



Annual Report *2010/11*



Welcome to the Annual Report 2010/11 of the Oxford Radcliffe Hospitals NHS Trust. This report describes how the Trust has performed over the last year and how we account for the public money spent by the Trust over this period.

Introduction

It has been a busy 12 months at the Oxford Radcliffe Hospitals NHS Trust, with many positive developments, as well as some setbacks and difficult issues that are still to be resolved.

In the last year we have reorganised the way in which the Trust is structured, to put clinicians at the heart of our decision making process. Specialties are now grouped in Divisions that take into account clinical alignment of services, integration of clinical, research and academic work, and geographic factors. The new clinical management structure within these Divisions is aimed at creating a single point of leadership and accountability, with increased clinical input into operational delivery.

This past year has seen some important developments in services at Oxford Radcliffe Hospitals (ORH). The Brodey Centre for the treatment of patients with cancer at the Horton General Hospital has been extended thanks to the amazing generosity of hundreds of people who fundraised over £0.5 million to make it happen. The expanded space in the new centre allows for more privacy for patients and relatives. The waiting area is bigger and the new treatment area is much improved.

A review by the Care Quality Commission of local stroke services in January 2011 found them to be amongst the best in the country. The report praised the service for working well to rehabilitate patients following stroke, and working well in partnership with Community Health Oxfordshire to support people on their return home.

This year saw the opening of a new Cancer Research Centre on the Churchill site, bringing together world class laboratory research with medical expertise to provide the best possible results for cancer patients nationwide.



Dame Fiona Caldicott
Chairman



Sir Jonathan Michael
Chief Executive

The Oxford Cancer Research Centre is a partnership between the Trust, the University of Oxford and Cancer Research UK.

This past year has also seen the start of a process that the Trust hopes to complete within the year, of integrating the Nuffield Orthopaedic Centre with our Trust. The main purpose of the merger is to deliver better patient care. By joining forces, the NOC and ORH will be more able to improve care pathways and ensure patients receive access to the best treatments available. Both Trusts already have strong research partnerships, and integration will strengthen the links between academic research, teaching and training, and clinical delivery.

A major challenge for the Trust over the last year was the savings target set for 2010/11 of £47 million, which the Trust achieved with a surplus of £1.289 million at the end of the financial year. This is no small achievement, and in this new financial year the Trust again faces a challenging figure – £52 million – that it must save by next April. The Trust will be faced with this magnitude of savings for the immediate years ahead. Some of the reasons behind these savings are very familiar from previous years: the annual national efficiency target that applies to all trusts in the form of the reduction in the amount they are paid for each procedure; the need to clear all historic debts; and the impact of reduced activity being purchased from the Trust by commissioners. Others, such as the reduced price for some education and training, have a greater impact in this particular year.

The Trust has worked hard during the year to strengthen the quality of care provided and the governance arrangements that support the Board in fulfilling its responsibilities to patients.

The NHS is the focus of much political debate. Whilst it is important for the Trust to listen and participate in this national debate about the future shape of the NHS, it is also important that there is a continued focus on delivering the best possible care to each patient with the resources at the Trust's disposal. Some of these resources are physical and financial, but some are also personal. The Trust's aim is to treat each patient – and treat each other – in the way we would like to be treated. Then we will find the best route through the difficulties ahead to the achievements we seek.



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About the Oxford Radcliffe Hospitals

At the Trust in 2010/11 there were:

- 642,487 outpatient appointments
- 121,626 attendances at the emergency departments
- 21,263 admissions for treatment as inpatients
- 83,195 admissions for emergency assessment or treatment
- 68,197 admissions for treatment as day cases (*116,782 if renal dialysis is included*)
- 9,219 babies delivered

The Oxford Radcliffe Hospitals NHS Trust (ORH) is one of the largest acute teaching trusts in the UK, with a national and international reputation for the excellence of its services and its role in teaching and research. The Trust consists of three hospitals: the John Radcliffe and Churchill Hospitals in Oxford, and the Horton General Hospital in Banbury. The Trust employed 10,268 people (equivalent to 8,001 full-time posts) at the end of the financial year and had a turnover of £663 million. The ORH provides general hospital services for people in Oxfordshire and neighbouring counties, and specialist services on a regional and national basis.

The ORH works in close partnership with the University of Oxford's Medical Sciences Division and Oxford Brookes University's School of Health and Social Care, and is a renowned teaching and education base for doctors, nurses and other healthcare professionals. The Oxford Biomedical Research Centre (OxBRC) is now in its fifth successful year of bringing together the research expertise of the Trust and the University of Oxford.

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

Our hospitals

The John Radcliffe Hospital

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

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

The Churchill Hospital

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

The hospital, and the adjacent Old Road campus, is a major centre for healthcare research, and hosts the departments of the University of Oxford's Medical Sciences Division and other major research centres such as the newly opened Oxford Cancer Research Centre, a partnership between Cancer Research UK, Oxford Radcliffe Hospitals and the University of Oxford.

The Horton General Hospital

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

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

Clinical services

Organisational structure

The ORH has changed the way we manage our services this year so that clinicians have a bigger say – and a greater responsibility for the way they are run.

The new structure means we have moved from three divisions to six, which bring together specialties in a way that best reflects the way they work together, their geographical location and how they integrate with the clinical research carried out in our hospitals with the universities.

Each Division is headed by a Divisional Director, a practising clinician who is supported by a Divisional Nurse and General Manager. The Divisions are responsible for the day-to-day management and delivery of services within their areas in line with Trust strategies, policies and procedures.

The Divisions include two or more Directorates, each of which contain clinical service units covering specific areas of services. Directorates are led by Clinical Directors and supported by Operational Service Managers, Matrons and other relevant experts. The Directorates include those with services on one or more sites, such as surgery and women's services, and those which are based on a single site, such as cardiac services and neurosciences.

An *Organisational Structure* chart is included as Appendix I of this report.

Division of Neurosciences, Trauma and Specialist Surgery

- Neurosciences: neurology; neurosurgery; neuropathology, neurophysiology and neuropsychology; neuro intensive care
- Specialist surgery: ENT; plastic surgery and craniofacial; ophthalmology; oral and maxillofacial surgery; trauma

Division of Cardiac, Thoracic and Vascular

- Cardiac medicine: cardiology and coronary care unit; technical cardiology; private patients
- Cardiac, vascular and thoracic surgery: adult cardiac surgery; cardiac critical care; vascular surgery; thoracic surgery

Division of Children's and Women's

- Paediatric medicine, surgery and neonatology: paediatric medicine and specialist medicine; neonatology; community paediatrics; paediatric surgery and specialist surgery (cardiac and neuro); paediatric intensive and high dependency care
- Women's: obstetrics and midwifery; gynaecology

Division of Emergency Medicine, Therapies and Ambulatory

- Emergency general medicine and therapies: emergency medicine; acute general medicine and Horton medicine; geratology and stroke medicine; therapies
- Specialist and ambulatory medicine: diabetes, endocrine and metabolism; dermatology; clinical immunology; clinical genetics; chest medicine; infectious diseases and genitourinary medicine

Division of Surgery and Oncology

- Surgery: upper and lower gastrointestinal surgery; acute surgery; gastroenterology; breast and endocrine surgery; gynae-oncology
- Oncology: clinical oncology; medical oncology; clinical haematology, haemophilia and thrombosis; medical physics and clinical engineering; palliative medicine
- Renal, transplant and urology: transplant and renal; urology

Division of Critical Care, Theatres, Diagnostics and Pharmacy

- Anaesthetics, critical care and theatres: anaesthetics; adult critical care; pre-operative assessment; resuscitation; pain service; theatres and day case unit
- Pathology and laboratories
- Radiology and imaging
- Pharmacy

The clinical Divisions services are supported by a group of operational and service improvement functions within the remit of the Director of Clinical Services including:

- general outpatients
- clinic preparation
- outpatients reception Horton
- service improvement
- patient access
- elective access
- switchboard and call centre
- central admissions
- transfer lounge
- Choose and Book
- clinic maintenance and letter production.

A Corporate Division covers the following services:

- Chief Executive's Office
- Finance and Procurement
- Planning and Information
- Human resources
- Medical Directorate
- Nursing and Midwifery
- Estates and Facilities

For more information on the Trust and its services visit:
www.oxfordradcliffe.nhs.uk

Improving our environment

Energy saving

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

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

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

Hospital environment

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

The inspections involve assessments of hospital cleanliness, food and food service, infection control, privacy and dignity and environmental standards, along with other related matters. The assessments are undertaken by a team made up of panel members from the Oxford Radcliffe Hospitals Patient and Public Panel and accompanied by members of the estates and facilities, nursing and infection control teams.

There are five possible scores, ranging from excellent to unacceptable. In 2010/11, The Churchill Hospital achieved a 'good' score for food and privacy and dignity and an 'acceptable' score for environment. The John Radcliffe Hospital also achieved 'good' for food and privacy and dignity and a score of 'acceptable' for environment. The Horton General Hospital achieved 'good' in food and 'acceptable' scores in privacy and dignity and environment.

Research

The **NIHR (National Institute for Health Research) Biomedical Research Centre, Oxford** (BRC) is a partnership between the research expertise of the University of Oxford and the Oxford Radcliffe Hospitals NHS Trust. The impact of its programme of translational research, funded by the NIHR, has had a positive effect on its partnership with the University of Oxford, industry, medical charities and other organisations. The BRC has submitted a proposal for continued recognition as a comprehensive BRC with renewed funding for the period 2012-17.

Just prior to the publication of this report, it was announced that this bid was successful and attracted a 50% increase in funding for the five year period.

Under the guidance of its Director Professor Keith Channon, Professor of Cardiovascular Medicine and Honorary Consultant Cardiologist, the BRC has had another very productive year with several research highlights, culminating with the successful bid for renewal.

Research highlights

The Oxford Acute Vascular Imaging Centre (AVIC), recently completed, will enable the BRC Heart, Stroke and Imaging Themes to progress unique clinical research in patients presenting as an emergency with acute coronary and acute cerebro-vascular syndromes. By combining interventional angiography with state-of-the-art magnetic resonance imaging, new insights will be gained in to how 'upstream' events in the culprit artery are related to 'downstream' damage in the heart or brain, allowing new treatment pathways and novel therapies to be evaluated in the emergency setting. The AVIC is a striking example of how the BRC Partnership can facilitate novel working practices within the NHS to enable unique clinical research opportunities.

Professor Adrian Hill, Dr Sarah Gilbert and colleagues in the Oxford BRC Vaccines Theme have developed a novel 'flu vaccine (MVA-NP+MI) that is the first 'flu vaccine designed to provide immunity to 'flu infection

through cellular responses to the pathogen rather than through antibodies. These 'flu vaccine studies have progressed rapidly from preclinical experimental work to 'first-in-man' studies, and have the potential to translate into new vaccine strategies with global importance.

Professor Peter Rothwell leads the Oxford Vascular Study (OxVASC) programme, which incorporates several BRC-supported studies aimed at improving the early triage and effective treatment of patients with TIA or minor stroke. OxVASC is the first ever population based study of acute vascular events without exclusion of the elderly. Over the next decade, OxVASC will become the most important UK source of data for health professionals, researchers and policy-makers interested in the incidence and outcome of vascular disease, related health-economic evaluations, and associated time-trends.

More information is available on the Oxford Biomedical Research Centre at:
www.oxfordbrc.org

Research governance

National developments

The National Institute for Health Research (NIHR) initiatives continue to have an impact on the activities of the Research and Development (R&D) team. The Co-ordinated System for Gaining NHS Permissions (CSP) is being implemented for an increasing number of research studies, as more are accepted onto the NIHR Portfolio.

The R&D Team are currently implementing NIHR Research Support Services (RSS), the aim of which is to promote streamlined, efficient and consistent processes within R&D on a national level.

Medicines and Healthcare products Regulatory Agency (MHRA) inspection

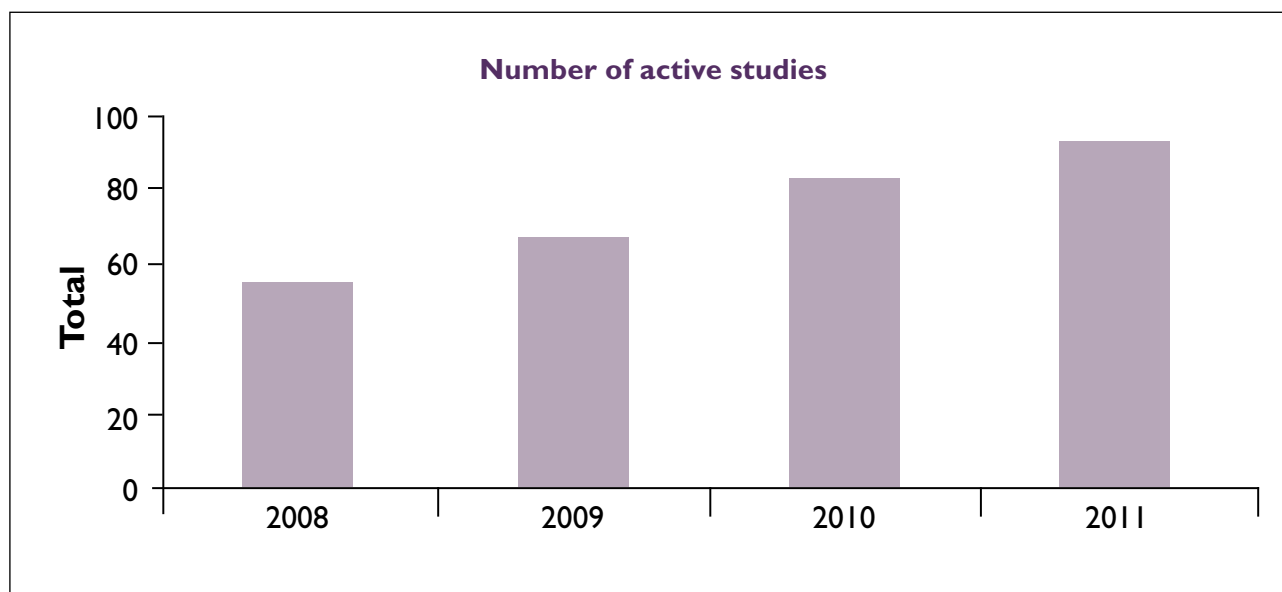
In February, the Trust was inspected by the MHRA for compliance with the Medicines for Human Use (Clinical Trials) Regulations 2004 and amendments. Since the last inspection in 2006, new systems to enable and monitor compliance have been introduced. This was the first inspection of these systems. The final report for this inspection has recently been received, and shows an improvement in levels of compliance.

Current research activity

There has been a progressive increase in the level of research activity within the Trust over the past years, and this increase promises to continue, according to current trends.

Joint research office with the University of Oxford

The University of Oxford and the Trust have created a joint research office to integrate the governance and management of research activity. The Trust's Research and Development team and the Clinical Trials and Research Governance team within the University continue to work towards harmonisation of systems and procedures, under the leadership of a Director of the combined function reporting to both organisations.



Our performance

Introduction

The Trust has faced some difficult challenges this year in meeting its performance targets. The ongoing issues surrounding delayed transfers of care have made it more difficult for the Trust to treat patients as quickly as it would like to. Whilst a significant improvement in performance has been achieved during the year, there remain key challenges to address during the first two quarters of 2011/12 before performance against these key standards can be seen to be stable.

The Trust started this year with over 4,000 patients potentially waiting beyond 18 weeks, and by the end of the year, through a number of initiatives to tackle this backlog, this had reduced to 875 patients. The Trust met its targets for referral to treatment times for non-admitted patients, but failed to make the target for the whole year for admitted patients, although it did meet them for the last quarter of the year. The Trust also continues to work with its commissioners and the Strategic Health Authority to improve cancer waiting times.

After a great deal of focus and hard work the Trust saw a greatly improved level of emergency performance by the end of the financial year. This ensured that, over the year, more than 95% of patients across the system were treated, discharged or admitted within four hours. From this year, new Clinical Quality Indicators will apply which will complement the single four hour target. They will give a much fuller picture of the whole of the patient's experience, and provide opportunities to improve the quality of the service, despite the pressures that the NHS will face over the coming years.

Overall volume of activity

	2007/08	2008/09	2009/10	2010/11
Emergency inpatient admission	84,492	88,872	87,275	83,195
Elective inpatient admission (IP)	21,224	22,866	20,955	21,263
Day case procedures (DC)	59,817	64,969	62,544	68,197
Total IP and DC episodes – subtotal	<u>163,633</u>	<u>174,795</u>	<u>161,552</u>	<u>172,655</u>
Emergency department attendance	115,603	117,922	123,592	121,626
Outpatient visits	564,389	609,656	614,056	642,487
Total patient contacts	843,625	902,373	899,200	936,768

Emergency access target

The national standard for emergency access for 2010/11 was that 95% of patients should be admitted, treated or discharged within four hours of arrival in our Emergency Departments and in Minor Injury Units in Oxfordshire.

The Trust achieved 95.12% for the 12 months (2010/11) which means it has met the national standard for this year. This represents a tremendous achievement by the clinical and operational teams.

In December 2010 the government announced new Emergency Department Clinical Quality Indicators that replace the simple four hour target from July 2011.

The goal of seeing, treating, discharging or admitting 95% of patients within four hours effectively remains as part of these new indicators. Some of these measures depend on the whole health system, not just the Emergency Departments. They are an opportunity for the Trust to improve quality and patient experience by looking at how it delivers care in this area.

The five main elements of the Clinical Quality Indicators are as follows:

Indicator	Performance management trigger
Unplanned re-attendance rate	A rate above 5%
Total time spent in Emergency Department (ED)	A 95th percentile wait above four hours for admitted patients and with the same threshold for non-admitted
Patient leaves ED without being seen	A rate at or above 5%
Time taken to initial assessment	A 95th percentile time to assessment above 15 minutes for ambulance cases
Time to treatment	A median wait above 60 minutes

Delayed transfers of care

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

The ORH continues to work with its partners in primary and social care to ensure that this issue is a priority for them. Acute hospital care is the most expensive NHS care there is, so it is in everyone's interest that, when patients are clinically fit, they move on to a more appropriate setting.

Controlling infection

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

The ORH has continued to screen appropriate elective admissions following the guidance from the Department of Health, and in January 2011 this was extended to all relevant emergency admissions. Patients who are found to be colonised with MRSA are asked, if not contraindicated, to have an antimicrobial wash and use a nasal cream for five days.

The Oxford Biomedical Research Centre has a major theme of focusing on infection within which there are four main areas of research. These are *Staphylococcus aureus*, *Clostridium difficile*, Norovirus (winter vomiting bug) and developing information technology to help analyse the data and feed back to staff. The work carried out on *Clostridium difficile* and *Staphylococcus aureus* has led to a greater understanding of these organisms and how they may be possibly transmitted within a hospital setting.

The Trust has met its national objectives for reducing the number of cases of MRSA and *Clostridium difficile* in our hospitals. Last year the Trust continued to focus on the insertion and aftercare of intravenous lines and the management of urinary catheters, with the aim of preventing overall infection in patients.

MRSA

Year	Target maximum number of cases	Actual number of cases
2008/09	96	48
2009/10	85	36
2010/11	12	9

C.Diff

Year	Target maximum number of cases	Actual number of cases
2008/09	459	308
2009/10	324	238
2010/11	205	146

18 week referral to treatment

The Trust began the year with over 4,000 patients potentially waiting beyond 18 weeks and by the end of the year, through a number of initiatives to tackle this backlog, this had reduced to 875 patients. The 90% target for admitted patients was not achieved in the year, although performance improved to 85.9% in March 2011. During the year, focus shifted from achieving the 95% non-admitted and 90% admitted targets to delivering against the 95th percentile and median standards. In the fourth quarter the Trust achieved the 95th percentile (95% of patients treated in the month had a shorter referral to treatment than the 27.7 week threshold) and the median standard (referral to treatment pathway for the middle patient is less than 11.1 weeks) were also met.

The Trust successfully delivered against the 95% standard for non-admitted for the year and also achieved the 95th percentile (95% of patients treated in the month had a shorter referral to treatment than the 18.3 week threshold) and median (the referral to treatment for the middle patient is less than 6.6 weeks) targets.

18 week referral to treatment performance

% seen within 18 weeks			
Total numbers admitted in quarter	2008/09	2009/10	2010/11
Q1	97	96	77
Q2	96	92	78
Q3	94	85	75
Q4	96	77	83
Total for year	96	88	78

% seen within 18 weeks			
Total numbers non-admitted in quarter	2008/09	2009/10	2010/11
Q1	96	99	97
Q2	97	93	96
Q3	95	95	96
Q4	97	95	96
Total for year	96	96	96

Admitted – patients requiring admission to hospital

Non-admitted – patients not requiring admission to hospital

Sections of the patient pathway

Length of stay and theatre use

The average length of stay is 4.28 days. We have maintained the efficient use of our operating theatres and 95.7% of our elective patients now come into hospital on the day of their operation rather than having to stay the night before. Overall the average length of stay has remained consistent across the year although this includes a significant increase in the number of patients staying beyond 21 days and an overall growth in bed days of nearly 5% compared to 2009/10. Only 3% of admitted patients had a length of stay of 14 days plus yet these accounted for 44% of total bed days.

Cancellations

The percentage of operations cancelled at the last minute for non-clinical reasons has risen very slightly from 1.08% in 2009/10 to 1.12% in 2010/11.

	2010/11 Last minute cancellations	Patients not operated on within 28 days of cancellation
Q1	195	13
Q2	205	10
Q3	234	11
Q4	311	33
2010/11	945	67

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

We have continued to try to keep the numbers of patients not attending their appointments down, through efforts to inform patients about the importance of attending appointments. The number of patients failing to attend their appointments has fallen slightly from 5.8% to 5.6% compared to last year. We continue to use our text messaging reminder service for patients and we know that this helps people keep their appointments.

Cancer waiting times

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

Last year the methodology for measuring cancer performance changed. Until then, any patient who exceeded a cancer target through choosing to wait, or had treatment delayed because of a clinical reason, would not have been counted as a 'breach' (i.e. a failure against the target). Under the new system, the target counts the whole wait, regardless of whether the delay is for patient choice or clinical reasons. For example, patient choice to not attend an appointment offered was previously a reason to exclude the time period lost in the pathway. This is no longer allowed.

The Trust has faced major challenges in cancer services and delivery against the core cancer standards was not achieved. The Trust has an agreed action plan with its commissioners and the South Central Strategic Health Authority to ensure all targets are delivered by the end of Quarter 1 in 2011/12.

Non attendance for first appointment (total numbers)

	First attendance	Did not attend first appointment	Did not attend rate %
Q1	74,021	4,103	5.43%
Q2	75,793	4,234	5.59%
Q3	67,976	4,206	6.18%
Q4	65,283	3,360	5.14%

Cancer waiting times 2010/11

	Q1	Q2	Q3	Q4
2-WEEK TARGET				
No. of patients seen	2,580	2,987	2,657	2,857
No. seen within target	2,328	2,649	2,399	2,251
%	90.6%	89.9%	90.3%	78.8%
31-DAY TARGET				
No. of patients seen	633	751	715	775
No. seen within target	625	732	696	753
%	98.7%	97.5%	97.3%	97.2%
62-DAY TARGET				
No. of patients seen	319.5	381.5	331	309.5
No. seen within target	254.5	296.5	256.5	235.5
%	79.7%	77.7%	77.5%	76.1%

Planning for the years ahead

Integration with the Nuffield Orthopaedic Centre

The ORH hopes to complete its integration with the Nuffield Orthopaedic Centre this autumn. Both trusts remain fully committed to creating an integrated organisation and the Board of South Central Strategic Health Authority supports the Business Plan for Integration which also has the backing of the trusts' commissioners. Both trusts believe that an enlarged organisation will make the most of the combined clinical and academic excellence to deliver better patient care for the people of Oxfordshire and beyond. The ORH and the NOC have been developing closer relationships for some time, and already collaborate in a number of clinical services.

Foundation Trust status

Although the delay in the integration with the NOC will impact on the exact timetable for Foundation Trust, much work is under way to prepare for the Trust's application as an integrated organisation. Before the Trust can apply to the Department of Health, a number of key milestones will need to be passed, including the agreement of an Integrated Business Plan and Long Term Financial Model, the performance of historical due diligence (an audit of the Trust's organisational readiness to take on the additional powers and responsibilities of an FT), and consultation with staff and the public. There are also a number of other key points that the Trust will need to deliver. As well as a successful integration with the NOC, the Trust needs to maintain financial stability, achieve consistent operational performance, and deliver the implementation of the Electronic Patient Record. The aim remains to achieve Foundation Trust status within 2013.

Electronic Patient Record

Work on the implementation of the Electronic Patient Record (EPR) continues. This will deliver real benefits for the Trust's patients as it will provide access to critical information for clinicians, when and where it is needed, in a secure, reliable and legible way. The Trust intends to introduce the system late in 2011. The Nuffield Orthopaedic Centre (NOC) has already gone live with the updated version of their EPR system, a development which paves the way for a fully integrated electronic record for the acute sector in Oxfordshire when the ORH is also using the system.

Vision for the Horton General Hospital

The Trust is working with the local community and its commissioners to develop a vision for the whole of the Horton General Hospital. The aim is to develop a secure future for the Horton and to increase the number of specialist services, such as dialysis, that can be delivered in Banbury rather than in Oxford. This work involves looking at the services that are currently delivered, what services the Trust's commissioners and the local population are likely to want in the future, and where these services can best be provided, both in terms of the Horton General Hospital site and also in the community. The Trust will continue to develop plans during the year ahead.

Newborn Intensive Care Unit

There is a growing demand for neonatal services. The ORH is best placed regionally to provide the specialist care that some babies need and the PCT Board of Commissioners has asked us to expand the service. The ORH has already expanded its Newborn Intensive Care Unit (NICU) twice over the last few years. The Trust is currently developing plans to double the number of Intensive Care cots from 10 to 20 and further expand the Unit in order to centralise the care for the sickest babies in the region at the John Radcliffe Hospital, the designated centre of care.

South of England Children's Congenital Heart Network

The ORH will continue to work with Southampton University Hospitals NHS Trust to develop the strategic partnership they have entered into, the South of England Children's Congenital Heart Network. The children's heart surgery centre in Southampton has been rated as providing the country's highest quality service outside London. Since Oxford stopped providing children's heart surgery in March 2010, patients who would have had their surgery or interventional cardiology procedure at the John Radcliffe Hospital in Oxford, have been having this part of their treatment in Southampton. This has been working well for patients who are often having their treatment carried out by clinical teams travelling from Oxford to the Southampton hospital.

The partnership with Southampton University Hospitals NHS Trust has increased the number of operations being carried out and puts Southampton within easy reach of the new requirements being introduced for centres that perform children's heart surgery in England. The national Safe and Sustainable review of children's heart surgery services recommends that children's heart surgery should only be provided in a smaller number of larger centres to achieve the best outcomes for children.

Adult cardiac surgery

The ORH may benefit from proposals from the South Central Specialist Commissioners to bring cardiac surgery activity to hospitals in the South Central region that is currently referred to tertiary providers in London. At the moment a number of district general hospitals are referring their patients to London providers, who charge a higher tariff because of their higher market forces factor. The proposals will potentially provide streamlined patient pathways and will help to sustain the service in Oxford. The Trust is responding to these proposals.

Trauma centre

As part of the national reconfiguration of major trauma services, the Strategic Health Authority is designating trauma centres and trauma units. The expectation is that the ORH will be designated a major trauma centre for North South Central as it is already a major provider of this service. The Trust will be expected to lead a network of trauma services linking the trauma centre to trauma units and local hospitals. Work will progress on this across the next year, subject to consultation.

Vascular surgery

PCTs across South Central are consulting on the reconfiguration of vascular surgery across the region. The Trust is already a major provider of vascular surgery. The ORH has been identified as the preferred site for complex and emergency vascular surgery for the Thames Valley. A phased implementation of this is planned, subject to the outcome of the consultation.

Making a difference, together

Oxford Radcliffe Hospitals Charitable Funds is the charity that supports all the ORH hospitals. Every year we are able to purchase life-changing medical equipment, fund ground-breaking research and provide a more comfortable environment for our patients. This year alone, thanks to the incredible generosity of all our supporters, over £6 million has been raised to support our hospitals.

A highlight of the year was the expansion of the Brodey Centre at the Horton General Hospital in Banbury. Thanks to over £500,000 worth of fundraising, the centre has now doubled in size, allowing 2,000 cancer patients a year to be treated closer to home. Thanking the donors, Mike Fleming, Director of the Horton, said: *"It is no exaggeration to say that without them we would not have our beautiful new centre which will be of so much benefit to local people."*

Another milestone was reaching the target to fund a high-tech videoconferencing and outreach education centre which will be installed at the Oxford Heart Centre.

Divisional Director, Dr Adrian Banning, explains: *"This new facility will transform the way we are able to discuss the best treatment for our patients. It will also allow us to collaborate with clinicians locally and others around the world, sharing and acquiring the latest knowledge about heart treatments. We are incredibly grateful to every single person who has helped to raise the money to make this possible."*

Fundraising for the Children's Hospital and children's services across the Trust continues to be very popular. Events such as the Oxford Mail OX5RUN, the Dorchester Abbey Christmas Concert, and the annual CHOx abseil attract thousands of supporters and raise huge sums. The 2010 OX5RUN alone raised over £57,000, which paid for a cooling machine and monitors that will help reduce the number of new born babies who develop cerebral palsy.

Throughout the year the Fundraising Team help clinical colleagues to run free educational events, such as the Heart Centre and Breast Cancer Open Days, and the Hospital Supporter Forums have proven hugely popular, helping us to share the latest developments and research with patients and supporters.

Director of Fundraising, Alice Hahn Gosling, said: *"In difficult financial times it is clear that there is still a huge desire from the public to support their local NHS hospitals. We are so grateful to all those who continue to make donations, join our events and raise money – allowing us to make a very real difference to our patients."*

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

To find out how you can get involved with fundraising for the ORH hospitals go to:
www.orhcharitablefunds.nhs.uk,
email: campaign@orh.nhs.uk or
telephone 01865 743444.

Measuring the quality of our services and assessing risk

Effective governance – the cornerstone of quality and safety

In order to be a high performing Foundation Trust, we must provide excellent, safe clinical care with compassion, and we also need the assurance that comes from having excellence in our systems and processes. This year, as well as the move to our new integrated clinical management structure, we have also reformed and improved our governance structure and arrangements. Governance is about the fabric of our decision-making processes, the committees that oversee our work, how we identify and reduce risk, and the checks and balances that we can bring to bear on difficult organisational decisions.

Governance can seem like a dry, technical subject, but it is essentially about how we all conduct ourselves, make decisions and assure ourselves and others that we are doing what we say we are. Because we are such a big and complex organisation, it is particularly important that our governance and decision making processes are simple, clear and effective.

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

The structure that we are creating at the ORH is aimed at linking the 'Board to the floor' – in other words having committees that can hear the voice of staff on the front line, and provide these staff with the clear parameters within which to deliver treatment and services.

Starting at the top, there has been a reorganisation of the Board's meetings. We have also set up a new Management Executive which includes not only Executive Directors, but also the Divisional Directors who are all practicing clinicians within our services. We established arrangements for supporting the new divisional structures, and we continue to review the subject specific and 'expert' committees that support the Trust.

To support the safety and quality agenda, we have strengthened the medical directorate and nursing directorate, and have also created a new role of Director of Assurance. This new Executive Director position, which reports directly to the Chief Executive, is key to the further development of the Trust's governance and assurance strategy. It will help us in ensuring compliance with regulation and accreditation with the bodies that monitor us, and making sure that our governance arrangements and quality of care are strong across all our hospitals.

More information about our governance structure can be found in the 'About us' section of our website:

www.oxfordradcliffe.nhs.uk/aboutus

Care Quality Commission reports

In September 2010, representatives from the Care Quality Commission (CQC) visited our three hospitals and spoke with staff and patients. This was part of their routine schedule of planned reviews of all health and social care providers. The CQC works with providers to measure their compliance against 16 quality outcomes. This review process contributes to our own systems for assuring ourselves, and reassuring others, of the quality and safety of services in our hospitals.

As part of the review process, the Trust informed the CQC of areas where the ORH might not fully meet the requirements of the quality outcomes, and where it was felt that more work was required.

The concerns that the CQC wrote about, when they published their reports in January 2011, reflected those that we shared with them. Indeed, by the time the CQC published its report, the Trust had either demonstrated improvements in these areas since the visit in September 2010, or was actively addressing them. The reports also recognised those areas of good performance against the national quality standards, and particularly how much the Trust's services and staff are valued and praised by patients.

The CQC reports highlighted some concerns about staffing levels, and the Trust was already addressing these in a number of areas. We are continuing to recruit to fill vacancies in the establishment so that we can reduce the use of agency staff. We will of course continue to look at how we organise our workforce across the Trust to ensure that we are using staff most efficiently. Having an effective, flexible workforce is vital if the NHS is to respond well to the financial challenges ahead and keep patients safe. Maintaining financial stability is essential, as it is the bedrock on which the safety and quality of our services rests.

Clinical teams have also significantly reduced the number of patients waiting over 18 weeks for treatment, and we have a clear action plan in place to tackle the delays that patients have been experiencing in some of our cancer services.

We have also continued to develop the structures and governance that underpin our clinical services (see above). Moreover, the new integrated clinical management structure, that gives direct authority and responsibility to clinicians for running clinical services, is a significant change and opportunity for the Trust.

This is not to say that we have solved all the issues that we and the CQC identified. For instance, the CQC reports highlighted the ongoing problem caused to the local health economy by the large number of patients who no longer need hospital care, but are unable to leave because they are waiting for the provision of care services within the community or at home. The CQC recognises this as a system-wide

issue, with the biggest causes of delays being the lack of provision of care services provided in people's homes and delays obtaining care home placement. These problems continue to be the subject of detailed discussions between the ORH, the PCT and the Social Services Department of the local authority.

A follow-up review was undertaken by the CQC in August 2011 and the initial feedback is of significant improvement in compliance, although some areas requiring further work remain. It is expected that these reports will be published towards the end of September 2011.

The full reports are available from the Care Quality Commission website: www.cqc.org.uk

Care Quality Commission registration

The ORH continues to be officially registered, without conditions, with the Care Quality Commission (CQC), under the system for monitoring quality and safety of care. **You can find out more about the registration process and standards here:** www.cqc.org.uk

Quality Accounts

The Quality Account will not form part of this Annual Report. It can be found in the 'About us' section of our website: www.oxfordradcliffe.nhs.uk/aboutus

The Quality Account is an annual report to the public about the quality of services that are delivered by the Trust. It demonstrates the commitment of staff and the Trust Board to continuous, evidence based quality improvement. The Quality Account focuses on three key elements of quality; patient safety, effectiveness and the patient experience, and for each of these details, achievements and priorities for the year ahead. Some parts of the content are mandatory, but most of it has been determined locally by staff and members of the public at a public engagement event.

Patient Safety First Week

For the second year in a row, the Trust took part in Patient Safety First Week. The week was an opportunity to raise awareness and commitment to safety, and share good practice. A number of activities took place before, during and after the week, based on nationally recommended simple steps to reduce risk. We promoted national online safety discussions and provided information and prompts to staff throughout the week, and members of the clinical governance team worked with clinical departments on specific areas promoted by the national campaign. These included falls; reduction in the incidence of pressure ulcers; insulin safety; 'track and trigger' protocols to identify patients in danger of clinical deterioration; anticoagulation and reducing the incidence of venous thromboembolism; leadership support for safety; and the role of 'human factors' – that is how systems and practices can change behaviour in a way that increases safety. The Trust has been congratulated in an independent review for implementing all National Patient Safety Alerts.

Patient information

Access to high quality, clear and timely patient information enables patients to make choices about their care, be actively involved in decision making, and give informed consent. The ORH has continued to develop its patient information, both in print and online over the year. This has included clinical information about specific conditions or procedures – for which we have over 500 leaflets. This also includes non-clinical information aimed at making sure patients have all that they need to prepare for their visit to or stay in hospital.

Travel and transport information is one of the most frequently requested types of information, so we have developed a simple 'travel sheet', improved the 'Find us' section of our website, and produced new maps for all of our hospitals. Because we know it is a significant issue for our patients and partners in healthcare, we have also worked to increase the amount of information available about leaving hospital. This includes work on staff and patient leaflets,

website information, and posters in all the wards, which are aimed at supporting the work to improve the discharge process across our hospitals.

Our website has increasingly become a major source of information for patients and is continuously developed. The information is constantly reviewed and more areas developed into 'microsites' which focus on particular areas of our hospital. Recent examples of these include our Eye Hospital (www.oxfordradcliffe.nhs.uk/eyehospital) and our Women's Services www.oxfordradcliffe.nhs.uk/women) websites. We have also developed 'virtual views' for the Oxford Heart Centre, which allow patients to have an online 360° preview of the facilities in this new building. Accessibility standards for the website have been improved, including large text and high visibility buttons on the front page. We have also launched a patient information intranet for our staff. This includes all the information needed for staff to produce high quality patient information, including contacts, guidance, templates, and best practice document examples.

Patient information can be viewed on our website: www.oxfordradcliffe.nhs.uk/patientinformation and specific printed information produced as required.

Data loss

The Trust is committed to protecting patient confidentiality and all staff are instructed about their responsibilities at their induction and reminded of them regularly.

During the year 2010/11 there has been one Serious Incident Requiring Investigation (SIRI) relating to a breach of confidentiality. This concerned a fax with prescription details being sent to the wrong number. The error was quickly recognised and no further faxes were sent. The Trust worked with the telephone service provider to identify the receiver of the faxes so that they could be destroyed. Pre-programmed dialling has now been put in place. All patients were contacted and there was no adverse effect on any patient.

Quality and risk

The ORH has used a variety of nationally recognised indicators to ensure quality of care throughout the Trust. Commissioning for Quality and Innovation (CQUINS) indicators, as well as measures required by our contract with our local commissioner, NHS Oxfordshire, from CQC registration and NHS Litigation Authority (NHSLA) standards, have all become important frameworks for measuring, achieving and ensuring quality within the organisation. Learning from adverse events has continued to be an important part of ensuring organisational cultural change. For example, organisational changes implemented this year include:

- guidance produced on the use of monitoring systems produced for different care settings;
- revision of incident reporting and incident investigation training;
- targeted care tools piloted to standardise the care of patients at risk of pressure ulcers and falls;
- specialised equipment purchased to mitigate the risk of pressure ulceration and venous thrombo-embolism;
- guidance introduced on the transfer of sick patients to the radiology department.

Clinical effectiveness

We constantly monitor the quality of our services by auditing our clinical practice. The Trust contributes data to over 60 national audits such as neonatal care, cardiac interventions, renal replacement therapy, bowel cancer, acute myocardial infarction and trauma. In addition, we conduct a range of local audits to check we deliver patient care to the highest standard. In November 2010, the Trust participated in the one day national audit of inpatients with diabetes. National audit reports are scrutinised by the Trust to ensure that our clinical services meet these reports' recommendations and that we achieve the best possible standards and therefore best outcomes for patients.

The Trust also participates in a Department of Health initiative known as Patient Recorded Outcome Measures (PROMS). Patients undergoing surgery for either varicose veins or inguinal hernias are asked to

complete a questionnaire both immediately prior to, and some months after, their operation.

The opinions of patients who have undergone surgery will provide valuable insight into how patients perceive their health and the impact that treatments or adjustments to lifestyle have on their quality of life. Although the questionnaires are voluntary, the majority of patients are willing to participate and provide their opinions of the treatment they receive, and the impact this has on their wellbeing. The data from this indicate that patients receiving these procedures at the ORH record a greater improvement in their quality of life and overall health when compared with all other trusts in England and Wales.

Meeting the National Institute for Health and Clinical Excellence (NICE) guidelines

The ORH requires that all NICE guidelines are implemented to ensure that our patients receive clinical care to the highest national standards. Each month, our clinicians take into account new guidance and benchmark their work to these standards. NICE calls for clinician input in the updating of current guidance and our Trust's consultants also contribute to the shaping and development of new guidelines throughout the year.

In addition to the development of guidelines NICE has taken on a number of new functions that will set national standards of healthcare that people can expect to receive. These new Quality Standards are a set of specific statements, that act as markers for the commissioning of clinical care and the evaluation of patient outcomes in treatment and prevention of different diseases and conditions. Our consultants have been contributing to the development of these service parameters. Last November, NICE consulted with the Trust's renal clinicians on the quality standards for chronic kidney disease. Already five Quality Standards have been introduced including Stroke, Dementia, Venous Thromboembolism (VTE) Prevention, Specialist Newborn Care and Chronic Kidney Disease.

Health and safety

The health and safety team were awarded the Royal Society for the Prevention of Accidents (ROSPA) silver achievement award in May 2010, for the health and safety management system and processes in place within the Trust in order to reduce the number of accidents and cases of ill health at work.

This year has seen an increase in the number of safety and environmental audits and inspections undertaken by the Health and Safety Team, which have resulted in positive improvements in safety and practice being achieved across the Trust. We have continued to deliver our health and safety management training, successfully achieving agreed performance targets.

As part of the leadership for safety intervention, Trust Executive Directors carried out 90 executive safety walk rounds (often with Non-executive Directors), which continue to prove an essential and vital addition to identifying safety concerns at service level within the Trust, and demonstrates Board level engagement by executives and non-executives. This has allowed examples of good practice to be promulgated, and prompt escalation of issues providing responsive support from the top of the organisation to service providers.

Continued good progress has been made in reducing risk through the Safety Action Groups (SAGs). Specific initiatives have been introduced to reduce needle stick injuries through the use of safer cannula devices; the conversion of non-latex examination gloves throughout the Trust to minimise the potential of dermatitis; introduction of policies on 'Health Surveillance' and the 'Awareness, Prevention and Management of Dermatitis', the development of a 'Skin Surveillance Protocol' and a project to consider and tackle health and wellbeing at work (including stress). In addition, the Improved Awareness SAG has introduced a mechanism for identifying and delivering organisational learning. There are also currently initiatives underway to investigate the conversion to safer needle devices for all needles used and to non-latex surgical gloves.

Legal services

The Trust's Legal Services Department provides advice on a range of healthcare issues and supports staff involved in inquest and Trust claims. There were 100 inquests this year and there were 145 claims, representing an 11% increase from the previous year.

Organisational learning from inquests and claims is identified at first notification and conclusion, reflecting the increased importance placed by the National Health Service Litigation Authority (NHSLA) on identifying the risk root causes.

The Trust's consent policy has been completely updated and expanded. Key trends for staff training have been, how to keep good healthcare records of patient care, and documentation of the consent to treatment process.

Training has continued for deprivation of liberty safeguards and the referral process to the supervisory body (NHS Oxfordshire). Pilots for in-house commercial and intellectual property legal advice have been successful.

Preparing for an emergency

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

The Trust has a very robust and detailed plan in place which was tested twice in real life incidents last year.

The extreme snowy weather in November and December 2010 needed a swift and co-ordinated approach, in terms of how both patients and staff could still access our hospitals. Despite the adverse weather conditions the Trust remained open throughout and continued to provide essential healthcare.

A bus crash on the M40 in December 2010 required the Trust's emergency plans to be activated. This incident required the Trust to prepare to treat a large number of casualties with a range of injuries in a very short time frame. The Trust responded very effectively and was more than ready to meet the challenges of the incident.

In addition, a number of exercises have been held to test and develop the Trust's plans. These included exercises to test ward and hospital evacuations, mass casualties, communications cascades and incidents involving contaminated casualties.

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

Safeguarding children and vulnerable adults

The Trust Board has specifically considered safeguarding children issues three times during 2010/11. In addition, the Trust's Care Quality Board reviewed safeguarding issues each quarter, and provided monthly updates to the Governance Committee. This included reviewing the Trust's policies to ensure that they meet the need to safeguard children as they access the Trust's services. In 2011/12 a review of all other safeguarding policies and procedures will be carried out. Compliance with the core standard and with the appropriate regulations, and consideration of internal management reviews on safeguarding children are ongoing, coordinated and managed by the Trust Safeguarding Strategy Group, now chaired by the Divisional Director of Children's and Women's Services. Ofsted and the CQC safeguarding joint inspections graded provision of services in Oxfordshire as 'good'.

The ORH is a member of the Oxfordshire Safeguarding Children Board, and has active membership at Board and sub-committee level.

The ORH continues to work closely with NHS Oxfordshire, Oxfordshire County Council and other bodies across the South Central region, to support the safeguarding agenda.

The organisation meets all its requirements in relation to Criminal Records Bureau (CRB) checks for new staff. The ORH's human resources policy and checklist clearly identifies staff requiring CRB checks according to NHS recruitment requirements. Reviews and re-checks on key staff were commenced in 2010/2011 in line with other organisations' requirements during partnership working.

Access to healthcare for people with a learning disability

The Trust has been working to implement the recommendations of the *Healthcare for All* report by Sir Jonathan Michael, published in 2008. This report made a number of recommendations to improve access to care, as well as the quality of care, for people with learning disabilities within acute hospital settings. Significant progress has been made in this area, but an action plan remains in place to ensure that protocols and mechanisms are fully implemented, to flag when people with learning disabilities access our services, and to make adjustments to ensure that their experience of the quality of care in the Trust is enhanced.

Child protection policies

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

Performance continues to improve with the availability of online programmes and additional classroom sessions. Training targets are monitored monthly and the nature of the training, linking in to the new e-learning package and the National Learning Management System, is also kept under review. Although training for staff who care for children is progressing well and we are able to demonstrate that all staff are up to date, in adult focused clinical areas staff training to recognise and respond to safeguarding children issues is currently below target.

The Board has designated professionals to take the lead on safeguarding children and vulnerable adults. They are clear about their role and their responsibilities are defined in their job descriptions. The Chief Nurse is the named Executive lead for safeguarding.

Our people

The Oxford Radcliffe Hospitals NHS Trust (ORH) is one of the largest acute teaching trusts in the UK, with a national and international reputation for the excellence of its services and its role in teaching and research. With a workforce of more than 10,000 staff, it is one of the largest employers within the Oxfordshire area.

Workforce information: *the table below shows the employee figures at 31 March 2011*

	TOTAL		MALE			FEMALE		
	Head count	Whole time equivalent	Full-time	Part-time	Total	Full-time	Part-time	Total
Admin and Clerical Staff including ward clerks, receptionists, medical secretaries, staff in finance and IT and non-clinical managers	2,010	1,601.0	347	72	419	805	774	1,579
Healthcare Assistants including staff working in support roles on wards, porters and other domestic staff	1,422	1,069.2	262	90	352	447	643	1,090
Healthcare Scientists including staff working in laboratory medicine, cardiology and medical physics	550	489.9	182	18	200	233	117	350
Medical and Dental Staff	1,641	1,319.5	700	204	904	492	245	737
Nursing Staff including all registered nurses and midwives	3,630	2797.7	218	69	287	1,849	1,494	3,343
Scientific, Therapeutic and Technical Staff including radiographers, occupational therapists, physiotherapists, pharmacists, optometry staff and staff in technical support roles	800	604.1	106	25	131	342	327	669
Externally Funded Staff staff working within the Trust whose costs are paid for by external organisations	207	120.1	9	22	31	70	106	176
Total	10,268	8,001.5	1,824	500	2,324	4,238	3,706	7,944

Nurses and midwives are the largest staff group and make up approximately 35% of the workforce. As can be seen above, over three-quarters of the workforce is female and over 36% of staff work flexibly – either part-time or under one of our varied flexible contracts, e.g. term-time working.

In addition to the numbers included in the table, we have approximately 560 medical staff who hold honorary contracts with the Trust. These include University medical staff who provide clinical services in our hospitals and doctors from other UK trusts and from overseas who wish to expand their knowledge and experience.

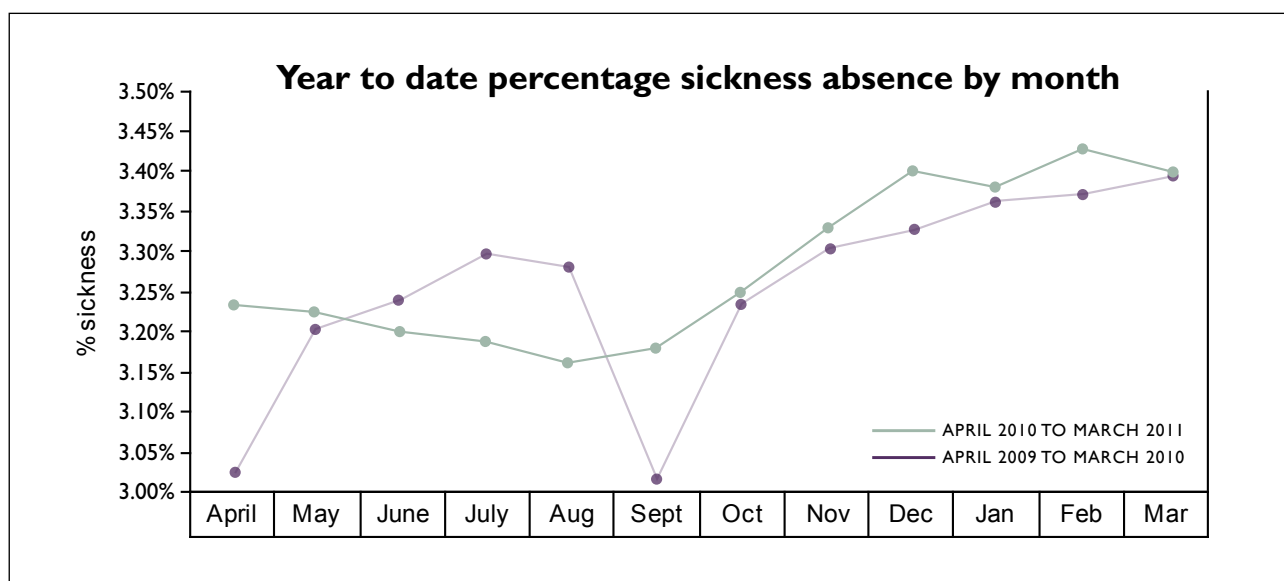
Staff turnover

The workforce has remained relatively stable throughout the year in line with other employers. At the end of March 2011 the turnover rate was 10.19%, almost the same as last year, and is well within the Trust's target of turnover between 10% and 14%.

Staff health

Staff provided continuous service throughout the Trust, even through the adverse weather conditions.

The graph shows year to date sickness absence rates and demonstrates the usual seasonal effect of sickness, with higher absences during winter months. It is notable that during this period sickness absence was not as high as predicted and by the end of March 2011 sickness rates were at 3.42% against a target of equal to or below 3.25%.



Occupational Health Service provision

The Occupational Health Service (OHS) has continued to give support and advice to the Trust's managers and employees during a period of intense organisational change. The department has a continuous process of modernisation and this year has introduced a range of new initiatives. This has included streamlining pre-employment health assessment, use of the digital transcription service and greater application of electronic means of communication, as well as a responsive system for triaging requests for support and advice.

The OHS will be required to meet new nationally agreed quality standards by March 2012. A gap analysis has been undertaken and work has started to address a number of issues. Successful recruitment to an Occupational Physiotherapist vacancy has enabled the OHS to reinforce physiotherapy treatment to assist employees with work-related musculoskeletal problems in remaining at, or returning to, work.

It is hoped that this appointment will provide a springboard to a range of health and wellbeing interventions.

The OHS continues to work with other partners in delivering a safer working environment, and has been particularly active in relation to the management and prevention of dermatitis, stress and inoculation injury.

The OHS is proud to have been able to deliver another successful flu immunisation campaign and to have immunised over 3,000 mainly front-line clinical staff within the ORH.

Employee engagement

Although the staff survey in 2010 found some positive developments, some similar themes emerged to those in previous years. The Trust Board has identified the need for greater employee engagement which has been reinforced by feedback from staff. The areas in particular that were identified following the staff survey were to increase the quantity and quality of personal development plans following appraisals; to increase the availability of hand washing materials and knowledge about infection control; to improve the safety of the working environment and reduce slips, trips and falls, and to improve contribution to decision making and communication.

The staff survey in 2010 found general improvements over the year in staff job satisfaction, quality of job design, support from immediate managers and perceptions of effective action from the employer towards violence and harassment. The Trust's best scores were for: fewer staff experiencing physical violence from patients, relatives or the public in the last 12 months; an increase in the percentage of staff using flexible working options; an increase in the percentage of staff believing the Trust provides equal opportunities for career progression or promotion and an increase in getting support from managers.

Employee benefits

The Trust recognises the need for work/life balance for its staff, and aims to provide a responsive and flexible approach to work, offering a range of benefits to support this. A variety of flexible working options are enjoyed across the Trust, including term-time-only working, job shares and flexi-time.

Additionally, a number of local businesses offer discounts to Trust staff. The Trust provides on-site shops and cash machines, subsidised restaurants, League of Friends cafeterias, a free shuttle between the John Radcliffe Hospital and the Churchill Hospital, cycle parking, a bicycle repair service, long service awards, retirement vouchers, a staff lottery, on-site accommodation for staff, on-site staff hotel rooms and support of the Key Worker Living Scheme.

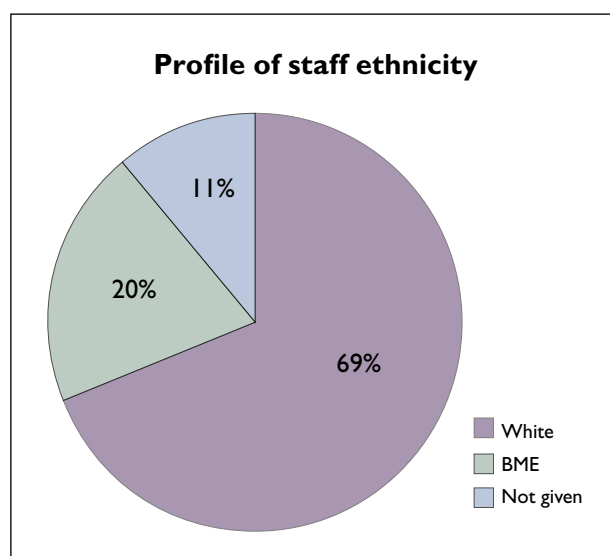
Equality and Diversity commitment

The Trust believes that it has a duty to respect the human rights of all our employees, patients and their carers and visitors, and that everyone has the right to be treated with dignity. The Trust also seeks to ensure that the individual needs of all its patients are met.

In order that the Trust complies with statutory human rights legislation and the Equality Act 2010, priority is given to training staff in equality awareness, listening to the views and feedback from people who may experience marginalisation or discrimination on the grounds of their disability, age, gender, race, religion or belief, sexual orientation, pregnancy, maternity or gender reassignment.

The Trust continues to monitor the effect on equality of all Trust activities to ensure that services are planned and provided appropriately. Any potential to discriminate can be challenged and corrected. For this reason, patients and the workforce are asked about their characteristics and this information is made publicly available.

The *Ethnic Profile of Patients* can be found in Appendix 2 of this report.



Learning, education and workforce development

The ORH has a strong commitment to developing the capabilities and skills of all its staff, and supports them by offering a wide range of learning opportunities that enable them to deliver care and treatment to patients safely and to a high standard.

Over 100 courses and learning opportunities are provided for staff within the Trust. The Trust also delivers a statutory, mandatory and essential training programme that ensures a competent and capable workforce. The Trust is a national leader in the provision and uptake of e-learning through the National Learning Management System, and constantly develops new and innovative ways of delivering education and training.

The Trust has worked closely with Oxford Brookes University to develop a foundation degree programme for trainee Assistant Practitioners and currently supports a significant number of staff on this programme. The foundation degree programme enables staff working as clinical support workers to gain new skills.

2010/11 has seen improvements in the way we manage the continuing professional development of staff through contracted arrangements with local higher education institutions and colleges of further education. This means that resources are concentrated effectively to ensure that patients benefit directly from the abilities of the Trust's dedicated and skilled workforce.

The Trust has received recognition from the Nursing and Midwifery Council for the quality of the teaching and learning experience that it offers undergraduate nurses on training placements across all hospital sites. A Clinical Leadership Programme has been implemented within the Trust. This programme has strengthened the capability of the Trust to meet its goals and objectives to provide a high standard of competent and compassionate care to the local community and beyond.

A key element of the Trust's approach to learning and development is to prioritise activities that help staff identify the needs of vulnerable and 'at risk' patients and to protect them from harm. A very successful training programme has been run in partnership with people with learning disabilities. This model of developing education and training programmes in partnership with patient groups will continue to be an important component of the approach to education, training and development at the Trust.

Medical Education

The George Pickering Education Centre (at the John Radcliffe Hospital in Oxford) and Terence Mortimer Postgraduate Centre (at the Horton General Hospital in Banbury) support the training of junior doctors, dentists, GPs, staff and associate specialists and consultants who are responsible for the educational supervision of junior doctors. The Trust appointed Dr Peter Sullivan to the post of Director of Medical Education on 1 March 2011.

In 2010, it became a statutory requirement for consultants who act as educational supervisors for junior doctors to be formally trained for the role. By the end of February 2011, the Trust had 400 consultants registered as educational supervisors with 88% of them having undertaken either an educational supervisors course or had equivalent experience recognised. This was against a Thames Valley Postgraduate Medical Deanery standard of 85%.

The following specialties came out as 'excellent' in the Deanery Advisory Committee (DAC) annual training report for 2010:

- Anaesthetics
- Intensive Care Medicine
- Community Obstetrics and Gynaecology – General Practice

A Medical Education Development Fund was set up to support junior doctors and educational supervisors who have an interest in medical education. In addition, a Focus Group was started in September 2010. This group consists of Foundation Doctors and the Medical Education Manager.

In the last year, the Education Centre ran over 20 continuing professional development (CPD) approved courses for both junior doctors and educational supervisors.

Healthcare libraries

The Trust's libraries provide a vital service to support patient care, teaching and research activities. The skills, expertise and resources of the library services are a core resource for those in formal training programmes and for staff undertaking further professional development. An innovative team of Outreach Librarians provides clinical enquiry services, training sessions, literature searches and one-to-one help and advice sessions in workplace locations across the Trust, including wards, offices and meetings. They support activities including direct patient care, clinical audit, guidelines development, service improvement and research.

All NHS and University staff and students working within the Trust have access to the library services. In Banbury, the Horton General Hospital Library and Information Service is situated on the first floor of the Terence Mortimer Postgraduate Centre. The Bodleian Health Care Libraries runs the two Oxford sites – the Cairns Library at the John Radcliffe Hospital and the Knowledge Centre serving the Churchill Hospital.

Together they offer comfortable and inviting library spaces with 24/7 access, private study spaces and group study rooms, training rooms, Wi-Fi access, and large and in-depth collections of books and journals. PCs are provided with access to the internet and to thousands of online databases and electronic journals. The computers can also be used for e-learning, word processing and other computer applications and are linked to the self-service printing, copying and scanning facilities.

As part of the work to improve online access for NHS staff, this year the service has continued to replace print subscriptions with electronic versions.

Engaging with our stakeholders

The ORH values the input of patients and relatives and of partner organisations, as this helps the Trust to deliver improvements in its services. The Trust has many mechanisms for doing this, such as the *Better Healthcare Programme for Banbury and surrounding areas*; the Trust's work with the Health Overview and Scrutiny Committee of Oxfordshire County Council; the formal patient involvement groups such as the Patient Panel and the Young People's Executive (YiPpEe), and through listening to complaints and comments received in different parts of the organisation.

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

Involving patients and the public and listening to their views

The ORH Patient and Public Panel, comprising 40 members of the public who mostly live in Oxfordshire, provides views on a range of issues such as Trust policies, letter formats to patients and service facilities. Currently 17 steering and project groups have been established in addition to service specific user groups such as the Cancer Services Panel. This group has been actively involved in reviewing cancer services, undertaking a patient experience survey, raising concerns on the availability of treatments recommended by NICE, canvassing for a direct bus service to the Churchill from the city centre and raising concerns regarding pharmacy waiting times. Members also maintain strong links with the Thames Valley Cancer Network.

The Trust is currently developing a new Public Involvement and Engagement Strategy to demonstrate our commitment to meaningful involvement with users of these hospitals and the general public.

This strategy includes close working with voluntary organisations such as Oxfordshire Carers and South and Vale Carers' Centre, to ensure that carers' needs are considered and met.

As a consequence of our increasing public engagement and consultation, the services provided by the Trust are becoming more patient centred.

Better Healthcare Programme for Banbury and surrounding areas

For the last few years the ORH has worked closely with NHS Oxfordshire and the local community in Banbury to develop sustainable services in paediatrics and obstetrics and gynaecology at the Horton General Hospital. The Programme Board, appointed to oversee the work, has now met for the last time, satisfied that the necessary changes to maintain services have already been made or are ongoing.

There are still some outstanding issues in the obstetrics service, but these are being addressed and monitored as part of the normal service between the ORH and NHS Oxfordshire.

In addition, work is being done to maintain sustainable services at the Horton over a wider range of services, including bringing more specialist clinics to the hospital so that the people of North Oxfordshire have the opportunity to be treated nearer to home.

The Trust has learned a great deal from the stakeholder engagement that has been important in building trust between the different organisations and individuals representing a broad range of interests in the communities in and around Banbury. Working in partnership with Cherwell District Council and the GP Consortium, steps are being taken to ensure that the good practice developed over the last couple of years remains in place. The outputs from these different strands of work are being woven into a new and vibrant vision for the Horton General Hospital.

For more details on the Better Healthcare Programme, including agendas and papers for meetings, please see:

www.oxfordshirepct.nhs.uk/bhp

Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service offers advice and information to patients, relatives and their carers, and assists them in raising any concerns they have regarding their treatment or the way the Trust functions. The PALS team works with hospital staff to resolve problems and assists in improving patient care. In 2010/11, PALS dealt with 5,074 enquiries, 623 at the Churchill Hospital, 1074 at the Horton General Hospital, 3,350 at the John Radcliffe Hospital and 27 non site specific.

Patients and staff can contact the service by telephone, email or letter, or call in person at the PALS offices based in the main reception areas of the John Radcliffe and Horton General hospitals.

Oxfordshire Local Involvement Network (LINK)

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

Oxfordshire LINK is made up of volunteer members, participants, groups and organisations with an interest in local care services.

The registered charity Help and Care has been the host organisation for the LINK in Oxfordshire from 2008-2011 as well as for several other local authority regions in the south of England. Their role is to support the network to be an effective voice for people in these areas. The LINK's host organisation will be changing to a new provider, Oxfordshire Rural Community Council, from 1 May 2011.

The current Volunteer Stewardship Group (steering group) of eight members represents a wide range of health and social care experiences. The group seeks views about services – good or bad – in order to prioritise issues, form project groups and ask health and social care providers to respond in order to improve services in Oxfordshire.

What Oxfordshire LINK can do for you

- Investigate specific issues of concern to the community.
- Use powers to hold services to account and get results.
- Ask for information and get answers in a specified amount of time.
- Carry out spot checks to see services are working well.
- Refer any outstanding issues to the local Overview and Scrutiny Committee of Oxfordshire County Council if it seems that action is not being taken.

Oxfordshire LINK can be contacted on 01865 883488 or by email at orcc@oxonrcc.org.uk

Volunteers

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

The Trust has over 300 active volunteers and a further 1,000 or more volunteers in other voluntary organisations, helping on average four hours per week. Volunteers support staff carrying out their duties to improve patients' experiences.

Volunteers help in various departments, talking to patients, helping at meal times on wards, taking the library trolley around wards, providing a friendly welcome and giving directions on help desks, working with the chaplaincy, and supporting staff with administrative duties.

Volunteers come from diverse areas and the Trust is pleased to work with a variety of agencies, charities and with disabled groups providing volunteer placements. Those applying to volunteer include people looking at changing careers, those who are unemployed, and students already in or applying for higher education places.

The Trust continues to work closely with the site based Leagues of Friends, Radio Cherwell and Radio Horton and charities such as the British Red Cross and SSNAP (Support the Sick Newborn and their Parents). The Trust also continues to develop links with local businesses, schools and Oxfordshire Community Volunteer Action (OCVA). The department has been involved with two local businesses, Darby's Solicitors and Amey, whose employees have volunteered maintaining two gardens in the Cancer Centre.

The Trust also has strong links with local education providers, and this year provided over 250 work experience placements for students aged 16-18 years of age.

In March 2010 the Department of Health circulated a document 'Towards Strategy – Supporting Volunteering in Health and Social Care' and the department is currently working on a volunteer strategy for the Trust. This will include marketing the opportunities for volunteers, provision of training, and involvement of volunteers and partners in our services.

Leagues of Friends

The Leagues of Friends are voluntary organisations that support the Trust by donating equipment and the small extras that enhance the environment for patients, through fundraising and income raised running cafeterias and tea bars in our Oxford hospitals, and a small shop at the Horton General Hospital. The Trust has several hundred Leagues of Friends volunteers, some of whom have been supporting the ORH for over 20 years. They are managed by Trustees, who meet every month to make decisions about how best to spend the money they raise.

Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC)

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

The Trust has continued to work with HOSC in 2010/11 to brief the committee and answer questions about our services.

Oxford Safer Communities Partnership

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

The ORH collects data related to attendances as a result of alcohol and/or violence at the Emergency Department at the John Radcliffe Hospital, which is then made anonymous and fed back to the group. This information can help police and the local council identify problem areas in the community.

Foundation Trust members

The ORH continues to work towards becoming a Foundation Trust and currently has about 4,500 public members. The Trust aims to achieve around 6,000 public members (1% of the population of Oxfordshire) by the time of first elections to the Foundation Trust Members' Council.

All Trust staff are automatically members unless they opt out, and so over 13,000 members of staff employed by the ORH, the University of Oxford's Medical Sciences Division and the Trust's Private Finance Initiative (PFI) partners (who supply catering, portering and cleaning staff at the John Radcliffe and Churchill Hospitals) are also considered to be members.

In the past year, Foundation Trust members have been invited to a programme of informative talks about our key services and to the open day demonstrating new research undertaken by OxBRC.

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

Young People's Executive (YiPpEe)

The Young People's Executive (YiPpEe) is a group of children and young people who work and meet with staff in the Children's Hospital to discuss improving services for young patients in hospital. All have either been in hospital themselves or have a brother, sister or close friend who has spent time in hospital.

YiPpEe meets during the school holidays. The age range is 9-18 years and there are currently 16 members. The group is facilitated and supported by the Trust's Children's Rights Lead Nurse, the Play Specialist team, and the Hospital School staff.

In 2010 the success of YiPpEe's contribution to children's services was recognised in the Oxfordshire Partnership Awards when the group was selected as one of the leaders in providing advice and support to new groups around the county.

YiPpEe has re-designed the way in which patients and their families can write or draw their comments. YiPpEe have also supported the children's services team by reviewing and commenting on policy development, providing challenging and constructive feedback that has influenced service development and professional practice.

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

Customer care

The Trust values the views of its patients and their families.

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

Comments and complaints

Formal complaints received by the Trust are investigated thoroughly, with the aim of being open and accountable. Where appropriate, we apologise for shortcomings and describe action taken to prevent future problems. Complaints are used not only to put things right, but to seek continuous service improvement and identify organisational learning. During this year the Trust received 827 complaints. The top two areas of concern raised in complaints were patient care and long waits for treatment. The Health Service Ombudsman formally investigated and upheld one complaint dating back to 2007, where communication with a patient's family was found to have fallen significantly below the standard that ought to have been provided.

Principles for remedy

We adhere to the principles for remedy as defined by HM Treasury in Managing Public Money. They are also cited as best practice in the NHS Finance Manual. In handling complaints and concerns we aim to:

- be customer focused
- be open and accountable
- act fairly and proportionately
- put things right
- seek continuous improvement.

Patient experience

The Picker Institute was commissioned by the ORH to undertake its annual Inpatient Survey in 2010. A total of 850 patients were sent a questionnaire. 833 patients were eligible for the survey, of which 410 returned a completed questionnaire, giving a response rate of 49.2%

In comparison to other trusts, the ORH compared favourably in regard to nursing care, and treating patients with both privacy and dignity when providing treatment or conveying personal information. Overall the Trust has significantly improved its performance in providing information to patients about treatment or conditions in the emergency departments, outpatient areas and wards, in providing same-sex accommodation and patients being able to obtain information from doctors about their condition.

Areas highlighted for improvement include waiting times in emergency departments, providing clearer information to patients about the risks or benefits of surgery, respecting patients' religious beliefs and customs and improving information provided to patients at the time of their discharge.

The Trust continues to develop its own internal processes for recording and reporting patient experience. Approximately 800 patient experience reports are collated each month from patient questionnaires, comments and suggestion forms, external NHS websites, as well as the Trust's own website, and comments from letters, email, telephone and made in person to the Patient Advice and Liaison Service (PALS).

The principal patient concerns reported throughout 2010 related to delays in answering the telephone, appointment delays or cancellations and difficulty in booking appointments. The PALS service is working with senior divisional staff to identify solutions to these problems which cause our patients so much frustration. In spite of these concerns 80% of the respondents to the question 'Would you recommend this hospital' gave a positive response.

This feedback is supported by the Picker survey which reported that only 2.9% of their respondents indicated that they would not recommend the hospital and 4.1% wanted to make a complaint.

The Patient Services team prepare monthly Board reports on patient feedback, including detailed individual and anonymised reports of all feedback information to all the matrons, divisional directors and nurses so that they can prepare action plans to improve patient care and experience.

The Trust plans to increase the opportunities for patients and their families or carers to record their views on the care they receive through the use of electronic patient survey devices, and to provide the opportunity for patients to record their views via the Hospedia bedside entertainment and telephone system.

Freedom of Information requests

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

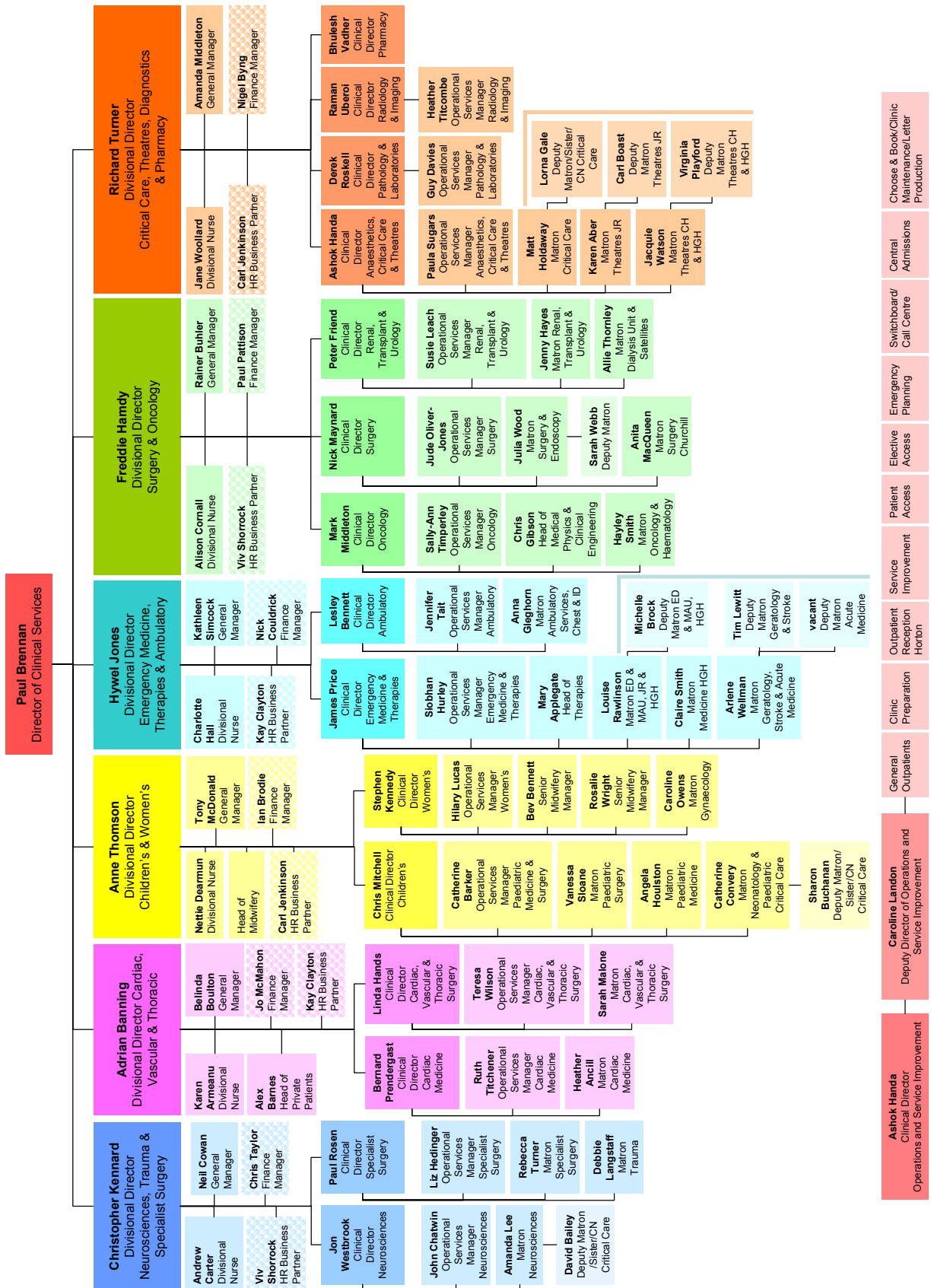
During 2010/11 the Trust received 251 requests for information with many including multiple questions. The sources of requests are broken down as follows:

- 33% Media
- 29% Individuals
- 18% Businesses
- 20% Other sources (*MPs, other NHS organisations, solicitors etc.*)

Of these requests, 66% were responded to within the 20 working days.

Appendices

APPENDIX I: Organisational Structure



APPENDIX 2: Ethnic profile of patients

Ethnicity of patient	% of total patients
White British	82.29%
White Irish	0.62%
Any other white background	3.47%
White and black Caribbean	0.69%
White and black African	0.34%
White and Asian	0.59%
Any other mixed background	0.54%
Indian	1.47%
Pakistani	1.59%
Bangladeshi	0.26%
Any other Asian background	0.91%
Caribbean	0.53%
African	0.81%
Any other black background	0.28%
Chinese	0.51%
Any other ethnic group	0.93%
Not stated	4.15%
TOTAL	100%

SECTION 2

Financial Report *2010/11*

Trust Board



Dame Fiona Caldicott*
Chairman



Sir Jonathan Michael*
Chief Executive

Non-executive Directors



Professor Sir John Bell*
(from 1 November 2009)



Mr Alisdair Cameron*
(from 1 May 2009)



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



Mr Geoffrey Salt*
(from 1 May 2009)



Mrs Anne Tutt*
(from 1 December 2009)



Mr Peter Ward*
(from 1 December 2009)

Executive Directors



Professor Edward Baker*
Medical Director



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



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



Mr Mark Mansfield*
*Director of Finance and
Procurement*



Mr Andrew Stevens*
*Director of Planning and
Information*



Mrs Elaine Strachan-Hall*
Chief Nurse

Other Executive Directors who attended Board Meetings in the year 2010/11 are Mr Graham Bennett who was Interim Director of Finance until June 2010 and Dr James Morris, Medical Director until 31 August 2010.

*Voting Member of the Trust Board

Board Committee Membership 2010/11

The Board reviewed its committee structure during 2010/11 and the report shows the situation to 31 December 2010 and the subsequent position from 1 January 2011.

TO 31 DECEMBER 2010

Audit Committee

Mr Alisdair Cameron (Chair), Mrs Anne Tutt and Mr Geoffrey Salt comprised the Committee during the year.

Finance and Performance Committee

This Committee stopped meeting in April 2010. For membership of this Committee, see the schedule of Trust Board members opposite, as the Committee has the same membership as the Trust Board. Dame Fiona Caldicott (Chairman) was Committee Chair throughout the year.

Governance Committee

Dame Fiona Caldicott, Mr Geoffrey Salt (Chair) and Mr Peter Ward comprised the Committee during the year.

FROM 1 JANUARY 2011

Audit and Finance Committee

Mr Alisdair Cameron (Chair), Mrs Anne Tutt and Mr Geoffrey Salt comprised the Committee from 1 January 2011.

Quality Committee

Dame Fiona Caldicott, Mr Geoffrey Salt (Chair), Mr Peter Ward, Sir Jonathan Michael, Professor Edward Baker, Mrs Elaine Strachan-Hall, Ms Sue Donaldson and Mr Paul Brennan comprised the Committee from 1 January 2011.

Board in Committee

The Board in Committee came into effect on 1 January 2011 and is made up of all Board members as listed above.

Remuneration and Appointments Committee – in place throughout the year

All Non-executive Directors are members of the Committee, of which the Chairman of the Trust is Chair. Meetings of the Committee are quorate if three members are present (one of whom should normally be the Chairman of the Board).

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

The Committee meets as necessary but at the minimum, not less than twice a year.

Declaration of Interests and Register of Interests of members of the Trust Board for the year 2010/2011

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

The interests for the year 2010/2011 are given below. Guidance to the codes defines 'relevant and material' interests as:

- a** Directorships, including Non-executive Directorships held in private companies or PLCs (with the exception of those for dormant companies);
- b** ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;
- c** majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS;
- d** a position of authority in a charity or voluntary organisation in the field of health and social care;
- e** any connection with a voluntary or other organisation contracting for NHS services;
- f** research funding/grants that may be received by an individual or department;
- g** interests in pooled funds that are under separate management

Director	a	b	c	d	e	f	g
Dame Fiona Caldicott, <i>Chairman</i>	Non-executive Director and Company Secretary Waters 1802 Ltd.	None	None	None	None	None	None
Professor Sir John Bell, <i>Regius Professor of Medicine</i> <i>Non-executive Director</i>	Non-executive Director, Roche AG, Genentech, and Oxagen	None	None	Trustee, Rhodes Trust, and Ewelme Almshouse Charity	Chairman, Office for Strategic Co-ordination of Health Research, Department of Health Genome Strategy Group, and Oxford Health Alliance	President of Academy of Medical Sciences	
Professor Edward Baker, <i>Medical Director from 01.09.10</i>	None	None	None	None	None	None	None
Mr Graham Bennett, <i>Interim Director of Finance to 30.06.10</i>	None	Director, Graham Bennett Associates	None	None	None	None	None
Mr Paul Brennan, <i>Director of Clinical Services, Associate Board Member</i>	None	None	None	None	None	None	None
Mr Alisdair Cameron, <i>Non-executive Director</i>	Non-executive Director of the E-Learning Foundation; Executive Director/Trustee of various British Gas/Centrica companies	None	None	None	Mrs Cameron is a member of Fundraising Committee for Children's Hospital	None	None
Ms Sue Donaldson, <i>Director of Human Resources and Organisational Development, (Associate Board Member)</i>	Governor of Oxford and Cherwell Valley College with effect from 14.12.10 to 13.12.12						
Mr Mark Mansfield, <i>Finance Director from 01/07/10</i>	None	None	None	None	None	None	None
Professor David Mant, <i>Associate Board Member</i>	Acting Head of the Oxford University Department of Primary Health Care				Research Grant holder from medical charities, EU, Department of Health and NIHR		
Sir Jonathan Michael, <i>Chief Executive</i>	None	None	None	None	None	None	None
Dr James Morris, <i>Medical Director to 31.08.10</i>	Non-executive Director, NHS Innovations South East	None	None	None	None	None	None
Mr Geoffrey Salt, <i>Deputy Chairman</i>	None	None	None	None	None	None	None
Mr Andrew Stevens, <i>Director of Planning and Information</i>	None	None	None	None	None	None	None
Mrs Elaine Strachan-Hall <i>Chief Nurse</i>	Director, Ollidoowedji Ltd.	Stepmother to Suzanne Hall who contracts for language and translation services	None	None	None	None	None

Director	a	b	c	d	e	f	g
Mrs Anne Tutt, <i>Non-executive Director</i>	Section 11 Trustee, Oxford Radcliffe Hospitals Charitable Funds from December 2010 Non-executive director of the Adventure Capital Fund Ltd; Non-executive Director of Social Investment Business Ltd; Non-executive Director of Bamboo Innovations Ltd; Non-executive Director of Identity and Passport Service	Ownership of private business, A Tutt Associates Ltd.		Consultant to the Cochrane Collaboration			
Mr Peter Ward, <i>Non-executive Director</i>	None	None	None	None	None	None	None
Mr Mike Fleming, <i>Executive Director Horton General Hospital</i>	None	None	None	None	None	None	None
Mr Ian Humphries, <i>Director of Estates and Facilities</i>	None	None	None	None	None	None	None

NOTE: The Adventure Capital Fund Ltd and the Social Investment Business Ltd are companies in a group that makes grants and loans to third sector organisations who may contract for NHS services. They also manage the following funds; Future Builders England, Community Builders and SEIF (on behalf of the Department of Health).

Financial review

Summary of financial position

At the outset of 2010/11 the Trust set itself the objective of achieving a balanced income and expenditure out-turn (or "break-even") for the year. This was considered a primary duty for the organisation in 2010/11.

This objective was achieved and a small surplus of £1.289m (0.2%) was delivered against the "break-even duty" for NHS trusts. This constituted a satisfactory outcome to the financial year.

This performance was achieved whilst the Trust was also managing considerable operational pressures, in particular during the winter period. The organisation delivered a cost improvement and efficiency programme of £44m whilst managing these operational imperatives.

Whilst the Trust achieved a break-even in 2010/11 it continues to carry the burden of cumulative deficits derived from the financial performance recorded in 2005/6 and 2006/7. In 2011/12 the organisation plans to make a surplus of 1% of turnover so as to make good this historic deficit.

In order to meet these historic and internally derived challenges and discharge our responsibilities with regard to local and national savings programmes, the Trust aims to deliver an efficiency plan of £52 million in 2011/12. This constitutes a challenge but it is one to which the Trust must respond if it is to achieve its strategic objectives in the longer term.

Basis of preparation

Since 1 April 2009, NHS organisations have been required to prepare their accounts under IFRS, rather than under UK Generally Accepted Accounting Principles. IFRS has been applied for both the 2010/11 and 2009/10 financial years.

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

Going concern

The accounts have been prepared on a going concern basis, reflecting the cash-flow forecasts of the Trust over the 15 months subsequent to the balance sheet date. The Trust is expecting to deliver a financial surplus going forward.

Contingent liabilities

The Notes to the Accounts disclose that at the year end the Trust had contingent liabilities of £12.4 million.

Format of the accounts

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

Four primary statements

- Statement of Comprehensive Income
- Statement of Financial Position
- Statement of Change in Taxpayers' Equity
- Statement of Cash-flows

The Annual Accounts also include

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

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

The full Annual Report for 2011 including:

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

is available upon request from:

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

It is also available on our website www.oxfordradcliffe.nhs.uk and in CD format from the Media and Communications Unit on 01865 231471.

Summary of financial duties

The Trust's performance measured against its statutory financial duties is summarised as follows.

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

The Trust reported a surplus of income over expenditure of £1.289 million for 2010/11, after Department of Health agreed exclusions of £11.918 million arising from the technical treatment associated with Private Finance Initiative schemes 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.

The Trust has not satisfied the requirements of the five year break-even duty applicable to NHS trusts. The surplus of £1.289 million is better than the break-even plan and forms part of a plan agreed by the Board to eliminate the cumulative deficit by the end of 2013/14.

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

NHS trusts are targeted to absorb the cost of capital at a rate of 3.5% of average net assets (as reflected in their opening and closing balance sheets for the year). In 2009/10 and 2010/11 the dividend payable on public dividend capital was based upon the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

External financing limit (an overall cash management control)

The Trust was set a target to reduce its level of external finance by £10.615 million in 2010/11. The Trust over achieved against this target by reducing its level of external finance by £18.399 million which was £7.784 million better than the target.

Performance over the last five years

Financial year	Turnover £000	Surplus/(deficit) before dividend £000	Retained surplus/(deficit) £000	CCA rate % (target 3.5% from 2003/4)
2010/11	663,770	19,794	13,207	3.5
2009/10	635,893	(40,420)	(48,100)	3.5
2008/9	614,371	15,599	2,405	4.0
2007/8	553,098	16,105	4,311	3.5
2006/7	484,559	1,174	(8,649)	3.4

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

For break-even performance, impairments and IFRIC 12 (International Financial Reporting Interpretations Committee) adjustments are excluded so performance in 2009/10 was accordingly £106,000 retained surplus and £1.289 million retained surplus in 2010/11.

Exit packages for staff leaving 2010/11

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 (total cost)	Number of departures included in (b) and (c) where special payments have been made (special payment element (totalled))
<£20,001	2	9	11 (£139,000)	
£20,001 - £40,000	1	12	13 (£401,000)	
£40,001 - £100,000	3	7	10 (682,000)	
£100,001 - £150,000	1	–	1 (£123,000)	1 (£12,000)
£150,001 - £200,000	–	–	–	–
Total number of exit packages by type (total cost)	7 (£404,000)	28 (£941,000)		
			Total number (and cost) of exit packages	Total number (and cost) of exit packages
			35 (£1,345,000)	1 (£12,000)

Summary financial statements

These accounts for the year ended 31 March 2011 have been prepared by the Oxford Radcliffe Hospitals NHS Trust under section 232 (Schedule 15) of the National Health Service Act 2006 in the form which the Secretary of State, with the approval of the Treasury, has directed.

The financial statements that follow are only a summary of the information contained in the Trust's Annual Accounts.

A printed copy of the full accounts is available, free of charge, on request from the Director of Finance and Procurement and is inserted as an appendix to this report. In addition the accounts are also available on the website www.oxfordradcliffe.nhs.uk in the section 'About us'. The Trust is required to include a Statement on Internal Control and this is shown at the end of this document.

Foreword to the accounts

The Trust made a surplus of £1.289 million against the break-even duty for 2010/11. The Trust accounts record a surplus of £13.207 million; the difference of £11.918 million relates to technical treatments associated with accounting for Private Finance Initiatives' schemes and revaluations of assets which are each excluded by the Department of Health when considering the performance of Trusts.

	2010/11	2009/10
Retained surplus/deficit for the year	13,207	(48,100)
IFRIC* 12 adjustment	(300)	46,594
Impairments	(11,618)	1,612
Reported NHS finance performance position [Adjusted retained surplus]	1,289	106

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

Statement of comprehensive income for the year ended 31 March 2011

	2010/11 £000	2009/10 £000
Revenue		
Revenue from patient care activities	546,704	513,569
Other operating revenue	117,066	122,324
Operating expenses	(625,079)	(657,788)
Operating surplus/(deficit)	38,691	(21,895)
Finance costs		
Investment revenue	87	61
Other gains (and losses)	(293)	(253)
Finance costs	(18,691)	(18,333)
Surplus/(deficit) for the financial year	19,794	(40,420)
Public dividend capital dividends payable	(6,587)	(7,680)
Retained surplus/(deficit) for the year	13,207	(48,100)
Other comprehensive income		
Impairments and reversals	(1,157)	(48,619)
Gains on revaluations	5,456	8,828
Receipt of donated/government granted assets	1,575	903
Net gain/(loss) on other reserves (e.g. defined benefit pension scheme)	0	0
Net gains/(losses) on available for sale financial assets	0	0
Reclassification adjustments:		
– transfers from donated and government grant reserves	(1,944)	(3,081)
– on disposal of available for sale financial assets	0	0
Total comprehensive income for the year	17,137	(90,069)

Statement of financial position as at 31 March 2011

	31 March 2010/11 £000	31 March 2009/10 £000
Non-current assets		
Property, plant and equipment	603,110	597,450
Intangible assets	4,063	3,182
Other financial assets	0	0
Trade and other receivables	2,587	2,171
Total non-current assets	609,760	602,803
Current assets		
Inventories	10,834	10,528
Trade and other receivables	25,851	29,438
Other financial assets	0	0
Other current assets	0	0
Cash and cash equivalents	19,477	10,364
	56,162	50,330
Non-current assets held for sale	0	0
Total current assets	56,162	50,330
Total assets	665,922	653,133
Current liabilities		
Trade and other payables	(78,449)	(73,164)
Other liabilities	0	0
Borrowings	(15,947)	(13,116)
Other financial liabilities	0	0
Provisions	(3,358)	(690)
Net current assets/(liabilities)	(41,592)	(36,640)
Total assets less current liabilities	568,168	566,163
Non-current liabilities		
Borrowings	(283,652)	(298,662)
Trade and other payables	(60)	(90)
Other financial liabilities	0	0
Provisions	(1,032)	(1,124)
Other liabilities	0	0
Total assets employed	283,424	266,287
Financed by taxpayers' equity:		
Public dividend capital	174,547	174,547
Retained earnings	(65,259)	(78,466)
Revaluation reserve	103,696	99,528
Donated asset reserve	68,626	68,838
Government grant reserve	71	97
Other reserves	1,743	1,743
Total taxpayers' equity	283,424	266,287

Statement of cash flows for the year ended 31 March 2011

	2010/11 £000	2009/10 £000
Cash flows from operating activities		
Operating surplus/(deficit)	38,691	(21,908)
Depreciation and amortisation	28,688	31,975
Impairments and reversals	(11,618)	46,594
Net foreign exchange gains/(losses)	0	0
Transfer from donated asset reserve	(1,944)	(2,986)
Transfer from government grant reserve	0	(95)
Interest paid	(17,565)	(18,097)
Dividends paid	(6,960)	(7,104)
(Increase)/decrease in inventories	(306)	(1,633)
(Increase)/decrease in trade and other receivables	2,492	4,609
(Increase)/decrease in other current assets	0	0
Increase/(decrease) in trade and other payables	7,329	(4,660)
Increase/(decrease) in other current liabilities	0	0
Increase/(decrease) in provisions	2,545	(470)
Net cash inflow/(outflow from operating activities)	41,352	26,225
Cash flows from investing activities		
Interest received	87	86
(Payments) for property, plant and equipment	(21,158)	(27,741)
Proceeds from disposal of property, plant and equipment	561	0
(Payments) for intangible assets	(1,805)	0
Proceeds from disposal of intangible assets	0	0
(Payments) for investments with Department of Health	0	0
(Payments) for other investments	0	0
Proceeds from disposal of investments with Department of Health	0	0
Proceeds from disposal of other financial assets	0	0
Revenue rental income	0	0
Net cash inflow/(outflow) from investing activities	(22,315)	(27,655)
Net cash inflow/(outflow) before financing	19,037	(1,430)
Cash flows from financing activities		
Public dividend capital received	0	1,961
Public dividend capital repaid	0	0
Loans received from the Department of Health	0	0
Other loans received	0	0
Loans repaid to the Department of Health	(4,736)	(4,736)
Other loans repaid	0	0
Other capital receipts	2,254	0
Capital element of finance leases and PFI	(7,442)	(4,718)

continued overleaf...

Net cash inflow/(outflow) from financing	(9,924)	(7,493)
Net increase/(decrease) in cash and cash equivalents	9,113	(8,923)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	10,364	19,287
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	19, 477	10,364

Better Payment Practice Code 2010/11 – measure of compliance

	Number	£000
Total non-NHS trade invoices paid in the year	98,303	237,483
Total non-NHS trade invoices paid within target	88,732	202,498
Percentage of non-NHS trade invoices paid within target	90%	85%
Total NHS trade invoices paid in the year	4,771	55,249
Total NHS trade invoices paid within target	3,540	44,785
Percentage of NHS trade invoices paid within target	74%	81%

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

Management costs

	2010/11 £000	2009/10 £000
Management costs	20,384	21,277
Income	663,770	635,893

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

Summary of financial statements

External audit services are provided by the Audit Commission

Audit fees of £378,231 including VAT in 2010/11 include charges for main Audit Fee of £198,528, £138,156 for value for money, £588 for the National Fraud Initiative, £16,959 for the review of arrangements for production of the Quality Account and £24,000 for advisory work commissioned separately by the Trust on the accuracy of clinical coding under the Payment by Results data assurance framework.

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

Summary of financial statements

Salary and pension entitlements of senior managers

A) Salaries and allowances

Name and title	2010/2011			2009/2010		
	Salary (bands of £5,000) £000	Other remuneration (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	Benefits in kind Rounded to the nearest £00
Dame Fiona Caldicott	20-25			20-25		
Mr Geoffrey Salt	5-10			5-10		
Mr Alisdair Cameron	5-10			5-10		
Professor Sir John Bell	5-10			0-5		
Mrs Anne Tutt	5-10			0-5		
Mr Peter Ward	5-10			0-5		
Professor David Mant	5-10					
Mr Trevor Campbell Davis (Left) (1)	-	95-100		140-145		
Sir Jonathan Michael	230-235					
Mr Graham Bennett (2)	90-95			60-65		
Mr Mark Mansfield (5)	105-110					
Dr James Morris (3)	15-20			40-45	175-180	
Mrs Elaine Strachan-Hall	115-120			115-120		
Mr Andrew Stevens	105-110			105-110		
Mr Paul Brennan (6)	115-120		60			
Ms Sue Donaldson	105-110					
Professor Edward Baker (4)	20-25	100-105				

NOTES

1. Left October 2009, a payment for compensation for loss of office was made in March 2011
2. Employed via agency, costs include agency commission and similar costs, left June 2010
3. Retired as Medical Director on 31 August 2010
4. Commenced September 2010
5. Commenced June 2010
6. Commenced June 2010

Salary and pension entitlements of senior managers

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 2011 (Bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 (Bands of £2,500) £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to Stakeholder Pension To nearest £100
Dr James Morris	0-2.5	2.5-5	40-45	120-125	0	0	0	0
Mrs Elaine Strachan-Hall	5-7.5	15-17.5	40-45	125-130	641	639	2	0
Mr Andrew Stevens	0-2.5	2.5-5	40-45	120-125	681	736	(56)	0
Mr Mark Mansfield	-0-2.5	-2.5-5	45-50	135-140	728	844	(69)	0
Mr Paul Brennan	7.5-10	22.5-25	50-55	160-165	874	841	33	0
Professor Edward Baker	10-12.5	35-37.5	80-85	250-255	1,674	1,357	106	0
Ms Sue Donaldson	0-2.5	2.5-5	5-10	25-30	132	128	4	0

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.

Independent auditor's report

Independent auditor's report to the Board of Directors of Oxford Radcliffe Hospitals NHS Trust

I have examined the summary financial statement for the year ended 31 March 2011 which comprises the Statement of Comprehensive Income, the Statement of Financial Position and the Statement of Cash Flows set out on pages 8 to 11.

This report is made solely to the Board of Directors of Oxford Radcliffe Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 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

The directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of Oxford Radcliffe Hospitals NHS Trust for the year ended 31 March 2011. I have not considered the effects of any events between the date on which I signed my report on the statutory financial statements of 9 June 2011 and the date of this statement.

Phil Sharman
Engagement Lead
Officer of the Audit Commission

Audit Commission
ISIS Business Centre,
Horspath Road, Cowley,
OXFORD, OX4 2RD

18 July 2011

Explanation of financial terms

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

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

Terms used within the Statement of Comprehensive Income

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

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

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

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

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

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

The **Statement of Financial Position** provides a snapshot of the Trust's financial condition at a specific moment in time – the end of the financial year. It lists assets (everything the Trust owns that has monetary value), liabilities (money owed to external parties) and taxpayers' equity (public funds invested in the Trust). At any given time, the assets minus the liabilities must equal taxpayers' equity.

Terms used within the Statement of Financial Position

Intangible assets are assets such as goodwill, licenses and development expenditure which although they have a continuing value to the business do not have a physical existence.

Tangible fixed assets include land, buildings, equipment and fixtures and fittings.

Debtors represent money owed to the Trust at the Balance Sheet date.

Creditors represent money owed by the Trust at the Balance Sheet date.

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

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

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

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

Terms used within the cash-flow statement

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

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

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

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

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

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

Statement on Internal Control for 2010/11

Scope of responsibility

1. The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets, for which I am personally responsible, as set out in the Accountable Officer Memorandum.
2. It is my responsibility to provide leadership to the Trust and to ensure that the Trust provides safe, effective, high quality and patient-centred care.
3. As Chief Executive, I work within a performance management framework established by the South Central Strategic Health Authority (SHA) and attend meetings of the SHA's Chief Executive group.
4. The Trust works in partnership with the local health and social care community and particularly with Oxfordshire Primary Care Trust (PCT) and Oxfordshire County Council through a number of formal mechanisms including:
 - 4.1 the Oxfordshire Safeguarding Boards
 - 4.2 the Oxfordshire Health Overview and Scrutiny Committee
 - 4.3 the Delayed Transfers of Care Programme Board
 - 4.4 the Creating a Healthier Oxfordshire Programme Board
5. Within the wider health economy, the Oxford Radcliffe Hospitals NHS Trust (ORH) has effective working relationships with other key commissioners, including the Berkshire, Buckinghamshire, Gloucestershire, Northamptonshire and Wiltshire PCTs, and with NHS acute trusts in those counties. The recent Ofsted review of system-wide safeguarding arrangements carried out with the Care Quality Commission (CQC) indicated good partnership working between the ORH and its key partners.
6. The Trust has a strong relationship with Oxford's two universities. Its partnership with the University of Oxford is led through the Strategic Partnership Board and a number of other mechanisms currently being formalised.

The purpose of the system of internal control

7. The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore provide reasonable, but not absolute, assurance of effectiveness. The system of internal control is based on an on-going process designed to:

- 7.1 identify and prioritise risks to the achievement of the organisation's policies, aims and objectives; and to
 - 7.2 evaluate the likelihood of those risks being realised, and the impact should they be realised and to manage these risks efficiently, effectively and economically.
8. The system of internal control has been in place in Oxford Radcliffe Hospitals NHS Trust for the whole year ended 31 March 2011, and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

9. The Board reviewed its arrangements for the management and leadership of all aspects of risk during September and October 2010 following an external review on all aspects of governance and assurance. As a result, changes took place in the responsibilities of individual Executive Directors, particularly in relation to safety, quality and risk. In addition, the Board agreed the appointment of a Director of Assurance and the post was filled early May 2011.
10. These changes were also informed by the two reviews of internal clinical governance practice and systems carried out in April 2010 following the pausing of paediatric cardiac surgery in March 2010.
11. The Board reviewed its committee structure to ensure that the appropriate governance and assurance systems were in place to support the Board and its management and leadership of all aspects of risk.

Detailed terms of reference were drawn up for the consideration and approval of the Board in November 2010 and the new committees came into being from 1 January 2011.

- 11.1 Audit and Finance Committee (replacing the Audit Committee)
 - 11.2 Quality Committee (replacing the Governance Committee)
 - 11.3 Remuneration and Appointments Committee
 - 11.4 Board in Committee
12. The Audit and Finance Committee is responsible for providing assurance to the Trust Board on the Trust's system of internal control by means of independent and objective review of financial and corporate governance, and risk management arrangements, including compliance with laws, guidance and regulations governing the NHS.

13. The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of quality of clinical care; governance systems for clinical, corporate, human resources, information and research and development issues; and regulatory standards of quality and safety.
14. A new management executive committee structure was introduced following the implementation of the new clinically-led organisation with six clinical divisions on 1 November 2011. The Executive Directors and the Divisional Directors form the Trust Management Executive, chaired by the Chief Executive.
15. The subcommittee structure, aimed at covering all key areas of control and risk, was agreed in late 2010 and includes:
 - 15.1 Clinical Governance Committee
 - 15.2 Strategic Planning Committee
 - 15.3 Workforce Committee
 - 15.4 Education and Training Committee
 - 15.5 Research and Development Committee
 - 15.6 Performance Review Committee
 - 15.7 Health Information and Technology Committee
16. In addition, the Electronic Patient Record (EPR) Programme Board, chaired by the Chief Executive, also reports to the Trust Management Executive.
17. Risk management and health and safety policies and procedures are available to all staff through the Trust intranet together with risk management training programmes. A number of the training materials and policies and procedures were reviewed during the second half of 2010/11 to reflect changes in the committee structures within the Trust, and to reflect the actions taken as part of the Paediatric Cardiac Action Plan.
18. The intranet is used as a resource for sharing internal documents and for highlighting areas of good practice across the Trust and from elsewhere. In particular, the expertise of the Nuffield Orthopaedic Centre (NOC) is being drawn on as policies and procedures are brought together in advance of the integration.

The risk and control framework

19. The review of the governance and assurance arrangements (paragraph 9 above) resulted in changes to the responsibilities of individual Directors. The Medical Director has assumed responsibility for clinical governance, the Chief Nurse for patient safety and reactive risk, and the Director of Assurance for assurance, governance and regulation.

The Director of Planning and Information became the lead Executive for Information Governance and the Senior Information Risk Officer (SIRO). The full impact of this on the risk and control framework will be seen in the early part of 2011/12.

20. The Medical Director has specific responsibility for the management of infection prevention and control, and works with the infection control team to ensure that the Board and the Trust Management Executive have been kept fully current with all issues associated with the management of healthcare associated infections. Quarterly reports are provided to the Quality Committee.
21. The governance, safety, quality and risk framework describes the integrated organisational governance, safety, quality and risk management structure and identifies key committees and responsibilities. The framework will next be reviewed in May/June 2011 and will draw on the reviews already undertaken (see paragraph 9 above), the requirements of National Health Service Litigation Authority (NHSLA) and the changes made (and to be made) in the governance and assurance systems and arrangements.
22. A key element in the framework is the Trust Risk Register which was reviewed by the Board on four occasions during the year following review and updating by the executive and divisional teams. The Trust Management Executive has responsibility for the review of risks and quality issues, drawing on work within the divisions and corporate directorates and considered the Register at its meeting in March 2011.
23. The Quality Committee at its March meeting undertook the final year-end review of the Board Assurance Framework and the Trust Risk Register. This monitoring role will be taken on by the Audit and Finance Committee for 2011/12; a joint meeting with the Quality Committee will be planned to ensure full review of both documents during the year.
24. The Director of Assurance will review the processes and systems that support risk management and the development of the Board Assurance Framework, working with Executive and Divisional Directors. This work started in May 2011 and will look to the preparation and consideration of updated documents, processes and assurance system by the end of July 2011. The work will also focus on supporting the NHSLA assessment during 2011/12.

25. Key risks during the year were categorised as follows:
 - 25.1 safety and quality – risks to the maintenance of CQC Registration following the compliance reviews published in January 2011, environmental and health and safety, and risks to the patient experience and data security;
 - 25.2 finance – delivery of the agreed year-end position taking account of income, cost improvement and expenditure targets;
 - 25.3 use of resources – risks arising from pressures on the capital programme, workforce and recruitment;
 - 25.4 performance – risks to the delivery of operational performance standards (and particularly the 4 hour wait, 18 week wait and delayed transfers of care standards);
 - 25.5 reputation – risks relating to all of the above and other events, including the Independent Review of Paediatric Cardiac Surgery and the CQC Compliance Review, that impact on the reputation of the organisation.
26. The Board delegated the review and monitoring of the Board Assurance Framework (BAF) for 2010/11 to the Governance Committee [June and September 2010] / Quality Committee [March 2011] but considered it in detail in July, September and November 2010, and in March and April 2011. In addition, the BAF was reviewed by the Trust Management Executive in March 2011.
27. All of the components defined by the Department of Health have been incorporated, including assurances and gaps in controls and assurances. The strategic goals and strategic objectives were approved by the Board as part of the Business Plan in April 2010. The Board subsequently agreed to a further review as part of the move toward Foundation Trust (FT) status and integration with the NOC.
28. For each strategic objective, risks have been identified. The Trust has named Executive leads to focus on these and gaps in controls and assurances on the controls have been identified.
29. Action plans have been in place throughout the year to meet gaps, and the BAF shows the status at the year end. Areas of concern remain in relation to:
 - 29.1 delivery of aspects of operational performance (including the 4 hour wait, cancer targets and 18 weeks);
 - 29.2 continued risks from operational performance pressures to the quality of care and the patient experience (and the need to achieve and maintain compliance with CQC regulations and outcomes);
30. The gaps and risks associated with the strategic objectives are being managed through the lead Executive Directors, the Trust Management Executive and the Board.
31. The ORH was registered unconditionally with the CQC in April 2010. Following the planned compliance review during August and September 2010, and the publication of the compliance reports in January 2011, the ORH was deemed not to be compliant in four outcome areas and to need to make improvements in a further two.
32. A detailed action plan, approved by the Board on 28 February 2011, is now in place with regular reports being provided to the Board through the Trust Management Executive. The plan builds on the progress already made across the Trust in these areas since August 2010. The Quality Committee will review the evidence provided in support of the completion of the agreed actions to assure the Board.
33. The Director of Planning and Information is the designated Senior Information Risk Officer (SIRO) [having taken over from the Chief Nurse in November 2010] and the Board lead for information governance. The Information Governance Group oversees information governance activity across the Trust. During the year, it carried out the agreed work programme, which included the review and updating of key information governance policies on confidentiality and information protection. The group also reviewed Freedom of Information requests, relevant incidents and oversaw the annual information governance toolkit self-assessment.
34. The Governance Committee (and from March 2011, the Quality Committee) considered detailed reports on information governance and endorsed the arrangements for the management of information governance, the information governance strategy and policy, and approved and monitored the Information Governance Group's work programme.
35. The outcome of the Information Governance Toolkit self-assessment showed a result of 72%. A complete review of Version 8 of the Toolkit was undertaken by the Connecting for Health policy team. This included reducing the number of requirements to 45 from 66 which required evidence to be uploaded when scores were automatically allocated. All requirements had to achieve a minimum level 2 to gain an overall pass. The amalgamation of requirements made it difficult to achieve the same results as previously, hence the lower score of 72% compared to 83% last year.

36. As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.
37. The Trust has undertaken risk assessments and a draft Carbon Reduction and Sustainability Strategy is scheduled for consideration by the Trust Board. Delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UK Climate Impacts Programme (UKCIP) 2009 weather projects, to ensure that obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.
38. The Trust has undertaken a climate change risk assessment and will be developing an Adaptation Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.
39. The current Major Incident Plan was approved in June 2010 but is currently under review and now includes: an assessment of the risk of flooding; the Business Continuity Plan in January 2009; the pandemic influenza plan in June 2010; and the Hospital Evacuation Plan in January 2010. The Trust works with the Local Resilience Forum (LRF) in the Thames Valley and Oxfordshire. The Major Incident Plan will be brought to the Board in June for approval following its review by the Trust Management Executive.
40. Control measures are in place to ensure compliance with all obligations under equality, diversity and human rights legislation. These include the requirement to complete a relevant section of the pro forma preface to Board papers, and to complete an impact assessment on submission of policies and other key documents for approval.
41. The Trust's Information Management and Technology services are provided by Oxfordshire Health Informatics Service (OHIS) with performance standards, contingency plans and risk management arrangements enshrined in the Service Level Agreement (SLA), managed by the Director of Planning and Information. The Trust's Information Systems Board, chaired by the Director of Planning and Information, with membership including the Caldicott Guardian, the Director of Clinical Services, the Care Records Service (CRS) Project Director and the Director of Finance, oversees the Trust's annual requirements, as set down in the Business Plan, and its longer-term strategic Information Technology (IT) requirements. The management of operational risks within OHIS is integrated with the Trust's risk management processes, and is taken account of through the Trust Risk Register.
42. Close working relationships have been fostered with patients and the public. Meetings were held throughout the year with several patient bodies and the Trust Patient and Public Panel. Joint work has included the development of patient public and involvement, infection control, privacy and dignity, equality and diversity, protected meal times and specialist surgery. Patients and patient representatives have maintained their contribution to the preparation of good quality information on services and procedures, including new clinical information leaflets produced during the year against an agreed programme.
43. The Trust has maintained contact with the membership recruited to date towards its application for authorisation as a Foundation Trust, and organised several members' events during the year, and has worked with the Oxford Biomedical Research Centre in its public events.
44. The Trust has maintained a regular briefing for key Trust stakeholders (other health organisations, local MPs, council leaders and chief executives, voluntary groups, charities, patient groups etc.). This briefing has been sent out every two months and has been well-received. The briefing contains regular updates on important issues within the Trust. In addition, the Trust also sends out a briefing to GPs every two months on issues that are of interest and relevance to them in their relationship with the Trust.
45. The Trust's directors and managers have continued to brief the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) and to maintain contact with the Oxfordshire Local Involvement Network (LINKS) organisation.
46. The ORH has been working closely with the Nuffield Orthopaedic Centre NHS Trust since September 2010 when both Boards agreed to work towards integration as a single organisation. The Boards subsequently agreed the business case in February 2011 and the intention is for integration by 1 July 2011 with the ORH Board remaining in place and the dissolution of the NOC Board, although current discussions with the Co-operation and Competition Panel (CCP) and the Department of Health may result in this timeline being amended.

47. A key element of the work has been the understanding of the risks and controls needed to mitigate the risks arising in the run up to the integration, during the integration and subsequent to the integration. The Integration Executive Group, that I chair, meets fortnightly to receive updates on the progress with implementation plans and the management and mitigation of risks.

Review of effectiveness

48. As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. This review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework (BAF), and on the controls reviewed as part of the internal audit work. Executive managers with responsibility for the development and maintenance of systems of internal control also provide me with assurance. The BAF itself also provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the arrangements set out below.

49. Directors have individually confirmed their acceptance of, and compliance with, the Codes of Conduct and Accountability, and their declarations of interest for the year have been recorded in public. Members of the Divisional teams and the consultant body have also declared their interests as a matter of public record.

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

51. The Audit Committee (now the Audit and Finance Committee) approved the counter fraud annual plan and will shortly consider the counter fraud annual report for 2010/11. It receives regular reports from the local counter fraud specialists at each of its regular meetings and a full briefing on the implications of the Bribery Act was provided to the Trust Management Executive. An action plan to deliver the necessary actions will be considered by the Trust Management Executive early in 2011/12.

52. The process for ensuring robust actions are taken in response to internal audit reports recommendations has been rigorously monitored by the Audit and Finance Committee. Controls remain in place to ensure that the delivery of the recommendations is timely and appropriate. Exceptions/failures are reported through the Director of Finance to me.

53. The Trust's Risk Register is based on the highest risks identified by the divisions, specific areas (including infection control and medicines management) and the corporate directorates.

54. I have determined, however, that the risk assessment, management and assurance processes need to be reviewed as referred to above (p 24).

55. The Audit and Finance Committee has reviewed the systems of internal control, and informed me, as Accountable Officer, of its view on the level of their effectiveness. The Committee has indicated that additional work needs to be done during 2011/12 to make further improvements on internal controls and assurance systems. The Committee's work plan for the coming year will include a focus on regular reviews of internal controls and will seek reports from the Trust Management Executive on key control areas including risk management, NHS Litigation Authority (NHSLA) and financial controls.

56. Plans are being implemented to address weaknesses and ensure continuous improvement of the system. These plans will be monitored by the Audit and Finance Committee on behalf of the Trust Board as part of its work programme agreed at the March meeting of the Committee.

57. The Head of Internal Audit has provided me with an overall opinion that satisfactory assurance can be given, that a generally sound system of internal controls is in place, designed to meet the organisation's objectives, and controls are generally being applied consistently and effectively with minor areas of improvement identified.

Significant control issues

58. The Trust actively co-operated with the Independent Review Panel that the Strategic Health Authority (SHA) established following the pause by the Trust of paediatric cardiac surgery in March 2010. The action plan covering the 15 recommendations made by the Panel in July 2010 has been monitored by the Board and regularly reported to the SHA. The SHA will be reviewing the final action plan report, together with the schedule of supporting evidence, during April and will make the report available for discussion with the Independent Review Panel members.

59. Following the CQC Compliance Review, a detailed action plan is in place aimed at ensuring return to full compliance with four outcomes and to deliver improvements in a further two areas. In addition, the developing governance and assurance arrangements within the ORH will ensure a focus on continued compliance across all of the 16 outcomes. A process has been agreed for the monitoring of the CQC Action plan through the Trust Management Executive, with reports to the Board and the Quality Committee.
60. It should be noted that the John Radcliffe Hospital was visited in May 2011 by the CQC as part of a compliance review in relation to outcomes 1 and 5. The report from that review will be published in July 2011.
61. 99 Serious Untoward Incidents (SUIs) – now known as Serious Incident Requiring Investigation (SIRIs) – were investigated during 2010/11 broken down into the following categories (key categories include pressure ulcers (60%), MRSA and C. Difficile bacteraemia (9%), medication errors (3%), care delays (3%), surgery and positioning (3%), information governance (4%), falls (3%) and a further seven categories with a single SIRI). The Board has considered an action plan to reduce the number of avoidable pressure ulcers and this work will continue in 2011/12 with a focus on risk assessments, training, equipment provision and practice.
62. There were four SIRIs during the year relating to information governance and data. One, now closed with all actions completed, related to the faxing of prescriptions to the wrong number, and a second related to the loss of documentation outside the hospital. The investigation is continuing. The two others, which took place in 2010, related to confidential information leaving the Trust. Appropriate steps were taken to deal with these matters.
63. The Audit and Finance Committee has reviewed all reports from Internal Audit during the year and has paid particular attention to those resulting in poor assurance: Business Continuity, Electronic Patient Record and Emergency Planning. Action plans are in place to meet the recommendations of these two reports and the delivery of the actions will be monitored through the Committee.
64. The Head of Internal Audit's opinion overall is based on an assessment of the design and operation of the underpinning assurance framework and supporting processes; an assessment of the range of individual opinions arising from risk-based audit assignments, taking account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and any reliance placed on third-party assurances.
65. With the exception of the internal control issues that I have outlined in this statement, my review confirms that the Oxford Radcliffe Hospitals NHS Trust has a generally sound system of internal controls that support the achievement of its policies, aims and objectives and that those control issues that require further work have been or are being addressed.

Signed



Sir Jonathan Michael
Chief Executive
8 June 2011

Tell us what you think

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

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

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

Email us: media.office@orh.nhs.uk

Write to us:

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

See our website: www.oxfordradcliffe.nhs.uk in the News section.

Glossary of NHS terms and abbreviations

Acute Trust

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

Care Quality Commission (CQC)

Formerly Healthcare Commission. Reports on the quality of services provided by NHS trusts.

Community Health Oxfordshire (CHO)

Part of NHS Oxfordshire (Oxfordshire Primary Care Trust)

Elective

Care that is planned in advance, for example an operation.

Electronic Patient Record (EPR)

A new system of recording patient notes on computer rather than paper.

Foundation Trust

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

GP

A doctor (General Practitioner) who, often with colleagues in partnership, works from a local doctor's surgery, providing medical advice and treatment to patients.

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.

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.

National Service Frameworks

National standards for the best way of providing particular services.

NHS trust

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

National Institute for Health and Clinical Excellence (NICE)

A body which evaluates drugs and treatments. It does not evaluate their clinical effectiveness (that is the responsibility of a European medical authority) but makes judgments on their cost-effectiveness. Trusts are not legally obliged to follow NICE guidelines but most trusts usually do.

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.

Outpatient

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

Oxford Biomedical Research Centre (OxBRC)

A partnership between the University of Oxford and Oxford Radcliffe Hospitals, funded by the National Institute for Health Research.

Patient Advice and Liaison Service (PALS)

A service providing support to patients, carers and relatives.

Primary care

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

Primary Care Trust (PCT)

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

Secondary care

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

Strategic Health Authority (SHA)

The SHA is responsible for developing strategies for local health services and ensuring high-quality performance. The SHA manages the NHS locally and is a key link between the Department of Health and local Trusts. There are 10 SHAs across the country. Our local SHA is NHS South Central which covers the counties of Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight.

Useful websites

For further information on all our services please visit www.oxfordradcliffe.nhs.uk or follow developments at Oxford Radcliffe Hospitals on our Twitter: <http://twitter.com/OxfordRadcliffe>

OTHER USEFUL WEBSITES

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
NHS Choices	www.nhs.uk
NHS Confederation	www.nhsconfed.org
NHS Connecting for Health	www.connectingforhealth.nhs.uk
NHS Direct	www.nhsdirect.nhs.uk
National Institute for Health & Clinical Excellence (NICE)	www.nice.org.uk
National Patient Safety Agency (NPSA)	www.npsa.nhs.uk
NHS Institute for Innovation and Improvement	www.institute.nhs.uk
NHS Oxfordshire	www.oxfordshire.nhs.uk
NHS PLUS - occupational health provider	www.nhsplus.nhs.uk
Nuffield Orthopaedic Centre	www.noc.nhs.uk
Oxford Biomedical Research Centre	www.oxfordbrc.org
Oxford Brookes School of Health & Social Care	http://shsc.brookes.ac.uk
Oxford Brookes University	www.brookes.ac.uk
Oxford City Council	www.oxford.gov.uk
Oxford Health NHS Foundation Trust	www.obmh.nhs.uk
Oxfordshire County Council	www.oxfordshire.gov.uk
Oxfordshire Learning Disability NHS Trust	www.oldt.nhs.uk
Patient Safety Federation	www.patientsafetyfederation.nhs.uk
Royal College of Midwives	www.rcm.org.uk
Royal College of Nursing	www.rcn.org.uk
Royal College of Physicians	www.rcplondon.ac.uk
Royal College of Surgeons	www.rcseng.ac.uk
South Central Strategic Health Authority	www.southcentral.nhs.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



John Radcliffe Hospital



Churchill Hospital



Horton General Hospital

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@orh.nhs.uk