Welcome to the Annual Review 2014/15 of Oxford University Hospitals NHS Trust. This report describes how the Trust has performed over the last year and how we account for the public money spent by the Trust over this period. We have published our Quality Account separately, which is a report outlining our activities and priorities to improve quality of care and outcomes for patients who use our services.

Message from the Chairman and Chief Executive

For us and the NHS as a whole, the enormous talent and commitment of our staff has allowed us to continue to innovate and improve care for our patients. Some of our performance targets have been challenging, in particular meeting the emergency department four hour waiting time standard and managing unscheduled care.

Both emergency care and planned clinical treatments and operations have continued to rise, and our staff have worked hard to maintain the quality of our services in the face of increasing demand and a challenging financial environment. We want to always provide patients with an excellent experience of our care and services and it is frustrating for us as it is for our patients when, on occasions, we find it difficult to treat patients as quickly as we, or they, would like. However, our clinical teams have increasingly risen to the challenges. While we have not always met the national waiting time standards for non-urgent treatment and some areas of cancer treatment, the perseverance and dedication of our staff has brought about steady improvement. We are optimistic that we will meet waiting time standards on a sustainable basis over the coming months.

Despite the pressures, we continue to evolve and improve our services through innovation and technology, and there have been many notable successes. We are well on the way to fully ‘digitising’ our patients’ clinical records enabling patients’ medical history and care requirements to be available electronically on our Electronic Patient Record (EPR) system. Our staff have speedier and more immediate access to clinical notes, and patient information. We took another big step with medicines prescribing, previously ordered via paper and now electronically processed across our inpatient wards by doctors using computers at the patient’s bedside. The Trust has been recognised as one of the most advanced for implementing EPR and other IT solutions and now administers more than 20,000 drugs daily using electronic prescribing.
**Other technological developments** include the introduction of robotic surgery for treating cancers of the head and neck. Operations which would have taken between 12 and 14 hours can now be undertaken in around three to four hours on average with reduced intensive care and hospital stay. Our patients are also benefiting from the introduction of minimally invasive keyhole surgery for liver cancer enabling the removal of large tumours which previously required major open surgery.

**Patient safety and quality of care** is our overriding priority and over the past year there has been a particular focus on managing patients with diabetes, a condition which affects around 15% of adults admitted to our hospitals. Our priority has been to improve the experience and outcomes of people with diabetes who use Trust services by establishing 130 diabetes ‘link’ nurses to support best practice on our wards.

Our children’s cancer services at the Horton General Hospital in Banbury have also been extended giving young patients and their families the option of being treated closer to where they live.

These excellent developments reflect just a small part of how we continually strive to deliver high quality outcomes for our patients. Looking ahead we have ambitious plans to transform the way we and our partners provide urgent healthcare services. Our partnership work involves developing a single plan for Oxfordshire which will pool the limited resources of the local organisations providing health and social care. The aim is for us and our partners to be flexible in addressing the changing demographics and healthcare needs of our population.

**Our collaborative working** has a particular focus on unscheduled urgent treatment, care of the frail and elderly and long-term chronic conditions. Our intention is to strengthen the range of services in community-based centres supported by the specialist skills of our hospital clinicians working alongside our community colleagues.

We achieved another milestone this year in electing our first Council of Governors. Elections were held in February 2015, with every seat contested. Working alongside our Trust’s Board of Directors, our Governors play a valuable role by holding our Directors to account, ensuring that the interests of the Trust’s members are taken into account and helping to shape our plans for the future.

Finally, we welcome Dr Bruno Holthof who, as the Trust’s new Chief Executive from 1 October 2015, will take forward our strategic programmes and build the future success of the organisation as a Foundation Trust.

We believe that a well-informed, motivated and engaged membership will help us to be a more responsive organisation with an improved understanding of the needs of our patients and local communities. The proof of our success will be in the experience of our patients, their families, our staff and stakeholders as we go forward in 2015/16.

Dame Fiona Caldicott  
Chairman

Sir Jonathan Michael  
Chief Executive

Dame Fiona Caldicott  
Chairman

Sir Jonathan Michael  
Chief Executive
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.
Oxford University Hospitals
NHS Trust (OUH)

We are one of the largest NHS teaching trusts in the UK, employing over 12,000 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.
- 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.

ABOUT US

During 2014/15 we provided:

- **1 MILLION PATIENT CONTACTS**
- **114,000 PLANNED ADMISSIONS**
- **89,500 EMERGENCY ADMISSIONS**
- **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**
- **12,163 STAFF**
- **3,800 NURSES / MIDWIVES**
- **2,000 DOCTORS**
- **1,300 HEALTHCARE SUPPORT WORKERS**

- **OUR TURNOVER IN 2014/15 WAS £916 MILLION**
- **THE TRUST HAS A CQC RATING OF ‘GOOD’**
Our clinical services

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

- Emergency departments
- Trauma and orthopaedic services
- Maternity, obstetrics and gynaecology
- Children’s services
- Generic medicine
- General surgery
- Cardiac services
- Critical care
- Cancer services
- Renal and transplant services
- Neurosurgery and maxillofacial surgery
- Infectious diseases and blood disorders
- Ophthalmology and specialist eye services
- Specialist surgery including ear, nose and throat (ENT)

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 emergency department, 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 the Oxford Centre for Diabetes, Endocrinology and Metabolic Medicine (OCDEM).

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 to those with limb amputation or complex neurological or neuromuscular disabilities suffered, for example, through stroke or head injury.

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

### 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>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>80,163</td>
<td>20,188</td>
<td>68,265</td>
<td>805,895</td>
</tr>
<tr>
<td>2011/12</td>
<td>83,778</td>
<td>19,477</td>
<td>73,266</td>
<td>835,958</td>
</tr>
<tr>
<td>2012/13</td>
<td>88,316</td>
<td>22,312</td>
<td>75,959</td>
<td>835,568</td>
</tr>
<tr>
<td>2013/14</td>
<td>87,741</td>
<td>24,015</td>
<td>84,533</td>
<td>906,513</td>
</tr>
<tr>
<td>2014/15</td>
<td>89,445</td>
<td>23,628</td>
<td>90,649</td>
<td>956,492</td>
</tr>
</tbody>
</table>
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.

For more information on the Trust and its services visit: www.ouh.nhs.uk
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 our local NHS and social care organisations, and also with a wider network of district general hospitals, universities and research institutions. Our role as a university teaching centre and focus on research and innovation is a defining feature and as such attracts patients from beyond our surrounding counties.

As a large tertiary acute centre, the Trust provides specialist treatment for patients from a wide geographical area. We are designated as a regional centre 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, neurosciences, and critical care services to patients from across the region.

The Trust provides services to two markets:

- A local market for general hospital services and a wider market for more specialist care. From April 2015:
  - 38.4% of the Trust’s income for the delivery of patient services comes from the Oxfordshire Clinical Commissioning Group.
  - 48.7% of income comes from specialist commissioners
  - 12.9% comes from other commissioners outside Oxfordshire.

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

The wider population served by the Trust’s specialised 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 2014/15, NHS England, which commissions specialist services from NHS providers, accounted for over 48% of the total revenue the Trust earned from patient care. A separate agreement for 2014/15 with the NHS England Thames Valley Area Team amounted to £11.8m to cover dentistry, offender health services and some screening services.

<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>
<td>351.8</td>
<td>47.1</td>
</tr>
<tr>
<td>Oxfordshire Clinical Commissioning Group (CCG)</td>
<td>286.6</td>
<td>38.4</td>
</tr>
<tr>
<td>Buckinghamshire CCGs (Aylesbury Vale and Chiltern)</td>
<td>16.9</td>
<td>2.3</td>
</tr>
<tr>
<td>Northamptonshire CCGs (Nene and Corby)</td>
<td>15.1</td>
<td>2</td>
</tr>
<tr>
<td>NHS England (Thames Valley Area Team)</td>
<td>11.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Other NHS Commissioners (&lt;1% share)</td>
<td>64.1</td>
<td>8.6</td>
</tr>
</tbody>
</table>
Clinical networks and 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

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. 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.

Working with our commissioners and other healthcare providers

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.

We work 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.

GP surgeries are grouping together in their healthcare provider role to form federations which will enable them to provide a greater range of services through local collaborative working.

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.
**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 for the Trust to be:

- at the heart of a sustainable and outstanding, innovative academic health science system;
- working in partnership and through networks locally, nationally and internationally;
- delivering 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.

**Our values** reflect what is important to staff and patients in terms not only of 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.

**Improving quality of care and treatment**

Supporting all our plans is a clear focus on the quality of care we offer in terms of patient safety, patient experience and the outcomes of care. We are committed to embedding and improving quality in everything that we do and our quality strategy seeks to ensure that what we do and how we work delivers the best outcomes for our patients in a safe and caring environment.

Our vision and strategic objectives remain the framework against which we have set our quality priorities for 2014/15 and in the next section of this report you will read about the quality improvements we plan to make over the next year (2015/16). Our aim is to drive standards higher every single day.

**Delivering compassionate excellence**

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

“Our vision and core values ensure that our staff operate with a common purpose and achieve our shared aspirations.”
Becoming a Foundation Trust

The Trust’s application to become a foundation trust (FT) was formally submitted to Monitor, the body that regulates foundation trusts, on 1 October 2014. Since then, the Trust has been assessed on the quality of governance arrangements, our business plan, our financial plan and our performance on access and outcomes standards. Monitor concluded that some improvements were needed and we have implemented new governance improvements including a refreshed Quality Strategy. It has also been important that we have clear action plans in place to maintain the national waiting time standards.

In the meantime, we have progressed our membership involvement and engagement, and elected our first Council of Governors in ‘shadow’ form in February 2015, prior to the Trust being authorised as a foundation trust.

As a Foundation Trust we will have greater freedom, stronger local ownership, and more involvement for the communities we serve. The Trust currently has a membership of more than 8,000 people. Through the newly elected Council of Governors, members have a role to play in helping determine the development of the Trust.

The process to becoming a foundation trust has involved intense scrutiny and review but we have used the assessment process to strengthen and improve the way we manage and run the organisation. FT status is recognition of the high quality services provided and the result of a commitment to improve and meet the cornerstone of FT status – good governance, local decision making and clear accountability.

Service improvement and redesign

The primary strategic focus for local services is the redesign of care pathways to integrate care. The aging demographic of our population means we can expect to see more frail and elderly patients in our hospitals. We are meeting this challenge by changing the setting of some clinical services to move more care outside hospital through joint working with our key stakeholders. Oxfordshire Clinical Commissioning Group and the providers of health and social care have agreed that the development of a single strategic plan would help to co-ordinate commissioning and the delivery of health and social care services.

A Single Health and Social Care Plan for Oxfordshire is being developed which will seek to integrate services and make the most of limited resources in the face of rising demand, particularly from the frail elderly and those with long-term chronic conditions. The aim is to prevent, where possible, and detect, problems early, through investing in more care and treatment outside hospital with GPs joining together to provide a broader range of services including those traditionally provided in hospital. The vision is that the single plan will strengthen the range of services available in local community-based centres supported by specialist skills from our hospital clinicians.

As part of this work, new 'outcomes-based' contracts are being developed for older people’s services and mental health services with Oxford University Hospitals and with Oxford Health NHS Foundation Trust respectively. This is a new form of contract between Trusts and commissioners where funding for services is linked to the achievement of agreed outcomes rather than the numbers of patients seen.

OUR INTEGRATED BUSINESS PLAN

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

A summary can be downloaded from the Trust’s website at: http://www.ouh.nhs.uk/about/publications/business-plans.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.
The Trusts were awarded the contract as ‘most capable provider’ for older people’s services in February 2015. Under this single contract there will be more freedom to design services to suit the needs of patients. Previously, there have been more than 20 contracts with commissioners to deliver services for people aged over 65.

We are now working with Oxford Health NHS Foundation Trust to plan services that will deliver patient-led outcomes which will improve and maintain the levels of health and an individual’s ability to live independently for longer.

Oxfordshire Alliance Programme

Together with Oxford Health NHS Foundation Trust we have set up the Oxfordshire Alliance Programme which aims to put in place a range of service configurations which will transform the way we provide urgent healthcare services for older people and adults who have long-term and complex health problems.

The programme will focus on:

- Developing 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 medical services in selected community hospitals.

- Providing care at home or as close to home as possible, where it is clinically appropriate to do so. This will be achieved by increasing ambulatory care and making use of technology, including telehealth, telecare and the use of diagnostics in non-acute settings.

- Enhancing patient independence and recovery through personalised care for older people and adults with complex health and social care needs, by providing them with the skills and resources to care for themselves and their families.

The Oxfordshire Alliance Programme will develop a new integrated model of care focused on the above priorities, underpinned by a formal partnership between the Trust and Oxford Health NHS Foundation Trust. Together we provide a large proportion of healthcare for these particular patient groups. However, other health and social care providers are vital in ensuring care is integrated across a range of services that patients are likely to access. Local GPs, social services, the ambulance trust and charities and voluntary organisations will also be involved as part of the Alliance or through new partnership arrangements.

Specialised services strategy

The Trust is the second largest NHS centre in England for the delivery of specialist services, drawing patients from across the country. As well as delivering services at its four hospital sites, the Trust’s strategy for specialist services involves a portfolio of inter-connected clinical networks to help partner trusts deliver acute services locally, supported by our role within the Academic Health Science Centre and the Academic Health Science Network.

For example, plans have been developed for satellite radiotherapy units to be sited at Milton Keynes Hospital and the Great Western Hospital in Swindon to serve their local populations. These units will be run and managed by OUH Trust clinical teams.

This will reduce the journeys for patients having to make multiple trips to Oxford for their radiotherapy treatment. Developing local radiotherapy services for the populations of Swindon and Wiltshire would mean significant reductions in time for over 13,000 patient journeys to radiotherapy treatment each year.

Focus on prevention through public health

The Trust is committed not just to treating disease, but to improving people’s health across Oxfordshire. It isn’t only our patients’ health that’s important to us; we have 12,000 staff members whom we want to keep healthy as well. We know that looking after our staff, physically and mentally, helps them in looking after our patients.

We are working with Oxfordshire County Council, and other local groups and organisations that share our goal of promoting health to our patients, visitors and staff. During 2014/15 we have continued to implement the Trust’s Public Health Strategy.

The Trust opened a unique health advice centre in August 2014. Here for Health helps patients, visitors and staff improve their health and wellbeing through lifestyle changes. The drop-in service is based in the Trust’s outpatients department at the John Radcliffe Hospital, and is open Monday to Friday from 9am to 5pm. It is staffed by health promotion specialists who provide information and advice about healthy lifestyle choices – particularly relating to diet, exercise, alcohol, smoking and weight management. They are also able to point people in the direction of further support available elsewhere.
Here for Health is a key element of the Trust’s Public Health Strategy, developed jointly with Oxfordshire County Council, which aims to improve health and prevent disease. Since opening, more than 300 people have used the centre for advice on improving their health and wellbeing.

In 2015/16 we plan to launch ‘pop-up’ health improvement centres on each of our hospital sites; train more staff in health promotion and identify ‘health champions’; and to take every opportunity to help people change their lifestyle in ways that could reduce their chances of becoming ill.

Nursing and Midwifery Strategy

The Trust has developed a new Nursing and Midwifery Strategy which aims to improve patient outcomes and establish the Trust as a leading UK centre with an outstanding international reputation as a leader in nursing and midwifery. The strategy sets the direction for developing nursing and midwifery at the Trust from 2015-18.

Consultation took place with more than 150 nurses and midwives at all levels across all the Trust. These demonstrated strong and consistent staff support for the strategy’s five key themes:

- Excellent nursing and midwifery clinical practice
- Career-enhancing education and professional development
- Leading the way in practice development research
- Growing exceptional nursing and midwifery leaders
- Developing innovative nursing and midwifery care models.

Led by Chief Nurse Catherine Stoddart, staff gave overwhelming support to building a culture of continuous quality improvement that aspires to ‘be the best’, delivering outstanding patient care and compassionate excellence.

The strategy, which is aligned with the Trust’s core values and the NHS England Five Year Forward View, takes account of key national and local data relating to nursing and midwifery and will play a key role in helping the Trust attract and keep the best nursing staff.

The Trust is working with other partners including Oxford Brookes University and Health Education Thames Valley to deliver a range of training and research programmes.
Building the digital hospital

During 2014/15 the Trust took another big step towards establishing fully digital hospitals, making patients’ medical history and care requirements available on the Trust’s electronic patient record (EPR) system.

Electronic Prescribing and Medicines Administration (ePMA) has been introduced to inpatient areas including Acute Medicine, Geratology, Stroke, Neurosciences and Neuro Intensive Care wards.

Hundreds of staff received training on the new digital systems and thousands of medication transactions, previously carried out on paper, are now completed digitally.

The Trust now administers more than 20,000 drugs daily using ePMA. Staff are able to administer medication just as quickly on the system as they previously would have on paper. Medicine requests are made via computer at the patient’s bedside and are sent to the pharmacy to be automatically selected and labelled.

Over the past few years, the Trust has implemented the electronic system Millennium to store and manage patient information. Clinical staff can now order diagnostic tests and view results electronically. Patient admissions, discharges and transfers are also being managed in this paperless way, helping to improve accurate recording. The Trust is recognised as one of the most advanced for implementing an electronic patient record system in the NHS. Every day, across the Trust, there are 1.2 million transactions via the EPR system used by more than 8,000 staff.

Providing better pathways of care through partnership working

As an acute healthcare provider we are experiencing increasing 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 with a focus on developing earlier intervention for those with urgent care needs to help avoid emergency admissions to hospital.

Discharge planning has also been a priority for the health and social care agencies in Oxfordshire with a review of system-wide discharge planning standards and a shared NHS/social care demand and capacity plan to match an increasing need for rehabilitation and care management with available services.

Supported Hospital Discharge Service

During 2014/15 we worked collaboratively on discharge planning with Oxfordshire County Council’s social care teams and with Oxford Health NHS Foundation Trust which runs community hospitals. The discharge planning teams work together to assess the long term care needs of patients to enable those who need ongoing care to move to community hospitals, nursing homes or to go home with an appropriate care package.

A key focus has been to reduce the delays for patients in hospital beds awaiting assessment for on-going care in the community or social care. We have worked with Oxfordshire County Council and Oxfordshire Clinical Commissioning Group to expand the Trust’s Supported Hospital Discharge Service.

The service enables patients to go home with additional support while their longer term care is organised by social services.

The Trust is registered as an authorised provider of domiciliary care in Oxfordshire, and the Supported Hospital Discharge Service provides valuable interim support to people in their own homes during the first two weeks after their discharge from hospital while social care is put in place. It also relieves pressure on the hospital’s acute wards.

In 2014/15, this service made around 3,500 visits every month to patients who didn’t need to be in hospital but still required daily care in order to return home. Around 48 staff, including care workers, physiotherapists and occupational therapists manage up to 60 patients at any one time, offering support and care at home, including visits up to three times a day.

“When expert teams assess patients promptly and tailor care to individual needs, the results are great quality of care and best value for money”

Dr James Price
OUH Clinical Director
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. These units are 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 consists of doctors, nurses, occupational therapists, physiotherapists and social workers and act as a halfway house between GPs and our hospital Emergency Departments. They aim to avoid unnecessary admission to hospital by early intervention. They provide treatment to patients following a referral from a GP or other healthcare professional and can treat any serious medical emergencies, except for heart attacks and strokes.

THE TRUST IS RECOGNISED AS ONE OF THE MOST ADVANCED FOR IMPLEMENTING AN ELECTRONIC PATIENT RECORD SYSTEM
CHILDREN’S CANCER SERVICES AT THE HORTON EXTENDED

More children living in north Oxfordshire who develop cancer can now receive a range of the services they need at the Horton General Hospital in Banbury instead of having to travel to Oxford. Young haematology and oncology patients can attend the hospital for:

- blood and platelet transfusions
- routine antibiotics or prolonged courses of antibiotics or antivirals
- immunity-boosting drug administration
- dressing changes and blood samples
- regular progress reviews.

A key part of our Children’s Strategy is bringing services closer to children, young people and their families and the communities in which they live. Our thriving children’s services at the Horton is one of the cornerstones of this strategy as we continuously develop and improve the services we provide in partnership with patients, their families and our staff.

ON-SCREEN ENTERTAINMENT IS A WELCOME DISTRACTION DURING SURGERY

Patients can watch a film, listen to music or surf the internet during operations at the Nuffield Orthopaedic Centre thanks to a new initiative using mobile technology. The entertainment options are available on a tablet device which is proving to be a welcome distraction to people having limb surgery under regional anaesthesia (RA) – which means they can stay awake throughout the procedure. The tablet, connected to the internet and loaded with audio-visual material, is mounted on a special docking unit. Noise-cancelling headphones reduce theatre noise.

The first patient to use one of the special tablets during surgery said: “It was a very enjoyable way to spend my two hours of surgery... I didn’t think at all of what was going on.” Another patient watched a film, checked his emails and even played chess against the computer during a nine and a half hour orthoplastic procedure.
YOUNG PATIENTS ARE GETTING TO GRIPS WITH VIRTUAL GYM

A ‘virtual gym’ is using computer game technology to appeal to young patients undergoing rehabilitation.

The interactive zone set up in the Children’s Outpatients Department at the Nuffield Orthopaedic Centre is designed to help with the management of chronic pain, juvenile arthritis, and neurological conditions, as well as recovery after orthopaedic and spinal surgery. It includes a treadmill, rowing machine, cross trainer, exercise bikes and a ‘CardioWall’ – all connected to computers.

Julia Smith, Specialist Paediatric Physiotherapist at the NOC said: “The interactive equipment adds a new dimension to exercising and acts as a distraction for our young patients who can choose to focus on the screen and what their ‘character’ is achieving, rather than focusing on any pain, stiffness or fatigue they may feel.”

ROBOTIC SURGERY REDUCES OPERATION TIME

The development of robotic surgery means that operations which would have taken 12-14 hours can now be done in just three or four hours. As a result patients are recovering more quickly and spending less time in hospital. Oxford is one of only a handful of centres offering trans-oral robotic surgery. Patients are taking part in trials comparing the impact of robotic surgery and other techniques on outcomes.

Pictured: Surgeons Stuart Winter and Pri Silva, who have undergone formal training on the use of the robot.

NEW KEYHOLE SURGERY TECHNIQUE INTRODUCED FOR LIVER PATIENTS

Our surgeons are among the first in the country to use a new technique to remove large tumours from the liver through keyhole (laparoscopic) surgery. Because this method uses only small incisions, patients are able to recover more quickly than under the previous procedure which involved major open surgery. The operations are carried out by the Hepatobiliary and Pancreatic Surgical Team at the Churchill Hospital.
NEW SERVICE HELPS PATIENTS GET FIT FOR SURGERY

Patients are benefitting from a new service which helps improve their fitness before having an operation.

A state-of-the-art Cardiopulmonary Exercise Test (CPET) facility opened in the new pre-assessment clinic at the Churchill Hospital. It helps assess a patient’s overall fitness level prior to major surgery. The equipment measures responses to varying levels of exercise by monitoring heart rate, blood pressure and the amount of oxygen and carbon dioxide in the blood during exercise. The information gives anaesthetists an insight into how the patient’s heart and lungs are likely to behave under the stress of surgery.

Patient Andrew Binks completed a CPET before undergoing major abdominal reconstructive surgery. He said: “Doing the exercise test, and having an anaesthetist talk me through the results straight away, really helped me and my partner feel more comfortable that I would be able to safely undergo the operation I was so desperate to have.”

Hundreds of patients have had the new test before operations including major liver surgery, colonic cancer surgery, major gynaecological surgery, transplant and urological surgery.

YOUNG SPINA BIFIDA PATIENTS BENEFIT FROM NEW ONE-STOP CLINIC

A multi-disciplinary clinic which allows young patients with spina bifida and other spinal problems to have all their appointments on a single visit has started at the Oxford Children’s Hospital.

The one-stop clinic includes urology, neurosurgery, orthopaedics, physiotherapy and diagnostic tests such as MRIs and X-rays. It brings down the number of hospital visits young patients need to make each year from ten or more to just one.

Roxanne Martire-Charlett, whose five-year-old daughter Ciara visits the one-stop clinic, said:

“The clinic has made a massive difference. To be able to have all of her appointments on the same day is fantastic. It means she has less time out of school and has been able to meet other children with similar conditions.”
The Trust’s Cardiology Department has been selected to carry out two heart procedures as part of a national evaluation. Both treatments involve devices being used inside the heart to reduce the future risk of stroke.

Oxford is one of a limited number of heart centres selected by NHS England to take part in its £15m ‘Commissioning through Evaluation’ programme which assesses promising specialised treatments where there is not yet enough evidence to support routine commissioning within the NHS. This is a vote of confidence in the treatment and care delivered by the Trust’s specialist heart centre.

The Trust’s new improved cardiology outpatient and echocardiography facilities at the John Radcliffe Hospital offers patients a one-stop shop for appointments. The new area, part of the Oxford Heart Centre, was funded jointly by the Trust and the hospital charity, with additional help from the League of Friends.

Previously, cardiology appointments and echocardiograms were carried out in different places. Now they take place together in a more comfortable environment with ten consulting rooms, seven echocardiography rooms and a host of features such as information screens and pagers for patients enabling them to leave the waiting area and be contacted when their appointment is next.

The hospital’s charity ran the two-year long Oxford Heartfelt Appeal and raised £870,000 to fund improvements to the area and the latest echocardiography equipment.
DELIVERING HIGH QUALITY SERVICES

OXFORD UNIVERSITY HOSPITALS NHS TRUST continues to be registered without conditions by the Care Quality Commission to provide health 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.

How we measure up – our hospital ratings

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 it 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.

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 in February 2014, with unannounced spot checks on 2 and 3 March 2014.

In May 2014, the CQC published its report and gave the Trust an overall rating of ‘Good’ across all five of the standards upon which the CQC judges the services and care we provide for patients.

We were particularly pleased that the inspectors observed caring and compassionate staff throughout the four hospitals and noted they worked well between teams and to provide excellent care for our patients.

RESULTS OF THE CQC INSPECTION WERE AS FOLLOWS:

In respect of the John Radcliffe Hospital, the Trust has undertaken a number of actions following the CQC inspection, including:

- Ensuring sufficient qualified, skilled and experienced staff are on duty at all times to safely meet people’s needs.
- The Trust delivers emergency care to people in a way that safeguards people’s privacy and dignity.
- Suitable inductions are delivered to staff in the areas where they work.

Out of 115 areas inspected across the Trust, 11 were identified as requiring improvement. At the John Radcliffe Hospital, the inspectors highlighted problems with staff shortages within the maternity department and on surgical wards and in theatres. They also highlighted the Trust’s failure to meet the national emergency department target to treat, admit, transfer or discharge patients within four hours. You can read our efforts to address this issue in the section on operational performance in this report.

THE INDIVIDUAL HOSPITALS WERE RATED AS follows:

<table>
<thead>
<tr>
<th>HOSPITAL SITE</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Overall</td>
<td>Good</td>
</tr>
<tr>
<td>John Radcliffe Hospital</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Horton General Hospital</td>
<td>Good</td>
</tr>
<tr>
<td>Churchill Hospital</td>
<td>Good</td>
</tr>
<tr>
<td>Nuffield Orthopaedic Centre</td>
<td>Good</td>
</tr>
</tbody>
</table>

OXFORD UNIVERSITY HOSPITALS NHS TRUST continues to be registered without conditions by the Care Quality Commission to provide health 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.

How we measure up – our hospital ratings

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 it 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.

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 in February 2014, with unannounced spot checks on 2 and 3 March 2014.

In May 2014, the CQC published its report and gave the Trust an overall rating of ‘Good’ across all five of the standards upon which the CQC judges the services and care we provide for patients.

We were particularly pleased that the inspectors observed caring and compassionate staff throughout the four hospitals and noted they worked well between teams and to provide excellent care for our patients.

RESULTS OF THE CQC INSPECTION WERE AS FOLLOWS:

In respect of the John Radcliffe Hospital, the Trust has undertaken a number of actions following the CQC inspection, including:

- Ensuring sufficient qualified, skilled and experienced staff are on duty at all times to safely meet people’s needs.
- The Trust delivers emergency care to people in a way that safeguards people’s privacy and dignity.
- Suitable inductions are delivered to staff in the areas where they work.

Out of 115 areas inspected across the Trust, 11 were identified as requiring improvement. At the John Radcliffe Hospital, the inspectors highlighted problems with staff shortages within the maternity department and on surgical wards and in theatres. They also highlighted the Trust’s failure to meet the national emergency department target to treat, admit, transfer or discharge patients within four hours. You can read our efforts to address this issue in the section on operational performance in this report.

THE INDIVIDUAL HOSPITALS WERE RATED AS follows:

<table>
<thead>
<tr>
<th>HOSPITAL SITE</th>
<th>RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Overall</td>
<td>Good</td>
</tr>
<tr>
<td>John Radcliffe Hospital</td>
<td>Requires improvement</td>
</tr>
<tr>
<td>Horton General Hospital</td>
<td>Good</td>
</tr>
<tr>
<td>Churchill Hospital</td>
<td>Good</td>
</tr>
<tr>
<td>Nuffield Orthopaedic Centre</td>
<td>Good</td>
</tr>
</tbody>
</table>
Newly qualified midwives are appropriately supported.

Patient records accurately reflect the care and treatment for each patient in line with good practice.

The Trust Board continues to monitor compliance against all of the CQC essential standards of quality and safety on an ongoing basis. The Board of Directors and the Quality Committee are updated monthly via the Integrated Quality Report.

You can find out more about the CQC assessment and ratings for the Trust here: www.cqc.org.uk

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 building high quality healthcare based on national and international comparisons and to improve our performance in three key domains:

- Patient safety
- Patient experience
- Clinical effectiveness and outcomes

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 in 2015/16

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.

Throughout the year, we have consulted with our patient groups and organisations representing our local communities to tell us what matters to them. Oxfordshire Healthwatch has helped to inform our quality priorities through its strategic joint needs assessment on what patients and the public feel are important to improve our services and outcomes.

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

In 2014/15, locally agreed CQUINs priorities were:

- Timeliness and communication around discharge
- 24/7 care
- Physician input into the care of surgical patients
- Integrated psychological support for patients
- Reduction in pressure ulcers
- Identification of patients with dementia to prompt appropriate referral and follow up after they leave hospital
- Expansion of the national Friends and Family Test

Our performance in respect of these priorities is detailed in the accompanying Quality Account at: www.ouh.nhs.uk/about/publications

The Quality Improvement Priorities for 2015/16 are:

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>CQC QUESTIONS</th>
<th>PRIORITIES FOR THE TRUST 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT SAFETY</td>
<td>Safe</td>
<td>• Preventing avoidable patient deterioration and harm in hospital</td>
</tr>
<tr>
<td></td>
<td>Caring</td>
<td>• Partnership working to improve urgent and emergency care</td>
</tr>
<tr>
<td></td>
<td>Responsive</td>
<td>• Improving recognition, prevention and management of acute kidney injury</td>
</tr>
<tr>
<td></td>
<td>Well led</td>
<td></td>
</tr>
<tr>
<td>CLINICAL EFFECTIVENESS</td>
<td>Effective</td>
<td>• Learning from deaths and harm to improve patient care</td>
</tr>
<tr>
<td></td>
<td>Safe</td>
<td>• Management of patients presenting with sepsis</td>
</tr>
<tr>
<td></td>
<td>Caring</td>
<td></td>
</tr>
<tr>
<td>PATIENT EXPERIENCE</td>
<td>Caring</td>
<td>• End of life: improving people’s care in the last few days and hours of life</td>
</tr>
<tr>
<td></td>
<td>Responsive</td>
<td>• Improving communication, feedback, engagement and complaints management.</td>
</tr>
<tr>
<td></td>
<td>Well led</td>
<td></td>
</tr>
</tbody>
</table>
Quality assurance

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

Ward inspections

The Trust has established a rolling programme of unannounced compliance inspections on all clinical wards and departments. Since April 2014, 57 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

The internal Peer Review Programme is an initiative aimed at strengthening the Trust’s processes by involving a range of clinicians, non-medical employees and patient representatives in determining how well patient care is delivered across the Trust.

During the year, they visited more than 100 wards and departments across the five divisions of the Trust, speaking to staff, patients and relatives to gain their views about the Trust, the care provided and patient experience.

The purpose of the Peer Review Programme is to support our divisions and departments in delivering continuous improvement and sharing good practice. The peer reviews use the CQC framework to review our services to ensure they are – safe, effective, responsive, caring, and well-led.

The process has been positively evaluated by those participating in the reviews. For the units and wards reviewed, staff stated that it helped them focus on issues that hadn’t been previously identified and that this ‘objective eye’ was a powerful tool to enable improvement.

The next phase of the programme will focus at clinical directorate level and the peer review principles are being piloted on a small number of thematic reviews, with the first of these reviews covering elements of the public health agenda.

Quality Improvement Nurse Educators

During 2014/15 we developed a new role for Quality Improvement Nurse Educators and a therapist who will work with ward/department sisters, charge nurses and matrons. These roles will focus on quality improvement in the clinical setting and will lead on a range of projects including, for example, the FallSafe Care Bundle to reduce the number and severity of in-patient falls, as well as improving nutritional assessments and care planning. The overall purpose is to work with and develop clinical staff to deliver harm-free care.

Tissue Viability – the prevention of pressure ulcers and management of wounds

During 2014/15 the Trust established a new specialist nursing team to support all four hospital sites to improve quality, consistency and patient outcomes relating to pressure ulcers and wound management.

Key programmes and initiatives to date include:

- the development of a strategic action plan with the ambition of achieving no avoidable hospital acquired pressure ulcers by 2016;
- standardising processes to reduce the risk of error, for example the introduction of an agreed pressure ulcer risk assessment tool to all clinical areas;
- producing special lanyards for all nursing staff, containing key messages on how to manage patients at risk of pressure ulcers;
- establishing pressure damage prevention competency frameworks for nursing staff;
- improving discharge procedures with specialist wound management devices;
- developing an e-learning programme and expanding online resources for staff;
- updating and developing specific guidelines to advise clinical staff decision-making.

The Tissue Viability team consists of six whole time equivalent specialist nurses, led by a Consultant Nurse in Tissue Viability.
Clinical summits

Clinical 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.

In 2013/14 we undertook three clinical summits in:
- Care of in-patients with diabetes
- Community acquired pneumonia
- Care provided in the Trust outside normal working hours – Care 24/7

Below describes the continuing progress made during 2014/15.

Providing better care for patients with diabetes

Diabetes is a common condition affecting about 5% of people in Oxfordshire. Approximately 15% of adult patients admitted to our hospitals for a range of illnesses and procedures have diabetes – and in some parts of the Trust this figure can be as high as 50%. These numbers are rising all the time.

The Trust has been working hard to improve its diabetes services following two diabetes risk summits in 2013 which brought together clinical specialists, patient representatives and commissioners.

Its priorities are to improve the experience and outcomes of people with diabetes using Trust services by:
- improving staff awareness and knowledge of diabetes;
- improving care pathways for people with diabetes;
- increasing staffing levels of specialists in diabetes care.

The Trust made significant progress during 2014/15 including:
- more than doubling the number of inpatients with diabetes (many admitted for reasons other than diabetes itself) who are seen by a specialist as part of their admission;
- starting an education programme for clinical staff;
- seeing over 85% of referrals within one working day;
- launching a new protocol to manage people with low blood glucose levels (hypoglycaemia).

Since January 2015, a dedicated diabetes specialist nurse has been based at each of the Trust’s hospital sites. There has been a 25% increase in numbers of diabetes specialist nurses at the John Radcliffe Hospital. The amount of time that diabetes specialist nurses and podiatrists have available to spend managing hospital patients with diabetes has tripled. In addition, two consultants were appointed to work across the Trust jointly in diabetes care and acute general medicine.

Diabetes staff education programmes have been developed with Oxford Brookes University. Some 130 diabetes ‘link’ nurses have been identified in a range of clinical areas to support best practice on the wards.

A Trust-wide audit of the standard of care of every patient with diabetes was carried out in November 2014. The feet of every inpatient with diabetes were also examined on the same day. This snapshot survey highlighted specific areas for development including the identification and management of hypoglycaemia. As a result, diabetes specialist nurses are delivering more specialised teaching and training to ward nurses and other staff. They will also be involved in the induction of new junior doctors, nurses and clinical support workers joining the Trust.

Looking ahead we have plans in place to further improve our diabetes services including:
- distributing standardised ‘hypo-boxes’ to 200 clinical areas to help manage episodes of low blood glucose in patients with diabetes more effectively;
- further training for diabetes ‘link’ nurses;
- delivering bespoke training on diabetes to several clinical areas where there are high numbers of patients with diabetes;
- establishing a ‘foot team’ to better manage patients with diabetic foot disease.

In addition, all capillary blood glucose tests will soon be transferred into each patient’s electronic record. This will enable the Trust to monitor patients experiencing low blood glucose values by site and by ward. The diabetes team can use this information to prioritise the patients who need to be seen and help wards track low blood glucose concentrations in their patients.
Care 24/7

Evidence shows that the limited availability of some hospital services outside normal working hours, such as access to therapists, radiology and diagnostic results, can cause delays in patients’ treatment and care. The Trust is working to improve the patient experience, making sure that they all receive safe, high quality services every hour of every day – wherever they are.

Risk Summits and other meetings were held with staff from all sites and a wide range of clinical services – as well as GPs and partners from other NHS organisations – to identify the key issues and potential solutions related to the delivery of care outside normal working hours, usually meaning from early evening through to the following morning and at weekends and on bank holidays.

Over the past year, the Care 24/7 project has looked at a range of factors, including potential new staffing models to better support doctors and other clinicians who are working across the hospital sites outside normal hours. There has also been a strong focus on handovers from one team to another, ensuring continuity of care for the patient.

We have made progress around access to pharmacy, radiology and other areas outside normal working hours and a weekend out-of-hours on-call plan was also successfully introduced.

An online resource has been set up to keep staff up-to-date with progress on the Care 24/7 project which is ongoing.

Care of patients with pneumonia

Mild cases of pneumonia can usually be treated at home with antibiotics and plenty of rest and fluids. More severe cases may need hospital treatment. The Trust recognises the importance of ensuring clarity and consistency in the way patients with community acquired pneumonia are seen, assessed and admitted. Over the past year, clinicians from key specialties including respiratory medicine, microbiology, and infectious diseases, have developed a ‘care bundle’ – a set of interventions that, when used together, significantly improve patient outcomes.

**Actions have included:**

- Implementing electronic chest X-ray requesting to speed up diagnosis of pneumonia and initiation of antibiotic treatment.
- Changing patient assessment models and implementing rapid nurse assessment process and rapid doctor assessment processes so that patients are seen by a senior doctor within 30 minutes. This facilitates earlier diagnostics and treatments.
- Agreed standards for radiology reporting times for chest X-rays and standards for senior doctors to interpret chest X-rays to speed up diagnosis.
- Development of a critical care outreach service whereby specialist nurses support ward staff in managing patients with respiratory failure and chronic obstructive pulmonary disease.
- Specialist respiratory doctors available on a daily basis to see referrals from the Acute Admitting Team.

Clinical effectiveness and audit

We constantly monitor the quality of our services by auditing our clinical practice. In 2014/15 the Trust participated in 48 national clinical audits and three national confidential enquiries covering relevant services that the Trust provides, including on neonatal care, pressure ulcer prevention, head and spinal injury, acute kidney injury and rehabilitation after critical illness. Also in 2014/15, the Trust undertook over 280 registered local clinical audits, carried out on a regular basis by staff.

For a complete list of clinical audits please see the [Quality Account](http://www.ouh.nhs.uk/about/publications) at: www.ouh.nhs.uk/about/publications
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 2015/16. The Trust’s Quality Account is available to read on our website at: www.ouh.nhs.uk/about/publications
OUR OPERATIONAL AND FINANCIAL PERFORMANCE

OUR CLINICAL SERVICES are assessed against a wide range of targets and other performance measures. We continue to work hard to ensure we diagnose and treat our patients without delay.

Meeting our access targets

We have experienced unprecedented demand for emergency services and there have been challenges around being able to move those emergency admissions into a bed on a ward within the national four hour standard. Delays in transferring those patients ready to leave our wards on to the next stage of their care in the community has also made it more difficult for the Trust to admit patients as quickly as it would like.

The table on the following page presents the Trust’s performance against national standards as an average for the year from April 2014 to the end of March 2015. In common with many other acute Trusts across the country, we did not achieve the standard of over 95% of patients seen, treated, admitted or discharged within four hours of attending our emergency departments. We were not able to always start treatment from referral by a GP within 18 weeks and we had difficulty in meeting three out of the eight cancer waiting time standards.

However, during the first quarter of this financial year (April, May and June 2015), the Trust’s performance against the national waiting time standards has improved further and we are aiming to meet all targets on a sustainable basis. We are working hard to improve the flow of patients through the system so that we are able to admit patients more quickly. In November 2014, there was a review of the emergency and urgent care system covering both health and social care by the national Emergency Care Intensive Support Team. In response to this, the Trust has developed an Urgent Care Improvement Programme to develop services people need while minimising the use of hospital beds.

We have improved and expanded the facilities in our Emergency Assessment Unit (EAU) at the John Radcliffe Hospital to support more people going home on the same day, improving the speed of diagnostic support available in the EAU and in our Surgical Emergency Unit.

The Trust continues to do well with waiting times for diagnostic tests. By October 2014, 97% of MRI scans were being provided within four weeks, enabling the overall standard of a six week wait for diagnostic tests to be met. The number of people waiting for diagnostic tests remains low with less than 1% of patients waiting more than six weeks.
### MEASURING OUR PERFORMANCE

#### PERFORMANCE AS AN AVERAGE THROUGHOUT 2014/15

<table>
<thead>
<tr>
<th>Category</th>
<th>Standard</th>
<th>Trust achievement 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral to treatment waiting times for non-urgent consultant-led treatment</strong></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>86.85%</td>
</tr>
<tr>
<td>Non-admitted patients (outpatients) to start treatment within a maximum of 18 weeks from referral</td>
<td>95%</td>
<td>94.75%</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>91.84%</td>
</tr>
<tr>
<td><strong>Diagnostic test waiting times</strong></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>99.1%</td>
</tr>
<tr>
<td><strong>Emergency Department waits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients should be admitted, transferred or discharged within four hours of their arrival at an emergency department</td>
<td>95%</td>
<td>89.8%</td>
</tr>
<tr>
<td><strong>Cancer waits – two week waits</strong></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>94.9%</td>
</tr>
<tr>
<td>Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>95.5%</td>
</tr>
<tr>
<td><strong>Cancer waits – 31 days</strong></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>95.9%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>94%</td>
<td>96.1%</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>100%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
<td>94%</td>
<td>91.5%</td>
</tr>
<tr>
<td><strong>Cancer waits – 62 days</strong></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>77.7%</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>93.1%</td>
</tr>
</tbody>
</table>
18 week waiting time standard

Due to the high volume of activity we have been unable to treat all elective patients within the standard 18 week waiting time and, in agreement with our commissioners and the Trust Development Authority (TDA), have implemented a recovery plan to reduce the number of patients waiting over 18 weeks for treatment. This includes holding 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 2014/15 and an action plan 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 with 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.

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 do not necessarily wait without being seen, and undergo assessment and diagnosis before moving on to the next stage of their care. Patients will always be seen based on their clinical priority and need.

The Trust has put in place improvements to its internal processes and systems to help address emergency department waiting times, including an ‘emergency navigator’ senior nurse role to help direct emergency GP referrals to the most appropriate unit on admission. It is also collaborating closely with other Oxfordshire NHS and social care services to shape and improve a whole-system approach to managing patients requiring urgent and emergency care, ensuring that patients are guided to the right service and don’t attend the emergency departments at either the John Radcliffe or Horton Hospital unnecessarily.

Infection prevention and control

Throughout 2014/15 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 minimising infection rates.

<table>
<thead>
<tr>
<th>INSTANCES OF INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford University Hospitals (cases across all hospital sites)</td>
</tr>
<tr>
<td>MRSA</td>
</tr>
<tr>
<td>Clostridium difficile</td>
</tr>
</tbody>
</table>

| Oxford University Hospitals (cases across all hospital sites) | Annual limit 2014/15 | Cases apportioned to the Trust in 2014/15 |
| MRSA | 0 | 7 |
| Clostridium difficile | 67 | 61 |
Factors impacting on our operational performance

Oxfordshire health and social care organisations recognise that they are co-dependent with regard to managing the pathway for patients. In particular, frail and elderly patients require a personal and holistic approach to their treatment, care and rehabilitation. This means that every step of the pathway needs to function smoothly in order to avoid delays and enable patients to go home as soon as they are medically fit to do so.

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 delayed transfers of care, with average monthly delays ranging from 133 to 159 patients. This equates to approximately 10% against the national standard of 3.5%.

The impact of delayed transfers on the Trust’s ability to manage emergency admissions is a concern. A lack of available beds can cause a ‘bottle-neck’ in the emergency departments where we continue to see increasing attendances with emergency care admissions continuing to grow at around 4% a year.

In addition, rising levels of referrals for routine operations, treatment, and appointments has put pressure on hospital beds, and our ability 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 wait longer than necessary is of concern to our patients and our clinical teams are working hard to improve the waiting times.

Over the past year, a number of improvements have been made to support access and discharge planning, including:

- A joint agency steering group meeting weekly to resolve discharge issues for individual patients who have been delayed.
- Input from social workers and support placement officers at weekends to speed up the discharge process.
- Collaboration with GPs on developing ambulatory care pathways that will improve access to treatment in hospital that does not require admission to a bed.
- Introduction of consultant physicians as part of emergency surgery to support the care of older people in trauma and orthopaedics.
- Opening of additional emergency assessment beds at the John Radcliffe and Horton Hospitals.

Financial performance overview

The Trust has an integrated business plan which sets out the Trust’s business strategy for the future. As with all other NHS trusts we are required to make significant savings and efficiencies over the coming years.

In the last financial year (to March 2015), we successfully delivered a challenging savings plan and achieved savings of £42.4m and a surplus of 1.25% of turnover on turnover of £916m. 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 £51.8m worth of savings to be made. We are doing everything we can to be more efficient behind the scenes. This includes internal efficiencies such as improving clinical pathways, increasing the benefits from Information Technology and seeking to make better use of our estate and the hospitals in which we work. Over the next five years we plan to make savings averaging £46.8m per annum (in nominal terms). This represents an average annual saving over these five years (2015/16 to 2019/20) of 5.2% each year.

Our integrated business plan sets out our ambition to be among the best in the UK at the care we provide. 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
**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 2014/15 there were NO Serious Incidents Requiring Investigation (SIRI) relating to a breach of confidentiality. 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 2014/15 the Trust received 629 Freedom of Information requests. This is an increase of 9.7% from 2013/14 when the Trust received 573 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, more complex requests do take longer than that to provide a comprehensive response.

During 2014/15, most requests resulted in full disclosure and of those closed during the period, 67% were responded to within 20 working days. This was an increase of 9% in the response rate from the previous year.

**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 an incident involving multiple casualties requiring extraordinary mobilisation of the emergency services.

The purpose of planning for emergencies is to ensure that we can provide an effective response to any major incident or emergency and to ensure the Trust returns to 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.
Revaluation of estate

In line with HM Treasury guidance each year the Trust commissions the District Valuer (DV) to provide valuations of the Trusts land and buildings. The valuation is based on modern equivalent assets (MEA) and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

The Trust first used an MEA valuation in 2010. This was also the year in which a full valuation was carried out. In the subsequent four years the DV carried out a desktop exercise supported by limited site visits. For 2015 a full valuation has been carried out. The DV has along with his staff visited all the Trust properties. The District Valuer has indicated that, in particular with respect to the three sites in Oxford though still to a degree in Banbury, it was appropriate for the MEA valuation to be provided on the basis of an ‘optimal site’. In assessing the value of the Trust’s land it was assumed that should the existing buildings be replaced by a modern equivalent asset, certain buildings would be rebuilt on a more intensive basis, on an alternative ‘optimal site’. Therefore a smaller landholding and buildings footprint was required while still maintaining the current level of service provision. This recognises any efficiencies that could be obtained if the sites were to be rebuilt, whilst maintaining the current level of service provision.

For non-operational buildings, including surplus land, the valuations were carried out at open market value. The impact of this revaluation is reflected in the full set of accounts available from www.ouh.nhs.uk

Sustainability update

The Trust, along with a number of other trusts and universities in Berkshire, Buckinghamshire, Milton Keynes and Bedfordshire, is part of the Oxford Academic Health Science Network. This provides an opportunity to realise significant carbon and cost savings from energy and sustainability projects. A benchmarking programme has already been completed to provide a baseline for generation of business cases. In the meantime, the Trust has joined forces with Oxford Brookes University and Oxford Health NHS Foundation Trust to share best practices in the areas of energy management and sustainability to fast track the adoption and implementation of projects and technologies that have been found effective among the partners.

The Trust also aims to sign up to the Good Corporate Citizenship Assessment Model this year to analyse and measure our progress on sustainable development. This will show how the Trust is performing across a range of criteria covering environmental, social and financial sustainability and it will support the subsequent development of a Sustainable Development Management Plan. It will also help benchmark against our peers and over the time can be used to provide valuable information on how sustainable development has been embedded in organisational performance.

PICTURED: A new Welcome Centre at the main entrance to the John Radcliffe Hospital will provide a more attractive environment for patients, visitors and staff entering and leaving the hospital. When complete in late 2015, the Welcome Centre will include a new main reception desk, a new patient information and seating area, and the office of the Patient Advice and Liaison Service (PALS). In addition, there will be space for three retail shops.
Energy

The Trust has spent just under £10.03 m on energy in 2014/15, which is a 4.16% increase on energy spend from last year. 0% of our electricity use comes from renewable sources.

Forward purchase of Carbon Reduction Commitment Energy Efficiency Scheme (CRCEES) allowances for 2014/15 helped the Trust save £26,000 on its carbon tax payments. For 2015/16, as a result of the latest guidance issued by the Environment Agency, the John Radcliffe Hospital site has now come out of CRCEES. This means a net reduction in our carbon tax liability of almost £2 million over the next five years.

On energy efficiency, we have made huge progress on the groundwork for key strategic projects in collaboration with the Carbon and Energy Fund (CEF), a £300 million plus fund to support projects in the NHS. Leveraging CEF’s expertise based on their work with 50 hospitals, the Trust will be able to upgrade its energy infrastructure. The benefits of this approach will be implementing a turnkey project via simplified procurement, access to technical and legal documentation and skilled advisors at reduced costs, a 25 years funding option and guaranteed savings.

The projects being considered:

- Provision of heat and electricity to the John Radcliffe and Churchill Hospitals, via an energy link, from 4.5 MWe natural gas fired Combined Heating and Power engine.
- Energy efficient lighting upgrade.
- Building Management System (BMS) controls and infrastructure upgrade including site wide metering and BMS optimization.
- Voltage optimization.
- Cavity wall insulation.

These initiatives will not only help the Trust become a more efficient user of energy, and thereby lower its associated carbon emissions, but also go a long way in improving operational resilience. In addition, the Trust will benefit from a reduction in both direct energy costs and non-energy charges in the form of lower carbon levies, Operational and Maintenance and service costs.

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

<table>
<thead>
<tr>
<th>WATER</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mains</td>
<td>m³</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>481,105</td>
<td>496,659</td>
<td>522,090</td>
</tr>
<tr>
<td>tCO²e</td>
<td>438</td>
<td>452</td>
<td>476</td>
</tr>
<tr>
<td>Water and sewage spend</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td></td>
<td>770,778</td>
<td>867,527</td>
<td>941,520</td>
</tr>
</tbody>
</table>
Health and safety

Reported incidents (non-clinical)

The number of non-clinical incidents reported during the period 1 April 2014 and 31 March 2015 are as follows. All incidents have been categorised by actual impact (No Harm, Minor, Moderate, Major, Severe).

There were 7,430 non-clinical incidents reported for 2014/15 including near miss incidents. Slips, trip and falls account for 38% of all the incidents. There were 14 ‘Major’ and 0 ‘Severe’ within the highest category. ‘No Harm’ incidents equated to 74% of all incidents within the Trust.

RIDDOR reported incidents

Overall the number of RIDDOR reportable incidents for 2014/15 was 20. An increase of four on the previous year. Of the incidents reported, below is a breakdown into Accident Type and RIDDOR Category. All 20 reported were related to staff.
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 to 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 continue to do) 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 the 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 or department to friends and family (if they needed similar care or treatment). This was introduced in inpatient wards, the Trust’s emergency departments at the John Radcliffe and Horton General Hospital, and in maternity services during 2013. It was extended to outpatient and day-case units in October 2014, and to children’s services in February 2015.

High response rates are important because it means that feedback is more meaningful, and more representative of the views of patients. Patients can give their feedback via our web-based Friends and Family Test questionnaire, or complete a paper questionnaire. In addition, patients who have attended the emergency departments, outpatient clinics or been on a day-case unit will receive a text message and automated phone call service to encourage feedback.

Breakdown of Trust scores between April 2014 and March 2015:

- **INPATIENTS**
  96% of patients are extremely likely or likely to recommend the ward they stayed on (based on 12,139 responses which was a 26% response rate).

- **EMERGENCY DEPARTMENTS**
  87% of patients are extremely likely or likely to recommend the care they received in the emergency departments (based on 8,353 responses which was a 14% response rate).

- **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. 94% of women are extremely likely or likely to recommend the Trust’s maternity services (based on 4,401 responses which was a 14% response rate).

- **OUTPATIENTS**
  95% of outpatients are extremely likely or likely to recommend the Trust’s outpatient services (based on 1,502 responses).

- **DAY-CASE UNITS**
  97% of day-case patients are extremely likely or likely to recommend the care they received (based on 656 responses).
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.

- 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.
- Patient stories – the Chief Nurse presents, with the patient’s permission, a case study and associated learning action plan to the Trust’s bi-monthly public Board meetings. These stories are also shared with our clinical teams to help them better understand what they do well and what needs to improve.
- A privacy and dignity workshop in February 2015 to co-produce privacy and dignity policy with voluntary and community groups and patient representatives.
- A workshop in November 2014 with Public Participation Groups and Trust staff to explore ways of developing the ‘patient voice’. This will entail a three year strategy to develop the way we work with patients and the public.
- A Carer’s Strategy – co-producing a carers feedback survey and methodology with carer representative groups to improve how we hear and act upon the views of patients and carers.
- A ‘Patient leaders’ programme funded by the Health Education Thames Valley (HETV) which will support patients and staff to work together to develop services, involving:
  - the production of patient partnership resources and toolkit;
  - a public engagement strategy;
  - a patient partnership education programme.
- Seldom heard people – this project is funded by the Health Education Thames Valley (HETV) and is supporting:
  - the Public Engagement Strategy development, and particularly the inclusion of ‘seldom heard people’ and vulnerable groups;
  - the carers’ feedback and engagement pilot in partnership with Carers Oxfordshire and Carers Voice.

**FRIENDS AND FAMILY TEST SCORES 2014/15**

<table>
<thead>
<tr>
<th></th>
<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>Number</td>
<td>19,954</td>
<td>5,161</td>
<td>849</td>
<td>348</td>
<td>337</td>
<td>402</td>
</tr>
<tr>
<td>Percentage</td>
<td>74%</td>
<td>19%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Engaging with patients and public

*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 2014/15 we have engaged patients and the public in a number of opportunities to help the Trust identify and set its priorities. These include:*
National patient surveys

In 2014, the Trust took part in the following two surveys:

- **Inpatient Survey**
- **Emergency Department 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.

The national **Inpatient Survey 2014** was sent to a sample of patients who were discharged from the Trust’s hospital wards in July 2014. The Care Quality Commission (CQC) collates and compares results across trusts. For our Trust, 53% of the sample group responded, which is higher than the average across other trusts at 47%.

The survey showed that 87% of inpatients who responded rated their care overall at seven or above on a scale of 0-10.

In particular, the survey highlighted delays in bedside call bells being answered. Currently around 45% of bells are answered within two minutes. While recognising there may be unavoidable short delays when wards are particularly busy, the Trust wants to ensure all patients are responded to promptly. It will run a series of staff involvement sessions to discuss how response times can be improved.

The plan to improve call bell response times will be incorporated into the campaign to achieve ‘Magnet’ accreditation recognising high-quality patient care and nursing excellence, led by the Trust’s Chief Nurse. The plan involves:

- Improving team working.
- Embedding Trust values for both staff and patients.
- Improving technology via the trial of a new ‘pager’ system.

The **National Emergency Department Survey 2014** was sent to a sample of patients who were discharged from the Trust’s Emergency Department in March 2014. The Care Quality Commission (CQC) collates and compares results across trusts. For our Trust, 37% of the sample group responded, which is higher than the average across other trusts at 34%.

The survey showed that 83% of emergency department patients rated their care overall at seven or above on a scale of 0-10.

The Emergency Departments improved significantly on the following questions since the 2012 survey:

- 86% of patients said their care was handed over from ambulance staff to emergency department staff within 15 minutes of arrival in 2014, an improvement from 72% in 2012.
- 81% said they were given the right amount of information about their condition or treatment in 2014 compared to 73% in 2012.
- 87% said they did not receive conflicting information from different staff in 2014, compared to 80% in 2012.
Patient Advice and Liaison Service (PALS)

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

The majority of PALS contacts relate to requests for information about hospital processes or putting people in touch with the correct department or individual who can help them. The service collates comments, suggestions and concerns made either directly to the service or through the patient experience feedback mechanisms available throughout the hospitals.

PALS is an integral part of the Patient Experience Team and works closely with the Complaints Department to provide a comprehensive service to patients and their families. PALS can be contacted by telephone, email, letter to the hospital or via the leaflet Let Us Know Your Views which is available in public areas on all hospital sites.

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 2014/15 the Trust received 1,009 formal complaints, an increase on the previous year when the Trust received 886 formal complaints.

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.

The Trust has undertaken a review of complaints to learn from the Francis Enquiry (into care at Mid-Staffordshire Hospital NHS Foundation Trust), and reports from Oxfordshire Healthwatch, the Parliamentary and Health Service Ombudsman and the Care Quality Commission.

Changes include:

- Simplifying the language used in response letters to include less jargon and better explain complex clinical information.
- Undertaking complainants’ satisfaction surveys in conjunction with the Patients’ Association.
- Assessment of serious complaints to establish if they should be investigated as a clinical incident – an important recommendation from the Francis Enquiry.

In 2015/16, we will introduce more detailed complaints monitoring at a divisional level through patient experience dashboards to enable the divisions to analyse their local patient experience metrics and complaints, and present the learning to the relevant services and departments. This will be supported by action logs presented at divisional clinical governance meetings to ensure actions are implemented and their effectiveness monitored.

**DURING 2014/15** PALS dealt with 3,323 requests, compliments and concerns. This is a decrease on the previous year’s total of 4,931 requests. The main categories related to patient care, communication and cancellations or delays in appointments. There were also compliments to various staff and departments.
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.

Supporting patients with dementia

A big area of focus for the Trust this year has been our work to improve the experience (and identification and diagnosis) of patients with dementia. Led by Dr Sarah Pendlebury, the Trust’s lead on dementia, a thorough programme of screening has been introduced to help identify those patients who are confused and need additional support.

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.

Five consultant 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.

We are also looking at ways we can improve the physical environment for patients with dementia – keeping ward areas as quiet as possible and providing patients with memory triggers such as signs depicting the date and weather for the day.

Psychological Medicine Service

The Trust’s pioneering psychological medicine service supports the care of patients with dementia, cognitive impairment, and other mental health issues. Over the past year, it has developed to become an integral part of the delivery of services where patients may require psychological assessment. Patient’s mental health can be impacted by their physical health. Research shows that around 10% of cancer patients and those receiving end of life care can suffer from depression and psychological issues. The service provides guidance and support to clinicians across the Trust and offers rapid psychological crisis assessment.

Knowing Me

We have introduced a document, called Knowing Me, for patients who may have difficulties in communicating. The booklet has been developed jointly with Oxford Health NHS Foundation Trust which provides care for patients with mental health problems. It will travel with vulnerable patients throughout their care and across different organisations and holds important information about the patient designed to make their care more personalized and comfortable.

The aim of the booklet is to promote consistent care across different settings and organisations. Patients and their families have fed back that they like the Knowing Me initiative’s simplicity, accessibility and ability to take a snapshot of everyday routines – right down to how an individual takes their tea and whether they prefer a bath or shower.

Our commitment to your privacy and dignity:

- We will involve patients and relatives in decision making about their health care – a 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, help plan their care in hospital and when they return home.
- We will work in partnership with our Palliative Care Team to ensure better end of life care that focuses on a patient’s wishes and protects their privacy and dignity.
Equality and diversity

The Trust works hard to ensure that its activities are as inclusive as possible for all patients, their families and carers. All employees undertake mandatory equality and diversity training, and all Trust policies and procedures are assessed prior to implementation to ensure equality issues have been considered.

Recent initiatives to support equality and diversity priorities include:

- The hospital passport for people with learning disabilities has been updated in response to feedback from carers, people with learning disabilities and healthcare professionals.
- The I-care card has been produced and is being used to assist in the identification of carers. This is a county-wide project, led by the Trust.
- The Trust’s bereavement service continues to be regarded by the four regional Islamic funeral directors as providing an exemplary service.
- The Knowing Me care planning document for vulnerable adults and particularly those with dementia has been developed in partnership with Oxford Health NHS Foundation Trust and Carers Oxfordshire.

Interpreting Services

Access to interpreting services is being improved through the PALS service providing support to people requiring interpreting services while in hospital or attending clinics. A key improvement includes a new platform of communication for the hearing impaired by having computers and webcams set up within departments enabling better access to BSL interpreters.

During 2015, the Trust’s Equality and Diversity Lead will review the appointment letters with the Services and Systems Manager, Elective Access. A Plain English review of our appointment letters is also underway to better support people who are sight or hearing impaired; have learning disabilities and other patient groups whose first language may not be English.

CASE STUDY

Want to know what an MRI scan feels like?
Ask John!

Patient John Milnes shared the benefit of his experience to help others having an MRI scan at the Churchill Hospital.

He played a major role in a YouTube video which has been watched over 1,000 times. John said: “Having an MRI scan for the first time is potentially quite daunting. I would have loved something like this showing me what to expect from a patient’s perspective before I had mine. Hopefully it will help other patients and allay any fears they may have before coming in for a scan.”

Anthony McIntyre, a Superintendent Radiographer at the Churchill, appears alongside John Milnes in the video. He said: “The video dispels some myths. I would recommend patients watch it before they come in if they have any doubts about the procedure.”

The video was coordinated by the Oxford Academic Health Science Network (Oxford AHSN) and filmed by Oxford Medical Illustration, based at the John Radcliffe. Find it on YouTube by searching for ‘MRI scan Oxford’.
RESEARCH AND DEVELOPMENT

As one of the largest acute trusts in the country our main priority is to deliver excellent healthcare for all 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.

Tackling 21st century healthcare challenges

Each treatment, assessment or operation given at Oxford University Hospitals has its roots in research. Research is a fundamental, but often unseen, part of the Trust’s work and plays a vital role in tackling the biggest healthcare challenges and improving the care we offer patients. Our research portfolio looks at new techniques and technologies and addresses major healthcare challenges, including heart disease, cancer and diabetes, through to much less common disorders and conditions.

The amount of research we are involved in continues to grow – there are currently well over 1,000 active research projects.

Research is integrated with our clinical care and carried out in partnership with world-leading academic partners at the University of Oxford’s Medical Sciences Division and Oxford Brookes University’s Faculty of Health and Life Sciences, other NHS trusts, including Oxford Health NHS Foundation Trust, and commercial partners.

Our research relies on patient involvement and participation. Anyone receiving care may be offered the opportunity to join a research study. Many studies are observational, which means patient data that is already routinely collected, such as blood pressure readings or scan images, are made available to researchers. Other studies may require additional tests or increased monitoring. New treatments and therapies are also trialled.

All our studies have ethical approval and adhere to rigorous governance procedures. Patient recruitment to studies is carried out by an informed consent process. Healthy volunteers are also recruited to take part in studies.

A new ‘matchmaking’ website is making it easier to match patient volunteers with trials and other research studies.
THROUGH OUR RESEARCH PARTNERSHIPS, the Trust seeks to deliver measurably better outcomes for patients.
Research as a strategic priority

It is a strategic priority of the Trust to continue to increase our research activity, further integrate it with clinical care and increase patient participation and involvement. Research and teaching is carried out in partnership with the University of Oxford’s 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 collaboration.

The Trust’s vision is to be at the heart of an innovative academic health science system. This involves partnerships:

- with the Oxford Biomedical Research Centre (BRC), funded by the National Institute for Health Research (NIHR), located on the John Radcliffe Hospital site and the Biomedical Research Unit (BRU) in Musculoskeletal Disease at the Nuffield Orthopaedic Centre. Both bring together the clinical excellence of the Trust with the academic expertise of the University of Oxford covering a range of research themes including cancer, dementia, cardiovascular disease, vaccines and infections, and orthopaedic surgery and conditions. All are pioneering new treatments, services and diagnostic tools and set the standard in translating science and research into new and better NHS clinical care.

- in the Oxford Academic Health Science Centre (OxAHSC), a designation by the Department of Health consolidating Oxford’s position as among world leaders in health research. Together the Trust, the University of Oxford, Oxford Brookes University and Oxford Health NHS Foundation Trust collaborate as one of just six AHSCs in England – a model that will attract increased funding for biomedical and clinical research which is of international standing.

- in the Oxford Academic Health Science Network, bringing the NHS, academia and industry together to boost health and wealth creation. This network of NHS Trusts, academic institutions and life science businesses covers the Thames Valley and South Midlands region and aims to enable swift uptake and adoption of health research by industry in developing innovative healthcare devices and treatments.

Public events open doors to research programmes

There were a number of opportunities to find out more about research programmes at Oxford University Hospitals during 2014/15. Clinicians and scientists invited the public to find out what goes on behind the scenes.

- An open day at the John Radcliffe Hospital in May 2014 organised by the Oxford Biomedical Research Centre included demonstrations of the latest technology and the chance to talk to research teams about the latest developments in cancer, dementia, heart disease and more.

- In March 2015 NHS researchers and colleagues from the University of Oxford showcased their work at OUH sites and other venues at a series of free ‘Open Weeks’ events. Behind-the-scenes opportunities included seeing the human brain in action from the control room of the ultra-high field MRI scanner at the JR.

IMPROVED RANKING FOR OUCH CLINICAL TRIALS

New figures from the National Institute for Health Research (NIHR) show an improvement in the proportion of trials at the Trust which recruit the first patient within 70 days when external permissions are in place. In the 12 months to 31 December, 2014, this was 95%, a significant increase on 34.7% in the 12 months to December 2013.

The Trust is ranked second out of England’s most research-active NHS Trusts for this key metric of how quickly clinical trials can be started. This will quicken the pace of translational research in the Trust and give assurance to outside investors in our research. This improvement has been led by Professor Keith Channon, Trust Director of Research and Development, and research staff are to be congratulated for this excellent performance.
‘Matchmaking’ website brings patients and researchers together

A new website (www.patientsactiveinresearch.org.uk) was launched in January 2015 to promote patient involvement in research by ‘match-making’ patients, carers and other members of the public who are interested in medical research with researchers working in hospitals.

Dr Sophie Petit-Zeman, Director of Patient Involvement, Oxford Biomedical Research Centre, explained that the website’s main aim is to link researchers with patients and others who want to support the planning of research and help inform how it is done. She said: “This can make research more relevant for patients. Having a route through which ‘match-making’ is made easier is a really important step.”

Trust comes second in recruiting patients for research

The latest research activity league table for the NHS, published by the National Institute for Health Research (NIHR), ranks the Trust second for acute trusts, by recruiting 18,422 patients to clinical trials. This league table details the number of studies undertaken by each individual trust, and the number of patients they recruited. The excellent clinical research recruitment performance from both OUH and Oxford Health NHS Foundation Trust is a great reflection of the close working between our research and development teams, principal investigators and partners of the Oxford Academic Health Science Centre (OxAHSC).

Botnar Research Centre opened by Duchess of Cornwall

The second phase of the University of Oxford’s Botnar Research Centre was officially opened by the Duchess of Cornwall on Friday 9 May 2014. The £12m facility, on the site of the Nuffield Orthopaedic Centre (NOC) in Headington, carries out research to improve the treatment of arthritis, osteoporosis and other bone and joint diseases. It brings world-leading research together with NHS clinical practice, accelerating discovery into new treatments and services for patients.

The Botnar Research Centre now comprises 4,000 m² of custom-built research facilities including state-of-the-art laboratories and flexible office accommodation. It can house up to 250 scientists, clinicians and support staff carrying out pioneering research into conditions such as osteoporosis, osteoarthritis and cancer.

It also houses research supported by the National Institute for Health Research (NIHR) Oxford Biomedical Research Unit, a collaboration between Oxford University Hospitals NHS Trust and the University of Oxford to translate innovation and discovery in musculoskeletal research into patient benefit.
Research work in Oxford has been at the forefront of the battle against Ebola which swept through parts of west Africa during 2014. The first volunteer received the new Ebola vaccine at the Churchill Hospital in September. It was then fast-tracked for trials before the end of 2014.

Initial results announced by the University of Oxford in January 2015 showed the vaccine was safe, well tolerated and generates an immune response. Further testing is planned in areas affected by the current outbreak to determine if it can offer protection against Ebola.

Oxford University Hospitals was chosen by NHS England in December 2014 as one of 11 new Genomic Medicine Centres to deliver the 100,000 Genomes Project. This project aims to transform healthcare by improving prediction and prevention of disease and diagnostic tests, and allow personalisation of drugs and other treatments.

The first patients began being recruited in February 2015.

In July 2014 the Trust was successful in winning the contract to continue hosting the internationally-renowned UK Cochrane Centre for five more years. The £4m contract runs to 2020. The UKCC produces and disseminates systematic reviews to improve healthcare, locally, nationally and worldwide. These help ensure that only the most effective and best value interventions are adopted.
£110M CANCER RESEARCH INSTITUTE GETS THE GO-AHEAD

In October 2014 it was announced that a Precision Cancer Medicine Institute would be developed alongside the Churchill Hospital to carry out research into a wide range of cancer therapies and diagnostics. It is the product of an international collaboration, led by the University of Oxford, which aims to make surgery and radiotherapy more precise and less invasive.

TELEHEALTH TECHNOLOGY DEVELOPED IN OXFORD WINS NATIONAL PRIZE

Smartphone based technology developed in Oxford to help women who develop diabetes during pregnancy won a national prize in October 2014. The GDm-Health project won the Best Digital Initiative award at the Quality in Care Diabetes Awards. The system transmits blood glucose readings from a Bluetooth-enabled blood glucose meter to a smartphone application, with results sent via a secure website where health professionals can review the information and follow-up with an SMS message to patients. It enables diabetes specialists to monitor patients remotely, assess results and provide feedback in real time. As a result patients get better care and spend less time in hospital. The project, a collaboration between the Trust, the University of Oxford and the Oxford Biomedical Research Centre, is now being rolled out to other hospitals.

FIRST INTERNATIONAL STANDARDS TO ASSESS THE GROWTH OF BABIES

The first international standards for fetal growth and newborn size were developed from Oxford in 2014. As a result it is now possible to detect underweight and overweight babies early in life – no matter where they are born – leading to better outcomes, especially in preventing chronic disease. The project was led by the University of Oxford.
WE ARE the third largest employer in Oxfordshire, with a total workforce of 12,000. We are extremely proud of our multi-professional staff, who deliver compassionate and excellent patient care whilst demonstrating great dedication and flexibility in meeting the daily demands and constant challenges associated with providing NHS services.
Our vision and strategy

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. The Strategy sets out the workforce priorities for the next five years and develops key themes drawn from consultation with stakeholders.

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

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

Our 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 are 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.

“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.”

The Trust’s vision for its workforce
Our workforce

The Trust’s workforce totals just over 12,000 members of staff (which includes all individuals holding a paid contract of employment and those who are engaged in research and development activities). 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 560 whole time equivalent (WTE) staff when compared to 2013/14. 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 60% of growth.

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 1,600, we have approximately 750 doctors who hold honorary contracts with the Trust. These include University of Oxford medical staff who provide clinical services and doctors from other UK trusts and from overseas who wish to expand their knowledge and experience. We also employ over 600 staff to provide facilities services at the John Radcliffe Hospital and Churchill Hospital sites. These members of staff are managed by our Private Finance Initiative (PFI) partners.
Staff attendance

The Trust is committed to reducing staff sickness absence and provides comprehensive and proactive occupational health and wellbeing services, whilst striving to maintain healthy working environments. The Trust aims to ensure attendance levels are high and sickness absence rates are minimised.

The overall Trust sickness absence rate was 3.7% at the end of March 2015. This represents the average for a rolling twelve month period. Whilst the recorded absence rate has increased within the last year, this is consistent with improved data quality following the introduction of FirstCare, an absence management system which fully integrates with absence procedures and processes.

Over the past year, significant changes have been made to the way in which OUH manages sickness absence. These changes include the introduction of a more robust absence management procedure, improved processes and links to Occupational Health services, and an increased focus on Health and Wellbeing initiatives. In the forthcoming year the introduction of an Employee Assistance Programme (EAP) will complement the work of FirstCare.

The organisation has moved from an ethos of absence management to attendance improvement. Improved reporting of sickness absence in real time, through FirstCare, is enabling line managers to act swiftly and consistently in supporting staff to return to health and work as quickly as possible.

Staff turnover

Overall staff turnover for the 12 month rolling period ending 31 March 2015 was 13.6%. Within certain staff groups, where there are national and local shortages, turnover levels are higher.

Recruitment and retention

Within the context of the prevailing national and local economic climate, the recruitment and retention of staff remains challenging.

We face pressures associated with the high cost of living in Oxford, and retention of our staff is adversely affected by the Trust’s relative proximity to the London NHS ‘market’ where salaries attract a weighting (high cost area supplement) equating to as much as 20% of basic pay. Oxford is recognised as being one of the least affordable cities in which to live, due to high property prices and rental costs regarded as being among the highest in the country.

We acknowledge the impact of continuing rises in the cost of living and lower annual pay increases within the public sector. We have introduced initiatives in response, including the introduction of new rates of pay for staff who work on our internal ‘bank’ in a flexible or part-time capacity helping to cover shifts or short-term vacancies.
The Trust also continues 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 can be met without compromising our service delivery.

Other benefits include salary sacrifice schemes for bus passes, car and bicycle leases; a home technology scheme; retirement vouchers; nursery school vouchers; discounts from a number of local and national retailers; and the provision of competitively priced on-site accommodation.

WE ARE DELIGHTED...
that the Trust was highlighted in a report by the Health Service Journal (HSJ) as one of the best places in the NHS to work. The HSJ’s ‘Best Places to Work’ is an annual celebration of the UK’s elite public sector healthcare employers. Identifying these organisations is a joint undertaking by the HSJ and Best Companies Group (BCG).

The HSJ reported that:
‘Engagement among its teams is one of the highest compared with all NHS organisations. Employees report effective team working, good communication between senior management and staff and low experiences of violence and harassment. The organisation also offers flexible working and career breaks to staff where possible.’

Education, learning and development
An important aspect of being a leading teaching hospital is our continuing commitment to support and educate the future workforce of the NHS. A key priority is to ensure staff have access to professional development opportunities and career advancement.

Education and training is delivered in a variety of ways to help meet the learning preferences of individuals, including blended learning with the use of e-learning programmes and videoconferencing. We work with our academic partners to provide pre-registration nursing and midwifery education to around 400 student nurses and midwives and 800 trainee doctors.

Key successes over the past year include:

- External recognition of how the Trust delivers and manages its training, winning ‘The Best Public Sector Project in the UK’ at the Cloud Awards 2015 and as a finalist in the in the 2014 ‘E-Learning Awards’.
- Development of the OUH Leadership and Talent Development Strategic Framework to attract, identify, develop and retain leadership capability of the highest quality.
- A successful evaluation of a ‘coaching’ pilot which will be rolled out during 2015, while the ‘front line’ Nursing Leadership Programme Safe in Our hands has been developed further and continues to support ward-based leaders.
- An increase in appraisal compliance rates following the introduction of an electronic appraisals system.

Leaders continue to access the core professional programmes sponsored by the NHS Leadership Academy and programmes delivered by Health Education Thames Valley. In addition, we have sought to widen participation in the Trust’s Care Support Worker Academy, through which care support workers are encouraged to undertake a programme of education that leads to the award of the higher certificate of fundamental care. Launched in 2012, the Academy is also active in recruitment; providing career and progression advice; and promoting apprenticeship opportunities within the Trust.

This year has also seen the commissioning of a far-reaching education review which, when completed along with the Leadership Development and Talent Framework, will provide a comprehensive approach to multi-professional education to ensure that we have the right skills, in the right place at the right time to deliver the very highest levels of patient care.
CASE STUDY: Helping young people get into the NHS
Oxford University Hospitals became the first Trust in the Thames Valley to run a Prince’s Trust ‘Get into the NHS’ programme to help young people find jobs and apprenticeships in the health service. The course, run at the John Radcliffe Hospital, provides a combination of training and work experience. Ten young people took part in the first programme which included first aid, customer service, employability skills and equality and diversity training. It was funded by Health Education Thames Valley. More than half of the participants are expected to find jobs at the Trust.

CASE STUDY: Clinical scientists harness innovation
The Trust has piloted new national training schemes for healthcare scientists whose behind-the-scenes work underpins frontline patient care. The first registered clinical scientists completed a three-year postgraduate programme in 2014/15.

CASE STUDY: More support for newly-qualified nurses
A new Foundation Programme for Registered Nurses at the OUH was launched in September 2014 by Chief Nurse Catherine Stoddart. It helps newly registered nurses develop their skills at the start of their professional lives through clinical supervision, one-to-one help, peer support and ‘buddying’ with experienced colleagues. At the end of the programme there is an opportunity for participants to access further education programmes.

CASE STUDY: from Care Support Worker to Assistant Practitioner
Alice Warder (pictured below), who started as a Care Support Worker for the Thrombosis Service, successfully completed a Trust apprenticeship to qualify as an Assistant Practitioner. Alice works alongside a team of specialist nurses who help support patients undergoing anticoagulation treatment such as Warfarin. Alice’s place on the apprenticeship scheme involved a two-year foundation degree course, with her time split between working in the thrombosis service and attending Oxford Brookes University once a week for study days. Since graduating in the summer of 2014, Alice has been working as a qualified Assistant Practitioner within the service.

PICTURED: Congratulations to Alice Warder who recently qualified as an Assistant Practitioner
Staff health and wellbeing

We recognise that a healthy and well-motivated workforce is fundamental to the delivery of good care. To this end, we have increased provision of health and wellbeing support and advice to staff through the activities of our Centre for Occupational Health and Wellbeing, which provides health promotion and support from occupational health, back care and physiotherapy staff.

A number of initiatives have been delivered during 2014-15 to promote healthier lifestyle choices for all employees. The initiatives are aimed at supporting staff to make small healthy changes through:

- increasing physical activity with newly designed ‘walk to work’ routes and cycle routes;
- encouraging staff to take the stairs rather than the lifts;
- lunchtime walks and pedometer challenges;
- charity physical activity events;
- taking part in on-site activity classes;
- promoting local leisure facilities which offer reduced gym membership.

Promoting public health to staff

The Trust’s Public Health Strategy aims to create a health-promoting environment in which healthy lifestyles and choices are highlighted 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 and exploring healthier food options at all Trust sites.

Looking forward to 2015-2016, the Trust has prioritised the Mentally Healthy Workplace Programme to support staff in managing stress, build resilience and to promote mental health training. A new Mindfulness research project is also planned for 2015 and we are maintaining focus on staff mental health through a policy which outlines procedures for identification of mental health problems, plus support and referral.

Staff engagement, recognition and consultation

Awards and recognition

Dozens of awards were presented at our annual Staff Recognition Awards in December 2014. The awards event was held at the Oxford University Museum of Natural History. The evening showcased the great work undertaken across the Trust’s four hospitals and recognises the outstanding achievements, commitment and dedication shown by individuals and teams every day of the year. The overall winners were chosen from more than 500 nominations.

The award categories covered: Excellence; Care and Compassion; Innovation; Leadership; Partnership, Team, Outstanding Achievement; Volunteering and Support.

A further 50 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’.

During the year, other external awards were made to staff, including:

- **Professor Michael Sharpe**, OUH lead for Psychological Medicine, was named ‘Psychiatrist of the Year’ at the Royal College of Psychiatrists (RCPsych) Awards in November 2014.
- **Dr Syed Masud** was named Emergency Medicine Consultant of the Year by the Oxford School of Emergency Medicine in December 2014.
- **Squadron leader Charlotte Thompson-Edgar**, military nurse at the John Radcliffe Hospital, was awarded an Associate of the Royal Red Cross for her services to the Princess Mary’s Royal Air Force Nursing Service as part of the British military’s Medical Emergency Response Team evacuating wounded troops from the battlefields of Helmand in Afghanistan.
Values-based engagement

As part of our strategy to deliver excellence and compassion in all that we do, the Trust has introduced *Values Based Interviewing* (VBI), which incorporates the Trust values into the recruitment process to assess candidates’ alignment and support for the values and behaviours we seek to uphold.

Training has also been introduced for staff to develop skills and techniques for ‘values based conversations’ (VBC) with their staff in the workplace. A total of 228 individuals have attended the VBC training. Awareness videos for both VBI and VBC support on-going promotion of the benefits of these initiatives.

Our aim is to continuously improve the quality of patient care through greater alignment of individual and organisational values. Through adopting a values-based approach to customer care we believe we will have more staff who adopt a person-centred approach to providing safe and compassionate care.

A *Delivering Compassionate Care* training programme has been developed and is being delivered to frontline staff. The one-day development intervention aims to help participants understand the impact of behaviour and attitudes on the patient, and to develop an understanding of effective communication styles with those who are vulnerable.

Listening into Action

The Trust has engaged 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.

Listening into Action puts staff at the centre of change by using their knowledge, ideas and enthusiasm to make changes that have a real impact. The methodology encourages group conversations at local team levels to consider what gets in the way of delivering the very best care for our patients and how they can implement change.

Teams are involved on 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.
The NHS Staff Survey

Each year the Care Quality Commission undertakes a survey of NHS staff based on five key themes relating to the working environment and individuals’ experience within the workplace, namely: Your Personal Development; Your Job; Your Manager; Your Organisation; Your Health, and Wellbeing and Safety at Work.

The 2014 NHS Staff Survey was undertaken between October and December. All directly employed staff received a survey questionnaire, which they were encouraged to complete and submit. The overall response rate of 31% represents a 7.2% decrease compared with the 2013 Survey and is consistent with a downward trend in responses across the majority of trusts, nationally.

The survey outcomes confirmed that 70% of those responding agreed or strongly agreed that they would recommend their hospital to family and friends as a place to be treated, against a national average for all acute trusts of 65%. OUH was in the top 20% of acute trusts in England for seven of the survey’s 29 key findings. Of these, the five key findings against which OUH compared most favourably when compared with all other acute trusts were:

- Staff motivation at work;
- Staff experiencing physical violence from staff in the last 12 months;
- Staff satisfied with the quality of work and patient care they deliver;
- Staff able to contribute towards improvements at work;
- Staff job satisfaction.

<table>
<thead>
<tr>
<th>NHS SURVEY FOR OUH 2014 – TOP SCORES</th>
<th>2014 SCORE</th>
<th>2013 SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff motivation (score out of 5)</td>
<td>3.98</td>
<td>3.88</td>
</tr>
<tr>
<td>% of staff experiencing physical violence from staff in the last 12 months</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>% of staff feeling satisfied with the quality of work and patient care they are able to deliver</td>
<td>84%</td>
<td>81%</td>
</tr>
<tr>
<td>% of staff able to contribute towards improvements at work</td>
<td>74%</td>
<td>72.5%</td>
</tr>
<tr>
<td>Job satisfaction (score out of 5)</td>
<td>3.69</td>
<td>3.64</td>
</tr>
</tbody>
</table>

There are other areas that have been identified as needing improvement throughout the Trust, for example staff receiving job relevant training, opportunities for career progression, appraisals and the number of staff that report errors.

<table>
<thead>
<tr>
<th>AREAS FOR IMPROVEMENT</th>
<th>2014 SCORE</th>
<th>2013 SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of staff receiving job-relevant training, learning or development in the last 12 months</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td>% of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>86%</td>
<td>91%</td>
</tr>
<tr>
<td>% of staff that believe the Trust provides equal opportunities for career progression and promotion</td>
<td>81%</td>
<td>89%</td>
</tr>
<tr>
<td>% of staff receiving health and safety training in the last year</td>
<td>69%</td>
<td>81%</td>
</tr>
<tr>
<td>% of staff appraised in the last 12 months</td>
<td>80%</td>
<td>80.5%</td>
</tr>
<tr>
<td>% of staff receiving equality and diversity training in the last 12 months</td>
<td>63%</td>
<td>79%</td>
</tr>
</tbody>
</table>
The five key findings for which OUH compared least favourably with all other acute trusts were:

- staff receiving job-relevant training, learning or development in the last 12 months;
- staff reporting errors, near misses or incidents witnessed in the last month;
- staff believing the Trust provides equal opportunities for career progression or promotion;
- staff receiving health and safety training in the last 12 months (this reflects the three year refresher periods within the Trust);
- staff appraised in the last 12 months (this reflects the dip in appraisal completion prior to the staff survey being launched).

The survey report also showed how OUH 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 staff engagement score of 3.82 was consistent with the previous year of 3.83 and is one of the best (i.e. highest 20%) across all acute trusts.

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.

Raising concerns

In its commitment to providing the highest standards of care and service for our patients and visitors, the Trust takes very seriously its responsibility for ensuring all members of staff feel confident and supported in being able to speak up when they believe these standards are being compromised, or could be compromised. We have clear processes to ensure that our staff feel able and safe to raise concerns, and have confidence they will be listened to and their concerns acted upon.

Where such issues are raised, they are generally addressed quickly and efficiently through our established processes detailed in the Trust’s Raising Concerns Policy. Under the terms of the policy, and in his capacity as Director of Organisational Development and Workforce, Mark Power, has a guardianship role in support of any employee who wishes to raise an issue of concern. In the interests of continuous improvement and learning, speaking up should be something that everyone does and is encouraged to do. Our Trust policy is frequently updated to ensure it fully supports this aim.

Staff consultation and negotiation

Consultation and negotiation between management and staff is conducted through a Joint Consultative and Negotiation Committee, which includes a mix of trades union representatives and elected staff representatives who meet on a regular basis. The purpose is to provide a constructive forum for discussion and exchange of views, and to consult on matters of common interest with regard to the Trust and its business. The committee provides an opportunity for staff to present their views and influence key Trust issues and decisions.
Equality and diversity commitment

As a responsible employer and provider of healthcare services, we are committed to recognising, valuing and supporting the diverse range of staff we employ and patients we care for. We endeavour to treat our patients, visitors and staff with dignity and respect and learn from occasions when our actions have fallen short of our high expectations.

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

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different groups and
- foster good relations between people.

The Equality Delivery System (EDS) is designed to support NHS providers to deliver better health outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The Trust has been using the EDS as a tool to benchmark compliance with the Equality Act and to support the development of its equality, diversity and inclusion objectives.

In order to enable the Trust to review its existing performance and to facilitate the identification of future priorities a workshop was conducted in November 2014 with representatives from the Trust Board and a cross-section of employees and carers.

This has supported work on the development of the Equality, Diversity and Inclusion Strategy for 2015-2018.

Equality, diversity and inclusion are core components of the Trust’s statutory and mandatory training for all staff, with 86% of employees successfully completing this for 2014/15, against a Trust target of 90%. The Trust also offers staff training on Unconscious Bias and Bullying and Harassment.

Bronze Standard Award

In 2014, the Trust was proud to be awarded a Bronze Standard Award for its work and commitment to equality and inclusion by the Employers Network for Equality and Inclusion (enei). This followed the benchmarking of our performance against five key areas of equality and diversity, namely:

- organisational commitment and leadership;
- knowing your workforce;
- integrating equality, diversity and inclusion;
- external relations and suppliers;
- organisational improvements.

Support for disabled employees

The Trust’s ongoing commitment to the employment of disabled people has been recognised and we continue to be awarded the Two Ticks disability symbol by Jobcentre Plus for a further twelve months. This demonstrates our commitment to ensuring that our recruitment processes do not disadvantage disabled applicants and that we actively support employees who have a disability and help those who become disabled to stay in employment. We review annually our plans and activities in support of disabled people, and promote disability awareness for all employees.
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 are supported by an army of volunteers, and we also work with charitable organisations to support community engagement and to share knowledge and expertise.

Our members and Council of Governors

During 2014/15, 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 more than 8,000 public members, along with a staff membership of around 11,000. As part of our process to become a Foundation Trust, we elected from our membership our first Council of Governors in shadow form in February 2015. The Council will work alongside the Trust Board. It is made up of 29 governors, plus a Chairman who is also the Chairman of the Trust’s Board of Directors. There are 15 elected public governors, six elected staff governors, and eight governors appointed by local organisations with which the Trust works closely.

You can find out more about our governors on our website at: www.ouh.nhs.uk/ft

PUBLIC GOVERNORS

<table>
<thead>
<tr>
<th>Buckinghamshire, Berkshire, Wiltshire and Gloucestershire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally-Jane Davidge</td>
</tr>
<tr>
<td>Brian Souter</td>
</tr>
<tr>
<td>Cherwell</td>
</tr>
<tr>
<td>Teresa Allen</td>
</tr>
<tr>
<td>Anita Higham OBE</td>
</tr>
<tr>
<td>Oxford City</td>
</tr>
<tr>
<td>Margaret Booth</td>
</tr>
<tr>
<td>Cecilia Gould</td>
</tr>
<tr>
<td>Northamptonshire and Warwickshire</td>
</tr>
<tr>
<td>Rosemary Herring</td>
</tr>
<tr>
<td>Vacant at time of going to press</td>
</tr>
<tr>
<td>South Oxfordshire</td>
</tr>
<tr>
<td>Ian Roberts</td>
</tr>
<tr>
<td>Sue Woollacott</td>
</tr>
<tr>
<td>Vale of White Horse</td>
</tr>
<tr>
<td>Martin Havelock</td>
</tr>
<tr>
<td>Jill Haynes</td>
</tr>
<tr>
<td>West Oxfordshire</td>
</tr>
<tr>
<td>Sue Chapman</td>
</tr>
<tr>
<td>Jane Doughty</td>
</tr>
<tr>
<td>Rest of England</td>
</tr>
<tr>
<td>Roger Morgan</td>
</tr>
</tbody>
</table>

STAFF GOVERNORS

<table>
<thead>
<tr>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris Cunningham</td>
</tr>
<tr>
<td>Jeremy Dwight</td>
</tr>
<tr>
<td>Jules Stockbridge</td>
</tr>
<tr>
<td>Chris Winearls</td>
</tr>
<tr>
<td>Non-clinical</td>
</tr>
<tr>
<td>Raymond James</td>
</tr>
<tr>
<td>Tom Mansfield</td>
</tr>
</tbody>
</table>

APPOINTED GOVERNORS

<table>
<thead>
<tr>
<th>Oxfordshire County Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cllr Judith Heathcoat, Cabinet Member for Adult Social Care</td>
</tr>
<tr>
<td>University of Oxford</td>
</tr>
<tr>
<td>Dr Catherine Paxton, Director of Student Welfare and Support Services</td>
</tr>
<tr>
<td>Oxford Brookes University</td>
</tr>
<tr>
<td>Professor June Girvin, Pro Vice-Chancellor and Dean of the Faculty of Health and Life Sciences</td>
</tr>
<tr>
<td>NHS England</td>
</tr>
<tr>
<td>Rachel Pearce, Interim Director Commissioning Operations – South Central</td>
</tr>
<tr>
<td>Oxfordshire Clinical Commissioning Group</td>
</tr>
<tr>
<td>Dr Paul Park, Deputy Clinical Chair</td>
</tr>
<tr>
<td>Oxfordshire Local Medical Committee (LMC)</td>
</tr>
<tr>
<td>Dr Paul Roblin, Chief Executive</td>
</tr>
<tr>
<td>Oxford Health NHS FT</td>
</tr>
<tr>
<td>Martin Howell, Chair</td>
</tr>
<tr>
<td>Young People’s Executive</td>
</tr>
<tr>
<td>To be nominated</td>
</tr>
</tbody>
</table>
Supporting your hospital charity

Throughout the past year Oxford Radcliffe Hospitals Charitable Funds has been working to support patients and their families. The charity seeks to make a difference in a variety of ways – from purchasing state-of-the-art medical equipment and innovative medical research to creating more comfortable and welcoming patient areas.

In the last financial year over £3 million was donated to the charity, helping to ensure that we deliver the best of patient care and transforming the lives of many.

The charity welcomed a new Director of Fundraising, Jayne Ozanne. Jayne has headed up marketing teams with Proctor & Gamble, Kimberly Clark and the BBC and also worked in senior roles with Oxfam, the Girl Guides and the Church of England. She said: “I am deeply struck by the energy and generosity that exists towards our hospitals. We are incredibly grateful to all those who support the charity in so many different ways.

“As I’ve got to know the various hospital areas it has been inspiring to discover quite how much charitable support has contributed to creating a positive patient experience. I believe there is real opportunity for even more innovative ways to support the Trust and benefit patients in the coming years.”

The new outpatients area at the Oxford Heart Centre is an example of what can happen when the charity and Trust work side by side to make real change.

The Heartfelt Appeal brought together clinicians and hospital supporters through abseiling, running and dining events to help transform the experience for cardiac outpatient.

Previously patients had to move between three separate areas to have their appointments – now they wait in one bright and airy space. Not only does this make appointments quicker and less stressful, it also allows clinicians to communicate more easily with each other. The department is also now equipped with the very latest cardiac imaging technology for diagnosis and treatment, funded by the charity.

Support for the Children’s Hospital has been strong throughout the year, with a hugely successful event at the restaurant Le Manor aux Quat’Saisons in the spring, hosted by Raymond Blanc. The dinner raised over £170,000 to purchase the very latest surgical equipment for children facing brain surgery.

Our Dorchester Abbey Christmas Concert attended by over 500 people, was another triumph. The evening, which raised £54,000 included fabulous readings from HRH Earl of Wessex, Joanna Trollope, Laurence Fox, Sam Waley-Cohen and nine-year-old patient Magnus Cameron.

The fundraising year for children’s was rounded off with the 2015 Oxford Mail OX5RUN, where 1,000 runners tackled a five mile route at Blenheim Palace, raising over £100,000.

Youngsters treated at the Horton General Hospital are some of the many patients to see the benefit of charitable support this year. A specialist children’s outpatients area, counselling room and a teenage area as well as the refurbishment of the parent’s room all took place, and were supported by the charity.

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 help to promote fundraising in their areas.

Fundraising for the year ahead is likely to focus on developing a strategy for broader support for the charity, as well as fundraising for a new Day Surgery Unit at the Churchill Hospital.

To find out how you can get involved with fundraising for the OUH hospitals visit www.hospitalcharity.co.uk
email: charity@ouh.nhs.uk, or telephone 01865 743444.
Our volunteers and supporters

Our volunteers benefit the Trust in numerous ways including helping ward staff at meal times, directing patients and visitors to their destinations, and supporting staff with administrative duties.

The Trust has a Voluntary Services Department that manages volunteers, other volunteer organisations and the work experience programme. We are very proud of, and grateful to, our loyal volunteers who support 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).

Celebrating a half-century of volunteering at the Nuffield Orthopaedic Centre

Trust Chief Executive Sir Jonathan Michael unveiled a plaque to celebrate 50 years support from League of Friends volunteers at the Nuffield Orthopaedic Centre (NOC).

Volunteers have raised over £1m for the hospital since starting to help in 1964. This has paid for an ultrasound scanner, videoconferencing, adjustable physiotherapy tables, wheelchair weighing scales and many more items. A team of 70 people currently volunteer at the NOC, helping patients every day.

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

Sir Jonathan Michael, Trust Chief Executive
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, and other related publications such as Quality Governance in the NHS, working hard to ensure it operates to high ethical and compliance standards.

Working alongside our Board of Directors is our Council of Governors. In February 2015, we elected our Council of Governors in shadow form, to come into full effect once authorised to become a Foundation Trust. The Governors play a valuable role by holding our Directors to account, ensuring that the interests of the Trust’s members are taken into account and helping to shape our plans for the future.

Our Council of Governors comprises 15 public governors elected from constituencies covering Oxford city, South Oxfordshire, Vale of White Horse, West Oxfordshire and Cherwell districts, Buckinghamshire, Berkshire, Gloucestershire, Wiltshire, Northamptonshire, and the rest of England and Wales. There are six staff governors, and a further eight appointed posts cover strategic partners.

The Trust Board membership comprises:

**Executive Directors**  
Sir Jonathan Michael, Chief Executive*  
Dr Tony Berendt, Medical Director*  
Mr Paul Brennan, Director of Clinical Services*  
Mr Mark Power, Director of Organisational Development and Workforce  
Mr Mark Mansfield, Director of Finance and Procurement*  
Mr Andrew Stevens, Director of Planning and Information  
Ms Catherine Stoddart, Chief Nurse*  
Mr Mark Trumper, Director of Development and the Estate  
Ms Eileen Walsh, Director of Assurance  
* Indicates those members holding voting positions

The Trust Board continued to meet bi-monthly. In the intervening months meetings of the Quality Committee and Finance and Performance Committee were held 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/aboutus

Further details of the Council of Governors are available at www.ouh.nhs.uk/aboutus

**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 Goard, Vice-chairman

The Chief Executive, Director of Finance and Procurement, and Director of Assurance normally attend the meetings of the Committee. In line with best practice, the Chairman of the Board is not a formal member of the audit committee but may be in attendance, along with any other Board member or senior executive, 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 Goard, Chairman
Mrs Anne Tutt, Vice-Chairman
Mr Geoff Salt
Dame Fiona Caldicott
Alisdair Cameron
Peter Ward

and the following Executive Directors:

Sir Jonathan Michael, Chief Executive
Mr Mark Mansfield, Director of Finance and Procurement
Dr Tony Berendt, Medical Director
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 met a total of six times during the year.

and the following Executive Directors:

Dr Tony Berendt, Medical Director
Mr Paul Brennan, Director of Clinical Services
Mr Mark Power, Director of Organisational Development and Workforce
Sir Jonathan Michael, Chief Executive
Ms Catherine Stoddart, 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.

REMUNERATION AND APPOINTMENTS COMMITTEE

The Remuneration Committee comprises all Non-executive Directors and is chaired by Professor Sir John Bell. The committee is established in accordance with good practice and with the requirements of NHS Codes and the Monitor Code of Governance (as an aspiring Foundation Trust). The Board delegates to the committee the responsibility for determining the organisation of 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 Remuneration Report (see page 73).

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 2014/15

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 2014/15 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 is shown on the following pages.
## Trust Board Members Register of Interests 2014-2015

<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>Research funding/grants</th>
<th>Pooled Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dame Fiona Caldicott</td>
<td>NED and Company Secretary Waters 1802 Ltd</td>
<td>Appointed in November 2014 as National Data Guardian, an independent consultant accountable for work on health and social care data on behalf of the public to the Secretary of State for Health in England</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Professor Sir John Bell</td>
<td>Gray Laboratory Cancer Research Trust – Non-Executive Director The Edward Jenner Institute for Vaccine Research – Non-Executive Director Isis Innovation Limited – Non-Executive Director Roche AG (pharma) – Non-Executive Director Genentech – Non-Executive Director Oxagen Ltd (biotech) – Non-Executive Director Atopix (biotech) – Non-Executive Director Oxford Health Alliance – Chairman GMEC – Chairman Atopix – Non-Executive Director Immunocore – Non-Executive Director Office for the Strategic Coordination of Health Research – Chairman UK Life Sciences Champion Genomics England Ltd Board – Member Science &amp; Technology Honours Committee – Chairman Advent Venture Partners – Advisor Hakluyt &amp; Co – Advisor Bill &amp; Melinda Gates Foundation – Advisor Robertson Foundation- Advisor California Institute for Regenerative Medicine SAB – Chairman Oak Foundation – Advisor GoH – Advisor</td>
<td>None</td>
<td>None</td>
<td>Rhodes Trust – Trustee</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>


### Trust Board Members Register of Interests 2014-2015

<table>
<thead>
<tr>
<th>BOARD MEMBER</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dr Tony Berendt</strong>&lt;br&gt;Medical Director</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 Paul Brennan</strong>&lt;br&gt;Director of Clinical Services</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 Alisdair Cameron</strong>&lt;br&gt;NED</td>
<td>Chief Financial Officer – Post Office Limited</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 Catherine Stoddart</strong>&lt;br&gt;Chief Nurse</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>&lt;br&gt;NED</td>
<td>Prescription Medicines Code of Practice Authority Appeals Board Member</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)</td>
<td>None</td>
</tr>
<tr>
<td><strong>Mr Mark Mansfield</strong>&lt;br&gt;Director of Finance and Procurement</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>Professor David Mant</strong>&lt;br&gt;Associate NED</td>
<td>Member of the Oxford University Nuffield Department of Primary Care Health Sciences Honorary Consultant with Oxford Health NHS Foundation Trust</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Research grant holder from medical charities, EU, Department of Health and NIHR</td>
<td>None</td>
</tr>
<tr>
<td><strong>Sir Jonathan Michael</strong>&lt;br&gt;Chief Executive</td>
<td>Director: Shelford Health Roundtable, Beechlawn Consulting Ltd</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Trustee – Kings Fund</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Mr Geoff Salt</strong>&lt;br&gt;Deputy Chairman</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Trustee, Nuffield Medical Trust Trustee, Oxford Kidney Unit Fund</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Mr Andrew Stevens</strong>&lt;br&gt;Director of Planning and Information</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 Mark Trumper</strong>&lt;br&gt;Director of Development and the Estate</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>BOARD MEMBER</td>
<td>Directorships, including Non-executive Directorships</td>
<td>Business, partnership or consultancies</td>
<td>Majority or controlling share holdings</td>
<td>Charity or voluntary organisation</td>
<td>Voluntary or other organisation</td>
<td>Research funding/ grants</td>
<td>Pooled Funds</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------------------------------------------------</td>
<td>----------------------------------------</td>
<td>----------------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------</td>
<td>--------------</td>
</tr>
</tbody>
</table>
| Mrs Anne Tutt NED            | NED and Trustee of The Social Investment Business Foundation Ltd  
Deputy Chair of the Social Investment Business Ltd and Chair of the Finance Committee.  
Member of Audit & Risk Assurance Committee of the Home Office  
Member of DEFRA Audit & Risk Assurance Committee  
Member of DFID Audit & Risk Assurance Committee  
Member of APHA Audit & Risk Assurance Committee  
Board Member of IASAB (the internal Audit Standard Advisory Board) Government body advising on the application of Internal Audit Standards in the public sector.  
NED of Social and Sustainable Capital LLP | Ownership of a private business – A Tutt Associates Ltd | None | None | None | Section 11 Trustee Oxford Radcliffe Hospitals Charitable Fund and Chairman Audit Committee  
Trustee and Chair of the Audit Committee of the International Network for the Availability of Scientific Papers (INASP) | None | None |
| Ms Eileen Walsh Director of Assurance | Director in Health Governance Limited from October 2014 | Partner in Health Governance Consulting to October 2014 | None | None | None | None | None |
| Mr Peter Ward NED            | Director of John Laing (Cambridge) Ltd, Forum Cambridge LLP | None | None | None | None | None | None |
| Mr Mark Power Director of Organisational Development and Workforce | None | None | None | None | None | None | None |
TRUST BOARD MEMBERS 2014/15

Dr Tony Berendt
Medical Director

Mr Paul Brennan
Director of Clinical Services

Mr Mark Mansfield
Director of Finance and Procurement

Mark Power
Director of Organisational Development and Workforce

Mr Andrew Stevens
Director of Planning and Information

Mark Trumper
Director of Development and the Estate

Ms Eileen Walsh
Director of Assurance

Catherine Stoddart
Chief Nurse

Geoffrey Salt
Vice Chairman

Professor Sir John Bell
Non-executive Director

Mr Alisdair Cameron
Non-executive Director

Mr Christopher Goard
Non-executive Director

Professor David Mant
Assoc. Non-executive Director

Mrs Anne Tutt
Non-executive Director

Mr Peter Ward
Non-executive Director

Sir Jonathan Michael
Chief Executive
Retired August 2015

Dame Fiona Caldicott
Chairman

Sir Jonathan Michael
Chief Executive
Retired August 2015

Dame Fiona Caldicott
Chairman
SECTION 2
FINANCIAL REVIEW
2014-15
Summary

This is the fourth report produced by Oxford University Hospitals NHS Trust which came into existence on the 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 with a surplus of £11.492m before the technical adjustments due to impairments and IFRIC 12, against an original plan to produce a surplus of £11.482m against the so-called ‘breakeven duty’ which NHS Trusts maintain. If this figure is then adjusted for impairments and IFRIC 12, a deficit under the IFRS regime of £10.036m results.

A summary of the financial results is shown in subsequent sections of the report. A glossary of technical financial terms used in this report is shown later in this report.

Summary financial statements are included on pages 77-81. 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 77.

Review of 2014/15 and outlook for future years

At the start of the year the Trust planned to make a surplus of £11.482m in 2014/15 after removing technical adjustments. The accounts indicate that the Trust achieved a surplus of £11.492m against the so-called ‘breakeven duty’. The Trust also had a target to achieve savings of £46.0M and the outturn was that savings of £42.4M (or 92% of the target) were achieved.

For 2015/16 the Trust is planning to break even on income and expenditure, after removing technical adjustments. Within this plan is an assumption that the Trust will deliver further significant cost improvements and it has plans to find at least £51.8M. The continuing need for significant savings reflects the financial constraints that are facing the whole public sector. The realistic outlook is that austerity within the public sector is set to continue for a number of years; this Trust has not been immune to the effects of this austerity so far and it likely that it will face further severe challenges in the forthcoming years.

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

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

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

FINANCIAL REVIEW AND OUTLOOK
Income from commissioners and other sources

Responsibility for commissioning services resides with Clinical Commissioning Groups, NHS England, (which has responsibility for commissioning a range of specialist services) and local authorities. The Trust’s income increased by £47.9m (5.5%) over the previous year and the main components of the Trust’s income for 2014/15 of £916.255m 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.

<table>
<thead>
<tr>
<th>OUR INCOME SOURCES</th>
<th>2014/15 (£000s)</th>
<th>2013/14 (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Commissioning Group</td>
<td>370,263</td>
<td>352,898</td>
</tr>
<tr>
<td>NHS England</td>
<td>373,371</td>
<td>359,253</td>
</tr>
<tr>
<td>NHS Trusts and FTs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Department of Health</td>
<td>7,500</td>
<td>0</td>
</tr>
<tr>
<td>NHS Other (Inc. Public Health England and Prop Co)</td>
<td>185</td>
<td>354</td>
</tr>
<tr>
<td>Non NHS – local authorities</td>
<td>8,058</td>
<td>6,552</td>
</tr>
<tr>
<td>Other Non NHS including RTA</td>
<td>11,687</td>
<td>11,349</td>
</tr>
<tr>
<td>Education and Research</td>
<td>97,914</td>
<td>96,459</td>
</tr>
<tr>
<td>Other non-patient services</td>
<td>33,967</td>
<td>31,537</td>
</tr>
<tr>
<td>Other</td>
<td>13,310</td>
<td>9,944</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>916,255</strong></td>
<td><strong>868,346</strong></td>
</tr>
</tbody>
</table>

(Source notes 4 to 7 of Annual Accounts 2014/15)

Operating expenses

The Trust spends on average just under £2.5m 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.

(Source Note 8 of Annual accounts 2014/15)

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. Over the next five years we plan to make savings averaging £46.8m per annum (in nominal terms). This represents an average annual saving over these five years (2015/16 to 2019/20) of 5.2% each year.

(Source Note 8 of Annual accounts 2014/15)
Capital resources

The capital programme is a key resource 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 £34.4m was expended in 2014/15 and the chart below provides an indication of the areas of investment the Trust pursued in the year.

<table>
<thead>
<tr>
<th>Category</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and surgical equipment</td>
<td>11,991</td>
</tr>
<tr>
<td>Information Management &amp; Technology (IM&amp;T)</td>
<td>6,576</td>
</tr>
<tr>
<td>Ward relocations</td>
<td>1,941</td>
</tr>
<tr>
<td>General estates</td>
<td>9,068</td>
</tr>
<tr>
<td>Other Trust business cases</td>
<td>1,963</td>
</tr>
<tr>
<td>PFI lifecycle and Equipment leasing</td>
<td>1,280</td>
</tr>
<tr>
<td>Other schemes</td>
<td>1,589</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34,408</strong></td>
</tr>
</tbody>
</table>

(Source Month 12 Trust Board Report TB2015.50)

Looking forward, the Integrated Business Plan (IBP) sets out the envisaged Capital Programme for the next five years and can be found on the Trust website.
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 £11,492,000 for 2014/15, after Department of Health agreed exclusions of £21,528,000 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 Oxford University Hospitals NHS Trust and its predecessors over the last five years.

<table>
<thead>
<tr>
<th>FINANCIAL YEAR</th>
<th>Turnover £000</th>
<th>Retained surplus/ (deficit) £000</th>
<th>Break-even cumulative position surplus/ (deficit) £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>911,279</td>
<td>11,492</td>
<td>18,169</td>
</tr>
<tr>
<td>2013/14</td>
<td>868,346</td>
<td>10,895</td>
<td>6,677</td>
</tr>
<tr>
<td>2012/13</td>
<td>821,705</td>
<td>3,646</td>
<td>(4,218)</td>
</tr>
<tr>
<td>2011/12</td>
<td>788,220</td>
<td>7,157</td>
<td>(7,864)</td>
</tr>
<tr>
<td>2010/11</td>
<td>745,957</td>
<td>2,171</td>
<td>(15,021)</td>
</tr>
</tbody>
</table>

(source note 43.1 Annual Accounts 2014/15)

NOTE: The figures are on the basis of the International Financial Reporting Standards (IFRS). For breakeven 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 £2.140 million in 2014/15. The Trust achieved this target by reducing its level of external financing requirement by £5.236 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 £33.309m which it could spend on capital and during the year it spent £33.304m thus undershooting it’s control limit by £0.005m.
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.

**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 NHS England. 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 and 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 and 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 formally known as the balance sheet provides a snapshot of the Trust’s financial position at a specific date, which in this case is the end of the financial year. It lists assets (what the trust owns or is owed), liabilities (what the Trust owes) and taxpayers equity (the amount of public funds invested in the Trust). At any given time, the trust’s total assets less its total liabilities must equal the taxpayer’s equity.

**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 and 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 and 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 and 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 and 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 and 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.)
The table below discloses the remuneration provided to Directors within the Oxford University Hospitals NHS Trust during 2014/2015 in a format which is comparable to that used in previous years.

**Salary and pension entitlements of senior managers**

<table>
<thead>
<tr>
<th>Name and title</th>
<th>2014-15</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary (£000)</td>
<td>Other remuneration (£000)</td>
</tr>
<tr>
<td>Dame Fiona Caldicott Chair</td>
<td>20-25</td>
<td>30-35</td>
</tr>
<tr>
<td>Mr Geoffrey Salt Non-executive Director</td>
<td>5-10</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr Alisdair Cameron Non-executive Director</td>
<td>5-10</td>
<td>10-15</td>
</tr>
<tr>
<td>Professor Sir John Bell Non-executive Director</td>
<td>5-10</td>
<td>10-15</td>
</tr>
<tr>
<td>Mrs Anne Tutt Non-executive Director</td>
<td>5-10</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr Peter Ward Non-executive Director</td>
<td>5-10</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr Christopher Goard Non-executive Director</td>
<td>5-10</td>
<td>10-15</td>
</tr>
<tr>
<td>Professor David Mant Non-executive Director</td>
<td>5-10</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr Mark Mansfield Director of Finance and Procurement</td>
<td>170-175</td>
<td>10-15</td>
</tr>
<tr>
<td>Dr Tony Berendt Medical Director</td>
<td>170-175</td>
<td>35-40</td>
</tr>
<tr>
<td>Mrs Elaine Strachan-Hall Chief Nurse</td>
<td>125-130</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Andrew Stevens Director of Planning and Information</td>
<td>155-160</td>
<td>10-15</td>
</tr>
<tr>
<td>Mr Paul Brennan Director of Clinical Services</td>
<td>155-160</td>
<td>10-15</td>
</tr>
<tr>
<td>Ms Sue Donaldson Director of Human Resources</td>
<td>60-65</td>
<td>10-15</td>
</tr>
<tr>
<td>Professor Edward Baker Medical Director</td>
<td>125-130</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Mark Trumper Director of Development and the Estate</td>
<td>115-120</td>
<td>15-20</td>
</tr>
<tr>
<td>Ms Eileen Walsh Director of Assurance</td>
<td>125-130</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Mark Power Director of Organisational Development and Workforce</td>
<td>125-130</td>
<td>5-10</td>
</tr>
<tr>
<td>Ms Liz Wright Interim Chief Nurse</td>
<td>40-45</td>
<td>85-90</td>
</tr>
<tr>
<td>Mr Paul Jones Interim Director of Human Resources</td>
<td>145-150</td>
<td></td>
</tr>
<tr>
<td>Ms Catherine Stoddart Chief Nurse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTES**

1. Appointed as Medical Director to Oxford University Hospitals April 2014
2. Resigned from Oxford University Hospitals August 2013
3. Resigned from Oxford University Hospitals October 2013
4. Other remuneration relates to clinical excellence awards
5. Appointed to Oxford University Hospitals February 2014
6. Acting Chief Nurse covering August 2013 to September 2014
7. Interim Director of Human Resources covering October 2013 to February 2014
8. Appointed to Oxford University Hospitals March 2014
9. Resigned as Medical Director March 2013.

*Performance related payments are paid in arrears and payments in 2014/15 relate to performance in 2013/14. See page 76 for further information relating to performance related payments.*
# 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)</th>
<th>Real increase in pension lump sum at age 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2014 (£000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2015 (£000)</th>
<th>Real increase in Cash Equivalent Transfer Value (£000)</th>
<th>Employer’s contribution to Stakeholder Pension To nearest £100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Andrew Stevens Director of Planning and Information</td>
<td>5-7.5</td>
<td>15-17.5</td>
<td>50-55</td>
<td>160-165</td>
<td>1,083</td>
<td>917</td>
<td>141</td>
<td>0</td>
</tr>
<tr>
<td>Mr Mark Mansfield Director of Finance and Procurement</td>
<td>7.5-10</td>
<td>25-27.5</td>
<td>65-70</td>
<td>200-205</td>
<td>1,287</td>
<td>1,063</td>
<td>196</td>
<td>0</td>
</tr>
<tr>
<td>Mr Paul Brennan Director of Clinical Services</td>
<td>5-7.5</td>
<td>15-17.5</td>
<td>60-65</td>
<td>185-190</td>
<td>1,219</td>
<td>1,048</td>
<td>142</td>
<td>0</td>
</tr>
<tr>
<td>Ms Eileen Walsh Director of Assurance</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>30-35</td>
<td>90-95</td>
<td>525</td>
<td>477</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>Mr Mark Power Director of Organisational Development and Workforce</td>
<td>2.5-5</td>
<td>12.5-15</td>
<td>15-20</td>
<td>55-60</td>
<td>370</td>
<td>252</td>
<td>111</td>
<td>0</td>
</tr>
<tr>
<td>Ms Liz Wright Acting Chief Nurse</td>
<td>10-12.5</td>
<td>32.5-35</td>
<td>25-30</td>
<td>75-80</td>
<td>569</td>
<td>312</td>
<td>248</td>
<td>0</td>
</tr>
<tr>
<td>Dr Tony Berendt Medical Director</td>
<td>7.5-10</td>
<td>22.5-25</td>
<td>85-90</td>
<td>260-265</td>
<td>1,870</td>
<td>1,608</td>
<td>219</td>
<td>0</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 (or other allowable beneficiary’s) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

**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 scheme or arrangement) and uses common market valuation factors for the start and end of the period.
Terms of office
The executive directors are employed within a standard employment contract which provides for a three month notice period. The exceptions to this are the following who are six months 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.

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 banding of the highest paid director in Oxford University Hospitals NHS Trust in the financial year 2014/2015 was £275,000 - £280,000. This was nine times the median remuneration of the workforce, which was £29,279, (2013/14 median £29,764).

No employees received remuneration in excess of the highest paid director during 2014-2015. Remuneration ranged from £14,294 - £277,800.

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 Oxford University Hospitals at 31 March 2015 is 10,759 (31 March 2014 9,901).

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 2015 there were eleven ‘off pay-roll engagements’, of which four have existed for less than one year, three for between one and two years and four for between two and three years. There were six new engagements between 1 April 2014 and 31 March 2015, none of them at Board member/senior officers with significant financial responsibility level. Assurance has been received from all engagements in relation to income tax and national insurance.

<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>30/04/2017</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>31/03/2016</td>
</tr>
</tbody>
</table>
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 the combined achievement of specific Corporate Objectives, which are aligned to the Trust’s strategic objectives as set out in the Annual Business Plan, and personal objectives.

Assessment of performance against Corporate Objectives is undertaken by the R&A Committee and this assessment determines the level of PRP to be applied. 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 paid as a single, taxable, non-consolidated payment, which does not attract pension benefits.

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 assessed via individual annual reviews.

The assessment of Executive Director performance for 2014/15 determined an achievement level of 72% against the specific corporate objectives. The proportionate PRP awards will be applied in 2015/16.

NOTE: The Medical Director is not eligible for participation in the Executive PRP Scheme. The Medical Director is employed on the nationally determined Consultant Contract terms and conditions, and receives a basic consultant salary (aligned to national pay scales) plus a responsibility allowance. The national consultant contract also includes eligibility to apply for Clinical Excellence Awards, which are paid to consultant medical staff in recognition of outstanding contribution to the delivery and development of patient services; teaching; innovation and academic achievement.

- Further details on remuneration and associated issues can be found in the full annual report and accounts available at www.ouh.nhs.uk
These accounts for the year ended 31 March 2015 have been prepared by Oxford University Hospitals NHS Trust under section 232 (schedule 15) of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

The financial statements that follow are only a summary of the information contained in the Trust’s annual accounts. Full copies of the accounts are available from the Publications page in the About us section of the Trust’s website (www.ouh.nhs.uk) or by contacting the Finance Department at 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 £11,492,000 against the breakeven duty for 2014/15. The accounts record a deficit of £10,036,000; the difference of £21,528,000 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>Statement of comprehensive income for year ended</th>
<th>2014/15 £000</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus / deficit for the year</td>
<td>(10,036)</td>
<td>17,432</td>
</tr>
<tr>
<td>IFRIC*12 Adjustment</td>
<td>(8,671)</td>
<td>(6,255)</td>
</tr>
<tr>
<td>Impairments</td>
<td>27,873</td>
<td>(2,171)</td>
</tr>
<tr>
<td>Adjustments iro donated asset/gov’t grant reserve elimination</td>
<td>2,326</td>
<td>1,889</td>
</tr>
<tr>
<td>Reported NHS finance performance position</td>
<td>11,492</td>
<td>10,895</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)

<table>
<thead>
<tr>
<th>Surplus/(deficit) for the financial year</th>
<th>2014/15 £000</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital dividends payable</td>
<td>(2,955)</td>
<td>24,991</td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>(10,036)</td>
<td>17,432</td>
</tr>
<tr>
<td>Other comprehensive income</td>
<td>(52,932)</td>
<td>(582)</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant and equipment</td>
<td>34,128</td>
<td>19,934</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangibles</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<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>
<td>0</td>
<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>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total comprehensive income for the year</td>
<td>(28,840)</td>
<td>36,784</td>
</tr>
</tbody>
</table>
## Statement of financial position as at 31 March 2015

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015 £000</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>652,888</td>
<td>696,042</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>11,211</td>
<td>9,215</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>5,091</td>
<td>4,945</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>669,190</td>
<td>710,202</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>14,715</td>
<td>11,807</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>42,211</td>
<td>24,361</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>79,383</td>
<td>86,448</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>136,309</td>
<td>122,616</td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>136,309</td>
<td>122,616</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>805,499</td>
<td>832,818</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015 £000</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(129,880)</td>
<td>(115,675)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(2,476)</td>
<td>(4,251)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(9,470)</td>
<td>(9,857)</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>(143,230)</td>
<td>(131,187)</td>
</tr>
<tr>
<td><strong>Net current assets/(liabilities)</strong></td>
<td>(6,921)</td>
<td>(8,571)</td>
</tr>
<tr>
<td><strong>Non-current assets plus/ less current assets / liabilities</strong></td>
<td>662,269</td>
<td>701,631</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(16,359)</td>
<td>(14,251)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(2,559)</td>
<td>(2,447)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(259,586)</td>
<td>(270,104)</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>(3,599)</td>
<td>(5,003)</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td>(282,103)</td>
<td>(291,805)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>380,166</td>
<td>409,826</td>
</tr>
</tbody>
</table>

**Financed by taxpayers’ equity:**

Public dividend capital | 208,115 | 208,935 |
Retained earnings       | 25,075  | 34,413  |
Revaluation reserve     | 145,233 | 164,735 |
Other reserves           | 1,743   | 1,743   |

**Total taxpayers’ equity** | 380,166 | 409,826 |
### Statement of changes in taxpayers’ equity for the year ended 31 March 2015

<table>
<thead>
<tr>
<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>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Balance at 1 April 2014</strong></td>
<td>208,935</td>
<td>34,413</td>
<td>164,735</td>
<td>1,743</td>
</tr>
<tr>
<td><strong>Changes in taxpayers’ equity for 2014/15</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>(10,036)</td>
<td>(10,036)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net gain on revaluation of property, plant, equipment</td>
<td>34,128</td>
<td>34,128</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>(52,932)</td>
<td>(52,932)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>698</td>
<td>(698)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Transfers under Modified Absorption Accounting – PCTs and SHAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reclassification Adjustments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New PDC received – cash</td>
<td>980</td>
<td></td>
<td></td>
<td>980</td>
</tr>
<tr>
<td>PDC repaid in year</td>
<td>(1,800)</td>
<td></td>
<td></td>
<td>(1,800)</td>
</tr>
<tr>
<td>PDC written off</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net recognised revenue/(expense) for the year</strong></td>
<td>(820)</td>
<td>(9,338)</td>
<td>(19,502)</td>
<td>0 (29,660)</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2015</strong></td>
<td>208,115</td>
<td>25,075</td>
<td>145,233</td>
<td>1,743</td>
</tr>
</tbody>
</table>

### Statement of changes in taxpayers’ equity for 2013/14

<table>
<thead>
<tr>
<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>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Balance at 1 April 2013</strong></td>
<td>207,673</td>
<td>14,608</td>
<td>147,362</td>
<td>1,743</td>
</tr>
<tr>
<td><strong>Changes in taxpayers’ equity for 2013/14</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>17,432</td>
<td></td>
<td></td>
<td>17,432</td>
</tr>
<tr>
<td>Net gain on revaluation of property, plant and equipment</td>
<td>19,934</td>
<td></td>
<td></td>
<td>19,934</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>(582)</td>
<td></td>
<td></td>
<td>(582)</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>1,979</td>
<td>(1,979)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Transfers under modified absorption Accounting – PCTs and SHAs</td>
<td></td>
<td></td>
<td></td>
<td>394</td>
</tr>
<tr>
<td><strong>Reclassification Adjustments</strong></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>1,262</td>
</tr>
<tr>
<td>PDC repaid in year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDC written off</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net recognised revenue/(expense) for the year</strong></td>
<td>1,262</td>
<td>19,805</td>
<td>17,373</td>
<td>0 (38,440)</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>208,935</td>
<td>34,413</td>
<td>164,735</td>
<td>1,743</td>
</tr>
</tbody>
</table>
### Statement of cash flows for the year ended 31 March 2015

<table>
<thead>
<tr>
<th>Cash flows from operating activities</th>
<th>2014/15 £000</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating surplus /(deficit)</td>
<td>17,483</td>
<td>44,987</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>37,792</td>
<td>36,706</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>18,959</td>
<td>(8,426)</td>
</tr>
<tr>
<td>Donated asset received credited to revenue but non-cash</td>
<td>(1,053)</td>
<td>(869)</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(20,408)</td>
<td>(20,499)</td>
</tr>
<tr>
<td>Dividends paid</td>
<td>(8,364)</td>
<td>(6,382)</td>
</tr>
<tr>
<td>(Increase) / decrease in inventories</td>
<td>(2,908)</td>
<td>(454)</td>
</tr>
<tr>
<td>(Increase) / decrease in trade and other receivables</td>
<td>(18,289)</td>
<td>672</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 payables</td>
<td>17,582</td>
<td>7,554</td>
</tr>
<tr>
<td>Increase /(decrease) in other current liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>(608)</td>
<td>(1,219)</td>
</tr>
<tr>
<td>Increase /(decrease) in provisions</td>
<td>(1,088)</td>
<td>3,373</td>
</tr>
</tbody>
</table>

**Net cash inflow / (outflow) from operating activities**

39,098 55,443

<table>
<thead>
<tr>
<th>Cash flows from investing activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest received</td>
</tr>
<tr>
<td>Payments for property, plant and equipment (PPE)</td>
</tr>
<tr>
<td>Payments for intangible assets</td>
</tr>
<tr>
<td>Payments for investments with DH</td>
</tr>
<tr>
<td>Proceeds from disposal of assets held for sale (PPE)</td>
</tr>
<tr>
<td>Proceeds from disposal of assets held for sale (intangible)</td>
</tr>
<tr>
<td>Proceeds from disposal of investments with DH</td>
</tr>
<tr>
<td>Proceeds from disposal of other financial assets</td>
</tr>
<tr>
<td>Rental revenue</td>
</tr>
</tbody>
</table>

**Net cash inflow/(outflow) from investing activities**

(33,034) (21,661)

**Net cash inflow/(outflow) before financing**

6,064 33,782

<table>
<thead>
<tr>
<th>Cash flows from financing activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital received</td>
</tr>
<tr>
<td>Public dividend capital repaid</td>
</tr>
<tr>
<td>Loans received from DH – new capital investment loans</td>
</tr>
<tr>
<td>Loans received from DH – new working capital loans</td>
</tr>
<tr>
<td>Loans repaid to DH – capital Investment loans repayment of principal</td>
</tr>
<tr>
<td>Loans repaid to DH – Working Capital Loans Repayment of Principal</td>
</tr>
<tr>
<td>Capital element of finance leases and On-SoFP PFI</td>
</tr>
<tr>
<td>Capital grants and other capital receipts</td>
</tr>
</tbody>
</table>

**Net cash inflow/(outflow) from financing**

(13,129) (12,991)

**Net increase/(decrease) in cash and cash equivalents**

(7,065) 20,791

**Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year**

86,448 65,657

**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**

79,383 86,448
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 2014/15 is set out below:

<table>
<thead>
<tr>
<th>Description</th>
<th>2014/15</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Value £000</td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS trade invoices paid</td>
<td>133,220</td>
<td>351,701</td>
</tr>
<tr>
<td>Total Non-NHS trade invoices within target</td>
<td>123,235</td>
<td>316,095</td>
</tr>
<tr>
<td>% Non-NHS trade invoices paid within target</td>
<td>92.50%</td>
<td>89.88%</td>
</tr>
</tbody>
</table>

Audit Disclosures

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 31 March 2015 was £216,000. 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.

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 18 May 2009.
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 and 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 full accounts lists the data for January 2014 – December 2014 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.

Exit packages and severance payments
Notes 10.4 and 10.5 to the full accounts set out the exit packages agreed in 2014/15. The actual date of departure might be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. This data is therefore presented on a different basis to other staff cost and expenditure notes in the accounts. Note 10.5 provides more detail about those payments on termination of employment that are not compulsory redundancies.

Off-payroll engagements
Details of the current position in respect of off-payroll engagement is set out in the Remuneration Report on page 75.

Land values
The carrying values for land and buildings in the Trust’s accounts are based upon the valuations by the Valuation Office Agency. For 2015 a full valuation has been carried out. The District Valuer (DV) has along with his staff visited all the Trust properties. In addition, where appropriate, the DV has adopted an ‘optimal site’ valuation. This recognises any efficiencies that could be obtained if the sites were to be rebuilt maintaining the current level of service provision.
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 Oxford University Hospitals NHS Trust’s policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally accountable in accordance with the responsibilities assigned to me.

1.2. I am also responsible for ensuring 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 2014 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**

3.1. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford University Hospitals NHS Trust; to evaluate the likelihood of those risks being realised, and the impact should they be realised; and to manage them efficiently, effectively and economically.

3.2. The system of internal control has been in place at Oxford University Hospitals NHS Trust for the year ended 31 March 2015 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. **Governance framework**

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, namely to:

- set strategic direction, define objectives and agree plans for the Trust
- monitor performance and ensure corrective action
- ensure financial stewardship
- ensure high standards of corporate and clinical governance
- appoint, appraise and remunerate executives
- 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 Remunerations 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 supports the Board in the achievement of the Trust’s strategic aims and objectives;
- maximising the value of the input from non-executive directors in scrutiny and challenge of executive management action;
- maximising the value of the input from non-executive directors, given their limited time, and providing clarity around their role; and
supporting the Board in fulfilling its role, given the nature and magnitude of the Trust’s wider agenda, to support background development work and to perform scrutiny in more detail than is possible at Board meetings.

4.3. In delivering its key functions, the Board reviewed reports at each meeting on the operational and financial performance of the Trust. It also reviewed and discussed other papers supporting the strategic development of the Trust in delivering its services including its application for foundation trust status and its key organisational aims.

4.4. The Audit Committee exists to oversee the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provide independent assurance to the Board. The Committee provides an oversight of the work of the local counter fraud service in preventing and detecting fraud. 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.

4.5. 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.

4.6. 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 and Development issues; and on standards of quality and safety. The Committee oversees the Trust’s on-going compliance with Care Quality Commission Essential Standards of Quality and Safety, and the management of risk through the NHS Litigation Authority’s Risk Management Standards. It works closely with the Audit Committee through joint membership and joint management support provided by the Director of Assurance.

4.7. The Remuneration and 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.

4.8. Each sub-committee provides a Chairman’s report to the Board following each meeting. These reports include a summary of the meeting and highlight, the risks considered as part of the meeting, the main action points from the meeting and any areas to be highlighted to the Board.

4.9. As an aspirant Foundation Trust the organisation has successfully held elections to the Council of Governors. All public and staff governor seats were filled through competitive election. The Council of Governors will operate in shadow form prior to authorisation and initial induction days were completed during March and April as part of a wider induction programme.
5. **Committee meetings: record of attendance**

5.1. The following tables show how many of the core members of each of the Board Committees attended meetings during 2014/15.

### Quality Committee

<table>
<thead>
<tr>
<th>Role</th>
<th>9-Apr-14</th>
<th>11-Jun-14</th>
<th>13-Aug-14</th>
<th>8-Oct-14</th>
<th>10-Dec-14</th>
<th>11-Feb-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair – Non-executive Director (GS)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Vice Chair – Non-executive Director (PW)</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chairman of the Trust Board (FC)</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (CG)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Associate Non-executive Director (DM)</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chief Executive (JM)</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medical Director (TB)</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chief Nurse (CS)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Director of Clinical Services (PB)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Director of Assurance (EW)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Director of Workforce (MP)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* (as Interim Medical Director)

### Audit Committee

<table>
<thead>
<tr>
<th>Role</th>
<th>21-May-14</th>
<th>4-Jun-14</th>
<th>17-Sep-14</th>
<th>19-Nov-14</th>
<th>18-Feb-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair – Non-executive Director (AT)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Vice Chair – Non-executive Director (CG)</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (AC)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

### Finance and Performance Committee

<table>
<thead>
<tr>
<th>Role</th>
<th>9-Apr-14</th>
<th>11-Jun-14</th>
<th>13-Aug-14</th>
<th>8-Oct-14</th>
<th>10-Dec-14</th>
<th>11-Feb-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair – Non-executive Director (CG)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chairman of the Trust Board (FC)</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (AT)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (GS)</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (PW)</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chief Executive (JM)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Director of Finance &amp; Procurement (MM)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medical Director (TB)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Director of Development and the Estate (MT)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Director of Clinical Services (PB)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* (as Interim Medical Director)

### Remuneration and Appointments Committee

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair – Non-executive Director (JB)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (CG)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (AC)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Chairman of the Trust Board (FC)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (GS)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (AT)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-executive Director (PW)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
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 six times in public in 2014/15, with additional meetings held in private. The meetings were held as follows:
- 14 May 2014 (Public and confidential meetings);
- 5 June 2014 (Confidential meeting only);
- 9 July 2014 (Public and confidential meetings);
- 10 September 2014 (Public and confidential meetings);
- 22 October 2014 (Confidential meeting only);
- 12 November 2014 (Public and confidential meetings);
- 14 January 2015 (Public and confidential meetings);
- 11 February 2015 (Confidential meeting only);
- 25 February 2015 (Confidential meeting only);
- 3 March 2015 (Confidential meeting only);
- 11 March 2015 (Public and confidential meetings).

5.6. The Board and the sub-committees review the effectiveness of their work against their terms of reference annually. These reviews take into account the UK Code of Governance and the NHS Foundation Trust Code of Governance. The results of the reviews form the basis of each sub-committees annual report to the Board. The 2014/15 annual reports are due to be reported in July 2015.

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 2014/15. The Trust’s Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions were updated in January 2015 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 was formally received at the Trust Board meeting in May 2015. 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 2015. No conflicts of interest were identified in the review of the Register. The Trust is compliant with the Fit and Proper Persons requirements that were introduced in November 2014. All Board members have completed self-assessment declarations in relation to this requirement.

6. Capacity to handle risk

6.1. The Trust has a Risk Management Strategy 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 quality, clinical governance and clinical risk, including incident management and joint responsibility with the Chief Nurse for patient safety;
- the Chief Nurse has responsibility for patient experience, and joint responsibility with the Medical Director for patient safety;
- 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 they believe require improvement.

6.3. The implementation of the Risk Management Strategy was reviewed during the year and the results presented to the Trust Board in November 2014. This demonstrated good progress has been made 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.

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 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. The existing risk assessment process is designed to consider the prevention of risk. 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. The risk register review processes in place encourage the in-year review of risks as they arise during the course of the year. This process is designed to enable new risks to be assessed and developed as they emerge.

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 is used as a strategic tool to provide assurance that appropriate controls are in place which are effective.

7.5. The Board Assurance Framework contains the following principal risks:

- **Principal Risk 1:** Failure to maintain the quality of patient services
- **Principal Risk 2:** Failure to maintain financial sustainability
- **Principal Risk 3:** Failure to maintain operational performance
- **Principal Risk 4:** Failure to achieve sustainable contracts with commissioners
- **Principal Risk 5:** Loss of share of current and potential markets
- **Principal Risk 6:** Failure to sustain an engaged and effective workforce
- **Principal Risk 7:** Failure to deliver the required transformation of services
- **Principal Risk 8:** Failure to deliver the benefits of strategic partnerships.
7.6. The Trust, through the Audit Committee, has implemented a systematic approach to ‘deep dive’ each of the principal risks included on the Board Assurance Framework at least once during the course of the financial year. This is reflected within the Audit Committee’s cycle of business. This enabled the Committee to consider the risks, controls and assurances in relation to each risk in more detail and provide further assurance to the Board that significant risks are recognised and appropriately managed.

8. Essential standards of quality and safety

8.1. The Trust is compliant with the registration requirements of the Care Quality Commission. The Trust was inspected by the Care Quality Commission in 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 Care Quality Commission identified a number of areas for improvement and issued five compliance actions. The Trust accepted these actions and developed an action plan accordingly. This action plan has been the subject of continuous monitoring during the course of the year.

8.2. Ratings for the four hospital sites operated by the Trust were as follows:
- John Radcliffe Hospital – Requires Improvement
- Churchill Hospital – Good
- Nuffield Orthopaedic Centre – Good
- Horton General Hospital – Good

8.3. During the course of the year the Trust has been subject to review by Monitor as an aspirant Foundation Trust. As a result of this process Monitor has provided the Trust with feedback in relation to the Trust’s assessment against the Monitor Quality Governance Framework. This has been useful to the organisation and a number of improvements to the quality governance processes have been made as a consequence. A summary of the work in this area was presented to the Board in May 2015.

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 has visibility of the performance against national priorities and other 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 accordance 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 2015, 84% of staff had completed this training within the previous 12 months, compared to 81% in 2013/14.

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 on-going 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. There were no level two Serious Incidents Requiring Investigation (SIRIs) during 2014/15 that were required to be reported to the Information Commissioner’s Office (ICO).
10.5. In December 2014, as part of the 2014/15 Internal Audit plan, internal audit conducted a review of the Trust’s IG Toolkit self-assessment. The results of the audit provided partial assurance at the time of completing the review. The review supported the Trust’s position that it would achieve an overall satisfactory rating (i.e. all requirements would be at a minimum of level two) by March 2015, on the basis that two medium priority recommendations were implemented during the year. As at 31 March 2015 the Trust’s IG Toolkit score was confirmed at 91% and it achieved a ‘satisfactory’ rating.

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 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 Care Quality Commission 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 role of the Quality Committee, and Finance and Performance Committee 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 and Safety, Clinical Governance, Workforce and Information Management and Technology, 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. All Cost Improvement Programmes/Schemes 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.

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

11.5. 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.
11.6. 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.

11.7. The Trust reviewed the systems in place to care for people with learning disabilities, based on recommendations set out in Healthcare for All (DH, 2008). The Trust confirmed it was compliant with the recommendations at the end of March 2013. The Quality Committee were updated on compliance at its meeting in August 2014.

11.8. The Trust has undertaken risk assessments in accordance with emergency preparedness and civil contingency requirements, as based on recommendations set out in UKCIP 2009 weather projections. In March 2015 the Trust approved a Full Business Case aimed at the delivery of a significant reduction in annual carbon footprint, to ensure that this organisation’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

11.9. The Trust’s Internal Auditors, KPMG LLP (UK), undertook a total of 21 audits during the year. The majority of the audits concluded that there was Significant Assurance, with the following exceptions where partial assurance was provided:

- Cyber Fraud and Information Security
- Bank and Agency Staff
- Information Governance Toolkit
- Sickness Absence

11.10. The Trust has accepted the recommendations made in relation to these reports and has developed actions which are subject to regular review by the Audit Committee.

12. **Review of Economy, Efficiency and Effectiveness in the Use of Resources**

12.1. The Trust has well developed systems and processes for managing its resources. The annual budget setting process for 2014/15 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 2014/15, the Trust achieved 92% 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. As mentioned above, 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, Ernst and Young LLP 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 conclusions in relation to this work are made available to the Trust and presented to the Audit Committee.
13. Annual Quality Account

13.1. Under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 the Trust Board is required 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. The content of the Quality Account is subject to a review by external audit for its compliance with relevant regulations and consistency with other specified information. The review also includes testing of specified indicators to ensure these are correctly calculated and comply with relevant guidance. This occurs prior to its publication.

13.2. The Medical Director leads on the Quality Account, and for 2014/15, the ‘refreshed’ Quality Strategy was used as the basis for the production of the Quality Account. The refreshed strategy establishes the link between the Trust’s strategic objectives, priorities in the Quality Account, and measurable goals against which progress can be monitored. For the future, the Trust will work closely with commissioners and other stakeholders to ensure that such priorities are in line with the Quality Strategy. Two quality events were held in January 2015, during which local people worked with trust staff to agree the organisation’s vision for quality and common themes for the coming year.

13.3. For monitoring purposes, regular updates of the Trust’s progress against its Quality Account priorities are provided both to the Quality Committee and the Trust Board.

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. The Head of Audit Opinion for the current year provided an overall opinion of ‘significant assurance with minor improvements’.

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 and 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 2014 to 31 March 2015 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 Trust Board 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. Workstreams addressing various aspects of this issue are being implemented.

15.1.2. The Trust has actively monitored its performance against national access and outcome standards throughout the year using the integrated performance reports and with reference to the principal risk in the Board Assurance Framework. Specific action plans have been developed to address performance issues during the year. In particular the Trust has developed the Urgent Care Action Plan to improve waiting times in its Emergency Departments.

15.1.3. Six Never Event incidents were reported in 2014/15. The incidents varied in type and comprised of the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>Level of Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two incidents in relation to wrong site surgery</td>
<td>Moderate</td>
</tr>
<tr>
<td>(wrong tooth removal)</td>
<td></td>
</tr>
<tr>
<td>Two incidents in relation to retained guide wire</td>
<td>Moderate</td>
</tr>
<tr>
<td>Misplaced of a nasogastric tube</td>
<td>Major</td>
</tr>
<tr>
<td>Retained swab</td>
<td>No harm</td>
</tr>
</tbody>
</table>

15.1.4. The Trust takes all such events very seriously and investigates them to establish the root cause. Findings have included failures to make existing processes routine. Action has been taken following each of these events, with work being undertaken with clinical departments to ensure that processes are consistently applied. The Trust has developed an overarching Never Event Action Plan that seeks to address wider issues of trust wide learning and this will be monitored through the Trust Management Executive.

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: 3 June 2015
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
They are an independent public body responsible for ensuring that public money is spent economically, efficiently, and effectively in the areas of local government, housing, health, criminal justice and fire and rescue services. They appoint the External Auditors for NHS Trusts.

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

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

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

Capital Absorption Rate
The Capital Absorption Rate is determined by dividing the PDC dividend (from the Statement of Comprehensive Income) by the average net relevant assets (owned assets of the trust at the beginning and end of the year less current liabilities and 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 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 whose value 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 and expenditure records.

**Elective inpatient activity**

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

**Electronic Patient Record (EPR)**

A new system of recording patient notes on computer rather than paper.

**Emergency inpatient activity**

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

**External Financing Limit (EFL)**

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

**Fixed assets**

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

**Foundation Trust (FT)**

NHS Foundation Trusts have been created to devolve decision-making from central Government control to local organizations and communities so they are more responsive to the needs and wishes of their local people. Foundation Trusts have a membership drawn from the community which they serve and an elected Governors’ Council. They also enjoy some financial freedoms not available to NHS Trusts.

**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)
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 help each NHS trust secure sustainable, high quality services for the patients and communities they serve.

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

Non-executive Directors
Non-executive Directors, including the Chairman, are Trust Board members but they are not full-time NHS employees. They are people from other backgrounds who have shown a keen interest in helping to improve the health of local people. They have a majority on the Board and their role is to bring a range of varied perspectives and experiences to strategy development and decision-making, ensure effective management arrangements and an effective management team is in place and hold the executive directors to account for 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 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 (CCG’s and NHS Commissioning Board) for NHS services. An SLA is an agreement that sets out formally the relationship between service providers and customers for the supply of a service by one or another.

**Thames Valley Local Education and Training Board (Health Education Thames Valley)**
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: 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 and 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 and Security Services
NHS Trust Development Authority
Oxford Academic Health Science network
Oxford Biomedical Research Centre
Oxford Brookes Faculty of Health and Life Sciences
Oxford Brookes University

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.hee.nhs.uk
http://thamesvalley.hee.nhs.uk
www.healthwatchoxfordshire.co.uk
www.medsci.ox.ac.uk
www.gov.uk/government/organisations/Monitor
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/nhsig
www.nhsba.nhs.uk/Protect
www.ntda.nhs.uk
www.Oxfordahsn.org
www.oxfordbrc.org
www.hls.brookes.ac.uk
www.brookes.ac.uk

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 Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nurses
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatricians and Child Health
Royal College of Pathologists
Royal College of Physicians
Royal College of Radiologists
Royal College of Surgeons
South Central Ambulance Service
NHS Foundation Trust
South Oxfordshire District Council
Southern Health
Thames Valley Health Innovation and Education Cluster
University of Oxford
Vale of White Horse District Council
West Oxfordshire District Council

www.oxford.gov.uk
www.oxfordhealth.nhs.uk
www.Oxfordshireccg.nhs.uk
www.oxfordshire.gov.uk
www.patients-association.com
www.patientsafetyfederation.nhs.uk
www.gov.uk/government/organisations/public-health-england
www.rcoa.ac.uk
www.rcem.ac.uk
www.rcgp.org.uk
www.rcm.org.uk
www.rcn.org.uk
www.rcog.org.uk
www.rcophth.ac.uk
www.rcpch.ac.uk
www.rcpath.org
www.rcplondon.ac.uk
www.rcc.ac.uk
www.rcr.ac.uk
www.southcentralambulance.nhs.uk
www.southernhealth.nhs.uk
www.tvhiec.org.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 financial statements. We publish this on our website and printed copies are available on request. We also produce a CD of all key documents, including the full accounts, which are also available from our website.

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

We are keen to have more feedback on both the content and format of the Annual Review, so that we can take your comments into account next year. To make a comment, please use the following contact information:

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

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

**See our website:** www.ouh.nhs.uk
FOUR HOSPITALS, ONE TRUST, ONE VISION