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### Reflecting on the past, looking to the future

Trevor Campbell Davis, Chief Executive

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Learning from our patients

by Sir William Stubbs, Chairman

Every successful business or organisation listens to its customers, and develops its products or services accordingly; the NHS is no different.

Within the world of patient choice, it not only makes good commercial sense to ensure that we listen to our customers and take account of their views as we manage our services – it is also our moral responsibility to do so. The NHS is, after all, funded by the public and should, therefore, reflect what the public needs from it. This applies equally to clinical care and all the other aspects of our services which affect the quality of a patient’s experience of treatment – for example, staff attitudes, the environment in which people are treated and the quality of information which they receive before, during and after their hospital visit.

So how do we develop our understanding of what patients and the public think about hospital services, and learn from their views?

Each year, we carry out a patient survey which is conducted on our behalf by the Picker Institute. This gives us general messages on how patients perceive the attitude of our doctors and nurses, the quality of the information they are given, and their treatment within our hospitals. In addition, many of our clinical services carry out their own surveys and audits.

We also have our own patient panel, which acts as a sounding board for a wide range of issues, and whose members sit on a variety of committees and working groups. We work closely with members of the Patient Forum and will work closely with the new Local Involvement Network for Oxfordshire.
Taking account of the views of our patients is not an activity which is separate from our day to day work – and this applies equally to all staff – be they doctor, nurse, porter, cleaner or Chairman.

We all have a duty to listen to what patients say about our services, and a responsibility to respond. To this end, the Trust has been focusing even more closely on developing a customer service strategy and as we move forward in 2008/9 with our application to become a Foundation Trust (FT) we will be planning for the Trust membership scheme and the Members’ Council, both key features of an FT.

In this Annual Review you will find many demonstrations of the quality of the Trust’s clinical work and the tremendous effort that goes into improving all aspects of patients’ experience of treatment. I would like to thank all our staff for their dedication and expertise, and our patients and the wider local community for their ongoing support for the ORH in all our endeavours.

Sir William Stubbs, Chairman
At the ORH in 2007/8

- 564,389 attended outpatient appointments
- 115,603 attended the emergency departments
- 82,322 people were admitted as inpatients for emergency assessment and treatment
- 59,686 people were treated as day cases (81,839 if renal dialysis is included)
- 21,214 people were treated as inpatients
- 8,767 babies were delivered

The ORH is one of the largest acute teaching trusts in the UK, with a national and international reputation for the excellence of its services and its role in teaching and research. The Trust consists of three hospitals, the John Radcliffe and Churchill Hospitals in Oxford and the Horton Hospital in Banbury.

At the end of the financial year, the Trust employed 9,433 people, and had a turnover of £553 million.

The ORH provides general hospital services for people in Oxfordshire and neighbouring counties, and specialist services on a regional and national basis. The main commissioner is Oxfordshire Primary Care Trust (PCT). Other key commissioners are Buckinghamshire, Berkshire Wiltshire, Northamptonshire and Gloucestershire PCTs. The ORH sits within South Central Strategic Health Authority (SHA), which includes the counties of Oxfordshire, Buckinghamshire, Berkshire, Hampshire and the Isle of Wight.

The ORH works in close partnership with the University of Oxford’s Medical Sciences Division and Oxford Brookes University’s School of Health and Social Care, and is a renowned teaching and education base for doctors, nurses and other healthcare professionals.

The ORH works closely with many partner organisations within and beyond the NHS, such as patient groups, Oxfordshire County Council and the Oxfordshire Joint Health Overview and Scrutiny Committee.
Sir William Stubbs, Chairman, Oxford Radcliffe Hospitals, marks the official opening of the new transfer lounge on Level 2 of the JR.

He told staff, patients and guests, “Going home from hospital can be a stressful, as well as a happy time. This new facility will make going home an easier process.”

In the first seven weeks of opening, the new transfer lounge cared for 556 patients, more than double the number who would have transferred through the old discharge lounge. These patients came from wards and departments across the JR.

The new lounge is being used more and more, and the current expected occupancy is between 20 and 30 patients each day. Its location on Level 2 provides easy access for relatives, friends and the ambulance service, and allows patients to wait in a comfortable environment.

Alex Barnes, Assistant Director, Planning said, “Previously, patients waiting to be discharged either stayed on their ward or waited in a small lounge on Level 5. The excellent facilities in the new lounge have proved to be enormously popular with both staff and patients and have significantly improved patient flow. We can now accommodate up to 20 sitting patients and four patients in beds. We have piped oxygen and suction available, and helpful luxuries like TV and reading materials to help pass the time. This will make a big difference to patients leaving us after their treatment.”

Games, books and magazines needed

If you have any games, books or magazines you would like to donate to the transfer lounge, please contact the transfer lounge – via the main switchboard.

News for staff, patients and visitors at the Churchill, Horton and John Radcliffe Hospitals
Foundation Trust status

During the year, the ORH began the process of becoming an NHS Foundation Trust. A Foundation Trust (usually known as an ‘FT’) is a new type of healthcare organisation run on very different lines. FTs are still fully part of the NHS, and continue to treat patients based on need, not ability to pay, but they have more freedom to determine their own future and are more accountable to staff, patients and the public, through a membership scheme and a Members’ Council.

The flexibility and freedoms offered by FT status will help improve the care that we give whilst strengthening the relationship with the local community. As the ORH moves towards FT status, it must meet a number of key challenges, including:

■ Compliance on all core standards
■ Meeting all indicators set by the Department of Health
■ Reducing MRSA rates and other healthcare associated infections
■ Reaching agreement on the future of services at the Horton Hospital.

FTs have more freedom from central government and more control over their finances. Clinical services will have more autonomy to control their own budgets and decide how to improve performance, invest, or reduce costs, at a local level.

FT status will also give us the freedom to enter into new kinds of partnerships; for example, joint ventures with others in the field of research and development. This adds exciting possibilities to the new partnership we are developing with the University of Oxford, and our status as a comprehensive Biomedical Research Centre.

Lord Darzi’s Next Stage Review published in June 2008, spoke of the development of a small number of ‘super league’ Academic Health Sciences Centres, designed to focus on world-class research, teaching and patient care. The ORH intends to be such a centre – an aspiration which will be easier to achieve as an FT, with the greater freedoms this will bring.
Developments

CANCER CENTRE

Work on the new Cancer Centre on the Churchill Hospital site (in conjunction with PFI partner Impreglio SpA) was completed in 2008. This development will include additional medical and surgical beds, a new radiology department, a head and neck cancer surgery centre, linear accelerators for radiotherapy and additional accommodation for chemotherapy patients.

The Centre will, for the first time, bring most cancer services together in a building designed with patients for patients and will enable us to:

■ Develop our cancer services still further
■ Create a truly patient-focused service based on patient needs and experiences
■ Minimise the distress to patients and their families by providing gardens, dayrooms and family facilities
■ Become a main hub for research to give patients access to the latest experimental drugs, earlier in their treatment
■ Be a first-class training centre for students and other healthcare professionals.

THE OXFORD HEART CENTRE

During the year, work progressed on the Oxford Heart Centre. The new facilities for the growing number of cardiac patients who are treated by non-surgical means and will include:

■ Two additional catheter laboratories, for diagnosing heart problems, and for monitoring patients undergoing cardiology treatment
■ A recovery unit, including a paediatric recovery area for child heart patients
■ 50 single en-suite rooms
■ 6 single intensive care and high dependency beds for cardiac patients
■ Family bedrooms and sitting areas
■ A patients’ gym
■ New facilities for staff
■ Facilities for medical teaching and for research into new treatments for heart disease.

The new buildings, due to open in 2009, are being built next to the current cardiac facilities at the John Radcliffe Hospital, adjacent to the emergency department and close to the Children’s Hospital. The £29 million project is supported by the Department of Health (National Heart Team), the SHA and local charities.
OXFORD BIOMEDICAL RESEARCH CENTRE

The Oxford comprehensive Biomedical Research Centre (OxBRC) is a partnership between the research expertise of the ORH and the University of Oxford. The OxBRC was founded in April 2007 with a competitively awarded grant of £57.5m over five years, from the Department of Health’s National Institute for Health Research (NIHR) under the programme “Best Research for Best Health”. This is a Government initiative to make the UK globally pre-eminent in research, healthcare education and training. The OxBRC is tasked to undertake “translational research“, meaning first time studies in patients of innovations, intended to improve healthcare. The fundamental principle of the OxBRC is to connect different scientific disciplines, healthcare professionals and patients to advance medical research and healthcare delivery.

In its first year, the OxBRC has consolidated its overarching strategic commitment to deliver translational biomedical research, underpinned by the exploitation of Oxford’s basic research excellence, multi-disciplinary approaches, well-characterised patient populations and partnerships with industry. Although the life cycle of a translational clinical research project may take between two to three years from the initial idea stage through to planning and approvals, through execution and data analysis, we are starting to see some interesting developments already.

- OxBRC funding has facilitated the completion of a major study of the long-term effects of aspirin on risk of colorectal cancer
- A study of e-monitoring of blood glucose and insulin requirements in type 2 diabetes is underway
- The OxBRC is looking to industry partners for additional funding and resources and a major European biotechnology company have supported the development of improved solutions for the analysis of genetic diseases.

Several key building projects will develop during the next year, including translational laboratories for genetics, immunology, infection and haematology and a metabolic study unit in addition to the clinical research facility in diabetes. These developments will have direct beneficial effects on the quality of healthcare provided for patients in the catchment area of the ORH.

More information on specific research projects is given on page 42.
A new round the clock treatment for suspected heart attacks is being piloted at the JR.

The standard treatment for acute heart attacks has, for many years, relied on patients being given ‘clot-busting’ drugs to reopen blocked arteries. However, increasing evidence now suggests that immediate, direct opening of a blockage using special balloons and metal stents, (also known as primary coronary intervention or PCI) is the preferred treatment.

In collaboration with the South Central Ambulance Service, the ORH Cardiac Department is piloting access, 24/7, to these specialist procedures. If a patient has a suspected heart attack, the ambulance staff will assess them, take an ECG (electrocardiogram) to identify if they are suitable for PCI then fax it through to the Coronary Care Unit for confirmation. The patient will then be transferred to the John Radcliffe where they will receive treatment before being moved to the Coronary Care ward.

It is hoped that this early intervention will not only save lives but reduce the time patients stay in hospital. Early results of the pilot study are positive and if they continue to make an impact on the outcome of heart attack patients, then the service could be offered across the Thames Valley in the future.

Dr Colin Forfar, consultant cardiologist said: “A heart attack can be a terrifying experience for anyone and can be life threatening. Our ability to treat patients day and night is a team effort involving expert recognition by paramedics and immediate mobilisation of a highly skilled team to meet the patient on arrival. With this procedure the blocked artery is opened up again more quickly and patients can often get back on their feet and be discharged after only three or four days. We also expect more patients to survive a heart attack with less damage to their hearts and early results of the pilot are positive.”
Clinical Services

The ORH provides general hospital services to the population of Oxfordshire and neighbouring counties, specialist services to a wider catchment area of about 2.5 million people and some very specialist care on a regional and national basis. In the future, the ORH plans to expand some of these specialist services, and develop new ones. The Trust’s services are best described within the following groupings:

**Defining services** – these are the bedrock of the ORH’s reputation as a Biomedical Research Centre. These services are large, have significant secondary and tertiary activity and address major causes of morbidity and mortality. They reflect national priorities and the research strengths of the University of Oxford and have international reputations. One of the ORH strategic objectives is to consolidate and advance the international status of the Trust’s defining services.

**Specialist services** – these are provided on a regional basis, distinguishing a regional hospital from a local general hospital. The range and quality of these services reflects the status of the ORH as a top-class teaching hospital and its research links to the University of Oxford. One of the Trust’s strategic objectives is to continue to strengthen the Trust’s portfolio of specialist services and to consolidate and extend the catchment area from which patients for specialist services are drawn.

**SPECIALIST MEDICAL SERVICES**
- Chronic pain relief
- Clinical genetics
- Clinical immunology
- Haemoglobinopathy
- Haematology
- Haemophilia
- Nephrology
- Chest medicine
- Endocrinology
- Infectious diseases

**SPECIALIST SURGICAL SERVICES**
- Specialist ear, nose and throat (ENT) surgery
- Specialist maxillo-facial surgery
- Specialist ophthalmology
- Specialist plastic surgery
- Craniofacial surgery
- Specialist trauma surgery
- Specialist urology
- Transplant surgery
- Vascular surgery

**SPECIALIST WOMEN’S SERVICES**
- Assisted reproduction
- Feto-maternal medicine
- High risk obstetrics
- Specialist gynaecological surgery including urogynaecology and laparoscopic surgery for endometriosis

**SPECIALIST CHILDREN’S SERVICES**
- Cardiology
- Neurology
- Cardiac surgery
- Chest medicine
- Endocrinology
- Neurosurgery
- Neuropsychology
- Gastroenterology
- Haematology

**CANCER SERVICES**
- Cancer surgery
- Clinical oncology
- Haematological oncology
- Medical oncology

**CARDIAC SERVICES**
- Cardiology
- Electrophysiology and Percutaneous Coronary Intervention (PCI)
- Cardiothoracic surgery

**GASTROINTESTINAL (GI) SERVICES**
- Gastroenterology (hepatology, inflammatory bowel disease and intestinal failure management)
- Diagnostic & screening endoscopy
- Gastrointestinal surgery (Upper GI, hepatobiliary and colorectal surgery)

**NEUROSCIENCE SERVICES**
- Neurology
- Neurosurgery
- Neuroradiology
- Neurophysiology
- Neuropsychology
- Neuropathology
Oncology
Pathology
Urology
Infectious diseases

CRITICAL CARE SERVICES
Adult Intensive Care Unit
Cardiothoracic Critical Care Unit
Coronary Care Unit
Horton Critical Care Unit
Neonatal and Paediatric Intensive Care Units
Neuro Intensive Care Unit

RADIOLOGY
Interventional radiology

Core services – these are secondary or general hospital services provided mainly to the local catchment population and typical of services provided in neighbouring acute general hospitals. Because of the high calibre of medical and other clinical staff and the back-up of specialist clinical teams and specialist support services, the ORH treats a higher proportion of complex and difficult cases referred on from neighbouring hospitals. One of the ORH’s strategic objectives is to provide high quality efficient and innovative core services that meet the needs of local patients and the challenges of the local health community.

MEDICAL SERVICES
Acute general medicine
Services for older people – geratology
Stroke services
Chronic diseases, including chronic obstructive pulmonary disease (COPD), chest medicine and diabetes, and chronic heart failure
Dermatology

SURGICAL SERVICES
General surgery
Breast surgery
Endocrine surgery
Paediatric surgery
Ear, nose and throat (ENT)
Maxillo-facial surgery
Ophthalmology
Plastic surgery
Urology

WOMEN’S SERVICES
Obstetrics
Maternity and midwifery services
Genito-urinary medicine
Gynaecology

CHILDREN’S SERVICES
Adolescent Unit
Community paediatrics
Hugh Ellis Paediatric Assessment Centre
Paediatric medicine
Paediatric psychology
Paediatric surgery
Special Care Baby Unit

EMERGENCY SERVICES
Emergency department
Paediatrics
Trauma

Emerging services – these are rapidly developing services at the leading-edge of medical practice. As a teaching hospital which aspires to be an Academic Health Sciences Centre, the ORH must maintain a position at the forefront of medical advances. This may require investment without an immediate return, and a higher degree of management focus. One of the ORH’s strategic objectives is to identify, evaluate, prioritise and nurture emerging services.

Genetics
Islet transplantation
Minimal access surgery
Intestinal transplants
Interventional radiology advances
Platform services – these are services that enable and support the diagnosis and treatment of patients across the range of specialties. They are fundamental to the delivery of patient care, the quality of the patient experience as well as the clinical outcome, the efficiency and performance of the Trust and our ability to deliver a good service to referring consultants. A number of these services – imaging, laboratories and pharmacy – provide an essential platform for research. One of the Trust’s strategic objectives is to ensure that the development of platform services parallels and advances the Trust’s strategy for frontline clinical services.

ANAESTHETICS AND THEATRES

RADIOLOGY SCIENCES
Radiology
CT
MRI
Nuclear medicine
Medical physics and clinical engineering

LABORATORY MEDICINE AND CLINICAL SCIENCES
Biochemistry
Cellular pathology
Haematology
Immunology
Microbiology and virology
Laboratory genetics

PHARMACY
Medicines management
Drug information

SPEECH AND LANGUAGE THERAPY

PHYSIOTHERAPY

OCCUPATIONAL THERAPY

DIETETICS
Cath lab – formal opening

A modular cardiac catheter lab was opened on 10 October by Dr Stephen Green, consultant to the vascular programme, from the Department of Health, and Trevor Campbell Davis, chief executive of the ORH NHS Trust.

This is the second modular catheter lab used by the cardiac services team to meet the growing demand for non-surgical cardiac procedures. The lab was lowered into a quadrant, beside the cardiac investigations unit, in sections using a super-size 121 metre crane weighing 500 tonnes.

The lab is leased from Regent’s Park Heart Clinics and is designed to deliver all types of interventional cardiology, electrophysiology and device procedures.

This new facility is providing extra capacity needed during the transition period between the expansion and upgrade of cardiac services which is currently underway on the John Radcliffe site. The building of the new £29m Heart Centre should be completed in early 2009 and will provide:

- Two additional catheter labs for diagnosing heart problems and for monitoring patients undergoing cardiology treatment located together with a new day unit
- A recovery unit, including a paediatric recovery area for children
- 50 single en-suite rooms
- 6 single intensive care and high dependency beds for cardiac patients
- Family bedrooms and sitting areas
- A patients’ gym
- New facilities for staff
- Facilities for medical teaching and research

Children’s takeover day

The children are taking over

On 23 November 2007, the 11 million children and young people in England will be invited to ‘takeover’ our institutions from schools to newspapers and councils. The JR is joining in with the fun and members of the young people’s executive or YiPpEe as it is more widely known, will be coming into the hospital and attending management meetings, deciding on decoration and purchasing and spending some time involved in photography and arts projects. They will also help give out meals in the Children’s Hospital and talk to patients there about hospital food.
Our strategy for the future

The ORH Strategic Review developed in collaboration with staff, the University of Oxford, and other key partners, was completed this year. The Review sets out the vision, values and strategic aims and objectives of the Trust. The five-year Integrated Business Plan, which is being produced as the Trust prepares for FT status, and the corporate business plan for 2008/9, reflect the strategy and set out how it will be implemented.

Trust vision

The Trust’s vision is to be a successful NHS academic health sciences centre, achieving international excellence in patient care, research and education and contributing to the health of current and future populations.

Our priorities for the future

Our strategy is based on work involving patient and public groups, staff, and colleagues in other organisations. As a consequence of our strategic review we have agreed four strategic aims:

- To be the hospitals of choice for patients by providing an outstanding environment for clinical services with customer-focused patient care that will be valued by our partners and the communities we serve.

- To be world-leading teaching hospitals and an Academic Health Sciences Centre (in partnership with the University of Oxford), with an international reputation for advancements in medicine and biomedical research, able to offer specialist expertise and outstanding teaching and treatment facilities.

- To achieve financial sustainability and long-term growth, by intelligent redesign of our hospital services based on improved leadership, productivity and efficiency.

- To be an excellent employer, with flexible and workable policies that will encourage the recruitment and retention of quality staff.
Trust values

In partnership with its patients and staff, the Trust has agreed a set of core values. These values reflect what patients and staff have told us the ORH should stand for. We strive to demonstrate these values in everything we do.

SAFE QUALITY CARE
We will continue to improve our high standards of care and treatment, ensuring that they are safe, leading-edge and informed by evidence.

ACADEMIC EXCELLENCE
We will carry out and support world class research, education and teaching, to benefit patients now and in the future.

A HEALTHY ENVIRONMENT
We will continue to invest in the quality of the built environment, and make sure that it is clean, well-maintained and safe.

INVOLVING OUR PATIENTS
We will involve our patients in their care through good communication and providing information to enable them to take informed decisions and make choices: we aim to meet expectations with humanity, dignity and honesty. We will engage with patients, stakeholders and the public when planning our services.

VALUING AND CARING FOR OUR STAFF
We will help staff to fulfil their potential so that they in turn can care fully for our patients. We will also help our staff to balance their home and their working lives.

WORKING WITH OTHERS
We will work together to build effective teams and develop our partnerships within the local community, for the benefit of all patients and stakeholders.

LISTENING AND LEARNING
We will continue to be a learning organisation, building on the experiences of other health providers, nationally and internationally. We will build on the feedback from our patients, commissioners and the wider community.
Plans for 2008/9

There is an ambitious and wide-ranging agenda for the coming year.

- This year the ORH will open new facilities: the Cancer Centre at the Churchill Hospital site and a new gerontology unit (services for older people) at the John Radcliffe Hospital site. Building work on the new Oxford Heart Centre has started and this is due to open in 2009.

- The ORH is working with Oxfordshire PCT to develop plans for future services at the Horton Hospital which are safe, sustainable and acceptable to stakeholders.

- The ORH is improving services, particularly for stroke and diabetes, in line with national and local strategies and further developing a number of cutting-edge services, notably intestinal and islet transplantation.

To support these planned developments the Trust is looking at ways of improving the services we deliver.

- We are asking clinicians referring patients to the ORH what they think of the Trust’s services so that the Trust can focus on their needs and improve communication.

- The ORH is developing a long-term workforce plan to ensure that sufficient trained staff are in place to enable the delivery of the strategy in future years.

- We are strengthening the partnership with the University of Oxford, building on the Trust’s status as a Biomedical Research Centre, and developing the Trust’s role as an Academic Health Sciences Centre with an international reputation.

- The ORH is developing plans for the future physical resources of the Trust, in particular imaging and radiology services, estates, and IT infrastructure, including financial reporting systems.

- The Trust is developing a set of internal indicators to monitor the clinical quality of services, particularly in regard to the Healthcare Commission Core Standards. It was disappointing that the Trust narrowly missed a rating of “Good” for the quality of services in the latest review, achieving “Fair” in October 2007 and work continues to ensure that the Trust improves on this score while maintaining standards of services and delivering national targets.
The ORH has continued to build on its strong performance this year. Achievements have included maintaining performance on the waiting times for urgent suspect cancer, and the significant accomplishment of reaching the 18 week referral to treatment target by the end of March 2008, some nine months ahead of the Government deadline of December 2008.

This means that since 2003 waiting times from GP referral to treatment have fallen from over 130 weeks in some cases. Even a year ago, maximum waits were 42 weeks. Our cancellation rate for planned operations has also fallen to 0.75%, exceeding our target of 0.8%.

As well as progress on the headline waiting times, in 2007/8 we sought to consolidate the significant efficiency and performance improvements made in the previous year. For example, in reducing length of stay, increasing the number of surgery day cases, and improving efficiency in theatre usage.

Work has been done to improve the patient pathway. This not only helps us achieve and sustain elective targets, but is also one of the most valuable tools we can use to maintain and improve standards of care. Pathway reform can reduce delays and waste, enhance the quality of care, improve clinical outcomes and patient safety, and increase patient satisfaction. For example, we have increased day case rates for keyhole gall bladder surgery at the Churchill Hospital from 25% to 73% in three months, as well as reducing non-attendance figures and reduced the number of people not attending.

The ORH has also performed well against its quality targets, notably exceeding the national target on the monitoring of patients’ ethnic groups for the first time. In infection control, the ORH achieved a reduction of MRSA cases from 101 in 2006/7 to 50 in 2007/8, exceeding the 50% reduction required by the PCT. We narrowly missed the PCT target of 432 cases of C.difficile in patients over 65 by eight cases.
Healthcare Commission
Annual Health Check

The first part of the Healthcare Commission Annual Health Check (which looks at a broad range of quality indicators, including patient amenities and the care environment, patient privacy and dignity, safety systems and policies), includes our performance against core standards. Our self-assessment shows that we were able to declare compliance with 41 of the 43 core standards for the full period of the financial year 2007/8. Because of improvements made within the year, as of 31 March 2008 we became compliant with all 43 standards.

The two standards on which we were not able to give sufficient assurance for the whole year with the standards related to mandatory staff training and patient privacy. Although there is good provision of staff training, the frequency and monitoring of attendance and follow-up needed further work before we could provide full assurance. Training material has also been updated, with e-learning modules being developed for the Trust website and intranet.

Excellent progress has been made throughout the year on environmental and operational improvements in the areas of patient privacy and confidentiality, allowing us to declare compliance by the end of March 2008. This was actively supported by clinical and operational teams across the Trust. Progress was subject to internal and external audit as well as spot-checks by the Healthcare Commission during the year. The 2007 Patient Survey also showed improvements in this area.

Further improvements will be provided with the opening of the new geratology unit in August 2008 which has all single-sex accommodation. The Trust’s new Cancer Centre and the new Oxford Heart Centre, due to open in 2009, both include a much higher proportion of single rooms and have been designed with help from patient groups.

Further details and the declaration of compliance can be found on the Trust’s website, at www.oxfordradcliffe.nhs.uk
JR ICU in the top 2.5%

The Intensive Care Unit (ICU) at the John Radcliffe is in the top 2.5% in the country, according to a comparative audit which measures performance across England.

The audit looked at how sick patients are when they arrive in the ICU, and how many of them survive. According to the report, at the JR we have sicker patients coming in, but a lower death rate, with 30% fewer deaths than the average ICU. This makes us one of the top teaching hospital ICUs in the country.

Commenting on these impressive results, Dr Duncan Young, consultant anaesthetist said, “This is the first time we have taken part in this audit and, although we knew we were good, we didn’t realise just how good we were. The results are far better than I would ever have predicted, and a credit to the whole team involved.”

By June 2008, a second ICU will be opening in the Churchill Hospital, increasing the number of beds available even more – from 14 to 16 plus two high dependency beds.
### Overall volume of activity

<table>
<thead>
<tr>
<th></th>
<th>2003/4</th>
<th>2004/5</th>
<th>2005/6</th>
<th>2006/7</th>
<th>2007/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency activity</td>
<td>76,707</td>
<td>84,227</td>
<td>91,482</td>
<td>90,432</td>
<td>82,537</td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>22,010</td>
<td>22,811</td>
<td>23,180</td>
<td>20,666</td>
<td>21,390</td>
</tr>
<tr>
<td>Day cases</td>
<td>59,460</td>
<td>61,437</td>
<td>77,673</td>
<td>76,251</td>
<td>81,839</td>
</tr>
<tr>
<td>Total finished consultant episodes</td>
<td>158,177</td>
<td>168,475</td>
<td>192,335</td>
<td>187,349</td>
<td>185,766</td>
</tr>
<tr>
<td>Emergency department attendance</td>
<td>116,791</td>
<td>125,482</td>
<td>123,852</td>
<td>123,914</td>
<td>115,603</td>
</tr>
<tr>
<td>Outpatients</td>
<td>510,320</td>
<td>514,613</td>
<td>525,710</td>
<td>520,835</td>
<td>564,389</td>
</tr>
</tbody>
</table>

### Waiting times in the emergency departments

The ORH achieved 97.2% in the 4-hour target for emergency access. This is below the national target of 98% and changes have been implemented to ensure full achievement of the target.

The ORH had no breaches of the 12-hour target for patients waiting for admission (once the decision to admit has been made) from either the John Radcliffe or the Horton Hospital emergency departments.

#### EMERGENCY DEPARTMENT FOUR-HOUR TARGET

<table>
<thead>
<tr>
<th></th>
<th>Total attendance</th>
<th>Number seen within 4 hours</th>
<th>% seen within 4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>29,601</td>
<td>28,826</td>
<td>97.38%</td>
</tr>
<tr>
<td>Q2</td>
<td>29,064</td>
<td>28,653</td>
<td>98.59%</td>
</tr>
<tr>
<td>Q3</td>
<td>28,788</td>
<td>27,586</td>
<td>95.82%</td>
</tr>
<tr>
<td>Q4</td>
<td>28,150</td>
<td>26,731</td>
<td>94.96%</td>
</tr>
</tbody>
</table>

#### DELAYED TRANSFERS OF CARE (SNAPSHOT AT END OF QUARTER)

Reducing the number of delayed transfers of care remains an issue because of challenges in the wider Oxfordshire health system. Patients need to be treated in the right place at the right time, and we will continue to work with our partners in primary care and Oxfordshire County Council to try to improve care for people in the community.

In 2008 the implementation of Electronic Immediate Discharge Documentation will enable relevant discharge documentation to be sent directly to GPs’ computers, streamlining the discharge process.

<table>
<thead>
<tr>
<th></th>
<th>Numbers 2005/6</th>
<th>Numbers 2006/7</th>
<th>Numbers 2007/8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>70</td>
<td>47</td>
<td>49</td>
</tr>
<tr>
<td>Q2</td>
<td>90</td>
<td>43</td>
<td>61</td>
</tr>
<tr>
<td>Q3</td>
<td>62</td>
<td>51</td>
<td>63</td>
</tr>
<tr>
<td>Q4</td>
<td>114</td>
<td>57</td>
<td>31</td>
</tr>
</tbody>
</table>
Cancer waiting times

The ORH is monitored against a number of existing national targets that affect the speed of diagnosis and treatment for cancer. The Trust has met all the government targets this year related to cancer waiting times. Over 8,042 patients were referred urgently by their GPs with suspected cancer and seen within 2 weeks. More than 2,800 patients received their first treatment for cancer during the year.

This achievement is based on well established multi-disciplinary team working on all tumour sites. Patient pathways continue to be reviewed and improved.

For example, the appointment of an additional consultant thoracic surgeon has meant that Oxfordshire patients can now have surgery in Oxford. Additional nurse specialist support in skin, lung and urological cancer was put into place to improve patients’ care and support.

Since October 2007 the Trust has participated as a national pilot site with the Cancer Services Collaborative Inpatient Improvement Programme. The aim of this pilot is to improve chemotherapy through better scheduling and a new approach to emergency admission and discharge processes for oncology and haematology patients.

### CANCER WAITING TIMES

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2-WEEK TARGET</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of patients</td>
<td>1,906</td>
<td>2,020</td>
<td>2,205</td>
<td>1,906</td>
</tr>
<tr>
<td>No. seen within target</td>
<td>1,906</td>
<td>2,020</td>
<td>2,205</td>
<td>1,906</td>
</tr>
<tr>
<td>%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>31-DAY TARGET</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of patients</td>
<td>722</td>
<td>727</td>
<td>715</td>
<td>740</td>
</tr>
<tr>
<td>No. seen within target</td>
<td>720</td>
<td>726</td>
<td>711</td>
<td>734</td>
</tr>
<tr>
<td>%</td>
<td>99.7%</td>
<td>99.9%</td>
<td>99.4%</td>
<td>99.2%</td>
</tr>
<tr>
<td><strong>62-DAY TARGET</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of patients</td>
<td>280.5</td>
<td>313.5</td>
<td>325</td>
<td>312.5</td>
</tr>
<tr>
<td>No. seen within target</td>
<td>278.5</td>
<td>305.5</td>
<td>316</td>
<td>305.5</td>
</tr>
<tr>
<td>%</td>
<td>99.3%</td>
<td>97.4%</td>
<td>97.2%</td>
<td>97.8%</td>
</tr>
</tbody>
</table>
Local TV, radio and newspapers have been spreading the word about the new £109 million Cancer & Haematology Centre, currently being built on the Churchill Hospital site.

Reports in local newspapers and TV news helped launch a £2 million fundraising campaign that will ensure the Centre is equipped with the latest state-of-the-art technology and equipment, benefiting cancer patients from Oxfordshire and beyond.

Past patients and supporters joined Neil Ashley, Chairman of the Campaign, hospital clinicians and those involved in the project for a tour of the new building, which is still under construction.

Oxford is already the fourth largest cancer service in the country, serving a population of 2.5 million for its more specialist services. These new facilities are due to open next year and will further enhance Oxford’s national and international reputation as a centre of excellence and research for cancer. There will be 217 patient beds, ten theatres and an intensive care unit dedicated to cancer patients.

Currently, cancer patients are treated in outdated and aged facilities across several sites. The Centre will bring together all these services in a purpose built environment, specifically designed around, and with, cancer and haematology patients. The building is also environmentally friendly, and has very low energy use – the design intentionally feels less like an NHS hospital with light open spaces and the use of natural materials, all of which help patients feel relaxed and therefore quicken recovery time.

Neil Ashley said, “I am delighted to see this enhancement of patient care, as well as research and training, continue in the new Cancer and Haematology Centre. The £2m will ensure the most high-tech equipment available for treatment, research and training can be provided – equipment and facilities that go beyond what the NHS can normally afford.”

The Centre is being developed in partnership with the consortium OCHRE Solutions Limited, through the Government’s Private Finance Initiative. Whilst all essential medical equipment will be provided by the NHS, the fundraising campaign will allow for equipment that goes beyond what the NHS can provide. An example of this technology is the Computerised Integrated Theatre (CIT). The CIT system will enable surgeons to carry out more advanced keyhole surgery as well as providing great educational benefits. Tele-conferencing enables high definition images, even those from inside the patient’s body, to be relayed live to trainee surgeons and medical students whether they are near or far.
18-week referral to treatment performance

<table>
<thead>
<tr>
<th>Admitted</th>
<th>% seen within 18 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>53.90%</td>
</tr>
<tr>
<td>Q2</td>
<td>61.50%</td>
</tr>
<tr>
<td>Q3</td>
<td>72.70%</td>
</tr>
<tr>
<td>Q4</td>
<td>91.80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-admitted</th>
<th>% seen within 18 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>81.30%</td>
</tr>
<tr>
<td>Q2</td>
<td>90.40%</td>
</tr>
<tr>
<td>Q3</td>
<td>90.70%</td>
</tr>
<tr>
<td>Q4</td>
<td>95.80%</td>
</tr>
</tbody>
</table>

Admitted – patients requiring admission to hospital
Non-admitted – patients not requiring admission to hospital

The 18-week target means that no patient should wait more than 18 weeks from GP referral to treatment in a consultant-led service. (There is a ‘tolerance’ built into the system that allows for some exceptions because of clinical reasons or patient choice, hence the thresholds for achievement are 90% for patients requiring admission to hospital and 95% for patients not requiring admission.) The ORH achieved this target some nine months ahead of the December 2008 government deadline. It means the maximum waits for each part of the pathway are now

- Outpatients – 4 weeks
- Diagnostics – 6 weeks
- Inpatient – 8 weeks

This target represents the coming together of the various waiting time targets for the different elements of hospital services. For the first time, in a similar way to our approach to cancer waiting times, the 18-week target will cover the whole patient pathway.

From a patient’s point of view, 18 weeks is a fairer and more inclusive target, and from the Trust’s point of view it is a more complete target that should enable us to measure and manage effectively all the timings of the care that we deliver. It is about the right care, at the right time, of the right quality, without unnecessary delay. As much as being about speed, it is about quality, equality, efficiency and customer service, and it should be a product of, and driver for, the improvements that we make in patient care.

Inpatient waiting times and numbers

As well as the achievement of the 18-week target, the Trust had no breaches of the three month waiting time target for cardiac revascularisation processes such as coronary artery bypass grafts and percutaneous transluminal angioplasty.

REvascularisation PROCedures

<table>
<thead>
<tr>
<th>Coronary artery bypass grafting</th>
<th>Percutaneous transluminal coronary angioplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 11</td>
<td>11</td>
</tr>
<tr>
<td>Q2 12</td>
<td>9</td>
</tr>
<tr>
<td>Q3 11</td>
<td>7</td>
</tr>
<tr>
<td>Q4 5</td>
<td>6</td>
</tr>
</tbody>
</table>

INPATIENT WAITING LIST

<table>
<thead>
<tr>
<th>All specialties (max wait in weeks)</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 19</td>
<td>6,500</td>
</tr>
<tr>
<td>Q2 19</td>
<td>5,947</td>
</tr>
<tr>
<td>Q3 19</td>
<td>5,856</td>
</tr>
<tr>
<td>Q4 8</td>
<td>4,087</td>
</tr>
</tbody>
</table>
Outpatient waiting times and numbers

Although the 18-week referral to treatment target will eventually replace nationally set individual component times, the Trust continues to work to component waits set by the SHA and PCT.


Diagnostic waits

By year end, diagnostic waits including MRI and CT scans were 6 weeks, down from 13 weeks last year.

Cancellations

We know that the cancellation of an operation is very disruptive for patients and their families. Last year, the ORH exceeded its target by reducing the number of last minute cancellations of planned surgery by nearly 300. We also increased the number of patients who were seen within 28 days of their cancelled operation.

<table>
<thead>
<tr>
<th>Last minute cancellations</th>
<th>Patients not operated on within 28 days of cancellation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>183</td>
</tr>
<tr>
<td>Q2</td>
<td>101</td>
</tr>
<tr>
<td>Q3</td>
<td>192</td>
</tr>
<tr>
<td>Q4</td>
<td>133</td>
</tr>
</tbody>
</table>

Non-attendance at first appointments in the outpatient department

Non-attendance at first appointment remains an important issue for patients and the Trust. In keeping with the 18-week guidance, the onus is now on patients rather than the Trust to rearrange missed appointments. Our outpatient non-attendance rate has fallen from 7.7% in 2006/7 to 7.2% in 2007/8.

In the last year we have continued to improve our outpatient correspondence and communications to try and help patients keep appointments. We are piloting the use of text message reminders for outpatient and inpatient appointments.

<table>
<thead>
<tr>
<th>Attendances</th>
<th>DNA (Did not attend)</th>
<th>Total</th>
<th>DNA rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>136,332</td>
<td>10,203</td>
<td>6.96%</td>
</tr>
<tr>
<td>Q2</td>
<td>137,126</td>
<td>10,596</td>
<td>7.17%</td>
</tr>
<tr>
<td>Q3</td>
<td>141,466</td>
<td>10,932</td>
<td>7.17%</td>
</tr>
<tr>
<td>Q4</td>
<td>149,465</td>
<td>11,587</td>
<td>7.19%</td>
</tr>
</tbody>
</table>

Outpatient waiting list

<table>
<thead>
<tr>
<th>All specialties (max wait in weeks)</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>11</td>
</tr>
<tr>
<td>Q2</td>
<td>11</td>
</tr>
<tr>
<td>Q3</td>
<td>11</td>
</tr>
<tr>
<td>Q4</td>
<td>4</td>
</tr>
</tbody>
</table>
Hospital environment

Patient Environment Action Team (PEAT) inspections were carried out across the Trust sites in March 2008. These inspections involve assessments of hospital cleanliness, food and food service, infection control, privacy and dignity, and environmental standards, along with other related matters. The assessments were undertaken by a team on each of the sites. Panel members from the Oxford Radcliffe Hospitals Patient and Public Panel attended each one, accompanied by members of the estates and facilities, nursing, and infection control teams.

The outcomes of the inspections were all scored and ranked, with the results forwarded to the National Patient Safety Agency. The ORH returned scores of 3 (acceptable) for the Churchill Hospital, 4 (good) for the Horton Hospital and 4 (good) for the John Radcliffe Hospital.

Stories that made the news

Ultrasound in Witney

Patients in West Oxfordshire can now have their ultrasound scans at Witney Community Hospital, instead of travelling to the JR. The Oxford Radcliffe Hospitals NHS Trust has invested £50,000 in the purchase of an ultrasound machine, which can be accessed by patients through their GP. About 2,500 patients who currently travel from West Oxfordshire to receive ultrasound diagnostics at the Oxford hospitals will benefit.

Linda Soderberg, Radiology Sciences Directorate Manager said, “We have worked closely with Oxfordshire Primary Care Trust and GPs in West Oxfordshire to provide the new radiology services in Witney and feel sure patients will benefit hugely from the convenience of having this resource in their locality.”

News for staff, patients and visitors at the Churchill, Horton and John Radcliffe Hospitals
Improving environmental performance

A key priority for the ORH has always been to reduce its impact on the environment through strict energy saving targets and ensuring any new buildings are as eco-friendly as possible.

This commitment to reducing energy use was proved last year when the Trust exceeded its own energy saving target of 7%. This year, a further target of 3% was set and achieved across all three sites. In real terms, this has meant an 8% reduction in electricity usage, 14% decrease in gas usage, 5% reduction in oil usage and a water saving of 22%. The fuel price rises over the winter, which affected households as well as businesses had an impact on the Trust’s energy costs. Taking this into account, the ORH still managed to reduce its overall spend to £6m.

The ORH has been recognised for its efforts in reducing carbon emissions. From 2005 to 2007, our annual fossil fuel emissions reduced from 14,871 tonnes CO₂ to 12,135 tonnes CO₂ – a saving of 18.4% and the Trust was awarded Low Carbon Client of the Year in February 2008 by the Chartered Institution of Building Service Engineers (CIBSE). This much coveted award was given for the brand new Cancer Centre at the Churchill Hospital. The Centre is designed to be the most energy efficient hospital in the UK and uses a geothermal system to heat and cool down the building. This works by using heat exchangers in the ground, coupled with heat pump technology so that the ground can be used as a source of heat during the winter and a sink for heat in the summer months.

The aim of energy and water conservation is to eliminate waste, not to lower standards. As part of its environmental strategy, the ORH is committed to responsible energy and water services management.
Our hospitals

The John Radcliffe Hospital

The John Radcliffe Hospital was opened in the 1970s and is Oxfordshire's largest acute hospital. It provides acute medical and surgical services, trauma, intensive care, cardiac services, women's services and children's services, laboratory, radiology and clinical support services. It is also the location of the county's main accident and emergency department. The hospital has 919 beds and is the largest of the Trust's hospitals. It houses many departments of the University of Oxford Medical School, and is the base for most medical students who are trained throughout the ORH.

The development of the new West Wing and Children's Hospital, in conjunction with Private Finance Initiative partners Carillion plc, has changed the landscape at the front of the John Radcliffe Hospital.

The Children's Hospital opened in 2007 at the John Radcliffe Hospital and houses almost all the Trust's paediatric services and includes 106 inpatient beds. It includes a spacious outpatients department next to the children's radiology department and paediatric assessment centre. Children are treated here for a range of conditions including heart disease, chest disease, childhood cancer, neurological disorders and those requiring general or specialist surgery. Parents can stay overnight, either next to their child's bed or in a dedicated accommodation suite.

The West Wing also opened in 2007 on the John Radcliffe site and provides accommodation for neurosciences, specialist surgery, critical care and a new day surgery unit. It also houses the Oxford Eye Hospital which relocated from the Radcliffe Infirmary. The West Wing has 142 beds, 14 theatres and a 19 bed day surgery unit, the new day surgery unit, and additional facilities for the University of Oxford.

A new geratology unit opened at the John Radcliffe Hospital in August 2008. It has 40 en-suite single rooms and some are large enough for a relative to stay overnight. There is also a therapy garden with an assessment area so that patients can practice walking on different surfaces and climbing steps.

Work has already started on the Oxford Heart Centre, which will provide an expansion of the existing cardiac facilities. The new building, due to open in 2009, is funded by the Department of Health (National Heart Team), University of Oxford Charitable Funding (Cardiovascular Research) and the ORH.

John Radcliffe Hospital
Headley Way,
Headington, Oxford OX3 9DU
Tel 01865 741166
Stories that made the news

**Bigger, better special care nursery facilities**

More babies can be looked after in the newly improved and expanded Special Care Nursery at the John Radcliffe hospital.

The NHS has invested nearly £1 million in refurbishing the unit, which cares for premature and sick full-term babies who are not quite ready to go home.

The Neonatal Unit is the lead centre for the Thames Valley Perinatal Network, covering Oxfordshire, Berkshire and Buckinghamshire, and provides specialist medical, surgical and cardiology care.

Professor Andrew Wilkinson, Clinical Director of the Neonatal Unit, said: “We are always busy, so it’s wonderful to have this improved and expanded facility. Over the last few years, medical advances have meant that more and more babies are surviving. We already see about 700 admissions every year, and we are now better placed to deal with the increased numbers. This really is an excellent facility for Oxfordshire and the surrounding regions.”

There are a range of facilities for parents including a breast milk expressing room, a sitting room, a quiet room and a flat for overnight stays before discharge. It is also home to one of only 16 human milk banks in the UK.

Members of SSNAP (Support for the Sick Newborn and their Parents), a locally based charity which helps to support parents, and fundraises to provide equipment for the Neonatal Unit, have also welcomed the new facilities.

Cessa Moore, SSNAP Chairman, said: “This is a wonderful facility. The babies in the special care nursery have usually moved over here from intensive care, so it’s a place where parents know that they are preparing to go home. There is now more room for parents in the nursery, which is great as we encourage them to spend time here and participate in their child’s care.”

“\’We have been here 129 days, and not a day has gone by that we do not think about how special the people who work here are. We have felt informed and involved in bringing up our child, despite the inevitable remoteness. We are delighted.\’ Kate Johnston-Biggs”

Kieron Salter and Kate Johnston-Biggs with their baby, Oscar Salter, on the day he went home for the first time.
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 224 beds and extensive outpatient and day care facilities. Several major University of Oxford research facilities are also located on the site.

A new Cancer Centre, costing over £120 million, brings together a wide range of medical, surgical and diagnostic services that were previously spread across the hospital site.

Other new developments on the Churchill Hospital site in recent years have included 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 into diabetes, endocrine and metabolic disorders, along with clinical treatment and education.

In February 2008 it became one of six centres across the UK to benefit from £10 million in government funding towards pioneering treatment for diabetes. The money will be used to offer transplants of insulin-producing cells to adults suffering from Type 1 diabetes.

Plans are also being developed for a new organ transplantation centre and a research institute on the site, to house the many programmes already running in this important area.
Official opening for new endoscopy facilities at the Horton General Hospital

Trevor Campbell Davis, Chief Executive, officially opened the new endoscopy facilities at the Horton General Hospital in February. More space and new equipment has enabled the endoscopy department to increase capacity and help reduce waiting times for endoscopy procedures across the Trust.

Dr Jonathan Marshall, Consultant Physician, Clinical Director Endoscopy at the Horton Hospital said, “We have spent about £400,000 on new equipment which has improved diagnostics here in Banbury. We were delighted that Trevor was able to come and spend some time with us and I know he was really impressed with the new facilities.”

Email advice for GPs

It’s three years since the Department of Endocrinology and Diabetes at the Churchill Hospital introduced a system whereby GPs could ask questions via email. The number of enquiries started as a small trickle but now it’s a steady stream and has been woven into the training commitment for endocrine/diabetes specialist registrars.

Kate Allen, Specialist Registrar, said, “Our centre was one of the first to offer an email enquiry service so that we could deal with clinical enquiries from primary care more efficiently. Compared to telephone interactions, the email service allows the registrar more chance to think through queries without distraction or interruption. There is also greater opportunity to seek advice from senior colleagues when needed and therefore provide more cogent responses.”

Since the service started, enquiries have tripled and about 530 emails were received in 2007. Neil Walker, Specialist Registrar said, “We can’t say at the moment whether or not the email service ultimately reduces referrals to our clinics but we are looking at ways of measuring this in the future. We feel focusing our resources on the most appropriate referrals is the best way forward for everyone concerned and the email service can help do that.”
The Horton Hospital

The Horton Hospital has 236 beds and provides a range of services for people in north Oxfordshire, south Northamptonshire and parts of Warwickshire. Services include an emergency department, acute general medicine and surgery, trauma, obstetrics and gynaecology, paediatrics, coronary care, and a cancer research centre.

A number of services run clinics with visiting consultants from Oxford, so that patients do not have to travel too far for their care. These include dermatology, neurology, rheumatology, ophthalmology, oncology, 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 rehabilitation services, and a cardiology service. Currently, there are four main operating theatres and a large developing day case unit.

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. Oxfordshire PCT 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.

In the last year £400,000 has been invested in the hospital’s day surgery unit providing state-of-the-art endoscopy facilities which will help clinicians treat patients suffering from bowel cancer and stomach ulcers more swiftly.

Elective orthopaedic patients at the Horton Hospital are treated at a new Independent Sector Treatment Centre on the Horton Hospital site. The service works collaboratively with the John Radcliffe Hospital’s trauma service, and the Nuffield Orthopaedic Centre (NOC).

The ORH is working with Oxfordshire PCT to develop plans for the future of paediatric services, obstetrics, gynaecology and the special care baby unit at the Horton Hospital. In a report, published in March 2008, the Independent Reconfiguration Panel (which was asked by the Secretary of State to look into proposals put forward by the ORH to change the way in which these services would be delivered in the future) recognised that services at the Horton Hospital must change but asked for a new set of proposals to be put forward. The PCT has already started a new round of stakeholder engagement, which is expected to take two years. Services at the Horton Hospital will not be changed during this time. The aim is to ensure a range of services which are safe, sustainable and acceptable to stakeholders.

The Horton Hospital
Oxford Road, Banbury, Oxon OX16 9AL
Tel 01295 275500
Our people

The Trust employs more than 9,000 people, making it one of the largest employers in the county. Staff include some of the UK’s leading clinicians in a number of fields.

Workforce information

The table below shows a snapshot of the workforce as at 31 March 2008.

<table>
<thead>
<tr>
<th>TOTAL</th>
<th>FEMALE</th>
<th>MALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heads</td>
<td>Whole time equivalent</td>
<td>Full time</td>
</tr>
<tr>
<td>Admin and clerical staff including ward clerks, receptionists, medical secretaries, staff in finance and IT and non-clinical managers</td>
<td>1,988</td>
<td>1,546.35</td>
</tr>
<tr>
<td>Healthcare assistants including staff working in support roles on wards, porters and other domestic staff</td>
<td>936</td>
<td>636.22</td>
</tr>
<tr>
<td>Healthcare scientists including staff working in laboratory medicine, cardiology and medical physics</td>
<td>695</td>
<td>583.58</td>
</tr>
<tr>
<td>Medical staff</td>
<td>1,419</td>
<td>1,162.25</td>
</tr>
<tr>
<td>Nursing staff includes all registered nurses and midwives</td>
<td>3,336</td>
<td>2,644.60</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff including radiographers, occupational therapists, physiotherapists, pharmacists, optometry staff and staff in technical support roles</td>
<td>885</td>
<td>687.48</td>
</tr>
<tr>
<td>Externally funded staff staff working within the Trust whose costs are paid for by external organisations</td>
<td>174</td>
<td>104.15</td>
</tr>
<tr>
<td>Total</td>
<td>9,433</td>
<td>7,364.62</td>
</tr>
</tbody>
</table>

Almost half (47%) of the female staff work part-time compared with approximately a fifth (20%) of male employees.
**Sickness absence**

The management of sickness absence is given a high priority within the Trust supported by regular reporting of sickness absence levels to managers. At the end of March 2008, the sickness absence rate was 3.13%, lower than the target rate of 3.25%. The table below indicates the absence rates which fluctuate over the year.

<table>
<thead>
<tr>
<th>Month</th>
<th>%sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>2.86</td>
</tr>
<tr>
<td>May</td>
<td>2.91</td>
</tr>
<tr>
<td>June</td>
<td>2.96</td>
</tr>
<tr>
<td>July</td>
<td>2.89</td>
</tr>
<tr>
<td>Aug</td>
<td>2.88</td>
</tr>
<tr>
<td>Sept</td>
<td>2.90</td>
</tr>
<tr>
<td>Oct</td>
<td>2.94</td>
</tr>
<tr>
<td>Nov</td>
<td>3.00</td>
</tr>
<tr>
<td>Dec</td>
<td>3.06</td>
</tr>
<tr>
<td>Jan</td>
<td>3.08</td>
</tr>
<tr>
<td>Feb</td>
<td>3.15</td>
</tr>
<tr>
<td>Mar</td>
<td>3.13</td>
</tr>
</tbody>
</table>

**Staff turnover**

Staff turnover rates in the ORH are low compared with other similar trusts and in 2007/8 the staff turnover rate of 12.08% was significantly lower than the previous year when it was 13.56%.

<table>
<thead>
<tr>
<th>Month</th>
<th>%turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>13.80</td>
</tr>
<tr>
<td>May</td>
<td>13.89</td>
</tr>
<tr>
<td>June</td>
<td>13.62</td>
</tr>
<tr>
<td>July</td>
<td>13.38</td>
</tr>
<tr>
<td>Aug</td>
<td>12.86</td>
</tr>
<tr>
<td>Sep</td>
<td>12.17</td>
</tr>
<tr>
<td>Oct</td>
<td>11.77</td>
</tr>
<tr>
<td>Nov</td>
<td>11.76</td>
</tr>
<tr>
<td>Dec</td>
<td>11.86</td>
</tr>
<tr>
<td>Jan</td>
<td>11.68</td>
</tr>
<tr>
<td>Feb</td>
<td>12.09</td>
</tr>
<tr>
<td>Mar</td>
<td>12.08</td>
</tr>
</tbody>
</table>
Electronic Staff Record

The Electronic Staff Record (ESR) is the new, integrated HR and payroll system for all NHS organisations. It enables once-only data input, and the information moves with the employee as they transfer from one NHS organisation to another.

Since December 2007, the ORH has operated the integrated ESR Recruitment Module which links staffing data direct to NHS Jobs, (www.jobs.nhs.uk), our recruitment website. E-recruitment allows all vacancies created within ESR to be managed online and it has significantly improved the time taken from advertisement to appointment.

Improving Working Lives

The Trust continues to implement the Improving Working Lives principles successfully throughout the organisation. A wide range of flexible working options are enjoyed across the ORH and the 2007 staff survey again showed the Trust comparing favourably with acute trusts in England in the percentage of its staff being offered flexible working options. Promotion of salary sacrifice and childcare vouchers continues and support and advice is regularly provided by the childcare co-ordinator who supports all three sites.

For the fourth year running, staff report being among the most satisfied workers in the NHS. According to the annual national survey of NHS staff, published by the Healthcare Commission, the ORH is among the top 20% of Trusts for having staff who say they are satisfied with their jobs, and work within a good team environment.

In the survey, the ORH has a higher than average percentage of staff who say they have supportive managers, good access to training and development and to flexible working opportunities. Staff also report working less overtime than in previous years. The survey shows that ORH staff are among the least stressed within the NHS, and that the number intending to leave the Trust is lower than last year and well below the national average.

In addition, compared with other Trusts, more respondents reported that communication between senior management and staff is effective, and fewer respondents reported suffering harassment, bullying or abuse from patients or the public.
The George Pickering Education Centre

The George Pickering Education Centre has expanded its facilities and it is envisaged that a much needed expansion to the Terence Mortimer Postgraduate Centre at the Horton Hospital will follow shortly to reflect the growing emphasis placed on training and education in the Foundation Programme and Specialty Training.

Occupational health

The ORH has an active and supportive occupational health department.

Proactive assessment, timely advice and therapy is provided for musculoskeletal problems through a funded occupational physiotherapy service. This is complementary to the preventive work undertaken by the manual handling and back care team. Greater priority is to be given to the prevention of manual handling injury through the department’s updated strategy.

Stories that made the news

Congratulations to Mike Murphy and team for receiving 1st prize in the Information Age Effective IT Awards 2007

The Information Age Effective IT AwardsTM celebrate IT strategies that demonstrate how technology provides indisputable business value. Projects are judged by senior IT executives all of whom have vast experience in corporate IT. They are entirely independent.

Our entry for the project, ‘Wireless Blood Tracking’, made the final shortlist of three in the category of The Most Effective Use of Communications Technologies. There were well over 300 high quality entries in this year’s Awards and we are delighted to announce that our entry won!

After the Effective IT 2007 Awards, members of each award-winning team will attend the unique Effective IT Leadership Day, which will take place in September 2007.
Learning and development

A new corporate study leave policy was launched in March 2008 which provides managers with clear guidelines on how to identify the training and development requirements of their staff.

Mandatory staff training was an area highlighted as needing improvement in the Healthcare Commission Annual Health Check. Changes to the induction programme have resulted in more new starters completing their statutory and mandatory training within the first three months of employment. A Training Manager has been appointed to raise awareness and improve the take up of statutory and mandatory training. Completed statutory and mandatory e-learning courses for the first three months of 2007/8 has increased by 400% over the same period in the previous year.

Funding was secured from the South East of England Development Agency in March 2007 to introduce a Virtual Learning Environment (VLE). This will enable staff to access statutory, mandatory and core skills courses via the internet using e-learning, workbooks, quizzes and podcasts.

Consultant appraisals are gradually increasing each year and further training programmes are planned to support this. Consultants have been encouraged to register with the on-line NHS appraisal toolkit which helps them to identify their training and development needs whilst allowing them to use their time efficiently. To date 30% have registered as appraisers or appraisees.

The Trust signed up to the health sector widening participation pledge in March 2008, along with another eight organisations. The pledge states that the ORH is

- committed to support our employees to gain the skills and qualifications that will support their future employability
- actively encourages and supports employees to acquire basic literacy and numeracy skills and work towards their first level two qualification
- demonstrably raising employees’ skills and competencies to improve organisation performance.
Health care libraries

Health care libraries (HCL) at the ORH provide physical library services and outreach services for all staff. The library service is open to all staff working at the ORH and is based on two sites: the Cairns Library in the JR, which is open 24/7 and the new Knowledge Centre near the Churchill Hospital, which opened in January 2008 and provides a base for HCL outreach services as well as excellent modern library facilities.

In the last year HCL services have been awarded the highest level of accreditation for health libraries, stage three accreditation of the national Helicon scheme. Helicon assessors particularly commended the proactive approach taken by library staff to support NHS requirements for workplace knowledge access and widened access to learning. Other aspects of the service, including the high quality of the physical libraries and IT provision, were also praised.

Volunteer services

There are 253 active volunteers working on the three hospital sites working in areas such as help desks, wards, chaplaincy, library trolleys, fundraising and clerical support. Last year, 96 new volunteers were recruited.

In the last year, 217 students aged between 15 and 18 years old attended work experience placements with the ORH. A new quarterly volunteer newsletter called vIP (Volunteer Information Paper) is a valuable communications tool for all volunteers.

To celebrate Volunteers Week 2007, in early June, strawberry teas were enjoyed by volunteers at the Horton Hospital and at the Churchill Hospital for those volunteers on the Oxford hospital sites.

The department continues to develop links with the community and other voluntary organisations by attending volunteering events arranged in the community and by Oxford City Council.

We hope all volunteers will become staff members of the ORH when it becomes an FT.
Equality and diversity

Staff

The Trust has a legal responsibility to promote equality of opportunity and good race relations between people of different racial groups. It also has a legal responsibility to ensure elimination of unlawful racial discrimination. Our race equality scheme seeks to address this responsibility and ensure that these principles are embedded in the Trust's policies and procedures. This policy applies to all activity taking place within the ORH and to all our staff, patients and visitors.

The ORH values its staff and is committed to providing an environment that is equally welcoming to people of all races, nationalities, cultures and religions. The ORH also values the input of international workers and is committed to ensuring that they are supported in forging a successful career within the Trust.

The policies and practices of the organisation reflect a commitment to ensuring staff are recruited, trained, and supported without any prejudice. The ORH now routinely monitors its workforce by ethnicity, gender and disability and also its recruitment applicants by ethnicity, gender, disability, sexual orientation and religion.

As a part of the ongoing implementation of the Trust's equality obligations, the ORH is working to ensure all staff have diversity awareness training.

The current staff ethnicity profile:

![Pie chart showing workforce by ethnic group]

**Patients**

The Trust continues to work to ensure that diversity is respected and valued by all staff. As part of this work it is evaluating all policies to ensure they promote the principles of equality and diversity. Further detail is available on our website www.oxfordradcliffe.nhs.uk

The ORH currently records the ethnicity of 90% of inpatients and is working to improve this. It is important information for use in health service planning and will also help to ensure equality of access to services.
Safety

Quality and Risk

In the past year, the Trust has worked hard at improving the quality and safety of services for all patients and to ensure that the working environment is safe for staff. This work is shaped by the governance, quality and risk framework which was updated during the year. The emphasis of the framework is to support clinical staff and managers in improving the quality of services; its aim is to make quality part of everyone’s daily business. Further progress has been achieved by improving the systematic management of risk, the monitoring and evaluation of quality indicators and the engagement of staff in improving the quality and efficiency of care.

To help the ORH achieve its main objectives and mitigate the risks to those objectives, the Trust Board uses its Assurance Framework. The regular review and updating of this framework provides the Board with assurance and supports the Board in its annual declaration of compliance with core standards.

The Assurance Framework brings together all objectives – clinical, business and operational – and ensures that the governance arrangements are integrated and cover all aspects of the Trust’s work.

Clinical Governance

Clinical Governance is the term used to describe the system by which the Trust ensures the treatment it provides for patients is of the highest quality with minimal risk.

Quality is managed through a process called clinical governance. The continued integration of clinical governance into the management processes within the three clinical divisions remains the main focus of activity. Last year, directorates revised their approach and this year the new approach will be evaluated and lines of accountability strengthened.

With the introduction of the Dr Foster information system (a system that allows clinical activity to be reviewed in some detail), the clinicians now monitor the data with the support of the governance team. This process, with other clinical information, such as clinical audit, allows the ORH to monitor the quality of care and provides assurances to the Board on the safety and quality of its services. As part of this process, the Trust monitors Hospital Standardised Mortality Rate (HSMR), which can be compared with other hospitals and the national average rate. Throughout the last year the ORH was consistently below the national average rate, which demonstrates a good performance.

Safety

Safety is at the heart of all work at the ORH. Key targets are set each year to improve on the safety of patients, staff, contractors and visitors to the hospital sites and in the last year we have improved safety in all key areas.

In medicines safety we have reduced the number of dispensing errors for the second year in a row. In other areas we are below national rates for medication errors, based on the National Patient Safety reports. Work is now being done to identify further medicines safety standards in key areas so we can continue to improve our performance.
The Trust has also reduced the number of patient falls. Patient falls are one of the most common accidents in any hospital. We monitor the number of falls we record and compare ourselves to the national average. The national average is 4.8 falls per 1,000 patients, the ORH rate is 4.5 falls per 1,000. Next year we will increase the focus on patient falls and see if we can reduce this even further.

Other key targets included reducing accidents at work. This year, we were able to reduce accidents at work by 8% in line with the Health and Safety Executive targets. This was achieved by improving the way we work in a number of key areas, such as needle safety and manual handling. The Trust also had fewer major accidents and dangerous occurrences that have to be reported to the Health and Safety Executive; the national average is 19.8 per 1,000 staff, the ORH rate is 7.7 per 1,000 staff.

The ORH underwent a successful level 1 Clinical Negligence Scheme for Trust’s assessment in October 2007, with a score of 48/50 on five standards, demonstrating a very high compliance and improved safety systems for patients. Achieving this level results in a 10% saving in the cost of its litigation insurance funding which can be re-invested into patient care.

**Clinical effectiveness and audit**

The ORH has taken part in a number of significant national audits including the Myocardial Infarction National Audit Project (MINAP), Cardiac Interventions Audit, National Oesophago-gastric Cancer Audit, National Bowel Cancer Audit and a range of national ENT audits. There has been a Trust-wide audit of pressure ulcers again this year, with results showing a marked reduction in prevalence.

**Clinical information**

The clinical information team has helped to develop high level indicators that are used to help monitor quality issues across the Trust. A wide range of indicators are being monitored, which alongside Dr Foster monitoring, provide good information on key quality and safety issues.

Patients’ and users’ views are essential in improving the quality of services. We have surveyed a large number of patients including those from the following services: cardiothoracic surgery, endoscopy, uro-oncology, pulmonary rehabilitation, breast cancer, colorectal surgery and the newborn hearing screening programme. This type of targeted and structured feedback allows staff to make changes and improvements to services that patients suggest and want. The intention for the coming year is to encourage more departments and services to set up a programme of regular patient surveys.

An essential part of gaining informed consent and a key element of clinical effectiveness is to ensure that patients have access to good quality information about their procedures, care and treatment. We have successfully completed the first year of a three-year project to improve the quality and availability of written clinical information leaflets. More than 50 new leaflets on procedures, conditions and treatments have been produced, in line with Trust, Department of Health and Healthcare Commission guidance. Particular progress has been made in children’s day surgery, ophthalmology, dermatology, maternity, cardiac rehabilitation and general surgery. This project is being overseen by the Patient Communications and Information Group.
Data loss

All NHS organisations must now include details of Serious Untoward Incidents involving data loss or confidentiality breach in their annual reports. The ORH had no Serious Untoward Incidents of this nature to report in 2007/8.

Legal services

The legal services team has provided the Trust with a very high level of expert advice and support during a year in which some high profile cases have arisen. The team has also been key to the implementation of the Mental Capacity Act both within the ORH and in the NHS in Oxfordshire.

Preparing for an emergency

The ORH has a major incident plan that details how the Trust will respond to an emergency or internal incident. The plan aims to bring coordination and professionalism to the often unpredictable and complicated events of a major incident, such as an accident involving multiple casualties, requiring extraordinary mobilisation of the emergency services.

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

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

Controlling infection

In 2003 the government set the NHS a target to reduce MRSA by 60% by 2008. The ORH has already seen a reduction in its rate of MRSA from 127 cases in 2003/4 to 50 in 2007/8.

This has been the result of a concerted effort by the ORH: a focus on hand hygiene, improving and auditing intravenous line practice, smarter usage of antibiotics and intensive monitoring and treatment.

A key factor has been the ‘root cause analysis’ of infections that occur. Each time our hospitals treat a patient with an MRSA infection, we seek to find out exactly what may have caused it so we can guard more effectively against it recurring. This is down to a dedicated team of specialist doctors, nurses, managers and epidemiologists who make up the Trust’s infection control team, as well as the diligence of staff throughout the organisation.

The Department of Health’s infection control team visited the ORH this year as part of their national review and praised the commitment of the organisation and staff to tackling infection.

However, the ORH is not complacent, and we are cautious about declaring ‘victory’ over healthcare associated infections. Some infection will always be a factor in healthcare, simply because it is an unavoidable element of the very serious and sometimes terminal illnesses that people are suffering from.
In March 2008, as part of a programme of visits to 120 NHS acute trusts in England, the Healthcare Commission made a two-day spot-check visit to the ORH to assess how we are complying with the government’s Hygiene Code. Overall, the resulting report showed that we have strong hygiene and infection control measures in our hospitals.

Areas highlighted for attention included further strengthening of staff training, increasing the display of cleaning schedules in public areas, and improved coordination of decontamination processes. These issues have all already been, or are being, addressed by the ORH. More details are available on the Healthcare Commission website.

The Trust has published MRSA and *C. difficile* rates on the ORH website for some time, and NHS Choices now publishes rates for all the hospitals in the country for patients to compare.

The better we can understand how these organisms behave, the better chance we have of controlling their impact on health. The ORH is at the forefront of research into the area – infectious diseases is one of the main research strands of the Oxford Biomedical Research Centre partnership with the University of Oxford.

Looking forward, this research will benefit from the ORH and the University of Oxford having recently been chosen as one of two major consortia dedicated to research into healthcare associated infections and antibiotic resistance. The research will exploit recent advances made in sequencing the DNA of bacteria and viruses, to improve and speed up their classification and identification. This should make it easier to track and deal with local outbreaks of infection, identify particularly virulent strains, and help to spot where infection control guidelines can be improved.

The ORH already screens patients on arrival if they are regarded as having a high risk of contracting MRSA. This includes all patients admitted from other hospitals and healthcare settings, patients admitted to critical care, as well as regular screening of patients who return to our hospitals for dialysis.

From March 2009, Department of Health Guidance will recommend that all elective patients are to be screened and the ORH is working towards that goal. In a sense, all patients should be treated as if they are colonised with the bacteria and could potentially spread it or acquire an infection – that way we can be sure we apply the best infection control practice to all patients.
Our patients have rapid access to the latest developments in the diagnosis and treatment of disease, thanks to the many research programmes and clinical trials being carried out in our hospitals. Trust researchers have continued to enhance their world-class reputation through the many hundreds of academic papers they publish every year – demonstrating the strength of the Trust’s partnership with its academic partners, the dedication of staff and the cooperation and support of patients.

Much of this work is in association with the University of Oxford and Oxford Brookes University, with funding provided by the major research councils, medical charities, the Department of Health, pharmaceutical and medical device companies. The quality of the research has led to major advances in the care provided to patients locally, nationally and internationally. Furthermore, our strong research portfolio helps to attract the very best clinicians and academics to the Trust.

The fusion of leading-edge research with clinical services is already happening in Oxfordshire, harnessing new technology and driving up standards of healthcare.

For example, the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM) provides state-of-the-art healthcare for metabolic diseases such as diabetes. Its pioneering research in the use of islet cell transplantation for treatment of hypoglycaemia in a group of people with Type 1 diabetes has been rewarded with extra funding from the Department of Health.

The centre will be one of only six in the country to share in an investment of up to £2.34 million in the first year. Over the past few years, pancreatic islet transplantation has achieved considerable clinical success with reversal of life-threatening hypoglycaemia and some patients achieving insulin independence. However, one of the main factors preventing the widespread application of the treatment is that it has, until now, been funded on a limited research grant basis.

Similarly, Oxfordshire stroke research is continually improving stroke prevention, in collaboration with our local primary care centres, and the new Acute Vascular Imaging Centre, under construction, will deliver the latest treatment for strokes and heart attacks, based on cutting-edge imaging techniques. Diabetes and stroke are two of the most severe diseases affecting an increasing number of patients, and all those served by Oxfordshire hospitals stand to benefit from the results of this research.
Other high profile research projects have included the work undertaken into the role of genetics in obesity; research into methods of preserving organs prior to transplantation, something that will eventually lead to an increase in the number of organs that can be available; and research into the use of daily aspirin by people who have had, or may be at risk of, strokes.

Another major benefit of research is that it allows, through clinical trials, more treatment options than might otherwise be the case. For example, cancer patients might have access to new drugs by virtue of the fact that they are in a clinical trial that would otherwise not be part of routine treatment. In this way patients benefit from the latest treatments. Drugs are often provided free of charge by pharmaceutical companies and researchers learn more about the best treatment regimens.

High quality research requires an expert and robust system of support to ensure that it complies with all the relevant regulations and the requirements of the Healthcare Commission and that participants’ rights and safety are a priority at all times. The partnership between the Trust and the University of Oxford has been reflected by a move towards a more integrated system of research governance. The sharing of expertise in this field enables a more streamlined approach and promotes high quality research applications.

The OxBRC will concentrate on areas which are already strong locally, and research projects have been selected that are most likely to deliver real improvements in healthcare in the shortest time possible.

The operation of the OxBRC will be greatly enhanced by the presence of new hospital facilities in Oxfordshire, including the new West Wing and the Cancer Centre at the Churchill Hospital. In addition, the University of Oxford is currently building a £56m centre for medical research based opposite the Churchill Hospital, which will include an Institute for Cancer Medicine to interact with the Cancer Centre. The addition of these new NHS and University resources to existing clinical facilities will make OxBRC one of the world’s largest experimental medicine research institutes, placing it in a better position to attract research funding available world-wide from industry investors and health charities, and enable the development and exploitation of rapidly advancing technologies and bring them to patients.

The OxBRC will also have a global perspective through, for example, the Oxford Tropical Network and the Clinical Trial Service Unit, with their links in SE Asia, Sub-saharan Africa, India, China and South America. This will give the Centre greater potential to rise to global health challenges that affect NHS patients, such as the threat of pandemic influenza and multi-resistant pathogens.

One of the early benefits of the OxBRC collaboration has been a greatly improved coordination and integration of research between the Trust and the University. It has also acted as a template for the two organisations to consider a wider degree of integration of research, teaching and patient care as part of developing its role as an Academic Health Sciences Centre.
THE OxBRC RESEARCH THEMES:

**Blood:** Stem cell transplantation, myelodysplasia, novel biomarkers in lymphoma, bleeding and thrombotic disorders.

**Brain:** Neuroimmunological diseases and dementia; the use of deep brain stimulation; treatment of sleep pathologies.

**Cancer:** Proof of principle studies of novel interventions including radiation biology using biomarkers of signal pathways.

**Diabetes:** Proof of concept studies in patients defined by new biomarkers; islet cell transplantation; telemedicine in self-management of diabetes.

**Heart:** Coronary revascularisation; molecular genetics, biomarkers and advanced imaging techniques.

**Immunity:** Immuno-suppressive and anti-inflammatory therapies in chronic viral infections and transplantation.

**Infection:** Rapid diagnostics based on sequencing and cellular immunity and improved response to infection.

**Vaccines:** Small scale production of vaccines for influenza, TB and meningitis tested through live challenges, biomarkers and reactive T cell measures.

**Stroke:** Early intervention directed by hyper-acute MRI; prevention through novel indices of risk and improved classification of TIA and stroke.

**Women’s Health:** Prenatal diagnosis and monitoring. MRI based diagnosis and treatment of endometriosis.

CROSS-CUTTING THEMES

**Bioengineering and technology:** Innovative devices and surgical technologies; tele-communication for personalised medicine; image analysis and processing.

**Chronic disease cohorts:** Well characterised, phenotyped, genotyped and annotated longitudinal cohorts of patients with major chronic diseases.

**Genetics and pathology:** To build a core set of platform technologies applicable across all research programmes and themes.

**Imaging:** Development of imaging technologies, methods and biomarkers for assessment of response and efficient proof of concept studies.

NIHR is also providing funding for research management and support at a national level for clinical trials. The comprehensive Local Research Network (CLRN) is in the process of being set up as part of the UK Clinical Research Network. The Thames Valley CLRN is hosted by the ORH Trust. One aim of the CLRN is to centralise and coordinate the approvals system for research to ensure that research is of high quality.
Fertility first for Oxford

The first babies in the UK to be conceived by IVM, IVF without fertility drugs, have been born, thanks to a collaboration between Oxford University researchers and the NHS. The revolutionary fertility treatment could provide a safer and cheaper alternative to conventional IVF.

The twins, a boy and a girl, were born on 18 October at the John Radcliffe Hospital. They were conceived thanks to the Oxford Fertility Unit, a private company whose consultants are all Oxford University researchers and honorary clinicians at the Oxford Radcliffe Hospitals.

IVM (In Vitro Maturation) is a safer, faster and cheaper alternative to standard IVF which does not involve injecting fertility drugs prior to egg collection. Instead, eggs are collected from the ovaries whilst still immature, and allowed to mature in a Petri dish before being fertilised and implanted into the womb.

Around 400 babies have been born from IVM worldwide, compared to about two million IVF babies. The safety of IVM over IVF is crucial for women with polycystic ovaries, who account for 30–40% of all women seeking fertility treatment. A dangerous side-effect of the fertility drugs used in IVF is severe ovarian hyperstimulation syndrome (OHSS), which occurs in 1 in 10 cycles of women with polycystic ovaries. Severe OHSS usually results in a week or more in hospital. In its most severe form, it can cause fluid to collect in lungs, abdominal cavity, and tissues.

So far only a handful of centres worldwide have used IVM. In January 2007 the Oxford Fertility Unit became the first unit in the UK to be licensed by the HFEA (Human Fertilisation and Embryology Authority) to offer the treatment.

The programme is led by Mr Tim Child, Senior Fellow in Reproductive Medicine at the University of Oxford and Consultant Gynaecologist at the Oxford Fertility Clinic.

In IVM, immature eggs (oocytes) are extracted directly from the ovaries, under the guidance of ultrasound, and then allowed to mature in vitro for 24-48 hours. The eggs that have successfully matured after this time are fertilised by injecting one sperm into an egg. Two to three days after fertilisation, the embryos are transferred to the mother’s womb.

Mr Child said, “After years of research and development into IVM, and after many months of working with the twins’ parents, it has been hugely exciting to see them born. They are beautiful babies and the whole family is doing well.”

To begin with, the Oxford Fertility Unit is only offering IVM to the 1 in 3 women presenting with polycystic ovaries. However, it is thought possible that in the long term the procedure might be a safer, cheaper alternative to IVF for all women.
Latex free

The cardiac angiography, pacing and day care unit at the JR are now, as far as possible, latex free zones, thanks to a project to eliminate the use of natural rubber latex in hospital supplies. The decision to make the change was taken after a member of staff became hypersensitive to latex.

Close examination of products used in the unit found that a small number contained latex and the hospital’s procurement team have replaced them with latex free alternatives.

Ruth Titchener, Matron, said, “We all know about latex gloves but latex is also contained in things like syringe caps. The project team representing all staff groups, assessed the risk and through collaboration with the team, were able to try alternatives.”

Dr David Major, Consultant Occupational Physician, told ORH News, “The last few years have seen a dramatic increase in the incidence of latex protein hypersensitivity among health care workers in the UK. The use of latex gloves as a barrier to infection has risen significantly and as this has happened, some people have found themselves to be sensitised. The symptoms vary from person to person. People with a latex allergy can develop symptoms immediately after being in contact with latex. Some people have a delayed reaction which is more likely to be an itchy rash. These people are more likely to be allergic to other substances in rubber production rather than the latex itself.

“The degree of allergic reaction also varies. Some people may have a mild reaction, which might include itchy eyes, sneezing, a runny nose or an itchy rash, while other people may have a severe allergic reaction, even anaphylactic shock.

“It’s something we are monitoring closely and the fact that we have been able to source products that do not pose a risk to hypersensitive staff is a big step forward.”
Patient partnership and involvement

The Patient Advice and Liaison Service (PALS)

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. In the last year, the PALS team has dealt with 2,109 enquiries, 272 at the Churchill Hospital, 404 at the Horton Hospital and 1,433 at the John Radcliffe Hospital.

Patients and staff can contact the service by telephone, email or letter, or call in person at the PALS offices based in the John Radcliffe Hospital (with a separate office in the West Wing), the Churchill Hospital and Horton Hospital.

Comments and complaints

How we handle your complaints

If issues cannot be resolved by the PALS team, patients can make a formal complaint to the Trust.

We adhere to the ‘principles of remedy’ to produce reasonable, fair and proportionate remedies as part of our complaints handling procedures.

In handling complaints and concerns, we aim to

- Be customer focused
- Be open and accountable
- Act fairly and proportionately
- Put things right
- Seek continuous improvement

Public involvement

There are many ways of getting involved in helping to develop and improve local health services. The ORH has continued to welcome and encourage patient feedback on services and real public involvement in a variety of service developments. Talk to PALS if you would like more information.

Number of written complaints between 1 April 2007 and 31 March 2008

553

% written complaints acknowledged in two working days

96%

% written complaints responded to within the 25 working day target

89%
**Patient Panel**

The ORH Patient Panel is made up of volunteers who work with the Trust on a number of projects including the plans for the Oxford Heart Centre, the new geratology unit and the production of patient information leaflets and service changes.

The ORH continues to bring a public view to discussions by linking members of the 40 strong Patient and Public Panel to an increasing number of activities and working groups across the ORH.

Examples of successful involvement include:

- Contributions to the dress and uniform policy
- Involvement in a working group to look at improving the format and content of information sent to patients
- Working closely with staff to amend the patient discharge policy
- Contributions to the ‘What constitutes a clean hospital?’ debate
- An arts group for the West Wing
- A customer services discussion group looking at how the hospitals deliver good customer care
- Participation in hospital environment inspections.

**Young People’s Executive**

The Young People’s Executive (YiPpEe) is a group of young people who are helping the Trust, by bringing children’s opinions to the running of the Children’s Hospital. A brochure has been produced by children, for children who are expecting to come into hospital, with input from YiPpEe. The group was also very active during the National Children’s Takeover Day in November 2007, by participating in a variety of activities within the ORH.

**User Groups**

Many user groups exist across the Trust. For example, the Oxford Centre for Diabetes and Endocrinology has a particularly active user group. A group of patients meet regularly with staff to discuss various topics of interest. They have placed a suggestion box in the atrium, which they manage and comments are discussed with staff.

*If you would like to know more about our patient partnership work please contact the patient partnership team on 01865 857734.*
Local Involvement Networks (LINks)

LINks are being set up nationally to replace the former patient and public involvement forums (PPIFs) and provide new ways to give people a stronger voice in how their health and social care services are delivered. Each local authority (that provides social services) has been given funding and is under a legal duty to make contractual arrangements that enable LINk activities to take place.

Each LINk group will be made up of volunteer members and participants, individuals, groups and organisations with an interest in local care services. ‘Help and Care’ has been appointed to be the host organisation for the LINk in Oxfordshire as well as for several other local authority LINks regions in the South of England. Their role is to support the LINks to be effective voices for people in these areas.

See www.helpandcare.org.uk

The role of the group could include:

- To promote public involvement in health and social care services
- Asking what people think about local healthcare services and asking them to suggest improvements
- Investigating specific issues of concern using its powers to hold services to account asking for information and expecting a timely reply checking to see if services are working well making reports and recommendations and receiving a response
- Referring issues to the local Health and Social Care Overview and Scrutiny Committees.

League of Friends

The Leagues of Friends are voluntary organisations which support the work of the three hospitals within the Trust. They are able to provide much needed equipment and extras for the benefit of patients and staff through the income raised by the work of volunteers.

Volunteers run cafeterias and tea bars for patients, visitors and hospital staff.
At the end of 2005, the League of Friends for the John Radcliffe Hospital made a decision which was to have a major impact on the work of the consultants and nursing staff across several disciplines. Under the chairmanship of Dr Beryl Andrews, the League agreed to fund a Critical Care Transfer Trolley – the first of its kind in the Thames Valley area.

This exciting development has since been specifically designed and custom built to meet the needs of the adult and neurosurgery intensive therapy areas, the emergency and cardiac departments, the Coronary Care Unit, the Medical Assessment Unit and others. It will be heavily used by all concerned.

Moving critically ill adults is an extremely difficult task. To move them safely, mobile life support and monitoring equipment is needed.

The JR often takes the most critically ill patients from around the region into its ITU or to the Cardiac Department because of the very high level of care available here. As soon as the patients are sufficiently well, it is necessary to transfer them nearer to home – for example to Slough or Stoke Mandeville. But during transfer, the patient needs the same level of monitoring, ventilation and total clinical care.

This is a new concept, and the new trolley will be available to all the areas under the care of the Transfer Link Nurse for the Trust.

The JR League of Friends donated the £60,000 needed for the trolley and all the on-board equipment like syringe drivers, ventilators, patient monitoring, suction, special mattresses, etc. The mounting blocks which hold the trolley into the ambulances were funded by the Ambulance Trust League of Friends, making this a very special collaboration.
The ORH is applying to become a Foundation Trust (FT). A Foundation Trust is a new type of healthcare organisation run on very different lines. FTs are still fully part of the NHS, and continue to treat patients based on need, not ability to pay, but they have more freedom to determine their own future and are more accountable to staff, patients and the public, through a membership scheme and through a Members’ Council.

Everyone who has worked for the ORH for over a year is a member, unless they choose to opt out. Staff working for the University of Oxford Medical Sciences Division for over a year are members too, helping to draw academic and NHS colleagues more firmly together.

Staff have the opportunity to elect colleagues to the new Council, or stand for election themselves. The Members’ Council will work alongside the Board of Directors of the ORH, and will help shape the future direction of the organisation.

As well as staff members, the Council will include representatives of Oxford’s two universities, the Primary Care Trust, the County Council, and the business community.

The Council will also include representatives of our older and younger patients, and our supporters. Most importantly, the majority of the Council will be members of the public, elected to represent local authority areas from which our patients are drawn.

This means not only Oxfordshire, but places further afield too. As a regional centre of expertise, it’s important that all of the communities which we serve are represented.

Foundation Trusts have more freedom from central government and more control over their finances. When we make a surplus, we will be able to decide how we spend it. We will be able to give clinical services more autonomy to control their own budgets, and decide how to improve performance, invest, or reduce costs, at a local level.

We will also be free to enter into new kinds of partnerships, for example joint ventures with others in the field of research and development. This adds many exciting possibilities to the new partnership we are developing with the University of Oxford, and our status as a comprehensive Biomedical Research Centre.

Lord Darzi’s Next Stage Review report talks about developing a small number of ‘super league’ Academic Health Science Centres, set up to focus on world-class research, teaching and patient care. The ORH aspires to be one of these centres – an aspiration which will be far easier to achieve as an FT, with the greater freedoms this will bring.
Trevor Campbell Davis,  
Chief Executive

In last year’s report, I reflected on a year of considerable achievements for the ORH. It was a year in which we met all of the key government targets whilst substantially reducing our costs. We opened the Oxford Children’s Hospital and the West Wing, our centre of expertise for head and neck services. We started work on the Oxford Cancer Centre and the Oxford Heart Centre.

This year, we have built on these achievements and demonstrated that we are sustaining success. We further developed our performance improvement programme, aimed at improving the patient experience while making more efficient use of our resources, with considerable success. For example, we have improved efficiency in our theatres, so that operations start promptly, patients are not kept waiting, and valuable staff time is not wasted. We have started phoning patients to remind them about their operations and thus greatly reduced the number who do not attend. We have increased the number of operations which are performed as day cases, so that patients do not need to stay in hospital overnight. These initiatives are popular with our patients and have helped us to achieve a financial surplus for the first time in many years.

This year saw the introduction of a challenging new target which means that patients wait no longer than 18 weeks from GP referral to treatment. By building on our performance improvement initiatives, we were among the first organisation in our Strategic Health Authority area to achieve the target, which we met some nine months ahead of the national deadline of December 2008.

This year has also seen the development of a much strengthened relationship with the University of Oxford. In 2007, we established the Oxford comprehensive Biomedical Research Centre (OxBRC), a partnership between the ORH and the University which enables us to build on our international reputation as a centre of clinical research in a way that directly benefits patients.

Reflecting on the past, looking to the future
Funded by the National Institute for Health Research and one of only five such Centres in the UK, the OxBRC is overseeing many major work programmes designed to ensure that innovative research rapidly benefits NHS patients. We have continued to discuss with the University other ways in which we can build on our partnership, and we share a joint aspiration to become an Academic Health Sciences Centre.

All of these achievements have helped us on our journey to become a Foundation Trust, preparation for which has been a major focus of the past twelve months. In particular, we have built on the work we undertook through our Strategic Review and developed an Integrated Business Plan, which looks forward to the next five years of the ORH. This sets out a vision of a successful, growing business which provides world-class clinical services, teaching and research, and which is an employer of choice for staff. Our achievements of the past two years have shown that this is a realistic goal for the ORH, which is already one of the UK’s foremost academic healthcare providers.

It is a great privilege to be the Chief Executive of our busy, successful and dynamic hospitals, and I am very proud of the commitment shown by staff and our supporters in the local community.

Trevor Campbell Davis
Chief Executive
Trust Board members

Non-executive Directors

Sir William Stubbs  
_Chairman_

Dame Fiona Caldicott

Caroline Langridge

Dr Ken Fleming

Dr Colin Reeves CBE

Brian Rigby CBE

Professor Adrian Towse

Executive Directors

Trevor Campbell Davis  
_Chief Executive_

Chris Hurst  
_Director of Finance and Procurement_

Andrew Stevens  
_Director of Planning and Information_

Dr James Morris  
_Medical Director_

Elaine Strachan-Hall  
_Director of Nursing and Clinical Leadership_
The following attend Trust Board meetings:

<table>
<thead>
<tr>
<th>Dr John Reynolds</th>
<th>Medical Director and Chair, Division A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moira Logie</td>
<td>Director of Operations, Division A</td>
</tr>
<tr>
<td>Mr Mike Greenall</td>
<td>Medical Director and Chair, Division B</td>
</tr>
<tr>
<td>Kathleen Simcock</td>
<td>Director of Operations, Division B</td>
</tr>
<tr>
<td>Dr David Lindsell</td>
<td>Medical Director and Chair, Division C</td>
</tr>
<tr>
<td>Joanna Paul</td>
<td>Director of Operations, Division C</td>
</tr>
<tr>
<td>Mike Fleming</td>
<td>Director, Horton General Hospital</td>
</tr>
<tr>
<td>Ian Humphries</td>
<td>Director of Estates and Facilities</td>
</tr>
<tr>
<td>Helen Peggs</td>
<td>Director of Media and Communications</td>
</tr>
<tr>
<td>Andrew Murphy</td>
<td>Director of Performance Improvement</td>
</tr>
</tbody>
</table>
Trust Board committees

Audit Committee – Dr Ken Fleming, Dr Colin Reeves (Chair), and Professor Adrian Towse.

Commercial Committee – Mrs Vickie Holcroft, Mr Ian Humphries, Mr Chris Hurst, Mrs Elaine Strachan-Hall, Dr James Morris, Mr Brian Rigby (Chair) and Mr Andrew Stevens.

Finance and Performance Committee – Dame Fiona Caldicott, Mr Trevor Campbell Davis, Dr Ken Fleming, Mr Chris Hurst, Ms Caroline Langridge, Mr Andrew Murphy, Dr Colin Reeves, Mr Brian Rigby, Mr Andrew Stevens, Professor Adrian Towse, and Sir William Stubbs (Chair).

Governance Committee – Dr Ken Fleming, Ms Caroline Langridge and Professor Adrian Towse (Chair).

Human Resources Committee – Dame Fiona Caldicott (Chair), one other Non-executive Director, Mr Mark Gammage, Dr James Morris and Mrs Elaine Strachan-Hall, a Divisional Director of Operations and a representative of staffside.

Remuneration and Appointments Committee – is responsible for agreeing the terms and conditions of employment of the Chief Executive and senior Directors (corporate and divisional) of the Trust, and the arrangements for their annual appraisals. The Committee will also set the number of discretionary points for award by the Trust’s discretionary points panel.

All Non-executive Directors are members of the Remuneration Committee: Prof Adrian Towse, Dr Ken Fleming, Dr Colin Reeves, Dame Fiona Caldicott, Ms Caroline Langridge and Mr Brian Rigby. The Trust Chairman, Sir William Stubbs, chairs this committee.

For the committee to be quorate, two Non-executive Directors must be present but normally two Non-executive Directors and the Chairman would attend.

The Remuneration and Appointments Committee agrees all senior Director salary and, on an annual basis, considers the inflationary pay award made for Agenda for Change as the basis for any inflationary pay award for senior Directors.

Every senior manager undertakes an annual appraisal resulting in objectives and a personal development plan. Achievement of objectives is used as the basis for judging performance.

Up to 10% of the total annual salary is subject to adherence to the performance conditions.

All senior managers receive permanent contracts. New Directors are entitled to three months notice on either side. Directors originally employed as full Board members are entitled to six months notice on either side. The Chief Executive is entitled to six months notice. Termination payments are normally limited to the notice period entitlement. Divisional Chairmen are consultants with permanent contracts who undertake the role for a fixed term.

One award of £60,000 during 2007/8 was made to the Director of Private Patients due to organisational change.

Declaration of Interests and Register of Interests of members of the Trust Board for year 2007/8

Declarations of Board members’ interests are sought each year and published through the public Board meetings and also in the Annual Report each year. Given overleaf are the interests for the year 2007/8. Guidance to the codes defines “relevant and material” interests as:

a) Directorships, including Non-executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).

b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

d) A position of Authority in a charity or voluntary organisation in the field of health and social care.

e) Any connection with a voluntary or other organisation contracting for NHS services.

f) Research funding/grants that may be received by an individual or their department.

g) Interests in pooled funds that are under separate management.
<table>
<thead>
<tr>
<th><strong>Director</strong></th>
<th><strong>a</strong></th>
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<td>Sir William Stubbs</td>
<td>None</td>
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<tr>
<td>Trevor Campbell Davis</td>
<td>European Communications Group Ltd, The Not So Silly Training Company Ltd</td>
<td>None</td>
<td>None</td>
<td>Trustee, NHS Confederation; Treasurer, Association of UK University Hospitals; Director, Future Healthcare Network Ltd; Director, NHS Confederation Trading Co Ltd</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Dame Fiona Caldicott</td>
<td>Director and Company Secretary Waters 1802 Ltd</td>
<td>None</td>
<td>None</td>
<td>Trustee, Nuffield Trust</td>
<td>Principal, Somerville College, University of Oxford</td>
<td>None</td>
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<tr>
<td>Kenneth Fleming</td>
<td>Non-executive Director of the ORHT Charitable Funds Committee</td>
<td>None</td>
<td>None</td>
<td>Director of the Gray Institute for Cancer Research; Trustee of the Jenner Foundation Nuffield Medical Trust</td>
<td>Head of the Medical Sciences Division, University of Oxford</td>
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<tr>
<td>Chris Hurst</td>
<td>None</td>
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<td>Caroline Langridge</td>
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<tr>
<td>James Morris</td>
<td>Non-executive Director, NHS Innovations South East</td>
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<tr>
<td>Colin Reeves</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Self-employed consultant undertaking NHS business</td>
<td>Honorary Treasurer of Headway (Brain injury charity)</td>
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<td>Brian Rigby</td>
<td>Director, Millfield School; Director, Partnership for Schools</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Visiting Fellow of Warwick University Business School</td>
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<td>Andrew Stevens</td>
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<tr>
<td>Elaine Strachan-Hall</td>
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<tr>
<td>Adrian Towse</td>
<td>Non Executive Director (without remuneration) of OHE-IPMMA Database Ltd</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Director of the Office of Health Economics</td>
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<td>Mark Gammage</td>
<td>None</td>
<td>Chairman of Dearden Consulting Ltd</td>
<td>None</td>
<td>None</td>
<td>Chairman of East Hertfordshire and West Essex Multiple Sclerosis Society</td>
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<td>Mike Greenall</td>
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<td>David Lindsell</td>
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<td>Trustee of Oxford Hospitals Services Charity and Nuffield Oxford Hospitals Trust</td>
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<td>Signatory of Radiology Charitable Fund</td>
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<td>Moira Logie</td>
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<td>Joanna Paul</td>
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<td>Helen Peggs</td>
<td>Non-executive Director, Asthma UK</td>
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Financial Review

Summary of financial position

The Trust generated a retained surplus of £4.3m in the year to 31 March 2008. This 2007/8 retained surplus was unaffected by non-recurrent adjustments or financial support. The normalised surplus in 2007/8 being the position after adjusting for any significant non-recurring items was therefore also a surplus of £4.3m. In the previous year the Trust generated a normalised surplus, after adjusting for the two non-recurrent items shown in the table below, of £7.9m. As previously reported these items were part of the plan agreed with the SHA for 2006/7 and the retained deficit of £8.65m was £350k better than the approved planned deficit of £9m.

Format of the accounts

The format of the accounts is as specified by the NHS Trust Manual for Accounts and consists of:

Four primary statements

- Income and expenditure account
- Balance sheet
- Cash flow statement and
- Statement of total recognised gains and losses.

The Annual accounts also include

- Notes to the accounts
- Statement on internal control
- Directors’ statement of responsibilities, and
- The auditor’s report.

A summary of the technical financial terms used in the Annual Review is shown at the end of this section.

The full Annual Review for 2008 including

- The full set of audited financial statements, including
- The Statement of the Accounting Officer’s responsibilities
- The Primary Financial Statements and notes
- The audit opinion and report

is available upon request from:

Director of Finance,
Oxford Radcliffe Hospitals NHS Trust,
Headley Way,
Headington,
Oxford
OX3 9DU

It is also available on our website www.oxfordradcliffe.nhs.uk and in CD-ROM format from the Media and Communications team on 01865 228932.
Income and expenditure account

The ORH generated a retained surplus of £4.3m in the year to 31 March 2008, unaffected by non-recurrent adjustments or financial support. The “normalised” surplus (the position after adjusting for any significant non-recurring items) was therefore also £4.3m. In the previous year, the normalised surplus, after adjusting for two non-recurrent items shown in the table below, was £7.9m. As previously reported, these items were part of a plan agreed with the SHA, and the retained deficit of £8.65m in 2006/7 was £350k better than the approved planned deficit of £9m.

### Note to the income and expenditure account for the years ended 31 March 2008 and 31 March 2007

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2007</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>4,311</td>
<td>(8,649)</td>
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<tr>
<td>Repayment/(Receipt) of financial support included in retained surplus/(deficit) for the year</td>
<td>0</td>
<td>7,000</td>
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<tr>
<td>Non-recurrent income adjustment to support Oxfordshire’s county-wide recovery plan</td>
<td>0</td>
<td>9,500</td>
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<tr>
<td>Normalised surplus/(deficit) for the year excluding financial support arrangements</td>
<td>4,311</td>
<td>7,851</td>
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</table>

The Trust did not receive any financial support or non-recurrent income in 2007/8
Summary of financial duties

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

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

The Trust reported an in-year surplus of £4.3m, better than the plan agreed with the SHA, prior to the start of the year. The Trust will not fully satisfy the requirements of the NHS Trust five year break-even duty until March 2012. The SHA accepts that it would be unreasonable to expect the Trust to make a sufficient surplus in 2008/9 and 2009/10 to fully recover the five year break-even duty. The Trust is now in recurrent surplus and can generate cash to repay its past loans. Future surpluses are expected to offset fully earlier deficits, but over seven and not five years.

**Capital costs absorption rate** (a measure of balance sheet management)

NHS Trusts are targeted to absorb the cost of capital at a rate of 3.5% of average relevant net assets (as reflected in their opening and closing balance sheets for the financial year). A tolerance of 0.5% is set around this target. In 2007/8 the Trust met the duty with an absorption rate of 3.5%.

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

The Trust was set an External Financing Limit (EFL) of £3,411k in 2007/8. Its actual external financing requirement was £2,914k i.e. £497k within its EFL.

Performance over the last five years

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Turnover £000</th>
<th>Surplus/(deficit) before interest £000</th>
<th>Retained surplus/(deficit) £000</th>
<th>CCA rate % (target 3.5% from 2003/4)</th>
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</thead>
<tbody>
<tr>
<td>2007/8</td>
<td>553,098</td>
<td>16,105</td>
<td>4,311</td>
<td>3.5</td>
</tr>
<tr>
<td>2006/7</td>
<td>484,559</td>
<td>1,174</td>
<td>(8,649)</td>
<td>3.4</td>
</tr>
<tr>
<td>2005/6</td>
<td>474,983</td>
<td>(9,929)</td>
<td>(19,409)</td>
<td>3.3</td>
</tr>
<tr>
<td>2004/5</td>
<td>452,102</td>
<td>8,978</td>
<td>1,580</td>
<td>3.2</td>
</tr>
<tr>
<td>2003/4</td>
<td>423,941</td>
<td>9,063</td>
<td>200</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Summary financial statements

These accounts for the year ended 31 March 2008 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 printed copy of the full accounts is available, free of charge, on request from the Director of Finance and Procurement and is inserted as an appendix to this report. In addition the accounts are also available on the website www.oxfordradcliffe.nhs.uk in the section ‘About Us’. The Trust is required to include a Statement on Internal Control and this is shown at the end of this document.
### Income and expenditure account for the year ended 31 March 2008

<table>
<thead>
<tr>
<th></th>
<th>2007/8 £000</th>
<th>2006/7 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>455,553</td>
<td>394,796</td>
</tr>
<tr>
<td>Other operating income</td>
<td>97,545</td>
<td>89,763</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(536,305)</td>
<td>(482,957)</td>
</tr>
<tr>
<td><strong>OPERATING SURPLUS/(DEFICIT)</strong></td>
<td>16,793</td>
<td>1,602</td>
</tr>
<tr>
<td>Cost of fundamental reorganisation/restructuring*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Profit/(loss) on disposal of fixed assets</td>
<td>(851)</td>
<td>(428)</td>
</tr>
<tr>
<td><strong>SURPLUS/(DEFICIT) BEFORE INTEREST</strong></td>
<td>15,942</td>
<td>1,174</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>1,218</td>
<td>1,026</td>
</tr>
<tr>
<td>Interest payable</td>
<td>(1,034)</td>
<td>(45)</td>
</tr>
<tr>
<td>Other finance costs – unwinding of discount</td>
<td>(21)</td>
<td>(21)</td>
</tr>
<tr>
<td><strong>SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR</strong></td>
<td>16,105</td>
<td>2,134</td>
</tr>
<tr>
<td>Public Dividend Capital dividends payable</td>
<td>(11,794)</td>
<td>(10,783)</td>
</tr>
<tr>
<td><strong>RETAINED SURPLUS/(DEFICIT) FOR THE YEAR</strong></td>
<td>4,311</td>
<td>(8,649)</td>
</tr>
</tbody>
</table>

### Balance sheet as at 31 March 2008

<table>
<thead>
<tr>
<th></th>
<th>2007/8 £000</th>
<th>2006/7 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIXED ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>4,315</td>
<td>4,419</td>
</tr>
<tr>
<td>Tangible assets</td>
<td>448,666</td>
<td>411,668</td>
</tr>
<tr>
<td>Investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>452,981</strong></td>
<td><strong>416,087</strong></td>
</tr>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks and work in progress</td>
<td>8,498</td>
<td>7,466</td>
</tr>
<tr>
<td>Debtors</td>
<td>57,553</td>
<td>52,467</td>
</tr>
<tr>
<td>Investments</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>12,498</td>
<td>734</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>78,849</strong></td>
<td><strong>60,673</strong></td>
</tr>
<tr>
<td><strong>CREDITORS:</strong> Amounts falling due within one year</td>
<td>(61,974)</td>
<td>(50,398)</td>
</tr>
<tr>
<td><strong>NET CURRENT ASSETS/(LIABILITIES)</strong></td>
<td>16,875</td>
<td>10,275</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS LESS CURRENT LIABILITIES</strong></td>
<td>469,856</td>
<td>426,362</td>
</tr>
<tr>
<td><strong>CREDITORS:</strong> Amounts falling due after more than one year</td>
<td>(32,415)</td>
<td>(31,759)</td>
</tr>
<tr>
<td><strong>PROVISIONS FOR LIABILITIES AND CHARGES</strong></td>
<td>(4,748)</td>
<td>(3,989)</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>432,693</td>
<td>390,614</td>
</tr>
<tr>
<td><strong>FINANCED BY:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TAXPAYERS’ EQUITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>169,547</td>
<td>157,632</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>182,317</td>
<td>164,190</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>67,374</td>
<td>64,269</td>
</tr>
<tr>
<td>Government grant reserve</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other reserves</td>
<td>1,743</td>
<td>1,743</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td>11,712</td>
<td>2,777</td>
</tr>
<tr>
<td><strong>TOTAL TAXPAYERS’ EQUITY</strong></td>
<td><strong>432,693</strong></td>
<td><strong>390,614</strong></td>
</tr>
</tbody>
</table>
## Statement of total recognised gains and losses for the year ended 31 March 2008

<table>
<thead>
<tr>
<th>Description</th>
<th>2007/8 £000</th>
<th>2006/7 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus/(deficit) for the financial year before dividend payments</td>
<td>16,105</td>
<td>2,134</td>
</tr>
<tr>
<td>Fixed asset impairment losses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unrealised surplus/(deficit) on fixed asset revaluations/indexation</td>
<td>27,556</td>
<td>25,087</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>1,019</td>
<td>972</td>
</tr>
<tr>
<td>Defined benefit scheme actuarial gains/(losses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additions/(reductions) in &quot;other reserves&quot;</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total recognised gains and losses for the financial year</strong></td>
<td><strong>44,633</strong></td>
<td><strong>28,240</strong></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><strong>44,633</strong></td>
<td><strong>28,240</strong></td>
</tr>
</tbody>
</table>
## Cash flow statement for the year ended 31 March 2008

<table>
<thead>
<tr>
<th></th>
<th>2007/8 £000</th>
<th>2006/7 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OPERATING ACTIVITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from operating activities</td>
<td>42,346</td>
<td>14,126</td>
</tr>
<tr>
<td><strong>RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>1,193</td>
<td>890</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(1,022)</td>
<td>(8)</td>
</tr>
<tr>
<td>Interest element of finance leases</td>
<td>(7)</td>
<td>(10)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from returns on investments and servicing of finance</td>
<td>164</td>
<td>872</td>
</tr>
<tr>
<td><strong>CAPITAL EXPENDITURE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Payments) to acquire tangible fixed assets</td>
<td>(33,210)</td>
<td>(30,052)</td>
</tr>
<tr>
<td>Receipts from sale of tangible fixed assets</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>(Payments) to acquire intangible assets</td>
<td>(571)</td>
<td>0</td>
</tr>
<tr>
<td>Receipts from sale of intangible assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Payments to acquire)/receipts from sale of fixed asset investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from capital expenditure</td>
<td>(33,781)</td>
<td>(30,032)</td>
</tr>
<tr>
<td><strong>DIVIDENDS PAID</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash inflow/(outflow) before management of liquid resources and financing</td>
<td>(3,065)</td>
<td>(25,817)</td>
</tr>
<tr>
<td><strong>MANAGEMENT OF LIQUID RESOURCES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Purchase) of investments with DH</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Purchase) of other current asset investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sale of investments with DH</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sale of other current asset investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from management of liquid resources</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) before financing</td>
<td>(3,065)</td>
<td>(25,817)</td>
</tr>
<tr>
<td><strong>FINANCING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td>11,915</td>
<td>17,416</td>
</tr>
<tr>
<td>Public dividend capital repaid (not previously accrued)</td>
<td>0</td>
<td>(11,785)</td>
</tr>
<tr>
<td>Loans received from DH</td>
<td>6,141</td>
<td>19,986</td>
</tr>
<tr>
<td>Other loans received</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans repaid to DH</td>
<td>(3,332)</td>
<td>0</td>
</tr>
<tr>
<td>Other loans repaid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other capital receipts</td>
<td>151</td>
<td>279</td>
</tr>
<tr>
<td>Capital element of finance lease rental payments</td>
<td>(46)</td>
<td>(43)</td>
</tr>
<tr>
<td>Cash transferred (to)/from other NHS bodies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from financing</td>
<td>14,829</td>
<td>25,853</td>
</tr>
<tr>
<td>Increase/(decrease) in cash</td>
<td>11,764</td>
<td>36</td>
</tr>
</tbody>
</table>
Better Payment Practice Code – measure of compliance

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>2007/8 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Non-NHS trade invoices paid in the year</td>
<td>94,387</td>
<td>190,366</td>
</tr>
<tr>
<td>Total Non NHS trade invoices paid within target</td>
<td>81,181</td>
<td>166,548</td>
</tr>
<tr>
<td>Percentage of Non-NHS trade invoices paid within target</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>4,274</td>
<td>41,991</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>2,946</td>
<td>35,762</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>69%</td>
<td>85%</td>
</tr>
</tbody>
</table>

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

Management costs

<table>
<thead>
<tr>
<th></th>
<th>2007/8 £000</th>
<th>2006/7 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management costs</td>
<td>17,865</td>
<td>15,546</td>
</tr>
<tr>
<td>Income</td>
<td>534,000</td>
<td>484,559</td>
</tr>
</tbody>
</table>

NOTE – Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/cs/en

External Audit Services

External Audit Services are provided by the Audit Commission. Audit fees of £352k in 2007/8 includes changes for:

a) Audit of Accounts of £209k (inc VAT) and
b) Audit of “use of resources” of 143k (inc VAT)

Directors of the Trust provide relevant information to the NHS auditors through the Director of Finance. In addition, individual directors work closely with the Audit Commission as required on specific aspects of the annual audit plan, including the annual audit of accounts. Directors will attend the Audit Committee for discussion in audits for which they are identified as the lead Director. The full Board receives copies of the full accounts information prior to formal sign off and receives a report from the Audit Committee prior to their consideration of the accounts. In addition, the Audit Committee prepares an annual report on its work for the consideration of the Trust Board.
### Salary and pension entitlements of senior managers

#### (A) Salaries and allowances

Past and present employees are covered by the provisions of the NHS Pensions Scheme. In the preparing the Accounts for the Trust for 2007/8, the NHS Accounting Policy on pension costs has been noted. The Remuneration report gives detail of pension benefits for Senior Management.

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2007/8</th>
<th>2006/7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>(£000)</td>
<td>Remuneration</td>
</tr>
<tr>
<td>Dame Fiona Caldicott</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Dr Kenneth Fleming</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Caroline Langridge</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Brian Rigby CBE</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Professor Adrian Towsie</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Dr Colin Reeves</td>
<td>5-10</td>
<td>5-10</td>
</tr>
<tr>
<td>Trevor Campbell Davis</td>
<td>160-165</td>
<td>175-180</td>
</tr>
<tr>
<td>Dr John Reynolds (2)</td>
<td>20-25</td>
<td>80-85</td>
</tr>
<tr>
<td>Mr M Greenall (2)</td>
<td>35-40</td>
<td>155-160</td>
</tr>
<tr>
<td>Dr David Lindbell (Chair)</td>
<td>40-45</td>
<td>185-190</td>
</tr>
<tr>
<td>Moira Logie (3)</td>
<td>90-95</td>
<td>70-75</td>
</tr>
<tr>
<td>Kathleen Simcock (4)</td>
<td>100-105</td>
<td>75-80</td>
</tr>
<tr>
<td>Joanna Foster (5)</td>
<td>80-85</td>
<td>60-65</td>
</tr>
<tr>
<td>Dr James Morris</td>
<td>40-45</td>
<td>170-175</td>
</tr>
<tr>
<td>Ian Humphries</td>
<td>90-95</td>
<td>90-95</td>
</tr>
<tr>
<td>Michael Fleming</td>
<td>95-100</td>
<td>100-105</td>
</tr>
<tr>
<td>Dr Mike Sinclair (8)</td>
<td>20-25</td>
<td>80-85</td>
</tr>
<tr>
<td>Julie Hartley-Jones (9)</td>
<td>0</td>
<td>35-40</td>
</tr>
<tr>
<td>Helen Munro (10)</td>
<td>0</td>
<td>80-85</td>
</tr>
</tbody>
</table>

**NOTES**

1. John Reynolds left post of Divisional Chair in October 2007
2. M Greenall was appointed as Divisional Chair in July 2006
3. M Logan joined the Trust in June 2006
4. I Paul joined the Trust in August 2006.
5. Amanda Middleton providing Maternity leave cover.
6. E. Strachan-Hall joined the Trust in February 2007
7. Mark Gammage employed through Dearden Consultancy Ltd. Salary figures derived from invoice analysis
8. M Sinclair retired in December 2006
9. Julie Hartley-Jones left the Trust in August 2006
10. H Munro left the Trust in February 2007
## Salary and pension entitlements of senior managers

### (B) Pension benefits

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>real increase in pension at age 60</th>
<th>real increase in pension lump sum at aged 60</th>
<th>Total accrued pension at age 60 as at 31 March 2008</th>
<th>Lump sum at aged 60 related to accrued pension at 31 March 2008</th>
<th>Cash Equivalent Transfer Value at 31 March 2007</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
<th>Employers contribution to Stakeholder Pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trevor Campbell Davis</td>
<td>0-2.5</td>
<td>2.5-5.0</td>
<td>10.0-15.0</td>
<td>30.0-35.0</td>
<td>217</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>Dr John Reynolds</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>50.0-55.0</td>
<td>155.0-160.0</td>
<td>814</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Mr M Greenall</td>
<td>12.5-15.0</td>
<td>42.5-45.0</td>
<td>80.0-85.0</td>
<td>250.0-255.0</td>
<td>1,550</td>
<td>1,262</td>
<td>202</td>
</tr>
<tr>
<td>Dr David Lindsell</td>
<td>17.5-20.0</td>
<td>52.5-55.0</td>
<td>90.0-95.0</td>
<td>280.0-285.0</td>
<td>1,675</td>
<td>1,329</td>
<td>242</td>
</tr>
<tr>
<td>Moira Logie, Director</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>30.0-35.0</td>
<td>95.0-100.0</td>
<td>476</td>
<td>458</td>
<td>12</td>
</tr>
<tr>
<td>Kathleen Simcock</td>
<td>2.5-5.0</td>
<td>12.5-15.0</td>
<td>15.0-20.0</td>
<td>50.0-55.0</td>
<td>216</td>
<td>151</td>
<td>46</td>
</tr>
<tr>
<td>Joanna Foster (Paul)</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>15.0-20.0</td>
<td>50.0-55.0</td>
<td>228</td>
<td>213</td>
<td>10</td>
</tr>
<tr>
<td>Amanda Middleton</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>15.0-20.0</td>
<td>50.0-55.0</td>
<td>228</td>
<td>213</td>
<td>10</td>
</tr>
<tr>
<td>Dr James Morris</td>
<td>0-2.5</td>
<td>5.0-7.5</td>
<td>30.0-35.0</td>
<td>90.0-95.0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Elaine Strachan-Hall</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>30.0-35.0</td>
<td>95.0-100.0</td>
<td>433</td>
<td>411</td>
<td>15</td>
</tr>
<tr>
<td>Chris Hurst</td>
<td>2.5-5.0</td>
<td>7.5-10.0</td>
<td>45.0-50.0</td>
<td>135.0-140.0</td>
<td>713</td>
<td>650</td>
<td>44</td>
</tr>
<tr>
<td>Andrew Stevens</td>
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<td>Helen Munro</td>
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As Non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-executive members.

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

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

A glossary of the key terms used in the Annual Report is outlined below.

Terms used within I and E accounts:

- **Income from activities** includes all income from patient care. The main source of income is from Primary Care Trusts (PCTs). Other sources of income include private patient income.
- **Other operating income** includes non-patient related income including education, training and research funding.
- **Profit/(loss) on disposal of fixed assets.** A fixed asset is an asset intended for use on a continuing basis in the business. The profit/(loss) is the difference between the sale proceeds of a fixed asset and its current value.
- **Other finance costs** – unwinding of discount. The unwinding charge reflects the difference between this year’s and last year's estimates for the current cost of future payments on financing charges relating to provisions.
- **A provision** is a liability where the amount and timing is uncertain. While there has been no cash payment, the Trust anticipates making a payment at a future date and so its net assets are reduced accordingly.
- **Public Dividend Capital Dividend.** At the formation of NHS Trusts, the purchase of Trust assets from the Secretary of State was half-funded by public dividend. It is similar to company share capital, with a dividend being the payable return on the Secretary of State’s investment.
- **Retained Surplus (Deficit).** This shows whether the Trust has achieved its financial target to break-even for the year. This is different from the statutory duty to break-even ‘taking one year with another’ which is measured over three, or exceptionally, five years.
- **The Balance Sheet** provides a snapshot of the Trust’s financial condition at a specific moment in time – the end of the financial year. It lists assets (everything the Trust owns that has monetary value), liabilities (money owed to external parties) and taxpayers’ equity (public funds invested in the Trust). At any given time, the assets minus the liabilities must equal taxpayers’ equity.

Terms used within the Balance Sheet

- **Intangible assets** are assets such as goodwill, licenses and development expenditure which although they have a continuing value to the business do not have a physical existence.
- **Tangible fixed assets** include land, buildings, equipment and fixtures and fittings.
- **Debtors** represent money owed to the Trust at the Balance Sheet date.
- **Creditors** represent money owed by the Trust at the Balance Sheet date.
- **A provision** is a liability in which the amount and timing is uncertain. While there has been no cash payment, the Trust anticipates making a payment at a future date and so its net assets are reduced accordingly.
- **Assets** represent rights or other access to future economic benefits controlled by the Trust as a result of past transactions or events.
- **Liabilities** represent obligations of the Trust to transfer economic benefits as a result of past transactions or events.
- **Public Dividend Capital Dividend.** At the formation of NHS Trusts, the purchase of Trust assets from the Secretary of State was half-funded by public dividend. It is similar to company share capital, with a dividend being the payable return on the Secretary of State’s investment.

The **cash flow statement** summarises the cash flows of the Trust during the accounting period. These cash flows include those resulting from operating and investment activities, capital transactions, payment of dividends and financing.

Terms used within the Cash Flow Statement

- **Net cash inflow from operating activities:** cash generated from normal operating activities.
- **Returns on investments and servicing of finance:** cash received on short-term deposits and interest paid relating to costs of financing the Trust.
- **Capital expenditure:** payments for new capital assets and receipts from asset sales. Capital expenditure relates to spending on buildings, land and equipment which exceeds £5,000.
- **Public dividend capital dividend.** At the formation of NHS Trusts, the purchase of Trust assets from the Secretary of State was half-funded by public dividend. It is similar to company share capital, with a dividend being the payable return on the Secretary of State’s investment.
- **Net cash inflow/(outflow) before financing.** This represents the additional cash the Trust needed over and above what it could generate itself to conduct its business. The Department of Health set a limit on the amount of external finance trusts can obtain.
- **Financing.** This provides detail of where additional cash came from to support cash needs.
The statement of total recognised gains and losses provides a summary of all the Trust’s gains and losses. The I and E account will only provide details of gains and losses that have been realised. But the statement provides a summary of all gains and losses regardless of whether or not they were shown in the I and E account of the balance sheet. It starts with the Trust’s surplus or deficit before the payment of dividends (taken from the I and E account) and then provides details of unrealised gains and losses (i.e. gains and losses which have not yet had any cash consequences) such as those arising from the revaluation of property.

Terms used within Statement of Total Recognised Gains and Losses

- Unrealised surplus/(loss) on fixed asset revaluations/indexation. This represents gains/losses that the Trust has made because of change in the asset values, but where the assets have not been sold so there is no ‘cash’ profit.

Statement on Internal Control for 2007/8

Scope of responsibility

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

2. All Board members are aware of their responsibility to monitor the systems of internal control. Board members receive regular updating regarding these responsibilities and the need to maintain an awareness of the Nolan Principles of good governance. Staff throughout the organisation are made aware of their responsibility to maintain high standards of conduct and accountability. In support of good governance, and to ensure the safekeeping and appropriate use of public funds, the Trust also maintains a proactive programme of counter-fraud and a “whistle blowing” policy.

3. Close working relationships exist within Oxfordshire, with local Trusts and Oxfordshire PCT and with the Social and Community Services Directorate of Oxfordshire County Council and the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC). Within the wider health economy, effective working relationships exist with other key commissioners, including the Buckinghamshire, Berkshire, Gloucestershire, Wiltshire, and Northamptonshire PCTs, and with the acute Trusts in these counties.

4. In addition, partnerships exist with both of Oxford’s Universities. The partnership with the University of Oxford has this year been formalised through a Strategic Partnership Board, which I chair. The establishment of the Biomedical Research Centre during 2007 has supported and strengthened the drive towards increasing congruence for strategy and discussions also continue on how governance arrangements might be developed during the Foundation Trust (FT) application process and how the Trust and University of Oxford can work together to create an Academic Health Sciences Centre.

5. Close working relationships have also been fostered with patients and the public, including meetings held throughout the year with the ORH Patient and Public Involvement Forum (disbanded from 31 March 2008) and the ORH Patient Panel.
6. I have delegated responsibility for the establishment and maintenance of a risk management system and Board Assurance Framework to the Director of Nursing and Clinical Leadership, in support of the system of internal control.

**The purpose of the system of internal control**

7. 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:
   7.1. Identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,
   7.2. evaluate the likelihood of those risks being realised and the impact should they be realised,
   7.3. monitor these risks throughout the year, and
   7.4. manage them efficiently, effectively and economically.

8. The system of internal control has been in place in the Trust for the whole year ended 31 March 2008 and up to the date of approval of the annual accounts.

**Capacity to handle risk**

9. The Board of the Oxford Radcliffe Hospitals NHS Trust reviewed and agreed the Governance, Quality and Risk Framework in January 2008, and has in place both a health and safety strategy and policy, and an incident reporting policy and procedure. The risk management and health and safety policies lay down clear responsibilities for named officers and for all staff across the Trust. Risk assessment procedures have been approved, and risk registers, covering risks for corporate directorates and the three clinical divisions, are in place and have been reviewed regularly by the Governance Committee. These individual risk registers are also reviewed by the relevant Divisional Board or corporate Directorate meetings in line with Trust policy.

10. The Trust–wide risk register was updated in November 2007 by the Executive Board and presented to the Trust Board for review after consideration by the Audit and Governance Committees. A further review is planned for July 2008.

11. The Director of Nursing and Clinical Leadership has delegated responsibility for risk and the risk management systems across the Trust. The Assistant Director of Quality and Risk and the Assistant Director of Governance meet bi-weekly with the Director of Nursing and Clinical Leadership and the Medical Director to review all aspects of risk and governance. In addition, the Medical Director has a specific responsibility as the Director of Infection Prevention and Control and, with the infection control team, has paid particular attention to ensuring that the Board and the Executive have been kept fully up to date with all issues associated with the management of healthcare associated infections.

12. The Governance Committee met throughout the year and the minutes are presented to the Trust Board in its public meetings. Appropriate areas of governance, including quality and risk, corporate and clinical governance, research governance and information governance, are covered as standing items on the agenda. The secretary to the Committee, the Assistant Director of Governance, has continued as secretary to the Audit Committee, to ensure the integration of these aspects of general and financial governance. Cross-membership exists between these two Committees, in order to strengthen their integration. Further work on integration will draw on the work described below.

13. Consideration has been given to the governance of the organisation as part of the developing FT application process. Work is underway on the review of Trust Board sub committees and the appointment of an FT secretary is underway. The development of the governance arrangements will continue as part of the FT process and take account of the compliance requirements set by Monitor.

14. Work has continued throughout the year on quality and risk reports from both the clinical divisions. The increased availability of information and data from the newly purchased Dr Foster databases has provided additional means to analyse performance and to benchmark against peer organisations. Increasingly the focus has been on the assurances to be drawn from reports on all areas of the Trust's activities and how best these can be presented.

15. The Executive Board has maintained its responsibility for the review of risks and quality issues, drawing on the work within the divisions and corporate directorates. A key element in the revised framework (see 7 above) has been the embedding of governance within the divisions, directorates and services, and the continued development of the risk assessment process.
The risk and control framework

16. The Trust Board has delegated the responsibility for the review and monitoring of the Board Assurance Framework (BAF) to the Governance Committee. The BAF has been reviewed throughout the year, ensuring that it has become a dynamic document, fully reflecting updates in the risk register and the achievement of assurances. The BAF was considered by the Trust Board in January 2008, following a final review and updating through the Governance Committee. In addition the Audit Committee has also reviewed the BAF in year. The Trust’s HR and Commercial Committees have been involved in the review of relevant objectives, strategies and risks, particular in order to provide assurances in relation to compliance with core standards.

17. The Chief Executive has delegated responsibility for the BAF to the Director of Nursing and Clinical Leadership, and it is prepared, updated and maintained by the Assistant Director of Governance. All of the expected components, as defined by the Department of Health, have been incorporated within the BAF, including assurances and gaps in controls and assurances. Actions plans have been in place throughout the year to meet these gaps.

18. The strategic goals and strategic objectives contained within the BAF were identified by the Trust’s Executive team and approved by the Trust Board as part of the Business Plan. The core standards have been cross-referenced to the strategic objectives and the risks are consistent with the strategic objectives. Each risk identified is the responsibility of a nominated lead, and review and updating of the BAF during the year has provided the opportunity for the risks (or changes to the risks) to be identified, evaluated and controlled, ensuring that the BAF was a dynamic document.

19. In addition, the BAF and the Trust Risk register have been brought together and cross referenced to show linkages throughout. The actions plans included within the BAF have also been ‘traffic-lighted’ to ensure that the Board and the Governance Committee have been kept up to date with changes and the completion of action plans throughout the year.

20. The Trust’s Declaration to the Healthcare Commission (HCC) on compliance with the core standards and the Hygiene Code has been supported by information and has reviewed the state of compliance during the year through regular reports to the Executive and Trust Board. In addition, directors have reviewed individual elements and core standards contributing to the Declaration. The corporate directorates and clinical divisions have continued to support the collection and collation of evidence in support of the Declaration and the BAF.

21. The Declaration has been supported by cross reference to, for example, the outputs from the HCC’s annual patient and staff surveys, the HCC spot checks on dignity in the care of the older person, and the benchmark indicators made available for the first time in March 2008.

22. Performance on other elements contributing to the quality element of the Annual Health Check has been monitored by the Executive Board and the Trust Board. Increased use has been made of benchmarking information so that the effectiveness of internal systems can be developed.

23. The BAF has been used by the Trust Board to provide it with reasonable assurance on compliance with the core standards, and a statement to this effect has been included in the ORH’s Declaration of Compliance with core standards to the HCC.

24. The Trust Board papers, including the BAF, the SIC and the minutes of Board Sub Committees, are public documents. Governance Committee papers are also available to the public on request.

25. The Information Governance Group, reporting to the Governance Committee, oversees information governance activity, including the management of risk, across the Trust, and during the year has carried out the agreed information governance work programme; this included the review and updating of key information governance policies on confidentiality and information protection. The group also reviews Freedom of Information requests, relevant incidents and oversees the annual information governance toolkit self-assessment. The Director of Planning and Information, was the Board lead for Information Governance.

26. As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

27. Meetings have been held throughout the year with the ORH Patient and Public Involvement Forum and the ORH Patient Panel. Joint work has continued on the control of infection, privacy and dignity, public and patient involvement, equality and diversity and standards of cleanliness. Patients and patient representatives have continued their contribution to the preparation of good quality information on services and procedures, including a number of new clinical information leaflets.
28. ORH Directors and managers have continued to brief HOSC, particularly in relation to the control of infection; members of the control of infection team attended HOSC meetings on two occasions during 2007/8.

Review of effectiveness

29. As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework, and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control also provide me with assurance. The BAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. The completion of action plans detailed within the BAF provides me with evidence that gaps in controls and/or assurances have been filled.

30. 2007/8 was the third year of the Auditor's Local Evaluation (ALE) system, and we have targeted and achieved an improvement in our performance against the ALE standards from the results achieved in the previous year. The ORH again established a project team to deliver this work, with named leads for each of the Key Lines of Enquiry (KLOEs) within the five domains and project management support. Progress has been monitored by the Board and the Audit Committee. The ALE assessment has provided valuable feedback across all of the domains, and highlighted both areas of particular strength and those for further development. The ALE framework has a specific domain for internal control, and the work done to assess our performance against the KLOEs and specific standards has provided me with assurance on the system of internal control.

31. The inspection process for five core standards carried out by the Healthcare Commission in June 2007 resulted in no qualification to our declaration and hence provided assurances to me and the Board that our processes for the collation of evidence and the provision of assurances are sound.

32. The ORH provided assurances to the SCSHA on the security of our bulk data transfers and the mapping of data flows processes. In addition, further work will be done in response to SCSHA. Advantage has been taken of the central procurement arrangements for encryption software which is currently being deployed in line with the agreed programme.

33. The outcome of the Information Governance Toolkit self-assessment showed an improvement to 81% reflecting the increased focus on this important area. Further work will be done with CEAC to ensure continued improvements and robustness.

34. The Trust's Standing Orders and Standing Financial Instructions (and associated documents) were reviewed during the year, and the outcome was considered by the Audit and Governance Committees prior to approval by the Trust Board in November 2007.

35. The Board and the Governance Committee have monitored delivery of action plans associated with the external review at the Horton Hospital (now completed and signed off by the SHA) and the Healthcare Commission's report on cardiothoracic surgical services. The ORH has worked with the SHA on the HCC report and many of the recommendations have now been met; work will continue with the aim of achieving completion and sign off from both the SHA and the HCC during 2008. The outcome of the Independent Reconfiguration Panel (IRP) and the Secretary of State's decision was received on 20 March and the ORH is now working closely with Oxfordshire PCT as it leads the next stage of the work.

36. My review is also informed by the work of the Audit Commission (the Trust's external auditors), including their Opinion on the Trust's financial statements, their annual governance letter, final accounts memorandum and annual audit letter.

37. In addition, the work of CEAC, the Trust's internal auditors, has informed this review of internal control; their reports have covered the following topics and have been referenced in the BAF:

37.1. Divisional and corporate directorate reviews, covering, inter alia, the accurate recording of vascular surgery patient activity; Pre operative waiting time for emergency surgery patients; Patient coding in PICU and gynaecology; admission processes in the Children's Hospital and privacy and dignity.

37.2. Physical security and commissioning.

37.3. Research Governance.

37.4. Information management audits and audit of safe haven procedures.

37.5. Specific aspects of human resources management, including the impact of restructuring.

37.6. Specific aspects of financial management and services, including income, procurement and creditor payments.

37.7. Standards for Better Health.

37.8. Integrated governance, and the required review of the BAF.
38. Counter-fraud work has also continued, with regular reports being made to the Audit Committee throughout the year.

39. A corporate risk register is also in use, based on the top ten risks identified by each clinical division and corporate directorate. The risk assessment procedure has been agreed, and the governance, quality and risk framework updated and agreed.

40. The SHA has reviewed both the BAF and the SIC at the year end.

41. The Governance and Audit Committees have each reviewed the systems of internal control, and assured me, as Accountable Officer, of their effectiveness. A process to address weaknesses and ensure continuous improvement of the systems, based on both ALE and governance and risk processes being developed through the FT application process, will be monitored by both Committees on behalf of the Trust Board.

42. The following activities also have supported my review of the effectiveness of the system of internal control:

   42.1. The work of our ‘expert’ committees including health and safety, clinical risk management, incidents, comments and complaints, human tissue governance group (established in response to the Human Tissue Act), hospital infection control, medicines management, blood transfusion, and radiation protection.

   42.2. Achievement of NHSLA level 1 in 2007.

   42.3. The Audit Committee in its review and scrutiny of the financial standards and processes and ALE throughout the year.

   42.4. The Governance Committee in its review of the key areas of clinical governance (including quality, research governance and information governance [through its sub-committee the Information Governance Group]) and corporate governance (the BAF and risk management and assessment).

   42.5. The Governance Committee and the Trust Board in their monitoring of compliance with the elements that make up the Annual Health Check, and in their monitoring of the external report on the Horton Hospital and HCC investigation report.

   42.6. The HR and Commercial Committees, both sub-committees of the Trust Board, have an assurance role and have played their part in the system of internal control. The Finance and Performance Committee has reviewed financial and operational performance issues throughout the year.

   42.7. The Trust Board, which reviewed and approved the BAF and the Trust Risk Register at its meeting in January 2008.

43. The Head of Internal Audit Opinion has provided me with an overall opinion “that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. Significant assurance was provided on the effectiveness of the management of those principal risks identified within the organisation’s Assurance Framework.

44. Internal Audit have also provided me with the following opinion on the BAF:

   44.1. “The Board Assurance Framework (BAF) is a valuable tool for any organisation in managing its principal risks, Oxford Radcliffe Hospitals NHS Trust (ORH) is no exception. The Assurance Framework is fully embedded in the Trust and effectively managed. Whilst the Board assume overall responsibility for the document the framework is managed by the Governance Committee.

   44.2. The Board have been involved in developing and maintaining the BAF, with further improvements from that audited the previous year. It has been noted that further updates have taken place.

   44.3. Recorded objectives are sufficiently strategic, well balanced and well referenced to the Standards for Better Health throughout. The risks linked to the objectives are high level, consistent with the objectives and are mapped through to the controls, and sources of assurance. However, not all red risks had been included in the BAF at the time of the audit, although this has been addressed since the audit was undertaken.

   44.4. Gaps in control and assurance were identified with action plans in place with appropriate timescales and officers identified.

   44.5. The overall opinion was of “significant assurance”.

45. Internal Audit have provided me with the following opinion on their audit of Standards for Better Health “we offer the Trust significant assurance …..the HCC core and standards have been addressed and work is well in hand to rectify weaknesses previously identified.”
46. An action plan has been drawn up to take account of points raised in the HOIA Opinion. In addition, as noted below, action plans are in place to achieve compliance with the remaining core standards. Plans are also in place to ensure continued improvement against the ALE standards. These will be implemented throughout the year, and progress will be monitored by the Governance and Audit Committees. This work will inform the application process for Foundation Trust status, and the development of the BAF for 2008/09, which is now in progress.

**Significant control issue**

47. The Trust's Declaration of Compliance with HCC Core Standards and the Hygiene Code, made on 30 April 2008, shows compliance with 41 of the 43 standards and compliance at the year end for two standards. For one of these standards C20b, compliance at the year end was achieved in line with the action plan included in the declaration for 06/07. The Trust Board has been assured that lack of compliance for the full year for these two standards did not pose any increased risk to patients, staff or the public, and that the relevant systems, processes and procedures are robust.

Trevor Campbell Davis  
Chief Executive  

June 2008
Further information

For further information about the Trust, or for additional copies of this report, please contact:

Director of Communications, Oxford Radcliffe Hospitals
John Radcliffe Hospital
Headley Way, Headington,
Oxford OX3 9DU

Tel: 01865 228932

If you need an interpreter or need a document in another language, large print, Braille or audio version, please call 01865 221473. When we receive your call we may transfer you to an interpreter. This can take some time, so please be patient.

Albanian
J'u lutemi telefononi në numrin 01865 221473, nëse keni nevoje për një përkohje apo dokument të përkohëve në një gjuhë tjeter, përjetim me shkonja të mëca. me shkonja për të verbërri apo kasetë audio. Kur të n'a telefononi, mund j'u transferojmë te një përkohje. Kjo mund të marrë pak kohë, kështu që j'u lutemi keni kohë durim.

Arabic
إذا كنت في حاجة إلى مترجم أو تحتاج إلى مساعدة بلغة أخرى أو بحث كبير أو بطريقة بريل أو على شكل نسخة صوتية، يرجى الاتصال ب 01865 221473. عندما تلتقي مكالمة، قد تقوم بتحويلك إلى مترجم. وقد يستغرق ذلك بعض الوقت، لهذا نرجو منك التحلي بالصبر.

Bengali
আপনার হয় একজন অনুবাদক প্রামাণ্য হয় বা এই নামাঙ্কিত অন্য ভাষা, বা প্রিন্ট, হ্যান্ডবার বা অতিরিক্ত ভাষায় প্রামাণ্য হয়, তাহলে অংশগ্রহণ করা, 01865 221473 নম্বর দিয়ে কথা বলুন। যখন আপনি আপনার কলটি পরে, আপনি একজন অনুবাদকের কাছে ধরাতল হাফসার বর্তমান। এতে কিছুটা সময় লাগাতে পারে, তবে অামি অ্যান্ড করে চেষ্টা করব, শুরু হয় ধরনের।

Mandarin
如果你需要一位口译员的协助，或者你需要本文件的其他语言，大字印刷、盲文或音频版本，请致电01865 221473。当我们接到你的来电时，我们会转到你推荐一位口译员，这可能会花费一点时间，所以请耐心等候。

Pashto
که ناسو د خپلو زاری یا سره د زه یا د وکار ولیکه او ولیکه د لاسنډ (دسانماری) به کله زه، خپل Nazi (بریل) کی سی چې د لاسه کری، لوپه له کری چې محصول یا هغه د شنکریو بایدی چې یو چې یو چې یو چې یو چې یو چې 01865 221473. کله چې یو نیولی پیر یو کی کې له چې له سانسان کیلو یو شپی کې یو چې یو چې یو چې یو چې 01865 221473. کله چې یو نیولی پیر یو کی کې له چې له سانسان کیلو یو شپی کې یو چې یو چې یو چې یو چې 01865 221473.

Polish
Jeżeli potrzebujesz tłumacza lub któryś z dokumentów w innej wersji językowej, dużym drukiem, brajtem lub w wersji dźwiękowej, prosimy o zatelefonowanie pod numer: 01865 221473. Po odebraniu Twojego telefonu prawdopodobnie połączymy Cię z tłumaczem. Apelujemy o cierpliwość, gdyż może to zabrać trochę czasu.

Portuguese
Se precisar de um intérprete ou de um documento traduzido para outra língua, em formato ampliado, em Braille ou em áudio, por favor ligue para o 01865 221473. Quando recebermos a sua chamada, podemos transferi-la para um intérprete. Isto pode demorar algum tempo, por isso pedimos-lhe que seja paciente.

Sorani
نتهکر پیویسیتی ور ورگیرکی هیدیه خاوه پیویسیتی ور ورکرید که هیه که های زمانیکی تی. جابی پیشی که ور ور. راچی جابی کرچکی ور خاوه. ور ورگیرکی تکنیکی تکنیک های که ور های زمانیکی. 01865 221473. پکاینی ور ورگیرکی هیدیه خاوه پیشی دکتر که ور ورگیرکی تکنیکی حاوی حاوی که ور ورگیرکی تکنیکی تکنیکی حاوی حاوی که ور ورگیرکی تکنیکی تکنیکی.

Urdu
اگر آپ کریم ہیں جو ضرورت ہے بی. پی. ایم کو ڈاکٹر کی ڈاکٹر میں ہے اور ڈاکٹر کی ڈاکٹر میں ہے اور ڈاکٹر کی ڈاکٹر میں ہے اور ڈاکٹر کی ڈاکٹر میں ہے اور ڈاکٹر کی ڈاکٹر میں ہے اور ڈاکٹر کی ڈاکٹر میں ہے اور ڈاکٹر کی ڈاکٹر میں ہے۔

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