SECTION 2

Financial Review 2011/12

Financial Review and outlook

Summary

This is the first report produced by the Oxford University Hospitals NHS Trust which came into existence on 1 November 2011 with the merger of the Oxford Radcliffe Hospitals NHS Trust and the Nuffield Orthopaedic Centre NHS Trust. In accordance with guidance issued by the Department of Health, the accounts of the Oxford University Hospitals NHS Trust have been prepared on a merger accounting basis. This means the accounts incorporate the performance of the two former separate legal entities for the first seven months of this year and set out the performance of the Trust as if it had been established for the full financial year. The Trust has also undertaken an exercise to restate the 2010/11 accounts so that the comparative balances shown in the 2011/12 accounts are also shown as if the trusts had always been merged. The accounts have been prepared under IFRS on a going concern basis, reflecting the cash-flow forecasts of the Trust over the 15 months subsequent to the balance sheet date.

The Trust ended with a surplus of £7,157,000, before the technical adjustments due to impairments and IFRIC 12, against an original plan to produce a surplus of £7.2m. If this figure is then adjusted for impairments and IFRIC 12, a technical surplus under the IFRS regime of £7,603,000 results.

A glossary of technical financial terms used in this report is shown later in this report.

Summary financial statements are included on pages 48-51. These may not contain sufficient information to fully understand the Trust's financial position and details of how to obtain a full set of accounts are set out on page 47.

Review of 2011/12 and outlook for future years.

The Trust had planned to make a surplus of £7.2m in 2011/12 after removing technical adjustments and the accounts indicate that the Trust achieved a surplus of £7.2m. The Trust also had a target to achieve savings of over £58m and the outturn was that savings of £57.2m (or 98% of the target) were achieved.

For 2012/13 the Trust is planning to make a small surplus on income and expenditure of (0.45%) £3.5m. Within this plan is an assumption that the Trust will deliver further cost improvements and it has plans to find at least £49m. The continuing need for significant savings reflects the financial constraints that are facing the whole public sector. Within the Oxfordshire health economy, the Trust is working with the PCT, GPs and our partners in Social Services to deliver a plan for Oxfordshire which seeks to find the best solution for the whole health economy. This initiative, called 'Creating a Healthy Oxfordshire' (CAHO), means that the Trust must continue to reduce its costs and seek alternative ways to deliver services if it is to remain in financial good health.

Vital to the continued success of the Trust is the management of risks which could affect service delivery. The Quality Committee is key to the timely and robust identification of risks, the formulation of mitigation plans / action plans and the monitoring of risks. The principal risks to the Trust are managed through two key mechanisms – the Corporate Risk Register and the Trust Assurance Framework. The Corporate Risk Register is used to identify risks relating to trust-wide priorities and corporate issues – for example, it identifies risks relating to delivery of Trust objectives such as access targets and how these will be managed.

The Trust Assurance Framework builds on the Risk Register in that it assesses the effectiveness of the controls in place to ensure delivery against each of the Trust's objectives. Gaps in controls and assurance are identified in the document and, where required, action plans are put in place to address identified weaknesses.

The highest organisational risks, as identified within the Assurance Framework and which may impact on the Trust's strategies and development, were reported to the Trust Board and are recorded in the Annual Governance Statement.

Income from Commissioners and other sources

The Trust's income increased by £45.6m (6.1%) over the previous year and the main components of the Trust's income for 2011/12 of £788m are shown in the table below. As can be seen from this table, over 80% of the Trust's resources come directly from Primary Care Trusts. The increase in income from PCTs arose because the Trust was able to meet the demand for more patient care services than was originally envisaged *(see Fig. 1 and 2).*

Fig 1

Our income sources	2011/12	2010/11
	£000s	£000s
Strategic Health Authorities	13,188	10,151
NHS Trusts and FT's	0	19
Dept of Health	1,435	1,034
Primary Care Trusts	627,551	593,237
Non-NHS including RTA	16,783	14,045
Education & Research	85,946	83,702
Other non-patient services	34,917	33,637
Other	8,400	6,787
Total income	788,220	742,612

(Source notes 4 to 7 of Annual Accounts 2011/12)

Fig 2: Sources of income 2011/12

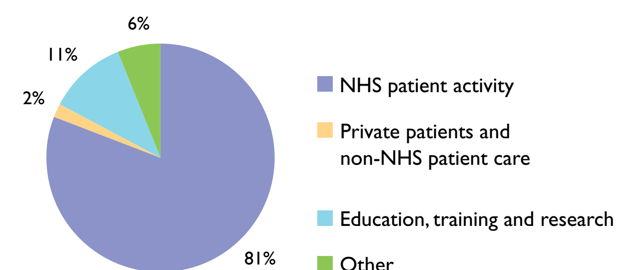
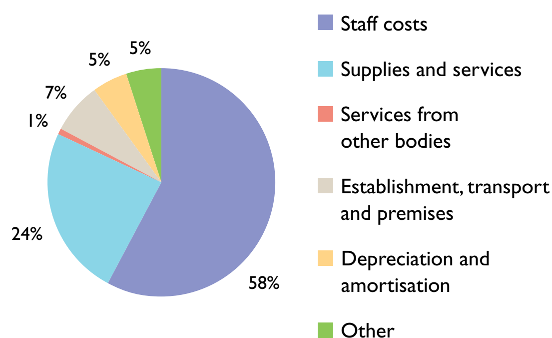


Fig 3: Operating expenditure 2011/12



Operating expenses (see Fig.3)

The Trust spends on average just over £2m each and every day. The largest item of expenditure is staff costs and the next most significant is clinical supplies and services. *Fig. 3* shows an analysis of how much of each pound spent is attributable to staff costs and the other main expenditure headings.

Looking ahead, the cost base of the Trust will alter as the Trust continues to use a number of external benchmarks to identify the potential for further efficiencies.

Capital resources

The capital programme is a key resource of funding to enable modernisation and to ensure that our services are delivered in a safe and well maintained environment. In general, the Trust has to generate sufficient surplus cash flow to finance capital investment by the retention of cash generated through operations (principally depreciation) for reinvestment.

Over £21m was expended in 2011/12 and *Fig. 4* provides an indication of the areas of investment the Trust pursued in the year. The Plan for 2012/13 can be summarised as *Fig. 5* (see right).

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 £7,157,000 for 2011/12, after Department of Health agreed exclusions of £446,000 arising from the technical treatment associated with Private Finance Initiative schemes, the elimination of the donated asset / government grant reserves and the revaluation of assets. 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.

External Financing Limit

(An overall cash management control)

The Trust was set a target to reduce its level of external finance by £15.714m in 2011/12. The Trust achieved this target by reducing its level of external finance by £33,087 million.

Capital Resource Limit

(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). However since 2009/10 the dividend payable on public dividend capital has been based upon the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

The Trust was set a limit of £22.761m which it could spend on capital and during the year it spent £20.201m, thus undershooting its control limit by £2.560m.

Fig 4: Capital expenditure 2011/12

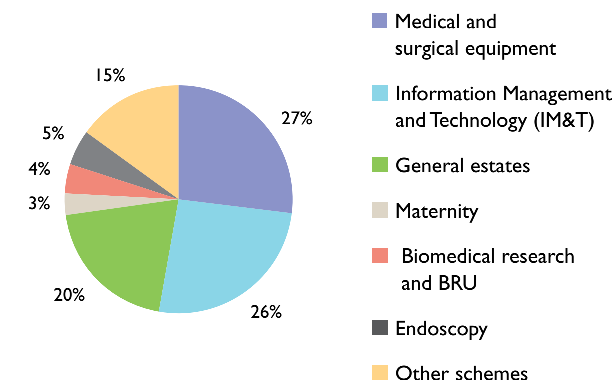


Fig 5:
Total funding of £20.9m is anticipated and it is proposed to use this for.

Scheme	£000s
Neonatal Intensive Care	2,685
Trauma Centre Business Case	790
Vascular Business Case	1,300
Cardiac (Adult) Business Case	1,400
Laboratory Business Case	2,000
Medical and Surgical Equipment	2,000
Radiotherapy	945
PACS Replacement	250
IT / EPR	3,000
Ward relocations	3,000
Pharmacy	411
General estates	1,240
IMRT	750
Other schemes	2,063
Total	21,834
Under/(over) commitment	(900)

[Source TB2012. jj Financial Plan 2012-13 (Revised) (v1)]

Performance over the last five years

This table summarises the performance of both the Nuffield Orthopaedic Centre and Oxford Radcliffe Hospitals NHS Trusts

Financial year	Turnover £000	Retained surplus / (deficit) £000	Break-even cumulative position surplus / (deficit) £000	CCA rate % (target 3.5% from 2003/4)
2011/12	788,220	7,603	(7,864)	3.5%
2010/11	745,957	13,604	(15,021)	3.5%
2009/10	714,827	(49,276)	(17,192)	3.5%
2008/9	686,836	2,464	(17,609)	4.0%
2007/8	627,168	4,367	(20,073)	3.5%

(Source note 43.1 Annual Accounts 2011/12)

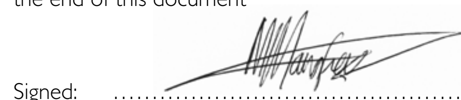
Note The figures given for years before 2008/9 are on the basis of UK Generally Accepted Accounting Principles as that is the basis on which the Trust reported its performance and on which its targets were set for those years. The figures for 2009/10 and subsequently are on the basis of the International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

For break-even performance, impairments and IFRIC 12 adjustments are excluded so performance in 2009/10 for the Oxford Radcliffe Hospitals and Nuffield Orthopaedic Centre combined was accordingly £417,000 retained surplus, £2,171,000 retained surplus in 2010/11 and £7,157,000 retained surplus in 2011/12.

Summary financial statements

These accounts for the year ended 31st March 2012 have been prepared by the Oxford University Hospitals NHS Trust under section 232 (schedule 15) of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

The financial statements that follow are only a summary of the information contained in the Trust's annual accounts. Full copies of the accounts are available from the Publications page in the About us section of the Trust's website (www.ouh.nhs.uk) or by contacting the Finance Department at the Oxford University Hospitals NHS Trust. The Trust is required to include an Annual Governance Statement, which is shown at the end of this document



Signed: ………………………………………….

Mark Mansfield, Director of Finance and Procurement

Foreword to the Accounts

The Trust made a surplus of £7,157,000 against the break-even duty for 2011/12. The accounts record a surplus of £7,603,000; the difference of £446,000 relates to technical treatments associated with accounting for Private Finance Initiatives' schemes, elimination of the donated asset / government grant reserve and revaluations of assets which are each excluded by the Department of Health when considering the performance of the Trust.

Statement of comprehensive income for year ended

	2011/12 £000
Retained surplus / deficit for the year	7,603
IFRIC*12 Adjustment	440
Impairments	(2,328)
Adjustments iro donated asset/gov't grant reserve elimination	1,442
Reported NHS finance Performance position (adjusted retained surplus)	7,157

*IFRIC stands for the International Financial Reporting Interpretations Committee. It is the Interpretations Committee for the International Accounting Standards Board (IASB).

	2011/12 £000	2010/11 £000
Revenue		
Employee benefits	**(435,111)**	(420,106)
Other costs	**(316,117)**	(279,466)
Revenue from patient care activities	**658,957**	618,486
Other operating revenue	**129,263**	124,126
Operating surplus/(deficit)	**36,992**	43,040
Finance costs:		
Investment revenue	**135**	108
Other gains and losses	**(159)**	(293)
Finance costs	**(20,471)**	(21,325)
Surplus/(deficit) for the financial year	**16,497**	21,530
Public dividend capital dividends payable	**(8,894)**	(8,498)
Retained surplus/(deficit) for the year	**7,603**	13,032
Other comprehensive income		
Impairments and reversals	**0**	(1,131)
Net gain / (loss) on revaluation of property, plant & equipment	**7,737**	8,783
Net gain / (loss) on revaluation of intangibles	**0**	0
Net gain / (loss) on revaluation of financial assets	**0**	0
Net gain / (loss) on revaluation on other reserves	**0**	0
Net gain / (loss) on revaluation on available for sale financial assets	**0**	0
Net actuarial gain / (loss) on pension schemes	**0**	0
Reclassification adjustment on disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year	**15,340**	20,684

Statement of financial position as at 31 March 2012

	31 March 2012 £000	31 March 2011 (restated) £000
Non-current assets		
Property, plant and equipment	**696,398**	703,411
Intangible assets	**7,301**	4,253
Trade and other receivables	**3,742**	4,259
Total non-current assets	**707,441**	711,923
Current assets		
Inventories	**12,761**	13,014
Trade and other receivables	**36,392**	28,746
Other financial assets	**0**	0
Other current assets	**70**	0
Cash and cash equivalents	**43,884**	25,799
Total current assets	**93,107**	67,559
Non-current assets held for sale	**0**	0
Total current assets	**93,107**	67,559
Total assets	**800,548**	779,482

	31 March 2012 £000	31 March 2011 (restated) £000
Current liabilities		
Trade and other payables	**(100,141)**	(86,848)
Provisions	**(8,421)**	(3,641)
Borrowings	**(12,626)**	(12,352)
Working capital loan from Department	**0**	(3,326)
Capital loan from Department	**(7,811)**	(9,215)
Total current liabilities	**(125,918)**	(107,577)
Non-current assets plus / less current assets / liabilities	**674,630**	671,905
Non-current liabilities		
Trade and other payables	**(1,930)**	(630)
Provisions	**(1,426)**	(1,565)
Borrowings	**(291,503)**	(303,510)
Working capital loan from Department	**0**	(3,326)
Capital loan from Department	**(7,811)**	(9,215)
Total non-current liabilities	**(302,670)**	(318,246)
Total assets employed	**371,960**	353,659
Financed by taxpayers' equity:		
Public dividend capital	**206,873**	203,912
Retained earnings	**15,600**	7,913
Revaluation reserve	**147,744**	140,091
Other reserves	**1,743**	1,743
Total taxpayers' equity	**371,960**	353,659

Statement of changes in taxpayers' equity for the year ended 31 March 2012

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2011	203,912	7,913	140,091	1,743	353,659
Opening balance adjustments		0	0	0	0
Restated balance at 1 April 2011	203,912	7,913	140,091	1,743	353,659
Changes in taxpayers' equity for 2011/12					
Retained surplus/(deficit) for the year	7,603			7,603	
Net gain on revaluation of property, plant, equipment			7,737		7,737
Impairments and reversals			0		0
Movements in other reserves				0	0
Transfers between reserves		84	(84)		0
Release of reserves to SOCI		0		0	
New PDC received	2,961				2,961
PDC repaid in year	0				
PDC written off					
Net recognised revenue/(expense) for the year	2,961	7,687	7,653	0	18,301
Balance at 31 March 2012	206,873	15,600	147,744	1,743	371,960
Included above: Transfer from revaluation reserve to retained earnings in respect of impairments		0	0		0

Statement of changes in taxpayers' equity for 2010/11

	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2010/11					
Balance at 1 April 2010	203,912	(5,261)	132,581	1,743	332,975
Retained surplus/(deficit) for the year		13,032			13,032
Net gain on revaluation of property, plant, equipment			8,783		8.783
Impairments and reversals			(1,131)		(1,131)
Movements in other reserves				0	0
Transfers between reserves		142	(142)		0
New PDC received	0				0
PDC repaid in year	0				0
PDC written off	0				0
Net recognised revenue/(expense) for the year	0	13,174	7,510	0	20,684
Balance at 31 March 2011	203,912	7,913	140,091	1,743	353,659
Included above: Transfer from revaluation reserve to retained earnings in respect of impairments		0	0		0

Statement of cash flows for the year ended 31 March 2012

	2011/12 £000	2010/11 £000
Cash flows from operating activities		
Operating surplus / (deficit)	**36,992**	43,040
Depreciation and amortisation	**34,850**	32,522
Impairments and reversals	**(2,328)**	(11,684)
Donated asset received credited to revenue but non-cash	**(45)**	(1,575)
Interest paid	**(20,436)**	(20,199)
Dividends paid	**(8,983)**	(8,521)
(Increase) / decrease in inventories	**253**	(529)
(Increase) / decrease in trade and other receivables	**(7,139)**	4,886
(Increase) / decrease in other current assets	**1**	0
Increase / (decrease) in trade and other payables	**13,448**	7,495
Increase / (decrease) in other current liabilities	**0**	0
Provisions utilised	**(1,171)**	(824)
Increase / (decrease) in provisions	**5,770**	3,607
Net cash inflow / (outflow) from operating activities	**51,212**	**48,218**
Cash flows from investing activities		
Interest received	**145**	108
(Payments) for property, plant and equipment (PPE)	**(14,018)**	(24,212)
(Payments) for intangible assets	**(3,420)**	(1,975)
(Payments) for investments with DH	**0**	0
Proceeds from disposal of assets held for sale (PPE)	**0**	561
Proceeds from disposal of assets held for sale (intangible)	**0**	0
Proceeds from disposal of investments with DH	**0**	0
Proceeds from disposal of other financial assets	**0**	0
Rental revenue	**0**	0
Net cash inflow/(outflow) from investing activities	**(17,293)**	**(25,518)**
Net cash inflow/(outflow) before financing	**33,919**	**22,700**

	2011/12 £000	2010/11 £000
Cash flows from financing activities		
Public dividend capital received	**2,961**	
Public dividend capital repaid		
Loans received from DH-new capital investment loans		
Loans received from DH-new working capital loans		
Loans repaid to DH-capital		
Investment loans repayment of principal	**(1,404)**	(1,404)
Loans repaid to DH-working		
Capital Loans repayment of principal	**(3,332)**	(3,332)
Capital element of finance leases and On-SoFP PFI	**(14,059)**	(8,518)
Capital grants and other capital receipts	**0**	2,254
Net cash inflow/(outflow) from financing	**(15,834)**	(11,000)
Net increase/(decrease) in cash and cash equivalents	**18,085**	**11,700**
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**25,799**	**14,099**
Effect of exchange rate changes on the balance of cash held in foreign currencies	**0**	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**43,884**	**25,799**

Public interest and other reports

1 Better payment practice Code

In accordance with the CBI prompt payment code, the Trust's payment policy is to pay all creditors within 30 days of receipt of goods or a valid invoice unless other payment terms are agreed. The performance for 2011/12 is set out opposite *(see Fig 6 and 7)*. The Trust has signed up to the Prompt Payment Code which is a payment initiative developed by Government and which was referenced in a letter from the NHS Chief Executive on 18 May 2009.

2 Audit disclosure

The Trust's external auditors are the Audit Commission. The statutory audit fee for the year ended 31 March 2012 was £360,000. There was no work on further assurance services or other services. The Audit Commission auditors report to the Audit and Finance Committee, which is a sub committee of the Trust Board chaired by a Non-Executive Director and whose membership is limited to the Non-Executive Directors of the Trust. Under the governance arrangements of the Audit Commission, the district auditor and senior audit manager are rotated every five years.

In line with current guidance, each Director has given a statement that as far as they are aware, there is no relevant audit information of which the Audit Commission, (the Trust's auditors) are unaware. They have taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Audit Commission are aware of that information.

3 Land values

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

4 Charging for information

The Trust has complied with Treasury's guidance on setting charges for information as specified within the Treasury guidance set out in appendix 6.3 of Managing Public Money.

5 Pension liabilities

Oxford University Hospitals NHS Trust staff are members of the National NHS Pension Scheme. Further details about the scheme are available in note 10.5 to the full accounts and in the remuneration report.

6 Contingent liabilities

The notes to the accounts (note 36) disclose that at the year end the Trust had contingent liabilities of £10,838,000.

7 Exit packages for staff leaving 2011/12

Redundancy costs have been paid in accordance with the provisions of the NHS Scheme and other departures are under a Mutually Agreed Resignation Scheme. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the table *(see Fig 8)*.

Fig 8

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
a	b	c	d
<£10,001	2	14	16
£10,001 - £25,000	0	31	31
£25,001 - £50,000	2	34	36
£50,001 - £100,000	1	17	18
£100,001 - £150,000	1	2	3
£150,001 - £200,000	0	1	1
>£200,000	0	0	0
Total number of exit packages by type (total cost)	6 (£295,000)	99 (£3,258,000)	105 (£3,553,000)

(Source note 10.4 Annual Accounts 2011/12)

Fig 6

	2011/12 Number	2011/12 Value £000
Total non-NHS trade invoices paid	117,965	272,347
Total non-NHS trade invoices within target	101,413	229,191
% non-NHS trade invoices paid within target	85.97%	84.15%

Fig 7

	2011/12 Number	2011/12 Value £000
Total NHS trade invoices paid	5,863	56,710
Total NHS trade invoices within target	4193	46,065
% NHS trade invoices paid within target	71.52%	81.23%

(Source note 11 to Annual Accounts 2011/12)

Remuneration report

The table below discloses the remuneration provided to Directors within the Oxford University Hospitals NHS Trust during 2011/12.

NOTES

1. Period of office of Nuffield Orthopaedic Centre NHS Trust senior managers 1 April 2011 to 31 October 2011
2. Resigned from Nuffield Orthopaedic Centre NHS Trust Board June 2011
3. Appointed to Nuffield Orthopaedic Centre NHS Trust Board July 2011
4. Appointed to Oxford University Hospitals NHS Trust 1 November 2011
5. Appointed to Oxford Radcliffe Hospitals NHS Trust June 2010
6. Appointed to Oxford Radcliffe Hospitals NHS Trust June 2010
7. Appointed to Oxford Radcliffe Hospitals NHS Trust September 2010. Other remuneration relates to clinical duties
8. Appointed to Oxford Radcliffe Hospitals NHS Trust May 2011
9. Appointed to Oxford Radcliffe Hospitals NHS Trust May 2011
10. Appointed to Nuffield Orthopaedic Centre NHS Trust Board March 2011

On 1 November 2011 the Nuffield Orthopaedic Centre NHS Trust merged with the Oxford Radcliffe Hospitals NHS Trust to form Oxford University Hospitals NHS Trust

Salary and pension entitlements of senior managers

a) Salaries and Allowances		2011/12				2010/11			
NAME AND TITLE		Salary (Bands of £5,000) £000	Other remuneration (Bands of £5,000) £000	Bonus payments (Bands of £5,000) £000	Benefits in kind Rounded to the nearest £00	Salary (Bands of £5,000) £000	Other remuneration (Bands of £5,000) £000	Bonus payments (Bands of £5,000) £000	Benefits in kind Rounded to the nearest £00
Dame Fiona Caldicott	Chair	20-25				20-25			
Mr Geoffrey Salt	Non-executive Director	5-10				5-10			
Mr Alisdair Cameron	Non-executive Director	5-10				5-10			
Professor Sir John Bell	Non-executive Director	5-10				5-10			
Mrs Anne Tutt	Non-executive Director	5-10				5-10			
Mr Peter Ward	Non-executive Director	5-10				5-10			
Mr Chris Goard[4]	Non-executive Director	0-5				0			
Sir Jonathan Michael	Chief Executive	215-220		30-35	250	210-215			250
Mr Mark Mansfield[5]	Director of Finance and Procurement	140-145		10-15		105-110			
Mrs Elaine Strachan-Hall	Chief Nurse	105-110		5-10		105-110		5-10	
Mr Andrew Stevens	Director of Planning and Information	110-115		5-10		105-110			
Mr Paul Brennan[6]	Director of Clinical Services	140-145		5-10	60	115-120			59
Ms Sue Donaldson	Director of Human Resources	100-105		5-10		100-105		0-5	
Professor Edward Baker[7]	Medical Director	160-165		55-60		95-100		30-35	
Mr Mark Trumper[8]	Director of Development and the Estate	115-120			55				
Ms Eileen Walsh[9]	Director of Assurance	105-110							
Nuffield Orthopaedic Centre									
Mr Chris Goard	Chair	10-15				10-15			
Professor Andrew Carr[2]	Non-executive Director	0-5				5-10			
Mr Michael Rogerson	Non-executive Director	0-5				5-10			
Mr Dale Haddon	Non-executive Director	0-5				5-10			
Dr Angela Coulter	Non-executive Director	0-5				5-10			
Professor Sue Dopson[3]	Non-executive Director	0-5							
Mrs Jan Fowler	Chief Executive	65-70		0-5		110-115			
Mr Kevin Davis[10]	Acting Director of Finance	45-50				0-5			
Mrs Sara Randall	Director of Operations and Performance	50-55				80-85			
Mrs Beverley Edgar	Director of Workforce and Organisational Development	45-50				75-80			
Dr Tony Berendt	Medical Director	40-45	25-30	20-25		75-80	40-45	35-40	

b) Pension benefits

Name and title		Real increase in pension at age 60 (Bands of £2,500) £000	Real increase in pension lump sum at age 60 (Bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2012 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2012 (Bands of £2,500) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to Stakeholder Pension To nearest £100
Mrs Elaine Strachan-Hall	Chief Nurse	0-2.5	0.2.5	40-45	125-130	744	641	83	0
Mr Andrew Stevens	Director of Planning and Information	0-2.5	5.0-7.5	40-45	130-135	810	681	108	0
Mr Mark Mansfield	Director of Finance and Procurement	-0-2.5	-2.5-0	45-50	140-145	835	728	84	0
Mr Paul Brennan	Director of Clinical Services	-5.0-2.5	-12.5-10	50-55	150-155	928	874	27	0
Professor Edward Baker	Medical Director	10-12.5	32.5-35	95-100	295-300	2,042	1,674	316	0
Ms Sue Donaldson	Director of Human Resources	0-2.5	2.5-5	10-15	30-35	172	132	36	0
Mr Mark Trumper	Director of Development and the Estate	2.5-5	0	35-40	0	341	221	104	0
Ms Eileen Walsh	Director of Assurance	0-2.5	2.5-5	25-30	75-80	403	317	71	0
Mrs Jan Fowler	Chief Executive	-2.5-0	40-45	45-50	140-145	856	767	38	0
Mr Kevin Davis	Acting Director of Finance	0-2.5	0-2.5	5-10	15-20	165	130	18	0
Mrs Sara Randall	Director of Operations and Performance	0-2.5	2.5-5	35-40	105-110	655	550	52	0
Mrs Beverley Edgar	Director of Workforce and Development	0-2.5	0-2.5	5-10	20-25	134	106	15	0
Dr Tony Berendt	Medical Director	7.5-10	27.5-30	70-75	215-220	1,412	979	235	0

NOTES

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.

Terms of office

The Executive Directors are employed within a standard employment contract which provides for a three month notice period. The exceptions to this are Chief Executive (six months) and Director of Planning and Information and Chief Nurse (six months). On termination of employment the director may be entitled to contractual severance terms and redundancy. Any payments above normal contractual levels would have to be approved by HM Treasury as an economic use of public funds before they were made.

Name and title		Date of appointment	End of term of office
Dame Fiona Caldicott	Chair	09/03/2009	08/03/2013
Mr Geoffrey Salt	Non-executive Director	01/05/2009	30/04/2013
Mr Alisdair Cameron	Non-executive Director	01/05/2009	30/04/2013
Professor Sir John Bell	Non-executive Director	01/11/2009	31/10/2013
Mrs Anne Tutt	Non-executive Director	01/12/2009	30/11/2013
Mr Peter Ward	Non-executive Director	01/12/2009	30/11/2013
Professor David Mant	Associate Non-executive Director	01/04/2010	31/03/2013
Mr Chris Goard	Non-executive Director	01/11/2012	31/03/2013

Reporting bodies are expected to disclose, in addition, the relationship between the remuneration of the highest-paid director in the organisation and the median average remuneration for the whole of the workforce. Organisations are also required to publish the year on year change in this ratio from the previous accounting period.

The remuneration of the highest paid director in the Oxford University Hospitals NHS Trust in the financial year 2011/12 was £275,000 - £280,000. This was nine times the median remuneration of the workforce, which was £30,471 (2010/11 median £30,234). It is difficult to make a year on year comparison in the ratio to 2010/11 because of the merger of the Oxford Radcliffe Hospitals NHS Trust and the Nuffield Orthopaedic Centre which changed the basis for the comparators.

No employees received remuneration in excess of the highest paid Director during 2011/12. Remuneration ranged from £13,903 - £277,500.

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The total full-time equivalent number of staff employed by the Oxford University Hospitals at 31 March 2012 is 8,772. This is below the position at 31 March 2011 when there was a combined total of 8,803 full-time equivalent staff employed by the former Oxford Radcliffe Hospitals NHS Trust and the Nuffield Orthopaedic Centre.

All employees, with the exception of medical staff, very senior managers and Executive Directors are subject to NHS 'Agenda for Change' Terms and Conditions of Service which include nationally agreed salary scales.

Similarly the pay and contractual arrangements of medical staff are determined by nationally agreed terms and conditions of service.

There are a small number of employees that are on very senior manager contracts. Their pay levels are determined by the Trust on the basis of the relative size and complexity of the role and take account, as far as possible, of benchmarking for comparable jobs across the NHS. The pay point for these individuals is fixed. Other terms and conditions of service are in line with Agenda for Change.

The remuneration arrangements of Executive Directors are determined by the Remuneration and Appointments Sub-committee of the Board, which comprises all of the Trust's Non-executive Directors. Remuneration packages are determined by the relative size and complexity of the role and take account, as far as possible, of benchmarking for comparable jobs across the NHS.

The remuneration arrangements for Executive Directors include an eligibility for unconsolidated annual bonus payment that is dependent on performance against targets determined by the Remuneration and Appointments Committee. The majority of Executive Directors were not eligible for a bonus payment in the financial year 2010/11, as they were not in post during 2009/10.

Independent Auditor's Report to the directors of Oxford University Hospitals NHS Trust

I have audited the financial statements of Oxford University Hospitals NHS Trust for the year ended 31 March 2012 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the table of pay multiples and related narrative notes.

This report is made solely to the Board of Directors of Oxford University Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error.

This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the financial position of Oxford University Hospitals NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I report to you if:

- in my opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- I refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because I have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- I issue a report in the public interest under section 8 of the Audit Commission Act 1998

I have nothing to report in these respects.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Respective responsibilities of the Trust and auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit

Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

- I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2011, as to whether the Trust has proper arrangements for:
- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2012.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2011, I am satisfied that, in all significant respects, Oxford University Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2012.

Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide assurance over the Trust's annual Quality Accounts. I am satisfied that this work does not have a material effect on the financial statements or on my value for money conclusion.

Maria Grindley
Officer of the Audit Commission
Audit Commission
Unit 5, ISIS Business Centre
Horspath Road
OXFORD OX4 2RD

7 June 2012

Explanation of financial terminology

The format of the accounts is specified by the Department of Health and reflects the adoption of the International Financial Reporting Standards (IFRS) by the NHS. A glossary of the terms used in the Annual Report is outlined below. This covers the terms used in the financial statements and in the Financial Review.

The four primary statements as specified by the NHS Trust Manual for accounts are:

Statement of Comprehensive Income
Statement of Financial Position (previously known as the Balance Sheet)
Statement of Changes in Taxpayers' Equity
Statement of Cash Flows.

The annual accounts also include:

a foreword
notes to the accounts
the directors Statement of Responsibilities
the Annual Governance Statement
the auditors report.

The full Annual Report for 2012 including:

The Primary Financial Statements and notes
The Annual Governance Statement
The Statement of the Accounting Officer's Responsibilities
The Audit Opinion and Report

is available from the 'Publications' page in the 'About us' section of the Trust's website (www.ouh.nhs.uk) or by contacting the Finance Department at the Oxford University Hospitals NHS Trust or the Media and Communications Unit on 01865 231471.

The Statement of Comprehensive Income records the Trust's income and expenditure for the year, together with any other recognised gains and losses in summary form. It includes cash-related items such as expenditure on staff and supplies as well as non-cash items such as a change in value of the Trust's assets. If income exceeds expenditure, the Trust has a surplus for the year and if expenditure exceeds income, there is a deficit.

Terms used within the Statement of Comprehensive Income

- **Revenue for patient care activities:** this includes all income from patient care, the largest element of which is from the Primary Care Trusts (PCTs). Other sources of income include private patient income and overseas patients.
- **Other operating revenue:** this includes non-patient related income including education, training and research funding.
- **Operating expenses:** this includes the costs of staff, supplies, premises and services received from other organisations.
- **Investment revenue:** this shows the interest received from bank accounts.
- **Other gains and losses:** This shows the gain or (loss) on the sale of an asset compared with the asset's value as recorded in the Statement of Financial Position.
- **Finance Costs:** this includes any bank interest payable and the interest on PFI obligations.
- **Public Dividend Capital Dividends payable:** this is the dividend payable to the Department of Health to reflect the public equity invested in the Trust.
- **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.
- **Impairments and reversals:** this shows reductions (or impairments) compared to asset values previously recorded in the Statement of Financial Position.
- **Gains on revaluation:** This shows increases compared to asset values previously recorded in the Statement of Financial Position.
- **Receipt of donated / government granted assets:** this is the value of assets donated during the year to the Trust or financed by non-Department of Health government grants.

The Statement of Financial Position which was formally known as the Balance Sheet provides a snapshot of the Trust's financial position at a specific date, which in this case is the end of the financial year. It lists assets (what the Trust owns or is owed), liabilities (what the Trust owes) and taxpayers' equity (the amount of public funds invested in the Trust). At any given time, the Trust's total assets less its total liabilities must equal the taxpayers' equity.

Terms used in the Statement of Financial Position

- **Non-current assets:** these are assets which the Trust expects to keep for more than one year.
- **Intangible assets:** these are assets such as computer software licences and patents which, although they have a continuing value to the Trust, do not have a physical existence.
- **Trade and other receivables:** these are amounts owed to the NHS Trust and are analysed between those due over 12 months (non- current) and those due within 12 months (current).
- **Current assets:** these are assets which the Trust expects to keep for less than one year.
- **Inventories:** these are stock such as theatre consumables.
- **Non-current assets held for sale:** these are long term assets (such as land) which the Trust expects to sell shortly.
- **Current liabilities:** reflect monies the Trust owes, including invoices it has not yet paid but which it expects to pay within a year.
- **Trade and other payables:** these are amounts which the NHS Trust owes and are analysed between those due to be paid within 12 months (current) and those due to be paid after more than 12 months (non-current)
- **Borrowings:** these are amounts which the NHS Trust owes and are analysed between those due to be paid within 12 months (current), and those due to be paid after more than 12 months (non-current); they include items such as bank overdrafts, loans and the loan element of PFI schemes.
- **Provisions:** these are liabilities where the amount and / or timing are uncertain. Whilst there has been no cash payment, the Trust anticipates making a payment at a future date and so its net assets are reduced accordingly.
- **Non-current liabilities:** reflect monies the Trust owes that it expects to settle after more than 12 months.
- **Public Dividend Capital:** the taxpayers' stake in the Trust, arising from the Government's original investment in the Trust when it was first created.
- **Retained earnings:** are the aggregate surplus or deficit the Trust has made in former years.
- **Revaluation reserve:** shows the increase in the value of the assets owned by the Trust.

The **Statement of Changes in Taxpayers' Equity** essentially shows the movement from the previous year on reserves and public dividend capital. It represents the taxpayers' investment in the Trust.

- Prior Period Adjustment: reflects adjustments made in an accounting period prior to that to which the statement refers.
- Impairments and reversals: reflects reductions in asset values compared to asset values previously recorded in the Statement of Financial Position.

The **Statement of Cash Flows** summarises the cash flows of the Trust during the year. It analyses the cash flows under the headings of operating, investing and financing cash flows.

Terms used in the Statement of Cash Flows

- **Depreciation and amortisation:** these are the non-cash items included within the operating surplus and they need to be removed to give the movement in cash during the year. As an example, depreciation is an accounting charge to reflect the use of capital assets and does not involve cash; hence it is added back to the operating surplus / deficit.
- **Impairments and reversals:** reflects reductions in asset values compared to asset values previously recorded in the Statement of Financial Position. These are the non-cash items included within the operating surplus and they need to be removed to give the movement in cash during the year.
- **Increase / (decrease) in provisions:** provisions are liabilities where the amount and / or timing are uncertain. Whilst there has been no cash payment, a change in the amount set aside for provisions impacts on the operating surplus and hence needs to be adjusted for to calculate the movement in cash during the year.
- **Net cash inflow from operating activities:** reflects the amount of cash received resulting from the Trust's normal operating activities.
- **Net cash inflow / (outflow) from investing activities:** reflects the amount of cash received / (paid) as a result of cash transactions that are not directly related to operating activities, for example purchasing new assets.
- **Capital element of finance leases and PFI:** where an asset is financed through PFI or a finance lease, a liability is shown on the Statement of Financial Position. This is the annual repayment of the capital part of that loan which is part of the unitary payment but not recorded as an expense in the Statement of Comprehensive Income.
- **Net cash inflow / (outflow) from financing:** reflects the amount of cash received / (paid) as a result of cash transactions that are related to the financing of the Trust. The Department of Health sets a limit on the amount of external finance a trust can obtain. This is known as the External Financing Limit (EFL.)

Annual governance statement 2011/12

1.0 Scope of responsibility

1.1. As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Oxford University Hospitals NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically, and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum, including recording the stewardship of the organisation to supplement the annual accounts.

2.0 The purpose of the system of internal control and governance framework of the organisation

2.1. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford University Hospitals NHS Trust; to evaluate the likelihood of those risks being realised, and the impact should they be realised; and to manage them efficiently, effectively and economically.

2.2. The system of internal control and governance framework described has been in place at the Oxford Radcliffe Hospitals NHS Trust and Nuffield Orthopaedic Centre prior to integration from April to November 2011, and subsequently at the Oxford University Hospitals NHS Trust from 1 November for the year ended 31 March 2012 and up to the date of approval of the Annual Report and Accounts.

2.3. Before integration each organisation had its own corresponding Board and sub-committee arrangements. Following due diligence, legacy documentation was prepared to ensure all committee functions of the Nuffield Orthopaedic Centre were incorporated into the structures in place from 1 November described below as part of the integration programme to harmonise management arrangements, including the management of risk.

2.4. The Board has overall responsibility for the activity, integrity and strategy of the Trust and is accountable, through its Chairman, to the Strategic Health Authority and the Secretary of State for Health. Its role is largely supervisory and strategic, and it has six key functions:

- to set strategic direction, define objectives and agree plans for the Trust
- to monitor performance and ensure corrective action
- to ensure financial stewardship
- to ensure high standards of corporate and clinical governance
- to appoint, appraise and remunerate executives
- to ensure dialogue with external bodies and the local community

2.5. The subcommittees of the Board and their functions are described below.

2.6. The Audit and Finance Committee exists to review the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the Board. The committee reviews the work and findings of external audit and provides a conduit through which its findings can be considered at Board. Each meeting operates in two distinct parts. Part A deals with assurance from internal and external audit activities and corporate governance. Part B deals with financial management, financial controls and performance, and policy. The committee maintains oversight of monitoring the Trust's Counter Fraud arrangements.

2.7. The Quality Committee is responsible for providing the Board with assurance on all aspects of the quality of clinical care; on governance systems, including the management of risk, for clinical, corporate, HR, Information Governance, research and development issues; and on standards of quality and safety. In particular, the Committee's work focuses on the framework of risk, control and related assurances that underpin the delivery of the Trust's objectives. The committee oversees monitoring of the Trust's ongoing compliance with CQC Essential Standards of Quality and Safety, and the management of risk through the NHS Litigation Authority's Risk Management Standards. It works closely with the Audit Committee through joint membership and management support.

2.8. The Remuneration and Appointments Committee is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for termination of contracts. The committee ensures that the right performance management arrangements are in place for Executive Directors and work with the Chief Executive to relate performance judgements to pay. In determining remuneration policy and packages, the committee has regard to the Trust's overarching reward and benefit strategy for all staff, the arrangements in the wider NHS and any extant guidance from the Treasury.

2.9. The Board in Committee was established as a development forum for Board members, forming part of the Board's education and development programme, and to update the Board on both internal and external developments. Following external review the committee was disestablished in March 2012 thus ensuring that the Trust's committees operate within best practice guidance.

2.10. The Board and subcommittee terms of reference, reviewed August 2011, stipulate that members must attend at least 50% of the meetings held in any 12 month period. Where attendance issues are identified, the Chairman and Chief Executive are informed and appropriate action taken. Committees are required to undertake an annual assessment of their effectiveness against their terms of reference and coverage of committee work. This will be carried out following year end to ensure the Trust has optimum governance structures to support its business.

2.11. Corporate governance within the Trust is monitored through the Audit Committee, supported by senior staff as part of the Trust's assurance arrangements. An assessment against the requirements of Monitor's Code of Corporate Governance and those set out in the Board Governance Assurance Framework has been undertaken to support Foundation Trust authorisation, and action plans put in place to address any identified deficiencies. These cover governance arrangements across our systems to monitor financial management and quality of services.

3.0 Capacity to handle risk

3.1. The Trust has in place a Risk Management Policy which clearly sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust. Operational responsibility for the implementation of risk management has been delegated to executive and other named directors. Risk management is a core component of the job descriptions of senior managers within the Trust.

3.2. A range of risk management training is provided to staff and there are policies in place which describe the roles and responsibilities in relation to the identification, management and control of risk. All relevant risk policies are available to staff via the Trust intranet.

3.3. The Trust learns from good practice through a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and application of evidence based practice.

4.0 Risk assessment

4.1. The process for the management of risk incorporates a combination of escalation and aggregation of risk at various levels throughout the organisation as set out in the Trust's Risk Management Strategy.

4.2. The Board Assurance Framework provides the mechanism for the Board to monitor risks, controls, and the outputs of its assurance processes. The Board Assurance Framework is monitored regularly by the Management Executive, Audit Committee and the Trust Board. The Board Assurance Framework is used to demonstrate assurance that controls are in place and effective as a strategic tool of the Board

4.3. The Trust's risk assessment process covers all of its business activities – clinical services, clinical support services and business support functions. Each Division and Directorate is responsible for maintaining its own detailed risk register in accordance with the procedures described in the Risk Management Strategy. These risk registers are reviewed regularly by directorate and divisional forums, and risks escalated for inclusion on the corporate risk register by the Trust Management Executive and by the Quality Committee.

4.4. The key risks identified through the process for the management of risk for 2011/12 are:

- Failure to meet national performance standards, specifically
  - breach of the performance threshold for delayed transfers of care
  - data quality issues affecting Trust reporting of referral to treat measures
  - attainment of the 90% target for risk assessment to prevent venous thromboembolism
- Inability to demonstrate sufficient standards of governance for Foundation Trust authorisation, with further assurance required in the following areas:
  - financial controls to meet agreed plans at corporate and Divisional level
  - Quality Governance Framework, through clear strategy with agreed plans, metrics and record of delivery
  - Clinical Outcomes, with continuing focus on SHMI and other identified outcome indicators
- Potential failure to agree contracts and forward plans with commissioners
- Achievement of carbon reduction plans to meet Climate Change Act obligations
- Lack of robustness in the access controls to and links between electronic systems for managing financial and patient information relating to private patient and overseas visitors.

4.5. During the year, an incident occurred relating to Information Governance which was rated in line with the Trust's Incident Reporting and Investigation Policy, and which in accordance with that assessment, is included in this statement. The incident related to the inadvertent disclosure of patient information. An incident investigation was carried out identifying remedial and preventative actions which have been completed. The incident was reported to the Information Commissioner's office which was satisfied that no further action was necessary.

4.6. In March 2012 the Trust was informed by a healthcare contractor that they had inadvertently collected patient information with items of product performance data that they routinely downloaded from equipment provided to the Trust. The Trust was one of a number of NHS organisations where this process had taken place and therefore the incident investigation and management was undertaken by the Department of Health. The joint view of the Department of Health and Information Commissioner is that the risk of harm to patients is negligible.

5.0 The risk and control framework

5.1. The Risk Management Policy and supporting toolkit for staff set out the key responsibilities for managing risk within the organisation, including ways in which the risk is identified, evaluated and controlled.

5.2. A risk management matrix is used to ensure a consistent approach is taken to assessing and responding to clinical and non-clinical risks and incidents. This determines the Trust's appetite for risk with clear processes for the management and monitoring of proactive risk assessments defined within the Risk Management Policy and supporting procedures. All serious incidents requiring investigation (SIRIs) and serious risks are reported to the Board of Directors via the established Governance Committee and reporting structures.

5.3. All new staff are given Information Governance training through corporate induction. They are informed of the law, NHS guidance and the Trust's policies with regards to the safe and appropriate processing of data.

5.4. In line with the requirements of the Information Governance Toolkit, there is a mandatory requirement for all existing staff to have annual Information Governance training. This is carried out via a series of modules on Connecting for Health's Information Governance Training Toolkit, and an online training package available through the Learning and Development Department. There is a range of policies, guidance, and best practice information on the Trust's intranet.

5.5. Ongoing monitoring of Information Governance and security is carried out by the Trust's Information Governance Committee.

5.6. All data security incidents are reported via the Trust's incident reporting system. Incidents are reviewed at the Information Governance Committee, chaired by the Caldicott Guardian. Where an ongoing information risk is identified it is recorded on the Trust's Risk Register.

5.7. Risk management is embedded in the organisation in a variety of ways. All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. The Trust receives assurance from the National Patient Safety Agency on how incident reporting rates compare with other similar organisations. The Trust is above the median rate of incident reporting and is assured that this risk management activity is embedded in the activity of the organisation. The Trust will seek to improve reporting rates as it develops its risk management and quality systems. Local management teams, via clinical governance groups, are responsible for developing and maintaining local risk registers and overseeing the management of adverse incidents. Management teams are responsible for the review of risk action plans and ensuring they are implemented through business planning and other established routes.

5.8. Further assurance on the effectiveness of risk management has been received with the achievement of compliance with the Risk Management Standards of the NHS Litigation Authority at level one for both acute and maternity services in September and November 2011 respectively. The Trust continues to work towards level two in both areas. The Trust aims to achieve level two against the standards at the start of the financial year 2013/14. Risk processes are monitored and reviewed by the Clinical Governance and Risk Management Committee, the Quality Committee and the Audit and Finance Committee.

5.9. The Trust's public involvement and consultation process ensures compliance with relevant legislation. All departments (both clinical and non-clinical) are responsible for planning and undertaking patient and public involvement initiatives. The process for engaging with our key stakeholders includes exploring risks that may have an impact on them and varies according to the nature of the development or change.

5.10. The views of patients have been sought in a variety of ways, including the patient survey, comment cards and through other patient involvement activities. As part of the business planning and investment process departments must demonstrate how stakeholders might be affected and the engagement plans they will follow to ensure patients and others are consulted and their views are considered before any investment is approved.

5.11. The Audit Committee provides the Board of Directors with an independent and objective review of financial and corporate governance, and internal financial control within the Trust. The sub-committee has received reports from external and internal audit including reports relating to the Trust's counter fraud arrangements.

5.12. The Trust has a Local Counter Fraud Officer and regularly reviews its counter fraud arrangements through a risk based approach relating to the prevention, detection and investigation of fraud.

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

5.14. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are met with updated objectives forming part of the Trust's Equality Delivery Scheme for 2012/16.

5.15. Control measures are in place to ensure patients, the public and staff with physical and sensory impairments are able to access buildings on both sites. All new estates schemes, including refurbishments or ad hoc improvements, are assessed to ensure they meet the Disability and Equality Act 2010. Issues identified through patient feedback, complaints or PALS contacts are used to inform priorities for estates improvements.

5.16. The Trust has reviewed and continues to monitor the systems in place to care for people with learning disabilities. A business case is in development to fulfil the full range of needs of people with learning disabilities, and the capacity and capability of the services that the Trust provides to support the additional and often complex needs of people with learning disabilities.

5.17. 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 projections, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5.18. The Trust is registered with the Care Quality Commission (CQC) to deliver services across all of its registered locations. The CQC visited the John Radcliffe Hospital in May 2011 as part of the national Dignity and Nutrition Inspection programme. This focused on Outcomes 1 and 5 of the CQC's Essential Standards of Quality and Safety. An action plan was put in place to meet the improvements identified in the CQC inspection. Compliance actions were put in place in relation to Outcome 5 and the follow up visit at the end of November 2011 resulted in compliance with this and all other outcomes.

5.19. The CQC followed up its compliance review visits in July 2011 (the John Radcliffe, the Horton General and the Churchill hospitals) and provided reports later in the year indicating compliance across all standards although with suggestions for improvements. Ongoing monitoring of compliance is reported through the Trust Management Executive and Quality Committee to the Board.

6.0 Review of economy, efficiency and effectiveness of the use of resources

6.1. As part of their annual audit, our external auditors are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They do this by examining documentary evidence and through discussions with senior managers. The audit working papers in relation to this work are made available to the Trust and presented to the Audit and Finance Committee.

6.2. The key processes to ensure that resources are used economically, efficiently and effectively across clinical services include Divisional performance reviews, and regular monitoring of clinical performance indicators on quality and safety.

6.3. The emphasis of internal audit work is on risk management, governance and internal control processes. Individual assignments have also raised issues relating to economy, efficiency and effectiveness. Where scope for improvement, in terms of value for money, was identified during an internal audit review, appropriate recommendations were made and action plans were agreed with management for implementation.

6.4. The Board Assurance Framework sets out the principal risks to delivery of key priorities and overarching strategic priorities (corporate objectives). The Executive Director with delegated responsibility for managing and monitoring each risk is clearly identified. The Board Assurance Framework identifies the assurances available to the Board of Directors in relation to the achievement of the Trust's key objectives. The principal risks to the delivery of these objectives are mapped to key controls. The Board Assurance Framework supports the process for monitoring ongoing compliance with the requirements for registration with the Care Quality Commission with mapping of the regulations to strategic priorities. The Board of Directors plays a role in procurement as part of compliance with the Trust's policies and procedures to ensure that resources are used efficiently and effectively.

7.0 Annual Quality Account

7.1. The Directors are required under the Health Act 2009 and the National Health Service (Quality Account) Regulations 2010 to prepare Quality Account for each financial year. Guidance has been issued to Trusts on the form and content of annual Quality Account which incorporate the above legal requirements and required external assurance arrangements.

7.2. The Chief Nurse was the nominated Trust Executive for the Quality Account until February, supported by the Quality Account Steering Group, with input from the Patient Experience and Clinical Governance teams. Following changes to executive responsibilities, the Medical Director now leads on the Quality Account.

7.3. To inform our priorities for the coming year, the Trust held a public engagement event to gain views on which elements of quality should be included in the Quality Account for the year.

7.4. In terms of monitoring, key elements of the Commissioning for Quality and Innovation payment framework programme and Quality Account are reported to the Board of Directors and directorate management teams. Updates are provided to the Board via the quality reports, produced jointly by the Chief Nurse and Medical Director. External assurance of aspects of our Quality Account is provided by the Trust's external auditors.

8.0 Review of effectiveness of risk management and internal control

8.1. As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the Executive and Divisional Directors within the Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account accompanying this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter, the Head of Internal Audit Opinion, and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Finance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

8.2. The Board of Directors and its committees have met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls. The Board reviews monthly performance reports showing the key relevant national priority and regulatory indicators, including Commissioning for Quality and Innovation targets with additional reports devoted to safety, clinical effectiveness and patient experience. A monthly qualitative summary is supplemented by more detailed exception reports on any areas of adverse performance.

8.3. The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection. The Board's dashboard is backed up by a cascade of more granular reports reviewed by Board sub-committees, directorates and individual services, with analysis at individual practitioner level.

8.4. The internal audit plan includes a programme of reviews of key indicators and responds to the identification of any risks associated with information assurance. There is clear evidence of action taken to resolve audit concerns with re-audits taken to assess performance improvement. The Trust has implemented revised processes in year to ensure improved achievement of actions in a timely manner. An assessment of the controls applicable to the key indicators is included as part of the monthly dashboard.

8.5. Wherever possible, electronic systems are used to capture data, allowing reports to be generated with minimal effort. This allows information to be traced to source and the information owners are held accountable for the validity of their information.

8.6. The Trust's Executive Directors and senior managers have provided the Board of Directors with reports on risk management, performance management and clinical governance through the Quality Committee and Audit and Finance Committee.

8.7. Internal audit has reviewed and reported upon control, governance and risk management processes, based on an audit plan approved by the Audit and Finance Committee of the Board. The work included identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Audit Standards. Where scope for improvement was found, recommendations were made and appropriate action plans agreed with management.

8.8. The Board Assurance Framework has been updated throughout the year to reflect the risks associated with failing to achieve the Trust's strategic objectives. Throughout the year the Trust has monitored its ongoing compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 against the 16 CQC Essential Standards of Quality and Safety. Where there are gaps in compliance, a detailed action plan is submitted setting out what needs to be undertaken in order to be compliant, and timescales for completion. The Trust's position against the 16 essential standards of quality and safety is monitored by the Trust Management Executive and the Quality Committee.

8.9. In 2011/12 the Trust has achieved compliance at level 1 of the NHS Litigation Authority's Risk Management Standards for both Maternity Services and Acute Services. This has provided an additional source of assurance on the effectiveness of the Trust's risk management systems.

8.10. The work programme to support Foundation Trust authorisation continues, addressing potential weaknesses in risk, quality and assurance, identified through internal and external review.

9.0 Significant issues

9.1. As identified through the Trust's risk management processes, the significant issues to report and corresponding remedial actions taken to address key risk issues are outlined below.

9.2. The Trust continues to work with colleagues across the local health and social care network to reduce the number of delayed transfers of care and improve performance against the thresholds.

9.3. Work is underway with the Trust supplier to address data quality issues affecting Trust reporting of referral to treat measures from the Electronic Patient Record.

9.4. The clinical governance team is working closely with divisional management teams to further develop the supporting systems and processes for carrying out risk assessment on admission for venous thromboembolism.

9.5. A comprehensive programme to improve the Trust's governance arrangements is in place to revise key supporting strategies to core business. These will form an important part of developing risk, quality and assurance in the Trust, as a means to support continuous quality improvement and the delivery of safe and high quality care.

9.6. Members of the Trust Management Executive continue to work with commissioners across the health economy to ensure the agreement of contracts and forward plans for the coming year, ensuring these are clinically and financially viable.

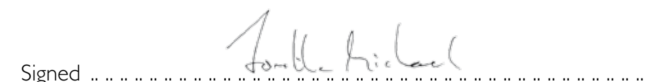
9.7. A significant review of sustainability has concluded and programmes developed for the coming financial year to reduce our carbon footprint. These will be taken to the Board for approval and to ensure Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projections, in order that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

9.8. Work has been undertaken to revise the processes for managing financial and patient information relating to private patient and overseas visitors, including improved security measures to control permission to access the electronic systems.

10.0 Conclusion

10.1. With the exception of the internal control issues that I have outlined in this statement, my review confirms that the 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: 7 June 2012

Glossary of NHS terms and abbreviations

Acute services
Medical and surgical interventions provided in hospitals.

Acute trust
A legal entity / organisation formed to provide health services in a secondary care setting, usually a hospital.

Annual Governance Statement
This has replaced the Statement of Internal Control (SIC) and is the mechanism by which the NHS trust accountable officers (in our case the Chief Executive) provide assurance about the stewardship of their organisations to the NHS Chief Executive, in his capacity as Accounting Officer for the NHS in the Department of Health.

The Governance Statement records the stewardship of the organisation to supplement the accounts. It will give a sense of how successfully it has coped with the challenges it faces and of how vulnerable the organisation's performance is or might be. This statement will draw together position statements and evidence on governance, risk management and control, to provide a more coherent and consistent reporting mechanism.

Assurance Framework
The Assurance Framework provides organisations with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the Annual Governance Statement.

Audit Commission
An independent public body responsible for ensuring that public money is spent economically, efficiently and effectively in the areas of local government, housing, health, criminal justice and fire and rescue services. They appoint the External Auditors.

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

Break-even (duty)
A financial target. In its simplest form it requires the Trust to match income and expenditure.

Capital
Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the NHS, expenditure on an item is classified as capital if its costs exceed £5000 and its useful life expectancy is greater than one year.

Capital Absorption Rate
The Capital Absorption Rate is determined by dividing the PDC dividend (from the Statement of Comprehensive Income) by the average net relevant assets (owned assets of the Trust at the beginning and end of the year less current liabilities and cash). The trust achieves the target if it achieves a rate of return of 3.5%.

Capital Resource Limit (CRL)
NHS Trusts are given a Capital Resource Limit (CRL) each year. They must not make capital expenditure in excess of this limit.

Care Quality Commission (CQC)
The Care Quality Commission was set up in April 2009 and it replaced the Healthcare Commission. It is an independent regulator to help improve the quality of healthcare. It does this by providing an independent assessment of the standards of services, whether provided by the NHS, the private sector or voluntary organisations.

Clostridium difficile *(C.difficile)*
Clostridium difficile is a bacterium that can cause an infection of the gut and is the major infectious cause of diarrhoea that is acquired in hospitals in the UK.

Community Health Oxfordshire (CHO)
Formally the provider arm of NHS Oxfordshire but now transferred to become part of Oxford Health NHS Foundation Trust.

Creating a Healthy Oxfordshire (CAHO)
This is an initiative involving all parties within the Oxfordshire Health Economy designed to improve quality and efficiency of health services in Oxfordshire in the context of the current economic climate and the challenges it faces in the next few years.

Current assets
Debtors, stocks, cash or similar whose value is, or can be converted into, cash within the next 12 months.

Depreciation
The measure of the wearing out, consumption or other loss of value of a fixed asset whether arising from use, passage of time or obsolescence through technology, and market changes. The process of charging the cost of an asset over its useful life as opposed to recording its cost as a single entry in the income and expenditure records.

Elective inpatient activity
Elective activity is where the decision to admit to hospital could be separated in time from the actual admission, i.e. planned. This covers waiting list, booked and planned admissions.

Electronic Patient Record (EPR)
A new system of recording patient notes on computer rather than paper.

Emergency inpatient activity
Emergency activity is where admission is unpredictable and at short notice because of clinical need.

External Financing Limit (EFL)
NHS trusts are subject to public expenditure controls on their use of cash. The control is an external financing limit (EFL) issued to each NHS trust by the Department of Health. The EFL represents the difference between the cash resources a trust can generate internally (principally retained surpluses and depreciation) and its approved capital spending. If its internal resources are insufficient to meet approved capital spend then it is able to borrow the difference.

Fixed assets
Land, buildings, equipment and other long term assets that are expected to have a life of more than one year.

Foundation Trust (FT)
NHS Foundation Trusts have been created to devolve decision-making from central Government control to local organisations and communities so they are more responsive to the needs and wishes of their local people. Foundation Trusts have a membership drawn from the community which they serve and an elected Governors' Council. They also enjoy some financial freedoms not available to NHS trusts.

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.

Health Innovation and Education Cluster
A local partnership hosted by Oxford Health NHS Foundation Trust.

Health Overview and Scrutiny Committee (HOSC)
An Oxfordshire County Council committee: the NHS is obliged to consult HOSC on any substantial changes it wants to make to local health services.

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

International Financial Reporting Interpretations Committee (IFRIC) 12
The International Financial Reporting Interpretations Committee issued an interpretation – IFRIC 12 – on Service Concession Arrangements. These are arrangements whereby a government (or the NHS) grants a contract for the supply of public services to private operators. Hence for the Trust, the PFI is an example of a scheme that is subject to IFRIC 12.

International Financial Reporting Standards (IFRS)
The International Financial Reporting Standards provide a framework of accounting policies which the NHS has adopted since April 2009 and which replace the UK Generally Accepted Accounting Practice (UK GAAP) which was the basis of accounting in the UK before international standards were adopted.

Investors in People
The Investors in People Standard provides a framework that helps organisations to improve performance and realise objectives through the effective management and development of their people.

Local Involvement Networks (LINks)
Oxfordshire LINk is made up of individuals and community groups who care about our health and social care services and work together to improve them.

Market Forces Factor
An index used in resource allocation to adjust for unavoidable variation in input costs. It consists of components to take account of staff costs, regional weighting, land, buildings and equipment.

Methicillin resistant staphylococcus aureus (MRSA)
This is a strain of a common bacterium, which is resistant to an antibiotic called methicillin.

Monitor
Monitor authorises and regulates NHS Foundation Trusts, making sure they are well managed and financially strong so that they can deliver excellent healthcare for patients. It was established in 2004.

National Institute for Health and Clinical Excellence (NICE)
A body which evaluates drugs and treatments. NICE's role was set out in the 2004 White Paper 'Choosing health: making healthier choices easier'. In it the Government set out key principles for helping people make healthier and more informed choices about their health. The Government wants NICE to bring together knowledge and guidance on ways of promoting good health and treating ill health.

National Institute for Health Research (NIHR)
NIHR provides the framework through which the research staff and research infrastructure of the NHS in England is positioned, maintained and managed as a national research facility.

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

NHS trusts
NHS Trusts are hospitals, community health services, mental health services and ambulance services which are managed by their own boards of directors. NHS trusts are part of the NHS and provide services based on the requirements of patients as commissioned by PCTs.

Non-executive Directors
Non-executive directors, including the Chairman, are Trust Board members but they are not full time NHS employees. They are people from other backgrounds who have shown a keen interest in helping to improve the health of local people. They have a majority on the Board and their role is to bring a range of varied perspectives and experiences to strategy development and decision-making, ensure effective management arrangements and an effective management team is in place and hold the Executive Directors to account for organisational performance.

Outpatient attendance
An outpatient attendance is when a patient visits a consultant or other medical outpatient clinic. The attendance can be a 'first' or 'follow up'.

Oxford Biomedical Research Centre (OxBRC)
A partnership between the University of Oxford and the Oxford University Hospitals funded by the National Institute for Health Research.

Patient Advice and Liaison Service (PALS)
A service providing support to patients, carers and relatives.

Private Finance Initiative (PFI)
The Private Finance Initiative (PFI) provides a way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases, manage new projects

Primary care
Family health services provided by family doctors, dentists, pharmacists, optometrists and ophthalmic medical practitioners

Primary Care Trust (PCT)
The two main functions of a Primary Care Trust are:

- engaging with its local population to improve health and well-being;
- commissioning a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources, across all service sectors; and

Primary Care Trusts commission a range of services from Oxford University Hospitals NHS Trust, which provides the majority of our income.

Prudential Borrowing Code (PBC)
This is the code provided by Monitor to determine the limit on the total amount of borrowing of an NHSFT and the same principles are applied by the Department of Health to NHS trusts.

Prudential Borrowing Limit (PBL)
This is the maximum cumulative borrowing a trust may have outstanding at any time and is set based on prudential borrowing code.

Risk Register
A register of all the risks identified by the organisation, each of which is assessed to determine the likelihood of the risk occurring and the impact on the organization if it does occur.

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

Service Level Agreement
A Service Level Agreement (SLA) is the main mechanism for service provision between NHS trusts and Primary Care Trusts for NHS services. An SLA is an agreement that sets out formally the relationship between service providers and customers for the supply of a service by one to another.

Strategic Health Authority (SHA)
The Strategic Health Authority is accountable to the Secretary of State for Health via the Chief Executive of the NHS and has a role to performance manage PCT's and local health systems, work to improve public health and reduce inequalities and ensure robust and integrated emergency planning.

Useful websites

For further information on all our services please visit www.ouh.nhs.uk or follow developments at Oxford University Hospitals Trust on Twitter: http://twitter.com/OUHospitals

Other useful websites

Organisation	Website
AirMed (air ambulances)	www.airmed.co.uk
Audit Commission	www.audit-commission.gov.uk
Care Quality Commission	www.cqc.org.uk
Cherwell District Council	www.cherwell.gov.uk
Department of Health	www.dh.gov.uk
Foundation Trust Network	www.foundationtrustnetwork.org
General Medical Council (GMC)	www.gmc-uk.org
Medical Sciences at Oxford University	www.medsci.ox.ac.uk
Monitor	www.monitor-nhsft.gov.uk
National Institute for Health and Clinical Excellence (NICE)	www.nice.org.uk
National Patient Safety Agency (NPSA)	www.npsa.nhs.uk
NHS Choices	www.nhs.uk
NHS Confederation	www.nhsconfed.org
NHS Connecting for Health	www.connectingforhealth.nhs.uk
NHS Direct	www.nhsdirect.nhs.uk
NHS Health at Work – occupational health provider	www.nhshealthatwork.co.uk
NHS Institute for Innovation and Improvement	www.institute.nhs.uk
NHS Oxfordshire	www.oxfordshirepct.nhs.uk
NHS Protect – Counter Fraud and Security Services	www.nhsba.nhs.uk/Protect
NHS South of England	www.southofengland.nhs.uk
Oxford Biomedical Research Centre	www.oxfordbrc.org
Oxford Brookes Faculty of Health and Life Sciences	www.hls.brookes.ac.uk
Oxford Brookes University	www.brookes.ac.uk
Oxford City Council	www.oxford.gov.uk
Oxford Health NHS Foundation Trust	www.oxfordhealth.nhs.uk
Oxfordshire County Council	www.oxfordshire.gov.uk
Oxfordshire Learning Disability NHS Trust	www.ridgeway.nhs.uk
Oxfordshire Link	www.oxfordshirelink.org.uk
Patients Association	www.patients-association.com
Patient Safety Federation	www.patientsafetyfederation.nhs.uk
Royal College of Midwives	www.rcm.org.uk
Royal College of Nurses	www.rcn.org.uk
Royal College of Pathologists	www.rcpath.org
Royal College of Paediatricians and Child Health	www.rcpch.ac.uk
Royal College of Physicians	www.rcplondon.ac.uk
Royal College of Surgeons	www.rcseng.ac.uk
South Oxfordshire District Council	www.southoxon.gov.uk
University of Oxford	www.ox.ac.uk
Vale of White Horse District Council	www.whitehorsedc.gov.uk
West Oxfordshire District Council	www.westoxon.gov.uk

If you need an interpreter or need a document in another language, large print. Braille or audio version, please call 01865 221473 or email PALSJR@ouh.nhs.uk

Albanian
Nëse keni nevojë për një përkthyes ose doni një dokument në një gjuhë tjetër, me shkronja të mëdha, Braille (alphabet për të verbërit) ose kasetë me zë, j'u lutemi telefononi në 01865 221473 ose e-mail PALSJR@ouh.nhs.uk.

Arabic
إذا كنت بحاجة إلى مترجم فوري أو إلى ترجمة إحدى مستنداتك إلى لغة أخرى، أو بالحروف الطباعية الكبيرة أو بطريقة برايل للمكفوفين أو بالصوت، يرجى الاتصال بالرقم 01865 221473 أو بالبريد إلكتروني على العنوان: PALSJR@ouh.nhs.uk.

Bengali
আপনার যদি কোন ইন্টারপ্রিটারের প্রয়োজন হয় অথবা অন্য কোন ভাষায়, বড় অক্ষরে, ব্রেইলে অথবা অডিও আকারে কোন ডকুমেন্টের প্রয়োজন হয়, তাহলে অনুগ্রহ করে 01865 221473 নম্বরে ফোন করুন অথবা এই PALSJR@ouh.nhs.uk ইমেইলে যোগাযোগ করুন।

Mandarin
如果您需要安排口译，或需要某文件翻译成另一种语言，或以大字体、盲文或音频格式提供，请致电：01865 221473，或发送电子邮件至：PALSJR@ouh.nhs.uk。

Pashtu
که ته یوه ترجمان ته اړتیا لرې یا په یوه بله ژبه، په غټوحرفونو، بریل (د ړندو لیک) یا سمعي بڼه یو سند غواړې هیله ده چې ۰۱۸۶۵۲۲۱۴۷۳ ته زنګ ووهي یا PALSJR@ouh.nhs.uk ته ایمیل ولیږی.

Polish
Jeśli potrzebne byłoby Państwu tłumaczenie ustne lub chcieliby Państwo otrzymać dokument w innym języku, w formacie dużym drukiem, w alfabecie Braille'a lub w postaci nagrania dźwiękowego prosimy zadzwonić pod numer telefonu 01865 221473 lub napisać na adres e-mail: PALSJR@ouh.nhs.uk.

Portuguese
Se precisar de um intérprete ou de um documento noutra língua, num formato ampliado, em Braille ou em áudio, deverá ligar para o 01865 221473 ou enviar um e-mail para PALSJR@ouh.nhs.uk.

Kurdish Sorani
ئەگەر پێویستت بە وەرگێری زارەکی هەیە یاخود بەڵگەنامەکانت بە زمانێکی تر یان بە پیتی چاپی گەورە یان دێری برەیل (بۆ نابینایان) یان لەسەر شریتی دەنگ دەوێت، تکایە پەیوەندی بکە بە ژمارەی 01865 221473 یا خود ئیمێل بنێرە بۆ PALSJR@ouh.nhs.uk.

Urdu
اگرآپ کوترجمان (انٹرپریٹر) چاہئے یا کوئی دستاویز کسی دیگرزبان، بڑے حروف کی چھپائی، بریل یا آڈیو پرر درکار ہوتو برائے مہربانی نمبر 01865 221473 پر کال کریں یا ای میل بھیجیں: PALSJR@ouh.nhs.uk

---

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 printed versions are available on request.

We aim to ensure that the Annual 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@ouh.nhs.uk

Write to us:
Media and Communications Unit, Level 3, John Radcliffe Hospital, Headley Way, Headington, Oxford OX3 9DU

See our website:
www.ouh.nhs.uk

John Radcliffe Hospital

Nuffield Orthopaedic Centre

Churchill Hospital

Horton General Hospital

*Four hospitals, **one Trust**, one vision*