Parliamentary regulator of NHS Foundation Trusts, we hope to achieve authorisation as a Foundation Trust in the first half of 2015.

We want a growing and active public membership to reflect the communities that we serve and to hold us to account for the services that we deliver. We have recruited nearly 7,000 public members to join our staff membership of around 11,000.
Developments and innovations in care

**An iPad-based early-warning system for patient monitoring** – this project uses the latest computer tablet technology to record and evaluate patients’ vital signs, replacing traditional paper charts. It will help to alert medical staff to patient deterioration early, quickly and reliably, and allow that data to be shared with specialists across the hospital sites.

Medical staff will input patient’s vital signs such as heart rate and blood pressure into an iPad tablet at the patient’s bedside and an early warning score will be calculated and displayed instantly. Clinical staff will use this score to help them decide whether further medical intervention is needed.

The new system is a major step towards the ‘digital hospital’ in which all sources of patient information are interlinked benefiting patient care and safety.

**Electronic prescribing** – electronic prescribing will cut prescription turnaround times by an hour for those waiting to leave hospital. This will speed up the patient discharge process and make beds available sooner. The project has been awarded a £200,000 grant from the NHS Technology Fund.

The new system will link electronic patient prescriptions made by doctors via an iPad at the patient’s bedside to the hospital’s new pharmacy robot – which picks, labels, verifies and packs medicines ready for collection or dispatch to the ward. This automated process is quicker, reduces transcription error and improves the recording of patient care. By cutting the time to prepare prescriptions, we are helping patients to leave our hospitals sooner and reduce pressure on bed numbers.

**New initiative to evaluate liver radiotherapy** – The Trust is one of ten cancer centres to be named by NHS England as a provider of Selective Internal Radiotherapy (SIRT). This new £4.8 million initiative is aimed at increasing access to specialist radiotherapy services. The specialist form of radiotherapy is used in the treatment of cancerous tumours in the liver and is offered to patients with primary liver cancer or cancer that has spread to the liver from other organs. For some of these patients there are no other treatment options available. It is offered to eligible patients as part of a national programme to broaden the evaluation of this form of radiotherapy.

**Award-winning service for children with diabetes** – an award-winning service for primary school children with diabetes has been developed by the Trust’s children’s diabetes team. This involves training volunteers in schools to help children with diabetes to better manage their condition. Poorly controlled diabetes can adversely affect a child’s education, with poor concentration, aggressive mood swings and altered behaviour associated with high blood glucose levels.
**Psychological medicine** – a unique integrated psychological medicine service, believed to be the first of its kind in the UK, has been set up by the Trust to enhance the psychological care and support given to patients admitted to our medical wards, particularly frail elderly patients. Specialist psychologist and psychiatric consultants now work as part of the medical teams to assess and treat patients with psychological needs as well as providing education and support to colleagues. The pioneering project is also being developed in the Cancer Centre, to offer patients specialist support alongside their treatment, and in the women’s centre, the Oxford Children’s Hospital, and on neuroscience wards for patients with conditions such as epilepsy.

“This is about delivering patient-centred care rather than different problems being dealt with by different services.” Professor Michael Sharpe, Project Lead.

**Focus on public health** – as a healthcare provider and large employer the Trust believes it has an important role to play in health promotion to its staff, patients and visitors. A public health approach is being embedded in the wide activity and interactions of the Trust to increase awareness and support health promotion. We have a Health and Wellbeing Team organising events and developing a network of health champions. Activities have included distribution of free fruit on the hospital wards and more than 1,000 pieces of fruit to football fans at Oxford United’s Kassam Stadium. The Trust’s public health strategy includes setting up ‘Healthy Hospital’ days across our hospital sites to promote health and wellbeing. A new drop-in health improvement clinic in the Trust’s outpatient department offers advice and guidance on healthy lifestyle options and also mental wellbeing.

**New day care unit for transplant patients** – A new facility at the Churchill Hospital offers day case treatment for transplant patients. A special ambulatory care area has been created on the haematology ward to allow ‘relatively well’ patients the opportunity to have stem cell and bone marrow infusions and be able to return home each evening. Previously patients would have had to be admitted for an overnight stay.

Helen Chambless was among the first patients to be treated in the new facility. She said: “To be at home whenever possible while undergoing this treatment is fantastic.”

It is hoped that it encourages an improved psychological state and a better dietary intake to speed recovery following a bone marrow transplant.
Increased support for surgical services – physicians have been introduced as part of the emergency surgery team and to support the care of older people in trauma and orthopaedics. Consultants are also on site in the Trust’s emergency departments and in diagnostic and maternity services seven days a week. An ‘emergency navigator’ senior nurse has been introduced to help direct emergency GP referrals to the most appropriate unit on admission. A paediatric clinical decision unit now runs adjacent to the John Radcliffe Hospital’s Emergency Department to support diagnosis and decisions on urgent referrals for children.

Renal service expands – the Trust has expanded its renal service to improve the care of patients from the Swindon area needing dialysis. The Oxford Kidney Unit has added four more treatment spaces to the satellite unit at the Great Western Hospital in Swindon. Around 12 patients have had to travel long distances to Oxford for their treatment three times a week, but can now be treated locally. The haemodialysis unit at Swindon can now treat up to 42 patients a day.

Children’s ear, nose and throat surgery – day case ear, nose and throat (ENT) surgery for children has been re-introduced to the Horton General Hospital in Banbury. This new service follows increased demand for ENT services in the Banbury and North Oxfordshire area. The hospital’s audiology service has also been expanded to accommodate pre-operative audiological testing. It is hoped to be able to expand the service in the future to include adult day-case ENT operations.

UK’s first abdominal wall transplant – The Churchill Hospital has carried out the UK’s first successful transplants of the skin and muscle around the stomach, known as abdominal wall transplants. The operations are carried out in conjunction with an intestinal transplant, to give bowel transplant patients a greater chance of returning to normal life. Previously, patients who had a significantly weakened abdominal wall, perhaps due to previous operations, were unable to have bowel transplants. Those who did often had to stay in hospital for long periods due to a lack of skin cover which increased the risk of infection. The operations use pioneering plastic surgery techniques with plastic surgeons working together with transplant surgeons. It helps to solve extremely difficult living conditions for patients, many of whom have spent years unable to eat solid food.

Landmark treatment boosts care for stroke patients – Doctors at the Acute Vascular Imaging Centre (AVIC) have achieved a milestone in treating critically ill patients who have suffered a stroke. Previously it has not been possible to scan patients who are extremely unwell. But the £13 million AVIC based at the John Radcliffe Hospital provides state-of-the-art MRI scanning technology integrated with clinical treatment. Working with the neurosciences intensive care unit, patients who have suffered a type of stroke known as subarachnoid haemorrhage can be scanned to gain new insight into how blood flow in the brain is affected by this type of stroke and to search for new ways to improve treatment.
Bringing the hospital to the roadside

Ambulance and hospital partnership delivers rapid response to patients at the scene

It is estimated that major trauma results in the death of around 5,500 people in the UK. It is a leading cause of fatalities in young people, with an average age of just 36 for those who sadly die from their injuries. Serving Oxfordshire, and the wider Thames Valley, a joint unit, combining highly trained trauma doctors and specialist paramedics, is helping to reduce these deaths and to drastically change patient outcomes following serious accidents.

Specialist emergency care physicians from the John Radcliffe Hospital have joined paramedics from South Central Ambulance Service to deliver rapid critical care at the scene to the most seriously injured or ill patients. The new Enhanced Care Response Unit (ECRU) responds to emergency calls either with a rapid response car, or by the Thames Valley and Chiltern Air Ambulance Service carrying specialist pre-hospital care doctors and paramedics on board. They stabilise the patient before transferring them to hospital emergency departments or the Major Trauma Centre at the John Radcliffe Hospital.

Dr Syed Masud, consultant in Emergency Medicine and Pre-hospital Care at the John Radcliffe Hospital, said: “With our ambulance and paramedic colleagues we are bringing the hospital to the roadside. By having an emergency medicine doctor going out to the scene as part of an initial rapid response, we are able to make clinical decisions for patients at the scene which can give a greater chance of survival.”
Our highlights

**Newborn Intensive Care Unit** – A £5.5m extension, which opened in July 2013, doubles the number of intensive care cots available (from 10 to 20), and increases the number of high dependency cots.

The Trust is the designated regional centre for providing newborn intensive care support for the most severely ill or premature babies who need significant medical interventions, life support machines, and/or surgery to survive, across the Thames Valley.

The newly expanded unit will care for all babies in the Thames Valley Region born before 27 weeks gestation.

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**New Echo-cardiology Unit** – In the spring 2014, work began on a new cardiology outpatient and imaging unit next to the Oxford Heart Centre at the John Radcliffe Hospital, bringing all echo-cardiology facilities together. Once open in late 2014, patients will no longer have to move between several areas located across the hospital. The new unit will have the very latest cardiac imaging technology available, including 3D heart scanners. Staff will be able to perform more scans, collaborate further in leading research, and perform more complex assessments and lifesaving procedures. The development has been supported by public donations through *The Heartfelt Appeal*.

“This development is going to transform the way we work and improve the whole experience for patients.”

*Dr Saul Myerson*
**Exemplar service for VTE** – The Trust has been recognised for providing high quality VTE (thrombosis/clot) prevention care to patients. It was judged to provide excellent, safe and innovative care, achieving the national target in 2013/14 of more than 95% of all adult in-patients being assessed for VTE.

Dr Nicola Curry, Lead for Thromboprophylaxis, said: “VTE assessment screens patients for their individual risk of VTE and prompts physicians to start treatments that can prevent fatal blood clots. It is an important part of the general assessment of patients at the time of admission and throughout their hospital stay.”

As a VTE Exemplar Centre the Trust will actively lead UK best practice for VTE prevention. A mobile phone application, which was designed by a team including Penney Clarke, senior thromboprophylaxis nurse, has been applauded as a fantastic means of providing high quality information to patients about how to help themselves prevent clots.

**Integrated Sexual Health Services** – The Trust is now providing integrated sexual health services across Oxfordshire to include Genitourinary Medicine (sexually transmitted infections) and family planning (contraception) services which were previously provided by separate organisations. A greater range of services including sexual health screening, treatment, advice and contraception is being delivered from a number of outreach sexual health clinics in towns across the county.

Specialist services continue to be delivered from the Churchill Hospital in Headington and the Orchard Health Centre in Banbury. These clinics offer the full range of sexual health services including complex screening, tests and sexually transmitted infection services.

The Trust is working closely with Oxfordshire County Council which has responsibility for public health promotion. A new website details services and clinics at [www.sexualhealthoxfordshire.nhs.uk](http://www.sexualhealthoxfordshire.nhs.uk)
The patient’s experience

Your thoughts, opinions and observations about all aspects of our hospitals are very important to us. 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.

Learning from you

The Trust is committed to seeking and acting upon feedback from patients and their friends and family. This is because we want every patient to have the best experience possible, and feedback helps our staff to know what we are doing well (and the things we should keep on doing) and what we need to change.

We do this by:

- Using questionnaires and comment cards.
- Listening to what you tell us in person.
- Responding to letters and emails you send us, and feedback posted on NHS choices.
- Listening to what you tell the Patient Advice and Liaison Service (PALS).
- Seeking ‘Patient Stories’: Asking patients to give us an in-depth account of their experience to help us to understand issues better.

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.

If you stay overnight in one of our hospitals, use maternity services, or attend the emergency department, you will be given a comment card asking whether you would recommend the ward/emergency to friends and family (if they needed similar care or treatment). This was introduced in inpatient wards and emergency departments in January 2013, and in maternity services in September 2013. High response rates are important because it means that feedback is more meaningful, and more representative of the views of patients. A low response rate can mean that feedback is unreliable.
The Trust achieved its target to increase response rates and 24% of inpatients and those attending the emergency departments at the Horton General and John Radcliffe Hospitals provided responses.

Breakdown of Trust scores:

- **Inpatients**
  The FFT score for inpatients between April 2013 and March 2014 was 73. This score is based on 11,100 responses. 96% of patients are extremely likely or likely to recommend the ward they stayed on.

- **Emergency Departments**
  The FFT score for Emergency Departments between April 2013 and March 2014 is 58. This score is based on 6,400 responses. 92% of patients are extremely likely or likely to recommend the care they received in the emergency departments.

- **Maternity Services**
  Women using maternity services are asked about their antenatal care, experiences at birth, care on the postnatal ward, and the postnatal community service. The FFT score for maternity services between October 2013 to March 2014 was 58. This score is based on 1,000 responses. 94% women are extremely likely or likely to recommend the Trust’s maternity services.

Acting on your feedback

Patient views are invaluable to help us improve our service delivery. We recognise the importance of listening to patients and their families to ensure we provide responsive care. During 2013/14 we have introduced a number of initiatives to improve our approach to involving people in decisions about their care. These include:

- **Improving the timeliness of discharge from hospital** – A group was set up to review the Trust’s discharge policy and procedures, and ensure these are followed consistently across the organisation. Discharge coordinators have been appointed and a discharge checklist has been put in place to assist staff and Pharmacy has been working with wards across the organisation to ensure there are systems for efficient ordering and processing of discharge medications, and reduce delays relating to waiting for medications.

- **Improving waiting times for appointments** – A full review of outpatient clinic appointment scheduling has been carried out and new appointment scheduling profiles are being implemented across the organisation.

- **Developing a customer care training programme**.

- **Enabling patients and the public to be involved in service developments** through attending patient and public involvement groups relating to the service they are interested in, or providing feedback to the service.

- **Asking patients to tell us about their experiences in detail** – These stories are shared with our clinical teams to help them better understand what they do well and what needs to be improved. With the patient’s permission the ‘patient stories’ and the associated learning action plans are discussed in the public Trust Board meetings.

- **Keeping patients, families and carers informed** – patient feedback is displayed in ward areas including Friends and Family Test results and comments, and what is being done in response to the feedback.

- **Developing a ‘Patient leaders’ programme** which will support patients and staff to work together to develop services.

**Friends and Family Test Scores 2013/14**

<table>
<thead>
<tr>
<th>Extremely likely</th>
<th>Likely</th>
<th>Neither likely nor unlikely</th>
<th>Unlikely</th>
<th>Extremely unlikely</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,381</td>
<td>3,945</td>
<td>663</td>
<td>196</td>
<td>189</td>
<td>246</td>
</tr>
<tr>
<td>73%</td>
<td>21%</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
<td>Excluded from %</td>
</tr>
</tbody>
</table>

1 This is the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent. The score can range from -100 to +100.
National patient surveys

There were two national surveys in 2013: The Inpatient Survey and The Maternity Survey. The surveys are part of the important work the Trust is doing to identify areas where patients feel that we can improve. Together with many other methods we have of gaining patient feedback, these results help the Trust focus on improving the overall experience of patients in hospital. The results from both surveys were very positive.

Women using maternity services rated their care on average:

- Care during labour and birth at 9.1/10 (significantly better than the national average),
- Care in hospital after birth at 8.1/10 (significantly better than the national average), and
- Interactions with staff at 8.7/10 (about the same as the national average).

The Maternity Survey 2013 showed that 29% of women who wanted breastfeeding advice did not receive consistent advice about breastfeeding. To address this, a breastfeeding strategy has been agreed, which includes the appointment of an infant feeding specialist midwife and implementation of Maternity Support Worker training.

The survey also showed positive results on the following questions:

- 98% of women were given a contact number for a midwife or team during their pregnancy.
- 91% said they were always spoken to in a way they could understand during their antenatal care, and a further 9% said this sometimes happened.
- 98% of women said that, if they had a partner or someone else close to them present, this person was able to be involved as much as was wanted.

97% of women said they were asked how they were feeling emotionally at home after the birth of their baby.

100% of women were visited by a midwife at home after birth, or saw them in a clinic.

The national Inpatient Survey 2013 was sent to a sample of patients who were discharged from the Trust’s hospital wards in July 2013. The Care Quality Commission (CQC) collates and compares results across trusts. For our Trust, 54% of the sample group responded, which is higher than the average across other trusts at 49%.

The survey showed that 87% of inpatients rated their care overall at 7 or above on a scale of 0-10 (results are shown below).

The survey highlighted delays in discharge as an issue for patients, with 43% of patients surveyed saying their discharge was delayed, and 57% said the delay was longer than two hours. The main reason for a delay was waiting for medicines (70%). The Trust is also doing less well on explaining the side effects of medication to patients on discharge from hospital. These results are being fed into the work currently underway to improve the discharge process for patients.

Since the survey of patients in 2012, patients have scored the Trust more highly in the following areas:

- Availability of hand gels
- How people feel about the length of time they were on a waiting list
- Wait to get a bed on a ward
- Cleanliness of wards
- Cleanliness of toilets
- Being given privacy for an examination or treatment.

### National Inpatient Survey 2013 results

<table>
<thead>
<tr>
<th>Rating</th>
<th>“I had a very poor experience of care”</th>
<th>“I had a very good experience of care”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0% 1% 2% 3% 4% 5% 6% 7% 8% 9% 10%</td>
<td></td>
</tr>
<tr>
<td>Percentage of respondents</td>
<td>1% 0% 1% 0% 1% 3% 7% 13% 23% 24% 26%</td>
<td></td>
</tr>
</tbody>
</table>
Patient Advice and Liaison Service

The Patient Advice and Liaison Service (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. Visit our website for full contact details www.ouh.nhs.uk/patient-guide/pals

During 2013/14, PALS dealt with 4,931 requests, compliments and concerns. This is significant increase on the previous year’s total of 3,514 requests. The main categories related to patient care, communication and cancellations or delays in appointments. There were also compliments to various staff and departments.

How we handle your complaints

The Trust aims to adhere to the ‘Principles of Remedy’ produced by the Parliamentary and Health Service Ombudsman in 2007 and the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, in order to produce reasonable, fair and proportionate resolutions as part of our complaints handling procedures. These include:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

In the financial year 2013/14 the Trust received 887 formal complaints which again shows an increase on the previous year’s total of 788. All complaints are handled individually with the complainant and in a manner best suited to resolve the particular concern raised. Methods of response can include a written response from the Chief Executive, a face-to-face resolution meeting with relevant staff or an independent review of the care provided. The main areas for concern were patient care, communication, access to appointments/services and delays.

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.

Outpatient Clinic

34,000 more appointment slots – We are working to improve outpatient administration to increase the booking slots available in clinics and shorten patient waiting times to a maximum of six weeks. We aim to release 34,000 more appointment slots and to enable more patients and GPs to book appointments through the Choose and Book system.
Dementia care

The Trust has signed up to a National Dementia Declaration to improve the quality of life for people with dementia and the care of people with dementia in hospitals.

We work with colleagues in social services, primary care, community hospitals, and mental health services across Oxfordshire to provide seamless and patient-centred care for people with dementia. We also work closely with charitable organisations such as Age UK, Dementia Action Alliance, Alzheimer’s Society and others to maximise expertise and resources.

The Trust’s pioneering psychological medicine service supports the care of patients with dementia and cognitive impairment. Consultant psychologists and psychiatrists work across the Trust and senior nurses are designated as ‘dementia champions’ to spread learning on how to assess and treat patients with dementia. Twenty nurses are being funded to attend an external Dementia Leaders Programme.

Our commitment:

- We will involve patients and relatives in decision making about their health care – Knowing You Card.
- We will plan discharge with patients and relatives to make sure their return to 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 now have consultants whose role is to provide expert advice and diagnosis on patients with mental impairment problems.”

Dr Sarah Pendlebury, dementia lead

Improving Dementia Care – The number of people aged 85 and over is set to rise from 14,683 in 2011 to 39,400 by 2035. The Trust recognises the need to ensure that patients with dementia are handled sensitively and their families are supported.

The Trust runs regular drop-in events for families, visitors, and carers to offer support, advice and guidance. Local charities and organisations are on hand including the Alzheimer’s Society, Guideposts Trust, Carers Oxfordshire, and Age UK and families and visitors are invited to talk to advisors over a cup of tea and cake.

Pictured right is Trust Chairman, Dame Fiona Caldicott at the launch of the John Radcliffe Hospital dementia café.
### Our operational performance

#### Meeting our access targets

<table>
<thead>
<tr>
<th>COMMITMENT</th>
<th>Standard</th>
<th>Trust achievement 2013/14</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>88.78%</td>
</tr>
<tr>
<td>Non-admitted patients (out patients) to start treatment within a maximum of 18 weeks from referral</td>
<td>95%</td>
<td>95.62%</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>91.90%</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>93.84%</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>93.23%</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>95.62%</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>96.86%</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>96.52%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>94%</td>
<td>95.66%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
<td>98%</td>
<td>99.78%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
<td>94%</td>
<td>87.76%</td>
</tr>
<tr>
<td>Cancer waits – 62 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>85%</td>
<td>80.9%</td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td>90%</td>
<td>94.41%</td>
</tr>
</tbody>
</table>
Increased demand

During 2013/14, the Trust provided more care and treatment than was expected and commissioned. Emergency care and operations have continued to grow at around 4% a year. Rising levels of referrals for non-emergency care (routine operations, treatment, and appointments) have required the Trust to provide extra planned surgical capacity in order to enable us to meet the national 18-week referral to treatment time standard.

The Trust is committed to achieving all local and national performance standards. We understand that any waiting longer than necessary is of concern to our patients and our clinical teams are working hard to improve the waiting times. The increase over the last year in outpatient activity has ultimately led to a build-up in some areas of patients waiting to be treated. Some services in particular have a high volume of referrals such as ophthalmology and Ear, Nose and Throat (ENT) departments.

Due to the high volume of activity we have been unable to treat all elective patients within the 18 week waiting time and have implemented a recovery plan to try and reduce the number of patients waiting over 18 weeks for treatment, in agreement with our commissioners and the Trust Development Authority (TDA). This includes operating additional theatre lists over six days a week. All emergency, urgent and cancer patients are treated as a matter of clinical priority.

62-day cancer waits

The 62-day standard refers to the time from the first urgent (suspected cancer) GP referral to the first definitive treatment for cancer. Performance in meeting this standard has declined in 2013/14 and an action has been put in place to improve waiting times. The Trust does not want any patient to be waiting longer than necessary and is committed to achieving all local and national performance standards.

The action plan focuses on quicker diagnosis to offer earlier treatment; the timeliness of referrals from other hospitals where patients have had an initial appointment; and better communication to ensure patients are aware of the reason for an urgent referral and the requirement to take up the appointments offered.

Emergency department performance

The Trust has not delivered the required standard that 95% of patients should be admitted, transferred or discharged within four hours of their arrival at one of our emergency departments every week. The demand on our health services has been higher than ever, particularly during the winter months. The Trust recognises this is an area of concern and there has been investment in:

- increasing the number of permanent beds across the hospital wards by 86;
- enhanced seven day working across various clinical services;
- an increase in senior clinical decision makers in our emergency departments and the Emergency Assessment Unit throughout the week.

This has included the introduction of emergency admission navigators – expert nurses who provide a single point of access to help assess patients coming into the emergency department and help reduce the admission rate for ambulatory patients.

Every week we see more than 2,400 people in our emergency departments and the vast majority of patients are assessed, treated, discharged or admitted to a ward within four hours. We are sorry when patients wait a little longer than the target time but it is important to understand that they would not necessarily have waited without being seen, and would undergo assessment and diagnosis before moving on to the next stage of their care. Patients will always be seen on the basis of their clinical priority and need.
Leaving hospital and delayed transfers of care

An important factor governing the Trust’s ability to deliver operational performance standards is the number of patients occupying hospital beds who are medically fit to leave hospital but are delayed in moving to a community bed, nursing home, or home-based care and support.

The local healthcare system remains one of the most challenged nationally in relation to such delayed transfers of care, with average monthly delays ranging from 133 to 152 patients. This equates to approximately 10% against the national standard of 3.5%.

A concern is the increasing number of attendances in our emergency departments and a noticeable slowing down of the flow of patients across the health and social care system which places an additional burden.

This presents a more acute problem in winter when we see an increase in the number of admissions due to health problems associated with colder weather and also a higher proportion of frail and elderly patients who require much more assessment and may need admission to a hospital bed. It is important that all partners in the whole health and social care system continue to work together to resolve this problem so that people can be seen and treated in the right setting and then returned home as soon as they are medically ready.

We have implemented a range of actions including setting up a Supported Hospital Discharge Service which takes patients direct from the ward to home and provides home-based support, seven days a week in order to relieve pressure on the hospital’s acute wards. This has led us to becoming an authorised provider of domiciliary care in Oxfordshire to help patients leave our hospitals, with support, as soon as they are fit and ready to do so.

Technological change

The Trust is leading the way in health technology and implementation of the Electronic Patient Record (EPR) system began in 2012. 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 being delivered in phases over a number of years. Clinical staff are now able to routinely order diagnostic tests and view results electronically. Nurses on medical wards electronically record patient admissions, discharges and transfers in real time and doctors are able to order laboratory and radiology investigations, complete venous thromboembolism (VTE) assessments, view and endorse results.

The stats:

- 130,000 tests are being ordered electronically every year
- 300,000 results are being generated every week — 150,000 of these results are for local GPs

As part of the Safer Hospitals and Safer Wards Technology Fund, OUH has received national funding to support three innovative projects linked to our EPR system:

- An iPad app developed with the Oxford Biomedical Research Centre which acts as an electronic patient observation chart and automatically calculates and records critical observations (see section on Developments and Innovation in Care).
- Online prescribing and automated dispensing of drugs (see section on Developments and Innovation in Care).
- Developing the Oxfordshire Care Summary patient records system which allows GPs and hospital clinicians to access summary information on patients’ prescription history and any allergies. The technology fund will allow the system to be enhanced to show data on patients with long-term conditions such as diabetes. It will also give patients the opportunity to view their own data.
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. It is based on the requirements given in the NHS Information Governance Toolkit and national legislation, polices and directives.

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

All NHS organisations must include in their annual reports details of incidents involving loss of confidential information.

During 2013/14 there were four Serious Incidents Requiring Investigation (SIRI) relating to a breach of confidentiality. These involved:

- Digital files accidentally sent to the incorrect Clinical Commissioning Group.
- Paper files sent to solicitor’s office failing to arrive.
- Paperwork found on pavement outside hospital.
- Briefcase containing limited clinical information was stolen from a doctor’s vehicle while travelling between hospital sites.

These incidents have been fully investigated and corrective action taken where necessary.

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.

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.

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 2013/14 the Trust received 573 Freedom of Information requests. This is an increase of 60.5% from 2012/13 when 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, responding to more complex requests does take longer.

During 2013/14, most requests resulted in full disclosure and of those closed during the period, 58% were responded to within 20 working days.

Preparing for an emergency

The Trust has a Major Incident Plan that details how the Trust 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 that the Trust returns to providing its 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.
Infection prevention and control

Throughout 2013/14 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 two years of MRSA and Clostridium difficile in our hospitals. We continue to reduce the number of cases of Clostridium difficile. Our objective for zero cases of MRSA in 2013/14 has been a challenge but the cases of MRSA reported below for 2013/14 were deemed unavoidable and did not incur any financial penalties for the Trust.

<table>
<thead>
<tr>
<th>John Radcliffe, Churchill, Horton</th>
<th>Annual limit 2012/13</th>
<th>Cases apportioned to the Trust in 2012/13</th>
<th>Annual limit 2013/14</th>
<th>Cases apportioned to the Trust in 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>7</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>88</td>
<td>92</td>
<td>70</td>
<td>65</td>
</tr>
</tbody>
</table>

*Although apportioned to the Trust, these cases were deemed unavoidable and therefore incurred no financial penalties.

More staff have flu vaccination. In the national NHS staff seasonal flu vaccination campaign 66% of our front-line staff received the flu jab. All frontline staff, those in direct contact with patients, are asked to protect themselves, their patients and their families by having the flu jab.

During October, November and December 2013 the Trust ran flu clinics across all of its four hospital sites. Having the vaccine reduces the chances of staff catching ‘flu at home and passing it to patients at work. By March 2014, the campaign had successfully vaccinated 6,095 of front-line staff (66%). This is an excellent result and compares against a national average of 48.6% and 53.3% in the Thames Valley region. For the Trust, this represented an increase of 8% on last year’s flu campaign and an amazing 53% up on the Trust’s first programme which ran in 2008. In total 7,836 vaccines were given to our 11,600 strong workforce.
Improving our hospital environment

Sustainability update
Sustainability has become increasingly important and we acknowledge this responsibility to our patients, local communities and the environment by working hard to minimize our footprint. As part of the NHS, it is our duty to contribute towards the goal set in 2009 of reducing the carbon footprint of the NHS by 10% (from a 2007 baseline) by 2015. It is our aim to meet this target by reducing our carbon emissions by 10% by 2015 using the 2007 as the baseline year.

Energy
The Trust has spent £9,634,513 on energy in 2013/14, which is a 2.1% increase on energy spend from last year. 0% of our electricity use comes from renewable sources. The Trust is registered and participates in both the EU Emissions Trading System and the Carbon Reduction Commitment Energy Efficiency Scheme.

Carbon footprint
An estimated total carbon footprint of 260,550 tonnes of equivalent carbon emissions.

For a full report on our sustainability activities visit: www.ouh.nhs.uk/publications
Health & Safety

RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) is the system laid down by the Health and Safety Executive for reporting certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses).

There was a total of 16 incidents reported to the HSE within 2013/14. This is a reduction from the 27 reported during 2012/13.

<table>
<thead>
<tr>
<th>RIDDOR Category</th>
<th>Number of instances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident – Direct to hospital</td>
<td>1</td>
</tr>
<tr>
<td>Accident – Over-seven-day</td>
<td>11</td>
</tr>
<tr>
<td>Accident – Specified Injury</td>
<td>5</td>
</tr>
</tbody>
</table>

Datix

Datix is the system used by the Trust to record non-clinical incidents. There were 6,909 non-clinical incidents reported for 2013/14, slips, trip and falls making up 39% of all the incidents.

<table>
<thead>
<tr>
<th>Accident Type</th>
<th>Number of instances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Another kind of accident</td>
<td>1</td>
</tr>
<tr>
<td>Exposure to harmful substance</td>
<td>1</td>
</tr>
<tr>
<td>Fall from height</td>
<td>1</td>
</tr>
<tr>
<td>Lifting and handling injuries</td>
<td>6</td>
</tr>
<tr>
<td>Slip, Trip, Fall same level</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Persons Affected</th>
<th>Contractor</th>
<th>Staff</th>
<th>Patient</th>
<th>Visitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>82%</td>
<td></td>
<td></td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of instances by type</th>
<th>Number of instances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Another kind of accident</td>
<td>1</td>
</tr>
<tr>
<td>Exposure to harmful substance</td>
<td>1</td>
</tr>
<tr>
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<td>1</td>
</tr>
<tr>
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<td>6</td>
</tr>
<tr>
<td>Slip, Trip, Fall same level</td>
<td>7</td>
</tr>
</tbody>
</table>
Delivering high quality services

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 and clinical effectiveness is maintained.

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, and depending on what this tells them, they may choose to inspect a hospital to ensure standards are being maintained. You can find out more about the CQC here: www.cqc.org.uk

Care Quality Commission rates the Trust as ‘good’

The CQC’s Chief Inspector of Hospitals inspected all four of our hospital sites in Oxford and Banbury as part of the CQC’s new inspection regime. The CQC report rates the Trust as ‘good’ with a small number of areas for improvement after the CQC inspection team looked at the quality and safety of the care provided by the Trust based on the things that matter most to local people.

In February 2014, a team of 51 inspectors visited the Trust’s four hospital sites for two days and made unannounced spot checks on 2 and 3 March. In advance of the inspection, the Trust provided thousands of pages of documentation to the CQC to help with their inspection.

The CQC spoke to patients, visitors, carers and staff to form an overall impression of the services the Trust provides and to rate the organisation and its services in five areas (known as domains): safe, effective, caring, responsive to people’s needs and well-led.

The CQC also held two public meetings, one in Oxford and one in Banbury to hear from local people about patients’ experiences, which were overwhelmingly positive. During the two weeks of the visit the inspectors repeatedly tested out their initial findings and have now given the Trust an overall rating of ‘good’ in all five of the above domains.

Among the many positive findings, the report provides a clear endorsement of our staff who were observed providing compassionate and excellent care throughout our four hospitals. Of 115 areas inspected across the Trust, 11 were identified as ‘requiring improvement’. The individual hospitals were rated as follows:

<table>
<thead>
<tr>
<th>CHURCHILL</th>
<th>HORTON</th>
<th>JOHN RADCLIFFE</th>
<th>NOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care</td>
<td>A&amp;E</td>
<td>A&amp;E</td>
<td>Medical care</td>
</tr>
<tr>
<td>Intensive/Critical care</td>
<td>Medical care</td>
<td>Medical care</td>
<td>Surgery</td>
</tr>
<tr>
<td>End of life</td>
<td>Surgery</td>
<td>Surgery</td>
<td>Outpatients</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Intensive/critical care</td>
<td>Intensive/critical care</td>
<td></td>
</tr>
<tr>
<td>Maternity &amp; family planning</td>
<td>Maternity &amp; family planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s care</td>
<td>Services for children and young people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of life care</td>
<td>End of life care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients</td>
<td>Outpatients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
</tr>
</tbody>
</table>

The Oxford University Hospitals NHS Trust continues to be registered without conditions by the Care Quality Commission to provide health services.
At the John Radcliffe Hospital, most of the services were delivered to a good standard, although the inspectors found that both the Emergency Department and surgery required some improvements. The report highlighted problems with staff shortages within the maternity department and on surgical wards and theatres; high bed occupancy; and failure to meet the national Emergency Department target to admit, transfer or discharge patients within four hours.

The CQC identified the following actions the Trust must take:

- The Trust must plan and deliver care safely and effectively to people requiring emergency, surgical and outpatient care.
- There must be enough qualified, skilled and experienced staff to safely meet people’s needs at all times.
- The Trust must plan and deliver emergency care to people in a way that safeguards people’s privacy and dignity.
- Staff must receive suitable induction in each area in which they work.
- The Trust must ensure that newly qualified midwives are appropriately supported.
- Patient records must accurately reflect the care and treatment for each patient in line with good practice.

The following were highlighted as areas of good practice:

- The system the Trust used to identify and manage staffing levels was effective and responsive to meet the needs of the hospitals.
- Services were innovative and professional.
- Caring compassionate staff throughout the four hospitals.
- Managers had a strong understanding of the risks in service and improvements required. Incident reporting and monitoring was well managed and the learning from incidents was evident. There was a strong commitment, supported by action plans, to improve the service.
- Staff worked well between teams. The value of an effective multidisciplinary approach, in improving outcomes for patients, was understood and actively encouraged.
- It was evident that significant efforts were made to improve the effective discharge of patients within medical areas. The hospital was working closely with commissioners, social services and providers to improve the transfer of patients to community services.
- There was good learning from incidents within critical care which translated into training and safer practice.
- There were processes in place throughout the hospitals which took into account patients’ diversity. These included an interpretation service and information provided in different formats according to patients’ needs.
- The Trust internal peer review process, in which over 100 clinical areas had been reviewed in a three month period across the trust.

The CQC inspection provides us with an opportunity to have the care and services we provide reviewed by an external body. The feedback they offer is important and 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

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“\nThis report has given us a richer and broader understanding of our organisation and how it is perceived both internally and externally. However, there is no room for complacency and areas highlighted in the report for improvement will be acted on swiftly.

We were aware of the areas listed for improvement through our own internal review processes and many have either been addressed or have action plans for improvement.”

Sir Jonathan Michael, Chief Executive
Working together to achieve quality

Each year we work with our patients, staff and commissioners to agree a number of priorities for development. The Trust’s Quality Strategy is aimed at providing high quality healthcare based on national and international comparisons and to improve our performance in three key domains:

1. **Patient Safety**
2. **Clinical Effectiveness and Outcomes**
3. **Patient Experience**

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 goals and priorities

We are committed to providing the highest standard of care and we listen to the views of our patients, our staff, our commissioners and other stakeholders to ensure we continue to deliver improvements.

In March 2013 and in April 2014, we invited the public and patients to tell us what matters to them to inform our quality goals. Those attending highlighted issues ranging from clinic appointment times to improving communication between staff and patients. In April 2014, we specifically focused on gaining feedback about our outpatient clinics and processes. We are now working to ensure ongoing patient involvement as we improve our outpatient service delivery.

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 2013/14,** our priorities were to deliver progress in:

### Patient Safety

**Safer care associated with surgery to include:**
- The creation of a Patient Safety Academy which brings together research and clinical teams.
- Ongoing review and compliance with surgical safety procedures.
- Real-time monitoring of surgical site infection in a number of specialties.

**Further work is underway on:**
- Monitoring ‘time to theatre’ for patients requiring emergency procedures.
- Standardised observational audits to better assess theatre safety beyond the current World Health Organisation surgical safety checklists.
- Reducing cancellations of operations and readmissions to hospital.

### Clinical Effectiveness and Outcomes

**Use of technology to improve care has included:**
- Use of mobile phone technology to promote self care and management.
- Rollout of a new electronic system for the requesting of tests by colleagues in Primary Care (ICE).
- Implementation of a ‘track and trigger’ or early warning system using an iPad application which acts as an electronic patient observation chart and automatically calculates and records critical observations.

### Patient Experience

**To improve the way we listen and act on feedback, and to improve care for people with cognitive impairment:**
- Establishment of dementia cafes and continued growth of the psychological medicine team which has made a major contribution to the care provided for patients with cognitive impairment.
- Rollout of the nationally-led Friends and Family Test.

**Further work is required in:**
- Improving the response rate to the Friends and Family Test.
- Demonstrating action and sustained improvement as a result of patient feedback.
- Development of dementia-friendly ward environments.
Looking forward, in 2014/15, our quality improvement priorities are:

**Patient Safety**
- Safer care associated with the development of our programme ‘Care 24/7’ which seeks to improve the out-of-hours medical cover and support across the four hospital sites.

**Clinical Effectiveness and Outcomes**
- Improving the care of adult inpatients with diabetes and pneumonia.
- Expanding the provision of physician input into the care of inpatients in surgical specialties.

**Patient Experience**
- Improving timeliness and communication about discharge from hospital.
- Improvements in the experience of patients using our outpatient services, including the booking of appointments and attendance at clinics.
- Developing services to provide integrated psychological support for patients with cancer.

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

**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. These have all become important frameworks for measuring, achieving and ensuring quality within the organisation.

**Ward inspections**

The Trust has established a rolling programme of unannounced compliance inspections on all clinical wards and departments. Since April 2013, 71 quality walk rounds have 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.

**Internal Peer Reviews**

During 2013/14, the Trust implemented a new internal ‘Peer Review Programme’ in an initiative led jointly by the Trust’s Medical Director and Director of Assurance. The programme is aimed at strengthening the Trust’s processes by involving a range of staff, patients and GPs in determining how well patient care is delivered across the Trust. Its purpose is to support our divisions and departments in delivering continuous improvement and sharing good practice. The peer reviews use the new CQC framework to review our services – are they safe; effective; responsive; caring; and well led?
Clinical Risk Summits

Risk summits are an important element of the Trust’s assurance and quality improvement work. The summits bring together a relevant cross-section of the Trust’s staff, along with patient representation and other interested parties for a workshop to review the Trust’s performance in a particular clinical area in relation to the outcomes of patient care. The workshops provide an opportunity to gather feedback from clinicians across the Trust on clinical processes; consider how resources are currently deployed; and consider what best practice looks like for the management of patients with a particular condition.

The summits help us to understand at a high level how care delivered locally may have gone less well than we would have liked, and to put in place improvement action plans.

In 2013/14 we undertook three clinical risk summits in:

- Care of in-patients with diabetes
- Community acquired pneumonia
- Care provided in the Trust outside normal working hours – ‘Care 24/7’

Clinical effectiveness and audit

We constantly monitor the quality of our services by auditing our clinical practice. In 2013/14 the Trust participated in 39 national clinical audits and other major studies including on cancer, heart disease, diabetes, trauma and neonatal intensive and special care. Also in 2013/14, the Trust undertook over 300 registered local clinical audits.

For a complete list of clinical audits please see the Quality Account on the Trust website at: www.ouh.nhs.uk/about/publications

The Trust also participates in a Department of Health initiative known as Patient Recorded Outcome Measures (PROMs). Patients undergoing surgery for four common procedures (hip and knee joint replacement, and surgery for varicose veins or inguinal hernias). Patients 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.
Research and development

As one of the largest acute trusts in the country our main priority is to deliver excellent healthcare for all of our patients. This is underpinned by bringing together academic research expertise with our clinical teams to translate medical science into better healthcare treatments. Our patients benefit from world-class discovery and innovation and our growing portfolio is addressing major conditions including cancer, dementia and stroke.

Research as a strategic priority

Oxford University Hospitals NHS Trust has an international reputation for research excellence and a vision to be at the heart of an “innovative academic health science system”. Research and teaching is carried out in partnership with the University of Oxford Medical Sciences Division, Oxford Brookes University’s Faculty of Health and Life Sciences and Oxford Health NHS Foundation Trust, combining clinical expertise with academic excellence. Research and clinical facilities are co-located on our hospital sites to foster a culture of collaboration.

Designation as an Academic Health Science Centre – In 2013/14 we took significant steps forward, strengthening our academic and industry partnerships and consolidating Oxford’s position regionally, nationally and internationally.

In November 2013, Oxford was designated as an Academic Health Science Centre (OxAHSC) by the Department of Health – becoming one of just six Academic Health Science Centres in England. Health Minister Lord Howe described the centres as “among the world leaders in health research, health education, patient care and working with industry to promote economic growth”.

The OxAHSC partners – Oxford Brookes University, Oxford Health NHS Foundation Trust, Oxford University Hospitals NHS Trust, and the University of Oxford – will combine individual strengths to address 21st century healthcare challenges.
Academic Health science networks – Oxford University Hospitals was also announced as the host NHS Trust for the newly created Oxford Academic Health Science Network (Oxford AHSN). This network of NHS Trusts, academic institutions and life science businesses covers the Thames Valley and South Midlands region and will enable the swift uptake, adoption and translation of healthcare research and innovations across this wider geography.

The Trust is also host to the National Institute for Health Research Comprehensive Research Network: Thames Valley South Midlands. This network will invest in clinical research staff to match patients with appropriate research opportunities, carry out the clinical duties required for the studies and cover research-related costs such as X-rays and scans.

Biomedical Research Centres – These new designations have strengthened a research position that continues to be underpinned by two significant National Institute for Health Research awards – the Oxford Comprehensive Biomedical Research Centre and Biomedical Research Unit in Musculoskeletal Disease.

Our goal is to take discovery and innovation ‘from bench to bedside’ and the Oxford Biomedical Research Centre is a £100m partnership that brings together the clinical excellence of the Trust with the academic expertise of the University of Oxford.

The Centre’s 14 research themes include cancer, dementia, cardiovascular disease, vaccines and infection, and are all pioneering new treatments, services and diagnostics tools.

The Trust also hosts an NHIR Biomedical Research Unit in musculoskeletal disease where teams based at the Nuffield Orthopaedic Centre are advancing orthopaedic surgery and developing new understanding of conditions including osteoarthritis and osteoporosis.

The following pages highlight the impact our research investment is having.

The number of active studies supported by Oxford University Hospitals was 1,357 in March 2014 compared to 1,175 the previous year and 554 in 2008.

Public engagement 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 in to meet our scientists and clinicians developing new and innovative treatments and techniques, and to tour some of the facilities housing our research.

Among those demonstrating research at the open day in May 2014 was Dr Sara Mazzucco, Neurologist and Clinician Scientist at the Stroke Prevention Research Unit. She said: “It was a great chance to explain our research to the public, why it is important and why it is important that people take part in studies. It was very encouraging that so many people were interested in what we do.”

The event is now in its fifth year and gives the public the chance to talk to leading researchers and medical professionals about issues ranging from DNA sequencing to the use of patient data.
Research collaborations making the headlines

Promising results in gene therapy for inherited blindness

A pioneering gene therapy trial for an inherited cause of blindness has shown very promising results. Nine patients with the condition choroideremia have been treated with the gene therapy in operations at the Trust’s Oxford Eye Hospital.

The condition is caused by a defective gene that affects light sensing cells in the eye. The gene therapy works by injecting a working copy of the faulty gene under the retina. Study results, reported in The Lancet, showed improvements in patients’ vision in dim light and two patients were able to read more lines on the eye chart.

The first patient to be treated, 65-year-old Jonathan Wyatt, said: “My left eye, which had always been the weaker one, was that which was treated as part of this trial. Now when I watch a football match on the TV, if I look at the screen with my left eye alone, it is as if someone has switched on the floodlights. The green of the pitch is brighter, and the numbers on the shirts are much clearer.”

Professor Robert MacLaren (pictured above left with Mr Markus Groppe) of the Nuffield Laboratory of Ophthalmology at the University of Oxford, and a consultant surgeon at the Oxford Eye Hospital, led the development of the retinal gene therapy and the first clinical trial.

New surgical ‘smart patch’ solution for shoulder injury

An innovative ‘surgical patch’ developed in Oxford could transform the success of shoulder repair operations. The patch will be used by surgeons to repair torn tendon tissue to bone, and patient trials are expected to begin in 2014. Made from a new material developed by a team of surgeons, engineers and biochemists, the ‘smart-patch’ promotes rapid regrowth of damaged tissue ensuring the injury heals more quickly and more successfully. Professor Andrew Carr, consultant orthopaedic surgeon and Nuffield Professor of Orthopaedic Surgery at the University of Oxford, led the development of the patch, which has been designed to repair damage to the rotator cuff.

More than 10,000 rotator cuff repairs are performed in the UK each year and the group’s own research has shown that internationally between 25 and 50 percent will fail to heal properly.

Professor Carr (pictured above) said: “One of the great strengths here in Oxford is having clinicians, engineers, bio-chemists and other specialists, working together across the partnership between the University of Oxford and Oxford University Hospitals NHS Trust. This multidisciplinary approach means that when unsolved clinical problems are identified we can investigate the cause, develop a solution, before returning to clinic to test if it helps patients.”
Thousands of women join health and pregnancy study

The OxWatch study is the first of its kind to research how women’s wellbeing and lifestyle affects their health in later life, especially after having children. To build a full and detailed picture, thousands of young Oxfordshire women who have not yet started their families are being invited to join the pioneering project.

The research team will follow the women through any subsequent pregnancy and beyond. By observing changes in health measures before, during and after pregnancy, new understanding of why some women develop conditions such as diabetes, pre-eclampsia, or anxiety and depression will be gained. The team hopes this will lead to better preparation for pregnancy, improved methods of preventing complications and earlier detection of problems when they do arise.

The study combines teams from the Women’s Centre at the John Radcliffe Hospital with the University of Oxford’s Nuffield Department of Obstetrics and Gynaecology, Nuffield Department of Primary Care Health Sciences and Division of Cardiovascular Medicine.

The OxWatch team wants to recruit 300 women in the first pilot-phase and then expand the numbers to 12,000 women in Oxfordshire and other national centres.

Dr Ingrid Granne, Consultant Gynaecologist said, “This study could help identify women who are susceptible to certain conditions much earlier so we can give better care.”
The Trust’s vision for its workforce is that: “as an employer of choice we will attract, recruit and retain compassionate, engaged, skilled and experienced staff who deliver excellent patient care and who work together to continuously improve the quality of the services and care we provide.”

Our Organisational Development and Workforce Strategy recognises that the delivery of compassionate excellence in care, by engaged, well-led and motivated members of staff, who believe in and demonstrate the OUH core values, underpins the future of the Trust and its services.

A range of initiatives and programmes support our strategy to deliver compassionate excellence, including:

- Recruitment, reward and internal recognition schemes.
- Expectations and standards of behaviours.
- Actively listening to our staff and involving teams and individuals in decision-making.
- Embedding a shared set of values and behaviours that have been developed by staff.
- Promoting education, training and leadership development.

Our values reflect how we behave and the decisions we take to deliver the best possible healthcare. We strive for excellence in healthcare by:

- Encouraging a culture of support, respect, integrity and teamwork.
- Monitoring and assessing our performance against national and international standards of care.
- Learning from our successes and setbacks.
- Working in partnership and collaboration with all agencies of health and social care in our healthcare economy.

Our Organisational Development and Workforce teams have been leading a range of initiatives which aim to develop and engage our staff in the delivery of compassionate excellence, and to recruit a workforce that shares and demonstrates our values. Part of this work has been the introduction of a process of values-based interviewing for prospective employees, which ensures that recruitment decisions are aligned with our Trust Values.

The Trust Board agreed a refreshed Organisational Development and Workforce Strategy for 2014 - 2019. Supporting the realisation of the Trust’s vision and strategic objectives, the Strategy sets out the strategic workforce priorities for the next five years and develops key themes drawn from consultation with stakeholders.
Our Workforce

The Trust’s workforce totals over 11,500 members of staff. Numbers and percentages associated with the main professions and staff groups are shown in the table, below (the number for administrative and clerical staff includes all corporate support services).

Our current workforce levels represent an increase of almost 500 whole time equivalent (WTE) staff when compared to 2012/13. Predominantly, the increase is associated with ‘front line’ posts (including nursing, midwifery and health care assistant roles), or with staff groups directly supporting the delivery of patient care (e.g. healthcare scientists, and therapeutic and technical staff) which, combined, accounted for almost 80% of growth. Overall, the number of posts associated with management roles reduced during the same period.

Nurses and midwives are the largest staff group and make up approximately 32% of the total workforce. In addition to a medical workforce of over 1,500, we have approximately 600 doctors 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 with us. We also employ over 600 staff to provide facilities services at the John Radcliffe Hospital and Churchill Hospital sites. These members of staff are managed by our Private Finance Initiative (PFI) partners.

Staff Turnover

Staff turnover for the 12 month rolling period ending 31 March 2014 was 11.4%, which is marginally higher than 2012/13. Whilst turnover amongst qualified nurses and midwives reduced during the course of the year, it was highest amongst Allied Health Professionals, where the average was 15.1%.
Recruitment

During 2013/14, a comprehensive review of recruitment processes and procedures was undertaken. The aim of this review was to identify ways in which recruitment timescales could be reduced, efficiencies to the overall process achieved and responsiveness by the recruitment function improved. A key outcome of the review was the purchase and implementation of a new automated recruitment application management system, called TRAC.

The introduction of the TRAC system, from January 2014, has achieved improvements in the management and tracking of applicants and the provision of better quality, real time data relating to each stage of the recruitment process. This is assisting line managers in recruiting more quickly and is improving the experience of candidates. On average, there are 20 applicants for each administrative and clerical vacancy, and seven for each nursing and midwifery vacancy advertised.

Staff Health and Wellbeing

The health and wellbeing of staff continues to be an important theme within the Organisational Development and Workforce Strategy. The progress made in the promotion of the healthy workplace and in the increased provision of health and wellbeing support and advice to staff is highlighted by the high scores achieved by the Trust in the second national organisational audit of NHS Trusts in England – Implementing NICE Public Health Guidance for the Workplace. The audit was conducted in the latter part of 2013/14 and the Trust’s outcomes represent a marked improvement in performance compared with the first audit conducted in 2010.

Annual flu vaccination programme

A total of 7,700 employees (approximately 66% of front line staff) were vaccinated in the 2013 flu vaccination campaign. This represented an increase of 8% on the uptake achieved in the previous year and compared favourably against a national average of 48.6% (and 53.3% in the Thames Valley region). Following the success of the 2013 campaign, OUH was nominated for an NHS Flu Fighter award in the Media and Digital category.

New Centre for Occupational Health and Wellbeing

A new Centre for Occupational Health and Wellbeing was opened by Sir Roger Bannister in May 2013 and its facilities have been admired both by staff and visitors. The new Centre brought together the Occupational Health (OH), back care, physiotherapy teams and the health and wellbeing promotion specialist in one location. The benefits of this centralisation include improved user experience for all staff, access to services for disabled employees and efficiency in the provision of integrated services.

A health and wellbeing specialist has been appointed, who now leads our work on health promotion for staff. The Centre for Health and Wellbeing has made good progress towards gaining national accreditation for the provision of Safe Effective Quality Occupational Health Services (SEQOHS), which is expected to be achieved in 2014. Accreditation is designed to provide assurance that services provided meet nationally agreed quality standards.

In July 2013, the health and wellbeing specialist, together with a group of junior doctors, nurses and allied health professionals, called Health4Healthcare, conducted a very successful ‘Healthy Hospital Day’ at the John Radcliffe Hospital. Two further events were held at the Nuffield Orthopaedic Hospital and at the Horton General Hospital in Banbury which, combined, saw over 1,000 visitors, patients and staff take part.
Promoting public health to staff

As part of an initiative to develop a Public Health Strategy, the Trust has worked with its public health specialty doctors to identify public health priorities through consultation with staff and key partners. These are aligned with public health priorities for the county, and are consistent with NICE public health guidance.

The Trust’s Public Health Strategy aims to create a health-promoting environment in which healthy lifestyles and choices are promoted to our staff, patients and visitors at every opportunity. Activities include:

- Training staff to deliver health promotion advice to colleagues, with the aim of developing a network of ‘health champions’ across the Trust.
- Promoting physical activity to staff through an employer cycle purchase scheme, availability of subsidised gym membership and on-site fitness classes.
- Exploring healthier food options across Trust sites.
- Focusing on staff mental health through a policy which outlines procedures for identification of mental health problems, plus support and referral.

Staff Attendance

Through the provision of comprehensive and proactive occupational health services and the maintenance of healthy working environments, the Trust aims to ensure staff attendance levels are high and sickness absence rates are minimised. Across the year, staff sickness absence averaged 3.2%, which compared favourably with 4.2% for the NHS, as a whole. Seasonal variations in sickness absence levels are shown in the table, below.

Education, Learning and Development

An important aspect of being a leading teaching hospital is our commitment to support and educate the future workforce of the NHS. In addition to the provision of statutory and mandatory training for all members of staff, the Trust promotes opportunities for employees across all professions and staff groups to gain new skills and to further their personal and career development. Education and training interventions are delivered in a variety of ways to help meet the learning preferences of individuals, including on-line access and e-learning programmes. A particularly successful intervention, involving collaboration with academic partners, has been the provision of pre-registration nursing and midwifery education to around 400 student nurses and midwives and 800 trainee doctors.

An important focus has been to raise the profile and importance of leadership development. Key activities have included the following:
Over 400 leaders, at all levels of the organisation, have attended internal conferences to learn more about other sectors and the longer term challenges of the NHS. This initiative is making good progress in identifying and supporting a core cohort of leaders, whose members now have access to a developing internal network.

A Trust-wide ‘front line’ Nursing Leadership Programme (‘Safe in Our hands’) has been designed and implemented for senior nurses working in wards, critical care units and in theatres.

The Trust has been successful in gaining places for staff on the core professional programmes sponsored by the NHS Leadership Academy and other short programmes provided by Health Education Thames Valley. Designed to develop outstanding leaders for every tier across the healthcare system, the programmes provide targeted development for people from all backgrounds and experience levels.

In order to further support the development of our staff, a new electronic appraisal process was launched in late 2013. This provides online tools to assist in objective setting and personal development aligned to the Trust’s values.

**Reward, Recognition and Engagement**

Our staff are employed under nationally determined terms and conditions, which allow limited local flexibility with respect to pay levels. All staff received the 2013 national pay award of 1% and many more employees benefitted from an annual increment rise associated with their particular pay band, which averaged between 2% and 3%. The Trust also continued to apply a range of flexible working practices, including the application of part-time hours, term-time contracts and job sharing arrangements, wherever the particular requests of individuals could be met without compromising our service delivery.

Recognising the impact of continuing rises in the cost of living and lower annual pay increases within the public sector, the Trust has extended its range of flexible staff benefits, which include salary sacrifice schemes for car and bicycle leases, and new for this year, a home technology scheme. Other ongoing benefits designed to have broad appeal to staff include: subsidised restaurant prices; nursery school vouchers; discounts from a number of local and national retailers; a staff lottery; retirement vouchers; and the provision of competitively priced on-site accommodation.

**Saying thank you**

The second Annual Staff Recognition Awards event took place at Blenheim Palace in November 2013. The introduction of the new electronic nomination process for the 2013 Awards, combined with targeted communication to further raise awareness, resulted in 500 nominations being received, compared with 230 in the previous year. The Award categories covered: Excellence; Compassion; Good Thinking; Leadership; Innovation, and Volunteering. Over 80 further nominations were received from Oxford Mail readers, for the Oxford Mail Hospital Heroes Awards, which recognised staff and volunteers who had ‘gone the extra mile’.

The winners were presented with their certificate and Award during the course of the evening at Blenheim, to which all finalists were invited.

Rowena Pierce (pictured), Advanced Nurse Practitioner for Children with Disability, was awarded the Oxford Mail Hospital Heroes award 2013.
**Listening into Action**

As part of our *Delivering Compassionate Excellence* strategy, the Trust has been engaging staff in discussions about how to improve outcomes and experiences for patients through an initiative called Listening into Action. This is an approach which empowers staff to take collective action in driving forward improvements in service delivery and patient care. The programme builds on the Trust’s values development and offers executive-led ‘big conversations’ with staff groups to help shape an inclusive and participative culture.

Teams are involved in a range of projects, based on the broad themes of:
- delivering the best patient experience;
- keeping our staff informed;
- working better together;
- environment and infrastructure;
- effective processes that support patient care.

**Equality and Diversity Commitment**

As a progressive employer of multiple professions and staff groups, we aim to support a diverse community and a diverse workforce. The Trust is fully committed to providing equity in its services, treating people fairly and with dignity, and valuing diversity, both as a provider of healthcare and as a responsible employer.

Through adherence to the requirements of the Equality Act 2010, the Public Sector Equality Duty (PSED) and the NHS Constitution provisions for service users and staff, the Trust strives to:
- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity;
- provide services which meet the individual needs of all patients;
- foster good relations between people.

A range of demographic data is collated for both patients and employees, and the introduction of the *Electronic Patient Record* (EPR) has enabled the collection and analysis of more information than ever before. The analysis of data relating to protected characteristics is important in assisting the Trust to better identify the needs of patients and employees and enable us to monitor services, policies and procedures to ensure the equitable treatment of people in our community. We aim to have easily accessible feedback mechanisms in place, enabling us to learn and take appropriate action to improve our services, systems and behaviours.

Engagement with the local community and groups, such as BME networks, charities supporting people with physical and learning disabilities, travellers, and *Oxford Pride*, has been essential in understanding our performance in meeting needs, learning, and improving our services.

**Assessing pain in children**

In response to feedback from the *Listening into Action* programme, a team of nurses working with a paediatric anaesthetist have devised and implemented a ‘toolkit’ for assessing pain in children. Using a scale of 0-3, the toolkit takes into account input from the child’s parents and knowledge of the staff treating the child. The aim is to achieve a standard set of tools for nursing staff to assess pain and empower them to actively treat it.

Ella Hughes, a senior staff nurse, has been appointed to train staff in the use of the toolkit, which is being introduced across the children’s wards, critical care units and emergency departments, as well as to play specialists, physiotherapists and clinical nurse specialists.
The Trust continues to use the Equality Delivery System (EDS) to assess our performance in a structured way, and members of the community and our own workforce are routinely asked to assess the Trust’s performance and identify improvements in relation to equality and diversity. This assists in revising our Equality Objectives, which aim to deliver further improvements in patient and employee experience throughout the Trust.

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 we demonstrate a commitment to ensure our recruitment processes do not disadvantage disabled applicants; to engage in regular consultation with employees who have a disability; to help people who become disabled to stay in employment; to develop disability awareness for all employees; and to review our plans and activities in support of disabled people.

What Our Staff Say

The NHS Staff Survey

The 2013 NHS Staff Survey was undertaken between September and December. All directly employed staff received a survey questionnaire, which they were encouraged to complete and submit. The survey covered five key themes relating to the working environment and individuals’ experience within the workplace, namely: Your Personal Development; Your Job; Your Managers; Your Organisation; Your Health, and Wellbeing and Safety at Work.

Overall, when compared with the 2012 outcomes for all 28 key findings, there was no statistically significant change (either positive or negative) in 2013. The one exception related to staff advocacy (i.e. staff recommendation of the Trust as a place to work or receive treatment), where there was a significant improvement. When compared with all acute trusts in 2013, we performed well — for 20 of the 28 key findings, OUH scored better than average, and was is in the best 20% of acute trusts in eight. Against four of the Key Findings, we were slightly worse than average, most noticeably for staff working extra hours.

The Survey report also showed how we compared with other acute trusts on an overall indicator of staff engagement. Possible scores ranged from 1 to 5, with 1 indicating that staff are poorly engaged with their work, their team and their organisation, and 5 indicating a highly engaged workforce. The Trust’s score of 3.83 was in the highest (best) 20% when compared with acute trusts of a similar size (the average score for all acute trusts was 3.74). This score represented the fourth successive increase since 2010.

Areas showing most improvement:

More staff had an appraisal review, with further work required to improve the overall effectiveness and quality of appraisals.

More staff are aware of the need to report errors and concerns; staff also gave positive feedback about changes made in response to reported errors.

More training available in areas such as Equality and Diversity, handling confidential information and Health and Safety.

More managers and staff taking positive action on the health and well-being.

More staff know how to report fraud, malpractice or wrongdoing.

The main areas where staff reported more dissatisfaction related to feeling pressure to come to work when not being well, and levels of pay. Staff also highlighted that more could be done to encourage the reporting of errors.

We will continue to use the feedback provided by our employees, through the annual NHS Staff Survey, to address areas of concern and to make further improvements to the working environments and experiences of our staff. From June 2014, we will also be undertaking our own quarterly local ‘pulse’ surveys, which will provide more regular and immediate feedback.
Working with our community

We recognise that delivering excellence for our patients, our staff, the NHS and its partners can best be achieved by full engagement and participation in the way we shape and deliver our services. We involve service users and seek the views of our patients, their families and the public on a range of issues. We also work with charitable organisations to support community engagement and to share knowledge and expertise.

Be part of our future

As we prepare to become a Foundation Trust, we have continued to invite our patients and the public to become 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, and aged over 16, can become a member and get involved in the Trust. Children and young people can get involved through our Young People’s Executive (YiPpEe).

We have nearly 7,000 public members, along with a staff membership of around 11,000. As part of our process to become a Foundation Trust, we will elect a Council of Governors from our membership who will work alongside the Trust Board. In October and November 2013 we held a number of events for members interested in standing for election to the Council of Governors, which will comprise of:

- 15 publicly elected governors,
- six staff governors, and
- seven governors appointed by stakeholder bodies.
The process for assessing NHS trusts aspiring to become Foundation Trusts has been delayed by national priorities, in particular the new requirement that all trusts must have gone through the Care Quality Commission's new inspection regime introduced from September 2013.

The Trust underwent its CQC inspection in February 2014 and expects to submit an updated FT application for consideration by the Trust Development Agency and the economic regulator Monitor during the summer and autumn of 2014.

If these milestones are met, the Trust hopes to be able to establish its Council of Governors to operate in shadow form in early 2015, prior to formal authorisation as a Foundation Trust by the spring of 2015.

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 to develop a sustainable vision for the future for the Horton General Hospital.

The Community Partnership Network (CPN) supports engagement work between local people, patients, councillors and other interested parties to consider the long term vision for the Horton General Hospital and the services it provides.

Vision for the Horton General Hospital

In February 2014, the Trust undertook joint public engagement with the Oxfordshire Clinical Commissioning Group on the strategic vision for the future of the Horton General Hospital in Banbury. A public meeting at Rye Hill Golf Club near Banbury was attended by more than 200 people who had an opportunity to ask questions and air their views on the long-term vision which sees an expansion of day surgery and outpatient clinics at the Horton General Hospital but with emergency abdominal surgery ceasing to take place at the Horton and being moved to the John Radcliffe Hospital instead.

As a district general hospital, the Horton is part of the Oxford University Hospitals NHS Trust and patients needing to access a wide range of specialist services will receive those services at the Trust’s Oxford based hospitals, including stroke and major trauma at the John Radcliffe Hospital.

Surgery has become ever more specialised and it is against this background that hospital clinicians and local GPs have supported the transfer of the small amount of emergency abdominal surgery, that used to take place at the Horton, to the John Radcliffe Hospital where the required specialist emergency surgical rota is maintained. The Oxfordshire County Council’s Health Overview and Scrutiny Committee (HOSC) has also supported the decision based on the recommendation that this was the best option for clinical and patient safety reasons. The Trust continues to review the situation with the CPN, as well as engaging the public in ongoing developments.

Recent developments at the Horton General Hospital

The Horton General Hospital runs an accident and emergency department, has a consultant-led midwifery unit and is one of only eight general hospitals in the country that has a 24/7 consultant-led children’s unit, which means all children’s medical care is delivered by consultants. Today, the Horton General Hospital has 46 full time equivalent consultant doctors, an increase of 15% over the past five years.

Recent developments at the Horton General Hospital have included:

- A new Renal Dialysis Unit.
- A daily fracture clinic.
- Work has recently begun to refurbish the Ultrasound Department and provide dedicated waiting facilities for ultrasound outpatients and inpatients.
- Paediatric day-case ear, nose and throat surgery has been re-introduced at the Horton.
- A rapid access paediatric clinic has been launched which will enable GPs to refer urgent cases which they do not think should wait for a normal clinic appointment.
- There are plans for a dedicated children’s outpatient facility and also plans to refurbish and redesign the reception area of the main adult outpatients department.
Throughout the past year Oxford Radcliffe Hospitals Charitable Funds has been working to support the Trust, its patients and their families.

The charity is made up of around 600 unique funds, covering every corner of our hospitals. From supporting individual hospital wards, purchasing state-of-the-art medical equipment and funding innovative medical research – the charity makes a difference to the lives of patients, young and old, across the Trust every day.

Donations from grateful patients and their families, supporters and other charitable organisations, together with legacies and fundraising events throughout the year have generated close to £5 million.

Events and Campaigns

The 2013 London Marathon saw an impressive £50,000 raised for numerous causes across our hospitals, including the Horton’s Maternity Ward, the Haematology Ward at the Churchill, The John Radcliffe’s Newborn Intensive Care Unit and our larger funds – Silver Star, I.M.P.S. and Head’s Up.

Abseils supporting many individual funds continued to be popular, raising over £80,000. The Oxford Mail OX5RUN, in aid of the Children’s Hospital, broke all records with 1,465 people signing up for the five miler at Blenheim.

The Heartfelt Appeal continued to be a key focus with several major donations and grants, as well as hundreds of smaller donations and fundraising activities.

This support has enabled us to purchase the very latest echocardiology machines as well as co-funding a new Cardiology Outpatients and Imaging Unit. Work started on the unit in Spring 2014 and we look forward to being able to show the new centre to supporters later this year.

Christmas 2013 saw a wonderful Carols and Canapés event for the Cancer Care Fund and Urology Fund at Ditchley Park and our Christmas tags appeal raised an unprecedented £26,000 with donations to almost every corner of our hospitals.

Cancer and Haematology Centre

At the Cancer and Haematology Centre the audio library continued to grow, providing entertainment and comfort to patients across many wards. The needs of teenagers and young adults with cancer were also recognised, and an area next to the Oncology Ward at the Churchill was given a fresh new look, complete with a chill-out area, TV, computer games and a jukebox.

Younger teens with cancer at the Children’s Hospital also received a boost with the creation of both indoor and outdoor chill-out spaces on Kamran’s Ward. Two state-of-the-art open incubators were purchased for babies in the Paediatric Intensive Care Unit, along with an ultra sound machine for minimally invasive surgery and high tech equipment to help research childhood meningitis and septicaemia. Items including an interactive 3D TV were also funded, helping to bring some distraction and fun to the Children’s Hospital.

We are very grateful to everyone who supports the hospital causes with such generosity and enthusiasm and all those colleagues across the Trust who join our events and promote fundraising in their areas.
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.

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 a small shop at the Horton General Hospital and Nuffield Orthopaedic Centre.

The Trust has over 200 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 five 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.

Donations in the spotlight

A microscope which enables neurosurgeons to track and target brain tumours by illuminating the affected tissue using a fluorescent light has been purchased by the Trust. The innovative procedure causes cancerous cells to glow brightly once introduced to fluorescent light and enables surgeons to identify and remove more complex tumours with increased confidence, accuracy and ease. The Trust has purchased this specialist equipment with the support of a significant donation from the West Wing League of Friends at the John Radcliffe Hospital.

Half a century supporting our hospital services

The League of Friends of the Nuffield Orthopaedic centre has marked 50 years of raising funds to support the hospital. Volunteers have collected over £1.1m during that time and they marked the milestone with a birthday tea. Trust Chief Executive sir Jonathan Michael and the league’s longest-serving volunteer, Jean Burley, cut a special birthday cake and unveiled a plaque next to the League of Friends shop.
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 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 in 2013/14:**

Chairman: Dame Fiona Caldicott*
Chief Executive: Sir Jonathan Michael*

**NON-EXECUTIVE DIRECTORS (NED)**

Professor Sir John Bell*
Mr Alisdair Cameron*
Mr Christopher Goad*
Professor David Mant (Associate Non-Executive Director)
Mr Geoffrey Salt (Vice Chairman)*
Mrs Anne Tutt**
Mr Peter Ward*

**EXECUTIVE DIRECTORS**

Professor Edward Baker Medical Director
(19 March, 2014)*
Mr Paul Brennan Director of Clinical Services*
Ms Sue Donaldson Director of Workforce
(11 November, 2013)
Mr Mark Power Director of Organisational Development and Workforce
(from 19 February, 2014)
Mr Mark Mansfield Director of Finance and Procurement*
Mr Andrew Stevens Director of Planning and Information
Mrs Elaine Strachan-Hall Chief Nurse*
(16 August, 2013)
Mr Mark Trumper Director of Development and the Estate
Ms Eileen Walsh Director of Assurance

The Trust Board considered the frequency of its meetings and agreed to meet bi-monthly from 1 May, 2013. In the intervening months it was agreed to hold meetings of the Quality Committee and Finance and Performance Committee to ensure that there was a regular consideration of quality, financial and operational performance. The Board met six times in public during the year.

Further details and biographies of the Board of Directors are available from the Trust’s website at: www.ouh.nhs.uk/about

* Indicates those members holding voting positions in line with The Health Service Trusts (Membership & Procedure) Regulations 1990.

**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:

Mrs Anne Tutt (Chairman)
Mr Alisdair Cameron
Mr Christopher Goad

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 five 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 Goad (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 (19 March, 2014)
Mr Mark Trumper, Director of Development and the Estate
Mr Paul Brennan, Director of Clinical Services

The committee met a total of six 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

and the following Executive Directors:

Professor Edward Baker, Medical Director (until 31 March, 2014)
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

Mrs Anne Tutt normally attends meetings of the Quality Committee in her capacity as Chairman of the Audit Committee to address cross-cutting issues.

The committee met a total of six times during the year.

RENUMERATION 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 their appraisal for 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 five times during the year. Full details of the senior managers’ 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 Organisational Development and 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 the Chief Executive and the Director of Organisational Development and Workforce, are under consideration.

Declaration of Interests and Register of Interests of members of the Trust Board for the year 2013/14

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 2013/14 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 below.
### Trust Board Members Register of Interests 2013-2014

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<tr>
<td><strong>Professor Edward Baker</strong>, Medical Director</td>
<td></td>
<td></td>
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<td></td>
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<td>None</td>
</tr>
<tr>
<td><strong>Mr Paul Brennan</strong>, Director of Clinical Services</td>
<td></td>
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</tr>
<tr>
<td><strong>Mr Alisdair Cameron</strong>, NED</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Director/Trustee of various British Gas/Centrica Companies</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Mrs Cameron, member of Fundraising Committee for Children’s Hospital</td>
<td>None</td>
</tr>
<tr>
<td><strong>Ms Sue Donaldson</strong>, Director of Organisational Development and Workforce</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Governor; Oxford &amp; Cherwell College</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Mr Paul Jones</strong>, Interim Director of Finance &amp; Procurement (November 2013 - Feb 2014)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Managing Director of own limited company, providing consultancy &amp; interim management services: Corporate Consulting Ltd</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><strong>Mr Christopher Goard</strong>, NED</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Medicines Code of Practice Authority Appeals Board Member</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Chairman of the Genetic Alliance UK (an organisation that cooperates with and lobbies both the NHS and the Government here and in Brussels), Magistrate on Buckinghamshire Bench for Adult Criminal Court and Family Court</td>
<td>None</td>
</tr>
<tr>
<td><strong>Mr Mark Mansfield</strong>, Director of Finance &amp; Procurement</td>
<td></td>
<td></td>
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<td>None</td>
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<td>None</td>
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<td>None</td>
</tr>
<tr>
<td><strong>Professor David Mant</strong>, NED</td>
<td></td>
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<tr>
<td></td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Member of the Oxford University Nuffield Department of Primary Care Health Sciences. Honorary Consultant with Oxford Health NHS Foundation Trust</td>
<td>Research grant holder from medical charities, EU, DH &amp; NHR</td>
</tr>
<tr>
<td><strong>Sir Jonathan Michael</strong>, Chief Executive</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Trustee – Kings Fund Director; Shelford Health Roundtable Director; Beechlawn Consultancy Ltd</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Mr Mark Power</strong>, Director of Organisational Development and Workforce (from 19 Feb, 2014)</td>
<td></td>
<td></td>
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<td>None</td>
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</table>
## Trust Board Members Register of Interests 2013-2014

<table>
<thead>
<tr>
<th>BOARD MEMBER</th>
<th>Directorships, including Non-executive Directorships</th>
<th>Business, partnership or consultancies</th>
<th>Majority or controlling share holdings</th>
<th>Charity or voluntary organisation</th>
<th>Voluntary or other organisation</th>
<th>Pooled Funds</th>
<th>Research funding/grants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Geoffrey Salt</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>Deputy Chairman</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs Elaine Strachan-Hall</td>
<td>Director; Ollidoowedji Ltd</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Andrew Stevens</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 Planning and Information</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mr Mark Trumper</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<td>None</td>
</tr>
<tr>
<td>Director of Development and the Estate</td>
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<tr>
<td>Mrs Anne Tutt, NED</td>
<td>Section 11 Trustee Oxford Radcliffe Hospitals Charitable Fund and Chairman of Audit Committee. NED and Trustee of The Social Investment Business Foundation Ltd. Deputy Chair of the Social Investment Business Ltd and Chair of the Finance Committee. NED Bamboo Innovations Ltd – Dissolved Jan 14. NED and Chair of Audit and Risk Assurance Committee of Her Majesty’s Passport Office – Contract ended Dec 13. Member of Audit &amp; Risk Assurance Committee of Home Office, member of DEFRA Audit &amp; Risk Assurance Committee. Board Member of IASAB (the internal Audit Standards Advisory Board) Government body advising on the application of Internal Audit Standards in the public sector. NED of Social and Sustainable capital LLP and Chair of the Audit and Finance Committee. International Network for the Availability of Scientific Publications – Director and Chair of Audit Committee.</td>
<td>Ownership of a private business – A Tutt Associates</td>
<td>None</td>
<td>None</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>Partner in Health Governance Consulting</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<td>None</td>
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<tr>
<td>Director of Assurance</td>
<td></td>
<td></td>
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<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>Acting Chief Nurse</td>
<td></td>
<td></td>
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<tr>
<td>Ms Liz Wright</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
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</tbody>
</table>
Section 2

Financial Review | 2013/14

THESE ARE SUMMARY ACCOUNTS
The full accounts for 2013/14 are available at www.ouh.nhs.uk or on request.
Financial Review and Outlook

Summary

This is the third report produced by the Oxford University Hospitals NHS Trust which came into existence on 1 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 the financial year with a surplus of £10,895,000 before the technical adjustments due to impairments and IFRIC 12, against an original plan to produce a surplus of £10.871m. If this figure is then adjusted for impairments and IFRIC 12, a technical surplus under the IFRS regime of £17,432,000 results.

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

Summary financial statements are included on pages 64-68. These may not contain sufficient information to fully understand the Trust’s financial position and details of how to obtain a copy of the Annual Report (which includes a full set of accounts) are set out on page 64.

Review of 2013/14 and outlook for future years.

At the start of the year the Trust planned to make a surplus of £10.871m in 2013/14 after removing technical adjustments. The accounts indicate that the trust achieved a surplus of £10.895m. The Trust also had a target to achieve savings of £44.7M and the outturn was that savings of £42.7M (or 96% of the target) were achieved.

For 2014/15 the Trust is planning to make a surplus on Income and Expenditure of £12.1M (1.3%). Within this plan is an assumption that the Trust will deliver further significant cost improvements and it has plans to find at least £46.0M. The continuing need for significant savings reflects the financial constraints that are facing the whole public sector.

The outlook is that austerity within the public sector is set to continue for a number of years thereby increasing the risks to financial health for individual organisations.

Within the Oxfordshire health and social care economy, the Trust is working with the Clinical Commissioning Group (CCG), NHS England and our partners in Social Services to deliver a plan for Oxfordshire which seeks to find the best solution for the whole health economy. 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 those 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

On 1 April 2013, the responsibility for commissioning services transferred from Primary Care Trusts to the Clinical Commissioning Groups, NHS England, (which assumed responsibility for commissioning a range of specialist services) and local authorities. The Trust’s income increased by £46.6m (5.7%) over the previous year and the main components of the Trust’s income for 2013/14 of £868m are shown in the table below.

As can be seen from the table below, over 80% of the Trust’s resources came from Clinical Commissioning Groups and NHS England. The increase in income from CCGs and NHS England arose because the Trust was required to meet a demand for more patient care services than was originally envisaged.

Operating Expenses

The Trust spends on average just under £2.3m each and every day. The largest item of expenditure is staff costs and the next most significant is clinical supplies and services. The graph below 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 introduce further efficiencies. We are doing everything we can to be more efficient. This includes internal efficiencies such as better theatre utilisation, and service moves to improve clinical adjacencies to make better use of our estate and the hospitals we work in.

Over the next five years we plan to make savings averaging £38.9m per annum (in nominal terms). This represents an average annual saving over these five years (2015/16 to 2019/20) of 4.3% each year.

Fig 1: OUR income sources

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2012/13</th>
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</thead>
<tbody>
<tr>
<td>Clinical Commissioning Groups</td>
<td>352,898</td>
<td>-</td>
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<tr>
<td>NHS England</td>
<td>359,253</td>
<td>-</td>
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<td>Primary Care Trusts</td>
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<td>658,520</td>
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<td>Strategic Health Authorities</td>
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<td>12,159</td>
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<td>NHS Trusts and FTs</td>
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<td>Department of Health</td>
<td>0</td>
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<tr>
<td>NHS Other (inc Public Health England and Prop Co)</td>
<td>354</td>
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<tr>
<td>Non-NHS – Local Authorities</td>
<td>6,552</td>
<td>0</td>
</tr>
<tr>
<td>Other Non-NHS including RTA</td>
<td>11,349</td>
<td>13,996</td>
</tr>
<tr>
<td>Education &amp; Research</td>
<td>96,459</td>
<td>98,152</td>
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<tr>
<td>Other non-patient services</td>
<td>31,537</td>
<td>33,479</td>
</tr>
<tr>
<td>Other</td>
<td>9,944</td>
<td>5,399</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td><strong>868,346</strong></td>
<td><strong>821,705</strong></td>
</tr>
</tbody>
</table>

(Source notes 4 to 7 of Annual Accounts 2013/14)
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 £23.3m was expended in 2013/14 and the chart below provides an indication of the areas of investment the Trust pursued in the year.

The Plan for 2014/15 can be summarised as follows; total funding of £41.1m is anticipated and it is proposed to use this for:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>£000</th>
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<tbody>
<tr>
<td>Medical and Surgical Equipment</td>
<td>5669</td>
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<tr>
<td>Estate Maintenance</td>
<td>2000</td>
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<tr>
<td>Ward Relocations</td>
<td>2700</td>
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<tr>
<td>JR theatre remodelling</td>
<td>550</td>
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<tr>
<td>Other maintenance</td>
<td>2962</td>
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<tr>
<td>Radiotherapy satellite units</td>
<td>2700</td>
</tr>
<tr>
<td>IT/ EPR</td>
<td>5500</td>
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<tr>
<td>EPR Re-procurement</td>
<td>4688</td>
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<td>Other Schemes</td>
<td>14356</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>41125</td>
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</table>

(Source: LTFM May 14)

Summary of Financial Duties

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

**Breakeven on Income and Expenditure (a measure of financial stability)**

The Trust reported a surplus of income over expenditure of £10,895,000 for 2013/14, after Department of Health agreed exclusions of £(6,537,000) 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 the ‘technical’ expenditure is included in the Trust’s Accounts, it is the position excluding these items which forms the basis of the break-even requirement, against which the Trust’s financial performance is judged by the Department of Health.

**Performance over the last five years**

The following table summarises the performance of the Oxford University Hospital Trust and its predecessors over the last five years.
NOTE: The figures are on the basis of the International Financial Reporting Standards (IFRS). For break-even performance, impairments and IFRIC 12 adjustments are excluded.

### External Financing Limit (an overall cash management control)

The Trust was set a target to decrease its level of external finance by £20.003 million in 2013/14. The Trust achieved this target by reducing its level of external financing requirement by £33.742 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 £23.354m which it could spend on capital and during the year it spent £23.336m, thus undershooting its control limit by £0.018m.
Summary Financial Statements

These accounts for the year ended 31st March 2014 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 and audit certificates are set out in the full Annual Report and Accounts which 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. 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 £10,895,000 against the breakeven duty for 2013/14. The accounts record a surplus of £17,432,000; the difference of £6,537,000 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.

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retained surplus/deficit for the year</strong></td>
<td>17,432</td>
<td>(1,316)</td>
</tr>
<tr>
<td>IFRIC*12 Adjustment</td>
<td>(6,255)</td>
<td>1</td>
</tr>
<tr>
<td>Impairments</td>
<td>(2,171)</td>
<td>4,568</td>
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<tr>
<td>Adjustments for donated asset/gov’t grant reserve elimination</td>
<td>1,889</td>
<td>393</td>
</tr>
<tr>
<td><strong>Reported NHS Finance Performance position (adjusted retained surplus)</strong></td>
<td>10,895</td>
<td>3,646</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)

### Revenue

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2012/13</th>
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<tbody>
<tr>
<td>Employee benefits</td>
<td>(481,311)</td>
<td>(450,750)</td>
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<tr>
<td>Other costs</td>
<td>(342,048)</td>
<td>(343,464)</td>
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<tr>
<td>Revenue from patient care activities</td>
<td>730,406</td>
<td>684,675</td>
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<tr>
<td>Other operating revenue</td>
<td>137,940</td>
<td>137,030</td>
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<tr>
<td><strong>Operating surplus/(deficit)</strong></td>
<td>44,987</td>
<td>27,491</td>
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</table>

### Finance costs:

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment revenue</td>
<td>243</td>
<td>189</td>
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<tr>
<td>Other gains and losses</td>
<td>394</td>
<td>(17)</td>
</tr>
<tr>
<td><strong>Finance costs</strong></td>
<td>(20,633)</td>
<td>(20,477)</td>
</tr>
<tr>
<td><strong>Surplus/(deficit) for the financial year</strong></td>
<td>24,991</td>
<td>7,186</td>
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<tr>
<td>Public dividend capital dividends payable</td>
<td>(7,559)</td>
<td>(8,502)</td>
</tr>
<tr>
<td><strong>Retained surplus/(deficit) for the year</strong></td>
<td>17,432</td>
<td>(1,316)</td>
</tr>
</tbody>
</table>

### Other comprehensive income

<table>
<thead>
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<th>2013/14</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairments and reversals</td>
<td>(582)</td>
<td>(4,650)</td>
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<tr>
<td>Net Gain /(loss) on revaluation of property, plant &amp; equipment</td>
<td>19,934</td>
<td>4,592</td>
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<tr>
<td>Net Gain /(loss) on revaluation of intangibles</td>
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<td>0</td>
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<tr>
<td>Net Gain /(loss) on revaluation of financial assets</td>
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<tr>
<td>Net Gain /(loss) on revaluation on other reserves</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net Gain /(loss) on revaluation on available for sale financial assets</td>
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<td>0</td>
</tr>
<tr>
<td>Net actuarial Gain /(loss) on pension schemes</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassification adjustment on disposal of available for sale financial assets</td>
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<td>0</td>
</tr>
<tr>
<td><strong>Total comprehensive income for the year</strong></td>
<td>36,784</td>
<td>(1,374)</td>
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## Statement of Financial Position as at 31 March 2014

<table>
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<th>31 March 2014</th>
<th>31 March 2013</th>
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<td><strong>Non-current assets</strong></td>
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<td>Property, plant and equipment</td>
<td>696,042</td>
<td>681,746</td>
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<td>Intangible assets</td>
<td>9,215</td>
<td>7,745</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>4,945</td>
<td>3,774</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>710,202</td>
<td>693,265</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>11,807</td>
<td>11,353</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>24,361</td>
<td>27,054</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>0</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>86,448</td>
<td>65,657</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>122,616</td>
<td>104,064</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>832,818</td>
<td>797,329</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(115,675)</td>
<td>(109,203)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(4,251)</td>
<td>(2,902)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(9,857)</td>
<td>(10,054)</td>
</tr>
<tr>
<td>Working capital loan from Department</td>
<td>0</td>
<td>0</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>(131,187)</td>
<td>(123,563)</td>
</tr>
<tr>
<td><strong>Net current assets/(liabilities)</strong></td>
<td>(8,571)</td>
<td>(19,499)</td>
</tr>
<tr>
<td><strong>Non-current assets plus/ less current assets/ liabilities</strong></td>
<td>701,631</td>
<td>673,766</td>
</tr>
</tbody>
</table>

### Non-current liabilities

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014</th>
<th>31 March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade and other payables</td>
<td>(14,251)</td>
<td>(11,616)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(2,447)</td>
<td>(1,602)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(270,104)</td>
<td>(282,755)</td>
</tr>
<tr>
<td>Working capital loan from Department</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital loan from Department</td>
<td>(5,003)</td>
<td>(6407)</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td>(291,805)</td>
<td>(302,380)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>409,826</td>
<td>371,386</td>
</tr>
</tbody>
</table>

### Financed by taxpayers' equity:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014</th>
<th>31 March 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital</td>
<td>208,935</td>
<td>207,673</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>34,413</td>
<td>14,608</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>164,735</td>
<td>147,362</td>
</tr>
<tr>
<td>Other reserves</td>
<td>1,743</td>
<td>1,743</td>
</tr>
<tr>
<td><strong>Total taxpayers' equity</strong></td>
<td>409,826</td>
<td>371,386</td>
</tr>
</tbody>
</table>
Statement of Changes in Taxpayers’ Equity for the Year Ended 31 March 2014

<table>
<thead>
<tr>
<th></th>
<th>Public dividend capital (PDC)</th>
<th>Retained earnings</th>
<th>Revaluation reserve</th>
<th>Other reserves</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balance at 1 April 2013</td>
<td>207,673</td>
<td>14,608</td>
<td>147,362</td>
<td>1,743</td>
<td>371,386</td>
</tr>
<tr>
<td>Changes in taxpayers’ equity for 2013-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain on revaluation of property, plant, equipment</td>
<td>-</td>
<td>-</td>
<td>19,934</td>
<td>-</td>
<td>19,934</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
<td>-</td>
<td>(582)</td>
<td>-</td>
<td>(582)</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>-</td>
<td>1,979</td>
<td>(1,979)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers under Modified Absorption</td>
<td>-</td>
<td>394</td>
<td>-</td>
<td>394</td>
<td></td>
</tr>
<tr>
<td>Accounting – PCTs &amp; SHAs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reclassification Adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New PDC Received – Cash</td>
<td>1,262</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,262</td>
</tr>
<tr>
<td>PDC Repaid in year</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PDC Written Off</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net recognised revenue/(expense) for the year</td>
<td>1,262</td>
<td>19,805</td>
<td>17,373</td>
<td>0</td>
<td>38,440</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>208,935</td>
<td>34,413</td>
<td>164,735</td>
<td>1,743</td>
<td>409,826</td>
</tr>
</tbody>
</table>

Statement of Changes in Taxpayers’ Equity for 2012-13

<table>
<thead>
<tr>
<th></th>
<th>Public dividend capital (PDC)</th>
<th>Retained earnings</th>
<th>Revaluation reserve</th>
<th>Other reserves</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balance at 1 April 2012</td>
<td>206,873</td>
<td>15,600</td>
<td>147,744</td>
<td>1,743</td>
<td>371,960</td>
</tr>
<tr>
<td>Changes in taxpayers’ equity for 2012-13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain on revaluation of property, plant, equipment</td>
<td>-</td>
<td>-</td>
<td>4,592</td>
<td>-</td>
<td>4,592</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
<td>-</td>
<td>(4,650)</td>
<td>-</td>
<td>(4,650)</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>-</td>
<td>324</td>
<td>(324)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Release of reserves to SOCI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reclassification Adjustments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New PDC Received</td>
<td>800</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>800</td>
</tr>
<tr>
<td>PDC Repaid in year</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PDC Written Off</td>
<td>-</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>-</td>
<td>(574)</td>
</tr>
<tr>
<td>Balance at 31 March 2013</td>
<td>207,673</td>
<td>14,608</td>
<td>147,362</td>
<td>1,743</td>
<td>371,386</td>
</tr>
</tbody>
</table>
# Statement of Cash Flows for the Year Ended 31 March 2014

<table>
<thead>
<tr>
<th>Cash Flows from Operating Activities</th>
<th>2013-14</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Surplus/(Deficit)</td>
<td>44,987</td>
<td>27,491</td>
</tr>
<tr>
<td>Depreciation and Amortisation</td>
<td>36,706</td>
<td>36,758</td>
</tr>
<tr>
<td>Impairments and Reversals</td>
<td>(8,426)</td>
<td>4,568</td>
</tr>
<tr>
<td>(Increase)/Decrease in Inventories</td>
<td>(454)</td>
<td>1,408</td>
</tr>
<tr>
<td>(Increase)/Decrease in Other Receivables</td>
<td>672</td>
<td>10,331</td>
</tr>
<tr>
<td>(Increase)/Decrease in Other Current Assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increase/(decrease) in Trade and Other Receivables</td>
<td>7,554</td>
<td>18,858</td>
</tr>
<tr>
<td>Increase/(decrease) in Other Current Liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions Utilised</td>
<td>(1,219)</td>
<td>(3,152)</td>
</tr>
<tr>
<td>Increase/(Decrease) in Provisions</td>
<td>3,373</td>
<td>(2,184)</td>
</tr>
<tr>
<td>Net Cash Inflow/(Outflow) from Operating Activities</td>
<td>55,443</td>
<td>63,084</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash Flows from Investing Activities</th>
<th>2013-14</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest Received</td>
<td>243</td>
<td>179</td>
</tr>
<tr>
<td>(Payments) for Property, Plant and Equipment (PPE)</td>
<td>(19,254)</td>
<td>(23,499)</td>
</tr>
<tr>
<td>(Payments) for Intangible Assets</td>
<td>(5,137)</td>
<td>(2,740)</td>
</tr>
<tr>
<td>Proceeds from disposal of assets held for sale (PPE)</td>
<td>2,487</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds from disposal of assets held for sale (Intangible)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds from Disposal of Investments with DH</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds from Disposal of Other Financial Assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rental Revenue</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from investing activities</td>
<td>(21,661)</td>
<td>(26,060)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) before financing</td>
<td>33,782</td>
<td>37,024</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash flows from financing activities</th>
<th>2013-14</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Dividend Capital Received</td>
<td>1,262</td>
<td>800</td>
</tr>
<tr>
<td>Public Dividend Capital Repaid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans received from DH-New Capital Investment Loans</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans received from DH-New Working Capital Loans</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans repaid to DH-Capital Investment Loans Repayment of Principal</td>
<td>(1,404)</td>
<td>(1,404)</td>
</tr>
<tr>
<td>Loans repaid to DH-Working Capital Loans Repayment of Principal</td>
<td>(3,326)</td>
<td>(11,321)</td>
</tr>
<tr>
<td>Capital element of finance leases and On-SoFP PFI</td>
<td>(12,849)</td>
<td>0</td>
</tr>
<tr>
<td>Capital grants and other capital receipts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from financing</td>
<td>(12,991)</td>
<td>(15,251)</td>
</tr>
</tbody>
</table>

| Net increase/(decrease) in cash and cash equivalents | 20,791 | 21,773 |
| Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year | 65,657 | 43,884 |
| 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 | 86,448 | 65,657 |
Public Interest and Other Disclosures

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 2013/14 is set out below.

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.

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Value £000</td>
</tr>
<tr>
<td>Total Non-NHS trade invoices paid</td>
<td>141,666</td>
<td>321,593</td>
</tr>
<tr>
<td>Total Non-NHS trade invoices within target</td>
<td>128,729</td>
<td>291,057</td>
</tr>
<tr>
<td>% Non-NHS trade invoices paid within target</td>
<td>90.87%</td>
<td>90.50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Value £000</td>
</tr>
<tr>
<td>Total NHS trade invoices paid</td>
<td>5,828</td>
<td>88,626</td>
</tr>
<tr>
<td>Total NHS trade invoices within target</td>
<td>5,341</td>
<td>84,899</td>
</tr>
<tr>
<td>% NHS trade invoices paid within target</td>
<td>91.64%</td>
<td>95.79%</td>
</tr>
</tbody>
</table>

(Source Note: 11 to Annual Accounts 2013/14)

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 2014 was £228,000. 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.

Counter Fraud

The Board is absolutely committed to maintaining an honest, open and well-intentioned atmosphere within the Trust. It is therefore committed to eliminating any fraud within the Trust, and to the rigorous investigation of any such cases. Where any acts of fraud or corruption are proven, the Trust will ensure that the people involved are appropriately dealt with, and will also take all appropriate steps to recover any losses in full. The Trust has adopted a Counter Fraud Policy & reporting procedures and has appointed KPMG to provide a counter fraud service.
**Charging for Information**

The Trust has complied with Treasury’s guidance on setting charges for information as specified by Chapter 6 of HM Treasury’s ‘Managing Public Money’.

**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 included at note 10.3 to the accounts lists the data for January 2013 - December 2013 which has been provided centrally for this purpose.

**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 10.6 to the full accounts and in the remuneration report.
The table below discloses the remuneration provided to Directors within the Oxford University Hospitals NHS Trust during 2013/2014 in a format which is comparable to that used in previous years. A revised format has been introduced in 2013/14 which adds in the derived increase in capital value of pension benefits at age 60, calculated using a legislated relevant valuation factor of 20 on annual pension at age 60, plus lump sum at age 60. This does not reflect an increase in remuneration during 2013-14 but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. This technical table in the new format, is shown on page 76 of this report.

### Salary and Allowances of senior managers

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary (bands of £5,000)</th>
<th>Benefits in kind (bands of £5,000)</th>
<th>Performance related pay (bands of £5,000)</th>
<th>Other remuneration (bands of £5,000)</th>
<th>Rounded to the nearest £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dame Fiona Caldicott</td>
<td>20-25</td>
<td>5-10</td>
<td>5-10</td>
<td>5-10</td>
<td>2025</td>
</tr>
<tr>
<td>Mr Geoffrey Salt</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Alisdair Cameron</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td>Professor Sir John Bell</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td>Mrs Anne Tutt</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Peter Ward</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Christopher Goard</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Andrew Stevens</td>
<td>125-130</td>
<td>125-130</td>
<td>10-15</td>
<td></td>
<td>125-130</td>
</tr>
<tr>
<td>Ms Sue Donaldson</td>
<td>85-90</td>
<td>85-90</td>
<td></td>
<td></td>
<td>85-90</td>
</tr>
<tr>
<td>Ms Liz Wright</td>
<td>10-15</td>
<td>10-15</td>
<td></td>
<td></td>
<td>10-15</td>
</tr>
<tr>
<td>Mr Mark Power</td>
<td>10-15</td>
<td>10-15</td>
<td></td>
<td></td>
<td>10-15</td>
</tr>
</tbody>
</table>

### Notes
1. Resigned from Oxford University Hospitals August 2013
2. Resigned from Oxford University Hospitals October 2013
3. Relates to clinical excellence awards and management allowance
4. Appointed to Oxford University Hospitals February 2014
5. Acting Chief Nurse covering August 2013 to March 2014
6. Interim Director of Human Resources covering October 2013 to February 2014
## Salary and pension entitlements of senior managers

### 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 2014 (bands of £5,000) £000</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2014 £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2013 £000</th>
<th>Real increase in Cash Equivalent Transfer Value £000</th>
<th>Employer’s contribution to Stakeholder Pension £000</th>
<th>To nearest £100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Elaine Strachan-Hall, Chief Nurse</td>
<td>-2.5-0</td>
<td>-2.5-5</td>
<td>45-50</td>
<td>135-140</td>
<td>824</td>
<td>792</td>
<td>15</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Andrew Stevens, Director of Planning and Information</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>45-50</td>
<td>140-145</td>
<td>917</td>
<td>862</td>
<td>37</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Mark Mansfield, Director of Finance and Procurement</td>
<td>5-7.5</td>
<td>19-21.5</td>
<td>55-60</td>
<td>170-175</td>
<td>1,063</td>
<td>899</td>
<td>144</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Paul Brennan, Director of Clinical Services</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>55-60</td>
<td>165-170</td>
<td>1,048</td>
<td>987</td>
<td>39</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Professor Edward Baker, Medical Director</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>105-110</td>
<td>315-320</td>
<td>2,308</td>
<td>2,166</td>
<td>95</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ms Sue Donaldson, Director of Human Resources</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>10-15</td>
<td>40-45</td>
<td>241</td>
<td>210</td>
<td>26</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Mark Trumper, Director of Development and the Estates</td>
<td>0-2.5</td>
<td>0</td>
<td>35-40</td>
<td>0</td>
<td>404</td>
<td>373</td>
<td>23</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ms Eileen Walsh, Director of Assurance</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>25-30</td>
<td>85-90</td>
<td>477</td>
<td>440</td>
<td>27</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mr Mark Power, Director of Human Resources</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>10-15</td>
<td>40-45</td>
<td>252</td>
<td>220</td>
<td>28</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ms Elizabeth Wright, Acting Chief Nurse</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>15-20</td>
<td>45-50</td>
<td>312</td>
<td>265</td>
<td>40</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

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. CETVs 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.
Overview of Executive Director Remuneration

Executive Directors 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.

PRP allocation and the assessment of performance against Corporate Objectives to determine and agree PRP is undertaken by the R&A Committee. 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. PRP is applied as a single annual ‘lump sum’ payment which does not attract pension benefits.

Details of the PRP scheme and payments arising from team performance against Corporate Objectives during 2013/14 are provided in the table below. The PRP for 2013/14 will be paid in 2014/15. 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.

NOTE: The Medical Director is employed on the nationally determined Consultant Contract which includes a basic salary from agreed payscales 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 Medical Director is not eligible for the Executive PRP Scheme.

<table>
<thead>
<tr>
<th>Delivering Compassionate Excellence</th>
<th>Comment</th>
<th>Potential PRP</th>
<th>Awarded PRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain/deliver national standards for access to services</td>
<td>Partly Achieved</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Maintain upper quartile performance (relative to Association of UK University Hospitals Group) and year on year improvement for patient and staff feedback</td>
<td>Achieved</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Deliver agreed Strategic Quality priorities</td>
<td>Achieved</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>Achieve national and local CQUIN targets (receiving at least 70% of available payments)</td>
<td>Achieved</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A well-Governed and Adaptable Organisation</th>
<th>Comment</th>
<th>Potential PRP</th>
<th>Awarded PRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve all required milestones towards Foundation Trust status</td>
<td>Achieved</td>
<td>25%</td>
<td>15%</td>
</tr>
<tr>
<td>Achieve all agreed milestones for Electronic Staff Record implementation</td>
<td>Partly Achieved</td>
<td>15%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivering Better Value Healthcare</th>
<th>Comment</th>
<th>Potential PRP</th>
<th>Awarded PRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver the financial plan, including cost improvement elements</td>
<td>Achieved</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivering Integrated Local Healthcare</th>
<th>Comment</th>
<th>Potential PRP</th>
<th>Awarded PRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce delayed transfers of care by 64 cases</td>
<td>Partly Achieved</td>
<td>15%</td>
<td>5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excellent Secondary and Specialist Care through Sustainable Clinical Networks</th>
<th>Comment</th>
<th>Potential PRP</th>
<th>Awarded PRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver the business cases for satellite radiotherapy provision</td>
<td>Achieved</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivering the Benefits of Research and Innovation to Patients</th>
<th>Comment</th>
<th>Potential PRP</th>
<th>Awarded PRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the new Academic Health Science Network structure</td>
<td>Achieved</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Achieve Academic Health Science Centre status</td>
<td>Achieved</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Establish a mechanism for supporting and monitoring innovation</td>
<td>Achieved</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TOTALS</th>
<th>Comment</th>
<th>Potential PRP</th>
<th>Awarded PRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>70%</td>
<td></td>
</tr>
</tbody>
</table>
Terms of office

The Executive Directors are employed within a standard contract which provides for a three month notice period. The exceptions to this are the following who have a six month notice period: Chief Executive, Director of Planning and Information, Chief Nurse, Director of Organisational Development and Workforce, Director of Finance and Procurement, Director of Clinical Services. 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>31/10/2017</td>
</tr>
<tr>
<td>Mrs Anne Tutt</td>
<td>01/12/2009</td>
<td>30/11/2017</td>
</tr>
<tr>
<td>Mr Peter Ward</td>
<td>01/12/2009</td>
<td>30/11/2017</td>
</tr>
<tr>
<td>Mr Christopher Goard</td>
<td>01/11/2012</td>
<td>31/03/2015</td>
</tr>
</tbody>
</table>

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 2013/2014 was £280,000 - £285,000. This was nine times the median remuneration of the workforce, which was £29,764, (2012/13 median £30,183).

No employees received remuneration in excess of the highest paid director during 2013-2014. Remuneration ranged from £14,294 - £281,300.

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 31 March 2014 is 9,901 (31 March 2013 9,382).

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. 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 March 2014 there were nine 'off payroll engagements', of which five have existed for less than one year and four for between one and two years. There were five new engagements between 1 April 2013 and 31 March 2014, including one Board member, covering the vacant Human Resources Director post for the period October 2013 to February 2014. Assurance has been received from all engagements in relation to income tax and national insurance.
## Salary and Pension Entitlements of Senior Managers

The table below shows the salary and pension entitlements of senior managers in the revised technical format adopted this year (see note on page 71). It should be noted that the total for the year includes Salary, Expense payments, Performance related pay, and Derived increase in capital value of pension benefits at age 60, calculated using a legislated relevant valuation factor of 20 on annual pension at age 60, plus lump sum at age 60. This does not reflect an increase in remuneration during 2013-14 but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. The pension benefit table (see page 72) sets out the cash equivalent transfer values.

### a) Salaries and Allowances

<table>
<thead>
<tr>
<th>Name and title</th>
<th>2013-14</th>
<th>2012-13</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary</td>
<td>Expense payments</td>
</tr>
<tr>
<td>Dame Fiona Caldicott</td>
<td>20-25</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Geoffrey Salt</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Alisdair Cameron</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Professor Sir John Bell</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Mrs Anne Tutt</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Peter Ward</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Christopher Goard</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Andrew Stevens</td>
<td>110-115</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Paul Brennan</td>
<td>140-145</td>
<td>47</td>
</tr>
<tr>
<td>Ms Sue Donaldson</td>
<td>60-65</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Mark Trumper</td>
<td>125-130</td>
<td>60</td>
</tr>
<tr>
<td>Ms Eileen Walsh</td>
<td>115-120</td>
<td>5-10</td>
</tr>
</tbody>
</table>

### NOTES

1. Resigned from Oxford University Hospitals August 2013
2. Resigned from Oxford University Hospitals October 2013
3. Performance Related Payment relates to clinical excellence awards and management allowance.
4. Appointed to Oxford University Hospitals February 2014
5. Acting Chief Nurse covering August 2013 to March 2014
6. Interim Director of Human Resources covering Oct 2013 to Feb 2014

7. Derived increase in capital value of pension benefits at age 60, calculated using legislated relevant valuation factor of 20 on annual pension at age 60, plus lump sum at age 60. The pension benefit table sets out the cash equivalent transfer values. This does not reflect an increase in remuneration during 2013-14 but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. The pension benefit table (see page 72) sets out the cash equivalent transfer values.

8. The total for the year includes Salary, Expense payments, Performance related pay, and Derived increase in capital value of pension benefits at age 60, calculated using legislated relevant valuation factor of 20 on annual pension at age 60, plus lump sum at age 60. This does not reflect an increase in remuneration during 2013-14 but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. The pension benefit table sets out the cash equivalent transfer values.
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 2014 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 GP-led Clinical Commissioning Groups and Specialised Commissioners. 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.
- Finance Costs: this includes any bank interest payable and the interest on PFI obligations.
- Public Dividend Capital Dividends payable: this is the dividend payable to the Department of Health to reflect the public equity invested in the Trust.
- Retained Surplus (Deficit): This shows whether the Trust has achieved its financial target to break even for the year. This is different from the statutory duty to break even ‘taking one year with another’ which is measured over three or exceptionally, five years.
- 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.
- Receipt of donated / government granted assets: is the value of assets donated during the year to the Trust or financed by non-Department of Health government grants.

The Statement of Financial Position which was formerly 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.

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).
- **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. 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 Liabilities**: reflect monies the Trust owes that it expects to settle after more than 12 months.

- **Public Dividend Capital**: The taxpayer’s stake in the Trust, arising from the government’s original investment in the Trust when it was first created.

- **Retained earnings**: are the aggregate surplus or deficit the trust has made in former years.

- **Revaluation reserve**: shows the increase in the value of the assets owned by the Trust.

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

1. **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. **Accountability**

2.1. In the delivery of my responsibilities and objectives, I am accountable to the Trust Board and my performance is regularly and formally reviewed by the Chairman on behalf of the Board. Since 1 April 2013 the Trust has reported to the NHS Trust Development Authority on financial, operational and strategic matters.

3. **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 ongoing 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 2014 and up to the date of approval of the Annual Report and Accounts. The Trust Board has set an Assurance Strategy which establishes 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 sets 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. **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 NHS Trust Development Authority 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 and Performance, Quality and Remuneration and 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. 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.

4.4. The Finance and 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.

4.5. The Quality Committee is responsible for providing the Trust 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.

4.6. 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 works 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.

5. Record of attendance at committee meetings

5.1. The following tables shows how many of the core members of each of the Board Committees attended meetings during 2013/14

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5.2. The membership of the Remuneration and Appointments Committee is limited to the Chairman and Non-executive Directors. The quorum is defined within the Terms of Reference as three Committee members, one of whom should be the Committee Chairman.

5.3. All meetings were quorate during the year.

5.4. The chairs of each of the sub-committees present written reports to the Board after each meeting, highlighting key issues and decisions made at their meetings.

5.5. The Board met a total of seven times in public in 2013/14, with an additional single meeting held in private. The meetings were held as follows:
   - 8 May 2013
   - 6 June 2013 (Confidential meeting only) – this meeting was held to consider the draft annual report and accounts for 2012/13
   - 10 July 2013
   - 11 September 2013
   - 13 November 2013
   - 22 January 2014
   - 12 March 2013

5.6. The Audit Committee, on behalf of the Trust Board reviewed compliance with UK Corporate Governance Code (‘the Code’), where it applies to NHS Trusts. The Audit Committee agreed that the evidence demonstrated that the Trust was compliant with all of the Main Principles of the Code, and no departures were identified.

5.7. All Board members have 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 during 2013/14. The Trust’s Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions were updated in January 2014 to reflect the role of the NHS Trust Development Authority. The Standing Orders were adhered to over the course of the year and no suspensions were recorded.

5.8. The Board’s Register of Interests was updated throughout the year, and it was formally received at the Trust Board meeting in May 2014. 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 May 2014. No conflicts of interest were identified in the review of the Register.

6. Capacity to handle risk

6.1. 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:
   - the Director of Assurance has delegated authority for the risk management framework, and is the executive lead for maintaining the Board Assurance Framework and its supporting processes;
   - the Director of Finance and Procurement has responsibility for financial governance and associated financial risk;
   - the Medical Director has responsibility for clinical governance and clinical risk, including incident management, and has joint responsibility with the Chief Nurse for quality;
   - the Chief Nurse has responsibility for patient safety and patient experience, and joint responsibility with the Medical Director for quality;
   - Executive Directors have responsibility for the management of strategic and operational risks within their individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates.

6.2. A range of risk management training is available to staff based on the nature of their role and position within the organisation. This includes risk awareness training which is provided to all new staff as part of their corporate induction programme. The Risk Management Strategy describes the roles and responsibilities of all staff in relation to the identification, management and control of risk, and encourages the use of risk management processes as a mechanism to highlight areas that they believe require improvement.

6.3. The implementation of the Risk Management Strategy was reviewed during the year and the results were presented to the Trust Board in November 2013. This demonstrated that there was good progress to embed risk management through the organisation and the risk maturity of the organisation had improved. Further actions were identified to continue to further embed risk management processes.

6.4. The Trust’s risk appetite was also reviewed having been agreed during the previous year in line with the development of the Risk Management Strategy. The review involved discussion at the Quality Committee, Finance & Performance Committee, Audit Committee and at the Trust Board Seminar in April 2014. The revised Risk Appetite statement will be presented to the Trust Board in July 2014 for approval.
7. Risk Assessment

7.1. 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.

7.2. 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.

7.3. 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.

7.4. The Board Assurance Framework provides the mechanism for the Board to monitor risks, controls, and the outputs of its assurance 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.

7.5. The Trust Board reviewed its SWOT (Strengths, Weaknesses, Opportunities and Threats) and PESTLE (Political, Economic, Social, Technological, Legal and Environmental) Analysis in January 2014. This helped the Trust Board identify the key issues which may impact on the Trust’s Strategy and helped identify risks which may not be identified through other routes.

7.6. The Trust Board at its seminar in April 2014 considered a range of future potential / emerging risks that may arise as a result of potential changes to the commissioning arrangements. These included the risks involved in embracing the need for greater integration across pathways and the Trust’s ability to handle these changes in terms of staffing and technological capacity and capability.

8. Essential Standards of Quality and Safety

8.1. 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 Trust has implemented an electronic tool for gathering evidence of compliance at a service level with the essential standards. This tool, called HealthAssure, has been rolled out across the Trust and regular reports on the self-assessments undertaken by the services were reported through the governance structure of the Trust. In addition to the self-assessments the Assurance Department has reviewed the evidence against the self-assessment and has given each service an assurance rating. This assurance rating has been communicated back to the services, alongside support and guidance on where further evidence was required to demonstrate compliance.

8.2. The Trust has introduced a Peer Review Inspection programme which ran from November 2013 to March 2014. The programme involved multidisciplinary teams, which included members of the public and patients, reviewing the services being delivered by the five clinical divisions. Data collected before the reviews was combined with the observations taken by the review members to develop a report which was then shared with the divisional management teams prior to holding a Quality summit to discuss the key issues arising from the report. An action plan was developed following each of the reviews and this will be monitored throughout the following financial year. This process highlighted some trust-wide themes that have been added to the Corporate Risk Register. These included: patient transportation and the co-ordination of care and the local implementation and monitoring of infection control and medicine management processes.

8.3. Following the identification of potential concerns within the Trust related to the care of patients with Pneumonia and Diabetes, risk summits have been held to discuss the potential issues and identify actions. Key stakeholders including clinicians and patient representatives were invited to attend the summits, which involved an initial summit for facilitated review of the data available and structured discussion to identify service gaps and potential improvement actions. Progress against the actions was then considered in a follow up risk summit. The outcomes of the risk summits were then presented to the Trust Management Executive for review and monitoring.
8.4. The Trust was inspected by the Care Quality Commission on 25/26 February 2014, and on a number of further occasions during the period until 12 March 2014. The Trust received an overall rating of Good for the service provided. The CQC identified a number of areas for improvement and issued five compliance actions. The Trust has accepted these actions and is working towards developing an action plan by 12 June 2014.

8.5. Ratings for the four hospital sites operated by the trust have also been issued as follows:
- John Radcliffe Hospital – Requires Improvement
- Churchill Hospital – Good
- Nuffield Orthopaedic Centre – Good
- Horton General Hospital – Good

8.6. The summary report for the Trust overall and the reports for each of the hospital sites were published by the CQC on 14 May 2014 and can be found at their website at: www.cqc.org.uk

9. Performance Management

9.1. The Trust has in place a robust performance management system which has been developed to ensure that the Trust’s management have visibility of the key operational, financial and quality metrics which affect the organisation. The performance information is presented in the form of an integrated performance report, which is supported by more detailed, area specific performance reports. These reports are presented to the Trust Board, Quality Committee and Finance and Performance Committee for review and challenge.

9.2. Performance monitoring of the five clinical divisions is undertaken through monthly performance management meetings and quarterly in-depth performance reviews. The outcomes of the quarterly reviews are reported to the Finance and Performance Committee.

10. Information Governance

10.1. 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, handling and storage of information.

10.2. 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 e-learning modules on the Trust’s e-learning management system. As at March 2014, 81% of staff had completed this training within the previous 12 months, compared to 76% in 2012/13.

10.3. Information security-related incidents are reported via the Trust’s incident reporting system. Incidents are reviewed by the Information Governance and Data Quality Group, which is chaired by the Trust’s Caldicott Guardian and Senior Information Risk Officer. Where an ongoing information risk is identified, this is recorded on the relevant Risk Register, along with a note of actions to be taken to minimise the chances of occurrence and impact.

10.4. During 2013-14, three level 2 Serious Incidents Requiring Investigation (SIRIs) were reported to the Information Commissioner’s Office (ICO). Each SIRI was investigated and appropriate measures were implemented to reduce the risk of reoccurrence. No further action was taken by the ICO. A number of other less serious information security related incidents were reported during the year but none of them required referral to the ICO.

10.5. In October 2013, as part of the 2013/14 Internal Audit plan, internal audit conducted a review of the Trust’s IG Toolkit self-assessment. The results of the audit indicated significant assurance and supported the Trust’s position that it would achieve an overall satisfactory rating (i.e. all requirements would be at a minimum of level 2) by March 2014, on the basis that two medium priority and one low priority recommendations were implemented during the year.

11. The risk and control framework

11.1. The Trust has in place arrangements to ensure that it discharges its statutory functions and that it complies with legislative requirements. These systems include, but are not limited to:
- The use of Internal Audit to consider the systems and processes which support the delivery of the Trust’s functions;
- Monitoring compliance with CQC registration requirements and reporting this to the Trust Board and its Committees;
- Monitoring compliance with quality, operational and financial performance standards, including the NHS Constitution;
- Consideration is given to the legal implication of proposed changes, utilising the in-house legal services team or external legal advice where required;
- All Board members have access to external legal and audit advice should they require this in line with undertaking their role;
- The Audit Committee’s role in providing oversight to the internal control systems within the Trust, with a particular focus on the management of risk. The Audit Committee is supported by more detailed work in relation to quality, finance and performance by the other Trust Board Committees;
• The Quality Committee and the Finance & Performance Committee’s role in providing assurance to the Trust Board, which is based around a cycle of business which is designed to consider the key issues affecting the Trust;
• The Trust Management Executive has ultimate responsibility for the delivery of the Trust’s stated outcomes, as described within the Annual Business Plan, and for ensuring compliance with regulatory and legislative requirements. The Trust Management Executive fulfils this function by delegating the detailed consideration and oversight of performance to its sub-groups. These sub-groups, which include Health & Safety, Clinical Governance, Workforce and IM&T, are constituted with clear Terms of Reference and are required to report to the Trust Management Executive after every meeting. This reporting requires the escalation of any issues and risks outside the remit of the sub-group and this would include potential breaches of regulation or legislation;
• The use of external independent reviewers to provide external assurance of the Trust’s systems where possible issues have been identified;
• The identification and nomination of responsible individuals to lead key work streams, for example Medical Revalidation and Safeguarding. These individuals are appointed as they have significant experience and knowledge in the specific area;

11.2. 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. The utilisation of Datix has improved throughout the year which has been demonstrated by an increase in the number of incidents reported. More details on the review of the incident reporting system is included in the Quality Account.

11.3. The Trust has achieved and maintained Level 1 accreditation status against the NHS Litigation Authority Risk Management Standards for Trusts. In November 2013 the Trust was successful in its accreditation against the level 2 Clinical Negligence Scheme for Trusts – Maternity – Clinical Risk Management Standards.

11.4. All Cost Improvement Programmes are assessed for their impact on quality. Where possible negative impact is identified, mitigating actions are identified or in cases of significant impact, the scheme is not progressed. In addition all policies are equality impact assessed to ensure that they do not negatively impact one or more groups of staff, patients or the public.

11.5. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure compliance with all employer obligations contained within the scheme. 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.

11.6. 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.

11.7. 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.

11.8. 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). The Trust confirmed that it was compliant with the recommendation by the end of March 2013. The Quality Committee received a further update at its meeting in February 2014 which confirmed that the Trust was compliant.

11.9. 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.

11.10. The Trust’s Internal Auditors, KPMG LLP (UK), undertook 16 audits during the year. All of the audits concluded that there was Significant Assurance, with one exception relating to Junior Doctors Rotas which was given an assurance opinion of Limited Assurance. The Trust has accepted the recommendations made and has developed an action plan which is due to be completed by 31 August 2014.
11.11. The Trust commissioned an additional report undertaken by the Trust’s Internal Auditors, KPMG LLP (UK), which had considered the process through which the proposed new Welcome Centre for the Trust was due to be procured. The procurement to which this report referred has since been aborted for reasons unconnected with the audit report. The Trust is now considering how best to proceed with a revised procurement process for the Welcome Centre, taking into account the conclusions of the internal audit report.

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

12.1. The Trust has well developed systems and processes for managing its resources. The annual budget setting process for 2013/14 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 83% of its agreed Cost Improvement Programme target, and it generated its planned surplus for the year.

12.2. Monthly financial and operational performance reports are presented to the Finance and 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.

12.3. 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.

13. Annual Quality Account

13.1. 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.

13.2. The Medical Director leads on the Quality Account, and each year priorities are agreed between the Trust and its commissioners. The Trust works 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 April 2014, 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.

13.3. 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. External assurance of aspects of the Quality Account will be provided by the Trust’s external auditors.

14. Review of effectiveness of risk management and internal control

14.1. 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 who 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 audit results report; the Head of Internal Audit Opinion and other reports.

14.2. 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.
14.3. 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 2013 to 31 March 2014 and supports preparation of the annual accounts on a going concern basis.

14.4. 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.

15. Significant issues

15.1. 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:

15.1.1. 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 work streams addressing the various aspects of this issue are being implemented, and the Trust, with its partners, is on track to achieve reductions in the numbers of delays.

15.1.2. During 2013/14 the Trust undertook detailed work to review the acuity and dependency of patients on the inpatient wards of the Trust. This identified that on a number of wards the skill mix of ward staff, between qualified and unqualified staff, was not in line with national guidance, and in some cases the ratio of nurses to patients was not ideal. Where urgent action was required additional staff were provided through NHS Professionals and through agency staffing. A business case was approved to address the shortfall in staff who would be recruited over a number of months to ensure that they could be fully integrated into the existing ward teams.

15.1.3. Three Never Event incidents were reported in 2013/14. The incidents varied in type and comprised wrong side surgery, wrong implant and a retained swab. The first incident resulted in moderate harm requiring the patient to have further surgery on the correct side. The latter two incidents resulted in minor harm. All incidents occurred due to a failure to embed existing processes. A number of actions were taken following these events and work has been undertaken with departments to ensure that processes are consistently applied.

15.1.4. Seven SIRIs were reported in 2013/14 concerning the Trust radiology Directorate. Two SIRIs related to a back-log of unreported plain films, two SIRIs concerned incorrect reporting of films resulting in delayed diagnosis and a further two SIRIs related to a failure to adequately follow-up/refer for further investigation/consideration of treatment when an abnormality was detected. The seventh SIRI related to the reporting delay combined with incorrect reporting. An overarching action plan is in place to resolve the issues identified. The delay in reporting has been resolved with the outsourcing of plain films to external reporting companies. The Directorate is also introducing a quality assurance processes with the establishment of internal systems and processes to support and maintain this.

15.1.5. In Ophthalmology demand for treatment of macular degeneration following the publication of NICE guidance has resulted in demand exceeding capacity with a very small number of patients not being followed up in a timely manner. The unit is in the process of investigating accessibility to the service with reference to patients who have been potentially harmed. Plans are underway to appoint a new Medical Retina Consultant and space is being identified to create more capacity.

16. Conclusion

16.1. 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.

Sir Jonathan Michael
Chief Executive
Date: 5 June 2014
Glossary of NHS terms and abbreviations

**Academic Health Science Centre/Network (AHSC/AHSN)**
An academic health science(s) centre (AHSC) or network (AHSN) is a partnership 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**
It is an independent public body responsible for ensuring that public money is spent economically, efficiently, and effectively in the areas of local government, housing, criminal justice and fire and rescue services. It appoints 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 its 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 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 have, in addition to GPs, a least one registered nurse and a doctor who is a secondary care specialist. Groups have boundaries that do not normally cross those of local authorities. All GP practices 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 the value of which is, or can be converted into, cash within the next twelve 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 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.

GP
A doctor (General Practitioner) who, often with colleagues in partnership, works from a local doctor’s surgery, providing medical advice and treatment to patients.

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.

Healthwatch Oxfordshire
Healthwatch Oxfordshire is an independent organisation that listens to people’s views and experiences of health and social care in Oxfordshire. It has taken over from the Local Involvement Network (LINK).

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.

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 guidance 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 helps 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.

**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 a range of 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 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 organisational 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 NHS Trust 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.

**Public Health England**

Public Health England was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service. It is an executive agency of the Department of Health.

**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 (CCGs 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) have taken 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)
Audit Commission
Care Quality Commission
Cherwell District Council
Department of Health
Foundation Trust Network
General Medical Council (GMC)
Health and Social Care Information Centre
Health Education England
Healthwatch Oxfordshire
Medical Sciences at Oxford University
Monitor
National Institute for Health & Clinical Excellence (NICE)
National Institute for Health Research
NHS Choices
NHS Confederation
NHS England
NHS Health at Work– occupational health provider
NHS Improving Quality
NHS Protect – Counter Fraud & Security Services
NHS Trust Development Authority
Oxford Academic Health Science network
Oxford Biomedical Research Centre
Oxford Brookes Faculty of Health & Life Sciences
Oxford Brookes University
Oxford City Council
Oxford Health NHS Foundation Trust
Oxfordshire Clinical Commissioning Group
Oxfordshire County Council
Patients Association
Patient Safety Federation
Public Health England
Royal College of Midwives
Royal College of Nurses
Royal College of Pathologists
Royal College of Paediatricians and Child Health
Royal College of Physicians
Royal College of Surgeons
South Oxfordshire District Council
Southern Health
Thames Valley Health Education
Thames Valley Health Innovation & Education Cluster
Thames Valley Local Education and Training Board
University of Oxford
Vale of White Horse District Council
West Oxfordshire District Council

www.airmed.co.uk
www.audit-commission.gov.uk
www.cqc.org.uk
www.cherwell.gov.uk
www.gov.uk/dh
www.foundationtrustnetwork.org
www.gmc-uk.org
www.hscic.gov.uk
www.hee.nhs.uk
www.healthwatchoxfordshire.co.uk
www.medsci.ox.ac.uk
www.monitor-nhsft.gov.uk
www.nice.org.uk
www.nihr.ac.uk
www.nhs.uk
www.nhsconfed.org
www.england.nhs.uk
www.nhshealthatwork.co.uk
www.england.nhs.uk/ourwork/qual-clin-lead/nhsiq
www.nhsbsa.nhs.uk/Protect
www.ntda.nhs.uk
www.Oxfordahsn.org
www.oxfordbrc.org
www.hls.brookes.ac.uk
www.brookes.ac.uk
www.oxford.gov.uk
www.oxfordhealth.nhs.uk
www.oxfordshireccg.nhs.uk
www.oxfordshire.gov.uk
www.patients-association.com
www.patientssafetyfederation.nhs.uk
www.gov.uk/government/organisations/public-health-england
www.rcm.org.uk
www.rcn.org.uk
www.rcpath.org
www.rcpch.ac.uk
www.rcplondon.ac.uk
www.rcseng.ac.uk
www.southoxon.gov.uk
www.southernhealth.nhs.uk
http://thamesvalley.hee.nhs.uk
www.tvhiec.org.uk
www.thamesvalley.hee.nhs.uk
www.ox.ac.uk
www.whitehorsedc.gov.uk
www.westoxon.gov.uk
Tell us what you think

*Every year we produce an Annual Review*, which summarises what we have done over the year and includes our summary accounts. We publish it on our website and make some printed copies available, on request. We also produce a CD of all key documents, including a full *Annual Report and Accounts*. All the documents are available on our website at [www.ouh.nhs.uk](http://www.ouh.nhs.uk) in the About Us section on the Publications page.

We aim to ensure that the information is accessible and we can arrange to have sections 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 this document, 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:**
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Level 3, John Radcliffe Hospital
Headley Way
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**See our website:** [www.ouh.nhs.uk](http://www.ouh.nhs.uk)

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