GETTING FIT FOR THE FUTURE

Annual Review 2004
The Oxford Radcliffe Hospitals NHS Trust strategic objectives

**Clinical Services**
To ensure that clinical services are maintained and developed appropriately, to meet the needs of patients safely, effectively and in a timely way.

**Patient Experience and Partnership**
To ensure that our services are patient-centred and planned and developed in direct partnership with our patients.

**Education and training; teaching; research and development**
To ensure that the Trust is a world-class centre for teaching, research and development, training and education.

**Workforce**
To ensure that the Trust recruits, retains, trains and develops staff to enable high quality services and to encourage flexibility and innovation in service delivery.

**Information management and technology**
The Trust will ensure it has access to, and can use, information and technology to support its operational needs, the delivery of its strategic objectives and in becoming a knowledge-based organisation.

**Assets**
To ensure that the existing capital asset base and all future investments realise maximum benefits and support for all the Trust’s service needs and provisions.

**Planning**
To ensure that the Trust’s services are planned and developed on a sound and sustainable strategic basis.
Finance
To ensure that the Trust operates within a sustainable revenue basis and meets its statutory financial duties.

Governance
To establish effective governance arrangements and ensure the Trust is run appropriately and in a way that inspires public and stakeholder confidence and meets legal and statutory requirements.

These strategic objectives were agreed by the Trust Board during the financial year 2003 to 2004. More information can be found in the Trust’s Assurance Framework, available on the website: www.oxfordradcliffehospitals.nhs.uk
Chairman’s Foreword

I was appointed Chairman in May 2003, at a time when the Trust was facing some pressing problems, including financial uncertainty. The organisation has worked extremely hard over the past year to tackle these difficulties, with, I am pleased to report, clear signs of success. My thanks go to Mike Williams, who took on the Chief Executive role during these difficult months until our new Chief Executive, Trevor Campbell Davis, took up his post. Through his leadership, the Trust not only maintained, but greatly improved its performance, despite the challenges the organisation was facing at the time.

At the end of the last financial year, the Trust broke even, although with some external financial support. We must ensure that the Trust reaches and maintains permanent financial stability, but this cannot be achieved in a single year. We had a stringent recovery plan in place last year, which contributed greatly to our break-even position. We are working even harder this year to fit our expenditure to our income. In the longer term, our Strategic Review will make sure that we focus on developing those services which patients want and which our Primary Care Trust and specialist commissioners are prepared to pay for.
The rigour with which the Trust has approached its financial problems, and the effort which it is investing into finding both immediate and longer term solutions, gives me confidence that recurring financial stability is achievable in the not too distant future.

Meanwhile, this last year has seen a number of milestones in the relocation and modernisation of our hospital buildings. In May of this year it gave me great pleasure to welcome the Earl and Countess of Wessex to the official opening of the impressive new Emergency Department at the John Radcliffe Hospital; the final deal for the £135 million Private Finance Initiative for the John Radcliffe development was signed at the end of 2003 and building on the new Children’s Hospital and adult wing are well under way; and the consortium has been chosen to work with the Trust on the £80 million Cancer Centre at the Churchill Hospital.

In July, we were awarded two stars in the Healthcare Commission Performance ratings. This illustrates a steady improvement from last year’s single star, and it was only three years ago that we were marked as a zero star Trust. I am also pleased to report that we are now achieving – and in many cases exceeding – all our targets for waiting times. This would not be possible, of course, without the hard work and commitment of all our staff, and the support of our health and social care partners in Oxfordshire and neighbouring counties.

Finally, I would like to welcome Brian Rigby, CBE, who joined the Board in January as a Non-Executive Director and to thank all our Board members for their support during the year. I would also like to show my appreciation to Trevor Campbell Davis for his hard work in his first year as Chief Executive, and all he has achieved so far in leading the organisation. I am confident that his plans for the Trust will ensure that we are able to build for a secure future.

Sir William Stubbs
Chairman
The NHS is meanwhile changing in a number of fundamental ways. These changes, together with rapid advances in medicine and drug treatments, raise questions about the future of some services.

Because of this changing environment, in December 2003 we announced a Strategic Review of the Oxford Radcliffe Hospitals and its services. The Review is considering:

- what services patients will want from the Trust in the future
- how we can improve our services and deliver them more efficiently
- which services should be provided in our hospitals and which should be provided in the community
- how we can achieve a balance between general services for the local community and more specialist services which also treat patients from further afield
- how we can strengthen our partnerships with the universities, in order to develop teaching, education and research.

We are involving staff, clinicians, colleagues in other organisations, patient groups and the public in the Review, to ensure that we listen to all their views. We will publish an interim report on the Review’s findings in the Spring of next year, and a final report in July 2005. By conducting this Review, and implementing its recommendations, I believe we can assure the future of the Trust for many years to come.”

Trevor Campbell Davis

“Looking to the Future

FROM THE CHIEF EXECUTIVE – LOOKING TO THE FUTURE

“When I was appointed to run the Oxford Radcliffe Hospitals, in September 2003, I was pleased to be joining an organisation with such a distinguished history and considerable reputation. This brief overview of our past year shows you that we have continued to develop and improve our patient care. We now need to bring a more planned approach to our future.

Our services have developed over many years, in response to specific patient needs, the interests of individual clinical staff and academics, and a multitude of separately funded initiatives. It would be surprising if the resulting mix fully met the current needs and aspirations of patients, service commissioners and other stakeholders. In particular, we do not know whether we have the right balance between general and specialist services.
About the Trust

The Oxford Radcliffe Hospitals is one of the largest teaching Trusts in the country, with a national and international reputation for the excellence of its services and its role in education and research. The Trust provides high quality general hospital services for the local population in Oxfordshire and neighbouring counties, and more specialist services on a regional and national basis.

The Trust employs over 9,000 staff and is one of the largest employers in Oxfordshire.

The Trust has more than 1500 inpatient beds across its four sites. In 2003/2004:

- 511,017 people attended outpatient appointments
- 117,021 people attended the emergency departments
- 48,323 people were admitted as inpatients to the hospitals for emergency treatment
- 20,233 people were admitted as inpatients for planned surgery
- 7,850 babies were delivered

The Trust has four hospitals:

The Radcliffe Infirmary is the original hospital, which opened in central Oxford in 1770. It is a base for regional neurosciences, specialist surgery and rehabilitation services for older people, and has 249 beds. Services currently based at the Radcliffe Infirmary will move to the Churchill and John Radcliffe Hospitals in 2007.

The John Radcliffe Hospital, in Headington, opened in the 1970s. It is the main accident and emergency site, and also provides acute medical and surgical services, trauma, intensive care, cardiac, women’s services and children’s services. The hospital has 725 beds. A new wing to house head and neck services, and the Oxford Children’s Hospital will open on the site in 2007.
The Churchill Hospital, with 317 beds, also in Headington, provides mainly non-emergency specialist services, including renal medicine and transplant, clinical and medical oncology, dermatology, chest medicine, infectious diseases and the recently extended palliative care centre. Work will start early in 2005 on building the new Cancer Centre and associated diagnostic facilities, due to be completed in 2007.

The Horton Hospital in Banbury has 277 beds and provides general hospital services, including accident and emergency services, maternity and paediatric services, to the growing local population in the north of Oxfordshire and surrounding areas.

As a teaching Trust, we have a vital role to play in the education and training of doctors, nurses, and other healthcare professionals. We do this in close partnership with the University of Oxford and Oxford Brookes University. The Trust is also involved in a wide variety of research programmes, in collaboration with the University of Oxford and many other research bodies.

The Trust works closely with many other partner organisations. These include patient groups, Primary Care Trusts, the Thames Valley Strategic Health Authority and other NHS organisations, as well as Oxfordshire Country Council Directorate of Social & Healthcare and the Health Overview and Scrutiny Committee. We value these partnerships and are working to strengthen and develop them.
The Trust employs over 9,000 staff and is one of the largest employers in Oxfordshire.

Improving our performance reducing waiting times for patients

Every year, the Government measures the performance of the Trust against a number of indicators aimed at helping to improve patient care. Last year, the Trust narrowly missed achieving two out of a possible three stars in the performance ratings. This year, the Trust was awarded two stars, the result of much hard work by staff throughout the organisation.
The Trust passed eight out of nine indicators:

- **Waiting time in the Emergency Departments for hospital admission.** The Trust is measured on how long patients have to wait in the Emergency Department for a hospital bed, if they need one. This year, no-one had to wait over twelve hours in the Emergency Department for hospital admission. In the past, patients have had to wait too long for hospital beds because of the number of people already in hospital who could be cared for elsewhere in the community. The Trust has been working closely with primary and social care colleagues to make sure that when patients are ready to leave hospital, they are swiftly discharged and transferred to care in community settings.

- **Total waiting time in the Emergency Departments.** At least 90% of patients should wait no longer than four hours to be seen, treated, discharged or admitted to hospital. 88% of patients waited less than four hours in the Emergency Departments at the John Radcliffe and Horton Hospitals last year. However, from May to July 2004, over 95% of patients were seen in four hours or less. This meant that, in July this year, the Trust was awarded £100,000 by the Department of Health for its achievements. The Trust plans to use the funding to develop a Medical Assessment Unit at the Horton Hospital in Banbury.

- **The length of time which patients with urgent suspected cancer wait for an initial consultant appointment.** The Trust met the Government target of ensuring that nearly all patients with urgent suspected cancer wait no more than two weeks from a GP referral for their first appointment with a consultant.

- **Financial management.** In the last financial year, the Trust returned to financial balance, with some external financial support. This year, the Trust has a rigorous financial recovery programme in place to maintain financial performance and has launched a Strategic Review to ensure long term financial stability.

- **Hospital cleanliness.** The Trust takes cleanliness extremely seriously, and has worked hard to ensure the target continues to be met. The Trust has employed housekeepers to take special responsibility for ward cleanliness and was praised in a National Audit Office for its work on infection control.

- **Improving Working Lives.** The Trust was awarded Practice status last year for the way in which it cares for its staff, and is working hard to achieve the next level, Practice Plus.
• **Operations and appointments booked in advance.** The Trust has to show the percentage of patients who had their appointments or operations booked in advance. The Trust exceeded the Government target.

• **Waiting times for outpatient appointments.** The Trust has greatly reduced the length of time which patients have to wait for a first outpatient appointment, so that by the end of the last financial year, no-one waited over 17 weeks.

• **Waiting times for planned operations.** The Trust has also greatly reduced the length of time which patients have to wait for a planned operation, so that no-one now waits over nine months. In addition, the Trust has recently reduced the number of cancelled operations by 40%.

The Trust was also judged on 35 subsidiary indicators. The Trust was average or above average for 27 of these indicators. It achieved particularly high scores for the number of people with suspected heart attacks who receive clot-busting drugs in the Emergency Department within a set period of time. It also achieved high scores for how quickly people with blocked arteries receive revascularization treatment.
Cutting waiting times is no accident

Reducing waiting times for treatment is a priority for the Trust, and important to patients. In a system of limited resources and increasing demand, however, the challenge is to produce sustainable reductions without compromising the quality of care. Until recently, many patients had to wait too long for treatment or hospital admission within the Trust’s two Emergency Departments. The major cause of difficulty was finding hospital beds for emergency patients needing admission, because of the high number of people already occupying beds and fit to be discharged, but who could not be moved on because of a lack of adequate care in a community setting. Over the past year, the Trust has worked hard to tackle these problems and to find solutions, with considerable success. Fundamental to this success was the Jonah Project, launched initially in the Emergency Departments, and then extended to wards, and to some of the community hospitals run by our primary care partners.

The Jonah approach takes each patient’s journey through the system as an individual project. A patient is assessed and, depending on their individual medical needs, a planned discharge date is set. Within the Emergency Department setting, this is applied to the four hour maximum waiting time. A ‘buffer management’ system allows any delays to be anticipated and resolved before the planned discharge date (or four hour waiting time) is breached. The progress of each patient is tracked by a computer programme. Different staff groups can look on the system for the tasks which need to be completed and the order in which they need to be done to achieve the patients’ planned discharge dates. If targets are missed, the reasons are recorded and analysed so that the common causes of delays can be identified. Senior managers work with clinical staff to monitor the progress of individual patients, to ensure that problems which might lead to delays are resolved quickly, and that common issues are tackled on a Trust-wide basis. Colleagues in primary and social care work in partnership with the Trust, to make sure that patients who are fit to be discharged are moved on much more rapidly.

The success of the Trust’s approach has been outstanding and is being adopted by NHS Trusts in other areas. The Trust once had the longest emergency waiting times in the country. It now has some of the shortest.
Theatre Direct

Although it is a great deal easier to predict the number of patients within the hospital at any one time for planned surgery, emergency pressures and delayed discharges can affect the number of beds available, and sometimes it is necessary to cancel operations. This is deeply unpopular with patients and their families. It is also a very poor use of expensive resources if, as a result, theatres stand empty and staff teams are unused.

For major surgery to take place, three elements have to be in place: admission beds, theatre time and post-operative beds. If any one of these is unavailable, the other two are wasted. This means delays or cancellation.

In order to look at how other healthcare systems tackled these problems, clinicians and managers visited Boston in the USA last year, and brought back with them a radical new approach to planning surgery. Known as ‘theatre direct’ this new approach is being introduced into the John Radcliffe Hospital initially.

Usually, a patient needing an operation is put on a waiting list and is allocated a date for it. The patient comes into hospital a day or so before surgery for an assessment to determine whether they are fit enough to undergo the operation. They stay in hospital after the surgery for an undefined length of time, until judged fit to be discharged.

Through the new scheme, which is being piloted in colorectal surgery, patients are pre-operatively assessed prior to admission, and then come in on the morning of the operation. They are also given a planned date for their discharge, and this is adhered to, unless there are medical reasons for a delay. It means patients are better prepared for their surgery and any consequences, and spend fewer days in hospital. At the same time, surgeons can plan sessions with the knowledge that pre-assessment work is already done and that operations will not be cancelled. Between May and July 2004 there were 34 same-day-admission colorectal surgery operations and none were cancelled.

A new pre-operative admission area, supported by capital funding from Thames Valley Strategic Health Authority, was opened in May 2004, and in July a special post-anaesthetic care unit was completed. The scheme will be extended to vascular surgery and other specialties later this year.
Activity last year

Waiting list total numbers – target and actual

<table>
<thead>
<tr>
<th>Month</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun 03</td>
<td>8,997</td>
<td>8,997</td>
</tr>
<tr>
<td>Sep 03</td>
<td>8,450</td>
<td>8,416</td>
</tr>
<tr>
<td>Dec 03</td>
<td>8,000</td>
<td>8,276</td>
</tr>
<tr>
<td>Mar 04</td>
<td>7,570</td>
<td>7,349</td>
</tr>
</tbody>
</table>

Outpatients - 13 week wait (total over 13 weeks) – target and actual

<table>
<thead>
<tr>
<th>Month</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun 03</td>
<td>955</td>
<td>955</td>
</tr>
<tr>
<td>Sep 03</td>
<td>649</td>
<td>621</td>
</tr>
<tr>
<td>Dec 03</td>
<td>490</td>
<td>701</td>
</tr>
<tr>
<td>Mar 04</td>
<td>304</td>
<td>28</td>
</tr>
</tbody>
</table>

Cancellations – number of operations cancelled on the day of surgery and breaches of the 28 day rule

<table>
<thead>
<tr>
<th>Period</th>
<th>Last minute cancellations</th>
<th>Number of operations cancelled on the day of surgery for non clinical reasons</th>
<th>Breaches of standard (patients not operated on within 28 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – Jun 03</td>
<td>188</td>
<td>92</td>
<td>27</td>
</tr>
<tr>
<td>July – Sep 03</td>
<td>211</td>
<td>125</td>
<td>44</td>
</tr>
<tr>
<td>Oct – Dec 03</td>
<td>219</td>
<td>140</td>
<td>46</td>
</tr>
<tr>
<td>Jan – Mar 04</td>
<td>229</td>
<td>88</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>847</td>
<td>445</td>
<td>163</td>
</tr>
</tbody>
</table>

*Last minute means on the day patients were due to arrive, after the patient has arrived in hospital or on the day of the operation.

Outpatient DNA** rate for first attendances

<table>
<thead>
<tr>
<th>Period</th>
<th>1st attendances</th>
<th>DNA</th>
<th>% DNA rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – Jun 03</td>
<td>47,085</td>
<td>3583</td>
<td>7.07%</td>
</tr>
<tr>
<td>July – Sep 03</td>
<td>47,933</td>
<td>3818</td>
<td>7.38%</td>
</tr>
<tr>
<td>Oct – Dec 03</td>
<td>48,294</td>
<td>3543</td>
<td>6.83%</td>
</tr>
<tr>
<td>Jan – Mar 04</td>
<td>50,882</td>
<td>3604</td>
<td>6.61%</td>
</tr>
</tbody>
</table>

** DNA = did not attend.
### Outpatients waiting times in clinics

<table>
<thead>
<tr>
<th></th>
<th>Total number</th>
<th>No. seen in 30 mins</th>
<th>% seen in 30 mins</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>of outpatients</td>
<td>or less</td>
<td>or less</td>
</tr>
<tr>
<td>April – Jun 03</td>
<td>124,607</td>
<td>115,386</td>
<td>92.6%</td>
</tr>
<tr>
<td>July – Sep 03</td>
<td>125,238</td>
<td>114,467</td>
<td>91.4%</td>
</tr>
<tr>
<td>Oct – Dec 03</td>
<td>123,808</td>
<td>113,161</td>
<td>91.4%</td>
</tr>
<tr>
<td>Jan – Mar 04</td>
<td>128,825</td>
<td>118,133</td>
<td>91.7%</td>
</tr>
</tbody>
</table>

### A&E four-hour wait (target = 90%)

<table>
<thead>
<tr>
<th></th>
<th>No. of A&amp;E</th>
<th>No. seen within 4 hours</th>
<th>% seen within 4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – Jun 03</td>
<td>29,914</td>
<td>25,213</td>
<td>84.3%</td>
</tr>
<tr>
<td>July – Sep 03</td>
<td>30,111</td>
<td>25,900</td>
<td>86.0%</td>
</tr>
<tr>
<td>Oct – Dec 03</td>
<td>28,826</td>
<td>24,903</td>
<td>86.4%</td>
</tr>
<tr>
<td>Jan – Mar 04</td>
<td>31,938</td>
<td>28,237</td>
<td>88.4%</td>
</tr>
</tbody>
</table>

### Cancer two-week wait performance

<table>
<thead>
<tr>
<th></th>
<th>No. of referrals</th>
<th>No. seen within 2 weeks</th>
<th>% seen within 2 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – Jun 03</td>
<td>1264</td>
<td>1253</td>
<td>99.1%</td>
</tr>
<tr>
<td>July – Sep 03</td>
<td>1390</td>
<td>1367</td>
<td>98.3%</td>
</tr>
<tr>
<td>Oct – Dec 03</td>
<td>1341</td>
<td>1324</td>
<td>98.7%</td>
</tr>
<tr>
<td>Jan – Mar 04</td>
<td>1412</td>
<td>1359</td>
<td>96.2%</td>
</tr>
</tbody>
</table>

### Patient activity

<table>
<thead>
<tr>
<th></th>
<th>2001/02</th>
<th>2002/03</th>
<th>2003/04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency activity</td>
<td>44,663</td>
<td>43,058</td>
<td>48,323</td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>19,889</td>
<td>19,251</td>
<td>20,233</td>
</tr>
<tr>
<td>Day cases</td>
<td>42,280</td>
<td>42,075</td>
<td>43,822</td>
</tr>
<tr>
<td>Total FCEs*</td>
<td>106,832</td>
<td>104,357</td>
<td>112,378</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>15,370</td>
<td>15,476</td>
<td>15,254</td>
</tr>
<tr>
<td>A&amp;E attendances</td>
<td>11,2721</td>
<td>114,489</td>
<td>117,021</td>
</tr>
<tr>
<td>Outpatients</td>
<td>41,4220</td>
<td>446,260</td>
<td>511,017</td>
</tr>
<tr>
<td>Renal dialysis patients</td>
<td>6062</td>
<td>6265</td>
<td>6287</td>
</tr>
<tr>
<td>Churchill services</td>
<td>24,664</td>
<td>25,518</td>
<td>24,723</td>
</tr>
<tr>
<td>John Radcliffe services</td>
<td>15,051</td>
<td>15,928</td>
<td>16,882</td>
</tr>
</tbody>
</table>

*FCE = Finished consultant episodes
Highlights of the year

This has been a year of major achievements in many areas for the Trust. Here are some of the highlights:

April 2003

• 26 ‘modern matrons’ are appointed to lead nursing across the Trust and improve patient care.

• The Trust is awarded ‘top hospital’ status by CHKS, which compares the performance of NHS Trusts. The award reflects good performance in a number of areas, including low mortality rates, low readmission rates after surgery, and the short length of time people wait for planned surgery. In April 2004, the Trust again achieves ‘top hospital’ status.

May 2003

• A one-stop skin cancer clinic opens in the dermatology department at the Churchill Hospital.

• Sir William Stubbs, former Chairman of the Qualifications and Curriculum Authority, is appointed Chairman.
• At the Trust’s annual Healthcare Conference, awards are made to six staff for significant achievements in their professional areas.

• The Heart Valve Bank at the John Radcliffe becomes one of only three in Britain to gain accreditation in a national inspection scheme, following £150,000 investment by the Trust in new laboratory facilities.

June 2003

• The Department of Health announces that the Trust, with Salisbury Health Care NHS Trust, is to become a regional centre of excellence for the treatment of children with cleft lip and palates.

• New laboratory facilities in the Transplant Centre at the Churchill Hospital are opened to support pioneering research into the use of pancreatic islets in the treatment of diabetes.

• The Trust’s Emergency and Outpatient Departments are praised in the annual patients’ survey.

July 2003

• The Kadoorie Centre opens. The Centre, which provides outstanding new facilities for research and education in critical care, was funded by businessman Michael Kadoorie.

• The Trust narrowly misses out on two stars in the Government’s performance ratings, relating to the previous financial year.

August 2003

• A pictorial account of the Trust’s four hospitals, by Oxford artist Jane Peart, is unveiled by Chairman Sir William Stubbs. Copies of the specially commissioned picture, which celebrates people and places across the Trust, hang in each hospital.
September 2003

• Trevor Campbell Davis, formerly Chief Executive of the Whittington Hospital in London, starts as Chief Executive of the Trust.

• The Secretary of State for Health, Dr John Reid, visits the Radcliffe Infirmary to inaugurate a new cancer research centre. During his visit, Dr Reid announces £3 million funding for the first phase of the Oxford Institute of Cancer Medicine, which will be based at the Cancer Centre at the Churchill Hospital. The Institute will provide a home for NTRAC, the National Translational Cancer Research Network, which will speed up patients’ access to new and experimental treatment.

• Oxford University marks the official launch of its Centre for Clinical Vaccinology and Tropical Medicine at the Churchill Hospital in Oxford. The Centre combines the results of laboratory and fieldwork with those of clinical practice, to aid the international effort to reduce the burden of infectious diseases.

October 2003

• The Trust commissions a double-decker bus advertising NHS careers to tour the county in a bid to boost staff numbers.
• The new £8.5million Trauma Centre at the John Radcliffe hospital, which opened in October 2002, is short-listed for an NHS Building Better Healthcare Award.

November 2003

• On World Diabetes Day, the Government announces the Trust is to become one of seven national centres funded to carry out pancreatic transplants.

• The Starter Home scheme, offering assistance to staff wishing to buy their own property, is extended, so that anyone working for the Trust is eligible to apply.

• A new physiotherapist-led hand clinic starts at the Radcliffe Infirmary, funded through the Government’s ‘Action on Plastic Surgery’ programme.

• A national survey reveals that patients having surgery at the Radcliffe Infirmary for serious nose and sinus problems, have the best outcomes in England and Wales.
December 2003

• The Chairman, Sir William Stubbs, announces a Strategic Review of the Trust, to be launched in July 2004.

• The Trust signs a £135 million deal with the Hospital Company for the development of the Oxford Children’s Hospital, and the new wing for the John Radcliffe Hospital.

• The Surgical Emergency Unit at the John Radcliffe celebrates its first anniversary, having treated 4000 patients in its first year, and won praise from a patients’ survey.

January 2004

• Science and Innovation Minister Lord Sainsbury announces a £540,000 grant to the NHS South East Innovations Hub, led by the Trust. The Hub encourages innovation in the NHS, and helps inventors to turn their ideas into commercially viable concerns.

• The new Emergency Department at the John Radcliffe Hospital opens its doors to patients. The official opening of the £10.5 million development is in May 2004, when the Earl and Countess of Wessex visit the Trust.

• A children’s consultation day is held with hospital teachers and play specialists to seek views on the new Children’s Hospital building

February 2004

• The official opening of a new dermatology centre at the Churchill Hospital. This provides new operating theatres, consulting rooms and much improved patient facilities.

• The £3.2 million Takeda Wing of the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM) opens. The new Wing houses leading edge research teams from Oxford University. OCDEM now offers a combination of patient care, education and world class research on diabetes and endocrine and metabolic disorders.

March 2004

• New cardiac monitoring equipment is donated to the Horton Hospital. The donation has been given to the hospital by the family and supporters of a young man who died suddenly as a result of a rare cardiac abnormality.

• Joint work with social and primary care partners to speed up the rate at which patients are discharged from the hospital when they no longer need acute care, shows results. Waiting time for patients in the Emergency Departments reduces significantly.
Clinical governance review—ensuring quality in all that we do

The Trust’s systems for clinical governance are designed to ensure that the quality of care we provide is as good as possible and continuously improving. They operate alongside similar systems to ensure the Trust uses its resources properly and manage risk effectively.

Over the past year, like other NHS Trusts, we have developed an assurance framework which brings these systems together and which shows the controls we have in place to manage risk. The Trust’s framework was highly commended by its internal auditors and the Strategic Health Authority, and is considered an exemplar of good practice.

During the year, we reinforced our clinical governance strategy by developing new policies for risk management and clinical effectiveness. Each of the clinical directorates developed an annual quality plan, setting out the work that they planned to do over the forthcoming year, including clinical audits to be completed, patient links to be strengthened or developed, risks to be managed and training issues to be addressed.

Learning from clinical audit
Clinical audit is a powerful way of reviewing the quality of care and identifying areas for improvement. Over the year, we have been involved in many different projects. Most of these are carried out within specialties as part of their day-to-day work. Our annual audit plan also included a series of Trust-wide audits, such as reviews of infection control issues; the quality of medical records; the use of and infections associated with indwelling intravenous cannulas; and the extent to which patients develop pressure ulcers.

All consultants are expected to participate in a regional or national audit, to enable them to compare their work with colleagues in other Trusts.
We estimate that, last year, over 90% of our consultants were involved in such audits. These include projects like the Royal College of Physicians’ review of chronic lung disease, the Royal College of Surgeons’ Ear Nose and Throat audit, participation in the national trauma audit and research network and contributing data to the National Confidential Enquiries into Patient Outcomes and Death (NCEPOD) and Maternal and Child Health (CEMACH).

Reducing risks
The Trust has developed a strong system of risk management. We were recently reassessed and reaccredited at level one for the Clinical Negligence Scheme for Trusts. This is the risk pool into which all NHS Trusts pay to indemnify themselves against clinical negligence claims. Achieving level one status demonstrates that we have good systems in place for reducing the chance of patients suffering adverse outcomes from their treatment. It also entitles the Trust to a significant 10% saving in the cost of its premium.

For the first time, we also were awarded level one status for a similar scheme (the Risk Pooling Scheme for Trusts – RPST) that recognises the systems we have in place for reducing staff and other third party injuries.

During the year, we launched a new incident reporting system. We have had a reporting system in place for many years, and about 13,000 incidents are reported annually. However, the new system standardises the information we report, enables us to grade incidents according to their severity so we can focus on the most important, and will enable us to link our system into the National Reporting and Learning System (NRLS), being launched by the NPSA later this year.

We have worked hard to improve the management and provision of training. We have identified the ‘must-do’ training which all staff have to complete, and provided additional courses in health and safety, manual handling, fire safety, and have updated our induction programmes to ensure new staff get a comprehensive introduction to the organisation as soon as they join.
Some practical examples of risk management

We have recently launched an initiative to reduce the chance of the wrong patient undergoing the wrong procedure or receiving the wrong treatment. A poster campaign ‘who are you?’ alerts patients and relatives to the need for them to identify themselves before accepting any treatment. At the same time, the Trust has introduced more rigorous policies to ensure that standard checks and procedures are completed before any patient has surgery.

We are also running programmes to reduce errors relating to the prescribing and dispensing of medicines, and to reduce patient falls. The latter has been achieved by introducing a standard assessment tool on the wards with which nurses can identify patients most at risk of falling and then ensure measures are in place to reduce the chances of this happening.

Our ‘handy hygiene’ programme aims to ensure that staff clean their hands every time they touch a patient. A key part of this is the use of alcohol rub gel, which has been used in the Trust since 2001. Alcohol rub is provided as close to patients as possible at point of care, such as the bedside or in locker-mounted dispensers, and a programme of training and education for all staff and is used to reinforce the importance of its use. Experience gained at the Trust has helped the formulation of the national ‘clean your hands’ campaign launched this summer by the National Patient Safety Agency (NPSA).

Future plans
Over the next year, we will introduce new types of quarterly reports to ensure we can monitor all these activities and that our clinical teams can demonstrate the quality of the services they provide and address any deficiencies. We will roll out a risk assessment process across the whole organisation, to enable us to compare and prioritise all types of risk alongside each other. We will continue to review our systems, strategies and policies to ensure that our clinical services are provided within a robust and effective framework of continuous quality assurance and improvement.
Partnership with patients

One of the Trust’s strategic objectives is to ensure that services are patient-centred and planned and developed in direct partnership with patients. This year, Julie Hartley-Jones, the Trust’s Chief Nurse, was given Board level responsibility for patient and public involvement. The Trust has a Patient and Public Panel comprising 35 members of the public recruited from across Oxfordshire. Panel members are involved in a range of Trust activities and working groups, and bring a fresh public view to their discussions. The Panel is also used as a discussion group for Trust staff to seek views and suggestions. Examples of their successful involvement so far include: links with the new building initiatives; contributions to discussions on nursing care; participation in the hospital environment inspections with Trust staff; and participation in discussions on patient restraint and discharge planning.

The Government has recently established external bodies to improve local accountability. The County Council Health Overview and Scrutiny Committee has a role in monitoring, reviewing and scrutinising local health services, and must be consulted on major service changes. The Patient and Public Involvement Forum (PPIF) has been established as an external body, made up of members of the public with an interest in health services. Their role is to seek the local community’s views on a range of health issues, monitor services through visits to premises and look at the wider issues which affect health, such as transport, social care and housing. The Trust is strengthening its relationships with both of these new bodies, and will continue to work in partnership with them.
The Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) offers advice and information to patients, relatives and their carers. Patients and staff can contact the service by phone, letter or email, or can call in to the office at the John Radcliffe Hospital. Patients and staff on other sites can telephone the office, and the PALS team visits other hospital sites. The number of enquiries to the PALS service has steadily increased each month and it is reducing the number of formal complaints to the Trust. In particular, the number of logged verbal complaints has dropped by 49%, from 189 in 2002/03 to 95 in 2003/04.

### Formal complaints

The number of written and verbal complaints the Trust received this year has dropped by 12% from 2002/03. The time it takes the Trust to acknowledge complaints within two days has improved by 22%, and the time it takes to respond to written complaints within 20 days has improved by 16%.

#### Response times for acknowledging complaints

<table>
<thead>
<tr>
<th>Working days</th>
<th>02/03</th>
<th>03/04</th>
<th>Percentage increase/decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 2 working days</td>
<td>499</td>
<td>598</td>
<td>up 22%</td>
</tr>
<tr>
<td>3 - 5 working days</td>
<td>82</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>over 5 working days</td>
<td>94</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>675</td>
<td>622</td>
<td>down 12%</td>
</tr>
</tbody>
</table>

#### Response times for written complaints

<table>
<thead>
<tr>
<th>Working days</th>
<th>02/03</th>
<th>03/04</th>
<th>Percentage increase/decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20</td>
<td>335</td>
<td>413</td>
<td>up 16%</td>
</tr>
<tr>
<td>21-30</td>
<td>174</td>
<td>96</td>
<td>15</td>
</tr>
<tr>
<td>Over 40</td>
<td>72</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>675</td>
<td>622</td>
<td>down 12%</td>
</tr>
</tbody>
</table>
The types of complaints received are compiled into a number of national category types and include areas such as staff behaviour, communication, delays and waiting times, hospital environment and patients’ experiences.

Face to face meetings with patients (and their families) have become an integral part of the local resolution stage of the complaints procedure. 24 such meetings were held during the year. Between 1 April 2003 and 31 March 2004, 12 complaints where concerns have remained unresolved have been referred on further for independent review. On the advice of external assessors, six panel requests were refused, and four were referred back to local resolution for further investigation. So far, one panel has taken place and one panel is pending.

**How comments and complaints help to improve services.** Patients, relatives and visitors have offered us feedback using the comments and complaints leaflet ‘Let us know your views’. These comments are all gratefully received, provide a valuable patient insight into our services and make a useful contribution to help us change and improve the way we do things. Some examples of ways in which the Trust has improved services which have been the subject of comments and complaints from patients include:

- The refurbishment of the John Radcliffe Emergency Department. The opening of the new Emergency Department and collaborative working across the Trust has greatly improved the patient’s journey and experience within the department. The reduction in the number of concerns raised is reflected in the above figures.

- Two changes have reduced the delays for patients waiting for TTOs (‘to take out’ medication). Set targets for medical staff to write TTOs allow the pharmacy to dispense the drugs prior to a patient’s discharge, and those TTOs required urgently can be prioritised. This is now included in the discharge policy. The introduction of an automated dispensing system for TTOs for patients on both the Radcliffe Infirmary and John Radcliffe sites has further reduced the dispensing time and improved efficiency.

- With the help of the League of Friends, a further 28 wheelchairs have been purchased over the last 18 months for the John Radcliffe site.

- Working with the Oxfordshire Association for the Blind (OAB) and the Oxford Macular Group, the Trust is taking forward plans to make staff more aware of the needs of patients with visual impairments. The Trust plans to distribute the OAB information leaflet, ‘Helping you to help your visually impaired patient’, to staff throughout this year. At the same time, the nationally recognised eye symbol will be available on the wards and used in health records or displayed (with consent) on patients’ beds.
Research and development

The Trust has an international reputation for the quality of its research and development work. As a member of the Oxford Research and Development Consortium, it has close links with both the University of Oxford and Oxford Brookes University, with many researchers working across the NHS and university divide. The Consortium is one of the largest NHS research bodies in the country, in terms of the impact of its research on patient care, funding and the number of research projects it carries out.

In 2004, there were 737 active studies taking place, involving 59,000 patients. The studies are spread throughout the various specialist medical and surgical departments of the Oxford Hospitals, and have included clinical therapeutic trials, development of diagnostic and prognostic systems and investigation of the cause and course of common and rare diseases.

The Trust leads, or is linked with, fifteen programmes of research, known as Collaborative Research Groups, (CRGs), which have been recognised by the Department of Health as being of a very high standard, both in terms of the research undertaken and their organisation. These programmes cover a wide range of clinical areas, including national health priorities such as cancer, cardiovascular disease and mental health. Consequently, the research has great benefits to Trust and other patients. In the past year, two new Collaborative Research Groups have been established: haematological sciences, led by Dr Chris Hatton; and wound management and tissue repair, led by Professor Fenella Wojnorowska.
Examples of research studies
Described below are some of the research studies currently being undertaken at the Trust:

• The development of a revolutionary new test for identifying people with tuberculosis (TB), one of the leading causes of death worldwide. As a result of this work, a spin-off company has been established to market and distribute the test to an international market.

• Oxford is a key centre for testing stents for treating arteries that have become narrowed due to heart disease. A stent is a small lattice-shaped metal tube that is inserted permanently into arteries. A particular focus of research has been to examine the benefits of stents that contain slow-releasing drugs (known as drug-eluting stents) which help to prevent narrowing in the future.

• Researchers have contributed to the development of a number of drugs designed to combat cancer. For example, ‘Iressa’ is a new class of drug which blocks the pathways that lead to cancer cell development. It is hoped that Iressa will help to treat patients with lung cancer. In addition, Rituximab and Glivec have been the focus of research leading to national guidance (through the National Institute for Clinical Excellence) for the treatment of cancer patients.

• Patients with chronic kidney disease are at high risk of developing coronary heart disease. Oxford researchers are playing a lead role in an international trial to examine the effects of reducing cholesterol levels as a means of preventing heart disease. If cholesterol-lowering is shown to be effective, then this will have a major impact on the treatment of patients with kidney disease.
• Oxford researchers were amongst the first to test an artificial heart pump for patients with end-stage heart failure. These pumps were shown to be successful and, in the longer term, are likely to make a significant contribution to the treatment of this group of patients.

• Researchers at the Trust are continuing to develop improved vaccines for the treatment of a number of diseases including meningitis, influenza, malaria and Hepatitis B & C. The results of this work will have implications locally, nationally and internationally.

• Oxford is a specialised centre for the treatment of, and research into, sleep disorders such as obstructive sleep apnoea (OSA). Such conditions are linked to cardiovascular and mental health problems. Researchers have helped to develop treatments which are not only effective in helping patients but also more cost-effective than conventional treatments.

• Oxford now has a gynaecological cancer centre that is helping to develop national guidelines for the treatment of this condition. In addition, a tumour bank has been established to collect samples of tumours from consenting patients. These samples will be used for future research examining the underlying causes of gynaecological cancer.

• Researchers at the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM) are undertaking a programme of research to help understand more about the underlying mechanisms and treatment of Type 2 diabetes (a disease which has now reached epidemic proportions). In addition, a separate group within OCDEM is examining the links between diabetes and associated obesity. This work is particularly important given the growing problem of obesity as highlighted by the Department of Health.
Valuing our staff

The Trust has some of the best doctors, nurses, other health professionals, managerial and support staff in the country, and our reputation depends on them. The Trust works hard to recruit high quality staff and to look after them in order to retain them.

Improving Working Lives

Improving Working Lives (IWL) is the national standard by which NHS Trusts are judged on how well they value and support their staff, and help them to achieve a reasonable work/life balance. The Trust has recruited IWL ‘champions’ from across the organisation to raise awareness and encourage good practice. In 2003, the Trust achieved IWL Practice status and we are now working to achieve Practice Plus, which is the highest standard an NHS organisation can achieve, early in 2005.

The Trust has developed a wide range of initiatives to improve support for staff:
- The Trust has been awarded the Disablement Employment Advisors’ Certificate.
- The Trust has developed and is implementing a race equality scheme.
- The Trust has a child-care co-coordinator, and has a range of initiatives to help staff with family responsibilities.
- More flexible working practices are in place including job share, annualised hours and career breaks.
- New policies and procedures are in place to deal with bullying and harassment. This includes a new scheme to train staff to provide support to colleagues who have experienced bullying or harassment.
Agenda for Change

Agenda for Change is the new pay system for all NHS staff, excluding doctors, dentists and very senior managers. By the end of next year, all appropriate staff groups have to move to the new pay system. To achieve this will be a significant task for the Trust. The Trust has been allocated funding from the Thames Valley Strategic Health Authority to support the work needed to prepare for the implementation of Agenda for Change. Workshops and training sessions are being held to raise awareness among staff and managers. Staff are also being trained to carry out the processes by which jobs will be evaluated within the new system, and guidance is being drawn up to assist managers in preparing job descriptions.

New consultant contract

Over the past year, the Trust has put considerable effort into preparing for the new consultant contract, which is currently being implemented.

The new contract provides the opportunity for consultants to have dedicated time for clinical audit and their own continuing professional development, in line with GMC requirements for doctors to keep up with new innovations in clinical practice, in order that they can be re-registered on a regular basis.

The new contract also provides the opportunity for individuals to rethink and renew their job plans, and over the next six months the Trust will be looking at different ways of working and engaging the consultant body to implement this.
Training and developing staff

The Trust has a broad training and staff development programme, offering statutory, mandatory and career-development courses for the full range of staff groups. Below are some examples:

• **Learning clubs.** Funded by the South East England Development Agency (SEEDA), the Trust’s three learning clubs are open every day to help staff to learn in a variety of ways, including through e-learning and one to one support.

• **Stepping stones programme.** This programme, run in partnership with Oxfordshire County Council’s Basic Skills’ Unit (and also funded by SEEDA) provides English language training, literacy, computer skills, maths and other basic skills for staff. It also assists in the development of other training programmes, for example, appraisal and health & safety training.

• **Coaching and mentoring.** The Trust has a programme to develop and train mentors, as a resource to support staff. The Trust Coach and Mentoring Practice is a corporate faculty member of the Oxford School of Coaching and Mentoring, and runs the OSCM Diploma in coaching and mentoring.

• **IT training.** The Trust’s IT team is now part of an Oxfordshire-wide team, Oxfordshire Health Informatics Service (OHIS). IT training is provided by OHIS in a wide range of subjects taught in a wide variety of ways, including training courses, on-line learning and open learning sessions. The NHS has adopted the European Computer Driving Licence as the standard for IT competence, and the team provides support and training for staff wishing to achieve this. OHIS is also an ECDL Accredited Testing Centre, which means that students can take their tests internally.

• **Senior Managers Learning and Communications Forum.** This forum, set up this year, allows senior managers from across the Trust to meet on a monthly basis to hear speakers and to discuss issues of current concern. The Chief Executive, Trevor Campbell Davis, speaks at the meeting on a regular basis.
Recruiting high quality staff

In August 2003, the Trust centralised recruitment into a single recruitment centre, based at the Churchill Hospital. The centre acts as a single point of contact for all recruitment and now receives over 1000 calls a month on its 0845 number. One of the advantages of the recruitment centre is the speed at which vacant posts can be filled – the time taken to fill a post has reduced by 40% since January 2004.

The advertising budget has also been centralised. A Trust-wide advertising and marketing forum now plans advertising schedules, controls spending and helps to ensure a co-ordinated approach. This has included the development of a new image for Trust advertising, and developing advertising through new channels, for example, through the recruitment bus described elsewhere in this report, and through our website.
### Staff numbers

<table>
<thead>
<tr>
<th>Category</th>
<th>Full time Female</th>
<th>Full time Male</th>
<th>Part time Female</th>
<th>Part time Male</th>
<th>Total number of staff</th>
<th>Whole time equivalent total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery</td>
<td>1886</td>
<td>252</td>
<td>1772</td>
<td>54</td>
<td>3964</td>
<td>2955</td>
</tr>
<tr>
<td>Admin and clerical</td>
<td>729</td>
<td>148</td>
<td>952</td>
<td>50</td>
<td>1879</td>
<td>1354</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>273</td>
<td>506</td>
<td>256</td>
<td>277</td>
<td>1312</td>
<td>968</td>
</tr>
<tr>
<td>Technicians</td>
<td>271</td>
<td>242</td>
<td>240</td>
<td>42</td>
<td>795</td>
<td>631</td>
</tr>
<tr>
<td>Ancillary</td>
<td>70</td>
<td>214</td>
<td>183</td>
<td>89</td>
<td>556</td>
<td>405</td>
</tr>
<tr>
<td>Allied Health Prof.</td>
<td>239</td>
<td>31</td>
<td>231</td>
<td>8</td>
<td>509</td>
<td>366</td>
</tr>
<tr>
<td>Senior Managers</td>
<td>158</td>
<td>108</td>
<td>47</td>
<td>2</td>
<td>315</td>
<td>290</td>
</tr>
<tr>
<td>Scientists</td>
<td>67</td>
<td>36</td>
<td>35</td>
<td>10</td>
<td>148</td>
<td>116</td>
</tr>
<tr>
<td>Maintenance</td>
<td>0</td>
<td>70</td>
<td>1</td>
<td>2</td>
<td>73</td>
<td>71</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>31</td>
<td>10</td>
<td>30</td>
<td>2</td>
<td>73</td>
<td>55</td>
</tr>
<tr>
<td>Optometrists</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Totals</td>
<td>3728</td>
<td>1618</td>
<td>3753</td>
<td>539</td>
<td>9638</td>
<td>7225</td>
</tr>
</tbody>
</table>
Building for the future

Plans to relocate services from the Radcliffe Infirmary to the John Radcliffe and Churchill Hospitals have been discussed for a number of years. Over the past three years, these plans have developed into specific projects and a £200 million capital building programme, most of it developed through the Government’s Private Finance Initiative, is well under way. By 2007, the Trust will have all of its Oxford-based services housed on the two hospital sites in Headington.

The first milestone in the relocation programme was the opening of the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM) at the Churchill Hospital in March 2003. In February 2004, the specialist diabetes research facility, the Takeda Wing, was added.

In December 2003, the final contract for new developments at the John Radcliffe Hospital was signed with the Hospital Company, one of a number of bidders who had worked with the Trust to develop proposals for the project. The Hospital Company and its partners will build the new facilities on the John Radcliffe site, and will provide facilities management after completion.

The new facilities will comprise the Oxford Children’s Hospital, and a centre for a range of services which are currently based at the Radcliffe Infirmary.
The new adult building will provide accommodation for:
- adult and children’s neurosciences
- neurophysiology, neuropsychology and audiology services
- neuropathology laboratories
- ophthalmology
- ear, nose & throat services
- outpatient services
- plastic surgery inpatient services
- adult day surgery services
- adult and children’s theatres
- adult radiology services
- adult intensive therapy and high dependency units
- supporting services, such as on-call rooms and relatives’ and carers’ accommodation
- University offices and labs and facilities management services
- staff dining and café facilities
- 100-place nursery and two shops.

A new 700-place staff car park will replace those spaces lost due to the construction of the new buildings, and 200 additional patient and visitor spaces will be provided both under and close to the new buildings.

The Oxford Children’s Hospital

The Children’s Hospital will bring together services which are currently based on the three separate hospital sites in Oxford. It will provide:
- inpatient, day care and adolescent services
- imaging department
- outpatient services
- relatives’ and carers’ accommodation
- University offices.

The cost of the Children’s Hospital is being supported by an extensive fund-raising campaign, which aims to generate £15 million of financial support. A fund-raising committee, chaired by Lord Drayson, has already been extremely successful in harnessing the support of a large number of local individuals, businesses and other organisations, who are all keen to see a purpose-built, state of the art, children’s hospital for families in Oxfordshire and neighbouring counties.
The Future of Cancer Care

The new Oxford Cancer Centre at the Churchill Hospital, also due to open in 2007, will provide a wide range of medical and surgical cancer services for patients. It will include three new operating theatres and a high dependency unit, inpatient and outpatient facilities, and other specialist departments. It will bring together services already at the Churchill Hospital with those which are currently based both at the Radcliffe Infirmary and at the John Radcliffe Hospital.

In April 2004, the Trust announced that Impregilo had been chosen as the consortium to work on the £80 million project.

The Cancer Centre will include:
• cancer medicine (clinical and medical oncology, clinical haematology and radiotherapy)
• cancer surgery (head & neck, gastrointestinal, breast, and gynaecological cancer surgery)
• diagnostic services (laboratories, radiology and breast screening).

The Cancer Centre will also provide a base for University research teams, and facilities for Cancer Research UK, working in partnership with NHS colleagues.
Fit for the future-
the Strategic Review of the Oxford Radcliffe Hospitals

‘To recommend the future configuration of ORH services to ensure that the needs of patients, service commissioners, teaching and research are delivered by the Trust, to the highest possible standard, within a predictable and stable financial framework’

A far reaching Strategic Review of the Oxford Radcliffe Hospitals was announced by the Trust in December 2003, and launched in July this year. The Review will look at the wide range of issues which are affecting the Trust at the moment.

These include:

• changes in the health of the population. People are living longer than ever before and health needs are changing. For example, people live far longer with conditions such as diabetes or after a stroke. We need to ensure we provide the right services for this population.

• the move towards providing care closer to patients’ homes. NHS and social care staff are working more closely together to support people better in the community, and the length of time which patients need to spend in acute hospitals is getting shorter.

• advances in treatment. Advances in technology and in medicines mean that treatment is more effective than ever before. Doctors are becoming increasingly specialised, and larger centres of expertise are developing, for example, for the treatment of cancer patients.

• patient choice and payment by results. Patients will soon be able to choose in which hospital they wish to be treated. Trusts will only be paid for the patients they treat, at nationally set rates. We need to ensure that we are providing services which patients want, and within these national rates.

• workforce issues. There are more doctors and nurses than ever before in the NHS, but it can be difficult to recruit and retain staff in a high cost area such as Oxfordshire. Limits on the hours which doctors can work, the new contract for consultants and Agenda for Change are all changing the way staff work.
• what our commissioners want. Primary Care Trusts who purchase hospital services on behalf of patients are developing clear ideas about what local populations want and need. GPs will also continue to influence the services and hospitals their patients choose.

• teaching, education and research. We want to work more closely with our University and other research partners, to ensure we have shared objectives.

How the Review will be structured. Working groups comprising doctors, nurses, managers and other staff will look at services across the Trust and report to a Strategic Review Programme Board, chaired by the Trust’s Chief Executive, Trevor Campbell Davis. The Trust will publish an interim progress report, outlining emerging themes, for discussion with staff, patients, the public and other partners in March 2005. At the end of the Review, in July 2005, a set of proposals will be published for further discussion by the Trust Board, and for further public consultation, if required.

As part of the Review, we will be looking at the Horton Hospital in Banbury, and how it serves the local community. We are committed to maintaining the Horton Hospital as the main provider of general hospital services for people in north Oxfordshire, and the Review will help us to find ways of ensuring we can achieve this.

More information can be found on the Trust website: www.oxfordradcliffehospitals.nhs.uk
Financial Review 2003 to 2004

The last financial year has been very challenging for the Trust, but one in which it made considerable progress in addressing its underlying problems. At the outset of the financial year, the Trust put forward to Thames Valley Strategic Health Authority a three-year financial recovery plan. The plan was endorsed by the Health Authority and will ensure that the Trust returns to a strong and sustainable financial footing by March 2006.

The Trust was successful in securing interim support of £25 million from the Department of Health during this first year of its financial recovery plan. In recognition of this support, the Trust undertook to make savings of £21.7 million to enable it to set a balanced budget for the year. This was a considerable challenge for Trust staff, in parallel to achieving a number of other significant improvements for patient services – for example, further reducing the time patients wait for planned surgery. However, this challenge was delivered and the Trust met the targets set within the first year of its financial recovery plan and achieved all of its principal financial duties.

At the year-end, full financial provision was made for the estimated costs of the new NHS consultant contract. The Trust’s main commissioners contributed funding in the year to this additional cost.

Financial Duties
The Trust’s performance against its statutory financial duties is summarised as follows:

*Break-even on income and expenditure*
The Trust reported a small surplus of £200,000 after receiving £25 million of non recurrent support from the NHS Bank. This surplus compensated for the small deficit (of £179,000) the Trust made in the previous financial year, to ensure that the Trust met its statutory duty to breakeven taking one year with another.

*Capital cost absorption rate (CCA Rate)*
NHS Trusts were set a target of 3% for this duty. The Trust achieved this duty with an actual rate of 3.6% in 2003/04.

*External finance limit*
This is an NHS Trust cash limit which the Trust must stay within. The Trust met this duty, reporting an external financing requirement of £2.023 million, which was within the limit set for it of £2.102 million.

*Capital resource limit*
This limit sets a control on the amount of the Trust’s capital investment in any one year, after taking into account the proceeds from any asset disposals it makes. The Trust achieved this duty, with actual (net) capital investment of £24.556 million in the year, against a capital resource limit of £24.561 million.
## Performance over the last five years

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Income £000</th>
<th>Surplus before interest £000</th>
<th>Retained Surplus/ (deficit) £000</th>
<th>CCA Rate* %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003 - 04</td>
<td>423,941</td>
<td>9,063</td>
<td>200</td>
<td>3.6</td>
</tr>
<tr>
<td>2002 - 03</td>
<td>382,847</td>
<td>13,302</td>
<td>(179)</td>
<td>6.2</td>
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<td>2001 - 02</td>
<td>332,174</td>
<td>12,419</td>
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<tr>
<td>2000 - 01</td>
<td>300,442</td>
<td>19,225</td>
<td>6,819</td>
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<td>1999 - 00</td>
<td>284,730</td>
<td>8,129</td>
<td>(2,664)</td>
<td>6.6</td>
</tr>
</tbody>
</table>

* Until 2002/03, the target rate of return was set at 6%. For 2003/04, the target rate changed to 3.5%.
Statement of Internal Control
2003/4

Scope of responsibility
1. The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation’s policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation’s assets for which I am personally responsible, as set out in the Accountable Officer Memorandum. As Chief Executive, I work also within the performance management framework established by the Thames Valley Strategic Health Authority.

2. I have delegated responsibility for the establishment and maintenance of a risk management system and assurance framework to the Chief Nurse, in support of the system of internal control.

The purpose of the system of internal control
3. The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation’s policies, aims and objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and manage them efficiently, effectively and economically.

4. The system of internal control has not been in place in the Oxford Radcliffe Hospitals NHS Trust for the whole year ended 31 March 2004, but was in place by 31 March 2004 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
5. The Board of the Oxford Radcliffe Hospitals NHS Trust has approved the risk management strategy and policy, a health and safety strategy and policy, and an incident reporting policy and procedure. Risk assessment procedures were in draft at the end of March 2004, and training was carried out to ensure a common understanding and consistency for risk assessment across the hospitals.

6. The following documents have been circulated together in paper form and placed on the intranet, together with a covering note from the Chief Nurse and Chief Executive:

- Risk management strategy and policy (including clinical risk management within maternity services)
• Health and safety strategy and policy
• Incident reporting policy and procedure and serious incident reporting procedure.

7. Clear structures for risk management have been put in place and responsibilities have been clarified. The Organisational Manual 2003/4 includes outline job descriptions for all executive and divisional directors, and identifies the clear responsibilities for risk management, health and safety and controls assurance.

8. The Chief Nurse has delegated responsibility for the risk management systems across the Trust, and for ensuring that clinical and non-clinical risk management systems are brought together. The Director of Estates and Facilities has delegated responsibility for health and safety.

9. The risk management and health and safety policies lay down clear responsibilities for named officers and for all staff across the Trust.

10. The committee structure for assurance has been clarified, and a Governance Committee has overall responsibility for assuring the Trust Board on the system of internal control; the Audit Committee scrutinises this process. An operational Risk Management Committee met for the first time in January 2004, and will meet quarterly, receiving reports from its sub-committees, which usually meet monthly. In addition, the Chief Nurse chairs a weekly meeting with the key staff involved in risk management.

11. The Risk Management Committee is a Committee of the Executive Board, and its Chair, the Chief Nurse, will ensure that the Board is informed appropriately and that due account is taken of the work of the Risk Management Committee and its sub-committees.
12. Controls assurance leads met regularly throughout 2003/4 and focused on delivering agreed action plans, previously reviewed and signed off by the appropriate executive director. The February and March 2004 meetings of the group focused on the timetable and management process for self-assessment and submission for 2003/4.

13. The Trust and Executive Boards held a full day meeting on 22 January 2004 to agree the strategic objectives and associated principal risks. Following this, the executive team – including the executive directors, divisional directors, the Trust Board Secretary and the Director of the Clinical Governance Support Unit, identified the controls required and the assurances necessary on those controls. An assurance framework has been developed to provide the evidence to support the SIC, and this has been audited by internal audit (CEAC) and the findings reported to the chair of the Governance Committee, the Audit Committee and the Trust Board.


15. Training has taken place in the last quarter of 2003/4 on health and safety – including training for Trust Board and Executive Board members – and on incident reporting.

16. Training on the use of the risk management and assessment has also been carried out, so that the key leads within the executive directorates, clinical and non-clinical risk, and the 21 controls assurance standard leads can both populate and maintain a dynamic risk register in support of the assurance framework. This training will be rolled out during 2004/5.

17. The Trust Board will receive reports on risk management at each meeting, in addition to any ad hoc reports from the Governance Committee. The Board will ensure that the reports inform its decision making and objective setting for 2004/5.
The risk and control framework

18. The approach to risk assessment has been agreed by the Trust Board, setting down the approach to be followed across both clinical and non-clinical risk areas in the Trust. The aim is to ensure consistency and continuity of approach across the range of services and activities of the Trust.

19. The introduction of the new incident reporting policy and procedure (from 9 March 2004) has highlighted risk issues and the assessment of risk across the organisation. The new forms for reporting incidents highlight specifically the relationships between likelihood and consequence.

20. The Risk Management Committee will oversee the introduction of the risk register, and subsequently review the assessment of the risks included in it. The register contains risks identified from the controls assurance self-assessment process and the divisional and directorate risk assessment processes. The register is dynamic and will be reviewed regularly by the Risk Management Committee, the Clinical Risk Management Committee, the Health and Safety Committee and all the divisional and directorate boards. Reports on organisational learning arising from the assessment and subsequent handling of risks are provided to the Risk Management Committee. The risk register will be rolled out to cover all areas during 2004/5, building on the work done in the final quarter of 2003/4.

21. Divisional and directorate boards are required to review their objectives and hence the risks associated with those objectives, as part of the development of the assurance framework.

22. The Trust Board papers, including the assurance framework and the SIC, are public documents.

23. The Trust Board’s principal objectives have been shared with commissioners and Thames Valley Health Authority. The assurance framework includes the following elements:

   • principal strategic objectives
   • principal risks
   • accountability for objectives and risks
   • key controls/systems in place
   • identified and potential assurances on effectiveness of these controls
   • positive assurances, gaps in control, and gaps in assurances identified for the Board.
24. Gaps in controls have been identified in clinical, operational, and financial areas and plans are in place to ensure that these are addressed. Both the Governance and Risk Management Committees will be involved in monitoring the implementation of plans.

25. Gaps in assurance have been identified in clinical, operational and financial areas, and steps will be taken with the executive directors, the Audit Committee and other appropriate bodies, to identify sources of assurances.

Review of effectiveness
26. As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

27. The annual audit letter and reports prepared by the Audit Commission (our external auditors), for example on:
- governance
- locum doctors
- financial standing
- acute services benchmarking
- internal financial controls
- standards of financial conduct.

28. Internal Audit reports on, inter alia,
- waiting list key indicators
- controls assurance core and non-core standards
- payroll and human resources
- financial management
- estates departments
- various divisional reviews
- review of prescribing drugs.

29. In addition, counter-fraud work has been effective in highlighting gaps in controls within the ORH, and within NHSP, particularly in relation to the authorisation of staff time sheets.
30. Thames Valley Health Authority has monitored the development of both the SIC and the CHI Action Plan. The most recent review of the CHI Action Plan took place on 13 January 2004.

31. The Governance Committee has considered the outcomes of external reviews, for example:
• NCEPOD “Who Operates When” II, at the December 2003 meeting
• an NHS survey on emergency services and outpatient services, at the March 2004 meeting.

32. The Trust has been implementing a series of actions prepared by PricewaterhouseCoopers following their report on the financial and operational management of the ORH during 2002/3. The progress on the action plan has been reviewed by Internal Audit.

33. The work of the ORH has also been assessed by the Health & Safety Executive, RPST (Level 1 awarded in March 2004), and CNST (Level 1 awarded in June 2004).

34. The Governance Committee and the Audit Committee have reviewed the systems of internal control, and assured me, as Accountable Officer, of their effectiveness. A process to address weaknesses and ensure continuous improvement of the systems is now in place, and will be monitored by the Governance Committee on behalf of the Trust Board.

35. The following have been involved in support of my review of the effectiveness of the system of internal control:
• the Risk Management Committee, supported by its reporting Committees
• the Executive Board in January, February and March 2004
• the Human Resources Committee (in its review of the HR elements of controls assurance and clinical governance)
• the Audit Committee (in its review and scrutiny of the financial standards and processes)
• the Chair of the Governance Committee (in his review of the controls assurance standards and the key areas in clinical governance (including research and information governance) and the assurance framework
• the Trust Board, which received a report on the development of the assurance framework (at its meeting on 26 February 2004)
• the Audit Committee has, in addition, provided me with a scrutiny of the processes used in the development of the assurance framework in place on 31 March 2004
• the Finance and Performance Committee has reviewed financial and operational performance issues throughout the year
• similarly, Internal Audit has already provided me, as Accountable Officer, with comments on the effectiveness of controls and the assurances, in the Head of Internal Audit Opinion for 2003/4.
36. The outcomes of the reviews of the effectiveness of the systems of internal control have been brought together in an action plan to address weaknesses and to ensure continuous improvements. In particular, the roll-out of the risk assessment process and the completion of the risk register will be crucial in the day-to-day management of services, and the engagement of divisional and directorate staff will be vital. All executive directors and divisional directors have identified individuals for work on risk assessment, and the risk register, and necessary training has or is being arranged.

37. The assurance framework was not in place throughout the whole of 2003/4, but was in place on 31 March 2004.

38. Work on the action plan will be overseen by the Chief Nurse, working through the Risk Management Committee and the Executive Board. Regular reports will be provided to the Trust Board through the Governance Committee and the Audit Committee.

39. I have no significant internal control issues to highlight in the Statement of Internal Control.

Trevor Campbell Davis
Chief Executive
1 July 2004
Summary financial statements

These accounts for the year ended 31 March 2003 have been prepared by the Oxford Radcliffe Hospitals NHS Trust under section 98 (2) of the National Health Service Act 1977 (as amended by section 24 (2), schedule 2 of the National Health Service and Community Care Act 1990) 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. A full copy of the Accounts is available, free of charge, on request from the Director of Finance and Procurement.

The Trust is required to include a statement of internal financial controls in its financial statements. The Trust’s statement is given below.

Chris Hurst
Director of Finance and Procurement

Respective responsibilities of Directors and Auditors
The Directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statements with the statutory financial statements. I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion
I conducted my work in accordance with Bulletin 1999/6 ‘The auditor’s statement on the summary financial statements’ issued by the Auditing Practices Board for use in the United Kingdom.

Opinion
In my opinion the summary financial statements are consistent with the statutory financial statements of the NHS Trust for the year ended 31 March 2004 on which I have issued an unqualified opinion.

Maria Grindley
District Auditor
## Income and Expenditure Account

for the year ended 31 March 2004

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>333,578</td>
<td>303,192</td>
</tr>
<tr>
<td>Other operating income</td>
<td>90,363</td>
<td>79,655</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(414,357)</td>
<td>(369,636)</td>
</tr>
<tr>
<td>Operating Surplus</td>
<td>9,584</td>
<td>13,211</td>
</tr>
<tr>
<td>Profit (loss) on disposal of fixed assets</td>
<td>(521)</td>
<td>91</td>
</tr>
<tr>
<td>Surplus before Interest</td>
<td>9,063</td>
<td>13,302</td>
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<tr>
<td>Interest receivable</td>
<td>476</td>
<td>536</td>
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<tr>
<td>Interest payable</td>
<td>(21)</td>
<td>(24)</td>
</tr>
<tr>
<td>Other financing costs - unwinding of discount</td>
<td>(39)</td>
<td>(34)</td>
</tr>
<tr>
<td>Other financing costs - change in discount rate on provisions</td>
<td>(170)</td>
<td>0</td>
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<tr>
<td>Surplus for the Financial Year</td>
<td>9,309</td>
<td>13,780</td>
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<tr>
<td>Public Dividend Capital dividends payable</td>
<td>(9,109)</td>
<td>(13,959)</td>
</tr>
<tr>
<td>Retained Deficit for the Year</td>
<td>200</td>
<td>(179)</td>
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</tbody>
</table>

Capital Cost Absorption Rate

3.6% 6.2%

## Balance Sheet at 31 March 2004

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Assets</td>
<td>328,372</td>
<td>309,835</td>
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<tr>
<td>Current Assets</td>
<td>32,135</td>
<td>31,203</td>
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<tr>
<td>Creditors: Amounts falling due within 1 year</td>
<td>(37,056)</td>
<td>(30,617)</td>
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<tr>
<td>Net Current Assets (Liabilities)</td>
<td>(4,921)</td>
<td>586</td>
</tr>
<tr>
<td>Total Assets less Current Liabilities</td>
<td>323,451</td>
<td>310,421</td>
</tr>
<tr>
<td>Creditors: Amounts falling due after 1 year</td>
<td>(583)</td>
<td>(553)</td>
</tr>
<tr>
<td>Provisions for Liabilities and Charges</td>
<td>(6,817)</td>
<td>(818)</td>
</tr>
<tr>
<td>Total Assets Employed</td>
<td>316,051</td>
<td>309,050</td>
</tr>
</tbody>
</table>

Financed by:
Capital and Reserves

316,051 309,050
NOTE TO THE INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2004

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>200</td>
</tr>
<tr>
<td>Financial support included in retained surplus/(deficit) for the year</td>
<td>25,000</td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year excluding financial support</td>
<td>(24,800)</td>
</tr>
</tbody>
</table>

Notes

The Trust
The Trust achieved a surplus of £200,000 after planned support from the NHS Bank of £25M. This offset the brought forward cumulative deficit from 2002/03 of £167,000 to give a cumulative surplus of £33,000 at 31 March 2004. Plans for 2004/05 encompass an extensive programme of savings, but nevertheless will include further support from the NHS Bank of £10M in order to break-even. The Thames Valley Healthcare System
The health system in Thames Valley reported a small underspend in 2003/04, although not all organisations managed to break even. Three NHS Trusts and no PCTs reported deficits in excess of 1% of turnover/allocation. The system’s underspend in 2003/04 was only achieved by £25M of NHS Bank support (to the Oxford Radcliffe Hospitals NHS Trust), £11M delayed payment of a grant for the transfer of learning disability homes, surpluses of £13M on land sales and over £5m slippage on spending new allocations. The Thames Valley health system has an underlying deficit of about £50M in 2003/04.

Further work is underway to identify additional savings to enable financial balance in 2004/05 and after.
Notes

The Trust
The Trust achieved a surplus of £200,000 after planned support from the NHS Bank of £25M. This offset the brought forward cumulative deficit from 2002/03 of £167,000 to give a cumulative surplus of £33,000 at 31 March 2004. Plans for 2004/05 encompass an extensive programme of savings, but nevertheless will include further support from the NHS Bank of £10M in order to break-even.

The Thames Valley Healthcare System The health system in Thames Valley reported a small underspend in 2003/04, although not all organisations managed to break even. Three NHS Trusts and no PCTs reported deficits in excess of 1% of turnover/allocation.

The system’s underspend in 2003/04 was only achieved by £25M of NHS Bank support (to the Oxford Radcliffe Hospitals NHS Trust), £11M delayed payment of a grant for the transfer of learning disability homes, surpluses of £13M on land sales and over £5m slippage on spending new allocations. The Thames Valley health system has an underlying deficit of about £50M in 2003/04.

Further work is underway to identify additional savings to enable financial balance in 2004/05 and after.

Note
Recognised gains and losses in 2003 were amended to reflect prior year adjustments in respect of an amendment to NHS guidance on the treatment of early retirement costs.

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2004

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net cash inflow/(outflow) from operating activities</td>
<td>30,183</td>
<td>16,926</td>
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<tr>
<td>Net cash inflow/(outflow) from returns on investments and servicing of finance</td>
<td>445</td>
<td>491</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from capital expenditure</td>
<td>(26,291)</td>
<td>13,536</td>
</tr>
<tr>
<td>Dividends paid</td>
<td>(9,109)</td>
<td>(13,959)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) before financing</td>
<td>(4,772)</td>
<td>16,994</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from financing</td>
<td>4,819</td>
<td>(17,721)</td>
</tr>
<tr>
<td>(Decrease) increase in cash</td>
<td>47</td>
<td>(727)</td>
</tr>
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</table>
## Salary and pensions entitlements of Trust senior managers

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Note</th>
<th>Age</th>
<th>Salary 1</th>
<th>Other Remuneration</th>
<th>Golden hellos/ compensation for loss of office</th>
<th>Real increase in pension at age 60</th>
<th>Total accrued pension at age 60</th>
<th>Benefits in kind</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(bands of £5000)</td>
<td>(bands of £5000)</td>
<td>(bands of £2500)</td>
<td>(bands of £5000)</td>
<td></td>
<td>(Rounded to the nearest £100)</td>
</tr>
<tr>
<td>Sir William Stubbs</td>
<td>Chairman (from 21 May 2003)</td>
<td></td>
<td>66</td>
<td>15-20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neil Ashley</td>
<td>Chairman (to 17 April 2003)</td>
<td></td>
<td>67</td>
<td>0-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Beer</td>
<td>Non-Executive Director (to 3 June 2003)</td>
<td></td>
<td>62</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dame Fiona Caldicott</td>
<td>Non-Executive Director</td>
<td></td>
<td>63</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stephen Dexter</td>
<td>Non-Executive Director (to 31 July 2003)</td>
<td></td>
<td>57</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Ken Fleming</td>
<td>Non-Executive Director</td>
<td></td>
<td>58</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caroline Langridge</td>
<td>Non-Executive Director</td>
<td></td>
<td>57</td>
<td>5-10</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Brian Rigby</td>
<td>Non-Executive Director (from 1 January 2004)</td>
<td></td>
<td>59</td>
<td>0-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adrian Towse</td>
<td>Non-Executive Director</td>
<td></td>
<td>47</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trevor Campbell Davies</td>
<td>Chief Executive (from 1 Sept 2003)</td>
<td>(1)</td>
<td>53</td>
<td>85-90</td>
<td>2.5-5.0</td>
<td>0-5.0</td>
<td>2.5 - 5.0</td>
<td>1.15</td>
<td></td>
</tr>
<tr>
<td>Rev Mike Williams</td>
<td>Acting Chief Executive (14 April to 31 Aug 2003)</td>
<td>(2)</td>
<td>45</td>
<td>80-85</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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</tr>
<tr>
<td>Dr James Morris</td>
<td>Medical Director</td>
<td></td>
<td>58</td>
<td>95-100</td>
<td>0-2.5</td>
<td>15-20</td>
<td>15-20</td>
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<tr>
<td>Julie Hartley-Jones</td>
<td>Chief Nurse</td>
<td></td>
<td>43</td>
<td>35-40</td>
<td>0-2.5</td>
<td>20-25</td>
<td>20-25</td>
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<td></td>
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<tr>
<td>Dr Chris Hunt</td>
<td>Director of Finance and Procurement</td>
<td></td>
<td>49</td>
<td>105-110</td>
<td>0-2.5</td>
<td>30-35</td>
<td>30-35</td>
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<tr>
<td>Andrew Stevens</td>
<td>Director of Planning</td>
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<td>43</td>
<td>80-85</td>
<td>0-2.5</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helen Monroe</td>
<td>Director of HR</td>
<td></td>
<td>43</td>
<td>60-65</td>
<td>0-2.5</td>
<td>35-40</td>
<td>35-40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ian Humphries</td>
<td>Director of Estates and Facilities</td>
<td></td>
<td>53</td>
<td>80-85</td>
<td>0-2.5</td>
<td>30-35</td>
<td>30-35</td>
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<td></td>
</tr>
<tr>
<td>Dr John Reynolds</td>
<td>Chair Division A</td>
<td></td>
<td>48</td>
<td>10-15</td>
<td>0-2.5</td>
<td>15-20</td>
<td>15-20</td>
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<td></td>
</tr>
<tr>
<td>Alix Gurney</td>
<td>Director Division A</td>
<td></td>
<td>58</td>
<td>80-85</td>
<td>0-2.5</td>
<td>15-20</td>
<td>15-20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Mike Sinclair</td>
<td>Chair Division B</td>
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<td>51</td>
<td>15-20</td>
<td>0-2.5</td>
<td>25-30</td>
<td>25-30</td>
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<tr>
<td>Fiona Maltas</td>
<td>Chair Division B</td>
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<td>31</td>
<td>60-70</td>
<td>0-2.5</td>
<td>10-15</td>
<td>10-15</td>
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<td></td>
</tr>
<tr>
<td>Dr David Lindell</td>
<td>Chair Division C</td>
<td></td>
<td>53</td>
<td>10-15</td>
<td>0-2.5</td>
<td>35-40</td>
<td>35-40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Philippa Blakely</td>
<td>Direct Division C</td>
<td>(3)</td>
<td>44</td>
<td>40-45</td>
<td>2.5-5.0</td>
<td>15-20</td>
<td>15-20</td>
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<tr>
<td>Neil Ashley</td>
<td>Chairman</td>
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<td>66</td>
<td>20-25</td>
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<tr>
<td>Peter Beer</td>
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<td>61</td>
<td>5-10</td>
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<tr>
<td>Dame Fiona Caldicott</td>
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<td>62</td>
<td>5-10</td>
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<tr>
<td>Dr Ken Fleming</td>
<td>Non-Executive Director</td>
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<tr>
<td>Caroline Langridge</td>
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<tr>
<td>Adrian Towse</td>
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<tr>
<td>Trevor Campbell Davies</td>
<td>Chief Executive (from 1 Sept 2003)</td>
<td>(1)</td>
<td>53</td>
<td>85-90</td>
<td>2.5-5.0</td>
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<td>2.5 - 5.0</td>
<td>1.15</td>
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<tr>
<td>Rev Mike Williams</td>
<td>Acting Chief Operating Officer</td>
<td>(1)</td>
<td>45</td>
<td>80-85</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td>Dr James Morris</td>
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<tr>
<td>Julie Hartley-Jones</td>
<td>Chief Nurse</td>
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<td>43</td>
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<tr>
<td>Dr Chris Hunt</td>
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<td>49</td>
<td>105-110</td>
<td>0-2.5</td>
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<tr>
<td>Andrew Stevens</td>
<td>Director of Planning</td>
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<td>43</td>
<td>80-85</td>
<td>0-2.5</td>
<td>5-10</td>
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<tr>
<td>Helen Monroe</td>
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<td></td>
<td>43</td>
<td>60-65</td>
<td>0-2.5</td>
<td>35-40</td>
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<tr>
<td>Ian Humphries</td>
<td>Director of Estates and Facilities</td>
<td></td>
<td>53</td>
<td>80-85</td>
<td>0-2.5</td>
<td>30-35</td>
<td>30-35</td>
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<tr>
<td>Dr John Reynolds</td>
<td>Chair Division A</td>
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<td>48</td>
<td>10-15</td>
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<td>15-20</td>
<td>15-20</td>
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<tr>
<td>Alix Gurney</td>
<td>Director Division A</td>
<td>(4)</td>
<td>58</td>
<td>80-85</td>
<td>0-2.5</td>
<td>15-20</td>
<td>15-20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Mike Sinclair</td>
<td>Chair Division B</td>
<td></td>
<td>51</td>
<td>15-20</td>
<td>0-2.5</td>
<td>25-30</td>
<td>25-30</td>
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<td></td>
</tr>
<tr>
<td>Fiona Maltas</td>
<td>Chair Division B</td>
<td></td>
<td>31</td>
<td>60-70</td>
<td>0-2.5</td>
<td>10-15</td>
<td>10-15</td>
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<td></td>
</tr>
<tr>
<td>Dr David Lindell</td>
<td>Chair Division C</td>
<td></td>
<td>53</td>
<td>10-15</td>
<td>0-2.5</td>
<td>35-40</td>
<td>35-40</td>
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<td></td>
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<tr>
<td>Philippa Blakely</td>
<td>Direct Division C</td>
<td>(3)</td>
<td>44</td>
<td>40-45</td>
<td>2.5-5.0</td>
<td>15-20</td>
<td>15-20</td>
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<td></td>
</tr>
</tbody>
</table>

Notes:
1. Trevor Campbell Davies joined the Trust on 1 September. Amounts shown relate only to this service.
2. Mike Williams was seconded from the Thames Valley Strategic Health Authority. Amounts shown relate only to his service with the Trust. His pension entitlements are recorded in the accounts of TVSHA.
3. Philippa Blakely is seconded from a New Zealand hospital. She is not a member of the NHS Pension Scheme.
4. The benefits-in-kind for 2002/03 disclosed for the Chief Nurse and former Chief Executive relate to the provision of leased cars.
5. Other remuneration for the former Chief Executive is pay in lieu of notice agreed in 2002/03. Half of this was paid in March 2003 and the remainder was accrued and paid in July 2003. The payment shown under Golden Hellos and Compensation is compensation for loss of office also paid in March 2003.
Using our resources wisely

The last 5 years

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Income £000</th>
<th>Surplus before interest £000</th>
<th>Retained Surplus (deficit) £000</th>
<th>CCA Rate** %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003 - 04</td>
<td>423,941</td>
<td>9,063</td>
<td>200</td>
<td>3.6</td>
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<tr>
<td>2002 - 03</td>
<td>382,847</td>
<td>13,302</td>
<td>(179)</td>
<td>6.2</td>
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<tr>
<td>2001 - 02</td>
<td>332,174</td>
<td>12,419</td>
<td>5</td>
<td>6.1</td>
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<td>2000 - 01</td>
<td>300,442</td>
<td>19,225</td>
<td>6,819</td>
<td>6.3</td>
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<tr>
<td>1999 - 00</td>
<td>284,730</td>
<td>8,129</td>
<td>(2,664)</td>
<td>6.6</td>
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</table>

** Capital Cost Absorption Rate.
The Trust is currently required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to average relevant net assets.

Prior to 2003/04, the cost of capital rate was 6% of relevant net assets. However, funding of NHS commissioners was also changed in 2003/04 to reflect this reduction, in such a way that the ability to meet the target was unaffected.
Better Payment Practice Code - measure of compliance

The NHS Executive requires Trusts to pay their non-NHS trade creditors in accordance with the CBI better payment practice code and Government Accounting rules. The target is to pay non-NHS trade creditors within 30 days of receipt of goods and services or a valid invoice (whichever is the later), unless other payment terms have been agreed with the supplier.

The Trust’s performance against the target is set out below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>£000</th>
<th>Number</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>90,159</td>
<td>106,150</td>
<td>81,284</td>
<td>96,431</td>
</tr>
<tr>
<td>2003</td>
<td>74,345</td>
<td>87,877</td>
<td>58,523</td>
<td>74,965</td>
</tr>
<tr>
<td>2002</td>
<td>82.46%</td>
<td>82.79%</td>
<td>72.00%</td>
<td>77.74%</td>
</tr>
</tbody>
</table>

Management costs

<table>
<thead>
<tr>
<th>Year</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>12,948</td>
<td>12,286</td>
</tr>
<tr>
<td>2003</td>
<td>409,500</td>
<td>375,671</td>
</tr>
<tr>
<td>2002</td>
<td>3.16%</td>
<td>3.27%</td>
</tr>
</tbody>
</table>

Management costs are defined in the document ‘NHS Management Costs 2002/03’, which can be found on the internet at http://www.doh.gov.uk/management costs
Trust Board members

Non-Executives
Sir William Stubbs, Chairman
Dame Fiona Caldicott
Caroline Langridge
Dr Kenneth Fleming
Mr Brian Rigby CBE
Professor Adrian Towse
One vacancy

Executives
Mr Trevor Campbell Davis, Chief Executive from 12 September 2003
Mr Chris Hurst, Director of Finance and Procurement
Ms Julie Hartley-Jones CBE, Chief Nurse
Dr James Morris, Medical Director
Mr Mike Williams, (acting Chief Executive to 31 August 2003 and Chief Operating Officer to November 2004)

The following attend Board meetings:
Professor Linda Challis attends meetings as Deputy Vice Chancellor, Oxford Brookes University
Mr Andrew Stevens, Director of Planning and Information
Mr Ian Humphries, Director of Estates and Facilities
Mrs Helen Munro, Director of Human Resources
Dr John Reynolds, Dr Mike Sinclair and Dr David Lindsell, Divisional Chairs
Mrs Ailsa Granne, Ms Fiona Dalton and Mrs Philippa Blakey, Divisional Directors
Mrs Megan Turmezei, Trust Board Secretary (until June 2004)
Mrs May Macpherson (from June 2004)
Trust Board Committees

The Trust Board reviewed its governance arrangements during the year to ensure that it had the proper structure in place. The Trust Board now has the following committees:

• The Audit Committee ensures that financial matters are reviewed and that proper financial and management controls are in place. The committee acts as a bridge between the auditors (external and internal) and Trust management. The members are as follows: Chairman, Mr Stephen Dexter (to 31 July 2003), Professor Adrian Towse (from August 2003); Non Executive Directors, Adrian Towse and Mr Peter Beer (to 4 June 2003) and Dr Ken Fleming. Dame Fiona Caldicott has also attended meetings.

• The Remuneration and Appointments Committee deals with the appointment of Executive Directors, including the Chief Executive, and their remuneration and also considers general matters relating to staff. The members are as follows: Chairman, Mr Neil Ashley (to 17 April 2003); Sir William Stubbs (from 21 May 2003); Non Executive Directors, Dr Ken Fleming and Ms Caroline Langridge.

• The Finance and Performance Committee keeps under review the performance of the Trust in relation to clinical activity, finance and other key areas. It also has oversight of planning for future performance. Its members include: Chairman, Sir William Stubbs; Professor Adrian Towse. Non Executive Directors attend this meeting together, with the Chief Executive, the Director of Finance and the Director of Planning and Information.

• The Human Resources Committee has been established to oversee the introduction of the Human Resources strategy and related policies and procedures. Its members include: Chairman, Dame Fiona Caldicott; Non Executive Directors (or equivalent) Peter Beer (to 4 June 2003) and Professor Linda Challis.; the Chief nurse, the Medical Director and the Director of Human Resources.

• The Governance Committee now covers both clinical governance and clinical and non clinical risk, areas bringing these two areas together as part of the Board’s developing assurance framework. Its members include: Chairman, Professor Adrian Towse; Non Executive Directors, Dr Ken Fleming and Ms Caroline Langridge. The Chairman also sits on the Risk management Committee, which held its first meeting in January 2004 under the Chairmanship of the Trust’s Executive lead for risk management, Julie Hartley-Jones.

• The Commercial Committee. This new committee provides assurance to the Trust Board on the adequacy and effectiveness of its commercial activities in relation to current and capital expenditure, marketing, income generation and future skill availability. Its members include: Chairman, Mr Brian Rigby CBE, the Director of Estates and Facilities, the Director of Finance and the Director of Planning and Information.