Oxford Radcliffe Hospitals NHS Trust

Annual Report

2005
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Foreword

Sir William Stubbs, Chairman

The Oxford Radcliffe Hospitals has a national, and an international, reputation for the quality of its services, its teaching and research. Some patients travel many miles to be treated by ORH consultants, and the Trust attracts staff from across the world.

However, the Trust has also had to face challenges, particularly in the way it was managed. Four years ago, according to the Government performance ratings, it was a no star trust struggling with a financial deficit which, at its worst, was predicted to be in the region of £40 million. Patients sometimes had to wait for many hours on trolleys in the emergency departments, or had operations repeatedly cancelled at the last minute.

Over the past few years, the Trust Board and staff have worked extremely hard to tackle these challenges, and the hard work has paid off. This year, for the second year running, the hospitals were awarded two stars in the Government’s performance ratings and for the first time passed all eight key targets. We also achieved break-even at the end of the financial year, with some financial support.

Some of the other achievements during the year include being selected once again as one of the UK’s ‘top hospitals’, by independent benchmarking organisation CHKS, and winning the Department of Health annual Building Better Healthcare Award for the design of the new Emergency Department at the John Radcliffe Hospital. Congratulations also to Ailsa Granne, Director of Division A, who was selected as the regional NHS Manager of the Year, for her leadership in tackling waiting times for emergency patients.

Notwithstanding these achievements, we still have some way to go until we reach the highest levels of operational and financial performance. The context we are working in this year is likely to make this particularly difficult. Whilst the Trust has largely put its financial house in order, as I write the wider Oxfordshire health system is facing extreme financial pressures. Our colleagues in primary care trusts in Oxfordshire, who are the major purchasers of our services on behalf of their patients, are financially constrained and as a result have limited resources to spend on patient services at the hospitals. It is in our interest to work co-operatively with them to manage this situation. In particular, we need to work with them to ensure that patient demand does not outstrip the resources available to us. No-one is pretending that this will be easy, and over the coming months there will be difficult debates about how to overcome this.

The achievements of the past year have given us much to celebrate and a stable platform on which to face the future - albeit a demanding one.

Finally, I should like to thank everyone throughout the hospitals for their work over the last year, and my fellow Trust Board members for the time and effort they have given to make the Trust more effective.

Sir William Stubbs
Chairman
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 has more than 1,500 inpatient beds and employs nearly 10,000 people across its four sites. In 2004/2005:

• 514,613 people attended outpatient appointments
• 125,384 people attended the emergency departments
• 84,299 people were admitted as inpatients for emergency assessment and treatment
• 19,640 people were admitted as inpatients for planned surgery, and 63,648 patients were treated for elective day surgery
• 7,896 babies were delivered.

The Trust has four hospitals - the Radcliffe Infirmary, the John Radcliffe Hospital and the Churchill Hospital in Oxford, and the Horton Hospital in Banbury.

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 partner organisations, such as patient groups, primary care trusts, Thames Valley Strategic Health Authority and other NHS organisations, as well as Oxfordshire County Council’s Directorate of Social & Healthcare and Health Overview and Scrutiny Committee. We value these partnerships and are working to strengthen and develop them. An important element of our collaborative working is the joint working on our emergency preparedness and major incident plans.

Clinical and Clinical Support Services

Services are grouped into three Divisions, each with a number of directorates. The directorates include those with services on more than one site, such as general surgery and women’s services, and those based on a single site, such as cardiac services and neurosciences.

Division A

• **Acute and emergency medicine and gerontology** - acute general medicine, Horton medicine, emergency departments in Oxford and Banbury, gerontology
• **Emergency access** - operational managers, emergency admissions, emergency access teams
• **Cardiac services** - cardiology, cardiothoracic surgery, technical cardiology, and cardiac investigative and diagnostic services
• **Renal services** - urology, renal medicine and dialysis, transplantation
• **Specialist medicine** - dermatology services, Oxford Centre for Diabetes, Endocrinology and Metabolism, haemophilia unit, clinical immunology, infectious diseases, respiratory medicine.

Division B

• **Cancer services** - medical and clinical oncology, clinical haematology, pain relief unit and palliative care
• **General surgery, vascular and trauma** - emergency surgery, gastrointestinal medicine and surgery, endocrine surgery, breast surgery, trauma surgery and orthopaedic surgery
• **Critical care, anaesthetics and theatres** - intensive care unit, neuro-intensive care unit and Horton critical care unit. Anaesthetics provide a service not only within the Trust but also to all other Trusts in Oxford
• **Specialist surgery and neurosciences**
  - ENT, cleft lip and palate surgery, plastics and reconstructive surgery, ophthalmology, oral and maxillofacial surgery, neurosurgery, neurology, neuropathology, neuropsychology and neurophysiology

**Division C**

• **Children’s services and clinical genetics** - paediatric medicine, paediatric surgery, specialist children’s services, community paediatrics, neonatal, paediatric intensive care, and clinical genetics

• **Women’s and sexual health** - obstetrics and maternity services, gynaecology and genito-urinary medicine

• **Laboratory medicine and clinical sciences** - cellular pathology, biochemistry, haematology, microbiology, immunology and genetics

• **Radiological sciences** - general radiology, CT, MRI, medical physics & clinical engineering, neuroradiology and nuclear radiology

• **Pharmacy and therapies** - pharmacy, physiotherapy, dietetics, speech and language therapy, and occupational therapy

**Corporate Services**

• Chief Executive’s Department
• Medical Directorate
• Nursing Directorate
• Human Resources
• Finance and Procurement
• Planning and Information
• Estates and Facilities
Strategic objectives

Each year, the Trust sets strategic objectives that inform every aspect of the organisation’s operations and forward planning.

The following objectives were set for 2004/5.

- **Clinical services** - to ensure that clinical services are maintained and developed to meet the needs of patients safely, effectively, efficiently 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, training, teaching, research and development** - to ensure that the Trust is a world-class centre for education, training, teaching, research and development.

- **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 sustainable financial parameters, and meets its statutory financial duties.

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

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

- **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.

In July 2005, the Trust Board agreed revised objectives for 2005/6, to take account of the priorities laid out in ‘Standards for Better Health’ published by the Healthcare Commission. These objectives are available on our website at www.oxfordradcliffe.nhs.uk.
Improving our performance

Every year, the Government measures the performance of the Trust against a number of indicators aimed at helping to improve patient care. This year the Trust has met all its key indicators and has maintained its two star status; the result of much hard work by staff throughout the organisation.

The key indicators are as follows:

Waiting time in the Emergency Departments for hospital admission
Previously, patients requiring admission often had to wait for many hours in our Emergency Departments before a bed could be found for them in hospital. This was bad for patients, and upsetting for staff. Thanks to a huge effort by Trust staff, working with social and health care colleagues, those days are past. This year, no-one had to wait for more than twelve hours for a hospital bed once a decision had been made to admit them, and 88% were admitted within two hours.

Waiting times for planned operations
No-one now waits over nine months for a planned operation. The number of patients waiting over six months has been significantly reduced.

Hospital cleanliness
The Trust takes cleanliness extremely seriously and has worked hard to ensure that high standards are maintained. Every year, the Trust is required to carry out an audit of cleanliness and the environment by a Patient Environment and Action Team. In 2004/5, patient representatives were included in the PEAT audit. All hospital sites passed the audit.

Financial management
In 2004/5, the Trust returned to financial balance, with some external financial support. This year, the rigorous financial recovery continues and one of the aims of the Strategic Review is to ensure long-term financial stability.

The Trust was also judged on 32 subsidiary indicators and achieved top marks for six of them. This included scoring the maximum possible for short waiting times for outpatient appointments and planned operations, and for how quickly patients with heart problems had access to the rapid access chest pain clinic and to revascularisation for blocked arteries.

Chief Executive, Trevor Campbell Davis, said “Four years ago, the Trust was a no star organisation. Last year, we were awarded two. This year, we have shown that not only can we sustain that performance, but improve it in many areas. I want to thank all our staff for their dedication and hard work during the year. At a time of financial recovery for the Trust, their commitment to maintaining and improving our services has been inspirational. I am confident that we will successfully deal with those areas in which we need to improve further.”
The Trust scored less well in four areas:

**The speed at which complaints are dealt with**
The Trust has restructured the patient complaints team, and merged it with the Patient Advice and Liaison Service, to create a new team dedicated to help patients who have concerns about their care. The aim of the Trust is to be able to provide a swift, high quality and appropriate response to all concerns and complaints.

**Deaths following a heart bypass operation**
The Healthcare Commission currently uses Hospital Episode Statistics (HES) data to measure this. These do not take account of how sick patients are before their operation, or the complexity of the procedure. The Trust, in common with other cardiac centres around the country, takes part in the independent audit of cardiac surgery carried out by the Central Cardiac Audit Database (CCAD). The CCAD figures show that the Trust’s clinical performance in cardiac services is comparable to that of other centres. Figures published in the Guardian newspaper for adult cardiac surgery showed the Trust to have results in line with national averages. A report on paediatric cardiac surgery published in February 2005 by Thames Valley Strategic Health Authority concluded that CCAD rather than HES data should be used to judge cardiac mortality figures, and that the Trust’s performance is not statistically different from the national average.

**Monitoring of the ethnic origin of staff and patients**
The Trust is working to improve the ethnic monitoring of both staff and patients.

**Last minute cancellation of operations**
The national average rate for last minute cancellations is 1.3% of all operations. The Trust average is 1.6% of operations. Operations are sometimes cancelled at the last minute because of the need to treat patients who are clinically more urgent. This year, the Trust is implementing a new system designed to minimise cancellations. Many surgical patients are now brought in on the day of their operation rather in advance, with a postoperative bed specially reserved for them which cannot be used for emergency patients.
Improving our performance

### Patient activity

<table>
<thead>
<tr>
<th></th>
<th>2002/03</th>
<th>2003/04</th>
<th>2004/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency activity</td>
<td>71,077</td>
<td>76,707</td>
<td>84,299</td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>18,346</td>
<td>19,015</td>
<td>19,640</td>
</tr>
<tr>
<td>Day cases</td>
<td>59,796</td>
<td>61,567</td>
<td>63,648</td>
</tr>
<tr>
<td>Total FCEs*</td>
<td>149,219</td>
<td>157,289</td>
<td>167,587</td>
</tr>
</tbody>
</table>

**A&E attendances**

- 2002/03: 114,489
- 2003/04: 117,021
- 2004/05: 125,384

**Outpatients**

- 2002/03: 487,589
- 2003/04: 510,320
- 2004/05: 514,613

*FCE = finished consultant episodes

### Outpatient waiting times in clinics

#### A&E four-hour wait

<table>
<thead>
<tr>
<th></th>
<th>A&amp;E attendances</th>
<th>Seen within 4 hours</th>
<th>% seen within 4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr – Jun 2004</td>
<td>31,898</td>
<td>30,773</td>
<td>96.5%</td>
</tr>
<tr>
<td>Jul – Sep 2004</td>
<td>32,036</td>
<td>30,844</td>
<td>96.3%</td>
</tr>
<tr>
<td>Oct – Dec 2004</td>
<td>30,269</td>
<td>29,281</td>
<td>96.7%</td>
</tr>
<tr>
<td>Jan – Mar 2005</td>
<td>30,580</td>
<td>30,047</td>
<td>98.3%</td>
</tr>
</tbody>
</table>

### Cancer two-week wait

<table>
<thead>
<tr>
<th></th>
<th>Referrals</th>
<th>Seen within 2 weeks</th>
<th>% seen within 2 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr – Jun 2004</td>
<td>1,397</td>
<td>1,366</td>
<td>97.78%</td>
</tr>
<tr>
<td>Jul – Sep 2004</td>
<td>1,496</td>
<td>1,491</td>
<td>99.67%</td>
</tr>
<tr>
<td>Oct – Dec 2004</td>
<td>1,581</td>
<td>1,568</td>
<td>99.18%</td>
</tr>
<tr>
<td>Jan – Mar 2005</td>
<td>1,444</td>
<td>1,429</td>
<td>98.96%</td>
</tr>
</tbody>
</table>

### Outpatient DNA (Did Not Attend) rates for first attendances

<table>
<thead>
<tr>
<th></th>
<th>Attendances</th>
<th>DNA</th>
<th>% DNA rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr – Jun 2004</td>
<td>51,024</td>
<td>4,103</td>
<td>7.4%</td>
</tr>
<tr>
<td>Jul – Sep 2004</td>
<td>54,260</td>
<td>4,188</td>
<td>7.2%</td>
</tr>
<tr>
<td>Oct – Dec 2004</td>
<td>54,586</td>
<td>4,211</td>
<td>7.2%</td>
</tr>
<tr>
<td>Jan – Mar 2005</td>
<td>53,850</td>
<td>4,190</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

### Cancellations

<table>
<thead>
<tr>
<th></th>
<th>Last minute cancellations</th>
<th>Number cancelled on the day of surgery for non-clinical reasons</th>
<th>Patients not operated on within 28 days of cancellation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr – Jun 2004</td>
<td>198</td>
<td>123</td>
<td>64</td>
</tr>
<tr>
<td>Jul – Sep 2004</td>
<td>212</td>
<td>110</td>
<td>55</td>
</tr>
<tr>
<td>Oct – Dec 2004</td>
<td>239</td>
<td>184</td>
<td>69</td>
</tr>
<tr>
<td>Jan – Mar 2005</td>
<td>343</td>
<td>152</td>
<td>69</td>
</tr>
<tr>
<td>Total</td>
<td>988</td>
<td>569</td>
<td>257</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.

### Outpatients - numbers exceeding 13 week wait for an appointment

<table>
<thead>
<tr>
<th></th>
<th>target</th>
<th>actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2004</td>
<td>300</td>
<td>153</td>
</tr>
<tr>
<td>September 2004</td>
<td>240</td>
<td>78</td>
</tr>
<tr>
<td>December 2004</td>
<td>171</td>
<td>33</td>
</tr>
<tr>
<td>March 2005</td>
<td>120</td>
<td>0</td>
</tr>
</tbody>
</table>

### Waiting list numbers for planned surgery

<table>
<thead>
<tr>
<th></th>
<th>target</th>
<th>actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2004</td>
<td>7,500</td>
<td>7,325</td>
</tr>
<tr>
<td>September 2004</td>
<td>7,380</td>
<td>6,874</td>
</tr>
<tr>
<td>December 2004</td>
<td>7,295</td>
<td>6,357</td>
</tr>
<tr>
<td>March 2005</td>
<td>7,150</td>
<td>6,410</td>
</tr>
</tbody>
</table>
The Radcliffe Infirmary

The Radcliffe Infirmary, Oxford’s first hospital, has 277 beds and provides specialist healthcare services across the Thames Valley and beyond. These include neurosurgery and neurology, cranio-facial, plastic and reconstructive surgery, ear, nose and throat, ophthalmology, genito-urinary medicine and rehabilitation services for older people.

The services currently offered at the Radcliffe Infirmary will be moving to the John Radcliffe and Churchill Hospital sites during 2007. Oxford University will develop new research centres on the Infirmary site, and consolidate some of their existing research and teaching facilities. Until then, the Trust will continue to invest in equipment and buildings to limit environmental deterioration and allow services to develop while the relocation takes place.

The first proposals to build a hospital for Oxford were made in 1758 at a meeting of the Radcliffe Trustees, who administered the estate of Dr. John Radcliffe (1650-1714), physician to Queen Anne. The sum of £4000 was released for the new hospital, which was constructed on land given by Thomas Rowney, MP for Oxford.

The hospital accommodated 68 patients in four wards, and the first patients were admitted in October 1770. The next year three additional wards (named Mordaunt, Bagot, and Drake after Radcliffe Trustees) opened. The hospital stood on a five-acre site in the open fields of St Giles, which was then well away from the city, and had its own three-acre garden.

The honorary physicians and surgeons gave their services free, maintaining themselves by private practice, although there were junior doctors on the paid staff. The hospital depended on voluntary giving, and larger donations conferred the status of Governor, with the right to elect officers and recommend patients. A patient could only be admitted on a Governor’s ‘turn’, a system which was ended officially in 1884. Some of the Governors continued to claim their right to admit patients until 1920, when 2d a week Contributory Scheme was introduced; within three years this was providing 60% of the hospital’s income.

Outpatients were first admitted in 1835, and the separation of medical and surgical patients in the wards began in 1845. The association with the University had begun whilst the hospital was still under construction. The medical staff were asked to prepare a schedule for the admission to the Infirmary of students in Physic and Surgery, and such students were admitted regularly from 1786. By 1939 there was a complete clinical school based at the Infirmary.
Bequests to the hospital and University by William Morris, later Lord Nuffield, led to the expansion on to the Radcliffe Observatory site in the 1930s. The Nuffield Maternity Home, a nurses' home, a private block, kitchens, a theatre and extensive wards were all built within an eight-year period.

On 27 January 1941, the first dose of penicillin was given intravenously at the Radcliffe Infirmary, and on 1 July that year the first accident service in Great Britain began. Pioneering work continued after the war, and does so to this day.

With the advent of the National Health Service in 1948, the Radcliffe Infirmary surrendered its independent status and became part of the United Oxford Hospitals, the Hospital Management Committee for Oxford. This continued until 1974, when responsibility passed to Oxfordshire Area Health Authority (Teaching) and then, in 1982, to Oxfordshire Health Authority. The Radcliffe Infirmary became an independent NHS Trust in 1993 and part of the Oxford Radcliffe Hospitals NHS Trust in 1999.
The John Radcliffe Hospital

The John Radcliffe Hospital was opened in the 1970s and is Oxfordshire’s main accident and emergency site. It also provides acute medical and surgical services, trauma, intensive care, cardiac services, women’s services and children’s services.

The John Radcliffe Hospital, or ‘JR’, is as much a feature of the Oxford skyline as the ‘dreaming spires’. It is situated in an elevated position in landscaped grounds in Headington, about three miles east of the City centre.

The JR, which has 616 beds, is the largest of the Trust’s hospitals, houses many departments of Oxford University Medical School, and is the base for most medical students who are trained throughout the Trust.

The JR, along with the nearby Churchill Hospital, will see major developments over the next few years, as services are relocated from the Radcliffe Infirmary and cardiac services are extended.

Building for the Future

Oxford Children’s Hospital & the West Wing

The development of the new West Wing and Children’s Hospital in conjunction with Private Finance Initiative partners Carillion plc, has dramatically changed the landscape at the front of the JR site. On the site of the former car park and helipad there are now two buildings - the white West Wing and the distinctive multi-coloured Children’s Hospital. The buildings are joined by an imposing five-storey glass atrium.

These buildings are scheduled for completion in December 2006, and the Trust is undertaking a major commissioning programme to ensure that every aspect and consequence of the move is considered and that any disruption to patient care is minimised.

Children have very different medical and surgical needs from adults, requiring an approach that takes account of the differences in their physical and emotional maturity. The delivery of care for children on a purpose-built site means that the full range of expertise needed by young patients will be readily available in one place.
The new Children’s Hospital, due to open early in 2007, will include:

- paediatric general and specialist surgery
- paediatric X-ray department
- paediatric medicine - including heart disease, chest disease and childhood cancer
- physiotherapy / speech therapy / occupational therapy
- services for disabled children
- paediatric neurology and neurosurgery
- paediatric outpatient department
- 106 inpatient beds
- overnight rooms and accommodation areas for parents
- external and internal play areas.

The new West Wing, which will also open its doors to patients in 2007, will provide modern, high quality and purpose-built accommodation for adult services, including:

- neurosciences (neurology and neurosurgery) specialist surgery (ophthalmology, ENT, plastic surgery)
- critical care facilities for specialist surgery and neurosurgery
- A new day surgery unit
- University of Oxford facilities.

The new Wing will have 142 beds, 14 theatres and a day surgery unit with 19 beds.

Cardiac expansion

Work is also progressing to expand existing cardiac facilities at the JR, following the formal approval of an outline business case by the Trust and Thames Valley Health Authority. In addition to the need to provide ‘state of the art’ services to an increasing, and ageing, local population, a driving force behind the expansion is the need to meet new Government standards and the target of treating all patients within 18 weeks of referral by 2008.

The £25 million cost of the expansion will be funded from capital with the National Heart Team, Thames Valley Health Authority and the University of Oxford.
The Churchill Hospital

The Churchill Hospital is a centre for cancer services and other specialties, including renal services and transplants, clinical and medical oncology, dermatology, haemophilia, infectious diseases, chest medicine, medical genetics and palliative care. It has 330 beds and extensive outpatient and day care facilities. The Hospital, together with the nearby John Radcliffe Hospital, is a major centre for healthcare research, housing departments of Oxford University Medical School and Oxford Brookes University’s School of Healthcare Studies.

The Churchill Hospital was begun in 1940 by the Ministry of Health, with the intention that it should serve as an emergency medical service hospital for local air raid casualties. This proved unnecessary, and on the completion of the buildings in January 1942 it was leased until 1944 to the medical services of the United States Army.

Oxford City Council took over the buildings when the American authorities left, followed by the Committee of the Radcliffe Infirmary, with some financial support from Oxford City and County Councils. Patients began to arrive in January 1946.

On 1 April 1993, the John Radcliffe Hospital and the Churchill Hospital were united as the Churchill John Radcliffe Hospital, and in 1994 the Oxford Radcliffe Hospital NHS Trust was formed; the final step in the merger of the John Radcliffe and Churchill Hospitals.

Developments in recent years include the opening of the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM), which is a collaboration between the University of Oxford, the NHS, and three partner companies, in a world-class centre for clinical research on diabetes, endocrine and metabolic disorders, along with clinical treatment and education.
The Future of Cancer Care

A new cancer centre is planned for the Churchill Hospital and is due to be completed in 2007. The centre, which will cost £120 million, will bring together a wide range of medical, surgical and diagnostic services that are currently based at the Churchill Hospital, the Radcliffe Infirmary and the John Radcliffe Hospital.

Throughout the last year, the Trust has been working with a consortium of companies, led by PFI partner Impregilo SpA, to finalise the design and detailed planning.

The centre will include:

- cancer medicine (clinical and medical oncology, clinical haematology and radiotherapy)
- cancer surgery (head and neck, gastrointestinal, breast, and gynaecological cancer and non-cancer surgery)
- diagnostic services (laboratories, radiology and breast screening)
- a base for University research teams, working in partnership with NHS colleagues.

The centre forms a key part of the Trust’s future strategy, ensuring that the Trust meets the NHS Plan and Cancer Plan requirements, in respect of improvements in patient care and reductions in waiting times.
The Horton Hospital

The Horton Hospital in Banbury, which serves the growing population in the north of Oxfordshire and surrounding areas, has 236 beds and is an acute general hospital providing a wide range of services, including:

- an emergency department (with a clinical decision unit)
- general surgery
- acute general medicine
- trauma & orthopaedics
- obstetrics and gynaecology
- paediatrics
- critical care unit (used flexibly for intensive care)
- coronary care
- cancer resource centre.

The majority of these services have inpatient beds and outpatient clinics, with the outpatient department running clinics with visiting consultants from Oxford, in dermatology, neurology, physical medicine, rheumatology, ophthalmology, radiotherapy, oral surgery and paediatric cardiology.

Acute general medicine also includes a short-stay admissions ward, a medical assessment unit, a day hospital as part of specialised elderly care rehabilitation services, and a cardiology service.

Other clinical services include physiotherapy, occupational therapy, dietetics, radiology and pathology. The radiology service includes a managed mobile MRI and a breast cancer screening unit.

The North Oxfordshire Primary Care Trust Partnership also provides on-site clinical services such as speech and language therapy and podiatry, and directly manages the GP out-of-hours service for the north of the county. Currently, there are also four main operating theatres and a large day case unit.

The Horton Hospital was built with money left by Mary Ann Horton, whose father had amassed a fortune from his invention of an elastic yarn for stockings. When it opened in 1872, the hospital had just twelve beds. In recent years the hospital has been expanded and modernised, and became part of the Oxford Radcliffe Hospitals NHS Trust in April 1998.

The hospital employs 1,200 people, making it one of Banbury’s biggest employers. The local community takes great pride in the hospital and provides exceptional levels of volunteer support through the League of Friends, the Authorised Volunteer Service, Pets as Therapy Volunteers and Horton Hospital Radio.

Integration across the Trust has provided a stimulus for closer clinical partnerships, with Horton clinical staff also providing clinical services in the other Trust hospitals, and supporting satellite outpatient clinics in towns such as Chipping Norton and Brackley.

Recent developments at the Horton include:

- The opening of a medical assessment unit, to facilitate quicker access for patients referred by their GPs.
- Excellent scores in audits of the hospital’s cleanliness and overall environment.
- Refurbishments to the hospital’s public areas, including new flooring, signage and the introduction of art work in many areas.
- The introduction of an enhanced security system in the maternity unit.
One of the hospital’s continuing challenges is the
difficulty caused in maintaining 24 hour children’s
services by a shortage of middle-grade doctors.
This problem is not unique to the Horton and an
Oxfordshire-wide review of children’s services is
currently being undertaken.

The installation of a state-of-the-art, 16 pro-slice
CT Scanner is well underway and is expected to
be operational by November 2005. The existing
scanner was installed in 1995 following a public
fundraising effort led by Mr Jack Friswell, a leading
local fundraiser and supporter of the hospital.
The new scanner will be at the cutting edge of
technology with enhanced image resolution, faster
processes and reduced doses of radiation. Its
enhanced performance means that a new range
of applications will be possible, particularly in
cardiiovascular and paediatric arenas where speed is
especially important.

Building work has begun for a new orthopaedic
treatment centre, scheduled to open in Summer
2006. The centre will include operating theatres and
outpatient facilities, and will deal with all elective
orthopaedic cases for the north of the county and
beyond. It will also house a new MRI scanner, a
much prized clinical development for the Horton
Hospital. The treatment centre will be managed by
Capio UK Ltd, for the North Oxfordshire Primary
Care Trust Partnership, as part of the Government’s
strategy of introducing independent sector
treatment centres across the country.
Valuing our staff

Thanks to its scale, history and status as an important teaching trust, the Trust benefits from 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 and retain these staff and to ensure that the quality of their working lives is enhanced. This is done by helping staff to accomplish their ambitions, develop their skills and achieve a good balance between work and home life. The following are key areas of activity in achieving these goals.

Staff are formally involved in decision-making through the Joint Staff Consultation and Negotiating Committee (JSCNC) which is held bi-monthly. All unions are invited. There is also a Recognition Agreement in place to support the formal process.

Consultant staff are formally involved through the quarterly Local Negotiation Committee, with BMA representation. A consultant representative and the Director of HR jointly chair this meeting.

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. In 2003, the Trust achieved IWL Practice status, and throughout 2004/5 has been working towards achieving Practice Plus, which is the highest standard an NHS organisation can achieve.

The Trust has developed a wide range of initiatives to improve support for staff in areas including, amongst other things, flexible working, advice and support for those with children, and other care responsibilities and a range of shared-ownership finance packages to support key-workers in buying homes.

The NHS-wide Staff Attitude Survey, published by the Healthcare Commission, indicated that, despite a challenging year for the Trust, its commitment to Improving Working Lives resulted in the organisation being placed in the top 20% of acute trusts nationally, for opportunities for flexible working and staff job satisfaction.

The Survey also showed, however, that staff were working very long hours and that a small number of people had experienced work-place bullying or harassment. In response to these findings, the Trust is continuing its active recruitment campaign and has also worked closely with union representatives to introduce harassment support colleagues - a role aimed at offering support and advice to staff that feel they may be bullied or harassed.

The Trust was awarded the IWL Practice Plus standard in August 2005.

Agenda for Change

Agenda for Change is an NHS-wide revision of pay arrangements for all directly employed staff, except very senior managers and those covered by the Doctors’ and Dentists’ Pay Review Body. Agenda for Change was agreed with the NHS unions in November 2004 and implementation began in December 2004 with the aim of all staff being assimilated by late 2005.

The Trust is currently implementing Agenda for Change and the job descriptions of all affected staff are being reviewed against the NHS Job Evaluation Scheme before being assimilated to new pay bands. These replace the old Whitley Council system and harmonise terms and conditions for all affected staff groups.
Knowledge and Skills Framework

Alongside the evaluation and assimilation work being undertaken for Agenda for Change, the Department of Health has also introduced the Knowledge and Skills Framework which defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a single, consistent, comprehensive and explicit framework on which to base review and development for all staff. The Knowledge and Skills Framework lies at the heart of the career and pay progression element of Agenda for Change and applies to all staff groups who come under the Agenda for Change agreement.

National and Local Clinical Excellence Awards

Clinical Excellence Awards are given to hospital consultants to recognise contributions to the NHS by those who perform beyond normal expectations, and who locally, nationally or internationally, demonstrate commitment to patient care and well-being or to improving public health. The Awards are also for those who sustain high standards in technical and clinical aspects of service, whilst providing patient-centred care, and demonstrating a clear commitment to the values and goals of the NHS.

In 2004, a total of nine new national awards, at a range of levels, were given to ORH consultants. Local Clinical Excellence Awards applications have also been increasing over the years, and in 2004/5 a total of 90 applications were received.

Training and development

Over the last year, the Trust has delivered a wide range of training and development programmes, with an increased focus on work-based learning initiatives. These include e-learning, coaching and mentoring and action learning sets in which groups meet to share experiences in order to develop solutions to specific issues. We also continue to run a series of successful programmes through the Stepping Stones initiative, which assists employees with numeracy, literacy, health and safety and other basic skills.

Statutory, mandatory and career development courses are provided for all staff groups and we work in partnership with a number of higher education institutions.

We have launched a leadership programme for newly appointed managers, and run a highly successful strategic leadership programme for senior managers.
Valuing our staff

Senior Managers’ Learning & Communication Forum

Supported by the Chief Executive, this is attended by a wide range of senior managers. One of the highlights this year has been the delivery of a series of innovative workshops on rôle redesign.

IT training

In preparation for Connecting for Health (the National Programme for Information Technology), we are training staff in readiness for the introduction of the Electronic Patient Record.

Modernising Medical Careers

The Trust ran an early pilot for the introduction of new ways of training junior doctors. We will be launching the new Foundation Programme in August this year, with 58 junior doctors. This new way of training junior doctors includes involvement with primary care, palliative medicine, public health medicine and sub-specialties of surgery and medicine.

Recruitment

There are national and local shortages of certain specialist staff, and recruitment continues to be one of the most significant challenges facing the organisation.

We are continuing to develop new ways of attracting and supporting staff. For example, we have been promoting our commitment to flexible working to encourage staff who have left the NHS to have families, or pursue alternative careers, to consider returning. We have also continued to take staff from overseas in addition to actively recruiting across the UK.

Staff numbers

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During the year, we have made progress by reinforcing the recently developed policy for risk management and reviewed our incident reporting policy. Each of the clinical directorates report quarterly on the quality of the service that they provide, and this reporting framework will be further enhanced over the next year to provide the basis of a ‘quality framework’. The recent appointment of an Assistant Director for Quality and Risk demonstrates the Trust’s commitment to the continuous improvement of care to our patients.

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. Also included is a series of Trust-wide audits, such as reviews of infection control issues,

Clinical governance

Continuously improving quality in the care that we provide

The Trust’s systems for clinical governance are designed to ensure that the quality of care we provide is maintained to a high standard and is continuously improving. It is important that clinical governance systems operate alongside other systems to ensure the Trust uses its resources properly and manages risk effectively.

The assurance framework, which was developed over a year ago, brings these systems together and shows the controls we have in place to manage risk. The Trust’s framework has once again been awarded the highest grade by the Trust’s internal auditors and the Strategic Health Authority, and remains an exemplar of good practice.

For 2005/6, we developed our assurance framework based on the ‘Standards for Better Health’, published last year by the Healthcare Commission. An initial assessment carried out in 2004/5 indicated that we were meeting the majority of the core standards and working towards many aspects of the developmental standards.
the quality of patient records, and the use of and infections associated with indwelling intravenous cannulas. We also audit the implementation of new policies and guidelines such as the campaign introduced last year ‘Who are you?’, which was to ensure that we have robust ways of patient identification in all areas of our four hospitals.

All consultants are expected to participate in a regional or national audit, to enable them to compare their work with colleagues in other trusts. These include projects such as an audit to measure our performance against government targets measuring the speed at which we give clot-busting drugs to patients experiencing heart attacks. Other examples include ensuring that we are meeting the National Institute of Clinical Excellence (NICE) guidelines on drugs given to patients following a kidney transplant, and the Royal College of Surgeons’ national prospective tonsillectomy audit. We also contribute data to the National Confidential Enquiries into Patient Outcomes and Death (NCEPOD), and continuously participate in clinical benchmarking audits (CHKS), comparing the ORH to trusts of similar size and complexity across England.

Reducing risks

The Trust has developed a strong system of risk management, which improves each year. Last year, we were reassessed and reaccredited at Level One for the Clinical Negligence Scheme for Trusts (CNST). 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 10% saving in the cost of its insurance premiums.

For the first time in 2004/5, we were also awarded Level One status in 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. A reassessment of these areas of risk management will take place during 2006.

We also launched an improved incident reporting system. 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 enables us to link our system into the National Reporting and Learning System (NRLS), launched by the National Patient Safety Agency. This year, we reviewed the effectiveness of the new system with the support and advice of members of our Patient and Public Involvement Panel. Changes have been made as a result of the review, which will improve the system to enable staff readily to report incidents or near misses so that the Trust can learn and further improve the care that we provide to patients.

We have continued to work hard to improve the management and provision of training. Last year we identified the ‘must-do’ training which all staff have to complete, and provided additional courses in health and safety, manual handling, and fire safety. An audit of compliance with this training will take place next year, including the effectiveness of our updated induction programmes to ensure new staff get a comprehensive introduction to the organisation as soon as they join.

Some practical examples of risk management

As a result of a review of all medication errors in the Trust, we have set up a tripartite approach to safety in the use of medicines. Jointly, the Medical Director, Chief Nurse and Chief Pharmacist meet to ensure that all medication incidents are reviewed and, where areas of concern are identified, a medication safety alert is produced for all clinical staff. In addition, we are running two-monthly safety campaigns, with identified target areas. A newsletter is circulated to inform staff of the campaigns and other activities associated with medicine safety. This work is supported by a senior nurse in medicine safety and a clinical governance pharmacist. In 2004/5, the Chief Pharmacist and senior nurse presented their work at a regional conference on patient safety and at the Trust’s annual healthcare conference. This work will be published as an exemplar of good practice.

Julie Hartley-Jones, CBE, Chief Nurse
Dr James Morris, Medical Director
Infection control

The Trust sees over 100,000 inpatients a year across four sites, with many very sick patients who have already spent time in other hospitals. This makes infection control a complex challenge.

The Trust team of infection control nurses and doctors gives advice on minimising the risks of infection occurring in individual patients, and on preventing the spread of infection between them. The team also provides information leaflets and is available to respond to enquiries from patients, relatives and members of the public.

Improved performance

From April 2004 to March 2005, the Trust reported 94 cases of MRSA, compared with 127 the previous year, despite a rise in the number of patients coming into the hospitals. MRSA rates are also calculated by incidence for each thousand bed days: over the past year, the Trust’s rates have reduced from 0.286 per thousand bed days to 0.212 per thousand bed days. As a result of this improved performance, the Trust has been highlighted by the Health Protection Agency as one of the top ten improvers nationally for the reduction in MRSA rates in its four hospitals over the last year. Chief Nurse, and Director of Infection Prevention and Control, Julie Hartley-Jones said “This is a credit to all our staff, especially our infection control team, who work extremely hard to tackle a wide range of hospital infections. I hope it offers reassurance to our patients and their families.”

IV practice

Intravenous devices (sometimes known as IVs or drips) are routinely inserted as part of patient care for many different reasons, such as administration of blood, fluids or drugs. Occasionally these devices can cause redness, swelling and pain where they pass through the skin, resulting in infection for the patient. Since 2002, there has been a project to improve the care of devices in the Trust and reduce the possibility of infection. This has involved regular auditing to raise awareness, additional training and the implementation of a scoring system that helps staff identify when a device must be removed before any serious complications have developed. The Trust is also changing the type of central lines used to ones that have a special antibiotic coating that is proven to reduce infection. Other practices to combat all infections include the use of side rooms and special ward areas, the use of appropriate protective clothing, and special decontamination procedures when necessary.

Hand hygiene campaign

Another key part of infection control is good hand hygiene, which helps prevent the transfer of infection from one patient to another. The Trust was one of the pioneering centres for the use of alcohol rub gel in 2001. The experience gained at the ORH helped in the formulation of the national ‘cleanyourhands’ campaign.

Public concern

Whilst infection has always been a potential - and sometimes unavoidable - complication of hospital treatment, it is only in the past few years that this has caused widespread public concern. This concern has, at times, turned to hysteria and by mid-2004, the Trust, like other trusts, was experiencing patients cancelling elective surgery for fear of contracting MRSA. So, in February 2005 the Trust undertook a campaign of staff education, stakeholder engagement and other communications activities to convey accurate information about hygiene and infection control. The aim was to dispel preconceptions, provide reassurance and continue to educate staff, who in turn would act as ambassadors for good infection control practice and information.

Staff education

Educational activities have included a presentation to the Trust Board, features in ‘ORH News’ (the Trust’s newsletter), a cleanyourhands stall at the John Radcliffe Hospital for patients who wished to ask questions. The infection control team has continued to work across all four Trust sites to audit hand hygiene compliance.
Stakeholder engagement

In November 2004, the Trust set up a meeting for the Patient and Public Panel focusing on hygiene and infection control, including presentations from the infection control and facilities teams. The session received a number of positive comments from panel members.

A wider public meeting was set up to allow the public the opportunity of getting direct answers from Trust staff. The meeting included presentations from the infection control and facilities teams, and from a local Health Protection Agency representative. It was, at times, a heated discussion, with many people inevitably bringing their individual experiences, including recent bereavements. However, no-one who came to the meeting with a personal issue left without having a one-to-one conversation with an appropriate member of Trust staff.

External media

The Trust has worked closely with local journalists to spread awareness of the facts about infection control, and coverage included items on local television and radio. These including an interview with Julie Hartley-Jones on BBC Oxford’s Anne Diamond Show, and a series of newspaper articles - including the front page of a local paper with the headline ‘DON’T PANIC’ and a double page spread entitled ‘FIGHTING THE MYTHS ON MRSA’.

External recognition

The Trust’s work on infection control has been recognised by a number of external organisations, including the NHS Modernisation Agency, the Strategic Health Authority and the Department of Health. The Trust was involved in the Department of Health’s ‘Saving Lives: a delivery programme to reduce Healthcare Associated Infection including MRSA’. It was also recently praised in a House of Lords debate on Hospital Acquired Infections for its efforts against antibiotic resistant bacteria. “The good news is that we know what is effective,” said crossbench Peer Baroness Murphy. “We know that the position has been reversed in much of the Netherlands and Scandinavia. Some parts of the NHS are making very good progress too - in particular, the Oxford Radcliffe Hospitals NHS Trust, which has a number of really effective schemes in progress.”
Research

Participating in research that will benefit patients at the Trust and elsewhere is essential if we are to deliver the highest quality care and attract the best staff. Consequently, the Trust participates in a very broad range of research across all clinical areas, working in partnership with other Oxford Trusts as well as the University of Oxford and Oxford Brookes University.

The impact of this work is acknowledged nationally and internationally, with researchers based at the Trust publishing over 1,000 peer reviewed academic papers a year. In addition, the Trust has been successful in identifying and exploiting intellectual property arising from research in the form of new medical devices, methods of service delivery or other innovative approaches to care. Most importantly, the research undertaken has a direct impact on the way that services are delivered to patients.

The last year has seen the introduction of new European legislation regarding the way in which clinical trials are conducted. The purpose of this legislation is to protect the interests and welfare of patients who are considering taking part in clinical drug trials. Naturally, the Trust is working with its staff to ensure that we comply with these new regulations and raise further the quality of clinical trial management.

Research areas

The Trust has thirteen main areas in which research is undertaken. These are:

- cancer
- cardiovascular medicine
- children’s health
- DEM (diabetes, endocrinology and metabolism)
- haematological sciences
- infection and immunity
- neurosciences
- perinatal medicine
- renal tract and impairment
- respiratory medicine
- urgent and emergency care
- women’s health
- wound management / tissue repair.

In addition, the Trust collaborates in work concerned with musculoskeletal and rehabilitation medicine (based at the Nuffield Orthopaedic Centre) and mental health (based at the Oxfordshire Mental Healthcare NHS Trust).
The proactive approach taken by Trust staff is key to maintaining such a broad-ranging and high quality research agenda, as it is often they who conceive of new research ideas and develop protocols that attract funding bodies. On top of clinical responsibilities, this represents a significant workload and reflects the dedication of staff.

Each of our research areas is formally assessed by the Department of Health, following the submission of a research and development annual report. The last assessment rated all but one of the research areas as being of the highest standard (in terms of the amount, quality and impact of the research undertaken). This is a significant achievement and builds on similar assessments in preceding years.

Specific research successes

Some notable examples of research being undertaken include:

- Research concerned with the treatment of advanced colorectal cancer has contributed to treatment guidelines issued by the National Institute for Clinical Excellence (NICE). These guidelines have a powerful effect in changing clinical practice across the NHS.
- The Trust is involved in a number of national trials concerned with different types of children’s cancer.
- Research into diabetes continues within ODEM based at the Churchill Hospital. Specific examples within this large programme include understanding the genetic basis of diabetes, dietary advice given to diabetics and preventing foot ulceration due to diabetes.
- High Intensity Focused Ultrasound (HIFU) is a relatively new technology for destroying unwanted cells in a very targeted way (e.g. cancer cells in the kidneys and liver). Oxford researchers are at the forefront in testing the possible applications of HIFU.
- The Oxford Transplant Centre undertakes research that has helped to improve success rates following kidney transplantation. For example, this work has examined the effectiveness of drugs that prevent rejection of transplanted organs by the recipient’s immune system.
- The Trust has worked in collaboration with the National Blood Service to develop barcode technology for labelling and tracking blood samples.
- Pleural infection affects many patients across the NHS, and Oxford researchers led a major national trial examining the best way to treat such patients.
- The Oxford Endometriosis Study is concerned with identifying the genetic factors that result in endometriosis in women. The results of this work are helping to develop drugs for the treatment of this condition.

The Trust’s Research and Development Annual Report is available on the website at www.oxfordradcliffe.nhs.uk/research
Working in partnership

In order for services to become more focused around patient needs, the Trust must listen to feedback and ensure the public perspective is included in planning service developments. This approach is becoming integral to the way Trust staff work, and it is becoming common practice to consult with community groups to listen to people’s experiences and opinions. Increasingly, comments books are available on wards and there are centrally collated comments leaflets. Both staff and the public have said that this process is productive and rewarding.

Another mechanism for engaging public opinion is the ORH Patient and Public Involvement Panel. The Panel is now eighteen months old and is still recruiting members of the public from across Oxfordshire, with the aim of ensuring a representative geographic and demographic spread. There are currently 35 members and each has been invited to become involved in some aspect of Trust activity.

Examples of Panel involvement within the Trust include:

• an organ donation focus group
• a patients’ experience of meals steering group
• consultation on the Trust’s website
• invitations to Strategic Review presentations
• participation in Brookes’ nurse training programme
• a review of the Supportive and Palliative Care Service Directory
• a discharge planning focus group
• ad hoc Trust environment inspections.

The Panel meets three times a year, with an agenda set in response to requests from its members. The agendas for recent meetings have included:

• PFI and relocation
• Environmental healing
• Infection control
• Facilities
• The role of senior ward housekeepers
• The Matron’s Charter.

The Trust also works with the Oxfordshire Patient and Public Involvement Forum. Patient and Public Involvement Forums were set up by the Government to give the public a greater input into the decisions made by NHS Trusts and care patients receive. Forums are made up of local volunteers and are independent of the NHS. They have legal powers to monitor, and work closely, with the NHS to ensure the public receive the best healthcare possible.

Full details of the Forum’s work plan are available from the Oxford and Area Consortium for Patient and Public Involvement in Health (OACPPIH).

For further details, or to join a PPI Forum, please contact OACPPIH, at 5 Bankside, Lodge Road, Hanborough Business Park, Long Hanborough, Oxfordshire OX29 8LJ, or call 01993 886643.

Diversity, race equality and equal opportunities

All public bodies are now bound by a duty to promote diversity, race equality and equal opportunities through positive action, to ensure equality of access in service delivery and opportunity in employment. The Trust Board approved the 2005-2008 Race Equality Scheme in April 2005. The full document is available on the Oxford Radcliffe website and hard copies are available on request. (www.oxfordradcliffe.nhs.uk)
The scheme sets out key activities to affirm the Trust’s commitment to working with all its partners in the healthcare system to eradicate institutional racism and raise awareness to combat health inequalities. It is closely linked with the public involvement strategy, and the Trust will continue to develop opportunities to listen to, involve and consult with people from different ethnic groups.

During this year work has progressed in tackling inequalities in access by improving the interpreting service. Staff have been educated in how to book the service and let the public know that this service is readily available.

The Race Equality Steering Group, set up by the Trust to monitor progress, is required to report to the Trust Board every six months. The key focus for the next twelve months will be to improve ethnicity monitoring, in order to ensure equal access to services and employment opportunities. Another challenge for a trust the size of the Oxford Radcliffe Hospitals is to ensure any policy that could possibly result in discrimination is assessed using a robust framework and adapted as necessary.
Customer care

Patient Advice and Liaison Service

The Patient Advice and Liaison Service (PALS) offers advice and information to patients, relatives and their carers, and assists them in raising any concerns they have regarding their treatment or the way the Trust functions. The PALS team investigates, reports on problems and facilitates improvements to services.

Examples of PALS’ work include:

- working with reception staff to improve the way patients’ appointment details are checked, to ensure patients are waiting in the correct place
- the introduction of a 24-hour, seven days a week system to prevent patients being discharged without sufficient funds to get home
- the provision of improved disabled toilet facilities
- increased liaison with adult wards that care for patients who are over 18 but have a very young mental age
- providing additional support and community liaison for staff working with patients with learning disabilities
- improved practical support for patients who need to sort out their financial affairs, when they are diagnosed with a condition requiring them suddenly to spend a long period as an inpatient.

Patients and staff can contact the service by telephone, letter or email, or can call at the office at the John Radcliffe Hospital. The PALS team has recently integrated with the Complaints team and staff are being introduced at the Horton and Churchill Hospitals.

Complaints

The comments and complaints service received 519 formal complaints in 2004/5, compared with 622 in the previous year. Work to improve the quality of responses to complaints led to an increase of 23% in the number taking more than 30 days to be completed. A review of the service has since been carried out, leading to the merger with PALS and the employment of additional staff.

<table>
<thead>
<tr>
<th>Acknowledging written complaints</th>
<th>04/05</th>
<th>03/04</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 – 2</td>
<td>480</td>
<td>598</td>
<td>Down 4%</td>
</tr>
<tr>
<td>3 - 5</td>
<td>18</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>5 +</td>
<td>21</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>519</td>
<td>622</td>
<td>Down 16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responding to written complaints</th>
<th>04/05</th>
<th>03/04</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 – 20</td>
<td>314</td>
<td>413</td>
<td>Down 6%</td>
</tr>
<tr>
<td>21 – 30</td>
<td>87</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>30 +</td>
<td>118</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>519</td>
<td>622</td>
<td>Down 16%</td>
</tr>
</tbody>
</table>
Trust Board membership

Non-executive Directors

Chairman
Sir William Stubbs

Dame Fiona Caldicott

Caroline Langridge

Dr Ken Fleming

Brian Rigby CBE

Professor Adrian Towse

Colin Reeves CBE From July 2005

Executive Directors

Chief Executive
Trevor Campbell Davis

Director of Finance and Procurement
Chris Hurst

Medical Director
Dr James Morris

Chief Nurse
Julie Hartley-Jones CBE
The following attend all Trust Board meetings:

**Director of Planning and Information**
Andrew Stevens

**Director of Estates and Facilities**
Ian Humphries

**Director of Human Resources**
Helen Munro

**Division A**
Dr John Reynolds
Ailsa Granne

**Division B**
Dr Mike Sinclair
Kathleen Simcock

**Division C**
Dr David Lindsell
Philippa Blakey

Deputy Vice Chancellor, Oxford Brookes University; Professor Linda Challis (until December 2004).

**Committees**

The Trust Board 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.
  
  *Chairman:* Professor Adrian Towse
  *Members:* Dr Ken Fleming, Colin Reeves (Chair from July 2005)

- **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.
  
  *Chairman:* Sir William Stubbs
  *Members:* Trevor Campbell Davis, Chris Hurst, Andrew Stevens, Professor Adrian Towse

- **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.
  
  *Chairman:* Sir William Stubbs
  *Members:* Dr Ken Fleming and Caroline Langridge

- **The Commercial Committee** provides assurance on the adequacy and effectiveness of the Trust’s commercial activities in relation to current and capital expenditure, marketing, income generation and future skill availability.
  
  *Chairman:* Brian Rigby
  *Members:* Ian Humphries, Chris Hurst, Vickie Lamb, Helen Peggs and Andrew Stevens

- **The Human Resources Committee** oversees human resources strategies and related policies.
  
  *Chair:* Dame Fiona Caldicott
  *Members:* Julie Hartley-Jones, Dr James Morris, Helen Munro, Divisional Chairs and Directors

- **The Governance Committee** assures the Trust Board that all the appropriate systems and processes are in place for the proper governance of the Trust. It covers corporate, clinical, information, and research governance. A particular role is the monitoring of the Trust’s Assurance Framework, strategic and principal objectives, the risks to achieving those objectives, the controls and measures in place to manage those risks, and the assurances for the Governance Committee and the Board.
  
  *Chairman:* Professor Adrian Towse
  *Members:* Non-executive Directors, Executive Directors, Divisional Chairs and Directors
Fit for the Future

Trevor Campbell Davis, Chief Executive

Oxford Radcliffe Hospitals is a large and complex organisation, and this review can provide only a snapshot of our services and achievements in the past year.

If there is a single message to be taken from these pages, it is that both the Trust and the NHS are in a period of transition. In the last two years, the Trust has moved from weak financial and operational performance to a stable platform, from which it has fully met its clinical and performance targets.

As the Chairman outlines in his foreword, however, we again face a tough year in Oxfordshire. The NHS in England is moving from a financial system in which hospitals are paid under block contracts for patient services, to one (called Payment by Results) under which we will be paid for each patient we treat, at an agreed national rate. At the same time, patients will be able to choose where they are treated.

In any healthcare system which is financially limited, as in England, this change presents problems for both commissioners and service providers. Ensuring that an area such as Oxfordshire uses services within the limits of available funding is challenging. This year, the cost of services being used by Oxfordshire is about £30 million more than the funded level. The ORH is working closely with GPs and Primary Care Trusts to bring the use of services back to an affordable level.

The changes to the NHS in England are radical. Recognising that the Trust needs a comparable change in culture and organisation, in July 2004 we launched a Strategic Review of our organisation and services. Its purpose is to consider all clinical and support services, their organisation and management, and the environment in which they will operate in the future, in order to identify the changes needed to make the ORH fit for the future. The Review is led by economist Julia Clarke, who comes to the Trust with experience of both the public and private sectors. Julia leads a small in-house team, and is working closely with clinical and managerial staff and with outside organisations involved in social and health care.

The Review Team has just published a summary of emerging themes, which I urge our staff and service users to read. The Review affirms the importance of the ORH’s role as a leading Academic Medical Centre, providing a wide range of clinical services, training and research. It makes clear the need for us to develop as an agile organisation, able to market our services, and flexible enough to change with the needs of our customers. The Review will publish its final report and recommendations early next year.

Although this year is difficult, as the NHS in Oxfordshire adjusts to affordable levels of demand, the ORH can be confident of its achievements and the quality of its services. I have no doubt that it will be fit for the future.

Trevor Campbell Davis
Chief Executive

* Copies of the emerging themes document are available from Megan Turmezei, Secretary to the Strategic Review, by telephoning 01865 220351.
Financial review

The Trust faced considerable financial challenges in 2004/05, but by the end of the year it had outperformed the targets agreed with Thames Valley Strategic Health Authority in June 2004.

A year earlier, we had committed to deliver significant savings in 2004/05, as part of the second year of the Trust’s three year financial recovery plan. However, at the beginning of the year it became apparent that a number of new cost pressures would make it difficult for the Trust to set a break-even budget. These pressures were associated with the implementation of new national quality initiatives, such as the new consultant contract and NICE drug guidelines, and the cost of further reducing the time patients wait to be seen by a specialist or to be treated.

In June 2004, the Trust Board agreed, with Thames Valley Strategic Health Authority’s support, that it should set a £10 million deficit budget to reflect the significant scale of financial pressures and risks it faced moving into the new financial year. With the support and commitment of staff, however, the Trust made new savings of over £17 million during the year and significantly reduced both outpatient and inpatient waiting times (ahead of Government targets). This enabled us to end the year with a small operational surplus of £1.58 million (0.3%). As in previous years, the Trust met all of its principal financial duties.

Summary of financial duties

The Trust’s performance measured against its statutory financial duties can be summarised as follows:

- **Break-even on income and expenditure**
  The Trust reported a year-end surplus of £1.58 million (0.3% of turnover). The Trust received planned non-recurrent income support of £10 million in support of its agreed financial recovery plan.

- **Capital cost absorption rate (CCA rate)**
  In 2004/05 NHS Trusts were set a target rate of 3.5% for capital absorption, with an approved tolerance of up to 0.5%. The Trust met this duty, achieving an actual rate of 3.2% over the year as a whole.

- **External financing limit**
  All NHS trusts are required to stay within this approved cash limit. The Trust was £98,000 within its approved limit.

- **Capital resource limit**
  This control sets a net limit for the total amount of capital investment the Trust can make in any year. The Trust achieved this duty, with actual capital investment of £2.1 million (net of sales of £12.3 million), which was £34,000 inside the limit set by the Thames Valley Strategic Health Authority.

Chris Hurst
Director of Finance and Procurement

Key financial information is included in the Summary Financial Statements elsewhere in this report and, in fuller form, in the Trust’s Annual Accounts. These are available on request from the Media and Communications Office (01865 228932).
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>2004/05</td>
<td>452,102</td>
<td>8,978</td>
<td>1,580</td>
<td>3.2</td>
</tr>
<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>
</tr>
<tr>
<td>2001/02</td>
<td>332,174</td>
<td>12,419</td>
<td>5</td>
<td>6.1</td>
</tr>
<tr>
<td>2000/01</td>
<td>300,442</td>
<td>19,225</td>
<td>6,819</td>
<td>6.3</td>
</tr>
</tbody>
</table>

* Note - Up to 2002/03, the target rate of return was 6%. From 2003/04, this was revised by the Department of Health to 3.5%, with a 0.5% tolerance.
Independent auditors' report to the Directors of Oxford Radcliffe Hospitals NHS Trust on the summary financial statements

I have examined the summary financial statements set out on pages 59 to 62.

This report is made solely to the Board of Oxford Radcliffe Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 54 of the Statement of Responsibilities of Auditors and of Audited Bodies, prepared by the Audit Commission.

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 Trust for the year ended 31 March 2005 on which I have issued an unqualified opinion.

Signature:  

Date: 29 September 2005

Name:  Mick West

Address:  Unit 5 Isis Business Centre, Horspath Road, Oxford OX4 2RD

Note – In 2004/5 the Oxford Radcliffe Hospitals NHS Trust paid the Audit Commission a fee of £273,000 for its audit services.
Summary financial statements

These accounts for the year ended 31 March 2005 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 copy of the full 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 control and this is shown at the end of this document.

### Income and Expenditure Account for the year ended 31 March 2005

<table>
<thead>
<tr>
<th></th>
<th>2004/5</th>
<th>2003/4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>364,962</td>
<td>333,578</td>
</tr>
<tr>
<td>Other operating income</td>
<td>87,140</td>
<td>75,922</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(443,013)</td>
<td>(399,916)</td>
</tr>
<tr>
<td><strong>Operating Surplus</strong></td>
<td><strong>9,089</strong></td>
<td><strong>9,584</strong></td>
</tr>
<tr>
<td>Profit (loss) on disposal of fixed assets</td>
<td>(111)</td>
<td>(521)</td>
</tr>
<tr>
<td><strong>Surplus Before Interest</strong></td>
<td><strong>8,978</strong></td>
<td><strong>9,063</strong></td>
</tr>
<tr>
<td>Interest receivable</td>
<td>1,147</td>
<td>476</td>
</tr>
<tr>
<td>Interest payable</td>
<td>(17)</td>
<td>(21)</td>
</tr>
<tr>
<td>Other financing costs – unwinding of discount</td>
<td>(39)</td>
<td>(39)</td>
</tr>
<tr>
<td>Other financing costs – change in discount rate on provisions</td>
<td>(170)</td>
<td></td>
</tr>
<tr>
<td><strong>Surplus for the Financial Year</strong></td>
<td><strong>10,069</strong></td>
<td><strong>9,309</strong></td>
</tr>
<tr>
<td>Public Dividend Capital dividends payable</td>
<td>(8,489)</td>
<td>(9,109)</td>
</tr>
<tr>
<td><strong>Retained Deficit for the Year</strong></td>
<td><strong>1,580</strong></td>
<td><strong>200</strong></td>
</tr>
<tr>
<td><strong>Capital Cost Absorption Rate</strong></td>
<td><strong>3.2%</strong></td>
<td><strong>3.6%</strong></td>
</tr>
</tbody>
</table>

### Note to the Income and Expenditure Account for the year 31 March 2005

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>1,580</td>
</tr>
<tr>
<td>Financial support included in retained surplus/(deficit) for the year - NHS Bank</td>
<td>10,000</td>
</tr>
<tr>
<td>Financial support included in retained surplus/(deficit) for the year - internally generated</td>
<td>8,700</td>
</tr>
<tr>
<td><strong>Retained surplus/(deficit) for the year excluding financial support</strong></td>
<td><strong>(17,120)</strong></td>
</tr>
</tbody>
</table>

### The Trust

The Trust achieved a surplus of £1,580,000, receiving non-recurrent income of £18.7 million, and its brought forward cumulative surplus of £33,000 at 31 March 2004 increased to £1,613,000 at 31 March 2005. The non-recurrent income is summarised as follows:

Planned support of £10 million from the NHS Bank, provided during year two of the Trust’s three year financial recovery plan, in recognition of the scale of the cost reduction programme planned by the Trust in the year (savings achieved £17.1 million).
Additional planned income support of £7 million from Thames Valley Strategic Health Authority, pending the increase of the Trust’s annual Research and Development income (by £7 million) from 2005/06.

Planned support of £1.7 million from Thames Valley Strategic Health Authority to fund agreed PFI fees in respect of the Radcliffe Infirmary relocation and Churchill Hospital Cancer Centre schemes (combined capital cost in excess of £250 million).

The Thames Valley Healthcare System

The total overspend of all organisations in Thames Valley in 2004/05 was in the region of £6 million, which is approximately 0.3% of the funding they had available to spend. This compares with small overall surpluses in previous years.

In previous years, there had been an underlying deficit of some £50 million, offset by NHS Bank support, land sales and slippage. The underlying position has improved to about £40 million overspend in 2004/05, and would have improved by more if it were not for the financial pressures caused by new NHS employment contracts. The 2004/05 financial position benefited from £10 million of NHS bank support to the Oxford Radcliffe; £4 million of other NHS bank support from national slippage; £10 million brokerage from the Department of Health to cover slippage on planned asset sales; and almost £10 million of local slippage on some large financial allocations used across the whole health economy. That, added to the £6 million reported overspend, gives an underlying financial position (not allowing for smaller-scale slippage in PCTs) of some £40 million overspend. The £40 million underlying overspend was mainly in the Buckinghamshire and Oxfordshire health economies.
## Balance Sheet at 31 March 2005

<table>
<thead>
<tr>
<th></th>
<th>2004/5</th>
<th>2003/4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Fixed Assets</td>
<td>364,216</td>
<td>328,372</td>
</tr>
<tr>
<td>Current Assets</td>
<td>44,281</td>
<td>30,583</td>
</tr>
<tr>
<td>Creditors: Amounts falling due within 1 year</td>
<td>(43,793)</td>
<td>(35,909)</td>
</tr>
<tr>
<td><strong>Net Current Assets (Liabilities)</strong></td>
<td>488</td>
<td>(5,326)</td>
</tr>
<tr>
<td><strong>Total Assets less Current Liabilities</strong></td>
<td>364,704</td>
<td>323,046</td>
</tr>
<tr>
<td>Creditors: Amounts falling due after 1 year</td>
<td>(379)</td>
<td>(178)</td>
</tr>
<tr>
<td>Provisions for Liabilities and Charges</td>
<td>(3,588)</td>
<td>(6,817)</td>
</tr>
<tr>
<td><strong>Total Assets Employed</strong></td>
<td>360,737</td>
<td>316,051</td>
</tr>
</tbody>
</table>

Financed by:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Reserves</td>
<td>360,737</td>
</tr>
</tbody>
</table>

## Statement of total recognised losses and gains for the year ended 31 March 2005

<table>
<thead>
<tr>
<th></th>
<th>2004/5</th>
<th>2003/4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus (deficit) for the financial year before dividend payments</td>
<td>10,069</td>
<td>9,309</td>
</tr>
<tr>
<td>Fixed asset impairment losses</td>
<td>0</td>
<td>(24,467)</td>
</tr>
<tr>
<td>Unrealised surplus/(deficit) on fixed asset revaluations/indexation</td>
<td>47,073</td>
<td>29,198</td>
</tr>
<tr>
<td>Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets</td>
<td>265</td>
<td>1,906</td>
</tr>
<tr>
<td>Reductions in the donated asset and government grant reserve due to the depreciation, impairment and disposal of donated and government grant financed assets</td>
<td>(2,094)</td>
<td>(1,938)</td>
</tr>
<tr>
<td>Additions/ (reductions) in “other reserves”</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total recognised gains and losses for the financial year</strong></td>
<td>55,313</td>
<td>14,008</td>
</tr>
<tr>
<td>Prior period adjustment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total gains and losses recognised in the financial year</strong></td>
<td>55,313</td>
<td>14,008</td>
</tr>
</tbody>
</table>

## Cash Flow Statement for the year ended 31 March 2005

<table>
<thead>
<tr>
<th></th>
<th>2004/5</th>
<th>2003/4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net cash inflow/(outflow) from operating activities</td>
<td>12,551</td>
<td>30,194</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from returns on investments and servicing of finance</td>
<td>1,116</td>
<td>445</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from capital expenditure</td>
<td>(3,678)</td>
<td>(26,291)</td>
</tr>
<tr>
<td>Dividends paid</td>
<td>(8,489)</td>
<td>(9,109)</td>
</tr>
<tr>
<td><strong>Net cash inflow/ (outflow) before financing</strong></td>
<td>1,500</td>
<td>(4,761)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from financing</td>
<td>(1,438)</td>
<td>4,819</td>
</tr>
<tr>
<td><strong>(Decrease) increase in cash</strong></td>
<td>62</td>
<td>58</td>
</tr>
</tbody>
</table>
### Table of Salaries

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2004/5 Salary</th>
<th>Other Remuneration</th>
<th>Benefits in Kind</th>
<th>2003/4 Salary</th>
<th>Other Remuneration</th>
<th>Benefits in Kind</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(bands of £5000)</td>
<td>(bands of £5000)</td>
<td>Rounded to the nearest £100</td>
<td>(bands of £5000)</td>
<td>(bands of £5000)</td>
<td>Rounded to the nearest £100</td>
</tr>
<tr>
<td>Sir William Stubbs Chairman</td>
<td>20-25</td>
<td>15-20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dame Fiona Caldicott Non-executive Director</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Ken Fleming Non-executive Director</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caroline Langridge Non-executive Director</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brian Rigby CBE Non-executive Director</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adrian Towe Non-executive Director</td>
<td>5-10</td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trevor Campbell Davis Chief Executive</td>
<td>165-170</td>
<td>85-90†</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr James Morris Medical Director</td>
<td>35-40</td>
<td>35-40</td>
<td>95-100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Julie Hardy Jones Chief Nurse</td>
<td>90-95</td>
<td>90-95</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chris Hurst Director of Finance &amp; Procurement</td>
<td>105-110</td>
<td>105-110</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Andrew Stevens Director of Planning &amp; Information</td>
<td>80-85</td>
<td>80-85</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helen Munro Director of Human Resources</td>
<td>90-95</td>
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<tr>
<td>Ian Humphries Director of Estates &amp; Facilities</td>
<td>80-85</td>
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<tr>
<td>Michael Fleming Director, Horton Hospital</td>
<td>90-95</td>
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<tr>
<td>Dr John Reynolds Chair, Division A</td>
<td>35-40</td>
<td>100-105</td>
<td>105-110</td>
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<tr>
<td>Ailsa Granne Director, Division A</td>
<td>75-80</td>
<td>65-70</td>
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<tr>
<td>Dr Mike Sinclair Chair, Division B</td>
<td>35-40</td>
<td>15-20</td>
<td>90-95</td>
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<tr>
<td>Fiona Dalton Director, Division B</td>
<td>20-25†</td>
<td>65-70</td>
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</tr>
<tr>
<td>Kathleen Simcock Director, Division B</td>
<td>25-30†</td>
<td></td>
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<tr>
<td>Dr David Lindsell Chair, Division C</td>
<td>40-45</td>
<td>10-15</td>
<td>110-115</td>
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<tr>
<td>Philippa Blakey Director, Division C</td>
<td>60-65</td>
<td>40-45</td>
<td></td>
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</tr>
</tbody>
</table>

Notes:
- † Fiona Dalton (salary £69,181pa) left 31/7/04 replaced by Kathleen Simcock who commenced 8/11/04 (salary £72,000pa)
- † Part slary.

### 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></th>
<th>2004/5</th>
<th>2004/5</th>
<th>2003/4</th>
<th>2003/4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000</td>
<td>Number</td>
<td>£000</td>
</tr>
<tr>
<td>Total bills paid in the year</td>
<td>96,387</td>
<td>115,794</td>
<td>90,159</td>
<td>106,150</td>
</tr>
<tr>
<td>Total bills paid within target</td>
<td>79,080</td>
<td>90,442</td>
<td>74,345</td>
<td>87,877</td>
</tr>
<tr>
<td>Percentage of bills paid</td>
<td>82%</td>
<td>78%</td>
<td>82%</td>
<td>83%</td>
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</tbody>
</table>

### Management costs

<table>
<thead>
<tr>
<th></th>
<th>2004/5</th>
<th>2003/4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Management costs</td>
<td>14,201</td>
<td>12,948</td>
</tr>
<tr>
<td>Income</td>
<td>450,602</td>
<td>409,500</td>
</tr>
<tr>
<td>Percentage</td>
<td>3.15%</td>
<td>3.16%</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
Statement of Internal Control 2004/5

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 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 also work 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, the impact should they be realised, and manage them efficiently, effectively and economically.

4. The system of internal control has been in place in the Oxford Radcliffe Hospitals NHS Trust for the whole year ended 31 March 2005 and up to the date of approval of the annual 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 have been approved and a programme of training for identified risk assessment leads has taken place. In addition, a programme of ‘train the trainers’ has also been started.

6. Policies and procedures (including the risk management strategy and policy) have been reviewed in year and updated versions of the incident reporting and the serious incident reporting procedures have been circulated to all wards and departments. The incident reporting procedure includes an updated incident reporting form. Training (provided by the clinical risk team) continues on the incident reporting and serious incident reporting procedures.

7. The Chief Nurse has delegated responsibility for risk and 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 for 2004/05 but, from April 2005, this responsibility passed to the Chief Nurse thereby bringing all areas of risk together.

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

9. The Governance Committee and the Risk Management Committee have met throughout the year. The minutes of the Governance Committee are presented to the Trust Board in its public meeting. The Chief Nurse has continued regular meetings with key staff involved in risk management.

10. The Risk Management Committee is a Committee of the Executive Board, and its Chair, the Chief Nurse, ensures that the Board is informed appropriately through regular reports from the Committee which are also presented to the Governance Committee.

11. The Assurance Framework (AF) has been in place throughout the year and is regularly monitored and updated. The Governance and Risk Management Committees received regular reports on the AF (including on mapping to division objectives). The Trust Board considered the full framework in January 2005 and agreed it was fit for purpose. The Governance Committee approved the final AF on behalf of the Trust Board in March 2005.

12. The Chief Nurse has reviewed the management arrangements for quality and risk following staff changes during March, April and May. As a result, the post of Assistant Director of Quality and Risk has been established. It is hoped that an appointment will be made in June 2005. The post holder will report to the Chief Nurse and provide leadership and management focus for the ORH’s risk, quality and clinical governance agenda, integrating clinical and non clinical risk (including health and safety) and taking forward risk assessment and the development, population and maintenance of the Risk Register.

The risk and control framework

13. The approach to risk assessment has been agreed by the Trust Board. The procedure and guidance (covering all aspects of risk - clinical, operational, reputational, business, health and safety, environmental) was approved by the Executive Board in February 2005. The aim is to ensure consistency and continuity of approach across the range of services and activities of the Trust.

14. The incident reporting procedure has highlighted risk issues. Reports on incidents, serious untoward incidents, comments, complaints and legal claims are made quarterly to the Divisions and Directorates and the Risk Management and Governance Committees.

15. The Risk Management Committee is responsible for signing off serious untoward incidents and the outcomes are reported to the Governance Committee.

16. The Governance Committee receives regular reports on quality from the Divisions. These are accompanied by statements from the Divisional Chairs and Directors commenting on the issues and risks contained within the reports, and proposed actions being taken to deal with these risks. These reports will continue although their form may change to ensure proper focus on quality and risk.

17. As part of the development of the AF, Divisional and directorate boards are required to review their objectives and hence the risks associated with those objectives. A report was made to the September Governance Committee showing how objectives mapped to the Assurance Framework.

18. The Director of Estates and Facilities commissioned a report on risks within his departments. The document has been considered and action plans are now in place to deal with issues raised.

19. The Trust Board papers, including the AF and the Statement of Internal Control (SIC), are public documents. Governance Committee papers are also available to the public on request.

20. The Trust Board’s principal objectives have been shared with commissioners and Thames Valley Health Authority. The assurance framework includes the following elements:
   • nine principal strategic areas and objectives (clinical services, patient and public partnership, education, training and Research & Development, workforce, Information Management & Technology, Assets, Planning, Finance and Governance);
   • 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.
21. Gaps in controls have been identified in clinical, operational, and financial areas and actions taken to ensure that these are addressed.

22. 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.

23. Monitoring of gaps in both controls and assurances has been carried out through the year and the AF updated accordingly. Steps are being taken to ensure that action plans are prepared for all gaps, whether in controls or in assurance. These action plans are the responsibility of the leads for each area.

24. A specific mapping exercise was undertaken in September to test the compliance against the core and developmental standards recently published by the Healthcare Commission. Work has continued since then on integrating these standards into the AF so that the ORH can be focused about its performance and plans for continuous improvement. The work done to date will lay the foundations for the Annual Health Check coming into place from April 2005.

25. The Chief Nurse meets regularly with the ORH Patient Forum and chairs the Patient Partnership Committee. A special open meeting was held this year on infection control and measures being taken within the ORH to minimise the risks. Another key area of work is the preparation of quality information for patients and relatives on clinical services.

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. As part of the internal audit work, 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. 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:

- The annual audit letter and reports prepared by the Audit Commission (our external auditors), for example on:
  - Agenda for Change
  - Acute hospitals portfolio (including A&E, Ward Staffing)
  - Benchmarking
  - Payment by Results
  - Data quality
- Internal Audit reports on, inter alia,
  - Procurement procedures
  - Research governance
  - Information management
  - Payroll and human resources
  - Financial management and financial services
  - Catering contracts at the JR
  - Estates department and capital
  - Security
  - Commissioning IT system
  - Radiology Systems review

27. In addition, counter-fraud work has covered the updating of the counter fraud policy for the Trust (approved by the Audit Committee in March 2005), increased awareness on deterring and preventing fraud, and training.

28. Thames Valley Health Authority has monitored the Commission for Health Improvement (CHI) Action Plan. The CHI Action Plan was signed off by the TVHA in February and this sign-off reported to the Governance Committee in March 2005.

29. TVHA has also monitored the Assurance Framework and organised a Thames Valley-wide self-assessment in January 2005. The SIC has also been reviewed by TVHA.

30. The Governance Committee has considered the outcomes of external reviews, for example:

- 2004 Patient surveys on outpatients and the emergency departments, published in February 2005 by the Healthcare Commission;
- 2004 Staff Attitude Survey.

31. The work of the ORH has also been assessed by Clinical Negligence Scheme for Trusts (Level 1 awarded in June 2004).

32. 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 systems is now in place, and will be monitored by the Governance Committee on behalf of the Trust Board.

33. 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 (including Health & Safety, clinical risk management, medicines management and blood transfusion);
- the Executive Board in its review on how our objectives map onto the core and developmental standards (October 2004);
- the Human Resources Committee in its review of the HR elements of risk management, assessment and corporate governance;
- the Audit Committee in its review and scrutiny of the financial standards and processes, and a scrutiny of the processes used in the development of the assurance framework in place on 31 March 2005;
- the Governance Committee in its review of the key areas in clinical governance (including quality, research governance and information governance (through its subcommittee the Information Governance Steering Group)) and corporate governance (the assurance framework and risk management and assessment);
- the Trust Board, which endorsed the assurance framework (at its meeting on 27 January 2005);
- 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 2004/5.

34. Good progress has been made on the roll-out of the risk assessment process and the identification of the top ten risks for all areas. A new database has been obtained for the completion of the risk register. All executive directors and divisional directors have identified individual leads for risk assessment and training on the new software is being planned. The action plan for the roll-out of the risk register is being finalised.

35. The assurance framework was in place on 1 April 2004 and remained in place throughout the whole of 2004/5 and up to the date of approval of the annual accounts.

36. 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.

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

Trevor Campbell Davis
Chief Executive
Date 14th July 2005
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Tel 01865 228932

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