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Welcome to this year’s Annual Review of the Oxford Radcliffe Hospitals. Reviews such as this have a legal purpose to fulfil in demonstrating accountability in the expenditure of public funds. They are also an opportunity to reflect on the recent history of the organisation, and to set out its future direction of travel.

This has been a rather special year for the ORH in a number of ways. We were delighted that in November, Her Majesty The Queen and The Duke of Edinburgh visited the John Radcliffe Hospital to celebrate the official opening of the Oxford Children’s Hospital and the West Wing. The Queen and the Duke made time during a very busy schedule to tour the new facilities and to talk to many staff, patients, students and colleagues from the University of Oxford and other organisations.

In March, the Prime Minister, the Right Honourable Gordon Brown MP, made a surprise visit to the new Cancer Centre at the Churchill Hospital, a few days before it officially opened to patients. The Centre brings together, under one roof, clinical and research teams previously based on several different sites, some with accommodation and facilities which were well below the standards patients expect in the modern NHS. The combination of innovation in environmental design with the concentration of clinical expertise makes the Cancer Centre one of the leading facilities of its type in the UK. It has been designed with the needs of patients in mind, incorporating artwork and the use of colours and light to create a calming environment. It took nearly ten years of planning and development and has won an award for its low energy use.

The year also included an extended educational visit by a group of Iraqi doctors, here by arrangement with the Iraqi and British governments, to update their clinical and managerial skills. The doctors spent six weeks in the Trust, shadowing clinical colleagues and taking part in workshops aimed at giving them an insight into the way in which the NHS is organised and the developing role of clinical managers. Following the visit, the Iraqi Health Minister, Dr Salih Al-Hasnawi, came with colleagues to visit the John Radcliffe Hospital to thank the staff who had been involved in the programme, and to emphasise the contribution the programme had made to the rebuilding of the Iraqi healthcare system.
This Review focuses not only on the special events of the past year, but on the Trust’s continuing improvements in key areas. As with other NHS organisations, our performance is measured against national criteria aimed at ensuring that patients have timely access to safe and high-quality care and that resources are used efficiently and effectively. These culminate in the Healthcare Commission’s annual health check, which reviews performance against more than sixty individual indicators. In October 2008, for the first time, we achieved the top rating of ‘excellent’ for the quality of our clinical care for the previous year, 2007/08. This is well deserved national recognition for both clinical and non-clinical staff within the organisation who have worked tirelessly to improve the high quality of our patient care, in many different areas.

During 2008/09 we also demonstrated our continued financial stability, and achieved a surplus, despite the fact that we treated more patients than had been planned in the contract which our principal commissioners hold with us.

It would be remiss of me to outline our many achievements without acknowledging the invaluable contribution made by my predecessor as Board Chairman, Sir William Stubbs. Sir William, who was Chairman from 2003 until November 2008, led the Trust through a period of significant development and improvement and left the organisation in considerably better health than he found it. On behalf of the Board of the Trust, I would like to thank Sir William for his wise leadership, his commitment to high quality patient care, and his concern for strong governance and robust financial management.

Although this year has largely been one of success for the Trust, we have had to come to terms with one major setback. In June 2008, Health Minister Lord Darzi announced the creation in the UK of a small number of Academic Health Science Centres, which will bring together the highest quality patient services with teaching and research. Oxford Radcliffe Hospitals, in co-operation with the University of Oxford and other academic and healthcare partners, submitted an application for the creation of an Oxford Academic Health Science Centre. Ours is an ambitious vision, requiring new structural and governance arrangements so that patient services, teaching and research are aligned both strategically and operationally within the organisation, and so that other partners can be brought in collaboratively.
This, we believe, will bring a wide range of benefits to our patients, who will have early access to new and innovative approaches to clinical care, provided by some of the best clinicians in their fields.

We were deeply disappointed when our application did not succeed at this time, but were encouraged by the feedback which we received, which indicated that another application would be welcome in due course. We still believe that patients, staff and the local community will all benefit from the establishment of the Oxford Academic Health Science Centre. We will continue to work with the University of Oxford, Oxford Brookes University, the Nuffield Orthopaedic Centre, Oxfordshire Primary Care Trust and other partners to further refine our proposals, and look forward to being able to apply again in the future. In the meantime, we will move forward with our Foundation Trust application based on the fact that our aim still remains to create an Academic Health Science Centre in Oxfordshire.

Dame Fiona Caldicott
Chairman
About the Oxford Radcliffe Hospitals

At the Trust in 2008/09

- 609,656 people attended outpatient appointments
- 22,826 people were treated as inpatients
- 117,922 people attended the emergency departments
- 86,725 people were admitted as inpatients for emergency assessment or treatment
- 64,816 people were treated as day cases (111,734 if renal dialysis is included)
- 8,722 babies were delivered
In October 2008 the Trust was given the highest rating of ‘excellent’ by the Healthcare Commission’s annual health check for the quality of patient care in 2007/08.

The Oxford Radcliffe Hospitals NHS Trust (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 General Hospital in Banbury. We employed 10,283 people (equivalent to 8,052 full-time posts) at the end of the financial year and had a turnover of £614 million.

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 Oxford Biomedical Research Centre (OxBRC) is now in its third successful year of bringing together the research expertise of the Trust and the University of Oxford. The Trust provides general hospital services for people in Oxfordshire and neighbouring counties, and specialist services on a regional and national basis.

The main commissioner of our services is Oxfordshire Primary Care Trust (PCT). Other key commissioners are Buckinghamshire, Berkshire, Gloucestershire, Northamptonshire and Wiltshire PCTs. The Trust sits within the South Central Strategic Health Authority (SHA), which includes the counties of Oxfordshire, Buckinghamshire, Berkshire, Hampshire and the Isle of Wight. We work closely with many partner organisations within and beyond the NHS, such as patients’ groups, local authorities and the Oxfordshire Joint Health Overview and Scrutiny Committee (a committee of Oxfordshire County Council).
Our Hospitals

THE JOHN RADCLIFFE HOSPITAL
Headley Way
Headington
Oxford
OX3 9DU
Tel 01865 741166

The John Radcliffe Hospital in Oxford is the largest of the Trust's hospitals and the home of many departments of the University of Oxford's Medical Sciences Division, although medical students are trained throughout the Trust.

It is the site of the county's main accident and emergency service and also provides acute medical and surgical services, trauma, intensive care and women's services. The Oxford Children's Hospital, the Oxford Eye Hospital and the new Oxford Heart Centre are also part of the John Radcliffe Hospital.

The Hospital has 854 inpatient beds, 96 maternity beds and 95 day-case beds (including the West Wing and the Children's Hospital).

Oxford Children’s Hospital

The Oxford Children's Hospital opened in 2007. It is devoted to the care of sick children and houses almost all the Trust's paediatric services. The facilities, from the atrium to the clinics and wards, have been designed specifically for the welfare of children and teenagers.

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. There is accommodation for parents to stay overnight, either next to their child's bed or in a dedicated accommodation suite.

The hospital also includes a spacious outpatients department, a children's radiology department and a paediatric assessment centre.

West Wing

The West Wing also opened in 2007 and adjoins the Children's Hospital. The building is light and airy, with good facilities for patients and visitors, including coffee bars and shops. It houses the majority of services that were previously based at the Radcliffe Infirmary, including; neurosciences (neurology and neurosurgery, neurophysiology, neuropsychology, neuroradiology), specialist surgery (ear, nose and throat (ENT), plastic surgery, craniofacial surgery, ophthalmology), critical care facilities for specialist surgery and neurosurgery, a new day surgery unit, operating theatres and University of Oxford facilities.

Oxford Heart Centre

Oxford’s cardiac services already have an international reputation and will soon have facilities to match with the building of the new £29 million Oxford Heart Centre. The Centre is due to open in 2009 and provides additional single rooms, a cardiac intensive care unit, five catheter labs and teaching and conference facilities. This exciting development provides state-of-the-art facilities for research and treatment of people with heart disease. Trust staff already work closely with those of the University of Oxford, and have contributed significantly to advances in the delivery of care to heart patients. Oxford has also earned an excellent reputation for its valve surgery, congenital service, electrophysiology and day-case activity, treating 26,000 patients a year.
The Churchill Hospital is a centre for cancer services and other specialties, including renal services and transplant, clinical and medical oncology, dermatology, haemophilia, infectious diseases, chest medicine, medical genetics, palliative care and sexual health.

It has 176 inpatient beds, 108 day care beds and extensive outpatient and day care facilities. The hospital, together with the nearby John Radcliffe Hospital, is a major centre for healthcare research, housing departments of the University of Oxford’s Medical Sciences Division and other major research centres such as Cancer Research UK.

Oxford Cancer Centre

The Oxford Cancer Centre, at the Churchill Hospital, opened to the first patients in March 2009. For the first time, patients living in Oxfordshire and the surrounding areas will receive their cancer care in a dedicated purpose-built Centre, which brings together a wide range of medical and surgical services that were at the Churchill and John Radcliffe Hospitals. The new buildings comprise cancer and haematology, surgery and diagnostics and a private patient wing. The Cancer Centre forms a key part of the Trust’s strategic plan, ensuring that we meet the NHS Plan and Cancer Plan requirements to improve patient care and reduce waiting times. In addition, it offers a base for university research teams, enabling patients to have rapid access to new treatments and to take part in clinical trials.

The Centre is a sixth-wave project under the Government’s Private Finance Initiative (PFI) and involves a capital investment of approximately £109 million.

The new facilities include:

Cancer and Haematology Centre

The Cancer Centre includes radiotherapy treatment and planning, clinical and medical oncology, clinical haematology inpatients, chemotherapy outpatients and other outpatient services including clinical treatment trials and research.

Surgery and Diagnostics

This includes a large radiology department, a breast screening unit, a theatre suite with 10 operating theatres and recovery facilities and a new high-dependency unit with eight beds. Some adult elective inpatient surgical services currently at the John Radcliffe Hospital, will relocate to this new building.

Developments in recent years include the opening of the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM), which is a collaboration of the University of Oxford, the NHS and three partner companies, to create a world-class centre for clinical research on diabetes, endocrine and metabolic disorders, along with clinical treatment and education.
The Wytham Wing
The Wytham Wing is a first-class private patients’ facility, run by Oxford Radcliffe Private Healthcare, part of the ORH. The two-storey Wing offers care to patients from a wide range of clinical specialties, including gastrointestinal surgery, breast surgery, haematology, oncology and urology. The upper floor has a modern inpatient ward with 20 single en-suite rooms. On the ground floor, there is an outpatient department with spacious consulting rooms, amenities for minor procedures and a chemotherapy suite.
The Horton General Hospital in Banbury provides services for the people of North Oxfordshire and surrounding counties. Services include an emergency department, acute general medicine and surgery, trauma, obstetrics and gynaecology, paediatrics, coronary care and a cancer resource centre. The Trust promotes close clinical partnerships between all three of its hospitals. Clinical staff at the Horton General Hospital provide services in the other Trust hospitals and satellite outpatient clinics in towns such as Chipping Norton in North Oxfordshire and Brackley in South Northamptonshire. There are also video-conference satellite links to Oxford and close integration of departments.

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

Acute general medicine also includes a short-stay admissions ward, a medical assessment unit, a day hospital as part of specialised elderly care rehabilitation services, and a cardiology service. Other clinical services include dietetics, occupational therapy, pathology, physiotherapy and radiology.

The hospital employs 1,200 people, making it one of Banbury’s biggest employers. It has 220 inpatient beds, 23 maternity beds and 21 day-case beds. The local community takes great pride in the hospital and provides exceptional levels of volunteer support through the League of Friends, the Authorised Volunteer Service, Pets as Therapy Volunteers and Horton General Hospital Radio.

Since early 2006, elective orthopaedic patients in Oxfordshire and neighbouring counties have had the option of being treated at the new Horton NHS Treatment Centre run by Ramsey Health Care for Oxfordshire PCT. This is part of the Government’s strategy of introducing Independent Sector Treatment Centres across the country. This has proved a popular choice for patients living in the north of the county.

Oxfordshire PCT 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 which is based at the Horton General Hospital.

Recent developments at the Horton General Hospital include:

- the opening of a medical assessment unit, to facilitate quicker access for patients referred by their GP
- refurbishments of the hospital’s public areas, including new flooring, signage and the introduction of art works in many areas
- the introduction of an enhanced security system in the maternity unit
- accreditation as a bowel screening centre.
Better Healthcare Programme for Banbury and Surrounding Areas

The Trust 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 General Hospital.

In March 2008, the Independent Reconfiguration Panel (IRP) 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. It recognised that services at the Horton General Hospital must change but asked for a new set of proposals to be put forward.

Following the Secretary of State’s decision, the PCT established the Better Healthcare Programme for Banbury and Surrounding Areas, a programme of engagement with local people and stakeholders including the Trust and other NHS organisations, to develop a plan for local health services and to address the recommendations of the IRP.

In March 2009, the PCT launched Invitation to Innovate, a competition inviting the development of feasible ideas and proposals for the future provision of clinical services at the Horton General Hospital.
Becoming an Academic Health Science Centre and an Academic Foundation Trust

What are Academic Health Science Centres?

Academic Health Science Centres will lead the field in the UK in the provision of high-quality patient services, teaching and research, and will compete internationally for talented staff and students and significant research investment.

We were disappointed by our unsuccessful application to become one of the first Academic Health Science Centres (AHSC). However, the application process has given us much to build upon and a clear idea of what we need to do to achieve AHSC status in the future.

The organisational partners for the Oxford AHSC include the Oxford Radcliffe Hospitals, the University of Oxford, Oxford Brookes University, the Nuffield Orthopaedic Centre NHS Trust, Oxfordshire PCT, Oxford Learning Disabilities NHS Trust, and Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust.

The partnership is committed to working together to align high-quality clinical services with education and research, because of the benefits this will bring to our patients, current and future health professionals, and the wider community.

The international panel which assessed our application acknowledged the outstanding science and biomedical research carried out in Oxford and commented on the excellent potential foundations for an Oxford AHSC. They also made several specific suggestions, which will be considered in more detail by the partners. Although the panel complimented Oxfordshire on the strength of its research and the impact that this has on patient care, they felt there was a need to demonstrate a greater focus on developing research to benefit patients in primary care as well as secondary care. We have been invited to apply again and plan to do so.
The ORH continues to work towards becoming an Academic Foundation Trust. During the spring and summer of 2008 the Trust had a successful consultation period with local stakeholders on its proposals and organised eight public meetings around Oxfordshire, 16 public information stands located in libraries and leisure centres around the county, numerous presentations, talks and drop-ins to a range of community, voluntary and public interest groups, and 53 meetings with Trust staff.

Key stakeholders in Oxfordshire and surrounding counties were also written to directly and asked to give their views on the Trust’s proposals. There were over 40 responses to the consultation, from individuals and institutions, which were largely supportive of the proposals. Some suggestions were made regarding the constituencies that were originally proposed by the Trust and these will be considered by the Board of Directors.

There are currently nearly 5,000 public members. The Trust aims to achieve about 6,000 public members (1% of the population of Oxfordshire) by the time of first elections to the Member’s Council. All Trust staff are automatically members unless they opt out, and so over 13,000 members of staff employed by the ORH, the University of Oxford’s Medical Sciences Division and the Trust’s PFI partners (catering, portering and cleaning staff at the John Radcliffe and Churchill Hospitals) are also considered to be members.

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### What is an Academic Foundation Trust?

An Academic Foundation Trust is a new type of healthcare organisation run on very different lines. Foundation Trusts 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 more accountability to staff, patients and the public, through a membership scheme and a Members’ Council. We aim to be an Academic Foundation Trust to reflect our aim to be an AHSC.
From September 2008 onwards, engagement events with members have been held regularly. These have focused on informing members about Foundation Trusts and on the role of the Members’ Council. So far, 254 members have attended election training events, having expressed an interest in standing for election to the Members’ Council. A programme of informative talks for Foundation Trust members introduces key services. The first of these, a tour of the new Oxford Cancer Centre at the Churchill Hospital, took place in March. Over 100 members took part.

*If you would like to know more about the membership scheme, and our work to become an Academic Foundation Trust, please contact our Foundation Trust Membership Office on 01865 743491 or email orhmembers@orh.nhs.uk*

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**THE MEMBERS’ COUNCIL**

Foundation Trust members will elect the Members’ Council which will have three main roles:

**Advisory** – it communicates to the Board of Directors the wishes of Members and the wider community

**Guardianship** – it ensures that the ORH is operating at it should and acts in a trustee role for the welfare of the organisation

**Strategic** – it advises on the longer term direction to help the Board effectively determine its policies.
Clinical services

The Oxford Radcliffe Hospitals NHS Trust 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. The Trust 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 Trust’s reputation as an academic teaching hospital. 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 our strategic objectives is to consolidate and advance the international status of the Trust’s defining services.

CANCER SERVICES
Cancer surgery
Clinical oncology
Haematological oncology
Medical oncology
Palliative care

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

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

NEUROSCIENCE SERVICES
Neurology
Neuropathology
Neuropsychology

Neuroradiology
Neurosurgery

TRANSPLANTATION
Combined kidney-pancreas transplantation
Renal transplant surgery
Small bowel transplant surgery

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 Trust 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
Chest medicine
Chronic pain relief
Clinical genetics
Clinical immunology
Cystic Fibrosis services
Endocrinology
Haemaglobinopathy
Haematology
Haemophilia
Infectious diseases
Nephrology
Sleep disorder services

SPECIALIST SURGICAL SERVICES
Craniofacial surgery
Specialist cleft lip and palate surgery
Specialist ear, nose and throat (ENT) surgery
Specialist endocrine surgery
Specialist maxillo-facial surgery
Specialist ophthalmology
Specialist plastic surgery
Specialist trauma surgery
Specialist urology
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
Cardiac surgery
Cardiology
Chest medicine
Endocrinology
Gastroenterology
Haematology
Infectious diseases
Neonatal Intensive Care Unit
Neurology
Neuropsychology
Neurosurgery
Paediatric High-dependency Unit
Paediatric Intensive Care Unit
Pathology
Urology

CRITICAL CARE SERVICES
Adult Intensive Care Unit
Cardiothoracic Critical Care Unit
Coronary Care Unit
Horton Critical Care Unit
Neuro Intensive Care Unit
Renal High-dependency Unit

RADIOLOGY
Cancer imaging
Head and Neck imaging
Interventional radiology
Paediatric imaging
PET/CT scanning

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 Trust treats a higher proportion of complex and difficult cases referred on from neighbouring hospitals. One of the Trust’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
Chronic diseases, including chronic obstructive pulmonary disease (COPD), chest medicine and diabetes, and chronic heart failure
Dermatology
Services for older people – gerontology
Stroke services

SURGICAL SERVICES
Acute general surgery
Breast surgery
Ear, nose and throat (ENT)
Endocrine surgery
Maxillo-facial surgery
Ophthalmology
Orthodontic surgery
Plastic surgery
Urology

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

CHILDREN’S SERVICES
Adolescent Unit
Community paediatrics
Paediatric medicine
Paediatric neurology
Paediatric psychology
Paediatric surgery
Special Care Baby Unit
EMERGENCY SERVICES
Emergency departments in Oxford and Banbury
Medical assessment units in Oxford and Banbury
Surgical emergency assessment service
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 Science 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 Trust’s strategic objectives is to identify, evaluate, prioritise and nurture emerging services.

Genetics
Interventional radiology
Minimal access surgery
Robotic surgery

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, CRITICAL CARE AND THEATRES

RADIOLOGICAL SCIENCES
Computerised Tomography (CT)
Fluoroscopy
Medical physics and clinical engineering
Magnetic Resonance Imaging (MRI)
Nuclear medicine
Radiology
Ultrasound

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

PHARMACY AND THERAPIES
Drug information
Medicines management
Occupational Therapy
Physiotherapy
Speech and Language Therapy
Dietetics
Improving our environment

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

The most recent example of this strong environmental ethos was the opening of the Oxford Cancer Centre. This facility is among the most eco-friendly and green NHS buildings in the UK and won a Chartered Institute of Building Service Engineers (CIBSE) Low Carbon Client of the Year award in late 2008. The Centre requires 70% less energy and emits 60% less CO₂ than an equivalent hospital of the same size.

It achieved this through a variety of means, the most notable being the use of a geothermal system that heats and cools the building. The system involves over 280 boreholes dug to a depth of 135m into the ground, drawing on natural heat sources. Water is then pumped through the pipes inserted into the boreholes and either heats or cools the building depending on its need. In addition, the new facility uses rain water harvesting and passive solar shading. The building materials have also come from sustainable or recycled sources.

Our hospital buildings vary from the very latest in building design and technology to those that date back to the nineteenth century. This presents different challenges in terms of reducing energy emissions and the Trust has achieved great success in lessening its impact on the local environment, supporting the national NHS Carbon Reduction Strategy for England.

Over the years, the Trust has set itself very ambitious energy reduction targets. In 2007 it met its target of 7%, and it met a further 3% energy reduction in 2008. This equals hundreds of thousands of pounds worth of savings and has been achieved through a number of ways:

- energy saving controls being fitted to the pumps that distribute hot and cold water around the hospital’s heating and cooling systems
- old lighting systems being replaced with more efficient, modern technology in wards
- upgrading heating and ventilation equipment.

As well as building design and reducing energy consumption, the Trust works hard to reduce the impact cars have on the environment, including limiting local congestion and reducing carbon emissions. The ORH works with relevant local authorities, looking at alternative ways for patients, staff and visitors to reach all its hospital sites. One of the most successful examples is the direct Park and Ride service to the John Radcliffe Hospital, which is very popular with staff and patients.

In 2008, Oxford Radcliffe Hospitals spent around £7 million on energy and water:

- 42 million kWh of electricity
- 64 million kWh on mains gas
- 1.4 million litres of oil

Since 2007, the Trust has achieved a 10% reduction in energy use. In real terms, this has meant:

- 8% reduction in electricity
- 14% reduction in gas use
- 5% reduction in oil use
- 22% reduction in water use
**Hospital environment**

Each year, the Trust receives a Patient Environment Action Team (PEAT) inspection. The PEAT programme was set up in 2000 to assess NHS hospitals and has been overseen by the National Patient Safety Agency since 2006.

The 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 are undertaken by a team made up of panel members from the Oxford Radcliffe Hospitals Patient and Public Panel and accompanied by members of the estates and facilities, nursing and infection control teams.

There are five possible scores, ranging from excellent to unacceptable. In 2007/08 the Trust achieved ‘good’ scores for the John Radcliffe and Horton General Hospitals and an ‘acceptable’ score for the Churchill Hospital.

In 2008/09, PEAT inspections were carried out during March and April. The outcome of each site inspection is scored and ranked, with the results forwarded to the National Patient Safety Agency. The Trust achieved ‘good’ scores for the Churchill and Horton General Hospitals and an ‘acceptable’ score for the John Radcliffe Hospital.
New facilities

**Oxford Cancer Centre**

A new £109 million Cancer Centre was opened to patients at the Churchill Hospital in March 2009. The new buildings comprise cancer and haematology, surgery and diagnostics and a private patient wing. The Centre brings together a wide range of medical and surgical services that were at the Churchill and John Radcliffe Hospitals.

The Centre forms a key part of the Trust’s strategic plan, ensuring that the Trust meets the NHS Plan and Cancer Plan requirements to improve patient care and reduce waiting times. In addition, it offers a base for university research teams.

**Oxford Heart Centre**

The new £29 million Oxford Heart Centre will open in 2009, providing additional single rooms, a cardiac intensive care unit, five catheter labs and teaching and conference facilities. This exciting development provides state-of-the-art facilities for research and treatment of people with heart disease.

**New Geratology Unit**

The new Geratology Unit at the John Radcliffe Hospital opened in August 2008. It provides 40 single en-suite rooms, some of which are large enough for a relative to stay in with the patient overnight. There are also attractive lounge areas where patients can spend time together.

A fundraising appeal enabled the Trust to develop a Sensory Garden in the rooftop courtyard on Level 4, which is directly accessible from the Geratology Unit. The garden has several seating areas, raised beds with easy maintenance planting and an outdoor therapy assessment area, so that patients can practice walking on different surfaces and climbing steps outdoors, before they go home.
Oxford Spires Midwifery-led Unit

The Oxford Spires Midwifery-led Unit opened in September 2008 at the John Radcliffe Hospital, for women with low-risk pregnancies. Midwifery-led facilities have been available for women at Chipping Norton, Wantage and Wallingford for some time, but this is the first time women from the City of Oxford have had this kind of unit available to them locally.

Horton General Hospital Endoscopy Unit

The Endoscopy Unit at the Horton General Hospital was fully refurbished and modernised in February 2008. This means that following further improvements undertaken in January 2009, it has secured accreditation as a Bowel Cancer Screening Programme Centre. It is anticipated that the service will commence in 2009, and it will initially act as the Bowel Cancer Screening Programme Centre for the whole of Oxfordshire.

Virtual Environment Radiotherapy Training (VERT)

Trainee radiographers at the ORH are learning how to treat cancer on virtual patients using Virtual Environment Radiotherapy Training (VERT), which is a virtual replica of a radiation therapy room. It gives users the sense of being present in an actual treatment room and offers students the chance to improve vital skills. Before this, radiotherapy training relied on real patients being happy to allow students to assist more senior staff. The equipment produces three-dimensional images, on a large screen, of a patient and a linear accelerator treatment machine. The equipment is so intricate that it even lets students view the exact spot in a patient’s body where each radiation dose has been delivered. The equipment was funded by the Department of Health as part of a nationwide programme to improve radiotherapy training.
The Oxford Biomedical Research Centre (OxBRC) is a partnership between the research expertise of the Oxford Radcliffe Hospitals NHS Trust and the University of Oxford. The OxBRC was founded in April 2007 through a competitively awarded grant of £57.5 million over five years from the Department of Health’s National Institute for Health Research (NIHR), under the programme Best Research for Best Health. The OxBRC is tasked to undertake ‘translational research’, which means first-time studies in patients of innovations that are intended to improve healthcare.

Almost two years on, the OxBRC is now funding, or part funding, 185 research projects across 14 therapeutic areas, eight of which are complete; it employs 300 (part and full-time) staff in posts ranging from principal investigators, data entry clerks, research nurses and finance support staff.

The OxBRC’s Director, Professor Keith Channon, is a Professor of Cardiovascular Medicine and Honorary Consultant Cardiologist. He took over from Professor Alastair Buchan, Head of the Medical Sciences Division of the University of Oxford, and a Non-executive Director of the Trust. Professor Buchan and Dr James Morris, ORH Medical Director, steered the OxBRC from bid stage to its current form as a vital network of people who are working in partnership to carry out research that is meaningful to patients and influences their care in a positive way.

The OxBRC is also about to launch its public and patient involvement strategy which will be carried out by the newly formed Public Engagement Group. Its main aims will be to:

- promote patient and public involvement in the research arena
- examine the health economics outcomes for the benefit of patients and the NHS, based on the work of the OxBRC
- support an ethics framework to ensure research is consistently funded on merit, probity and value for money.

To contribute to the aims of this group, Dr Louise Locock has been appointed for three years as OxBRC Dipex Fellow. Dr Locock started in October and has an extensive background working with patients to record and analyse their personal experiences of illness.
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.
Oxford Radcliffe Hospitals get top rating In 2008

The ORH was, for the first time, given the top rating of ‘excellent’ for its services to patients. The Healthcare Commission (HCC) assessed hospital performance against key standards which were then used to calculate the overall quality rating. It published its results in October 2008 which relate to the year 2007/08.

Core standards

The first part of the health check examines whether NHS Trusts are meeting 44 ‘core standards’, covering areas such as safety, the hospital environment, clinical and cost effectiveness and patient focus. The Healthcare Commission assessed the Trust as having fully met these standards.

Existing national targets

‘Existing national targets’ look at whether or not the Trust is meeting a range of standards, particularly focusing on how long patients wait for treatment, including diagnosis and treatment for cancer, waiting times in the emergency department and waiting times for planned operations. Again, the Commission assessed the Trust as having fully met these targets. In terms of inpatient and outpatient waiting times the Trust met the national targets early. The only targets that the trust did not quite meet in this category were the national target for ‘Thrombolysis: 60 minute call to needle time’ and for waiting times in the emergency department.

New national targets

The ‘new national targets’ focus on the ways in which healthcare organisations are helping to improve the health of the population in England. The indicators include diverse factors, such as smoking cessation, drug misuse, teenage pregnancy and obesity, and the treatment of heart and stroke patients. The Healthcare Commission has assessed the Trust as ‘excellent’ in this category.

The Trust met eight out of the ten standards, under-achieving on just two indicators, the reduction of emergency bed days, and the participation in clinical audits.

Use of resources

The Trust also scored ‘fair’ for ‘use of resources’. This is an improved score for the Trust. The Trust reported an in-year surplus of £4.3 million for the last financial year – better than in the plan agreed with the Strategic Health Authority.

New regulator for health, mental health, and adult social care

The Care Quality Commission (CQC) is the new independent regulator of all health and adult social care in England, and replaces the Healthcare Commission.

CQC inspects all health and adult social care services in England, whether they’re provided by the NHS, local authorities, private companies or voluntary organisations. It makes sure that essential common standards of quality are met everywhere that care is provided, from hospitals to private care homes, and works towards their improvement.

Find out more at www.cqc.org.uk
Sustaining performance and developing services

The Trust has finished the financial year having succeeded in meeting all of the national elective and emergency targets including the four-hour emergency department target (despite one of the busiest winters in a decade), and waiting times for urgent suspect cancer referrals. The Trust achieved the 18-week referral to treatment patient pathway nine months ahead of the Government target of April 2008, and this has been sustained for the year.

As part of meeting these headline waiting times, we have continued to improve the underlying elements of care. For example, the average length of stay in hospital has fallen, and the percentage of operations cancelled at the last minute for non-clinical reasons has remained the same as last year at just 0.7%. At the same time, the efficient use of our operating theatres has increased, and 90% of our patients now come into hospital on the day of their operation rather than having to stay the night before.

Thanks to efforts to inform patients about the importance of attending appointments and the launch of a text message reminder service, the number of patients failing to attend their appointments has fallen from 7.2% to 5.5%. Apart from the obvious benefits for patients in being seen more quickly, this also saves administration costs and clinicians’ time.

All of these things directly benefit patients and increase the smooth running of our hospitals because they mean less time spent in hospital, less waiting, and as little disruption as possible to people’s lives.

Overall volume of activity

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency activity</td>
<td>74,954</td>
<td>82,217</td>
<td>80,901</td>
<td>82,592</td>
<td>86,993</td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>22,698</td>
<td>23,105</td>
<td>20,667</td>
<td>21,224</td>
<td>22,854</td>
</tr>
<tr>
<td>Day cases</td>
<td>40,282</td>
<td>54,004</td>
<td>53,130</td>
<td>59,817</td>
<td>64,948</td>
</tr>
<tr>
<td>Total finished consultant episodes</td>
<td>137,934</td>
<td>159,326</td>
<td>154,698</td>
<td>163,633</td>
<td>174,795</td>
</tr>
<tr>
<td>Emergency department attendance</td>
<td>125,482</td>
<td>123,852</td>
<td>123,914</td>
<td>115,603</td>
<td>117,922</td>
</tr>
<tr>
<td>Outpatients</td>
<td>514,613</td>
<td>525,710</td>
<td>520,835</td>
<td>564,389</td>
<td>609,656</td>
</tr>
</tbody>
</table>

These figures exclude renal dialysis and babies born and are based on all finished consultant episodes.
Waiting times in the emergency departments

The Trust met its target for keeping waiting times down in the emergency departments. 98.21% of patients were seen within the four-hour target for emergency access. This is above the national target of 98%.

The Trust also ensured that no patient waited more than 12 hours for admission (once the decision to admit has been made) from either the John Radcliffe or the Horton General Hospital emergency departments, meeting its target here too.

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>30,140</td>
<td>29,544</td>
<td>98.02</td>
</tr>
<tr>
<td>Q2</td>
<td>29,229</td>
<td>29,027</td>
<td>99.31</td>
</tr>
<tr>
<td>Q3</td>
<td>29,752</td>
<td>29,117</td>
<td>97.87</td>
</tr>
<tr>
<td>Q4</td>
<td>28,801</td>
<td>28,125</td>
<td>97.65</td>
</tr>
</tbody>
</table>

Delayed transfers of care
(snapshot at end of each quarter)

Reducing the number of delayed transfers of care remains an issue because of the 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.

The implementation of Electronic Immediate Discharge Documentation (eIDD) in April 2008 has enabled relevant discharge documentation to be sent electronically to GPs.

<table>
<thead>
<tr>
<th>Numbers 2005/06</th>
<th>Numbers 2006/07</th>
<th>Numbers 2007/08</th>
<th>Numbers 2008/09</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 Trust is monitored against a number of existing and new national targets that affect the speed of diagnosis and treatment for cancer. The Trust has met all the national targets in 2008 (Quarters 1-3) related to cancer waiting times. Since January 2009 (Quarter 4) an extended and revised set of targets has been introduced. We are awaiting confirmation of the targets for this expanded group of measures.

Over 8,900 patients were referred urgently by their GPs with suspected cancer and seen within two weeks. More than 2,900 patients received their first treatment for cancer during the year. This achievement is based on well-established multidisciplinary team working on all tumour sites. Patient pathways continue to be reviewed and improved.

The appointment of an additional gynaecological consultant surgeon, Mr Roberto Tozzi, has meant that this service is now able to provide services compliant with National Institute for Health and Clinical Excellence (NICE) guidelines, expanding the range of treatments and geographical cover to this group of patients. The Trust welcomed Karen Mitchell to the post of Cancer Lead Nurse in March 2009 when she joined the cancer management team.

The Trust has participated as a national pilot site with the Cancer Services Collaborative Inpatient Improvement Programme since October 2007. 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>2,245</td>
<td>2,317</td>
<td>2,232</td>
<td>2,216</td>
</tr>
<tr>
<td>No. seen within target</td>
<td>2,245</td>
<td>2,317</td>
<td>2,232</td>
<td>2,061</td>
</tr>
<tr>
<td>%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>97%</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>769</td>
<td>758</td>
<td>689</td>
<td>740</td>
</tr>
<tr>
<td>No. seen within target</td>
<td>768</td>
<td>754</td>
<td>680</td>
<td>734</td>
</tr>
<tr>
<td>%</td>
<td>99.9%</td>
<td>99.5%</td>
<td>98.7%</td>
<td>97.8%</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>358</td>
<td>346.5</td>
<td>339</td>
<td>275.5</td>
</tr>
<tr>
<td>No. seen within target</td>
<td>350</td>
<td>334</td>
<td>330.9</td>
<td>229.5</td>
</tr>
<tr>
<td>%</td>
<td>97.8%</td>
<td>96.3%</td>
<td>97.6%</td>
<td>83.3%</td>
</tr>
</tbody>
</table>
18-week referral to treatment performance

The 18-week target means that no patient should wait more than 18 weeks from GP referral to treatment in a consultant-led service. A ‘tolerance’ is 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 Trust achieved this target some nine months ahead of the December 2008 deadline.

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.

<table>
<thead>
<tr>
<th>% seen within 18 weeks</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Admitted</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>53.90</td>
<td>97</td>
</tr>
<tr>
<td>Q2</td>
<td>61.50</td>
<td>96</td>
</tr>
<tr>
<td>Q3</td>
<td>72.70</td>
<td>94</td>
</tr>
<tr>
<td>Q4</td>
<td>91.80</td>
<td>96</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% seen within 18 weeks</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-admitted</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>81.30</td>
<td>96</td>
</tr>
<tr>
<td>Q2</td>
<td>90.40</td>
<td>97</td>
</tr>
<tr>
<td>Q3</td>
<td>90.70</td>
<td>95</td>
</tr>
<tr>
<td>Q4</td>
<td>95.80</td>
<td>97</td>
</tr>
</tbody>
</table>

Admitted – patients requiring admission to hospital
Non-admitted – patients not requiring admission to hospital
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></th>
<th>Coronary artery bypass grafting</th>
<th>Percutaneous transluminal coronary angioplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Q2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Q3</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Q4</td>
<td>11</td>
<td>12</td>
</tr>
</tbody>
</table>

Inpatient waiting list

<table>
<thead>
<tr>
<th>All specialties</th>
<th></th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>(max wait in weeks)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>8</td>
<td>3,831</td>
</tr>
<tr>
<td>Q2</td>
<td>11</td>
<td>4,611</td>
</tr>
<tr>
<td>Q3</td>
<td>18</td>
<td>4,782</td>
</tr>
<tr>
<td>Q4</td>
<td>19</td>
<td>5,177</td>
</tr>
</tbody>
</table>

Outpatient waiting list

<table>
<thead>
<tr>
<th>All specialties</th>
<th></th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>(max wait in weeks)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>5</td>
<td>6,613</td>
</tr>
<tr>
<td>Q2</td>
<td>9</td>
<td>5,146</td>
</tr>
<tr>
<td>Q3</td>
<td>10</td>
<td>4,717</td>
</tr>
<tr>
<td>Q4</td>
<td>11</td>
<td>6,326</td>
</tr>
</tbody>
</table>

Diagnostic waits

By year end, diagnostic waits including MRI and CT scans were maintained at six weeks as they had been last year. However, during the course of the year the Trust reported 32 patients as waiting longer than six weeks.

Cancellations

We know that the cancellation of an operation is very disruptive for patients and their families. In 2008/09, the Trust exceeded its target by continuing to reduce the number of last minute cancellations of planned surgery by over 50. 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>107</td>
</tr>
<tr>
<td>Q2</td>
<td>96</td>
</tr>
<tr>
<td>Q3</td>
<td>159</td>
</tr>
<tr>
<td>Q4</td>
<td>191</td>
</tr>
</tbody>
</table>
Non-attendance at first appointment in the outpatients 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 7.2% in 2007/08 to 5.5% in 2008/09.

<table>
<thead>
<tr>
<th>First attendances</th>
<th>Did not attend first appointment</th>
<th>Did not attend rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 54,864</td>
<td>3,778</td>
<td>5.9</td>
</tr>
<tr>
<td>Q2 60,667</td>
<td>3,605</td>
<td>5.6</td>
</tr>
<tr>
<td>Q3 61,913</td>
<td>3,363</td>
<td>5.2</td>
</tr>
<tr>
<td>Q4 65,665</td>
<td>3,520</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Non-attendance costs the Trust money

The performance improvement team calculated that each non-attendance for surgery costs the NHS about £1,500, resulting in a substantial loss. So the team developed a plan to try and cut the numbers and save the Trust money.

Checking in

The Performance Improvement Team developed a ‘checking-in’ system which requires patients to contact us fourteen days before their surgery date and confirm their attendance. If we don’t hear from them, we telephone patients seven to ten days before surgery and remind them that they have an appointment.

Text messaging

Since September 2008 the Trust has been trialling a text messaging service to remind patients to attend their outpatient appointments. We are now looking to expand this service. On average the Trust is sending 300 to 350 texts per working day.

Improving, innovating, developing

Performance is about more than targets and efficiency is about more than money – they are about delivering the right care at the right time, without unnecessary waste. As well as dedicated staff at all levels of the organisation making these a reality, a particular boost has been given this year by our pioneering Fellowship in Clinical Management programme. Piloted as a single appointment in August 2007, the programme takes junior doctors in training and offers them the opportunity to be involved with clinical management as an alternative to the more traditional options of research or clinical training alone.

In her first year, the surgical registrar who held the first fellowship worked on projects with the Churchill Hospital’s Day Surgery Unit and Surgical Emergency Unit. She continues to be involved in a range of projects, including improving emergency theatre utilisation and a service improvement project in CT scanning.
On the basis of this first successful pilot, four further Fellows in Clinical Management have been recruited from disciplines as diverse as medicine, radiology, public health and surgery. Each Fellow has a clinical and management mentor, and the ambition is to link up with the NHS Education’s South Central training programmes in clinical leadership and management.

Examples of projects they have led or facilitated include:

- **Extraordinary Developments**, which is looking at making sustained performance easier at the John Radcliffe Hospital’s emergency department and improving standards of patient care. The project focuses on problem solving and is driven by front-line staff to ensure that improvements are sustainable – and always keeping quality and patient safety in mind.

- **Voice of the Customer** in CT Radiology at the John Radcliffe Hospital, which has employed something called Lean. This is a proven method of providing the best possible care to patients with no delays in a way that is cost-effective and easy for staff. This project has led to a less stressful working environment for staff, reduced waiting times and created a more pleasant experience for patients.

- Project to improve the efficiency of trauma theatres. Linking the project to the national fractured neck of femur 48-hour surgery target has increased focus on both the target and the project. The result has been a successive improvement in the time trauma theatre starts every morning, meeting the target more consistently, as well as strengthening communication and teamwork in the unit.

- Collaboration work with our partners in primary care, including work with the Clinical Collaborative in Oxfordshire, a group of hospital doctors and GPs, who work to support demand management and provide clinical advice to inform the commissioning of our services by the PCT. Relationships between our emergency departments and the GP Out-of-Hours Service are also being strengthened, as well as work with nursing homes to improve the end-of-life care provided to patients.

All of these projects have only been possible because of the enthusiasm and commitment of staff in the departments concerned.
New heart attack treatment will save lives

A procedure, known as primary percutaneous coronary intervention (PPCI), has been piloted at the John Radcliffe Hospital, where the introduction of a successful round-the-clock service is helping influence the Government’s health strategy. Thrombolysis, the injection of life-saving clot-busting drugs, is today still the most common treatment for heart attack patients. But the results coming out of the John Radcliffe, and ten other pilot hospitals in England, have confirmed that primary angioplasty provides much better outcomes for patients, provided that it can be delivered quickly.

Angioplasty is the procedure of inserting, then inflating, a small balloon in the blocked coronary artery, leaving a rigid support (or stent) to scaffold the artery and restore blood flow to normal.

While angioplasty works out about £800 more expensive per patient than the clot-busting drugs, it is viewed as being cost-effective because it reduces the risk of complications and further heart attacks, cuts the length of stay in hospital, and helps prevent strokes.

We now hope to extend this life-saving treatment to a larger number of patients and establish Oxford as the regional heart centre for a wider geographical area. A key element of this will be the opening of the new Oxford Heart Centre at the John Radcliffe, built next to the current cardiac facilities and adjacent to the emergency department and the Children’s Hospital. Both adults and children with heart problems in the region will have access to the new £29 million facilities, which are particularly aimed at the growing number of cardiac patients who can be treated without the need for heart surgery.

The Trust’s pilot scheme has involved a close collaboration with the local ambulance service because the new primary percutaneous coronary intervention system gives a vital role to paramedics. They now employ electrocardiogram tracing to establish whether a patient is suitable for angioplasty and transmit the information by telemetry to the coronary care unit for confirmation. It means heart attack patients bypass the emergency departments and are fast-tracked to the cardiac catheter lab for ‘the balloon treatment’ which must take place within 120 minutes of the emergency call.
Our strategy for the future

The Trust Business Plan was published in March 2009 and sets out the challenges facing the organisation. Key to the Plan is the need to improve the quality of services while improving efficiency to maintain a strong financial basis. The Trust is also finalising its five year Integrated Business Plan, the key document supporting the Foundation Trust application. The two documents build on the work of the Strategic Review.

The Trust is setting forward its strategy in the context of its aim to become an Academic Foundation Trust and Academic Health Science Centre (AHSC). It is also working in the context of Lord Darzi’s Next Stage Review of the NHS published in June 2008 (which announced AHSCs) and the strategic objectives of South Central Strategic Health Authority and Oxfordshire Primary Care Trust, the Trust’s main commissioner of services.

Our vision

Our vision is to be a successful Academic Health Science 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

- **To be 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 Science Centre** (in partnership with the University of Oxford and others), 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 stability 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.
Our 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.
Looking towards the future

In recent years, the local NHS has seen unprecedented levels of investment – some of it visible through our new buildings, equipment and facilities, some of it less visible, such as the reductions in waiting times for patients.

During this coming year, and the years which follow, our patients will continue to benefit from this investment, and they will receive diagnosis and treatment more swiftly, and in much improved facilities. However, increases in investment will not continue and our emphasis will be on ensuring that we can maintain safe, high-quality services, meet all of our targets and use our resources with ever increasing efficiency. This is a challenge, but one which is by no means unique to Oxfordshire, and something which we can only tackle by working closely with our health and social care partners.

Plans for the year

In 2004, the ORH launched a Strategic Review to consider the long-term development of the organisation. The principles established by the Review remain the guiding framework for business planning for the organisation. In particular, the ORH remains committed to the drawing together of clinical services, teaching and research and working towards becoming an Academic Health Science Centre, in conjunction with health and academic partners; and an Academic Foundation Trust. Sections elsewhere in this Review explain our progress towards these aspirations.

Every year, the ORH agrees a Business Plan, based on these underlying principles.

This year, the key themes of this Business Plan are:

- a focus on safety and quality
- an emphasis on ensuring that planned activity levels are consistent with the plans of commissioning PCTs
- strengthening links with GPs and primary care
- increased involvement in activities designed to promote the health and well-being of the population
- participation in the Better Healthcare Programme for Banbury and Surrounding Areas
- the development of cancer and cardiac services
- continuing work to develop structures to bring together our clinical services, teaching and research
- a robust programme of performance improvement and cost reduction measures.

Within all of our themes, there is a particular focus on strengthening our relationships and partnerships with academic bodies, other NHS organisations including district general hospitals and commissioning primary care trusts, local government bodies and voluntary and patient groups.
Our objectives

Specific business objectives set out in the Plan are:

Defining services

*These are comprehensive services in areas of national disease priority with significant academic and research support. Patients can be referred on a regional and national as well as a local basis.*

This year our plans include completion of the new Heart Centre as a base for expanded cardiac services, and the development of services in the new Cancer Centre.

Core services

*These are hospital services such as maternity and children’s services, emergency and acute medical services which are provided mainly to the local catchment population.*

Plans include involvement with the PCT in the development of services at the Horton General Hospital, through the Better Healthcare Programme, implementing a new model of care for diabetes, agreeing a strategy for the treatment of people who have suffered a stroke and strengthening end-of-life care for patients in all of our hospitals.

Specialist services

*These services, which often draw on rare or unique expertise, are provided for patients throughout the region.*

This year we plan to develop a clinical network for vascular services, and move forward with our plans to expand our perenatal services.

Emerging services

*These are relatively new and rapidly expanding services which are likely to gain in importance in the future.*

We will continue to enhance the role of the Oxford Biomedical Research Centre and support its many research programmes, which are designed to ensure that patients benefit rapidly from developments in the diagnosis and treatment of disease. Our specific objectives include installing a PET/CT scanner for treatment and research purposes and developing a response to the national dementia strategy, in conjunction with colleagues in mental health services.

Platform services

*These are ‘back room’ functions such as laboratory medicine, radiology and pharmacy and therapy services which support the frontline clinical services.*

This year our plans include the establishment of the imaging facility within the Cancer Centre, the development of plans to upgrade operating theatres at the John Radcliffe Hospital, and the development of a critical care strategy for all of our hospitals.
Organising for strategic advantage

Each year, we look at ways in which we can improve our productivity and the quality of our services while, at the same time, increasing our efficiency and reducing costs. This year’s programme of activities includes plans to further develop service-line management, giving clinical services more freedom to plan and market their activities, and manage their own finances. This will build on successful pilots in maternity and cardiac services last year. We will develop an estates strategy, to ensure that we are making best use of our land and buildings, and also continue our work to implement the new Care Record Service.

Given the financial context within which we are working, a considerable amount of emphasis will be put on programmes of work aimed at making better use of our resources and our people, enabling us to reduce costs without affecting quality. This will include further work to cut the length of stay for our patients, and increase the number of procedures which can be carried out as day cases.

Looking towards future years

As this Review goes into production, the media continue to predict a worsening financial situation for the public sector. While this can be worrying for both patients and staff, it is important to remember the huge progress within the NHS which has taken place during the past few years. It is also important to remember that safety, quality and efficiency are not mutually exclusive priorities, but, as we have demonstrated successfully so far, are compatible components of excellent patient care.
In July 2008, the NHS celebrated its 60th anniversary. Over the last 60 years, the hard work and skill of NHS staff, coupled with medical progress, has continually helped drive up standards and quality of care for millions of people. People now live on average at least ten years longer than they did in 1948. Deaths from cancer and heart disease have fallen dramatically and Britain is one of the safest places in the world to give birth. The values of the NHS – universal, tax funded and free at the point of need – remain as fundamental today to the NHS as they were when it was launched in 1948.

BBC News 24 broadcast from the John Radcliffe Hospital to celebrate the 60th birthday of the NHS. Throughout the day, staff were interviewed about their work and their memories for hourly bulletins on the BBC News 24 channel. The hospital was also used as a backdrop for the main BBC bulletins for the day.

How the NHS has changed

It is easy to forget that the standards in the NHS we now take for granted were once novel.

Did you know...?

- In 1948, a cataract operation meant a week of total immobility with the patient’s head supported by sandbags. Eye surgery is now over within 20 minutes, and most patients are out of hospital the same day.
- In the 1960s, hip replacements were so unusual that the surgeon who invented them asked patients to agree to their return after they died? The NHS now carries out 1,000 of these replacements every week.
- The world waited until 1978 for Britain to produce the first baby born through in vitro fertilization (IVF). 6,000 IVF babies are now born here annually.
- The breast screening programme introduced in 1988 now helps to save the lives of 1,400 women a year.
- The introduction of NHS Direct in 1998 launched a pioneering alternative to GP services that currently handles more than 500,000 calls a month.
The Royal visit

On 27 November 2008, Her Majesty The Queen and His Royal Highness The Duke of Edinburgh visited the John Radcliffe Hospital to celebrate the official opening of the West Wing and the Oxford Children’s Hospital – an event to remember for the many patients, staff and guests involved.

The Royal party were greeted at the Hospital by a cheerful crowd of flag-waving children from local schools and nurseries. After formal introductions to Sir William Stubbs, Trust Chairman; Trevor Campbell Davis, Trust Chief Executive and Dr John Hood, the Vice-Chancellor of the University of Oxford; the Queen and Duke were taken on separate tours of the new facilities. The Queen met patients, staff and supporters in Kamran’s Ward of the Children’s Hospital, and then watched Professor Tipu Aziz give a short presentation of the benefits of deep brain stimulation for patients with Parkinson’s Disease. At the same time, the Duke visited one of the new integrated operating theatres, and met surgical students being taught with the new technology. Both the Queen and Duke were clearly pleased by the many staff who lined the corridors to greet the guests.

Before departing, the Queen unveiled a plaque commemorating the formal opening.
Thanks a million!

Nearly £7 million in charitable support for the hospitals was received in the last financial year, up on last year’s figure by around £200,000. In addition, £700,000 in new pledges were made by individuals, organisations and businesses. This is a fantastic result – especially in the current economic climate – and shows the great generosity of individuals, businesses and charitable trusts. The money came in through a variety of means; from organised events such as abseils, runs, walks and dinners, through to major gifts from individuals, businesses and organisations. A significant amount of support is provided in the form of gifts in wills.

Alice Hahn Gosling, Director of Fundraising said: “This is a phenomenal amount of money and we are incredibly grateful to everyone for their continued goodwill and support. Thank you to everyone.”

Fundraising for the hospitals has attracted some major celebrity supporters. Prince William’s girlfriend Kate Middleton helped to organise an 80s style roller disco to raise funds for Tom’s Ward at the Children’s Hospital, whilst Lawrence Dallaglio, Matthew Pinsent, PD James and Jeffrey Archer all supported black-tie dinners in aid of the Cancer Centre and Jason Donovan played a secret fundraising gig for hospital staff. Substantial amounts of positive press, local, national and international, has also been created through fundraising initiatives.

£6.6 million was spent in 08/09 funding equipment and facilities to improve treatment and comfort for patients, and making ground-breaking research and specialist medical training possible.

We are currently purchasing three Computer Integrated Theatres (CITs) – costing over £1 million – which help surgeons with cancer keyhole surgery, hastening the recovery process and lessening the risk of infection. The Cancer Centre has also greatly benefited from the creation of four beautiful patient gardens all paid for through Charitable Funds. Whilst in the Children’s Hospital three incubators (costing £17,000 each) were bought using a large donation from the Dorchester Concert Committee, and eight children’s rooms have been kitted out with multi-media equipment to help link long-term patients with their friends and families. These are just a few examples of where Charitable Funds have helped to make a huge contribution to the Trust. Thank you.

Find out more about how you can help with fundraising and all the events we have coming up at our website www.orhcharitablefunds.nhs.uk, by emailing campaign@orh.nhs.uk or calling 01865 743444.

Oxford Radcliffe Hospitals Charitable Funds supports the John Radcliffe, Churchill and Children’s Hospitals in Oxford and the Horton General Hospital in Banbury.
Protecting our patients

Safety, quality and risk

There is an increasing national focus on ensuring that safety is at the heart of the healthcare agenda. Lord Darzi’s *High Quality Care for All* report, published last year, introduced Quality Accounts which mean that all Trusts will now have to produce public reports looking at safety, patient experience and outcomes.

Over the past year, the Trust has undertaken a wide range of activities to embed a robust approach to safety throughout the organisation, led by the Board of Directors.

During the year, the Board approved strategic frameworks for both patient and staff safety, which set out a series of initiatives designed to embed safety at all levels, with outcomes that can be measured to show how improvements are being made.

In addition, this year has seen the introduction of Executive Safety Walk-rounds designed to keep senior managers informed about the safety concerns of frontline staff. It is a way of listening to and supporting staff when issues of safety are raised, and is part of promoting an open culture.

Following a review of risk management training requirements, all new staff receive incident reporting and health and safety e-learning during their induction. In addition, sessions are now provided for managers on incident investigation, health and safety management, risk assessment and control of substances hazardous to health (COSHH).

Perhaps because of the increased awareness of the importance of safety the total number of reported incidents has increased from 10,481 in 2006/07 to an estimated 12,600 by the end of 2008/09.

Learning from adverse events is key to improving safety. For example, following an incident this year we made changes across the Trust to eliminate the risk of scalding from hot water in bathrooms. From January 2008, in line with guidance from the SHA, the Trust has been investigating as Serious Untoward Incidents (SUI) all instances where MRSA or Clostridium difficile has been mentioned on Part 1 of a death certificate.

Patient safety

NHS South Central has placed patient safety as central to its agenda and has established the Patient Safety Federation, which aims to improve safety in all healthcare organisations across the South Central area, and to lead the way in reducing harm to patients. The ORH is an active member of this federation.

At Trust level, a lot of work has taken place aimed at reducing patient harm. Additional safety action groups and professional advisory groups have been set up to complement some of the groups already in existence, aimed at reducing avoidable harm in key areas, including:

- infection prevention
- thromboprophylaxis
- wound healing
- falls reduction
- medicine safety
- musculoskeletal disorders
- diabetes management.

Patient falls are among the most common accidents in hospital. We record and monitor these and compare ourselves against the national average. Currently, this average is 4.8 falls per 1,000 patients; the Trust’s rate is 4.5 per 1,000. Through the Falls Reduction Safety Action Group we have focused on patient falls and are still intent on reducing this rate further.
Staff safety

Good progress has been made in reducing risk to staff, including reducing the number of accidents at work. Over the year, we reduced accidents by 3.4% and we are on track to achieve the national targets for the reduction of RIDDOR reportable incidents in two areas – major injuries to staff where the ten-year target is to reduce to six per year by 2014/15, and for injuries where staff have to take more than three days off work, which is to be reduced to 36 per year by 2014/15.

Specific initiatives launched during the year include a project to reduce needle stick injuries through the introduction of safer cannula devices, the adoption of non-latex gloves to minimise the potential of dermatitis, and a project to consider and tackle stress at work.

Medicines safety

The Trust continues to work to reduce the number of dispensing errors. The National Patient Safety Association (NPSA) cluster for medicine-related incidents is above the average for an acute teaching trust’s cluster, which the NPSA views as a positive indication of a safety conscious organisation. Work is now being done to identify further medicines safety standards in key areas so we can continue to improve our performance. A Prevent Adverse Drug Incidents committee is being established to help achieve this aim. All reported incidents are reviewed by the medicine safety team and the medicine safety group.

Clinical effectiveness

Gaining feedback from patients on the quality of their experiences is an integral part of improving the care and services we provide. In addition to the annual Patients’ Survey carried out for us by the Picker Institute, over the year, more than 1,000 patients were approached via questionnaire surveys about their experiences of care in a range of specialty and clinic specific surveys. Patients have been invited to give us their structured and detailed views of the following services: breast, urological and lung cancers, endoscopy, sleep studies, pulmonary rehabilitation and children’s pre-operative assessment.

Patient information

Access to high-quality, evidence-based patient information is important for patients to make the correct choices about their care and give informed consent. A project to improve the quality of patient clinical information for patients was set up two years ago. More than 100 new leaflets on clinical topics have been produced through the project and are available in the new patient information library on the Trust’s website.
Meeting the National Institute for Health and Clinical Excellence (NICE) guidelines

The National Institute for Health and Clinical Excellence provides the reference for best practice in the NHS and sets national standards for clinical care. Each month, NICE issues guidelines that relate to clinical practice, technology appraisals and interventional procedures. NICE guidelines related to drugs are reviewed by the Medicines Advisory Committee. The Technology Advisory Committee receives monthly NICE guidelines to ensure that new technical equipment or clinical or surgical procedures and training are assessed through the Trust’s review process.

NICE guidelines are distributed regularly to the relevant clinicians and clinical areas for review and comment. Over the last year, the Trust has continued to raise the profile of these guidelines within the organisation through an expanded communication and feedback process, which ensures that not only are the services directly affected informed, but that others, including support services, are briefed too.

Using information to reduce risk

Conducting audits of clinical care is an important way in which the Trust measures effectiveness and improves patient safety. This year the Trust appointed three audit facilitators, each dedicated to one clinical Division. The team ensures that the full range of clinical audit activity across the Trust is captured and, importantly, that the outcomes of audits are transferred into improved patient care. Every specialty now has its own annual programme of audit which is scrutinised by the respective clinical directorates.

The Trust continues to participate in all of the national audits relevant to the range of services provided by our hospitals. This includes auditing NICE guidance to ensure the Trust is compliant with nationally recommended best practice. Our involvement in these and other audits is monitored by Oxfordshire PCT.

In addition to clinical audits, there are a number of ways in which information is used to monitor and help improve staff and patient safety. The Ulysses Safeguard software allows efficient and auditable communications on safety, and provides the Trust with information for trend analysis and organisational learning. The Trust also uses software from the healthcare intelligence company Dr Foster which alerts us if our performance deviates from the national average or the expected performance on patient mortality. We can compare our performance against a suitable peer group of hospitals.
Strengthening surgical safety

Surgeons and theatre teams have always conducted a series of clinical and technical checks as part of a patient being prepared for surgery.

But incidents still occur, sometimes serious ones. In response to this, the World Health Organisation (WHO) has devised a three-phase checklist that complements existing processes, and focuses them into short concentrated minutes of final checking. This checklist covers three phases of an operation: before the induction of anaesthesia, prior to the incision of the skin and before the patient leaves the operating room. In each phase, the operating team completes a set of checks designed to augment safe surgical practice.

The process is very simple, but it works. It’s been shown in international studies to improve anaesthetic safety, ensure correct site surgery, reduce surgical site infections and improve team communication with consequent reduction in post-surgical complications. The Trust is now replacing the surgical checklist currently in use with the WHO checklist.

Inquests

New guidance to Coroners following the Shipman Inquiry has resulted in an increase in the number of new inquests. Over the year, the Legal Services team supported 53% more inquests than in 2007/08 and provided assistance to the Coroners in Oxfordshire, Berkshire, Northamptonshire, Wiltshire and Milton Keynes. The team has worked particularly with the Oxfordshire Coroner’s office to improve the speed at which information is provided.

Legal claims

Over the year, there has been an increase of 10% in the number of new clinical negligence, employer’s liability and occupier’s liability claims handled by the Legal Services department. Legal Services deal with all pre-action requests for medical records under the Data Protection Act 1998 where litigation against the Trust is contemplated, and obtain the background information required by the National Health Service Litigation Authority (NHSLA) for the preliminary analysis reports, and during the claim.

Other issues

The Legal Services team, with patient safety colleagues, provided quarterly training to doctors about to apply for their first consultant post on issues of risk management and litigation.

The team worked closely with Oxfordshire County Council and other Oxfordshire NHS Trusts on implementation of the Mental Capacity Act 2005 and on the more recent introduction of Deprivation of Liberty safeguards (DOLs). This involved working with clinical areas to introduce revised practice and procedures to ensure that they are compliant with the new legislation.
**Data loss**

The Trust takes patient confidentiality seriously and all staff have been reminded of their responsibility in the handling of confidential information in a leaflet distributed with pay slips in February 2009. When there is a breach of confidentiality, it is investigated thoroughly and measures put in place to ensure it does not happen again.

During the year, there were three SUI investigations following a breach of confidentiality or loss of data.

In July 2008, a patient’s confidential medical diagnosis was released unintentionally to the patient’s own doctor. The patient was informed of the breach of confidentiality in person. In response to the incident the department has reviewed their practice and has produced a standard operating procedure for handling confidential patient information.

In July 2008 there was a report of the unauthorised disclosure of patient identifiable data including name, address and hospital number of one patient to a third party. The individual was notified of the incident by telephone. In response to the incident there has been a review of the Trust guidance on the use of fax machines which has been disseminated widely across the Trust and the incident is being included in Trust-wide information governance training.

In December 2008 there was an investigation into the loss of data when an inadequately protected electronic storage device, which contained the names and dates of birth of five patients, was lost outside secured NHS premises. The five individuals concerned were notified by post and the department has altered practice to negate the requirement to store information on portable electronic storage devices. The Trust’s Information Protection Policy has been re-issued via all directorate managers.

**Preparing for an emergency**

The Trust has a major incident plan, which details how the organisation will respond to an internal incident or external emergency, including pandemics. The plan aims to bring co-ordination and professionalism to the often unpredictable and complicated events of a major incident, such as an accident involving multiple casualties, requiring extraordinary mobilisation of emergency services.

The purpose of planning for emergencies is to ensure that we can provide 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 with partner organisations across Oxfordshire including other NHS Trusts, the emergency services, local councils and emergency planning experts.

In July 2008, the John Radcliffe Hospital was at the centre of a dramatic emergency planning exercise when a simulated chemical accident took place on the M4. The staged major incident was code-named Exercise Orpheus, and actors were brought in to play the part of people caught up in the accident.
The major incident exercise was organised and funded by the Health Protection Agency and the Department of Health, who choose one hospital in the region each year to carry out this real-time training. The Health Protection Agency filmed the whole event and the footage will be used to help train other trusts across the country.

**Controlling infection**

The control of avoidable infection in our hospitals remains a key priority for us. In the last year, the Trust has continued to strengthen its infection control processes and performance, as well as further developing a culture that seeks to minimise the risk of infection wherever possible. Since 2004, there has been a 70% reduction in MRSA infections at the ORH, as well as a 22% reduction in Clostridium difficile in the same period. This means that we have met both national and locally agreed infection control targets for the last year.

This has been the result of a range of measures. For Clostridium difficile, the main initiatives have been the rapid isolation of suspected cases, increased cleaning with a specialised product wherever the bug is identified, and better antibiotic management (to make patients less susceptible to the bug in the first place). For MRSA, as well as the focus on hand hygiene and cleanliness, crucial work continues to be done around the management of intravenous lines and catheters – because we know that this is particularly effective in reducing bloodstream infections. This work includes steps such as continually monitoring and re-evaluating practice, making sure we procure the best products, and training staff in the best aseptic, non-touch techniques for inserting lines.

Evidence that we get from investigating every case of MRSA bloodstream infection (so called ‘root cause analysis’) has also led us to focus on training and guidance around wound management, which is also paying dividends in reducing the risk of infection.

Since March 2009, we have been screening all non-emergency patients for MRSA before they come into hospital for their operations or procedures, in line with national guidelines.

Over the last ten years, we have carried out MRSA screening on patients regarded as having a high risk of contracting MRSA. This includes, among others, all patients admitted from other hospitals and healthcare settings and patients admitted to critical care, as well as regular screening of patients who return to our hospitals for dialysis.

Extending this to all elective procedures simply means that, during their appointment with an outpatients’ nurse, patients have a swab taken. The majority of patients are offered a skin cleanser for them to wash with the night before and the morning of surgery. Patients who are found to be colonised with MRSA are asked to continue with this wash and a nasal cream for five days.

From January 2008, in line with guidance from the SHA, the Trust has been investigating as SUI incidents all instances where MRSA or Clostridium difficile has been mentioned on Part 1 of a death certificate. In 2008/09 there were 12 SUI investigations for Clostridium difficile and seven for MRSA recorded in Part I of death certificates.
Pandemic flu plans implemented

The emergence of a virulent new form of flu, A Virus (H1N1), which started in Mexico and quickly spread to countries worldwide, caused NHS Trusts to implement their flu pandemic plans in April. Health organisations have been expecting a flu pandemic for a number of years and have detailed plans prepared to help deal with the pressures it would place on health services.

In our area the plans are coordinated by the Primary Care Trust (PCT) in Oxfordshire, which also coordinates the plans for neighbouring counties, Buckinghamshire and Berkshire, and works closely with the Health Protection Agency.

Preventing the spread of germs is the most effective way of slowing the spread of diseases such as swine flu and the ‘Catch it, Bin it, Kill it’ flu message has featured prominently in media coverage both locally and nationally.

Flu cases are handled in the community and patients are encouraged to contact:
Flu Hotline number 0800 1 513 513
NHS Direct 0845 4647 www.nhsdirect.nhs.uk
Health Protection Agency www.hpa.org.uk or to telephone their GP. Do not visit the GP practice or attend hospital emergency departments.

What to do
‘Catch it, Bin it, Kill it’

Everyone can take simple steps to help prevent the spread of colds and flu – ‘Catch it, Bin it, Kill it’. Covering your nose and mouth with a tissue when you cough and sneeze, CATCHING your germs and disposing of the tissue as soon as possible into a BIN and washing your hands as soon as you can to KILL THEM are all important actions that can help prevent the spread of germs.

Research has revealed that people don’t understand what a huge difference using and disposing of tissues correctly and washing hands can make in helping prevent the spread of the common cold and the more serious flu virus. Most adults suffer two to five colds a year and infants and pre-school children have an average of four to eight.

If we all follow the simple rule of CATCH IT, BIN IT, KILL IT, we can help reduce the spread of colds, flu and other viruses. We all have an important role to play in preventing ourselves, our families and others from spreading germs.

The messages of CATCH IT, BIN IT, KILL IT are simple:

CATCH IT – Germs spread easily. Always carry tissues and use them to catch your cough or sneeze.
BIN IT – Germs can live for some time on tissues. Dispose of them as soon as possible.
KILL IT – Hands can transfer germs to any surface you touch such as door handles and telephones, so clean your hands as soon as you can.
Our people

Human resource management supports the Trust’s strategic goal to be a model employer by ensuring the organisation has a diverse, flexible and well-trained workforce.

Workforce information

The table below shows a snapshot of the workforce as at 31 March 2009.

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>FEMALE</th>
<th>MALE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Heads</td>
<td>Whole time equivalent</td>
<td>Full-time</td>
</tr>
<tr>
<td>Admin and clerical staff</td>
<td>2,150</td>
<td>1,695.03</td>
<td>875</td>
</tr>
<tr>
<td>including ward clerks, receptionists, medical secretaries, staff in finance and IT and non-clinical managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare assistants</td>
<td>990</td>
<td>679.56</td>
<td>282</td>
</tr>
<tr>
<td>including staff working in support roles on wards, porters and other domestic staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>763</td>
<td>645.48</td>
<td>315</td>
</tr>
<tr>
<td>including staff working in laboratory medicine, cardiology and medical physics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>1,517</td>
<td>1,241.32</td>
<td>457</td>
</tr>
<tr>
<td>Nursing staff</td>
<td>3,678</td>
<td>2942.00</td>
<td>1,991</td>
</tr>
<tr>
<td>including all registered nurses and midwives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>970</td>
<td>752.90</td>
<td>403</td>
</tr>
<tr>
<td>including radiographers, occupational therapists, physiotherapists, pharmacists, optometry staff and staff in technical support roles</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Externally funded staff</td>
<td>175</td>
<td>96.37</td>
<td>58</td>
</tr>
<tr>
<td>staff working within the Trust whose costs are paid for by external organisations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10,243</td>
<td>8,052.66</td>
<td>4,381</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff by gender</th>
<th>Full and part-time staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Staff by gender" /></td>
<td><img src="image" alt="Full and part-time staff" /></td>
</tr>
</tbody>
</table>

Over three quarters of our workforce are female, and almost half (45%) of the female staff work part-time compared with a fifth (20%) of male employees, as shown below.
Sickness absence

The management of sickness absence within the Trust is given high priority supported by regular reporting of sickness levels to managers. The target rate for the end of year was for sickness to be equal to or below 3.25%. By the end of the year we achieved our target. The graph below indicates the seasonal nature of sickness absence rates.

![Year to date percentage sickness absence by month](image)

Staff turnover

Staff turnover rates have steadily declined since October 2008. The turnover rate of 10.84% for the financial year ending March 2009 was significantly lower than the previous year when it was 12.08%. The economic climate may well be a significant factor for the reduced turnover rate.

![Rolling year percentage turnover](image)
Improving working lives

There is a range of benefits for staff that supports their work/life balance, and a variety of flexible working options are enjoyed across the Trust, including term-time only working, job shares and flexi-time.

Additionally we offer discounts for local opticians, beauty salons, hairstylists, bus and rail tickets and at gyms and leisure facilities. There are also shops and cash machines, subsidised restaurants, League of Friends cafeterias, a free shuttle between the John Radcliffe Hospital and the Churchill Hospital, cycle parking, a bicycle repair service, long service awards, retirement vouchers, a staff lottery, on-site accommodation for staff, on-site staff hotel rooms, and support of the Key Worker Living Scheme.

The salary sacrifice and childcare voucher schemes continue for nursery places and are supported by a Childcare Co-ordinator.

Staff survey

For the fifth consecutive year, staff survey results indicate ORH staff are amongst the most satisfied workers in the NHS. The annual survey of NHS staff, published by the Care Quality Commission, has revealed that the ORH is among the top 20% of acute trusts for having staff who feel they are valued by colleagues, have an interesting job, have supportive managers, are able to contribute towards improvements at work, have job satisfaction and work for a Trust committed to work-life balance.

The survey shows better than average results for a variety of subjects including receiving relevant job-related training and development, being appraised with a personal development plan, and having fair and effective procedures for reporting incidents. It also shows staff to be amongst the least stressed staff within the NHS and the number intending to leave the organisation is lower than last year and among the lowest 20% of acute trusts.

Occupational health

The Trust has an active and supportive occupational health department. Occupational health provides an impartial and confidential advisory service to staff and their managers on health issues related to work and the work environment.

There are positive benefits from having access to a comprehensive NHS occupational health service. These include:

- improved overall health and fitness at individual and organisational levels
- reduced absenteeism, ill health and staff turnover
- reduced accident and incident figures
- reduction in potential litigation and organisational risk
- reduced incidence of industrial injuries and occupational ill health
- improved morale, motivation and performance
- enhanced job satisfaction
- reduced stress and ‘burnout’
- employees making informed choices on their health and safety and wellbeing whilst at work.

These result in a reduction of the overall administration costs of workplace ill health and an increase in the health and well-being of staff whilst at work. By ensuring a healthy workforce, patient care can be enhanced. Managers and employees are required to work in partnership with our occupational health team, aim for high standards of workplace health and achieve the benefits of health improvement.
NHS Plus provider

The ORH is an NHS Plus provider, offering specialist professional occupational health advice to employers and businesses across England. NHS Plus offers support to industry, commerce and the public sector, with a focus on small and medium-sized enterprises.

ORHi – intranet site

This year has seen the launch of ORHi, the new intranet for staff. It has a range of improvements on the old system and a number of innovative features. It is already making the day-to-day work of staff that little bit easier – whether it’s finding important documents, keeping up-to-date with Trust news and events or passing on important information.

People across the organisation, and beyond, contributed to ORHi’s design and development to make sure the resource is what the organisation needs.

Programmed by the Oxford Health Informatics Service (OHIS) using Microsoft Sharepoint, the new intranet shows what can be achieved with in-house collaboration, making the development cost-effective as well as successful. The technology is also being adopted by Oxfordshire PCT and the Nuffield Orthopaedic Centre, increasing the potential for closer online links between the organisations. ORHi is also accessible by colleagues in the University of Oxford and other NHS organisations in Oxfordshire.

Learning and development

This has been a period of change within the learning and development department. To meet the needs of the organisation, the Trust is in the process of developing new ways of delivering and monitoring training activity. One of the most exciting of these innovations is the Trust being chosen as one of only six pilot sites for the NHS National Learning Management System (LMS) e-learning programme. This enables staff to access e-learning and other training through the Electronic Staff Record system. The first stage of the pilot was completed in October 2008.

Staff will have easier access to the training directory from a larger number of computers via the new intranet site, ORHi. OHIS have provided much support to ensure all computers have the appropriate software to run the programmes.

The first in-house e-learning programmes have been developed by the resuscitation team and the smoking cessation team. We also plan to offer two of the Core Learning Unit’s ‘national content’ e-learning courses: Health and Safety, and Fire. In combination with the classroom-based teaching provided by the Trust Fire Officer, 5,000 staff will be asked to complete their statutory fire training using the e-learning package to ensure they can provide a safe environment in which to work.

Oxfordshire Health Care Apprenticeship Scheme

As part of our commitment to education, the Trust endorses the Oxfordshire Health Care Apprenticeship Scheme. This programme was developed to help local people who might not have more formal qualifications to develop the skills to become nurses through a nursing-related access course. The course is designed to provide vocational training and a two-year clinical placement.
Equality and diversity

The Board of Directors values diversity and the need to promote equality and is committed to meeting its legal obligations under equality legislation. The Trust’s Single Equality Scheme and progress reports are available on the website and on request from: publicinvolve@orh.nhs.uk

The ORH continues to listen to people’s experiences of accessing and using Trust services, information which contributes towards planned actions to improve services for all. The Trust welcomes interest from any individual or group who may wish to contribute to this work.

Priority activities include raising staff awareness of equality issues through training provision and assessing policies and service changes for their impact on various groups who may be affected, due to disability, age, ethnicity, religion and belief, gender and/or sexuality.

Following assessment, disability access is being improved, via methods such as replacing doors to enable wheelchair access and the installation of more hearing loops. The use of interpreting has increased over the year and documents in different formats are available on request.

The Trust monitors the ethnicity of patients and staff to ensure any potential to discriminate is challenged and corrected.

The current staff ethnicity profile:

![Workforce by ethnic group](image)

Patients

The Trust continues to work to ensure that diversity is respected and valued by all staff and has worked hard this year to improve the recording of patients’ ethnicity. This is important information for use in health service planning and to ensure equality of access to services. As a result, the Trust now records the ethnicity of 94.8% of inpatient admissions as compared to 90% last year.

Total number of inpatient admissions by ethnic group

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black and minority ethnic</td>
<td>18,437</td>
</tr>
<tr>
<td>Unknown / not stated</td>
<td>10,978</td>
</tr>
<tr>
<td>White</td>
<td>175,114</td>
</tr>
<tr>
<td>White other</td>
<td>5,177</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>212,439</strong></td>
</tr>
</tbody>
</table>
Healthcare libraries

The Trust provides both physical library space and outreach services, free of charge, for all staff both in Oxford and Banbury. Healthcare libraries operate on two sites: the Cairns Library at the John Radcliffe Hospital and the new Knowledge Centre near the Churchill Hospital, which opened in January 2009. In Banbury, all staff have access to the Horton General Hospital Library and Information Service.

Our services support healthcare practice, management, education, research, lifelong learning and continuing professional development. We provide constant access, clinical enquiry services, timetabled and one-to-one training sessions, study space, large and in-depth collections of books and journals, access to the internet and to a large number of online databases and journals, word processing and other computer applications and a range of outreach and current awareness services.

The Knowledge Centre

A new library for all staff and students close to the Churchill Hospital offers comfortable and contemporary library space, and replaces the libraries in the Churchill Research Institute and Rosemary Rue Building. It is just five minutes from the Churchill Hospital in the Old Road Campus Research Building.

The Knowledge Centre provides access to high-quality collections of books (the George Weimik Collection), journals and electronic resources with spacious and quiet spaces for private study, WiFi access, networked University and Trust intranet computers, MS Office, internet access and self-service printing and scanning. It is open to all staff 24/7 and complements the work of our outreach librarians.

The George Pickering Education Centre

The George Pickering Education Centre and Terence Mortimer Postgraduate Centre (at the Horton General Hospital in Banbury) support the training for junior doctors, dentists, GPs, staff and associate specialists and consultants who are responsible for the educational supervision of junior doctors.

One of the major challenges has been delivering a Foundation Programme which has continued to grow in size. In August 2008 there were 173 Foundation doctors compared to the August 2005 programme when there were 96. For the first time this year Foundation doctors were also offered a place on a simulation course run in conjunction with the Nuffield Department of Anaesthetics. The feedback from this course has been excellent, with all but one doctor saying they would recommend it to their colleagues.

Continuing Professional Development (CPD) approved training for supervisors and assessors continues. As part of the support for the training of junior doctors, the Trust has appointed a new Clinical Tutor for Assessors, two District Clinical Tutors, a Foundation Training Director and an Associate Clinical Tutor.

There has been much needed expansion at the Terence Mortimer Postgraduate Centre due to the growing emphasis placed on training and education. Both centres welcome other groups, both medical and non-medical, to use the facilities (for example, 15% of usage is for GPs).
Engaging with our stakeholders

The Trust values the input of individuals and other partner organisations as this can drive real improvements in our services. The Trust has many mechanisms for doing this, such as the Better Healthcare Programme for Banbury and Surrounding Areas; the Trust’s work with the Health Overview and Scrutiny Committee of Oxfordshire County Council; the formal patient involvement groups such as the Patient Panel and the Young People’s Executive (YiPpEe), and listening to complaints and comments received in many different parts of the organisation.

The Trust has a Patient and Public Involvement Strategy (available on our website: www.oxfordradcliffe.nhs.uk), which confirms our commitment to meaningful involvement. Following the publication of the Our Health, Our Care, Our Say White Paper, the Department of Health announced it was replacing Patient and Public Involvement (PPI) Forums from April 2008 with Local Involvement Networks (LINks). The Trust valued the contribution made by our Oxfordshire PPI Forums, and would like to thank those involved for their work. The Trust is now developing contacts with the new Oxfordshire LINk (Local Involvement Network) and working with voluntary sector organisations to increase contacts in the community and listen to people’s experiences of accessing and using Trust services.

We are committed to working in partnership with patients and carers, ensuring their needs are met. We ask for, and respond to feedback and collate and analyse comments so that we can learn from them. The Trust also has ongoing feedback and discussion with various user groups across the Trust.
Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service 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 works with hospital staff to resolve problems and assists in improving patient care. In 2008/09, PALS dealt with 2,212 enquiries, 386 at the Churchill Hospital, 445 at the Horton General Hospital and 1,381 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 main reception areas of all three of our hospitals.

Patient Advice and Liaison Service Offices

Each hospital site has a Patient Advice and Liaison Service office. If an enquiry is about a specific hospital, then the enquiry needs to be passed to the appropriate office. For more general enquiries, any of the offices will be able to help. Each Patient Advice and Liaison Service office is located by the main entrance of its hospital.

JOHN RADCLIFFE HOSPITAL
Main entrance, Level 2
Telephone: 01865 221473
Email: palsjr@orh.nhs.uk

CHURCHILL HOSPITAL
Main entrance
Telephone: 01865 235856
Email: palsch@orh.nhs.uk

HORTON GENERAL HOSPITAL
Main entrance
Telephone: 01295 229259
Email: palshh@orh.nhs.uk
Local Involvement Networks (LINks)

Oxfordshire LINk has been set up to replace the Patient and Public Involvement Forums and is a new way for local people to have a stronger voice in how their health and social care services are delivered. Each local authority that provides social services (in Oxfordshire, the County Council) has been given funding and is obliged to make arrangements to ensure that LINk activities take place.

Oxfordshire LINk is made up of volunteer members, groups and organisations with an interest in local care services. Registered charity Help and Care has been appointed to be the host organisation for the LINk in Oxfordshire as well as for several other local authority regions in the South of England. Their role is to support the Network to be an effective voice for people in these areas.

The Oxfordshire LINk Stewardship Group has now been elected and consists of ten volunteers representing a wide range of health and social care experience. The group will establish arrangements for taking LINk forward for the people of Oxfordshire. The group would like to hear what people think about local health or social care services – good or bad. A feedback form is currently being circulated to gather information from the wider community. It is available from the LINks website (www.makesachange.org.uk), local hospitals, doctor’s surgeries, dental surgeries, and local libraries; or you can contact the LINk office directly and they will send you one. Additionally, the LINk is seeking to recruit volunteers to join project groups and to become authorised to visit health and social care services within the terms of the legislation.

For further information and to sign up to participate in your local LINk please go to the LINks website: www.makesachange.org.uk; email OxfordshireLINk@makesachange.org.uk or call 01993 862855 or 0300 111 0102 (information line).
Patient Panel

The Patient Panel at the ORH is made up of over 40 volunteers who have worked with the Trust this year on a number of projects, including the plans for the new Oxford Heart Centre, the refurbished Geratology Unit and the production of patient information leaflets and service changes. Panel members collectively and individually respond to consultations on key Trust documents and strategies. In addition, in June the Panel were consulted over nominations for the Better Healthcare Programme for Banbury and Surrounding Areas Forum. Fifteen responses were received and a member is now sitting on the Forum. Patient Panel members are able to give particularly valuable advice on documents such as the draft Guidance on Relatives Visiting, to which 19 members contributed.

User groups

Many user groups exist across the Trust. One such group, which involves staff as well as patients, is the Oxford Centre for Diabetes and Endocrinology (OCDEM) user group. A suggestion box in the OCDEM atrium provides patients with an opportunity to make suggestions. Feedback from the comments box is discussed by the user group and has often led to practical problems being identified and solutions sought. The group organised a survey to find out what patients thought about the newly introduced appointments system, and has set up focus groups on specific issues to help with research projects.

Young People’s Executive (YiPpEe)

The Young People’s Executive is a group of children and young people who work and meet with staff in the Children’s Hospital to discuss improving services for young patients in hospital. All have either been in hospital themselves or have a brother, sister or close friend who has spent time in hospital. They were formally established in 2006 following work with the architects for the Children’s Hospital over colour schemes and signage.

The age range of members of YiPpEe is 10 to 18 years and there are currently 14 members. There have been up to 26 members in recent times. The group is facilitated and supported by the Trust’s Children’s Rights Lead Nurse, the Play Specialist team, and the Hospital School staff. YiPpEe engages with the wider patient group (patients in the Children’s Hospital).

There are feedback books on every ward for patients and their families to write or draw comments in. YiPpEe reviews all these books at the start of every meeting and pick up any issues that emerge from them. One such issue was noise at night in the adolescent unit from telephones on the nurses’ station. As a result, telephone volumes were turned down and staff made aware of this issue, and no further negative comments have been received.

YiPpEe also designed Splats! These are coloured pieces of paper that patients and other visitors can write or draw a comment on and pin up on a board on each floor. The aim of these is to pick up comments about the environment on each floor of the Children’s Hospital, which can be passed on to our PFI partner, Carillion, which manages the buildings. In addition, YiPpEe has created a questionnaire and a comment form, which have been placed in every playroom with a post box for completed forms.

If you would like to know more about our patient partnership work, please contact the patient partnership team on 01865 857734.
Many of the comments from all these sources are very positive but some issues have been highlighted by these methods.

The Trust is also part of the Oxfordshire Children’s Participation Network. This brings together all the key organisations in Oxfordshire from schools and children’s services to health providers and young offenders’ centres. The aims of the network are to improve and develop the involvement of young people across all these services and to co-ordinate involvement more effectively. For example, a multi-agency, Oxfordshire-wide group for children with disabilities is being established.

Work experience and volunteering

We have many volunteers from diverse areas and we are pleased to work with a variety of agencies, charities and groups providing volunteer placements. The Voluntary Services department has been working over the last two years with a charity supporting the long term unemployed, and work experience placements have been found for them in the Medical Records department. Four people on these placements have subsequently gained employment with the Trust.

The work experience programme receives on average 500 applications per year requesting placements, and 230 students aged 16 to 18 attended placements in the Trust in 2008/09.

The Voluntary Services department won an award from the local Education and Business Partnership in July 2008 for providing outstanding work experience placements, and continues to develop links with local schools and colleges.

The Trust has 277 active volunteers (which rises to over 1,000 if you include the many other charitable organisations which regularly support our hospitals). Volunteers do not perform the roles of NHS employees, but support the staff carrying out their duties to improve the patient experience. Volunteers help in various departments, talking to patients, helping at mealtimes on wards, taking the library trolley around wards, giving a friendly welcome and giving directions on help desks and working with the chaplaincy. The League of Friends and WRVS volunteers run tea bars and shops whilst hospital radio volunteers entertain the patients.

Approximately 65% of our volunteers are retired and in the 60 - 80 age group. A further 12% of our volunteers aged between 16 and 21 are using volunteering to gain experience of the workplace, particularly those wishing to follow medicine as a career.

The Trust celebrates the work of volunteers during National Volunteers Week in June each year and organises a strawberry tea party. We recognise the long service of volunteers during the week. The department has also developed links with Oxfordshire Community Volunteer Action and is looking into developing employee volunteers in the Trust, and forging closer links with Foundation Trust members who may be interested in becoming more involved with volunteering.
**Leagues of Friends**

The Leagues of Friends are voluntary organisations providing much needed equipment and extras through income raised running cafeterias and tea bars for patients, visitors and hospital staff at the John Radcliffe and Churchill Hospitals, and a shop at the Horton General Hospital. The Trust has several hundred Leagues of Friends volunteers, some of whom have been supporting us for over 20 years. They are managed by Trustees, who meet every month to make decisions about how to spend the money they raise.

**Oxford Safer Communities Partnership**

The Trust works with the Oxford Safer Communities Partnership, a collaboration between the police, the NHS, local councils and other statutory and voluntary organisations, to help tackle crime in Oxford.

In our emergency departments, we collect data related to attendances as a result of alcohol and/or violence which we make anonymous and then feed back to the group. This information can help police and the local council identify problem areas in the community.

**Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC)**

The Oxfordshire Joint Health Overview and Scrutiny Committee, part of Oxfordshire County Council, has a legal responsibility to scrutinise local health services. It also makes sure that they are run in the best interests of local people, and that appropriate communication, consultation and engagement takes place regarding any changes in those services. Representatives from the Trust attend meetings of HOSC and work to ensure that its members are kept informed of relevant developments. This includes consulting members of the Committee about service issues and plans.
Customer care

The views of our patients and their families are very important to us. It is our aim that all patients should have a positive experience in our hospitals and that their care should be excellent. There are occasions when our services fall short of the expectations of our patients and their families, and when this occurs, it is vital that we know about their concerns and that we act upon them to make sure that we learn from any mistakes. In addition to the positive work that we do with patients to learn from them, we also have formal systems for learning through our complaints.

Comments and complaints

Patients, carers and visitors are encouraged to tell a member of staff if they are worried or unhappy with any element of care or treatment at the Trust. Most concerns are dealt with straight away on an informal basis and some are resolved through our Patient Advice and Liaison Service (PALS).

Formal written complaints made to the Trust are taken very seriously. We invest time in addressing individual problems, but also in understanding what went wrong and how it could be avoided in the future. 96.4% of all complaints in 2008/09 were responded to in writing within NHS Complaints Procedure timescales (25 working days). We received 496 written complaints in the year.

The Healthcare Commission investigated seven complaints following local resolution. None were upheld or recommendations made for further work for the Trust.

PRINCIPLES FOR REMEDY

We adhere to the principles for remedy as defined by HM Treasury in Managing Public Money. They are also cited as best practice in the NHS Finance Manual.

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.
Patient survey

46% of patients, who have stayed in the John Radcliffe Hospital or Churchill Hospital in Oxford, or in the Horton General Hospital in Banbury, rated the overall standard of care as ‘excellent’, compared with a national average for all hospitals of 42%, according to the national patients’ survey, published by the Healthcare Commission in May 2008. 92% of patients rated the standard of care in these hospitals as excellent, very good or good.

The Trust is among the top 20% for 16 other areas, including the information given to patients about their care, whether or not they were treated with dignity and afforded privacy, and whether they witnessed nurses washing their hands. Year-on-year, doctors and nurses working for the Trust are consistently rated by patients as better than average for questions which consider trust, confidence in clinical judgement and communications, and these scores have improved again this year.

The survey, which asked patients 82 questions about their stay in hospital, and then compared the results from different Trusts, is carried out nationally every year by the independent research body, the Picker Institute. 850 patients who had been treated in our hospitals were sent questionnaires and 484 people replied; a higher than average response rate.

According to the survey, the Trust was judged by patients to be better than average for 52 of the 82 questions. The Trust received higher scores compared with last year for 40 of the indicators. In particular, scores for cleanliness have risen, as has the percentage of patients who were cared for in our single-sex accommodation.

Patients rated the two hospital emergency departments more highly than before, and scores were better than the national average for several questions.

The survey results also showed, however, that the number of patients experiencing a delay before their discharge from hospital was reduced, although the way in which the discharge process is handled for patients was improved.
Chief Executive’s Foreword

This Review demonstrates the strong performance of the ORH over the past year, and the many ways in which we have improved the patient experience while also ensuring that our use of resources remains efficient and effective.

The fact that we have achieved in the three domains of quality, operational performance and finance is due to the hard work of staff in all of our hospitals, and reflects their tireless commitment to ensuring the best possible care for patients. Visitors to the organisation often comment on the energy, enthusiasm and innovative spirit of the staff they meet, and it is these qualities, which are very much part of the day-to-day life of the ORH, which enable us to succeed, no matter how many challenges we face.

These attributes will be just as important during the current year, when the demands made of us are as great, or even greater. In particular, in common with other NHS organisations, we face the challenge of continuing to improve our performance and the quality of our services, while working within budgets which are considerably more constrained than in previous years.

There are a number of reasons for this, including the fact that the Government requires all NHS trusts to make 3% cost efficiencies every year and our PCT commissioners are increasingly looking to provide more health care closer to patients in the community rather than in hospital. While this is done in the interests of patients, it has an inevitable impact on our finances and the way in which we provide our services. It would also be foolish to assume that the public sector will be immune to the effects of the wider economic situation, and we must therefore prepare accordingly. The Oxford Cancer Centre is also an additional cost pressure in this, its first year, although in the longer term, the new facilities will attract more patients and income from beyond Oxfordshire, and it will pay its way within the organisation.

While these pressures are difficult for us, I am confident that we can succeed, and without sacrificing the high quality of our services, for which we are now nationally recognised. Over recent years we have developed a reputation as an organisation with considerable skills and experience in using improved efficiency and new ways of working to improve patient care. A concrete example is the way in which we reorganised planned operations for some patients, which means that people are now in hospital for a shorter time, unnecessary delays have been greatly reduced and fewer procedures are cancelled. This has resulted in improved patient satisfaction, as well as much better use of very expensive facilities and staff. A number of the initiatives we have instigated have been developed by some of our younger clinical and managerial staff, who, as the NHS leaders of the future, are keen
to engage in innovation and, perhaps, more inclined to question the status quo. Over the coming year, we will build on their interest and continue to encourage innovative approaches to problem solving.

It would be wrong for me to comment on this year by concentrating only on those issues, which occupy the minds of my managerial colleagues (and that includes those clinicians involved in management and leadership). It is important to remember that from the point of view of patients, this year we will be providing high-quality services in some new facilities, which are among the best in the country. Over the past few years, we have overseen an unprecedented level of investment in new buildings, facilities and equipment. At the John Radcliffe Hospital, this includes the Oxford Children’s Hospital, the West Wing for adult services, and the Oxford Heart Centre. The Oxford Cancer Centre and adjacent facilities, which also opened earlier this year, represent by far the most substantial redevelopment of the Churchill Hospital in its 70-year history.

We will continue to improve our facilities for our patients. For example, due to a tremendous local fundraising effort, our plans to develop the Brodey Centre for cancer patients at the Horton General Hospital in Banbury are coming to fruition, and we have begun looking at how we can expand our neonatal intensive care facilities in Oxford to meet medical science’s increasing ability to sustain life in the youngest of premature babies.

To conclude this Review of the Oxford Radcliffe Hospitals, I must thank staff throughout the organisation who work so tirelessly to ensure that our patients get high-quality care, in high-quality environments. Our patients see the doctors, nurses and other health professionals who are directly involved in clinical care. They are enormously important, but would not be able to do their jobs so well without the many staff who support them in so many different ways – laboratory colleagues, cleaning, maintenance and estates teams, finance, secretarial and administrative staff, to give but a few examples. All of them make a contribution to the quality of our patient care.

This current year promises to be exciting, rewarding, and, yes, sometimes difficult. I know that staff will rise to both opportunities and challenges alike, and ensure that once again we succeed in those three domains of quality, performance and financial sustainability.

Trevor Campbell Davis
Chief Executive
Board of Directors

Non-executive Directors

Dame Fiona Caldicott

Professor Alastair Buchan

Caroline Langridge

Dr Colin Reeves CBE

Brian Rigby CBE

Professor Adrian Towse

Executive Directors

Trevor Campbell Davis
Chief Executive

Chris Hurst
Director of Finance and Procurement

Dr James Morris
Medical Director

Andrew McLaughlin
Chief Operating Officer (from 1 April 2009)

Andrew Stevens
Director of Planning and Information

Elaine Strachan-Hall
Director of Nursing and Clinical Leadership
The following attended Executive Board meetings in 2008/09

Dr Hywel Jones
Divisional Chair
Division A

Moira Logie
Director of Operations,
Division A

Mike Greenall
Divisional Chair
Division B

Kathleen Simcock
Director of Operations,
Division B

Dr David Lindsell
Divisional Chair
Division C

Amanda Middleton
Director of Operations,
Division C

Sue Donaldson
Director of Human Resources
and Organisational
Development*

Mike Fleming
Director, Horton General
Hospital

Ian Humphries
Director of Estates and
Facilities

Helen Peggs
Director of
Communications

Andrew Murphy
Director of Performance
Improvement

Jerry Park
Board Secretary*

* also attends all meeting of the Board of Directors
Committees of the Board of Directors

Audit Committee – Dr Ken Fleming (until 30 September 2008), Dr Colin Reeves (Committee Chair) and Professor Adrian Towse.

Commercial Committee – Mrs Vickie Holcroft, Mr Ian Humphries, Mr Chris Hurst, Dr James Morris, Mr Brian Rigby (Committee Chair), Mr Andrew Stevens and Mrs Elaine Strachan-Hall. During 2008/09, this Committee was redesignated from a Board Committee to an Executive Committee.

Finance and Performance Committee – Professor Alastair Buchan (from 1 October 2008), Dame Fiona Caldicott (Committee Chair from 1 December 2008), Mr Trevor Campbell Davis, Dr Ken Fleming (until 30 September 2008), Mr Chris Hurst, Ms Caroline Langridge, Dr Colin Reeves, Mr Brian Rigby, Mr Andrew Stevens, Sir William Stubbs (Committee Chair until 30 November 2008) and Professor Adrian Towse. In addition, all other Executive Directors are invited to attend all meetings of the Committee.

Governance Committee – Dr Ken Fleming (until 30 September 2008), Ms Caroline Langridge and Professor Adrian Towse (Committee Chair).

Human Resources Committee – Dame Fiona Caldicott (Committee Chair), Mr Mark Gammage, Ms Moira Logie, Dr James Morris, Ms Debbie Pearman, Mr Brian Rigby and Mrs Elaine Strachan-Hall. During 2008/09, this Committee was redesignated from a Board Committee to an Executive Committee.

Remuneration and Appointments Committee – All Non-executive Directors are members of the Committee, of which the Chairman of the Trust is Chair. Meetings of the Committee are quorate if two Non-executive Directors are present, but two Non-executive Directors and the Chairman usually attend.

The 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 sets the number of discretionary points for award by the Trust’s discretionary points panel.

Each year, the Committee considers the national cost-of-living pay awards made for Agenda for Change as the basis for any pay awards to senior directors.

Every senior manager undertakes an annual appraisal, resulting in objectives and a personal development plan for the coming year. 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 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 Chairs are consultants with permanent contracts who undertake the role for a fixed term.

Declaration of Interests and Register of Interests of members of the Board of Directors for the year 2008/09

Declarations of Board members’ interests are sought each year and published through the public Board meetings and also in the Annual Review each year. Given overleaf are the interests for the year 2008/09. Guidance to the codes defines ‘relevant and material’ interests as:

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

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

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

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

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

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

g) Interests in pooled funds that are under separate management.
<table>
<thead>
<tr>
<th><strong>Director</strong></th>
<th><strong>a</strong></th>
<th><strong>b</strong></th>
<th><strong>c</strong></th>
<th><strong>d</strong></th>
<th><strong>e</strong></th>
<th><strong>f</strong></th>
<th><strong>g</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sir William Stubbs</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Dame Fiona Caldicott</td>
<td>Non-executive Director and Company Secretary, Waters 1802 Ltd</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Professor Alastair Buchan</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Trustee, Jenner Foundation; Trustee, Nuffield Trust; Trustee, Stroke Centre, the Charité Hospital, Berlin; Member, Governing Body, Repton School</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Trevor Campbell Davis</td>
<td>Chairman, European Communications Group Ltd</td>
<td>None</td>
<td>None</td>
<td>Trustee, NHS Confederation; Council Member NHS Confederation; Executive Board Member, Association of UK University Hospitals</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Kenneth Fleming</td>
<td>Non-executive Director of the ORH Charitable Funds Committee</td>
<td>None</td>
<td>None</td>
<td>Director, Gray Institute for Cancer Research; Trustee, Jenner Foundation; Nuffield Medical Trustee</td>
<td>Head of the Medical Sciences Division, University of Oxford</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Chris Hurst</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Caroline Langridge</td>
<td>Non-executive Director, ORH Charitable Funds Committee</td>
<td>None</td>
<td>None</td>
<td>Lay Member, Fitness to Practice Committee, General Medical Council; Lay Member, Judicial Review Panel</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>James Morris</td>
<td>Non-executive Director, NHS Innovations South East</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Colin Reeves</td>
<td>None</td>
<td>Self-employed consultant undertaking NHS business</td>
<td>None</td>
<td>Honorary Treasurer of Headway UK; Member of Audit Committee, Oxfam International</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Brian Rigby</td>
<td>Director, Partnership for Schools</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Visiting Fellow of Warwick University Business School</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Andrew Stevens</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Elaine Strachan-Hall</td>
<td>Director of Olliedoo Wedji</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Adrian Towse</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Summary of financial position

For the second consecutive year the Trust made an operating surplus in the year and an underlying (normalised) operating surplus for the third consecutive year. At £2.405m its final retained surplus for the year was marginally better than its planned surplus of £2.3m. In addition, in the face of a deteriorating economic environment, the Trust successfully took action to further strengthen its cash position (liquidity) in the second half of the financial year. As a result, it starts 2009/10 with a strong underlying cash position. This is essential given the scale of financial challenges which can be expected to face public services over the next five years.

In preparation for the NHS’s adoption of the new International Financial Reporting Standards (IFRS) from 2009/10, the exemption which previously allowed NHS organisations not to comply fully with the accounting standards used for preparing company accounts – that is, Generally Accepted Accounting Practice (UK GAAP) has been withdrawn. This, coupled with the difficult general economic situation, has focused attention on the carrying value of the Trust’s land and building assets in the Balance Sheet. The carrying value of the Trust’s land and building holdings has been revised substantially downwards to reflect movements in relevant indices since the last professional valuation.

In 2009/10, the introduction of IFRS for annual accounts prepared from April 2009, will result in the Trust’s two privately financed (PFI) hospital schemes coming on Balance Sheet. It is also possible that further falls in land and building prices, coupled with changes in the valuation methods specified by the Royal Institution of Chartered Surveyors, may impact on the valuation of the Trust’s assets in 2009/10.

Format of the accounts

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

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

The annual accounts also include
- Notes to the accounts
- Statement on internal control
- Directors’ statement of responsibilities
- 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 2009 including:
- the full set of audited financial statements
- 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 format from the Media and Communications Unit on 01865 231471.
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 £2.405m, which is 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 2009/10 and 2010/11 to fully recover the five year break-even duty. The Trust is now in recurrent surplus and can generate 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 2008/09 the Trust met the duty with an absorption rate of 4.0%.

External Financing Limit (an overall cash management control)

The Trust was set an External Financing Limit (EFL) of £15.243m in 2008/09. Its actual external financing requirement was £0.154m, that is £15.089m 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 2003/04)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>614,371</td>
<td>15,599</td>
<td>2,405</td>
<td>4.0</td>
</tr>
<tr>
<td>2007/08</td>
<td>553,098</td>
<td>16,105</td>
<td>4,311</td>
<td>3.5</td>
</tr>
<tr>
<td>2006/07</td>
<td>484,559</td>
<td>1,174</td>
<td>(8,649)</td>
<td>3.4</td>
</tr>
<tr>
<td>2005/06</td>
<td>474,983</td>
<td>(9,929)</td>
<td>(19,409)</td>
<td>3.3</td>
</tr>
<tr>
<td>2004/05</td>
<td>452,102</td>
<td>8,978</td>
<td>1,580</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Summary financial statements

These accounts for the year ended 31 March 2009 have been prepared by the Oxford Radcliffe Hospitals NHS Trust under section 232 (Schedule 15) of the National Health Service Act 2006 in the form, which the Secretary of State has, with the approval of the Treasury, directed.

The financial statements that follow are only a summary of the information contained in the Trust’s Annual Accounts. 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 years ended 31 March 2009 and 31 March 2008

<table>
<thead>
<tr>
<th></th>
<th>2008/09 £000</th>
<th>2007/08 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>499,533</td>
<td>455,553</td>
</tr>
<tr>
<td>Other operating income</td>
<td>114,838</td>
<td>97,545</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(598,538)</td>
<td>(536,305)</td>
</tr>
<tr>
<td><strong>OPERATING SURPLUS/(DEFICIT)</strong></td>
<td>15,833</td>
<td>16,793</td>
</tr>
<tr>
<td>Profit/(loss) on disposal of fixed assets</td>
<td>(223)</td>
<td>(851)</td>
</tr>
<tr>
<td><strong>SURPLUS/(DEFICIT) BEFORE INTEREST</strong></td>
<td>15,610</td>
<td>15,942</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>1,134</td>
<td>1,218</td>
</tr>
<tr>
<td>Interest payable</td>
<td>(1,124)</td>
<td>(1,034)</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>15,599</td>
<td>16,105</td>
</tr>
<tr>
<td>Public Dividend Capital dividends payable</td>
<td>(13,184)</td>
<td>(11,794)</td>
</tr>
<tr>
<td><strong>RETAINED SURPLUS/(DEFICIT) FOR THE YEAR</strong></td>
<td>2,405</td>
<td>4,311</td>
</tr>
</tbody>
</table>

### Balance sheet as at 31 March 2009

<table>
<thead>
<tr>
<th></th>
<th>31 March 2009 £000</th>
<th>31 March 2008 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIXED ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>3,875</td>
<td>4,315</td>
</tr>
<tr>
<td>Tangible assets</td>
<td>415,923</td>
<td>448,666</td>
</tr>
<tr>
<td>Financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL FIXED ASSETS</strong></td>
<td>419,798</td>
<td>452,981</td>
</tr>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks and work in progress</td>
<td>8,895</td>
<td>8,498</td>
</tr>
<tr>
<td>Debtors</td>
<td>52,957</td>
<td>57,853</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>19,287</td>
<td>12,498</td>
</tr>
<tr>
<td><strong>TOTAL CURRENT ASSETS</strong></td>
<td>81,139</td>
<td>78,849</td>
</tr>
<tr>
<td><strong>CREDITORS:</strong> Amounts falling due within one year</td>
<td>(79,478)</td>
<td>(61,974)</td>
</tr>
<tr>
<td>Financial liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>NET CURRENT ASSETS/(LIABILITIES)</strong></td>
<td>1,661</td>
<td>16,875</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS LESS CURRENT LIABILITIES</strong></td>
<td>421,469</td>
<td>469,856</td>
</tr>
<tr>
<td><strong>CREDITORS:</strong> Amounts falling due after more than one year</td>
<td>(34,323)</td>
<td>(32,415)</td>
</tr>
<tr>
<td><strong>PROVISIONS FOR LIABILITIES AND CHARGES</strong></td>
<td>(2,259)</td>
<td>(4,748)</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>384,877</td>
<td>432,693</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>172,586</td>
<td>169,547</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>133,449</td>
<td>182,317</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>64,824</td>
<td>67,374</td>
</tr>
<tr>
<td>Government grant reserve</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>Other reserves</td>
<td>1,743</td>
<td>1,743</td>
</tr>
<tr>
<td>Income and expenditure reserve</td>
<td>12,198</td>
<td>11,712</td>
</tr>
<tr>
<td><strong>TOTAL TAXPAYERS’ EQUITY</strong></td>
<td>384,877</td>
<td>432,693</td>
</tr>
</tbody>
</table>
Statement of total recognised gains and losses for the year ended 31 March 2009

<table>
<thead>
<tr>
<th>Description</th>
<th>2008/09 £000</th>
<th>2007/08 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus for the financial year before dividend payments</td>
<td>15,599</td>
<td>16,105</td>
</tr>
<tr>
<td>Fixed asset impairment losses</td>
<td>(55,316)</td>
<td>0</td>
</tr>
<tr>
<td>Unrealised surplus on fixed asset revaluations/indexation</td>
<td>18,311</td>
<td>27,556</td>
</tr>
<tr>
<td>Increases in the donated asset and government grant reserve due to receipt of</td>
<td>741</td>
<td>1,019</td>
</tr>
<tr>
<td>donated and government grant financed assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defined benefit scheme actuarial gains/(losses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additions/(reductions) in “other reserves”</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total recognised gains and losses for the financial year</strong></td>
<td><strong>(20,665)</strong></td>
<td><strong>44,633</strong></td>
</tr>
<tr>
<td>Prior period adjustment</td>
<td>(6,986)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total gains and losses recognised in the financial year</strong></td>
<td><strong>(27,651)</strong></td>
<td><strong>44,633</strong></td>
</tr>
</tbody>
</table>
### Cash flow statement for the year ended 31 March 2009

<table>
<thead>
<tr>
<th></th>
<th>2008/09 £000</th>
<th>2007/08 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPERATING ACTIVITIES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from operating activities</td>
<td>48,946</td>
<td>42,346</td>
</tr>
<tr>
<td>RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>1,232</td>
<td>1,193</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(1,106)</td>
<td>(1,022)</td>
</tr>
<tr>
<td>Interest element of finance leases</td>
<td>(3)</td>
<td>(7)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from returns on investments and servicing of finance</td>
<td>123</td>
<td>164</td>
</tr>
<tr>
<td>CAPITAL EXPENDITURE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Payments) to acquire tangible fixed assets</td>
<td>(36,386)</td>
<td>(33,210)</td>
</tr>
<tr>
<td>Receipts from sale of tangible fixed assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Payments) to acquire intangible assets</td>
<td>(146)</td>
<td>(571)</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>-</td>
<td>0</td>
</tr>
<tr>
<td>(Payments to acquire)/receipts from sale of financial instruments</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from capital expenditure</td>
<td>(36,532)</td>
<td>(33,781)</td>
</tr>
<tr>
<td>DIVIDENDS PAID</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash inflow/(outflow) before management of liquid resources and financing</td>
<td>(657)</td>
<td>(3,065)</td>
</tr>
<tr>
<td>MANAGEMENT OF LIQUID RESOURCES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Purchase) of investments with the Department of Health</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 the Department of Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sale of other current financial assets</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>(657)</td>
<td>(3,065)</td>
</tr>
<tr>
<td>FINANCING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td>10,955</td>
<td>11,915</td>
</tr>
<tr>
<td>Public dividend capital repaid (not previously accrued)</td>
<td>(7,916)</td>
<td>0</td>
</tr>
<tr>
<td>Loans received from the Department of Health</td>
<td>7,900</td>
<td>6,141</td>
</tr>
<tr>
<td>Other loans received</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans repaid to the Department of Health</td>
<td>(3,946)</td>
<td>(3,332)</td>
</tr>
<tr>
<td>Other loans repaid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other capital receipts</td>
<td>503</td>
<td>151</td>
</tr>
<tr>
<td>Capital element of finance lease rental payments</td>
<td>(50)</td>
<td>(46)</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>7,446</td>
<td>14,829</td>
</tr>
<tr>
<td>Increase/(decrease) in cash</td>
<td>6,789</td>
<td>11,764</td>
</tr>
</tbody>
</table>
Better Payment Practice Code 2008/09 – measure of compliance

<table>
<thead>
<tr>
<th>Number</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Non-NHS trade invoices paid in the year</td>
<td>96,150</td>
</tr>
<tr>
<td>Total Non-NHS trade invoices paid within target</td>
<td>85,553</td>
</tr>
<tr>
<td>Percentage of Non-NHS trade invoices paid within target</td>
<td>89%</td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>4,385</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>3,496</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>80%</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>2008/09 £000</th>
<th>2007/08 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management costs</td>
<td>19,245</td>
<td>17,865</td>
</tr>
<tr>
<td>Income</td>
<td>614,371</td>
<td>534,000</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/fs/en

External Audit Services

External Audit Services are provided by the Audit Commission. Audit fees of £0.287m in 2008/09 include charges for:

a) Audit of Accounts of £0.157m (excl VAT) and
b) Audit of “use of resources” of £0.130m (excl 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 Board of Directors.
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 preparing the Accounts for the Trust for 2008/09, 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>2008/09</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary</td>
<td>Other remuneration</td>
</tr>
<tr>
<td></td>
<td>(£000)</td>
<td>(£000)</td>
</tr>
<tr>
<td>Sir William Stubbs (1)</td>
<td>Chairman</td>
<td>15-20</td>
</tr>
<tr>
<td>Dame Fiona Caldicott (2)</td>
<td>Chairman</td>
<td>10-15</td>
</tr>
<tr>
<td>Dr Kenneth Fleming</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Caroline Langridge</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Brian Rigby CBE</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Professor Adrian Towse</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Dr Colin Reeves CBE</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Professor Alastair Buchan (3)</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Trevor Campbell Davis</td>
<td>Chief Executive</td>
<td>185-190</td>
</tr>
<tr>
<td>Chris Hurst</td>
<td>Director of Finance and Procurement</td>
<td>145-150</td>
</tr>
<tr>
<td>Andrew Stevens</td>
<td>Director of Planning and Information</td>
<td>115-120</td>
</tr>
<tr>
<td>Sue Donaldson (4)</td>
<td>Director of Human Resources</td>
<td>40-45</td>
</tr>
<tr>
<td>Dr James Morris</td>
<td>Medical Director</td>
<td>35-40</td>
</tr>
<tr>
<td>Mrs Elaine Strachan-Hall (6)</td>
<td>Director of Nursing and Clinical Leadership</td>
<td>105-110</td>
</tr>
<tr>
<td>Ian Humphries</td>
<td>Director of Estates and Facilities</td>
<td>95-100</td>
</tr>
<tr>
<td>Michael Fleming</td>
<td>Director of Horton General Hospital</td>
<td>110-115</td>
</tr>
<tr>
<td>Dr John Reynolds</td>
<td>Divisional Chairman, Division A</td>
<td>-</td>
</tr>
<tr>
<td>Dr Hywel Jones (5)</td>
<td>Divisional Chairman, Division A</td>
<td>35-40</td>
</tr>
<tr>
<td>Michael Greenhall</td>
<td>Divisional Chairman, Division B</td>
<td>35-40</td>
</tr>
<tr>
<td>Dr David Lindsell</td>
<td>Divisional Chairman, Division C</td>
<td>35-40</td>
</tr>
<tr>
<td>Moira Logie</td>
<td>Director of Operations, Division A</td>
<td>95-100</td>
</tr>
<tr>
<td>Kathleen Simcock</td>
<td>Director of Operations, Division B</td>
<td>95-100</td>
</tr>
<tr>
<td>Amanda Middleton</td>
<td>Director of Operations, Division C</td>
<td>80-85</td>
</tr>
<tr>
<td>Joanna Paul (6)</td>
<td>Director of Operations, Division C</td>
<td>-</td>
</tr>
</tbody>
</table>

NOTES
1 Retired in 30 November 2008
2 Non-executive Director; Interim Chairman from 1 December 2008; substantive Chairman from 9 March 2009
3 Non-executive Director from 1 October 2008
4 Director of Human Resources and Organisational Development from 1 November 2008
5 Divisional Chair from May 2008
6 On return from maternity leave took up a different post
### Salary and pension entitlements of senior managers

#### (B) Pension benefits

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension at age 60 (Bands of £2,500)</th>
<th>Real increase in pension lump sum at age 60 (Bands of £2,500)</th>
<th>Total accrued pension at 31 March 2009 (Bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2009 (Bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2009 (Bands of £2,500)</th>
<th>Cash Equivalent Transfer Value at 31 March 2008 (Bands of £2,500)</th>
<th>Real increase in Cash Equivalent Transfer Value (Bands of £2,500) £000</th>
<th>Employers contribution to Stakeholder Pension £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trevor Campbell Davis</td>
<td>Chief Executive</td>
<td>0-2.5</td>
<td>5.0-7.5</td>
<td>10-15</td>
<td>40-45</td>
<td>339</td>
<td>201</td>
<td>93</td>
</tr>
<tr>
<td>Chris Hurst</td>
<td>Director of Finance and Procurement</td>
<td>7.5-10.0</td>
<td>22.5-25.0</td>
<td>50-55</td>
<td>160-165</td>
<td>1,197</td>
<td>713</td>
<td>327</td>
</tr>
<tr>
<td>Andrew Stevens</td>
<td>Director of Planning and Information</td>
<td>0-2.5</td>
<td>5.0-7.5</td>
<td>35-40</td>
<td>110-115</td>
<td>664</td>
<td>461</td>
<td>134</td>
</tr>
<tr>
<td>Sue Donaldson</td>
<td>Director of Human Resources</td>
<td>0-2.5</td>
<td>5.0-7.5</td>
<td>15-20</td>
<td>115-120</td>
<td>97</td>
<td>52</td>
<td>13</td>
</tr>
<tr>
<td>Dr James Morris</td>
<td>Medical Director</td>
<td>2.5-5.0</td>
<td>7.5-10.0</td>
<td>30-35</td>
<td>100-105</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Elaine Strachan-Hall</td>
<td>Director of Nursing and Clinical Leadership</td>
<td>0-2.5</td>
<td>2.5-5.0</td>
<td>35-40</td>
<td>105-110</td>
<td>581</td>
<td>433</td>
<td>95</td>
</tr>
<tr>
<td>Ian Humphries</td>
<td>Director of Estates and Facilities</td>
<td>0-2.5</td>
<td>5.0-7.5</td>
<td>45-50</td>
<td>140-145</td>
<td>853</td>
<td>729</td>
<td>74</td>
</tr>
<tr>
<td>Michael Fleming</td>
<td>Director of Horton General Hospital</td>
<td>2.5-5.0</td>
<td>10.0-12.5</td>
<td>45-50</td>
<td>140-145</td>
<td>1,004</td>
<td>700</td>
<td>201</td>
</tr>
<tr>
<td>Dr John Reynolds (1) Divisional Chairman, Division A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Hywel Jones (2) Divisional Chairman, Division A</td>
<td></td>
<td>15.0-17.5</td>
<td>45.0-47.5</td>
<td>65-70</td>
<td>205-210</td>
<td>1,661</td>
<td>940</td>
<td>448</td>
</tr>
<tr>
<td>Michael Greenall Divisional Chairman, Division B</td>
<td></td>
<td>10.0-12.5</td>
<td>30.0-32.5</td>
<td>95-100</td>
<td>285-290</td>
<td>0</td>
<td>1,550</td>
<td>1,112</td>
</tr>
<tr>
<td>Dr David Lindsell Divisional Chairman, Division C</td>
<td></td>
<td>12.5-10</td>
<td>37.5-35.0</td>
<td>80-85</td>
<td>250-255</td>
<td>2,042</td>
<td>1,675</td>
<td>228</td>
</tr>
<tr>
<td>Moira Logie</td>
<td>Director of Operations, Division A</td>
<td></td>
<td>0-2.5</td>
<td>2.5-5.0</td>
<td>30-35</td>
<td>100-105</td>
<td>659</td>
<td>476</td>
</tr>
<tr>
<td>Kathleen Simcock</td>
<td>Director of Operations, Division B</td>
<td></td>
<td>2.5-0</td>
<td>2.5-0</td>
<td>15-20</td>
<td>50-55</td>
<td>273</td>
<td>216</td>
</tr>
<tr>
<td>Joanna Paul</td>
<td>Director of Operations, Division C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>213</td>
<td></td>
</tr>
<tr>
<td>Amanda Middleton</td>
<td>Director of Operations, Division C (Acting)</td>
<td></td>
<td>5.0-7.5</td>
<td>17.5-20.0</td>
<td>20.0-25.0</td>
<td>65.0-70.0</td>
<td>377</td>
<td>273</td>
</tr>
</tbody>
</table>

**NOTES**
1. Left October 2007
2. From May 2008

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.
A glossary of the key terms used in the Annual Review

The Income and Expenditure (I and E) Account records the income and the costs incurred by the Trust during the year in the course of running its operations. It includes cash expenditure on staff and supplies as well as non-cash expenses such as depreciation (a charge that reflects the consumption of the assets used in delivering healthcare). It is the equivalent of the profit and loss account in the private sector. If income exceeds expenditure, the Trust has a surplus. If expenditure exceeds income, a deficit is incurred.

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.
- **A glossary of the key terms used in 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.

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.
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.

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 Strong partnerships exist with both Oxford's Universities. The partnership with the University of Oxford has this year been formalised through a Strategic Partnership Board, which I chair. The Biomedical Research Centre has been in existence for two full years and has supported and strengthened the drive towards increasing congruence of patient care, teaching and research.

5 Discussions also continue on how arrangements can be taken forward to develop the work done during the application process to become an Academic Health Science Centre, which proved unsuccessful in March 2009.

6 I have delegated responsibility for the establishment and maintenance of a risk management system and the 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 2009, and up to the date of approval of the annual report and accounts.

Capacity to handle risk

9 Risk remained a high profile topic throughout the organisation throughout the year. The Board of Directors considered the Trust Key Risks throughout the year at its public meetings and focused on all aspects of risk management at a Board development session in March 2009. The Leaders’ Briefings in January 2009 highlighted both Fraud Awareness (delivered by the Trust’s Local Counter Fraud Specialist) and Governance and Assurance. In addition, the risk management training sessions were delivered at the March Leaders’ Briefing sessions by the Director of Nursing and Clinical Leadership.

10 The ORH has in place risk management and health and safety policies and procedures which lay down clear responsibilities for named officers and for all staff across the Trust. These are due for review in the coming year as part of the preparatory work for assessment by the National Health Service Litigation Authority. 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.

11 The Governance Committee of the Board of Directors reviewed the Governance, Quality, Risk and Safety Framework in March 2009 (formerly the Risk Management Strategy) and a programme of work has been agreed for the coming year, focusing on clarity.
for risk management and control, the development of assurance mechanisms and further delivery of agreed safety action plans.

12 The Trust-wide Risk Register was updated in both July 2008 and March 2009 by the Governance Committee. The full register was reviewed by the Board in July 2008 and is collated into the Trust Key Risks document reviewed by the Board at its public meetings.

13 The Director of Nursing and Clinical Leadership has delegated responsibility for risk and the risk management systems across the Trust. The Associate Director of Safety, Quality and Risk and the Associate Director of Governance meet 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 as evidenced during the recent inspection of the Hygiene Code by the Healthcare Commission.

14 The Governance Committee met throughout the year and the minutes are presented to the Board of Directors in its public meetings with a covering sheet from the committee chair highlighting particular issues of note. Appropriate areas of governance, including safety, quality and risk, corporate and clinical governance, research governance and information governance, are covered as standing items on the agenda. To strengthen the integration of the governance of the Trust, there has been cross-membership at Non-executive Director level, and some Executive Directors and officers attend meetings of both Committees. The Governance Committee and the Audit Committee are now serviced by the Secretary to the Board following his appointment in January 2009.

15 The development of the governance arrangements will continue as part of the FT application process and take account of the compliance requirements set by Monitor. In particular, the Director of Nursing and Clinical Leadership is leading work to ensure that the risk management and assurance committee structures meet the requirements of the Board.

16 Work has continued throughout the year on quality and risk reports from the clinical divisions. The increased availability of information and data from 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.

17 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.

The risk and control framework

18 The Board of Directors has delegated the responsibility for the review and monitoring of the Board Assurance Framework (BAF) to the Governance Committee with reports being made to the full Board at least twice a year. 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 in detail by the Board of Directors in both July 2008 and January 2009, with a final review by the Governance Committee in March 2009. In addition the Audit Committee has also reviewed the BAF during the year.

19 The BAF is prepared, updated and maintained by the Associate 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. Action plans have been in place throughout the year to meet these gaps and the BAF shows how these gaps have been met at the year end.

20 The strategic goals and strategic objectives contained within the BAF were identified by the Trust’s Executive Team and approved by the Board of Directors as part of the Business Plan in March 2008. 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 is a dynamic document.

21 The Board of Directors considered and approved the strategic business planning framework with its goals and objectives in September 2008 and considered and approved the Business Plan for 2009/10 at its meeting in March 2009. The Business Plan identifies risks to the strategic objectives and these will form the basis of the BAF for 2009/10 now in preparation.
The BAF and the Trust Risk Register are cross-referenced to show linkages throughout and a further link is maintained through the referencing of the Trust Risk Register in the Trust Key Risks document. All core standards and relevant indicators are linked to the BAF. The status of action plans included within the BAF are ‘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.

The Trust is fully compliant with the core standards outlined in the Standards for Better Health. The Trust’s Declaration to the Care Quality Commission (CQC) has been supported by regular reports to the Executive Board, the Governance Committee and the Board of Directors. 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. The Declaration has been supported by cross-reference to, for example, the outputs from the HCC's annual patient and staff surveys, the HCC Hygiene Code inspection carried out in February 2009 (on the 2006 Hygiene Code) and the benchmark indicators made available by the HCC in February 2009.

Performance on other elements contributing to the quality element of the annual health check has been monitored by the Executive Board and the Board of Directors through the two monthly reports. Increased use has been made of benchmarking information so that the effectiveness of internal systems can be developed.

The BAF has been used by the Board of Directors 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 CQC.

The Board of Directors approved the application document submitted to the Care Quality Commission (CQC) to seek registration in relation to its compliance with Healthcare Associated Infections (HCAI) regulations and stating its position in relation to the nine criteria in the Hygiene Code as revised by the 2008 Act. Unconditional registration has been achieved with effect from 1 April 2009. Work will start in the coming months to prepare for registration with the CQC for all ORH provided services from 1 April 2010.

The Board of Directors’ 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.

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 which included the review and updating of key information governance policies on confidentiality and information protection. The group also reviews Freedom of Information requests and relevant incidents and oversees the annual information governance toolkit self-assessment. The Director of Planning and Information was the Board Lead for information governance up to 1 October 2008 when these responsibilities were taken over by the Director of Nursing and Clinical Leadership.

Detailed reports on information governance are considered by the Governance Committee and subsequently reported to the Board of Directors. The Director of Nursing and Clinical Leadership has been designated as the Senior Information Risk Owner (SIRO). The Committee reviewed and endorsed the arrangements for the management of information governance, the information governance strategy and policy prepared by the Information Governance Group, chaired by Dr Bunch, the Caldicott Guardian. The Information Governance Group works to a programme agreed each year by the Governance Committee and it reports regularly to the Committee and, through it, to the Board of Directors.

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 in to 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.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.

The ORH has a service level agreement (SLA) with OHIS for the provision of its information technology services. The IT and business recovery plan has been reviewed during the year and approved by the Trust Information and Communication Systems Management Board, chaired by the Director of Planning and Information and attended, inter alia, by the Caldicott Guardian, the
Chief Operating Officer, the CRS Project Director and the Director of Finance. This group oversees the ORH’s annual requirements, as set down in the Business Plan, and its longer term strategic IT requirements. The Director of Planning and Information has retained his role in the high level monitoring of the SLA but the responsibility for the provision of the day-to-day services provided by OHIS has now passed to the Director of Finance and Procurement. The management of operational risks within OHIS integrated into the ORH’s risk management processes and are taken account of through the Trust Risk Register.

33 Close working relationships have also been fostered with patients and the public, including meetings held throughout the year with a number of patient bodies 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 new clinical information leaflets produced during the year in line with an agreed programme.

34 The Trust has worked closely with its developing Membership, recruited as part of the application process for Foundation Trust status and a number of specific Member events have been held during the year.

35 ORH Directors and managers have continued to brief the Oxfordshire Heath Overview and Scrutiny Committee, particularly in relation to the control of infection, the Horton General Hospital, and the Foundation Trust application process. In addition, work is now underway with the new LINks organisation for Oxfordshire.

Review of effectiveness

36 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 has 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.

37 The Trust’s Standing Orders and Standing Financial Instructions (and associated documents) were reviewed during the year and approved by the Board of Directors in January 2009. All Board members confirmed their acceptance and compliance with the Codes of Conduct and Accountability.

38 2008/09 was the third year of the Auditor’s Local Evaluation (ALE) system, and we have targeted 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 (through the annual health check compliance reports) 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. Improvements resulted following the development of training for the Board and senior managers on risk.

39 The outcome of the Information Governance Toolkit self-assessment showed a result of 73% (green). Although a reduction on last year’s score, this largely reflects changes in the criteria. However, plans are already in place to ensure further improvements, reflecting the increased focus on this important area of governance. Further work will be done with CEAC to ensure continued improvements and robustness.

40 The Board and the Governance Committee have continued to monitor delivery of the action plan associated with the Healthcare Commission’s report on cardiothoracic surgical services published in March 2007. The ORH has worked with the SHA on the HCC report and the follow-up report published in October 2008 and all recommendations have now been met. ORH signed off the report in January 2009 and the SHA signed off the report as completed at its Board meeting on 24 March 2009.

41 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.
42 In addition, the work of CEAC, the Trust’s internal auditors, has informed this review of internal control; their reports (agreed as part of the annual risk–based programme) have covered the following topics and have been referenced in the BAF:
42.1 Divisional and corporate directorate reviews, covering, inter alia,
42.2 Physical security and commissioning.
42.3 Research Governance.
42.4 Information management audits and audit of safe haven procedures.
42.5 Specific aspects of human resources management, including the impact of restructuring.
42.6 Specific aspects of financial management and services, including income, procurement and creditor payments.
42.7 Standards for Better Health audit carried out in March 2009.
42.8 Integrated governance, and the required review of the BAF.

43 Counter fraud work has also continued, with regular reports being made to the Audit Committee throughout the year.

44 The Audit Committee has strengthened its monitoring of internal audit reports undertaken by CEAC, and has ensured the active follow-up of recommendations, particularly relating to reports where areas of limited assurance were noted or where delays were being seen in the completion of required actions. I am confident that the controls in place to ensure delivery against these recommendations are sufficient and that the action plans have now been delivered or are due to be completed to an agreed timetable.

45 The Trust Risk Register is also in use, based on the top risks identified by the divisions, specific areas (including infection control and medicines management) and the corporate directorate. The risk assessment procedure has been agreed, and the governance, quality and risk framework reviewed and updated and the programme for 2009/10 agreed.

46 The SHA has reviewed both the BAF and the SIC at the year end and the BAF in December 2008.

47 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 Board of Directors.

48 The following activities have also supported my review of the effectiveness of the systems of internal control:
48.1 The continued work of our ‘expert’ committees, including health and safety, clinical risk management, incidents, comments and complaints, human tissue governance, hospital infection control, medicines management, blood transfusion, and radiation protection.
48.2 The Audit Committee in its review and scrutiny of the financial standards and processes and ALE throughout the year.
48.3 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).
48.4 The Governance Committee and the Board of Directors in their monitoring of compliance with the elements that make up the annual health check, and in their monitoring of the HCC investigation report on cardiothoracic surgical services.
48.5 The Finance and Performance Committee has reviewed financial and operational performance issues throughout the year, with a particular focus on cost improvements and the control and prevention of infection.
48.6 The Board of Directors, which reviewed and approved the BAF and the Trust Key Risks at its meeting in January 2009. The final year end review of the BAF was carried out by the Governance Committee at its meeting on 25 March 2009.

49 The Head of Internal Audit (HOIA) 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”. The Opinion provided significant assurance on the effectiveness of the management of those principal risks identified within the organisation’s Assurance Framework.
50 Internal Audit have also provided me with the Opinion on the BAF with overall assurance as excellent with the following points being made:

50.1 The components of the Assurance Framework are in place – Excellent Assurance

50.2 The Board has been involved in developing and maintaining the Assurance Framework – Excellent Assurance

50.3 Objectives are sufficiently strategic, well-balanced and referenced to the Healthcare Standards – Excellent Assurance

50.4 Risks are sufficiently strategic/high level and consistent with the objectives – Excellent Assurance

50.5 Key controls have been identified and evaluated with regard to their effectiveness to manage the risks – Excellent Assurance

50.6 Sources of assurance have been identified and are accurately mapped to the objectives, risks and controls – Excellent Assurance

50.7 Gaps in controls and assurances are accurately recorded and action plans established – Excellent Assurance

50.8 The Assurance Framework is fully embedded and significant issues are being escalated to the Board – Excellent Assurance

51 Internal Audit have provided me with the following opinion on their audit of Standards for Better Health carried out in March 2009 “we offer the Trust full assurance …..that the HCC core standards have been addressed and work is well in hand to rectify weaknesses previously identified.”

52 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 2009/10, which is now in progress.

Significant control issue

53 The Board has declared compliance with all core standards with the exception of C15b on which it declared insufficient assurance for the period of May 2008 to the end of September 2008. The Board, in its final review on compliance, agreed that no significant lapses existed at the year end and that it had reasonable assurances to support its declaration.

54 Three serious untoward incidents occurred during the year following a breach of confidentiality or loss of data as outlined below:

54.1 In an incident reported in July 2008 a patient’s confidential medical diagnosis was released unintentionally to the patient’s own doctor. The patient was informed of the breach of confidentiality in person. In response to the incident the department has reviewed their practice and has produced a standard operating procedure for the processes of handling confidential patient information.

54.2 In July 2008 there was a report of the unauthorised disclosure of patient identifiable data including name, address and hospital number of one patient to a third party. The individual was notified of the incident by telephone. In response to the incident there has been a review of the Trust guidance on the use of fax machines which has been disseminated widely across the Trust and the incident is being included in Trust wide information governance training.

54.3 In December 2008 there was an investigation into the loss of data when an inadequately protected electronic storage device which contained the names and dates of birth of five patients was lost outside secured NHS premises. The individuals concerned were notified by post and the department has altered practice to negate the requirement to store information on a portable electronic storage devices. The Information Protection Policy has been re-issued via all directorate managers.

55 The Trust takes patient confidentiality very seriously and all staff have been reminded of their responsibility in the handling of confidential information in a leaflet disseminated with pay slips in February 2009.

Trevor Campbell Davis
Chief Executive
May 2009
Further information

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Tell us what you think

Every year we produce an Annual Review, which summarises what we have done over the year, and includes our accounts. We publish it on our website and make some printed versions available, on request. We also produce a CD of all the key documents, including the full accounts.

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

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

Email us: media.office@orh.nhs.uk
Write to us:
Media and Communications Unit
Level 3, John Radcliffe Hospital
Headley Way
Headington
Oxford OX3 9DU

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NHS Institute for Innovation and Improvement
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NHS PLUS – occupational health provider
Nuffield Orthopaedic Centre
Our NHS Our Future
Oxford Brookes School of Health & Social Care
Oxford Brookes University
Oxford City Council
Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust
Oxfordshire County Council
Oxfordshire Learning Disability Trust
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Glossary of NHS terms and abbreviations

Acute Trust
A legal entity/organisation formed to provide health services in a Secondary Care Setting, usually a hospital.

Elective
Care that is planned in advance. It may be as an outpatient or inpatient.

Foundation Trust
A new type of healthcare organisation, which have patients, the public and staff joining as members to help set the future direction of the organisation and to ensure local accountability.

GP
A doctor who, often with colleagues in partnership, works from a local surgery providing medical advice and treatment to patients registered on his list.

Inpatient
A patient whose care involves an overnight stay in hospital.

National Service Frameworks
Set national standards for the best way of providing particular services.

NHS Trust
A legal entity or organisation providing health and social care services within the NHS.

National Institute for Health and Clinical Excellence (NICE)
Evaluates drugs and treatments. It does not evaluate their clinical effectiveness (that is the responsibility of a European medical authority) but makes judgements on their cost-effectiveness. Trusts are not legally obliged to follow NICE guidelines but most often do.

Outpatient
A patient who attends hospital for an appointment or procedure that does not involve an overnight stay, e.g. a follow up appointment, day case or surgery.

Patient Advice and Liaison Service (PALS)
Provides support to patients, carers and relatives, representing their views and resolving local difficulties speedily.

Primary care
GP-led services provided by family doctors and those who work with them including district nurses, therapists, local dentists, pharmacists, opticians and other community health professionals.

Primary Care Trust
An NHS trust that provides all local GP, community and primary care services and commission hospital services from other NHS trusts.

Secondary care
Hospital-led services provided by NHS and Foundation Trusts.

Strategic Health Authority
Responsible for developing strategies for local health services and ensuring high-quality performance. They manage the NHS locally and are a key link between the Department of Health and the NHS.