OXFORD UNIVERSITY HOSPITALS
NHS FOUNDATION TRUST

Annual Report and Accounts
1 April 2017 – 31 March 2018

Oxford University Hospitals NHS Foundation Trust

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Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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This report describes how Oxford University Hospitals NHS Foundation Trust has performed over the last financial year and how we account for the public money spent by the Trust over this period. This report includes our Quality Report, outlining our activities and priorities to improve quality of care and outcomes for patients who use our services.

WELCOME

Message from the Chief Executive

Welcome to the Annual Report from 1 April 2017 to 31 March 2018 of Oxford University Hospitals NHS Foundation Trust.

As we celebrate the seventieth anniversary of the NHS in 2018, I would like to reflect on a year of not only significant challenges but also notable successes in 2017-18.

On behalf of the Trust Board I would like to thank personally all our staff who have gone above and beyond the call of duty over the last 12 months to maintain safe, high quality care for patients.

During one of the busiest and most demanding winters which the NHS has experienced for many years, our staff braved adverse weather conditions to ensure that patients who rely on us continued to receive the best possible care.

At our Staff Recognition Awards in December 2017, we heard patients, families and staff colleagues talk about the life-changing impact which remarkable teams and individual members of staff make every day of the year.

In common with other NHS trusts, as demand on services continued to increase in 2017-18, we found it difficult to meet some of our key performance standards – especially in relation to the four hour ED access target and the 18 week referral to treatment standard.

In response we are investing in strengthening the leadership of all our services and providing them with more support in order to deal with the increasing challenges.

2017-18 was a year of many significant achievements by staff across the Trust – the examples below give just a flavour of our successes.

- The hip fracture service at the Horton General Hospital was ranked as the best in the country when the latest National Hip Fracture Audit was published in October 2017.
- A new Energy Centre, which was officially opened at the John Radcliffe Hospital in November 2017, will cut the Trust's CO_2 output by 10,000 tonnes per year.
- Stereotactic radiosurgery, a highly specialised treatment for small brain tumours, has

been introduced at the Churchill Hospital so that cancer patients can be treated locally.

As we look forward to the future, we are committed to improving services in Oxfordshire by working with our staff, patients, Foundation Trust members and governors, partners in health and social care, GPs, MPs, local councillors, Healthwatch and others.

The CQC's report into Oxfordshire's health and social care system, published in February 2018, highlighted the need for better co-ordination in order to improve our patients' experience of their care.

We also need to learn the lessons from Phase 1 of the Oxfordshire Transformation Programme in order to engage better and differently with the communities we serve when developing ideas to modernise and improve services.

2018-19 promises to be a busy and eventful year with so much to look forward to.

We plan to expand both chemotherapy treatment and renal dialysis at the Horton General in Banbury, as part of our commitment to healthcare in north Oxfordshire, following Oxfordshire Clinical Commissioning Group's confirmation in March 2018 that there are no plans to downgrade ED or Paediatrics at the Horton.

On the John Radcliffe Hospital site we are looking forward to the development of a new Ronald McDonald House – a 'home from home' for parents of our youngest patients – and the expansion of the Resuscitation area in ED.

On the Churchill Hospital site we are delighted that Sobell House – which provides palliative and end of life care – will be expanded so that more families can benefit from this essential service.

I look forward to working with our staff and all those who have an interest in and passion for the NHS in this seventieth anniversary year.

Dr Bruno Holthof
Chief Executive

OVERVIEW AND PERFORMANCE ANALYSIS

Introduction

The purpose of the overview section of the report is to give the reader a short summary that provides them with sufficient information to understand the Trust, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

ABOUT US

Oxford University Hospitals (OUH) is one of the largest NHS teaching trusts in the UK with a national and international reputation for the excellence of its services and its role in education and research. Clinical care is delivered by experienced specialists. Our Trust consists of four hospitals – the John Radcliffe Hospital (which also includes the Children's Hospital and West Wing), Churchill Hospital and the Nuffield Orthopaedic Centre, all located in Oxford, and the Horton General Hospital in Banbury.

Oxford University Hospitals NHS Trust was formally established on 1 November 2011 when the Nuffield Orthopaedic Centre NHS Trust merged with the Oxford Radcliffe Hospitals NHS Trust. On the same date a formal Joint Working Agreement between the Trust and the University of Oxford came into effect. This Agreement builds on existing working relationships between the two organisations.

We have well over one million patient contacts each year and, in addition to providing general hospital services, we draw patients from across the country for specialist services not routinely available elsewhere.

Most services are provided in our hospitals, but over 6% are delivered from 44 other locations. These include outpatient peripheral clinics in community settings and satellite services in a number of surrounding hospitals such as:

- a satellite surgical centre at Milton Keynes General Hospital;
- renal dialysis units at Stoke Mandeville Hospital and at the Great Western Hospital in Swindon.

The Trust delivers services from community hospitals in Oxfordshire, including midwifery-led units. It is also responsible for a number of screening programmes, including those for bowel cancer, breast cancer, diabetic retinopathy, cervical cancer and chlamydia.

During 2017-18 we provided:

- **1.4 million patient contacts**
- **107,371 planned admissions**
- **96,223 unplanned and emergency admissions**
- **1.3 million meals for inpatients**
- **135,964 Emergency Department attendances**

and we delivered 7,500 babies!

The Trust has a CQC rating of 'good'

At the end of 2017-18, we provided:

- **1,298 beds including 157 for children**
- **61 wards**
- **48 operating theatres**
- **11,612 staff**
- **3,803 nurses and midwives**
- **1,811 doctors**
- **1,473 healthcare support workers**

Our turnover in 2017-18 was £1.03 billion

Our Integrated Business Plan

The Trust Board set out its Integrated Business Plan (IBP) that explains the organisation's plans over a five year period until 2019-20. It describes the services we provide, our plans for developing our services for the future, the money we spend and the people we employ.

The Trust's Integrated Business Plan can be found on the Trust website, alongside the Annual Business Plan www.ouh.nhs.uk/about/publications/business-plans.aspx

There is an immediate focus on improving care for older, vulnerable patients, with plans to reduce delays in transfer from hospital care and to improve the psychological support and care given to this significant and growing group of patients. There is a continuing focus on integrating care pathways so that more seamless care is provided across many of our services and also across organisational boundaries.

Our hospitals

The John Radcliffe Hospital in Oxford is the largest of the Trust's hospitals. It is the site of the county's main accident and emergency service, the Major Trauma Centre for the Thames Valley region, and provides acute medical and surgical services, intensive care and women's services. The Oxford Children's Hospital, the Oxford Eye Hospital and the Oxford Heart Centre are also part of the John Radcliffe Hospital.

The site has a major role in teaching and research and hosts many of the University of Oxford's departments, including those of the Medical Sciences Division.

The Churchill Hospital in Oxford 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, palliative care and sexual health. It also incorporates the Oxford Centre for Diabetes, Endocrinology and Metabolism (OCDEM).

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

The Horton General Hospital in Banbury serves the people of north Oxfordshire and surrounding counties. Services include an Emergency Department, acute general medicine and elective day case surgery, trauma, maternity services and gynaecology, paediatrics, critical care and the 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.

Review of services at the Horton

In October 2016, due to a lack of medical staff, obstetric services at the Horton General Hospital were temporarily suspended and replaced with a Midwifery-led Unit. In January 2017 Oxfordshire Clinical Commissioning Group started a formal public consultation which included proposals to permanently operate a Midwifery-led Unit at the Horton General Hospital, as well as centralising acute stroke and level 3 critical care services at the John Radcliffe Hospital (these latter proposals will affect a very small number of patients a year and were agreed). The proposals surrounding the Midwifery-led Unit were subject to an unsuccessful judicial review and were referred to the Secretary of State who in turn asked the Independent Reconfiguration Panel (IRP) to examine them.

The IRP reported back in January 2018 and Oxfordshire Clinical Commissioning Group and Oxfordshire Health Overview and Scrutiny Committee are taking forward the recommendations to work with neighbouring authorities' Health Overview and Scrutiny Committees.

In the meantime, Oxfordshire Clinical Commissioning Group has made clear that it has no plans to consult on any further reorganisation of services at the Horton and supports the Trust's desire to keep the Emergency Department at the Horton fully functioning.

The other elements of the consultation that were approved include a major investment in ambulatory and diagnostic services at the Horton which will lead to 90,000 episodes of care involving patients travelling from north Oxfordshire to Oxford for treatment being able to receive their care at the Horton in Banbury.

The Nuffield Orthopaedic Centre has been treating patients with bone and joint problems for more than 80 years and has a world-wide reputation for excellence in orthopaedics, rheumatology and rehabilitation. The hospital also undertakes specialist services such as children's rheumatology, the treatment of bone infection and bone tumours, and limb reconstruction. The renowned Oxford Centre for Enablement (OCE) is based on the hospital site and provides rehabilitation to those with limb amputation or complex neurological or neuromuscular disabilities suffered, for example, through stroke or head injury.

The site also houses the University of Oxford's Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences. The Trust's clinical genetics department has relocated from the Churchill to the Nuffield Orthopaedic Centre this year.

For more information on the Trust and its services visit **www.ouh.nhs.uk**

Patient activity

Financial year	Emergency and unplanned patient admissions	Elective inpatient admissions	Daycase procedures	Outpatient attendances	Emergency Department attendances
2013-14	87,741	24,015	84,553	906,513	119,847
2014-15	89,445	23,628	90,649	956,492	123,539
2015-16	91,902	23,711	84,139	1,026,162	127,433
2016-17	96,273	23,317	86,000	1,070,328	131,166
2017-18	96,223	21,352	86,019	1,064,533	135,964

Growth continued in Emergency Department attendances and emergency admissions to hospital.

Admissions for elective (planned) care reduced in 2017-18, as did the number of outpatients seen.

Our clinical services

We offer a wide range of local and specialist services, including:

- Accident and emergency
- Trauma and orthopaedic
- Maternity, obstetrics and gynaecology
- Newborncare
- General and specialist surgery
- Cardiac services
- Critical care
- Cancer
- Renal and transplant
- Neurosurgery and maxillofacial surgery
- Infectious diseases and blood disorders

OUR OPERATIONAL PERFORMANCE

Our clinical services are assessed against a range of targets and other performance measures. Our staff work hard to diagnose and treat our patients without delay. In common with other NHS trusts across England we have had a difficult year and have not achieved waiting time standards in all areas.

Meeting our access targets and factors affecting our performance

Our clinical services are measured against a range of performance standards. In our services, as across the NHS in England, several of the main waiting time standards were not met during 2017-18.

We are committed to achieving local and national performance standards. We understand that any wait for treatment is of concern to our patients and our clinical teams work hard to improve waiting times. We have been affected by shortages of staff during 2017-18 and have needed to apply limited financial resources carefully while emergency, cancer and elective care services have all been under pressure.

The NHS is experiencing the most prolonged period of low funding growth in its history. Despite the efforts of Trust staff and management, OUH made a loss of £9.4m in 2017-18 after adjusting for the effects of valuation gains on its properties. This meant that the Trust missed the budget it had agreed and the financial target which had been set for it by NHS Improvement.

Making a loss means that the Trust has less cash to invest in replacing equipment or improving its care facilities. Missing NHS Improvement's financial target also meant that the Trust lost out on £20m that would have been paid to it as an incentive had it achieved the financial surplus target set by the regulator.

In 2018-19 the Trust expects to continue to operate in an exceptionally challenging environment. Funding growth continues to be inadequate to meet rising demand for services, to recruit and retain the staff needed to deliver care within national waiting time standards and to meet continuing expectations that services' quality and responsiveness will improve each year. Capital investment is likely to be restricted as a result. However, the opportunity exists to plot a path back to financial sustainability if the Trust exercises control over spending, becomes more productive, takes advantage of the commercial opportunities open to it given its international reputation and gains better value from its substantial land holdings in Oxfordshire.

Urgent care

In 2017-18, growth continued in the numbers of people attending and being admitted for urgent care. As shown below, in most months of the year there were more Emergency Department (ED) attendances and emergency admissions than in 2016-17. There was also considerable variation. The highest number of attendances per day was seen in June and November 2017 and the highest number of admissions per day in January to March 2018.

Over the past three years, emergency admissions have grown by a higher percentage than attendances, reflecting the ageing population that OUH is caring for.

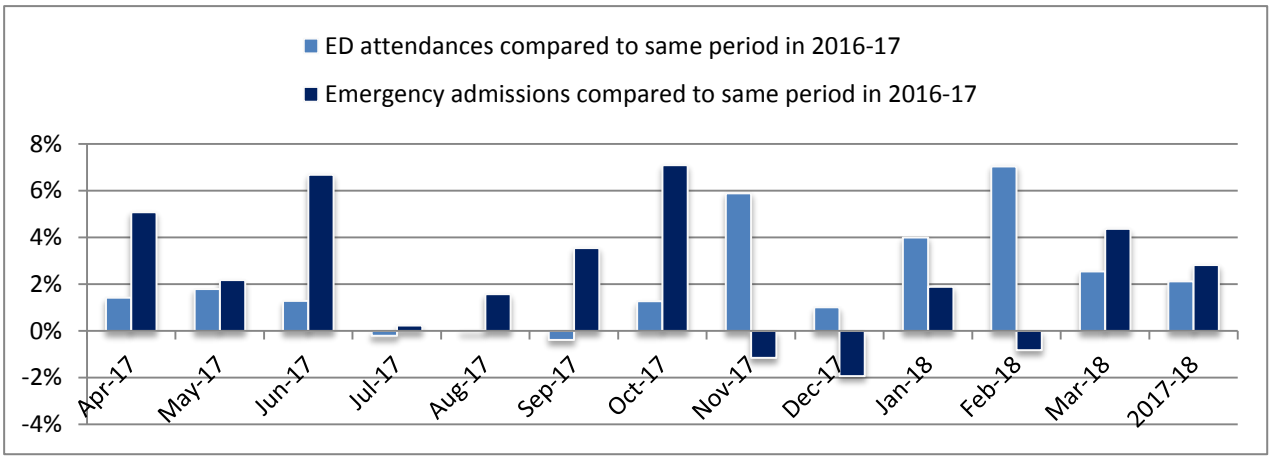


Figure 1: OUH Emergency Department attendances and Emergency admissions (Non-elective first finished consultant episodes) per month in 2017-18 compared to the year before

The growth seen by OUH in 2017-18 was above that in the NHS in England for ED attendances (OUH 2.83%, England 2.21%) but lower for emergency admissions (OUH 2.13%, England 3.71%). This may indicate some success in local measures to provide alternatives to admission.

However, OUH has faced significant challenges in delivering the capacity required to see, treat, admit or discharge people within four hours of arrival at its Emergency Departments. The 95% four hour standard has not been met by the NHS in England or by OUH since July 2015. As shown in Figure 2, performance reduced during the year, with a rapid drop from October 2017 in national performance in comparable Emergency Departments.

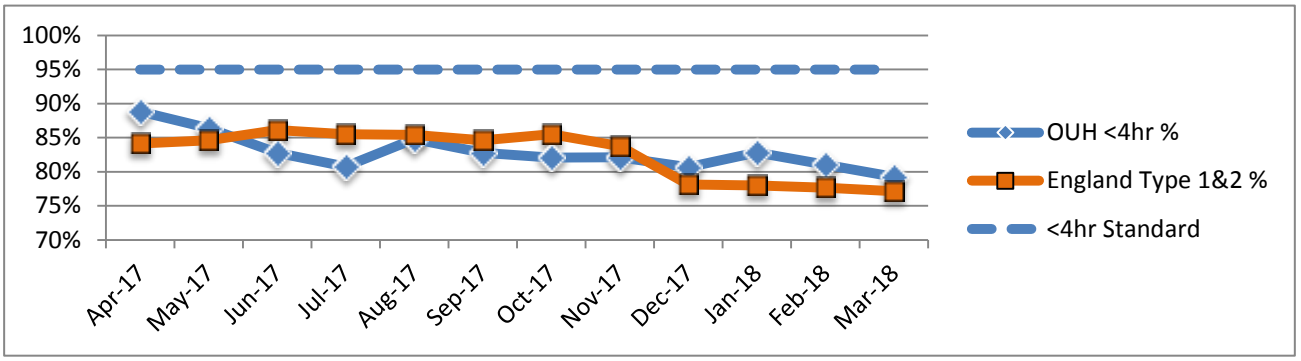


Figure 2: OUH <4 hour wait %, 2017-18, and NHS England performance for Type 1 and Type 2 Emergency Departments[1]

OUH continued to have a high level of bed occupancy through the autumn and winter. Locally and nationally, monitoring began of the numbers of patients assessed as medically fit for discharge but still in hospital as inpatients. Throughout February and early March 2018, 47-57% of OUH's General and Acute beds[2] were occupied by patients in this category. From late summer 2017, shortages of nursing staff meant that OUH needed temporarily to close some inpatient beds. These staffing-related bed closures particularly affected services at the Churchill Hospital and Nuffield

[1] Type 1 being 'major' Emergency Departments, as at the John Radcliffe and Horton General, and Type 2 being single-specialty departments as at the Oxford Eye Hospital.

[2] Beds where overnight care is provided, excluding maternity and neonatal care beds.

Orthopaedic Centre, with a staff incentive scheme used to keep adult inpatient beds operational at the John Radcliffe, open additional beds and avoid weekend closures.

On 2 January 2018, the National Emergency Pressures Panel (NEPP) recommended that NHS providers extend the normal reduction in elective activity seen over the Christmas and New Year period, maintaining reductions throughout the month of January where this was necessary to maintain prompt access to emergency care services. OUH postponed non-cancer and non-urgent planned surgery for some 100 patients per week until services were able to return to normal by 12 February.

Actions to improve urgent care and shorten waits included changes to the operation of the Emergency Assessment Unit and short stay wards, improved internal communications, close work with system partners on capacity and patient flow and strengthened arrangements for bed management. Learning from experience elsewhere, arrangements were also strengthened for the provision of clinical 'Board rounds' on wards and the review of patients ready for discharge.

Planned care

The national standard that 92% of patients will wait for planned care for no more than 18 weeks from GP referral has not been met by the NHS in England or by OUH since February 2016.

Recognising that planned levels of outpatient and surgical care locally did not match the number required to meet demand, detailed work was carried out in 2017 with lead commissioners and local GPs to develop plans in the most challenged clinical services.

Commissioners provided some additional funding in summer 2017 to increase activity in five services and from August an overall reduction was achieved in the total size of the Trust's waiting list. However, downward pressure continued on OUH's ability to deliver the amount of planned care it meant to. Shortages of ward nursing staff, particularly at the Churchill Hospital, led to beds not being available for a range of planned surgery. Shortages of operating theatre staff, particularly in autumn 2017 at the John Radcliffe's West Wing, led to cancellations and postponements of specialist surgery, affecting people receiving care from services including spinal surgery, ENT and neurosurgery.

Gynaecology had been using a temporary operating theatre at the John Radcliffe during 2017, but this was removed in January 2018. The nationally-mandated reduction in elective surgery in January and early February 2018 also had an impact on a range of services. Into March, patients admitted as emergencies (particularly but not only at the John Radcliffe Hospital) required the use of beds which would otherwise have been available for planned care. All these pressures combined to mean that despite being slightly ahead of its plan for the year at the end of September 2017, OUH ended 2017-18 having provided 3,318 fewer elective inpatient admissions (13.1%) than it had planned. Long waits for surgery grew in several services, notably Gynaecology, where additional funds were sought to treat patients waiting for over 52 weeks for surgery. Performance against the 92% standard reduced from 87.83% in August 2017 to 85.13% in March 2018.

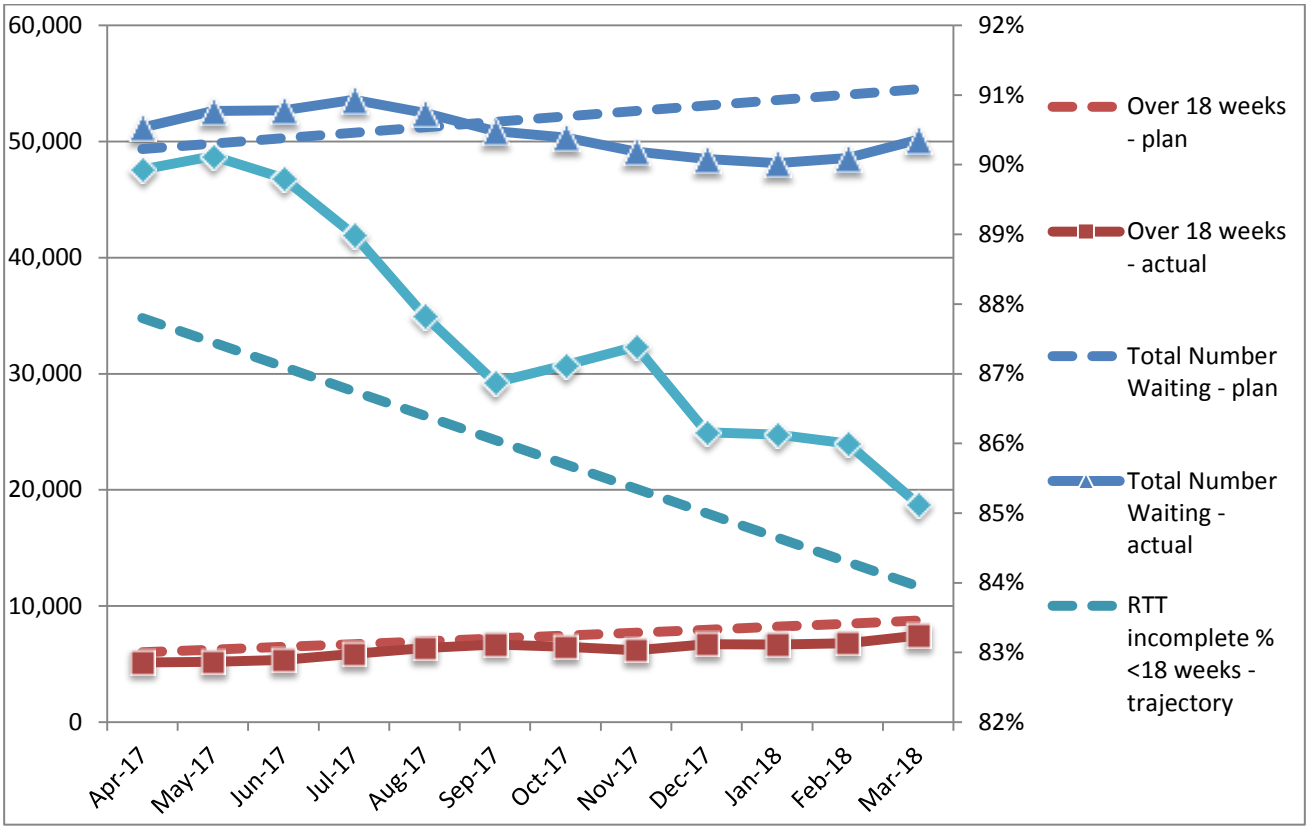


Figure 3: Numbers waiting for planned care (RTT incomplete pathways) and % treated within 18 weeks, 2017-18

It can be seen from Figure 3 that despite the pressures faced in 2017-18, the overall waiting list size and the number of people waiting for more than 18 weeks did not grow as much as expected (recognising that the volume of care being resourced did not keep pace with demand).

Apparent success in reducing the waiting list should not be overstated, though, as referrals to (and numbers for) Orthopaedics care reduced rapidly after Oxfordshire CCG's introduction of a referral management service in October 2017 to provide musculoskeletal care before referral to OUH's surgical service. The long-term effect of this is not yet known, but in the short term it has contributed to a reduction in the waiting list.

It is clear that pressures continue on OUH's elective capacity and that the level of elective care it is resourced to provide continues to be below what is needed to meet national waiting time standards.

Cancer

The Trust's wide range of cancer services continued to be provided in line with eight national waiting time standards.

Most standards were met during 2017-18 but difficulty continued to be experienced in meeting the standard to give patients their first treatment for cancer within two months of an urgent referral by a GP. This 62-day standard has not been met by the NHS in England in any month since December 2015. OUH did not meet it for eight months of 2017-18.

Standard	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
At least 93% of patients referred from a GP with suspected cancer will be seen within 2 weeks of referral.												
At least 93% of patients referred from a GP with breast symptoms but not suspected cancer will be seen within 2 weeks of referral.												
At least 96% of patients will receive first definitive treatment within 31 days of a decision to treat.												
At least 85% of patients will receive their first treatment within 62 days of referral.												
At least 94% of patients will receive subsequent treatment with surgery within 31 days of a decision to treat.												
At least 98% of patients will receive subsequent treatment with anti-cancer drug regimen within 31 days of a decision to treat.												
At least 94% of patients will receive subsequent radiotherapy within 31 days of a decision to treat.												
At least 90% of patients will receive their first treatment within 62 days following referral from a screening service.												

Figure 4: Achievement by month of the national cancer waiting time standards, 2017-18

Most waits of more than 62 days were in the urological, head and neck, gynaecological oncology, lung and lower gastrointestinal tumour site groups, affecting a total of 21-35 patients per month.

Following an agreed protocol, any cancer patient waiting for over 104 days for treatment has a review conducted of potential for clinical harm from the delay and details are reported to the Trust's Clinical Governance Committee.

Despite concerns raised about levels of staffing to support chemotherapy at the Churchill Hospital, the standard to provide drug treatment within 31 days was met throughout the year.

Diagnostic waits

In five months of 2017-18, more than 1% of patients awaiting one of a specified range of diagnostic tests at OUH waited for more than six weeks from referral. This standard was not met by the NHS in England in any month of 2017-18.

The number of people waiting for diagnostic tests at OUH rose from 12,102 in April 2017 to 12,497 in March 2018, with particular growth in MRI and non-obstetric ultrasound (the investigations performed for most people). Improvements were made during the year to radiological imaging capacity.

The following table presents the Trust's performance against national standards from 1 April 2017 to the end of March 2018.

PERFORMANCE AS AN AVERAGE FOR 2017-18

COMMITMENT	Standard	Trust achievement in 2017-18
Referral to treatment waiting times for non-urgent consultant-led treatment		
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	73.7%
Non-admitted patients (outpatients) to start treatment within a maximum of 18 weeks from referral	95%	86.1%
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	85.1%
Diagnostic test waiting times		
Patients waiting for a diagnostic test should have been waiting no more than six weeks from referral	99%	99.0%
Emergency Department waits		
Patients should be admitted, transferred or discharged within four hours of their arrival at an emergency department	95%	82.8%
Cancer waits – two week waits		
Maximum two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	95.8%
Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	98.1%
Cancer waits – 31 days		
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%	96.6%
Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	96.2%
Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	99.8%
Maximum 31 day wait for subsequent treatment where that treatment is a course of radiotherapy	94%	98.0%
Cancer waits – 62 days		
Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	83.5%
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	95.1%

Financial Performance Overview

Oxford University Hospitals NHS Foundation Trust has operated as a foundation trust since 1 October 2015. This report relates to the 12 month period 1 April 2017 to 31 March 2018.

Section 5 of this report provides our financial statements for this period, which have been prepared in line with the guidance we have received from NHS Improvement and other national bodies. Within the accounts you will find our accounting policies which are set out in *Note 1* to the accounts.

The Trust is forecasting a financial deficit in delivering its services in 2018-19 and it anticipates that it may take some time before it can achieve financial balance on a sustainable basis. The Board of Directors has carefully considered the principle of 'Going Concern' and the directors have concluded that there are uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast doubt about the ability of the Trust to continue as a Going Concern.

Nevertheless, the Going Concern basis remains appropriate. This is because the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006, s42a) to continue to deliver the full range of mandatory services for the foreseeable future. The assessment accords with the statutory guidance contained in the NHS Foundation Trust Annual Reporting Manual and the Department of Health Group Accounting Manual (GAM). For this reason, they continue to adopt the Going Concern basis in preparing the accounts. Note 1.1.2 to the accounts records this decision.

Financial strategy

The Trust's financial strategy aims to support the achievement of the Trust's healthcare, education and research objectives and to do this in line with our core values. The Board of the Trust has determined that these objectives can only be delivered if the Trust's finances are managed in a sustainable way.

The NHS is operating within the tightest financial environment of any time in its history. Funding growth over recent years has been significantly below the long run average. The Board does not accept that this will lead to an unsustainable financial performance by the Trust and has set an ambitious target of the Trust covering its running costs and generating enough surplus cash to fund new capital investments.

This means that the Trust has set itself a medium-term target of delivering an underlying EBITDA surplus of approximately £7.5m per month or over £20m per quarter. This is an extremely stretching objective which we believe, if achieved, would currently outperform all other NHS organisations. The next section of the report provides information on the achievement against our underlying EBITDA target for 2017-18 and illustrates the magnitude of medium term ambitions.

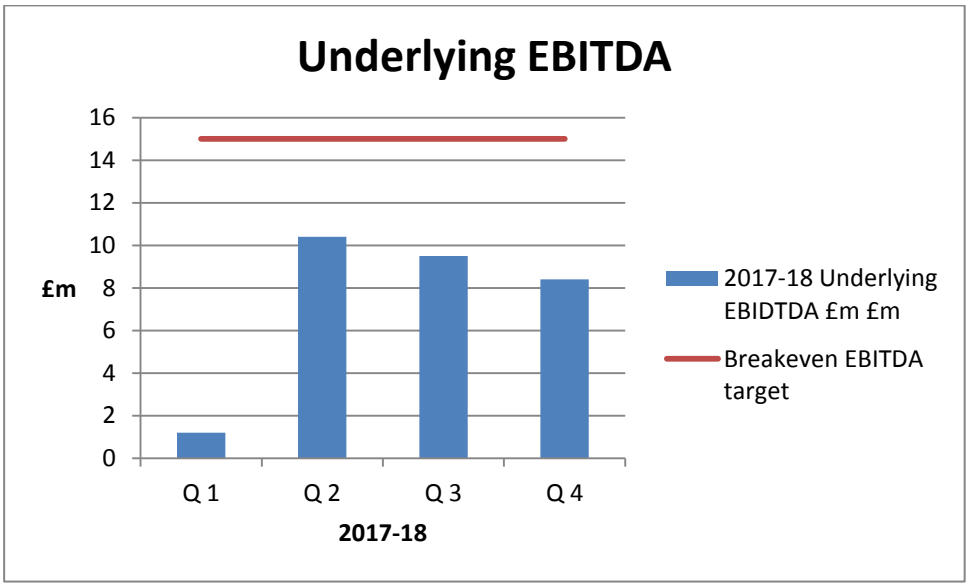
The Trust will not do this by delivering low quality care, but through:

- a strict control of its costs;
- becoming more productive; and
- taking advantage of the commercial opportunities open to it given its international reputation and getting better value from its substantial land holdings in Oxfordshire.

Underlying financial performance

The Trust Board and management focus on the underlying financial performance of the Trust because this is the measure that determines our long-term financial sustainability. Changes to accounting estimates and one-off items such as asset sales or central income are reported in our accounts, but they potentially obscure the underlying financial performance of the Trust. One of our key tasks in communicating the financial performance is to help Trust staff, patients and the wider community to focus on the underlying numbers.

The graph below shows the underlying EBITDA performance for each quarter of last year and compares this with the target of achieving an EBITDA target of £15m per quarter which is the level necessary to achieve a breakeven financial position.



Unfortunately, the Trust did not achieve the breakeven target in any quarter last year and hence it must continue to seek and implement measures to improve the underlying EBITDA performance in order to ensure long term viability.

For 2017-18, the Trust's underlying financial performance was supported by a number of non-recurring items and the financial outcome is reported below.

Financial performance

2017-18 has been a very challenging year financially for the NHS, with a significant number of providers reporting a deficit. The Trust has however reported a small surplus for the year of £3,548,000 as set out below.

Income and Expenditure Performance 2017-18	actual £m	Note
Income		
Clinical income (incl. revenue from other patient activity)	863.38	
Other operating income	166.58	(excludes receipt of Capital grants & donations)
Sub-total: income	**1029.96**	TB2018.46
Operating expenditure		
Pay		
Medical and dental	(207.34)	
Nursing	(161.93)	
Health care assistants and support	(50.60)	
Scientific, therapeutic, technical	(72.68)	
Non-clinical	(92.39)	
Sub-total: pay expense	(584.94)	(excludes Staff Costs capitalized as part of assets)
Non-pay		
Clinical supplies and services	(117.96)	
Clinical negligence	(36.88)	
Drugs (including gases)	(121.19)	
Premises and fixed plant	(52.26)	
General supplies and services	(24.95)	
Other non-pay	(45.31)	
Sub-total: non-pay expenses	(398.55)	
Total operating expenses	**(983.49)**	TB2018.46
EBITDA (Income less Operating expenses**)**	46.46	TB2018.46
Non-operating expenditure		
Depreciation	(32.42)	
Donated asset receipts	0.25	
Impairment	13.27	
Interest expense (non-PFI)	(0.13)	
Interest expense (PFI leases and liabilities)	(13.56)	
Non-operating PFI costs (e.g. contingent rent)	(6.61)	
Other finance costs	(0.72)	
Interest receivable	0.14	
Other gains / losses on investments	3.17	
Profit / (loss) on asset disposals	0.24	
PDC dividend	(6.55)	
Sub-total: non-operating expenditure	**(42.92)**	TB2018.46
Surplus / (deficit) for the year from continuing operations (EBITDA less non-operating expenditure)	**3.55**	Statement of Comprehensive Income

(Please note that the Income and Expenditure analysis analyses certain costs in a different way to the statutory accounts)

The Trust's financial performance is monitored by NHS Improvement via the mechanism of an agreed control total. The control total represents the minimum level of financial performance, which the Trust will be held directly

accountable to deliver. At the beginning of the year, OUH agreed a financial target with NHS Improvement of a £36.7m surplus contingent on the Trust achieving a number of key operational and financial targets.

The initial plan aimed for an underlying operating margin of 8% with a further 2% margin coming from Sustainability and Transformation funding. This plan was made before the financial performance in the last quarter of 2016-17 was known. The Trust finished 2016-17 with an underlying deficit of just over £27m and with the trajectory of our underlying performance deteriorating.

As a result of this significant deterioration in the Trust position at Quarter 4 of 2016-17 the Trust completed a detailed re-forecast exercise. This revised forecast, approved by the Finance and Performance Committee and the Trust Board prior to submission to NHSI, was an EBITDA of £42.0m and a deficit on the control total of £5.2m, which reflected a deterioration of £24.2m compared to the initial plan.

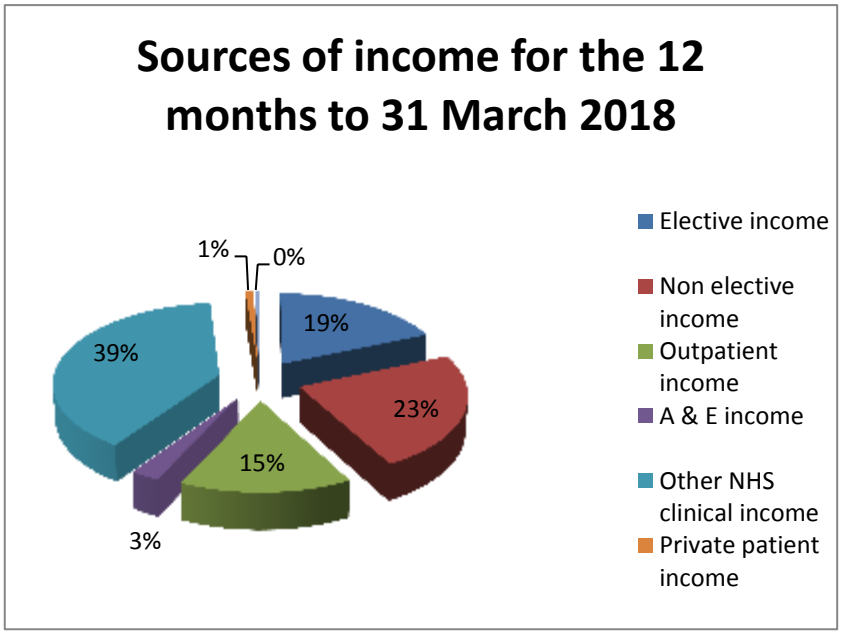
Unfortunately, the outturn at the end of the year fell short of this target with the Trust deficit on a control total basis (excluding Sustainability and Transformation Fund income) of £12,698,000 (Supplementary Note to Statement of Comprehensive Income) which compares with the revised forecast deficit on the control total of £5.2m.

The main reasons why the Trust did not achieve its financial plan were:

- the impact of elective cancellations and increased costs due to winter pressures including Emergency Department and urgent care pathway developments;
- a number of commercial transactions being delayed to 2018-19 when it had initially been assumed they would occur in 2017-18;
- other delays / non-delivery of reforecast improvement the Trust had envisaged to be achievable at the time of the re-forecast exercise.

Operating income

The Trust receives the majority of its income for the delivery of patient care services. In the 12 months to 31 March 2018 £863m was received, representing 84% of the total income for the period. The vast majority of this comes from the commissioners of NHS services, predominately Oxfordshire Clinical Commissioning Group and NHS England. The chart below shows the income by patient care activity.

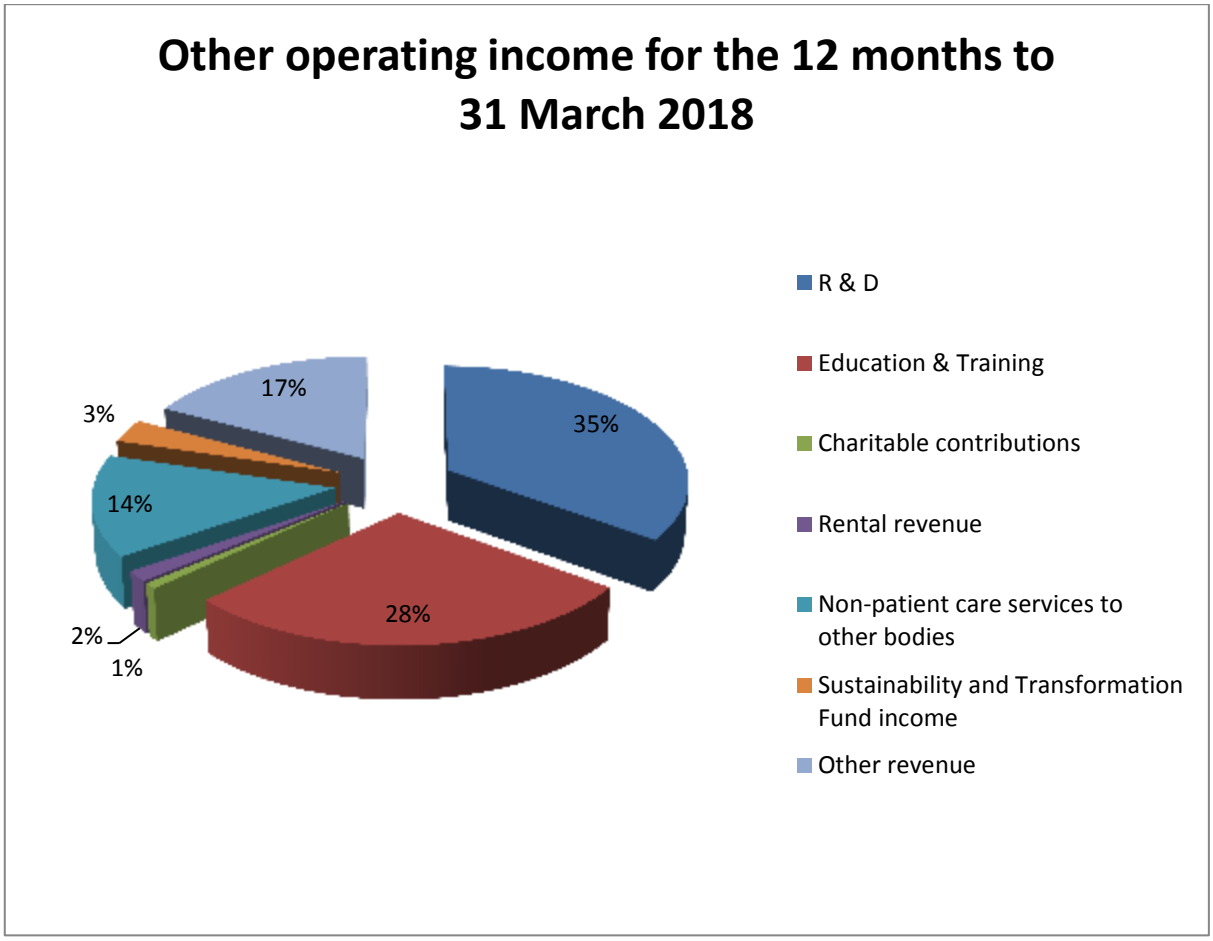


(Source note 3.1 to accounts)

Other operating income

The Trust received £166.8m for the delivery of non-patient care services, with £58.3m coming to fund research and with £47.1m to support the costs of providing education and training to NHS staff. Other sources of income include the provision of non-patient care services to other organisations and charitable contributions to expenditure.

The following graph sets out the income received for non-patient care income by the Trust over the 12 months to 31 March 2018.



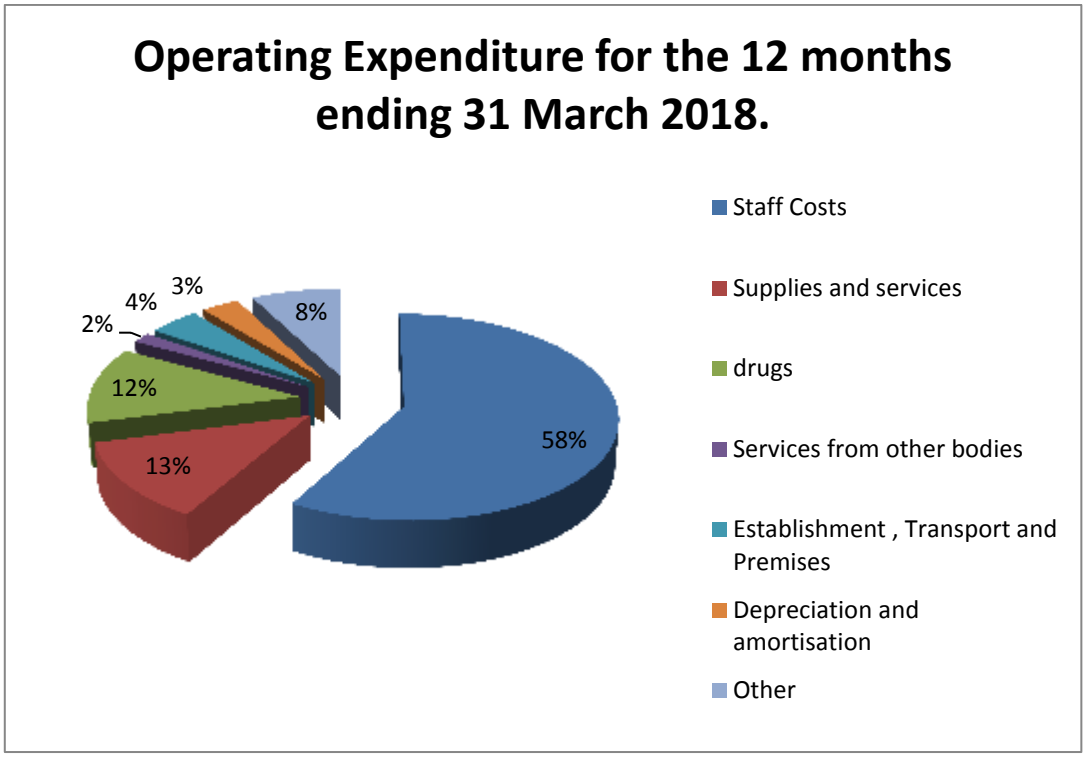
(Source Note 4 to the accounts)

Research and development and education and training activities are core objectives of the Trust and are generally delivered on a breakeven basis after making a fair contribution to Trust overheads. Equally the Trust provides some infrastructure (e.g. IT services) to other NHS bodies on the same basis. However, the Trust also makes a contribution from commercial activities. For example, the Trust rents land and buildings to a variety of NHS, academic and commercial organisations. The Trust also recognised its stake in various spin-out companies in its accounts reflecting the success of our staff, working with the University of Oxford, in commercialising discoveries made by our colleagues engaged in research and development.

NHS legislation states the Trust should primarily deliver NHS funded healthcare which is measured by testing that non-NHS activity is no more than 49% of total income. The two charts above show that the Trust has met this requirement with NHS healthcare activities comprising 84% of total income. Our analysis shows that these non-NHS healthcare activities either break-even and support our NHS work directly, e.g. research and development and education and training, or make a contribution (e.g. private patient activity, land rentals etc.).

Operating expenses

The Trust spends on average just under £2.75m every day or over £19.2m per week, which is slightly less than 12 months ago. It employs in excess of 11,600 whole time equivalent staff and expenditure on pay costs is the single largest item of expenditure for the Trust with £585m spent during the 12 months to 31 March 2018, representing 58% of total operating expenses. Of the non-pay related expenditure, the two biggest items are clinical supplies costs which accounts for £118m which is 12% of operating expenses, and expenditure on drugs at £121.2m which is also 12% of operating expenses. The graph below sets out the major headings of operating expenses for the Trust.



(Source Note 6.1 from the accounts).

Balance sheet – land, buildings and equipment

The Trust invested £37m in buildings and equipment during the year. This included expenditure of nearly £18m on the carbon energy scheme. The Trust's land and buildings were revalued as at 31 March 2018 by the District Valuer. Following public sector accounting rules, the buildings were valued on what it would cost to replace them with an equivalent facility built as efficiently as possible. For the PFI buildings that meant estimating the replacement cost of a single facility rather than on three sites across Oxford. This revaluation distorts the reported financial results hence the Trust's focus on the underlying position, but it does reflect the best estimate we can makes within the accounting rules of the value of our buildings for healthcare use.

Balance sheet – cash

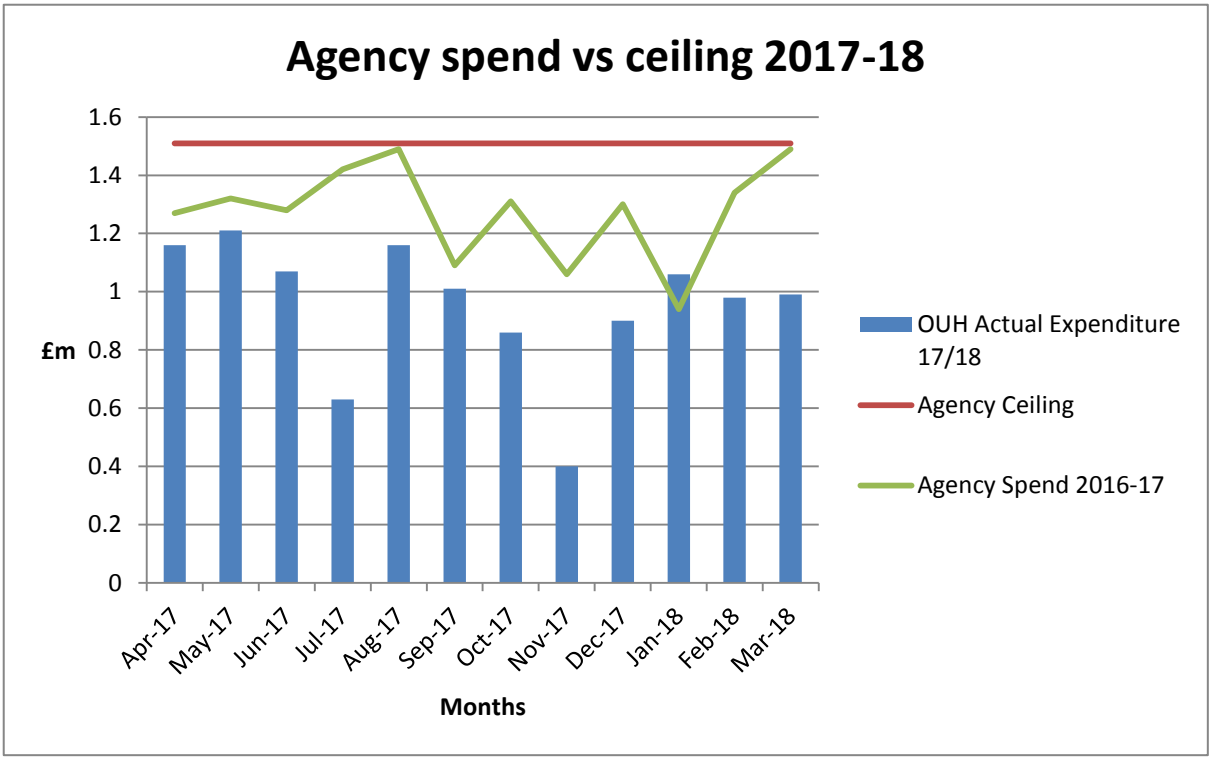
The amount of cash available to the Trust has fallen slightly through the year. The opening position on 1 April 2017 was a balance of £41, and by 31 March 2018 this had reduced to a closing balance of £39.9m. Whilst this is only a reduction of £1.7m this position was only possible because of a number of non-recurrent measures including:

- reduced capital expenditure due to slippage on the capital programme;
- improvements in cash-flow management.

Quality productivity and efficiency

For 2017-18 the Trust decided to move away from a traditional Cost Improvement Plan approach to align with emerging best practice from financial improvement at other providers, which addresses cost control and productivity separately. This is based on the assumption that cost control is part of regular management and should happen locally albeit facilitated by Trust-wide policies and tools, whereas significant productivity improvement requires Trust-wide enablers such as technology or process change albeit the resulting financial improvement must be rigorously identified in local budgets.

Within the overall productivity programme for 2017-18, good progress has been made in some areas, including the reduction in agency spend where the Trust had a target to spend no more than £18.1m and finished the year having spent £11.43m compared with £15.3m in 2016-17. The graph below illustrates the achievement of this goal.



A look forward

Although the NHS has been protected from the full impact of austerity since 2010, with funding for the NHS increasing by more than the rate of inflation, the increase is substantially less than the increase in demand for services and other cost pressures. This is compounded by the relative lack of investment in other public services, especially social care. NHS organisations are having to manage growing disparities between rising demand for services - and the staff needed to provide them - and the amount of funding available, while continuing to meet public and patient expectations.

The increasing demand for services is from a growing population comprising older people and a greater prevalence of long-term, often complex patient conditions, all of which is keeping sustained pressure on available resources at a time of rising costs.

NHS trusts are engaged on programmes to improve quality and drive up efficiency yet these require additional resource and will take time to deliver results. Resources in the current climate are focused on meeting urgent patient and service user needs. NHS trusts have already met and are continuing to deliver productivity above the national average. The NHS must continue to focus on improving productivity by tackling variations in care, improving clinical practice and making better decisions about how money is spent.

The latest planning guidance confirms that for 2018-19 revenue for NHS England will grow by £2.14 billion, comprised of the £1.6 billion announced in the Autumn Budget in November, and a further £540 million that the Department of Health has subsequently agreed to make available. Overall this represents a 2.4% real terms increase in NHS England's funding for 2018-19. A significant funding slowdown is planned for 2019-20, with NHS England receiving just a 0.2% real terms uplift in that year, translating into a drop (-0.8%) in spending per person when age-weighted population growth is taken into account.

Against this background, the Trust Board will continue with its financial strategy. However, the shortfall in financial performance in 2017-18 means that it will take at least a year longer to achieve the objective of long-term sustainability.

The two pillars of the plan to deliver this strategy are:

1) rigorous cost control to ensure that the Trust gets value for money from every pound that it spends;
2) continuous productivity improvement driven by our belief that high quality costs less.

The Trust is also developing an ambitious capital programme that can only be afforded if the day-to-day finances improve. In response to our current financial challenges, the Trust will prioritise essential equipment replacement and those building projects required to improve safety, quality and productivity.

Jason Dorsett
Chief Finance Officer
23 May 2018

Emergency Department performance

The demand on our health services has been higher than ever, and where once this demand seemed specific to the winter months, now demand remains high year-round. For the last two years the Trust has seen more than a 3% increase in attendances, despite the work done to avoid unnecessary visits to our Emergency Departments.

Every week we see more than 2,600 people in our Emergency Departments and the vast majority of patients are assessed, treated, discharged or admitted to a ward within four hours. We are sorry when patients wait longer than the target time, but it is important to understand that they will have been seen and may undergo further assessment and diagnosis before moving on to the next stage of their care. Patients will always be seen based on their clinical priority and need. The majority of patients who fall into the category of waiting longer than four hours are waiting for admittance to our hospitals, and the difficulty in speeding this up is in having sufficient beds available. This in turn is related to the problems that the health system faces with delayed transfers of care.

The Trust has worked hard to improve its internal processes and systems to help address Emergency Department waiting times. It has continued to work closely with GPs to ensure that patients are directed straight to the most appropriate unit on admission and to avoid our Emergency Departments wherever possible. It is also collaborating closely with other Oxfordshire NHS and social care services to shape and improve a whole system approach to managing patients requiring urgent and emergency care, which this year has led to further improvements to assessment services at the Horton and John Radcliffe, increased support and advice for GPs and continuing to develop the Trust's Home Assessment Reablement Team (HART) service supporting patients at home after leaving hospital and to avoid admission.

The aim is to ensure that patients are guided to the right service and do not unnecessarily attend the Emergency Departments at either the John Radcliffe or Horton General hospitals.

Infection prevention and control

Throughout 2017-18 the Trust's Infection Prevention and Control Team, in partnership with staff, has driven forward safer practices in order to minimise 'preventable infections'.

Oxford University Hospitals ***(cases across all four hospital sites)***	**Annual allowed limit for 2016-17**	**Number of cases apportioned to the Trust in 2016-17**	**Annual allowed limit for 2017-18**	**Total number of cases apportioned to the Trust in 2017-18**
Avoidable MRSA Bacteraemia (Bacteria in the Blood Stream)	0	6	0	0
Clostridium difficile	69	53	69	72

OUR HEALTHCARE MARKET

The Trust's hospitals in Oxford serve an Oxfordshire population of 655,000, and the Horton General Hospital in Banbury has a catchment population of around 150,000 people in north Oxfordshire and neighbouring communities in south Northamptonshire and south east Warwickshire.

We have strong partnerships with our local NHS and social care organisations, and also with a wider network of district general hospitals, universities and research institutions. Our role as a university teaching centre and focus on research and innovation is a defining feature and as such attracts patients from beyond our surrounding counties.

The Trust provides services to two markets: a local market for general hospital services and a wider market for more specialist care. From 1 April 2017 to 31 March 2018:

- ***40%*** of the Trust's income for the delivery of patient services came from the Oxfordshire Clinical Commissioning Group
- ***48%*** of income came from specialist commissioners
- ***12%*** came from other commissioners outside of Oxfordshire.

The Trust provides the majority of acute services for Oxfordshire with a small volume of activity going to neighbouring district general hospitals and private providers which have contracts for a limited range of orthopaedic and other planned care.

The wider population served by the Trust's specialised services is one of approximately 2.5 million within the local authority areas of Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire, Swindon, Gloucestershire, Northamptonshire and Warwickshire. Some specialist services serve an even larger catchment population, with national and international elements. In 2017-18, NHS England, which commissions specialist services from NHS providers, accounted for 45% of the Trust's total commissioning income.

As a large tertiary acute centre, **the Trust provides specialist treatment for patients from a wide geographical area. We are designated as a regional centre for major trauma, vascular surgery and critical care for newborn babies. We also have multidisciplinary teams working jointly with teams at Southampton General Hospital as part of the South of England Children's Hospitals Network. This involves senior clinicians and surgeons from both trusts working together to deliver specialist children's heart, neurosciences and critical care services to patients from across the region.**

FIGURES FOR 1 APRIL 2017 TO 31 MARCH 2018

Commissioner	Service Level Agreement (SLA) income (£ million)	%
NHS England South (Wessex Area Team)	415	48%
Oxfordshire Clinical Commissioning Group (OCCG)	347	40%
Buckinghamshire CCGs (Aylesbury Vale and Chiltern)	20	2%
Northamptonshire CCGs (Nene and Corby)	18	2%
Other NHS Commissioners (<1% share)	63	8%

Clinical networks and specialised commissioning

Clinical networks have an important input into specialist commissioning. The networks develop responses to the recommendations of national service improvement programmes with a common feature being recommendations to centralise specialist resources and expertise. In close collaboration with academic clinical research, the networks work reciprocally with providers across a region to ensure the best outcomes for patients by providing seamless access to specialist healthcare when needed.

Oxford University Hospitals is involved in the following clinical networks:

- Cancer
- Cardiovascular (including cardiac surgery, cardiology, vascular and stroke services)
- Critical care
- Maternity
- Neonatal
- Pathology
- Renal
- Trauma

Working with our commissioners and other healthcare providers

We have productive relationships with our local community health and social care partners and we work together to deliver solutions to improve patient care across organisational boundaries.

We work closely with the GP-led Oxfordshire Clinical Commissioning Group (OCCG), and with the local authority-led Health and Wellbeing Boards, which were introduced to understand local community needs and priorities and to help health and social care services to work in a more joined-up way.

Clinical commissioning groups – made up of doctors, nurses and other professionals – buy health services for patients, while local councils are responsible for promoting public health, reducing health inequalities and ensuring social care needs are met.

OUR AMBITION AND FUTURE PRIORITIES

Our mission is the improvement of health and the alleviation of suffering and sickness for the people we serve. We will achieve this through providing high quality, cost-effective and integrated healthcare.

Building on our foundations as an organisation with a clinically-led structure, we have developed a ***strategy and a five year business plan*** to deliver the Trust's vision. The Trust's vision is to:

- be at the heart of a sustainable and outstanding, innovative academic health science system;
- work in partnership and through networks locally, nationally and internationally;
- deliver excellence and value in patient care, teaching and research within a culture of compassion and integrity.

Underpinning this vision is our strategy built on six pillars, our ***strategic objectives*** – which shape our annual plans and business priorities.

The Trust's strategic objectives are to deliver the following.

1. **Compassionate excellence** – the kind of healthcare we would all expect for ourselves and our families
2. A well-governed and adaptable organisation
3. Better value healthcare
4. Integrated local healthcare
5. Excellent secondary and specialist care through sustainable clinical networks
6. The benefits of research and innovation to patients

A future vision for Oxford University Hospitals

Strategic themes

The Trust has continued to develop its strategic vision through the prism of the five key themes: *Home Sweet Home*, *Focus on Excellence*, *Go Digital*, *Masterplanning*, *High Quality Costs Less* and the underpinning themes, *Building Capabilities* and *Sustainable Compliance*. The Trust's focus is on how quality improvements can be made to drive up performance and use resources more effectively, in turn helping to secure financial sustainability. Developments in the key areas are outlined below.

Home Sweet Home

The Trust has worked with its staff, GPs, other NHS trusts, commissioners and social care providers to ensure the best possible care outside hospital so that inpatient care is available rapidly for those who need it. This year we have worked closely with Oxford Health, Care Providers and Oxfordshire County Council on a successful joint recruitment campaign to encourage people to come and work as care workers for one of our organisations.

The Trust has continued to develop its support for patients outside our hospitals through our Home Assessment Reablement Team (HART), the Acute Hospital at Home (AHaH) and increasing the availability of services that can be accessed by patients in day units without needing an overnight stay.

Focus on Excellence

The Trust has been developing a strategy for all services so that it is making decisions about investment in potentially world-class specialised services in a way that supports excellence in our 'general hospital' care and has strong alignment with the work of our university partners. In developing this work, the Trust has been mindful of the interdependence of services, particularly at the Horton General Hospital. The Trust is identifying world-class centres of excellence within our services and developing a robust strategy for demand growth.

Go Digital

The Trust has a commitment to using technology to transform the experience of the care we provide. A key aim is to fully utilise the Trust's Electronic Patient Record (EPR) system and other clinical systems so that the Trust can become paperless by 2020.

The Trust was named as a Global Digital Exemplar by the Department of Health as a recognition that we are at the forefront of the use of digital technology to deliver exceptional treatment and care. The Trust is using its funding to champion the use of digital technology to drive radical improvements in the care of patients.

Every day, across our four hospital sites, there are 1.2 million transactions via the Electronic Patient Record system used by more than 8,000 staff. Clinical staff routinely order diagnostic tests and view the results electronically. Nurses record patient admissions, discharges and transfers in real-time. Doctors order laboratory and radiology investigations, view and endorse results, plus order and administrate medications.

As one of the 12 most digitally advanced hospital trusts in the NHS, in 2018-19 the Trust has worked on delivering a range of initiatives including the following.

- Implementing population health, which allows doctors in primary and secondary care to see the full patient notes and proactively manage both at population level and an individual patient level chronic conditions;
- implementing a secure patient portal, so patients can see their medical records, book and rebook appointments and receive copies of their doctors' letters;
- introducing a new way for doctors to dictate notes digitally directly into the patient's notes;
- extending the process of scanning in correspondence about an individual patient to their electronic record.

Moving forward the Trust will be:

- hosting a Digital Showcase to share best practice across the Health Sector;
- developing new digital interventions using Artificial Intelligence, to support doctors in their decision-making.

Masterplanning

This critical piece of work is the planning of facilities and transport to make possible the care the Trust would like to offer patients. It is intended to support future investment in infrastructure to support clinical services, research and education for the Trust. The three key themes are the Headington campus (our Oxford hospital sites), the Horton General, and utilising future technologies to support transport and eco sustainable options.

The Trust owns some buildings that are not fit-for-purpose, and one of our aims is to move patients and staff out of our older buildings and poorer quality estate and into better quality accommodation. In addition, a key driving factor has been to move staff who do not need to be on our busy Oxford hospital sites off-site to a dedicated additional workspace that the Trust has leased, to release space on site and relieve pressure on parking.

The first staff moved to our new offices in Cowley in 2017 and they have been joined by a number of colleagues this year. We now have 460 staff based there.

Plans are being worked up for all of the Trust's hospital sites as part of masterplanning work which is being undertaken jointly with the University of Oxford and in conjunction with Oxford Health NHS Foundation Trust and other partners where we have shared use of land.

Considerable progress has been made on the Masterplanning Programme in 2017-18. Phase One of the planning was completed which included defining the Masterplan Vision for the Trust's estate 'to create a world-class centre of healthcare, research and education', an update of the Trust's Estates Strategy and engagement with the transport and planning departments in Oxfordshire.

Phase Two will continue throughout 2018-19 and will involve developing the Masterplan to align with the Clinical Services Strategy, further development of the Travel and Transport Strategy to address our car parking issues and continued liaison with local stakeholders and local planners as the plans become defined in more detail.

In 2018-19 the following developments from within the Masterplan will be coming on stream: the Neurosciences Research facility (John Radcliffe Hospital site), the Ronald McDonald House parents' accommodation (John Radcliffe Hospital site) and the key-worker accommodation development on the Churchill Hospital site which will increase access to accommodation for our staff.

High Quality Costs Less

This strategic theme is about quality as an organising principle, and about making a business success out of quality. By improving quality through disciplined methodologies the Trust will do the right things for patients, improve staff satisfaction and release resources for further investment in care.

High quality healthcare is what everyone wishes to receive and all staff want to deliver. It is incompatible with waste, inefficiency and unreliability. Improving quality allows a reduction in resource consumption so that these resources can be redeployed to treat more patients or to invest in new estate or equipment.

The Trust also has two supporting themes that were identified as crucial to achieving our five main themes.

Building Capabilities

This is ensuring the Trust has the resilience to deliver the key aims and objectives through having the right people, doing the right jobs with the right resources and training. You can read more about how we have been working to this theme in the section on workforce.

Sustainable Compliance

The Trust will maintain compliance with its relevant regulatory bodies. This assures the public that the services that the Trust provides are safe and as they would wish to find them.

SERVICE DEVELOPMENTS AND INNOVATION IN CARE

Pilot scheme speeds up diagnosis

A new 'one stop shop' designed to speed up cancer diagnosis and help save lives was rolled out at the Churchill Hospital.

NHS England's **A**ccelerate, **C**o-ordinate, **E**valuate (ACE) programme is testing innovative ways of diagnosing cancer earlier and is being piloted in ten areas including Oxford.

It adopts the Multidisciplinary Diagnostic Centre (MDC) concept from Denmark so patients can have several diagnostic tests in one location, at the same time, for a faster diagnosis.

The aim is to help patients with vague or non-specific symptoms which in some cases can be the signs of cancer or other serious illnesses.

The Oxford pilot, which is called the **Suspected CANcer (SCAN) pathway**, includes:

- rapid diagnostic imaging using a CT (Computed Tomography) scan;
- laboratory tests;
- further testing or an appointment with a specialist depending on the results of the initial scans and lab tests.

The aim of our pilot scheme is for patients to receive a diagnosis and begin treatment faster. Vague symptoms such as weight loss and tiredness can be the signs of a serious illness, so it's important that we diagnose patients more quickly. The scheme is a good example of how clinicians in primary and secondary care are working together closely to improve the patient pathway.

Unique childhood cancer service shortlisted for national award

The Oxford Reproductive Tissue Cryopreservation (ORTC) service, the UK's only comprehensive fertility preservation treatment programme for children and young people with cancer, has been shortlisted for the Cancer Care Team category of the British Medical Journal (BMJ) Awards 2018.

The service at Oxford Children's Hospital is a collaboration between Oxford University Hospitals and the University of Oxford, supported by Oxford Hospitals Charity.

Over 80% of children and young adults diagnosed with cancer now survive the disease, but infertility is a common long-term complication of treatment.

Around 4,000 people under the age of 25 are newly diagnosed with cancer in the UK each year, and 10-15% of them will be at high risk of infertility at a young age.

The service saw its first patients in 2013, and now cryopreserves (freezes) the reproductive tissue of more than 150 children and young people from all over the country every year.

The tissue can then be used to restore their fertility when they are ready to start a family later in life. Psychological research undertaken as part of the ORTC programme has shown that being offered fertility preservation treatment reduced patients' anxiety and depression, both during and after their cancer treatment.

OUH radiographers lead the way in non-medical prescribing

Therapeutic radiographers at Oxford University Hospitals NHS Foundation Trust have trained to become non-medical prescribers. Non-medical prescribing allows certain named groups of non-medical health professionals, such as nurses, pharmacists, dietitians and radiographers, to prescribe medications and drugs. It removes the delay associated with identifying a hospital doctor or GP to prescribe for the patient (which would also involve a separate consultation).

Therapeutic radiographers were first granted the legal right to train to prescribe in March 2016, and the group from Oxford University Hospitals, which graduated in June 2017, was among the first in the UK to qualify. The course is run by Oxford Brookes University, but the requirements for training are set out by the Nursing and Midwifery Council (NMC) and Health and Care Professions Council (HCPC).

Trainees learn for one day a week for the first term of the academic year, followed by 90 hours of supervised practice and 150 hours of face-to-face learning with a designated medical practitioner. Once qualified, the radiographer can diagnose their patient's condition, identify a potential treatment and advise the patient on the risks, benefits and outcomes of the medication before prescribing it.

Radiographers qualified to prescribe are now making a huge impact on the treatment of cancer patients at OUH, particularly improving access to medication to control symptoms.

Oxford immunologist chosen to be healthcare science role model

A clinical scientist who works at Oxford's Churchill Hospital has been chosen for special leadership training with a view to becoming a national role model inspiring the next generation of healthcare scientists.

Dr Lisa Ayers, who works in Oxford University Hospitals NHS Foundation Trust's Department of Clinical and Laboratory Immunology, was one of four female healthcare scientists to receive the Chief Scientific Officer's (CSO) Women in Science and Engineering (WISE) Fellowship, which started in September 2017.

The prestigious programme was launched in 2016 in conjunction with International Women's Day, and this year attracted more than 50 applications from female healthcare scientists.

Over her year in post, Lisa is receiving bespoke leadership development training and being mentored by senior leaders in healthcare, industry and academia, as well as speaking and ambassadorial opportunities through the CSO and WISE networks.

She will also have the opportunity to join senior leaders at NHS England healthcare science advisory meetings.

Lisa, who has worked for OUH for the past 12 years, volunteers as a science, technology, engineering and mathematics (STEM) ambassador, providing support to schools, local career fairs and national science competitions.

She undertook her clinical scientist training in immunology, studying for a Masters and PhD part-time. During this time she combined both clinical and academic roles through the support of two National Institute for Health Research (NIHR) fellowships. In 2016, she was awarded the Chief Scientific Officer Healthcare Science Rising Star - Life Sciences Award, recognising her work as a Clinical Academic.

Optometrist nominated for top national award

An optometrist from Oxford Eye Hospital has been nominated in the Optician / Optometrist of the Year category for this year's Macular Society Awards for Excellence.

Rasmeet Chadha, who has worked at the Trust since 2000 and is deputy head of optometry, has been recognised for exceptionally good practice in the care of people with macular degeneration. She has also been praised for her work with young people with sight loss and for passing on skills and knowledge to ophthalmology trainees.

She was instrumental in setting up the hospital's Paediatric Low Vision Clinic. The clinic helps to determine how much a child can see, any problems they may be experiencing as a result of sight loss and practical solutions and low vision aids to help them in their day-to-day lives. The clinic forms part of a strong Optometry and multidisciplinary service in Oxfordshire supporting patients with sight loss.

Now in its ninth year, the Macular Society Awards for Excellence is run by the charity to celebrate the inspirational work done to provide services and care for people with macular disease all over the UK.

John Radcliffe teams pass first stage of UNICEF baby friendly accreditation

The Maternity department and newborn care services teams at the John Radcliffe Hospital have both moved a step closer to achieving the gold standard for infant feeding care.

Maternity has been awarded Stage 1 of the UNICEF UK Baby Friendly Initiative. Newborn Care Services recently received their certificate of commitment from UNICEF UK Baby Friendly Initiative.

Introduced to the UK in 1995, Baby Friendly is an evidence-based initiative formulated by UNICEF and the World Health Organization to improve health outcomes, and is recognised internationally.

It is designed to support all families with infant feeding, while at the same time normalising, protecting and promoting breastfeeding and parent infant relationships by working with public services to improve standards of care. It is the first ever national intervention to have a positive effect on breastfeeding rates in the UK. Research has found that UK mothers delivering in Baby Friendly accredited hospitals are 10% more likely to initiate breastfeeding than those who deliver in non-accredited units or units with a

Certificate of Commitment.

The Baby Friendly Initiative is an accreditation programme that is implemented over several years, using a staged approach. Accreditation is based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centre services.

Oxford University Hospitals NHS Foundation Trust is committed to achieving full UNICEF Baby Friendly Accreditation. Maternity aims to be awarded Stage 2 by December 2018.

Specialist radiosurgery treatment now available at the Churchill Hospital

Patients in Oxfordshire who need a highly specialised treatment for small brain tumours (metastases) are now able to undergo the procedure at the Churchill Hospital's Radiotherapy Department. Previously, patients would have needed to travel further afield for this kind of treatment, including to London and Sheffield.

Stereotactic radiosurgery (SRS) is a way of targeting a high dose of radiotherapy very precisely at the tumour in a single treatment. As the radiotherapy machine rotates around the patient, the shape of the beam is constantly modified using small leaflets so that the treatment can be sculpted around small tumours.

Oxford University Hospitals was one of 17 centres to have been awarded a contract as a recommended service provider by NHS England to deliver SRS for patients from across Thames Valley and Northamptonshire. The first patients received the treatment in Oxford in June 2017. Over the next six months, patients with other types of small tumours were also able to receive SRS treatment in Oxford.

SRS has the advantage of being accurate to less than 1mm, so that radiotherapy can be directed on the tumour without damage to surrounding healthy tissue in areas such as the brain stem or optic nerve. The department had to undergo rigorous quality assurance checks to demonstrate that the high degree of accuracy achieved by the SRS treatment is in line with all the other centres delivering this treatment.

A similar focused body treatment called stereotactic ablative body radiotherapy (SABR) is used to treat lung and certain liver cancers and small volume metastatic cancer. It has been available in the Trust for over five years.

Refurbished Day Surgery Unit opened at the Churchill Hospital

The newly-refurbished Day Surgery Unit at the Churchill Hospital has officially opened. The unit, which is based in the Cancer Centre, supports ten operating theatres where over 8,000 operations are performed each year. The majority of these patients will spend time in the Day Surgery Unit as they wait to be admitted for their operation, and afterwards when recovering.

The Trust has invested £2.1 million to redevelop the Day Surgery Unit, which has been designed to reduce stress and anxiety, with privacy and comfort in mind. In addition, 63 thousand pounds was raised by Oxford Hospitals Charity, through a combination of donations and fundraising events such as abseiling down the John Radcliffe Hospital.

There are now six individual consultation rooms, two single rooms with en-suite facilities and two six-bed same-sex bays, bringing the unit up to national same-sex standards. The reception area is now brighter and more welcoming, and non-clinical and staff areas have also been redeveloped. The courtyard garden - which provides a quiet, outside area for patients and relatives to sit - has also been redeveloped.

Safety huddles result in cardiac arrest reduction

A pilot project which involves staff having regular 'huddles' to assess the health of patients has resulted in a reduction in the number of cardiac arrests on wards. A key part of this quality improvement project, which is being held on Acute General Medicine and Vascular Surgery wards at the John Radcliffe, is safety huddles, held a number of times throughout the day.

These short gatherings allow staff on each ward to highlight concerns about patients whose condition they feel might be deteriorating. This ensures that all staff are aware of each patient's condition so that those most at risk can be prioritised. Each ward focuses on particular areas, whether improving handovers or their escalation procedures.

The aim of the pilot was to achieve a 20% fall in cardiac arrests in two years, but one ward has already achieved this after one year, while another has also registered a reduction. There are now plans to roll out this approach to other areas with a higher incidence of cardiac arrests and where it will have the greatest impact, such as in neurosciences and on surgical wards.

Another important factor is that the Trust has moved from reporting observations on paper to the SEND electronic documentation system on tablets, which also allows doctors to keep track of patients' progress remotely.

New role to support care at the end of life

Oxford University Hospitals has appointed its first Consultant Pharmacist for palliative and end of life care, only the third post of its kind in the UK.

End of life care has been identified as a Trust priority, with a new strategy having been written. Sobell House Hospice Charity, working closely with OUH, has granted resources to fund a two-year project to improve end of life care across our four hospitals.

A big part of the end of life care project will relate to training and education of anyone - doctors, nurses, pharmacists - who has interaction with patients. A key part of the role is ensuring that patients are identified and given the right care.

SERVICE IMPROVEMENT AND REDESIGN

Oxfordshire's vision for service improvement

Transforming services in Oxfordshire

OUH has continued to work with system partners on the (previously named) Oxfordshire Transformation Programme. During 2017, the main area of focus was on the consultation and decision-making related to proposals where there were pressing concerns about workforce, patient safety and healthcare (for example, where temporary changes have been made) or where the proposed changes have been piloted. These included:

- critical care facilities;
- stroke care;
- changes to bed numbers in order to reduce delayed transfers of care and move to an ambulatory model of care;
- obstetric services - the obstetric unit at the Horton General Hospital has been closed (on a temporary basis) since October 2016 due to a lack of medical staffing;
- improvements to planned care.

In August 2017, Oxfordshire Clinical Commissioning Group (OCCG) agreed to recommendations relating to critical care, stroke care, bed numbers and planned care. Implementation of agreed changes in these areas has been ongoing. This has included the direct conveyance of all stroke patients to the hyperacute stroke unit at the John Radcliffe Hospital with the aim of maximising improvements to patient outcomes, creating a county-wide early supported discharge service for stroke patients and centralising the care of level 3 critical care patients to improve experience and outcomes.

These changes were subject to a number of challenges. The decisions by OCCG were subsequently subject to a Judicial Review which challenged the consultation process on a number of grounds, including the phased approach and adequacy of the public consultation and of the NHS England Bed Test. The hearing was heard in December 2017 and the challenge was not upheld.

The decision to make the temporary changes to obstetric services at the Horton General Hospital permanent was referred to the Secretary of State by the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC). The Secretary of State asked the Independent Reconfiguration Panel (IRP) to advise him on whether a full review was required. OCCG received written confirmation in March 2018 that the Secretary of State had accepted the IRP advice that further actions are required locally before a final decision is made about the future of maternity services in Oxfordshire. This work is now underway.

Alongside this, a recent Care Quality Commission (CQC) Local System Review has emphasised the need for much better health and social care planning together as a system rather than from individual organisations and the need for an overarching vision and strategy for health and care in Oxfordshire.

Building on this, system partners have agreed to fundamentally review the Oxfordshire Transformation Programme and concentrate on developing place-based, local discussions that address the needs of the local population, taking into account geography and available services.

In relation to the Horton General Hospital, the decision has been taken to work collaboratively to create sustainable services retaining the Emergency Department and paediatric services. OUH is working with system partners to address the demonstrable need to improve the provision of urgent and emergency care in north Oxfordshire.

Improving our hospital environment

Sustainability update

The Trust takes its responsibility as a major employer and consumer of energy and resources seriously and is committed to helping to reduce the adverse effects of its operations on the wider environment.

The Trust is now a member of the South Region Sustainability and Health Network (SRSHN). This network brings together health professionals from across the South of England, and is one of four networks across England. The primary purpose of the network is to support a rapid transformation of the health and care system in the south of England to a sustainable resilient system.

Energy

The overall Trust spend was £10.63m on energy in 2017-18, which is 6.0% below the energy spend from the previous year. The main reason for the reduction was having the Combined Heat and Power (CHP) commissioned in October 2017.

The total calculated emissions in 2016-17 reported in July 2017 were 18,966 tonnes of CO_2 under the Carbon Reduction Commitment (CRC) energy efficiency scheme. Under the EU Emission Trading System (EU ETS) the total emissions for 2017 were 12,227 tonnes of CO_2.

Utilities cost elements

The table below shows the breakdown of the cost elements for Trust utilities for 2016-17 and 2017-18.

There is a significant drop in electricity consumption coupled with a significant rise in Trust gas consumption. Along with this, the medium oil cost at CH was zero in 2017-18. This effect was mainly due to commissioning of the John Radcliffe – Churchill Hospital Energy Link from the CHP at the John Radcliffe Hospital site.

Water costs also came down significantly due to some credit adjustment on consumptions, a leak detection by the Estates Team and water efficiency awareness.

The other charges to PFI sites and the tenant's income are a reflection on the utility price increase compared to 2016-17. For 2018-19 the trend is unfortunately heading upwards with a projection of a 10.6% rise in the electricity rate and 5.2% in gas.

Taxable commodity	2016-17		2017-18	
	Cost	Unit Kwh	Cost	Unit Kwh
Trust electricity	£5,266,656.28	47,488,950	£3,718,104.75	42,221,381
Trust gas	£1,474,412.71	71,813,475	£2,549,453.31	109,557,294
JR PFI electric	£1,595,063.07	14,866,828	£1,821,788.15	14,932,312
JR PFI gas	£271,920.85	13,253,285	£370,653.64	14,377,778
CH PFI electric	£1,140,102.38	10,193,154	£1,340,743.77	10,655,125
CH PFI gas	£99,128.71	4,547,038	£139,419.71	5,664,855
Trust oil CH	£382,472.18	10,271,880	£0.00	0
Trust water	£1,074,767.33	580,520 m^3	£683,538.58	516,219 m^3
Total Trust Utility	£11,304,523.51		£10,629,701.91	
Less tenants' recharge income	-£1,841,109.91		-£2,100,767.59	
Total net utility cost	**£9,463,413.60**		**£8,528,934.32**	

Hospital Energy Project

The Trust has upgraded its energy infrastructure in the retained estate at the John Radcliffe and Churchill hospital sites. Practical completion of the project was 1 October 2017, with the additional chiller works on schedule for completion in late spring 2018. The Trust has entered into a 25 year partnership agreement with *Vital Energi*, with the capital investment provided by *Aviva*.

In 2018 the Hospital Energy Project has won two Awards:

- IHEEM Healthcare Estates Awards - Sustainability Project of the Year
- Hospital Business Awards - Estates & Facilities Innovation Award

and was shortlisted for a further six.

The benefits

- A 4.5 MWe natural gas-fired Combined Heat and Power (CHP) unit provides heat and electricity to the retained estate in the John Radcliffe and Churchill hospitals.
    - An Energy Link connects both sites.
    - The Churchill Hospital retained estate is now 100% National Grid-free.
    - Reduced reliance upon the National Grid for electricity at the John Radcliffe Hospital.
    - Significant reduction in electricity costs / but higher dependence upon natural gas.
- Energy efficient lighting upgrade.
- Building Management System (BMS) controls and infrastructure upgrade. This real-time live data on energy usage will help evidence-based planning for the future.

These initiatives have helped the Trust to become a more efficient user of energy, and thereby lower its associated carbon emissions, and significantly improved operational resilience. In addition, the Trust is benefiting from reduced direct energy, maintenance and service costs and non-energy charges in the form of lower carbon levies.

Our hospital grounds

The Trust's estates team worked tirelessly over the winter months of 2017-18 to keep the hospitals' roads and footpaths clear of ice and snow and their outstanding work was appreciated by staff, patients and visitors alike.

The estates team also undertook a full tree survey at the John Radcliffe Hospital which showed a number of trees needed pruning or felling. When a tree was felled, another was planted (although not always in the same place).

Other works to enhance the environment have included working with the Friends of the Lye Valley - the Site of Specific Scientific Interest (SSSI) next to the Churchill Hospital - magnificent summer flower displays on all sites and introducing bees to Oxford hospital sites from stock bred at the Shrewsbury and Telford Hospital.

Sustainable waste disposal

The Trust focuses on sustainable waste disposal practice such as reusing, recycling and recovering value, for instance 'energy from waste' rather than sending waste to landfill.

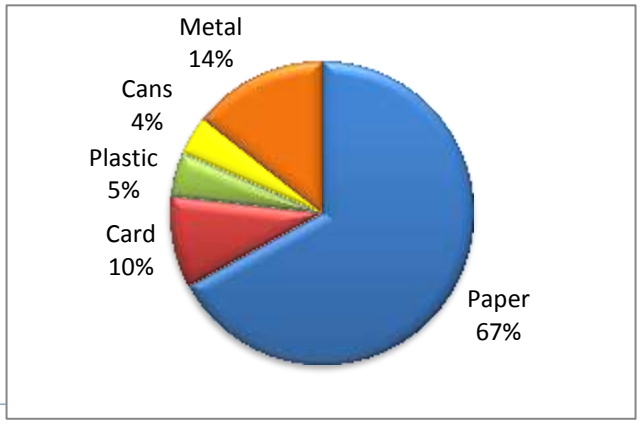
All of the Trust's clinical waste is either incinerated or sent for alternative treatment (AT). No waste goes to landfill. Incinerated waste produces 100% steam recovery and 100% recycled residues of bottom ash and lime. Alternative treatment waste produces 100% flock recovery which is used as a fuel source. The Trust's total solid recovered fuel (SRF) for this AT treatment in year 2017-18 can be quantified in the following terms.

All of the Trust's general waste is processed at an Energy From Waste (EFW) facility where 100% of waste is burned for energy and all of the recyclable waste is processed at a Materials Recovery Facility where 100% of waste is recycled. The table below shows how we can quantify this waste recovery across the Trust for year 2017-18.

Annual Eco Saving	TOTAL
Trees saved	2,502
CO^2 saved (Kg)	591,229
Power generated (MWh)	1,015

Waste segregation trends within the Trust

The Trust continues to enhance its waste segregation processes and collates data to ascertain current trends and areas for further review. Year 2017-18 recycling segregation can be broken down as described below.



Waste quantifying and evaluation methodology will continue to improve in line with legislation and best practice to yield best value for money to the Trust.

Sustainable Development Plan

The Trust is currently working with the Oxfordshire Clinical Commissioning Group's Sustainable Development lead to develop a Sustainable Development Management Plan (SDMP). The Trust is also working to complete the Sustainable Development Assessment Tool (SDAT), previously the Good Corporate Citizen which incorporates sustainable development and a reduction in health inequalities through trusts' day-to-day activities. As a significant purchaser and provider of goods and services such as waste, energy, water, building works and transport, the Trust intends to continue to work towards limiting our environmental impact. A draft sustainable development strategy by Q4 2018 will inform the plan and intends to reduce our carbon emissions and other environmental impacts.

Sustainable transport

The Trust is committed to improving access to its sites by public transport, reducing car journeys for those patients and visitors who are able to use public transport or other methods of travel, and to reduce staff reliance on cars and parking.

The Trust is a founder member of the green travel network, Easit, and staff can use this to get information, subsidies and offers on:

- trains (single journey and season tickets)
- bikes (discounts from 10% to 20%)
- local and national bike shop repairs, parts and hire
- electric bikes
- folding bikes
- electric cars and charging points
- bus discounts and one week bus taster tickets
- travel-related products for the Trust.

The Trust works closely with the Oxfordshire bus companies and Oxfordshire County Council on new routes, offers for staff and initiatives such as bike-friendly buses and demand-led transport. The Trust has representation on committees such as the Oxford Quality Bus Partnership which allows the Trust to share ideas, views and needs with the bus companies and the City and County councils. We are also actively looking at future opportunities for initiatives such as an OUH Park and Ride scheme.

With the University of Oxford, Oxford Brookes University, Oxford Health NHS Foundation Trust and Oxfordshire County Council, the Trust jointly runs the Oxon Bikes Scheme, which offers staff and visitors the opportunity to hire bikes and electric bikes on our sites and from elsewhere in Oxford.

The Trust encourages cycling to our sites by supporting a maintenance service (the Bike Doctor), dealing with abandoned bicycles and maintaining facilities and servicing for cyclists. The Trust has applied for Department for Transport funding as part of an initiative with the University of Oxford to request support for more hire bikes through Oxon Bikes, more bike shelters, signage and better cycle ways. Some of this has already been included in the Access to Headington works.

The Trust has its own dedicated car sharing scheme called OUH Liftshare which enables organised lift sharing by connecting people travelling in the same direction. We currently have around 460 active members.

The Trust has a free staff shuttle bus between the John Radcliffe Hospital, Nuffield Orthopaedic Centre and the Trust offices at OUH Cowley, which is run by Oxford Bus Company. This service uses modern, comfortable, vehicles with Wifi. There is also a shuttle service between the John Radcliffe Hospital, Nuffield Orthopaedic Centre and the Churchill Hospital. This service is also free for staff and is run on behalf of the Trust by South Central Ambulance Service (SCAS).

The Travel and Transport Team has been working closely with Oxfordshire County Council on the Access to Headington roadworks and has supported several events to inform staff and patients about the roadworks. Over the last year, the team has continued to send out updates and communications for staff to explain the works and effects on access, patients and local traffic.

During the snow and icy conditions in the winter months in 2017-18, the Travel and Transport and Operational Estates teams worked around the clock to keep all the visitor car parks, roads and pavements open. It also liaised with all major transit companies and the Trust's Communications Team to ensure that the most up-to-date travel information was available via social media, the website and internal communication channels.

The Travel and Transport Team are planning upgrades to car parks at all sites to reduce congestion and improve patient experience. New lineage, hatching and signage for the sites has also been ordered to aid with traffic flow and relieve current 'pinch points'. Card payment facilities were installed in the car parking offices.

CQC ratings

The Trust is governed by a regulatory framework set by the Care Quality Commission (CQC) which has a statutory duty to assess the performance of healthcare organisations. The CQC requires that hospital trusts are registered with the CQC and therefore licensed to provide health services.

The Care Quality Commission (CQC) has published three reports about the Trust in March 2017.

- Maternity (focusing on the John Radcliffe Hospital site);
- Oxford Centre for Enablement (OCE) at the Nuffield Orthopaedic Centre;
- Well-led domain (leadership and governance of the Trust).

These reports are available on the CQC website. They relate to three separate inspections carried out by the CQC in November 2017.

The CQC said that they "found Oxford University Hospitals NHS Foundation Trust was led by an experienced leadership team with the skills, abilities and commitment to provide high-quality services. They were approachable, visible and supportive to their staff and actively empowered individuals to help drive improvement in their own areas.

"The leadership were aware of many of the areas raised with them as a result of our inspection and had already put measures in place to combat issues highlighted. However, many of the plans were new in formation making it too early to judge their impact.

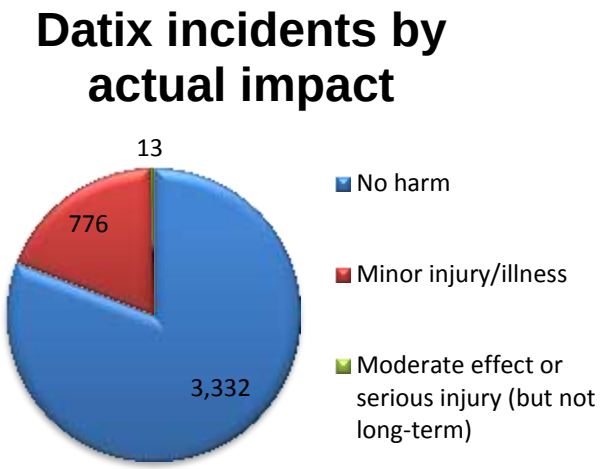
"We have fed back our findings to the Trust and the leadership knows what it must do to bring about improvements in the areas identified. We will return at a later date to check on what progress has been made."

Since the inspections were carried out in November 2017 and initial feedback was provided by the CQC's inspectors, the Trust has been working on key actions to tackle areas for improvement which were identified in order to improve services for patients.

Our Trust's overall rating of 'Good' remains unchanged.

Health and safety

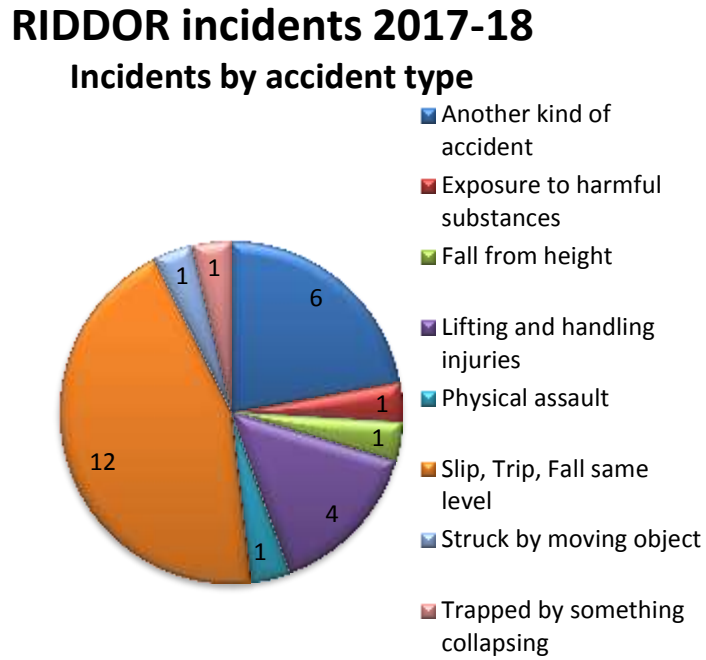
The number of non-clinical incidents reported during the period 1 April 2017 to 31 March 2018 is shown below. All incidents have been categorised by actual impact (no harm, minor, moderate, major, severe).



There were 4,121 non-clinical incidents reported for the period including near miss incidents. There were no incidents categorised as major or severe. There was no harm identified in 81% of all incidents, the same figure as last year.

RIDDOR reported incidents

Overall the number of RIDDOR reportable incidents for 2017-18 was 27. Below is a breakdown into accident type.



THE PATIENT'S EXPERIENCE

Your thoughts, opinions and observations about all aspects of our hospitals are very important to us. Our aim is that every patient's experience is an excellent one and understanding what matters most for our patients and their families is a key factor in achieving this.

Learning from you

OUH actively asks for feedback from patients, their friends, families and carers, and acts on it. This is because we want every patient to have the best experience possible. Feedback helps our staff to know what we are doing well (and the things we should keep on doing) as well as what we need to change.

We do this by:

- using questionnaires, text messaging and online surveys;
- listening to what you tell us in person;
- responding to letters and emails you send us, and feedback posted on NHS Choices;
- listening to what you tell the Patient Advice and Liaison Service (PALS);
- holding meetings with community groups;
- hearing from the Trust's Public Partnership Groups and Patient and Public Forums;
- seeking 'patient stories' (asking patients to give us an in-depth account of their experience, to help us to understand the issues better).

Building a culture of compassionate care – the Friends and Family Test

Seeking and acting on patient feedback is key to improving the quality of healthcare services. After you have received care from the Trust, patients are asked for feedback via the Friends and Family Test (FFT) survey, which asks whether they would recommend the department to friends and family (if they should need similar care or treatment).

Text messaging is used to seek feedback in many of the Trust's departments, and has improved response rates. High response rates are important because it means that feedback is more meaningful, and more representative of the views of patients. Patients can provide feedback via multiple channels; text, agent call, paper and online. As well as increasing the number of responses, the use of telephone calls and texts means that staff in the departments do not need to hand out questionnaires, allowing them to focus on caring and clinical duties.

Sharing the learning from Friends and Family Test – survey feedback

In April 2017, the Trust introduced a process for learning from FFT feedback. Each month, the Patient Experience Team reviews the Trust's feedback, and selects one department with excellent feedback, and one department with feedback for improvement, according to agreed criteria. The feedback is analysed to identify themes. The Patient Experience Team contacts the department with excellent feedback to congratulate them and ask what helps them to provide positive experiences for patients.

The department with feedback for improvement is asked what they plan to do to improve experiences for patients. The Patient Experience Team revisits the departments six months later, to establish what progress has been made, both in terms of the changes that were planned, and whether this has had an effect on the feedback received.

Friends and Family Test – how did we do?

The following results are for the period covered by this report, 1 April 2017 to 31 March 2018.

Inpatients and day cases

- 96% of patients are extremely likely or likely to recommend the ward they stayed on *(based on 32,966 responses)*.

Emergency Departments

- 86% of patients are extremely likely or likely to recommend the care they received in the Emergency Departments *(based on 14,573 responses)*. This is similar to other Trusts in terms of ratings.

Maternity services

- Women using maternity services are asked about their antenatal care, experiences at birth, care on the postnatal ward, and the postnatal community service. 96% of women are extremely likely or likely to recommend the Trust's maternity services *(based on 3,398 responses)*.

Outpatients

- 94% of outpatients are extremely likely or likely to recommend the Trust's outpatient services *(based on 70,764 responses)*.

National Patient Survey Programme

In 2017, the Trust took part in the National Patient Survey; an annual process required of all trusts by the Care Quality Commission. The feedback from these surveys forms part of the important work the Trust is doing to identify areas where patients feel that we can improve within departments or as a Trust. Together with many other methods of gaining patient feedback, these results help the Trust focus on improving the overall experience of patients in hospital. National surveys also allow us to compare how we are rated against other trusts nationally, as well as demonstrate self-improvement year on year.

National Inpatient Survey

For the National Inpatient Survey, the mandatory number of patients all trusts must attempt to contact is 1,250. The Trust chose to survey an additional sample of approximately 3,400, and has done so for three years now, meaning that approximately 4,650 surveys are sent out in total to a sample of patients who were discharged from the Trust's hospital wards in July 2017. The Trust's intention is that this will provide a broader perspective of the quality of our services. The Care Quality Commission (CQC) collates and compares the results from mandatory patient samples across all trusts nationally.

In 2017, the Trust continued to work on two priorities for improvement chosen in 2015 and 2016 as a result of comments and feedback from the recent surveys: to improve responsiveness to patient needs (measured via call bells), and to reduce noise at night from staff. These were both areas in which the Trust performed worse than other trusts. However, results for both of these areas have

improved overall from 2014 to 2016. This is as a result of raising awareness with clinical staff and discussing the importance of attending to patients' needs in a timely manner, while keeping noise to a minimum to allow rest and recuperation.

Embargoed results from the 2017 survey have been shared with clinical divisional teams and presented to some senior staff and a group of Public Governors. The results are very positive overall and responses were received from 43% of the mandatory sample. The Care Quality Commission will publish the results nationally in May-June 2018.

National Maternity Survey 2017

The Trust also took part in the National Maternity Survey in 2017. The mandatory number of patients to be surveyed is lower due to the smaller patient population. The Trust sent the survey to 539 women, and received completed surveys from 275, giving a response rate of 51%. The highest score achieved was 9.9 (out of 10) for the question 'During your pregnancy, did you have a telephone number for a midwife or midwifery team that you could contact?' This was 9.7 in the last survey, taken in 2015.

When examining the feedback about birth and labour, the Care Quality Commission's published results (January 2018) show that the Trust performed better than most trusts on two questions: being able to move around and choose the most comfortable position during labour, and staff introducing themselves before examination or treatment.

Engaging with patients and public

In order to enable the right improvements to our organisation and services, the Trust needs to have the views of people who use them. We have therefore continued to engage with patients and the public in a number of ways to help the Trust make improvements.

Participation in the setting of the Trust's quality priorities

Foundation Trust members, Public and Staff Governors and members of patient groups were invited to two meetings, in June 2017 and January 2018, where the Trust's current and proposed priorities were outlined and people gave feedback on these, as well as identifying the focus of priorities for the forthcoming year.

Progress against the Patient and Public Involvement Strategy (2016-19) has been made and an annual review was presented to the Trust Board in January 2018.

- A 'Guide to Setting up and Running a Public Partnership Group (PPG)' was written and approved. It provides guidance and resources and support for patient groups and members. This includes advice about recruitment, terms of reference, confidentiality and providing an opportunity for groups to share learning and activities.

- Patient and public involvement in service developments through attending Patient and Public Partnership Groups (PPGs) relating to the service they are interested in, or providing feedback to

the service.

- Patient and Public Forum. In June 2017, a new opportunity for patient and public involvement was established. The forum invited public and staff attendees to discuss any problems that they felt the Trust needed to address. Two priorities were voted on by the group - communication and discharge (bridging the gap between hospital and community services). Two Patient and Public Reference Groups were created, with staff and public volunteers, to take these work streams forward. The second forum was held in November 2017, to review progress, and a further forum meeting will take place in summer 2018.

- Patient stories. The Chief Nurse presents a written case study and associated learning alternately to the Trust's bi-monthly public Board meetings and Quality Committee meetings. These stories, volunteered by patients and relatives, are shared with relevant clinical teams to help them better understand, from the patient's perspective, what they do well and what could be improved.

In October 2017, a new version of presenting these stories was introduced, called 'My Story, My Voice' and involved two members of the public (a young carer and a former adult carer) and one member of staff talking about their experiences directly to an audience of staff and public. Feedback from the session was very positive and further 'My Story, My Voice' events will be planned for 2018-19.

Children's patient experience

Young People's Executive (YiPpEe)

YiPpEe is the Trust's Public Partnership Group for children and young people. The group has been involved in a wide range activities over 2017-18, which include:

- delivering a seminar to children's nursing students, at Oxford Brookes University, on service user involvement;
- investigating the main causes of noise at night on children's wards, in response to the Trust's results for the National Children and Young People's Inpatient and Day Case Survey 2016;
- attending the 'The Big Youth Forum Meet Up', at Great Ormond Street Hospital for Children, where they had the opportunity to meet similar groups from across the country.

YiPpEe has two members elected to represent children and young people on the Trust's Council of Governors.

National Children and Young People's Inpatient and Day Case Survey 2016

In November 2017, results were published for the National Children and Young People's Inpatient and Day Case Survey 2016. This surveyed patients, and their parents / carers, between the ages of 15 days and 15 years old.

Questionnaires were sent by the Trust to 1,250 patients, with 462 returned, giving a response rate of 37%. The Trust performed better than most trusts on 15 questions including, patients being able to

talk to staff without parents or carers present, parents having enough information to be involved in care decisions, and overall patient experience.

In partnership with YiPpEe, three areas have been identified for improvement:

- reducing avoidable noise on children's wards at night;
- improving the information provided on discharge;
- involving children and young people more in decisions about the care and treatment they receive.

The Carers Project

Since 2015, the Trust has been working closely with the team at Carers Oxfordshire to ensure that carers are identified and supported while their loved ones are in, or visiting, our hospitals. A Carer Liaison Worker from Carers Oxfordshire dedicates three days per week to supporting carers in the hospital setting. A new Carer Liaison Worker started with the Trust in September 2017 and since then she has made contact with 74 carers (as visitors of the Trust), and 12 staff carers to offer support and advice. This has been via drop-in 'surgeries' on the Neurosciences Ward, attendance at Healthy Hospital Days, and attendance at the monthly Dementia Information Café. The Carer Liaison Worker is also taking part in several public involvement initiatives, as a representative of the needs of carers.

The Trust's Carers Policy was redeveloped, consulted upon (both externally and internally) and approved in 2017. The new policy acts as a guide and resource for staff, particularly those in a patient-facing role.

Since early 2016, the Trust has worked with other organisations - Oxford Health NHS Foundation Trust, Oxfordshire County Council and Oxfordshire Clinical Commissioning Group, and Carers Oxfordshire - with carers themselves, to put together the 'Oxfordshire's Commitment to Carers'. The final version of the commitment was chosen by voting (cast by over 100 carers) at the Carers Oxfordshire Care Matters conference in November 2017. The document outlines how each organisation plans to support and work with carers as partners in care. The commitment will be launched countywide in 2018.

Patient Advice and Liaison Service (PALS)

PALS is a first-stop service for patients, their families and carers who have a query or concern about our hospitals or services. The team provides an impartial and confidential service and aims to help resolve issues by addressing them as quickly as possible.

Where PALS is unable to help, the enquirer is directed to a more appropriate person or organisation.

The majority of PALS contacts relate to requests for information about hospital processes or putting people in touch with the correct department or individual who can help them. The service also collates comments, suggestions and concerns made either directly to the service or through the patient experience feedback mechanisms available throughout the hospitals.

PALS is an integral part of the Complaints Team and works closely with the Patient Experience Team to provide a comprehensive service to patients and their families.

PALS can be contacted by telephone, email, letter to the hospital or via the leaflet 'We're here to help' which is available in public areas on all hospital sites. The PALS team also meets with patients on the wards or in departments should this be required. The team works Monday to Friday 9am to 5pm.

During 2017-18 PALS dealt with 1,932 recorded requests, compliments and concerns. The main categories related to communication, appointments, admission and discharge, information requests and cancellations or delays in appointments. There were also compliments to various staff and departments.

How we handle your complaints

The Trust aims to adhere to the *Principles of Remedy* produced by the Parliamentary and Health Service Ombudsman in 2007 and the *Local Authority Social Services and National Health Service Complaints (England) Regulations 2009*, in order to produce reasonable, fair and proportionate resolutions as part of our complaints handling procedures. These include:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement.

In the financial year 2017-18 the Trust received 989 formal complaints. The main theme of the complaints are related to clinical treatment, appointments, communications, admissions and discharge, patient care, and in relation to the Trust's values and behaviours amongst staff.

All complaints are managed individually with the complainant and in a manner best suited to resolve the particular concern raised. Each complaint is assigned a named Complaints Co-ordinator, who will, where possible, discuss with the complainant how they wish their complaint to be responded to. Methods of response can include a written response from the Chief Nurse on behalf of the Chief Executive, a face-to-face resolution meeting with relevant staff, and later potentially if unresolved an independent review of the care provided.

The Trust reviewed the way it dealt with complaints to learn from the Francis Enquiry (into care at Mid-Staffordshire NHS Foundation Trust), and reports from Oxfordshire Healthwatch, the Parliamentary and Health Service Ombudsman and the Care Quality Commission. Changes include:

- simplifying the language used in response letters to include less jargon and better explain complex clinical information;
- assessment of serious complaints to establish if they should be investigated as a clinical incident.

Your privacy and dignity

The Trust is committed to delivering patient-centred care via our clinical teams who understand the principles of privacy, dignity and respect for everybody. Problems concerning privacy and dignity are taken very seriously and the Trust wants to ensure that patients feel confident, comfortable and supported when in hospital.

Supporting patients with dementia

In 2017-18, there has been a continued focus on improving the process of care and therefore the experience of patients with dementia and cognitive impairment through a programme of on-admission cognitive screening, diagnosis and documentation. The aim is to identify those patients who are confused and need additional support and this cognitive testing is mandatory for patients aged 70 or over who have an unplanned admission, or for younger patients at-risk (e.g. with brain disease, or illness as a result of alcohol).

Screening is completed in the Electronic Patient Record (EPR) system and is then used to automatically trigger specific nursing care plans, and to inform discharge documentation to GPs. Consent forms (for procedures and treatment) have been amended to prompt consideration of capacity issues in patients with dementia or cognitive impairment.

The Trust works with colleagues in social services, primary care, community hospitals and mental health services across Oxfordshire, to provide seamless and patient-centred care for people with dementia. The Trust also works closely with charitable organisations such as Age UK, Dementia Action Alliance, Alzheimer's Society and others, to maximise expertise and resources. The Trust's monthly Dementia Information Café provides support to members of the public and staff. The café is supported by Trust staff, the Alzheimer's Society and Carers Oxfordshire.

To ensure its staff members are trained appropriately, the Trust provides two levels of dementia education:

- Tier 1 education raises awareness for all staff and is delivered to those attending either the Corporate or Nursing and Midwifery induction programmes. There is also an electronic learning module available for staff.
- Tier 2 education offers knowledge as well as practical support for nurses, allied health professionals (AHP) and nursing assistants caring on a regular basis for patients with dementia. Tier 2 focuses on frameworks, in-depth knowledge of the condition, role play and scenario-based discussion, including simulation training in a practical setting. Videos of realistic scenarios are offered in order to improve the way staff respond to, and anticipate, challenging behaviour in order to keep patients safe and secure.

Training is overseen by a member of the Quality Improvement Nursing and AHP Team. The content of Tier 2 has been developed through a multidisciplinary approach involving a consultant gerontologist, consultant psychiatrist and the wider Trust education team. The Trust identified Dementia Leads in 2016 who received additional training in dementia care to support teams in priority clinical areas in the management of patients with dementia. In 2017 the Trust identified and refreshed the team of dementia educators who have received training in delivering Tier 2 training to their respective clinical teams. In addition, 11 consultant psychiatrists work across the Trust to provide support to our patients and education to the multidisciplinary teams.

The Trust is continuing to explore ways in which it can improve the physical environment for patients with dementia, such as allocating patients to observable quiet areas on wards to reduce sensory stimulation, and using ambulatory assessment areas rather than the Emergency Departments, where appropriate. Clinical areas also employ a range of different techniques to support patients. On the Stroke Unit, for example, coloured curtains help patients to recognise which bay they are in and plans are in place for a dementia-friendly day room for patients on medical wards at the Horton General Hospital.

The trauma wards have improved the ward environments to be more dementia-friendly, including reminiscence music through iPods and 'quiet rooms', with décor designed to stimulate long-term memory. A colour-focused approach is also used so that patients can identify their bed by the colour of the counterpane and other items. Dementia Champions from the team meet bi-monthly to discuss local strategy and feedback from recent events. The Trauma Service Outpatients Department has a method for flagging notes for patients at risk of cognitive impairment and these patients are accommodated accordingly.

The Trust Dementia Strategy was reviewed and updated in 2016. The updated strategy was approved by the Trust Board and included the ongoing aims related to cognitive screening, changes to consent forms, staff training and audit and research around the inpatient population with confusion.

The Trust has a number of Dementia Reminiscence Therapy machines with games, photos, speeches, audio books and music. Some staff members are trained in how to use the machines for the best advantage of patients, as well as encouraging family members to use the machines to interact with those they are visiting. They can provide stimulation and reminiscence therapy to patients with temporary or permanent cognitive impairment.

Equality and diversity

The Trust works hard to ensure that its activities are as inclusive as possible for all patients, their families and carers. All employees undertake mandatory equality and diversity training, and all Trust policies and procedures are assessed prior to implementation to ensure equality issues have been considered.

An Equality and Diversity Steering Group is chaired by the Director of Improvement and Culture. This group reports to the Trust's Quality Committee and oversees the patient and staff equality and diversity programme of work.

The Trust collected evidence of how it is supporting patients with the nine characteristics protected under the Equality Act 2010. The evidence was presented to a public panel in 2016 as part of the Equality Delivery System (EDS2). The results were published with the Equality and Diversity Annual Report in July 2016. A progress report was presented to the Trust Board in January 2017, and the next assessment panel will be held in June 2018.

Equality and diversity also applies to the values in the way in which our staff are treated, both by their colleagues and patients.

Supporting people with a learning disability

The Trust employs a Learning Disability Acute Liaison Nurse with an additional learning disability nurse recruited in 2017-18. The Learning Disability Liaison Team oversees the care of patients with a learning disability within the Trust as well as providing expertise and training. The Learning Disability Acute Liaison Nurse is a point of contact for people with learning disabilities, families, carers and healthcare professionals and is available to support both children and adults. Looking forward, particular focus will be given to providing a specialist Learning Disability Liaison Nurse within Epilepsy services and to support the case co-ordination of people with learning disabilities and complex needs.

The Trust makes use of the Hospital Passport scheme which gives useful information about a patient's needs and wishes for those caring for them whilst they are in our hospitals. The Trust has also developed Easy Read leaflets and Easy Read appointment letters for patients.

Advancing multi-faith support

The Trust has worked hard to expand its Chaplaincy service to offer better support to Muslim patients. This has included appointing a part-time Muslim Chaplain to join the service. The facilities for multi-faith prayer space at the John Radcliffe Hospital have been reviewed and the need for alternative accommodation has been raised as part of our estates planning.

As part of a review of the suitability of the Trust's facilities, the chapel and washrooms at the Churchill Hospital have been adapted to support the requirements of Muslim prayer. A multi-faith quiet space has also been developed at the Nuffield Orthopaedic Centre. This was created by a specialist designer, working with patient representatives of different faiths.

The Trust's Bereavement Service to continues offer a supportive service to the four regional Islamic funeral directors and the communities in general. The Trust is currently exploring ways to enable funerals to take place quickly in line with the requirements of some faiths.

Clinical patient information leaflets

The Trust's library of clinical patient information leaflets continues to grow, with a current library of over 1,400 leaflets. These leaflets support our patients and their carers with well-written and clear information, which helps to improve their overall hospital and care experience.

Our leaflets help patients (and / or their carers) to make a choice about treatment, including information about safety, risks, benefits and alternatives.

The Trust shares the content of many of our leaflets with other trusts and healthcare providers around the world.

NHS England Accessible Information Standard

The Trust has several projects running to ensure it is achieving the NHS England Accessible Information Standard (AIS). The Trust will continue to work in line with this standard, by updating and streamlining processes to make information available to patients with different communication requirements (e.g. Braille, large print, audio, Easy Read).

The Trust is working to enable the Electronic Patient Record (EPR) system to alert staff to patients' communication needs. This will enable staff to recognise when a patient may need information in other formats, and plan how to meet their needs in advance.

Interpreting and translation services

A quality improvement project for interpreting services commenced in May 2017. The project aims to improve quality, availability and value for money when language interpreters are needed.

The Interpreting Officer has visited departments in the Trust to update staff on the appropriate use of interpreters, in line with the revised Interpreting and Translation Policy. During the visits, the Interpreting Officer reinforced guidance on when to use telephone or face-to-face language interpreters, and informed teams to always ensure that professional interpreters are provided when needed. This also included the review of telephony equipment.

Communication cards are available to staff and can be used by patients to communicate their needs. The cards can be used by patients with limited communication capability, as well as those with limited English, as they have also been translated into 28 different languages. Communication cards are a very useful way of bridging the gap for simple conversation or requests when an interpreter is not immediately available.

The Trust has produced leaflets in other languages, as well as translating patient letters and notes. Departments are continuing to translate their most popular leaflets into the top five languages used by patients.

There is a plan to launch a video interpreting service for both language and British Sign Language interpreting. Video interpreting will be useful in situations where patients or their carers need an interpreter to be visually involved, without needing the interpreter to be physically present, and will increase availability of interpreters, as some requests are short notice. As an additional benefit, the limited resource of qualified language and British Sign Language interpreters available to the Trust will be more efficiently utilised.

RESEARCH AND DEVELOPMENT

As one of the largest acute trusts in the country our main priority is to deliver excellent healthcare for all of our patients. This is underpinned by bringing together academic research expertise with our clinical teams to translate medical science into better healthcare treatments.

Teaching and research are essential components of the DNA of our hospitals. This is demonstrated by our strong relationship with the University of Oxford, named the world's best institution for medical and health teaching and research. With thousands of academic researchers working alongside our clinical staff, we aim to give our patients opportunities to take part in research and to ensure that they benefit from the latest medical breakthroughs.

OUH works in close partnership with the University of Oxford in clinical research that encompasses a broad range of medical sciences, looking at cutting-edge techniques and technologies and addressing major healthcare challenges. We have major clinical research programmes including cardiovascular, stroke, dementia, cancer, infection, vaccines and surgery, as well as inter-disciplinary collaborations in digital health and imaging.

A culture of collaboration is fostered by the fact that research and clinical facilities are located alongside each other on our hospital sites This is further strengthened by effective support in areas such as research governance, contracts and finance provided by the specialist teams from OUH and the University, which together make up the Joint Research Office (JRO).

OUH was designated a Genomics Medicine Centre in 2015, helping to deliver the 100,000 Genomes Project and so improve understanding of the genetic causes of cancer and rare diseases. So far the Oxford GMC has recruited more than 4,200 patients to the project.

Record high for research studies

It is a strategic priority of the Trust to continue to increase our research activity, further integrate it with clinical care and increase patient participation and involvement.

Indeed, the number of research studies conducted at OUH has risen year on year, and as of March 2018, some 2,002 studies were being conducted, a record high for the Trust. Of these 556 were being carried out in partnership with the University of Oxford, while 173 were sponsored by the Trust itself. More than 400 of the studies were being conducted with commercial partners.

The Trust is a national leader amongst the most research-active trusts in the key government performance metrics, including overall patient recruitment and time to recruit the first patient and recruitment to time and target. OUH has achieved over 92% compliance with the target on time taken to initiate interventional trials research and on effective delivery of commercial trials.

Patient and public involvement

The success of our research is dependent on the participation of patients. Anyone receiving care may be offered the opportunity to join a research study, whether observational, when patient data that is routinely collected, such as blood pressure readings or scan images, are anonymised and shared with researchers with permission; or studies that might require additional tests or increased monitoring, or where a new treatment is trialled.

We are keen for patients and members of the public not only to take part in studies, but also to help shape our research and ensure that patients' views are taken into consideration when designing clinical trials.

Partnerships and research infrastructure

OUH carried out its research and teaching not only with the University of Oxford's Medical Sciences Division, but also Oxford Brookes University's Faculty of Health and Life Sciences and Oxford Health NHS Foundation Trust, as well as commercial partners. Together these institutions form a large, integrated health science campus comparable to anything in the world.

This ties in with the Trust's vision to be at the heart of an innovative academic health science system. Through partnerships with the following bodies, the Trust seeks to deliver measurably better outcomes for patients.

The NIHR Oxford Biomedical Research Centre (BRC) is a partnership between OUH and the University of Oxford, funded by the Department of Health's National Institute for Health Research (NIHR) to support the translation of scientific research and innovation into real clinical benefits for NHS patients – from the bench to the bedside.

In April 2017, Oxford BRC received a five-year grant worth £113.7m to pioneer new treatments, services and diagnostic tools, its third such award and a recognition of the outstanding healthcare research that takes place in Oxford.

Oxford BRC works across 20 research themes, all led by world-leading clinical scientists. Four of the themes are cross-cutting (imaging, molecular diagnostics, informatics, partnerships) to support key infrastructures; while individual research themes have been brought together in clusters (Precision Medicine, Technology and Big Data, Immunity and Infection, and Chronic Diseases) to foster cross-disciplinary activities.

The Oxford Academic Health Science Centre (AHSC) co-ordinates clinical and academic excellence between OUH, the University of Oxford, Oxford Brookes University and Oxford Health NHS Foundation Trust. The Oxford AHSC is an integrated research environment, physically and strategically embedding basic and translational research with clinical evaluation. The partnership, one of just six AHSCs in England, aims to achieve patient benefit by enabling the smooth transition of innovations through the stages of the research lifecycle and into clinical practice.

The Oxford Academic Health Science Network (AHSN) brings together the NHS, academia and industry together to boost health and wealth creation. This network of NHS trusts, academic institutions and life science businesses covers Berkshire, Buckinghamshire, Milton Keynes and Oxfordshire and aims to enable swift uptake and adoption of health research by industry in developing innovative healthcare devices and treatments.

The NIHR Clinical Research Network (CRN) Thames Valley and South Midlands, hosted by OUH, is responsible for ensuring the effective delivery of research in the trusts, primary care organisations and other qualified NHS providers throughout the Thames Valley and South Midlands.

Artificial Intelligence

Oxford, in the shape of the University and OUH, with support from the BRC, is at the forefront of using Artificial Intelligence (AI) on scans to improve diagnosis of heart disease and lung cancer.

The AI systems developed at the John Radcliffe Hospital are far more accurate in analysing scans than human doctors, which should result in a drastic reduction in the number of misdiagnoses, meaning that fewer at-risk patients are sent home or fewer undergo unnecessary surgery.

The systems, which could save the NHS millions of pounds, will be rolled out across the UK in 2018.

Gestational diabetes app first fruit of Drayson deal

A smartphone app that allows women with gestational diabetes to monitor their condition from home, reducing hospital visits while keeping in regular contact with their healthcare team, was recommended for publication in the NHS Digital Tools Library.

The GDm-health app is one of the first fruits of a five-year Strategic Research Agreement between Drayson Technologies, the University of Oxford and OUH in the field of digital health to commercialise innovations developed and trialled in the Oxford BRC.

A randomised controlled trial of the app showed that remote blood glucose monitoring with GDm-health was safe, data capture was better and women preferred it. It also led to reductions in caesarean sections and pre-term births, and cost on average £1,000 less per birth.

New haematology centre launched

A new Oxford Centre for Haematology (OCH) has been launched, with Oxford BRC funding, bringing together University of Oxford researchers and OUH clinicians to improve the understanding and treatment of blood diseases and disorders, integrate academic and clinical haematology programmes, and deliver even better care for patients.

The virtual centre will raise funds through philanthropy to invest in research and a therapy acceleration programme, which will conduct state-of-the-art analyses on patient samples and innovative clinical trials. The OCH will also fund its own programmes, including a comprehensive biobanking programme, an education fund for nurses and allied health professionals, and a pump-priming fund.

First-in-humans cancer drug testing

A ground-breaking cancer drug trial conducted by OUH has moved into its expansion phase after the successful completion of the dose escalation stage.

The trial of CXD101, led by Professor Mark Middleton at the Churchill Hospital's state-of-the-art Cancer Centre, is the first time the drug has been given to humans, and the study, involving patients with advanced forms of cancer for which there is no approved form of treatment available, has given encouraging results. CXD101 inhibits certain molecules in the cell that are important for the growth of some cancers, but it also stimulates the patient's immune system to fight the disease. The Churchill's Early Phase Clinical Trials Unit is a 24-bed facility in the hospital that treats about 200 patients each year from the earliest safety testing to more advanced research into effectiveness.

A good night's sleep!

Hospital patients often complain of lack of sleep caused by lights and noise throughout the night. This can have a severe impact on a patient's experience and has been linked to increased use of medication, delayed discharge and worse health outcomes.

There have been small-scale studies in intensive care settings, but SleepSure, a randomised controlled trial conducted on wards across the OUH hospitals, was one of the first in a general adult inpatient population.

Dr Bruno Holthof
Chief Executive

ACCOUNTABILITY

DIRECTORS' REPORT

The Board is responsible for the management of the Trust and ensuring proper standards of corporate governance are maintained. It attaches great importance to making sure the Trust adheres to the principles set out in the *NHS Constitution and Monitor NHS Foundation Trust Code of Governance*, and other related publications such as *Quality Governance in the NHS*, and is working hard to ensure it operates to high ethical and compliance standards.

Working alongside our Board of Directors is our Council of Governors. Our governors play a valuable role by holding our non-executive directors to account for the performance of the Board, ensuring that the interests of the Trust's members are taken into account and helping to shape our plans for the future.

Our Council of Governors comprises 15 public governors elected from constituencies covering Oxford City, South Oxfordshire, Vale of White Horse, West Oxfordshire and Cherwell districts, Buckinghamshire, Berkshire, Gloucestershire, Wiltshire, Northamptonshire, and the rest of England and Wales. There are six staff governors, and a further eight appointed governors from strategic partners.

The Trust Board membership comprises the following.

Non-Executive Directors (NEDs)

Dame Fiona Caldicott, *Chairman**

Professor Sir John Bell*

Mr Christopher Goard*

Ms Paula Hay-Plumb*

Professor David Mant*

Mr Geoffrey Salt *(Vice Chairman)**

Ms Anne Tutt*

Executive Directors

Dr Bruno Holthof, *Chief Executive**

Dr Tony Berendt, *Medical Director**

Mr Paul Brennan, *Director of Clinical Services**

Mr Jason Dorsett, *Chief Finance Officer**

Mr John Drew, *Director of Improvement and Culture*

Ms Sam Foster, *Chief Nurse**

Mr Peter Knight, *Chief Information and Digital Officer*

Ms Eileen Walsh, *Director of Assurance*

* *Indicates those members holding voting positions, in line with The Health Trust's (Membership and Procedure) Regulations 1990.*

The Trust Board continued to meet in public bi-monthly. In the intervening months meetings of the Quality Committee and Finance and Performance Committee were held to ensure that there was a regular consideration of quality, financial and operational performance. The Board met six times in public during the full year 2017-18.

Further details and biographies of the Board of Directors are available from the Trust's website at www.ouh.nhs.uk/aboutus

In November 2017, the CQC undertook an inspection to ascertain whether services at the Trust are well-led, and the CQC's report was published in March 2018.

The CQC stated that it found that the Trust was "led by an experienced leadership team with the skills, abilities and commitment to provide high-quality services [and that the leadership team was] approachable, visible and supportive to their staff and actively empowered individuals to help drive improvement in their own areas."

Having regard to NHS Improvement's well-led framework, the Trust is developing a detailed action plan to implement measures aimed at bringing about

improvements in areas identified by the CQC, taking into account also the findings of the CQC's focused inspections of maternity services at the John Radcliffe Hospital, and of the inpatient ward at the Oxford Centre for Enablement.

Progress in implementation of the Action Plan associated with the findings of all three of the CQC's reports published in March 2018 will be monitored and reported to the Trust Board and through its sub-committees, and will continue to inform overall evaluation of the Trust's performance, including the strength of internal control and the governance of quality.

In November 2017, the Trust also participated in the CQC's review of Oxfordshire's health and social care system. The CQC's report of that system-wide review, published in February 2018, included comment on system-wide governance. The CQC made a point of praising the dedication of frontline staff across the system, but also highlighted areas for improvement which senior managers in the NHS, social care and other organisations need to act upon to make the whole health and care system work better. Oxfordshire County Council was asked to take the lead in developing an action plan which has been agreed across the health and social care system. The Trust is committed to working with its partner organisations to improve Oxfordshire's health and social care system, and the good governance thereof, through implementing the agreed action plan.

ATTENDANCE AT TRUST BOARD MEETINGS 2017-18

The Trust Board met in public six times during the year 2017-18.

Trust Board - Public		10-May-17	12-Jul-17	13-Sep-17	08-Nov-17	17-Jan-18	14 Mar - 18
Chairman, Non-Executive Director	Dame Fiona Caldicott	✓	✓	✓	✓	✓	✓
Chief Executive	Dr Bruno Holthof	✓	✓	✓	✓	✓	✓
Vice Chairman, Non-Executive Director	Mr Geoff Salt	✓	✓	✓	✓	✓	✓
Non-Executive Director	Sir John Bell	✓	✓	✓	✓	×	✓
Non-Executive Director	Mr Christopher Goard	✓	✓	✓	✓	✓	✓
Non-Executive Director	Ms Paula Hay-Plumb, took up post 4 September 2017			✓	✓	✓	✓
Non-Executive Director	Professor David Mant	×	✓	✓	✓	✓	✓
Non-Executive Director	Ms Anne Tutt	×	✓	✓	✓	✓	✓
Non-Executive Director	Mr Peter Ward, left post 30 November 2017	✓	✓	✓	✓		
Medical Director	Dr Tony Berendt	✓	✓	✓	✓	✓	✓
Chief Nurse	Ms Sam Foster, took up post 4 September 2017 Liz Wright, Acting Chief Nurse 1 April to 30 April 2017 Andrew MacCallum, Interim Chief Nurse 30 April to 3 September 2017	✓	✓	✓	✓	✓	✓
Director of Clinical Services	Mr Paul Brennan	✓	✓	✓	✓	✓	✓
Chief Finance Officer	Mr Jason Dorsett	✓	✓	✓	✓	✓	✓
Director of Assurance	Ms Eileen Walsh	✓	✓	✓	✓	✓	✓
Chief Information and Digital Officer	Mr Peter Knight	✓	✓	✓	✓	✓	✓
Director of Improvement and Culture	Mr John Drew (from October 2017)				✓	✓	✓
Interim Director of Workforce	Mr Mark Power left post as Director of Organisational Development and Workforce on 27 April 2017 Ms Susan Young was in post from 19 April to 31 October 2017	✓	✓	✓			

Key

✓ In attendance (or represented by deputy)

× Not in attendance

Not in post

Council of Governors (as at 31 March 2018)

Public

Sally-Jane Davidge	*Buckinghamshire, Berkshire, Gloucestershire and Wiltshire*
Brian Souter	*Buckinghamshire, Berkshire, Gloucestershire and Wiltshire*
Anita Higham OBE	*Cherwell*
Keith Strangwood	*Cherwell*
Anthony Bagot-Webb	*Northamptonshire and Warwickshire*
Rosemary Herring	*Northamptonshire and Warwickshire*
Cecilia Gould[1]	*Oxford City*
John Harrison[2]	*Oxford City*
Steve Candler	*Rest of England and Wales*
Art Boylston	*South Oxfordshire*
Vacancy[3]	*South Oxfordshire*
Martin Havelock	*Vale of White Horse*
Jill Haynes	*Vale of White Horse*
Susy Brigden	*West Oxfordshire*
Sue Chapman	*West Oxfordshire*

Staff

Simon Brewster	*Clinical*
Lucy Carr	*Clinical*
Jules Stockbridge	*Clinical*
Chris Winearls	*Clinical*
Thomas Snipe	*Non-clinical*
Mariusz Zabrzynski	*Non-clinical*

Appointed

Elizabeth Gemmill[4]	*University of Oxford*
Martin Howell	*Oxford Health NHS Foundation Trust*
Gareth Kenworthy[5]	*Oxfordshire Clinical Commissioning Group*
David Radbourne[6]	*NHS England*
Astrid Schloerscheidt[7]	*Oxford Brookes University*
Lawrie Stratford[8]	*Oxfordshire County Council*
Lewis and Emily[9]	*Young People's Executive*
Vacancy	*Berkshire, Buckinghamshire and Oxfordshire Local Medical Committees*

NOTES

1. *Re-elected unopposed as Lead Governor up to 28 November 2018, as reported to the Council of Governors at its meeting held on 30 January 2018.*
2. *Oxford City governor Margaret Booth resigned on 25 April 2017.*
3. *South Oxfordshire governor Simon Clark resigned on 5 July 2017.*
4. *Following the resignation of the previous governor from the University of Oxford Elizabeth Gemmill was appointed on 19 April 2017.*
5. *Following the resignation of the previous governor from the Oxfordshire Clinical Commissioning Group Gareth Kenworthy was appointed on 5 January 2018.*
6. *Following the resignation of the previous governor from NHS England David Radbourne was appointed on 24 October 2017.*
7. *Following the resignation of the previous governor from Oxford Brookes University Astrid Schloerscheidt was appointed on 1 June 2017.*
8. *Following the resignation of the previous governor from Oxfordshire County Council Lawrie Stratford was appointed on 25 October 2017.*
9. *Following the resignation of both governors from the Young People's Executive Lewis and Emily were appointed on 1 September 2017.*

Details of the Council of Governors are available at www.ouh.nhs.uk/ft

For information about the Register of Interests for governors or to contact any of our governors, please email: governors@ouh.nhs.uk

The Chairman updates the Board regularly on issues arising from the Council of Governors and this will include the Trust's membership strategy, including the representativeness of the membership, membership engagement and numbers. For more information about our membership, please see page 116.

The Council of Governors has now completed its second full year of operating following authorisation as a foundation trust. Over that time, there has been regular and increasing engagement with the Board, within the context of which concerns may be raised by the Council as a whole, or by individual governors.

ATTENDANCE: COUNCIL OF GOVERNORS MEETINGS

Governor Name	07 Apr 17	05 Jul 17	05 Oct 17	30 Jan 18	Notes
CHAIRMAN					
Dame Fiona Caldicott	✓	✓	✓	✓	
PUBLIC					
Brian Souter	✓	✓	x	✓	
Sally-Jane Davidge	✓	✓	✓	✓	
Ruth Barrow	✓	✓			Term ended 30 Sept 2017
Anita Higham OBE	✓	✓	✓	✓	
Keith Strangwood			✓	x	Elected from 1 Oct 2017
Rosemary Herring	✓	x	✓	x	
Blake Stimpson	x	✓			Term ended 30 Sept 2017
Tony Bagot-Webb			x	✓	Elected from 1 October 2017
Margaret Booth	x				Resigned 25 April 2017
Cecilia Gould	✓	✓	✓	x	
John Harrison			x	x	Elected from 1 Oct 2017
Steve Candler	✓	✓	✓	✓	
Simon Clarke	✓				Resigned 5 July 2017
Ian Roberts	x	✓			Term ended 30 Sept 2017
Art Boylston			✓	✓	Elected from 1 Oct 2017
Jill Haynes	✓	✓	✓	✓	
Martin Havelock	✓	✓	✓	✓	
Sue Chapman	✓	x	✓	✓	
Brenda Churchill	x	x			Term ended 30 Sept 2017
Susy Brigden			x	x	Elected from 1 Oct 2017
STAFF					
Chris Winearls	x	✓	✓	✓	
Lucy Carr	x	✓	✓	x	
Chris Cunningham	x	✓			Term ended 30 Sept 2017
Jules Stockbridge	✓	✓	✓	✓	
Simon Brewster			x	✓	Elected from 1 Oct 2017
Richard Soper	✓	✓			Term ended 30 Sept 2017
Mariusz Zabrzynski	✓	✓	x	✓	
Tommy Snipe			✓	✓	Elected from 1 Oct 2017
APPOINTED					
Paul Roblin	x				Resigned 30 June 2017
Rachel Pearce	x	x			Resigned 13 Sept 2017
David Radbourne				✓	Appointed 24 Oct 2017
Linda King	x				Resigned on 31 May 2017
Astrid Schloerscheidt			✓	x	Appointed 1 June 2017
Martin Howell	x	✓	✓	✓	
Paul Park	x	x	x		Resigned 31 Oct 2017
Gareth Kenworthy				✓	Appointed 5 Jan 2018
Judith Heathcoat	✓	x	x		Resigned 4 May 2017
Lawrie Stratford				✓	Appointed 25 Oct 2017
Elizabeth Gemmill		✓	✓	✓	Appointed 19 April 2017
Millie	x	x			Resigned 31 Aug 2017
Hannah	✓	x			Resigned 31 Aug 2017
Emily		x	x	✓	Appointed 1 Sept 2017
Lewis			x	x	Appointed 1 Sept 2017

Key

✓ In attendance ✖ Not in attendance

Not in post

The following also attended on 7 April 2017:

Clare Dollery, Deputy Medical Director

Christopher Goard, Non-Executive Director

Mark Power, Director of Organisational Development and Workforce

Andrew Stevens, Director of Strategy and Planning

The following also attended on 5 July 2017:

Paul Brennan, Director of Clinical Services

Jason Dorsett, Chief Finance Officer

Christopher Goard, Non-Executive Director

Bruno Holthof, Chief Executive

Geoffrey Salt, Non-executive Director

Eileen Walsh, Director of Assurance

Peter Ward, Non-Executive Director

Susan Young, Interim Director of Workforce

The following also attended on 5 October 2017:

Tony Berendt, Medical Director

Christopher Goard, Non-Executive Director

The following also attended on 30 January 2018:

Paul Brennan, Director of Clinical Services

Jason Dorsett, Chief Finance Officer

Paula Hay-Plumb, Non-Executive Director

Anne Tutt, Non-Executive Director

AUDIT COMMITTEE

The Audit Committee is responsible for providing assurance to the 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. It also reviews the Trust's annual statutory accounts before they are signed off by the Trust Board, and monitors the Trust's Counter Fraud arrangements.

The Audit Committee is made up exclusively of independent, Non-Executive Directors:

Ms Anne Tutt, *Chair*
Mr Alisdair Cameron *(up to 30 April 2017)*
Mr Christopher Goard, *Vice Chair*
Ms Paula Hay-Plumb *(from 4 September 2017)*

The Chief Executive, Chief Finance Officer and the Director of Assurance (or her Deputy) normally attend the meetings of the Audit Committee. In line with best practice, the Chairman of the Board is not a formal member of the Audit Committee but may be in attendance, along with any other Board member or senior executive, at the invitation of the Audit Committee Chairman.

Representatives from Internal Audit and External Audit and Counter Fraud Services normally attend meetings to deal with audit issues, and they also hold private meetings with the Audit Committee Chairman to discuss confidential matters.

The Audit Committee met five times during the year 2017-18

AUDIT COMMITTEE Committee Members		27 Apr 2017	24 May 2017	20 Sep 2017	22 Nov 2017	15 Feb 2018
Committee Chairman, Non-Executive Director	Ms Anne Tutt	✓	✓	✓	✓	✓
Committee Vice Chairman, Non-Executive Director	Mr Christopher Goard	✓	✓	✓	✓	✓
Non-Executive Director	Mr Alisdair Cameron up to 30 April 2017, Ms Paula Hay-Plumb with effect from 4 September 2017	✓	✓	✓	×	✓

Key

✓ In attendance

× Not in attendance

FINANCE AND PERFORMANCE COMMITTEE

The Finance and Performance Committee is responsible for reviewing the Trust's financial and operational performance against annual plans and budgets, and for overseeing the development of the Trust's medium and long-term financial plans. It also monitors performance of the Trust's physical estate and non-clinical services. In addition, the Committee is responsible for reviewing the delivery of annual efficiency savings programmes, and monitoring the effectiveness of the Trust's financial and operational performance reporting systems.

The Finance and Performance Committee as at 31 March 2018 comprises:

Non-Executive Directors:

Mr Geoff Salt, *Chair from 13 December 2017*

Ms Anne Tutt, *Vice Chair*

Dame Fiona Caldicott

Mr Christopher Goard.

and the following **Executive Directors:**

Dr Bruno Holthof, *Chief Executive*

Mr Jason Dorsett, *Chief Finance Officer*

Dr Tony Berendt, *Medical Director*

Mr Paul Brennan, *Director of Clinical Services*

Mr Peter Knight, *Chief Information and Digital Officer*

The committee met six times during the year 2017-18

FINANCE AND PERFORMANCE COMMITTEE Committee Members		12 Apr 2017	14 Jun 2017	09 Aug 2017	11 Oct 2017	13 Dec 2017	14 Feb 2018
Committee Chairman, Non-Executive Director	Mr Peter Ward until 30 November 2017 Mr Geoff Salt from 1 December 2017	✓	✓	✓	✓	✓	✓
Non-Executive Director	Mr Geoff Salt up until 30 November 2017; then took over Chairmanship of the Committee (see above)	✓	✓	✓	✓	*NED tbc*	*NED tbc*
Committee Vice Chairman, Non-Executive Director	Ms Anne Tutt	✓	✓	✓	✓	✓	✓
Non-Executive Director	Dame Fiona Caldicott	×	✓	×	×	✓	✓
Non-Executive Director	Mr Christopher Goard	✓	✓	✓	✓	✓	✓
Non-Executive Director	Mr Alisdair Cameron left post 30 April 2017	×					
Chief Executive	Dr Bruno Holthof	×	✓	✓	✓	✓	✓
Chief Finance Officer	Mr Jason Dorsett	✓	✓	✓	✓	✓	✓
Medical Director	Dr Tony Berendt	✓	✓	✓	✓	✓	✓
Director of Clinical Services	Mr Paul Brennan	✓	✓	✓	✓	✓	✓
Chief Information and Digital Officer	Mr Peter Knight	✓	✓	✓	×	✓	✓

Key

✓ In attendance (or represented by deputy)

× Not in attendance

Not in post

INVESTMENT COMMITTEE

The Investment Committee was established in July 2017 and is responsible for advising the Trust Board in relation to investments. Its remit includes review of the Trust's approach to making and monitoring investments, including the policies by which investments are considered, and review of the Trust's approach to financing investments over the medium to long term.

The Investment Committee's core membership as at 31 March 2018 comprises:

Non-Executive

Directors:

Ms Anne Tutt, *Chair*

Mr Geoffrey Salt

Mr Christopher Goard

Ms Paula Hay-Plumb

and the following **Executive Directors:**

Mr Jason Dorsett, *Chief Finance Officer*

Dr Tony Berendt, *Medical Director*

Ms Eileen Walsh, *Director of Assurance*

The committee met five times during the year 2017-18

Investment Committee Members		5 Jul 2017	18 Jul 2017	24 Oct 2017	19 Dec 2017	15 Feb 2018
Committee Chairman, Non-Executive Director	Ms Anne Tutt	✔	✔	✔	✔	✔
Non-Executive Director	Mr Geoff Salt	✔	✔	✔	✗	✔
Non-Executive Director	Mr Christopher Goard	✔	✗	✔	✗	✔
Non-Executive Director	Mr Peter Ward until 30 November 2017					
	Ms Paula Hay-Plumb from 1 December 2017	✔	✔	✔	✔	✔
Finance Director	Mr Jason Dorsett	✔	✔	✔	✔	✔
Medical Director	Dr Tony Berendt	✔	✔	✔	✔	✔
Director of Assurance	Ms Eileen Walsh	✔	✔	✔	✔	✔

Key

✓ In attendance (or represented by nominated alternate or deputy)

× Not in attendance

Not in post

QUALITY COMMITTEE

The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of the quality of clinical care; on governance systems, including the management of risk, for clinical, corporate, human resources, information governance, research and development issues; and on standards of quality and safety.

The Quality Committee's core membership as at 31 March 2018 comprises:

Non-Executive Directors:
Professor David Mant, *Chair*
Mr Geoffrey Salt, *Vice Chair*
Dame Fiona Caldicott
Mr Christopher Goard *(to provide cross-membership with the Audit and Finance and Performance Committees)*

and the following **Executive Directors:**

Dr Bruno Holthof, *Chief Executive*
Dr Tony Berendt, *Medical Director*
Mr Paul Brennan, *Director of Clinical Services*
Ms Sam Foster, *Chief Nurse (appointed September 2017)*
Ms Eileen Walsh, *Director of Assurance*
Mr Peter Knight, *Chief Information & Digital Officer*

Dr Clare Dollery, *Deputy Medical Director,* is also a member of the Quality Committee in her capacity as Chair of the Clinical Governance Committee.

Ms Anne Tutt also normally attends meetings of the Quality Committee in her capacity as Chair of the Audit Committee to address cross-cutting issues.

The committee met six times during the year 2017-18

QUALITY COMMITTEE Committee Members		12 Apr 2017	14 Jun 2017	09 Aug 2017	11 Oct 2017	13 Dec 2017	14 Feb 2018
Mr Geoffrey Salt, *Chair to December 2017*	Non-Executive Director	✓	✓	✓	✓	✓	✓
Professor David Mant, *Chair from December 2017*	Non-Executive Director	✓	✓	✓	✓	✓	✓
Dame Fiona Caldicott	Chairman of the Trust Board	×	✓	×	×	✓	✓
Mr Christopher Goard	Non-Executive Director	✓	✓	✓	✓	✓	✓
Mr Peter Ward	Non-Executive Director *(to 30 November 2017)*	✓	✓	×	✓		
Dr Bruno Holthof	Chief Executive	×	✓	✓	✓	✓	✓
Dr Tony Berendt	Medical Director	✓	✓	✓	✓	✓	✓
Mr Paul Brennan	Director of Clinical Services	✓	✓	×	✓	✓	✓
Dr Clare Dollery	Deputy Medical Director	✓	✓	✓	✓	✓	✓
Mr Peter Knight	Chief Information and Digital Officer	✓	✓	✓	×	✓	✓
Mr Mark Power	Director of Organisational Development and Workforce *(up until 27 April 2017)*	✓					
Ms Eileen Walsh	Director of Assurance	✓	✓	✓	✓	✓	✓
Ms Sam Foster	Chief Nurse *(took up post 4 September 2017)*				✓	✓	✓
Mr Andrew MacCallum	Interim Chief Nurse *(30 April 2017 to 3 September 2017)*		✓	✓			
Ms Liz Wright	Acting Chief Nurse *(1 April 2017 to 30 April 2017)*	✓					

Key

✓ In attendance (or represented by nominated alternative or deputy)

× Not in attendance

Not in post

REMUNERATION AND APPOINTMENTS COMMITTEE

For information about the work of the Remuneration and Appointments Committee, please see page 85.

TRUST MANAGEMENT EXECUTIVE

The Trust Management Executive is the senior managerial decision-making body for the Trust. It is chaired by the Chief Executive and consists of the Trust's Executive Directors, the five Divisional Directors, the Deputy Medical Director and Chair of the Clinical Governance Committee, the Head of the Division of Medical Sciences of the University of Oxford, the Head of Communications, and the Head of Corporate Governance and Trust Board Secretary. It has delegated powers from the Trust Board to oversee the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the Trust's objectives.

Declaration of Interests and Register of Interests of members of the Trust Board for the year 2017-18, up to 31 March 2018

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 12 months for directors whose appointments have terminated in-year.

The interests for the year 2017-18 up to 31 March 2018 are given on pages 74 to 80. Guidance to the codes defines 'relevant and material' interests as follows.

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 shareholdings 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.

Full table detailing Register of Interests of Board Members follows on page 74.

	Register of Interest								
Board member	**Post**	**Directorships, including Non-Executive Directorships**	**Business, partnership or consultancies**	**Majority or controlling shareholding**	**Charity or voluntary organisations**	**Voluntary or other organisation contracting for NHS services**	**Research funding / grants**	**Pooled funds**	**Royalties, licence fees or similar**
Professor Sir John Bell	Non-Executive Director	Oxford University - Regius Professor of Medicine Scholar at Christ Church Emeritus Fellow at Magdalen Gray Laboratory Cancer Research Centre - Non-Exec Director Roche AG Pharma - Non-Exec Director Genetech - Non-Exec Director Oxford Health Alliance - Non-Exec Director Immunocore - Non-Exec Director Drayson Technologies - Non-Exec Director Oxford Sciences Innovation Plc - Non-Exec Director UK Life Sciences Champion Genomics England Ltd Board - Member Hakluyt & Co - Advisor Robertson Foundation - Advisor Oak Foundation - Advisor GoH Capital - Advisor Carrick Therapeutics Ltd - Advisor Office for the strategic coordination of health research - Chairman Science and Technology Honours Committee - Chairman Bill and Melinda Gates Foundation global health SAB - Chairman			Rhodes Trust – Emeritus Trustee Ewelme Almshouse Charity – Master Trustee Marlborough College				

	Register of Interest								
Board member	**Post**	**Directorships, including Non-Executive Directorships**	**Business, partnership or consultancies**	**Majority or controlling shareholding**	**Charity or voluntary organisations**	**Voluntary or other organisation contracting for NHS services**	**Research funding / grants**	**Pooled funds**	**Royalties, licence fees or similar**
Dame Fiona Caldicott	Trust Chairman, Non-Executive Director	NED and Company Secretary Waters 1802 Ltd	Consultancy for the DOH 1-2 days per week			National Data Guardian for Healthcare			
Dr Tony Berendt	Medical Director								
Mr Paul Brennan	Director of Clinical Services								
Mr Andrew MacCallum **in post from 30 April to 3 September 2017**	Interim Chief Nurse								
Mr Alisdair Cameron **in post up until 30 April 2017**	Non-Executive Director	Chief Financial Officer - Post Office Limited Non-Exec Director of Dover Harbour Board			(Spouse): member of fundraising Committee for Children's Hospital, Member of the Salus organisation fundraising group. Magnus Cameron (son), member of Young People's Executive (YIPpEe)				
Mr Jason Dorsett	Chief Finance Officer								
Mr John Drew **with effect from 3 October 2017**	Director of Improvement and Culture								
Ms Sam Foster **with effect from 4 September 2017**	Chief Nurse					T Level Health Panel - Panel Member (ongoing) Trust gets employer allowance - £1,000 per quarter			

	Register of Interest								
Board member	**Post**	**Directorships, including Non-Executive Directorships**	**Business, partnership or consultancies**	**Majority or controlling shareholding**	**Charity or voluntary organisations**	**Voluntary or other organisation contracting for NHS services**	**Research funding / grants**	**Pooled funds**	**Royalties, licence fees or similar**
Mr Christopher Goard	Non-Executive Director	Prescription Medicines Code of Practice Authority Appeals Board Member - part of the pharmaceutical industry regulatory framework via ABPI			Chairman of the Genetic Alliance UK (an organisation that cooperates with and lobbies both the NHS and the Government here and in Brussels)	Magistrate on Buckinghamshire Bench for Adult Criminal Court & Family Court			
Ms Paula Hay-Plumb **With effect from 4 September 2017**	Non-Executive Director	The Crown Estate Hyde Housing Association Aberforth Smaller Companies Trust PLC Trustee of Calthorpe Estates and Director of associated Calthorpe property companies (WEF October 2017)						Small investment in Aberforth Smaller Companies Trust PLC	
Dr Bruno Holthof	Chief Executive	Barco NV - Board Member Armonea - Board Member			Aceso Global - Board Member				
Mr Peter Knight	Chief Information and Digital Officer						Big Data Institute, University of Oxford		
Professor David Mant	Non-Executive Director	Member of the Oxford University Nuffield Department of Primary Care Health Sciences Honorary Consultant with Oxford Health NHS Foundation Trust			Chair of the South West General Practice Trust	Appointed Governor, Oxford Health NHS Foundation Trust	Research grant holder from NIHR		
Mr Mark Power **In post up until 27 April 2017**	Director of Organisational Development and Workforce								

	Register of Interest								
Board member	**Post**	**Directorships, including Non-Executive Directorships**	**Business, partnership or consultancies**	**Majority or controlling shareholding**	**Charity or voluntary organisations**	**Voluntary or other organisation contracting for NHS services**	**Research funding / grants**	**Pooled funds**	**Royalties, licence fees or similar**
Mr Geoffrey Salt	Non-Executive Director and Vice-Chairman				Trustee, Nuffield Medical Trust, Oxford Kidney Unit Fund				
Mrs Anne Tutt	Non-Executive Director	International Network for the availability of Scientific Publications - Non-Exec Director and Chair of Audit Committee Member of Audit & Risk Assurance Committee of Home Office to 31 July 2017 Member of DFID Audit & Risk Assurance Committee Member of APHA Audit & Risk Assurance Committee to 30 November 2017	Ownership of a private business - A Tutt Associates		Director and Trustee of Oxford Hospitals Charity and Chairman of the Audit Committee Advisor to Episcopal Church of South Sudan and Sudan University Partnership Board Member of IASAB (the internal Audit Standard Advisory Board) Government body advising on the application of Internal Audit Standards in the public sector				
Ms Eileen Walsh	Director of Assurance	Director in Health Governance Consulting Limited							

Register of Interest	Register of Interest	Register of Interest	Register of Interest	Register of Interest	Register of Interest	Register of Interest	Register of Interest	Register of Interest	Register of Interest
Mr Peter Ward **in post up until 30 November 2017**	Non-Executive Director	Director of John Laing (Cambridge) Ltd, Forum Cambridge LLP			Member of the United Nations Economic Commission for Europe PPP Business Advisory Board.				
Ms Liz Wright **in post from 1 April to 30 April 2017**	Acting Chief Nurse								
Ms Susan Young **in post from 19 April to 31 October 2017**	Interim Director of Workforce								

Register of Gifts Hospitality and Sponsorship (Trust Board)		
Name	**Position**	**Return/Details**
Trust Board Members		
Dame Fiona Caldicott	Chairman	
Mr Geoffrey Salt	Non-Executive Director	
Ms Anne Tutt	Non-Executive Director	
Mr Peter Ward	Non-Executive Director	
Mr Alisdair Cameron	Non-Executive Director	
Professor Sir John Bell	Non-Executive Director	
Mr Christopher Goard	Non-Executive Director	
Professor David Mant OBE	Non-Executive Director	
Ms Paula Hay Plumb	Non-Executive Director	
Dr Bruno Holthof	Chief Executive	Dinner – Data and Health meeting - 20.3.18 Invitation to speak at a conference in Grenoble: Public Health in Local Public Policy (travel and accommodation expenses paid) 1- 3 November 2017
Dr Tony Berendt	Medical Director	
Mr Paul Brennan	Director of Clinical Services	
Mr Jason Dorsett	Chief Finance Office	Dinner in Reading as guest of Deloitte LLP - 24.04.17 Dinner at Balliol College, Oxford as guest of Director of UK Cochrane Centre - 27.04.17 Dinner in London as guest of Medical Sciences Division - 04.05.17 Dinner in London as guest of Mayo Clinic - 18.09.17
Mr John Drew	Director of Improvement and Culture	GTC Fellows Dinner – 31.10.17 Trinity College Dinner – 22.11.17 HSJ Summit Dinner – 19.04.18
Ms Sam Foster	Chief Nurse	
Mr Peter Knight	Chief Information and Digital Officer	Dinner - London - HCRUK- 26.3.18 AHSN Dinner - 23.11.17 Dinner with Cerner - 27.11.17 Dinner with built environment networking - 18.9.17 Dinner with OxSTaR - 20.9.17 Dinner with Barco - 8.6.17 Dinner with NIHR - 27.6.17 Dinner with Banner Health - 29.6.17
Mr Andrew MacCallum	Interim Chief Nursing Officer *(from 30 April to 3 September 2017)*	
Mr Mark Power	Director of Organisational Development and Workforce *(until April 17)*	

Register of Gifts Hospitality and Sponsorship (Trust Board)		
Name	**Position**	**Return/Details**
Ms Eileen Walsh	Director of Assurance	
Ms Liz Wright	Acting Chief Nurse *(from 1 April to 30 April 2017)*	
Ms Susan Young	Interim Director of Workforce *(from 19 April to 31 October 2017)*	

Freedom of Information (FOI)

The Trust operates a transparent and open system of access to information about its services, whilst recognising and adhering to best practice on protecting the confidentiality of certain types of information.

From 1 April 2017 to 31 March 2018 the Trust received 685 Freedom of Information requests.

The majority of requests contain multiple questions that require input across the Trust's Divisions.

The Trust tries to respond to all requests within 20 working days. 73% were completed within 20 working days.

Preparing for an emergency

The Trust has a Major Incident Plan that details how the Trust will respond to an emergency or internal incident. It brings co-ordination and professionalism to the unpredictable and complicated events of a major incident that may require extraordinary mobilisation of the emergency services.

The purpose of planning for emergencies is to ensure that we provide an effective response to any major incident or emergency and that the Trust returns to its normal services as quickly as possible. The plan has been put together in collaboration with partner organisations across Oxfordshire including other NHS trusts, the emergency services, local councils and emergency planning experts.

Directors' responsibility for the annual report and accounts

The Directors are responsible for preparing the annual report and accounts. The directors consider that the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance and strategy.

Disclosures

Better Payment Practice Code

The Trust has responsibility to pay its suppliers in line with the payment terms agreed at the time of purchase. Failure to do this harms the reputation of the Trust and the wider NHS, as well as damaging supply sources and straining relationships with suppliers. The national *better payment practice code* requires the Trust to aim to pay all valid invoices within 30 days of receipt or the due date – whichever is the later. The Trust's detailed performance against this target is set out in the table below. During this period the Trust did not pay anything arising from claims made under The Late Payment of Commercial Debts (Interest) Act 1998.

Better Payment Practice Code	Number	£000
Performance for 12 months ending 31 March 2018		
Non-NHS payables		
Total non-NHS trade invoices paid in the period	146,336	521,025
Total non-NHS trade invoices paid within the target	130,683	467,660
Percentage of non-NHS trade invoices paid within the target	89.3%	89.8%
NHS payables		
Total NHS trade invoices paid in the period	5,380	127,573
Total NHS trade invoices paid within the target	4,783	123,555
Percentage of NHS trade invoices paid within the target	88.9%	96.9%

Cost allocation and charging requirements

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Audit disclosure

So far as the directors are aware, there is no relevant audit information of which the auditors are unaware, and the directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Quality

The Trust uses a variety of nationally-recognised indicators to ensure quality of care. Quality measures are reported to the Board and these reports have been reviewed and revised this year. We also undertake monitoring of quality via the contract and quality review meetings with Oxfordshire Clinical Commissioning Group.

These, along with CQC registration and NHS Litigation Authority (NHSLA) Standards, have all become important frameworks for measuring, achieving and ensuring quality within the organisation.

The Trust has established a rolling programme of walk rounds on all clinical wards and departments that are led by members of the executive team, Non-Executive Directors, senior nurses, Divisional Directors and clinical leads. There is an emphasis on the patient experience as well as patient and staff safety. The multi-professional inspection teams focus on compliance with national standards covering quality of care, competence and behaviour of staff, as well as quality and cleanliness of the environment.

Throughout 2017-18 we have been updating our staff, our local commissioners and other stakeholders about our Quality Priorities for the year. You can read more about this in the Quality Account in Chapter 4 from page 149.

Income disclosures as required by section 43(2A) of the NHS Act 2006

Details of how the Trust has met the requirements of the act are included in the performance report on page 24. The Trust has a number of income-generating activities, and the surplus these activities generate is used by the Trust to fund the provision of goods and services for the purposes of the health service in England.

Overseas operations

The Trust has no overseas operations.

Investments

The Trust is in the process of establishing new joint venture entities, for more information please see note 21 to the accounts on page 256.

Political donations

The Trust made no political donations during the financial year.

Important events since balance sheet date

On 15 January 2018, the High Court appointed the Official Receiver as liquidator of Carillion Plc, Carillion Services Limited, Carillion Integrated Services Limited, Carillion Construction Limited, Planned Maintenance Engineering Limited and Carillion Services 2006 Limited.

The Trust has a contract with The Hospital Company (THC) which operates the John Radcliffe West Wing and Children's PFI hospital. The Trust's contract with THC has seen a change in service provider from 17 April 2018 following the liquidation of Carillion Services Limited who were previously contracted by THC.

For staff and patient users of the services provided by our facilities company there will be no change. All staff who were employed directly by Carillion or their contract staff have been offered a continuation of employment at the John Radcliffe Hospital. Staff who retained their employment with the Trust when Carillion took over provision of these services will now take direction from the new service provider. To date, no formal decision has been made that affects the financial arrangements surrounding the John Radcliffe West Wing and Children's PFI hospital.

REMUNERATION AND STAFF REPORT

Our people and values

We are the third largest employer in Oxfordshire, with a workforce of more than 12,000 people. We are extremely proud of our staff who deliver compassionate and excellent patient care whilst demonstrating great flexibility in meeting the challenges facing the NHS operating environment.

Our vision and strategy for people

The Trust's vision is to make OUH an exciting place to work, where the development and care of our people is recognised as being as important as the care for our patients. The Trust needs to be able to attract, recruit and retain appropriately skilled and experienced staff, who demonstrate their alignment with our core values, and who are able to work together to continuously improve the quality of the services and care we provide. We recognise that the delivery of compassionate excellence in care, by engaged, well-led and motivated members of staff, underpins the future of the Trust and its services. The strategic workforce priorities support the Trust's strategic objectives, and include the following.

- Strategic workforce planning, to increase substantive workforce capacity (thereby reducing reliance on agency staff, alleviating pressures associated with high vacancy levels, and improving both patient and staff experience).
- Applying targeted recruitment and retention incentives (where these are necessary and cost-effective) and widening participation (encouraging and facilitating more people to enter or return to the employment with the Trust).
- Mitigating the high cost of living (recognising the constraints imposed by national pay scales which do not recognise local pressures).
- Building skills and capabilities, improving professional development opportunities and career advancement (in order to promote and sustain longer-term employment within the Trust).
- Making OUH a great place to work, creating and sustaining the right environment (ensuring staff are treated with dignity and respect, are listened to and consulted with, and supported and involved in making changes which improve services).
- Developing compassionate, inclusive and effective leaders and managers, who are visible, capable and who model our values.

Our values - Learning; Respect; Delivery; Excellence; Compassion; Improvement - reflect how we would wish our staff to behave towards each other, and towards the people who use our hospital services, and inform the decisions we take in deliver the best possible healthcare.

We have continued to extend our values-based interviewing as a key part of our recruitment process, for a wider range of roles including frontline staff, consultant medical staff and members of the Board.

Annual statement on remuneration of senior managers

Remuneration and Appointments Committee

The definition of a 'senior manager' is 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust'. The Trust deems these to be the executive and non-executive members of the Board of Directors. The terms of service, including remuneration, associated with executive directors are determined by the Remuneration and Appointments Committee. The Committee does not determine the terms and conditions of office of the Chairman and Non-Executive Directors - these are decided by the Council of Governors. Other managers are paid in accordance with the national NHS Agenda for Change pay system. Membership of the Remuneration and Appointments Committee is limited to the chairman and non-executive directors of the Trust. The Chair of the Committee is elected by the Committee.

During the 12 month period to 31 March 2018 the Committee met six times and the membership of the Committee was as follows:

Remuneration and Appointments Committee	10.5.17	12.07.17	26.07.17	13.09.17	08.11.17	23.02.18
Professor Sir John Bell (Chair)	✓	✓	✓	✓	✓	✓
Dame Fiona Caldicott	✓	✓	✓	✓	✓	✓
Mr Christopher Goard	✓	✓	✓	✓	✓	X
Ms Paula Hay-Plumb				✓	✓	X
Professor David Mant OBE	X	✓	✓	✓	✓	✓
Mr Geoffrey Salt	✓	✓	✓	✓	✓	✓
Ms Anne Tutt	X	✓	✓	✓	✓	X
Mr Peter Ward	✓	✓	✓	✓	✓	

Key

✓ In attendance

× Not in attendance

Not in post

The Committee has delegated responsibilities for the remuneration and terms of service for the Chief Executive and Executive Directors of the Trust. Its responsibility includes all aspects of salary and provision of other benefits, arrangements for termination of employment and other principal contractual terms. The Committee reviews the salaries of the Executive Directors, taking into consideration benchmarking data in relation to comparable posts, for example, when new Directors are appointed and where it is necessary to reflect organisational structural changes and enhancement to role specifications. For the purpose of assisting with its business and informing its decision-making, the Committee may commission external expert advice, as necessary, from specialist agencies.

Professor Sir John Bell
Chair of Remuneration and Appointments Committee.

Nominations and Remuneration Committee

Upon authorisation as a NHS foundation trust on 1st October 2015, the Council of Governors established a Nominations and Remuneration Committee (NRC). NRC's terms of reference included responsibility for reviewing the remuneration of Non-Executive Directors (including the Chairman), and for making recommendations to the Council of Governors on the re-appointment of Non-Executive Directors on first renewal. Throughout the year 2017-18, the Governors' Nominations and Remuneration Committee met once, in July. The business that was considered included the process to be followed in the appointment of Non-Executive Directors, including the Chairman. NRC also recommended the re-appointment of Ms Anne Tutt, Non-Executive Director for a term of three years from 30 November 2017, up to 30 November 2020, and this was approved by the Council of Governors at its meeting held on 5 October 2017.

An Appointment Panel for Non-Executive Directors was convened to appoint a replacement for Mr Alisdair Cameron, whose term of office expired on 30 April 2017. The Appointment Panel's recommendation to appoint Ms Paula Hay-Plumb as Non-Executive Director was approved by the Council of Governors in July 2017. The Appointment Panel for Non-Executive Directors also undertook recruitment of a Non-Executive Director to replace Mr Peter Ward, whose term of office expired on 30 November 2017. However, the Appointment Panel was not able as a result of that recruitment to recommend any candidate for immediate appointment as a Non-Executive Director.

Remuneration, Nominations and Appointments Committee

In October 2017, the Council of Governors agreed to establish a Remuneration, Nominations and Appointments Committee (RNAC), merging membership of the Nominations and Remuneration Committee with that of the Appointment Panel required under the Constitution for any new appointments of Non-Executive Directors, including the Chairman.

The newly merged Remuneration, Nominations and Appointments Committee met once before 31 March 2018, when it considered the outcome of the Chairman's appraisal, which was subsequently reported to the Council of Governors in January 2018. The Remuneration, Nominations and Appointments Committee also recommended the re-appointment of Professor Sir John Bell as the Non-Executive Director representing the University of Oxford (as provided for under section 22.3 of the Constitution) up to 31 October 2018, and this was approved by the Council of Governors in January 2018.

Senior managers' remuneration policy

Executive directors' contracts of employment include: a fixed annual salary payment, which is disclosed in the Annual Report and Accounts; and, until the end of 2016-17, eligibility for the receipt of a variable performanc- related payment (PRP) linked to the delivery of corporate objectives, as set out in the Annual Business Plan, and personal objectives. Starting salaries for executive directors are determined by the Remuneration and Appointments Committee by reference to independently obtained NHS salary survey information, internal relativities, and equal pay provisions and other labour market factors where relevant, for example for cross-sector, functional disciplines such as human resources. In making its decisions

regarding components of and increases to senior managers' remuneration packages the Remuneration and Appointments Committee takes into account the pay and conditions of the Trust's employees, including any annual NHS pay award. The trust's employees were not consulted in 2017-18 regarding decisions relating to senior managers' remuneration. Progression is determined by the Committee, with respect to:

- annual inflation considerations in line with nationally published indices (RPI / CPI), Department of Health guidance and other nationally determined NHS pay settlements;
- specific review of individual salaries in line with independently obtained NHS salary survey information, other labour market factors where relevant, e.g. for cross-sector, functional disciplines, internal relativities and equal pay provisions. Such review is only likely where an individual director's portfolio of work or market factors change substantially.

The Remuneration and Appointments Committee decided during 2016-17 that the performance-related pay scheme would be discontinued.

Notes:

1. *The Medical Director is employed on the nationally determined Consultant Contract which includes a basic salary from agreed pay scales plus a responsibility allowance. It also includes eligibility for Clinical Excellence Awards which are paid to consultant medical staff in recognition of outstanding clinical teaching or academic achievement. The Medical Director is not eligible for participation in the executive PRP scheme.*

Contracts of employment

Contracts of employment for Executive Directors are normally substantive (permanent), and subject to termination by written notice of six months, by either party (as set out in the table below). On occasion, as required by the needs of the organisation, appointments may be of an 'interim' or 'acting' nature, in which case a shorter notice period is likely to be agreed.

Termination liabilities for executive directors

Unless employment is terminated for reasons of gross misconduct, bankruptcy or other insolvency, or conviction of a criminal offence, Executive Directors are eligible to receive six months' notice of termination of employment by the Trust, and are usually required to provide six months' notice of termination. Payment in lieu of notice, as a lump sum payment, may be made at the discretion of the Trust. Statutory entitlements also apply in the event of unfair dismissal. No payments for loss of office were made to senior managers in 2017-18.

The balance of annual leave earned but untaken would be due to be paid on termination.

Details of service contracts for executive directors are as follows:

Name	Post	Date of contract	Unexpired term	Notice period	Provision for compensation for early termination	Other termination liability
Dr Bruno Holthof	Chief Executive	October 2015	Substantive	Six months	Discretionary Payment in Lieu of Notice	See paragraph on previous page.
Dr Tony Berendt*	Medical Director	April 2014	Substantive	Six months	Discretionary Payment in Lieu of Notice	See above with respect to Medical Director responsibilities
Mr Paul Brennan	Director of Clinical Services	February 2010	Substantive	Six months	Discretionary Payment in Lieu of Notice	See above
Mr Jason Dorsett	Chief Finance Officer	October 2016	Substantive	Six months	Discretionary Payment in Lieu of Notice	See above
Mr John Drew	Director of Improvement and Culture	October 2017	Substantive	Six months	Discretionary Payment in Lieu of Notice	See above
Ms Sam Foster	Chief Nurse	September 2017	Substantive	Six months	Discretionary Payment in Lieu of Notice	See above
Mr Peter Knight	Chief Information and Digital Officer	August 2016	Substantive	Six months	Discretionary Payment in Lieu of Notice	See above
Mr Mark Power	Director of Organisational Development and Workforce	Resigned April 2017	Substantive	Six months	Discretionary Payment in Lieu of Notice	See above
Ms Eileen Walsh	Director of Assurance	May 2011	Substantive	Six months	Discretionary Payment in Lieu of Notice	See above
Mr Andrew MacCallum	Interim Chief Nursing Officer	May 2017-September 2017	Interim	n/a	n/a	n/a
Ms Liz Wright	Interim Chief Nursing Officer	April 2017	Interim	n/a	n/a	n/a
Ms Susan Young	Interim Director of Workforce	April 2017-October 2017	Interim	n/a	n/a	n/a

* Dr Tony Berendt's substantive appointment is as a Medical Consultant, to which consultant contract termination liabilities apply.

Details of terms of office for Non-Executive Directors are as follows:

Name	Period of Initial Appointment	Re-appointment	Previous term ended	Current term ends
Dame Fiona Caldicott	21 May 2002 – 20 May 2006	21 May 2006 – 20 May 2010 (2nd term) Appointed Chair 9 March 2009 9 March 2013	8 March 2013	**7 March 2019** extension approved by Council of Governors on 20 October 2016
Professor Sir John Bell	1 November 2009 – 31 October 2013	1 November 2013	31 October 2017	**31. October 2018** extension approved by Council of Governors on 30 January 2018
Mr Alisdair Cameron	Appointment ceased on 30 April 2017			
Mr Christopher Goard	1 November 2011– 31 March 2013 Appointed Senior Independent Director (SID) July 2012	1 April 2013 1 April 2015	31 March 2015	**21 October 2018** extension approved by Council of Governors on 1 July 2016
Ms Paula Hay-Plumb	4 September 2017 – 31 August 2020.			**31 August 2020**
Professor David Mant	1 April 2010 – 31 March 2013 (Associate Non-Executive Director)	1 April 2013 (Associate Non-Executive Director) Appointed Non-Executive Director on 1 October 2015 at the Inaugural FT meeting	31 March 2016	**21 October 2018** extension approved by Council of Governors on 1 July 2016
Mr Geoffrey Salt	1 May 2009 – 30 April 2013 Appointed Vice-Chairman 5 November 2009	16 April 2013		**29 April 2019** extension approved by Council of Governors on 20 October 2016
Ms Anne Tutt	1 December 2009 – 30 November 2013 Member of the Section 11 Trustees from 1 December 2010 for 4 years. Reappointed December 2014 – December 2018	1 December 2013 1 December 2017	30 November 2017	**30 November 2020** extension approved by Council of Governors on 5 October 2017
Mr Peter Ward	Appointment ceased on 30 November 2017			

Future Policy Table

	Salary / Fees	Taxable Benefits[1]	Annual Performance related bonus	Long Term Related Bonus	Pension Related Benefits
Support for the long-term strategic objectives of the Trust	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives.		Ensures incentivisation of directors to deliver the strategic objectives of the Trust [JD to check current status]	Not applicable	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives.
How the component operates	Paid monthly		Single lump sum payment which does not attract pension benefits	Not applicable	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme.
Maximum payment	As set out in the remuneration table Salaries are determined by the Trust's Remuneration & Appointments committee.		20% of Annual salary for Chief Executive and 10% of Annual salary for other directors	Not applicable	Contributions are made in accordance with the NHS Pension Scheme.
Framework used to assess performance		Not applicable	Linked to Corporate Objectives, as set out in the Annual Business Plan.	Not applicable	Not applicable
Performance period	Concurrent with the financial year	Concurrent	Previous financial year	Not applicable	Not applicable
Explanation of whether there are any provisions for the recovery of sums paid to directors, or provisions for withholding payments	Any sums paid in error may be recovered. In addition there is provision for recovery of payments in relation to Mutually Agreed Resignation Scheme(MARS) payments where individuals are subsequently employed in the NHS.	Any sums paid in error may be recovered.	Any sums paid in error may be recovered.	None Paid	Any sums paid in error may be recovered

Note

1. *The Taxable benefit disclosed is in respect of residual payments relating to a lease car scheme.*
2. *The PRP scheme was applied for the final time in 2016-17, prior to its permanent withdrawal*

In respect of those senior managers who are paid more than £150,000, the Trust has considered comparable data from other similar organisations in determining the rate that should be paid to attract and retain staff of the calibre required to deliver the Trust's objectives.

Salary and Pension Entitlements of Senior Managers

a. Directors' Remuneration

The table below discloses the remuneration provided to directors within the Oxford University Hospitals NHS Trust during the period 1 April 2017 to 31 March 2018 in a format which is comparable to that used in previous years.

A revised format was introduced in 2013/14, which adds in the derived increase in capital value of pension benefits at pension age,(calculated using legislated relevant valuation factor of 20 on annual pension at pension age, plus lump sum at pension age). This does not reflect an increase in remuneration during the year, but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. This revised format is shown on page 122 of this report.

Salary and Pension Entitlements for Senior Managers

A) DIRECTORS' REMUNERATION

Name and Title		2017-18 (12 months to 31 March 2018)				2016-17 (12 months to 31 March 2017)			
		Salary (bands of £5000) £000	**Other Remuneration (bands of £5000) £000**	**Performance related pay (bands of £5000) £000**	**Benefits in kind to nearest £00**	**Salary (bands of £5000) £000**	**Other Remuneration (bands of £5000) £000**	**Performance related pay (bands of £5000) £000**	**Benefits in kind to nearest £100 £00**
Dame Fiona Caldicott[1]	Chairman	55-60				70-75			
Mr Geoffrey Salt [2]	Non-executive Director	15-20				20-25			
Mr Alisdair Cameron[3, 4]	Non-executive Director	0-5				15-20			
Professor Sir John Bell[3]	Non-executive Director	10-15				15-20			
Mrs Anne Tutt [2]	Non-executive Director	15-20				20-25			
Mr Peter Ward [2,5]	Non-executive Director	10-15				20-25			
Mr Christopher Goard[2]	Non-executive Director	15-20				20-25			
Professor David Mant[3]	Non-executive Director	10-15				15-20			
Mrs Paula Hay-Plumb[3, 6]	Non-executive Director	5-10							
Dr Bruno Holthof	Chief Executive	270-275			36	270-275		20-25	
Mr Mark Mansfield[7]	Director of Finance and Procurement					25-30		10-15	
Ms Maria Moore[8]	Interim Chief Finance Officer					40-45			
Mr Jason Dorsett[9]	Chief Finance Officer	170-175				80-85			
Dr Tony Berendt[10]	Medical Director	205-210				200-205			
Mr Andrew Stevens[11]	Director of Planning and Information					100-105		5-10	
Mr Paul Brennan	Director of Clinical Services	170-175			91	170-175		10-15	71
Ms Eileen Walsh	Director of Assurance	125-130				125-130		5-10	
Mr Mark Power[12]	Director of Organisational Development and Workforce	40-45				130-135		5-10	

Name and Title		2017-18 (12 months to 31 March 2018)				2016-17 (12 months to 31 March 2017)			
		Salary (bands of £5000) £000	**Other Remuneration (bands of £5000) £000**	**Performance related pay (bands of £5000) £000**	**Benefits in kind to nearest £00**	**Salary (bands of £5000) £000**	**Other Remuneration (bands of £5000) £000**	**Performance related pay (bands of £5000) £000**	**Benefits in kind to nearest £100 £00**
Ms Catherine Stoddart[13]	Chief Nurse					160-165		10-15	
Mr Peter Knight[14]	Chief Information and Digital Officer	130-135				75-80			
Ms Elizabeth Wright[15]	Interim Chief Nurse	5-10							
Mr Andrew MacCallum[16]	Interim Chief Nurse	45-50							
Mrs Samantha Foster[17]	Chief Nurse	65-70			96				
Ms Susan Young[18]	Interim Director of Workforce	90-95							
Mr John Drew[19]	Director of Improvement and Culture	85-90							

Notes

1 The level of remuneration to be paid to the Chairman per annum was reviewed and approved by the Council of Governors in April 2016. It was agreed that the revised level of remuneration should take effect from 1 October 2015, being the date upon which the Trust was authorised as a foundation trust.

2 The level of remuneration to be paid to Non-Executive Directors who discharge additional responsibilities (defined as being the Vice-Chairman of the Trust, Chairmen of the Quality Committee, Finance & Performance Committee and Audit Committee, and the Senior Independent Director) was reviewed and approved by the Council of Governors in April 2016. It was agreed that the revised level of remuneration should take effect from 1 October 2015, being the date upon which the Trust was authorised as a foundation trust.

3 The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of 15-20.
The level of remuneration to be paid to Non-Executive Directors per annum was reviewed and approved by the Council of Governors in April 2016. It was agreed that the revised level of remuneration should take effect from 1 October 2015, being the date upon which the Trust was authorised as a foundation trust.
The annual remuneration of Non-Executive Directors is within the band of 10-15.

4 Term of Office ended April 2017

5 Term of Office ended November 2017

6 Appointed from September 2017

7 Resigned from Oxford University Hospitals May 2016

8 Interim Chief Finance Officer from June 2016 to September 2016

9 Appointed as Chief Finance Officer to Oxford University Hospitals October 2016

10 Other remuneration relates to clinical excellence awards

11 Stepped down from Trust Board January 2017

12 Resigned from Oxford University Hospitals April 2017 and salary figure includes a payment in lieu of notice.

13 Resigned from Oxford University Hospitals March 2017

14 Appointed to Oxford University Hospitals August 2016

15 Acting Chief Nurse from 1 April 2017 to 30 April 2017

16 Interim Chief Nursing Officer from May 2017 to September 2017

17 Appointed to Oxford University Hospitals September 2017

18 Interim Director of Workforce from April 2017 to October 2017

19 Appointed to Oxford University Hospitals October 2017

* See Page 86 for further information relating to performance related payments

b Pension Benefits (information subject to audit)

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Employer's contribution to stakeholder pension To nearest £100
Mr Paul Brennan	Director of Clinical Services	0-2.5	-7.5- -5	75-80	230-235	1,643	75	1,552	0
Ms Eileen Walsh	Director of Assurance	0-2.5	-2.5-0	40-45	100-105	706	59	640	0
Mr Mark Power	Director of Organisational Development and Workforce	-10- -7.5	-25- -22.5	15-20	45-50	351	-137	483	0
Dr Tony Berendt	Medical Director	0-2.5	5-7.5	95-100	285-290	2,238	152	2,065	0
Jason Dorsett	Chief Finance Officer	2.5-5	-	0-5	-	43	29	14	0
Mr Peter Knight	Chief Information and Digital Officer	-2.5-0	-10- -7.5	25-30	50-55	386	-11	394	0
Mr Andrew MacCallum	Interim Chief Nurse	-40- -37.5	-122.5- -120	15-20	50-55	373	-836	1,197	0

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2018 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2017 £000	Employer's contribution to stakeholder pension To nearest £100
Mrs Samantha Foster	Chief Nurse	0-2.5	-2.5-0	35-40	95-100	578	47	525	0
Mr John Drew	Director of Improvement and Culture	0-2.5	-	0-5	-	17	17	0	0

TRUST BOARD MEMBERS

AT 31 MARCH 2018

Dr Bruno Holthof
Chief Executive

Dame Fiona Caldicott
Chairman

Dr Tony Berendt
Medical Director

Mr Paul Brennan
Director of Clinical Services

Mr Jason Dorsett
Chief Finance Officer

Mr John Drew
Director of Improvement and Culture

Ms Sam Foster
Chief Nurse

Mr Peter Knight
Chief Information and Digital Officer

Ms Eileen Walsh
Director of Assurance

Mr Geoffrey Salt
Vice Chairman

Professor Sir John Bell
Non-executive Director

Mrs Paula Hay-Plumb
Non-executive Director

Mr Christopher Goard
Non-executive Director

Professor David Mant
Non-executive Director

Mrs Anne Tutt
Non-executive Director

Non-Executive Directors do not receive pensionable remuneration (2016-17: nil). The Trust did not contribute to any Director's stakeholder pension scheme (2016-17: nil).

Pension details have only been disclosed for those Directors in post during the last twelve months up to 31 March 2018. Balances for those in post during 2016-17 can be obtained from the 2016-17 Annual Report.

Cash Equivalent Transfer Value

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 (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This reflects the increase in CETV funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement)

Pay multiples *(information subject to audit)*

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Oxford University Hospitals NHS Foundation Trust in the financial year 2017-18 was £275,000-£280,000 (2016-17: £295,000-£300,000). This was 9.2 times (2016-17: 10) the median remuneration of the workforce, which was £30,270 (2016-17: £29,333). In 2017-18, no (2016-17: no) employees received remuneration in excess of the highest-paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The median and the ratio include bank and locum staff but do not include agency staff.

BAND OF HIGHEST PAID DIRECTORS

As at 31 March 2018		As at 31 March 2017
Band of Highest Paid Director's Total Remuneration (£'000)	275-280	295 -300
Median Total Remuneration (£)	30,270	29,333
Ratio	9.2	10.2

OUR WORKFORCE

The Trust employs over 12,000 individuals, some of whom are part time and some of whom are full time. This equates to a total whole time equivalent (wte) number of staff employed by Oxford University Hospitals at 31 March 2018 of 11,612 (31 March 2017 11,534). All employees, with the exception of medical staff, Very Senior Managers and executive directors are subject to NHS *Agenda for Change* terms and conditions of service which include nationally agreed salary scales. Similarly the pay and contractual arrangements of medical staff are determined by nationally agreed terms and conditions of service. There are a small number of employees who are on Very Senior Manager contracts. The pay point for these individuals is fixed. Other terms and conditions of service are in line with *Agenda for Change*.

The table below sets out an analysis of staff costs split between permanently employed staff and others.

Information subject to audit

	2017-18			2016-17
	Permanently employed[1]	Other[2]	Total	Total
	£000	£000	£000	£000
Salaries and wages	449,890	7,025	456,915	441,408
Social security costs	41,053	-	41,053	39,379
Apprenticeship levy	2,069	-	2,069	-
Employer's contributions to NHS pensions	48,438	-	48,438	46,483
Pension cost - other	4	-	4	5
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	155	-	155	259
Temporary staff	-	38,159	38,159	37,572
TOTAL GROSS STAFF COSTS	541,609	45,184	586,793	565,106
Recoveries in respect of seconded staff	-	-	-	-
TOTAL STAFF COSTS	541,609	45,184	586,793	565,106
Of which				
Costs capitalised as part of assets	1,689	175	1,864	1,677

Note

1	Staff with a permanent (UK) employment contract directly with the Trust (this includes executive directors but not non-executive directors)
2	Staff engaged on the objectives of the entity that do not have a permanent (UK) contract directly with the Trust. This includes employees on short-term contracts of employment, agency / temporary staff, locally engaged staff overseas and inward secondments from other entities

The average number of staff employed by the Trust as at 31 March 2018 is set out in the table below (the number for administrative and clerical staff includes all corporate support services):-

Information subject to audit

	2017-18			2016-17
	Permanent contract	Other Staff	Total number	Total number
	Average wte	Average wte	Average wte	Average wte
Medical and dental	1,751	60	1,811	1,758
Ambulance staff	0	0	0	0
Administration and estates	2,344	76	2,420	2,415
Healthcare assistants and other support staff	1,348	125	1,473	1,378
Nursing, midwifery and health visiting staff	3,500	303	3,803	3,913
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	1,227	61	1,288	1,242
Healthcare science staff	737	9	746	749
Social Care Staff	0	0	0	0
Agency and contract staff				
Bank staff				
Other	71	-	71	79
TOTAL average numbers	10,978	634	11,612	11,534
Of which:				
Number of employees (WTE) engaged on capital projects	72	16	88	59

Gender distribution of the workforce as at 31 March 2018

Category	Female	Male	Total
Directors[1]	5	10	15
Senior Managers	0	0	0
Other Staff[2]	9507	3115	12622
Total[3]	9512	3125	12637

Note

1	Defined as voting and non-voting members of the Board
2	Everyone else in the organisation
3	Everyone in the organisation including the Board

Gender Pay Gap

The Gender Pay Reporting Legislation requires organisations to publish figures relating to their pay gap on an annual basis, and against a prescribed methodology which looks at mean and median gender pay gaps. The pay gap is not the same as equal pay, which is a legal requirement. So, for example, an organisation would have a gender pay gap if a higher proportion of men are in top jobs compared to women, despite paying male and female employees the same amount for similar roles.

The gender pay gap is the percentage difference between average hourly earnings for men and women. According to the Office for National Statistics (ONS), across the UK, men earned 18.4% more than women in April 2017. Below are the figures for OUH as of March 31st 2017:

- For ordinary pay, the mean and median pay gaps are 25.97% and 10.89% in favour of men, respectively.
- For bonus pay (which is largely driven by additional payments to consultant doctors), the mean and median pay gaps are 64.29% and 74.47% in favour of men, respectively.
- 2.57% of women and 7.79% of men received bonus pay within the last 12 months.
- The distribution of men and women within each quartile of the pay structure is as follows (Q1 being low and Q4 being high), showing that there are nearly double the proportion of men compared to women in the highest paid roles:

Quartile		Female	Male
1	Lowest paid roles	25.85%	21.98%
2		26.16%	21.73%
3		27.58%	16.97%
4	Highest paid roles	20.41%	39.31%

(source TB2018.31)

Analysis has identified some key findings and reasons for the gaps noted in the above figures. These are:

- The Trust has a higher proportion of men in more senior positions within the Trust. This has a disproportionate impact on the mean pay gaps reported.
- Analysis of gaps within pay bands show that women could be staying within pay bands longer and suggests that more could be done to help women progress in their careers.
- Bonus pay is largely driven by additional payments to consultant doctors, and given that a relatively high proportion of consultant doctors are men, this creates a larger gap.
- The NHS's national pay structure - Agenda for Change - is effective in ensuring that staff in equivalent roles get paid equally, regardless of gender.
- The Trust has agreed a number of actions to investigate issues that have been highlighted as a result of this report. These are set out in the table on the next page

Action	Lead	Timescale	Success Measure
Introduce a salary scale for staff within the VSM Banding.	Head of Resourcing	July 2018	Salary scale introduced with new starters placed on this. Aim to move all VSM staff onto this scale over time.
Conduct an audit into pay decisions for the medical and dental staff group.	Workforce EDI Lead	July 2018	Audit undertaken with actions produced as a result
Analyse Trust data to look at relative likelihood of progression and recruitment by AfC band for women as compared to men.	Workforce EDI Lead & Workforce Information Team	July 2018	Analysis undertaken with actions produced as a result.
Hold consultation with staff across the Trust to discuss the gender pay gap and potential barriers to progression.	Workforce EDI Lead & Head of Resourcing	July 2018	Consultation undertaken with staff from across the Trust's pay structure involved. Actions produced as a result.
Investigate the Athena SWAN charter to see if there are any good practice initiatives that could be implemented in OUH.	Workforce EDI Lead	July 2018	
Create an update report for the EDI Steering Group with revised action plan.	Workforce EDI Lead	August 2018	Report and new action plan are accepted and approved.

(source TB2018.31)

Staff sickness absence

The Trust is required to disclose details of staff sickness absences. This disclosure is included below:

	1 January 2017 – 31 December 2017	1 January 2016 – 31 December 2016
Total days lost	79,896	79,800
Total staff years[1]	10,865	10,842
Average working days lost[2]	7.4	7.4

1 The number of equivalent years of staff service worked during the current year based on the number of working days in a year

2 The number of working days lost on average for each employee. This is calculated by dividing the total number of days lost by the total of staff years

It is a Treasury requirement that public bodies must report sickness absence data and the data must be consistent to permit aggregation across the NHS and with similar data from the Department of Health. The table shows the data on a calendar year basis, for the years ended 31 December 2016 and 31 December 2017 and has been provided centrally for this purpose.

Recruitment and retention

Within the context of the prevailing national and local economic climate, the recruitment and retention of staff remains challenging.

We face pressures associated with the high cost of living in Oxford, and retention of our staff is adversely affected by the Trust's relative proximity to the London NHS 'market' where salaries attract a weighting (high cost area supplement) equating to as much as 20% of basic pay. Oxford is recognised as being one of the least affordable cities in which to live, due to high property prices and rental costs regarded as being among the highest in the country.

We acknowledge the impact of continuing rises in the cost of living and lower annual pay increases within the public sector. We have introduced initiatives in response, including the introduction of new rates of pay for staff who work on our internal bank in a flexible or part-time capacity helping to cover shifts or short-term vacancies.

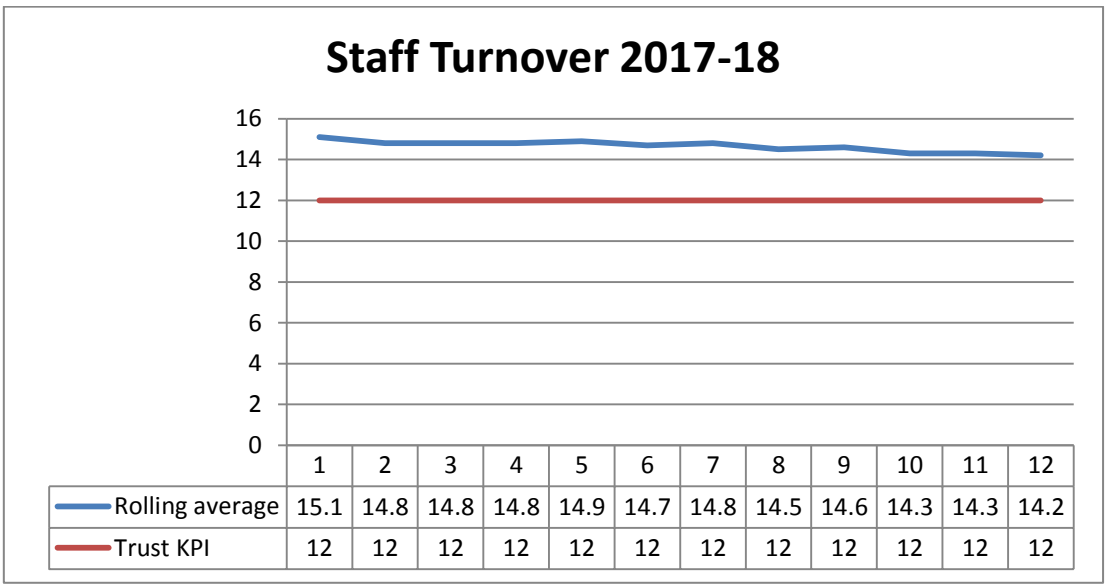
The Trust also continues to apply a range of flexible working practices, including the application of part-time hours, term-time contracts and job sharing arrangements, wherever the particular requests of individuals can be met without compromising our service delivery.

Other benefits include retirement vouchers; nursery school vouchers; discounts from a number of local and national retailers; and the provision of competitively priced on-site accommodation.

Staff turnover

Staff turnover for the period 1 April 2017 to 31 March 2018 was on average 14.65%. The graph below shows the position through the year and indicates that as at 31 March 2018, overall turnover had

decreased by 0.9% over the twelve month period. Turnover remains highest within clinical support, and nursing and midwifery staff groups.



	1	2	3	4	5	6	7	8	9	10	11	12
Rolling average	15.1	14.8	14.8	14.8	14.9	14.7	14.8	14.5	14.6	14.3	14.3	14.2
Trust KPI	12	12	12	12	12	12	12	12	12	12	12	12

Education, learning and development

An important aspect of being a leading teaching hospital is our continuing commitment to support and educate the future workforce of the NHS. A key priority is to ensure staff have access to professional development opportunities and career advancement.

We are now delivering the OUH Learning and Education Strategy for 2015-2020 to improve the quality of learning, education and training provision within our Trust.

The strategy provides:

- **career-enhancing education** – ensuring careers are developed and sustained so that our workforce meets current and future patient needs;
- **talent and leadership development** – developing and retaining effective and inspirational leaders who are focused on delivering our Trust's mission, vision and values through engaged teams;
- **quality and patient safety** – the need to continuously improve quality and safety standards informs our learning.

We deliver this through:

- **innovative learning** – using technology where appropriate to enhance learning opportunities;
- **learning together** – making sure that we maximise interdisciplinary work and effective teamwork, knowing that this will bring the greatest dividends for patients;
- **developing inspiring learning environments** – improving our estate and infrastructure support to encourage high quality learning and education.

Currently education and training is delivered in a variety of ways to help meet the learning preferences of individuals, including blended learning with the use of e-learning programmes and video conferencing. We work with our academic partners to provide pre-registration nursing and midwifery

education to around 400 student nurses and midwives and 800 trainee doctors.

Leaders continue to access the core professional programmes sponsored by the NHS Leadership Academy and programmes delivered by Health Education Thames Valley. In addition, we have sought to widen participation in the Trust's Support Worker Academy, through which care support workers are encouraged to undertake a programme of education which leads to the award of the higher certificate of fundamental care. Launched in 2012, the Care Support Worker Academy is also active in recruitment; providing career and progression advice; and promoting apprenticeship opportunities within the Trust. We offer a range of apprenticeship options in clinical and non-clinical areas. The OUH young apprenticeship programme offers a fixed-term contract with training and assessment provided by locally-based established training providers, a work-based supervisor, a manager and the OUH Support Worker Academy.

Staff health and wellbeing

The Trust's Public Health Strategy is designed to promote healthy lifestyles and choices for our staff, patients and visitors at every opportunity.

We recognise that a healthy and well-motivated workforce is fundamental to the delivery of good care. To this end, we continue to offer health and wellbeing support and advice to staff through the activities of our Centre for Occupational Health and Wellbeing and the Trust's Here for health advice centre.

A number of initiatives have been delivered during 2017/18 to promote healthier lifestyle choices for all employees.

Managing Stress and Building Resilience

The Trust has put in place the Mentally Healthy Workplace Programme to support staff in managing stress and building resilience and has promoted mental health training for staff. Courses are offered throughout the year by the Centre for Occupational Health and Wellbeing to support this initiative. Mindfulness sessions are also available for staff and we are maintaining focus on staff mental health through a policy which outlines procedures for identification of mental health problems, plus support and referral.

In addition an Employee assistance programme is available for all staff to access via a variety of methods which provides advice, support and counselling if needed.

Promoting public health to staff

The Trust is improving physical activity through

- providing walk to work routes mapped and charted as well as health walks on all 4 sites for staff to use
- facilitating on site classes and encourage walking or cycling between sites
- monthly featured newsletters on how to increase physical activity with a plethora of external links to local facilities
- promotion of discounted leisure centre memberships.

The Trust is encouraging healthier eating and weight management through

- supporting policy development and CQUIN undertaken by Public Health registrars in relation to the Trust Food and Nutrition strategy which is both patient and staff focused
- working with Food Providers via the Trust's healthier eating group to influence healthier choices in all the Trust's food outlets, including healthier vending
- supporting staff who want to lose weight or make healthier choices.

Staff engagement, recognition and consultation

Awards and recognition

The Trust held its annual awards ceremony on 6 December 2017 to honour the achievements of our staff over the last year.

The Staff Recognition Awards ceremony at Oxford Town Hall was attended by more than 200 staff from all areas of the Trust. Winners and highly commended runners-up were selected from each of the eight award categories, designed to celebrate the excellent contribution that they had made to patient care and working life at OUH throughout 2017.

The ceremony - which was supported in part by the generosity of Oxford Hospitals Charity - was hosted by local BBC Oxford newsreader, Geraldine Peers. Winners and runners up were picked from over 600 nominations by a panel of staff and patients.

The Patients' Choice Award, which was launched in 2016, went to Craniofacial Specialist Nurse, Kari Ashton. Her nominator, Sarah, said: "Kari is a wonderful lady. She treated myself and my family as individuals - not just patients. She listened to our concerns every step of the way. Her impact on our family was huge. I can never thank Kari enough for all she has done for us."

Other highlights included a festive opening performance from St Joseph's School Choir, the Chairman's Award, and a photography slideshow finale showcasing the best moments from the evening.

OUH Vice Chairman, Geoff Salt, closed the evening by thanking winners and nominators for their hard work, support and dedication.

For a full list of winners and photographs of the ceremony please visit www.ouh.nhs.uk/about/staff-recognition

Values-based engagement

As part of our strategy to deliver excellence and compassion in all that we do, the Trust uses ‘Values Based Interviewing’ which incorporates the Trust values into the recruitment process to assess candidates’ alignment and support for the values we hold.

Training has also been introduced for staff to develop skills and techniques for ‘values based conversations’ with their staff in the workplace.

Our aim is to continuously improve the quality of patient care through greater alignment of individual and organisational values. Through adopting a values-based approach to customer care we believe we will have more staff who adopt a person-centred approach to providing safe and compassionate care.

The design of the Delivering Compassionate Care programme, aimed at frontline staff, is in progress, with pilot schemes underway. The project aims to help staff better support patients and their families at times of great vulnerability.

The programme provides staff with tools to adapt their communication and approach depending on the needs of the patient and to understand the impact that staff behaviours and attitudes may have on a vulnerable person.

The NHS Staff Survey

Recognised as being an important intervention in supporting the delivery of the NHS Constitution., the annual Staff Survey is a mandatory undertaking for all NHS trusts. The Survey results are primarily intended for use by local organisations to help them review and improve staff experience, which is accepted as having a direct impact on the quality of care and the patient experience. The Care Quality Commission (CQC) uses the annual survey results to monitor on-going compliance with essential standards of quality and safety. Used effectively, survey data are also of value in developing the 'employee voice', alongside the patient voice, and in supporting the delivery of the Trust's quality priorities.

All trusts are obliged to appoint an independent Survey administrator, which is responsible for selecting a minimum sample set of staff, co-ordinating the issue, collation and analysis of Survey questionnaires, and producing a full Survey report. The Survey administrator appointed by OUH is Picker Institute Europe. The Survey questionnaire covers five key themes relating to the working environment and individuals' experience within the workplace, namely: 'Your Job'; 'Your Managers'; 'Your Health, Wellbeing and Safety'; 'Your Personal Development'; 'Your Organisation'

The Survey outcomes provide for an overall staff engagement score, which is referred to by the main regulatory bodies as the 'Employee Engagement Index' (EEI) score. The score is the product of the combined responses to nine particular questions relating to three specific domains, namely 'advocacy', 'involvement' and 'motivation'. Responses to the 2017 Survey provided for a Trust EEI score of 3.78 (out of a maximum score of 5.0), (2016 Trust EEl score 3.87). The current Trust score of 3.78 compares to the national average for acute trusts of 3.79. This year the OUH score has fallen back to 2015 levels, having been on an improving trend for the previous 6 years.

Summary of performance – NHS staff survey

Details of the key findings from the latest (2017) NHS staff survey are as follows:

- The response rate for the 2017/18 survey was **39%** and the table below sets this in a wider context by comparing it with the response rate the Trust achieved in the previous year and also how our performance compares with the average achieved by all acute trusts

Response rate				
	2016-17	**2017-18**		**Trust improvement**
	Trust	**Trust**	**Benchmarking group (acute trust) average**	
Response rate	39%	39%	44%	No change

- The top five ranking scores (where the Trust achieved its best results) are set out in the table below

Top 5 ranking scores				
	2016-17	**2017-18**		**Trust improvement / (deterioration)**
	Trust	**Trust**	**Benchmarking group (acute trust) average**	
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (the lower the score the better)	10%	12%	15%	(2%)
KF15. Percentage of staff satisfied with the opportunities for flexible working patterns (the higher the score the better)	52%	52%	51%	No change
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (the lower the score the better)	23%	26%	28%	(3%)
KF6. Percentage of staff reporting good communication between senior management and staff (the higher the score the better)	36%	35%	33%	(1%)
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents (the higher the score the better)	3.75	3.74	3.73	(0.01)

- The bottom five ranking scores (where the Trust achieved it's poorest results) are set out in the table below

Bottom 5 ranking scores				
	2016-17	**2017-18**		**Trust improvement / (deterioration)**
	Trust	**Trust**	**Benchmarking group (acute trust) average**	
KF24. Percentage of staff / colleagues reporting most recent experience of violence (the higher the score the better)	62%	60%	66%	(2%)
KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse (the higher the score the better)	39%	39%	45%	No change
KF11. Percentage of staff appraised in last 12 months (the higher the score the better)	81%	78%	86%	(3%)
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	94%	88%	90%	(6%)
KF16. Percentage of staff working extra hours (the lower the score the better)	73%	75%	72%	(2%)`

Future priorities and targets

The Staff Survey results are concerning for us as a Board. It is important that we respond to the feedback we have received from our staff, including asking divisions and directorates to engage with their own staff and the detailed reports which they receive for their areas.

Based on the outcome of the survey, the six key themes were identified as requiring Trust-level and local attention in 2018-19, namely: staff recognition, greater empowerment, training and development for line managers, improved appraisals, health and wellbeing, and fairness, dignity and respect.

In response to concerns about staff health and wellbeing, the Centre for Occupational Health and Wellbeing (COHWB) will continue to develop and implement initiatives that are consistent with the Trust's commitment to the NHS Healthy Workforce Programme, and which also support the achievement of specific 'commissioning for quality and innovation' (CQUIN) criteria. These include: the provision of support across musculoskeletal health, mental health, and physical activities; the uptake of flu vaccinations by frontline healthcare staff; and ensuring the food and drink provided and sold on the Trust's various sites promotes healthy choices. Further work will be undertaken to ensure maximum benefit is being derived from the reporting and data analysis available through the FirstCare management system, and to raise awareness amongst the workforce of the range of support and assistance available to individuals and teams.

Bullying, harassment, discrimination and victimisation are inconsistent with OUH values and desired

behaviours. Consistent with these values, and with a widespread desire to identify and robustly tackle inappropriate behaviour, OUH has revised and relaunched its policy under the banner of 'Dignity and Respect' together with a number of initiatives including;

- provision of awareness training for staff and line managers (to include unconscious bias);
- implementation of guidance for staff who experience harassment, bullying or abuse by patients or visitors;
- provision of a series of staff conferences, commencing in May 2017, entitled 'Bullying and Harassment in a Modern NHS' (to cover current issues, such as the role of social media in bullying, how to handle bullying behaviour exhibited by patients and visitors, and the impact of the European Union referendum vote);
- further local surveying; and
- appointment of Freedom to Speak Up Guardians from April 2017.

Contemporary research and associated literature highlights the importance of regular appraisal activity in the context of staff engagement and motivation, and the improving the overall patient experience. Whilst the Staff Survey outcomes indicate an increase in the number of staff participating in an appraisal, almost two thirds of respondents stated that the appraisal discussion did not include the agreement of clear objectives, and did not help them to improve their performance. Furthermore, values and behaviours were not consistently discussed. Therefore, an opportunity exists to more effectively use the appraisal process to reinforce the importance of the Trust's values and positive behaviours, and to align personal and team objectives with key operational and strategic goals.

In response, key interventions will include the full implementation of new 'Values into Action' appraisal training for line managers and senior leaders, aimed at improving the quality of appraisal activity, combined with the provision of audio-visual guidance and instruction relating to effective objective-setting. Concurrently, the existing appraisal process, including recording, is to be re-evaluated and improved.

Staff Friends and Family Test

The degree to which staff are willing to recommend their organisation both as a place for their friends and families to be treated, and as a place to work, are strong indicators of staff engagement and motivation. These key areas of advocacy are included within the annual NHS Staff Survey and also tested as part of the quarterly Staff Friends and Family Test (Staff FFT), which was first introduced in June 2014. The results, including free text comments provided by individuals, are reported at the Workforce Committee and disseminated through divisional management structures.

With respect to the two key advocacy questions associated with the annual NHS Staff Survey, compared with national scores the Trust's performance is as follows.

Recommendation of the organisation as a place to be treated 75%

Average (median) for acute trusts 71%

Recommendation of the organisation as a place to work 57%

Average (median) for acute trusts 61%

The Trust strives to improve these scores, and therefore the quality of its services, by:

- using both the national Staff Survey and Staff FFT data to inform the internal peer review process;
- more widely publicising the data through local communication channels at ward level, to ensure it is more visible to staff;
- inviting staff to contribute to the development and implementation of local divisional and corporate improvement plans.

Raising concerns

In its commitment to providing the highest standards of care and service for our patients and visitors, the Trust takes very seriously its responsibility for ensuring all members of staff feel confident and supported in being able to speak up when they believe these standards are being compromised, or could be compromised. We have clear processes to ensure that our staff feel able and safe to raise concerns, and have confidence they will be listened to and their concerns acted upon.

Where such issues are raised, they are generally addressed quickly and efficiently through our established processes detailed in the Trust's Raising Concerns Policy. Under the terms of the policy, and in her capacity as Freedom to Speak up (FTSU) Lead Guardian Jane Herve has a guardianship role in support of any employee who wishes to raise an issue of concern. In the interests of continuous improvement and learning, speaking up should be something that everyone does and is encouraged to do. Our Trust policy is frequently updated to ensure it fully supports this aim.

Staff consultation and negotiation

Consultation and negotiation between management and staff at the Trust is conducted through a joint consultative negotiation committee which includes a mix of trade's union representatives and elected staff representatives who meet on a monthly basis. The purpose is to provide a constructive forum for discussion and exchange of views, and to consult on matters of common interest with regard to the Trust and its business. It provides an opportunity for staff to present their view and influence key Trust issues and decisions.

Trade Union Facility Time 1 April 2017 to 31 March 2018

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into effect on 1 April 2017. Under the Regulations Oxford University Hospitals NHS Foundation Trust is legally required to publish the following information for the period 1 April 2017 to 31 March 2018, and then annually thereafter.

Relevant union officials	
What was the total number of your employees who were relevant union officials during the relevant period?	
Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
33	10,978

Percentage of time spent on facility time	
How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?	
Percentage of time	*Number of employees*
0%	16
1%-50%	15
51%-99%	1
100%	1

Percentage of pay bill spent on facility time	
Percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.	
Total cost of facility time[3]	£90,760
Total pay bill[4]	£586,793,000
Percentage of the total pay bill spent on facility time [5]	0.02%

Paid trade union activities	
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?	
Time spent on paid trade union activities as a percentage of total paid facility time hours[6]	100%

[3] Calculated including employer pension and national insurance contributions
[4] Calculated including employer pension and national insurance contributions
[5] Calculated as (total cost of facility time ÷ total pay bill) x 100
[6] Calculated as (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100

Equality, Diversity and Inclusion Commitment

As a responsible employer and provider of healthcare services, we are committed to recognising, valuing and supporting the diverse range of staff we employ and patients we care for. Our aim is to treat all patients, visitors and staff with dignity and respect and learn from occasions when our actions have fallen short of our high expectations. We recognise our responsibility to provide (as far as is reasonably practicable) job security of all employees.

Through adherence to the requirements of the *Equality Act 2010*, the public sector equality duty and the NHS Constitution provisions, the Trust strives to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different groups and
- foster good relations between people.

Our policies ensure full and fair consideration of applications for employment made by disabled persons, having regard to their particular aptitudes and abilities; for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period; and for the training, career development and promotion of disabled employees.

Our policies aim to ensure that no job applicant or employee receives less favourable treatment where it cannot be shown to be justifiable on the grounds of:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

The *Equality Delivery System* (EDS2) is designed to support NHS providers to deliver better health outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The Trust has been using this system as a tool to benchmark compliance with the *Equality Act 2010* and to support the development of its equality and diversity objectives.

Equality and diversity is a core component of the Trust's statutory and mandatory training for all staff.

Bronze Standard Award

In 2017, the Trust was proud to be awarded a Bronze Standard Award for its work and commitment to equality and inclusion by the Employers Network for Equality and Inclusion (ENEI). This followed the benchmarking of our performance against five key areas of equality and diversity:

- organisational commitment and leadership;
- knowing your workforce;
- integrating equality, diversity and inclusion;
- external relations and suppliers;
- organisational improvements.

Support for Disabled Employees

The Trust's ongoing commitment to the employment of disabled people has been recognised and in September 2017 we were awarded Level 2: Disability Confident Employer by the Department for Work and Pensions Disability Confident Scheme for a further two years. This demonstrates our commitment to ensuring that our recruitment processes do not disadvantage disabled applicants, and that we actively support employees who have a disability and help those who become disabled to stay in employment. We review our plans and activities in support of disabled people annually, and ensure disability awareness for all employees.

Policy on counter fraud and corruption

This Trust is committed to providing a zero tolerance culture to fraud, bribery and corruption whilst maintaining an absolute standard of honesty and integrity in dealing with our assets. We are committed to the elimination of fraud and illegal acts within the Trust and ensure rigorous investigation and disciplinary sanctions or other actions as appropriate. We adopt best practice procedures to tackle fraud, as recommended by the NHS Counter Fraud Authority.

Over 2017-18 we have raised awareness of fraud and bribery throughout the Trust, and this work is ongoing. We have anti-fraud and anti-bribery policies in place. In the 2017-18 financial year, counter fraud received 21 referrals of fraud and opened 13 new cases. Two cases were referred for disciplinary consideration.

The Providers Self-Review Tool assessment was undertaken by the LCFS on behalf of the Trust for the anti-fraud, bribery and corruption work conducted during the period 01 April 2017 to 31 March 2018 inclusive which provided the Trust with an overall rating of green. This confirms that the Trust assessment was that it met the required standard set by the NHS Counter Fraud Authority.

Counter Fraud is accountable to the Chief Finance Officer and the Audit Committee. All concerns are investigated by our counter fraud team.

WORKING IN PARTNERSHIP

We recognise that delivering excellence for our patients, our staff, the NHS and its partners can best be achieved by full engagement and participation in the way we shape and deliver our services. We are supported by an army of volunteers, and we also work with charitable organisations to support community engagement and to share knowledge and expertise.

Foundation Trust membership

During 2017-18, we have continued to invite our patients and the public to become members of the Trust to help us shape the way we operate and deliver our health services. Anyone aged 16 or over living in England and Wales can become a member of the Trust. We aim to recruit and develop a membership which fairly represents people living in the communities served by the Trust. This includes patients, former patients, carers and members of the public, particularly in Oxfordshire, but also from our surrounding counties, Berkshire, Buckinghamshire, Northamptonshire, Warwickshire and Gloucestershire.

Our membership is broadly in line with the ethnic breakdown of the population of Oxfordshire and the geographic spread of our patient base. The FT membership team works with colleagues tomaximise the opportunities to recruit from hard to reach groups. Our membership is disproportionately balanced towards older age groups, with people aged over 50 over-represented. We are working hard to encourage younger people to sign up by attending school careers fairs and apprenticeship events. We have undertaken recruitment in our hospitals and at many places around the county. Two of our biggest recruitment events annually are the annual OX5Run in aid of the Children's Hospital at Blenheim Palace in Woodstock and the Cancer Research Race for Life event at the University Parks in Oxford.

Our membership strategy aims to build a substantial, engaged and representative membership, supporting our members to be well-informed and motivated, and to provide our members with opportunities to help shape how our services develop. Delivering these aims is intended to support OUH in meeting its objectives, not least through being a responsive organisation with a good understanding of the needs of its patients and the communities it serves.

In addition, we provide a range of services for people from further afield in England and Wales, and people in this wider area are also invited to play their part in our future by joining as members. As at 31 March 2018 we have just over 8,500 members in total, as follows.

Public Constituencies	**8,537**
Oxford City	1,962
Cherwell	1,326
South Oxfordshire	898
Vale of White Horse	1,216
West Oxfordshire	915
Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	1,217
Northamptonshire and Warwickshire	493
Rest of England and Wales	507

The Council of Governors is made up of 29 governors, plus a Chairman who is also the Chairman of the Trust's Board of Directors. There are 15 elected public governors, six elected staff governors and eight governors appointed by local organisations with which the Trust works closely.

Non-executive and executive directors regularly attend the Council of Governors meetings to observe and at the request of governors, to speak to particular issues. A number of seminars have also been held to encourage closer working and governors are encouraged to attend Trust Board meetings.

You can find out more about our governors on our website at **www.ouh.nhs.uk/ft**

Our volunteers and supporters

Our volunteers continue to provide additional help and support to staff which ultimately improves the patient, family and service user experience. They assist in numerous ways, including helping ward staff at mealtimes, directing patients and visitors to their destinations, assisting within Chaplaincy and Charitable Funds and supporting departments with administrative duties.

The Trust has a Voluntary Services Department that manages volunteer recruitment along with the volunteer first day induction. They continue to identify, increase and enhance volunteering opportunities across the four hospital sites working in conjunction with managers and departments.

Work experience applications along with the work experience programmes that are on offer no longer come under the remit of Voluntary Services as they are now managed by the Workforce Directorate.

We are very proud of, and grateful to, our loyal volunteers along with our Host Charitable Volunteer Organisations which support us, such as the Leagues of Friends, Radio Cherwell, Radio Horton, the British Red Cross and Support for the Sick Newborn and their Parents (SSNAP), Ronald McDonald House as well as Sobell House Hospice, and Maggie's Centre, Oxford.

Oxford Hospitals Charity – *Raising smiles across our hospitals*

Our hospital charity helps to transform care - funding the best medical equipment, research, training and facilities for patients and staff. The charity works across the John Radcliffe, Churchill, Nuffield Orthopaedic Centre, Horton General and Oxford Children's Hospital, with every corner of each hospital able to benefit from the positive impact of donations and fundraising.

From the small things - like providing quality reclining chairs for cancer patients having lengthy chemotherapy, to larger projects - such as funding computerised surgical equipment to help with the most complicated of operations – Oxford Hospitals Charity supports our hospitals.

The charity works very closely with the Trust and clinical colleagues - under the guidance of the charity trustees - to ensure donations are well spent and have the maximum impact for patients and staff. The charity has recently become a fully independent charity and are no longer Oxford Radcliffe Hospitals Charitable Funds, but simply Oxford Hospitals Charity, with a new charity number of 11052176.

This is mainly a technical change of governance caused by changing guidelines from the Department of Health and it does not change the fundamental mission and approach of the charity. In fact it should allow them to provide even more support across the hospitals and we hope the new name and improved visibility of the charity will help them raise more in the coming years.

Due to this change we are reporting the income of the old charity – Oxford Radcliffe Hospitals Charitable Funds – from April 2017 to end of December 2017, just nine months of the year. During this time generous donations helped us achieve income of £3.6million. The Oxford Children's Hospital 10th Anniversary Appeal was a particular highlight, with an array of special events taking place throughout the year.

The appeal is supporting a number of important enterprises – including new parent's accommodation to provide support for families with the most poorly of children and babies.

Other highlights during this time include the funding of technology to improve prostate cancer diagnosis; research to improve patient care following a heart attack, a transport system to move critically ill newborn babies and a staff room upgrade to give surgical theatre staff a proper break in between operations.

The Trust and the charity are very grateful to everyone who supports their local hospital causes with such generosity and enthusiasm. To find out how you can get involved with fundraising make a donation or hear about the positive impact of gifts in Wills, please get in touch:

Phone: 01865 743444

Email: charity@ouh.nhs.uk

Visit: www.hospitalcharity.co.uk

With your vital support we can continue to transform the hospitals that care for you and your loved ones.

EXPENSES FOR GOVERNORS AND DIRECTORS

Directors' expenses

No taxable expenses were paid to any non-executive during the reporting period. The taxable benefits paid to the executive directors are recorded in the remuneration tables.

Governors' expenses

Governors are not remunerated, but are entitled to claim expenses for costs incurred while undertaking duties for the Trust as a governor (e.g. travel expenses to attend Council of Governors meetings). A total of £2,211 was paid as expenses to 6 governors in the period from 1 April 2017 to 31 March 2018.

There were 44 governors who were on the council during at least part of this period.

Consultancy expenditure

Reporting bodies are required to disclose the expenditure on consultancy. For the purposes of this report, 'consultancy' is defined as in the NHS Manual for Accounts (strategy; finance; organisational and change management; IT; property and construction; procurement; legal services; marketing and communications; HR, training and education; programme and project management; technical). The expenditure incurred in the period 1 April 2017 to 31 March 2018 was £3,994,000 (2016-17 £5,299,000).

Payment to past directors

The Trust has not made any payment to any person who was not a director at the time the payment was made, but who had been a director of the Trust previously. (This excludes any payments of regular pension benefits which commenced in previous years, payments in respect of employment for the Trust other than as a director and sums disclosed in the single total remuneration disclosure or the disclosure of compensation for early retirement or loss of office.)

Off-payroll engagements

In accordance with the HM Treasury annual reporting guidance the Trust is required to report the number of off-payroll engagements for more than £245 per day that last for longer than six months. From April 2017, the government have reformed the legislation associated with off-payroll payments so that public sector bodies are responsible for deducting and paying all employment taxes and national insurance contributions from the individuals concerned. The Trust has worked hard to eliminate the off payroll arrangements that were in place in previous years and has implemented a policy that no individuals are paid off-payroll unless the employing manager submits evidence from HMRC that they are certified self-employed.

Table 1: Off-payroll engagements longer than 6 months

No. of existing engagements as of 31 March 2018	0
Of which…	
No. that have existed for less than one year at time of reporting.	
No. that have existed for between one & two years at time of reporting.	
No. that have existed for between two and three years at time of reporting.	
No. that have existed for between three and four years at time of reporting.	
No. that have existed for four or more years at time of reporting.	

Table 2: New Off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which…	
No. assessed as caught by IR35	
No. assessed as not caught by IR35	
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	
No. of engagements reassessed for consistency / assurance purposes during the year.	
No. of engagements that saw a change to IR35 status following the consistency review	

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. (1)	0
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements. (2)	21

Note

(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

Exit packages *(information subject to audit)*

The tables below discloses the total of all staff exit packages agreed in the twelve months to 31 March 2018. Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the accounting period of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included within this table.

Exit packages	**2017-18**			**2016-17**		
Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	1	-	1	1		1
£10,000 - £25,000	2	-	2	3	1	4
£25,001 - £50,000	1	1	2	1		1
£50,001 - £100,000	1	-	1	1		1
£100,001 - £150,000	-	-	-	1		1
£150,001 - £200,000	-	-	-			
>£200,000	-	-	-			
Total number of exit packages by type	5	1	6	7	1	8
Total resource cost £k	156	37	193	244	15	259

	2017-18		**2016-17**	
Exit packages other (non-compulsory) departure payments	Agreements Number	Total Value of Agreements £000	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	37	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval *	-	-	1	15
Total[1]	1	37	1	15
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary.	-	-	-	-

Note

1 As individual exit packages can be made up of several components, each of which listed in this table, the total number of payments listed in this table may exceed the total number of other departures agreed shown in the first table, which will be the number of individuals.

2 The Remuneration Report provides details of exit payments payable to individuals named in that Report.

* Includes any non-contractual severance payment made following judicial mediation, and non-contractual payments in lieu of notice.

Information subject to audit – salary and pension entitlements of senior managers

Name and Title		2017-18 (12 months to 31st March 2018)						2016-17 (12 months to 31 March 2017)					
		Salary	Expense payment Taxable	Performance related pay	Long term Performance related pay	All pension related benefits	Total inc all pension related benefits	Salary	Expense payment Taxable	Performance related pay	Long term Performance related pay	All pension related benefits	Total inc all pension related benefits
		(bands of £5000) £000	£'s to the nearest £100 £	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£'s to the nearest £100 £	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Dame Fiona Caldicott[1]	Chairman	55-60					55-60	70-75					70-75
Professor Sir John Bell[2]	Non-executive Director	10-15					10-15	15-20					15-20
Mr Alisdair Cameron [2, 3]	Non-executive Director	0-5					0-5	15-20					15-20
Mr Christopher Goard[4]	Non-executive Director	15-20					15-20	20-25					20-25
Ms Paula Hay-Plumb[2, 5]	Non-executive Director	5-10					5-10						
Professor David Mant[2]	Non-executive Director	10-15					10-15	15-20					15-20
Mr Geoffrey Salt [4]	Non-executive Director	15-20					15-20	20-25					20-25
Ms Anne Tutt [4]	Non-executive Director	15-20					15-20	20-25					20-25
Mr Peter Ward [4, 6]	Non-executive Director	10-15					10-15	20-25					20-25
Dr Bruno Holthof	Chief Executive	270-275	36				275-280	270-275		20-25			295-300
Dr Tony Berendt[7]	Medical Director	205-210				17.5-20	225-230	200-205				0	200-205
Mr Paul Brennan	Director of Clinical Services	170-175	91			0	180-185	170-175	7100	10-15		225-227.5	415-420
Mr Jason Dorsett[8]	Chief Finance Officer	170-175				37.5-40	205-210	80-85				17.5-20	100-105
Mr John Drew[9]	Director of Improvement and Culture	85-90				20-22.5	105-110						
Ms Samantha Foster[10]	Chief Nurse	65-70	96			17.5-20	90-95						

Information subject to audit – salary and pension entitlements of senior managers

Name and Title		2017-18 (12 months to 31st March 2018)						2016-17 (12 months to 31 March 2017)					
		Salary	Expense payment Taxable	Performance related pay	Long term Performance related pay	All pension related benefits	Total inc all pension related benefits	Salary	Expense payment Taxable	Performance related pay	Long term Performance related pay	All pension related benefits	Total inc all pension related benefits
		(bands of £5000) £000	£'s to the nearest £100 £	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£'s to the nearest £100 £	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Mr Peter Knight[11]	Chief Information and Digital Officer	130-135				0	130-135	75-80				152.5-155	230-235
Mr Andrew MacCallum[12]	Interim Chief Nurse	45-50				0	45-50						
Mr Mark Mansfield[13]	Executive Director of Finance and Procurement							25-30		10-15		0	40-45
Ms Maria Moore[14]	Interim Chief Finance Officer							40-45				7.5-10	50-55
Mr Mark Power[15]	Director of Organisational Development and Workforce	40-45				0	40-45	130-135		5-10		55-57.5	200-205
Mr Andrew Stevens[16]	Director of Planning and Information							100-105		5-10			110-115
Ms Catherine Stoddart[17]	Chief Nurse							160-165		10-15			170-175
Ms Eileen Walsh	Director of Assurance	125-130				22.5-25	150-155	125-130		5-10		87.5-90	225-230
Ms Elizabeth Wright[18]	Interim Chief Nurse	5-10					5-10						
Ms Susan Young[19]	Interim Director of Workforce	90-95					90-95						

The table above shows the salary and pension entitlements of senior managers in the revised technical format adopted in 2013-14. It should be noted that the total for the year includes salary, expense payments, performance-related pay, and derived increase in capital value of pension benefits at pension age, calculated using legislated relevant valuation factor of 20 on annual pension at pension age, plus lump sum at pension age. This does not reflect an increase in remuneration during 2017-18 but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. This approach is mandated in the guidance produced by the NHS Business Services Authority – Disclosure of Senior Managers' Remuneration (Greenbury) 2015. The pension benefit table (on page 95) sets out the Cash Equivalent Transfer Values.

Notes

1 The level of remuneration to be paid to the Chairman per annum was reviewed and approved by the Council of Governors in April 2016. It was agreed that the revised level of remuneration should take effect from 1 October 2015, being the date upon which the Trust was authorised as a foundation trust.

2 The level of remuneration to be paid to Non-Executive Directors who discharge additional responsibilities (defined as being the Vice-Chairman of the Trust, Chairmen of the Quality Committee, Finance & Performance Committee and Audit Committee, and the Senior Independent Director) was reviewed and approved by the Council of Governors in April 2016. It was agreed that the revised level of remuneration should take effect from 1 October 2015, being the date upon which the Trust was authorised as a foundation trust.

3 Term of Office ended April 2017

4 The level of remuneration to be paid to Non-Executive Directors per annum was reviewed and approved by the Council of Governors in April 2016. It was agreed that the revised level of remuneration should take effect from 1 October 2015, being the date upon which the Trust was authorised as a foundation trust.
The annual remuneration of Non-Executive Directors is within the band of 10-15.
The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of 15-20.

5 Appointed from September 2017

6 Term of Office ended November 2017

7 Other remuneration relates to clinical excellence awards

8 Appointed as Chief Finance Officer to Oxford University Hospitals October 2016

9 Appointed to Oxford University Hospitals October 2017

10 Appointed to Oxford University Hospitals September 2017

11 Appointed to Oxford University Hospitals August 2016

12 Interim Chief Nursing Officer from May 2017 to September 2017

13 Resigned from Oxford University Hospitals May 2016

14 Interim Chief Finance Officer from June 2016 to September 2016

15 Resigned from Oxford University Hospitals April 2017 and salary includes a payment in lieu of notice

16 Stepped down from Trust Board January 2017

17 Resigned from Oxford University Hospitals March 2017

18 Acting Chief Nurse from 1 April 2017 to 30 April 2017

19 Interim Director of Workforce from April 2017 to October 2017

Dr Bruno Holthof
Chief Executive
23 May 2018

NHS FOUNDATION TRUST CODE OF GOVERNANCE

NHS foundation trusts in their annual reports are required to disclose information relating to the Code's requirements. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. Oxford University Hospitals NHS Foundation Trust has applied the principles of the *NHS Foundation Trust Code of Governance* on a comply or explain basis.

For each item following, the information, its reference in the Code of Governance and its location within the Annual Report are shown. The reference "ARM" indicates a requirement not of the Code of Governance, but of the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

The Trust considers that it complies with the specific disclosure requirements as set out in the *NHS Foundation Trust Code of Governance and NHS Foundation Trust Annual Reporting Manual* (FT ARM).

A full table evidencing the Trust's compliance to the Code is included overleaf.

Ref. Nos	Code provision	Annual Report and Accounts section
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors.	The Scheme of Delegation agreed by the Board in January 2018 includes a statement of the roles and responsibilities of the Council of Governors. The Trust's Constitution, also agreed in October 2015, sets out a dispute resolution procedure.
A.1.2	The Annual Report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those committees and individual attendance by directors.	Following discussion with governors, Mr Christopher Goard was appointed as Senior Independent Director in October 2015. See also pages 62, 68-72 and 85.
A.5.3	The Annual Report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The Annual Report should also identify the nominated Lead Governor.	See section in Directors' Report on pages 65 and 116.
FT ARM	The Annual Report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors.	See section in Directors' report on page 67.
B.1.1	The Board of Directors should identify in the Annual Report each non- executive director it considers to be independent, with reasons where necessary.	All of the non-executive directors of the Trust are considered to be independent in accordance with Monitor's *NHS Foundation Trust Code of Governance* with the exception of John Bell who is appointed by the University of Oxford.
B.1.4	The Board of Directors should include in its Annual Report a description of each director's skills, expertise and experience. Alongside this, in the Annual Report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	The Annual Report refers people to our website which contains details of the skills, expertise and experience of each of our directors.
FT ARM	The Annual Report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated.	See section in Directors' report on pages 86 and 89.
B.2.10	A separate section of the Annual Report should describe the work of the Nominations Committee(s), including the process it has used in relation to board appointments.	Section on Remuneration on pages 85 and 86.
FT ARM	The disclosure in the Annual Report on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Not applicable.
B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report.	See section in Directors' report on page 75.
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	See section on FT membership on page 116.

Ref. Nos	Code provision	Annual Report and Accounts section
FT ARM	If, during the financial year, the governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the Annual Report. This is required by paragraph 26(2) (aa) of schedule 7 to the *NHS Act 2006*, as amended by section 151 (8) of the *Health and Social Care Act 2012*. *Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). **As inserted by section 151 (6) of the *Health and Social Care Act 2012*).	Not applicable.
B.6.1	The Board of Directors should state in the Annual Report how performance evaluation of the Board, its committees and its directors, including the chairperson, has been conducted.	See page 62.
B.6.2	Where there has been external evaluation of the Board and/or governance of the Trust, the external facilitator should be identified in the Annual Report and a statement made as to whether they have any other connection to the Trust.	See page 62.
C.1.1	The directors should explain in the Annual Report their responsibility for preparing the Annual Report and Accounts, and state that they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	Annual Governance Statement (pages 136-148) and Directors' Responsibilities (page 82) – under the heading *Annual Quality Account* – this sets out the approach to the report, responsibilities and data quality assessment.
C.2.1	The Annual Report should contain a statement that the Board has conducted a review of the effectiveness of its System of Internal Controls.	Annual Governance Statement (pages 136-148) – part of the review of effectiveness section.
C2.2	A Trust should disclose in the Annual Report: a) if it has an internal audit function, how the function is structured and what role it performs; or b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Annual Governance Statement (pages 136-148) – part of the review of control framework section.
C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the Annual Report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not applicable.
C.3.9	A separate section of the Annual Report should describe the work of the Audit Committee in discharging its responsibilities. The Report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re- appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	See section in Directors' Report on page 68. Also covered in the Annual Governance Statement. This is covered by reporting to the Audit Committee (Feb 2017 the results were discussed and agreed)

Ref. Nos	Code provision	Annual Report and Accounts section
D.1.3	Where an NHS foundation trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the Annual Report.	The generic email to contact our governors is advertised on our website and on page 66 of the Annual Report.
E.1.5	The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the Board, and in particular the Non-Executive Directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Attendance of Non-Executive and Executive members of the Board at Council of Governors meetings is recorded on page 67 and their joint work is referenced under membership on page 117.
E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the Annual Report.	The Chairman regularly updates the Board on matters relating to the Council of Governors and a report on membership can be found on page 116.
FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	See page 116.
FT ARM	The Annual Report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the Annual Report to simply state how members of the public can gain access to the registers instead of listing all the interests in the Annual Report.	See page 66.

Ref. Nos	Narrative in the code	OUH compliance
A.1.4	The Board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its healthcare delivery.	Confirmed: the Board of Directors receives detailed monthly reports on operational performance, quality and finance. There is a Board Assurance Framework and a system of internal controls in place as detailed in the Annual Governance Statement.
A.1.5	The Board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.	Confirmed: the Board of Directors/ Finance and Performance Committee receives a monthly operational performance scorecard.
A.1.6	The Board should report on its approach to clinical governance.	Confirmed: the Annual Quality Account provides details of the Trust's approach to clinical governance.
A.1.7	The Chief Executive as the accounting officer should follow the procedure set out by Monitor for advising the Board and the Council and for recording and submitting objections to decisions.	Confirmed: the Chief Executive is aware of this provision in the Accounting Officer Memorandum.
A.1.8	The Board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.	Confirmed: the Code of Conduct for Board members and governors includes the Trust's values and the NHS values.
A.1.9	The Board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	As above. The Code of Conduct also incorporates the Nolan Principles of public life.
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Confirmed: the Trust is a member of the NHSLA. The Trust's NHS Foundation Trust Constitution states that providing directors act honestly and in good faith, any legal costs incurred in the execution of their functions will be met by the Trust.
A.3.1	The chairperson should, on appointment by the Council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	Confirmed: the Trust Chairman and Chief Executive are compliant with this provision. The Trust's Chairman meets the independence criteria.
A.4.1	In consultation with the Council, the Board should appoint one of the independent non-executive directors to be the Senior Independent Director.	Following discussion with governors, Mr Christopher Goard was appointed as Senior Independent Director in October 2015.
A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.	Confirmed: the Trust Chairman holds regular meetings with non- executive directors.
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes.	Confirmed: all discussions at Board of Directors meetings are contained in the minutes of each meeting.
A.5.1	The Council of Governors should meet sufficiently regularly to discharge its duties.	Confirmed: the Council of Governors meets quarterly which is in line with other NHS foundation trusts. There is provision to hold additional meetings if required.

Ref. Nos	Narrative in the code	OUH compliance
A.5.2	The Council of Governors should not be so large as to be unwieldy.	Confirmed: the size of the Council of Governors is considered to be appropriate and will be kept under review.
A.5.4	The roles and responsibilities of the Council of Governors should be set out in a written document.	Confirmed: the roles and responsibilities of the Council of Governors is set out in the NHS Foundation Trust's Constitution which is available on the Trust's website.
A.5.5	The chairperson is responsible for leadership of both the Board and the Council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other executives and non- executives, as appropriate.	This is in place.
A.5.6	The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.	See page 117.
A.5.7	The Council should ensure its interaction and relationship with the Board of Directors is appropriate and effective.	Confirmed: the Board of Directors and Council of Governors keep this relationship under review.
A.5.8	The Council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the Board.	Confirmed: the process for removing the Chairman and non- executive directors is set out in the Trust's NHS Foundation Trust Constitution.
A.5.9	The Council should receive and consider other appropriate information required to enable it to discharge its duties.	Confirmed: the Trust is fully compliant with this provision.
B.1.2	At least half the Board, excluding the chairperson, should comprise non- executive directors determined by the Board to be independent.	Confirmed: see B1.1 above.
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	Confirmed: the Trust is fully compliant with this provision.
B.2.1	The Nominations Committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	Confirmed: this provision is incorporated into the terms of reference of the committees.
B.2.2	Directors on the Board of Directors and governors on the Council of Governors should meet the Fit and Proper Persons Test described in the provider licence.	Confirmed: Directors on the Board of Directors confirmed they met the Fit and Proper Persons Test. Declarations required of governors on appointment meet the requirements of the Fit and Proper Persons Test.
B.2.3	The Nominations Committee(s) should regularly review the structure, size and composition of the Board and make recommendations for changes where appropriate.	Confirmed: the Trust is fully compliant with this provision.
B.2.4	The chairperson or an independent Non-Executive Director should chair the Nominations Committee(s).	Confirmed: details of the Nominations Committee set out on page 86.
B.2.5	The governors should agree with the Nominations Committee a clear process for the nomination of a new chairperson and Non-Executive Directors.	Confirmed: the Trust is fully compliant with this provision.
B.2.6	Where an NHS foundation trust has two Nominations Committees, the Nominations Committee responsible for the appointment of Non-Executive Directors should consist of a majority of governors.	Confirmed: the Council of Governors' Remuneration, Nominations and Appointment Committee comprises a majority of governors.

Ref. Nos	Narrative in the code	OUH compliance
B.2.7	When considering the appointment of non-executive directors, the Council should take into account the views of the Board and the Nominations Committee on the qualifications, skills and experience required for each position.	Confirmed: the Council of Governors' Remuneration, Nominations and Appointment Committee's Terms of Reference includes this requirement.
B.2.8	The Annual Report should describe the process followed by the Council in relation to appointments of the chairperson and non-executive directors.	See page 86.
B.2.9	An independent external advisor should not be a member of or have a vote on the Nominations Committee(s).	Confirmed: this provision is set out in the Remuneration, Nominations and Appointment Committee's Terms of Reference.
B.3.3	The Board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.	Confirmed: the Trust is compliant with this provision.
B.5.1	The Board and the Council of Governors should be provided with high quality information appropriate to their respective functions and relevant to the decisions they have to make.	Confirmed: the Board of Directors and Council of Governors receive high quality information appropriate to their respective functions.
B.5.2	The Board, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant advisor for each and every subject area that comes before the Board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	Confirmed: the Board of Directors' minutes provide evidence of executive and non-executive directors' challenge. In addition, the Board of Directors' assurance committees provide the opportunity to test systems and processes in more detail and to confirm a level of assurance.
B.5.3	The Board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	Confirmed: the Chief Executive is aware of this provision and will make available independent professional advice as and when appropriate.
B.5.4	Committees should be provided with sufficient resources to undertake their duties.	Confirmed: this is considered as part of the committees' annual reviews of their effectiveness.
B.6.3	The Senior Independent Director should lead the performance evaluation of the chairperson.	Confirmed: the Senior Independent Director leads the performance evaluation of the Trust's Chairman.
B.6.4	The chairperson, with assistance of the Board Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as Board members.	Confirmed: the Board of Directors regularly discusses whether there are any development needs and these are addressed by the Board of Directors' programme of seminars, away days and external training events.
B.6.5	Led by the chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	See page 66.
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the Council, for the removal from the Council of any governor who consistently and unjustifiably fails to attend the meetings of the Council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Confirmed: the Trust's NHS Foundation Trust Constitution sets out the criteria and process for removing a governor.

Ref. Nos	Narrative in the code	OUH compliance
B.8.1	The Remuneration Committee should not agree to an executive member of the Board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the Board first having completed and approved a full risk assessment.	The Trust complies with this requirement when appropriate.
C.1.2	The directors should report that the NHS foundation trust is a Going Concern with supporting assumptions or qualifications as necessary.	Confirmed: see note 1.1.2 to the accounts on page 223.
C.1.3	At least annually and in a timely manner, the Board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Confirmed: the Trust's Annual Report and Annual Quality Accounts Reports are presented to the Annual Members' Meeting and are available from the Trust's website.
C.1.4	The Board of Directors must notify Monitor and the Council of Governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. The Board of Directors must notify Monitor and the Council of Governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: the NHS foundation trust's financial condition; the performance of its business; and/or the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	Confirmed: the Board of Directors is aware of this requirement.
C.3.1	The Board should establish an Audit Committee composed of at least three members who are all independent non-executive directors.	Confirmed: the Trust's Audit Committee comprises three independent non-executive directors.
C.3.3	The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.	Confirmed: the Council appointed the external auditors, following authorisation as an FT, in October 2015.
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	Confirmed: the Council of Governors is aware of this requirement.
C.3.7	When the Council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	Confirmed: the Trust's Chairman is aware of this requirement and will inform Monitor if and when appropriate.
C.3.8	The Audit Committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Confirmed: the Audit Committee receives regular reports from the Trust's Counter Fraud Service.

Ref. Nos	Narrative in the code	OUH compliance
D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Confirmed: the Board of Directors' Remuneration and Appointments Committee is responsible for determining the eligibility for executive directors to receive performance related bonuses after a detailed review of each executive director's performance.
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	Confirmed: the Council of Governors' Remuneration, Nominations and Apointment Committee determined the remuneration of the Chairman and other non- executive directors after taking into account the time commitment and responsibilities of their roles.
D.1.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Confirmed: this will be undertaken if and when required.
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Confirmed: the Terms of Reference of the Board of Directors Remuneration and Appointments Committee include this provision.
D.2.3	The Council should consult external professional advisors to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	Confirmed: the Council of Governors' Remuneration, Nominations and Appointment Committee does take account of external benchmarking data as part of their work in determining the level of remuneration for the Chairman and other non-executive directors.
E.1.2	The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Confirmed: the Trust has a Membership and Engagement Strategy.
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the Board as a whole.	The Chairman regularly updates the Board at each meeting on issues from the Council of Governors.
E.2.1	The Board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	Confirmed: the Trust fully meets this requirement.
E.2.2	The Board should ensure that effective mechanisms are in place to co- operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	Confirmed: the Trust fully meets this requirement.

Regulatory ratings

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes.

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement Capability (well led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place.

Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

Oxford University Hospitals NHS Foundation Trust has been segmented into category 3. This segmentation information is the Trust's position as at 6 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website www.improvement.nhs.uk

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Care Quality Commission (CQC)

At 31 March 2018, the Trust had an overall rating of 'Good' from the CQC. Details of the Trust's performance against the quality indicators used by NHS Improvement's oversight of the Trust can be found in the Quality Report section.

Dr Bruno Holthof
Chief Executive

MONITOR RISK RATINGS 1 APRIL 2017 TO 31 MARCH 2018

Area	Metric	2017-18 scores				2016-17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	4	4	4	4	3	2
	Liquidity	3	3	4	4	3	2
Financial efficiency	I & E margin	3	4	4	4	2	2
Financial controls	Distance from financial plan	4	4	4	4	4	4
	Agency spend	1	1	1	1	1	1
Overall scoring		3	3	3	3	3	3

Statement of the Chief Executive's responsibilities as the Accounting Officer of Oxford University Hospitals NHS Foundation Trust

The *NHS Act 2006* states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in t*he NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.*

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Oxford University Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Oxford University Hospitals NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *Department of Health Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a Going Concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Dr Bruno Holthof
Chief Executive
23 May 2018

Annual Governance Statement 2017-18

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Oxford University Hospitals NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a Risk Management Strategy which sets out the Trust's protocol for the management of risk and individual responsibilities and accountabilities in this regard. Operationally, responsibility for the implementation of risk management has been delegated to Executive Directors as follows:

- the Director of Assurance has delegated authority for the risk management framework, and is the executive lead for maintaining the Board Assurance Framework and its supporting processes;
- the Chief Finance Officer has responsibility for financial governance and associated financial risk;
- the Medical Director has responsibility for quality, clinical governance and clinical risk, including incident management and joint responsibility with the Chief Nurse for patient safety ;
- the Chief Nurse has responsibility for patient experience, and joint responsibility with the Medical Director for patient safety;
- Executive Directors have responsibility for the management of strategic and operational risks within their individual portfolios. These responsibilities include the maintenance of a risk register and the promotion of risk management training to staff within their directorates.

A range of risk management training is available to staff based on the nature of their role and position within the organisation. This includes risk awareness training which is provided to all new staff as part of their corporate induction programme. The Risk Management Strategy describes the roles and responsibilities of all staff in relation to the identification, management and control of risk, and encourages the use of risk management processes as a mechanism to highlight areas they believe require improvement.

The risk and control framework

Approach to risk

The Trust's risk and control framework consists of:

- Risk Management Strategy;
- The Board Assurance Framework;
- Risk registers and assessment processes;
- The Trust's governance structure;

The Risk Management Strategy sets out an integrated approach to the management of risk across the organisation. The aim is to encourage considered risk taking, within authorised limits, and in line with the Trust Board's risk appetite, but to reduce those risks that impact on patient and staff safety, and have an adverse effect on the Trust's reputation as well as its financial and operational performance.

The Risk Management Strategy describes how risks are linked to one or more of the Trust's strategic themes or operational objectives. It provides the framework for the proactive risk identification and management of risks, through risk registers, risk assessment and the Board Assurance Framework. The strategy describes the process which the Board takes to develop and review the Board's risk appetite statement, this is subject to review annually and was discussed in detail at the Board seminar in January 2018. In addition it describes the reactive mechanisms in place to encourage learning from incidents.

The Risk Management Strategy describes how to consider a full range of risks including the assessment and consideration of risks to patients. The Trust's Risk Management toolkit provides information on the range of sources used to inform risk assessment and identification including patient feedback and surveys and patient experience groups.

The Board Assurance Framework provides the mechanism for the Trust Board to monitor risks, controls, and the outputs of its assurance processes. During the course of the year the content and use of the Board Assurance Framework has been reviewed with a view to improving the assurance derived from it. This development has been reported to the Audit, Finance & Performance, and Quality Committees and the Trust Board.

The Board Assurance Framework and Corporate Risk Register was presented to the Board in March 2018 and to Board Sub- Committees regularly during the year. The Board Assurance Framework and the Corporate Risk Register is independently reviewed annually by Internal Audit and was rated as 'significant assurance'.

The Trust's risk assessment process covers all of its activities – clinical services, clinical support services and business support functions. Each Division and Directorate is responsible for maintaining its own risk register in accordance with the Risk Management Strategy. These risk registers are reviewed regularly by directorate and divisional forums, and they are required to escalate risks, where their ratings warrant this, for inclusion on the Corporate Risk Register. During the course of the year the Trust Board has reviewed the Corporate Risk Register this included high (principal) scoring risks relating to:

- financial planning and financial performance;

- delivery of national performance targets (A&E performance for the four hour waiting time; trust wide performance of the referral to treatment time targets)
- Compliance with Care Quality Commission (CQC) standards.

At this time these are the principal risks that are considered to be relevant for both 2017-18 and future years. The Trust conducts a year-end review of the Corporate Risk Register annually to ensure that the transition between accounting years is considered. The review of effectiveness section describes the key actions taken in relation to these risks this includes the submission of timely and accurate information to assess risks to compliance with the trust's licence.

Risk management is embedded within the organisation in a variety of ways. All members of staff have a duty to report on incidents, hazards, complaints and near misses in accordance with the relevant policies. The utilisation of DATIX, the Trust electronic incident reporting system, has continued to improve throughout the year demonstrated by an increase in the number of incidents reported. Information on incident management, serious incidents and never events are reported to the Quality Committee in a dedicated report at each of its meetings. It is also the subject of an annual report to the Quality Committee and the Trust Board.

All significant operational change projects are assessed for their impact on quality. Where possible negative impact is identified, mitigating actions are identified or in cases of significant impact, the scheme is not progressed. In addition all policies are equality impact assessed to ensure that they do not negatively impact one or more groups of staff, patients or the public.

The Board has overall responsibility for the performance of the Trust and is accountable to its NHS foundation trust members and governors, through its Chairman. The Board's role is largely supervisory and strategic, and it has the following functions to:

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

The Board operates with the support of six committees: Audit, Finance & Performance, Quality, Remunerations & Appointments, Investment (newly established in 2017-18) and Trust Management Executive. These committees have been established on the basis of the following principles:

- the need for committees to strengthen the Trust's overall governance arrangements and support the Board in the achievement of the Trust's strategic aims and objectives;
- the requirement for a committee structure that strengthens the Board's role in strategic decision making and supports the non-executive directors in scrutiny and challenge of executive management action;
- the need to maximise the value of the input from non-executive directors, given their limited time, and providing clarity around their role;

- the need to ensure that the Board is supported in fulfilling its role, given the nature and magnitude of the Trust's wider agenda, to support background development work and to perform scrutiny in more detail than may be possible at Board meetings.

The chairs of each of the Board sub-committees present written reports to the Trust Board after each meeting, highlighting significant issues of interest to the Trust Board, including key risks identified and other issues considered, and decisions made at their meetings. In addition each committee, including the Board, undertakes an annual review of the effectiveness of the committee, taking into account an assessment against the Corporate Governance Code. The Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the UK principles of the UK Corporate Governance Code issues in 2012. The Board considers that for 2017-18, the Trust has complied with the Code. These reviews is are used to produce an annual report, providing a summary of the activities of the committee in terms of the risks and assurances considered, from each of the Board Sub-committees to the Trust Board. These annual reports have been used to provide additional assurance in formulating this statement.

During the year there have been a number of changes in Trust Board membership. Two new Executive Directors and one new Non-Executive Director joined the Trust Board. Full details of all changes to individual posts are provided as part of the Annual Report.

In addition to the Board sub-committees, the Trust has an active Council of Governors. The Council is composed of governors elected by public and staff members as well as appointed representatives from local organisations with which the Trust works. The Trust is accountable through the foundation trust membership and Council of Governors to its local communities. Governors hold Non-Executive Directors to account for the performance of the Trust Board, and appoint the Non-executive Directors of the Trust. Details of how the Council of Governors is formed and how it works are available from the Trust website.

Work of the Board sub-committees

The Audit Committee exists to oversee the establishment and maintenance of an effective system of internal control throughout the organisation. It ensures there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provide independent assurance to the Board.

The Committee reviews the work and findings of External Audit and provides a conduit through which their findings can be considered by the Trust Board. It also reviews the Trust's annual statutory accounts before they are presented to the Trust Board, ensuring that the significance of figures, notes and important changes are understood. The Committee maintains oversight of the Trust's Internal Audit and Counter Fraud arrangements.

The Audit Committee has received regular reports in relation to the work conducted by the Local Counter Fraud Specialist (LCFS) of the trust. These reports include review of the following trust policies: Counter Fraud and Corruption Policy, Overseas Policy, Declarations of Interest Policy and Whistleblowing Policy.

In addition proactive work has been undertaken by the LCFS in relation to the Code of Conduct, Conflicts of Interest / Declarations of Interest and Gifts and Hospitality, Fraud and bribery regulations; Overpayment of

salaries; overseas referrals and a number of confidential referrals from Human Resources. The LCFS annual report concluded that the Trust's Self-Review Tool reported an overall green rating on counter fraud provision.

The Audit Committee receives a range of assurance from the Executive Directors during the course of the year. These have included detailed reviews of capital projects, business case process, reference costs, data security standards including General Data Protection Regulation (2018), the revision of the Trust's financial plan and forecast outturn position, and assurances on various aspects of health and safety risks. In addition the Audit Committee was regularly updated on progress with the development of the Board Assurance Framework and Corporate Risk Register, and the review of the compliance with accreditation and regulation.

For the year to 31 March 2018 the Audit Committee received eight Internal Audit opinions rated as 'Significant Assurance with minor improvements'. These included the following.

- Board Assurance Framework and Risk Management
- Key Financial Systems
- Information Governance Toolkit
- Patient Pathways: End of Life Care
- Immigration Compliance
- Midwifery Led Care
- Information Technology General Controls (ITG): Web and Mail Systems
- ITG: General Ledger.

There were no high risk recommendations raised as a result of the above reviews.

The following reports were assessed by Internal Audit as 'Partial assurance with improvements required'. These related to the following.

- Oracle Fusion Implementation Review (trust electronic financial ledger system)
- Oracle Fusion Implementation Re-Review
- Mental Capacity Act Compliance and Deprivation of Liberty Safeguards
- Medicines Managements
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR,
- Consultant Job Planning
- Divisional IT Governance: Silo Systems

From these seven reports a number of high risk recommendations were made and are summarised as follows.

- Oracle Fusion Implementation; five high risk recommendations were raised relating to the governance of the project to update the Trust's accounting system including resourcing, project planning, system security and data migration. A further review of the implementation was conducted in February 2018. This found that the Trust has taken appropriate action to delay the implementation of the project until all significant issues have been resolved in order for a 'go-live' decision to be made.

- RIDDOR; one high risk recommendation was made regarding the need to improve the standardisation of practices throughout the Trust. An action plan was developed in response and updates regarding implementation of the plan are reported to the Audit Committee.
- Mental Capacity Act and Deprivation of Liberty Safeguards; one high risk recommendation was made regarding the clarification of the processes required to undertake mental capacity assessments. The Trust has taken immediate action to address this issue.

As part of their annual audit plan, the Trust's internal auditors provide an Annual Head of Internal Audit Opinion (HIAO), based on the work conducted throughout the year. The conclusions in relation to this work are made available to the Trust and presented to the Audit Committee. This year the HIAO provided the Trust with significant assurance.

In addition to these reports the Audit Committee has been tracking progress in relation to the negotiation of commercial issues under the Trust's PFI contracts and the implementation of the Carbon Energy Project.

The Finance and Performance Committee's main responsibilities are to review the Trust's financial and operational performance against annual plans and budgets, and to provide an overview of the development of the Trust's medium and long term financial models. Other responsibilities include reviewing in-year delivery of annual efficiency savings programmes, and monitoring the effectiveness of the Trust's financial and operational performance reporting systems. Key risks identified by the Finance and Performance Committee and reported to the Board included:

- the delivery of RTT activity in relation to the medium-term plan and the recruitment of appropriately trained staff to support its delivery;
- maintaining capacity and flow within the Urgent Care Pathway;
- the Trust's financial plans 2017-18;
- the financial re-forecasting plans for 2017-18.

Significant areas of interest reported from the Committee to the Trust Board included the following key assurance activities.

- The review of operational performance and improvement plans related to the Trust's performance which were used as a source of further assurance for NHS Improvement and actively monitored by the Committee during the course of the year. This included reviewing the delivery and monitoring of the Urgent Care Improvement Plan.
- The oversight of divisional productivity, capacity planning and financial performance with the Committee gaining assurance through the development of divisional performance reporting metrics.
- The re-prioritisation of capital investment and capital contingency plans to manage in-year capital spend with the development of improved reporting on the capital programme.

The Quality Committee is responsible for providing the Trust Board with assurance on all aspects of the quality of clinical care; on clinical governance systems, and on standards of quality and safety. The Committee oversees the Trust's on-going compliance with Care Quality Commission Fundamental Standards of Quality and Safety. It works closely with the Audit Committee.

Key risks discussed by the Quality Committee and reported to the Trust Board for information included:

- Compliance with venous thromboembolism (VTE) risk assessments and quality indicators;
- The effect of nurse staffing shortages and the impact upon patient care;
- High risk cleaning scores;
- Issues arising from discussions in relation to the experiences noted from the presentation of patient stories.

Specific assurance arising from the quality reports reported to the Quality Committee included the following:

- tracking progress in the achievement of national and local CQUINs including compliance with dementia and cognitive screening;
- continued oversight on issues raised by the Oxfordshire Clinical Commissioning Group;
- Gaining further information and improved reporting on safety incident data;
- Seeing an improvement in SHMI Mortality information noting that indicators had decreased from 0.96 to 0.94; influenced by the decrease in observed deaths for secondary malignancies and cancer of the bronchus.

The Quality Committee received assurance in relation to the following:

- infection control issues through the regular reports from the Infection Control team and a specific report on cleaning assurance standards;
- safe staffing issues, with specific papers in relation to staffing in maternity and recruitment and retention measures put in place;
- the need to maintain focus on the safety aspects of performance against NHS national targets, considering reports in relation to the use of the Mental Health Act and 52 week clinical harm reviews.

The Investment Committee is responsible for advising the Trust Board in relation to investments. The Committee ensures that there are appropriate monitoring arrangements in place for investments and that capital cases are subject to Trust Board approval, where necessary. It reviews proposals to set up special purpose vehicles where such an action requires Trust Board approval.

The Remuneration and Appointments Committee is responsible for determining the policy on executive remuneration, approving contracts of employment for executives and agreeing arrangements for termination of contracts. The Committee ensures that appropriate performance management arrangements are in place for Executive Directors.

On behalf of the Trust Board the Trust Management Executive is responsible for the delivery of the Trust's Annual Business Plan, and for ensuring compliance with regulatory and legislative requirements. The Trust Management Executive (TME) is supported to fulfil this function by its sub-groups. These sub groups are constituted with clear terms of reference and are required to report to the TME on a regular basis.

Key areas discussed by TME and reported to the Trust Board for information included:

- The review of achievement of operational performance standards, including constitutional standards relating to A&E performance, cancer care and 18 week Referral to Treatment standard;
- Performance of financial controls including non-pay expenditure through the development of pay and non-pay control panels and the review of performance against short, medium and long term financial plans at a divisional level with the development of a 'leading indicators' reporting matrix;

- Consideration of the risks associated with changes in nursing workforce availability and the actions required to assist with improvement in recruitment and retention of staff.

In addition TME has considered the importance of promoting a culture of safety following the enforcement notice issued in relation to fire safety and feedback from the Care Quality Commission.

Discharging statutory functions

The Trust has arrangements in place to ensure that it discharges its statutory functions and complies with legislative requirements. These include, but are not limited to the following.

- Use of Internal Audit to consider the systems and processes which support the delivery of the Trust's functions.
- Monitoring compliance with Care Quality Commission requirements and reporting this to the Board and its sub-committees.
- Monitoring compliance with quality, operational and financial performance standards, including the NHS constitutional standards.
- Consideration of the implication of any proposed service changes with legal advice as required.
- Access to external legal and audit advice to all Board members, should they require this in line with undertaking their role.
- Oversight of the internal control systems within the Trust by the Audit Committee, with a particular focus on the management of risk.
- Assurance provided to the Board by the work of the Quality Committee and the Finance & Performance Committee.
- Use of external independent reviewers to provide external assurance of the Trust's systems where possible issues have been identified.

All of the above arrangements have been used to support the Annual Governance Statement.

Compliance with key mandated statements

The Trust is required to report on four mandated statements in relation to the following.

- Care Quality Commission compliance
- NHS Pension Scheme control measures
- Equality and Diversity
- Carbon Reduction Delivery Plans

In relation to Care Quality Commission compliance: As a provider of care the Trust is registered and regulated by the Care Quality Commission (CQC). The Trust is fully compliant with the registration requirements of the CQC and is currently registered with the CQC without restrictions and has an overall 'Good' rating, based on the CQC's rating process.

During the second half of the year the Trust was reviewed by the CQC as follows:

- As part of the Oxfordshire system (Planned review - date November 2017)
- A well-led inspection (Planned inspection - date November 2017)

- A maternity services inspection (Responsive Inspection- date November 2017)
- An Oxford Centre for Enablement inspection (Two Responsive Inspections: one initial inspection, date August 2017, and one follow-up visit, date November 2017).

The reports relating to the most recent CQC inspections, all conducted in November 2017 were published by CQC on 27 March 2018. The Trust is working to complete actions in relation to the recommendations raised in these reports.

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

In relation to equality and diversity, control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

In relation to carbon reduction: The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has well developed systems and processes for managing its resources. The annual budget setting process for 2017-18 was approved by the Board before the start of the financial year and was communicated to all managers in the organisation. The Chief Finance Officer and his team have worked closely with divisional and corporate managers throughout the year to ensure that a robust annual budget was prepared. However, the Trust did not deliver the planned budget that was set for the year - this is described later in this statement.

Monthly financial and operational performance reports are presented to the Finance and Performance Committee, the Trust Management Executive and to the Trust Board. The Trust makes use of both internal and external audit functions to ensure that controls are operating effectively and to advise on areas for improvement. In addition to financially related audits, the internal audit programme covers governance and risk issues. Individual recommendations and overall conclusions are risk assessed, such that action plan priorities are agreed with Trust management for implementation. As mentioned previously, all action plans are monitored and implementation is reviewed and reported to the Audit Committee as appropriate. The Audit Committee has maintained a focus on Internal Audit recommendations and has ensured they are followed up in a timely and effective manner by management. During the course of the year the Foundation Trust Governors, with the assistance of the Audit Committee, undertook the competitive re-tendering of the external audit services.

As part of their annual audit, the Trust's external auditors, Ernst and Young LLP are required to satisfy themselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness

in its use of resources. They do this by examining documentary evidence and through discussions with senior managers. The conclusions in relation to this work are made available to the Trust and presented to the Audit Committee.

Information governance

The Trust is committed to managing information in line with the relevant information legislation and regulations.

All new staff are provided with Information Governance (IG) training at corporate induction. This includes an outline of the relevant legal position, NHS guidance and the Trust's policies relating to the safe and appropriate processing, handling and storage of information.
Additionally, in accordance with the requirements of the IG Toolkit, all existing staff are required to undergo IG training on an annual basis. This is carried out mainly via e-learning modules on the Trust's e-learning management system.

Incidents related to breaches in the Trust's information security processes are reported via the Trust's incident reporting system. Incidents are reviewed by the Information Governance and Data Quality Group, which is chaired by the Trust's Caldicott Guardian/Senior Information Risk Officer. The table below provides information in relation to serious incidents reported to the Information Commissioner and the status of the incident. During the year the Trust declared four serious incidents to the Information Commissioner (ICO) and no further action was taken by the ICO.

Incident Date	Detail	Status
July 2017	Two paper diaries containing patient information taken and covert recordings made by ex-staff member.	Completed - Reported as a Section 55 Data Protection Act 1998 offence to ICO – no further action taken by the ICO.
September 2017	Spread sheet containing information about medical trainees and details about their training supervisor emailed to medical trainees in error.	Completed - no further action taken by the ICO.
November 2017	Two clinical letters containing sensitive medical information were stapled together and sent in error	Completed - no further action taken by the ICO.
March 2018	An unencrypted memory stick containing patient data was lost at a London conference	Under ongoing investigation

As part of national reporting requirements the Trust is required to undertake an annual assessment using the national Information Governance Toolkit process. The Trust's IG Toolkit self-assessment was submitted in March 2018. The assessment results scored 100% in line with the toolkit requirements, the first time the Trust has achieved this score. The Trust's IG Toolkit self-assessment is subject to annual review by internal audit, this review was reported to the Audit Committee in February 2018. The results of the audit provided an

opinion of 'Significant assurance'. The audit results supported the Trust's position that it would achieve an overall 'Level 1' rating (highest rating) by March 2018.
Where an on-going information risk is identified, this is recorded on the relevant Risk Register, along with a note of actions to be taken to minimise the chances of occurrence and impact.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Quality Account is subject to a full External Audit review, using the arrangements set out in the guidance, prior to its publication. This review provides assurance that the Quality Account has been produced based on valid data and is accurate. External assurance of aspects of the Quality Account is provided by the Trust's external auditors.

The Medical Director leads on the Quality Account and, for 2017-18, the Quality Strategy and the Trust's quality priorities were used as the basis for the production of the Quality Account. The strategy established the link between the Trust's strategic objectives, priorities in the Quality Account, and measurable goals against which progress can be monitored. For monitoring purposes, regular updates of the Trust's progress against its Quality Account priorities were provided both to the Quality Committee and the Board. The Quality Account sets out the Trust's processes in relation to the assessment and validation of the accuracy of data in relation to the reporting against national targets, including the waiting time data. This includes information about the Trust's data quality infrastructure and data quality audit processes. In addition the director's statement included within the Quality Account more fully describes the full process undertaken to review the accuracy of the data and the sources of assurance used for the compilation of the account.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. In addition my review has been informed by the reports from the CQC in relation to the Trust and the Oxfordshire system. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee, the Quality Committee and Finance & Performance Committee and plans to address weaknesses and ensure continuous improvement of the system are in place.

The effectiveness of the system of internal control has been reviewed by the Trust Board via its sub-committees and individual management responsibilities at Executive and Divisional Director level.

Regular reports have been received from Board sub-committees or individual senior managers in relation to all of the key risks. Annual reports have been received by the Trust Board relating to all important areas of activity, and ad hoc reports in-year wherever these were required and as mentioned previously in this statement the annual review of effectiveness of the Board Sub-committees has resulted in annual reports from the sub-committees to the Board. The reports demonstrated assurance that the Sub-committees has all operated effectively in relation to their terms of reference.

Based on national guidance, the Trust Management Executive and the Audit Committee have reviewed a number of issues in advising the Board and myself as to the content of this statement. It is my view as Accountable Officer, as supported by the Trust Board and Audit Committee, that the issues reviewed did not constitute significant gaps in control.

The following issues were noted as sufficient to highlight within the statement as actions had to be taken within the year, however it was concluded that both issues, once reviewed, did not constitute a significant gap in control in relation to the delivery of the Trust's strategic objectives:

- In May 2017, the Trust received an enforcement notice in relation to governance over its elective waiting times. This followed the conclusion of an NHSI investigation into the Trust's operational progress and plans to improve performance against the three core national waiting time standards. The investigation concluded that the Trust was not meeting national performance targets in relation to treatment (RTT) waiting times and did not have a sufficiently robust plan to address the issue. The Trust agreed to a number of specific undertakings. These included:
    - Action to develop a short term remedial plan which was in place from June 2017.
    - The development of a more detailed longer term sustainable plan which was developed and presented to the Trust Board in November 2017, including the production of detailed demand and capacity modelling.
    - Undertaking system wide work with the NHSI Intensive Support Team and completing the RTT Sustainability Assessment Tool, involving Chief Executives from Oxfordshire Clinical Commissioning Group and Oxford Health NHSFT. Working with system partners to strengthen the system governance of RTT pathways across Oxfordshire.
    - Improving the level of detail of the monthly reporting of performance in relation to RTT performance to the Trust Board and the Finance & Performance Committee

- Consideration has been given to the significance of NHSI's investigation into the Trust's financial performance. The investigation was prompted by the Trust's 2016/17 financial results, which did not achieve the financial control total, and has not concluded. The Trust has reflected on the themes discussed during the investigation which include governance over financial decision-making in 2016/17 and 2017/18. The Trust considers that financial governance needs to be strengthened. It has agreed, and begun to implement, actions in respect of divisional financial governance and cash management. It also implemented additional financial controls in April and May 2017. It is developing a plan to recover financial performance and achieve a sustainable financial position. The Trust will continue to review the process governing the preparation of control total budgets and financial forecasts during 2018/19.

Conclusion

The Trust has faced a number of challenges in terms of organisational and financial performance over the course of the past year and has worked to maintain the quality of service provided to its patients and to continue to focus on developing the safety culture of the organisation.

Positive independent opinions have been received from both KPMG (the Trust's Internal Auditors) and Ernst & Young (the Trust's External Auditors).

As part of their Head of Internal Audit Opinion, the Internal Auditors stated that *"'Significant with minor improvements' assurance can be given on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control"*.

In respect of the Value for Money opinion, the External Auditors stated that they *"did not identify any significant deficiencies in internal control that we considered required reporting to those charged with governance"*.

However, the Trust Board recognises the need to continue to make further improvements to the system of internal control during 2018/19.

The Trust has concluded that no significant control issues have been identified.

Chief Executive
Date: 23 May 2018

QUALITY REPORT

(CONTAINING THE QUALITY ACCOUNT 2017-18)

Annual Quality Report containing the Quality Account 2017-18

Contents

Grey highlighted text indicates mandated statements from the guidance documents for writing the Quality Account.

Version	Date	Author	Outcome
1	17/01/2018	Dr Clare Dollery/ Siobhan Teasdale	Reviewed by Clinical Governance Committee (CGC).
3	21/03/2018	Dr Clare Dollery/ Siobhan Teasdale	Reviewed by Clinical Governance Committee (CGC).
5	10/04/2018	Dr Clare Dollery/ Siobhan Teasdale	Updated contents.
5	11/04/2018	Dr Clare Dollery/ Siobhan Teasdale	Reviewed by Quality Committee.
5	12/04/2018	Dr Clare Dollery/ Siobhan Teasdale	Reviewed by Trust Management Executive (TME). Minor changes from Dame Fiona Caldicott made.
9	18/04/2018	Dr Clare Dollery/ Siobhan Teasdale	Reviewed by Clinical Governance Committee (CGC).
9a	30/04/2018	Dr Clare Dollery/ Siobhan Teasdale	Reviewed by Council of Governors.
13	02/05/2018	Dr Clare Dollery/ Siobhan Teasdale	Reviewed by Audit Committee.

Part 1: Statement on quality from the Chief Executive 2017-18

In our Quality Account section we set out how Oxford University Hospitals NHS Foundation Trust (OUH) improves quality and safety. In order to achieve our objective of delivering compassionate excellence to our patients, we work with our health and social care partners to ensure that, when we fall short of meeting the standards which patients should expect, we learn from our mistakes to improve services in the future.

Our staff remain committed to delivering the highest quality care for our patients from Oxfordshire and beyond. Some of their exceptional achievements are included in this report, including the care of hip fracture patients at the Horton, care delivered to patients who are acutely unwell but can spend the night in their own bed rather than in hospital (with the support of the ambulatory units), and the community Cardiology service in partnership with GPs which offers reviews closer to home.

Along with many other NHS trusts, we did not achieve the constitutional standards for access (e.g. 4 hour A&E target and 18 week referral to treatment time targets) this year. Reviews were conducted by the Trust to be sure that the delay (beyond the time allowed for in the standard) did not affect patient outcome. Towards the end of the year this additionally attracted the attention of the regulator, NHS Improvement.

Performance against some national standards is included in this report, but is discussed in detail in prior sections of the Annual Report of which this Quality Account is a part. However, we maintained our progress against the cancer wait standards and a new “one stop shop” service to speed up cancer diagnosis is being piloted at the Churchill Hospital as part of NHS England’s Accelerate, Co-ordinate, Evaluate (ACE) programme.

Oxford University Hospitals is leading the way in the use of technology in the NHS and has been named a ‘global digital exemplar’ which recognises that we are at the forefront of the use of digital technology to deliver exceptional treatment and care. We will use the resources linked to this status (£10 million) to champion the use of digital technology to drive radical improvements in the care of patients. One major project was for electronic core clinical documentation to enable nursing staff to record their care plans in real time into the electronic patient record (EPR). We were proud to be re-validated in October 2017 as a venous thrombo-embolism (VTE) exemplar centre. The Director of the VTE Exemplar Centres Network wrote: “We were particularly impressed with the electronic solutions used to improve risk assessment and prescription of thromboprophylaxis and the pharmacy-led audit”.

Patent safety innovations in the past 12 months included the development of the Trust patient safety alert intranet page which has received over 16,900 hits in 11 months, with a steady increase in the number of views, and our Serious Incident (SIRI) Forum attendance which has doubled in every staff group, with the greatest increase among doctors. The Care Quality Commission well-led inspection also said that the SIRI Forum was seen as “an effective multidisciplinary meeting. The group operated in line with the Trust’s value of respect and was a forum where learning took place”.

However, during 2017-18 we reported that eight clinical incidents classified as Never Events took place. Immediate actions were introduced while these incidents were fully investigated. The Healthcare Safety Investigation Branch (HSIB) was invited into the Trust to review a set of similar incidents to see if some novel system changes could be suggested.

Positive clinical events have started to be reported in some parts of the Trust with good effect. This process has been encouraged via the Clinical Governance Committee to be rolled out across other clinical areas.

Our collaboration with the University of Oxford underpins the quality of the care that is provided to patients, from the delivery of high quality research, bringing innovation from the laboratory bench to the bedside, to the delivery of high quality education and training of doctors, nurses and other health professionals.

In March 2017 the National Quality Board published guidance based on the recommendations from the Care Quality Commission (CQC) report "Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England". In accordance with the new national guidance the revised OUH Standardised Mortality Review Policy was published on 30 September 2017 and structured mortality review was introduced from 1 October 2017. Learning from deaths was reported to the Trust Board as required and specifications to improve patient care addressed. OUH is committed to continuously learning from all patient deaths to improve systems into the future.

As a provider of care the Trust is registered and regulated by the Care Quality Commission (CQC). The Trust is fully compliant with the registration requirements of the CQC and is currently registered with the CQC without restrictions and has an overall 'Good' rating, based on the CQC's rating process. During the second half of the year the Trust was reviewed by the CQC as follows: as part of the Oxfordshire system (Planned review); a well-led inspection (Planned inspection); a maternity services inspection (Responsive inspection); and an Oxford Centre for Enablement inspection (two Responsive inspections: one initial and one follow-up visit). The reports relating to the most recent CQC inspections were received by the Trust on 23 March 2018. The Trust is working to complete actions in relation to the recommendations raised in these reports.

We have continued to work hard to protect our patients from hospital-acquired infection. However, the number of patients acquiring *C difficile* during their hospital stay exceeded the level set for Oxford University Hospitals NHS Foundation Trust by three cases and the zero level of MRSA infections deemed 'avoidable' was not met, with one case apportioned to the Trust during 2017-18.

We believe that looking after our staff helps them to provide the high quality care that we all want to see being delivered. Activities have continued this year to support staff health and wellbeing, including the successful increase in the percentage of frontline staff who received the flu vaccination this year. The Health and Wellbeing Commissioning for Quality and Innovation (CQUIN) goal has influenced this by encouraging all food outlets to have healthier foods available around the counters and improving access to physiotherapy for members of staff.

This Quality Account, as well as looking back on how we performed against our standards and priorities in 2017-18, also looks ahead to priorities for 2018-19. This year, like last year, we gave patients, public, stakeholders and our staff a much greater voice in choosing our Quality Priorities. At our Quality Conversation public event in January 2018 we asked the 100 attendees to pick priorities to be maintained and suggest new priorities both from developing areas in the Trust and from their own ideas. These are very strongly represented in the choices of priorities for 2018-19.

I am responsible for the preparation of this report and its contents. To the best of my knowledge, the information contained in this Quality Account is accurate and a fair representation of the quality of healthcare services provided by Oxford University Hospitals NHS Foundation Trust.

Dr Bruno Holthof
Chief Executive

Introduction

Quality Accounts are annual reports to the public from NHS providers about the quality of the services provided. They aim to enhance accountability to the public for the quality of NHS services. The Quality Account for Oxford University Hospitals NHS Foundation Trust (OUH) sets out where the Trust is doing well, where improvements in quality can be made and the priorities for the coming year.

Part 2: Priorities for future quality and statements of assurance from the Board

Our Quality Priorities for 2018-19

The essence of the Trust and the NHS is a commitment to the delivery of compassionate and excellent patient care. OUH's mission is to provide excellent and sustainable services to the people of Oxfordshire and to patients who come to the Trust in order to access specialist regional, national and international care which may be unique to our Trust. Our quality of care has its foundation in the commitment of our staff to their patients and the focus on future excellence which is the essence of our clinical strategy and our research and training programmes. Contained within this account are commitments to Quality Priorities within the domains of patient safety, clinical effectiveness and patient experience.

How we chose our priorities

Throughout 2017-18 we have reported to our Board, our staff and our commissioners on progress against our Quality Priorities. A well-received Quality Conversation public engagement event was held at the Trust on 16 January 2018. This event included short films outlining the 2017-18 Quality Priorities and why they might continue, as well as round table discussions in which participants could highlight their most important areas of work from the current priorities, other quality improvement work going on in the Trust and suggestions for new areas of focus. Feedback from the event showed that 98% of attendees felt they were able to contribute to decisions about the future Quality Priorities and 96% found the table discussions useful or extremely useful. The outputs from this event were reviewed by the Trust's Quality Committee.

Staff have also been involved in setting Quality Priorities via our business planning process and discussions in Clinical Governance Committees across the Trust.

Our Quality Priorities for 2018-19
Do no harm (patient safety)

a. Preventing patients deteriorating

Why we chose this Quality Priority	How we will evaluate success
Identifying deterioration early can allow prompt treatment to reduce the duration and severity of subsequent illness. This priority was the one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event in January 2018.	**Cardiac Arrest Reduction** Our goal is a 25% reduction in general ward areas and a 15% overall reduction (which would include areas within the Heart Centre). **Antibiotics delivered within one hour of a sepsis flag** We will improve upon our 2017-18 achievement of 65% patients receiving antibiotics within one hour of alerting for sepsis, and set the target of >90%. We will develop and deliver a sepsis training package to >50% of regular clinical staff working in the emergency departments by 31 March 2019.

b. Safe surgery and procedures

Why we chose this Quality Priority	How we will evaluate success
National Safety Standards for Invasive Procedures (NatSSIPs) have been produced to address many of the underlying causes of Never Events (events that should be wholly avoidable due to the consistent application of specific safety checks e.g. WHO surgical safety checklist). The aim is to produce Local Safety Standards for Invasive Procedures (LocSSIPs) and thereby reduce the incidence of avoidable adverse events. The OUH had eight Never Events in 2017-18 and that is why focus on these standards has been chosen to be a Quality Priority.	Establish a new Safety Standards for Invasive Procedures group. Develop the remaining key overarching policies from which the specific LocSSIPs will develop. Develop/review LocSSIPs relevant to the eight Never Events that occurred in 2017-18. Scope other surgical and invasive procedural areas across the Divisions where LocSSIPs should be developed.

c. Right patient every time

Why we chose this Quality Priority	How we will evaluate success
This Quality Priority is key to ensuring safe diagnostic tests, procedures and treatments are identified with the correct patient every time. We chose this priority following a number of incidents, particularly in Radiology where the wrong patient received a test or procedure in the previous year. We are committed to learning from these events.	**Positive patient identification (PPID)** Delivery of a campaign to promote PPID across the Trust. Questions on PPID will be rotated through the new Matron's Assurance App during 2018-19. The app is being launched for Matron's assurance audits. Achieve a 50% reduction in PPID incidents in Radiology compared to 2017-18

War on waste (Clinical effectiveness)

a. Go Digital

Why we chose this Quality Priority	How we will evaluate success
Oxford University Hospitals NHS Foundation Trust is one of the UK Global Digital Exemplar Trusts and Go Digital is one of our strategic priorities. This was also one of the 2016-17 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.	**Global Digital Exemplar programme - patient portal** The patient portal will be live in Q4 2018-19 (January-March) for use by OUH staff. During Q4 (January-March) 2018-19 a phased release across different departments will allow patients to view appointments, results and contribute information to their health records via the portal.

b. Lean Processes

Why we chose this Quality Priority	How we will evaluate success
We chose this because we want to increase efficiency within the directorates in order to eliminate waste (including respecting patients' time) and improve patient experience. This will include consideration of streamlining administration processes that meet the needs of patients.	The Transformation Team will train a core team of Divisional staff in lean processes. Each directorate will then complete a lean pathway exercise for at least one patient pathway.

Respect for patients and partners (Patient experience)

a. Partnership working – we will work with system partners to implement a Systematic Stranded Patient Review process

Why we chose this Quality Priority	How we will evaluate success
This was the one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.	A Systematic Stranded Patient Review process will be embedded to ensure critical clinical decision-making prevents harm from deconditioning and patients leave hospital for their next destination in a timely way. Use outcomes of Systematic Stranded Patient Review process to advise joint funding priorities and to advise 2018-9 winter plan. Actively participate in the End Pyjama Paralysis campaign and report progress in the 2018-19 Quality report.
	Home Assessment Reablement Team (HART) We will maintain our 2017-18 achievement of 50% direct face-to-face contact time with patients. In addition we will aim for the stretch target of up to 55% by 30 September 2018

	which we will thereafter aim to maintain.

b. End of life care

Why we chose this Quality Priority	How we will evaluate success
This was the one of the 2017-18 priorities that stakeholders voted to continue into 2018-19 at our Quality Conversation public event.	An electronic care plan will be in place to document end of life care to ensure clear communication and continuity of end of life care across the Trust.

Monitoring and reporting

- Regular reports on all Quality Priorities go to the Trust level Clinical Governance Committee (CGC) and from there to the Quality Committee and the Trust Board.

Statements of assurance from the Board of Directors

A review of our services

During 2017-18 Oxford University Hospitals NHS Foundation Trust provided and sub-contracted 141 relevant health services.

Oxford University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 141 of these relevant health services.

The income generated by the relevant health services reviewed in 2017-18 represents 100% of the total income generated from the provision of relevant health services by Oxford University Hospitals NHS Foundation Trust for 2017-18.

Participation in clinical audits and National Confidential Enquiries

Participation in national clinical audits

During 2017-18, 75 national clinical audits and five national confidential enquiries covered relevant health services provided by Oxford University Hospitals NHS Foundation Trust.

During that period Oxford University Hospitals NHS Foundation Trust participated in 93% of all the eligible national clinical audits as detailed in the table below and 100% of national confidential enquiries in which we were eligible to participate.

The reports of 58 national clinical audits were reviewed during 2017-18 and a summary of the actions the Trust intends to take to improve the quality of the healthcare we provide is described.

The reports of 430 local clinical audits were reviewed during 2017-18 and a summary of the actions taken by Oxford University Hospitals NHS Foundation Trust to improve the quality of healthcare are provided.

Participation in national clinical audits during 2017-18

Audit title	OUH Participation	% of cases submitted
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
Adult Cardiac Surgery	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	Ongoing
Congenital Heart Disease (CHD) - Adult	Yes	Ongoing
National Heart Failure Audit	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	98%
*National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Secondary Care	No	
Coronary Angioplasty National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%
Oesophago-gastric Cancer (NAOGC)	Yes	78%
National Prostate Cancer Audit	Yes	97%
Bowel Cancer (NBOCAP)	Yes	98%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
National Lung Cancer Audit (NLCA) - Lung Cancer Clinical Outcomes Publication	Yes	100%
**Head and Neck Cancer Audit	No	
National Audit of Dementia	Yes	100%
Elective Surgery (National PROMs Programme) - Hips and Knees	Yes	100%
Elective Surgery (National PROMs Programme) - Groin Hernia	Yes	61.3%
Elective Surgery (National PROMs Programme) - Varicose veins	Yes	65%
Sentinel Stroke National Audit programme (SSNAP)	Yes	100%
National Paediatric Diabetes Audit(NPDA)	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audits - Female Stress Urinary Incontinence Audit	Yes	100%
Maternal, Newborn and Infant Clinical Outcome review Programme	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	90%
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	100%
Paediatric Intensive Care (PICANet)	Yes	100%

Audit title	OUH Participation	% of cases submitted
Pain in Children (care in emergency departments)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK national haemovigilance scheme	Yes	100%
***National Comparative Audit of Blood Transfusion programme - Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	No	
2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Yes	100%
****Inflammatory Bowel Disease (IBD) programme/IBD Registry	No	
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
National Core Diabetes Audit	Yes	Ongoing
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly Care and Neurology)	Yes	100%
Endocrine and Thyroid National Audit	Yes	93.75%
Fractured Neck of Femur (care in emergency departments)	Yes	Ongoing
Case Mix Programme (CMP) - Intensive Care Audit	Yes	100%
Major Trauma Audit	Yes	100%
National Joint Registry (NJR) - Knee replacement	Yes	Ongoing
National Joint Registry (NJR) - Hip replacement	Yes	86%
National Emergency Laparotomy Audit (NELA)	Yes	71.07%
National Audit of Intermediate Care (NAIC)	Yes	100%
National Ophthalmology Audit - Adult Cataract surgery	Yes	92%
National Bariatric Surgery Registry (NBSR)	Yes	98%
*****National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	
National Vascular Registry	Yes	65%
Neurosurgical National Audit Programme	Yes	100%
Fracture Liaison Service Database	Yes	100%
National Inpatient Falls	Yes	15%
National Hip Fracture Database	Yes	100%
Procedural Sedation in Adults (care in emergency departments)	Yes	Ongoing

Audit title	OUH Participation	% of cases submitted
BAUS Urology Audits - Radical Prostatectomy Audit	Yes	40%
BAUS Urology Audits - Cystectomy	Yes	68%
BAUS Urology Audits - Nephrectomy Audit	Yes	66%
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)	Yes	Ongoing

***** Resources are currently being identified to allow healthcare professionals to ensure collection of patient data in real time, development of Electronic Patient Record (EPR) systems to allow required automatic data field completion and 'push through' to national Royal College of Physicians website.

******In April 2018, the ENT Head and Neck Team are participating in a national audit to collect follow-up data on head and neck cancer patients. The British Association of Head and Neck Oncology (BAHNO) Cancer Surveillance Audit 2018 assesses compliance with the national MDT guidance *Follow-up after treatment for head and neck cancer*, and therefore offers the team an opportunity to review current performance.
******* Due to low staffing levels of Transfusion Practitioners, OUH has been unable to participate in this re-audit. However OUH collects these data through the Trust's ORBIT reporting system and feeds back regularly to clinicians.

******** National ethical approval for the IBD database does not require patient consent, which conflicts with Oxford's generic ethical consent for the 2500 patient IBD database. OUH maintains a local registry.

********* OUH continues to submit high quality data to the Trauma Audit and Research Network including specific measures in relation to the provision of rehabilitation to major trauma patients.

Selected actions taken following review of the national clinical audits

Audit title	Summary
The Myocardial Ischaemia National Audit Project 2015 (MINAP) & QS68 Acute Coronary Syndromes (including myocardial infarction)	The primary angioplasty team are second best nationally with median door to balloon time at 26 minutes, meaning patients have the blood supply restored to their hearts very quickly by keyhole balloon treatment, which limits heart attack size and aids recovery and prognosis.
National Paediatric Diabetes Audit Report, including Verbal Update on the Publication of the 2015-16 National Paediatric Audit (NPDA) PREM reports	Compared to the national average, patient HbA1c levels for the Trust are better than the national average, and this should translate into long-term improvements in complications, reduced morbidity and mortality.
Sentinel Stroke (SSNAP) - Clinical Report (Aug-Nov 2016) - period 15 – JR	The John Radcliffe Hospital Stroke Service was rated B and as 'good and improving' by the Sentinel Stroke National Audit Programme
NHS Blood & Transplant - Annual Report on Pancreas & Islet Transplantation for 2015/16	Oxford Transplant Centre was noted to be one of the biggest centres in the country performing 60-90 transplants every year. The waiting time for a pancreas transplant in Oxford is in line with the national median and this has been decreasing due to changes in the national organ allocation policy. However, cancellation of transplants due to lack of intensive care unit beds remains a problem and has been identified as a risk by the Trust which is looking at increasing ITU / HDU capacity.
National Cardiac Arrest Audit (NCAA) 2016-17 - Quarter 4	The percentages of patients with return of spontaneous circulation for more than 20 minutes, and who survive to hospital discharge, are higher than nationally, with fewer cardiac arrests per 1000 admissions than the available national comparator

Audit title	Summary
	which coincides with the introduction of the Cardiac Arrest Reduction Strategy.
RCEM 2016-17 Asthma	The audit highlighted poor performance with recording initial observations, prescription of oxygen and vital medication. Monthly reports now indicate that the initial recording of observations has improved with the use of System for Electronic Notification and Documentation (SEND). A local champion has been appointed to promote the management of asthma.
National Neonatal Audit Programme – Neonatal Intensive and Special Care (NNAP)	The Newborn Care Unit at the JR was noted to be the best performing network in England for two year follow-up with significantly higher normal outcomes, the lowest incidence of bronchopulmonary dysplasia, and for use of magnesium sulphate. JR Newborn Care Unit was also the top performer for doctors giving information to parents and top quartile for magnesium sulphate administration and breast milk at discharge.
National Lung Cancer Outcomes Publication	The audit confirmed continuous increasing numbers of lung resections performed for lung cancer. Despite this increase in activity, survival rates at both 30 and 90 days have demonstrated consistent improvements over the last four years.
Falls and Fragility Fracture Audit Programme: NHFD Annual Report 2017	The Horton General Hospital (HGH) remains one of the best performing hospitals in the country for hip fracture care. In 2016 HGH was the first out of 177 sites for achieving best practice tariffs and for time to theatre.
Care 24/7 Trust-wide audit	The overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was noted reduced from 100% in September 2016 to 97% in March 2017 and the patients requiring a daily consultant review and reviewed by a consultant had reduced from 100% in September 2016 to 91% in March, but the results for both the standards significantly exceeded the national mean.
National Emergency Laparotomy Audit	Case ascertainment increased significantly from 40% to 72.3% as a result of action taken during the reporting cycle to improve case tracking. There has been a significant increase in the proportion of CTs reported pre-operatively from 49% to 71.1% as a result of changes to, and clarification of, the forms of words used and timings in the CT report. The proportion of patients reaching theatre in a timely fashion has increased to 76.8% from 62% last year and is under monthly review, and has been significantly helped by the introduction of an electronic booking system.
National Joint Registry 2016-17 data (for NOC)	It was noted that the standard revision rates for hip and knee replacement and standardised mortality ratio lie within the accepted range.
Neuro ICU ICNARC CMP Annual Report	This report defines the high levels of critical care activity provided by the Neurosciences ICU when measured against all other national participating units. It also demonstrates improvement in the rate of unplanned readmission of patients within 48 hours of discharge. The Neurosciences ICU continues to demonstrate a strong and consistent performance against all remaining quality indicators. In particular, the risk-adjusted mortality remains below the national benchmark.

Actions taken following review of the local clinical audits

Paper name	Summary
Maternal and child nutrition (QS98)	The maternity unit reported 100% compliance with the three standards applicable to OUH. The maternity unit is working towards UNICEF Baby Friendly Level 2 accreditation.
QS87 Osteoarthritis (OA)	The audit has highlighted areas of excellence in the physiotherapy department's assessment of patients with OA. However, there were some areas where further improvements could be made to the recording of treatments and clinical discussions to better reflect compliance by highlighting them within teaching, increasing the supply of appropriate educational literature and encouraging physiotherapists to ask patients to sign their goal sheets once goals have been established.
QS119 Anaphylaxis	The audit shows that the ED is performing well against referral of patients with anaphylaxis to an allergy clinic and education in the use of an automatic injector.
QS105 Intrapartum Care Audit	Compliance was noted with the majority of the standards; however improved compliance was required with the documentation of women having skin-to-skin contact with their babies after the birth. A 'back to basics' presentation had been made available on the intranet to highlight the significance of skin-to-skin contact and options are explored for mandatory reporting of skin-to-skin contact within EPR.
Venous Thromboembolism (VTE) Prophylaxis Audit	The audit demonstrated maintained improvement in patients receiving appropriate Thromboprophylaxis (TP), with overall 98% of patients receiving appropriate TP and demonstrated overall improvement in levels of prescribing mechanical TP when appropriate. The Trust had revalidated its VTE exemplar centre status in October 2017 particularly being commended for the electronic solutions used to improve risk assessment and prescription of TP and the pharmacy-led audit.
Reducing duplication of point of care and laboratory U&Es in EMU	The audit was completed to avoid unnecessary and duplicate tests. Pre intervention there was 20% duplication of the test results. New posters were created and emails sent to the staff along with face-to-face reminders. Post intervention there was a noted decrease with only 5% duplication of the test results. There is now a formalised process agreed via local induction for the junior doctors and nurses by senior clinicians, posters displayed on wards and awareness raised periodically as a part of staff education especially at times of staff changeover.
Adult Pre-operative Fasting Audit - Elective Surgery	The audit highlighted that the pre-operative advice for patients should be changed to specifically advise patients to eat and drink in, but not after, the hour before the two hour cut-off for fluid and six hour cut-off for food. There should be continuing education for patients and staff (including anaesthetists, surgeons and nursing staff) regarding the importance of not only adequate starving of patients for safety, but also the issues related to starving patients for too long.
Improving Access to the Young Adult Hip Service Clinic	Analysis of the results suggested that clinical fellows/registrars most frequently booked follow-up appointments without instituting a treatment plan. As a consequence of this audit, a guide for the management of common young adult hip disorders was produced for fellows/registrars, including suggested management strategies specifically for the Nuffield Orthopedic Centre (NOC) Young Adult Hip Service.
Anaesthetic Review in Cardiothoracic Preassessment Clinic (CT PAC): Optimising Data Capture and Communication	This was a Quality Improvement (QI) project to explore the possibility of converting the paper consultant anaesthetic review data into an electronic format in the Pre-Assessment Clinic (PAC). More than 80% of thoracic patients seen in CT PAC by a consultant anaesthetist now have their review recorded electronically and securely communicated to the anaesthetic consultant responsible for their

Paper name	Summary
	perioperative care. As part of the project it is now in the Electronic Patient Record. Feedback confirmed that our digital system has improved time management and list planning for thoracic surgery.
QS114 Irritable Bowel Syndrome in Adults	Routine blood tests and dietary specialist advice were offered to the vast majority of patients. More expensive and invasive endoscopic procedures are frequently requested. Faecal calprotectin, which is relatively cheap, is a non-invasive tool for distinguishing between irritable bowel syndrome and bowel inflammation. This was only requested in a minority of cases, however, it could probably reduce the number of colonoscopies performed. The team is currently promoting faecal calprotectin testing in primary and secondary care through education and promotion of diagnostic algorithms.

The national clinical audits and confidential enquiries that Oxford University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2017-18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Confidential Enquiries into Patient Outcome and Death (NCEPOD) 2017-18

NCEPOD studies in 2017-18	Clinical questionnaire returned	Case notes returned
Cancer in Children, Teens and Young Adults Study (ongoing)	80%	80%
Chronic Neurodisability (CN) focusing on cerebral palsy study	69%	54%
Young People's Mental Health Study	56%	56%
Heart Failure Study	38%	31%
Peri-operative Management of Surgical Patients with Diabetes Study (ongoing)	52%	46%

In order to improve participation in future NCEPOD studies the Trust will be taking the following actions.

- Liaising with Divisional Directors and Divisional Medical Directors in sending out monthly email reminders to the responsible clinician reminding them of the deadline with each of the studies.
- The Clinical Audit Governance Manager will monitor monthly progress against NCEPOD studies together with the Clinical Governance Facilitator by producing a Trust NCEPOD Excel spreadsheet.
- Quarterly NCEPOD study reports from the Clinical Audit Manager to the Trust Clinical Effectiveness Committee for review and action.

Our participation in clinical research

OUH is one of the United Kingdom's leading university hospital trusts, committed to achieving excellence and innovation through clinical research. OUH and its research partners aim to find new ways to diagnose and treat our patients locally, and to contribute to healthcare advances nationally and internationally. This is underpinned by bringing together academic research expertise with our clinical teams to translate medical science into better healthcare treatments.

OUH hosts the Oxford Academic Health Science Network (AHSN) and is a founder member of the Oxford Academic Health Sciences Centre (AHSC). In particular, OUH works in close partnership with the University of Oxford in clinical research, encompassing major programmes in all areas of medical sciences, including cardiovascular, stroke, dementia, cancer, infection, vaccines, surgery and imaging, as well as inter-disciplinary collaborations in digital health. In genetics, OUH was designated a Genomics Medicine Centre in 2015, and the partnership between OUH and the University of Oxford has made major contributions to the 100,000 Genomes Project, with Genomics England.

The OUH-University of Oxford (OU) Biomedical Research Centre (BRC) had previously been awarded funding of £113.7 million for the period 2017-22, following a competitive bidding process. The OUH-OU BRC is working with the new Oxford Health NHS Foundation Trust (OH)-OU BRC in mental health (which has been awarded funding of £12.8 million) and with the Oxford AHSC, to develop innovations in areas such as working with 'big data', personalised medicine and tackling the problems of multiple long-term conditions and dementia. Through a cross-cutting Theme in Partnerships for Health, Wealth & Innovation, the OUH-OU BRC is also supporting enhanced capabilities for working with industry, provision of clinical research facility (CRF) and good manufacturing practice (GMP) manufacturing capabilities, and for patient and public involvement.

In the last year, there have been more than 1,880 active clinical research studies hosted by OUH. During 2017-18 the Trust initiated 244 new studies and hosted 365 studies with commercial partners. There are 163 staff who are directly supported by the National Institute for Health Research Biomedical Research Centre (NIHR BRC) funding and 222 staff supported by the National Institute for Health Research Clinical Research Network (NIHR CRN). During 2017-18, OUH's performance against the NIHR's 70 day benchmark for the initiation of clinical trials was one of the best of any of the large research-active hospitals in England. In League 1, consisting of the 27 most research-active NHS trusts, OUH is the only trust to have continued to achieve more than 90% compliance with the 70 day target for the last two years.

The number of patients receiving relevant health services provided or sub-contracted by Oxford University Hospitals NHS Foundation Trust in 2017-18 that were recruited during that period to participate in research approved by a research ethics committee was 13,443 participants recruited to 416 studies which are CRN portfolio registered.

Our education and training

Over the last year the Trust has supported approximately 1000 pre-registration non-medical students across the organisation and there are 908 trainee doctors working at OUH.

Our achievements in 2017-18 included the following.

As part of a refresh of the induction process, nurses and midwives new to the Trust are given a bespoke programme to support their transition into the organisation and to enable them to work to their registration at the earliest opportunity.

Approximately 220 new non-medical professional registrants, including nurses, midwives and allied health professionals (AHPs) are currently undertaking the Trust's 12 month Foundation programme with a similar number having completed the programme. A Year 2 Foundation Year programme was launched in January this year to support the retention of Band 5 nurses and approximately 73 nurses have registered to undertake the programme.

Work continues to develop the Trust's in-house education faculty with an increased range of post-graduate certificate programmes now being offered in addition to our successful Leading Compassionate Excellence in Nursing and Midwifery programme.

In the 2017 General Medical Council (GMC) trainee survey, half of trainees at OUH reported concerns over the workload they experienced, however 78.89% (just below the national average of 79.30%) trainees expressed 'overall satisfaction' with their training programmes and over 90% expressed satisfaction with the level of clinical supervision they received. Concerns about post-graduate medical training in Neurosurgery, Medical Oncology and Clinical Radiology have also been reported via Health Education England, Thames Valley and there are action plans in place to remediate these problems which are being monitored via the Workforce Committee.

The Trust continues to focus on the development of clinical skills for its non-medical workforce with a projection that at the end of March 2018 in excess of 1,500 staff will have been trained in such clinical skills as venepuncture and cannulation, injectable medicines and tracheostomy care. Since April 2017 173 people have completed the Care Certificate programme.

Following the annual senior leader visit (March 2017) the Health Education England (HEE) team noted that "there was evidence of innovation in educational practice, and strong leadership from the educational team in the Trust."

Our Peer Review programme

During 2017-18 we have completed our Directorate review of the Peer Review programme which has now seen trained teams of our staff, stakeholders and patients review all of the clinical facing directorates in the Trust. The programme aims to improve quality of care for patients by informing and empowering staff. We continue to see the benefits that a deeper understanding at clinical directorate level of the Care Quality Commission (CQC) fundamental standards, 'closing the loop' on learning and improvement, and staff empowered to take local action in timely way, brings. The emphasis is on a developmental approach and culture which has been very well-received by staff and recognised as good practice by NHS Improvement. We have spent some time reviewing the effectiveness of the programme and are developing further plans to ensure it progresses in 2018-19.

Our Human Factors training

- Oxford Simulation, Teaching and Research (OxSTaR) has continued to run one day Human Factors courses. Over 180 staff members attended 18 very highly rated sessions in 2017-18 with teams from all the clinical Divisions in OUH. Most importantly, these courses are

multidisciplinary and allow teams to come together in a safe training environment to explore and develop ways to work more effectively together for the benefit of our patients.

- The course combines classroom-based lectures and small group exercises with experiential learning in immersive hi-fidelity scenarios in the simulation suite and attract external continuing professional development (CPD) points. Attendance of the course is captured on the Trust electronic Learning Management System (eLMS).

Our Transformation Team

The Transformation Team has worked with partner organisations in Oxfordshire, Buckinghamshire and West Berkshire to deliver the Quality, Service Improvement and Redesign (QSIR) course. This course has been developed by NHS Improvement and focuses on training front-line staff equipping them with the 'know how' to design and implement more efficient patient-centred services. Other projects included: establishing a community-based nurse-led early pregnancy service for women, setting up a satellite radiotherapy unit to provide treatment closer to home, maximising the efficiency of the gynaecology service to improve patient experience and reduce delays and improving the flow of patients from the Emergency Department through to the most appropriate clinical area.

Our clinical teams: examples of outstanding practice

Our Trust is proud to announce that we were re-validated in October 2017 as a venous thrombo-embolism (VTE) exemplar centre. The Director of the VTE Exemplar Centres Network wrote that "We were particularly impressed with the electronic solutions used to improve risk assessment and prescription of thromboprophylaxis and the pharmacy led audit".

Five Trust teams were shortlisted for the Health Service Journal prestigious national awards which recognise and reward outstanding efficiency and improvement.

- A partnership between the Trust, Oxford University's Institute of Biomedical Engineering and Drayson Health has been shortlisted in two categories.
    - System for Electronic Notification and Documentation (SEND); this system has standardised the recognition of deteriorating patients so that staff are alerted earlier and patients can receive the treatment they need as quickly as possible.
    - GDm-Health: this smartphone app enables pregnant women with diabetes to manage their condition during their pregnancy by connecting to their glucose monitors and automatically collecting blood glucose readings so that clinical staff can review the readings and provide feedback. Previously women would have had to keep a written diary and attend regular hospital clinics. The app has been tried and tested by more than 1,000 pregnant women and has reduced hospital visits by a quarter.
- Our Procurement and Supply Chain team's work in partnership with clinical teams to improve efficiency through innovative financial management.
- The Future Leaders Programme; a year-long programme to develop the leadership and quality improvement skills of newly-appointed consultants.

- The Hospital Energy Project to remove old boilers from the Churchill and John Radcliffe hospitals and replace them with a new energy and heating infrastructure to cut the Trust's CO^2 output by 10,000 tonnes per year.

The winners will be announced at an awards ceremony in Manchester in June 2018.

The Horton hip fracture team were finalists in the 'patient safety' category for a British Medical Journal (BMJ) award for their pioneering work in transforming hip fracture treatment and reducing the rehabilitation time from theatre to patient discharge.

The Oxford Reproductive Tissue Cryopreservation Service at Oxford Children's hospital is the country's only comprehensive fertility service. The programme is a collaboration between OUH and the University of Oxford; the team behind this service were announced as highly commended and runners-up in the Cancer Care Team category at the BMJ Awards ceremony on 10 May 2018.

Guardian of Safe Working Hours consolidated Annual Report

Doctors in Training: safe working hours

Nationally, 'Doctors in Training' represent 40% of the medical workforce. New terms and conditions of service (TCS) were introduced for this group in 2016. The 2016 TCS include governance processes that require partnership working between Doctors in Training and their employing trusts to ensure safe hours working practices and to enable enhanced executive supervision of this group.

Number of Doctors in Training	2017			2018
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
Total (including Trust Grade doctors)	850	850	850	850
On 2016 TCS	250	674	674	710

Oxford University Hospitals NHS Foundation Trust has taken the following actions to ensure compliance with the 2016 TCS, and so the quality of its services.

- All Doctors in Training (typically around 700) are provided with 'Work Schedules' that are compliant with both the 2016 TCS and European Working Time Directive.

- Through the process of 'Exception Reporting' all Doctors in Training are able to document in real-time, any instance when their actual working hours vary from those in their agreed work schedule.

- The Exception Reporting process has also been used to raise immediate safety concerns related to staffing levels and, in parallel with the Datix system of incident reporting, concerns can be investigated through established governance processes.

- A 'Guardian of Safe Working Hours' has been appointed, a senior and managerially neutral appointment to ensure that issues of compliance with safe working hours regulations are addressed.

- Through quarterly and annual reports, the Guardian provides assurance to the Board that doctors' working hours are safe. (The Board is responsible for providing annual reports to

external bodies, including Health Education England (Local office), Care Quality Commission, General Medical Council and General Dental Council).

- The Guardian has convened a 'Junior Doctor Forum', which includes junior doctor colleagues from across OUH, the Joint Local Negotiating Committee and the Director of Medical Education.

- The Director of Medical Education and the Guardian have provided monthly education sessions for GMC-recognised Educational Supervisors who have key responsibilities with work schedule design and exception reporting.

Exception reporting		2017			2018	Total
		Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	
Number of exception reports		142	209	121	53	525
Number of doctors reporting		23	47	41	26	99
Specialties receiving reports		10	14	18	11	25
Nature of exception	Education	9	2	9	16	36
	Hours & rest	136	207	116	44	503
Additional hours worked per exception report		1.6	1.4	1.7	1.8	1.5

Locum shifts		2017 Oct-Dec	2018 Jan-Mar	Total
Total		2978	2761	5739
Agency		1353	1179	2532
Bank		1625	1582	3207
Reason for locum shift	Vacancy	74.4%	74.8%	74.6%
	Non-vacancy	25.6%	25.2%	25.4%

Oxford University Hospitals NHS Foundation Trust has recognised that the following actions are required to ensure improved rostering oversight of Doctors in Training.

- Central collation of data describing the number and causes of rostering gaps. An electronic rostering tool ('HealthRoster') facilitates collection of this data and has been fully implemented across nursing groups. HealthRoster is being rolled out for Doctors in Training, with the agreement that reporting on Doctors in Training staffing levels will be reported using the principles already established for their colleagues in nursing.

Our CQUIN performance

A proportion of Oxford University Hospitals NHS Foundation Trust income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between Oxford University Hospitals NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the *Commissioning for Quality and Innovation* (CQUIN) payment framework. Further details of the agreed goals for 2017-18 and for the following 12 month period are available electronically at:

www.ouh.nhs.uk/about/publications/documents/cquins-2017-18.pdf

NHS foundation trusts must include a statement that includes a monetary total for income in 2017-18 conditional on achieving quality improvement and innovation goals, and a monetary total for the associated payment in 2016-17.

The monetary total for Oxford University Hospitals NHS Foundation Trust income in 2017-18 is conditional on achieving quality improvement and innovation goals will be known after 31 May 2018.
The monetary total for the associated payment in 2016/17 is as follows:
Plan £17,192K
Actual £17,390K

Statement regarding how OUH is implementing the priority clinical standards for seven day hospital services.

Since February 2016 OUH has been one of a number of early adopter trusts aiming to be fully compliant with four priority standards for seven day services by March 2017. These four standards have been identified as priorities on the basis of their potential to positively affect outcomes for patients.

- Standard 2 – Time to first consultant review (e.g. by a senior level doctor)
- Standard 5 – Access to diagnostic tests (e.g. X-rays and heart scans)

- Standard 6 – Access to consultant-directed interventions (e.g. interventional radiology and emergency surgeon)
- Standard 8 – Ongoing review by consultant twice daily if high-dependency patients, daily for others

We have audited patient records every six months to check compliance against these standards and are pleased that our results have consistently put us in the top quartile of trusts across the UK.

Statements from the Care Quality Commission (CQC)

Oxford University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions. The Care Quality Commission has not taken enforcement action against Oxford University Hospitals NHS Foundation Trust during 2017-18.

Oxford University Hospitals NHS Foundation Trust has participated in a special reviews by the Care Quality Commission relating to the following areas during 2017 18: the commissioning of services across the interface of health and social care and an assessment of the governance in place for the management of resources. The review looked specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. Oxford University Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC: OUH has worked with other partner organisations in the Oxfordshire care system and a joint action plan has been developed to address the conclusions reported by the CQC in its report published in February 2018.

The majority of actions are due for completion during 2018/19. OUH will ensure progress to address the need for better co-ordination in order to improve our patients' experience of their care. This is monitored by the Health and Wellbeing Board.

The CQC conducted a focused inspection in November 2017 looking at the Trust level leadership (well-led inspection). The results from this inspection were not rated on this occasion. The inspection found the following.

- The Trust had an experienced and credible leadership team. They were approachable, visible and supportive to their staff and to people who used or supported the work of the Trust.
- The Trust Board presented as a cohesive and supportive leadership team and we saw evidence of sufficient challenge.
- The Trust had a clear vision and set of values informed by quality and sustainability. Candour, openness, honesty, transparency in general were the norm and the Trust applied duty of candour appropriately.
- The leadership team actively promoted staff empowerment to drive improvement.

A number of improvements were identified in relation to the risk management process, the performance review process and aspects of equality and diversity. These are being addressed through a series of actions to be undertaken in 2018-19.

In addition to the above review the Care Quality Commission conducted a review of the health and social care system in Oxfordshire. The CQC report made a point of praising the dedication of front-line staff

across the system. The report found that significant progress has been made in tackling delayed transfers of care as well as highlighting areas for improvement which senior managers in the NHS, social care and other organisations need to act upon to make the whole health and care system work better. A joint action has been developed with partners across the system to address the issues raised.

- CQC ratings grid is provided below for the Trust overall and by site.

The CQC conducted an inspection at the John Radcliffe Hospital site in November 2017 in relation to maternity services. The CQC rated the service as 'Requires improvement'.

The CQC inspectors noted areas of good practice, including the completion of mandatory training by all staff, and the completion and updating of risk assessments for each patient, which informed individual plans of care. It was noted that staff were positive about the support they received from their managers. It was recognised that the maternity service had links with local academic organisations and collaborated to provide accredited courses which provided development opportunities for staff at many levels. The CQC also reported that there were appropriate governance committees and meetings were in place, which provided a structure to the processes for providing assurance to the Board. A number of recommendations were made in the CQC report that was published in March 2018, in relation to infection prevention, medicine management, wider learning from incidents and the consistent monitoring of risk and quality across the maternity service; these are being formally managed by the related action plan.

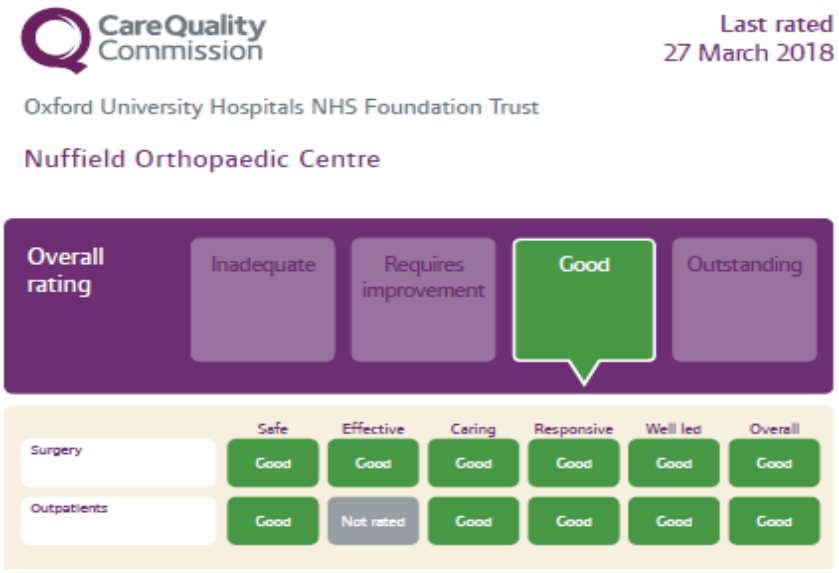
The rating for the John Radcliffe site is included below but remains as 'Requires improvement'.

The CQC has conducted two unannounced focused inspections at the Oxford Centre for Enablement (OCE) on the Nuffield Orthopaedic Centre site on 9 August 2017 and a follow-up visit on 8 November 2017. These inspections followed a Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) notification concerning a safety incident that occurred on 8 July 2017. The first inspection looked into the incident and the Trust response to the incident and made a number of recommendations, which the Trust was managing via an action plan. The follow-up visit concluded that good progress had been made in developing a more effective method of tracking and managing the patient's pathway via the use of daily quality board reviews. It also noted the following.

- *Staff followed the Trust Policy and assessed their patient's capacity using the Mental Capacity Act. There was documentary evidence to support this.*
- *Some work on the environment had been completed to help protect the patients from harm.*
- *There had been changes and development in the way unit managed and considered patients' safety.*
- *Staff were complimentary about the unit's local leadership and the general team.*
- *Staff were clear about their responsibilities to report incidents and how to do this. There was a process for feedback on incidents, actions and learning.*
- *Staff managed and administered medicines safely.*
- *The leadership team was involved in various research projects for improving patient outcomes.*

A number of recommendations were made in the CQC report that was published in March 2018, in relation to the continued completion of the action plan from the previous report, the need to review cleaning processes and the consistent monitoring of risk in the unit: these are being formally managed by the related action plan.

The rating for the Nuffield Orthopaedic Centre site is included below but remains as 'Good'.



Our data quality

Good quality information underpins the effective delivery of patient care and is essential to both improvements in the quality of care and for patient safety. The collection of data is vital to the decision-making process of any organisation. It forms the basis for meaningful planning and helps to alert us to any unexpected trends that could affect the quality of our services. We are committed to pursuing a high standard of accuracy, timeliness, reliability and validity, within all aspects of data collection in accordance with NHS data standards and expect that every staff member seeks to achieve these standards of data quality.

The Trust has an established data quality infrastructure which is overseen by the Information Governance and Data Quality Group for monitoring and improvement. This group is chaired jointly by the Trust's Strategic Data Quality Lead, the Chief Information and Digital Officer and the Caldicott Guardian. A data quality assurance framework requires the data underpinning all the Trust's key performance indicators to be rated according to the data quality and the level of assurance. An update on the Trust data quality activities and performance is included in the six monthly information governance updates to the Trust Board.

Oxford University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality.

- 'Deep dive' audits on specific Data Quality Performance Indicators to validate existing process and data capture.
- Establishing the embedded elements of the data quality diamond into its internal audits to ensure it is covering each aspect within each audit; the elements cover accuracy, validity, reliability, timeliness, relevance and completeness.
- Each of the clinical Divisions will continue to strengthen arrangements for securing good quality data making use of internal audit to identify areas for improvement: the quarterly compulsory audit programme for each Division is monitored by the Information Governance and Data Quality Group.
- In addition to this programme of audits, the Divisions also undertake a monthly programme of validation of key performance data underpinning the referral to treatment 18 week waiting time standard and the cancer waiting time standards. A programme of coding audits is undertaken by the Trust's Coding Department in collaboration with individual specialties.
- Upgrading the Electronic Patient Record system with a Right First Time approach which in turn will ensure more robust data quality at source.
- Continuing to enhance our data quality monitoring by adding additional reports via the Trust's business intelligence tool for both clinical and administrative tasks to promote the active management of performance on locally agreed requirements.

Oxford University Hospitals NHS Foundation Trust submitted records during 2017-18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

SUS dashboards at month 11 17-18

Inpatients	OUH	National average
Valid NHS number	98.5%	99.4%
General Medical Practice Code	100.0%	99.9%

Outpatients	OUH	National average
Valid NHS number	99.7%	99.6%
General Medical Practice Code	100.0%	99.8%

A&E	OUH	National average
Valid NHS number	96.9%	97.4%
General Medical Practice Code	100.0%	99.3%

Information Governance Toolkit

Oxford University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2017-18 is 100% and graded green (satisfactory).

Clinical coding error rate

Oxford University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017-18.

National core set of quality indicators

Mortality - Preventing People from Dying Prematurely

The Summary Hospital-level Mortality Indicator (SHMI) is the preferred hospital mortality indicator adopted by NHS England. The SHMI is the ratio between the reported number of patient deaths, during admission or within 30 days of their discharge, against the expected number of deaths based upon the characteristics of the patients treated. A SHMI value of less than 1.00 indicates that a Trust is performing better than the national average.

The latest SHMI, published on 22 March 2018, for the data period October 2016 to September 2017, is 0.92. This value is banded 'as expected' using NHS Digital 95% confidence intervals adjusted for over-dispersion.

The Trust considers these data are as described for the following reasons.

- The Trust has a process in place for collating data on hospital admissions, from which the SHMI is derived.
- Data are collected internally and then submitted on a monthly basis to NHS Digital via the Secondary Uses Service (SUS). The SHMI is then calculated by NHS Digital.
- Data are compared to the national benchmark, and our own previous performance, as set out in the table below.

- The Trust reviews the SHMI in conjunction with other published mortality measures and the information from our internal review of deaths.

Source: NHS Digital	Jan-16 to Dec-16	Apr-16 to Mar-17	Jul-16 to Jun-17	Oct-16 to Sept-17
SHMI Value	0.94	0.94	0.93	0.92
SHMI Banding	2 - as expected	2 - as expected	2 - as expected	2 - as expected
% deaths with palliative care coding	37.29	38.93	41.98	44.08

The Trust SHMI has improved from 0.94 to 0.92. There has been a decrease in the number of observed cases for frequent mortality diagnoses of pneumonia, acute cerebrovascular disease and congestive heart failure which has contributed to the improved SHMI.

The Trust Mortality Review Group meets monthly under the chairmanship of the Deputy Medical Director with responsibility for clear mortality reporting to the Board. The Mortality Review Group has multidisciplinary and multi-professional membership with clinical representation from all five clinical Divisions.

Our Trust target is for 100% of patient deaths to be reviewed to ensure that any omissions or actions taken are identified and learnt from to improve care. An analysis of the mortality reports for April 2017 to December 2017 indicate that 83% of deaths were reviewed within eight weeks.

Implementation of Learning from Deaths guidance

The Trust Mortality Review Policy was revised in accordance with the national guidance and published on 30 September 2017. Structured mortality reviews, derived from the Royal College of Physicians' Structured Judgement Review methodology, have been in place since quarter three 2017-18.

During 2017-18 2,433 of OUH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 539 in the first quarter; 552 in the second quarter; 647 in the third quarter; 695 in the fourth quarter.

By 31 March 2018, 964 (55%) case record reviews and four investigations have been carried out in relation to 1738 of the deaths included above. The reviews of deaths which occurred during the fourth quarter are underway and the summary will be included in the next Quality Account.

In four cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 341 (63%) in the first quarter; 280 (51%) in the second quarter; 343 (53%) in the third quarter.

None of the patient deaths (0%) reviewed during the reporting period is judged to be more likely than not to have been due to problems in the care provided to the patient.

Key learning points, actions and assessment of the impact of the actions following structured reviews

Clinical Support Services

- A Nitric Oxide machine failure was reported to the Medicines and Healthcare products Regulatory Agency (MHRA).

- The vulnerability of the Nitric Oxide machine was reported to the manufacturer.
- All critical care areas in the Trust were advised of the vulnerability of the Nitric Oxide machine and the need for care when introducing the machine into a cramped space. All critical care areas are to ensure that their staff are familiar with the auxiliary Nitric Oxide port.
- When deciding to use a side room on the Adult Intensive Care Unit the team is to consider if the patient safety risk due to the limited space outweighs the increased infection control risk of placing the patient within the open ward.
- The Division highlighted issues with handover between clinical teams and the Intensive Care Unit. This led to the formalising and standardising of theatre handovers and the development of a new electronic handover document.
- The Division highlighted the importance of using a Picture Archiving and Communication System (PACS) standard screen when viewing radiological images as using a regular computer screen may lead to subtle signs being missed.

Medical Rehabilitation and Cardiac

- The Acute General Medicine Unit identified the following areas for improvement in the cases reviewed.
    - The requirement for improved communication regarding the patient's discharge.
    - The need for improved documentation for patient transfers.
    - The requirement for more detail in Post Take Ward Round notes.
    - The Post Take Ward Round notes for younger patients with pneumonia should include the appropriate tool to assess the severity of pneumonia.

  The mental capacity assessment and environmental risk assessment form used in the Emergency Department (ED) was updated to include a question regarding 1:1 assessment or frequency of observations and clarity for call bells or other potential ligature points. The system for escalation of the need for additional staff, when demand and acuity change, was being reinforced within the ED team. Emergency Department Psychiatric Service (EDPS) staff are to be co-located in ED where there is a greater opportunity for them to carry out face-to-face review and assess high-risk patients earlier in their admission.

- There were observational audits in ED of the CARE process (CARE is an acronym for Consider, Assess, Resuscitate, and Escalate). The CARE process, developed by the Thames Valley Trauma Network, aims for the early identification of elderly trauma patients to expedite early senior assessment of these patients. ED implemented the use of laminated cards in patients' notes to provide a readily visible indication that the patient required senior review. The induction training of all new medical and nursing staff in ED includes highlighting the importance of clear written discharge plans for each patient on the Electronic Patient Record (EPR) and the importance of clear discharge care planning to include discharge analgesia, written and ideally verbal communication with care home staff and/or family in the case of an elderly patient with cognitive impairment. The importance of the discharge summaries has also been included in the 'Hold the Front Door' ED newsletter which is widely read by ED staff.

- The OUH MIL (Medicines Information Leaflet) on Warfarin reversal is to be updated to include isolated haemoglobin drop (< 20g/L) in the definition of a major bleed.

- A drug interaction between the choice of antibiotic and the anticonvulsant a patient is taking will be included in Micro Guide, the mobile app used by the Trust for the publication of antibiotic guidelines to clinicians.

- The Cardiac Surgery Unit identified actions to review the outcomes of acute dissection surgery and the guidelines for the management of malperfusion in relation to type A dissection.

Children's and Women's

- A Standard Operative Procedure for Gynaecology Theatre rules and standards is being developed to ensure that patients in the Recovery area are overseen by the immediate operating team until they are transferred to the wards.
- Practical Obstetric Multi-Professional Training (PROMPT), an evidence-based training package for obstetric emergencies, is being introduced for all OUH obstetric and midwifery staff.
- The Maternity Unit is completing a review of the patient information leaflet 'After your waters break' together with representatives of service users.
- The Maternity Unit has completed a review of the processes for communication of potential urgent deliveries and for midwifery requests for an obstetric review of a cardiotocogram (CTG).
- Maternity guidelines related to referral and care during labour were reviewed and updated to be consistent in relation to referral criteria to transfer or seek medical opinion.

Surgery and Oncology

- The OUH Renal Service now documents permanent Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions for long-term dialysis patients from any location within the Renal Service, including the satellite units, on the OUH Electronic Patient Record banner. This enables the unit to maintain continuity and consistency of care.

- The Division highlighted the need for raised awareness and skills in managing difficult discussions regarding end of life issues. This has been particularly pertinent to patients who are transferred across specialties for specific interventions. The Intensive Care and Palliative Care teams were invited to the Surgery Directorate governance meeting to join the mortality review discussions. The OUH Chaplain was involved in discussions regarding the challenges of breaking bad news and end of life discussions including the mechanisms for supporting staff. The Oncology Unit held reflective lunches for challenging cases in order for staff to discuss and learn from their experiences.

- Sobell House Hospice identified issues with the completion of forms for the identification of pacemakers and raised concerns that families were paying undertakers for the removal of pacemakers. This service is provided free of charge by the John Radcliffe Hospital Mortuary. The Bereavement Officer will review the process for pacemakers with the Palliative Medicine Clinical Lead.

- A case that had a structured mortality review and was also investigated as a Serious Incident Requiring Investigation (SIRI) prompted an action for the development of a Local Safety Standards for Invasive Procedures (LocSSIP) for the management of patients requiring a colonic stent.

- The reviews of deaths within 30 days of chemotherapy identified the requirement for DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) discussions to occur with outpatients. It was underlined to all doctors to consider increasing primary antiepileptic prior to initiating additional agents. The importance of the patient's relatives feeling heard by the clinical team when expressing concerns about changes in the patient's condition was highlighted in one case.

Neurosciences, Orthopaedics, Trauma and Specialist Surgery

- The Neurosciences Intensive Care Unit highlighted to their team the need to define the level of care and frequency of observations required for a patient following discharge from critical care to the ward.

- The Division identified a requirement to review and improve the pathway for complex non-elective haemorrhagic stroke patients admitted to OUH. In order to facilitate this, a cross divisional multidisciplinary team (MDT) is being set up to review and improve this pathway.

- The Division recognised the need for timely and appropriate referral of patients to the Palliative Care Team. Those cases where palliation could have been improved have been discussed with the respective teams.

- The prolonged stay of a patient in the John Radcliffe Hospital Emergency Department (ED) had been highlighted in a structured review. A secondary review concluded that the length of stay of the patient in ED was not optimal. The management and monitoring of the patient overnight in ED was appropriate.

Patient Reported Outcome Measures (PROMs)

PROMs are used to ascertain the outcome following planned inpatient surgery for any of four common procedures (groin hernia surgery, hip and knee replacement and varicose vein surgery). Patients are asked to complete a questionnaire before and after their surgery to self-assess improvements in health from the treatment, rather than using scoring systems or judgements made by the treating clinicians.

The Trust considers that the PROMs data are as described for the following reasons.

- The Trust has a process in place for collating data on patient reported outcomes.
- Data are then sent to the approved external company on a monthly basis which collates the PROMs responses and sends these to NHS Digital.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as set out in the tables.

The national mandatory varicose vein surgery and groin hernia surgery national PROMs collections ended on 1 October 2017. The final annual data publication for the half year 2017-18 data will take place in May 2018.

The tables in this section show the improvement in health (adjusted health gain) perceived by patients following these four procedures. Comparisons are shown with all health providers who carry out the same procedure in England. The latest final data publications available from NHS Digital are for the

previous financial year 2016-17. The final annual data publication for 2017-18 will be available later in 2018 and will be published in our 2018-19 Quality Account.

Repair of a groin hernia – average health gain	2014-15	2015-16	2016-17	Provisional 2017-18 (Apr-Sept 2017)
OUH	**0.09**	**0.12**	**0.09**	*
National average	0.08	0.09	0.09	0.09
Highest	0.15	0.16	0.13	0.14
Lowest	0.00	0.02	0.01	0.00

*Where necessary for the protection of patient confidentiality, figures between 1 and 5 have been suppressed by NHS Digital and derived figures have also been suppressed.

Primary hip replacement – average health gain	2013-14	2014-15	2015-16	Provisional 2016-17
OUH	**0.47**	**0.44**	**0.42**	**0.43**
National average	0.44	0.44	0.44	0.44
Highest	0.54	0.52	0.51	0.54
Lowest	0.31	0.33	0.32	0.31

Primary knee replacement – average health gain	2013-14	2014-15	2015-16	Provisional 2016-17
OUH	**0.34**	**0.29**	**0.26**	**0.31**
National average	0.32	0.31	0.32	0.32
Highest	0.42	0.42	0.40	0.40
Lowest	0.21	0.20	0.20	0.24

OUH knee replacement PROMs is in the expected range.

The future actions by the Knee Service are to review the 2017-18 data to analyse trends, focus on the internal audit of PROMs data and establish the internal collection of PROMs data as a routine part of practice.

Varicose Veins – average health gain	2014-15	2015-16	2016-17	Provisional 2017-18 (Apr-Sept 2017)
OUH	**0.09**	**0.06**	**0.08**	*
National average	0.09	0.10	0.09	0.10
Highest	0.15	0.15	0.15	0.13
Lowest	-0.01	0.02	0.01	0.00

*Where necessary for the protection of patient confidentiality, figures between 1 and 5 have been suppressed by NHS Digital and derived figures have also been suppressed.

Emergency readmissions within 28 days of discharge from hospital

The Trust routinely monitors emergency readmissions as one of the indicators of the efficacy of the provision of care and treatment. In some cases, readmissions may be inevitable and appropriate. The complete circumvention of emergency readmissions would likely be reflected by a prolonged length of stay and lead to an inappropriate degree of risk aversion. As part of the Trust's discharge support, patients are encouraged to seek support directly if they are experiencing symptoms of ill health following a treatment or procedure. The method of contact by patients would usually be by telephone but patients may also attend at hospital. Emergency departments are situated at the John Radcliffe and Horton

General hospitals but patients known to the Trust's services may also be admitted directly to the Churchill Hospital.

The last available readmissions data from NHS Digital is for 2011-12. Dr Foster Intelligence has provided more recent data.

The Trust considers these data are as described for the following reasons.

- The Trust has a process in place for collating data on hospital admissions, from which the readmissions indicator is derived.
- Data are collected internally and then submitted on a monthly basis to NHS Digital via the Secondary Uses Service (SUS). The data is then used to calculate readmission rates.
- NHS Digital develops the SUS data into Hospital Episode Statistics (HES).
- Dr Foster takes an extract from HES data to provide benchmarked clinical outcome data.
- Data are compared to peers, highest and lowest performers, and our own previous performance.

Readmissions	**2016-17**			**2017-18 (*April 2017- August 2017 only)**		
	Under 16	16 and over	Total	Under 16	16 and over	Total
Discharges	29975	164750	194725	11885	67040	78925
28 day readmissions	2398	14234	16632	905	6061	6966
28 day readmission rate	8.00%	8.60%	8.50%	7.6%	9.0%	8.3%

Dr Foster analyses all hospital data and categorises a readmission as 'any readmission within 28 days to any specialty.' The analysis does not differentiate between a readmission due to a complication or deficiency in the provision of care or an admission for a new medical issue.

A red alert is triggered when the readmission rate for a procedure or condition is over the national average. These data represent an early warning system and the alerts are investigated by the respective clinical units to identify any learning or improvement areas.

Patient experience

Patient views count and help drive learning and improvement. Patients' thoughts, opinions and observations about all aspects of our hospitals are very important to us. Our aim is that every patient's experience is an excellent one. Understanding what matters most for our patients and their families is a key factor in achieving this.

Compassionate Care

Our Trust Values underpin our drive for continuous improvement in delivering high quality services that exceed our patients' expectations.

The Trust Values

Learning Respect Delivery Excellence Compassion Improvement

The Trust's responsiveness to the personal needs of its patients during the reporting period.

Responsiveness to inpatients personal needs	2014-15	2015-16	2016-17
OUH	**71**	**71.7**	**71.0**
National average	68.9	69.6	68.1
Highest scoring trust	86.1	86.2	85.2
Lowest scoring trust	59.1	58.9	60.0

Source: Health and Social Care Information Centre website - indicators.hscic.gov.uk/webview - indicator 4.2.

Note: This data set is part of NHS Outcomes Framework Indicators – the data are published once a year and patient experience is measured by scoring the results of a selection of questions from the National Inpatient Survey focusing on the responsiveness to personal needs. This creates a compound metric where a perfect score would be 100 - comparison is made above with National results. The results for 2016-17 were published on 24 August 2017. The results for 2017-18 will be published on 23 August 2018.

Patient recommendation of our hospitals to family and friends

Results from the OUH Friends and Family Test (FFT) survey. *Note: results are from beginning of April 2017 to end of March 2018*	
FFT: inpatients and day cases	96% of patients were extremely likely or likely to recommend their ward, based on 32,966 responses.
FFT: emergency departments	86% of patients were extremely likely or likely to recommend the care they received in the Emergency Department, based on 14,573 responses.
FFT: outpatients	94% of outpatients were extremely likely or likely to recommend the care they received, based on 70,764 responses.
FFT: maternity	96% of women were extremely likely or likely to recommend the Trust's maternity services (labour and birth only), based on 3398 responses.

The table below shows the Trust's overall results from the FFT survey for this 12 month period.

April 2017 to March 2018	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know
Number of responses	100343	13860	2694	1692	2330	782

overall						
Percentage	82.5%	11.4%	2.2%	1.4%	1.9%	0.6%

Oxford University Hospitals NHS Foundation Trust considers that these data are as described for the following reasons.

- The Trust has a robust process in place for checking and processing the data. For example, the data are checked for anomalies against previous data sets.
- These data are checked and signed off by the Chief Nurse or Deputy Chief Nurse before submission.
- Data are collated internally and then submitted on a monthly basis to NHS England.

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of our services as follows.

- Automated surveys (via text message) are in place across all services except some inpatient wards. Successful trials of texting for inpatients have taken place and an improvement in response rates has been seen. The introduction of texting to all adult inpatient areas (excluding palliative care and women's and maternity services) is planned for 2018.
- A member of the Patient Experience Team attends the volunteers' induction sessions to promote the Friends and Family Test and explain to the new volunteers about how they can support patients to complete the FFT questionnaires and also support staff to gather feedback consistently.
- Starting in May 2017, the Patient Experience Manager focused on each clinical Division's response rate in the monthly Board Quality Report. The Surgery and Oncology Division achieved a significantly higher response rate following the support provided.
- In March 2017, the Patient Experience Team introduced a process of reporting and learning from FFT feedback, following advice from the Non-Executive Directors. The process focuses on one area with excellent feedback and one area with feedback for improvement each month. The feedback is analysed to identify themes. The area with excellent feedback is asked what processes they have in place to enable them to get such good feedback. The area with feedback for improvement is asked what they are doing or will do to improve. A review of this process has been undertaken in November 2017, by revisiting all areas that had feedback for improvement, who were contacted more than six months ago. The Patient Experience Team asked the team leaders what changes they had made, and what further changes were planned.
- Teams across the Trust are consistently encouraged to raise patient awareness about feedback via automated methods, encourage patients to respond, opt out patients who do not wish to receive a text message, and offer paper questionnaires to those patients.
- All team leaders of outpatient and day case areas have been encouraged to use the website where the automated feedback is uploaded – Envoy Messenger. There are facilities on the site

to create ‘You said, we did’ posters and to create action plans around any feedback that requires follow-up and the training has shown staff how to use this tool.

- Further training sessions have been organised for staff to learn how to use the site and automated reports are easily set up for those who wish to display results and examine comments in detail. A list of staff who attended the training will be publicised so that colleagues in their directorate and Division can go to them with questions about accessing feedback.

Staff recommendation of our hospitals to family and friends

NHS Staff Survey results

Recommendation of the organisation as a place to be treated:

OUH scores	2013-14	2014-15	2015-16	2016-17	2017-18
OUH	**76%**	**70%**	**75%**	**79%**	**71%**
National average	65%	65%	69%	70%	71%
Highest scoring trust	89%	89%	85%	85%	86%
Lowest scoring trust	40%	38%	46%	49%	47%

Recommendation of the organisation as a place to work:

OUH scores	2013-14	2014-15	2015-16	2016-17	2017-18
OUH	**67%**	**57%**	**60%**	**61%**	**57%**
National average	59%	58%	61%	61%	61%
Highest scoring trust	79%	78%	78%	76%	77%
Lowest scoring trust	34%	32%	42%	41%	43%

Oxford University Hospitals NHS Foundation Trust is taking the following actions to improve the outcomes associated with these indicators, and therefore the quality of its services.

- Completing a comprehensive review of the Appraisal process in order to roll out a values- based approach in 2018.
- Designing and developing more health and wellbeing interventions, launching a wellbeing newsletter, further promoting the Employee Assistance Programme and providing staff with fast track access to physiotherapy.
- Organising seven Trust-wide Staff Listening Events called 'Changing Things for the Better' regarding the NHS staff survey results, supported by the CEO and Executive Team to produce a Trust-wide action plan. A follow up Trust-wide Listening Event will take place to track progress in September 2018.
- A specific inbox is available and being used by staff to give further feedback and suggestions for improvements, plus showcase good patient care which will be shared.

Infection prevention and control

Oxford University Hospitals NHS Foundation Trust considers that these data are as described for the following reasons.

- The Trust has a process in place for collating data on *C difficile* cases.
- Data is collated internally and submitted on a daily basis to Public Health England.

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of our services.

- A root cause analysis of each *C difficile* case is presented at the monthly Health Economy meeting which includes representation from OUH, Oxford Health, Oxfordshire CCG and Public Health England.
- The purpose of this meeting is to review all reported cases of *C difficile* to apportion responsibility, identify causality and trends, identify lapses in care and develop agreed action plans for quality improvement.
- Data is compared to peers, highest and lowest performers, and our own previous performance, as set out below.

***C Difficile* rates per 100,000 bed days**	**2014-15**	**2015-16**	**2016-17**	**2017-18**
Trust attributed (number)	**61**	**57**	**53**	**72**
Total bed days	**414,213**	**394,104**	**408,361**	Awaiting PHE figure publication date June 2018
Rate per 100,000 bed days (Trust attributed cases)	**13.9**	**14.1**	**13.0**	Awaiting PHE figure publication date June 2018
National average	15.0	14.9	13.3	Awaiting PHE figure publication date June 2018
Best performing trust	0.0	0.0	0.0	Awaiting PHE figure publication date June 2018
Worst performing trust	40.2	41.1	82.7	Awaiting PHE figure publication date June 2018

Throughout 2017-18 the Infection Prevention and Control Team has continued to work with the multidisciplinary team to minimise avoidable infections.

The number of cases of *C difficile* this financial year is three over the agreed trajectory of 69 set by the Oxfordshire Clinical Commissioning Group (OCCG).

In February we had 12 cases apportioned to OUH, having been under trajectory for the rest of the year. The number of frail elderly on antibiotics being cared for in the Trust at that time was unusually high, due to the high number of influenza-associated admissions. Whole genome sequencing of geographically associated isolates has shown evidence of nosocomial transmission in only one case.

Through case review with feedback, typing and/or sequencing of isolates, the continued promotion of antimicrobial stewardship, and good infection prevention practices, we continue to educate and promote a reduction in cases.

Patient safety incidents

Trusts across England upload data relating to incidents reported locally to the National Reporting and Learning System (NRLS). The number of patient safety incidents and near misses reported at OUH via our electronic Datix system is similar to the previous financial year. The Trust believes this reflects a positive culture of reporting incidents. The Trust actively encourages staff to report clinical incidents so lessons can be learned from incidents and near misses in order to improve care. Measures used by NHS England

and others to indicate a positive 'safety culture' within an organisation include the rate of incident reporting (the higher the better) and the proportion with significant patient harm (the lower the better).

Oxford University Hospitals NHS Foundation Trust considers that these data are as described for the following reasons.

- The Trust has a process in place for collating data on patient safety incidents (Datix).
- Incident reporting has increased following the implementation of Datix in 2012.
- Data are collated internally and then submitted on a monthly basis to the NRLS.
- Data are compared to peers, highest and lowest performers, and our own previous performance, as below.

	Oxford University Hospitals NHS Foundation Trust			
	Apr 14 to Mar 15	**Apr 15 to Mar 16**	**Apr 16 to Mar 17**	**Apr 17 to Sept 17**
Number of patient safety incidents	**17,784**	**17,788**	**17,121**	**8,545**
National average (acute non-specialist trust)	8,735	9,465	7,661	5,226
Highest reporting rate	24,804	24,078	27,991	13,425
Lowest reporting rate	478	3,058	2,880	697
Number of patient safety incidents that resulted in severe harm or death	**44**	**44**	**11***	**10**
National average (acute non-specialist trust)	43	39	38	18
Highest reporting rate	225	183	190	121
Lowest reporting rate	2	2	3	0
Percentage of patient safety incidents that resulted in severe harm or death	**0.20%**	**0.20%**	**0.06%**	**0.12%**
National average (acute non-specialist trust)	0.60%	0.40%	0.40%	0.37%
Highest reporting rate	10.70%	2.00%	1.38%	1.98%
Lowest reporting rate	0.10%	0.00%	0.02%	0.00%

Source: NRLS, Organisation Patient Safety Incident reports which are published six months in arrears.

*There is a reduction in severe harm or death incidents during April 2016 to March 2017. This may reflect closer monitoring of levels of harm in the Trust's weekly SIRI forum and validation of the level of harm every month by the Clinical Risk Management Team.

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of our services.

Facilitating the Serious Incident Requiring Investigation (SIRI) Forum which is a weekly meeting where front-line staff, executives and leads for specialist areas such as tissue viability, pharmacy, venous thromboembolism (VTE) and information governance attend as required. The Care Quality Commission

well-led inspection in 2017 said that the SIRI Forum was seen as “an effective multidisciplinary meeting. The group operated in line with the Trust’s value of respect and was a forum where learning took place”.

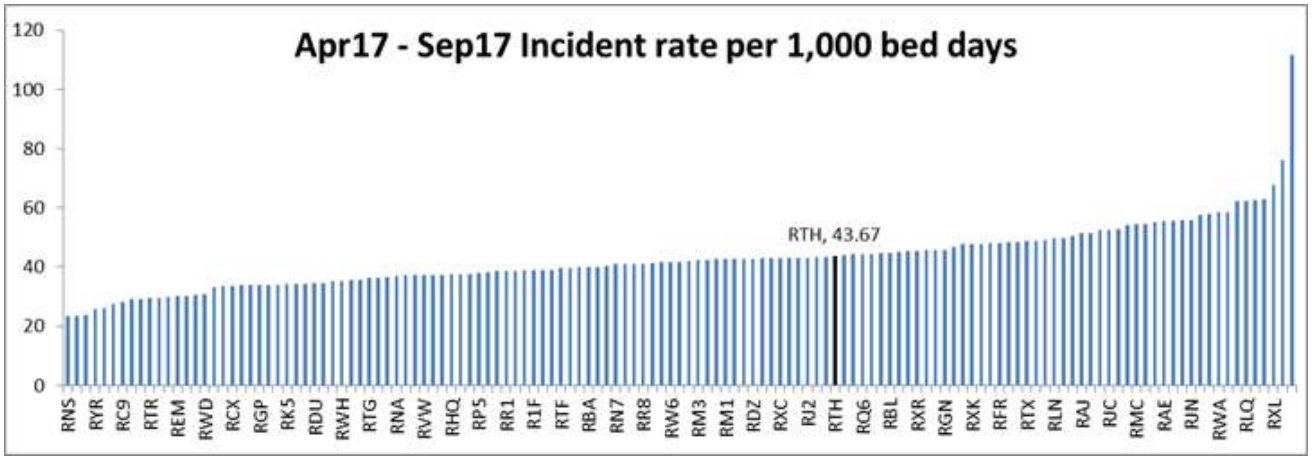
The purpose of the forum is:

- to provide an open, honest and transparent process in the decision-making of calling SIRIs
- to provide assurance to the Trust Management Executive (TME)
- to disseminate Trust-wide learning from SIRIs as close to the time of the incident as possible.

The attendance at this SIRI Forum continues to increase. During financial year (FY) 2017-18 there were 1,537 documented attendees compared to FY 2016-17 where there were 1,346 documented attendees. This equates to an increase of 14%.

During 2017-18 94 SIRIs were declared on the Strategic Executive Information System (STEIS) with three being downgraded. This follows a concerted effort to improve timeliness and extent of escalation of incidents.

Incident Rates					
	Apr 15 to Sep 15	Oct 15 to Mar 16	Apr 16 to Sep 16	Oct 16 to Mar 17	Apr 17 to Sept 17
Incident rate (per 1,000 bed days)	**41.9**	**41.4**	**44.1**	**40.4**	**43.67**
National average (acute non-specialist trust)	39.3	39.6	40.8	41.1	42.84
Highest reporting rate	74.67	75.91	71.8	69.0	111.69
Lowest reporting rate	18.07	14.77	21.2	23.1	23.47



Source: NRLS, Organisation Patient Safety Incident reports

Never Events

A Never Event is described as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers. There are 16 types of incidents categorised as such by NHS England.

In 2017-18 Oxford University Hospitals NHS Foundation Trust reported eight incidents that met these criteria, compared to two Never Events in 2016-17 and seven Never Events in 2015-16. The Never Events

in 2017-18 were as follows:

1. Overdose of insulin due to abbreviations or incorrect device
2. Wrong site surgery: wrong patient received a cystoscopy
3. Retained foreign object post procedure: retained swab
4. Wrong site surgery: wrong site nerve block
5. Wrong site surgery: wrong site nerve block
6. Wrong site surgery: wrong site nerve block
7. Wrong site surgery: wrong side ureteric stent (recognised and rectified during the procedure)
8. Wrong site surgery: wrong patient received laser eye therapy

The learning stemming from the incidents, with a particular focus on the system changes made to reduce the probability of recurrence.

Overdose of insulin due to abbreviations or incorrect device.

Recommended system changes include:

- all point of care blood gas machines will be programmed to include 'up' and 'down' arrows for glucose outside critical limits
- all blood gas values out of range should be highlighted in EPR
- all World Health Organisation (WHO) safety checklists should be modified to include 'what medications has the patient received in the last 12 hours prior to surgery?' And 'does the patient require glucose monitoring?'
- the hyperkalaemia medicines information leaflet (MIL) algorithm will include a warning saying 'always draw up insulin in an insulin syringe'.

Wrong site surgery: Wrong patient.

Recommended system changes include:

- all outpatient departments and day case units in the Trust should review their practice regarding wristbands for patients undergoing invasive procedures, as specified in the Trust Patient Identification Policy
- staff carrying out procedures should receive specific training and information about consent procedures as part of their induction, including positive patient identification

Retained foreign object post procedure: retained swab.

System changes include the following.

- A sticker on the back of the hand with the initial 'VP' for patients with a vaginal pack in situ is to be introduced, and should only be removed once the pack is removed or a plan for its removal after discharge has been made with the patient.

- A bespoke WHO safety checklist for Gynaecology will be designed and will include the questions: Are there any packs, tampons or drains?' and 'If yes, describe these in detail and document the plan for their removal'.
- The current Maternity Swabs, Needles and Instruments Appendix 2016 within the Trust's Swabs, Sharps, Instruments and Accountable Items Policy 2016 should include a section for Gynaecology. It should highlight that a 'VP' sticker should be used whenever a pack is inserted; this is to be added to both the Trust Policy and the Maternity Appendix clarifying the need to check the wound before the 'VP' sticker is removed. If the pack is to remain in situ on discharge, then the person removing the 'VP' sticker must ensure there is a robust plan for its subsequent removal.

The remaining Never Events are in the process of being investigated, however immediate actions have been put in place.

- A new check is being used during ureteric stenting between the radiographer and surgeon prior to stent deployment.
- A meeting between the Medical Director and Divisional, directorate and clinical leads has occurred following the incidents.
- Additional training sessions for medical and theatre staff with respect to 'stop before you block'.
- An audit of 'stop before you block' practice carried out within two weeks of the first wrong site block was presented to the anaesthetic governance day.
- Advice has been sought from the Healthcare Safety Investigation Branch (HSIB) and other trusts. HSIB came on site to walk through the areas where the wrong site block Never Events occurred and to contribute their knowledge and suggested immediate actions to the Never Event investigation finalisation meeting in relation to the first two wrong site block incidents.
- The meeting with the HSIB, Divisional team, the investigators of two of the blocks and the Medical Director's Team discussed means to standardise the environment in which blocks are done; the importance of consensus and buy-in in the success of any intervention; the absence of an accepted national approach which contrasted with the WHO checklist approach-the HSIB was asked to assist with raising this at national level.
- A 'stop before you zap' protocol is being trialled on the laser eye lists.

How learning of never events has been shared at all levels in the organisation and externally.

Internally

- The learning has been reported at committees within the Trust. This includes the Patient Safety and Clinical Risk Committees, Clinical Governance Committee and Quality Committee.
- The Never Events reports have been discussed within departments, for example for Gynaecology morbidity and mortality meeting, Directorate and Divisional Governance meetings and departmental staff meetings.
- Patient safety alerts have been placed on the front page of the intranet where appropriate.

Externally

- The OCCG and NHS England have read the completed reports and will undertake assurance visits to the departments once the action plans are complete

- The CQC and NHS Improvement are informed of a Never Event when it occurs and a 72-hour report is sent to them for information.

Duty of Candour

Continuing significant work has gone on to embed the legal, professional and regulatory Duty of Candour in the Trust. This has involved extensive work in the Divisions and monitoring via the SIRI Forum as described above.

Compliance with Duty of Candour in the last calendar year is as follows.

	Verbal	Letter
Q1	100% (50)	98% (49)
Q2	100% (20)	100% (20)
Q3	100% (19)	100% (19)
Q4	100% (16)	100% (16)

Q1 written compliance is lower (49 completed out of a total of 50) as the patient requested not to receive a letter.

Venous thromboembolism (VTE)

Venous thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and pulmonary embolus (PE). A DVT is a blood clot which blocks the blood flow in one or more veins of the leg. A PE occurs when a blood clot breaks free from the DVT and travels to the lungs where it blocks the blood supply to part of the lung.

The Trust has met and exceeded the 95% target for VTE risk assessment of patients for 2017-18

Oxford University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons.

- The Trust has a robust process in place for collating data on venous thromboembolism assessments.
- Data is collated internally and then submitted on a quarterly basis to the Department of Health.
- Data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.

VTE	2015-16	2016-17	2017-18	Comment
OUH VTE assessment rate	**97%**	**96%**	**98%**	
National average	96%	96%	95%	2017-18 based on Q1-3
Best performing trust	100%	100%	100%	
Worst performing trust	81%	79%	76%	

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services.

- Education
    - The e-Learning VTE prevention and safe anticoagulation modules have been updated for doctors, nurses and nursing assistants. The Safe anticoagulation module is now mandatory. A bespoke Maternity VTE learning package for midwives was due for completion at the end of December 2017.
- Guidelines
    - New specific VTE Prevention Guideline for lower limb immobilisation in adult outpatients.
- Sustained robust Trust-wide audit of critical patient safety measure
    - Pharmacy support enabled a robust independent audit of 'appropriate thromboprophylaxis (TP)' in July 2016 and this has continued quarterly. The feedback of good quality data has helped drive improvement in patient safety.
- Reporting of all hospital associated thrombosis (HAT) incidents
    - Discussion of potentially preventable HATs in the Serious Incident Requiring Investigation (SIRI) Forum and dissemination of learning outcomes.
- Prescription of anti-embolism stocking (AES)
    - This has been improved by linking the electronic VTE risk assessment to e-prescribing (December 2016).
- Improving patient information with regard to hospital associated VTE on discharge
    - In order to provide all patients with information on discharge, a statement on VTE risk on discharge has been included in electronic discharge summary since July 2017.
- OUH was re-validated as a VTE exemplar centre in October 2017. The Director of the VTE Exemplar Centres Network wrote that "We were particularly impressed with the electronic solutions used to improve risk assessment and prescription of thromboprophylaxis and the pharmacy led audit".

Part 3: Other information

Progress against priorities for 2017-18

Patient Safety		
Priority One: Partnership working		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
This was the top choice from our Quality Conversation public event in January. It is also a major strategic aim for the Trust to work with system partners across Oxfordshire in areas such as the Sustainability and Transformation Programme (STP) across Buckinghamshire, Oxfordshire and Berkshire. We also recognise the value of our services that provide national and international expertise and will work to enhance care in this area particularly for rare diseases. Our Commissioning for Quality and Innovation (CQUIN) programme this year includes partnership networks with other local / regional hospitals to deliver best quality care together for spinal surgery, infection of the liver from a virus (hepatitis C), specific blood disorders and chemotherapy etc.	We will evidence the benefit to patients from taking a whole system approach to our strategy including the University of Oxford, our commissioners, other trusts, our STP area, Oxford Academic Health Science Network (AHSN) and stakeholders. Home Assessment and Reablement Team (HART) service development: we will ensure that the 50% of time is specifically for patient contact. This figure is derived by taking into consideration staff annual leave, sickness, maternity leave and travel time between each patient in the community as well as non-patient-facing organisational activities. By ensuring the Operational Delivery Networks (ODNs)-collaborations of doctors, nurses, managers and allied professionals we will offer opportunities to share learning and develop solutions within and across networks at regional and national levels, to build collaboration and accelerate change for patients. This will be evaluated via achievement of the CQUIN requirements. By fully embedding the OUH Public Health / Health and Wellbeing Strategy we will continue to improve the organisational infrastructure that underpins staff health and wellbeing. We will implement a management development programme to equip line managers with the skills and capabilities to manage teams and services. This will provide managers with the tools to help create a healthy workplace for staff.	STP: We Achieved this. Home Assessment and Reablement Team (HART) service development: We achieved this. Operational delivery networks (ODN): ODNs- We partially achieved this. The regional Spinal network holds regular MDT meetings and the network has produced regional policies to manage spinal emergencies including emergency imaging and transfer. The hepatitis C ODN has a greater than 98% cure rate. Haemoglobinopathies: By the end of Q3, 70% of patients had received an MDT review. Auto immune rheumatic disease: By the end of Q3, more than 90% of patients had received a MDT review. OUH Public Health / Health and Wellbeing Strategy. We achieved this. We implemented a management development programme.
Priority Two: Safe discharge		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
Patients have told us that delays caused by their medicines not being ready when they expect to leave the hospital are a source of frustration. We have also had feedback from GPs that this is an area we can improve upon. This	Our aims are to improve the experience of discharge and the accuracy of discharge communication for future medication. • We will bring forward the time medicines to take home are reconciled / written, significantly	We partially achieved this. Analysis of January and February 2018 discharges before noon show an increase to 22.5% (mean average). It is anticipated that end of year data will show improvement on the 22.5% recorded to date. The percentages of patients on the wards in which the pilot is live,

was the favourite new priority identified at our Quality Conversation public event and will build upon work we did last year to improve medicines safety.	increasing the number of patients discharged before 12 noon, and reduce the number of changes needed on medicines to take home so they are ready at the time of discharge. • Furthermore we aim to reduce the overall time it takes to turn around discharge medicines and ensure availability to the patient when they are ready to go home. • We will aim to increase the percentage of patients discharged before noon from 8% to 30%. We will examine information from our electronic system (Cerner) and carry out audits to check our results.	who were discharged before 12 noon is as follows: Complex Medical Unit (CMU) A – 23% Complex Medical Unit (CMU) B – 37% Complex Medical Unit (CMU) C – 28% Complex Medical Unit (CMU) D – 42% Trauma Adams – 17% Trauma 7F – 26% SEU D, E, F – 14% Stroke – 17%.
Priority Three: Preventing patients from deteriorating – delivering time critical care [heart attack, stroke, blood clots in the lungs, sepsis including the use of the System for Electronic Notification and Documentation (SEND)]		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
This was the third most popular priority to continue at our Quality Conversation public event and is a theme from our analysis of incidents or near misses in 2016-17.	• Through a programme of changes supported by the monitoring system SEND and as part of the cardiac arrest reduction strategy we expect to achieve a 10% reduction in cardiac arrests in 2017-18 from 2016-17. • We will establish an education and communication programme to fully inform our staff about rapid response treatment for time critical diagnoses which may cause deterioration in hospital. • We will work to achieve national priorities to improve care for patients with sepsis as described in the 2017-18 CQUIN.	Reduction in cardiac arrests: We achieved this. There is a 20% decrease in the instance of cardiac arrest in general ward areas between April 2017 and February 2018 when compared with the same period the previous year. Education and communication programme: We partially achieved this. The number of midwives completing the recognition and treatment of the acutely ill and deteriorating patient (RAID) assessor training has increased and RAID assessments are now underway in maternity. This subject has also been included in all medical induction sessions since August 2017 (646 doctors). The groundwork is now complete for the e-learning package for time critical illnesses and the anticipated go live date for the training is by 31 May 2018. Sepsis CQUIN: We fully achieved the screening element and partially achieved the intravenous antibiotics within an hour element. % of eligible patient encounters screened against a target of >90%: Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 99.2% 99.3% 99.4% 99.3% 99.4% 99.3% 98.2% 98.7% 97.4% 95.4% 97.2% 96.0% % of IV antibiotics given less than 60 minutes from Alert against a target of 50-90%, ideally >90%: Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 59.6% 56.6% 68.8% 59.3% 58.6% 70.7% 71.2% 63.0% 54.4% 67.6% 66.7% 70.7%
Clinical Effectiveness		
Priority Four: Mental health in patients coming to our hospitals		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
We know that the Emergency Department (ED) is not the best place to care for patients with mental illness and we will be working with Oxford Health NHS	• For patients attending ED we will collaborate with Oxford Health to achieve the CQUIN target for 2017-18. We aim to reduce by 20% the ED	Mental health in ED CQUIN: We have achieved this with a 46% reduction in attendances since April for this patient cohort.

<table>
<tr><td>Foundation Trust to find ways to prevent the need to come to ED for some of these patients. We will also work on further improving care for those with mental illness complicating physical illness who are admitted to our hospitals. This was the second most popular suggested new priority at our Quality Conversation public event.</td><td>attendances of those within a selected cohort of frequent attenders in 2016-17 who would benefit from psychiatric and psychological interventions.
• For inpatients, our Psychological Medicine Team will identify, train and support medical and nursing champions for psychological and psychiatric care of our patients in all key Trust services.</td><td>Education / training quality initiative: We achieved this.</td></tr>
<tr><td colspan="3">Priority Five: Cancer pathways</td></tr>
<tr><td>Why we chose this priority</td><td>How we will evaluate success</td><td>Evaluation March 2018</td></tr>
<tr><td>We plan to review cancer pathways with a focus on reducing the number of, and time between, patient encounters (coming to hospital as an in- or outpatient or for tests) in order to consistently improve patient experience, meet cancer targets and provide diagnosis and treatment in a timely manner.</td><td>We aim to improve patient experience by increasing the numbers of individuals who are diagnosed and treated for cancer within target. We also aim to avoid unnecessary delays and we have a programme for quality in each cancer pathway. We will:
• increase the timeliness of first contact or visit for individuals with a suspected cancer so that >93% of referrals are seen within 14 days
• increase the number of individuals confirmed with cancer who are treated within 62 days from 2 Week Wait referral to treatment start (Aim: >85% in 2017-18)
• increase the number of patients who are treated within 31 days of decision to treat (Aim: 96% or greater in 2017-18)</td><td>We partially achieved this.
The table provides the trend data:
<table><tr><th>Target (%)</th><th>Apr 17</th><th>May 17</th><th>Jun 17</th><th>Jul 17</th><th>Aug 17</th><th>Sep 17</th><th>Oct 17</th><th>Nov 17</th><th>Dec 17</th><th>Jan 18</th><th>Feb 18</th></tr><tr><td>2ww(93)</td><td>92.4</td><td>92.0</td><td>96.8</td><td>96.1</td><td>97.0</td><td>97.7</td><td>97.6</td><td>96.9</td><td>95.3</td><td>95.7</td><td>97.0</td></tr><tr><td>62(85)</td><td>86.3</td><td>82.7</td><td>83</td><td>84.9</td><td>85</td><td>85.4</td><td>81.6</td><td>81.7</td><td>87.0</td><td>81.9</td><td>81.4</td></tr><tr><td>31 day first (96)</td><td>98.4</td><td>96.6</td><td>97.5</td><td>97.7</td><td>96.4</td><td>96.8</td><td>96.1</td><td>96.1</td><td>96.7</td><td>93.6</td><td>97.5</td></tr></table></td></tr>
<tr><td colspan="3">Priority Six: Go Digital</td></tr>
<tr><td>Why we chose this priority</td><td>How we will evaluate success</td><td>Evaluation March 2018</td></tr>
<tr><td>We have been named a ‘global digital exemplar’ which recognises that we are at the forefront of the use of digital technology to deliver exceptional treatment and care. As a digital exemplar, we have ambitious plans to accelerate the opportunities that digital technology offers, in line with the ambition of the NHS to be ‘paper-free’ and for patient records to</td><td>• We will establish a patient portal to be used for appointment booking, receipt of letters and review of parts of the clinical record (for limited numbers of patients).
• We will deliver a major project for Core Clinical Documentation: this major project will be accelerated to deliver the capability providing the outstanding online</td><td>Patient portal: We did not achieve this. Preparatory work to facilitate this has been undertaken by the OUH, in partnership with Cerner, to upgrade Cerner Millennium Code from 2015 to 2018.

Core Clinical Documentation: We partially achieved this. The latest documentation standards for Nursing Care Plans, Assessments and Clinical Referrals went live as planned across the NOC site on 19 February 2018. A decision on the rollout approach to remaining OUH sites will be based on learning from live use at the NOC.</td></tr>
</table>

be held electronically and accessible across different systems. We will leverage electronic health records, data and technology to innovate and join up how we provide patient care across organisational boundaries and support self-care and research. We are committed to ensuring these processes improve our safety, effectiveness and patient experience.	documentation required by clinical staff to document electronically in real-time into the patient record. It includes Care Plans, Assessments, Decision Support Rules, extended catalogues of orderables (clinical referrals), and 'best practice' clinical pathway guidance.	

Patient Experience

Priority Seven: End of life care: improving people's care in the last few days and hours of life		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
This was the second most popular priority to continue when we asked our patients and the public at our event in January 2017. We agree that while we achieved a lot last year we can still do more to develop our end of life care in 2017-18.	• We will implement further improvements in end of life care as described in our work plan for 2017-18. The work plan is based on our End of Life Care (EoLC) Strategy and builds on last year's work plan. • We will deliver and learn from the daily palliative care input to the Emergency Department (ED) and Emergency Admissions Unit (EAU) as part of the End of Life Care Project funded by Sobell House Hospice Charity. • We will increase the number of wards with enhanced skills in supporting end of life care. • We will continue to gather feedback from bereaved families to understand their experience of care in the Trust and incorporate learning in the work plan.	We completed the EOLC work plan. Palliative care input to ED and EAU: We achieved this. Increasing ward accreditation: We partially achieved this. Juniper, Laburnum and the Critical Care Unit at the Horton are currently preparing to accredit as is the Emergency Admissions Unit (EAU) at the JR. This should be complete early in 2018-19. Bereavement survey: We achieved this.
Priority Eight: Dementia care		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
We are committed to providing an excellent standard of care for all patients but we know that we particularly need to ensure that those who are vulnerable and frail are getting the best possible care. Dementia is an increasingly common condition and we want to continue to build on last year's progress in this area.	• We will implement a paperless process for cognitive screening. A uniform core electronic clerking pro forma should help improve screening because junior doctors will then become familiar with using the same core form regardless of specialty. • We will modify our consent forms to prompt consideration of the need for a capacity assessment prior to consent. • We will design electronic systems to trigger individualised nursing care plans / bundles once the cognitive screen has been	Paperless screening; We achieved this. Consent forms: We achieved this modification. The modifications to the consent forms have been approved by the Clinical Governance Committee (CGC) and will launch shortly. Individual care plans: We partially achieved this. A new form to record the assessment of the patient's mental capacity has been agreed for use once the cognitive screen is positive however the rollout of

	completed and it is positive.	the triggered individualised nursing care plans / bundles will not take place before 31 March 2018.
Priority Nine: Learning from complaints		
Why we chose this priority	**How we will evaluate success**	**Evaluation March 2018**
It is fundamental that we listen to our patients and learn from their experiences therefore we want to make this an explicit priority this year. Communication is one of the top three themes from complaints and this will be an area of focus.	• We will carry out an in-depth review of 2016-17 complaints related to communication to better develop actions and stories which will have the greatest impact for staff. • We will also review complaints about access to treatment to ensure the Trust is listening to the patient's views on what aspects of access really matter for their experience. • This will be used to understand where improvements can be made.	Completed a review of complaints about communication. Access to treatment: We partially achieved this. A programme of work led by the Director of Nursing is underway and will complete after 31 March 2018.

Our 2017-18 performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement

Indicators		Performance			Quarterly Trend				
		Target	Actual		Q1	Q2	Q3	Q4	Last update
Cdiff	Rates of Clostridium difficile	< 69	72		15	21	10	26	17/04/2018
18Incomp	RTT - incomplete % within 18 weeks	> 92%	85.1%		89.8%	86.9%	86.2%	85.1%	19/04/2018
AESITREP4	4 Hour Target Sitrep Months	> 95%	82.8%		85.9%	82.7%	81.6%	81.0%	17/04/2018
CancerUrgTreat	Maximum waiting time of 62 days from urgent referral to treatment for all cancers	> 85%	83.5%		83.7%	85.0%	83.3%	81.4%	10/03/2018
CancerNatScr	Extended 62-Day Cancer Treatment Targets (following detection via national screening programme of hospital specialist)	> 90%	95.0%		91.9%	99.1%	95.4%	91.7%	10/03/2018
VTES	% of all adult inpatients who have had a VTE risk assessment	> 95%	97.5%		97.6%	97.6%	97.8%	97.0%	17/04/2018
DIV01	Maximum 6-week wait for diagnostic procedures	> 99%	99.0%		99.0%	98.9%	99.4%	98.6%	17/04/2018

Emergency Department (ED) access: 95% ED patients wait less than four hours

Oxford University Hospitals NHS Foundation Trust considers that these data are as described for the following reasons.

- The Trust has a robust process in place for collating data on ED attendances and four hour breaches.
- Data is collated internally and then submitted on a monthly basis to the Department of Health.

- Data is compared to peers, highest and lowest performers, and our own previous performance, as set out in the table below.
- The Trust is regularly and independently audited to ensure accuracy of the figures

Emergency Department	2013-14	2014-15	2015-16	2016-17	2017-18
No of four hour Breaches	8,994	14,017	15,893	21,046	26,673
No of attendances	132,838	137,883	145,473	151,073	155,352
Performance	93.23%	89.83%	89.07%	86.07%	82.83%
Nat average	95.69%	93.64%	91.91%	89.13%	88.36%
Best performing trust	100%	100%	100.00%	100.00%	100.00%
Worst performing trust	88.48%	82.03%	78.49%	72.37%	70.95%

The patients presenting to ED and to the other assessment areas are requiring more investigations and treatments followed by admission. In Quarter 1 and 2 2016-17 (April to September) ED managed to achieve approximately 85% (ranged from 82% to 89%). In Quarter 3 and 4 2017-18 (October to March), compliance with the four hour standard reduced to approximately 81%.

Oxfordshire has had a particularly difficult time this winter with the levels of Flu-like illness being particularly high and prolonged. This has led to high numbers of medical admissions.

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services.

- Over the past year, a number of interventions have been put in place to help improve the performance – increased capacity in ambulatory care (JR and HGH), consultant phone holding in acute general medicine (AGM), direct referral to medicine from paramedic ambulance crews, recruitment to the Home Assessment Reablement Team (HART), development of Acute Hospital at Home (AHaH) and systematic reviews of patients in hospital over seven days.
- There has been a focus to ensure that patients in the Minor Injuries section of ED do not remain in the department for more than four hours. In addition to the above, ED has added a junior and senior medical staff member over night.
- We have expanded the medical workforce with increased numbers of senior doctors to support early decision-making. This has been coupled with nurse-led streaming to ensure patients get seen by the most appropriate team directly.

Cancer waits

Oxford University Hospitals NHS Foundation Trust is responsible for meeting eight national cancer wait standards. In February 2018 (the latest month reported), all were met except the 62 day wait from GP urgent referral to first cancer treatment. The number of people waiting for over 62 days continues to reduce and Oxford University Hospitals NHS Foundation Trust aims to meet this standard in and from

April 2018.

It is recognised nationally that a small proportion of patients may remain on a 62 day cancer pathway and wait for more than 104 days for first treatment, i.e. for six weeks beyond the 62 day standard. We developed an agreed protocol that any patient reaching a 104 day wait should have a clinical review conducted to establish whether any potential clinical harm resulted from the delay. The findings from such reviews are received in quarterly reports by the Trust's Clinical Governance Committee. Patient-level detail from these reviews is shared with the clinical teams involved and with lead commissioners on a weekly basis to ensure that any emerging trend is identified quickly.

Post-diagnostic and slow decision-making, particularly for patients on complex clinical pathways, and late referrals from other trusts have been identified as the two key causal factors in cancer waits at Oxford University Hospitals NHS Foundation Trust during the year 2017-18.

A cancer performance improvement plan was implemented, together with individual tumour site-specific actions for improving performance, with particular focus given to the Urology, Lower Gastrointestinal (LGI), Gynaecological Oncology, Lung and Head and Neck tumour site groups which together accounted for over half of the people waiting for over 62 days from referral for first treatment.

During the year Urology achieved the 62 day standard in six months, LGI and Gynaecological Oncology saw some improvement, whilst in February 2018 waits worsened in the Head and Neck and Lung tumour site groups.

Additional support that was introduced during 2017-18 included:

- twice weekly 'cancer huddle' teleconference involving service managers, senior clinicians and the Trust-wide cancer management team, focusing on checking progress and resolving issues involving patients waiting for over 42 days on pathways from GP urgent referral to first treatment (85% of which should be completed within 62 days)
- pathway coordinator employed on behalf of the Thames Valley Cancer Network to assist with tertiary referrals from other hospitals
- collaborative working with NHS Improvement and individual tumour site clinical teams to improve systems and processes.

Waits for planned care

The national standard of 92% of people waiting no more than 18 weeks from referral to treatment for elective care (on what are termed 'incomplete pathways') has not been met since June 2015 for patients waiting for treatment by Oxford University Hospitals NHS Foundation Trust (OUH).

Performance

At the end of February 2018, 6,802 of 48,585 patients on incomplete pathways in our Trust were waiting for over 18 weeks. This was the first month of growth in the total waiting list size since July 2017 with an increase of 440 patients compared to January 2018.

Performance from April 2017 to February 2018 was better than the agreed trajectory, which reflected the fact that the numbers of treatments that OUH was being funded to carry out was not sufficient to meet the national standard. Performance against the 92% standard continues to worsen and was 86% at the end of February 2018.

Speciality waits

The number of people waiting for over 52 weeks for treatment grew from 90 in December 2017 to 157 in January 2018 and again to 176 in February. The number of women waiting for over 52 weeks for gynaecological surgery rose to 150 in February, when a further 26 patients were waiting for over 52 weeks in 18 other specialties.

Activity

Following guidance to all NHS trusts from the National Emergency Pressures Panel, Oxford University Hospitals NHS Foundation Trust postponed some elective inpatient procedures for adults in January and restarted in February 2018.

Elective activity was also lost due to staffing shortages causing the closure of inpatient beds and some operating theatre sessions, and adverse weather also had an impact. OUH provided 793 fewer elective inpatient admissions than planned in January. Although this was offset by 453 more day case admissions than planned, it took the Trust to 189 elective admissions below its plan for the year to date.

The total size of the waiting list reduced by 0.75%, with most of the reduction in waits for first outpatient attendance offset by growth in the number of people waiting in the 'diagnosis' stage of their pathway (between having a first outpatient attendance and a decision being taken on surgery).

Key risks we are mitigating

- Staffing continues to pose the greatest risk to Oxford University Hospitals NHS Foundation Trust delivering its planned and commissioned level of elective care. Shortages of ward staff led to unplanned bed closures and shortages in theatre staff led to loss of operating sessions, particularly affecting specialist surgery at the John Radcliffe in autumn 2017 and affecting surgical services at the Churchill from early 2018.
- Work has continued to secure theatre capacity and has focussed on the recruitment and training of anaesthetic and recovery nurses and theatre scrub nurses. There was an overall reduction in the cancellation of operating sessions since late 2017.
- The scale of elective activity growth continues to be greater than is funded by commissioners or than can be provided in the short term by Oxford University Hospitals NHS Foundation Trust. Discussions have therefore taken place with independent sector providers to identify alternative capacity to provide surgery for our patients, using our surgeons wherever possible. The focus is on treating patients experiencing the longest waits, such as within gynaecology.

Statements
Annexe 1: Statements from commissioners, local Healthwatch organisation and Overview and Scrutiny Committees

NHS
Oxfordshire
Clinical Commissioning Group

Jubilee House
5510 John Smith Drive
Oxford Business Park South
Cowley
Oxford
OX4 2LH

Telephone: 01865 336795
Email: oxon.gpc@nhs.net

11 May 2018

Statement from Oxfordshire Clinical Commissioning Group (OCCG)

OCCG has reviewed the Oxford University Hospitals Foundation Trust (OUHFT) Quality Account and believes that it provides accurate information. The OUHFT is a large NHS organisation that covers many services and, consequently, the CCG recognises that this document will never fully be able to provide the public with full assurance about the quality of NHS services. This Quality Account highlights many of the challenges faced by the Trust and describes areas of quality improvement work which have been undertaken.

The Account sets out the Trust's performance against the nine quality priorities for 2017/18. Of these, five were achieved in full and four were partially achieved. The CCG would like the Trust to consider how areas not fully completed from the 17/18 priorities could be taken forwards so as not to lose the good work already completed.
The priorities for 2018/19 have been developed by the Trust in partnership with stakeholders, including patients and the public. The CCG welcomes the priorities agreed. In particular the choice of 'safe surgery and procedures' and 'right patient every time' will provide a welcome focus on areas which have been identified through serious incidents and never events.

The CCG was disappointed that the Trust did not meet the agreed trajectories for timeliness of discharge summaries, outpatient clinical communication and the endorsement of test results. The CCG recognises the difficulties in achieving these targets and wishes to continue to work with the Trust to deliver the improvements in system working and patient safety.

A skilled and motivated workforce is essential to the delivery of high quality healthcare. It is important

that the Trust does everything it can attract, support and develop staff. The staff survey measure of the percentage of staff who would recommend the organisation as a place to work is therefore an important indicator. OCCG would encourage the Trust to look to other Trusts which score more highly in this domain to understand whether there is anything that could be applied to Oxfordshire to improve staff morale and boost recruitment and retention.

The work of the Trust on implementing the requirements of the CQC's report 'Learning, Candour and Accountability' is to be commended. The Trust has implemented a structured mortality review process. OCCG looks forward to seeing the improvements in patient care which will result from the better understanding of mortality.

There were eight never events declared by the Trust in 2017/18. This is a significant increase on previous years. The Trust has done some excellent work in providing human factors training, developing patient safety alerts, and raising the profile of learning from serious incidents. The number of these incidents is extremely concerning for the CCG. The prevention of further never events in this complex environment is extremely challenging. An understanding of the importance of cultural factors is essential. The CCG welcomes the approach the Trust has taken in inviting the external expertise of the Health Services Investigation Branch and other organisations which may be able to share insight and expertise

High levels of demand have resulted in quality issues such as long waiting times and 12 hour trolley waits in A&E. Managing quality in these circumstances is extremely challenging and requires the Trust to develop a systematic approach to maintaining quality when performance falls below expected levels. The CCG recognises the considerable efforts made by the Trust to ensure the quality of care provided to patients during the extremely busy winter period.

While a number of NHS Constitution targets were not met in 2017/18 the Trust has worked hard to deliver five out of six of the cancer targets.

The Oxford University Hospitals Foundation Trust Quality Account is presented in a clear format. OCCG believes that this Quality Account gives readers confidence that the Trust is being open and honest about the quality of services across the organisation and is committed to driving continuous quality improvement. We recognise that 2018/19 will be a challenging year for the NHS and look forward to working collaboratively with the Trust to ensure quality and safety remains central. The CCG believes that the system should work together in a culture of openness to face the current challenges. We encourage the Trust to be ambitious in its delivery of high quality compassionate care.

NHS England Specialised Commissioning statement on Oxford University Hospitals NHS Foundation Trust 2016-17 Quality Accounts

NHS
England (South)
Specialised Commissioning
60 Caversham Road
Reading
Berkshire
RG1 7EB

Email address: england.speccomm-south@nhs.net

15 May 2018

Dear Colleague

Thank you for sharing the Oxford University Hospitals NHS Foundation Trust (OUH) Quality Account with NHS England. The quality account has been reviewed from the perspective of NHS England as the Specialist Commissioner for the Trust and it is our view this quality account provides an accurate picture of the challenges the Trust faces and improvements made during the year in relation to the quality agenda.

During this year the Trust has further developed its clinical governance and the processes established in place in previous years have helped to strengthen the Trust's safety culture. The Trust recognised eight Never Events during 2017/18 and NHS England acknowledges the depth of investigation and speed of remedial actions carried out by OUH for those incidents relating to Specialised Commissioned Services. The Trust has recognised this is an area requiring focus and included specific work as a priority for 2018/19, which is welcomed by NHS England as is the emphasis the trust is placing on ensuring patients leave hospital in a timely manner.

The 2018/19 quality priorities for OUH have been identified against well-defined and appropriate rationale and it is pleasing to see the involvement of the wider Trust community in establishing the priorities for the future. It would have been beneficial to have included greater detail in relation to project plans and goals with clarity provided on the outcomes that were anticipated.

We are pleased to see good participation in national clinical audits and evidence of changes made as a result of these audit findings. Local clinical audit activity and follow up provides evidence of the Trust's commitment to focus on clinical effectiveness. NHS England is assured that the actions the trust intends to adopt in relation to response to NCEPOD studies will improve response rates in this area.

The OUH Quality Account provides clarity in relation to the Trust's major challenges and demonstrates the openness and transparency of the Trust where standards have not been met. The extraordinary winter pressures experienced by OUH impacted on the Trust's ability to achieve all of the NHS Constitutional standards, notably the referral to treatment time (RTT) standard. NHS England is supporting OUH to rectify this position.

NHS England endorses this Quality Account and we look forward to enhancing our effective relationships in order that improvements to the quality of care will continue for the patients using OUH specialised services.

Yours sincerely

Wendy Cotterell
Director of Nursing – Specialised Commissioning

Response from the Health Overview and Scrutiny Committee to Oxford University Hospitals NHS Foundation Trust Quality Accounts

Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Re: OUHT Quality Account 2017/18

Thank you for sharing the Oxford University Hospitals Trust (OUHT) draft Quality Account with the Joint Health Overview and Scrutiny Committee (HOSC) for comment. This document is a valuable tool in helping the public to understand the Trust's performance and priorities for improving the quality of local services.

The progress against OUHFT's 2017-18 quality priorities and the emerging priorities for 2018-19 were considered by HOSC at its meeting on 19th April 2018 and since then Committee members have reviewed the full draft document.

The Committee is pleased to note improvements made in a number of services. They are particularly pleased to see the progress made on services for patients with mental health illnesses. The Committee would however like to seek assurance from the Trust that there will be a continued focus on the quality targets that were not achieved within 2017-18. In particular:

- HOSC would be keen to see end of life care be considered more holistically in future so the care available to patients in a hospital setting can be provided for those who wish to die at home.

- HOSC would wish to see a continued effort to improve the cancer pathways to avoid unnecessary delays in diagnosis and treatment. The Committee recently received a presentation from OUHFT regarding the chemotherapy services it provides and therefore understands some of the challenges in ensuring quality and performance. The Committee is keen to understand more detail of the quality across each cancer pathway, which contributes to the overall performance in this area.

- The Committee would like to encourage the Trust to continue making improvements to the complaints process and management to ensure they are listening to patients.

In addition to these points discussed at the HOSC meeting on the 19th of April, I would like to urge the Trust to prioritise quality improvements in the areas of Emergency Department (ED) waiting times and on delayed transfers of care. HOSC are particularly keen to see OUHFT bring its ED wait times of 82.83% of patients seen within four hours

in line with the national average of 88.36%. Finally, whilst recognising the complexities and system-wide challenges in reducing delayed transfers of care, I would like to urge the Trust to consider giving this a priority in its quality improvements.

The Committee welcomes the Trust's approach to engaging with patients and stakeholders in their 'Quality Conversation' and look forward to seeing how the priorities identified through this process develop through the 2018/19 Quality Priorities. The Committee would welcome further discussion at a future HOSC meeting about the progress being made against the Trust's 2018-19 priorities.

Yours Sincerely

Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

healthwatch Oxfordshire

15th May 2018

Healthwatch Oxfordshire contribution to the Quality Account 2017/18 for Oxford University Hospitals NHS Trust

Healthwatch Oxfordshire welcomes the opportunity to contribute to Oxford University Hospitals NHS Trust's Quality Account. The Account sets out a significant level of achievements by the Trust in delivering a range of services to the people of Oxfordshire and further beyond.

During 2017/18 Healthwatch attended all four hospital sites as part of our listening to patients' experiences outreach programme. Together with the information gathered on our web site feedback centre the common themes that have appeared are:

1. Most people we have heard from report that they have had a very positive experience when asked about their treatment and care, and staff. "I was in the JR for a long period of time and they were wonderful." People felt listened to and thought the quality of care and treatment were good.
2. The two areas that patients are most dissatisfied about are access to services, and administration. These areas include parking, multiple letters about appointments, cancelled appointments, length of time waiting for an appointment and waiting times when attending for appointments. We believe that the good work that has been done at the eye hospital around improving communications and administration has resulted in improved patient experience. **Healthwatch asks that within the quality action plans for 2018/19 the Trust will once again focus on improving administration and communication with patients.**

As reported in the Quality Report the Trust was reviewed as part of the CQC Planned review of the Oxfordshire system. The key messages from this review were that there was no collective vision or joined

up leadership across the system. Healthwatch welcomes the joint response from the system leaders and believes that the Trust must continue to work collaboratively with other health and social care partners to improve patient experience; particularly around delayed transfer of care and A&E waiting times. As such we welcome the partnership working priority within the Trust's Respect for patients and partners (Patient Experience) quality priority for 2018/19.

Healthwatch Oxfordshire will continue to work with Trust to ensure that patient experiences are heard from as many people as possible.

Oxford University Hospitals
NHS Foundation Trust

Feedback from OUH Governors dated 17th May 2018

In March 2018, the Council of Governors' Patient Experience, Membership and Quality [PEMQ] Committee received an update from the Deputy Medical Director on the development of Quality Priorities for 2018/19 and was also asked to select the quality indicator for external audit. After due consideration, the Committee recommended that 'Patient recommendation of our hospitals to family and friends' should be selected as the quality indicator for external audit. This was subsequently approved by Governors.

At its meeting held on 30 April, the Council of Governors then reviewed the latest available draft of the OUH Quality Account 2017/18, presented by the Deputy Medical Director.

In discussion of the Quality Account, Governors took the opportunity to raise queries in relation to some specific points, including the work that was noted to be underway to reduce the number of 'stranded' patients, related to the Quality Priority for Partnership Working.

A final draft of the OUH Quality Account 2017/18 (as shared with external stakeholders, including the Oxfordshire Health Overview and Scrutiny Committee and Oxfordshire Clinical Commissioning Group) was then circulated to all Governors in May and this elicited some further helpfully detailed drafting comments which the Trust has taken into account.

Overall, Governors have welcomed the Quality Account as a comprehensive document, and have commented that it includes information on a lot of very good work that is being done to maintain high quality care for patients in Oxfordshire.

Annexe 2: Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017-18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to May 2018
  - papers relating to Quality reported to the Board over the period April 2017 to May 2018
  - feedback from commissioners dated 11th May 2018 (Oxfordshire Clinical Commissioning Group), 15th May 2018 (NHS England Specialised Commissioning).
  - feedback sought from Governors May 2018
  - feedback from local Healthwatch organisations dated 15th May 2018
  - feedback from Overview and Scrutiny Committee dated 15th May 2018
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13th September 2017
  - the (latest) national patient survey dated August 2017
  - the (latest) national staff survey September to November 2017
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 18th April 2018
  - CQC inspection reports dated 27/03/2017 (System-wide review, Well-Led inspection, Maternity inspection and the Oxford Centre for Enablement inspection)
  - the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
  - the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

NB: sign and date in any colour ink except black

Chairman
23 May 2018

Chief Executive
23 May 2018

Independent auditor's report to the Council of Governors of Oxford University Hospitals NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Oxford University Hospitals NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of Oxford University Hospitals NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

This report is made solely to the Trust's Council of Governors, as a body, in accordance with our engagement letter dated 14 May 2018. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018 to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our examination, for this report, or for the conclusions we have formed.

Our work has been undertaken so that we might report to the Council of Governors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period on page 194;
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge on page 194; and
- Friends and Family Test Inpatients Survey (locally selected) on page 179 and 180.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and Ernst & Young LLP

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2017/18' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS Foundation Trust Annual Reporting Manual 2017/18' , which is supported by NHS Improvement's Detailed Requirements for quality reports 2017/18;
- the quality report is not consistent in all material respects with the sources specified in detailed in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2017/18' and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS Foundation Trust Annual Reporting Manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the 'Detailed Guidance for External Assurance on Quality Reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the other information sources detailed in Section 2.1 of the 'Detailed guidance for external assurance on quality reports 2017/18'. These are:

- Board minutes for the period April 2017 to May 2018
- Papers relating to quality reported to the Board over the period April 2017 to May 2018
- feedback from commissioners, dated 11/05/2018
- feedback from governors, dated 17/05/2018
- feedback from local Healthwatch organisations, dated 15/5/2018
- feedback from Overview and Scrutiny Committee dated 15/05/2018
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13/09/2017
- the latest national patient survey, dated 2016
- the latest national staff survey, dated 2017
- Care Quality Commission inspection, dated 27/03/2018, and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 18/04/2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Oxford University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Oxford University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Oxford University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included, but were not limited to:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the 'NHS Foundation Trust Annual Reporting Manual 2017/18' to the categories reported in the Quality Report.
- reading the documents.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a

negative conclusion on the Quality Report. The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance. The scope of our assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Oxford University Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2018 and the Detailed requirements for quality reports 2017/18 published in January 2018 (updated in February 2018) issued by NHS Improvement
- the Quality Report is not consistent in all material respects with the sources specified in 'Detailed guidance for external assurance on quality reports 2017/18' and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with NHS Foundation Trust Annual Reporting Manual 2018 and the Detailed requirements for quality reports 2017/18 published in January 2018 (updated in February 2018) issued by NHS Improvement .

Ernst & Young LLP

Ernst & Young LLP
Reading
23 May 2018

The following foot note should be added to the assurance report when it is published or distributed electronically:

Notes:

1. The maintenance and integrity of the Oxford University Hospitals NHS Foundation Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Report since it was initially presented on the web site.

2. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

FINANCIAL STATEMENTS AND NOTES

FINANCIAL STATEMENTS

These accounts cover the twelve months from 1 April 2017 to 31 March 2018 and have been prepared by the Oxford University Hospitals NHS Foundation Trust under in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

The Audit Certificate is included within the accounts.

Jason Dorsett
Chief Finance Officer
23 May 2018

Foreword to the Accounts

The Trust made a deficit of **£9,371,000** as reported to NHS Improvement for the twelve months to 31 March 2018. The accounts record a surplus of £3,548,000; the difference of £12,919,000 relates to technical treatments associated with accounting for Private Finance Initiatives' schemes, elimination of the donated asset / government grant reserve, removing prior year risk reserve adjustments and revaluations of assets which are each excluded by NHS Improvement when considering the performance of the Trust.

		2017-18 £000	2016/17 £000
Retained surplus / (deficit) for the year		3,548	(57,196)
Add back impairments and reversal of impairments included in the surplus above	6.1	(13,269)	58,209
Surplus /(deficit) before impairments and transfers		(9,721)	1,013
Add back Gain/(loss) on asset disposals*1	13		330
Add back Donations and grants received for PPE and intangible assets	4	(251)	(636)
Add back Depreciation and amortisation –donated granted assets		2,678	2,908
Retain impact of DEL I&E (impairments) / reversals	7	(30)	
Surplus /(deficit) on a control total basis (including STF, including CQUIN risk reserve)		**(7,324)**	**3,615**
Less: Sustainability and transformation fund income		(5,374)	(9,945)
Surplus/(deficit) on a control total basis (excluding STF)		**(12,698)**	**(6,330)**
Surplus/(deficit) on a control total basis (including STF, including CQUIN risk reserve)		**(7,324)**	**3,615**
Less: CQUIN Risk Reserve - 1617 CT non-achievement adjustment		(2,047)	
Surplus/(deficit) on a control total basis (including STF, excluding CQUIN 1617)		**(9,371)**	**3,615**

*1 *Note that gains / (losses) on asset disposal are no longer excluded from the control total calculation in 2017-18.*

Oxford University Hospitals NHS Foundation Trust

Statutory Accounts for the Year Ended 31 March 2018

Oxford University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

Foreword to the accounts

Oxford University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Oxford University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed 

Name Bruno Holthof
Job title Chief Executive
Date **23 May 2018**

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	863,377	835,174
Other operating income	4	166,832	162,826
Operating expenses	6, 8	(1,002,649)	(1,032,772)
Operating surplus/(deficit) from continuing operations		**27,560**	**(34,772)**
Finance costs			
Finance income	11	145	151
Finance expense	12	(21,017)	(19,404)
PDC dividends payable		(6,552)	(7,001)
Net finance costs		**27,424**	**(26,254)**
Other gains / (losses)	13	3,412	3,830
Share of profit of associates/joint arrangements	20	-	-
Gains/ (losses) arising from transfers by absorption		-	-
Corporation tax expense	13	-	-
Surplus/(deficit) for the year from continuing operations		**3,548**	**(57,196)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	14	**-**	**-**
Surplus/(deficit) for the year		**3,548**	**(57,196)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(534)	(32,326)
Revaluations	18	11,145	3,521
Share of comprehensive income from associates and joint ventures	20	-	-
Other recognised gains and losses		-	-
Re-measurements of the net defined benefit pension scheme liability/asset	37	-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on available-for-sale financial investments	13	-	-
Recycling gains/(losses) on available-for-sale financial investments	13	-	-
Foreign exchange gains / (losses) recognised directly in OCI	13	-	
Total comprehensive income/(expense) for the period		**14,159**	**(86,001)**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	7,285	8,763
Property, plant and equipment	16	566,345	536,492
Investment property	19	12,785	12,265
Investments in associates and joint ventures	20	-	-
Other investments / financial assets	21	3,600	295
Trade and other receivables	24	6,134	6,089
Other assets	25		-
Total non-current assets		**596,149**	**563,904**
Current assets			
Inventories	23	22,664	19,969
Trade and other receivables	24	66,041	54,256
Other investments / financial assets	21	-	-
Other assets	25	503	
Non-current assets held for sale / assets in disposal groups	26	-	-
Cash and cash equivalents	27	39,910	41,627
Total current assets		**129,118**	**115,852**
Current liabilities			
Trade and other payables	28	(105,201)	(91,501)
Borrowings	31	(11,973)	(11,635)
Other financial liabilities	29	-	-
Provisions	33	(1,446)	(4,389)
Other liabilities	30	(18,291)	(18,951)
Liabilities in disposal groups	26	-	-
Total current liabilities		**(136,911)**	**(126,476)**
Total assets less current liabilities		**588,356**	**553,280**
Non-current liabilities			
Trade and other payables	28	-	-
Borrowings	31	(255,105)	(242,099)
Other financial liabilities	29	-	-
Provisions	33	(2,492)	(2,609)
Other liabilities	30	(9,134)	(12,201)
Total non-current liabilities		**(266,731)**	**(256,909)**
Total assets employed		**321,625**	**296,371**
Financed by			
Public dividend capital		223,045	211,950
Revaluation reserve		125,552	115,172
Available for sale investments reserve		-	-
Other reserves		1,743	1,743
Merger reserve		-	-
Income and expenditure reserve		(28,715)	(32,494)
Total taxpayers' equity		**321,625**	**296,371**

The notes on pages 223-273 form part of these accounts.

Name	Dr Bruno Holthof
Position	Chief Executive
Date	**23 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 – brought forward	**211,950**	**115,172**	**1,743**	**(32,494)**	**296,371**
Surplus/(deficit) for the year	-	-	-	**3,548**	**3,548**
Transfers by absorption: transfers between reserves	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-
Impairments	-	**(534)**	-	-	**(534)**
Revaluations	-	**11,145**	-	-	**11,145**
Transfer to retained earnings on disposal of assets	-	**(231)**	-	**231**	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-
Re-measurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-
Public dividend capital received	**11,095**	-	-	-	**11,095**
Public dividend capital repaid	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-
Other reserve movements	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2018	**223,045**	**125,552**	**1,743**	**(28,715)**	**321,625**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**202,781**	**144,358**	**1,743**	**24,321**	**373,203**
Surplus/(deficit) for the year	-	-	-	**(57,196)**	**(57,196)**
Transfers by absorption: transfers between reserves	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-
Impairments	-	**(32,326)**	-	-	**(32,326)**
Revaluations	-	**3,521**	-	-	**3,521**
Transfer to retained earnings on disposal of assets	-	**(381)**	-	**381**	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	-	-
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-
Public dividend capital received	**9,169**	-	-	-	**9,169**
Public dividend capital repaid	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-
Other reserve movements	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2017	**211,950**	**115,172**	**1,743**	**(32,494)**	**296,371**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
This reserve reflects historical balances formed when the Horton General Hospital became a part of the trust.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus/(deficit)		27,560	(34,772)
Non-cash income and expense:			
Depreciation and amortisation	6.1	32,425	36,000
Net impairments	7	(13,269)	58,209
Income recognised in respect of capital donations	4	(251)	(636)
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase)/decrease in receivables and other assets		(14,567)	(14,233)
(Increase)/decrease in inventories		(2,695)	(4,291)
Increase/(decrease) in payables and other liabilities		11,917	(29,690)
Increase/(decrease) in provisions		(3,066)	4,179
Tax (paid)/received		-	-
Operating cash flows movement of discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated from/(used in) operating activities		**38,054**	**14,766**
Cash flows from investing activities			
Interest received		145	151
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(2,470)	(2,439)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(17,852)	(32,747)
Sales of property, plant, equipment and investment property		350	60
Receipt of cash donations to purchase capital assets		-	38
Prepayment of PFI capital contributions		-	(1,319)
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions / disposals of subsidiaries		(655)	-
Net cash generated from/(used in) investing activities		**(20,482)**	**(36,256)**
Cash flows from financing activities			
Public dividend capital received		11,095	9,169
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care	31	(1,405)	(1,405)
Movement on other loans	31	7,500	-
Other capital receipts		-	-
Capital element of finance lease rental payments	31	(832)	(315)
Capital element of PFI, LIFT and other service concession payments		(9,979)	(6,840)
Interest paid on finance lease liabilities		(79)	(115)
Interest paid on PFI, LIFT and other service concession obligations		(20,815)	(19,149)
Other interest paid		(57)	(103)
PDC dividend paid / (refunded)		(4,717)	(7,559)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from/(used in) financing activities		**(19,289)**	**(26,317)**
Increase/(decrease) in cash and cash equivalents		**(1,717)**	**(47,807)**
Cash and cash equivalents at 1 April – brought forward		**41,627**	**89,434**
Prior period adjustments		**-**	**-**
Cash and cash equivalents at 1 April – restated		**41,627**	**89,434**
Cash and cash equivalents transferred under absorption accounting	44	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	27.1	**39,910**	**41,627**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going Concern
The Trust is forecasting a financial deficit in delivering its services in 2018/19 and it anticipates that it may take some time before it can achieve financial balance on a sustainable basis. The Board of Directors has carefully considered the principle of 'Going Concern' and the directors have concluded that there are uncertainties related to the financial sustainability (profitability and liquidity) of the Trust which may cast doubt about the ability of the Trust to continue as a Going Concern without access to external finance.

Nevertheless, the Going Concern basis remains appropriate. This is because the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources in the form of financial support from the Department of Health (NHS Act 2006, s42a) to continue to deliver the full range of mandatory services for the foreseeable future. The assessment accords with the statutory guidance contained in the NHS Foundation Trust Annual Reporting Manual and the Department of Health Group Accounting Manual (GAM).

Note 1.2 Critical judgements in applying accounting policies
In the application of the NHS Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. The estimate is considered reasonable at the time it is made and would not differ materially to the actual result. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the

most significant effect on the amounts recognised in the financial statements:

PFI and service concessions classification
The Trust has assessed the three PFI schemes, Welcome Centre, and Carbon Energy Scheme against the international financial reporting standards and relevant NHS accounting guidance and judges that all are capitalised under the IFRIC 12 criteria. Estimates for the assets, liabilities and amounts chargeable to the SOCI are determined as per the estimation paragraph in section 1.2.1. The Welcome Centre has no economic outflow from the Trust so is reported under deferred income following the guidance.

Leases
New operating leases are considered against the criteria to determine whether substantially all the risks and rewards of ownership have been transferred to the Trust. More detail is contained in 1.14.

Capitalisation of staff costs
The Trust makes judgements about which of its staff costs are related to capital improvements that meet the definitions in 1.7. These judgements are based on timesheets and the Trust's understanding of what is being achieved by the individuals carrying out the work.

Note 1.2.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Property valuations
The Trust has used valuations carried out in March 2018 by the District Valuer to determine the value of property. These valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health.

Estimation of contract income
Achieving early closure of accounts means that the accounts must be prepared before the normal cycle for contract income is complete. Contract income includes some estimated values and assessment of income risk based on actual activity for the first 10 months of the Financial Year. Actual amounts may differ from the estimate depending on actual activity levels, but not materially so. Included in the income figure is an estimate for partially completed spells.

Estimation of payments for the PFI and service concession assets, including finance costs
The assets and liabilities relating to the three PFI schemes have been brought onto the statement of financial position based on estimations from the DH financial model as required by the Department of Health guidance. The models also provide estimates for interest payable and contingent rent as disclosed in Note 11.
A similar model has been developed to estimate the accounting entries for the Trust's Carbon Energy Scheme which is capitalised under IFRIC12 as a service concession. A liability also exists for future commitments and the model estimates the interest payable as disclosed in Note 12.

Estimation of asset lives as the basis for depreciation calculations

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets. Managers have adjusted estimated lives at the end of the accounting period, where their estimate of useful life is significantly different to the original. The estimate of asset lives may

differ to the actual period the Trust utilises the asset but any difference would not be material.

Impairment of receivables
The Trust is required to judge when there is sufficient evidence to impair individual receivables. It does this based on the aged profile and class of the receivables. Different classes of receivables attract different rates of impairment depending on the Trust's assessment of the level of risk associated with the collection of the debt. The Trust adopts a prudent policy of providing against debt that is more than 90 days overdue, the amount that is judged to be impaired generally increases the older the debt is. The Trust makes every effort to collect the debt, even when it has been impaired, and only writes off the debt as a final course of action after all possible collection efforts have been made. The actual level of debt written off may be different to that which had been judged as impaired, but not materially so.

Accruals and prepayments
Each year the Trust sets detailed guidance for its managers in order to assist them in calculating accruals and prepayments including de-minimis levels. The Trust uses a number of techniques to calculate its best estimate for accruals. Techniques that are used include:-
- Trend analysis
- Expert judgement of Finance Managers
- Supplier statements
- Formulaic approach based on historical cost information

Prepayments are not normally sensitive to future events, and they can be reliably estimated. Accruals are a matter of judgement, based on past experience and information available at the time. Once realised, accruals can be different to the original estimate, but not materially so.

Note 1.3 Interests in other entities

Subsidiaries
Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Associates
Associate entities are those over which the trust has the power to exercise a significant influence. Associate entities are recognised in the trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the trust's share of the entity's profit or loss or other gains and losses (e.g. revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, e.g., share dividends are received by the trust from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and "fair value less costs to sell".

Joint ventures
Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

Joint operations
Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Note 1.4 Income
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred. Projects with high levels of deferred income are reviewed to ensure income has been appropriately recognised.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue related to patient care spells that are part completed at the end of the accounting period are apportioned across the financial periods on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts based on the rate advised in the accounting manual.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to

the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000 or

• collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.
• IT hardware that is attached to a network is considered to be interdependent regardless of whether it can be used without a network. The effect of this is that all IT hardware where all of the criteria above are met will be capitalised.
• Assets which are capital in nature, but which are individually valued at less than £5,000 but more than £250, may be capitalised as a collective or "Grouped Asset' where they form part of the initial equipping and setting-up costs of a new building, ward or unit.
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Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Land and buildings (including operational dwellings) used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
• land and non-specialised buildings – market value for existing use
• specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

In agreement with the District Valuer, where appropriate the Trust has applied an 'optimal site' valuation which recognises any efficiencies that could be obtained if the site were to be rebuilt, whilst allowing the current level of service provision to be maintained. This valuation approach is based on a detailed review by qualified valuation staff of the land and buildings on the Trust's John Radcliffe, Churchill and Nuffield Orthopaedic Centre sites and Horton General Hospital site. This approach is consistent with the concepts provided under Depreciated Replacement Cost valuation based on modern equivalent assets. For non-operational buildings, including surplus land, the valuations are carried out at open market value.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated, and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT transactions which meet the IFRIC12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Note 1.7.6 Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Land	n/a	n/a
Buildings, excluding dwellings	12	66
Dwellings	12	32
Plant & machinery	5	25
Transport equipment	7	7
Information technology	3	8
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Mote 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, e.g.,

the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	8
Development expenditure	-	-
Websites	-	-
Software licences	5	8
Licences & trademarks	-	-
Patents	3	3
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.10 Investment properties
Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.11 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.
The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as "fair value through income and expenditure" or loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items

classified as “available-for-sale” are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in “finance costs” in the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals or discounted cash flow analysis.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at “fair value through income and expenditure” are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

The Trust operates a bad debt provision based upon a calculation which is reviewed annually taking account of debt profile, classification and performance. The Trust does not make any judgement on this provision, but it does review overdue debt and writes off debt that is considered to be irrecoverable, after all efforts to collect the money have been exhausted.

Note 1.14 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is

accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.
Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the trust is disclosed at note 33.2 but is not recognised in Trust’s accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any “excesses” payable in respect of particular claims are charged to operating

expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayment of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

The Trust's activities relate to the provision of goods and services relating to healthcare and the Trust is not registered as a limited company. On this basis the Trust is not liable for corporation tax.

Note 1.20 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the Trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS or local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

The following list shows recently issues accounting standards and amendments which have not yet been adopted within the *FReM*, and are therefore not applicable to DH group accounts in 2017/18:
IFRS 9 Financial Instruments - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 14 Regulatory Deferral Accounts - Not yet EU-endorsed.*
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.
IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 22 Foreign Currency Transactions and Advance Consideration - Application required for

accounting periods beginning on or after 1 January 2018.

IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.
** The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries.*

Note 2 Operating Segments

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across all locations and the appropriate policies, procedures and governance arrangements are Trust wide. As a NHS Trust, all services are subject to the same regulatory environment and standards set by external performance managers. The Trust operates one segment and in the period to 31 March 2018 reported to the Board in this format. No discrete activities of the business have individual revenue exceeding 10% of the total combined revenue or assets.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	£000	£000
Acute services		
Elective income	160,457	160,210
Non elective income	202,539	176,772
First outpatient income	52,929	50,970
Follow up outpatient income	76,623	80,539
A & E income	21,689	19,147
High cost drugs income from commissioners (excluding pass-through costs)	-	-
Other NHS clinical income	337,768	335,159
All services		
Private patient income	7,826	8,620
Other clinical income	3,546	3,757
Total income from activities	**863,377**	**835,174**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:

	2017/18 £000	2016/17 £000
NHS England	414,669	417,619
Clinical commissioning groups	426,347	395,510
Department of Health and Social Care	-	-
Other NHS providers	-	-
NHS other	178	-
Local authorities	10,087	8,916
Non-NHS: private patients	7,826	8,620
Non-NHS: overseas patients (chargeable to patient)	1,298	1,181
NHS injury scheme (was RTA)	2,248	2,576
Non NHS: other	724	752
Total income from activities	**863,377**	**835,174**
Of which:		
Related to continuing operations	863,377	835,174
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2017-18 £000	2016-17 £000
Income recognised this year	1,298	1,181
Cash payments received in-year	1,030	893
Amounts added to provision for impairment of receivables	-	134
Amounts written off in-year	162	379

Note 4 Other operating income

	2017/18 £000	2016/17 £000
Research and development	58,288	55,165
Education and training	47,080	46,772
Receipt of capital grants and donations	251	636
Charitable and other contributions to expenditure	1,391	1,169
Non-patient care services to other bodies	23,489	22,235
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and Transformation Fund income	5,374	9,945
Rental revenue from operating leases	2,526	2,228
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis	9,288	8,135
Other income	19,145	16,541
Total other operating income	**166,832**	**162,826**
Of which:		
Related to continuing operations	166,832	162,826
Related to discontinued operations	-	-

Other income includes income from car parking £3.5m (16/17 £4.0m), Estates energy recharges £2.1m (16/17 £1.5m) and a one-off rebate from HMRC related to a historic claim of £1.0m

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18 £000	2016/17 £000
Income from services designated (or grandfathered) as commissioner requested services	854,253	825,373
Income from services not designated as commissioner requested services	9,124	9,801
Total	**863,377**	**835,174**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The Trust did not dispose of any land and building assets used in the provision of Commissioner Requested Services during the year ended 31 March 2018.

Note 5 Fees and Charges	2017/18 £000	2016/17 £000
Income	12,606	12,630
Full cost	(9,380)	(9,398)
Surplus /(deficit)	**3,226**	**3,232**

Note that this relates to private patient income of £7.8m, car parking income of £3.5m and overseas patient income of £1.3m

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	8,955	6,438
Purchase of healthcare from non NHS bodies and non-DHSC bodies	7,497	9,131
Purchase of social care		-
Staff and executive directors costs	536,982	524,604
Remuneration of non-executive directors	166	233
Supplies and services – clinical (excluding drugs costs)	117,963	106,778
Supplies and services - general	8,084	7,260
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	121,185	115,589
Inventories written down	2	132
Consultancy costs	3,994	5,218
Establishment	9,313	7,908
Premises	28,548	30,434
Transport (including patient travel)	4,246	3,145
Depreciation on property, plant and equipment	28,464	32,341
Amortisation on intangible assets	3,961	3,659
Net impairments / (reverse impairments)	(13,269)	58,209
Increase/(decrease) in provision for impairment of receivables	(556)	1,210
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	33	266
Audit fees payable to the external auditor		
audit services- statutory audit	108	108
other auditor remuneration (external auditor only)	6	6
Internal audit costs	171	248
Clinical negligence	36,516	33,674
Legal fees	855	372
Insurance	381	25
Research and development	44,981	44,668
Education and training	7,419	2,326
Rentals under operating leases	823	1,132
Early retirements	-	-
Redundancy	155	259
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	34,665	30,840
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-	-
Car parking & security	1,270	1,466
Hospitality	46	24
Losses, ex gratia & special payments	34	23
Grossing up consortium arrangements	-	-
Other services, e.g. external payroll	3,905	1,360
Other	5,746	3,605
Total	**1,002,649**	**1,032,772**
Of which:		
Related to continuing operations	1,002,649	1,032,772
Related to discontinued operations	-	**-**

Note 6.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	6	6
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**6**	**6**

Note 6.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2m (2016-17: £2m).

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	30	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	(13,299)	58,209
Other		-
Total net impairments / (reverse impairments) charged to operating surplus / deficit	**(13,269)**	**58,209**
Impairments charged to the revaluation reserve	534	32,326
Total net impairments / (reverse impairments)	**(12,735)**	**90,535**

There are two reasons for the impairments above:
i. the impairment on revaluation to a modern equivalent asset basis when a new building or enhancement to an existing building is first brought into use
ii.the changes in market price arising from the revaluation as at 31 March 2018 which results in impairments and reverse impairments

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	456,915	441,408
Social security costs	41,053	39,379
Apprenticeship levy	2,069	-
Employer's contributions to NHS pensions	48,438	46,483
Pension cost - other	4	5
Other post-employment benefits	-	-
Other employment benefits	-	-
Termination benefits	155	259
Temporary staff (including agency)	38,159	37,572
Total gross staff costs	**586,793**	**565,106**
Recoveries in respect of seconded staff		**-**
Total staff costs	**586,793**	**565,106**
Of which		
Costs capitalised as part of assets	1,864	1,677
Temporary staff comprises		
Bank staff	26,719	22,267
Agency staff	11,440	15,305
	38,159	**37,572**

Agency staff includes a £0.9m one-off rebate from HMRC in respect of a claim related to prior periods

Note 8.1 Retirements due to ill-health

During 2017/18 there were 3 early retirements from the trust agreed on the grounds of ill-health (4 in the twelve months ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £209k (£351k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with

approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.
The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders

Due to a change in the law, all employers are required to automatically enrol certain workers in a pension scheme. If employees meet the scheme's eligibility criteria they will be enrolled in the NHS Pension Scheme. If an employee cannot be enrolled in the NHS Pension Scheme for whatever reason, they are automatically enrolled in an alternative qualifying pension scheme. For OUH employees this scheme is the National Employee's Savings Trust (NEST). At the present time there are very few employees (<0.1%) in this scheme.

Note 10 Operating leases

Note 10.1 Oxford University Hospitals NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Oxford University Hospitals NHS Foundation Trust is the lessor.

The Trust has a number of areas within properties where it acts as a lessor. These are generally buildings or areas within buildings on the various hospital sites where space has been let to universities, charities or other organisations.

	2017/18 Total £000	2016/17 Total £000
Operating lease revenue		
Minimum lease receipts	-	-
Contingent rent	-	-
Other	2,526	2,228
Total	2,526	2,228

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	2,223	1,117
- later than one year and not later than five years;	4,859	4,444
- later than five years.	22,547	22,136
Total	29,629	27,697

Note 10.2 Oxford University Hospitals NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Oxford University Hospitals NHS Foundation Trust FT is the lessee.

The Trust's operating leases fall into two categories:

a) Leases of items of plant and equipment which are not treated as finance leases. These are predominantly items of office equipment or motor vehicles. There is no material contingent rental, and the leases are for fixed terms. There are no restrictions in these leases other than those which would commonly be found in commercial leases of this kind.

b) Leases of property. Typically these are leases of space in other NHS facilities. These leases are negotiated for fixed terms.

	2017/18 Total £000	2016/17 Total £000
Operating lease expense		
Minimum lease payments	823	1,132
Contingent rents	-	-
Less sublease payments received	-	-
Total	**823**	**1,132**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	134	304
- later than one year and not later than five years;	130	253
- later than five years.	-	-
Total	**264**	**557**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18 £000	2016/17 £000
Interest on bank accounts	145	151
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total	**145**	**151**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health	55	101
Other loans	62	-
Overdrafts	-	-
Finance leases	79	115
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	14,208	14,002
Contingent finance costs on PFI and LIFT scheme obligations	6,607	5,148
Total interest expense	**21,011**	**19,366**
Unwinding of discount on provisions	6	38
Other finance costs	-	-
Total	**21,017**	**19,404**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2017/18 £000	2016/17 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains/ (losses)

	2017/18 £000	2016/17 £000
Gains on disposal of assets	350	-
Loss on disposal of assets	(109)	(330)
Total gains/(losses) on disposal of assets	241	(330)
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	520	3,865
Fair value gains / (losses) on financial assets / investments	2,651	295
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-
Total other gains / (losses)	**3,412**	**3,830**

Note 14 Discontinued operations

The Trust does not have any operations that are classified as discontinued in the year ended 31 March 2018.

Note 15.1 Intangible assets - 2017/18

	Software licences	Patents	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**6,730**	**9**	**20,997**	**728**	**28,464**
Transfers by absorption	-	-	-	-	**-**
Additions	628	-	972	883	**2,483**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	728	(728)	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	(4,278)	-	-	-	**(4278)**
Gross cost at 31 March 2018	**3,080**	**9**	**22,697**	**883**	**26,669**
Amortisation at 1 April 2017 - brought forward	**5,620**	**9**	**14,072**	**-**	**19,701**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	331	-	3630	-	**3,961**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	(4,278)	-	-	-	**(4,278)**
Amortisation at 31 March 2018	**1,673**	**9**	**17,702**	**-**	**19,384**
Net book value at 31 March 2018	**1,407**	**-**	**4,995**	**883**	**7,285**
Net book value at 1 April 2017	**1,110**	**-**	**6,925**	**728**	**8,763**

Note 15.2 Intangible assets - 2016/17

	Software licences	Patents	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**6,878**	**9**	**18,909**	**289**	**26,085**
Transfers by absorption	-	-	-	-	**-**
Additions	320	-	1,355	704	**2,379**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	(468)	-	733	(265)	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / de-recognition	-	-	-	-	**-**
Valuation/gross cost at 31 March 2017	**6,730**	**9**	**20,997**	**728**	**28,464**
Amortisation at 1 April 2016 - brought forward	**2,728**	**9**	**13,305**	**-**	**16,042**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	362	-	3,297	-	**3,659**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	2,530	-	(2,530)	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / de-recognition	-	-	-	-	**-**
Amortisation at 31 March 2017	**5,620**	**9**	**14,072**	**-**	**19,701**
Net book value at 31 March 2017	**1,110**	**-**	**6,925**	**728**	**8,763**
Net book value at 1 April 2016	**4,150**	**-**	**5,604**	**289**	**10,043**

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**56,111**	**424,091**	**616**	**4,541**	**187,493**	**654**	**17,745**	**3,668**	**694,919**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	6,727	-	5,547	21,787	-	310	174	**34,545**
Impairments	-	(573)	-	-	-	-	-	-	**(573)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	2,720	7,458	8	-	-	-	-	-	**10,186**
Reclassifications	-	-	-	(371)	371	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(30)	(5,163)	-	(5,482)	(10)	**(10,685)**
Valuation/gross cost at 31 March 2018	**58,831**	**437,703**	**624**	**9,687**	**204,489**	**654**	**12,573**	**3,832**	**728,393**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**-**	**-**	**-**	**143,281**	**575**	**11,516**	**3,055**	**158,427**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	14,268	29	-	12,365	22	1,561	219	**28,464**
Impairments	888	(34)	-	30	-	-	-	-	**884**
Reversals of impairments	(2,592)	(11,600)	-	-	-	-	-	-	**(14,192)**
Revaluations	1,704	(2,634)	(29)	-	-	-	-	-	**(959)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	(30)	(5,054)	-	(5,482)	(10)	**(10,576)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**150,592**	**597**	**7,595**	**3,264**	**162,048**
Net book value at 31 March 2018	**58,831**	**437,703**	**624**	**9,687**	**53,897**	**57**	**4,978**	**568**	**566,345**
Net book value at 1 April 2017	**56,111**	**424,091**	**616**	**4,541**	**44,212**	**79**	**6,229**	**613**	**536,492**

Note 16.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**56,111**	**515,547**	**635**	**1,108**	**181,188**	**612**	**18,430**	**3,579**	**777,210**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	11,949	-	3,433	10,263	56	811	112	**26,624**
Impairments	-	(101,282)	-	-	-	-	-	-	**(101,282)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(2,115)	(19)	-	-	-	-	-	**(2,134)**
Reclassifications	-	(8)	-	-	8	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / de-recognition	-	-	-	-	(3,966)	(14)	(1,496)	(23)	**(5,499)**
Valuation/gross cost at 31 March 2017	**56,111**	**424,091**	**616**	**4,541**	**187,493**	**654**	**17,745**	**3,668**	**694,919**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**-**	**-**	**-**	**132,592**	**562**	**11,672**	**2,771**	**147,597**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	16,372	30	-	14,431	27	1,187	294	**32,341**
Impairments	1,462	(10,437)	-	-	-	-	-	-	**(8,975)**
Reversals of impairments	(1,462)	(310)	-	-	-	-	-	-	**(1,772)**
Revaluations	-	(5,625)	(30)	-	-	-	-	-	**(5,655)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / de-recognition	-	-	-	-	(3,742)	(14)	(1,343)	(10)	**(5,109)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**143,281**	**575**	**11,516**	**3,055**	**158,427**
Net book value at 31 March 2017	**56,111**	**424,091**	**616**	**4,541**	**44,212**	**79**	**6,229**	**613**	**536,492**
Net book value at 1 April 2016	**56,111**	**515,547**	**635**	**1,108**	**48,596**	**50**	**6,758**	**808**	**629,613**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018									
Owned	50,380	203,269	624	9,687	26,261	57	4,952	493	**295,723**
Finance leased	-	-	-	-	1,984	-	-	-	**1,984**
On-SoFP PFI contracts and other service concession arrangements	-	188,211	-	-	24,071	-	-	-	**212,282**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	8,451	46,223	-	-	1,581	-	26	75	**56,356**
NBV total at 31 March 2018	**58,831**	**437,703**	**624**	**9,687**	**53,897**	**57**	**4,978**	**568**	**566,345**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned	48,011	198,850	616	4,541	33,152	79	6,194	515	**291,958**
Finance leased	-	-	-	-	2,421	-	-	-	**2,421**
On-SoFP PFI contracts and other service concession arrangements	-	180,084	-	-	6,335	-	-	-	**186,419**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	8,100	45,157	-	-	2,304	-	35	98	**55,694**
NBV total at 31 March 2017	**56,111**	**424,091**	**616**	**4,541**	**44,212**	**79**	**6,229**	**613**	**536,492**

Note 17 Donations of property, plant and equipment

The donated assets acquired in the year were mostly donated by Oxford Hospitals Charity, and other trust funds associated with Oxford University Hospitals NHS Foundation Trust. There were no restrictions or conditions imposed by the donor on the use of the donated assets.

Note 18 Revaluations of property, plant and equipment

The Trust's land and buildings were revalued as at 31st March 2018 by the District Valuer. The valuation was an open market value using the modern equivalent asset basis of valuation. In assessing the value of the Trust's land it was assumed that should the existing buildings be replaced by a modern equivalent asset, certain buildings would be rebuilt on a more intensive basis, on an alternative 'optimal site'. Therefore a smaller landholding and buildings footprint is required while still maintaining the current level of service provision.

Asset lives of buildings are updated at the end of each statutory reporting period on the expert advice of the District Valuer. The update does not affect depreciation in the current period of accounts and does not have a material impact on future accounting periods.

Note 19.1 Investment Property

	2017/18 £000	2016/17 £000
Carrying value at 1 April – brought forward	**12,265**	**-**
Prior period adjustments	**-**	**-**
Carrying value at 1 April - restated	**12,265**	**-**
Transfers by absorption	-	-
Acquisitions in year	-	8,400
Movement in fair value	520	3,865
Reclassifications to/from PPE	-	-
Transfers to/from assets held for sale	-	-
Disposals	-	-
Carrying value at 31 March	**12,785**	**12,265**

Note 19.2 Investment property income and expenses

	2017/18 £000	2016/17 £000
Direct operating expense arising from investment property which generated rental income in the period	(17)	(11)
Direct operating expense arising from investment property which did not generate rental income in the period	(3)	-
Total	**(20)**	**(11)**
Investment property income	825	561

Note 20 Investments in associates (and joint ventures)

The Trust is in the process of establishing new joint venture entities, for more information please see note 21.

Note 21 Other investments / financial assets (non-current)

	2017/18	2016/17
	£000	£000
Carrying value at 1 April – brought forward	**295**	**-**
Prior period adjustment	**-**	
Carrying value at 1 April - restated	**295**	**-**
Transfers by absorption	-	-
Acquisitions in year	654	-
Movement in fair value	2,651	295
Net impairment	-	-
Transfers to / from assets held for sale and assets in disposal groups	-	-
Amortisation at the effective interest rate (assets held at amortised cost only where applicable)	-	-
Current portion of loans receivable transferred to current financial assets	-	-
Disposals	-	-
Carrying value at 31 March	**3,600**	**295**

Other investments includes the Trust's equity shareholding in research and development spin-out companies which are valued at the most recent price any other stakeholder has invested at. The total value attributed to OUH is £3.0m.

Other investments also includes the Trust's start-up costs of £0.6m in respect of a new joint venture with the University of Oxford (Oxford University Clinic LLP - 50% owned by OUH). OUC has made one significant investment to date (Mayo Clinic Healthcare in partnership with Oxford University Clinic LLP) which is a 50:50 joint venture with the Mayo Clinic. The Trust and the University have incorporated some intermediary holding companies that are not trading. None of the entities are yet to produce statutory financial statements. It is anticipated that in the 2018/19 accounts, the Trust will present group consolidated financial statements.

Note 21.1 Other investments / financial assets (current)

The Trust does not have any other investments or financial assets that would be classified as current.

Note 22 Disclosure of interests in other entities

The Trust is in the process of establishing new joint venture entities, for more information please see note 21.

Note 23 Inventories	31 March 2018 £000	31 March 2017 £000
Drugs	3,865	3,949
Work In progress	-	-
Consumables	17,508	14,839
Energy	183	206
Other	1,108	975
Total inventories	**22,664**	**19,969**
Of which:		
Held at fair value less costs to sell	**-**	**-**

Inventories recognised in expenses for the year were £73,842k (2016/17: £69,819k). Write-down of inventories recognised as expenses for the year were £2k (2016/17: £132k).

Note 24.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	48,327	42,568
Capital receivables (including accrued capital related income)	-	-
Accrued income	13,631	8,367
Provision for impaired receivables	(7,320)	(8,093)
Deposits and advances	-	-
Prepayments (non-PFI)	4,800	4,807
PFI prepayments: Capital contributions	67	67
PFI Lifecycle replacements	402	1,386
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	-	1,249
VAT receivable	2,813	2,334
Corporation and other tax receivable	-	-
Other receivables	3,321	1,571
Total current trade and other receivables	**66,041**	**54,256**
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	80	80
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	57	114
PFI prepayments :Capital contributions	1,137	1,204
PFI prepayments: Lifecycle replacements	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	4,860	4,691
Total non-current trade and other receivables	**6,134**	**6,089**
Of which receivables from NHS and DHSC group bodies:		
Current	38,069	35,209
Non-current	**-**	**-**

Note 24.2 Provision for impairment of receivables

	2017/18 £000	2016/17 £000
At 1 April as previously stated	**8,093**	**7,489**
Prior period adjustments	-	-
At 1 April - restated	**8,093**	**7,489**
Transfers by absorption	-	-
Increase in provision	(556)	1,210
Amounts utilised	(217)	(606)
Unused amounts reversed	-	-
At 31 March	**7,320**	**8,093**

A provision is made against trade receivables based on the number of days by which the invoice is overdue and the class of debt.

Note 24.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	77	-
90- 180 days	862	-	729	-
Over 180 days	6,458	-	7,287	-
Total	**7,320**	**-**	**8,093**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	3,950	-	6,420	-
30-60 Days	3,246	-	2,328	-
60-90 days	2,202	-	934	-
90- 180 days	1,579	-	883	-
Over 180 days	3,103	-	938	-
Total	**14,080**	**-**	**11,503**	**-**

The great majority of trade is with NHS England and CCGs. As commissioners are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary

Note 25 Other assets

	2017/18 £000	2016/17 £000
Current		
EU emissions trading scheme allowance	503	-
Other assets	-	-
Short term PFI lease asset	-	-
Total other current assets	**503**	-
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	-	-
Total other non-current assets	-	-

Note 26 Non-current assets for sale and assets in disposal groups

	2017/18 £000	2016/17l £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**-**
Prior period adjustment	-	**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**-**	**-**
Transfers by absorption	**-**	**-**
Assets classified as available for sale in the year	**-**	**-**
Assets sold in year	**-**	**-**
Impairment of assets held for sale	**-**	**-**
Reversal of impairment of assets held for sale	**-**	**-**
Assets no longer classified as held for sale, for reasons other than disposal by sale	**-**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 26.1 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 27.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**41,627**	**89,434**
Prior period adjustments	-	-
At 1 April (restated)	**41,627**	**89,434**
Transfers by absorption	-	-
Net change in year	(1,717)	(47,807)
At 31 March	**39,910**	**41,627**
Broken down into:		
Cash at commercial banks and in hand	30	197
Cash with the Government Banking Service	39,880	41,430
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**39,910**	**41,627**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**39,910**	**41,627**

Note 27.2 Third party assets held by the NHS foundation trust

Oxford University Hospitals NHS Foundation Trust held cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	1	1
Monies on deposit	-	-
Total third party assets	**1**	**1**

Note 28.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	54,286	38,977
Capital payables	4,989	7,579
Accruals	24,176	25,298
Receipts in advance (including payments on account)	-	-
Social security costs	5,988	5,754
VAT payable	28	109
Other taxes payable	5,431	5,154
PDC dividend payable	586	-
Accrued interest on loans	63	3
Other payables	9,653	8,627
Total current trade and other payables	**105,201**	**91,501**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payable	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	-	-
of which payables to NHS and DHSC group bodies		
Current	12,525	8,905
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

There are no early retirements in NHS payables above

Note 29 Other financial liabilities

The Trust does not have any liabilities classified as other financial liabilities

Note 30 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	18,291	18,951
Deferred grants	-	-
PFI Deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	**18,291**	**18,951**
Non-current		
Deferred income	9,134	12,201
Deferred grants		-
PFI Deferred income / credits		-
Lease incentives		-
Net pension scheme liability		-
Total other non-current liabilities	**9,134**	**12,201**

Note 31 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Social Care	790	1,405
Other loans	67	-
Obligations under finance leases	10	251
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	11,106	9,979
Total current borrowings	**11,973**	**11,635**
Non-current		
Loans from the Department of Health and Social Care	-	790
Other loans	7,433	-
Obligations under finance leases	1,099	1,489
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	246,575	239,820
Total non-current borrowings	**255,105**	**242,099**

Note 32 Finance leases

Note 32.1 Oxford University Hospitals NHS Foundation Trust as a lessor

The Trust does not have any finance lease receivables as a lessor

Note 32.2 Oxford University Hospitals NHS Foundation Trust as a lessee

Obligations under finance leases where Oxford University Hospitals NHS Foundation Trust is the lessee.

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities	**1,228**	**1,915**
of which liabilities are due:		
- not later than one year;	73	330
- later than one year and not later than five years;	928	1,331
- later than five years.	227	254
Finance charges allocated to future periods	(119)	(175)
Net lease liabilities	**1,109**	**1,740**
of which payable:		
- not later than one year;	10	251
- later than one year and not later than five years;	873	1,233
- later than five years.	226	256
Total of future minimum sublease payments to be received at the reporting date	**-**	**-**
Contingent rent recognised as an expense in the period	-	-

The Trust has a number of finance lease arrangements which have been used to acquire items of medical plant and equipment. Typically these leases provide for an option to purchase at the end of the primary term. The leases do not include any escalation clauses, nor do they include any restrictions other than those which would be expected to apply in a normal lease contract on normal commercial terms.

Note 33.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	legal claims £000	Re-structuring £000	Continuing care £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	other £000	Total £000
At 1 April 2017	**2,794**	**117**	**-**	**-**	**-**	**-**	**4,087**	**6,998**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Change in the discount rate	33	-	-	-	-	-	-	**33**
Arising during the year	37	16	-	-	-	-	1,028	**1,081**
Utilised during the year	(185)	(51)	-	-	-	-	-	**(236)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	**-**
Reversed unused	(8)	-	-	-	-	-	(3,936)	**(3,944)**
Unwinding of discount	6	-	-	-	-	-	-	**6**
At 31 March 2018	**2,677**	**82**	**-**	**-**	**-**	**-**	**1,179**	**3,938**
Expected timing of cash flows:								
- not later than one year;	185	82	-	-	-	-	1,179	**1,446**
- later than one year and not later than five years;	742	-	-	-	-	-	-	**742**
- later than five years.	1,750	-	-	-	-	-	-	**1,750**
Total	**2,677**	**82**	**-**	**-**	**-**	**-**	**1,179**	**3,938**

The Trust is reasonably certain about the amounts and timings of Pensions relating to staff and former Directors as the calculation is based on NHS Pension Agency payments and determined nationally on an actuarial basis.

The Trust is reasonably certain about the amounts and timings of legal claims as the information is provided by the NHS Resolution (formerly NHS Litigation Authority).
Other provisions reflect commercial claims for which the value is reasonably certain but the timing is dependent on final resolution.

Note 33.2 Clinical negligence liabilities

At 31 March 2018, £539m was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Oxford University Hospitals NHS Foundation Trust (31 March 2017: £388m).

Note 34 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(30)	(63)
Employment tribunal and other employee related litigation	(50)	-
Redundancy	-	-
Other	-	(28)
Gross value of contingent liabilities	**(80)**	**(91)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(80)**	**(91)**
Net value of contingent assets	**-**	**-**

Contingent liabilities are the legal claims under the liability to third parties and property expenses administered by the NHS Resolution (formerly NHS Litigation Authority) amounting to £0.03m and the employee related claims totalling £0.05m.

Other contingencies do not yet have an estimated financial value and include commercial claims which carry a high degree of uncertainty and do not currently represent financial outflow to the Trust. This is not expected to be material to the accounts.

Note 35 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	312	6,898
Intangible assets	-	-
Total	**312**	**6,898**

Note 36 Other financial commitments	31 March 2018 £000	31 March 2017 £000
The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:		
not later than 1 year	86,815	115,317
after 1 year and not later than 5 years	89,549	170,696
paid thereafter	12,118	17,786
Total	**188,482**	**303,799**

Note 37 Defined benefit pension schemes

The Trust does not operate any material defined benefit pension schemes other than the statutory NHS Pension Scheme

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has three PFI schemes comprising the John Radcliffe West Wing, Churchill Cancer Centre and the Nuffield Orthopaedic Centre. The John Radcliffe Welcome Centre is recognised as an asset with no liability as there are no payments being made, instead a deferred income liability is recognised.

The Trust's Carbon Energy Scheme is new in 2017/18 and is recognised as an IFRIC12 asset with corresponding liability.

Note 38.1 Imputed finance lease obligations

Oxford University Hospitals NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**435,017**	**416,460**
Of which liabilities are due		
- not later than one year;	25,424	23,538
- later than one year and not later than five years;	85,792	80,594
- later than five years.	323,801	312,328
Finance charges allocated to future periods	(177,338)	(166,661)
Net PFI, LIFT or other service concession arrangement obligation	**257,679**	**249,799**
- not later than one year;	11,106	9,979
- later than one year and not later than five years;	32,395	30,681
- later than five years.	214,178	209,139

Note 38.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	929,667	908,970
Of which liabilities are due:		
- not later than one year;	43,338	40,835
- later than one year and not later than five years;	178,443	166,791
- later than five years.	707,886	701,344

Note 38.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2017-18:

	31 March 2018 £000	31 March 2017 £000
Unitary payment payable to service concession operator	63,229	58,935
Consisting of:		
- Interest charge	14,208	14,002
- Repayment of finance lease liability	9,978	6,840
- Service element and other charges to operating expenditure	28,390	26,821
- Capital lifecycle maintenance	3,302	4,738
- Revenue lifecycle maintenance	342	-
- Contingent rent	6,607	5,148
- Addition to lifecycle prepayment	402	1,386
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	5,933	4,019
Total amount paid to service concession operator	**69,162**	**62,954**

Note 39 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust does not have any off-SoFP PFI, LIFT or other service concession arrangements

Note 40 Financial instruments

Note 40.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust's regulators. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for

the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 40.2 Carrying values of financial assets

	Loans and receivables at book value £000	Assets at fair value through the I&E at book value £000	Held to maturity at book value £000	Available-for-sale at book value £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non-financial assets	41,593	-	-	-	**41,593**
Other investments / financial assets	-	3,600	-	-	**3,600**
Cash and cash equivalents at bank and in hand	39,910	-	-	-	**39,910**
Total at 31 March 2018	**81,503**	**3,600**	**-**	**-**	**85,103**

	Loans and receivables at book value £000	Assets at fair value through the I&E at book value £000	Held to maturity at book value £000	Available-for-sale at book value £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	33,386	-	-	-	**33,386**
Other investments	-	295	-	-	**295**
Other financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	41,627	-	-	-	**41,627**
Total at 31 March 2017	**75,013**	**295**	**-**	**-**	**75,308**

Note 40.3 Carrying value of Financial liabilities

	Other financial liabilities at book value £000	Liabilities at fair value through the I&E at book value £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	8,290	-	**8,290**
Obligations under finance leases	1,109	-	**1,109**
Obligations under PFI, LIFT and other service concession contracts	257,679	-	**257,679**
Trade and other payables excluding non-financial liabilities	93,165	-	**93,165**
Other financial liabilities	-	-	**-**
Provisions under contract	1,173		**1,173**
Total at 31 March 2018	**361,416**	**-**	**361,416**

	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total £000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	2,195	-	**2,195**
Obligations under finance leases	1,740	-	**1,740**
Obligations under PFI, LIFT and other service concession contracts	249,799	-	**249,799**
Trade and other payables excluding non-financial liabilities	80,484	-	**80,484**
Other financial liabilities	-	-	**-**
Provisions under contract	3,787	-	**3,787**
Total at 31 March 2017	**338,005**	**-**	**338,005**

Note 40.4 Fair values of financial assets and liabilities

The book value (carrying value) is considered to be a reasonable approximation of fair value of the financial assets and liabilities the Trust has disclosed.

Note 40.5 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	106,308	95,906
In more than one year but not more than two years	3,727	12,462
In more than two years but not more than five years	31,402	20,242
In more than five years	219,979	209,395
Total	**361,416**	**338,005**

Note 41 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	16	10	28	22
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	60	174	148	383
Stores losses and damage to property	2	197	3	281
Total losses	**78**	**381**	**179**	**686**
Special payments				
Compensation under court order or legally binding arbitration	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	54	35	76	26
Special severance payments	-	-	1	15
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**54**	**35**	**77**	**41**
Total losses and special payments	**132**	**416**	**256**	**727**
Compensation payments received				

Details of cases individually over £0.3m

There were no individual cases in excess of £0.3m

Note 42 Gifts

There were no gifts in excess of £0.3m

Note 43 Related parties

During the accounting period none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any significant transactions with Oxford University Hospitals NHS Foundation Trust.

The Department of Health is regarded as a related party. During the accounting period Oxford University Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example:

- Other NHS foundation trusts
- Other NHS trusts
- CCGs and NHS England
- Other health bodies
- NHS Resolution
- NHS Business Services Authority

The significant balances with related parties are as follows:

	Receivables 31 March 2018 £000	**Payables 31 March 2018 £000**
Oxfordshire CCG	2,224	2,270
NHS England - Wessex Commissioning Hub	17,103	-
Total	**19,327**	**2,270**

	Income 2017/18 £000	**Expenditure 2017/18 £000**
Oxfordshire CCG	343,976	64
NHS England - Wessex Commissioning Hub	396,197	-
Department of Health	46,130	2
Health Education England	42,143	34
NHS Resolution (formerly NHS Litigation Authority)	-	36,516
NHS England - South Central Local Office	20,635	-
Nene CCG	17,838	-
Aylesbury Vale CCG	11,720	-
Chiltern CCG	7,947	-
Milton Keynes CCG	7,502	-
Total	**894,088**	**36,616**

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

Statutory payments of £48m in 2017-18 were made to NHS Pensions in respect of employer pension contributions. As at 31 March 2018 the Trust owed £7m to NHS Pensions which included employee and employer contributions.

Statutory payments of £43m in 2017-18 were made to HMRC in respect of employer national insurance contributions and apprenticeship levy pay over. As at 31 March 2018 the Trust owed £11.4m to HMRC which included employee PAYE, employee and employer national insurance contributions and apprenticeship levy pay over.

The Trust paid £39m in 2017-18 to NHS Professionals in respect of temporary staffing of which £6.3m was payable as at 31 March 2018.

Most of the trading-type transactions have been with Oxfordshire County Council and are for various services including Genito-Urinary Medicine services, salary recharges associated with social services and supported hospital discharges as well as sub-lease arrangements for rental of property space.

The Trust has also received revenue and capital payments from a number of charitable funds, none of these are material, certain of the trustees for which are also members of the Trust board.

Consolidated accounts to include Oxford Hospitals Charity are not prepared as this entity is now a company limited by guarantee and is independent from Oxford University Hospitals NHS Foundation Trust and therefore the charity is not controlled by the Trust.

Please see note 21 for details of the Trust's newly established sub-entities

Note 44 Transfers by absorption
The Trust did not have any transfers by absorption during the accounting period

Note 45 Prior period adjustments
The Trust does not have any prior period adjustments

Note 46 Events after the reporting date

On 15 January 2018, the High Court appointed the Official Receiver as liquidator of Carillion Plc, Carillion Services Limited, Carillion Integrated Services Limited, Carillion Construction Limited, Planned Maintenance Engineering Limited and Carillion Services 2006 Limited.

The Trust has a contract with The Hospital Company (THC) who operate the John Radcliffe West Wing and Children's PFI hospital. The Trust's contract with THC has seen a change in service provider from 17 April 2018 following the liquidation of Carillion Services Limited who were previously contracted by THC.

For staff and patient users of the services provided by our facilities company there will be no change. All Staff who were employed directly by Carillion or their contract staff have been offered a continuation of employment at the John Radcliffe Hospital. Staff who retained their employment with the Trust when Carillion took over provision of these services will now take direction from the new service provider.

To date, no formal decision has been made that affects the financial arrangements surrounding the John Radcliffe West Wing and Children's PFI hospital.

Note 47 Final period of operation as a provider of NHS healthcare

This is not the Trust's final period of operation as a provider of NHS healthcare

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Opinion

We have audited the financial statements of Oxford University Hospitals NHS Foundation Trust ('the Foundation Trust') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of changes in equity, Statement of Cash Flows and the related notes 1 to 47, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts.

In our opinion, the financial statements:

- give a true and fair view of the state of Oxford University Hospitals NHS Foundation Trust's affairs as at 31 March 2018 and of its income and expenditure and cash flows for the year then ended; and

- have been prepared in accordance with the Department of Health Group Accounting Manual 2017/18 and the directions under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

This report is made solely to the Council of Governors of Oxford University Hospitals NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the company's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

Key audit matters	• Risk of fraud in revenue and expenditure recognition • Risk of management override
Materiality	• Overall materiality of £10m which represents 1% of operating expenditure.

Key audit matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in our opinion thereon, and we do not provide a separate opinion on these matters.

Risk	Our response to the risk	Key observations communicated to the Audit Committee
Risk of fraud in revenue and expenditure recognition arising as a result of inappropriate cut off via manipulation of year-end accruals and **Operating revenue £1,030m (2016/17 £998m)** **Operating expenses £1,002m, (2016/17 £1,032m)** The Foundation Trust agreed a revised deficit control total of £5.2m with NHS Improvement. The pressure of meeting this target, and the continuing pressures on finances, lead to a risk of inappropriate revenue and expenditure recognition. The risk has increased in the current year due to the deterioration of financial performance at the end of 2016/17. We evaluated the income and expenditure streams of	We identified the significant income and expenditure streams of the Trust and considered the accounting policies related to these. When completing our substantive testing, we ensured that any recognition of income and expenditure was compliant with the Trust's accounting policy i.e. income is recognised when and to the extent that performance occurs, and expenditure recognised when, and to the extent that goods and services have been received. Our testing strategy focused on the following material streams: - Income from contracts: year-end adjustments to contract income - as the regular monthly payments from key commissioners are less open to manipulation - Income accruals: specifically non-system manual accruals as these involve management estimation and judgement, rather than transactions created through routine invoicing processes. - Expenditure accruals: specifically non-system manual accruals as these involve management estimation and judgement, rather than transactions created through routine invoicing processes.	There were no findings arising from our work to report to the Audit Committee.

the Foundation Trust and identified that those areas where management are more likely to be able to override existing controls is where the risk of inappropriate revenue and expenditure recognition lies, specifically: • year-end income accruals for contracts with the CCGs; • accounting estimates including accruals; and • through omission of expenditure from the financial statements In the prior year, our auditor's report included a key audit matter in relation to fraud in revenue and expenditure recognition.	We extended our cut-off procedures with testing on cash and accounts payable transactions around year-end. We obtained the NHS Agreement of Balances mismatch report from the National Audit Office ('NAO'), which identifies income, expenditure, debtors and creditors balances not agreed by the counterparty. We investigated all variances over the reporting threshold of £300,000, set by the NAO, by discussing with management and agreeing to corroborating evidence. We obtained corroborative documentation to support sampled creditor and accrual transactions. Where appropriate, we have evaluated the estimation approach for reasonableness and where traced to subsequent payment. We obtained system reports/cash book entries for all payments made in 2018/19 to 11 May 2018. We confirmed the transaction was allocated to the correct period. We tested cutoff by inspecting the accounts receivable ledger, invoices and other supporting documents 4 weeks before and after period-end, as we consider that this is an appropriate period for management to make any adjustments We obtained corroborative documentation for NHS and Non-NHS debtors to support sampled transactions and subsequent receipt where possible. We undertook increased testing of accrued income balances to supporting documentation and subsequent receipt where possible. We used data analytics to select a sample of journal entries based on specific risk criteria. We agreed these journal entries back to supporting documentation.	
Misstatement due to fraud or error/Management override As described above, the pressure of meeting this target, and the continuing pressures on finances, lead to a risk of management overriding controls to inappropriately recognise revenue or expenditure. Our work on the risk of management override therefore focussed on	We tested the appropriateness of journal entries recorded in the general ledger, and other adjustments made in the preparation of the financial statements; We reviewed accounting estimates for evidence of management bias (as noted above relating to revenue and expenditure recognition); and We evaluated the business rationale for any significant unusual transactions.	There were no findings arising from our work to report to the Audit Committee.

manual journal entries, through the use of our data analytics tools, as this is the way in which management would most easily be able manipulate accounting records.		

An overview of the scope of our audit

Tailoring the scope

Our assessment of audit risk, our evaluation of materiality and our allocation of performance materiality determine our audit scope for the Foundation Trust. This enables us to form an opinion on the financial statements. We take into account size, risk profile, the organisation of the Foundation Trust and effectiveness of controls, including controls and changes in the business environment when assessing the level of work to be performed. All audit work was performed directly by the audit engagement team.

Materiality

The magnitude of an omission or misstatement that, individually or in the aggregate, could reasonably be expected to influence the economic decisions of the users of the financial statements. Materiality provides a basis for determining the nature and extent of our audit procedures.

We determined materiality for the Trust to be £10 million (2016/17: £10.3 million), which is 1% (2016/17: 1%) of operating expenses. We believe that operating expenditure provides us with an appropriate basis for materiality as it is the key driver of the Trust's financial position.

During the course of our audit, we reassessed initial materiality and recalculated it based on the draft accounts submitted for audit.

Performance materiality

The application of materiality at the individual account or balance level. It is set at an amount to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality.

On the basis of our risk assessments, together with our assessment of the Trust's overall control environment, our judgement was that performance materiality was 75% (2016/17: 75%) of our planning materiality, namely £7.5million (2016/17: £7.7million). We have set performance materiality at this percentage due to our understanding of the entity as updated during the planning of the audit and the past history of misstatements.

Reporting threshold

An amount below which identified misstatements are considered as being clearly trivial.

We agreed with the Audit Committee that we would report to them all uncorrected audit differences in excess of £0.5 (2016/17: £0.5m), which is set at 5% of planning materiality, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds.

We evaluate any uncorrected misstatements against both the quantitative measures of materiality discussed above and in light of other relevant qualitative considerations in forming our opinion.

Other information

The other information comprises the information included in the annual report set out on pages 1 -148 other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

We read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

We have nothing to report in this regard.

Opinion on other matters prescribe by the Code of Audit Practice issued by the NAO

In our opinion:

- the information given in the performance report and accountability report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the parts of the Remuneration and Staff report identified as subject to audit has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Matters on which we report by exception

The Code of Audit Practice requires us to report to you if

- We issue a report in the public interest under schedule 10(3) of the National Health Service Act 2006;
- We refer the matter to the regulator under schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency;
- We are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources as required by schedule 10(1)(d) of the National Health Service Act 2006;
- we have been unable to satisfy ourselves that the Annual Governance Statement, and other information published with the financial statements meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 and is not misleading or inconsistent with other information forthcoming from the audit; or
- we have been unable to satisfy ourselves that proper practices have been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

The NHS Foundation Trust Annual Reporting Manual 2017/18 requires us to report to you if in our opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the NHS Foundation Trust acquired in the course of performing our audit.
- otherwise misleading.

We have nothing to report in respect of these matters.

Responsibilities of Accounting Officer

As explained more fully in the Accountable Officer's responsibilities statement set out on page 135, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the company's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors intend to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Auditor's responsibilities with respect to value for money arrangements

We are required to consider whether the Foundation Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. This is based on the overall criterion that "in all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people".

Proper arrangements are defined by statutory guidance issued by the National Audit Office and comprise the arrangements to:

- Take informed decisions;
- Deploy resources in a sustainable manner; and
- Work with partners and other third parties.

In considering your proper arrangements, we draw on the requirements of the guidance issued by NHS Improvement to ensure that our assessment is made against a framework that you are already required to have in place and to report on through documents such as your annual governance statement.

We are only required to determine whether there are any risk that we consider significant within the Code of Audit Practice which defines as:

"A matter is significant if, in the auditor's professional view, it is reasonable to conclude that the matter would be of interest to the audited body or the wider public. Significance has both qualitative and quantitative aspects".

Our risk assessment supports the planning of sufficient work to enable us to deliver a safe conclusion on arrangements to secure value for money and enables us to determine the nature and extent of further work that may be required. If we do not identify any significant risk there is no requirement to carry out further work. Our risk assessment considers both the potential financial impact of the issues

we have identified, and also the likelihood that the issue will be of interest to local taxpayers, the Government and other stakeholders.

Certificate

We certify that we have completed the audit of the financial statements of Oxford University Hospitals NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General (C&AG).

Maria Grindley
Associate Partner
for and on behalf of Ernst & Young LLP
Reading
23 May 2018

The maintenance and integrity of the Oxford University Hospitals NHS Foundation Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Explanation of Financial Terminology

The format of the Accounts is specified by NHS Improvement (the sector regulator) and reflects the adoption of the International Financial Reporting Standards (IFRS) by the NHS. A glossary of the terms used in the Annual Report is outlined below. This covers the terms used in the financial statements and in the review of financial performance.

The four primary statements as specified by the Foundation Trust Annual Reporting Manual (FT-ARM) are:

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

The Annual Accounts also include:

- A foreword
- Notes to the accounts
- The Directors' Statement of Responsibilities
- The Auditors' Report.

The ***Statement of Comprehensive Income*** records the Trust's income and expenditure for the year, together with any other recognised gains and losses in summary form. It includes cash-related items such as expenditure on staff and supplies as well as non-cash items such as a change in value of the Trust's assets. The other recognised gains and losses are those that the Trust has made but not yet realised, for example, if the value of assets has increased, but the assets have not been sold so there is no cash profit. If income exceeds expenditure, the Trust has a surplus for the year and if expenditure exceeds income, there is a deficit.

Terms used within the Statement of Comprehensive Income

- **Operating income from patient care activities:** includes all income from patient care, the largest elements of which are from the clinical commissioning groups (CCGs) and NHS England. Other sources of income include private patient income and overseas patients.
- **Other operating income:** includes non-patient related income including education, training and research funding.
- **Operating expenses:** includes the costs of staff, supplies, premises and services received from other organisations.
- **Finance income:** represents interest received on assets and investments in the period.
- **Finance expenses:** represents interest and other charges involved in the borrowing of money.

- **Public Dividend Capital Dividends payable:** this is the dividend payable to the Department of Health to reflect the public equity invested in the Trust.
- **Surplus / (deficit) for the accounting year:** is a key measure of the overall financial performance of the Trust. The Trust can use any retained surplus to develop its business.
- **Surplus / (deficit) on a control total basis (including STF):** the surplus / deficit for the period is measured by NHS Improvement and includes Sustainability and Transformation funding.
- **Impairments:** shows reductions (or impairments) compared to asset values previously recorded in the Statement of Financial Position.
- **Revaluations:** shows increases compared to asset values previously recorded in the Statement of Financial Position.
- **Other recognised gains and losses:** any other gains and losses not recorded elsewhere in the Statement of Comprehensive Income.
- **Surplus / (deficit) on a control total basis (including STF):** the surpus / deficit for the period is meaured
  by NHS Improvement and includes Sustainibility and Transformation Funding/

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

Terms used in the Statement of Financial Position:

- **Non-current assets:** These are assets which the Trust expects to keep for more than one year.
- **Intangible assets:** are assets such as computer software licences and patents which, although they have a continuing value to the Trust, do not have a physical existence.
- **Trade and other receivables:** are amounts owed to the Trust and are analysed between those due over 12 months (non-current) and those due within 12 months (current).
- **Current assets:** which the Trust expects to keep for less than one year.
- **Inventories:** are stock such as theatre consumables
- **Non-current assets for sale and assets in disposal groups:** long term assets (such as land) which the Trust expects to sell shortly.
- **Current liabilities:** monies the Trust owes, including invoices it has not yet paid but which it expects to pay within a year.
- **Trade and other payables:** amounts which the Trust owes and are analysed between those due to be paid within 12 months (current) and those due to be paid after more than 12 months (non-current).
- **Other liabilities:** deferred goods and services income analysed between that due to be paid within 12 months (current) and that due to be paid after more than 12 months (non-current).

- **Borrowings:** amounts which the Trust owes and are analysed between those due to be paid within 12 months (current), and those due to be paid after more than 12 months (non-current); they include items such as bank overdrafts, loans and the loan element of PFI schemes.
- **Provisions:** liabilities where the amount and / or timing are uncertain. Whilst there has been no cash payment, the trust anticipates making a payment at a future date and so its net assets are reduced accordingly.
- **Non-current liabilities:** monies the Trust owes that it expects to settle after more than 12 months.
- **Public Dividend Capital:** the taxpayer's stake in the Trust, arising from the government's original investment in the Trust when it was first created.
- **Revaluation reserve:** shows the decrease in the value of the assets owned by the Trust.
- **Other reserves:** reflects historical balances when the Horton General Hospital became part of the Trust.
- **Income and expenditure reserve:** cumulative surplus/ deficit reported by the FT, including amounts brought forward from when it was an NHS trust.

The ***Statement of Changes in Equity*** essentially shows the movement from the previous year on reserves and Public Dividend Capital. It represents the taxpayer's investment in the Trust.

- **Impairments and reversals:** reflects reductions in asset values compared to asset values previously recorded in the Statement of Financial Position.

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

Terms used in the Statement of Cash Flows

- **Depreciation and amortisation:** the non-cash items included within the operating surplus that need to be removed to give the movement in cash during the year. As an example, depreciation is an accounting charge to reflect the use of capital assets and does not involve cash; hence it is added back to the operating surplus / deficit.
- **Net Impairments:** reductions in asset values compared to asset values previously recorded in the Statement of Financial Position. These are the non-cash items included within the operating surplus and they need to be removed to give the movement in cash during the year.
- **(Increase) / decrease in receivables and other assets:** Changes in the levels of any of these impact on the amount of cash the Trust has, so they need to be accounted for here. The money owed to the Trust will already have been recorded as income in the Statement of Comprehensive Income, despite the cash not having been received yet. To understand the cash impact, the operating surplus / deficit has to be reduced by the amount of cash the Trust is still waiting to receive.

  However, the receivables due at the end of the previous year are likely to have been received

during the year, and these will not be reflected in the Statement of Comprehensive Income or in the operating surplus / deficit. So it is the difference between the receivables owing at the end of the current and previous years that will impact on the cash held. An increase in receivables (more cash owing) means the operating surplus/deficit has to be reduced to understand the cash impact.

- **Increase/ (decrease) in inventories:** similarly changes in the level of stocks held by the Trust have to be taken into account when looking at the cash impact. An increase in stock means the operating surplus/deficit has to be increased to understand the cash impact.
- **Increase/ (decrease) in payables and other liabilities:**
  similarly changes in the level of money owed by the Trust have to be taken into account when looking at the cash impact. An increase in payables (more cash owed)
  means the operating surplus/deficit has to be increased to understand the cash impact.
- **Increase/ (decrease) in provisions:** provisions are liabilities where the amount and / or timing are uncertain. Whilst there has been no cash payment, a change in the amount set aside for provisions impacts on the operating surplus and hence needs to be adjusted for to calculate the movement in cash during the year.
- **Net cash inflow from operating activities:** the amount of cash received resulting from the Trust's normal operating activities.
- **Net cash inflow / (outflow) from investing activities:** the amount of cash received / (paid) as a result of cash transactions that are not directly related to operating activities, for example purchasing new assets.
- **Capital element of finance leases and PFI:** where an asset is financed through PFI or a finance lease, a liability is shown on the Statement of Financial Position. This is the annual repayment of the capital part of that loan which is part of the unitary payment but not recorded as an expense in the Statement of Comprehensive Income.
- **Net cash inflow / (outflow) from financing:** the amount of cash received / (paid) as a result of cash transactions that are related to the financing of the Trust.

Glossary of NHS terms and abbreviations

Academic Health Science Centre / Network (AHSC / AHSN)

An academic health science(s) centre (AHSC) or network (AHSN) is a partnership between one or more universities and healthcare providers focusing on research, clinical services, education and training. AHSCs are intended to ensure that medical research breakthroughs lead to direct clinical benefits for patients.

Acute care

Also known as secondary healthcare, where a patient receives active but short term treatment for a severe injury or episode of illness, an urgent medical
condition, or during recovery from surgery. Acute care services are generally delivered by teams of healthcare professionals from a range of medical and surgical specialties.

Acute trust

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

Annual Governance Statement

This has replaced the Statement of Internal Control (SIC) and is the mechanism by which the NHS trust's accountable officer (in our case the Chief Executive) provides assurance about the stewardship of the organisation in his capacity as accountable officer for the Trust.

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

Assurance Framework

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

Better Payment Practice Code

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

Breakeven (duty)

A financial target. In its simplest form it requires the Trust to match income and expenditure.

Capital

Expenditure on the acquisition of land and premises, individual works for the provision, adaptation, renewal, replacement and demolition of buildings, items or groups of equipment and vehicles, etc. In the

NHS, expenditure on an item is classified as capital if its costs exceed £5000 and its useful life expectancy is greater than one year.

Care Quality Commission (CQC)

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

Clinical Commissioning Groups (CCGs)

Clinical Commissioning Groups are groups of GPs that are responsible for designing local health services in England. They do this by commissioning or buying health and care services working with patients and healthcare professionals and in partnership with local communities and local authorities. On their governing body, groups have, in addition to GPs, at least one registered nurse and a doctor who is a secondary care specialist. Groups have boundaries that do
not normally cross those of local authorities. All GP practices have to belong to a Clinical Commissioning Group.

Clostridium difficile (C difficile)

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

Control Total

The Control Total is the figure which represents the minimum level of financial performance against which trust boards, governing bodies and chief executives must deliver, and for which they will be held directly accountable.

Current assets

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

Depreciation

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

Elective inpatient activity

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

Electronic Patient Record (EPR)

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

Emergency inpatient activity

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

Fixed assets

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

Foundation trust (FT)

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

GP

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

Health Overview and Scrutiny Committee (HOSC)

A statutory committee of the local social services – in our Trust's case, Oxfordshire County Council. The NHS is obliged to consult HOSC on any substantial changes it wants to make to local health services.

Healthwatch Oxfordshire

Healthwatch Oxfordshireisanindependent organisation that listens to people's views and experiences of health and social care in Oxfordshire.

Inpatient

A patient whose care involves an overnight stay in hospital.

International Financial Reporting Interpretations Committee (IFRIC) 12.

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

International Financial Reporting Standards (IFRS)

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

Investors in People

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

Market forces factor

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

Methicillin resistant staphylococcus aureus (MRSA)

This is a strain of a common bacterium, which is resistant to an antibiotic called methicillin.

Monitor

Monitor authorised and regulated NHS foundation trusts, making sure they are well-managed and financially strong so that they can deliver excellent healthcare for patients. It was established in 2004. On 1 April 2016, it came together with the NHS Trust Development Authority to form NHS Improvement.

National Institute for Health and Care Excellence (NICE)

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

National Institute for Health Research (NIHR)

NIHR provides the framework through which the research staff and research infrastructure of the NHS in England is positioned, maintained and managed as a national research facility.

National service frameworks

National standards for the best way of providing particular services.

NHS England (NHSE)

NHS England (formally the NHS Commissioning Board) is the body which oversees the day-to-day operation of the NHS as set out in the Health and Social Care Act 2012. It oversees the Clinical Commissioning Groups and commissions certain specialist services directly.

NHS Digital

NHS Digital (formally the Health and Social Care Information Centre) is an executive non-departmental body, sponsored by the Department of Health. NHS Digital uses information and technology to improve health and care.

NHS Improvement

On 1 April 2016, the NHS Trust Development Authority and Monitor came together to form NHS Improvement. The role of NHS Improvement is to provide governance and accountability for NHS trusts and foundation trusts in England and delivery of the foundation trust pipeline. NHS Improvement helps each NHS trust and foundation trust secure sustainable, high quality services for the patients and communities they serve.

NHS Resolution

It is the operating name of the NHS Litigation Authority, an arm's length body of the Department of Health. It changed its name in April 2017. It overseas the operation of a number of indemnity schemes (both clinical and non-clinical) on behalf of the members of the indemnity schemes.

NHS Trust Development Authority (NHSTDA)

The role of the NHS Trust Development Authority (NHS TDA) was to provide governance and accountability for NHS trusts in England and delivery of the foundation trust pipeline. On 1 April 2016, it came together with Monitor to form NHS Improvement.

NHS trusts

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

Non-executive directors

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

Outpatient attendance

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

Oxford Biomedical Research Centre (OxBRC)

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

Patient Advice and Liaison Service (PALS)

A service providing support to patients, carers and relatives.

Private Finance Initiative (PFI)

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

Primary care

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

Public Health England

Public Health England was established on 1 April 2013 to bring together public health specialists from more than 70 organisations into a single public health service. It is an executive agency of the Department of Health.

Risk register

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

Secondary care

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

Service Level Agreements

Service Level Agreements (SLA) are the main mechanism for service provision between NHS trusts and the commissioners (CCGs and NHS England) for NHS services. An SLA is an agreement that sets out formally the relationship between service providers and customers for the supply of a service by one or another.

Sustainability and Transformation Funding (STF)

The Sustainability and Transformation Fund (STF) was first made available in 2016/17 and its receipt is linked to the achievement of financial controls, with 30% of its value dependent on providers also meeting trust-specific agreed performance trajectories — for A&E, RTT and 62 day cancer waiting standards.

Sustainability and transformation partnerships (STPs)

NHS organisations and local councils are developing shared proposals to improve health and care, these sustainability and transformation partnerships (STPs) are designed around the needs of whole areas, not just individual organisations. In 2016, every sustainability and transformation partnership published their initial proposals for development. A number of the partnerships have now evolved into integrated or 'accountable' care systems (ACSs). Over time, some STPs will become accountable care systems (ACSs), in which NHS providers and commissioners choose to take on collective responsibility for resources and population health, often in partnership with local authorities.

Thames Valley Local Education and Training Board (Health Education Thames Valley)

Local Education and Training Boards (LETBs) are responsible for workforce planning and development and education and training of the healthcare and public health workforce.

USEFUL WEBSITES

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

OTHER USEFUL WEBSITES

Association of Air Ambulances	www.associationofairambulances.co.uk
Care Quality Commission	www.cqc.org.uk
Cherwell District Council	www.cherwell.gov.uk
Department of Health	www.gov.uk/dh
General Medical Council (GMC)	www.gmc-uk.org
Health Education England	www.hee.nhs.uk/
Health Education Thames Valley	www.hee.nhs.uk/hee-your-area/thames- valley
Healthwatch Oxfordshire	www.healthwatchoxfordshire.co.uk
Medical Sciences at Oxford University	www.medsci.ox.ac.uk
National Institute for Health and Care Excellence (NICE)	www.nice.org.uk
National Institute for Health Research	www.nihr.ac.uk
NHS Choices	www.nhs.uk
NHS Confederation	www.nhsconfed.org
NHS Counter Fraud Authority	www.cfa.nhs.uk
NHS Digital	www.digital.nhs.uk
NHS England	www.england.nhs.uk
NHS England South East	www.england.nhs.uk/south-east
NHS Health at Work – occupational health provider	www.nhshealthatwork.co.uk
NHS Improvement	www.improvement.nhs.uk
NHS Protect – Counter Fraud & Security Services	www.nhsba.nhs.uk/Protect
NHS Providers	www.nhsproviders.org
NHS Resolution	www.resolution.nhs.uk
Oxford Academic Health Science network	www.oxfordahsn.org
Oxford Biomedical Research Centre	www.oxfordbrc.nihr.ac.uk
Oxford Brookes Faculty of Health and Life Sciences	www.hls.brookes.ac.uk
Oxford Brookes University	www.brookes.ac.uk
Oxford City Council	www.oxford.gov.uk
Oxford Health NHS Foundation Trust	www.oxfordhealth.nhs.uk
Oxfordshire Clinical Commissioning Group	www.oxfordshireccg.nhs.uk
Oxfordshire County Council	www.oxfordshire.gov.uk
Oxfordshire Healthcare Transformation Programme	www.oxfordhealthcaretrasnformation.nhs.uk
Patients' Association	www.patients-association.org.uk
Patient Safety Federation	www.patientsafetyfederation.nhs.uk

Public Health England	www.gov.uk/government/organisations/public-health-england
Royal College of Anaesthetists	www.rcoa.ac.uk
Royal College of Emergency Medicine	www.rcem.ac.uk
Royal College of General Practitioners	www.rcgp.org.uk
Royal College of Midwives	www.rcm.org.uk
Royal College of Nurses	www.rcn.org.uk
Royal College of Obstetricians and Gynaecologists	www.rcog.org.uk
Royal College of Ophthalmologists	www.rcophth.ac.uk
Royal College of Paediatricians and Child Health	www.rcpch.ac.uk
Royal College of Pathologists	www.rcpath.org
Royal College of Physicians	www.rcplondon.ac.uk
Royal College of Radiologists	www.rcr.ac.uk
Royal College of Surgeons	www.rcseng.ac.uk
South Central Ambulance Service NHS Foundation Trust	www.scas.nhs.uk
South Oxfordshire District Council	www.southoxon.gov.uk
Southern Health NHS Foundation Trust	www.southernhealth.nhs.uk
Sustainable Improvement Team	www.england.nhs.uk/sustainable improvement/
Thames Valley Air Ambulance	www.tvairambulance.org.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

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 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@ouh.nhs.uk**

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

See our website: www.ouh.nhs.uk