Welcome to the Annual Report 2009/10 of the Oxford Radcliffe Hospitals. This report describes how the Trust has performed over the last year and how we account for the public money spent by the Trust over this period.
Introduction

The NHS touches many aspects of our lives. This means that as our society, our culture and the wider economy change, the National Health Service must change as well in order to provide the services that patients need, and do so in a way that is clinically effective and financially sound.

The Government’s plans for the NHS mean big changes for the organisations that buy healthcare on behalf of the population. Hospitals will need to adapt to these changes whilst ensuring that the services provided remain safe, of high quality and focused on the needs and wishes of patients. At the Oxford Radcliffe Hospitals (ORH), we are changing our leadership and management structures and revising our approach to the delivery of care across the wide range of clinical services we provide, in order that we are better equipped to respond to the new environment within the NHS. Alongside the delivery of patient care, education and research remain central to the Trust’s tri-partite role, and fundamental to the improvement in the quality of care we provide, not only for the people of Oxfordshire, but from across the UK. We are strengthening our partnership with the two universities in Oxford, as well as with the rest of the local NHS, local authorities and those other organisations with which we collaborate. Effective partnership between organisations that provide health and social care services is crucial if we are going to provide the most efficient, appropriate and innovative healthcare to our patients.

This must be achieved during a period with leaner funding than the NHS has been used to over recent years. To keep pace with rising demand and to meet the published efficiency requirements, the NHS will have to deliver around £20 billion of efficiency savings over the next four years. NHS Oxfordshire, the organisation that plans healthcare for the people of Oxfordshire, has announced likely savings of around £200 million by 2014. During 2010/11 the ORH needs to deliver a £47 million savings and efficiency programme, which is required because of an imbalance between the Trust’s cost base and its income, national and local efficiency requirements, and the need to meet a reduction in Trust activity and income as more care is provided in the community.

Although it would be wrong to promise that all services will remain unchanged as we address these financial challenges, safe and efficient care can often be cheaper, not more expensive, to provide. Delays and inefficiency cost money, as well as cause frustration to patients and staff.
The Trust is just one component of the health system and economy across Oxfordshire and beyond. To address the challenges across the system, we are working with other NHS organisations and GPs to examine all aspects of healthcare provision. This work includes:

- looking at how we can better support patients to manage their own health, and how we support carers
- improving communication with, and service to, GPs and other community services, to help patients get some of the treatment usually provided in hospitals nearer to, or in, their own homes
- improving the processes of referral to hospital, when appropriate, and shortening the time people need to spend in hospital once they are there
- making sure that all services and treatments that are provided are clinically effective and efficiently delivered.

During 2010/11 the ORH will refresh its strategy for the years ahead, and implement a new integrated clinical management structure.

Once the Trust is confident that it can demonstrate reliable delivery of financial, operational and quality standards, it will then be in a position to progress broader goals. One of these is to achieve Foundation Trust status, and the Trust is restarting the planning required for an application.

The Trust has also not lost sight of the vision of being part of one of the leading academic health science communities in the UK and beyond. We are looking at ways of moving this forward with our partners in the NHS and university sector, to start building this into a reality that reflects the strength and reputation of Oxford in healthcare science, education and patient care.

Dame Fiona Caldicott
Chairman

Sir Jonathan Michael
Chief Executive
Making a difference – big and small

Despite our challenges, we have had our fair share of success in the last year.

In October 2009 the new Oxford Heart Centre opened on the John Radcliffe site – a regional centre of excellence for treatment, research and teaching. This new facility has 50 single rooms for patients, just part of our progress over the last 12 months to eliminate the majority of mixed-sex accommodation across our three hospitals. The Trust also opened a new satellite department of the Oxford Kidney Unit at Stoke Mandeville Hospital, Aylesbury, which means patients receiving dialysis in that area receive their treatment closer to home, and their quality of life is improved.

The Trust worked in partnership with Community Health Oxfordshire to enable the opening of the new 20 bed Oxford City Community Hospital within the John Radcliffe Hospital – an excellent example of partnership working in the Oxfordshire NHS.

Staff deserve praise for work this year that has been both day-to-day and extraordinary at the same time. Whether it’s those who looked after patients trapped overnight by bad weather in our satellite renal unit in High Wycombe; or staff who walked miles to work through the January snow; the clinicians who enabled a young patient to hear for the first time last Christmas thanks to a newly available cochlear implant operation at the John Radcliffe; or the countless other examples of staff going beyond the call of duty. They are all to be commended, and serve as a reminder that behind every big change or significant achievement, it is the individual patient that we are all here for.
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. The Trust employed 10,136 people (equivalent to 7,924 full-time posts) at the end of the financial year and had a turnover of £636 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 fourth 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 NHS Oxfordshire (the Primary Care Trust for Oxfordshire). Other key commissioners are Buckinghamshire, Berkshire, Gloucestershire, Northamptonshire and Wiltshire Primary Care Trusts (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, our Local Involvement Network (LINk), local authorities and the Oxfordshire Joint Health Overview and Scrutiny Committee (a committee of Oxfordshire County Council).

About the Oxford Radcliffe Hospitals

At the Trust in 2009/10 there were:

- 614,056 outpatient appointments
- 19,688 admissions for treatment as inpatients
- 123,592 attendances at the emergency departments
- 87,275 admissions for emergency assessment or treatment
- 62,062 admissions for treatment as day cases (108,308 if renal dialysis is included)
- 8,077 babies delivered
Our hospitals

THE JOHN RADCLIFFE HOSPITAL

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 educated 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 CHURCHILL HOSPITAL

The Churchill Hospital is the centre for the Trust’s cancer services and a range of other specialities. These include: renal services and transplant, clinical and medical oncology, dermatology, haemophilia, infectious diseases, chest medicine, medical genetics, palliative care and sexual health. It also incorporates OCDEM (the Oxford Centre for Diabetes, Endocrinology and Metabolic Medicine).

The hospital, and the adjacent Old Road campus, is a major centre for healthcare research, and hosts the departments of the University of Oxford’s Medical Sciences Division and other major research centres such as Cancer Research UK.

THE HORTON GENERAL HOSPITAL

The Horton General Hospital in Banbury serves the people of North Oxfordshire and surrounding counties. Services include an emergency department, acute general medicine and general surgery, trauma, obstetrics and gynaecology, paediatrics, critical care and a cancer treatment unit.

The majority of these services have inpatient beds and outpatient clinics, with the outpatient department running clinics with specialist consultants from Oxford in dermatology, neurology, ophthalmology, oral surgery, paediatric cardiology, radiotherapy, rheumatology, oncology, pain rehabilitation, ear nose and throat (ENT) and plastic surgery. Acute general medicine also includes a medical assessment unit, a day hospital as part of specialised elderly care rehabilitation services, and a cardiology service. Other clinical services include dietetics, occupational therapy, pathology, physiotherapy and radiology.

The hospital employs 1,200 people, making it one of Banbury’s biggest employers. It has 194 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 Horton League of Friends, the Authorised Volunteer Service and Horton General Hospital Radio.
Better Healthcare Programme for Banbury and surrounding areas

For some years now concerns have been raised about the viability of the paediatric service and the obstetric service at the Horton General Hospital because of the difficulty in recruiting and retaining paediatricians required to support both services.

The paediatric service traditionally has relied on middle grade doctors to ensure a doctor is available for 24 hours a day. However, there has never been any training recognition for paediatric posts at the Horton, because of the low numbers of patients. This, together with national changes in the medical workforce, has meant that these posts have become increasingly unattractive and difficult to fill.

Since March 2008, the ORH has been working with NHS Oxfordshire to develop plans for the future of paediatric, obstetrics and gynaecology services and the special care baby unit at the Horton. The Better Healthcare Programme for Banbury and surrounding areas (BHP) was set up in 2008 to find an alternative to the proposals originally put forward by the ORH to have a midwifery-led unit at the Horton and to transfer overnight paediatric care to Oxford.

The Trust has been committed to maintaining all services at the Horton as they are now for a period of two years while they have been working with NHS Oxfordshire through the BHP to develop long-term solutions for the services in Banbury.

At a special meeting of its Trust Board, held in June 2010, the ORH agreed to implement proposals from NHS Oxfordshire for the delivery of paediatric and maternity services at the Horton. These proposals are for consultant-delivered services in pediatrics and maternity at the Horton, reducing the reliance on middle grade doctors, and the introduction of strengthened anaesthetic services. The Board has set up a new management team.

At the same meeting the Board considered a framework for developing a new vision for the services to be provided from the Horton and agreed to set out a new strategic plan for the hospital.

For more details on the Better Healthcare Programme, including agendas and papers for meetings, please see: www.oxfordshirepct.nhs.uk/bhp
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.

The list below provides an overview of clinical services in the Trust.

Division A

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

Division B

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

- **Children’s services and clinical genetics** – paediatric medicine, paediatric surgery, specialist children’s services, community paediatrics, neonatal, paediatric intensive care, and clinical genetics.
- **Women’s and sexual health** – obstetrics and maternity services, gynaecology, and genitourinary medicine.
- **Laboratory medicine and clinical sciences** – cellular pathology, biochemistry, haematology, microbiology, immunology, and genetics.
- **Radiological sciences** – general radiology, CT, MRI, medical physics and clinical engineering, neuroradiology, and nuclear radiology.
- **Pharmacy and therapies** – pharmacy, physiotherapy, dietetics, speech and language therapy, and occupational therapy.

A fourth Division covers corporate services including Chief Executive’s Office; Chief Operating Officer, Finance and Procurement; Planning and Information; Estates and Facilities; Human Resources; Nursing and Midwifery; Medical Directorate and Private Patients.

For more information on the Trust and its services visit: [www.oxfordradcliffe.nhs.uk](http://www.oxfordradcliffe.nhs.uk)
Improving our environment

Energy saving

The Trust is fully committed to reducing its carbon footprint and has, over the years, put in place many energy saving measures – from the quality and green credentials of its new builds, to more simple measures, such as changing lighting and heating patterns.

In 2009, the Department of Health launched the national NHS Carbon Reduction Strategy for England and now, more than ever, there is an emphasis on all NHS Trusts to go even further in reducing their energy consumption.

The Trust’s own Energy Awareness Campaign – Keep it Low – is part of our ongoing commitment to become a truly green organisation.

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 2009/10, the Trust achieved ‘good’ scores for the Churchill Hospital in all categories. Food standards were maintained as ‘good’ at the Horton General Hospital and ‘acceptable’ for environment and privacy and dignity. The John Radcliffe Hospital received an ‘acceptable’ score for environment but maintained ‘good’ scores for food and privacy and dignity.
New facilities

Oxford Heart Centre
The new £29 million Oxford Heart Centre opened in October 2009, providing additional single rooms, a cardiac intensive care unit and five catheter labs. This exciting development provides state-of-the-art facilities for research and the treatment of people with heart disease. Trust staff already work closely with those at 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.

Oxford City Community Hospital
Oxford’s community hospital relocated to the John Radcliffe Hospital in October 2009, after previously being based on the Churchill site. The new 26-bed unit, temporarily housed on Level 7, was renamed City Community Hospital. It is run by Community Health Oxfordshire, the healthcare provider arm of NHS Oxfordshire, with medical staffing provided by the clinical geratology team at the ORH.

Stoke Mandeville Renal Unit
Stoke Mandeville Hospital is now home to a satellite renal unit opened by the Trust’s Oxford Kidney Unit in May 2009. It serves 24 patients from Aylesbury and the surrounding area and is one of four satellite units – the others are in Swindon, High Wycombe and Milton Keynes.

The Oxford Kidney Unit has been providing renal replacement therapy and transplantation to patients with kidney failure for over 40 years to more than 350 patients.

Oxford Ataxia Centre
The new Oxford Ataxia Centre at the John Radcliffe Hospital provides patients with better access to specialist services and research. It is one of only three specialist centres in the UK and has been granted formal accreditation by Ataxia UK, the national charity for people affected by ataxia.

Ataxias are neurological disorders affecting speech, balance and co-ordination. Many ataxias are inherited genetically and are progressive, and may also be a symptom of other conditions such as multiple sclerosis or cerebral palsy. Unfortunately there is no cure for ataxia. However, there are a range of treatments to help ease the symptoms, including medications, speech therapy and physiotherapy.
Research

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. It was set up in April 2007 with a competitively awarded grant of £57.5 million over five years from the Department of Health’s National Institute for Health Research (NIHR). The OxBRC’s aim is to develop a research portfolio and enhance its international reputation for world-class medical and biomedical research. The OxBRC undertakes ‘translational research’, which means first-time studies in patients of innovations that are intended to improve healthcare.

Under the guidance of its Director Keith Channon, Professor of Cardiovascular Medicine and Honorary Consultant Cardiologist, the OxBRC is funding, or part funding, 185 research projects across 14 therapeutic areas. 75 consultants now have dedicated research time in areas such as cardiology, diabetes, neurology, stroke and oncology. For the second year in a row the OxBRC has been accredited by ISO9001. This illustrates a commitment to transparency, accountability and probity for the money they have been entrusted to spend on translational research.

Strategic and operational developments

The OxBRC has established joint appointments and shared operational structures in the ORH’s Research and Development and University Research Services offices. This means seamless management of important research functions such as research governance, grants and contracts.

The Oxford Cancer Centre at the Churchill Hospital includes major new investment in cancer and cancer research by the ORH with partners including the Medical Research Council, Cancer Research UK, the Engineering and Physical Sciences Research Council and Oxford University. These developments bring together NHS clinicians, scientists and University departments in a single facility on one campus.

Particular research highlights

- The application of innovative technology to clinical problems including a unified data system to improve patient monitoring in the Emergency Department and ITU. Also, mobile phone technology to allow personal blood glucose monitoring and to aid rapid decision making and triage in acute stroke management.
- New approaches to diagnosis and tracking hospital acquired infections (MRSA, Clostridium Difficile), and their relationship to infection in the community, using statistical and genetic techniques to rapidly identify individual organisms and reveal routes of transmission.
- Establishing state-of-the-art genetics technology and processes involving DNA sequencing and mutation detection in inherited cardiac and neurological diseases, cancer and micro-organisms.
- Support of internationally leading vaccine developments in paediatrics (e.g. meningitis), TB and influenza, including the ‘first in man’ testing of a new influenza vaccine strategy.
- Taking new immune phenotyping techniques, initially established in the basic science research laboratory, to clinical laboratory tests for use in allergic skin diseases, HIV and hepatitis C infection, autoimmune disease and transplantation.
- New programmes of work in gastroenterology and respiratory medicine, through links with the immunity, infection, imaging and tissue banking / cohorts themes.
Assessing the quality of care in our hospitals

Annual Health Check 2009

The Oxford Radcliffe Hospitals NHS Trust (ORH) was given a top rating of ‘excellent’ for the quality of services to patients for the second year running, and ‘good’ for the quality of financial management – an improvement on the previous year.

The Care Quality Commission (CQC) assessed trust performance against core standards and national targets which was then used to calculate the overall quality rating. Results published in October 2009 relate to the year 2008/09.

The CQC is the independent regulator of all health and adult social care in England and inspects all health and adult social care services. 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

Care Quality Commission registration

The ORH has been officially registered, without conditions, with the Care Quality Commission (CQC), under the new system for monitoring quality and safety of care.

Registration with the CQC reflects the work at all levels in the Trust to ensure that patients continue to provide a high quality and safe service. The new registration system for health and adult social care makes sure that people can expect services to meet essential standards of quality and safety that respect their dignity and protect their rights.

The new system is focused on outcomes rather than systems and processes, and places the views and experiences of people who use services at its centre.

You can find out more about the registration process and standards here: www.cqc.org.uk

Quality Accounts

This year, for the first time, there is a legal requirement for each NHS Trust to produce a Quality Account. The Quality Account will not form part of this Annual Report. It can be found in the News section of our website: www.oxfordradcliffe.nhs.uk/news

The Trust’s Quality Account is about improved public accountability, and the further engagement of the Trust Board in quality improvements. The Quality Account focuses on three key elements of quality; patient safety, effectiveness and the patient experience. The Quality Account has been prepared for our key stakeholders – patients, staff and the wider public, and the Oxfordshire Primary Care Trust has been involved in its production. The CQC regularly check on our compliance with these standards.
Our performance

For almost every year for over a decade, the ORH has seen an increase in the number of patients it sees. In 2009/10, the total number of patients admitted to hospital declined very slightly, which is in line with NHS Oxfordshire's aim of commissioning more care outside hospital, a trend that the Trust expects to see continue in the coming years.

Despite this reduction, patient activity for the Trust’s main commissioner, NHS Oxfordshire, was still higher than originally planned and funded for, which presented the ORH with a challenge in how it used available resources.

This, and other factors outlined below, have meant that it has been a difficult year for performance at the ORH – and indeed there have been pressures on the whole health economy. In November, we called in support from a nationally available pool of experts – the NHS Intensive Support Team – to work with our clinical and support teams to help us achieve financial and performance targets. In performance, the team worked in two areas: the four hour Emergency Access Target and the 18 week referral to treatment pathway.

Although the Trust did not meet these two targets across the whole year, it has made recent progress, and the improvement work being done has underlined the importance of streamlined and efficient patient pathways being at the heart of sustainable performance. In other words, as the NHS adapts to the financial pressures, increasing resources to hit targets will no longer be an option, and health providers must focus on seeing patients in the right place at the right time, first time.

Overall volume of activity

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
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</thead>
<tbody>
<tr>
<td>Emergency activity</td>
<td>82,906</td>
<td>84,492</td>
<td>88,872</td>
<td>87,275</td>
</tr>
<tr>
<td>Elective inpatients</td>
<td>20,667</td>
<td>21,224</td>
<td>22,866</td>
<td>20,955</td>
</tr>
<tr>
<td>Day cases</td>
<td>53,130</td>
<td>59,817</td>
<td>64,969</td>
<td>62,544</td>
</tr>
<tr>
<td>Total finished</td>
<td>154,698</td>
<td>163,633</td>
<td>174,795</td>
<td>161,552</td>
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<tr>
<td>consultant episodes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency department attendance</td>
<td>123,914</td>
<td>115,603</td>
<td>117,922</td>
<td>123,592</td>
</tr>
<tr>
<td>Outpatients</td>
<td>520,835</td>
<td>564,389</td>
<td>609,656</td>
<td>614,056</td>
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</tbody>
</table>

These figures exclude renal dialysis and babies born, and are based on all finished consultant episodes. (A finished consultant episode is where a patient has completed a period of care under a consultant / midwife / consultant nurse and is either transferred to another consultant / midwife / consultant nurse or discharged).
Emergency access target

The national target for emergency access for 2009/10 was that 98% of patients must be admitted, treated or discharged within four hours of arrival in our emergency departments and in minor injury Units in Oxfordshire. For this year, although the majority of patients (97.16%) were seen within this target, with many seen much more quickly, this is still an underachievement on a national target. The figures for the ORH are below. These only make up part of the overall target figure.

Emergency Department 4 hour target

<table>
<thead>
<tr>
<th>Total attendance during quarter</th>
<th>Number seen in 4 hours</th>
<th>% seen in 4 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 31,982</td>
<td>31,009</td>
<td>96.96</td>
</tr>
<tr>
<td>Q2 29,916</td>
<td>29,044</td>
<td>97.09</td>
</tr>
<tr>
<td>Q3 30,796</td>
<td>29,448</td>
<td>95.62</td>
</tr>
<tr>
<td>Q4 28,290</td>
<td>27,409</td>
<td>96.89</td>
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</table>

The Trust achieved the target of ensuring that no patient waited more than 12 hours for admission (once the decision to admit had been made) to either the John Radcliffe or the Horton General Hospital emergency departments.

The final weeks of the financial year saw some improvement in our performance, a reflection of the work done within the emergency access pathway. Areas of work have included improving patient journeys through inpatient specialties and improved frameworks for support services including social services. Ongoing development of an ‘electronic whiteboard’ for the Emergency Departments will allow better ‘at-a-glance’ information for clinicians about waiting times.

The ORH is also working with South Central Ambulance Service and NHS Oxfordshire to improve the time it takes ambulance crews to deliver patients to emergency department clinicians and be ready for their next job. As a result of the introduction of a new electronic handover system in September and improved triage and patient flow in the Emergency Department and Medical Assessment Unit, turnaround delays at the John Radcliffe Hospital decreased in the second half of the financial year.
This shows that hitting the emergency target is not just about performance within the emergency departments, but rather a ‘whole system’ issue – in other words, the flow of patients at every stage of their journey through the hospital. This includes, crucially, effective and timely discharge. The Trust faced very high demand brought on by the severe winter pressures in December and January, but staff coped admirably through this period of snow.

**Delayed transfers of care**

Pressures have also been increased by the longstanding issue for health and social care in Oxfordshire of the large number of patients in our hospitals who are medically fit for discharge, but are unable to leave our hospitals for non-clinical reasons.

<table>
<thead>
<tr>
<th>Numbers 2006/07</th>
<th>Numbers 2007/08</th>
<th>Numbers 2008/09</th>
<th>Numbers 2009/10</th>
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<tbody>
<tr>
<td>Q1 47</td>
<td>49</td>
<td>45</td>
<td>29</td>
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<tr>
<td>Q2 43</td>
<td>61</td>
<td>41</td>
<td>42</td>
</tr>
<tr>
<td>Q3 51</td>
<td>63</td>
<td>38</td>
<td>29</td>
</tr>
<tr>
<td>Q4 57</td>
<td>31</td>
<td>41</td>
<td>43</td>
</tr>
</tbody>
</table>

The ORH is establishing a new, more robust reporting system to help quantify the extent of such delayed discharges, and will continue to work with its partners in primary and social care to ensure that this issue is a priority for them. Acute hospital care is the most expensive NHS care there is, so it is in everyone’s interest that, when patients are clinically fit, they move on to a more appropriate setting.
18 week referral to treatment

The 18 week referral to treatment target measures how long elective, non-urgent patients have to wait for their first hospital treatment following referral by their GP. The national target in 2009/10 for patients being seen within 18 weeks was 90% for patients requiring inpatient treatment (‘admitted’ patients) and 95% for those who do not requiring inpatient treatment (‘non-admitted’ patients.)

This year the ORH has struggled to consistently meet this target due to two main issues. Firstly, it has been a difficult year for the Trust in both emergency and elective performance, with the number of patients coming to the ORH being above planned levels. Prioritising emergency patients has had an impact on non-urgent cases. The Trust has worked hard to address these conflicting priorities.

Secondly, the Trust has also had to examine data quality issues. Data quality is important because it helps the Trust to measure and then manage. To do this the Trust has to pull together data that records several aspects, the ‘components’ of the patient pathway. This can include a patient’s outpatient appointment, any diagnostics such as scans and blood tests, and the time then waited for inpatient treatment, which could involve being seen across several areas.

During the year, the Trust’s review of the quality of its data showed that it was not as good as it should have been. The Trust had found it increasingly difficult to measure all the patient journeys accurately and to provide itself and others with assurance on the 18 week performance figures. Data quality problems meant that the Trust was counting the components of waits, but not always the whole pathway, taking account of gaps between these components. The Trust has worked to improve its data quality throughout the year and this has meant that its performance against the 18 week referral to treatment target appeared to drop as the figures reflected the whole process more accurately.
Taking the year as a whole, although the Trust achieved the ‘non-admitted’ target, more work will need to be done going into the financial year 2010/11 in order to get back on track with delivery of the 18 week target across the board. Getting the 18 week patient pathway right involves the whole health economy working together to ensure patients are seen in the right place at the right time, first time. The Trust has also received funding from NHS Oxfordshire to treat specific groups of patients who were in danger of waiting too long.

Patients should be reassured that the Trust also continually reviews feedback from patients, doctors and GPs to assess patient expectations and satisfaction with their waiting times.

18 week referral to treatment performance

<table>
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<tr>
<th>% seen within 18 weeks</th>
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| Total numbers admitted in quarter | 2007/08 | 2008/09 | 2009/10 |
| Q1 | 53.90 | 97 | 95.90 |
| Q2 | 61.50 | 96 | 92.44 |
| Q3 | 72.70 | 94 | 85.14 |
| Q4 | 91.80 | 96 | 76.47 |

Threshold 90%

Total for year 87.85

<table>
<thead>
<tr>
<th>% seen within 18 weeks</th>
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| Total numbers non-admitted in quarter | 2007/08 | 2008/09 | 2009/10 |
| Q1 | 81.30 | 96 | 98.56 |
| Q2 | 90.40 | 97 | 93.01 |
| Q3 | 90.70 | 95 | 94.71 |
| Q4 | 95.80 | 97 | 95.15 |

Threshold 95%

Total for year 95.53

Admitted – patients requiring admission to hospital
Non-admitted – patients not requiring admission to hospital
Sections of the patient pathway

Outpatient waiting times

Outpatient waiting list
(snapshot at end of quarter)

<table>
<thead>
<tr>
<th>All specialties (max wait in weeks)</th>
<th>Numbers of patients</th>
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<tbody>
<tr>
<td>Q1 13</td>
<td>6,830</td>
</tr>
<tr>
<td>Q2 13</td>
<td>7,227</td>
</tr>
<tr>
<td>Q3 13</td>
<td>6,776</td>
</tr>
<tr>
<td>Q4 16</td>
<td>7,023</td>
</tr>
</tbody>
</table>

The national target that the Trust aimed to meet was a 13 week maximum wait. Unfortunately, the Trust’s forecast that it would achieve this has been reduced to an ‘under-achieve’ after 17 breaches (i.e. failures to meet the target) at the end of March in oral and maxillofacial surgery.

Diagnostic waits

This year the Trust was unfortunately unable to maintain diagnostic waits (including MRI and CT scans) at six weeks, as they were last year. The endoscopy diagnostic wait was reduced to six weeks in Quarter 3.

Number of patients exceeding a 6 week wait for an MRI or CT scan (snapshot at end of quarter)

| Q1 | 18 |
|    |    |
| Q2 | 28 |
| Q3 | 30 |
| Q4 | 28 |

Number of patients exceeding a 6 week wait for other diagnostic tests (snapshot at end of quarter)

| Q1 | 0  |
|    |    |
| Q2 | 274|
| Q3 | 124|
| Q4 | 167|
Inpatient waiting times

Inpatient waiting times and numbers
(snapshot at end of quarter)

<table>
<thead>
<tr>
<th>All specialties (max wait in weeks)</th>
<th>Numbers of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>20</td>
</tr>
<tr>
<td>Q2</td>
<td>65</td>
</tr>
<tr>
<td>Q3</td>
<td>26</td>
</tr>
<tr>
<td>Q4</td>
<td>114</td>
</tr>
<tr>
<td></td>
<td>5,831</td>
</tr>
<tr>
<td></td>
<td>6,107</td>
</tr>
<tr>
<td></td>
<td>6,749</td>
</tr>
<tr>
<td></td>
<td>8,037</td>
</tr>
</tbody>
</table>

Cardiac revascularisation

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
(snapshot at end of quarter)

<table>
<thead>
<tr>
<th>Coronary artery bypass grafting (max wait in weeks)</th>
<th>Percutaneous transluminal coronary angioplasty (max wait in weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>12</td>
</tr>
<tr>
<td>Q2</td>
<td>11</td>
</tr>
<tr>
<td>Q3</td>
<td>12</td>
</tr>
<tr>
<td>Q4</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
</tbody>
</table>

Length of stay and theatre use

The average length of stay is the same as last year, at 4.6 days. We have maintained the efficient use of our operating theatres and, as last year, 90% of our patients now come into hospital on the day of their operation rather than having to stay the night before.
Cancellations

The percentage of operations cancelled at the last minute for non-clinical reasons has risen from 0.7% in 2008/09 to 1.08% in 2010/11.

<table>
<thead>
<tr>
<th></th>
<th>2009/10 Last minute cancellations</th>
<th>Patients not operated on within 28 days of cancellation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>203</td>
<td>2</td>
</tr>
<tr>
<td>Q2</td>
<td>223</td>
<td>4</td>
</tr>
<tr>
<td>Q3</td>
<td>189</td>
<td>10</td>
</tr>
<tr>
<td>Q4</td>
<td>252</td>
<td>12</td>
</tr>
<tr>
<td>Year Total</td>
<td>867</td>
<td>27</td>
</tr>
</tbody>
</table>

We know that the cancellation of an operation is very disruptive for patients and their families. The Trust therefore tries very hard not to make last minute cancellations and to rearrange operations as soon as possible whenever there is a cancellation.
Non attendance for first appointment (total numbers)

<table>
<thead>
<tr>
<th></th>
<th>First attendance</th>
<th>Did not attend first appointment</th>
<th>Did not attend rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>64,252</td>
<td>4,219</td>
<td>6.6</td>
</tr>
<tr>
<td>Q2</td>
<td>68,442</td>
<td>3,590</td>
<td>5.2</td>
</tr>
<tr>
<td>Q3</td>
<td>68,412</td>
<td>4,023</td>
<td>5.9</td>
</tr>
<tr>
<td>Q4</td>
<td>66,489</td>
<td>3,609</td>
<td>5.4</td>
</tr>
</tbody>
</table>

We have continued to try to keep the numbers of patients not attending their appointments down, through efforts to inform patients about the importance of attending appointments. However, the number of patients failing to attend their appointments has risen slightly from 5.5% to 5.8%. In the second half of the year, we restarted our text messaging reminder service for patients and we know that this helps people keep their appointments.

Cancer waiting times

Cancer waiting times 2009/10

<table>
<thead>
<tr>
<th></th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-WEEK TARGET</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of patients seen</td>
<td>2,439</td>
<td>2,559</td>
<td>2,395</td>
<td>2,322</td>
</tr>
<tr>
<td>No. seen within target</td>
<td>2,237</td>
<td>2,285</td>
<td>2,279</td>
<td>2,139</td>
</tr>
<tr>
<td>%</td>
<td>92%</td>
<td>89%</td>
<td>95%</td>
<td>92%</td>
</tr>
</tbody>
</table>

|                |       |       |       |       |
| 31-DAY TARGET  |       |       |       |       |
| No. of patients seen | 749   | 692   | 764   | 704   |
| No. seen within target | 723   | 676   | 750   | 694   |
| %               | 96.5% | 97.7% | 98.2% | 98.6% |

|                |       |       |       |       |
| 62-DAY TARGET  |       |       |       |       |
| No. of patients seen | 302.5 | 336   | 342   | 321   |
| No. seen within target | 236.5 | 263.5 | 291.5 | 245.5 |
| %               | 78.18%| 78.42%| 85.23%| 76.48%|

The Trust is monitored against a number of national targets that aim to improve the speed of diagnosis and treatment for cancer.

This year the methodology for measuring cancer performance changed. Until this year, any patient who exceeded a cancer target through choosing to wait, or had treatment delayed because of a clinical reason, would not have been counted as a ‘breach’ (i.e. a failure against the target).

Under the new system, the target counts the whole wait, regardless of whether the delay is for patient choice or clinical reasons. For example, patient choice to not attend an appointment offered was previously a reason to exclude the time period lost in the pathway. This is no longer allowed.
To allow for this change there is now a larger ‘tolerance’ in the target. This brings cancer targets in line with the methodology used for the 18 week referral. Furthermore, the new methodology takes into account follow up procedures after the initial cancer treatment (such as chemotherapy following surgery).

This way of measuring allows us to be more aware of the impact of choice and treatment complexity on our cancer performance.

For the ORH, the change in methodology has meant poorer reported performance against the two week wait and 62 day standards for patients urgently referred, diagnosed and treated with cancer.

Since January 2010, a new target of a two week wait for all patients referred with suspected breast cancer was included. This target was met in January 2010, but in February, March and April a high number of patients chose not to take up offered appointments. This resulted in the target not being met.

Overall, over 9,500 patients were seen in urgent two week wait clinics, a greater than 10% increase in urgent suspected cancer referrals from the previous year. We worked with NHS Oxfordshire to raise awareness amongst patients and GPs in order to improve the take-up of these urgent appointments.

Since December 2009 the Trust has been putting in extra work to ensure that it meets all its new targets across all its services. Particular focus has been on the gynae-oncology, colorectal and urological cancer teams, where the patient pathways have been reviewed to make them as streamlined and direct as possible.
Planning for the years ahead

After many years of growth, the public sector and the NHS are facing a much leaner future. Primary Care Trusts, which purchase services from the ORH on behalf of the population, will receive some additional funding in 2010/11. However, in order to keep pace with rising demand and to meet the challenges of the national debt, the NHS will have to save several billion pounds over the next four to five years.

The ORH’s main commissioner, NHS Oxfordshire, has announced likely savings in excess of £200 million by 2014. In addition they will want to spend no more than they spent last year on services from the ORH. All NHS trusts nationally must save 3.5% of their costs as part of national efficiency gains, and as a Trust we still have work to do.

This means that the financial pressure on the ORH will increase, so we must find new ways of delivering on performance and fulfilling our central function of providing high quality, safe, sustainable patient care.

However, the ORH is just one element of healthcare provision locally. To address the challenges across the system, NHS Oxfordshire has established a programme called Creating a Healthy Oxfordshire, which will examine all aspects of healthcare locally. This includes:

- looking at how we can help support patients to manage their own health and support carers;
- increasing access to GP services, which will reduce the need for people to go to hospital;
- stopping services that are shown to be ineffective and inefficient;
- shortening the time people need to spend in hospital.

In support of this, the ORH is moving to a new Clinical Management Structure. This will mean changing from our current three divisions to six new clinical divisions.

Each of these new divisions will be led by a practising clinician, who will devote a significant part of their time to leadership and management and have accountability for quality of the services provided. These clinicians will continue to be supported by professional NHS managers.

Many of our key leaders in the Trust are already doctors, nurses and other health professionals; our Chief Executive is a former renal consultant. Clinicians are engaging more and more in leadership and management roles. The new structure reinforces the importance of these roles at the heart of the management of the Trust – granting greater local devolved authority to services, but also formalising responsibility and accountability.

Once the Trust is confident that it can demonstrate its ability to deliver financial, operational and quality standards regularly and reliably, it will then be in a position to move forward with future goals. One of these is to achieve Foundation Trust status, and the Trust will restart the application process during 2010/11.

The Trust has also not lost sight of the vision of being part of one of the leading academic health science communities in the UK and beyond. The Trust is looking at ways of moving this forward with its partners in the NHS and university sector to start building this into a reality that reflects the strength and reputation of Oxford in healthcare science, education, research and patient care.
Gearing up for 'Put Your Heart Into It'  
Scenes from our cancer and heart walk

In this issue

THE OXFORD RADCLIFFE CHARITABLE HEADLINES

News for Supporters of Oxford Radcliffe Hospitals Charitable Funds

PAGE 10:
How music and art are helping patients across the ORH Trust

Glorious sunshine added to the warm communal glow as heart and cancer supporters in their hundreds joined October’s ‘It’s Not Just a Walk in the Park’.

Graham Brogden, Head of Community Fundraising said: ‘Over 450 people took part and I’d like to thank each and every one of them. Giving up just a couple of hours on their Sunday morning has helped to raise over £36,000 which is even better than last year, a fantastic result.’

Many were remembering loved ones they have lost to cancer or heart disease – the UK’s two biggest killers. A large group of family and friends walked in memory of Brian Jackson – who took part in last year’s walk. Brian’s widow Nicola, said: ‘We were determined to do the walk again – and will do so every year, because Brian was so keen to thank the staff who looked after him during his fight with cancer.’

Using email and online sponsorship helped many of the walkers to bring in fantastic totals for the two causes. Judith Timber and James Miller both raised thousands by taking part in the walk. James explained “I have sponsored so many people over the years that it was great to get my own back by getting them to sponsor me for once. I just emailed everyone in my mailbox and was overwhelmed by the response. It’s a great cause and I enjoyed doing my bit to help.’

Walkers of all ages showed their support for Oxford Radcliffe Hospitals’ Cancer and Heart Centres

TURN TO PAGES 6 AND 7 TO SEE MORE PICTURES FROM THE DAY

TORCH is the Oxford Radcliffe Hospitals Charitable Funds’ quarterly Newsletter. It is free to all supporters, staff and visitors to the Trust and can be found in each hospital’s main entrance or online at:

www.orhcharitablefunds.nhs.uk
Another great year for Charitable Funds

Thanks to the generosity of its many supporters, over £6 million has been spent this year by the Oxford Radcliffe Hospitals Charitable Funds to support the very latest medical equipment, greatly improved patient facilities, advanced staff training and ground-breaking research.

A highlight of the year was the great success of the Cancer Campaign. With the help of the local community, businesses, legacy gifts and trusts, an amazing £2.82 million was raised against the original £2.2 million goal. In November 2009, at a Patient and Public Open Day, staff and supporters were able to see some of the gardens and high-tech surgical equipment the campaign made possible at the Churchill Hospital. The Horton General Hospital’s Brodey Centre Appeal has also been a great success and work is underway to extend and refurbish the Brodey Centre (the cancer treatment centre at the Horton).

The new Hospital Innovation and Enhancement Fund (CHIEF) has also got off to a good start. Gifts made generally to the hospitals and other income is put into this fund to which all staff can apply. It allows Charitable Funds to take advantage of unforeseen opportunities, provide initial funding for projects that may attract other donors and support services like operating theatres that do not usually receive gifts directly.

Fundraising for the Fund for Children at the ORH also continued to be successful. A record 800 runners joined the Rt Hon David Cameron MP for the 2009 Oxford Mail OXSRUN and raised £57,000, while abseilers once again summoned the courage and raised £41,000. These gifts supported everything from incubators to an animated video for children undergoing radiotherapy. Work also started on ‘Homeward Bound Rooms’ for the Neonatal Unit, where parents can get used to caring for their babies before taking them home.

In spite of the economic downturn, supporters have still made support for their local hospitals a priority. New supporters have come forward through Facebook, Twitter and a new schools’ programme.

To find out more, contact Oxford Radcliffe Hospitals Charitable Funds at: www.orhcharitablefunds.nhs.uk

Email: campaign@orh.nhs.uk
or telephone 01865 743444.

The Oxford Heart Campaign continued with Put Your Heart Into It events across the region in February 2009 and a dinner with Chris Patten and Rory Bremner raising £56,000. Both the Cancer and Heart Centres benefitted in 2009 when 450 people walked three miles to raise £36,000 during It’s Not Just a Walk in The Park – an annual event held in October.
Serious about safety

The delivery of high quality and safe services is central to the NHS and the ORH Trust. Delivering healthcare – particularly the type of advanced and complicated procedures now available – does carry risks. How effectively we manage these risks, and learn from errors that do happen, is a good measure of how safe services are. So, we work to reduce the risks, we learn through the reporting of untoward incidents in our hospitals, and we build patient feedback into the delivery of services and the training of staff.

This year the Trust has been undertaking a programme called Serious about Safety and Standards that looks at sharing best practice to improve safety, effectiveness and patient experience, developing clinical leadership, and helping us to define and promote excellence in all aspects of care. The programme has strong support from, and the involvement of, the Trust Board.

We also signed up to the national Patient Safety First Campaign, and we are promoting safety initiatives to staff. Trust Executive and Non-executive Directors continue to participate in ‘patient safety walk rounds’ to wards and departments to see first-hand the work being done, and to develop a better understanding of the issues facing clinical staff on a day-to-day basis.

The Trust Board continues to prioritise safety in its business plan, and since the beginning of last year the Trust has had a new ‘Care Quality Group’, ‘which brings together clinical and operational leadership, to review the quality of care delivered against measures such as infection rates, serious untoward incidents, patient-reported outcomes and other care quality measures.

Building on these new arrangements, in April 2010 we also started a wider review of clinical governance and risk management processes at the Trust, to make sure governance and reporting systems are as clear and streamlined as possible. The Trust Board is considering the recommendations arising from the Strategic Health Authority report into paediatric cardiac surgery, following the suspension of the service in March 2010. At the ORH we are committed to ensuring that, as well as recognising success and best practice, we tackle problems and concerns in an open and transparent way.

Paediatric cardiac surgery services

In March 2010 the Trust took the decision to suspend the paediatric cardiac surgery service, whilst concerns were investigated following the deaths of some very young patients who underwent surgery at the John Radcliffe Hospital. An Independent Review was established by the South Central Strategic Health Authority (SHA), involving experts from outside the Trust. The Independent Review Panel reported its findings to the SHA at the end of July 2010 and these are available on their website at: www.southcentral.nhs.uk

An action plan responding to the Review Panel’s recommendations is being prepared.

A National Review of paediatric cardiac services in England – called Safe and Sustainable – is also taking place, and is due to begin public consultation in October 2010. More information about the National Review is available at: www.ncg.nhs.uk
Quality and risk

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

Learning from adverse events has continued to be an important part of ensuring organisational cultural change. For example, organisational changes implemented this year include:

- on admission any baby under ten days of age will now routinely have a blood sugar analysis;
- the Trust-wide guidance for the management storage of insulin and heparin has been updated;
- all staff have been issued with a leaflet outlining their responsibilities in relation to security of patient personal information;
- review of the manufacturer’s guidance on the pre-operative preparation of all heart valves used in the Trust;
- the reason for, and the categorisation of, all caesarean sections will now be documented.

The Trust took part in Patient Safety First week, focusing each day on a new initiative designed to improve patient care and outcomes. The Trust is also taking part in Patient Safety Focus weeks in 2010. The focus areas are:

- count your emergency calls
- how human factors affect healthcare delivery
- ventilator care bundles and how these reduce ventilator related pneumonia
- insulin prescribing and how care bundles can improve safety.
Surgical safety

A checklist, similar to those used by airline pilots as part of their pre-take-off safety check, is now being used in the Trust’s operating theatres. The World Health Organisation (WHO) conducted research in eight countries, and devised a 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
- 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. An international study of nearly 8,000 patients showed that it improved anaesthetic safety, ensured correct site surgery and reduced both surgical-site infections and post-surgical complications. The Trust introduced it to all theatres from September 2009.

Safety in this area is also about learning from our mistakes. Following the tragic death of a child during surgery at the ORH in 2006, the Trust Board took the decision to establish an externally chaired working party – the Surgical Working Group – to examine the management of surgical risk, so that the Trust could produce the highest standards of surgical safety.

In March 2010, recommendations were welcomed and accepted by the Trust Board. A formal system of authorisation and/or validation protocols for the use of new surgical techniques and equipment is being adopted, alongside new assurances on clinician competence and training approvals. Further protocols around verbal communications within surgical and operating theatre teams before and during surgery will mean that all individuals feel able to speak freely. New systems are being developed to audit compliance with safe practice. These systems might include the use of technology to record activities within operating theatres, to support learning and teaching, to enhance incident investigation and to contribute to research and development.

Patient safety

As a member of the Patient Safety Federation, the Trust has set up new safety action groups and professional advisory groups to complement those already established. These groups mirror those developed by the Patient Safety Federation and aim to improve patient safety by reducing avoidable harm. Key areas being focused on are:

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

Patient falls are the most common accident to occur in hospital. We record and monitor these and compare ourselves against the national average. The Falls Reduction Safety Action Group have focused on:

- piloting a multi-strategy approach to reducing falls and the potential associated serious injuries on the medical short stay ward;
- production of a prevention and management of falls policy including an assessment tool;
- providing comprehensive information to patients, carers and staff on falls prevention and consideration of care bundles targeting the known causes of patient falls. The group will also develop ways of measuring patient falls in different areas.
Medicines safety

The ORH continues to work to reduce the number of medication 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. All reported incidents are reviewed by the medicine safety team and the medicine safety group. The ORH is one of ten UK hospitals invited to implement and evaluate Concentrated Injectable Medicines under the World Health Organisation High 5s Project. For more details visit: www.ccforpatientsafety.org/High5sProject

Clinical effectiveness

Gaining feedback from patients on the quality of their experiences is a key 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 past year, more than 1,000 patients were approached via questionnaires about their experiences of care in a range of specialties as well as through clinic specific surveys. Patients using the following services have been invited to give us their views on:

- leg ulcer clinics
- stoma care
- head and neck cancer
- paediatric oncology
- inherited heart conditions
- theatre direct admissions.

The Trust also participates in a new Department of Health initiative known as Patient Recorded Outcome Measures (PROMS). Patients undergoing surgery for either varicose veins or inguinal hernias are asked to complete a questionnaire both immediately prior to, and some months after, their operation.

The opinions of patients who have undergone surgery will provide valuable insight into how patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life. Although the questionnaires are voluntary, the majority of patients are willing to participate and provide their opinions of the treatment they receive, and the impact this has on their wellbeing.

Patient information

Access to high-quality, clear and timely patient information enables patients to make choices about their care and give informed consent. A project to improve the quality of clinical information for patients has led to many new leaflets on clinical topics being produced and made available on the ORH website: www.oxfordradcliffe.nhs.uk/patientinformation

Several of our leaflets were recognized in the 2009 BMA patient information awards.

General inpatient and outpatient leaflets about the Trust’s three sites have also been produced in ‘Easy Read’ format, for patients with learning disabilities.
Meeting the National Institute for Health and Clinical Excellence (NICE) guidelines

NICE sets out best practice in the NHS and national standards for clinical care. Each month, NICE issues guidelines for clinical practice, technology appraisals and interventional procedures. NICE guidelines related to drugs are reviewed by the Trust’s Medicines Advisory Group. The Trust’s 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 which ensures that all services, those that are directly affected and support services, are briefed.

Using information to reduce risk

Conducting audits of clinical care is an important way in which the Trust measures effectiveness and improves patient safety. The Trust continues to participate in the major national audits relevant to the range of services provided by our hospitals.

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.

Legal services

The Trust’s Legal Services Department provides advice on a range of healthcare issues and supports staff involved in inquests and Trust claims. There has been a stabilisation in numbers of inquests and a 10% reduction in claims when compared to 2008/09.

Organisational learning from inquests and claims is identified at first notification and conclusion; reflecting the increased importance placed by the National Health Service Litigation Authority (NHSLA) on identifying the clinical risk root causes. The Trust has been involved in a national project that involves retrospective review of records to identify episodes of unintended patient harm.

The consent policy for NHSLA assessment has also been updated and played a pivotal role in the communication and training strategy for Deprivation of Liberty safeguards and implementation of the Trust’s referral process to the Supervisory Body (NHS Oxfordshire).
Data loss

The Trust takes patient confidentiality seriously, and all staff are reminded of their responsibilities at their induction programme and with regular updates via the Trust intranet.

During the year 2009/2010 there has been one Serious Untoward Incident (SUI) relating to a breach of confidentiality. This concerned faxes containing medical details that had erroneously been sent from outside the Trust to a member of the public rather than to departments in the Trust.

Information that GPs use for referring patients has now been checked and is up to date.

Preparing for an emergency

Emergency planning is important for any NHS hospital as it sets out how the organisation will respond in the face of a major incident. A major incident could range from a serious road traffic accident involving multiple casualties to a chemical spill, or any other scenario where the hospital needs to react to an extraordinary or unpredictable situation.

The Trust has a very robust and detailed plan in place which was tested twice in real life incidents last year. The extreme snowy weather in early 2010 needed a swift and co-ordinated approach, in terms of how both patients and staff could still access our hospitals. Despite the adverse weather conditions the Trust remained open throughout and continued to provide essential healthcare.

The H1N1 virus, known as Swine Flu, involved close joint working between the Trust, NHS Oxfordshire, social services colleagues and others. Although the threat of Swine Flu remained changeable, the cross-county working was a success in terms of timely public health messages and clinical co-ordination.

The Trust’s Emergency Plan is continually updated and works in conjunction with plans from partner organisations in Oxfordshire including other NHS trusts, the emergency services, local councils and emergency planning experts.
Controlling infection

Reducing infections in hospitals – and effectively treating those that do arise – remains a focus for the ORH. This year, the ORH has once again met its targets (set by NHS Oxfordshire) for reducing the numbers of patients contracting MRSA blood stream infections and *Clostridium difficile* in its hospitals.

The ORH has continued to screen elective admissions following the guidance from the Department of Health. Extending this to all elective procedures simply means that, during their appointment with, an outpatients’ nurse, patients have a swab taken. The ORH carried out 63,520 MRSA screens from April 2009 to March 2010. 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.

The Infection Control Service at the ORH has run and maintained an Oxfordshire Health Economy Continence group. This group was established as patients had developed MRSA blood stream infections as a result of their long-term urinary catheter. The focus for this group is to improve health care workers’ understanding of how to manage patients with urinary incontinence and methods to reduce the need for a long-term urinary catheter.

The ORH has four main infection themes within biomedical research. These are *Staphylococcus aureus*, *Clostridium difficile*, *Norovirus* (winter vomiting bug) and developing information technology to help analyse the data and feed back to staff. The work carried out on *Clostridium difficile* led the Trust to change policy on when to take samples to test for the disease. This was because a significant number of patients were testing positive but did not have the disease.

The work in infection control demonstrates the cumulative power of small changes, and the ORH can apply the principles learnt in infection control to other areas. For example, the Trust will shortly be using the methodology of root cause analysis, which helped establish how patients developed an infection, to reduce the incidence of pressure ulcers.
Safeguarding children and vulnerable adults

The Trust Board has specifically considered safeguarding children issues four times during 2009/10. In addition, the Care Quality Board will review safeguarding issues each quarter and provide reports to the Governance Committee. This will include the review of policies and procedures, compliance with the core standard, and from April 2010, compliance with the appropriate regulations, and consideration of internal management reviews on safeguarding children.

The ORH is a member of the Oxfordshire Safeguarding Children Board and has active membership at Board and sub-committee level. The ORH continues to work closely with NHS Oxfordshire, Oxfordshire County Council, Government Office of the South East (GOSE) and other bodies across South Central to support the safeguarding agenda.

The organisation meets all its requirements in relation to Criminal Records Bureau (CRB) checks. The ORH’s Human Resources policy and checklist clearly identifies staff requiring CRB checks according to NHS recruitment requirements.

Access to healthcare for people with a learning disability

The Trust has been working to implement the recommendations of the Healthcare for All Report by Sir Jonathan Michael. This report made a number of recommendations to improve access to care as well as the quality of care for people with learning disabilities within acute hospital settings. Significant progress has been made in this area but an action plan remains in place to ensure that protocols and mechanisms are fully implemented, to flag when people with learning disabilities access our services and to make adjustments to ensure that their experience of the quality of care in the Trust is enhanced.
Child protection policies

The Trust has in place robust and appropriate child protection policies and all staff are able to access the policies via the Trust intranet. Internal and Oxfordshire Safeguarding Children’s Board procedures and guidance are also made available on the intranet. A new and improved flagging system is being implemented following additional guidance from the Information Commissioner. A new protocol for flagging potential risks will be introduced to support the Emergency Departments and the Outpatient Departments. Existing arrangements continue to be used in the interim to ensure all children considered to be at risk by agencies in Oxfordshire are identified in a timely fashion, promoting support and safety for these children.

Although training for staff who care for children is progressing, the requirement for all staff training to be trained at level 1 is currently below target. Performance continues to improve with the availability of online programmes and additional classroom sessions. Training targets are monitored monthly and the nature of the training, linking in to the new e-learning package and the National Learning Management System, is also kept under review.

The Board has designated professionals to take the lead on safeguarding children and vulnerable adults. They are clear about their role and their responsibilities are defined in their job descriptions. The Director of Nursing and Clinical Leadership is the named Executive lead for safeguarding.
Our people

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. With a workforce of 10,136 staff (equivalent to 7,924 full-time posts), it is one of the largest employers within the Oxfordshire area.

It is through the contribution, effort and support of its staff that the Trust is able to provide the excellence in service and quality of patient care that it has become renowned for. This is reflected in the Trust having been given the highest rating of ‘excellent’ by the Care Quality Commission for the quality of patient care for the second time in 2008/09.

Workforce information

The table below shows the workforce figures at 31 March 2010.

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>MALE</th>
<th>FEMALE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Head count</td>
<td>Whole time equivalent</td>
<td>Full-time</td>
</tr>
<tr>
<td>Admin and Clerical Staff including ward clerks, receptionists, medical secretaries, staff in finance and IT and non-clinical managers</td>
<td>2,010</td>
<td>1,597.03</td>
<td>347</td>
</tr>
<tr>
<td>Healthcare Assistants including staff working in support roles on wards, porters and other domestic staff</td>
<td>1,423</td>
<td>1,035.83</td>
<td>244</td>
</tr>
<tr>
<td>Healthcare Scientists including staff working in laboratory medicine, cardiology and medical physics</td>
<td>536</td>
<td>472.55</td>
<td>173</td>
</tr>
<tr>
<td>Medical and Dental Staff including all registered nurses and midwives</td>
<td>1,584</td>
<td>1,313.15</td>
<td>698</td>
</tr>
<tr>
<td>Nursing Staff including all registered nurses and midwives</td>
<td>3,619</td>
<td>2,809.52</td>
<td>236</td>
</tr>
<tr>
<td>Scientific, Therapeutic and Technical Staff including radiographers, occupational therapists, physiotherapists, pharmacists, optometry staff and staff in technical support roles</td>
<td>785</td>
<td>594.11</td>
<td>97</td>
</tr>
<tr>
<td>Externally Funded Staff staff working within the Trust whose costs are paid for by external organisations</td>
<td>179</td>
<td>101.40</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>10,136</td>
<td>7,924</td>
<td>1,805</td>
</tr>
</tbody>
</table>
Nurses and midwives are the largest staff group and make up approximately 35% of the workforce. As can be seen below, over three-quarters of the workforce are female. Many staff work flexibly – almost half (46%) of the female staff and a fifth (20%) of male employees work part-time.

![Staff by gender](image)

In addition, we have approximately 550 medical staff who hold honorary contracts with the Trust. These include University medical staff who provide clinical services in our hospitals and doctors from other UK trusts and from overseas who wish to expand their knowledge and experience.

### Stable workforce

Staff turnover rates have remained relatively stable throughout the year. The turnover rate at the end of March 2010 was 10.9%. This is within the Trust's target of turnover between 10% and 14%. Low turnover is seen as a positive indicator of a stable workforce.

### Staff health

Through the dedication of staff a continuous provision of services has been possible through times of difficulty, including the outbreak of flu and adverse snowy weather conditions.

The graph on the next page shows year to date sickness absence rates and demonstrates the usual seasonal effect of sickness, with higher absences during winter months.

It is notable that during this period sickness absence was not as high as predicted in light of the pandemic. By the end of March 2010 sickness rates were at 3.42% against a target of equal to or below 3.25%. Although higher than the same period last year (3.25%), figures show that despite the pandemic flu outbreak absence levels were contained. By way of comparison, the average sick absence rate for NHS South Central during 2009 was 3.76%, and nationally for acute trusts was 4.17%.

Sickness absence is managed within the ORH, with regular reports on sickness levels provided to managers. This both ensures that absence levels are monitored against target, and helps ensure a healthy workforce, with the assistance of the Occupational Health Department.
Occupational health service provision

The Trust has an active and supportive Occupational Health Department, which provides an impartial and confidential advisory service to staff and their managers on health issues related to work and the work environment. By ensuring a healthy workforce, patient care can be enhanced. In addition, the Trust is an NHS Plus provider, offering specialist professional occupational health advice to employers and businesses across England, which includes private industry, commerce and the public sector, with a focus on small and medium-sized enterprises.

Benefits resulting from effective occupational health involvement include improved morale, motivation and performance, enhanced job satisfaction, reduced stress and ‘burnout’, and employees making informed choices on their health and safety and wellbeing whilst at work. This is in addition to reduced accident and incident figures, improved overall health and fitness at individual and organisational levels and reduced absenteeism, ill health and staff turnover.

Workforce development and education

The Trust is committed to the development of its staff, and in order to meet the ambition of the organisation to continue to be a leading teaching trust, it has developed new ways of delivering and monitoring training activity. The Trust was 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 and staff survey results have shown improvements in access to e-learning due to this.

The ORH continues to use e-learning as a tool to enable staff to complete their statutory fire training and ensure they can provide a safe environment in which to work. Staff also have improved access to the training directory from a large number of computers via the new intranet site, ORHi.
As part of the Trust’s commitment to education, it hosts the Oxfordshire Health Care Apprenticeship Scheme. This programme was developed to help local people who might not have formal qualifications to develop the skills to become nurses through a nursing-related access course.

The course is designed to provide vocational training and clinical placements over a two year period. To date the programme has enabled 127 apprentices to enter professional training. An exciting development in this area is the establishment of trainee Assistant Practitioner posts. The Trust plans to support 20 places on this programme in 2010, which will help us develop new roles to support patient pathways and redesign some of our services, to ensure that they are highly focused on what patients tell us they want.

**European Working Time Directive**

The need to balance training and service delivery has been in sharp focus in 2009 because of the European Working Time Directive which came into force in August 2009, limiting the hours doctors in training can work to 48 per week. Specialties have worked hard with the help of a planning group to achieve compliance with this Health and Safety legislation, without compromising the quality of training, and have been largely successful. The Trust has been granted a derogation for a middle grade rota in Obstetrics and Gynaecology at the Horton General Hospital in recognition of the recruitment difficulties that have been experienced in this specialty over the past year. Meanwhile, the Trust has funded the equivalent of approximately 20 posts as a direct result of the reduction of hours.

**Employee feedback**

All NHS trusts in England conduct an annual staff survey to collect the views of staff about working in the Trust. The most recent survey indicated that staff feel very satisfied with the quality of work and patient care they provide, believing that their role really makes a difference to patients. However the feedback also suggested that the Trust could improve opportunities for training and development, systematically ensure appraisals are completed for staff and that more time could be invested in communicating and engaging with staff. These areas form the basis of a focused action plan. The staff survey is just one of a range of tools the Trust uses to gather information in relation to its staff. Others include a new staff feedback email address and regular briefing sessions with managers where feedback is encouraged.

**Employee benefits**

The Trust recognises the need for work/life balance for its staff, and aims to provide a responsive and flexible approach to work, offering a range of benefits to support this. A variety of flexible working options are enjoyed across the Trust, including term-time-only working, job shares and flexi-time. The 2009 staff survey reflected that 73% of staff had taken advantage of at least one of the flexible working options.

Additionally, a number of local businesses offer discounts to Trust staff. The Trust provides on-site 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.
Equality and Diversity commitment

The Trust is fully committed to supporting an inclusive culture, where the needs of individuals are respected. The Trust Board endorses its legal duty to actively promote equality and reduce all discrimination. Our Single Equality Scheme outlines all actions to take place over a three year period to promote equality.

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 and languages are available on request.

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

Patients

The Trust continues 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 95.8% of inpatient admissions as compared to 94.8% last year.

The current staff ethnicity profile:
Healthcare libraries

A wide range of physical library spaces and outreach services are available free of charge for all staff and students working within the Trust. In Oxford, healthcare libraries operate on two sites – the Cairns Library at the John Radcliffe Hospital and the Knowledge Centre at the Churchill Hospital. In Banbury, all staff have access to the Horton General Hospital Library and Information Service.

The libraries provide:

- 24/7 access
- clinical enquiry services
- timetabled and one-to-one training sessions
- private study spaces and group study rooms
- large and in-depth collections of books and journals
- WiFi access
- self-service printing and scanning
- access to the internet and to a large number of online databases and electronic journals
- word processing and other computer applications
- a range of outreach and current awareness services.

This year the healthcare libraries continued to provide proactive support for a wide range of staff and Trust activities, including continuing professional development, patient care, guidelines development, clinical and non-clinical research, and management decision making. This was delivered from all three sites and from workplace locations across the Trust by the innovative Outreach Librarian service.
Education Centres

The George Pickering Education Centre (at the John Radcliffe Hospital in Oxford) and Terence Mortimer Postgraduate Centre (at the Horton General Hospital in Banbury) support the training of 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 is the delivery of a Foundation Programme, encompassing not only the ORH but the Nuffield Orthopaedic Centre, Public Health, Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust and GPs. The Foundation Programme has continued to grow in size to 200 Foundation doctors.

Following the success of 2009’s simulation course, run in conjunction with the Nuffield Department of Anaesthetics, further funding has been secured from NHS Education South Central (NESC) to continue this course.

The centres continue to run monthly courses to ensure that all consultants, who act as educational supervisors, are trained and accredited by 2010 in line with PMETB (Postgraduate Medical Education and Training Board) regulations.

The centres also deliver Continuing Professional Development (CPD) approved training for supervisors and assessors.
Engaging with our stakeholders

The ORH values the input of patients and other individuals and of partner organisations as this can help the Trust deliver real improvements in its 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 through listening to complaints and comments received in different parts of the organisation.

In addition, in 2010, the Trust has developed a bimonthly bulletin for its key stakeholders on news from the Trust. This is sent to leaders in other health organisations, local government, local MPs, patient representatives and other interested parties. It is also posted on the Trust’s website, www.oxfordradcliffe.nhs.uk, so that it is widely available.

The Trust produces a newsletter three times a year for its Foundation Trust members on a range of issues. This is also available on the website. Foundation Trust members living in Banbury and the surrounding areas receive the Better Healthcare Programme for Banbury newsletter if they have requested it (this is also posted on the Trust’s website).

The Trust has a Patient and Public Involvement Strategy (available on the website at www.oxfordradcliffe.nhs.uk), which confirms our commitment to meaningful involvement from users of our services. This year has seen the strengthening of the Trust’s relationship with the Local Involvement Network (LINk). In addition, the Trust is working with voluntary sector organisations, charities and patient groups to increase contacts in the community and listen to people’s experiences of using Trust services.

The ORH is committed to working in partnership with patients and carers, ensuring their needs are met. The Trust asks for, and responds to, feedback and collates and analyses comments so that it can learn from them. The Trust also has on-going feedback and discussion with various user groups.
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 2009/10, PALS dealt with 3,596 enquiries, 615 at the Churchill Hospital, 659 at the Horton General Hospital, 2,263 at the John Radcliffe Hospital and 59 non site specific.

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.

Contact John Radcliffe Hospital, West Wing and Children’s Hospital PALS
Monday to Friday 9.00am – 4.00pm
Telephone: 01865 221473 / 740868
Email: PALSJR@orh.nhs.uk

Contact Churchill Hospital PALS
Monday to Friday 9.00am – 4.00pm
Telephone: 01865 221473 / 740868
Email: PALSCH@orh.nhs.uk

Contact Horton General Hospital PALS
Monday to Friday 9.00am - 4.00pm
Telephone: 01295 229259
Email: PALSHH@orh.nhs.uk
Oxfordshire Local Involvement Network (LINk)

Oxfordshire LINk enables local people to have a stronger voice in how their health and social care services are delivered. Each local authority that provides social care services has been given annual funding and is obliged to make arrangements to ensure that LINk activities take place. In Oxfordshire, this is the responsibility of the County Council.

Oxfordshire LINk is made up of volunteer members, participants, groups and organisations with an interest in local care services. Registered charity Help and Care is 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 current Volunteer Stewardship Group (steering group) of nine members represents a wide range of health and social care experiences. The group seeks views about services – good or bad – in order to prioritise issues, form project groups and ask health and social care providers to respond in order to improve services in Oxfordshire.

For further information and to sign up to participate in the local LINk

Please see their website: www.oxfordshirelink.org.uk
Email: OxfordshireLINk@makesachange.org.uk
Telephone: 01993 862855
Public involvement

The ORH has a duty to ensure public views on service developments as well as new initiatives are sought. There are many different ways that the Trust listens to people’s views to improve the services provided, including patient feedback forms, surveys, audits, comments from websites and issues raised with the Patient Advice and Liaison Service.

PATIENT PANEL: More than 40 volunteers take part in the Patient Panel which meets three times a year. The Panel works with the Trust on a range of projects, including the production of patient information leaflets and service changes.

USER GROUPS: Ten user groups currently exist across the Trust and several more are planned or are in the process of being convened. These user groups work with clinical centres (such as renal medicine, cardiothoracic services and endocrinology) in order to collate patient experience, which helps to improve patient care, the provision of additional patient and carer facilities and patient information resources. Feedback from user groups is reported monthly to the Trust’s Care Quality Board.

CARERS: The ORH endeavours to identify all patients and their immediate family members who have a caring responsibility, so that appropriate care and support can be offered both during treatment and discharge. The Trust continues to develop links and resources with local voluntary sector organisations and community groups such as Oxfordshire carers’ organisations. To find out more about the Trust’s patient partnership work, please contact the Patient Services team on 01865 857734.

Young People’s Executive (YiPpEe)

The Young People’s Executive (YiPpEe) 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.

YiPpEe meet during the school holidays. The age range is 10 to 18 years and there are currently 12 members. The group is facilitated and supported by the Trust’s Children’s Rights Lead Nurse, the Play Specialist team, and the Hospital School staff.

In 2009 the success of YiPpEe’s contribution to children’s services was recognised in the South Central region when the group was selected as one of three finalists in the Health and Social Care Awards category of the Leadership in Improvement Awards.

YiPpEe has designed 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 picks up any issues that emerge from them.

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. In 2009 YiPpEe was part of the Turn it Up film which showcased them as one of a number of initiatives in Oxfordshire where children are being given a voice.
Work experience and volunteering

Volunteers play an invaluable part in allowing staff to offer an enhanced service to patients. The Trust has a Voluntary Services Department that manages volunteers, other volunteer organisations and the work experience programme.

The Trust has over 300 active volunteers and a further 1,000 or more volunteers in other voluntary organisations, helping on average four hours per week. Volunteers are not allowed to perform the role of an employed person but support staff carrying out their duties to improve patients’ experiences. This year 250 students aged 16 - 18 years had work experience placements in the Trust.

Volunteers help in various departments, talking to patients, helping at meal times on wards, taking the library trolley around wards, giving a friendly welcome and giving directions on help desks, working with the chaplaincy and photocopying or filing.

Volunteers come from diverse areas and the Trust is pleased to work with a variety of agencies, charities and with disabled groups providing volunteer placements. The ORH has been working over the last two years with a charity supporting the long-term unemployed, and four volunteers have gained employment with the Trust following their work experience.

The Trust continues to develop links with schools and colleges and with Oxfordshire Community Volunteer Action (OCVA).
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 the ORH for over 20 years. They are managed by Trustees, who meet every month to make decisions about how best to spend the money they raise.

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.

The Trust works with HOSC, particularly over the Better Healthcare Programme for Banbury and surrounding areas. HOSC has representatives on the Programme Board and on the Community Partnership Forum that work with NHS Oxfordshire and the ORH on the Better Healthcare Programme for Banbury and the surrounding areas.
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.

The ORH collects data related to attendances as a result of alcohol and/or violence at the Emergency Department at the John Radcliffe Hospital, which is then made anonymous and fed back to the group. This information can help police and the local council identify problem areas in the community. In February 2010 the Trust welcomed the Home Secretary, Alan Johnson MP, on a visit to the Emergency Department to see this work in action.

Foundation Trust members

The ORH continues to work towards becoming a Foundation Trust and currently has nearly 5,000 public members. The Trust aims to achieve around 6,000 public members (1% of the population of Oxfordshire) by the time of first elections to the Foundation Trust Members’ 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 Private Finance Initiative (PFI) partners (who supply catering, portering and cleaning staff at the John Radcliffe and Churchill Hospitals) are also considered to be members.

Since September 2008, the Trust has held regular meetings for members. These initially focused on informing members about Foundation Trusts and on the role of the Members’ Council. In the past year, a programme of eight informative talks for Foundation Trust members have been held about our key services and new research undertaken by OxBRC.

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

The Trust values the views of its patients and their families. It is the aim of the ORH that all patients should have a positive experience in its hospitals and that their care should be excellent. There are occasions when services fall short of the expectations of patients and their families, and when this occurs, it is vital that the Trust knows about their concerns and that it acts upon them to make sure that mistakes are learnt from. In addition to the positive work with patients, there is also a formal system for learning through complaints.

Comments and complaints

Formal complaints received by the Trust are investigated with a customer focused approach. The aim is to be open and accountable; and not only to put things right, but to seek continuous service improvement and identify organisational learning. During this year the Trust received 579 complaints; 96% of which were responded to within the NHS Complaints Procedure timescale of 25 working days. The top two areas of concern raised in complaints were the patient care experience, and delays/waiting times. The Ombudsman carried out a preliminary review on three complaints and decided not to investigate further. They are currently formally investigating one complaint.

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.

NHS Constitution

The NHS Constitution was one of the recommendations in Lord Darzi’s report High Quality Care for All published on the 60th anniversary of the NHS.

The NHS Constitution became law in January 2010. It gives patients legal rights to:

- access NHS services
- drugs and treatments approved by NICE (the National Institute for Health and Clinical Excellence)
- choice about where they receive their care
- be treated with dignity and respect.

The Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The ORH, like all other NHS bodies, now takes account of the Constitution in its decisions and actions.

The Constitution will be renewed every 10 years, with the involvement of the public, patients and staff and any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.
Patient survey 2009

The Picker Institute was commissioned by the ORH to undertake its annual Inpatient Survey in 2009. A total of 850 patients were sent a questionnaire. 834 patients were eligible for the survey, of which 428 returned a completed questionnaire, giving a response rate of 51%.

The ORH uses the patient survey to assess whether we are improving our performance year on year and to see how it compares to other trusts. The ORH significantly improved its performance in four areas over the last year and did not get significantly worse in any area. In other areas performance was largely the same as last year.

The four areas of improvement over the previous year were significant drops in patients expressing concern about: sharing toilet and bathing areas with patients of the opposite sex; toilets not being sufficiently clean; doctors and nurses not always washing their hands in between each patient contact. There were no areas in which the Trust's performance was measured by patients to be significantly worse than last year.

In comparison to other trusts, the ORH compared favourably in areas as diverse as: the information given to patients in the Emergency Department; the cleanliness of hospital toilets; healthy food on the hospital menu; clear answers to questions from nurses; nurses cleaning their hands between touching patients; explanation of what would be done during an operation; patients receiving copies of letters sent between hospital doctors and GPs on discharge from the hospital; recommending the hospital to family/friends; religious beliefs being respected by hospital staff.

The areas in which the Trust compared unfavourably to other trusts were: patients not being offered a choice of hospitals (although this is not a service that the ORH provides directly, as it would be in primary care that patients are offered a choice); shared sleeping bays with the opposite sex; insufficient information on how to complain about care in the form of posters and leaflets.

The Trust has been carrying out a major programme of work this year to provide same-sex accommodation and hopes that next year it will considerably improve its position on this aspect of patient care. Although there are leaflets and posters on display around the Trust about how to complain, the Trust will look at ways in which it can improve communication in this area.

Freedom of Information Requests

The Freedom of Information Act, 2000 gives everyone the right of access to public information, subject to exemptions. The Trust endeavours to respond to all requests within the 20 working days time frame. However, the more complex requests do take longer on occasions.

During 2009 the Trust received 236 requests for information with many including multiple questions. The sources of requests are broken down as follows:

- 32% Media
- 23% Individuals
- 20% MPs
- 25% Other sources (researchers, businesses, other NHS organisations etc)

Of these requests, 72% were responded to within the 20 working days.
SECTION 2

Financial Report 2010
Trust Board

Dame Fiona Caldicott*
Chairman

Sir Jonathan Michael*
Chief Executive
(from 1 April 2010)

Non-executive Directors

Professor Sir John Bell*
(from 1 November 2009)

Mr Alisdair Cameron*
(from 1 May 2009)

Professor David Mant
(Associate Non-executive Director from 1 April 2010)

Mr Geoffrey Salt*
(from 1 May 2009)

Mrs Anne Tutt*
(from 1 December 2009)

Mr Peter Ward*
(from 1 December 2009)

Other Non-executive Directors who were members of the Board in the year 2009/10 are:
Professor Alastair Buchan* (until 31 August 2009), Ms Caroline Langridge* (until 31 October 2009), Dr Henry Reece* (until 31 July 2009), Dr Colin Reeves* (until 5 November 2009), Mr Brian Rigby* (until 18 January 2010), and Associate Non-executive Director Professor Adrian Towse (until 31 December 2009).

Executive Directors

Professor Edward Baker*
Medical Director

Mr Paul Brennan
Director of Clinical Services (Associate Board Member)

Ms Sue Donaldson
Director of Human Resources and Organisational Development (Associate Board Member)

Mr Mark Mansfield*
Director of Finance and Procurement

Mr Andrew Stevens*
Director of Planning and Information

Mrs Elaine Strachan-Hall*
Director of Nursing and Clinical Leadership

Other Executive Directors who attended Board Meetings in the year 2009/10 are:
Mr Trevor Campbell Davis*, Chief Executive (until 5 October 2009); Mr Graham Bennett*, Interim Director of Finance (until 30 June 2010); Mr Paul Farenden*, Interim Chief Executive (until 31 March 2010); Mr Jo Farrar*, Interim Director of Finance (until 11 February 2010); Mr Chris Hurst*, Director of Finance and Acting Chief Executive (from 1 August 2009 until 30 September 2009); Mr Andrew McLaughlin, Chief Operating Officer and Associate Board Member (until 5 February 2010); Dr James Morris*, Medical Director (until 31 August 2010); Mr Colin Whipp, Director of Interim Support and Associate Board Member (until 12 February 2010).

*Voting Member of the Trust Board
During 2009/2010, the following were members of Trust Board Committees.

**Audit Committee**
Mr Alisdair Cameron (Committee Member from 16 July 2009, and Committee Chair from 5 November 2009), Dr Colin Reeves (Committee Member and Committee Chair to 5 November 2009), Professor Adrian Towse (Committee Member to 30 April 2009) and Mrs Anne Tutt (Committee Member from 29 January 2010) comprised the Committee during the year.

**Finance and Performance Committee**
For membership of this Committee, see the schedule of Trust Board Members above, as the Committee has the same membership as the Trust Board. Dame Fiona Caldicott (Chairman) was Committee Chair throughout the year.

**Governance Committee**
Dame Fiona Caldicott (Committee Member, and Committee Chair from 1 May 2009 to 29 January 2010), Professor Alastair Buchan (Committee Member to 31 August 2009), Ms Caroline Langridge (Committee Member to 31 October 2009), Mr Geoffrey Salt (Committee Member from 16 July 2009, and Committee Chair from 29 January 2010), Professor Adrian Towse (Committee Member and Committee Chair to 30 April 2009) and Mr Peter Ward (Committee Member from 29 January 2010) comprised the Committee during the year.

**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.

The Committee is established in accordance with good practice, and with the requirements of NHS Codes and the Monitor Code of Governance. It comprises exclusively all of the non-officer Board Members (Non-executive Directors), and is chaired by the Chairman of the Board. The Chief Executive may be asked to attend meetings (or parts of meetings) at which the appointment, remuneration and terms of service of officer Board Members (Executive Directors), other than the Chief Executive, are under consideration. The Board delegates to the Committee the responsibility for determining for the Chief Executive and officer Board Members (Executive Directors) the organisation of their appraisal; all aspects of salary (including any performance-related elements or bonuses); provisions for other benefits (including pensions and cars); and the arrangements for terminating employment and other contractual terms.

The 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 Trust Board members and the Chief Executive are entitled to six months’ notice on either side. Termination payments are normally limited to the notice period entitlement. Divisional Chairmen are consultants with permanent contracts who undertake the role for a fixed term.

**Declaration of Interests and Register of Interests of members of the Trust Board for the year 2009/2010**

Declarations of interests by Members of the Trust Board are sought at each meeting of the Board and its Committees, and recorded in the minutes of the relevant meetings. The Register of Interests of Board Members is published each year in the Annual Report, and includes those interests recorded during the preceding twelve months for Directors whose appointments have terminated in-year.

The interests for the year 2009/2010 are given below.

Guidance to the codes defines ‘relevant and material’ interests as:

- **a** Directorships, including Non-executive Directorships held in private companies or PLCs (with the exception of those for dormant companies)
- **b** ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS
- **c** majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS
- **d** a position of authority in a charity or voluntary organisation in the field of health and social care
- **e** any connection with a voluntary or other organisation contracting for NHS services
- **f** research funding/grants that may be received by an individual or department
- **g** interests in pooled funds that are under separate management.
<table>
<thead>
<tr>
<th>Director</th>
<th>a</th>
<th>b</th>
<th>c</th>
<th>d</th>
<th>e</th>
<th>f</th>
<th>g</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dame Fiona Caldicott</td>
<td>Chairman</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Non-executive Director and Company Secretary, Waters 1802 Ltd.</td>
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<tr>
<td>Professor Sir John Bell</td>
<td>Non-executive Director, Roche AG; Genentech; and Oxagen</td>
<td></td>
<td></td>
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<tr>
<td>from 1.11.09</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mr Graham Bennett</td>
<td>Interim Director of Finance from 12.2.10</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Non-executive Director</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>to 31.8.09</td>
<td></td>
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</tr>
<tr>
<td>Mr Paul Brennan</td>
<td>Interim Chief Operating Officer (Associate Board Member) from 8.2.10 to 31.03.10</td>
<td></td>
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</tr>
<tr>
<td>Mr Alisdair Cameron</td>
<td>Non-executive Director from 1.5.09</td>
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</tr>
<tr>
<td>Mr Trevor Campbell Davis</td>
<td>Chief Executive to 5.10.09</td>
<td></td>
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</tr>
<tr>
<td>Ms Sue Donaldson</td>
<td>Director of Human Resources and Organisational Development (Associate Board Member)</td>
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</tr>
<tr>
<td>Mr Paul Farenden</td>
<td>Interim Chief Executive from 12.10.09</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Mr Jo Farrar</td>
<td>Interim Director of Finance from 1.9.09 to 11.2.10</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Mr Chris Hurst</td>
<td>Director of Finance and Procurement (and Acting Chief Executive from 1.8.09) to 30.9.09</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ms Caroline Langridge</td>
<td>Non-executive Director to 31.10.09</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Non-executive Director, ORH Charitable Funds Section 11 Trustee</td>
<td></td>
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</tr>
<tr>
<td>Non-executive Director, Trust, Rhodes Trust, and Ewelme Almshouse Charity</td>
<td></td>
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</tr>
<tr>
<td>Chairman, Office for the Strategic Co-ordination of Health Research; Department of Health Genome Strategy Group; and Oxford Health Alliance</td>
<td></td>
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</tr>
<tr>
<td>Trustee, Jenner Foundation; Trustee, Nuffield Trust; Trustee, Stroke Centre, the Charité Hospital, Berlin; Member, Governing Body, Repton School</td>
<td></td>
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<tr>
<td>Head of Medical Sciences Division, University of Oxford; Member of Council, University of Oxford; Member of Governing Body, Green College, University of Oxford</td>
<td></td>
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<tr>
<td>Trustee, NHS Confederation; Council Member; NHS Confederation; Executive Board Member, Association of UK University Hospitals</td>
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<tr>
<td>Lay Member, Fitness to Practice Committee, General Medical Council; Lay Member, Judicial Review Panel</td>
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<td></td>
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<tr>
<td>Research funding from MRC, NHF and Wellcome Trust</td>
<td></td>
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<td></td>
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<td>Financial Report 2010</td>
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<tr>
<td>Director</td>
<td>a</td>
<td>b</td>
<td>c</td>
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</tr>
<tr>
<td>Mr Andrew McLaughlin (Chief Operating Officer) from 1.4.09 to 5.2.10</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Dr James Morris (Medical Director)</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>Dr Henry Reece (Associate Board Member) to 31.7.09</td>
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</tr>
<tr>
<td>Dr Colin Reeves (Non-executive Director to 5.11.09)</td>
<td>None</td>
<td>Self-employed consultant undertaking NHS business</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Mr Brian Rigby (Non-executive Director to 18.1.10)</td>
<td>Director, Partnership for Schools</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Mr Geoffrey Salt (Non-executive Director from 1.5.09)</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>Mr Andrew Stevens (Director of Planning and Information)</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Mrs Elaine Strachan-Hall (Director of Nursing and Clinical Leadership)</td>
<td>Director, Ollidoowedj Ltd.</td>
<td>Stepmother of Suzanne Hall, who contracts for language and translation services</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Professor Adrian Towse (Non-executive Director to 31.12.09 (Associate Board Member from 1.5.09))</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>Mrs Anne Tutt (Non-executive Director from 1.12.09)</td>
<td>The Adventure Capital Fund Ltd. The Social Investment Business Ltd. (formerly Futurebuilders England Fund Management Ltd.); Bamboo Innovations Ltd. A Tutt Associates Ltd. Non-executive Director of the Identity and Passport Service and member of the Audit Committee of the Home Office</td>
<td>Ownership of private business A Tutt Associates Ltd.</td>
<td>None</td>
<td>The Adventure Capital Fund Ltd. and The Social Investment Business Ltd. are the top companies in a group that makes grants and loans to third sector organisations who may contract for NHS services. They also manage the following funds – Futurebuilders England, Communitybuilders, SEIF (on behalf of the Department of Health)</td>
<td>The Adventure Capital Fund Ltd. and The Social Investment Business Ltd. are the top companies in a group that makes grants and loans to third sector organisations who may contract for NHS services. They also manage the following funds – Futurebuilders England, Communitybuilders, SEIF (on behalf of the Department of Health)</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Mr Peter Ward (Non-executive Director from 1.12.09)</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>Mr Colin Whipp (Director of Intensive Support (Associate Board Member) from 26.10.09 to 12.2.10)</td>
<td></td>
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</tbody>
</table>
Summary of financial position

2009/10 was a difficult financial year for the Trust. Patient activity for the Trust’s main commissioner, NHS Oxfordshire, was significantly higher than originally planned, which meant that the Trust’s costs were also higher than originally budgeted for. However, because of an income cap within the contract with the PCT, the Trust did not receive payment for all of this activity. The gap between the value of the activity and the payment received was approximately £12 million. The Trust therefore found itself with additional costs and insufficient income to fund these.

Furthermore, the Trust had a significant cost improvement or efficiency programme to deliver, totalling £40 million. Although significant savings had been identified, it was some £15 million short of meeting the target through recurrent savings schemes and the Trust needed to find other measures to compensate.

Mid-year discussions with NHS Oxfordshire and the South Central Strategic Health Authority resulted in financial support for the Trust, to compensate for the impact of the income cap, through the payment of an additional £6 million of non-recurrent income and agreement of a revised year-end financial target of a £3 million deficit.

Even with this additional support the Trust continued to face considerable pressure, and implemented further actions to contain expenditure and deliver non-recurrent savings, to ensure that its year end target could be achieved.

The hard work and focus on delivering these actions has, however, resulted in the Trust achieving a small surplus of £106,000 at the end of the year, rather than the £3 million deficit predicted earlier, after taking account of the agreed Department of Health exclusions (impairments and the net International Financial Reporting Standards (IFRS) impact of PFI schemes).

This is clearly good news but the Trust cannot be complacent. Looking forward to the new financial year, it has to make good the recurrent shortfalls from last year’s cost improvement programme, as well as delivering savings to meet the new cost improvement targets. There is as a result a very challenging savings target of £47 million for 2010/11. The income cap, present in the NHS Oxfordshire contract in 2009/10, has now been removed and therefore, in the new financial year, the Trust will receive payment for all the activity it delivers. In addition, to support the Trust’s cash position, an application has been made to the Department of Health for a working capital loan of £16.7 million.

Basis of preparation

From 1 April 2009, NHS organisations have been required to prepare their accounts under IFRS, rather than under UK Generally Accepted Accounting Principles. Accordingly, the Statements of Financial Position at 31 March 2008 and 31 March 2009, and the Statement of Comprehensive Income for the year ended 31 March 2009, have been restated. The principal effects of this change were that the previous surplus on retained earnings at 31 March 2009 of £12.2 million was converted to a deficit of £37.3 million and that the previously reported surplus of £2.4 million in the year ended 31 March 2009 became a deficit of £32.6 million. The main factor in this adjustment was that the Trust’s two Private Finance Initiative schemes were added to the Trust’s balance sheet. The construction costs of these schemes exceeded the open market valuation at completion, and therefore the effect of bringing these on-statement was that an impairment in value had to be charged to income and expenditure.

The carrying values for land and buildings in the Trust’s accounts are based upon valuations by the Valuation Office Agency.
Going concern

The accounts have been prepared on a going concern basis, reflecting the cash-flow forecasts of the Trust over the 15 months subsequent to the balance sheet date. While the Trust is expecting to deliver a financial surplus, a loan has been requested from the Department of Health to mitigate the effect of the historical deficit. This has the support of the Strategic Health Authority.

Contingent liabilities

The Notes to the Accounts disclose that at the year end the Trust had contingent liabilities of £12.3 million.

Format of the accounts

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

Four primary statements
• Statement of Comprehensive Income
• Statement of Financial Position
• Statement of Change in Taxpayers’ Equity
• Statement of Cash-flows

The Annual Accounts also include
• Notes to the accounts
• Statement of internal control
• Directors’ statement of responsibilities, and
• The auditor’s report.

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

The full Annual Report for 2010 including:

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

is available upon request from:

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

It is also available on our website www.oxfordradcliffe.nhs.uk and in CD format from the Media and Communications team 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 a surplus of income over expenditure of £106,000 for 2009/10, after Department of Health agreed exclusions of £46.6 million of impairments for land and buildings, and additional expenditure of £1.6 million on PFI assets arising from accounting changes following the introduction of the new International Financial Reporting Standards. Although this expenditure is included in the Trust’s Accounts, it is the position excluding these items which forms the basis of the break-even requirement and against which the Trust’s financial performance is judged by the Department of Health.

The Trust has not satisfied the requirements of the five year break-even duty applicable to NHS Trusts. The Trust Board has approved a four-year financial plan to deliver break-even in 2010/11 and surpluses of approximately £7.5 million for the following three years, which will recover the accumulated deficit by the end of 2013/14.

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 net assets (as reflected in their opening and closing balance sheets for the year). From 2009/10 the dividend payable on public dividend capital is based upon the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

External Financing Limit (an overall cash management control)
The Trust was set an External Financing Limit (EFL) of £17.615 million in 2009/10. Its actual external financing requirement was £6.704 million, which is £10.911 million within its EFL.

Performance over the last five years

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Turnover £000</th>
<th>Surplus/(deficit) before dividend £000</th>
<th>Retained surplus/(deficit) £000</th>
<th>CCA rate % (target 3.5% from 2003/4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>635,893</td>
<td>(40,420)</td>
<td>(48,100)</td>
<td>3.5</td>
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<tr>
<td>2008/9</td>
<td>614,371</td>
<td>15,599</td>
<td>2,405</td>
<td>4.0</td>
</tr>
<tr>
<td>2007/8</td>
<td>553,098</td>
<td>16,105</td>
<td>4,311</td>
<td>3.5</td>
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<tr>
<td>2006/7</td>
<td>484,559</td>
<td>1,174</td>
<td>(8,649)</td>
<td>3.4</td>
</tr>
<tr>
<td>2005/6</td>
<td>474,983</td>
<td>(9,929)</td>
<td>(19,409)</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Note: “The figures given for years prior to 2008/9 and prior years are on the basis of UK Generally Accepted Accounting Principles as that is the basis on which the Trust reported its performance and on which its targets were set for those years. The figures for 2009/10 are on the basis of International Financial Reporting Standards.

Severance payments

During the year the Trust made an extra-contractual severance payment of £15,000 to a medical consultant. This payment was approved by HM Treasury.

Summary financial statements

These accounts for the year ended 31 March 2010 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, with the approval of the Treasury, has 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.
Foreword to the accounts

The Trust’s position in relation to break-even duty for the year 2009/10 was a surplus of £0.1m. Whilst the Trust’s accounts record a deficit of £48.1m for the year, this was considered technical in nature. Of this sum, £46.6m arose from reductions in the valuations attributed to the Trust’s land and buildings and £1.6m was due to the revenue impact of accounting for Private Finance Initiative schemes in accordance with new International Financial Recording standards. Both these items are excluded by the Department of Health in calculating the Trust’s performance against its statutory break-even duty.

<table>
<thead>
<tr>
<th>2009/10</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained deficit for the year</td>
<td>(48,100)</td>
</tr>
<tr>
<td>Impairments included within the deficit</td>
<td>46,594</td>
</tr>
<tr>
<td>IFRS impact upon PFI scheme accounting</td>
<td>1,612</td>
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<tr>
<td>Surplus for reporting break-even performance</td>
<td>106</td>
</tr>
</tbody>
</table>
## Statement of comprehensive income for the year ended 31 March 2010

<table>
<thead>
<tr>
<th></th>
<th>2009/10 £000</th>
<th>2008/09 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from patient care activities</td>
<td>513,569</td>
<td>499,533</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>122,324</td>
<td>115,273</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(657,788)</td>
<td>(623,669)</td>
</tr>
<tr>
<td><strong>Operating surplus/(deficit)</strong></td>
<td>(21,895)</td>
<td>(8,863)</td>
</tr>
<tr>
<td><strong>Finance costs</strong></td>
<td></td>
<td></td>
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<tr>
<td>Investment revenue</td>
<td>61</td>
<td>1,134</td>
</tr>
<tr>
<td>Other gains (and losses)</td>
<td>(253)</td>
<td>(223)</td>
</tr>
<tr>
<td>Finance costs</td>
<td>(18,333)</td>
<td>(11,466)</td>
</tr>
<tr>
<td><strong>Surplus/(deficit) for the financial year</strong></td>
<td>(40,420)</td>
<td>(19,418)</td>
</tr>
<tr>
<td>Public dividend capital dividends payable</td>
<td>(7,680)</td>
<td>(13,194)</td>
</tr>
<tr>
<td><strong>Retained surplus/(deficit) for the year</strong></td>
<td>(48,100)</td>
<td>(32,612)</td>
</tr>
<tr>
<td><strong>Other comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>(48,619)</td>
<td>(63,474)</td>
</tr>
<tr>
<td>Gains on revaluations</td>
<td>8,828</td>
<td>18,459</td>
</tr>
<tr>
<td>Receipt of donated/government granted assets</td>
<td>903</td>
<td>2,155</td>
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<tr>
<td>Reclassification adjustments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- transfers from donated and government grant reserves</td>
<td>(3,081)</td>
<td>(3,435)</td>
</tr>
<tr>
<td>- on disposal of available for sale financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total comprehensive income for the year</strong></td>
<td>(90,069)</td>
<td>(78,907)</td>
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</table>
## Statement of financial position as at 31 March 2010

<table>
<thead>
<tr>
<th></th>
<th>31 March 2010 £000</th>
<th>31 March 2009 £000</th>
<th>1 April 2008 £000</th>
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<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>597,450</td>
<td>687,144</td>
<td>602,289</td>
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<tr>
<td>Intangible assets</td>
<td>3,182</td>
<td>3,875</td>
<td>4,315</td>
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<tr>
<td>Trade and other receivables</td>
<td>2,171</td>
<td>2,355</td>
<td>5,656</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>602,803</td>
<td>693,644</td>
<td>612,260</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>10,528</td>
<td>8,895</td>
<td>8,498</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>29,438</td>
<td>34,239</td>
<td>36,077</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>10,364</td>
<td>19,287</td>
<td>12,498</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>50,330</td>
<td>62,421</td>
<td>57,073</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>653,133</td>
<td>756,065</td>
<td>669,333</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(73,164)</td>
<td>(78,060)</td>
<td>(60,811)</td>
</tr>
<tr>
<td>Department of Health working capital loan</td>
<td>(3,332)</td>
<td>(3,332)</td>
<td>(3,332)</td>
</tr>
<tr>
<td>Department of Health capital loan</td>
<td>(1,404)</td>
<td>(1,404)</td>
<td>(614)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(8,380)</td>
<td>(9,126)</td>
<td>(4,603)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(690)</td>
<td>(1,361)</td>
<td>(3,763)</td>
</tr>
<tr>
<td><strong>Net current assets/(liabilities)</strong></td>
<td>(36,640)</td>
<td>(30,862)</td>
<td>(16,050)</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>566,163</td>
<td>662,782</td>
<td>596,210</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Borrowings</td>
<td>(281,385)</td>
<td>(285,356)</td>
<td>(144,737)</td>
</tr>
<tr>
<td>Department of Health working capital loan</td>
<td>(6,658)</td>
<td>(9,990)</td>
<td>(13,322)</td>
</tr>
<tr>
<td>Department of Health capital loan</td>
<td>(10,619)</td>
<td>(12,023)</td>
<td>(5,527)</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(90)</td>
<td>(120)</td>
<td>(1,376)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(1,124)</td>
<td>(898)</td>
<td>(985)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>266,287</td>
<td>354,395</td>
<td>430,263</td>
</tr>
</tbody>
</table>

### Financed by taxpayers’ equity:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2010</th>
<th>31 March 2009</th>
<th>1 April 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital</td>
<td>174,547</td>
<td>172,586</td>
<td>169,547</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>(81,767)</td>
<td>(37,330)</td>
<td>(9,785)</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>96,278</td>
<td>139,885</td>
<td>189,753</td>
</tr>
<tr>
<td>Donated asset reserve</td>
<td>75,389</td>
<td>77,434</td>
<td>79,005</td>
</tr>
<tr>
<td>Government grant reserve</td>
<td>97</td>
<td>77</td>
<td>0</td>
</tr>
<tr>
<td>Other reserves</td>
<td>1,743</td>
<td>1,743</td>
<td>1,743</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td>266,287</td>
<td>354,395</td>
<td>430,263</td>
</tr>
</tbody>
</table>
Statement of cash flows for the year ended 31 March 2010

<table>
<thead>
<tr>
<th></th>
<th>2009/10 £000</th>
<th>2008/09 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating surplus/(deficit)</td>
<td>(21,908)</td>
<td>(8,863)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>31,975</td>
<td>28,679</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>46,594</td>
<td>32,131</td>
</tr>
<tr>
<td>Net foreign exchange gains/(losses)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfer from donated asset reserve</td>
<td>(2,986)</td>
<td>(3,321)</td>
</tr>
<tr>
<td>Transfer from government grant reserve</td>
<td>(95)</td>
<td>(114)</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(18,097)</td>
<td>(13,604)</td>
</tr>
<tr>
<td>Dividends paid</td>
<td>(7,104)</td>
<td>(13,194)</td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>(1,633)</td>
<td>(397)</td>
</tr>
<tr>
<td>(Increase)/decrease in trade and other receivables</td>
<td>4,609</td>
<td>5,880</td>
</tr>
<tr>
<td>(Increase)/decrease in other current assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increase/(decrease) in trade and other payables</td>
<td>(4,660)</td>
<td>13,482</td>
</tr>
<tr>
<td>Increase/(decrease) in other current liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>(470)</td>
<td>(2,632)</td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow from operating activities)</strong></td>
<td>26,225</td>
<td>38,047</td>
</tr>
</tbody>
</table>

| **Cash flows from investing activities** |              |              |
| Interest received                  | 86           | 1,232        |
| (Payments) for property, plant and equipment | (27,741) | (39,840) |
| (Payments) for intangible assets    | 0            | (146)        |
| **Net cash inflow/(outflow) from investing activities** | (27,655) | (38,754) |
| **Net cash inflow/(outflow) before financing** | (1,430) | (707) |

| **Cash flows from financing activities** |              |              |
| Public dividend capital received     | 1,961        | 10,955       |
| Public dividend capital repaid       | 0            | (7,916)      |
| Loans received from the Department of Health | 0 | 7,900 |
| Loans repaid to the Department of Health | (4,736) | (3,946) |
| Other capital receipts              | 0            | 503          |
| Capital element of finance leases and PFI | (4,718) | 0 |
| **Net cash inflow/(outflow) from financing** | (7,493) | 7,496 |

| **Net increase/(decrease) in cash and cash equivalents** |              |              |
| Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year | 19,287 | 12,498 |
| Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year | 10,364 | 19,287 |
Better Payment Practice Code 2009/10 – measure of compliance

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-NHS trade invoices paid in the year</td>
<td>92,253</td>
<td>234,219</td>
</tr>
<tr>
<td>Total non-NHS trade invoices paid within target</td>
<td>82,693</td>
<td>202,709</td>
</tr>
<tr>
<td>Percentage of non-NHS trade invoices paid within target</td>
<td>90%</td>
<td>87%</td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>4,254</td>
<td>53,171</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>3,127</td>
<td>43,813</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>74%</td>
<td>82%</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. The Trust is a signatory to the Prompt Payment Code.

Management costs

<table>
<thead>
<tr>
<th></th>
<th>2009/10 £000</th>
<th>2008/9 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management costs</td>
<td>21,277</td>
<td>19,245</td>
</tr>
<tr>
<td>Income</td>
<td>635,893</td>
<td>614,371</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

External audit services

External audit services are provided by the Audit Commission.

Audit fees of £360,000 including VAT in 2009/2010 include charges for use of resources of £141,000 and for the national anti-fraud initiative of £2,000.

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

## Salary and pension entitlements of senior managers

### A) Salaries and allowances

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary (bands of £5,000)</td>
<td>£000</td>
</tr>
<tr>
<td>Dame Fiona Caldicott</td>
<td>Non-executive Director (Chairman)</td>
<td>20-25</td>
</tr>
<tr>
<td>Ms Caroline Langridge (1)</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Mr Brian Rigby CBE (2)</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Professor Adrian Touse (3)</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Dr Colin Reeves (4)</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Professor Alastair Buchan (5)</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Mr Geoffrey Salt (6)</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Mr Alisdair Cameron (7)</td>
<td>Non-executive Director</td>
<td>5-10</td>
</tr>
<tr>
<td>Professor Sir John Bell (8)</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Mrs Anne Tutt (9)</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Mr Peter Ward (10)</td>
<td>Non-executive Director</td>
<td>0-5</td>
</tr>
<tr>
<td>Mr Trevor Campbell Davis (11)</td>
<td>Chief Executive</td>
<td>140-145</td>
</tr>
<tr>
<td>Mr Paul Farenden (12)</td>
<td>Interim Chief Executive</td>
<td>155-160</td>
</tr>
<tr>
<td>Mr Chris Hurst (13)</td>
<td>Director of Finance and Procurement</td>
<td>75-80</td>
</tr>
<tr>
<td>Mr Jo Farrar (14)</td>
<td>Interim Director of Finance and Procurement</td>
<td>60-65</td>
</tr>
<tr>
<td>Mr Graham Bennett (12)</td>
<td>Interim Director of Finance and Procurement</td>
<td>60-65</td>
</tr>
<tr>
<td>Dr James Morris</td>
<td>Medical Director</td>
<td>40-45</td>
</tr>
<tr>
<td>Mrs Elaine Strachan-Hall</td>
<td>Director of Nursing and Clinical Leadership</td>
<td>115-120</td>
</tr>
<tr>
<td>Mr Andrew Stevens</td>
<td>Director of Planning and Information</td>
<td>105-110</td>
</tr>
<tr>
<td>Mr Andrew McLaughlin (15)</td>
<td>Chief Operating Officer</td>
<td>150-155</td>
</tr>
<tr>
<td>Mr Paul Brennan (16)</td>
<td>Interim Chief Operating Officer</td>
<td>-</td>
</tr>
</tbody>
</table>

### NOTES

1. Left October 2009
2. Left January 2010
3. Left December 2009
4. Left November 2009
5. Left September 2009
6. Commenced May 2009
7. Commenced November 2009
8. Commenced December 2009
9. Left October 2009
10. Employed via agency, costs include agency commission and similar costs
11. Left September 2009
12. On secondment from London SHA
13. On secondment from Dudley, no costs chargeable in 2009/10
14. On secondment from Dudley, no costs chargeable in 2009/10
Salary and pension entitlements of senior managers

B) Pension benefits

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Salary and pension entitlements to nearest £100</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Bands of £2,500)</td>
</tr>
<tr>
<td>Mr Trevor Campbell Davis (1) Chief Executive</td>
<td>0-2.5</td>
</tr>
<tr>
<td>Mr Chris Hurst (2) Director of Finance and Procurement</td>
<td>2.5-5</td>
</tr>
<tr>
<td>Mr Andrew McLaughlin (3) Chief Operating Officer</td>
<td>0-2.5</td>
</tr>
<tr>
<td>Dr James Morris Medical Director</td>
<td>2.5-5</td>
</tr>
<tr>
<td>Mrs Elaine Strachan-Hall Director of Nursing and Clinical Leadership</td>
<td>-0-2.5</td>
</tr>
<tr>
<td>Mr Andrew Stevens Director of Planning and Information</td>
<td>0-2.5</td>
</tr>
</tbody>
</table>

NOTES

1 Left October 2009
2 Left September 2009
3 Left February 2010

As Non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-executive members.

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

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

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

The Statement of Comprehensive Income 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 the Statement of Comprehensive Income

- **Income from activities** includes all income from patient care. The main source of income is from Primary Care Trusts (PCTs). Other sources of income include private patient income.

- **Other operating income** includes non-patient related income including education, training and research funding.

- **Profit/(loss) on disposal of fixed assets.** A fixed asset is an asset intended for use on a continuing basis in the business. The profit/(loss) is the difference between the sale proceeds of a fixed asset and its current value.

- **Other finance costs** – unwinding of discount. The unwinding charge reflects the difference between this year’s and last year’s estimates for the current cost of future payments on financing charges relating to provisions.

- **A provision** is a liability where the amount and timing is uncertain. While there has been no cash payment, the Trust anticipates making a payment at a future date and so its net assets are reduced accordingly.

- **Public Dividend Capital Dividend.** At the formation of NHS trusts, the purchase of trust assets from the Secretary of State was half-funded by public dividend. It is similar to company share capital, with a dividend being the payable return on the Secretary of State’s investment.

- **Retained Surplus (Deficit).** This shows whether the Trust has achieved its financial target to break-even for the year. This is different from the statutory duty to break-even ‘taking one year with another’ which is measured over three, or exceptionally, five years.

Terms used within the Statement of Financial Position

- **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 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.

- **Assets** represent rights or other access to future economic benefits controlled by the Trust as a result of past transactions or events.

- **Liabilities** represent obligations of the Trust to transfer economic benefits as a result of past transactions or events.

- **Public Dividend Capital Dividend.** At the formation of NHS trusts, the purchase of trust assets from the Secretary of State was half-funded by public dividend. It is similar to company share capital, with a dividend being the payable return on the Secretary of State’s investment.

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

- **Net cash inflow from operating activities**: cash generated from normal operating activities.

- **Returns on investments and servicing of finance**: cash received on short-term deposits and interest paid relating to costs of financing the Trust.

- **Capital expenditure**: payments for new capital assets and receipts from asset sales. Capital expenditure relates to spending on buildings, land and equipment which exceeds £5,000.

- **Public dividend capital dividend**. At the formation of NHS Trusts, the purchase of Trust assets from the Secretary of State was half-funded by public dividend. It is similar to company share capital, with a dividend being the payable return on the Secretary of State’s investment.

- **Net cash inflow/(outflow) before financing**: This represents the additional cash the Trust needed over and above what it could generate itself to conduct its business. The Department of Health set a limit on the amount of external finance trusts can obtain.

- **Financing**: This provides detail of where additional cash came from to support cash needs.
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.

2. It is my role to provide leadership to the Trust and to ensure that the Trust provides safe, effective, high quality and patient-centred care.

3. As Chief Executive, I work within a performance management framework established by the South Central Strategic Health Authority (SHA) and attend meetings of the SHA’s Chief Executive group.

4. The Trust works in partnership with the local health and social care community and particularly with Oxfordshire Primary Care Trust (PCT) and Oxfordshire County Council through a number of formal mechanisms including:
   4.1 the Oxfordshire Safeguarding Boards
   4.2 the Oxfordshire Joint Health Overview and Scrutiny Committee
   4.3 the Delayed Transfers of Care Programme Board
   4.4 the Creating a Healthy Oxfordshire Programme Board

5. Within the wider health economy, the ORH has effective working relationships with other key commissioners, including the Berkshire, Buckinghamshire, Gloucestershire, Northamptonshire and Wiltshire PCTs, and with NHS acute trusts in those counties.

6. The Trust has a strong relationship with Oxford’s two universities. Its partnership with the University of Oxford is led through the Strategic Partnership Board and a number of other formal and informal mechanisms.

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 provide reasonable, but not absolute, assurance of effectiveness. The system of internal control is based on an ongoing process designed to:
   7.1 identify and prioritise 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 and to manage these risks efficiently, effectively and economically.

8. The system of internal control has been in place in Oxford Radcliffe Hospitals NHS Trust for the whole year ended 31 March 2010, and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk
9. The Board’s Governance Committee reviewed the Governance, Quality, Risk and Safety Framework in March 2010. A programme of work has been agreed for 2010/11 that will:
   9.1 focus on assurance, risk assessment and management;
   9.2 support the development of clear information systems;
   9.3 deliver agreed safety action group plans for patient and staff safety closely aligned to the SHA’s priorities;
   9.4 support a review of the Trust’s committee arrangements; and
   9.5 prepare for NHSLA Level 2 assessment in 2011.

10. The Trust Board has reviewed the Trust Red Risk Register at each of its public meetings during the year and held a risk management training session in March 2010.

11. The appropriate risk management and health and safety policies and procedures are available to all staff through the intranet together with risk management training programmes. The intranet is used as a resource for sharing internal documents and for highlighting areas of good practice across the Trust and from elsewhere.

12. The Governance Committee covers the following areas:
   12.1 safety, quality and risk (including review of the risk register three times in the year);
   12.2 corporate and clinical governance, including review of the Board Assurance Framework four times a year;
   12.3 research governance; and
   12.4 information governance.

13. The Director of Nursing and Clinical Leadership has delegated responsibility for risk and risk management systems across the Trust. The Medical Director has specific responsibility as the Director of Infection Prevention and Control, and works with the infection control team to ensure that the Board, the Finance and Performance Committee and the Executive Team have been kept fully current with all issues associated with the management of healthcare associated infections.
The risk and control framework

14. The governance, safety, quality and risk framework describes the integrated organisational governance, safety, quality and risk management structure and identifies key committees and responsibilities. The strategy is reviewed bi-annually by the Governance Committee and approved each year by the Trust Board.

15. A key element in the framework is the Trust red risk register which is reviewed by each public Board meeting following review and updating by the executive and divisional teams. The Executive Team and the Care Quality Board have responsibility for the review of risks and quality issues, drawing on work within the divisions and corporate directorates. Work in the coming year will focus on mitigation plans to provide assurance to the Board that identified risks are being managed.

16. Key risks during the year were categorised as follows:
   16.1 safety and quality – risks to the delivery of core standards, CQC registration, control of infection, environmental and health and safety, and risks to the patient experience and data security;
   16.2 finance – delivery of the agreed control target taking account of income, cost improvement and expenditure targets;
   16.3 use of resources – risks arising from pressures on the capital programme, workforce and recruitment;
   16.4 performance – risks to the delivery of operational performance standards (e.g. 4 hour, 18 weeks);
   16.5 reputation – risks relating to all of the above (and external events) that impact on the reputation of the organisation – e.g. risks to achievement of Foundation Trust status.

17. The Board delegated the review and monitoring of the Board Assurance Framework (BAF) to the Governance Committee but has considered it in detail in both July 2009 and March 2010.

18. All of the components defined by the Department of Health have been incorporated, including assurances and gaps in controls and assurances. The strategic goals and strategic objectives were approved by the Board as part of the Business Plan in March 2009. The Board subsequently endorsed these goals and objectives in January 2010; and agreed to a further review in the autumn of 2010. The risks to each strategic objective have identified Executive leads and gaps in controls and assurances on the controls have been identified.

19. Action plans have been in place throughout the year to meet gaps, and the BAF shows the status at the year end. Areas of concern remain in relation to:
   19.1 delivery of aspects of operational performance (including the 4 hour wait and 18 weeks) and delivery of the cost improvement programme;
   19.2 local and system wide affordability issues impact across all areas of the ORH’s activity including shortage of capital;
   19.3 the safe and sustainable delivery of paediatric and maternity services at the Horton General Hospital; the ORH continues to partake fully in the work of the Better Healthcare Programme Board;
   19.4 continued risks from operational performance pressures to the quality of care and the patient experience;

20. The gaps and risks associated with the strategic objectives are being managed through the lead Executive Director, the Executive Team and the Board.

21. The Trust was fully compliant with the core standards and in December 2009 made its Declaration to the Care Quality Commission (CQC) for the period up to 31 October 2009. Executive and Non-executive directors reviewed the evidence supporting individual core standards so contributing to the Board’s assurance on its Declaration.

22. The Board has used the BAF to provide it with reasonable assurance of compliance with the core standards, and a statement to this effect has been included in the Trust’s Declaration to the CQC.

23. The Trust applied for registration with the CQC, and this was granted without qualification in March 2010 for all the Trust’s regulated activities.

24. The Director of Nursing and Clinical Leadership is the designated Senior Information Risk Officer (SIRO) and the Board lead for information governance. The Information Governance Group oversees information governance activity across the Trust. During the year, it carried out the agreed work programme, which included the review and updating of key information governance policies on confidentiality and information protection. The group also reviewed Freedom of Information requests, relevant incidents and oversaw the annual information governance toolkit self-assessment.

25. The Governance Committee considered detailed reports on information governance and endorsed the arrangements for the management of information governance, the information governance strategy and policy, and approved and monitored the Information Governance Group’s work programme.
26. As an employer whose staff are entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member pension records are accurately updated in accordance with the timescales detailed in the regulations.

27. The Trust has undertaken risk assessments and Carbon Reduction Delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust belongs to the carbon reduction group for the local health economy, and has undertaken a study to confirm its comprehensive and inclusive carbon emissions. In addition, a proposal to establish a carbon reduction plan has been obtained from the Carbon Trust, and is under consideration.

28. The current Major Incident Plan was approved in April 2008 but is currently under review and now includes an assessment of the risk of flooding; the Business Continuity Plan in August 2009; and the Hospital Evacuation Plan in January 2010. The Trust works with the Local Resilience Forum (LRF) in the Thames Valley and Oxfordshire. The Trust has been actively involved in the LRF Pitt Review and Warning and Informing workstreams. Its business continuity arrangements include back-up provision for utilities.

29. Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with. These include the requirement to complete a relevant section of the pro forma preface to Board papers, and to complete an impact assessment on submission of policies and other key documents for approval.

30. The Trust has a service level agreement with OHIS for the provision of its information technology (IT) services. The Trust’s Information and Communications System Management Board, chaired by the Director of Planning and Information, with membership including the Caldicott Guardian, the Chief Operating Officer, the CRS Project Director and the Director of Finance, oversees the Trust’s annual requirements, as set down in the Business Plan, and its longer-term strategic IT requirements. The management of operational risks within OHIS are integrated with the Trust’s risk management processes, and are taken account of through the Trust Risk register. The Director of Planning and Information is responsible for monitoring the SLA and for the provision of the day-to-day services provided by OHIS.

31. Close working relationships have been fostered with patients and the public. Meetings are held throughout the year with several patient bodies and the Trust Patient and Public Panel. Joint work has included the development of public and patient involvement, infection control, privacy and dignity, equality and diversity, protected meal times and specialist surgery. Patients and patient representatives have maintained their contribution to the preparation of good quality information on services and procedures, including new clinical information leaflets produced during the year against an agreed programme.

32. The Trust has maintained contact with the Foundation Trust membership recruited to date towards its application for authorisation as a Foundation Trust, and organised several members’ events during the year.

33. The Trust’s Directors and managers have continued to brief the Oxfordshire Joint Health Overview and Scrutiny Committee, and to maintain contact with the Oxfordshire LINks organisation.

Review of effectiveness

34. As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. This 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 BAF, and on the controls reviewed as part of the internal audit work. Executive managers with responsibility for the development and maintenance of systems of internal control also provide me with assurance. The BAF itself also provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the arrangements set out below.

35. At its meeting in March 2010, the Board approved revisions to the Standing Orders previously reviewed in January 2009. Directors individually confirmed their acceptance of, and compliance with, the Codes of Conduct and Accountability.

36. 2009/10 was the third year of the Auditor’s Local Evaluation (ALE) system. The Trust 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. Progress has been monitored through reports to the Audit Committee.
37. The ALE assessment provided valuable feedback across all the domains, and highlighted areas of strength and those needing improvement. The ALE framework has a specific domain for internal control, and the work of assessing our performance against this KLOE and specific standards has provided me with assurance on the system of internal control. The expectation is that the overall outcome for the quality of financial management will be an assessment of fair for 2009/2010.

38. The outcome of the Information Governance Toolkit self-assessment showed a result of 89%, compared with 73% in 2008/09. To provide further assurance, internal audit has been asked to review the requirements where attainment levels have improved to level 3.

39. 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.

40. The Audit Committee approved the counter fraud annual plan and will shortly consider the counter fraud annual report for 2009/10. It receives regular reports from the local counter fraud specialists at each of its regular meetings.

41. In March 2010 the ORH strengthened the process for ensuring robust actions are taken in response to internal audit reports to include the active follow-up of recommendations. I am confident therefore that the controls now in place to ensure delivery against these recommendations are sufficient and that the action plans have either been delivered or are due to be completed within an agreed timetable.

42. The Trust's Risk Register is based on the highest risks identified by the divisions, specific areas (including infection control and medicines management) and the corporate directorates. The risk assessment procedure has been agreed, and the governance, quality and risk framework reviewed, updated and the programme agreed for 2010/11.

43. The Audit Committee has reviewed the systems of internal control, and informed me, as Accountable Officer, of the level of their effectiveness. Plans are being implemented to address weaknesses and ensure continuous improvement of the system. These plans will be monitored by the Audit Committee on behalf of the Trust Board.

44. During the year Internal Audit completed 20 reports on the operation of the Trust's systems and controls. 11 of these had overall opinions that were lower than satisfactory. Measures have either been taken or are being taken to address the weaknesses identified.

**Significant control issues**

45. The Trust has responded to the CQC alert in 2009 on adult cardiothoracic surgery, and delivery of the consequent action plan is being monitored. The Trust is also actively cooperating with the Independent Review Panel that the SHA established following the pause by the Trust of paediatric cardiac surgery in March 2010. The preliminary outcome of the Review was reported to the SHA at the end of May 2010.

46. The Head of Internal Audit's opinion overall is based on an assessment of the design and operation of the underpinning assurance framework and supporting processes, an assessment of the range of individual opinions arising from risk-based audit assignments, taking account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; an assessment of the process by which the Trust arrived at its declaration regarding standards for better health; and any reliance placed on third-party assurances.

47. With the exception of the internal control issues that I have outlined in this statement, my review confirms that the Oxford Radcliffe Hospitals NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Signed

Sir Jonathan Michael*
Chief Executive

Date 8 June 2010

* Sir Jonathan Michael did not become Chief Executive of the Trust until immediately after the financial year 2009/10 had closed.
Further information

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Tell us what you think

Every year we produce an Annual Report, 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 Report 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 Report, 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

See our website: www.oxfordradcliffe.nhs.uk in the News section.
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**
is care that is planned in advance, for example an operation.

**Foundation Trust**
A type of healthcare organisation, which has 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 (General Practitioner) who, often with colleagues in partnership, works from a local doctor’s surgery, providing medical advice and treatment to patients.

**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 Trusts usually 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.

**Primary care**
Health services provided in the local community. GPs often act as a first point of consultation for patients. Other primary care professionals are district nurses, pharmacists, local dentists, opticians, therapists and others who work in community health.

**Primary Care Trust**
Primary care services are managed by local primary care trusts. In Oxfordshire, the Primary Care Trust is called NHS Oxfordshire. The PCT works with local authorities and other agencies that provide health and social care locally to make sure that the local community’s needs are being met.

**Secondary care**
Services provided by medical specialists. Usually they do not have first contact with patients. Secondary care is mostly delivered in hospitals or clinics and patients are generally referred to secondary care by their primary care provider (usually their GP).

**Strategic Health Authority (SHA)**
The SHA is responsible for developing strategies for local health services and ensuring high-quality performance. The SHA manages the NHS locally and is a key link between the Department of Health and local Trusts.

There are 10 SHAs across the country. Our local SHA is NHS South Central which covers the counties of Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight.
Useful websites

FOR FURTHER INFORMATION ON ALL OUR SERVICES, SEE OUR WEBSITE www.oxfordradcliffe.nhs.uk or follow developments at Oxford Radcliffe Hospitals on our Twitter: http://twitter.com/OxfordRadcliffe

OTHER USEFUL WEBSITES

Airmed air ambulances
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Care Quality Commission
Cherwell District Council
Department of Health
Foundation Trust Network
General Medical Council (GMC)
Medical Sciences at Oxford University
Monitor
NHS Confederation
NHS Connecting for Health (The National Programme for IT)
NHS Direct
National Institute for Health & Clinical Excellence (NICE)
National Patient Safety Agency (NPSA)
NHS Institute for Innovation and Improvement
NHS Oxfordshire
NHS Oxfordshire Web Portal
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
Patient Safety Federation
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians
Royal College of Surgeons
South Central Strategic Health Authority
South Oxfordshire District Council
University of Oxford
Vale of White Horse District Council
West Oxfordshire District Council

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www.monitor-nhsft.gov.uk
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