OXFORD UNIVERSITY HOSPITALS
NHS FOUNDATION TRUST

Annual Report and Accounts for
1 April 2018 – 31 March 2019

Oxford University Hospitals

NHS Foundation Trust

Annual Report and Accounts

1 April 2018 – 31 March 2019

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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.

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WELCOME

Message from the Chief Executive

Welcome to the Annual Report from 1 April 2018 to 31 March 2019 of Oxford University Hospitals NHS Foundation Trust.

I would like to reflect on a year of not only significant challenges but also notable successes in 2018-19.

On behalf of the Trust Board I would like to thank personally all our staff who have gone the extra mile over the last 12 months to maintain our commitment to delivering compassionate excellence and safe, high quality care for all our patients.

In July 2018 we agreed a series of enforcement undertakings with NHS Improvement which committed the Trust Board to clear plans leading to improvements in performance on key priorities which the Board has already identified for 2018-19 – emergency care, planned care (including cancer and elective care) and financial sustainability – underpinned by governance and strategic workforce planning.

Thanks to the efforts of all staff and a focus on these key priorities, we were able to demonstrate tangible improvements by the end of the financial year.

- 4.2% year on year improvement in A&E performance
- Reduction in the number of elective patients on waiting lists for 52 weeks from 203 in August 2018 to just eight patients on 31 March 2019
- Achievement of our financial control total by delivering a £13 million surplus for 2018-19 compared with the target of a £10.4 million surplus

This year also saw positive results from our commitment to improving services by working closely with our partners in the Oxfordshire health and social care system.

- The CQC's report into Oxfordshire's health and social care system, published in February 2018, had highlighted the need for better co-ordination in order to improve our patients' experience of their care – the CQC's follow-up report, published in January 2019, stated that significant work has been done to join up services and improve care for patients.
- Health and care organisations have been working together to improve patient flow through the system to reduce 'delayed transfers of care', so that patients who are physically well enough to leave hospital can do so at the appropriate time.

- For the first time this year we set up a system-wide Winter Team, based at the John Radcliffe Hospital but working across the entire health and social care system in Oxfordshire, which led to improved A&E performance and a marked increase in the number of patients being discharged from hospital.

2018-19 was a year of exciting developments across the Trust.

- The hip fracture service at the Horton General Hospital in Banbury was ranked in the top five in the country in the National Hip Fracture Audit.
- Our Integrated Psychological Medicine Service was named Team of the Year at the Royal College of Psychiatrists Awards.
- We broke ground on the development of a new Ronald McDonald House – a 'home from home' for families of sick children.
- We announced a groundbreaking partnership with Philips to transform our pathology services as the hub and centre of expertise for digital pathology.

I would like to take this opportunity to thank Dame Fiona Caldicott for her service to the NHS in Oxford over many years - for the last 10 years as our Chairman. We are very fortunate to have benefited from her knowledge, wisdom and sound judgement. She brought a wealth of experience and expertise to her role as Trust Chairman. We wish Dame Fiona all the very best for the future.

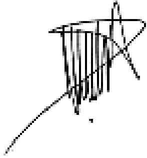
2019-20 promises to be another busy and eventful year with much to look forward to – under the leadership of our new Trust Chair, Professor Sir Jonathan Montgomery, who took up his post on 1 April 2019.

We will continue to work closely with Oxfordshire Clinical Commissioning Group, the Horton Joint Health Overview and Scrutiny Committee (HOSC), and other key stakeholders to shape a bright future for healthcare services at the Horton General Hospital, as part of our commitment to local residents.

On the John Radcliffe Hospital site the long-awaited expansion of our Emergency Department (A&E) is now underway, which will create an extra nine bays for the immediate care of seriously ill patients.

On the Churchill Hospital site we are delighted that work is now well underway to expand Sobell House – which provides palliative and end of life care – so that more families can benefit from this essential service.

I look forward to working with our staff, patients, Foundation Trust members and governors, our partners in the local health and social care system, GPs, MPs, local councillors, Healthwatch and many others in the year to come.



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 2018-19 we provided:

- **1.4 million patient contacts**
- **105,190 planned admissions**
- **80,491 unplanned and emergency admissions**
- **1.2 million meals for inpatients**
- **142,889 Emergency Department attendances**

and we delivered 7,585 babies!

The Trust has a CQC rating of 'good'

At the end of 2018-19, at OUH there were:

- **1,185 beds including**
  - **946 general and acute**
  - **64 critical care level**
  - **18 rehabilitation**
  - **157 for children**
- **60 wards**
- **48 operating theatres**
- **11,836 staff including**
  - **3,779 nurses and midwives**
  - **1,829 doctors**
  - **1,622 healthcare support workers**

Our turnover in 2018-19 was £1.073 billion

Our Business Plan

The Trust Board has an 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 will be working on a revised Integrated Business Plan in the year 2019-20 looking ahead to the next five years.

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

In September 2018 the Trust set out an Updated Trust Business Plan for 2018/19 in response to Enforcement Undertakings from NHS Improvement in July 2018. The updates reflected revisions to required performance trajectories.

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 hospital has 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 is working with the new Horton Health Overview and Scrutiny Committee which incorporates membership from Oxfordshire and surrounding counties to look again at the way the public has been consulted on the proposals.

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 implementation of these proposals was on hold subject to the outcome of an appeal of the Judicial Review. This has now been settled and so in the coming year the Trust will be working with Oxfordshire Clinical Commissioning Group and engaging with local people on plans for the Horton.

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 Nuffield Orthopaedic Centre also hosts the Trust's Clinical Genetics department.

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
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
2018-19	101,130	20,286	84,904	1,094,731	142,889

Growth in both Emergency Department attendances and emergency admissions to hospital continue on a steep upward trend, in line with the national picture. Admissions for elective (planned) care and daycases slightly reduced in 2018-19, but the number of outpatients seen was the highest ever.

Our clinical services

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

- Accident and emergency
- Trauma and orthopaedics
- 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 2018-19.

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 2018-19 and have needed to apply limited financial resources carefully while emergency, cancer and elective care services have all been under pressure.

In 2018-19, OUH set a number of trajectories with NHS England and NHS Improvement for key operational targets as part of a Trust-wide improvement programme.

The NHS is continuing to experience a prolonged period of low funding for growth and the underlying financial performance once again recorded a deficit for the year. However, through the efforts of Trust staff and management, OUH made a surplus of £13m in 2018-19 after allowing for the effects of a number of one-off items. These one-off items included a sale of 10 acres of land on the east side of the Churchill Hospital site to the University of Oxford and a prior period adjustment of £18m for income recognition.

As NHS Improvement's financial target was met it meant that the Trust also gained over £24m of Provider Sustainability Funding (PSF) which included an incentive for the Trust having exceeded its control total performance, as well as a proportion of nationally unearned PSF. In total therefore, the Trust finished 2018-19 with a surplus of £37.3m.

In 2019-20 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 will continue to be restrained. 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 2018-19, a monthly trajectory to improve performance of the Emergency Department four hour standard metric was agreed with NHS England, NHS Improvement and Oxfordshire Clinical Commissioning Group. As you will see from Figure 1, the trajectory was achieved for the first four months of 2018-19, but for the latter eight months it was not achieved. However, the actual monthly performance saw an improvement over 11 months when compared to 2017-18.

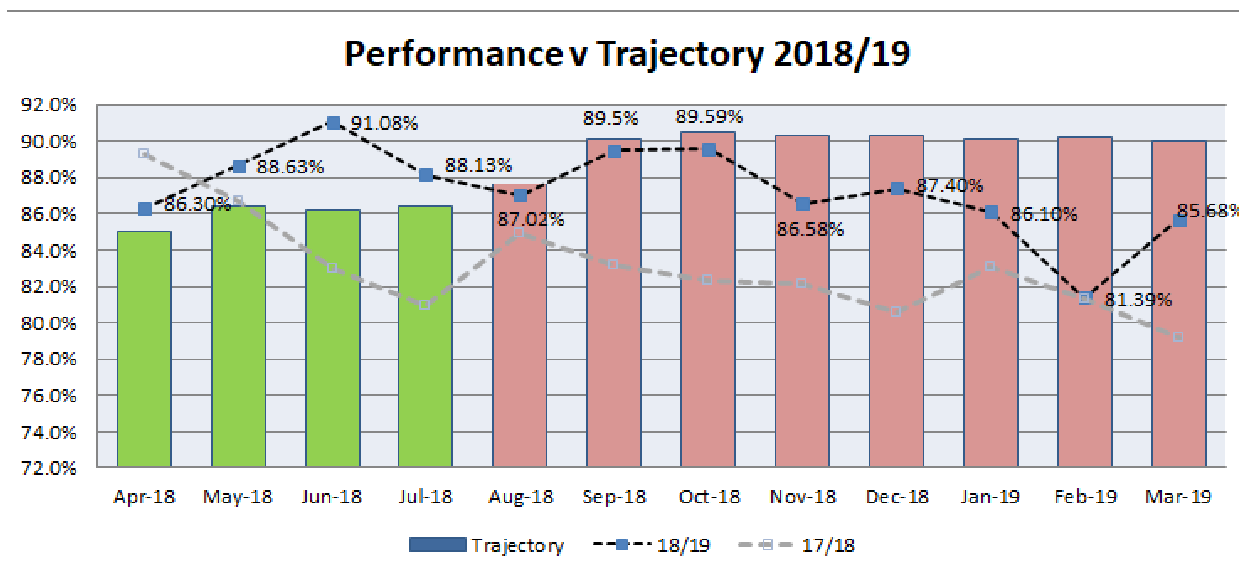


Figure 1: OUH 'four hour wait performance' 2018-19, compared to 2017-18 and agreed trajectory (green and red bars)

Attendances per day continued to increase in 2018-19, along with emergency admissions. There were no 12 hour decisions to admit (DTA) breaches across the year in 2018-19, a significant improvement on 2017-18. For the winter months, a System Winter Director and a System Winter Team were appointed to support Winter Plans (November 18 – March 2019). Winter Plans were developed across the Oxford health system to support the acute sites achieving 92% bed occupancy, which would support patient flow through the emergency departments.

Emergency Department attendances and admissions per day

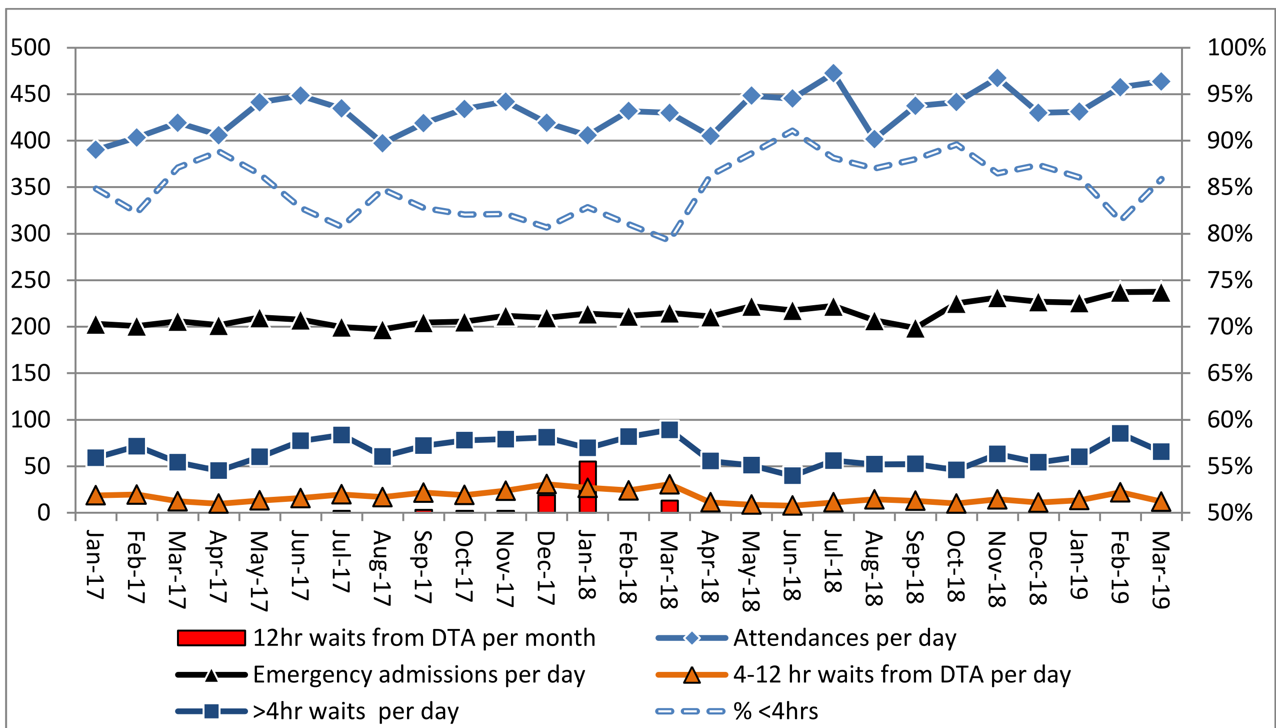


Figure 2: OUH Emergency Department attendances and emergency admissions, daily average, including 12 hour DTA breaches January 2017-March 2019

92% bed occupancy levels were not delivered in any month through November 2018 – March 2019, which had a direct impact on OUH's delivery against the four hour standard. Emergency admission growth was a significant factor in this.

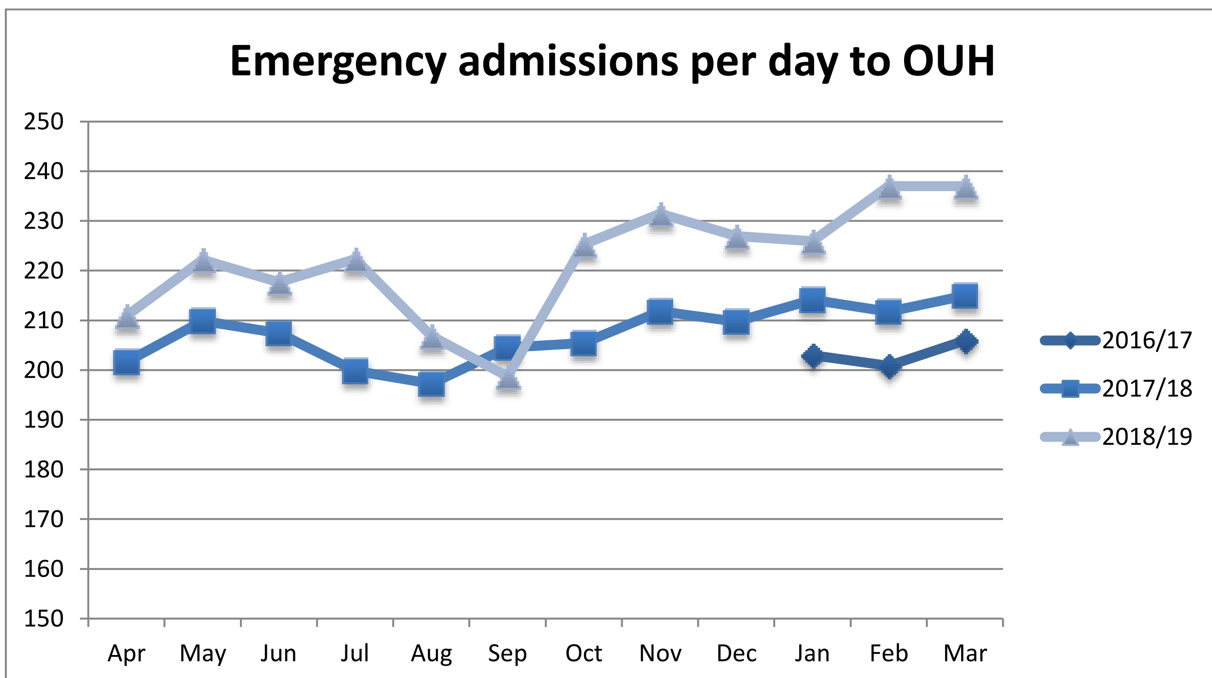


Figure 3: Emergency admissions per day at OUH 2016-17 – 2018-19

In February and March 2019, OUH experienced its highest ever daily average of emergency admissions per day, set out in Figure 3, which had a direct impact on bed occupancy. February 2019 saw an increase in emergency admissions which had a direct correlation with a drop in 'four hour wait' performance to 81.39%.

Throughout 2018-19 OUH achieved performance above that of the Shelford Group average. OUH followed a similar trend to the national picture, with performance worsening during winter months, but an upward improvement in March 2019. Figure 4 below demonstrates this.

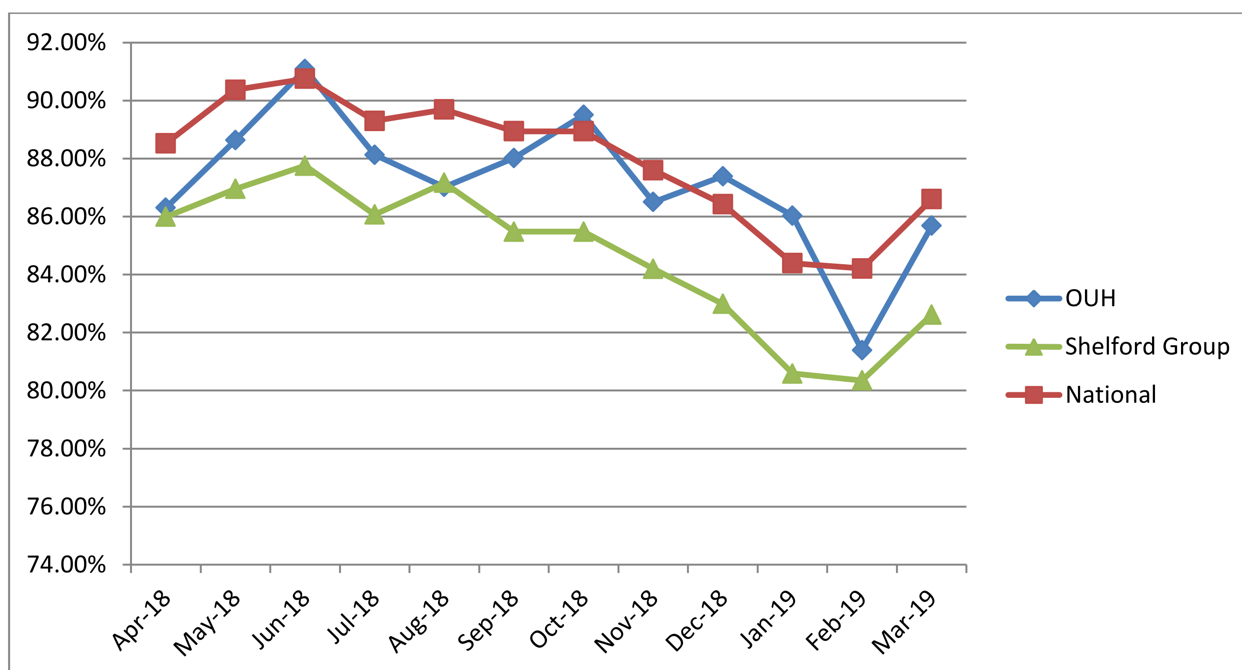


Figure 4: OUH <4 hour wait %, 2018-19, Shelford Group (representing ten of the largest teaching and research NHS hospital trusts in England) and NHS England performance.

Planned care

Referral to Treatment (RTT) Performance

OUH agreed as part of its plan for 2018-19 two key metrics with regards to the 18 week Referral to Treatment Time (RTT) national metrics. These were:

- reduce the number of people waiting on incomplete elective care pathways for care at OUH to a waiting list size of 50,147 by March 2019;
- halve the number of patients waiting over 52 weeks by the end of March 2019.

On 31 March 2019, 49,706 people were waiting on incomplete elective pathways for care at OUH. This was a decrease of 441 pathways when compared to March 2019, meaning that the agreed target waiting list size of 50,147 was achieved.

The number of patients waiting over 52 weeks reduced from a peak of 203 during 2018-19 to eight by 31 March 2019.

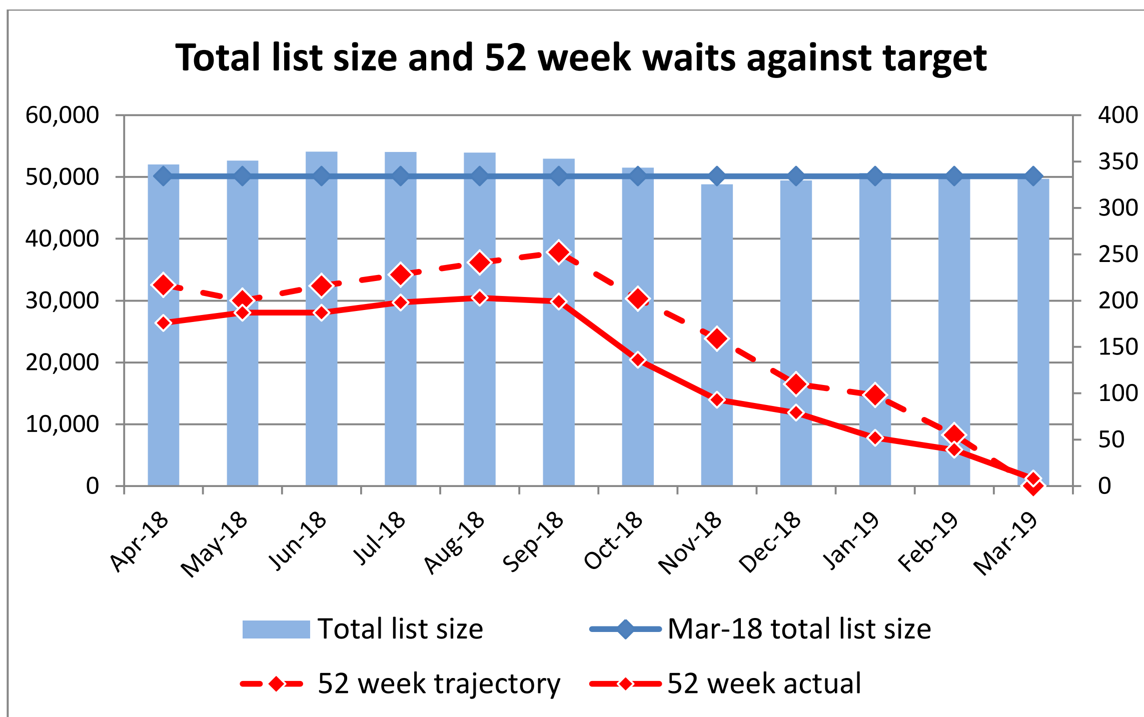


*Figure **5**: RTT incomplete waiting list size and over 52 week waits, OUH, from April 2018*

Cancer

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

OUH consistently achieved the 'two week from GP referral' cancer national standard every month through 2018-19. Another four of the standards were achieved for the majority of months across 2018-19, however the 62 day standard for treatment has provided our biggest challenge throughout the year. Nationally there has been a decline in achievement of the 62 day standard. The 62-day standard has not been met by the NHS in England in any month since December 2015.

Standard	OUH											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
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 94% of patients will receive subsequent treatment with surgery within 31 days of decision to treat.												
At least 98% of patients will receive subsequent treatment with anti-cancer drug regimen within 31 days of decision to treat.												
At least 94% of patients will receive subsequent radiotherapy within 31 days of a decision to treat.												
At least 85% of patients will receive their first treatment within 62 days of referral from a GP.												
At least 90% of patients will receive their first treatment within 62 days following referral from a screening service.												

Figure 6: Achievement by month of the national cancer waiting time standards, 2018-19

The most significantly challenged tumour sites remained in the urological, head and neck, gynaecological oncology, lung and lower gastrointestinal tumour site groups.

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.

Diagnostic waits

Throughout 2018-19 we did not achieve the required 99% standard of patients receiving their diagnostic test within six weeks from request. At the end of March 2019, 97.9% of OUH patients received their diagnostic test within six weeks from request.

The number of people waiting for diagnostic tests at OUH rose from 12,497 in April 2018 to 14,418 in March 2019, with particular growth in MRI and non-obstetric ultrasound (the investigations performed for most people).

The following table presents the Trust's performance against national standards from 1 April 2018 to the end of March 2019.

PERFORMANCE AS AN AVERAGE FOR 2018-19

COMMITMENT	Standard	Trust achievement in 2018-19
Referral to treatment waiting times for non-urgent consultant-led treatment		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	83.73%
Diagnostic test waiting times		
Patients waiting for a diagnostic test should have been waiting no more than six weeks from referral	99%	97.93%
Emergency Department waits		
Patients should be admitted, transferred or discharged within four hours of their arrival at an emergency department	95%	87.19%
Cancer waits – two week waits		
Maximum two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	96.7%
Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	94.2%
Cancer waits – 31 days		
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%	93.2%
Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	95.01%
Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	99.49%
Maximum 31 day wait for subsequent treatment where that treatment is a course of radiotherapy	94%	96.61%
Cancer waits – 62 days		
Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	72.29%
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	79.42%

Financial Performance Overview

The Trust achieved its headline financial objective to meet the NHS Improvement control total surplus in 2018-19. Against a control total of £10.4m, prior to NHS financial incentives, the Trust recorded a surplus of £13m. This financial performance earned the Trust a further £24.3m of incentive payments from the Provider Sustainability Fund (PSF). This is the first time that the Trust has achieved its control total since this regime was introduced in 2016-17. Section 5 of this report sets out the Trust accounts and note 1.2 to these accounts describes why these accounts have been prepared on a 'going concern basis'.

Looking to the future, the Trust is forecasting a financial surplus of £37.9m 2019-20 supported, as in 2018-19, by material one-off items.

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.

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

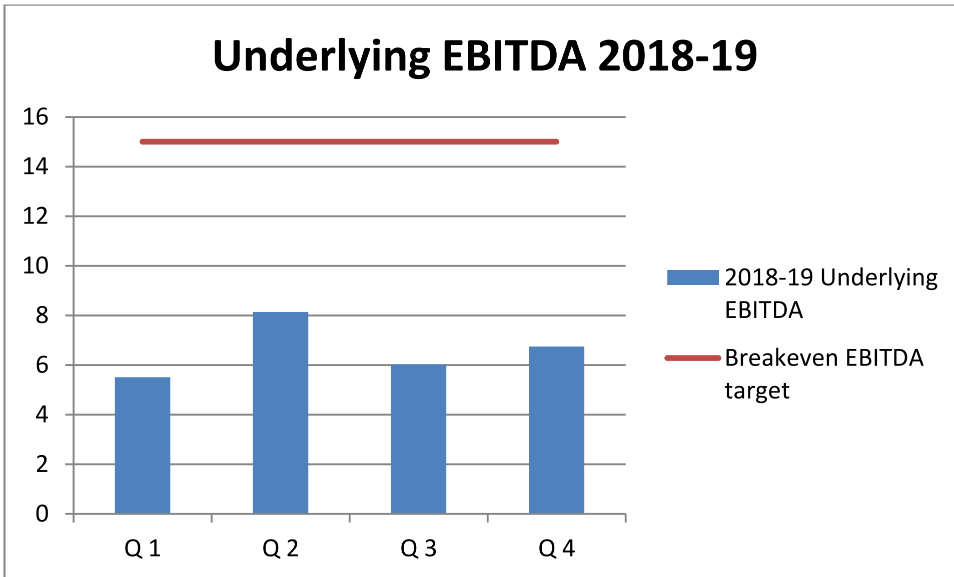
- a strict control of its costs;
- becoming more productive; and
- taking advantage of the commercial opportunities open to it given its international reputation and getting better value from its substantial land holdings in Oxfordshire.

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 overleaf 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.

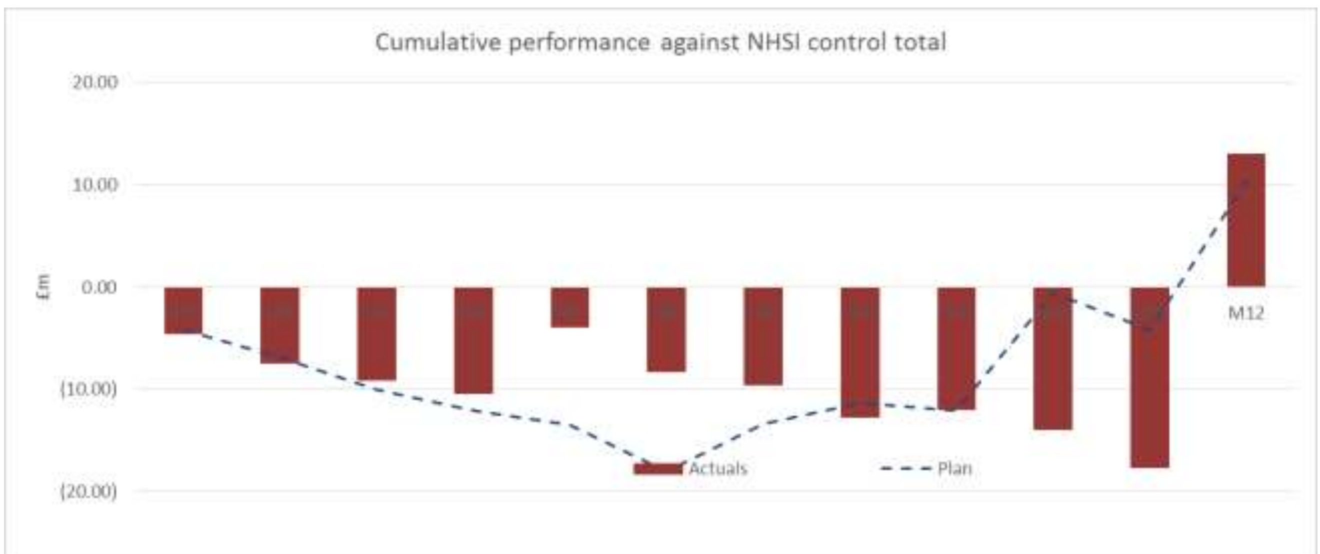


The Trust did not achieve the breakeven target in any quarter last year without Provider Sustainability Fund (PSF) and hence it must continue to seek and implement measures to improve the underlying EBITDA performance in order to ensure long-term viability.

In 2018-19, the Trust's underlying financial performance was supported by a number of planned non-recurring items and these enabled the Trust to record a surplus £13m on a 'control total basis' which was £2.6m higher than initially planned. There were two factors leading to this outcome:

- a larger than planned underlying deficit, which at the end of year was £32.1m
- offset by greater than initially forecast proceeds from one-off items which in total amounted to £45.1m in 2018-19.

The overall position is shown in the graph below.



These one-off items included a sale of ten acres of land on the east side of the Churchill Hospital site to the University of Oxford and a prior period adjustment of £18m for income recognition. 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 surplus of £10.4m and the Trust finished the year with a surplus of £13m.

On top of the control total performance, core Provider Sustainability Funding (PSF) of £11.4m has been earned, based on delivery of the full year financial performance and delivery of the Q1 ED 4 hour standard by the Oxfordshire system. Performance against the ED 4 hour standard for Q2, Q3 and Q4, worth £3.9m in eligible PSF, was not achieved. A further £12.9m in bonus PSF has also been received, which includes an incentive for the Trust having exceeded its control total performance, as well a proportion of nationally unearned PSF. As a result the Trust has recorded a surplus at the end of 2018-19 of £37.3m as shown in the Statement of Comprehensive Income in section 5 of this report.

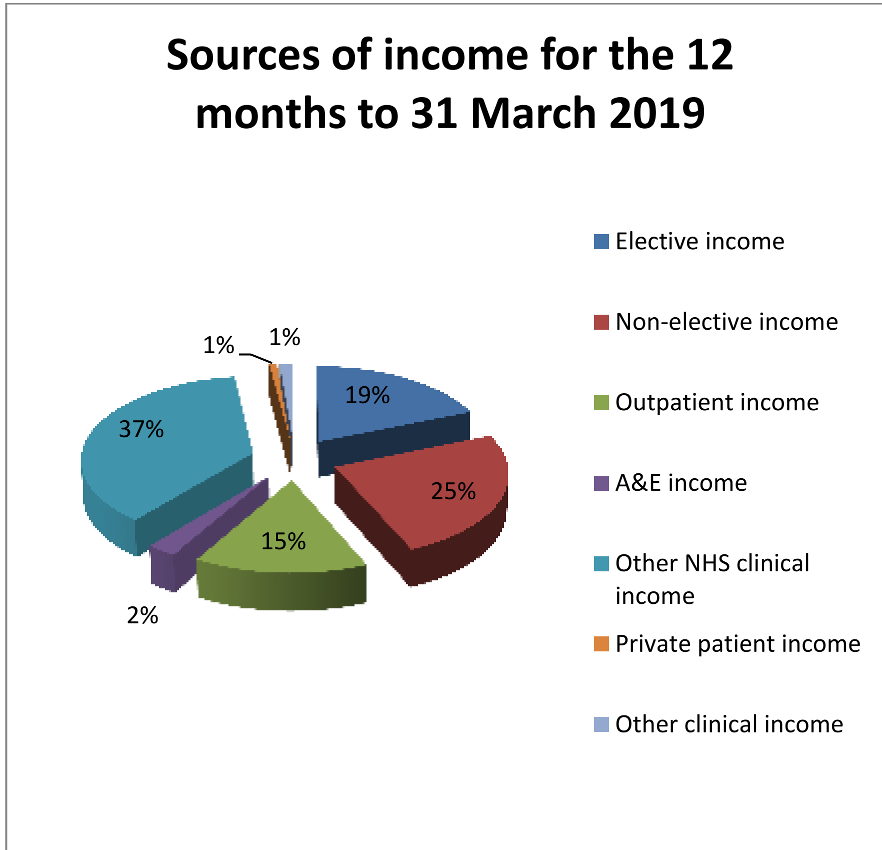
The table below summarises the financial results for the year.

Income and Expenditure Performance		£000	£000	£000	£000
	income	1048.1			
	pay	-621.8			
	non-pay	-399.8			
	non-EBITDA	-58.6			
underlying financial outturn			-32.1		
add					
One-off items			26.7		
Prior period adjustment			18.4		
Surplus against Control Total				13	
add					
Core Provider Sustainability Funds (PSF)				11.4	
Bonus Provider Sustainability Funds				12.9	
Adjusted financial performance surplus / (deficit) as per SOCI					37.3

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

Operating income

The Trust receives the majority of its income for the delivery of patient care services. In the 12 months to 31 March 2019 £888m was received, representing 83% 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.

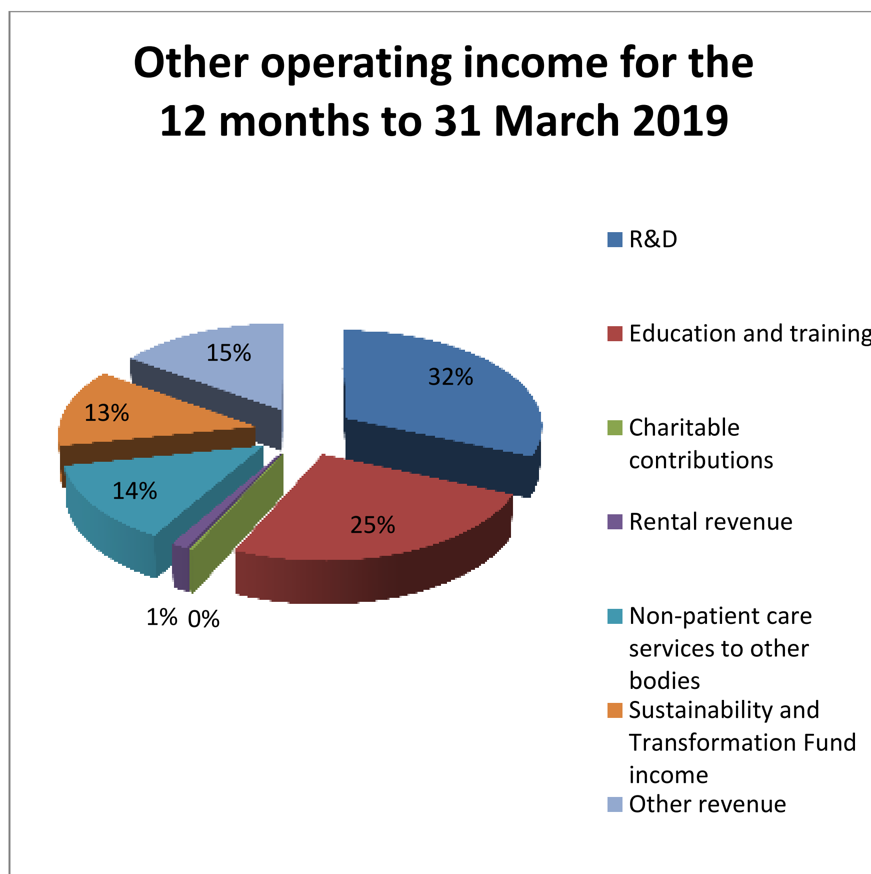


(Source Note 3.1 to accounts.)

Other operating income

The Trust received £185.9m for the delivery of non-patient care services, with £58.5m 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 2019.



(Source Note 4 to the accounts.)

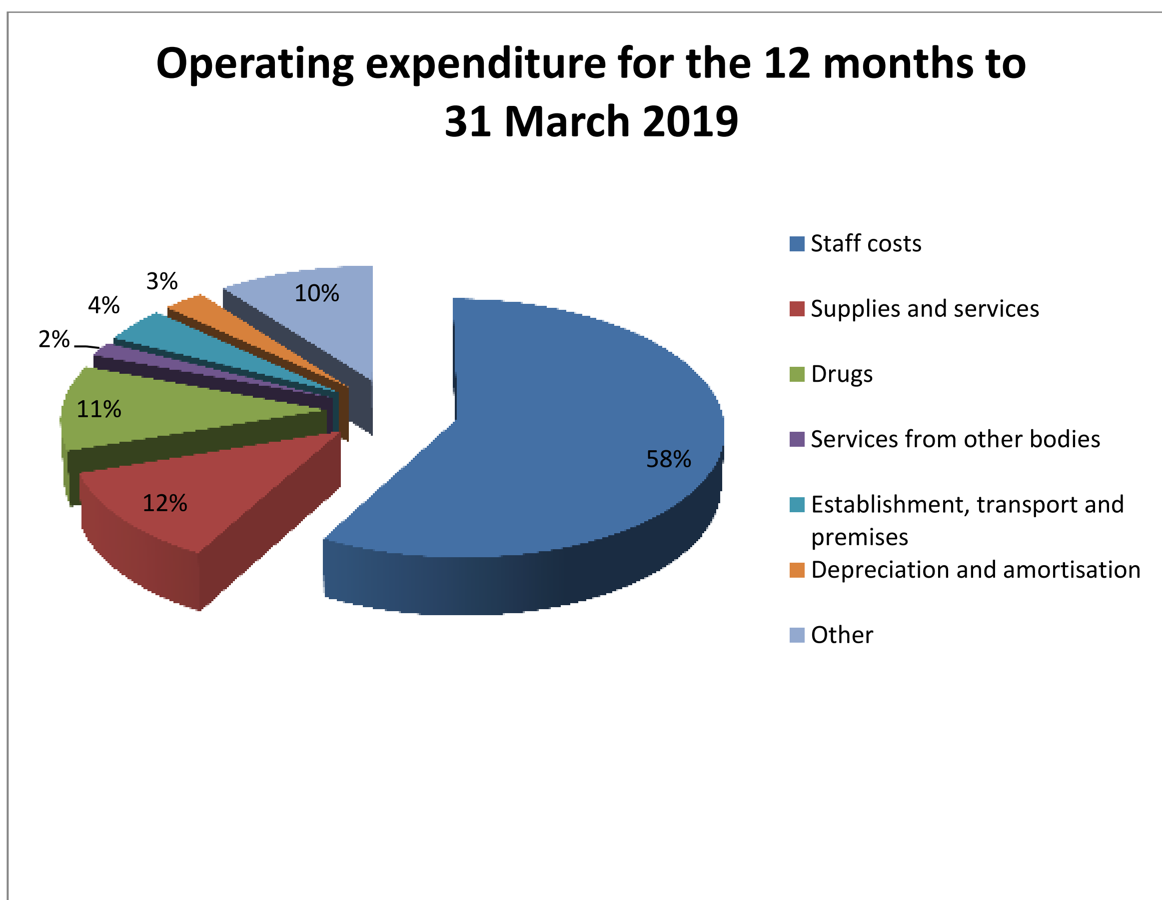
Research and development and education and training activities are core objectives of the Trust and are generally delivered on a breakeven basis after making a fair contribution to Trust overheads. Equally the Trust provides some infrastructure (e.g. IT services) to other NHS bodies on the same basis. 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 83% 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 £3m every day or over £20.7m per week. It employs in excess of 11,800 whole time equivalent staff and expenditure on pay costs is the single largest item of expenditure for the Trust with £622m spent during the 12 months to 31 March 2019, representing 58% of total operating expenses. Of the non-pay related expenditure, the two biggest items are clinical supplies costs which accounts for £119m which is 11% of operating expenses, and expenditure on drugs at £115.8m which is also 11% of operating expenses. The graph below sets out the major headings of operating expenses for the Trust.



(Source Note 7.1 from the accounts).

Balance sheet – land, buildings and equipment

The Trust invested £24m in buildings and equipment during the year. This included expenditure of over £7m on the Swindon Radiotherapy scheme. The Trust's land and buildings were revalued as at 31 January 2019 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 make within the accounting rules of the value of our buildings for healthcare use.

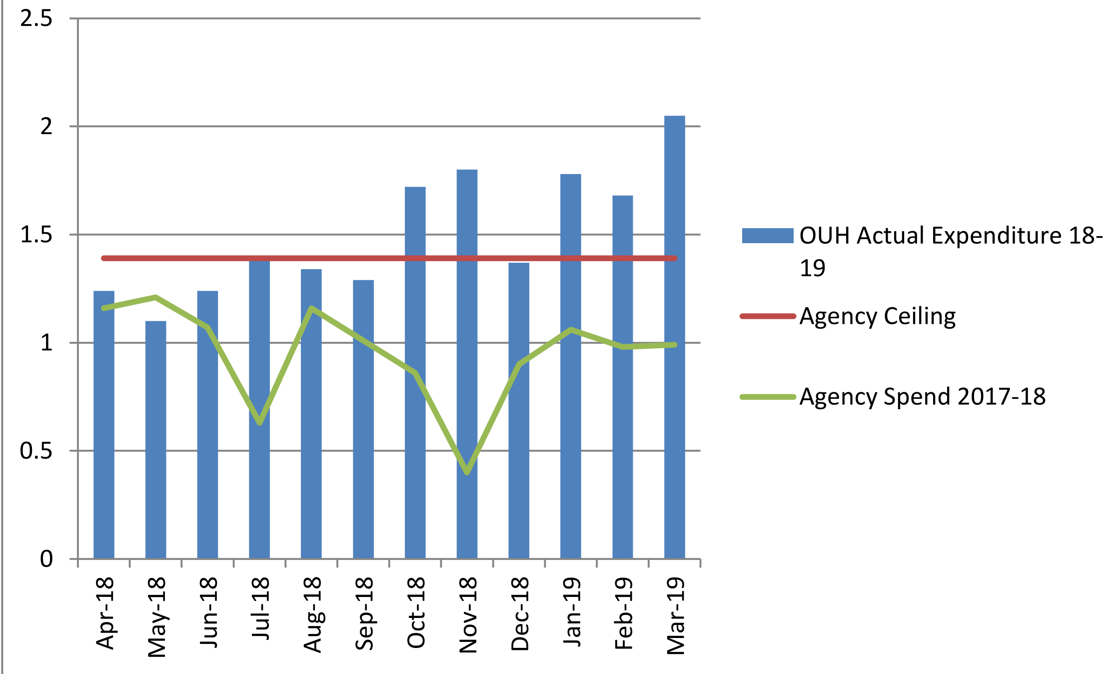
Balance sheet – cash

The amount of cash available to the Trust has risen slightly through the year. The opening position on 1 April 2018 was a balance of £40m, and by 31 March 2019 this had risen to a closing balance of £53m. However, the various one-off items, such as land sales, mask the underlying position which is actually a decrease in the underlying cash position during the year.

Quality productivity and efficiency

In 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 2018-19, one focus was on the reduction in agency spend where NHS Improvement set the Trust a target to spend no more than £16.7m. The expenditure on agency staff for the full year to March 2019 was £18m, due to the spend on staff required to maintain operational capacity to meet performance standards. This was £1.3m higher than the ceiling and represented a breach of the cap. The graph oveleaf illustrates this.



Agency Spend vs Ceiling 2018-19
2.5
2
1.5
1
0.5
0
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
OUH Actual Expenditure 18-19
Agency Ceiling
Agency Spend 2017-18

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 have 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.

Against this background, the Trust Board will continue with its financial strategy. However, the continuing weakness in the underlying financial performance means that we have not yet achieved 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.

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
22 May 2019

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 General and John Radcliffe hospitals, 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 2018-19 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 2017-18**	**Number of cases apportioned to the Trust in 2017-18**	**Annual allowed limit for 2018-19**	**Total number of cases apportioned to the Trust in 2018-19**
Avoidable MRSA Bacteraemia (Bacteria in the Blood Stream)	0	2	0	2
Clostridium difficile	69	72	68	51

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 our focus on research and innovation are defining features and as such attract 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 2018 to 31 March 2019:

- ***41%*** of the Trust's income for the delivery of patient services came from the Oxfordshire Clinical Commissioning Group
- ***46%*** of income came from NHS England for specialised and other services
- ***13%*** came from other NHS commissioners outside Oxfordshire and Oxfordshire County Council.

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 2018-19, NHS England, which commissions specialist services from NHS providers, accounted for 46% 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 2018 TO 31 MARCH 2019

Commissioner	Service Level Agreement (SLA) income (£ million)	%
NHS England	409	46%
Oxfordshire Clinical Commissioning Group (OCCG)	358	41%
Buckinghamshire CCGs	21	2%
Nene CCG (Northamptonshire)	19	2%
Other Commissioners (NHS & Non-NHS) (<1% share)	71	8%
Oxfordshire County Council	10	1%

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

A future vision for Oxford University Hospitals

Strategic themes

This year, the Trust has continued to make progress against our five strategic themes, celebrating successes across the following key areas.

Home Sweet Home

By working more closely across our local health and care system with GPs, commissioners, social care providers and neighbouring NHS trusts, we have seen multiple examples of how partnership working can deliver better care for patients, closer to home.

A key highlight has been collectively achieving improved system working on urgent care, including through setting up a joint Winter Team. Together, we have reduced length of stay and the number of long-staying patients by taking a 'home first' approach and working together to put the right packages of care in place to support patients to move out of an acute setting more quickly.

We have expanded capacity at the Horton General Hospital so north Oxfordshire patients can receive treatment closer to home. Recent developments include a refurbished Endoscopy Unit; CT scanner; X-ray replacement; additional chemotherapy chairs; expanded trauma capacity and rollout of the Bowel Scope Screening Programme.

We also opened the Community Early Pregnancy Assessment Unit (EPAU) at Rose Hill to provide an accessible service to women in the early stages of pregnancy who are experiencing pain, bleeding or have other pregnancy-related problems which are concerning them.

Focus on Excellence

As part of prioritising investment in services to deliver world-class excellence, this year we launched the IMPACT Programme (Improving Performance And Care in Teams) to help spread excellence across our services. The programme runs as a year-long development programme for eight directorate and service leadership teams, integrating leadership development and service improvement through a series of Learning Summits.

We have also continued to strengthen our research capability, such as through the Oxford Biomedical Research Centre (OxBRC), which oversees £113.7m of translational research in four clusters: Precision Medicine, Technology and Big Data, Immunity and Infection and Chronic Disease. OUH is currently placed as number one in patient research studies for the amount of patients we recruit to take part in our studies. OUH will lead the National Consortium of Intelligent Medical Imaging (NCIMI) centre funded by the government which will develop artificial intelligence (AI) for improved diagnosis and delivery of precision treatments.

Working with system partners, we have been able to support each other to achieve more timely elective services, including approved joint dermatology posts and clinics with the Royal Berkshire Hospital; and working with both Royal Berkshire and Buckinghamshire to support each other on urology, gynaecology and bariatric pathways.

Go Digital

The Trust is committed to using technology to transform how we work so that we can provide better coordinated and improved patient care. In 2016 we were named as a Global Digital Exemplar by the Department of Health and Social Care. We now have a single integrated software system across the whole organisation, with 1.2 million transactions via the Electronic Patient Record (EPR) system across OUH each day. We have also implemented ePrescribing and electronic requesting of laboratory and radiology tests to be more efficient, accurate and safe.

As a hub for digital innovation, we have seen a variety of developments, including pioneering wristband barcode-driven specimen label printing, alongside the development of a new app - System for Electronic Notification and Documentation (SEND) for recording patient vital signs across the Trust.

This year we also signed a deal with Drayson Technologies ltd and the University of Oxford to ensure royalties from digital health products commercialised by the company flow back to the Trust.

Masterplanning

This year, through our long-term planning we have been able to implement a range of projects to improve our estate, facilities, transport and infrastructure.

The Emergency Department at the John Radcliffe is undergoing a two-storey extension which will house eight new treatment bays, a paediatric resuscitation room, CT scanner, nurse base and improved bereavement rooms. We are also developing a new Ronald McDonald House. The new 62 bed house will provide free accommodation for families who have seriously ill children being treated in the Oxford Children's Hospital.

We have also seen the development of a new Clinical Genetics facility and the Botnar 3 facility at the Nuffield Orthopaedic Centre, alongside the Sobell House Extension at the Churchill Hospital. In Cowley we have invested in a new Pharmacy Purchasing and Distribution Unit and at the Horton General Hospital the Trauma Unit has been relocated and capacity expanded.

High Quality Costs Less

This strategic theme is about quality as an organising principle for how we work at OUH. This year saw five Trust teams receive recognition through being shortlisted for Health Service Journal (HSJ) national awards for outstanding efficiency and improvement (2018). Our Horton Hip Fracture Team was a finalist in the 'patient safety' category for a British Medical Journal (BMJ) award for its work in transforming hip fracture treatment and reducing rehabilitation time from theatre to patient discharge.

Through implementation of the Saving Babies Lives Care Bundle, and an additional pilot project on risk assessment and scanning on fetal growth, we have seen a significant reduction in stillbirths after 36

weeks of pregnancy and in cases of asphyxia (oxygen deprivation to the brain) for babies before, during and after birth from 2016 to 2017-18. The result was that 50 fewer families will have had poor outcomes compared to the situation before these tests were introduced.

We have also been making improvements to our quality governance, including implementation of our new Quality Impact Assessment Policy and focusing on how we can improve performance in relation to Harm reviews, Never Events and our overall Trust approach to patient safety.

Underpinning all of this has been a focus on strengthening Quality Improvement (QI) capability, and this year we have begun delivering Quality Service Improvement and Redesign (QSIR) training for staff.

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

Building Capabilities

This theme is all about our people, and this year, we published our three-year People Strategy to ensure that we make the most of and develop our staff, so that we can deliver the best care for patients. This year we have seen improved staff availability, retention and engagement and reduced turnover. We have also developed our workforce planning and modelling capability, working through the Divisions to ensure we have a more structured and detailed approach.

Sustainable Compliance

A significant focus for the Trust is ensuring we meet the statutory requirements necessary to deliver safe and effective care for patients.

This year, we reduced the overall waiting list size to below target level and significantly reduced the number of patients waiting 52 weeks for treatment to below ten. In terms of urgent care, we have delivered improved Emergency Department performance this year, consistently reducing the number of patients waiting over four hours in our Emergency Departments.

SERVICE DEVELOPMENTS AND INNOVATION IN CARE

Innovation and service development at the Horton

New integrated services hub at the Horton to improve care for patients

A new integrated services hub at the Horton General Hospital is improving care for patients by refining the co-ordination of their care and hospital discharge.

Designed to support patients returning home from hospital, the hub hosts services like Occupational Therapy, Physiotherapy, Hospital at Home, Stroke Early Supported Discharge, and the Home Assessment Reablement Team (HART).
Bringing these services together will benefit patients by improving timely discharge from hospital to home. Daily 'huddles' will also take place with all services involved.

The hub is located in the old Rowan Day Centre, and is fully refurbished to enable a fit-for-purpose team base.

Brand new X-ray equipment delivered at the Horton

State-of-the-art X-ray equipment is now in use in the Emergency Department at the Horton General Hospital.

The brand new equipment has recently been installed, and there have been several improvements to the surrounding room, including new flooring, a new ceiling, new lighting, a new ventilation system, new X-ray doors with integrated warning signs and a complete redecoration.

The state-of-the-art equipment will improve image quality and reduce patient radiation dosage in comparison with the previous equipment. The new equipment can also automatically move itself between lying and standing patient positions - reducing the risks to staff from moving and handling the X-ray equipment manually around the room.

The equipment, which went live shortly before Christmas 2018, also makes life easier for patients. The wireless digital plates used to record images can be moved around the room, so patients can be scanned on trolleys where necessary, reducing the need to use a computed radiography system or to move immobilised patients on to the X-ray examination couch.

The improvements were funded as part of £3.2 million from the Department of Health and Social Care to upgrade wards and Emergency Departments. In September 2018, the Government announced that the NHS nationally was to receive £145m in emergency funding to make improvements.

Horton team helping ease pressure on Emergency Department

A special team at the Horton General Hospital has been easing pressure on the Horton's Emergency Department by treating approximately 300 patients a month who would otherwise be in a hospital bed.

The Rowan Ambulatory Unit receives patient referrals from the Emergency Department, GPs, and wards within the hospital, and the unit then provides treatment and help patients receive community or home-based care.

The team treats a wide variety of conditions, ranging from chest pains, deep vein thrombosis, infected wounds and cellulitis.

The unit also extended their opening hours to 8.00am to 8.00pm. These longer hours mean referrals can be received later in the day, which is ideal as patients can still be referred for same day treatment even from afternoon GP surgeries.

New chemotherapy chairs installed at Brodey Cancer Centre

Extra chemotherapy chairs have been installed at the Horton General Hospital's cancer centre so more patients from the local area can access first-class treatment closer to home.

Based in the Brodey Cancer Centre, Horton nursing staff can now treat around 100 patients every week in a revamped 11-chair chemotherapy suite, expanded from eight.

The three new chairs, installed in August costing £1,700 each, were funded by the Brodey Centre Cancer Fund, which is part of the Horton General Hospital Charity, as was the £30,000 of work to reconfigure the department to allow the expanded service and make it more welcoming, as well as the creation of a new drugs room.

A number of generous donations from Tadmarton Heath Golf Club, the Carriage Company and the Horton League of Friends, as well as a very special donation from a local family, all helped fund the refurbishment and the new chairs. The new additions mean more north Oxfordshire patients can receive treatment closer to home, instead of having to travel to the John Radcliffe Hospital in Oxford.

Bowel Scope Screening Programme expanded to the Horton General Hospital

An award-winning cancer screening programme in Oxfordshire has rolled out bowel scope screening at the Horton General Hospital.

The bowel scope screening test is a quick and easy method of screening currently being rolled out across Oxfordshire, and came to the Horton General Hospital in December 2018.

All men and women aged 55 who are registered with a GP practice that has been attached to the Bowel Scope Screening Programme will be invited automatically, with invitation letters arriving from October 2018.

Those aged between 56 and 59 whose GP practice is attached to the programme can also self-refer onto it.

The test takes 20 minutes and aims to prevent bowel cancer from developing by finding and removing any small bowel growths, called polyps, which could eventually turn into cancer.

Earlier in 2018, the Oxfordshire screening programme was praised for its excellent service and patient care by Public Health England, who especially commended the service for maintaining its 'two-week wait' cancer pathway for the past five years. The 'two-week wait' standard is the time between referral to the hospital following a positive screening, and receiving initial assessment for treatment.

Innovation

New system helping Trust diagnose flu more quickly

The Trust introduced a new quicker way of testing patients for flu, with nurses and doctors using a bedside device that gives results in just ten minutes.

Point of Care Testing (POCT) for flu was introduced in December 2018 at the John Radcliffe Hospital in Oxford and in January 2019 at the Horton General Hospital in Banbury.

Before POCT, in order to test for flu all samples would have to be sent to the lab to be analysed - a process that could take several hours for patients at the Horton as samples needed to be transported to Oxford.

However, with POCT, we can quickly diagnose who may be well enough to be looked after at home, and effectively treat and isolate patients needing admission to hospital to reduce the risk of transmission to other patients.

State-of-the-art baby monitoring system introduced

A new world-leading system has been introduced at the John Radcliffe Hospital to help monitor babies' health and detect potential distress, before the onset of labour. The system is based on computerised monitors (CTGs) that record and analyse the patterns of the babies' heartbeats. The computerisation has been entirely designed and tested in Oxford for over 40 years.

The Silver Star Society, part of Oxford Hospitals Charity, funded the introduction of the equipment. Four of the very latest CTG machines have been funded by the charity - which also hopes to fund a further two.

The monitors are mobile, which means they can be taken to the bedside. In addition to monitoring babies, several of these state-of-the-art machines can also provide a facility for monitoring maternal observations.

In a world-first, all the computerised monitors are linked so that the information gathered can be viewed across all areas of the hospital, and continuously checked to maintain and improve its diagnostic accuracy.

Trust opens new Psychological Medicine Centre

The Oxford Psychological Medicine Centre brings together the Trust's existing clinical psychology team for adults, clinical psychology team for children, and the clinical psychiatry team together with a University of Oxford research team to improve the effectiveness, efficiency and patient experience of the care it provides.

Based in the West Wing at the John Radcliffe Hospital, the centre was opened by Trust Chairman Dame Fiona Caldicott on Tuesday 27 November 2018.

The new centre will benefit each team as it will provide service, teaching and research space. As well as providing teaching for medical students, the centre's teaching programme will also benefit the Trust's nurses, doctors and other staff. The centre's research programme delivers cutting-edge clinical

research. Current projects include the HOME study, a multicentre trial of enhanced psychiatric care for elderly medical inpatients.

Alcohol Care Team reduces stigma and tackles drink issues

A new team was launched at the Trust during Alcohol Awareness Week in November 2018 to help patients manage their alcohol consumption.

The Alcohol Care Team is made up of two specialist nurses who can support patients with their drinking, with services ranging from an informal chat to help with accessing community support.

Some of the team's key aims include reducing the stigma of people talking about their alcohol habits, guiding patients through community care, and ultimately reducing repeat admissions to hospital as a result of alcohol-related complications.

Open visiting hours and visitors' charter launched

The Trust introduced open visiting in October 2018 with an aim of reducing patient anxiety and stress, improving communication between staff and visitors, and increasing emotional and physical support for patients.

The new visiting hours at the Trust's hospitals are from 10.00am until 10.00pm, except for critical care and high dependency units. These departments are exempted because they have comparatively limited space and offer more acute care.

Earlier in 2018, the Trust carried out a survey of both members of the public and staff on the prospect of open visiting hours. More than 500 people took part, and the feedback helped form a new Visitors' Charter which also launched in October. The document outlines what visitors can expect from staff, and what will be expected of them when visiting our hospitals.

App to connect parents to newborns being cared for at the John Radcliffe Hospital

A pioneering project is helping parents with poorly newborns cared for at the John Radcliffe Hospital to watch their babies' progress, even if they are unable to be at their cotside.

The vCreate app, launched at the Oxford hospital on Tuesday 17 July 2018, allows nursing staff to record videos of babies in their care.

Videos are sent securely to parents' smartphones and tablets and, over time, a video diary builds up

that can be downloaded and kept forever once the baby has been discharged.

The six iPads were funded by Oxford Hospitals Charity at a cost of £2,000. The running costs of the software, funded by Support for Sick Newborn and their Parents (SSNAP), total £480 a month. Trust neonatologist, Dr Cordwell, was motivated to introduce the system based on her own experiences of different systems available to nurseries and preschools.

New developments

Department of Health funding for refurbishment ahead of winter 2018-19

The Trust officially opened three newly refurbished areas thanks to £3.2 million of funding from the Department of Health and Social Care, given to upgrade wards and Emergency Departments and provide new beds. In September 2018, the Government announced that the NHS was to receive £145m in emergency funding to help it cope with the pressures of winter.

In December, Dr Bruno Holthof, Chief Executive of Oxford University Hospitals, officially opened the new Assessment Area in the Emergency Department and the newly refurbished Complex Medicine Unit (CMU) Ward A on Level 7 - both in the John Radcliffe Hospital.

A few days later, the newly refurbished Operational Centre in the John Radcliffe Hospital was reopened and the Winter Team moved in to join the OUH's operational managers. The Operational Centre has been fully modernised and expanded with new equipment including screens on the walls to help the Trust's operational team to plan services across the Trust's four hospitals and to work closely with the Winter Team who were based there to plan care across the health and social care system over the difficult winter months.

The new Assessment Area in the Emergency Department is part of a project to improve the patient environment. The new Assessment Area means that patients will be seen earlier (within the first half hour of arrival) by senior clinicians to determine what diagnostic tests or treatment they may need. It is anticipated that the new area will help reduce the time to first treatment for more seriously ill patients. Adult patients who may have serious illnesses or injuries will be directed to this area to be assessed before being taken for further tests, moved to a ward area or theatre, or discharged. This area was previously used as office space.

The Complex Medicine Unit Wards A and B on Level 7 have been refurbished and the whole area made more dementia-friendly with specialist painting schemes (colour contrasts in doorways and on handrails help dementia patients) and artwork that helps patients orientate themselves better, as well as the reconfiguration of the nurse bases on each ward. Oxford Hospitals Charity contributed £110,000 towards these improvements. Other improvements include a handrail in the corridor to assist frail patients, artwork for each bed space to help patients find their own bed, new flooring, lighting, wall protection and ceilings throughout.

Trust given go-ahead for Emergency Department expansion

A better use of space, more diagnostic equipment, and improved dignity and privacy for patients as well as improved turnaround times for ambulances are among the benefits of the Emergency Department expansion project.

The Trust submitted a planning application in July 2018 to build the extension that will allow an extra nine bays for the immediate care of seriously ill patients.

The new space will include a paediatric resuscitation room and an isolation room with an adjacent CT scanner and control room as well as a nurses' bay and improved bereavement and relatives' rooms.

As a part of the expansion project, six ambulance spaces will be created with a more efficient drop-off point at the entrance of the new building.

The project, consisting of the building extension and the refurbishment of the current Emergency Department, will be carried out in different phases and is hoped to be completed by spring 2020.

Funding finally secured for new radiotherapy centre in Swindon

A new radiotherapy centre, to be built and run by Oxford University Hospitals NHS Foundation Trust at the Great Western Hospital in Swindon, has moved a step closer following an announcement that £2.9 million has now been raised to fund the project and that negotiations with the Department of Health to help fund the rest of the project are nearly complete.

Swindon-based charity Brighter Futures began fundraising for the centre, which will bring radiotherapy closer to home for thousands of cancer patients, in May 2015. The £2.9 million raised by Brighter Futures will buy specialist equipment for the centre, which will be run by Oxford University Hospitals as an expansion of the service provided from the Churchill Hospital, and is expected to save over 13,000 journeys to Oxford every year. It is hoped that work can start on site next year.

Trust given funding for new maternity theatre

The Department of Health has given funding of £1.8 million to develop a new Delivery Suite theatre at the John Radcliffe Hospital in Oxford. It was part of an NHS England initiative to give more patients world-class care in world-class facilities, with capital funding of £963 million provided to 75 new schemes across the country.

The building work will consist of upgrading and refurbishing an old maternity theatre, which had been decommissioned, to modern standards and to provide a surgical recovery room on the Delivery Suite. The intention is also to improve facilities on the postnatal ward, allowing the formation of a dedicated area for women who require an elective (planned) caesarean birth.

An important benefit of this work will be to free up much-needed capacity for the Trust's gynaecology work, as currently some gynaecology theatre capacity is being taken up by maternity.

SERVICE IMPROVEMENT AND REDESIGN

Service Improvement and Redesign

In July 2018 we set up our Integrated Improvement Programme to drive improvements on core operational priorities. Our core ambitions were to improve our performance on A&E waiting times and reduce long waits for elective treatment. Workforce availability was our core challenge to achieving these goals so we included a dedicated programme to address these issues.

We designed the programme so that if we achieved our ambitions, we would also improve productivity through reducing length of stay and increasing activity, which would be an important contribution to achieving our financial control total – alongside other deliverables. Underpinning all of these is our focus on improving the safety and quality of patient care.

Our final priority was to make improvements to our governance to help ensure delivery and accountability of our goals. A more detailed summary of each strand of the programme is set out below.

The Elective Programme

This aimed to reduce the number of patients waiting 52 weeks or more by 31 March 2019. The Trust successfully reduced this to eight patients waiting over 52 weeks which is a significant improvement on the August 2018 position of 203 patients waiting. The most challenged specialty was gynaecology and here we saw a significant reduction and only had one patient waiting over 52 weeks at the end of March. We also committed to maintaining the waiting list size at no more than 50,147 patients. In fact, we reduced the waiting list to 49,706 patients which is a further reduction of 441 patients.

The Urgent Care Programme

The goal on waiting times in our Emergency Departments has varied month on month ranging from an average of 80.22% to 91.08%. Although we did not deliver the 90% average goal, we did achieve a year-on-year improvement of 4.2% compared to the same time last year, despite an increase in attendances. A significant proportion of the Urgent Care Programme was delivered – for example, we made real progress on reducing length of stay - but the plans were predicated on the Oxfordshire system Winter Capacity Plan delivering 92% bed occupancy and unfortunately this was not achieved.

The Workforce Programme

Under this programme we launched the Workforce Strategy, developed evidence-based workforce plans by Directorate and launched three staff incentive schemes to increase staffing availability during the winter months. The target of reducing turnover amongst Band 5 nurses by 2% has been achieved and we have recruited to vacancy hot spots.

The Finance Programme

The Trust achieved our financial control total by delivering a £13 million surplus for 2018-19 compared with the target of a £10.4 million surplus. The Trust's underlying financial performance was supported by a number of planned non-recurring items and these enabled the Trust to record a surplus £2.6m higher than initially planned.

The Governance Improvement Plan

This was structured into six key workstreams.

- Overarching Governance - a governance handbook has been drafted and is due to be circulated for consultation.
- External Well-led Review - this has been completed, an action plan developed and it is being implemented.
- Quality Governance - a Quality Impact Assessment Policy has been endorsed by the Trust Board.
- Leadership Development and Strategic Planning, including clinical leadership - a Board development programme has commenced.
- Risk Management and Performance Management - all four Divisional risk registers have been reviewed and live annotation of the Corporate Risk Register is now in place in all Board subcommittees.
- Performance Information - further developments are in progress.

The Integrated Improvement Programme has been refreshed and will continue to focus on successful delivery of core operational priorities in 2019-20 under the leadership of the Chief Operating Officer.

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 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. It is jointly run by NHS England and Public Health England.

On NHS Sustainability Day 2019, OUH joined Refill Oxford to help cut down on the use of single-use plastic water bottles. All OUH food and drink outlets had Refill stations where staff and visitors were invited to fill up their bottles for free to reduce the use of plastic water bottles across the Trust.

Energy

The overall Trust spend was £10.39m on energy in 2018-19, which is 5.4% 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 2017-18 reported in July 2018 were 17,533 tonnes of CO_2 under the Carbon Reduction Commitment (CRC). Under the EU Emission Trading System (EU ETS) the total emissions for 2018 were 18,345 tonnes of CO_2.

Utilities cost elements

The table below shows the breakdown of the cost elements for Trust utilities for 2017-18 and 2018-19.

There is a significant drop in electricity consumption coupled with a significant rise in Trust gas consumption. 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 have increased by 5% and the Trust has changed the water supplier from Castle Water to Wave Water in December 2018.

The other charges to PFI sites and the tenant's income are a reflection on the utility price increase compared to 2017-18. For 2019-20 the trend is unfortunately heading upwards with a projection of a 10% rise in the electricity rate and 15% in gas for 2019-20.

Taxable commodity	2017-18		2018-19	
	Cost	Unit Kwh	Cost	Unit Kwh
Trust electricity	£3,718,104.75	42,221,381	£2,360,054,.50	44,142,447
Trust gas	£2,549,453.31	109,557,294	£3,096,604.20	126,514,246
JR PFI electric	£1,821,788.15	14,932,312	£2,048,993.79	15,009,859
JR PFI gas	£370,653.64	14,377,778	£370,785.34	13,182881
CH PFI electric	£1,340,743.77	10,655,125	£1,372,952.96	9,628,177
CH PFI gas	£139,419.71	5,664,855	£114,229.75	4,146,624
Trust water	£893,380.64	516,219 m^3	£937,468.93	517,694 m^3
Total Trust Utility	£10,629,701.91	£10,301,089.47	£10,301,089.47	
Less tenants' recharge income	-£2,100,767.59			
Total net utility cost	**£8,782,620.96**			

Maintaining our hospitals and hospital grounds

The Trust's Operational Estates Team was named Team of the Year at 2018's Institute of Healthcare Engineering & Estate Management (IHEEM) Awards. IHEEM is the UK's largest specialist institute for the healthcare estates sector and the peer group who judge the entries ensure an extremely high standard of award winners. Operational Estates was also named the Trust's Patients' Choice Team of the Year at their annual Staff Recognition Awards. The team was particularly pleased and honoured by both awards as so much of their work is done behind the scenes.

The Operational Estates and Facilities Team has also worked closely with the Capital Projects Team on many large and small projects to improve the hospitals' environment. For example, the Emergency Department extension, refreshing two wards and the refurbishment of the main corridor in the John Radcliffe Hospital, and the new X-ray room at the Horton General Hospital.

Sustainable waste disposal

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

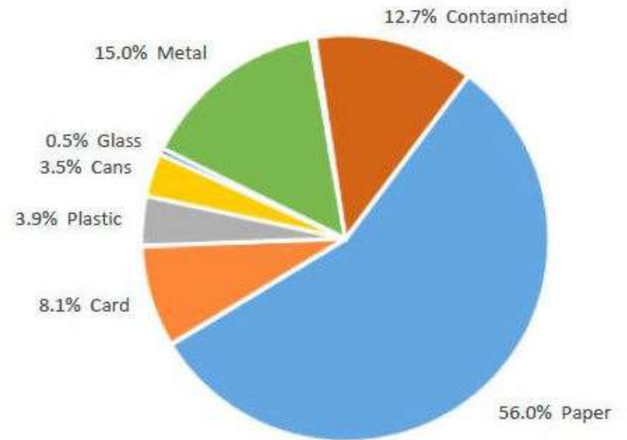
All of the Trust's clinical waste is either incinerated or sent for alternative treatment (AT). No waste goes to landfill. Incinerated waste produces 100% steam recovery and 100% recycled residues of bottom ash and lime. Alternative treatment waste produces 100% flock recovery which is used as a fuel source.

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 2018-19.

Annual Eco Saving	TOTAL
Trees saved	2,068
CO_2 saved (Kg)	520,078
Power generated (MWh)	894,92

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 2018-19 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 Management 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 2018-19 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.

The Trust announced in March 2019 that it will be fitting Automatic Number Plate Recognition (ANPR) and Variable Messaging System (VMS) equipment in the visitor car parks at the JR and Churchill Hospitals. In 2018, car park barriers at the Horton were replaced and new pay machines installed to take both cards and cash. The ANPR and VMS at the JR and Churchill should be operational by the first week in September 2019 and it is anticipated that it should greatly improve parking on both sites as well as giving the Trust new data on car park usage to help with future planning.

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, in partnership with the University of Oxford, will also be installing new covered bicycle racks at the John Radcliffe Hospital in 2019.

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.

In 2019 the Trust subsidised the University of Oxford's shuttle buses from Oxford City Station to the John Radcliffe and Churchill hospitals as a free service for staff. This shuttle runs in addition to the existing staff shuttle buses between the John Radcliffe Hospital, Nuffield Orthopaedic Centre and the Trust's offices at OUH Cowley that are run by Oxford Bus Company, and the service between the John Radcliffe Hospital, Nuffield Orthopaedic Centre and the Churchill Hospital that is run on behalf of the Trust by South Central Ambulance Service (SCAS). All these shuttles are free for staff and are well-used.

The Travel and Transport Team has also been working closely with Oxfordshire County Council on

the Access to Headington roadworks, which have taken longer than originally announced. When the work on Headley Way was launched in spring 2018, it was supposed to be a 12-week programme; but it has now exceeded 52 weeks. The Council has recently amended the design of the final phase and expects to finish now in early summer 2019. The work is designed to improve access to the Headington area for buses and cyclists to give greater priority to these more sustainable transport options.

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 Trust has been subject to a number of recent visits from the CQC: they have covered the following.

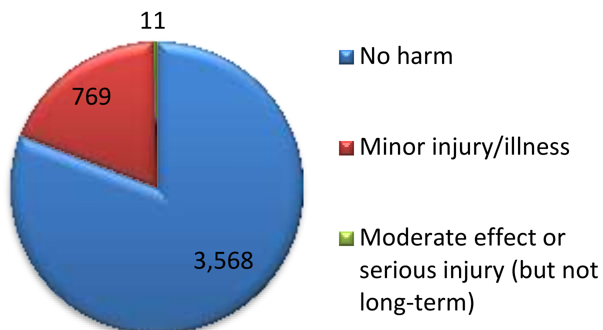
- System wide review follow-up: this was a review of the health and social care processes with a focus on the care of patients over the age of 65 across all aspects of health and social care in Oxfordshire. The review was a follow up to a review undertaken in November 2017. This follow-up found a significant improvement across the system and the report is published on the CQC website.
- Core service reviews: this was an unannounced series of inspections conducted over November and December 2018 and mainly focused on the Maternity, Gynaecology, Urgent Care and Surgery core services. The report is still awaited.
- Use of resources (conducted by NHSI using CQC methodology and resources) in December 2018, the outcome from this inspection is still awaited.
- Well led Review: this was a planned inspection conducted in January 2019. The report is still awaited.

The Trust uses every opportunity for feedback in a proactive and positive way. Whenever a report is received an action plan is developed with executive leadership to address the issues. For example, during the core service reviews the Trust received a Section 31 notice in relation to the John Radcliffe theatres complex. The action plan is owned by the Director of Clinical Services and is subject to weekly monitoring internally and reported to the CQC on a weekly basis. The issues found within the theatres have been considered more widely by the Trust and any further learning in particular in relation to current practice for storage, cleaning, privacy and dignity and access into all theatre suites is being proactively considered across all theatre suites in all Trust locations.

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

Health and safety

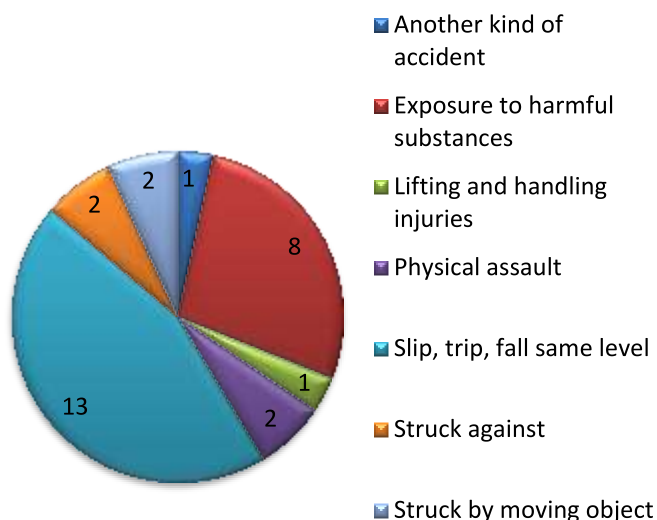
The number of non-clinical incidents reported during the period 1 April 2018 to 31 March 2019 is shown below. All incidents have been categorised by actual impact (no harm, minor, moderate, major, severe).



There were 4,348 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 82% (compared to 81% in 2017-18) of all incidents.

RIDDOR reported incidents

Overall the number of RIDDOR reportable incidents for 2018-19 was 29, an increase of two from the previous year. 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 the NHS website;
- 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 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 receiving 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. A high response rate is 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

The Trust continues to learn from the FFT as each month the Patient Experience Team reviews the Trust's feedback. The feedback is analysed to identify themes. This is shared with the Trust's senior management and Divisional leads and themes reflected in that feedback are highlighted and included via the Trust's reporting systems to recommend areas for improvement according to agreed criteria. This feedback is central for the development of the Chief Nurse's Patient Experience Delivery Plan which commenced in January 2019 and will be ready for implementation in January 2021. The Patient Experience Delivery Plan focuses on ten key areas via a process of engagement with patients and staff to deliver service improvements to enhance the experience of each patient.

Friends and Family Test – how did we do?

The following results are for the period covered by this report, 1 April 2018 to 31 March 2019.

Inpatients and day cases

96% of patients are extremely likely or likely to recommend the ward they stayed on.

Emergency Departments

88% of patients are extremely likely or likely to recommend the care they received in the Emergency Departments.

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. 95% of women are extremely likely or likely to recommend the Trust's maternity services.

Outpatients

94% of outpatients are extremely likely or likely to recommend the Trust.

Children's inpatients and day cases

98% of patients are extremely likely or likely to recommend the ward they stayed on.

National Patient Survey Programme

In 2018, 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 2018

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 3,200, and has done so for four consecutive years now, meaning that approximately 4,450 surveys are sent out in total to a sample of patients who were discharged from the Trust's hospital wards in July 2018. 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.

Embargoed results from the 2018 survey will be shared with clinical Divisional teams and presented to senior staff and a group of Public Governors. The results are positive overall and responses were received from 51% of the mandatory sample, an 8% increase from 2017. The Care Quality Commission will publish the results nationally in May-June 2019.

National Maternity Survey 2018

The Trust also took part in the National Maternity Survey in 2018. The mandatory number of patients surveyed is lower due to the smaller patient population. The national response rate was 36.8% whilst the Trust received a response rate of 46.9%. The sampling included women aged 16 and over who gave birth in February 2018.

When examining the feedback about birth and labour, the Care Quality Commission's published results (February 2019) show that the Trust scored in the top 20% of trusts nationally on nine questions and 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.

The Trust's average score was 81% (100% being the highest score). The Trust's results were broadly the same as the previous survey (in 49 questions). The Trust showed at least 5% improvement on three questions in comparison to the 2017 score, and no questions showed a 5% or more worsening of score. The remaining questions showed less than 5% in change in score since 2017.

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.

Progress was measured against the Patient and Public Involvement Strategy (2016-19) which is now replaced by the Chief Nurse's Patient Experience Delivery Plan 2019-2021. The Patient Experience Delivery Plan was approved by the Trust Board in January 2019. The plan has ten focus areas to engage patients, staff and stakeholders and the results are used to inform improve services. The focus areas include the following.

- Patient waiting times in our Emergency Departments
- Delivering same-sex accommodation
- Cancelled procedures and admissions
- Patient-centered care plans for patients with cancer
- Home First
- Reduction of noise at night
- Bridging the gap discharge processes
- End of life
- PLACE – Patient led assessment of the care environment
- Car parking

An action plan has been developed that details the engagement activities to support implementation of the Delivery Plan. The plan details the engagement of staff, diverse patients and Trust members and key stakeholders to provide their views and experience of using Trust services. Results of the engagement process will inform the development of service improvements projects.

Engaging with diverse groups

As part of wider engagement with diverse communities, the Chaplaincy service worked together with the Patient Experience team to engage with the Oxford Council of Faiths. A presentation was provided at the Council of Faith's meeting, on 13 March 2019, about the range of activities that patients and community groups could engage on with the Trust to provide their views and feedback on their experiences of services. A discussion also took place about how the group could be engaged with the Patient Experience Delivery Plan.

Engagement with TransOxford had been undertaken to enable transpeople to be engaged within the Patient Experience Delivery Plan.

Patient Participation Groups and Patient Forums

The Patient Experience team continues to work with Divisional leads to promote the engagement of patients who use Trust services. The Trust has Patient Participation Groups led by staff to encourage patients to share their experiences, provide feedback for service improvements and act as support groups to each other, especially for those with long-term conditions and needing follow-up care - for example patients undergoing dialysis and patients who have been admitted to the Intensive Care Unit and the Stroke Unit.

Patient stories

The Chief Nurse continues to present 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. The range of patient stories presented from April 2018 to March 2019 included stories that led to service improvements in various service areas.

They included:

- learning from complaints relating to miscarriage
- engagement with dialysis patients
- improvements to changing places for people with disabilities
- positive experience of the new Home First Service
- learning from complaints around cancelled operations and
- appointments
- a film about bereavement support
- a story about the support provided by the Trust to a patient with learning disabilities and her family, enabling her to have a choice of treatment and to die at home surrounded by loved ones, rather than in hospital.

Participation in the setting of the Trust's Quality Priorities

The Trust organises Quality Conversation events on an annual basis to engage with patients and the wider stakeholders about Trust priorities. Approximately 75 patients, Foundation Trust governors and members and staff took part in an event on 15 January 2019, to set the Trust's Quality Priorities.

A showcase of the achievements of the Quality Priorities was held in Tingewick Hall prior to table discussions of possible future Quality Priorities. The Chairman of the Governors' Patient Experience, Membership and Quality Committee provided an update on its role and work over the last year to the attendees. A series of 'Dragons' Den' style films of existing quality priorities was shown and tables submitted recommendations for those they most wished to

continue. The event was planned and co-ordinated by the Clinical Governance and Patient Experience teams.

The feedback from the Quality Conversation event was very positive with 86% finding the event useful or extremely useful and 80% describing the organisation of the event as good or excellent.

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. After discussion with the executive team the proposed Quality Priorities are as follows.

1. **Safety First**

- Preventing Never Events - particularly around safe surgery and procedures.
- Patient safety response teams
- Reducing stillbirths

2. **Partnership working**

- Home Assessment Reablement Team (HART) services
- Reducing the number of stranded patients.
- Care of patients with mental health issues

3. **Preventing deterioration**

- Sepsis care – antibiotics within one hour
- Launching National Early Warning System (NEWS) 2
- Digital

4. **Patient portal to support better interaction with hospital services**.

- Roll-out of the Surginet module in Cerner Millennium to support best care for patients undergoing surgery and procedures

Bridging the discharge gap

The Bridging the Gap Group, co-chaired by a Lay Governor, the Liaison Hub and the OUH Discharge Liaison Nurse Team Manager, has been formed to support the work of the Trust's Discharge Assurance Group, and encompasses representatives from the clinical teams from the acute and community settings, the Patient Experience Team and patient representatives.

The group developed a 'Leaving Hospital' questionnaire, which was distributed as a Survey Monkey questionnaire to Foundation Trust members who have expressed an interest in receiving survey requests (circa 2,500 members). The survey ran over four weeks and closed on 28 January 2019, with 112 completed surveys. Analysis of survey results was discussed at the group's meeting on 7 February 2019 and has been presented to the Discharge Assurance Group meeting. The results of the survey will help inform the development of the Patient Experience Delivery Plan.

Children’s patient experience: Friends and Family Test

The results covered by this report from 1 April 2018 to 31 March 2019 indicate that 98% of Children’s inpatients and day cases are extremely likely or likely to recommend the ward they stayed on.

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 of activities over 2018-19, which include:

- delivering a seminar to children’s nursing students at Oxford Brookes University on service user involvement;
- a sleepover investigating the main causes of noise at night on children’s wards;
- launch of a video produced by YiPpEe and the Trust to prepare children for an operation;
- attending the ‘The National Big Youth Forum Meet Up’, at Royal Derby Hospital, discussing issues surrounding mental health and wellbeing;
- involvement in Takeover Challenge, a national event which supports the UK Government’s commitment to the United Nations Convention on the Rights of the Child, giving young people the opportunity to directly participate in decision-making about the issues that affect them.

YiPpEe has two members elected to represent children and young people on the Trust’s Council of Governors, and were involved in the appointment of the new Trust Chair.

National Children and Young People’s Inpatient and Day Case Survey 2018

The survey commenced in November 2018 and is set to run until June 2019.

Open Visiting Policy and Visitors’ Charter Project

Supported by the Chief Nurse, the Trust engaged with staff, patients, Foundation Trust members and key stakeholders on their views for the development of the Open Visiting Policy. The policy allows for family, friends and relatives to visit their relative in the hospital from 10.00am to 10.00pm and was introduced from 1 October 2018. The new visiting times are receiving positive feedback from family and friends since introduction.

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 contacts with PALS 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 9.00am to 5.00pm.

During 2018-19 PALS dealt with 2,044 recorded requests, compliments and concerns. The main categories related to communications, appointments, values and behaviour and clinical treatment – in that order. 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 2018-19 the Trust received 1,073 complaints. The main themes were clinical treatment, communications, values and behaviour and admissions and discharge – in that order.

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 if still 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

The Dementia Café continues to take place on the first Tuesday of each month between 2.00pm and 3.00pm in the League of Friends Café on Level 2 of the John Radcliffe Hospital.

The Patient Experience Team hosts the event which is focused on signposting carers, staff and patients with dementia towards support organisations and support services and our partner organisations.

The Café is well supported by volunteers from Alzheimer's UK, Oxfordshire Age UK, Carers Oxfordshire and clinical staff from the Trust as well as the staff from the League of Friends.
A wide range of attendees have benefitted from the information provided and several invitations have been received by the team to speak with community-based groups to talk about 'living with and caring for someone with dementia'.

The Trust continues to work 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. 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.

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, Diversity and Inclusion 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.

In 2018, the Trust undertook the Equality Delivery System (EDS2) to identify priorities in terms of advancing equality for patients. The Trust collected evidence looking at the experience of patients under each of the nine protected characteristic groups. This evidence was then presented to two public panels held in June and July 2018. The panels graded the Trust's progress against EDS2 and recommendations were provided to improve the experience of our diverse patient population. The outcomes of this process were reported to the Trust's Quality Committee in February 2019 as part of the Equality, Diversity and Inclusion Progress Report; with the recommendations being incorporated into the Trust's Equality, Diversity and Inclusion Action Plan.

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 three Learning Disability Acute Liaison Nurses. 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, a specialist Learning Disability Epilepsy Liaison Nurse will work within Epilepsy Services 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

As part of wider engagement with diverse communities to improve patient experience, the Chaplaincy service worked together with the Patient Experience Team to engage with the Oxford Council of Faiths.

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 continues to offer a supportive service to the four regional Islamic funeral directors and the communities in general. The Trust is in the process of implementing a procedure for the Time Critical release of bodies 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 1,500 leaflets. These Trust-approved leaflets support our patients and their carers with well-written and clear information, helping to improve their overall hospital and care experience.

Our leaflets help patients (and/or their carers) to make choices 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.

A project is being carried out during 2019 to look at improving the review and production process of patient information. Directorates and Divisions are looking closely at their leaflets, to prioritise those that need review most promptly.

NHS England Accessible Information Standard

The Accessible Information Standard (AIS) is a requirement for health and social care providers to meet the information and communication support needs of patients with a disability, impairment or sensory loss. NHS provider organisations are required to meet all of the five elements within the Standard:

- asking,
- recording,
- flagging/alerting,
- sharing
- acting.

This requirement is specified in Service Condition 13.2 of the NHS Standard Contract. The Trust has several projects running to ensure it is achieving the 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. Once the required changes to EPR are made, the Trust will roll out a suite of training to staff to ensure that they effectively comply with AIS.

Interpreting and translation services

Improvements continue to be made to the provision of interpreters for patients and their carers. Following the project carried out over the end of 2016 and into 2017, changes have been made to the way face to face language interpreters are booked, which has improved availability and value for money.

It has been agreed that clinical staff members whose first/native language is the same as the patients are now able to interpret clinical conversations. A project is in place to look into training non-clinical staff members, to enable OUH and other Oxfordshire NHS healthcare providers access to qualified interpreters of rare languages.

There is comprehensive information available on the staff intranet about the appropriate use of interpreters, as well as the Interpreting and Translation Policy. This includes guidance on when to use telephone or face-to-face language interpreters and clarification of why family members/friends/(un-trained) non-clinical staff members shouldn't be used to interpret clinical discussions (safeguarding risk).

Communication cards are also available for patients to use to communicate their needs if they have either limited communication capability or limited English (they are available in 28 different languages). These 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 both to and from English.

The use of video interpreting for both language and British Sign Language interpreting is still being considered and will be looked at as a project later in 2019. 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. It will increase the availability of interpreters, as some requests are short notice or might otherwise have required the

interpreter to travel some distance. This means 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 part of the DNA of our hospitals, as evidenced 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 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.

Research and clinical facilities are located alongside each other on our hospital sites, fostering a culture of collaboration. This is further strengthened by effective support in areas such as research governance, contracts and finance provided by 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. During the course of the project, Oxford sent more than 6,500 samples to the UK Biorepository. Speaking at a special genomics event in February 2019 to celebrate the success of the 100,000 Genomes Project and explore how genomic medicine becomes a routine part of NHS care, Professor Dame Sue Hill, Chief Scientific Officer for NHS England, praised the 'significant contribution to the national programme' made by Oxford.

Around 2,000 active studies

OUH is one of the largest research-active university hospital trusts in the UK, and 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.

In 2018-19, 29,340 OUH patients participated in 508 NIHR LCRN portfolio studies (a nationally selected group of clinical studies and trials); only one Trust recruited more people. The total number of active research studies at OUH is currently around 2,000 – nearly four times more than ten years ago, and double the number of OUH studies five years ago.

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's R&D teams have developed the Studyline project and portfolio management system. This has had a profound impact on the management of research at OUH, as well as the University. Its benefits – including an interactive dashboard of the Trust's research activities – will be extended to other groups across the Trust during 2019.

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 routinely-collected patient data, 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 and monitoring clinical trials.

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Partnerships and research infrastructure

OUH carries 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 and Social Care's (DHSC) 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) coordinates 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 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.

Leading the way in anti-microbial resistance

Oxford BRC researchers have pioneered new techniques using whole genome sequencing (WGS) for mycobacteria, including tuberculosis (TB), to identify particular bacteria causing infections, relatedness in contact/outbreak mapping, and resistance determinants to anti-tuberculosis drugs. These new techniques have proven far quicker than the laborious and time consuming techniques used in traditional microbiology labs. WGS for TB is now rolled out nationally in the NHS through the Regional Centre for Mycobacteriology (RCM) at Birmingham, with implementation of an analysis and reporting pipeline through Oxford and integration with Public Health England.

During the year, Oxford BRC-backed scientists were at the forefront of a landmark study that may herald a quicker, more tailored treatment for people living with tuberculosis worldwide. They demonstrated how our understanding of TB's genetic code is now so detailed that we can predict which commonly used anti-TB drugs are best for treating a patient's infection and which are not. The findings were announced at a special UN General Assembly session on TB.

Similar WGS techniques have been applied by OUH researchers to revolutionise our understanding of *Clostridium difficile* infections, showing that many infections in hospital are related to infection in the community rather than in-hospital transmission.

In emerging infections that pose major challenges to NHS hospitals, research using WGS provides the ability to rapidly understand the source and transmission. This was exemplified by OUH researchers using WGS, allied to analysis of electronic patient data and good infection control, to halt an outbreak of *Candida auris*, the first time an outbreak of this potentially deadly fungal pathogen had been completely ended with a clear understanding of the cause.

Oxford's pre-eminence in the field of anti-microbial resistance resulted in OUH and the BRC being awarded £1.8 million in capital funding by the DHSC to expand its work to not only target common diseases for which antibiotics are often unnecessarily prescribed, but also to develop new vaccines that can tackle AMR in the NHS. The funding boosted Oxford's 'genome sequencing pipeline' with the purchase of: three genetic sequencing machines; powerful computers to analyse the results; two flow cytometers that allow for multiple samples to be analysed simultaneously; and robots that automate the process of extracting DNA and RNA from samples from clinical vaccine trials.

Tackling rare and common causes of blindness

Researchers in Oxford carried out the world's first gene therapy operation to tackle the root cause of age-related macular degeneration (AMD), the UK's most common cause of sight loss. The procedure, carried out at the John Radcliffe Hospital by Professor Robert MacLaren, involves detaching the retina and injecting a solution containing a virus underneath. The virus contains a modified DNA sequence, which infects cells and corrects a genetic defect that causes AMD. The aim is to halt the progress of the condition and preserve what vision remains. If successful, it is hoped that gene therapy can be used on patients with early AMD and so halt the disease before their vision starts to deteriorate.

Professor MacLaren has run similar ground-breaking gene therapy trials for rarer causes of blindness, choroideremia and X-linked retinitis pigmentosa. The choroideremia trial, the results of which were announced in October, showed positive results, with a significant gain in vision across the group of participants as a whole.

Oxford research in retinal gene therapy led to the creation of Nightstar Therapeutics Limited, which was floated as a publicly traded company on the NASDAQ stock exchange in September 2017, with a market capitalisation estimated at more than $600m.

Predicting heart attacks

BRC-supported researchers at the John Radcliffe Hospital have developed a new technology based on analysis of computed tomography (CT) coronary angiograms that can identify patients at risk of heart attacks years before they occur. Heart attacks are usually caused by inflamed plaques in the coronary artery causing a blockage and preventing blood getting to the heart. The research team showed that the most dangerous plaques release chemical signals that modify the surrounding fat, and these can be detected in CT images. These advances have led to a new spin-out company, Caristo Diagnostics. Another Oxford spin-out, Perspectum Diagnostics, applies new MRI techniques, originally developed for the heart, to the diagnosis of liver disease.

Oxford's leadership in medical imaging and artificial intelligence to accelerate and improve image analysis in the NHS is reflected in the recent award of £15m from Innovate UK for the Oxford-led National Consortium for Intelligent Medical Imaging (NCIMI), a collaboration involving multiple NHS trusts and imaging companies nationally.

Ruling out pre-eclampsia

A new test that predicts with almost 100 percent accuracy that a pregnant woman will not develop pre-eclampsia in the next seven days has been approved as standard clinical practice at OUH, following a trial conducted at the John Radcliffe Hospital Women's Centre. The Oxford AHSN is overseeing its introduction into other hospitals.

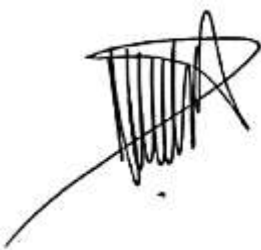
The blood test, developed by Roche Diagnostics, measures the ratio of two placental factors that are released into the mother's blood. Without the test, there is no accurate method to determine who will get the disease. Currently, any patients with suspected PE are often admitted to hospital, sometimes for several days, in order to make the diagnosis. In March 2019, the initiative was named winner of the Best Healthcare Provider Partnership category at the HSJ Partnership Awards.

…perchance to dream

A new digital cognitive behavioural therapy (CBT)-based treatment for insomnia is being rolled out to patients across the south east of England as an alternative to sleeping pills. The Sleepio app, which can be accessed via smartphone or the internet, followed the largest ever research trial into the impact of digital CBT on adults with insomnia, by Oxford BRC-funded researchers, which demonstrated that Sleepio improved overall wellbeing, mental health and quality of life.

Rethink on knee replacements

Many more patients could be given a partial - instead of a total - knee replacement, resulting in improvements in their quality of life and lower costs for the NHS, Oxford BRC-supported researchers have found. Using data from the National Joint Registry, they found that the procedure is less invasive, allows for a faster recovery, carries less post-operative risks and provides better function. It is also a cheaper short- and long-term intervention.



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 (there are currently two vacancies, so only six in post).

The Trust Board membership comprises the following.

Non-Executive Directors (NEDs)

Dame Fiona Caldicott, *Chairman**
Ms Anne Tutt, *Vice Chairman**
Mr Christopher Goard*
Ms Paula Hay-Plumb*
Professor David Mant*
Professor Gavin Screaton*

Executive Directors

Dr Bruno Holthof, *Chief Executive**
Mr Jason Dorsett, *Chief Finance Officer**
Mr John Drew, *Director of Improvement and Culture*
Ms Sam Foster, *Chief Nurse**
Dr Meghana Pandit, *Medical Director**
Ms Sara Randall, Acting *Director of Clinical Services**
Ms Eileen Walsh, *Director of Assurnce*

** 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 2018-19.

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

During the 2018-19 year the Board has continued to participate in monthly Board seminars which include the provision of Board training and development as well as opportunities to explore specific issues in more detail than is possible in the context of formal Board meetings. In the most recent year these sessions have included Board-level training in both Cyber Security and Health and Safety. The Board seminar sessions have been expanded to include senior leaders from each of the Clinical Divisions and there are scheduled sessions that include the Council of Governors.

In the latter part of 2018 the Trust commissioned an external review of leadership and governance arrangements within the Trust under the relevant elements of the well-led framework. The final report was received in January 2019 and all recommendations were accepted by the Trust.

Having regard to this report and NHS Improvement's well-led framework, the Trust has developed a detailed action plan to implement measures aimed at bringing about improvements in the areas identified with a Board lead for each element of the plan. Progress in implementation of the action plan will be monitored and reported to the Trust Board and through its sub-committees, and will continue to inform the overall evaluation of the Trust's performance, including the strength of internal controls and the governance of quality.

Arrangements have been made for externally-facilitated Board development sessions to be undertaken, building on the recommendations of the report.

The Trust is currently implementing an updated Board and senior management structure in line with the recommendations of the report. Recommendations in relation to areas in which there was a need to strengthen knowledge and experience at Board level were also taken into consideration during the most recent non-executive director recruitment process.

ATTENDANCE AT TRUST BOARD MEETINGS 2018-19

The Trust Board met in public six times during the year 2018-19.

Committee Members		**09-May-18**	**11-Jul-18**	**12-Sep-18**	**14-Nov-18**	**16-Jan-19**	**13-Mar-19**
Chairman – Non-Executive Director	Dame Fiona Caldicott	✓	✓	✓	✓	✓	✓
Chief Executive	Dr Bruno Holthof	✓	✓	✓	✓	✓	✓
Non-Executive Director	Sir John Bell	×	✓	Not in post	Not in post	Not in post	Not in post
Medical Director	Dr Tony Berendt (until Sept 2018) Dr Clare Dollery (From Sept 2018 - Jan 2019), Professor Meghana Pandit (from Jan 2019)	✓	✓	✓	✓	✓	✓
Director of Clinical Services	Mr Paul Brennan Ms Sara Randall (Acting from July 2018)	✓	✓	✓	✓	✓	✓
Chief Finance Officer	Mr Jason Dorsett	✓	✓	✓	✓	✓	✓
Director of Improvement and Culture	Mr John Drew	✓	✓	✓	✓	✓	✓
Chief Nurse	Ms Sam Foster	✓	✓	✓	✓	✓	✓
Non-Executive Director	Mr Christopher Goard	✓	✓	✓	✓	✓	×
Non-Executive Director	Ms Paula Hay-Plumb	✓	✓	✓	✓	×	✓
Chief Information and Digital Officer	Mr Peter Knight	✓	✓	Not in post	Not in post	Not in post	Not in post
Non-Executive Director	Professor David Mant	×	✓	✓	✓	✓	✓
Non-Executive Director (Vice –Chairman to Sept 2018)	Mr Geoff Salt	✓	✓	✓	Not in post	Not in post	Not in post
Non-Executive Director	Professor Gavin Screaton	Not in post	Not in post	✓	✓	✓	✓
Non-Executive Director (Vice Chairman from Sept 2018)	Ms Anne Tutt	✓	✓	✓	✓	✓	✓
Director of Assurance	Ms Eileen Walsh	✓	✓	✓	✓	✓	✓

Key

✓ In attendance (or represented by deputy)

× Not in attendance

■ Not in post

Council of Governors (as at 31 March 2019)

Public

Sally-Jane Davidge	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire
Sue Woollacott	Buckinghamshire, Berkshire, Gloucestershire and Wiltshire
Anita Higham	Cherwell
Keith Strangwood	Cherwell
Anthony Bagot-Webb	Northamptonshire and Warwickshire
Rosemary Herring	Northamptonshire and Warwickshire
Cecilia Gould[1]	Oxford City
John Harrison	Oxford City
Jonathan Wyatt	Rest of England and Wales
Art Boylston	South Oxfordshire
Janet Knowles	South Oxfordshire
Mark Booty	West Oxfordshire
Graham Shelton[2]	West Oxfordshire

Staff

Simon Brewster	Clinical
Shahab Khan	Clinical
Ibifunke Pegba-Otemolu[3]	Clinical
Jules Stockbridge	Clinical

Appointed

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

NOTES:

1. *Re-elected as Lead Governor up to 30 November 2019.*
2. *West Oxfordshire governor Susy Brigden resigned on 30 July 2018.*
3. *Staff Clinical governor Rebecca Lownds resigned on 10 March 2019.*
4. *Following the resignation of Lewis, Sara was elected on 4 January 2019.*

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 128.

The Council of Governors has now completed its third 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 GOVERNOR MEETINGS

Constituency	Governor name	30/04/2018	18/07/2018	20/11/2018	10/12/2018	22/01/2019	20/03/2019	Notes
Public								
Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	Sally-Jane Davidge	✓	✓	✓	✓	✓	✓	
Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	Brian Souter	x	x					Term ended 30 September 2018
Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	Sue Woollacott			✓	✓	✓	✓	Elected from 1 October 2018
Cherwell	Anita Higham OBE	✓	✓	✓	✓	✓	✓	Re-elected from 1 October 2018
Cherwell	Keith Strangwood	x	x	✓	✓	✓	x	
Northamptonshire and Warwickshire	Tony Bagot-Webb	✓	✓	✓	✓	✓	x	
Northamptonshire and Warwickshire	Rosemary Herring	✓	✓	✓	✓	✓	✓	Re-elected from 1 October 2018
Oxford City	Cecilia Gould	✓	x	✓	✓	✓	✓	Re-elected from 1 October 2018
Oxford City	John Harrison	x	✓	✓	✓	✓	✓	
Rest of England and Wales	Steve Candler	✓	✓					Term ended 30 September 2018
Rest of England and Wales	Jonathan Wyatt			✓	✓	✓	✓	Elected from 1 October 2018
South Oxfordshire	Arthur Boylston	✓	✓	✓	✓	✓	✓	
South Oxfordshire	Janet Knowles			✓	✓	✓	✓	Elected from 1 October 2018
Vale of White Horse	Martin Havelock	✓	✓	✓	✓	✓	✓	Re-elected from 1 October 2018
Vale of White Horse	Jill Haynes	✓	✓	✓	✓	✓	✓	
West Oxfordshire	Mark Booty			✓	x	✓	✓	Elected from 1 October 2018
West Oxfordshire	Susy Brigden	x	x					
West Oxfordshire	Susan Chapman	✓	x					Term ended 30 September 2018
West Oxfordshire	Graham Shelton			✓	✓	✓	✓	Co-opted from 1 October 2018

Constituency	Governor name	30/04/2018	18/07/2018	20/11/2018	10/12/2018	22/01/2019	20/03/2019	Notes
Staff								
Clinical	Simon Brewster	✓	✓	✓	✓	✓	x	
Clinical	Lucy Carr	✓	x					Term ended 30 September 2018
Clinical	Shad Khan			✓	✓	✓	✓	Elected from 1 October 2018
Clinical	Rebecca Lownds			✓	✓	✓		Elected on 1 October 2018, resigned on 10 March 2019
Clinical	Ibifunke Pegba-Otemolu						✓	Elected from 11 March 2019
Clinical	Jules Stockbridge	✓	x	✓	✓	✓	x	
Clinical	Chris Winearls	✓	✓					Term ended 30 September 2018
Non-Clinical	Rebecca Cullen			✓	✓	✓	✓	Elected from 1 October 2018
Non-Clinical	Tommy Snipe	✓	✓	x	✓	✓	✓	
Non-Clinical	Mariusz Zabrzynski	✓	✓					Term ended 30 September 2018
Appointed								
Berkshire, Buckinghamshire & Oxfordshire Local Medical Committees	Paul Roblin							Resigned 30 June 2017
NHS England (South)	David Radbourne	✓	✓	✓	x	✓	x	
Oxford Brookes University	Astrid Schloerscheidt	✓	x	x	x	x	✓	
Oxford Health NHS Foundation Trust	Martin Howell	✓	✓	x	x	x	x	Stood down on 31 March 2019
Oxfordshire Clinical Commissioning Group	Gareth Kenworthy	✓	✓	x	✓	✓	✓	
Oxfordshire County Council	Lawrie Stratford	✓	x	x	x	x	x	
University of Oxford	Elizabeth Gemmill	✓						Resigned on 1 May 2018
YiPpEe	Emily	x	x	x	x	x	x	
YiPpEe	Lewis	x	x					Resigned on 31 August 2018
YiPpEe	Sara						✓	Elected from 4 January 2019

Key

✓ In attendance x Not in attendance ▇ Not in post

The following also attended on 30 April 2018:

Clare Dollery, Deputy Medical Director

Christopher Goard, Non-Executive Director

The following also attended on 18 July 2018:

Peter Knight, Chief Information and Digital Officer

Liz O'Hara, Interim Director of Workforce

Geoffrey Salt, Vice Chairman

The following also attended on 20 November 2018:

Martin Bull, Interim Associate Director of Financial Services

Anne Tutt, Vice Chairman

The following also attended on 10 December 2018:

Christopher Goard, Non-Executive Director

The following also attended on 22 January 2019:

Ian Bottomley, Deputy Winter Director

Clare Dollery, Deputy Medical Director

Jason Dorsett, Chief Finance Officer

John Drew, Director of Improvement and Culture

Christopher Goard, Non-Executive Director

Bruno Holthof, Chief Executive

Meghana Pandit, Medical Director

Sara Randall, Acting Director of Clinical Services

Eileen Walsh, Director of Assurance

The following also attended on 20 March 2019:

Anne Tutt, Vice Chairman

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, *Chairman*

Mr Christopher Goard, *Vice Chairman*

Ms Paula Hay-Plumb

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 six times during the year 2018-19

		18-Apr-18	02-May-18	22-May-18	19-Sep-18	16-Nov-18	20-Feb-19
Chairman, Non-Executive Director	Ms Anne Tutt	✓	✓	✓	✓	✓	✓
Non-Executive Director	Mr Christopher Goard	×	×	✓	✓	✓	✓
Non-Executive Director	Ms Paula Hay-Plumb	✓	✓	✓	✓	✓	✓

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 2019 comprises:

Non-Executive Directors:

Ms Paula Hay Plumb, *Chairman*

Ms Anne Tutt, *Vice Chairman*

Dame Fiona Caldicott

Mr Christopher Goard

and the following **Executive Directors:**

Dr Bruno Holthof, *Chief Executive*

Mr Jason Dorsett, *Chief Finance Officer*

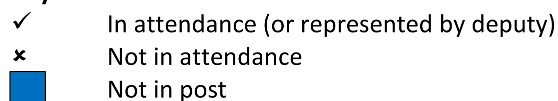
Ms Sam Foster*, Chief Nurse*

Professor Meghana Pandit, *Medical Director*

Ms Sara Randall, *Acting Director of Clinical Services*

The committee met seven times during the year 2018-19

Committee Members		**11-Apr-18**	**13-Jun-18**	**08-Aug-18**	**10-Oct-18**	**12-Dec-18**	**13-Feb-19**	**27-Feb-19**
Committee Chairman, Non-Executive Director	Geoff Salt (until Sep 2018) Paula Hay-Plumb (from Dec 2018)	✓	✓	✓	×	✓	✓	×
Non-Executive Director	Dame Fiona Caldicott	✓	✓	✓	×	✓	✓	✓
Chief Executive	Dr Bruno Holthof	✓	✓	×	×	✓	✓	✓
Medical Director	Dr Tony Berendt (until Sep 2018) Dr Clare Dollery (From Sept 2018 - Jan 2019) Professor Meghana Pandit (from Jan 2019)	✓	✓	✓	✓	✓	✓	✓
Director of Clinical Services	Mr Paul Brennan Ms Sara Randall (Acting from July 2018)	✓	✓	✓	✓	✓	✓	✓
Chief Finance Officer	Mr Jason Dorsett	✓	✓	✓	✓	✓	✓	✓
Chief Nurse	Ms Sam Foster	×	✓	✓	×	✓	✓	✓
Non-Executive Director	Mr Christopher Goard	✓	✓	×	✓	✓	✓	✓
Non-Executive Director (Vice - Chair)	Ms Anne Tutt	✓	×	✓	✓	×	✓	✓



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 2019 comprises:

Non-Executive Directors:

Ms Anne Tutt, *Chairman*

Mr Christopher Goard

Ms Paula Hay-Plumb

and the following **Executive Directors:**

Mr Jason Dorsett, *Chief Finance Officer*

Professor Meghana Pandit, *Medical Director*

Ms Eileen Walsh, *Director of Assurance*

The committee met seven times during the year 2018-19

Committee Members		**18-Apr-18**	**21-Jun-18**	**02-Jul-18**	**14-Sep-18**	**16-Nov-18**	**22 Jan 209**	**20-Feb-19**
Committee Chairman, Non-Executive Director	Ms Anne Tutt	✓	✓	✓	✓	✓	✓	✓
Medical Director	Dr Tony Berendt (until Sep 2018), Dr Clare Dollery (From Sept 2018 - Jan 2019), Professor Meghana Pandit (from Jan 2019)	✓	✓	✓	✓	✓	×	✓
Chief Financial Officer	Mr Jason Dorsett	✓	✓	✓	✓	✓	✓	✓
Non-Executive Director	Mr Christopher Goard	×	✓	✓	×	✓	✓	×
Non-Executive Director	Ms Paula Hay-Plumb	✓	×	✓	✓	✓	✓	✓
Non-Executive Director	Mr Geoff Salt (until Sep 2018)	×	✓	✓				
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 2019 comprises:

Non-Executive Directors:

Professor David Mant, *Chairman*

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

Ms Sam Foster, *Chief Nurse*

Professor Meghana Pandit, *Medical Director*

Ms Sara Randall, Acting *Director of Clinical Services*

Ms Eileen Walsh, *Director of Assurance*

The committee met six times during the year 2018-19

Committee Member		11-Apr-18	13-Jun-18	08-Aug-18	10-Oct-18	12-Dec-18	13-Feb-19
Committee Chairman, Non-Executive Director	Professor David Mant	✓	✓	✓	✓	✓	✓
Non-Executive Director	Dame Fiona Caldicott	✓	✓	✓	×	✓	✓
Chief Executive	Dr Bruno Holthof	✓	✓	✓	×	×	✓
Medical Director	Dr Tony Berendt (until Sep 2018) Dr Clare Dollery (From Sept 2018 - Jan 2019) Professor Meghana Pandit (from Jan 2019)	✓	✓	✓	✓	✓	✓
Director of Clinical Services	Mr Paul Brennan Ms Sara Randall (Acting from July 2018)	✓	✓	✓	✓	✓	✓
Deputy Medical Director	Dr Clare Dollery (Acting Medical Director as above)	✓	✓	✓	✓	✓	✓
Chief Nurse	Ms Sam Foster	✓	✓	✓	×	✓	✓
Non-Executive Director	Mr Christopher Goard	✓	✓	×	✓	✓	✓
Chief Information and Digital Officer	Mr Peter Knight (until Aug 2018)	×	×	✓	□	□	□
Non-Executive Director	Mr Geoffrey Salt (until Sep 2018)	✓	✓	✓	□	□	□
Director of Assurance	Ms Eileen Walsh	✓	✓	✓	✓	✓	✓

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 97.

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 four Divisional Directors, the Deputy Medical Director (as Chairman of the Clinical Governance Committee), the Head of Communications, and the Head of Corporate Governance (as 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 2018-19, up to 31 March 2019

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 2018-19 up to 31 March 2019 are given on pages 85 to 91. 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 85.

Board member	Post	Register of Interest								
		Directorships, including non-executive directorships	Business, partnership or consultancies	Majority or controlling shareholdings	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 (to 7 August 2018)	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							

	Register of Interest								
Board member	**Post**	**Directorships, including non-executive directorships**	**Business, partnership or consultancies**	**Majority or controlling shareholdings**	**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 (to 7 August 2018 cont.		Science and Technology Honours Committee - Chairman Bill and Melinda Gates Foundation global health SAB - Chairman							
Dr Tony Berendt (to 14 September 2018)	Medical Director								
Mr Paul Brennan (to 31 July 2018)	Director of Clinical Services								
Dame Fiona Caldicott	Trust Chairman, Non-Executive Director	NED and Company Secretary Waters 1802 Ltd Member of the Executive Committee of Oxford University Clinic	Consultancy for the DOH 1-2 days per week			National Data Guardian for Health and Social Care			
Dr Clare Dollery (from 15 September 2018 – 1 January 2019)	Acting Medical Director	Member of the Executive Committee of Oxford University Clinic							
Mr Jason Dorsett	Chief Finance Officer	Member of the Executive Committee of Oxford University Clinic. Director of OUH Commercial Partners Limited Member of OUH Ventures LLP							
Mr John Drew	Director of Improvement and Culture					National Churches Trust – Trustee St.Peters Baptist Church, Worcester –Trustee 4 Front Theatre – Trustee			

	Register of Interest								
Board member	**Post**	**Directorships, including non-executive directorships**	**Business, partnership or consultancies**	**Majority or controlling shareholdings**	**Charity or voluntary organisations**	**Voluntary or other organisation contracting for NHS services**	**Research funding / grants**	**Pooled funds**	**Royalties, licence fees or similar**
Ms Sam Foster	Chief Nurse					T Level Health Panel - Panel Member (ongoing) Trust gets employer allowance - £1,000 per quarter time reimbursement			
Mr Christopher Goard	Non-Executive Director	Prescription Medicines Code of Practice Authority Appeals Board Member - part of the pharmaceutical industry regulatory framework via ABPI				Presiding Justice at Thames Valley Family Court			
Ms Paula Hay-Plumb	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						Small investment in Aberforth Smaller Companies Trust PLC	
Dr Bruno Holthof	Chief Executive	Tristel Plc - Non-Executive Director Armonea - Board Member Member of the Executive Committee of Oxford University Clinic							
Mr Peter Knight (to 6 September 2018)	Chief Information and Digital Officer						Big Data Institute, University of Oxford		

	Register of Interest								
Board member	**Post**	**Directorships, including non-executive directorships**	**Business, partnership or consultancies**	**Majority or controlling shareholdings**	**Charity or voluntary organisations**	**Voluntary or other organisation contracting for NHS services**	**Research funding / grants**	**Pooled funds**	**Royalties, licence fees or similar**
Professor David Mant	Non-Executive Director	Emeritus Professorship Oxford University (Nuffield Department of Primary Health Care and Kellogg College)			Chair of the South West General Practice Trust				
Professor Meghana Pandit (From 2 January 2019)	Medical Director						Professor of Practice and Course Director, MSc in Healthcare Operational Management at Warwick University		
Ms Sara Randall (from 30 April 2018)	Acting Director of Clinical Services								
Mr Geoffrey Salt (to 19 September 2018)	Non-Executive Director and Vice-Chairman				Trustee, Nuffield Medical Trust, Oxford Kidney Unit Fund Trustee of Oxford Transplant Foundation				
Professor Gavin Screaton (from 1 September 2018)	Non-Executive Director	GSK Vaccines R&D Advisory Board member MRC Strategy Board member until January 2019 Member of the Executive Committee of Oxford University Clinic Member of Oxford University Council Member of Siriraj Research and Innovation					Grants from Wellcome Trust		

	Register of Interest								
Board member	**Post**	**Directorships, including non-executive directorships**	**Business, partnership or consultancies**	**Majority or controlling shareholdings**	**Charity or voluntary organisations**	**Voluntary or other organisation contracting for NHS services**	**Research funding / grants**	**Pooled funds**	**Royalties, licence fees or similar**
Professor Gavin Screaton (from 1 September 2018) cont.		Advisory Committee, Faculty of Medicine Siriraj Hospital, Mahidol University, Bangkok – from Oct 2018							
Mrs Anne Tutt	Non-Executive Director	International Network for the availability of Scientific Publications - Non-Exec Director and Chair of Audit Committee Member of DFID Audit & Risk Assurance Committee Member of the Executive Committee of Oxford University Clinic	Ownership of a private business - A Tutt Associates		Director and Trustee of Oxford Hospitals Charity and Chairman of the Audit Committee Trustee of the 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 Gifts Hospitality and Sponsorship (Trust Board)		
Name	**Position**	**Return/Details**
Trust Board Members		
Professor Sir John Bell	Non-Executive Director (to 7 August 2018)	
Dr Tony Berendt	Medical Director (to 14 September 2018)	
Mr Paul Brennan	Director of Clinical Services (to 31 July 2018)	
Dame Fiona Caldicott	Chairman	
Dr Clare Dollery	Acting Medical Director (from 15 September 2018 – 1 January 19)	Oxford Mayo Launch Meeting/Event held at the American Embassy, London, December 2018
Mr Jason Dorsett	Chief Finance Office	Oxford University Clinic Workshop and Dinner, Oxford, April 2018 Oxford University Clinic Workshop and Dinner, Oxford, June 2018 Mayo Clinic Dinner, Oxford, August, 2018
Mr John Drew	Director of Improvement and Culture	Speaker at Medtronic conference in Madrid, flights and expenses paid, May 2018 Speaker at Global Leadership Forum, dinner May, 2018 FT Seminar and dinner at St Antony's College, June 2018 Management in Medicine Dinner at Green Templeton College, July 2018 Fellows Xmas Dinner at Green Templeton College December,2018 Speaker at Latin American Healthcare Workshop, July 2018. Paid fee of £300 subsequently donated to a clinical service at OUH.
Ms Sam Foster	Chief Nurse	Odgers dinner with CQC Chair
Mr Christopher Goard	Non-Executive Director	
Ms Paula Hay Plumb	Non-Executive Director	
Dr Bruno Holthof	Chief Executive	Oxford University Clinic Workshop & Dinner held at Trinity College, Oxford, April 2018 Oxford Life Sciences Dinner held at Christchurch College, Oxford, April 2018 Drinks event held at Odgers Berndtson offices, London, April 2018 Annual Dinner with McKinseys held at The National Gallery, London , May 2018 AMC Conference & Networking Dinner held at the Hospital de la Santa Creu, Barcelona, May 2018 – McKinsey paid for flights and accommodation NHS Data Dinner with Lord O'Shaughnessy held at Royal Horseguards, London, June 2018 Management in Medicine Dinner held at Green Templeton College, Oxford, July 2018 Dinner with Quinnipiac Delegation University /Trinity/Select Medical held at Pembroke College, Oxford, July 2018 Cerner Conference/CEO Summit held in California, July 2018 Dinner with the Clinical Team held at Cherwell Boathouse, Oxford, August 2018 Roche Board Dinner held at Magdalen College, Oxford, September 2018 Dinner with Lord Winston, Baroness Royall and Peter Wyman held at Somerville College, November 2018 NHS Providers Dinner with Peter Wyman and Ian Trenholme (CQC) held at The Grosvenor, London, December 2018 Oxford Mayo Launch Meeting/Event held at the American Embassy, London, December 2018 Dinner with Boston Scientific held at Malmaison, Oxford, January 2019 BRC Networking dinner at Exeter College, February 2019

Register of Gifts Hospitality and Sponsorship (Trust Board)		
Name	**Position**	**Return/Details**
Mr Peter Knight	Chief Information and Digital Officer (to 6 September 2018)	
Professor David Mant OBE	Non-Executive Director	
Professor Meghana Pandit	Medical Director (from 2 January 2019)	Invited panelist at ICHOM conference in Rotterdam, May 2019 – ICHOM paid for accommodation.
Ms Sara Randall	Acting Director of Clinical Services (WEF 30 April 2018)	
Mr Geoffrey Salt	Vice Chairman Non-Executive Director (to 19 September 2018)	
Professor Gavin Screaton	Non-Executive Director (from 1 September 2018)	Oxford University Clinic Workshop & Dinner held at Trinity College, Oxford, 11 April 2018 Dinner with Quinnipiac Delegation University /Trinity/Select Medical held at Pembroke College, Oxford, 18 July 2018 Roche Board Dinner held at Magdalen College, Oxford, 25 September 2018 Oxford Mayo Launch Meeting/Event held at the American Embassy, London, 11 December 2018 Dinner with Boston Scientific held at Malmaison, Oxford, 15 January 2019
Ms Anne Tutt	Vice Chairman Non-Executive Director	Oxford University Clinic Workshop & Dinner held at Trinity College, Oxford 11 April 2018
Ms Eileen Walsh	Director of Assurance	

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. Under the Freedom of Information Act, the Trust has a statutory obligation to respond to all requests within 20 working days or seek an extension from the requestor.

From 1 April 2018 to 31 March 2019 the Trust received 698 Freedom of Information requests.

A number of these requests contained multiple questions that required input from more than one Division.

Reduced staffing within the Information Governance Team had an adverse impact on response rates in the May – December period resulting in 466 requests (66.8%) being responded to in the statutory timeframe.

With increased IG team staffing from December and a change to the senior sign off process, 82% of 186 FOIs received were responded to with the 20 day limit.

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 paid £52k 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 2019		
Non-NHS payables		
Total non-NHS trade invoices paid in the period	144,793	572,518
Total non-NHS trade invoices paid within the target	134,477	522,830
Percentage of non-NHS trade invoices paid within the target	92.9%	91.3%
NHS payables		
Total NHS trade invoices paid in the period	4,687	122,906
Total NHS trade invoices paid within the target	4,155	116,027
Percentage of NHS trade invoices paid within the target	88.6%	94.4%

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-recognized 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 Resolution (NHSR) 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 2018-19 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 from page 169.

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 22 to the accounts on page 306.

Political donations

The Trust made no political donations during the financial year.

Important events since balance sheet date

There have been no material events after the reporting date which require disclosure.

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 aim of the Trust's People Strategy is to make OUH a place where people are proud and excited to work, where teams and individuals are trusted with responsibility and accountable for what they do, and 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 employment with the Trust).
- Mitigating the high cost of living (within 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 delivering the best possible healthcare.

We have continued to extend values-based interviewing (VBI) 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 Executive Directors and Very Senior Managers

Remuneration and Appointments Committee

Membership of the Remuneration and Appointments Committee is limited to the Trust Chairman and Non-Executive Directors of the Trust. The Chairman of the Committee is elected by the Committee. The Committee has delegated responsibilities for the remuneration and terms of service for the Chief Executive, Executive Directors, Divisional Directors and other 'Very Senior Managers' (VSMs) at the Trust i.e. all other senior managers who are on VSM contracts and not paid under nationally determined terms and conditions - Medical and Dental contracts or Agenda for Change. Its responsibility includes all aspects of salary and provision of other benefits, arrangements for termination of employment and other principal contractual terms.

The Committee does the following.

- Sets the remuneration policy, contracts, terms and conditions of service, termination arrangements and pensions for the Chief Executive, Executive Directors and VSMs reporting directly to the Chief Executive, Divisional Directors and all other VSMs.
- Sets the salary range for appointments to all VSM posts, taking into consideration national NHS guidance, relevant benchmarking data in relation to comparable posts, internal relativities, gender pay gap data, labour market conditions and any organisational structural changes and/or enhancement to role specifications which have been implemented or are planned.
- Monitors and evaluates the performance and oversees the setting of objectives for the Chief Executive, Executive Directors, VSMs reporting to the Chief Executive and Divisional Directors on an annual basis. Ensures that performance, talent management, succession planning and skills assessments are applied as necessary for these individuals.
- Ensures compliance with relevant NHS Improvement and other guidance on all of the above matters.
- Considers recommendations from NHS Improvement on the annual cost of living award for VSMs.

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. The Committee applies national NHS policies and guidance which are in force at the time. The Committee does not determine the terms and conditions of office of the Chair and Non-Executive Directors - these are decided by the Council of Governors' Remuneration, Nominations and Appointments Committee (see page 110).

During the 12 month period to 31 March 2019 the Committee met ten times. The membership and attendance at the Committee was as follows:

Remuneration and Appointments Committee	11/04/18	22/05/18	22/06/18	12/09/18	03/10/18	10/10/18	03/12/18	19/12/18	07/03/19	27/03/19
Professor Sir John Bell (Chair up to 07/08/18)	√	√	√							
Ms Paula Hay-Plumb (Chair from 12/09/18)	x	√	√	√	√	√	√	√	√	√
Dame Fiona Caldicott	√	x	√	√	√	x	√	√	√	√
Mr Christopher Goard	√	√	√	√	√	√	√	x	x	√
Professor David Mant OBE	√	√	√	√	x	√	√	√	√	√
Mr Geoffrey Salt	√	√	√							
Professor Gavin Screaton	-	-	-	√	x	√	√	x	x	x
Ms Anne Tutt	√	x	√	√	x	√	√	x	√	x

Key

✓ In attendance
× Not in attendance
Not in post

Executive Directors and Very Senior Managers' remuneration policy

The Remuneration and Appointments Committee agreed a new Pay and Reward Policy for Executive Directors in 2018-19 for recommendation to the Trust Board. Executive Directors' contracts of employment include a fixed annual salary payment, which is disclosed in the Annual Report and Accounts. This policy includes the incorporation of an 'earn-back' provision in Executive Director contracts in line with NHSI guidance i.e. a requirement to meet agreed performance objectives to earn back an element of base pay (10%) which is therefore placed at risk. This will be applied to contracts going forward from the date of final approval. Starting salaries for Executive Directors are determined by the Remuneration and Appointments Committee as set out above.

In making its decisions regarding Senior Managers' remuneration, the Remuneration and Appointments Committee takes into account a wide range of local and national factors and information including the pay and conditions of the Trust's employees, incorporating any recommended annual NHS pay award. As these are considered the most relevant matters for the Committee to consider, there was no local consultation with the Trust's employees in 2018-19 regarding senior managers' remuneration.

The Trust plans to introduce a further Pay and Reward Policy during 2019-20 for the small number of VSM posts outside of Executive Directors.

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 Executive Directors in 2018-19. 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 above.
Dr Tony Berendt*1	Medical Director	Retired September 2018	Substantive	Six months	Discretionary Payment in Lieu of Notice	See note 1 below.
Mr Paul Brennan	Director of Clinical Services	Resigned July 2018	Substantive	Six months	Discretionary Payment in Lieu of Notice	See paragraph above.
Mr Jason Dorsett	Chief Finance Officer	October 2016	Substantive	Six months	Discretionary Payment in Lieu of Notice	See paragraph above.
Mr John Drew	Director of Improvement and Culture	October 2017	Substantive	Six months	Discretionary Payment in Lieu of Notice	See paragraph above.
Ms Sam Foster	Chief Nurse	September 2017	Substantive	Six months	Discretionary Payment in Lieu of Notice	See paragraph above.
Mr Peter Knight	Chief Information and Digital Officer	Resigned September 2018	Substantive	Six months	Discretionary Payment in Lieu of Notice	See paragraph above.
Professor Meghana Pandit	Medical Director	January 2019	Substantive	Six months	Discretionary Payment in Lieu of Notice	See paragraph above.
Ms Eileen Walsh	Director of Assurance	May 2011	Substantive	Six months	Discretionary Payment in Lieu of Notice	See paragraph above.
Dr Clare Dollery*2	Acting Medical Director	September 2018-January 2019	Acting			See note 2 below.

Name	Post	Date of contract	Unexpired term	Notice period	Provision for compensation for early termination	Other termination liability
Ms Sara Randall	Acting Director of Clinical Services	From April 2018	Acting			

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

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

Notes:

1. *The previous Medical Director, Dr Tony Berendt, was 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.*
2. *The current Medical Director, Professor Meghana Pandit, is on a Trust VSM contract of employment.*

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	**31 March 2019** extension approved by Council of Governors on 20 October 2016
Professor Sir Jonathan Montgomery	Appointed from 1 April 2019			
Professor Sir John Bell	Appointment ceased in August 2018			
Mr Christopher Goard	1 November 2011– 31 March 2013 Appointed Senior Independent Director (SID) July 2012	1 April 2013 1 April 2015 21 October 2018	21 October 2018	**12 October 2019** extension approved by Council of Governors on 30 April 2018
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 21 October 2018	21 October 2018	**12 October 2019** extension approved by Council of Governors on 30 April 2018
Mr Geoffrey Salt	Appointment ceased in September 2018			
Professor Gavin Screaton	1 September 2018 – 31 August 2021			
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 Trustee – Oxford Hospitals Charity Appointed Trust Vice-Chairman	1 December 2013 1 December 2017	30 November 2017	**30 November 2020** extension approved by Council of Governors on 5 October 2017

Future Policy Table

This table provides a description of each of the components of the remuneration package for senior managers

	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		Not applicable	Not applicable	Ensure the recruitment / retention of directors of sufficient calibre to deliver the Trust's objectives
How the component operates	Paid monthly		Not applicable	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		Not applicable	Not applicable	Contributions are made in accordance with the NHS Pension Scheme
Framework used to assess performance		Not applicable	Not applicable. However, an earn-back scheme is in place for some Executive Directors (depending on the date of their appointment) in which 10% of their annual salary is put at risk dependent on performance	Not applicable	Not applicable
Performance period	Concurrent with the financial year	Concurrent	Not applicable	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	Not applicable	None Paid	Any sums paid in error may be recovered

Note

1. *The Taxable benefit disclosed are described in the notes on page 139*

In respect of Executive Directors 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, in line with national NHS guidance. All Executive Director and Very Senior Manager salaries above £150,000 require the approval of NHS Improvement and this was sought on each relevant occasion in 2018-19.

Salary and Pension Entitlements of Senior Managers

a. Directors' remuneration

The table below discloses the remuneration provided to directors within Oxford University Hospitals NHS Foundation Trust during the period 1 April 2018 to 31 March 2019 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 136 of this report.

Salary and Pension Entitlements for Executive and Non-Executive Directors of the Trust

A) **DIRECTORS' REMUNERATION**

Name and title		2018-19 (12 months to 31 March 2019)				2017-18 (12 months to 31 March 2018)			
		Salary (bands of £5000) £000	**Other Remuneration** (bands of £5000) £000	**Performance related pay** (bands of £5000) £000	**Benefits in kind** to nearest £100 £	**Salary** (bands of £5000) £000	**Other Remuneration** (bands of £5000) £000	**Performance related pay** (bands of £5000) £000	**Benefits in kind** to nearest £100 £
Dame Fiona Caldicott[1]	Chairman	55-60				55-60			
Professor Sir John Bell[2, 3]	Non-Executive Director	0 - 5				10-15			
Mr Alisdair Cameron[3, 4]	Non-Executive Director					0-5			
Mr Christopher Goard[5]	Non-Executive Director	15 - 20				15-20			
Professor David Mant[3]	Non-Executive Director	10 - 15				10-15			
Ms Paula Hay-Plumb[3, 6]	Non-Executive Director	10 - 15				5-10			
Mr Geoffrey Salt [5, 7]	Non-Executive Director	5 - 10				15-20			
Professor Gavin Screaton[3,8]	Non-Executive Director	5 - 10							
Ms Anne Tutt [5]	Non-Executive Director	15 - 20				15-20			
Mr Peter Ward [5 ,9]	Non-Executive Director					10-15			
Dr Bruno Holthof [10, 23,]	Chief Executive	280 - 285			7,700	280-285			7,400
Dr Tony Berendt' [11]	Medical Director	90 - 95				205-210			
Mr Paul Brennan[12]	Director of Clinical Services	90 - 95			2,500	170-175			9,100
Dr Clare Dollery[13]	Acting Medical Director	55 - 60							
Mr Jason Dorsett	Chief Finance Officer	170 - 175				170-175			

Name and title		2018-19 (12 months to 31 March 2019) Salary (bands of £5000) £000	2018-19 Other Remuneration (bands of £5000) £000	2018-19 Performance related pay (bands of £5000) £000	2018-19 Benefits in kind to nearest £100 £	2017-18 (12 months to 31 March 2018) Salary (bands of £5000) £000	2017-18 Other Remuneration (bands of £5000) £000	2017-18 Performance related pay (bands of £5000) £000	2017-18 Benefits in kind to nearest £100 £
Mr John Drew[14]	Director of Improvement and Culture	180 - 185				85-90			
Ms Sam Foster[10,15]	Chief Nurse	140-145				80-85			
Mr Peter Knight[16]	Chief Information and Digital Officer	55 - 60				130-135			
Mr Andrew MacCallum[17]	Interim Chief Nurse					45-50			
Professor Meghana Pandit [18]	Medical Director	55 - 60							
Mr Mark Power[19]	Director of Organisational Development and Workforce					40-45			
Ms Sara Randall[20]	Acting Director of Clinical Services	110 - 115							
Ms Eileen Walsh	Director of Assurance	130 - 135				125-130			
Ms Elizabeth Wright[21]	Interim Chief Nurse					5-10			
Ms Susan Young[22]	Interim Director for HR					90-95			

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. She retired from the Trust in March 2019.
2	Resigned from Oxford University Hospitals August 2018
3	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. The annual remuneration of Non-Executive Directors is within the band of 10-15.
4	Term of Office ended April 2017
5	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. The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of 15-20.

6	Appointed from September 2017
7	Resigned from Oxford University Hospitals September 2018
8	Appointed from September 2018
9	Term of Office ended November 2017
10	Following discussion with auditors, the salary figures are shown as the gross amount prior to any salary sacrifice deductions
11	Retired from Oxford University Hospitals September 2018
12	Resigned from Oxford University Hospitals July 2018, the benefit in kind relates to a lease car
13	Acting Medical Director from September 2018 to January 2019
14	Appointed to Oxford University Hospitals October 2017
15	Appointed to Oxford University Hospitals September 2017
16	Resigned from Oxford University Hospitals September 2018
17	Interim Chief Nursing Officer from May 2017 to September 2017
18	Appointed from January 2019
19	Resigned from Oxford University Hospitals April 2017 and salary figure includes a payment in lieu of notice
20	Acting Director of Clinical Services from April 2018
21	Acting Chief Nurse from 1 April 2017 to 30 April 2017
22	Interim Director of HR from April 2017 to October 2017
23	A life assurance and income protection premium are also paid in respect of the CEO and are shown as a benefit in kind

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 2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2019 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employer's contribution to stakeholder pension To nearest £100 £
Dr Tony Berendt	Medical Director	-5 - -2.5	-10 - -7.5	90 - 95	275 - 280	0	0	2,238	0
Mr Paul Brennan	Director of Clinical Services	0 – 2.5	2.5 - 5	80 - 85	240 - 245	1,897	89	1,643	0
Mr Jason Dorsett	Chief Finance Officer	2.5 - 5	0	5 - 10	0	89	20	43	0
Mr John Drew	Director of Improvement and Culture	2.5 - 5	0	5 - 10	0	61	18	17	0
Ms Sam Foster	Chief Nurse	-2.5 - 0	-10 - -7.5	35 - 40	85 - 90	650	38	578	0
Mr Peter Knight	Chief Information and Digital Officer	2.5 - 5	5 – 7.5	35 – 40	65 - 70	497	34	386	0
Ms Sara Randall	Acting Director of Clinical Services	12.5-15	37.5-40	55-60	170-175	1,385	369	970	0
Ms Eileen Walsh	Director of Assurance	0 – 2.5	-2.5 - 0	40 - 45	100 - 105	835	89	706	0

Non-Executive Directors do not receive pensionable remuneration (2017-18: nil), (2017-18: nil). The Trust did not contribute to a Director's stakeholder pension scheme (2017-18: nil). Pension details have only been disclosed for those Directors in post during the last 12 months up to 31 March 2019. Balances for those in post during 2017-18 can be obtained from the 2017-18 Annual Report.

TRUST BOARD MEMBERS

AT 31 MARCH 2019

Dr Bruno Holthof
Chief Executive

Dame Fiona Caldicott
Chairman

Mr Jason Dorsett
Chief Finance Officer

Mr John Drew
Director of Improvement and Culture

Ms Sam Foster
Chief Nurse

Prof Meghana Pandit
Medical Director

Ms Sara Randall
Acting Director of Clinical Services

Ms Eileen Walsh
Director of Assurance

Mrs Anne Tutt
Non-executive Director

Mr Christopher Goard
Non-executive Director

Mrs Paula Hay-Plumb
Non-executive Director

Professor David Mant
Non-executive Director

Prof Gavin Screaton
Non-executive Director

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 2018-19 was £285,000-£290,000 (2017-18: £285,000-£290,000). This was 8.7 times (2017-18: 9.5) the median remuneration of the workforce, which was £32,917 (2017-18: £30,270). In 2018-19, no (2017-18: one) employee received remuneration in excess of the highest-paid director. Remuneration ranged from £8k to £288k (2017-18 £1k-£294k).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments, 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 2019		As at 31 March 2018
Band of Highest Paid Director's Total Remuneration (£'000)	285-290	285-290
Median Total Remuneration (£)	32,917	30,270
Ratio	8.7	9.5

Ms Paula Hay-Plumb
Chairman of Remuneration and Appointments Committee

Remuneration, Nominations and Appointments Committee

The Council of Governors has in place a Remuneration, Nominations and Appointments Committee (RNAC). The RNAC's terms of reference include responsibility for reviewing the remuneration of Non-Executive Directors (including the Trust Chairman), and for establishing appropriately constituted Appointment Panels to make recommendations to the Council of Governors on the appointment of Non-Executive Directors and the Trust Chairman.

During the year 2018-19, the Governors' RNAC met on four occasions: in April 2018, June 2018, October 2018 and February 2019. The business that was considered included the extension of the terms of office of Mr Geoff Salt, Mr Christopher Goard and Professor David Mant as non-executive directors by a year in each case, a decision that was ratified by the Council of Governors on 30 April 2018. On 22 June 2018 the Committee agreed to recommend the appointment of Professor Gavin Screaton as the University of Oxford's nominated Non-Executive Director and this recommendation was accepted by the Council of Governors on 18 July 2018. Following the departure of Mr Geoff Salt from the Trust, the Committee also discussed the recommendation that Ms Anne Tutt be appointed as the new Trust Vice-Chairman at its meeting on 15 October 2018 and this was approved by the full Council on 30 October 2018. RNAC has also received reports of the appraisals of non-executive directors and the Trust Chairman.

An Appointment Panel for the appointment of a Trust Chairman was convened by the RNAC to select a replacement for Dame Fiona Caldicott, whose term of office was due to expire in March 2019. The Committee was regularly updated on progress regarding the recruitment process and the Appointment Panel's recommendation to appoint Professor Sir Jonathan Montgomery as Trust Chair was unanimously approved by the Council of Governors in December 2018. In addition, an Appointment Panel for non-executive directors was convened by the Committee to appoint a replacement for Mr Geoff Salt. The Appointment Panel's recommendation to appoint Ms Claire Flint as Non-Executive Director was approved by the Council of Governors in March 2019. In both cases the panels employed open advertising and made use of an external search consultancy.

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 2019 of 11,836 (31 March 2018 11,612). All employees, with the exception of medical and dental 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 and dental 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

	2018-19			2017-18
	Permanently employed[1]	Other[2]	Total	Total
	£000	£000	£000	£000
Salaries and wages	471,640	7,097	478,737	456,915
Social security costs	42,648		42,648	41,053
Apprenticeship levy	2,160		2,160	2,069
Employer's contributions to NHS pensions	51,150		51,150	48,438
Pension cost - other	11		11	4
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	639		639	155
Temporary staff	-	49,153	49,153	38,159
TOTAL GROSS STAFF COSTS	568,248	56,250	624,498	586,793
Recoveries in respect of seconded staff	-	-	-	-
TOTAL STAFF COSTS	568,248	56,250	624,498	586,793
Of which				
Costs capitalised as part of assets	2,106	58	2,164	1,864

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 2019 is set out in the table below (the number for administrative and clerical staff includes all corporate support services).

Information subject to audit

	2018-19			2017-18
	Permanent contract	Other Staff	Total number	Total number
	Average wte	Average wte	Average wte	Average wte
Medical and dental	1749	80	1,829	1,811
Ambulance staff	0	0	0	0
Administration and estates	2,370	92	2,462	2,420
Healthcare assistants and other support staff	1,450	172	1,622	1,473
Nursing, midwifery and health visiting staff	3,429	350	3,779	3,803
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	1,255	66	1,321	1,288
Healthcare science staff	743	10	753	746
Social Care Staff	0	0	0	0
Agency and contract staff				
Bank staff				
Other	70		70	71
TOTAL average numbers	11,066	770	11,836	11,612
Of which:				
Number of employees (WTE) engaged on capital projects	64	7	71	88

Gender distribution of the workforce as at 31 March 2019

Category	Female	Male	Total
Directors[1]	7	6	13
Senior Managers	0	0	0
Other Staff[2]	9608	3095	12703
Total[3]	9615	3101	12716

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 31 March 2018.

- For ordinary pay, the mean and median pay gaps are 26.6% and 15.2% 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 76.6% and 88.4% in favour of men, respectively.
- 6.3% of women and 11.2% 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	79.0%	21.0%
2		79.6%	20.4%
3		79.9%	20.1%
4	Highest paid roles	61.1%	38.9%

(source TB2019.38)

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

- The mean pay gap has remained fairly consistent (with a small increase of 0.6%) between March 2017 and March 2018, but there has been a larger increase in the median pay gap of 4.3%, bringing it up to 15.2%.
- The Trust has a higher proportion of men in more senior positions, in addition the proportion of women earning higher salaries within the Trust has decreased slightly, contributing to an increased gender pay gap;
- More work is required to understand the reasons for the above two points so that appropriate measures can be taken to address them.
- Incentive schemes have enabled more women to receive bonus payments, however, this has created a larger bonus pay gap due to the lower amounts received compared to other bonus payments such as Clinical Excellence Awards (CEAs). CEAs are awarded to consultants who are recognised as making great contributions to the delivery of safe and high quality care, and are much higher in value than the incentives provided by the Trust to support staff to work extra hours. 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 overleaf.

Action	Lead	Timescale	Success measure
Conduct a Trust-wide consultation into the gender pay gap (alongside consultation for WRES and WDES)	EDI Manager	July 2019	Consultation engagement to be measured (with demographics captured as part of this). Feedback from consultation to be used to form the next Gender Pay Gap Report
Produce a gender pay gap Report on pay gap data from March 2019	EDI Manager	September 2019	Report and action plan produced – presented at Board in Sep 19.
Introduce a salary scale for staff within the VSM Banding	Head of Resourcing	August 2020	Salary scale introduced with new starters placed on this. Aim to move all VSM staff onto this scale over time.
Evaluate other interventions undertaken by the Trust in terms of gender impact	EDI Manager	N/A	Gender impact analysed and reported in evaluation of interventions to EDI Steering Group.
Rollout scoring matrix	Head of Resourcing	May 2019	Improvement in relative likelihood of diverse groups being successful at interview.
Hold International Women's Day Event	Women's Network	March 2019	Engagement at event will be measured and feedback will be captured.

(source TB2019.38)

Staff sickness absence

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

	1 January 2018 – 31 December 2018	1 January 2017 – 31 December 2017
Total days lost	128,678	79,896
Total staff years[1]	10,909	10,865
Average working days lost[2]	7.27	7.4

(data is supplied by DHSC)

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 2017 and 31 December 2018 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. However, during the course of this year we have made progress and ended the year with around 150 more substantive staff than at the start of the year.

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.

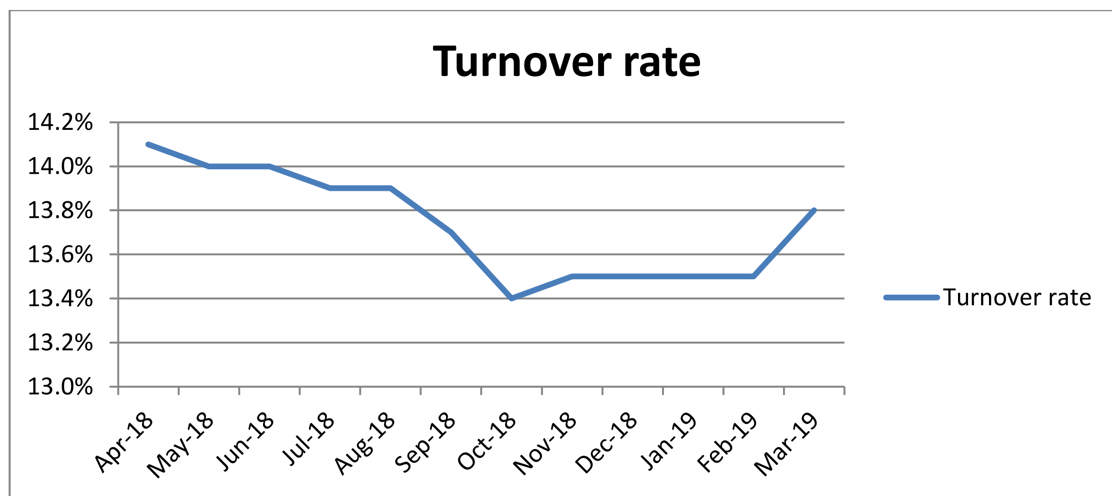
We acknowledge the impact of continuing rises in the cost of living and lower annual pay increases within the public sector. We have introduced initiatives in response, including the introduction of new rates of pay for staff who work on our internal bank in a flexible or part-time capacity helping to 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. We have also raised the profile of the 'retire-and-return' option for experienced staff to continue working for us after they reach retirement age.

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 fell during the period 1 April 2018 to 31 March 2019. In April 2018 turnover was at 14.1% and at March 2019 it was 13.8%. The graph below shows the position through the year. Turnover remains highest within clinical support, and nursing and midwifery staff groups.



In year the turnover rate reached a low of 13.4% (October 2018) although the rate has increased since this point. The 'spike' in March reflects an increase in leavers. The largely declining turnover rate is set against national shortages in many professions.

One of our clinical Divisions, NOTSSCaN, focused heavily on improving retention this year and successfully reduced turnover from 14.1% to 11.8% and ended the year at 12.6%. The learning from this successful initiative has been shared with the other Divisions.

Reported turnover levels exclude fixed term contract holders.

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 2015-20 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 within the Thames Valley and Wessex region. In addition, we have sought to widen participation in the Trust's Care 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 Care Support Worker Academy.

Continuing to improve the breadth and effectiveness of our training and education offer for our staff is a key theme in our People Strategy, and will be a priority for 2019-20.

Promoting public health to staff

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. We also continue to work in partnership with colleagues from the Here for Health team, Organisational Development, Learning and Development and Human Resources.

There are many factors that affect a staff member's perception of what constitutes an 'Organisation that definitely takes positive action on health and wellbeing' such as strategies, policies, safe staffing, leadership and local management.

What did we achieve in 2019-20?

The two highest reasons for referral to the Centre for Occupational Health and Wellbeing (COHWB) are due to mental health and musculoskeletal (MSK) issues. Figures in brackets are comparable data for 2017-18.

- During the year COHWB saw 713 (528) members of staff for mental health issues.
- 460 (509) members of staff were seen for MSK problems with 600 (539) initial physiotherapy treatment sessions plus reviews (includes both self and management referral for treatment).
- Display Screen Equipment online training is now mandatory for the Trust and, as a result, COHWB is providing managers with increasing support regarding appropriate ergonomic adjustments.
- There were 60 workplace assessments completed across OUH for teams and individuals with complex ergonomic issues.
- New initiatives are being explored to improve the fast-track service for mental health issues with waiting times.

Employee Assistance Programme (EAP)

The Trust offers an Employee Assistance Programme (EAP) for all OUH staff. Staff are able to access the service for counselling, advice and information for a variety of issues. Contact can be face-to-face, by telephone or online. During 2018-19 Employee Assistance Programme (EAP) usage continued to increase with the number of staff accessing the service for counselling in 2018 totalling 518 (440). This is an increase of 17% over the same period last year and reflects the increases seen by COHWB.

Health and wellbeing initiatives

Support for staff through COHWB, Organisational Development (OD), Divisional Practice Development Nurses (PDN) and Human Resources (HR) continues and courses aiming to support staff and managers are on offer across the Trust.

Resilience and mindfulness courses were offered to 1,545 staff (1,258 for the same period last year). This is in response to requests from managers to offer departmental sessions across the Trust. Other sessions have included managers' training, Foundation Year 1 and 2 doctors and other teams of doctors, and COHWB offers a 45-minute session on raising awareness and building resilience to all new nurses joining the Trust as part of their induction.

Other initiatives to support staff health and wellbeing include working with the Sleep and Rest Group, raising the profile of the benefits of short periods of rest in an 'energy pod' for those working very long hours; 'Think, pause, recharge' breaks (a campaign for nursing staff working jointly with Safe Staffing); exploring Mental Health First Aid training and Schwarz Rounds, or similar, in order to develop a plan in line with the recommendations from the Thriving at Work paper.

We continue to promote the healthier eating agenda when possible particularly at the four Healthy Hospital Days. The Trust was awarded The Golden Teaspoon by Good Food Oxford for all the work on the Sugar Smart agenda.

The physical activity agenda is promoted through our close links with external providers offering discounts on gym membership, newsletters focused on moving more and the lunchtime health walks.

Here for Health also supports the OUH staff wellbeing agenda via self-referral and also signposting and referral from COHWB. During the last financial year there were 895 contacts, 608 of which were first time contacts. 339 staff attended for blood pressure checks and this was the most common reason for attendance, with weight management (175), chronic disease risk (144) and smoking (109) being the next highest numbers. Staff groups seen by Here for Health included doctors, nurses, AHPs, support workers and non-clinical employees.

Future plans include the following.

- Maintain fast-track access to MSK and mental health resources from the COHWB.
- Work closely with First Care and the EAP provider to ensure that staff are signposted or referred to the most appropriate service in a timely manner.
- Offer resilience and mindfulness courses and explore new programmes as above.
- Increase the proactive service offered by the OH Physiotherapists to identify workplace issues and work with staff to decrease risk of MSK issues occurring.
- Training in relation to volunteer health champions has been affected by staffing levels and therefore training is now done on an individual basis.
- Work with the Communications Team to promote services and proactive initiatives available for staff.
- Work with leading clinicians and Divisions on issues that impact on staff health and wellbeing such as rostering, recruitment and retention and breaks within the working day.

The work with Public Health is currently under pressure due to changes in leadership and a shortage of Public Health Registrars. However, we continue to work on the healthier eating agenda to promote the Health and Wellbeing Strategy for the Trust.

The development of strategies to support short periods of rest are currently in train following BMA fatigue guidance.

Staff engagement, recognition and consultation

Awards and recognition

The Trust held its annual awards ceremony on 5 December 2018 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 award categories, designed to celebrate the excellent contribution that they had made to patient care and working life at OUH throughout 2018.

The ceremony - which was supported by the generosity of Oxford Hospitals Charity - was hosted by local BBC Oxford newsreader, Geraldine Peers. Winners and runners-up were picked from over 1000 nominations by a panel of staff and patients.

The Patients' Choice Award, which was launched in 2016, went to the Trust's Estates Department for their dedication and daily efforts to keep our hospital buildings running smoothly. Mark Neal, Interim Director of Estates, said: "I'm absolutely thrilled the team have won this award. They're incredibly special - they're behind the scenes every day of the year, at weekends, and overnight. They're the people who keep the lights on, keep the heating going, and work away in the background to keep everything ticking along.

"During last year's snowy weather, the Estates team volunteered to get to work at 4.00am to shovel snow and ice and make sure the hospitals were accessible for everybody."

Other highlights included a festive opening performance from St Joseph's School Choir, the Chairman's Award, and the Trust also publicly recognised Trust Chairman Dame Fiona Caldicott, whose term of office came to an end in March 2019.

OUH Chief Executive, Dr Bruno Holthof, closed the evening by thanking winners and nominators for their hard work, support and dedication and a reminder that hardworking staff were looking after patients as the ceremony went on.

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.

This year we have also redesigned our appraisal process for non-medical staff to be better aligned with our values, and have now trained over 500 staff to carry out values-based appraisals.

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 ongoing 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, who 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 2018 Survey provided for a Trust EEI score of 3.76 (out of a maximum score of 5.0), (2017 Trust EEI score 3.78). However, we see a wide range in the EEI at directorate level and detailed analysis has been carried out to understand the drivers of engagement.

Staff engagement

In response to the Staff Survey results, a series of Chief Executive-led listening events were held across all of our main sites during March 2019, and were used as a platform to share learning from what is working well in the most engaged directorates. These will be followed by directorate-level events giving staff the opportunity to review the findings for their own department and to develop ideas which will

help to improve the day to day experience for frontline staff.

NHS Staff Survey 2018

The response rate to the 2018 Survey among Trust staff improved significantly to 48%, compared to 39% in 2017, putting the OUH response rate above the national average response rate (45%) for the first time in five years. This was achieved through a higher profile internal communications campaign, led jointly by the Chief Executive and the Staff-side Chairman, and reinforced by line managers speaking directly to staff and reminding them to complete the survey and by incentives for the two directorates which achieved the most improved response rates.

The survey has around 80 questions and this year the vast majority were judged to have not changed in a statistically significant way, with ten scoring significantly worse and 3 scoring significantly better. Two of the questions which improved significantly relate to aspects of appraisals.

In the 2018 Staff Survey, the results from questions were grouped into ten themes for the first time to give overall scores against each. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. Scores for each indicator together with that of the survey benchmarking group (Acute Trusts) are presented below.

	2018-19		***2017-18***		***2016-17***	
	Trust	***Benchmarking Group***	***Trust***	***Benchmarking Group***	***Trust***	***Benchmarking Group***
Equality, diversity and inclusion	8.9	9.1	9.0	9.1	9.1	9.2
Health and wellbeing	5.7	5.9	5.9	6.0	6.3	6.1
Immediate managers	6.7	6.7	6.7	6.7	6.8	6.7
Morale	5.9	6.1				
Quality of appraisals	5.3	5.4	5.3	5.3	5.5	5.3
Quality of care	7.3	7.4	7.4	7.5	7.6	7.6
Safe environment – bullying and harassment	7.9	7.9	7.9	8.0	8.3	8.0
Safe environment – violence	9.5	9.4	9.5	9.4	9.7	9.4
Safety culture	6.6	6.6	6.6	6.6	6.7	6.6
Staff engagement	6.9	7.0	7.0	7.0	7.2	7.0

These results show a slight decline in scores in 2018 compared to 2017, and that OUH remains below the national average across most of the ten themes.

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. Although many actions were taken during 2018-19, these have not yet converted into increased scores in the Staff Survey and so continued attention will be needed against these same themes.

The Board has agreed to a programme to improve staff culture and leadership, based on an approach and set of tools developed by the NHS Leadership Academy which is now part of NHS Improvement.

The programme will launch in May 2019 and begins with the 'Discover' phase, which is expected to last 3-6 months and will be led by an internal Change Team. Progress will be overseen by a steering committee of six Board members, chaired by the Trust Chairman and including the Chief Executive.

Staff Friends and Family Test

The degree to which staff are willing to recommend their organization, both as a place for their friends and families to be treated, and as a place to work, is a strong indicator of staff engagement and motivation. In turn, staff engagement is also a good predictor of safety, quality and other aspects of performance. A set of questions related to advocacy - willingness to recommend the Trust as a place to work - 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 fed back through Divisional management structures and reported at the Workforce Committee and shared with the Board.

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 74% (75% in 2017)

Average (median) for acute trusts 71%

Recommendation of the organisation as a place to work 57% (57% in 2017)

Average (median) for acute trusts 62%

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 Hervé 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. A separate Freedom to Speak Up Annual Report is presented to TME and the Trust Board.

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 trades 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 also provides a forum for successes to be shared and celebrated, and provides an opportunity for staff to present their views and influence key Trust issues and decisions.

Trade Union Facility Time 1 April 2018 to 31 March 2019

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 annually.

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*
28	11,066

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%	10
1%-50%	16
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[1]	£82,455
Total pay bill[2]	£621,849,530
Percentage of the total pay bill spent on facility time [3]	0.01%

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[4]	20%

[1] Calculated including employer pension and national insurance contributions
[2] Calculated including employer pension and national insurance contributions
[3] Calculated as (total cost of facility time ÷ total pay bill) x 100
[4] 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 aim to *embrace* equality, diversity and inclusion. This means that we actively recognise, value and support 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.

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.

Policies and procedures

All of our policies are equality impact assessed to ensure that no-one impacted by a policy receives unjustifiably less favourable treatment on the grounds of:

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

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are reporting requirements that support the Trust to identify where black and minority ethnic (BME) and disabled staff face barriers in terms of their employment within the Trust. Through consultation with BME and disabled staff, the Trust develops actions that address barriers and which aim to improve the experience of BME and disabled staff, as well as the experience of the workforce as a whole.

The Trust also undertakes reporting on its gender pay gap on an annual basis. We use this exercise to enable us to identify differences in the experience of men and women working within the Trust and plan actions to mitigate them.

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 for a further two years, Level 2: 'Disability Confident Employer' by the Department for Work and Pensions Disability Confident Scheme: we aim to renew this commitment in 2019. 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. We ensure the rigorous investigation of reported matters of fraud, bribery or corruption and the pursuance of redress for financial losses stemming from such acts, and the application of disciplinary sanctions or other actions as appropriate. We adopt best practice procedures to tackle fraud, bribery and corruption, as recommended by the NHS Counter Fraud Authority.

Over 2018-19 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 2018-19 financial year, counter fraud received 16 referrals of fraud which were investigated. No concerns were raised relating to bribery or corruption. Four 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 1 April 2018 to 31 March 2019 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 2018-19, 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 to maximise 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 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 2019 we have just over 8,100 members in total, as follows.

Public Constituencies	**8,143**
Oxford City	1,849
Cherwell	1,247
South Oxfordshire	837
Vale of White Horse	1,147
West Oxfordshire	929
Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	1,130
Northamptonshire and Warwickshire	464
Rest of England and Wales	540

The Council of Governors is made up of 29 governors, plus a chair 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 improve the experience of our patients and their families. Our volunteers assist in numerous ways, including helping ward staff at mealtimes, directing patients and visitors to their destinations, assisting within Chaplaincy, helping Oxford Hospitals Charity with fundraising events, along with supporting departments with administrative duties.

The Trust has a Voluntary Services Department that manages volunteer recruitment and first day induction. It continues to identify, increase and enhance volunteering opportunities across the four hospital sites working in conjunction with managers and departments. A new area recently requesting volunteer help is the Pharmacy Department where volunteers are assisting with the delivery of dispensed medicines to ward areas, thus improving patient discharge.

Approximately 1,000 dedicated individuals of all ages volunteer with the Trust and with its Host Charitable Organisations. As we recruit volunteers throughout the year our volunteer numbers have remained quite static over the last two years.

Oxford Hospitals Charity

Oxford Hospitals Charity – *A year of extra special support.*

Oxford Hospitals Charity helps transform our hospitals - funding the very latest medical equipment, innovative research and specialist training for clinical staff. Fundraising, donations and gifts in wills also help to improve the hospital environment for patients and staff - making wards, waiting rooms, staff areas and hospital spaces more welcoming and comfortable.

Our charity works across the John Radcliffe, Churchill, Nuffield Orthopaedic Centre, Horton General and Oxford Children's Hospital, with every ward and department able to benefit from the positive impact of charitable support. This is all thanks to thoughtful and generous groups and individuals who donate to make a difference in their local community.

From the smaller things, like providing music on wards and improvements to hospital spaces, to larger projects, such as funding state-of-the-art laboratory equipment that can rapidly diagnose conditions like sepsis and meningitis - this is your local charity helping your local hospitals.

We work very closely with Trust and clinical colleagues, under the guidance of our dedicated charity trustees, to ensure donations are well spent and have the maximum impact for patients and staff.

In 2018-19 we are delighted to have spent around **£6 million** on projects and enhancements across the hospitals – a big increase on recent years’ support.

This includes our substantial contribution towards the new parent's accommodation currently being created at the John Radcliffe. Working with our friends at Ronald McDonald House Charities, the new building will dramatically increase the number of rooms available for parents who need to stay close to their child whilst they are in hospital.

Oxford Hospitals Charity is donating £2.5 million over two years towards this vital project. This is in addition to £750,000 being spent on state-of-the-art monitors for all children's areas across the Trust. We have also funded equipment in the Neuro Intensive Care Unit, refurbishments at the Women's Centre and the Complex Medical Unit at the John Radcliffe, and improvements to many staff rooms across all our hospitals.

We are also delighted to have significantly increased our support at the Horton General. In recent months we have funded the latest echocardiography machine for the Horton's Cardiac Physiology Department and major improvements to the Horton Physiotherapy Department. These two innovations alone will benefit thousands of patients every year. The Horton has become a major focus for the charity in 2019-20 with new Horton General Hospital Charity brand being promoted across the hospital and a series of fundraising events planned.

Another highlight of the year was the introduction of a new Small Grants Fund. This encourages staff from across the hospitals to apply for funding of up to £3,000 to make improvements in their area.

The new scheme was introduced in June 2018 and has already funded over £100,000 of projects across every corner of the Trust. It has been fantastic to see the range of inventive and thoughtful new ideas getting off the ground – from life-like livers to educate patients in a more thought-provoking way, to special hand-shaped comforters to improve the wellbeing of tiny babies in intensive care.

It's been an exciting and productive year and, with your vital support, we can continue to do this good work across the hospitals that care for you and your loved ones.

To find out more about the impact of Oxford Hospitals Charity visit
www.hospitalcharity.co.uk/impact

To get involved with fundraising, make a donation or hear about the positive impact of gifts in wills, please visit www.hospitalcharity.co.uk or use the contact details below.

Horton General Hospital Charity

charity@ouh.nhs.uk

01865 743444

Oxford Hospitals Charity

@OxHospCharity

Oxford Hospitals Charity
Unipart House Business Centre, Oxford, OX4 2PG
www.hospitalcharity.co.uk

OXFORD HOSPITALS CHARITY (REGISTERED CHARITY NUMBER 1175809) – A COMPANY LIMITED BY GUARANTEE (11052176)

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 £2,863.13 was paid as expenses to 13 governors in the period from 1 April 2018 to 31 March 2019.

There were 25 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 2018 to 31 March 2019 was £4,160,000 (2017-18 £3,994,000).

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 has 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 six months

No. of existing engagements as of 31 March 2019	1
Of which…	
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and 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 2018 and 31 March 2019, 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 2018 and 31 March 2019	1
Of which…	
No. assessed as within the scope of IR35	
No. assessed as not within the scope of IR35	1
No. engaged directly (via PSC contracted to Trust) and are on the Trust's 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 2018 and 31 March 2019.

No. of off-payroll engagements of Board members, and / or, senior officials with significant financial responsibility, during the financial year. Note 1.	0
(2) 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. Note 2.	19

Notes

(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 disclose the total of all staff exit packages agreed in the 12 months to 31 March 2019. 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	**2018-19**			**2017-18**		
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	2	-	2	1	-	1
£10,000 - £25,000	1	-	1	2	-	2
£25,001 - £50,000	1	-	1	1	1	2
£50,001 - £100,000	2	-	2	1	-	1
£100,001 - £150,000	2	-	2	-	-	-
£150,001 - £200,000	1	-	1	-	-	-
>£200,000	-	-	-	-	-	-
Total number of exit packages by type	9	-	9	5	1	6
Total resource cost £k	639	0	639	156	37	193

	2018-19		**2017-18**	
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 *	-	-	-	-
Total[1]	-	-	1	37
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 is 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	Title	2018-19 (12 months to 31 March 2019) Salary	Expense payment taxable	Performance related pay	Long-term performance related pay	All pension related benefits	Total inc all pension related benefits	2017-18 (12 months to 31 March 2018) 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	55-60					55-60
Professor Sir John Bell[2, 3]	Non-executive Director	0 - 5					0 - 5	10-15					10-15
Mr Alisdair Cameron[3, 4]	Non-executive Director							0-5					0-5
Mr Christopher Goard[5]	Non-executive Director	15 - 20					15 - 20	15-20					15-20
Professor David Mant[3]	Non-executive Director	10 - 15					10 - 15	10-15					10-15
Ms Paula Hay-Plumb[3, 6]	Non-executive Director	10 - 15					10 - 15	5-10					5-10
Mr Geoffrey Salt [5, 7]	Non-executive Director	5 -10					5 - 10	15-20					15-20
Professor Gavin Screaton[3, 8]	Non-executive Director	5 - 10					5 - 10						
Ms Anne Tutt [5]	Non-executive Director	15 - 20					15 - 20	15-20					15-20
Mr Peter Ward [5 ,9]	Non-executive Director							10-15					10-15
Dr Bruno Holthof[10,23]	Chief Executive	280 - 285	7,700				285 - 290	280-285	7,400				285-290
Dr Tony Berendt [11]	Medical Director	90 - 95				0	90-95	205-210				17.5-20	225-230
Mr Paul Brennan[12]	Director of Clinical Services	90 - 95	2,500			7.5-10	100-105	170-175	9,100			0	180-185
Dr Clare Dollery' [13]	Acting Medical Director	55 - 60					55-60						
Mr Jason Dorsett	Chief Finance Officer	170 - 175				37.5-40	210-215	170-175				37.5-40	205-210

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

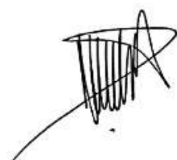
Name and Title		2018-19 (12 months to 31 March 2019)						2017-18 (12 months to 31 March 2018)					
		Salary	**Expense payment taxable**	**Performance related pay**	**Long-term performance related pay**	**All pension related benefits**	**Total inc all pension related benefits**	**Salary**	**Expense payment 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 John Drew[14]	Director of Improvement and Culture	180 - 185				40-42.5	220-225	85-90				20-22.5	105-110
Ms Sam Foster[10, 15]	Chief Nurse	140 - 145				0	140-145	80-85				17.5-20	95-100
Mr Peter Knight[16]	Chief Information and Digital Officer	55 - 60				67.5-70	125-130	130-135				0	130-135
Mr Andrew MacCallum[17]	Interim Chief Nurse							45-50				0	45-50
Professor Meghana Pandit’[18]	Medical Director	55 - 60					55-60						
Mr Mark Power[19]	Director of Organisational Development and Workforce							40-45				0	40-45
Ms Sara Randall[20]	Acting Director of Clinical Services	110 - 115				272.5-275	385-390						
Ms Eileen Walsh	Director of Assurance	130 - 135				15-17.5	150-155	125-130				22.5-25	150-155
Ms Elizabeth Wright[21]	Interim Chief Nurse							5-10					5-10
Ms Susan Young[22]	Interim Director for HR							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.

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

The all pension related benefits figure is calculated including the cash value of payments (whether in cash or otherwise) in lieu of retirement benefits and all benefits in year from participating in pension schemes. As mandated in the guidance produced by the NHS Business Services Authority – Disclosure of Senior Managers' Remuneration (Greenbury) 2015, the annual pension figure is calculated using legislated relevant valuation factor of 20 on annual pension at pension age, plus lump sum at pension age. These are the aggregate input amounts calculated using the method set out in section 229 of the Finance Act 2004 and any employee contributions are excluded from the figure arrived at to reach the amount which is disclosed. This does not reflect an increase in remuneration during 2018-19 but an annual pension value multiplied by a notional value of 20 which may be realised following retirement. The pension benefit table (on page 107) 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. She retired from the Trust in March 2019.
2	Resigned from Oxford University Hospitals August 2018
3	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. The annual remuneration of Non-Executive Directors is within the band of 10-15.
4	Term of Office ended April 2017
5	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. The annual remuneration of Non-Executive Directors who discharge additional responsibilities is within the band of 15-20.
6	Appointed from September 2017
7	Resigned from Oxford University Hospitals September 2018
8	Appointed from September 2018
9	Term of Office ended November 2017
10	Following discussion with auditors, the salary figures are shown as the gross amount prior to any salary sacrifice deductions
11	Retired from Oxford University Hospitals September 2018
12	Resigned from Oxford University Hospitals July 2018, expense payment relates to lease car.
13	Acting Medical Director from September 2018 to January 2019
14	Appointed to Oxford University Hospitals October 2017
15	Appointed to Oxford University Hospitals September 2017
16	Resigned from Oxford University Hospitals September 2018
17	Interim Chief Nursing Officer from May 2017 to September 2017
18	Appointed from January 2019
19	Resigned from Oxford University Hospitals April 2017 and salary figure includes a payment in lieu of notice.
20	Acting Director of Clinical Services from April 2018
21	Acting Chief Nurse from 1 April 2017 to 30 April 2017
22	Interim Director of HR from April 2017 to October 2017
23	A life assurance and income protection premium are also paid in respect of the CEO and are shown as a benefit in kind



Dr Bruno Holthof
Chief Executive
22 May 2019

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. No.s	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 2019 includes a statement of the roles and responsibilities of the Council of Governors. The Trust's Constitution, initially 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 72, 78-81 and 98.
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 74 and 128.
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 76.
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 and Gavin Screaton who were 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 101 and 110
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 page 110.
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.	See section on Nominations and Remuneration Committee on page 110.
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 86.
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 128.

Ref. No.s	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 72.
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 72.
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 152-168) and Directors' Responsibilities (page 93) – 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 152-168) 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 152-168) – 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 78. Also covered in the Annual Governance Statement. The Trust's External Audit Provider changed for the 18-19 financial year end and the process was subject to a competitive tender process. This is the first year with the new providers and effectiveness will be reviewed following conclusion of the first year work.

Ref. No.s	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 74 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 78 and their joint work is referenced under membership on pages 128-129.
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 128.
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 128.
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 74.

Ref. No.s	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 NHS Resolution. The Trust's 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. Separate Directors and Officers Liability Insurance is held by the Trust, this was reported to the Board of Directors in July 2018.
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. No.s	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 are set out in the 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 129.
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 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.	During the year there have been a number of changes in Trust Board membership. The membership at the end of the year consists of seven executive directors (EDs) and six non-executive directors (NEDs). The Constitution states that the Board shall comprise between five and nine members from both the EDs and the NEDs. To maintain fair outcomes in decision making for the Trust there should be the same number of EDs to NEDs. Although membership of the Board has not been within the Constitution quorum, the Board has not encountered the need to cast votes during 2018-19 and thus not breached the constitution. Full details of all changes to individual posts are provided as part of the Annual Report.
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.

Ref. No.s	Narrative in the code	OUH compliance
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. The Trust recently undertook a review of the functioning of the Trust Board as a result of the Deloitte well-led review of governance.
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 110.
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. No.s	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 110.
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 75.
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 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 1.2 to the accounts on page 264.
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 a tender exercise in 2017-18.
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 NHS Improvement 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. No.s	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 this see page 98.
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 Appointment 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.

Segmentation

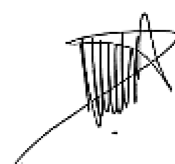
Oxford University Hospitals NHS Foundation Trust has been segmented into category 3. This segmentation information is the Trust's position as at 25 April 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website www.improvement.nhs.uk.

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 2019, the Trust had an overall rating of 'Good' from the CQC. The CQC. are currently carrying out checks on services provided by the Trust and they will publish the reports when their checks are complete. 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 2018 TO 31 MARCH 2019

Area	Metric	2018-19 scores				2017-18 scores			
		Q4	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**	**Q2**	**Q1**
Financial sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	2	4	3	3	3	3	4	4
Financial efficiency	I & E margin	1	3	3	4	3	4	4	4
Financial controls	Distance from financial plan	1	2	1	1	4	4	4	4
	Agency spend	2	1	1	1	1	1	1	1
Overall scoring		3	3	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 and Social Care 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 and Social Care 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
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy 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 the *NHS Foundation Trust Accounting Officer Memorandum*.

Dr Bruno Holthof
Chief Executive
22 May 2019

Annual Governance Statement 2018-19

Scope of responsibility

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

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 2019 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. 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 Board Assurance Framework has been reported to the Audit, Finance & Performance, and Quality Committees and the Trust Board.

The Board Assurance Framework and Corporate Risk Register were presented to the Board in September 2018 and January 2019 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 2018-19 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; and
- 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 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 2018-19, the Trust has complied with the Code.

These reviews 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. The membership at the end of the year consists of seven Executive Directors (EDs) and six Non-Executive Directors (NEDs). The Constitution states that the Board shall comprise between five and nine members from both the EDs and the NEDs. To maintain fair outcomes in decision-making for the Trust there should be the same number of EDs to NEDs. Although membership of the Board has not been within the Constitution quorum, the Board has not encountered the need to cast votes during 2018-19 and thus not breached the Constitution. 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 Trust's External Audit providers (Mazars) were appointed as auditors by the Council of Governors from 2018-19 following a procurement exercise involving the Audit Committee and Council of Governors.

The Audit Committee has received regular reports from the Trust's Local Counter Fraud Specialist (LCFS) on actions being taken to address the findings by NHS Counter Fraud Authority (NHSCFA) on the Trusts compliance with fraud standards. LCFS have assessed the Trust's exposure to key counter fraud risks and developed actions through the year to mitigate the risks. The Audit Committee has received updates on the progress since the NHSCFA's review which shows good progress, with the level of staff engagement being an area of focus, ensuring sufficient training in counter fraud awareness is delivered.

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, and 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 2018-19 the Audit Committee received Internal Audit opinions rated 'Significant Assurance with minor improvement opportunities'. These include:

- Procurement
- Maternity Standards Compliance
- Financial Management
- Board Assurance Framework
- Risk Management
- Data Quality
- Positive Patient ID (no high risk recommendations).

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

The following reports were assessed by the Internal Audit as ‘Partial Assurance with improvement opportunities’ and they related to:

- Medicines Management
- IR(ME)R follow-up (no high risk recommendations)
- Divisional IT Governance
- GDPR Compliance (no high risk recommendations)
- IT General Controls – ESR Payroll
- Data Security and Protection Toolkit (no high risk recommendations).

From these reports, high risk recommendations were made and summarised as follows.

- **Medicines Management**: the Trust has been advised to identify and differentiate clinical rooms classed as drug cupboards from those that require additional secure storage. The level of access to these areas should be assessed and reinforced to staff. Action plans have been adapted within Divisions to aid in providing safe storage of medicines and the continuous assessment of risks. This will be subject to further review by the Audit Committee.
- **Divisional IT Governance**: the review identified that a number of systems have single points of failure within the Trust. Some of the systems have been developed and supported by a single individual, for which the Trust does not have an adequate replacement for should those individuals not be available. Plans are in place to replace the relevant Pathology systems and also the Pharmacy system. Relevant business cases are in development and funding is being sought to ensure these are replaced in a timely fashion by March 2020.
- **IT General Controls – ESR Payroll**: two high risk recommendations were raised in relation to the processes of adding new starters to ESR and removing staff who leave the Trust from ESR. In both cases the controls were reconsidered by the Trust and improvements were made as a result.

Trust Management Executive (TME) retains the responsibility for ensuring all actions from Internal Audit reports are complete. The Audit Committee has maintained a close oversight of overdue recommendations and timeliness of management responses to audit reports. Any concerns are escalated to TME for further focus and immediate resolution.

During the year by way of example, the Committee has tracked the completion of internal audit recommendations in relation to the Cash Management report; the recommendations asked the Trust to consider more advanced means of cash forecasting and tracking to ensure consistency. The Trust has taken immediate action to address the recommendations as some actions overlap with ongoing projects being implemented.

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 with minor improvements required.

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 following.

- Insufficient capacity for the urgent care pathway on elective activity and the achievement of Referral to Treatment Time (RTT).
- The 62 days to first treatment after GP referral and after screening service Cancer Standard.
- Workforce constraints affecting the ability to treat elective patients and manage non-elective flow.
- Financial Sustainability and delivery of costs in line with plan versus forecast.

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

- The continued monitoring of the NHS Improvement undertakings with a focus on strengthening the prioritisation of the five programmes with a designated Programme Management Office to coordinate the development and implementation of the plans. Scrutinising the additional support needed whilst identifying the maturity levels of the programmes and identifying their interdependencies to support and provide sufficient resource for execution.
- Continued emphasis on the delivery of plans related to the NHSI undertakings, with a particular focus on delivery of the 52 week target and the need to commit to an achievable trajectory for achievement of the 62 week cancer standard.
- Review of the current metrics being measured to support Divisional performance reviews undertaken to ensure that these are sufficient, and to identify any further metrics for monitoring, which could then be built into the Trust's electronic data reporting system.

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 ongoing 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 the following.

- Increased number of same-sex accommodation breaches reported as a result of the change to the nation requirements on reporting.
- Fragility of maintaining staffing levels with a particular focus on the workforce planning, a recommendation on NHSI undertakings.
- Clinical prioritisation with regards to cancellations of surgery.
- Current operational and financial pressures having an adverse impact on patient safety and quality of care.

The Quality Committee received assurance in relation to the following.

- Patient experience delivery plan, envisaged to improve the Trust's care and services identified from the national patient surveys.
- Continued fulfilment of the principles outlined in the new guidance 'Learning from Deaths – Guidance for NHS Trusts on working with bereaved families and carers', issued by the National Quality Board in July 2018.
- Schemes, and workforce programmes being established to ensure the current Trust's workforce challenges are capturing associated risks, central to plans and captured within projects.
- Quality Impact Assessments; moving away from the Cost Improvement Programme to a standalone policy to analyse and thoroughly quantify the cost reduction changes against care quality.

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 and carry out scrutiny of 'one-off and unusual transactions'.

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 (TME) is responsible for the delivery of the Trust's Annual Business Plan, and for ensuring compliance with regulatory and legislative requirements. 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 following.

- Recruitment and retention of appropriately qualified staff in key clinical areas, highlighting the development of action plans focused on areas where a shortage of workforce constrains the amount of activity that can be delivered.
- The revision and strengthening of the Trust's financial plan for the year as part of the Financial Recovery Plan, monitoring the financial performance and focusing on the possible underlying EBITDA.
- The review of achievement of operational performance standards, including constitutional standards relating to A&E performance, cancer care and 18 week Referral to Treatment (RTT) standard.

The TME has also focused on the five programmes of work associated with the NHSI undertaking, monitoring the planning, inter-dependencies and resources allocated to the workstreams, to effectively deliver on the plans set out.

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.

Developing workforce safeguards

The Trust's Sub-Committees discuss and deliver to the Board all workforce plans undertaken in different workstreams in order to align workforce planning to the triangulated approach defined

within the Nation Quality Board (NQB) and escalate any risks associated with staffing to the Trust Board for consideration.

Over the past year the Workforce Committee (WFC) has established groups to monitor and provide assurance on the delivery of safe staffing that is financially sustainable whilst providing high quality and compassionate care to patients both short-term and long-term within the Trust.

Derived from the three year People Strategy, a Workforce Improvement Plan has been developed to address the Trust's workforce objectives, action plans and desired outcomes with a focus on the following themes.

1. **Making OUH a great place to work**: recruitment, retention and engagement.
2. **Improving workforce planning**: performance information and workforce modelling.
3. **Making best possible use of our workforce**: workforce availability, job planning, skills mix and productivity.

The Trust has been engaging in activities throughout the year to ensure compliance with 'Developing workforce safeguards' through the following.

- Development of action plans focused on areas where a shortage of workforce constrains the amount of activity that can be delivered with further considerations to extend the staff incentive schemes e.g. participation rates on the bank and flexible staff pool.
- Utilisation of the Quality Impact Assessment tool, updated September 2018, to analyse changes and risks identified within working areas and clearly defined consideration of the impact on staffing and mitigation of 'at risk' shifts.
- Deployment of SafeCare as an evidence-based tool to gain assurance on current staffing levels, providing transparency on Care Hours per Patient Day (CHPPD). Utilising SafeCare in conjunction with e-Rostering, Qlikview and Orbit to capture the skill mix, monitoring and capturing any changes; whilst providing the Board with greater assurance on actual versus planned staffing.
- Recruitment both in the UK and internationally steered by the Nursing and Midwifery Recruitment, Retention and Education (NMRRE) steering group collaboratively working with Oxford Brookes University to recruit new graduates to work in the Trust and remain resident within Oxford. A successful recruitment drive has also spanned across to India and the Philippines with plans to continue with the campaign in India.
- Improving the Staff Recognition Programme to engage existing staff by promoting excellence, encouraging inclusivity and rewarding exemplary behaviours and efforts. Staff feedback has aided the changes to the programme in 2018-19 which seeks to recognise the contribution and success of the Trust through its workforce.
- Continued support for staff to undertake courses that will enable personal development. Sessions being provided to both clinical and non-clinical staff for Quality Service, Improvement and Redesign and promoting statutory and mandatory training through reporting monthly.

- NMRRE working collaboratively with Centre for Occupational Health and Wellbeing to provide support for staff to undertake workshops, exercise classes and healthier eating to improve wellbeing and mental health.

Written reports are presented to the Board on the Workforce Improvement Plan, with all areas of interest and issues highlighted for the Board.

Compliance with key mandated statements

The Trust is required to report on four mandated statements in relation to:

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

In relation to **Care Quality Commission compliance**: as a provider of care the Trust is registered and regulated by the Care Quality Commission. 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.

The CQC conducted the below inspections and reviews during 2018-19.

- Unannounced inspection on Core Services (Maternity, Gynaecology, Surgery and Emergency Department) (unplanned - November 2018)
- Well-Led inspection (planned – January 2019)
- Use of Resources (conducted by NHSI using CQC methodology and resources – December 2018)

The CQC provided verbal and informal feedback post-inspection for both the Well-Led Inspection conducted January 2019 and the Unannounced November 2018 inspections. The Trust was served with a notice under Section 31 of the Health and Social Care Act 2008 for surgical procedures conducted in the JR2 Theatres complex. Immediate actions have been taken to address issues with the estate and a full action plan was developed and a group set up to oversee the completion of actions. A weekly update is sent to the CQC to demonstrate actions taken. A medium term 'refresh' of the JR2 Theatres complex commenced on 8 April 2019. At the point of time this statement was written, the Trust is still awaiting the formal publication of the outcomes of the inspection activity from November 2018 to January 2019.

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 the Executives; the Trust has published an up-to-date register of interests for decision-making staff within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

In relation to carbon reduction: the Trust has undertaken risk assessments and has a sustainable development management plan in place, which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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 2018-19 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. For this financial year the Trust delivered the planned budget that was set for the year, some of which was as a result of one-off non-recurrent items – this is described later in this statement.

Monthly financial and operational performance reports are presented to the Finance & 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 maintains a focus on Internal Audit recommendations and has ensured they are followed up in a timely and effective manner by management.

As part of their annual audit, the Trust's external auditors, Mazars, 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; in addition they are informed by the conclusion drawn in previous years which have been unqualified.

Information Governance

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

All new staff are required to undertake Information Governance (IG) training within the first three months of their employment within the Trust. Existing staff are required to undergo IG training on an annual basis. Training is provided via e-Learning modules on the Trust's e-Learning Management System but bespoke face-to-face teaching sessions are also provided.

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 on the next page provides information in relation to serious incidents reported to the Information Commissioner and the status of the incident.

Incident date	Detail	Investigation type	Status	Lessons learned
Dec 2018	Email sent to wrong recipient outside of the Trust.	External – reported to ICO	Investigation completed	Addressees of emails must always be checked by staff before pressing 'Send'. Reduced staffing levels and increased workloads can lead to errors. Mitigations need to be put in place to reduce workloads where possible to reduce the potential for error.
Jan 2019	Information concerning an appointment relayed to person unauthorised to receive information.	External – reported to ICO	Under investigation	Trust-wide standardisation required for providing information by phone.
Feb 2019	Corruption of EPR name field led to letter being opened by NOK resulting in data breach.	External – reported to ICO	Under investigation	Change to EPR alert required.
Mar 2019	Letter of another patient received by a patient with her clinic letter.	External – reported to ICO	Under investigation	Zero tolerance to postal errors.

In 2018-19 NHS Digital replaced the annual Information Governance toolkit assessment with the Data Security and Protection toolkit. The new tool allows the Trust to measure its performance against the National Data Guardian's ten data security standards and provides assurance that good standards of data security are being practised and that information is handled correctly.

The toolkit was submitted to NHS Digital on 29 March 2019. The Trust declared compliance against 23 mandatory assertions in its 2018-19 return. Nine assertions have not been met; these have been included as part of an action plan to be mutually agreed between NHS Digital and the Trust.

Where an ongoing 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.

The Trust has produced an outline action plan with the assistance of NHS Digital and Templar Executives, to address areas of compliance with the data security assessments aligned to Cyber Essentials Plus (CE+). This follows recommendations from the Chief Information Officer of the NHS to all NHS organisations to work towards compliance with the CE+ standard by June 2021. During February and March 2019, an extensive external review of the Trust's cyber security capabilities was undertaken. This highlighted some progress that has already been made and further recommendations to achieving the standard. In 2018-19, the Trust introduced a programme of work to achieve the CE+ standard by June 2020.

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 'limited assurance engagement' 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 result of this work, in relation to testing undertaken on the accident and emergency four hour wait data, resulted in a qualified 'except for' opinion. This means that the external auditors were unable to provide an opinion on the quality of the data used to compile this aspect of the quality account. As a result the Trust is undertaking additional work to assess the quality of accident and emergency waiting time data.

The Medical Director leads on the Quality Account and, for 2018-19, 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 Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the

internal control framework. I have drawn on the information provided in 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. 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 systems 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 the Board Sub-Committees or individual senior managers in relation to all its 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 reports from the Sub-Committees to the Board. The reports demonstrated assurance to the Board that they have operated effectively in relation to their terms of reference.

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 these issues, once reviewed did not constitute a significant gap in control in relation to the delivery of the Trust's strategic objectives.

- The Trust declared a total of 11 never events during the year; each incident was subject to thorough investigation and actions have been put in place to address the root causes identified as a result.
- The Trust has, as described previously in the statement, been subject to a number of CQC inspections during the course of the year, including a Well Led Inspection at Board level. The Trust also received a Section 31 notification in relation to the JR2 Theatres complex; a detailed action plan is in place to address the issues raised by the CQC. The reports from the inspections are still awaited.
- Following on from the 2017 investigation by NHSI on the Trust's operational progress and plans to improve performance, the Trust agreed a series of Enforcement Undertakings with NHSI. Key priorities identified were, emergency care, planned care, financial sustainability as well as governance and strategic workforce planning. The Board Sub-Committees focused on scrutinising and seeking assurance on the plans set out to address the Undertakings. This has been achieved by the following methods.
    - Utilising a PMO structure to coordinate the five improvement programmes, in order to understand their interdependencies and allocate appropriate resources for the delivery of the plans.
    - Establishing clear and concise performance dashboard that quantifies the work being completed for the Elective Care Plan, with a focus from the outset to identify cancer harm reviews, diagnostic capability and capacity. Through the

    year a reduction in patients waiting for treatment has been reported and for those specialties where a cause for concern was identified, an action plan to mitigate the issues was developed.
  - Receiving support from the NHSI economics team to focus on evidence-based prioritisation and quantifying expected deliverables for the Urgent Care Plan. This included the schemes rolled out in support of the Winter Plan.
- During the year the Trust has continued to monitor performance against its budgeted financial outturn position. The Trust delivered its financial control total as planned.
- The Trust has worked closely with NHS Digital and received external support from Templar Executives to produce an action plan for compliance with the Cyber Essentials Plus standard to deliver robust cyber security capabilities and develop a robust cyber and information security culture. While some gaps in control have been identified it was concluded that these do not represent a significant control issue and the action plan developed should enable the Trust to meet the standards.

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/did not constitute significant gaps in control.

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.

Subject to the areas highlighted above the Trust has concluded that no significant control issues have been identified.

Dr Bruno Holthof
Chief Executive Date: 22 May 2019

QUALITY REPORT

(CONTAINING THE QUALITY ACCOUNT 2018-19)

Quality Account 2018-19

Contents

Part 1: Statement on quality from the Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Board

Part 3: Other information

Statements from NHS England or relevant clinical commissioning groups, local Healthwatch and overview and scrutiny committees

Statement of Directors' responsibilities in respect of the Quality Report

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

Version	Date	Author	Outcome
	13 February 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft 2019-20 Quality Priorities reviewed by Quality Committee.
	20 February 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft 2019-20 Quality Priorities reviewed by Clinical Governance Committee.
5	20 March 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Account reviewed by Clinical Governance Committee.
5	10 April 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Account reviewed by Quality Committee.
5	17 April 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Account reviewed by Audit Committee.
5	17 April 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Account reviewed by Clinical Governance Committee.
	25 April 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Priorities reviewed by Trust Management Executive.
	9 May 2019	Dr Clare Dollery/ Siobhan Teasdale	Draft Quality Account reviewed by Audit Committee.
	20 May 2019	Dr Clare Dollery/Siobhan Teasdale	Draft Quality Account reviewed by Audit Committee

Part 1: Statement on quality from the Chief Executive 2018-19

In our Quality Account 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 are committed to delivering the highest quality care for our patients and this year we have celebrated their successes which have included the following.

- Winning the Best Healthcare Provider Partnership category at the *HSJ* Partnership Awards for a new test for pre-eclampsia which was a collaborative achievement with the Oxford Academic Health Science Network (AHSN) and Roche Diagnostics.
- Being re-awarded Centre of Clinical Excellence status by Muscular Dystrophy UK for providing outstanding care for people with muscle-wasting conditions.
- Winning a national Unsung Hero Award after a team of four staff at the Cancer and Haematology Centre at the Churchill Hospital developed a system to handle chemotherapy drugs more efficiently and free up nurses' time for patients.
- Winning the Psychiatric Team of the Year award at the Royal College of Psychiatrists Awards in recognition of the groundbreaking work of the Trust's Integrated Psychological Medicine Service.
- Being awarded Stage 2 Baby Friendly Initiative (BFI) accreditation by UNICEF for the efforts of the Maternity and Newborn Care Unit teams at the John Radcliffe Hospital to promote, protect and support breastfeeding.
- Winning two categories at the annual British Medical Association (BMA) Patient Information Awards in recognition of the work of Oxford Medical Illustration (OMI), the in-house design, photography and video production team at OUH, to communicate information to patients in new and innovative ways through the use of video.
- State-of-the-art Endoscopy Department at the Horton General Hospital has been re-accredited by the prestigious Joint Advisory Group (JAG) on Gastrointestinal Endoscopy for the second year in a row.

- Along with many other NHS trusts, we did not achieve the constitutional standards for access (e.g. four hour A&E target and 18 week referral to treatment time targets) this year.

  However, thanks to the efforts of all staff we were able to demonstrate tangible improvements by the end of the financial year.

  - 4.2% year-on-year improvement in the four hour wait aspect of Emergency department performance.
  - Reduction in the number of elective patients on waiting lists for 52 weeks from 203 in August 2018 to eight patients on 31 March 2019.
  - We consistently achieved the two week from GP referral cancer national standard every month through 2018-19.
  - Another four of the cancer performance standards were achieved for the majority of months across 2018-19.

  However, the 62 day standard for cancer treatment has provided our biggest challenge throughout the year. Nationally there has been a decline in achievement of the 62 day standard. This 62 day standard has not been met by the NHS in England in any month since December 2015.

  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.

  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.

  As a provider of care the Trust is registered and regulated by the Care Quality Commission (CQC). The Trust was inspected by the CQC in 2018-19 for core services, use of resources and the Well-Led domain. The reports of these investigations are awaited.

  Patent safety innovations in the past 12 months included the following.

  - The re-launch of the Safe Surgery & Procedures Group – this group has focused on the development of Local Safety Standards in Invasive Procedures.
  - A Harm Review Group was set up with an external Chair and representation from Oxfordshire CCG to review all patients who

have waited in excess of 52 weeks to assess any clinical and psychosocial harm – the majority of which identified no harm or minor harm, and by the end of March 2019 only eight patients had waited 52 weeks.

- In January 2019 a new weekly Safety Message email, sent to all staff from the Chief Medical Officer and Chief Nursing Officer, was launched to raise awareness of important patient safety issues.
- In March 2019 a Patient Safety Response Team pilot was started on the John Radcliffe Hospital site to review all moderate and above clinical harm incidents daily – this multidisciplinary staff team discusses any incidents in the previous 24 hours and, if required, senior doctors and nurses will visit clinical areas to meet the staff and patient involved to offer support and ensure the safety of all those involved.

Regrettably during 2018-19 we reported 11 clinical incidents classified as Never Events. Immediate actions were taken whilst these incidents were being fully investigated. Due to the higher number of Never Events this year a strategic Never Event Improvement Plan was devised and progress against this is reported regularly to the Trust Management Executive and Quality Committee. Two Never Event Risk Summits were held for staff and stakeholders to co-design approaches to prevent Never Events. OUH received funding from NHS Improvement to facilitate a number of initiatives to support some of the actions in the improvement plan such as running an action plan workshop for key staff to ensure that actions arising from Never Event investigations are the correct ones to change systems to prevent re-occurrence.

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.

The Trust is committed to improving services by working closely with our partners in the Oxfordshire health and social care system.

- We have continued to reduce 'delayed transfers of care' by working closely with our system partners.
- For the first time this year we set up a system-wide Winter Team,

based at the John Radcliffe Hospital but working across the entire health and social care system in Oxfordshire.

- This winter saw improved A&E performance and an increase in the number of patients being discharged from hospital.

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 taken enforcement action against Oxford University Hospitals NHS Foundation Trust during 2018-19. This was a Section 31 enforcement notice in relation to theatres in the JR2 Theatre Complex.

Oxford University Hospitals NHS Foundation Trust has participated in a special review by the Care Quality Commission relating to the following areas during 2018-19: the follow-up review of 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. The CQC's follow-up to their system report of 2018 was published in January 2019, and stated that significant work has been done to join up services and improve care for patients.

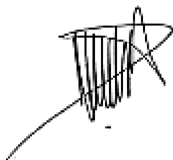
The Trust has been subject to a number of recent visits from the CQC. They have covered the following.

- Core service reviews: this was an unannounced series of inspections conducted over November and December 2018 and mainly focused on the Maternity, Gynaecology, Urgent Care and Surgery core services. The formal publication of the outcome from this review is still awaited.
- Use of resources (conducted by NHSI using CQC methodology and resources) in December 2018; the outcome from this inspection is still awaited.
- Well-Led Review: the formal publication of the outcome from this review is still awaited.

The Trust uses feedback in a proactive and positive way; whenever a report is received an action plan is developed with executive leadership to address the issues.

We have continued to work hard to protect our patients from hospital-acquired infection and whilst we have finished the year under the assigned upper limit for the number of *C.difficile* infections, the zero level of MRSA infections deemed 'avoidable' was not met, with two cases apportioned to the Trust during 2018-19, one of which was unavoidable. Since the introduction of MRSA screening, mandatory surveillance, post-infection root cause analyses and bundles of care to reduce MRSA transmission, and in line with national data, our MRSA bacteraemia rates have decreased by over 95% in the last decade. We have recently introduced a targeted screening programme to optimise cost-effectiveness, and continue to promote 'aseptic no-touch technique' (ANTT), together with an active programme of education and audit around hand hygiene. This Quality Account, as well as looking back on how we performed against our standards and priorities in 2018-19, also looks ahead to the priorities for 2019-20. 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 2019 we asked the 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 2019-20.

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 2019-20

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

The draft OUH 2019-20 Quality Priorities originated from the OUH 'Quality Conversation' event held in January 2019 which involved patients, Foundation Trust governors and members, staff and other key stakeholders.

They have further evolved through a process of engagement and feedback at various OUH committees including Governors' Patient Experience, Membership and Quality Committee (PEMQ) Quality Committee, Audit Committee and Clinical Governance Committee as well as with the responsible Executives and Leads.

Our Quality Priorities for 2019-20

Patient Safety

	Why we chose this Quality Priority	How we will evaluate success
Reducing Never Events- particularly around safe surgery and procedures.	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 more OUH Local Safety Standards for Invasive Procedures (LocSSIPs) and thereby reduce the incidence of avoidable adverse events. The OUH had 11 Never Events in 2018-19 and this Quality Priority was voted to continue from last year.	1. A minimum of ten LocSSIPs will be developed over the course of the year. 2. Finalise the remaining overarching procedures and policies relating to Never Events in the next six months, to include: 3. WHO Surgical Safety Checklist Policy. 4. Prosthesis Verification Policy. 5. Aim for 100% compliance with WHO Surgical Safety Checklist. 6. Run an action planning workshop with input from NHSI, Patient Safety Academy and Clinical Governance to ensure robust actions are put in place to prevent recurrence of serious incidents / Never Events. 7. Complete all actions from RCAs following NEs in 2018-19. 8. Demonstrate learning across all Divisions at Governance meetings.
Launching the National Early Warning Score (NEWS 2).	In April 2018 NHS England mandated the implementation of NEWS2 across all acute hospital trusts and ambulance services by March 2019. (Patient Safety Alert NHS/PSA/RE/2018/003).	Identify actions required to ensure, by 30th June 2019, there is Trust-wide adoption of NEWS2; and share examples of local challenges and best practice with the NEWS2 network on request. a. Define a process for the use of Scale 1 (Standard chart). b. Define a process for the assessment and recording 'Acute Confusion.' c. Produce revised escalation guidance. d. Define the process for use of scale 2 (Chart for patients with Type 2 Respiratory Failure). e. Design and deliver a training update for nurses and nursing assistants. f. Design and deliver a communication strategy for the launch of NEWS2. g. Define and deliver the technical requirements for the deployment of NEWS2 within the System for Electronic Notification and Documentation (SEND) platform.
Patient Safety Response Teams.	This award-winning concept has been successfully introduced in another Trust.	A Patient Safety Response Team will be piloted for 8-12 weeks in the JR and West Wing and evaluated before being considered for Trust-wide roll out.

	Why we chose this Quality Priority	How we will evaluate success
Reducing stillbirths.	The NHS recently set out a national ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020. 'Saving babies' Lives' care bundle Version 2 (2019). The impact on the families who lose a much-loved baby or mother or those caring for a child with a birth-related brain injury is devastating, especially when the outcome could have been prevented.	Reduction in stillbirth rate by 20% by 31 March 2020. Reducing stillbirth rate from 5.2 per 1000 births to 4.0 per 1000 births by the introduction of the five elements recommended in the 'Saving Babies' Lives' Care Bundle: Element 1 – Reducing smoking in pregnancy. Element 2 – Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction. Element 3 – Raising awareness of reduced fetal movement. Element 4 – Effective fetal monitoring during labour. Element 5 – Reducing the number of preterm births.

Clinical Effectiveness

	Why we chose this Quality Priority	How we will evaluate success
Sepsis care – antibiotics within 1 hour.	Identifying deterioration early can allow prompt treatment to reduce the duration and severity of subsequent illness. This priority was one of the 2018-19 priorities that stakeholders voted to continue into 2019-20 at our Quality Conversation public event in January 2019.	1. Increase from 74% to more than 90% the proportion of sepsis patients receiving antibiotics within an hour by 31 March 2020. 2. Undertake an audit of sepsis in which the first dose of antibiotics was delayed > 1h in order to identify and share learning by 31 March 2020. **3.** Include 'Sepsis' as a subject for learning on a 'Grand Round' by 31 March 2020.
Reducing the number of stranded patients.	This was one of the 2018-19 priorities that stakeholders voted to continue into 2019-20 at our Quality Conversation public event in January 2019.	We will achieve a 16% reduction in the number of patients with an extended Length of Stay (LOS) of over 21 days, to fewer than 110 patients by 31 March 2020.
Digital – Roll-out of the SurgiNet module in Cerner Millennium to support best care for patients undergoing surgery and procedures.	Adding SurgiNet and Anaesthesia modules to the existing Electronic Patient Record (EPR). 1. Reduces potential risk created by 'paper gaps' in clinical information used during the surgical pathway. 2. Enables any problems identified at pre-assessment to flow into the EPR. 3. Provides consistent	By 30 June 2019 the new modules will have been designed by OUH clinicians and administrative staff. By 30 September 2019 modules will have been built by our partner. By 28 February 2020 modules will have been thoroughly tested by OUH clinicians and administrative and technical staff. By 31 March 2020 clinical and administrative staff will have commenced training in the first suite of theatres to go live.

	Why we chose this Quality Priority	How we will evaluate success
	documentation standards for anaesthetic records. 4. Replaces older technical systems which are now difficult to support and are not properly integrated for scheduling of surgical procedures.	

Patient experience

	Why we chose this Quality Priority	How we will evaluate success
Patient portal to support better interaction with hospital services.	The Trust's patient portal offers patients a new route to engage with our services. It went live in its first pilot department (Diabetes) in January 2019. Over the next year the portal will be deployed across other services with increasing functionality that better meets users' needs whilst enhancing the efficiency and efficacy of care.	By 31 March 2020 the portal: - will be available to all services that are ready to deploy it. - will enable patient access to lab, radiology and pathology results with a short delay (that will be determined in consultation with all users). - will enable patients to contribute information through 'clipboard' surveys and secure messaging. - will be accessible through a smartphone application as well as a website.
Care of patients with mental health issues.	National recommendation	The child and adolescent mental health services (CAMHS) and emergency department psychiatric service (EDPS) see 100% of patients within an hour of referral by 31 March 2020. The length of stay of patients with mental health issues in the emergency department will always be under 12 hours by 31 March 2020.
The Home Assessment Reablement Team (HART) services.	This was one of the 2018-19 priorities that stakeholders voted to continue into 2019-20 at our Quality Conversation public event in January 2019.	In 2017 and 2018, the proportion of patients returned to functional independence following hospital discharge reablement was 51% and 57% respectively. By 31 March 2020 we will aim to further increase the proportion of those returning to independent living to 60%.

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 2018-19 Oxford University Hospitals NHS Foundation Trust provided and sub-contracted 139 relevant health services.

Oxford University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 139 of these relevant health services.

The income generated by the relevant health services reviewed in 2018-19 represents 100% of the total income generated from the provision of relevant health services by Oxford University Hospitals NHS Foundation Trust for 2018-19.

Participation in clinical audits and National Confidential Enquiries

Participation in national clinical audits

During 2018-19, 67 national mandatory clinical audits and four 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 96% of all the eligible national clinical audits as detailed within Appendix A and 100% of national confidential enquiries in which we were eligible to participate as presented within Appendix B of the report.

The reports of 43 national clinical audits were reviewed during 2018-19 and a summary of the actions the Trust intends to take to improve the quality of the healthcare we provide is described in Appendix C.

Participation in national clinical audits during 2018-19 (Appendix A)

Audit title	OUH Participation	% of cases submitted
Adult Cardiac Surgery	Yes	Ongoing
Adult Community Acquired Pneumonia	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Cystectomy	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Nephrectomy	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Yes	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Radical Prostatectomy	Yes	Ongoing
Cardiac Rhythm Management (CRM)	Yes	100%
Case Mix Programme (CMP)	Yes	100%
*Hip & Knee Elective Surgery - National Patient Reported Outcome Measures (PROMs) Programme	Yes	114%
Fracture Liaison Service Database	Yes	78%
National Hip Fracture Database	Yes	100%
Inpatient Falls	Yes	100%
Feverish Children (care in emergency departments)	Yes	100%
Inflammatory Bowel Disease programme / IBD Registry	No	---
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
Major Trauma Audit	Yes	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	100%
Maternal, New-born and Infant Clinical Outcome Review Programme	Yes	100%
Perinatal Mortality and Morbidity Confidential Enquiries	Yes	100%
Perinatal Mortality Surveillance	Yes	100%
Maternal Mortality Surveillance and Mortality Confidential Enquiries	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Ongoing
**National Audit of Breast Cancer in Older People (NABCOP)	Yes	Ongoing
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia	Yes	100%

Audit title	OUH Participation	% of cases submitted
***National Audit of Intermediate Care	No	
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	100%
National Audit of Pulmonary Hypertension	Yes	100%
National Audit of Seizures and Epilepsies in Children and Young People	Yes	95%
National Bariatric Surgery Registry (NBSR)	Yes	95%
National Bowel Cancer Audit (NBOCAP)	Yes	Ongoing
National Cardiac Arrest Audit (NCAA)	Yes	100%
****National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	15%
*****National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	
Use of Fresh Frozen Plasma and Cryoprecipitate in Neonates and Children	Yes	100%
Management of Massive Haemorrhage	Yes	100%
National Congenital Heart Disease (CHD)	Yes	100%
National Core Diabetes Audit	Yes	100%
National Diabetes Foot Care Audit	Yes	Ongoing
National Pregnancy in Diabetes Audit	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	53%
National Heart Failure Audit	Yes	100%
National Joint Registry (NJR)	Yes	87%
National Lung Cancer Audit (NLCA)	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Mortality Case Record Review Programme	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	100%
National Oesophago-gastric Cancer (NAOGC)	Yes	Ongoing
National Ophthalmology Audit	Yes	99%
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Prostate Cancer Audit	Yes	Ongoing
National Vascular Registry	Yes	77%
Neurosurgical National Audit Programme	Yes	100%
Non-Invasive Ventilation - Adults	Yes	Ongoing
Paediatric Intensive Care (PICANet)	Yes	100%
Perinatal Mortality Review Tool	Yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic stewardship	Yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic consumption	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	100%

Audit title	OUH Participation	% of cases submitted
Seven Day Hospital Services	Yes	100%
Surgical Site Infection Surveillance Service	Yes	100%
UK Cystic Fibrosis Registry	Yes	99%
Vital Signs in Adults (care in emergency departments)	Yes	100%
Venous thromboembolism (VTE) risk in lower limb immobilisation (care in emergency departments)	Yes	100%

* The expected figures are based upon Hospital Episode Statistic for previous years so if activity increases, the participation can appear as 114% of expected cases submitted.

** The Cancer multidisciplinary teams (MDTs) have faced challenges in terms of providing complete datasets of a high quality and robust analysis, within the context of the additional clinical workload to meet the elective access targets. The data is collected as part of the Cancer Outcomes and Services Dataset (COSD) and the national team oversees this which has made obtaining participation figures difficult until final publication of the report.

*** OUH did not participate 2018-19 however quality standard audits QS123 'Home care for older people' and NG27 Audit 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs' were completed in 2018-19 and presented to Clinical Effectiveness committee which provided assurance. .

**** The team has now increased their resources to maximise adherence and achieve greater compliance with data submission.

*****Project closed in June 2018 and 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.

The reports of 43 national clinical audits were reviewed by the provider in 2018-19 and Oxford University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. **(**Appendix C)

Description of selected actions:

Audit title	Summary
National Cardiac Audit Programme (NCAP) Annual Report 2018 – MINAP	The Heart Centre offers immediate treatment for heart attacks by direct admission and access to keyhole balloon treatment. The percentage of patients arriving by ambulance with call to balloon time less than 150 minutes is 89% versus national average at 78%. There has been a significant increase to 100% (national average 96%) in the proportion of patients seen or assessed by a member of the Cardiology team during hospital admission due to the Cardiology outreach advanced nurse practitioners at the Horton and John Radcliffe sites.

Audit title	Summary
PICANeT Annual Report 2018	Metrics for Mortality, Ventilator free days, and 48 hour readmissions (currently at less than 1% compared to national average 1.6%) compare favourably with national outcomes. OUH PICU is consistently well within acceptable adjusted mortality rates. There is now a full complement of substantive consultants and junior medical staff. Nursing recruitment and retention continues to be an ongoing challenge as with the rest of OUH and nationally.
Intensive Care National Audit and Research Centre (ICNARC) Case Mix Program (CMP) Annual Quality Report for 2017-18	The risk-adjusted mortality rates (SMR) for the Adult and Churchill Intensive Care Units (ICUs) are 0.82, and 0.67, both greater than two standard deviations (SDs) better than the national benchmark. The SMR for the Neurosciences ICU is 1.07 which is within the expected range. The Cardiothoracic Critical Care unit SMR is greater than three SD better than the national benchmark.
National Hip Fracture Database Annual Report 2018	The Horton General Hospital remains one of the very best performing hospitals in the country for hip fracture care. Both sites continue to perform very well on all metrics pertaining to Orthogeriatric medicine (Horton 100%, John Radcliffe 97% versus national average 90%). Both sites have performed above the national average in newly introduced measures including nutritional assessment, delirium prevention and early mobilisation. Delirium prevention at the Horton was 76%, 70% at the John Radcliffe (JR) with the national average at 70%. Early mobilisation at the Horton was 89%, JR 92% and the national average was 81%. The 30 day mortality at the JR is in line with the national average, and at the Horton is lower than the national average.
Insulin Pump Audit - National Diabetes Audit Programme	The audit shows that 16% of people with Type 1 diabetes seen in OUH adult diabetes clinics were treated with insulin pump therapy compared with 16% across all participating centres. This suggests our rates are on a par with the national average. Patients seen within OUH however have a higher than national average achievement of the 'triple target' – Blood Pressure, Cholesterol and a blood test for diabetic control- HbA1c (28% vs nationally 19 %).
National Neonatal Audit Program – 2018 (2017 data) John Radcliffe Hospital, Neonatal Intensive Care Unit	The Neonatal Intensive Care Unit (NICU) at the JR achieved "Outstanding" outlier status (>3 standard deviations (SD) above average) (91% versus national average of 715) for administration of magnesium sulphate ($MgSO_4$) and "Excellent" outlier status (>2 SD above average) (71% versus national average of 65%) for thermoregulation. (A big improvement from just below average (59%) last year following a successful Quality Improvement project).
Seven Day Services Audit – 4 Priority Standards 24/7	Overall benchmarked results indicate that OUH performs better than the national average in most categories. However, OUH results have dipped at weekends and on the Monday during the 7 day audit period measured. Variation between the previous audit (March 2017) and this, indicates a slight fall in performance time to first review within 14 hours of admission from 97% in March 2017 to 92% in April 2018. However, this remains ahead of the national. The overall proportion of patients who required twice daily consultant reviews and were reviewed twice by a consultant was 100%- exceeding the national average.

Audit title	Summary
Trauma Audit and Research Network (TARN) Clinical Report 3 2017: Head and Spine injuries	Median length of stay has improved for patients with an Injury severity score <15, from eight days in 2016-17 to seven days from April 2017 to March 2018. For patients with an Injury severity score >15, length of stay remained constant at nine days. The survival rate has improved to +0.57 additional patient survivors per 100 patients (from 0.30 previously), according to outcome at 30 days or discharge. Patients admitted with an open fracture injury are receiving stabilisation within 24hrs of injury in 96% of cases, and soft tissue cover in 79% of cases. This is currently the best performance of any major trauma centre in the country.
National Lung Cancer Audit 2017	OUH continues to have a lung cancer resection rate of 27.4% -one of the highest resection rates in the country. One year survival rates have increased to 49% from 43% (national average 37%). The number of patients with small cell carcinoma who receive chemotherapy is above the national average. 89% patients at OUH receive chemotherapy (68% National average).
Falls & Fragility Fracture Audit (FFFA) – Fracture Liaison Service Database Report 2017: Royal College of Physicians	OUH supported this audit and was the highest submitting Fracture Liaison Service in the UK. The team meet the national average for time to assessment (74%), DXA (Dual-energy X-ray absorptiometry) scan (55%) and just above national average for monitoring at 16 weeks (49%). However focus on improving identification of vertebral fractures, reducing time to DXA, improving documentation of falls risk, reducing monitoring timings and improving monitoring outcomes at 16 and 52 weeks was required which has been addressed through a robust action plan.
2016 Re-audit of Patient Blood Management in scheduled surgery	Overall the audit found that OUH compared favourably with national standards and acted to minimise transfusion use in accordance with best practice. There was an improvement in a single unit approach to post-operative transfusion from 27% - 59%. There has been improved intraoperative use of cell salvage (38% - 59%).
Stroke in Adults: Sentinel Stroke National Audit Programme (SSNAP)	The John Radcliffe Hospital Stroke Service (JRH) improved to the top rating of "A". New Advanced Nurse Practitioners have been recruited to support this achievement and improve other areas. The delivery of Occupational Therapy continues to be an area of sustained excellent practice. There was improvement in the Thrombolysis domain with an increase in the percentage of patients treated with clot busting drugs.
National Cardiac Arrest Audit (NCAA)	The National Cardiac Arrest Audit (NCAA) report showed fewer cardiac arrests per 1000 admissions (1.04) than the available national comparator (1.6) and a decrease in comparison with the same period last year (both Quarter 2). More individuals survived to hospital discharge than predicted for all three included hospitals. The percentage (28.2%) remains higher than nationally (18.4%).
National Oesophago-gastric Cancer Annual Report (NOGCA)	86% of patients were discussed at the multidisciplinary team meeting. Between 2012-13 and 2016-17, the proportion of patients receiving active treatment (endoscopic or surgical treatment) for high-grade dysplasia increased from 70% to 75%. 90% of patients had an initial CT scan to assess the spread of cancer. Survival rates after surgery remain at a high, with over 96% of patients alive 90 days after surgery.

Audit title	Summary
National Audit of Breast Cancer in Older People (NABCOP)	The audit demonstrated that OUH local guidelines are compliant with national guidelines and treat all women the same irrespective of age. It is recommended that each patient is assigned a named breast Clinical nurse specialist to provide relevant information, and psychological support, and help guide the patient and her family through their diagnosis, treatment and follow-up [NICE 2009a; 2009b]. OUH has 100% compliance in both age groups which is well above the national average (63% and 56%).
National Bowel Cancer audit 2018 and Surgeon's Outcomes 2018	OUH has an active engagement with the screening programme. We have consistently lower than national 90 day (1.4%) and two year mortality rates (13%) for those undergoing major resections. Rectal surgery showed excellent removal of cancer demonstrated by the high negative Circumferential Resection Margin (CRM) rate (49%). OUH has a very low rate of patients still having a stoma 18 months after their operation (29% versus national figure of 52%), a priority identified by the National Bowel Cancer audit team impacting Quality of Life.

The reports of 271 local clinical audits were reviewed by Oxford University Hospitals NHS Foundation Trust in 2018-19 and Oxford University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Description of actions taken following review of the local clinical audits (Appendix D)

Paper name	Summary
NG50 Cirrhosis	The majority of patients treated for cirrhosis had imaging surveillance for Hepatocellular carcinoma (HCC) (91%) and screening endoscopies for varices (83%). However, the audit has highlighted the need to improve on documentation of risk stratification scores and surveillance of varices. There are now actions in place to improve varices and cancer surveillance, creating a surveillance pathway where the subsequent ultrasound scan or gastroscopy is requested by the relevant department at the time of current investigation.
QS126 Motor Neurone Disease (MND)	The MND Association produces a set of auditable standards against which each care centre is expected to assess their care every two years. The results for OUH were positive across the domains of recognition and referral (96%), cognitive assessments (100%), organisation of care, (87%) psychological support (93%), saliva management (100%), equipment and adaptations (94%), gastrostomy, communication (93%) and non-invasive ventilation (94%). Information packs have been reviewed to include recommended information leaflets regarding end of life and therapy exercise sheets. The findings highlighted some gaps in the Care Centre documentation, which have already been altered and the need for a physiotherapist in the core

Paper name	Summary
	team.
Validation audit against reported Hand Hygiene Compliance	The Validation audit is undertaken by the Infection Prevention and Control (IPC) team in all inpatient wards and Day Treatment units across all four OUH sites at least once in the financial year 2017-18. No area achieved a 100% score; Cardiac Day Unit achieved the highest score of 93%. One area only achieved 7% and underwent an intense hand hygiene education programme and in a re-audit in December achieved 68%.The team conducted 72 hand hygiene audits this year which is 32 more than last year.
Venous thromboembolism (VTE) Prophylaxis Audit	The audit demonstrates overall 99% improvement in compliance with patients receiving appropriate thromboprophylaxis (TP). Actions have included: feedback of robust data around appropriate thromboprophylaxis, upskilling of pharmacists in VTE prevention, the linking of an updated electronic VTE risk assessment to electronic-prescribing in December 2016, and education around mechanical TP thromboprophylaxis undertaken by the VTE prevention nurses.
NG60 HIV testing: increasing uptake among people who may have undiagnosed HIV	The Sexual Health service performs a continuous audit of HIV screening. The current data for Quarter 2 2018 show 83% of patients are offered HIV testing and 69% of patients accept testing.
QS122 Bronchiolitis in children audit	This audit demonstrated 98% compliance with the clinical standard 'Children with bronchiolitis are not prescribed antibiotics to treat the infection'. A need for additional training around the use of the Patient Information Leaflet and of the need for accurate documentation in the healthcare record was identified. The recommendation therefore is that clinicians will ensure the information is being relayed to parents and carers, that it is understood and that the content of the conversation is clearly documented in the healthcare records.
QS123 Home Care for Older People	The records maintained by the Home Assessment Reablement Team (HART) service demonstrated that all support workers have had supervision within the time frame. 92 % have a home care plan that identifies how their personal priorities and outcomes will be met.
QS25 Asthma	OUH results were largely comparable to national results, although results were low for the prompt administration of oral corticosteroids to these patients, recording peak expiratory flow rates on admission and the percentage completing five days of oral steroids. There was improvement in the proportion discharge on inhaled corticosteroids since the last audit: now >95%, and also there has been some improvement in the number with objective testing 26% to 35% though this remains less than the national average. The asthma outpatient service at OUH is good, with follow up of patients better than national average. Nearly 53% of patients have a hospital review within four weeks of discharge. A direct access acute airways service to pre-emptively treat and triage acutely deteriorating asthma has

Paper name	Summary
	recently been set up at John Radcliffe emergency department.

The national clinical audits and confidential enquiries that Oxford University Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2018-19, 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 (Appendix B)

NCEPOD studies in 2018-19	Clinical questionnaire returned	Case notes returned	Organisational questionnaires returned
***Peri-operative Management of Surgical Patients with Diabetes Study**	52%	46%	100%
Pulmonary Embolism	93%	93%	100%
Acute Bowel Obstruction	100%	Ongoing	100%
Long Term Ventilation	Ongoing	Ongoing	Ongoing

*Data collection for this NCEPOD study was completed in 2017-18 following which processes have been changed.

In order to improve participation in future NCEPOD studies the Trust has taken the following actions with resultant improvement in participation.

- NCEPOD have now moved to an online questionnaire which is assigned directly to the clinician by the local reporter for the Trust. This allows compliance to be monitored on a regular basis. A live dashboard which reflects compliance with the NCEPOD study is sent weekly to the Divisions.

- The Clinical Audit Governance Manager and Clinical Governance Facilitator have introduced systems and processes to ensure progress against NCEPOD studies is monitored at monthly checkpoints and any lack of progress is identified swiftly and escalated appropriately.

- The Trust Clinical Effectiveness Committee has responsibility for oversight, review and action of NCEPOD studies and is apprised of progress on a quarterly basis.

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 Science 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 2,088 active clinical research studies hosted by OUH. During 2018-19 the Trust initiated 363 new studies and hosted 446 studies with commercial partners. There are 205 OUH staff who are directly supported by the National Institute for Health Research Biomedical Research Centre (NIHR BRC) funding and 299 staff supported by the National Institute for Health Research Clinical Research Network (NIHR CRN). During 2018-19 the NIHR withdrew the longstanding '70 day' metric used to assess performance in initiating clinical research for interventional trials. The times taken to recruit the first participant, and the reason for any delays, must still be reported, but these are no longer defined in relation to the binary 70 day metric.

The number of patients receiving relevant health services provided or sub-contracted by Oxford University Hospitals NHS Foundation Trust in 2018-19 who were recruited during that period to participate in research approved by a research ethics committee was 29,716 participants recruited to 512 studies which are CRN portfolio registered.

Examples of the impact on patients of research published or announced during 2018-19 include:

- Infection: Genome sequencing techniques to diagnose and track *Clostridium difficile*, TB (Mycobacterium) and new NHS infections, with greater accuracy and speed

The Oxford BRC Infection Theme pioneered new techniques using Whole-Genome Sequencing (WGS) for mycobacteria, including tuberculosis (TB), to identify particular bacteria causing infections, relatedness in contact/outbreak mapping, and resistance determinants to anti-tuberculosis drugs. These new techniques greatly accelerate the laborious and time-consuming techniques used in traditional microbiology labs, from 4-12 weeks down to seven days. WGS for TB is now rolled out nationally in the NHS through the Regional Centre for Mycobacteriology (RCM) at Birmingham, with implementation of an analysis and reporting pipeline through Oxford (ISO15189-2012 accredited) and integration with Public Health England.

Similar WGS techniques have been applied by OUH researchers to understand *Clostridium difficile* (C diff) infections that have been the causes

of major outbreaks and disruption in many NHS hospitals. The research revolutionised the understanding of *Clostridium difficile* infections, showing that many infections in hospital are related to infection in the community rather than in-hospital transmission. In emerging infections that pose major challenges to NHS hospitals, research using WGS provides the ability to rapidly understand the source and transmission, exemplified by OUH's solving of outbreaks *Candida auris* fungal infections in intensive care patients, (New England Journal of Medicine 2018).

- Urological Surgery: Establishing Optimal Treatment Strategies for Prostate Cancer
  - Research by Oxford urology surgeons has had international impact on the management of prostate cancer, including high-profile studies on the utility of screening tests (published in JAMA 2018), and the justification for surgery vs. conservative treatment (the ProtecT Trial, two papers in the New England Journal of Medicine in 2016). Research has also advanced clinical management through the development of robotic surgery, intraoperative imaging techniques for image-guided surgery and new technologies to treat cancer, such as high-intensity focussed ultrasound (HIFU) and ultrasound-directed drug delivery. These advances led to the spin-out company OxSonics Ltd.

- Imaging: Oxford's research facilities in imaging are co-located and/or embedded in the OUH's hospitals, and have produced advances and innovations that have both international impact and direct benefits for local NHS patients.

  - In neuroimaging, world-leading expertise in functional MRI (fMRI) results from the pioneering work of the Oxford Centre for Functional Magnetic Resonance Imaging of the Brain (FMRIB). This is now a key part of Oxford's recently awarded Wellcome Trust Centre for Integrative Neuroimaging (WIN), providing insights into pain, analgesia, dementia, recovery from stroke and stratification of patients undergoing functional neurosurgery.

  - In cardiovascular disease, Oxford MRI expertise is world-recognised, with both technical advances (such as licencing of Oxford-developed techniques to Siemens), involvement of OUH

clinicians in international leadership, and impact on international clinical guidelines. Cross-disciplinary research collaborations have applied new MRI techniques, originally developed for the heart, to the diagnosis of liver disease, through a new Oxford spin-out company, Perspectum Diagnostics. In cardiac CT imaging, basic science research involving OUH patients led to the discovery of new imaging techniques to predict the risk of heart attacks (published in the Lancet in 2018), leading to a new spin-out company, Caristo Diagnostics.

- In respiratory disease, researchers at the OUH's Churchill Hospital have pioneered the use of hyperpolarised xenon MRI imaging to evaluate lung function, and have spun out companies to implement advances in imaging of lung nodules detected on CT scans (Mirada Medical and Optellum).

- Oxford's leadership in medical imaging and artificial intelligence to accelerate and improve image analysis in the NHS is reflected in the recent award of ~£15m from Innovate UK for the Oxford-led National Consortium for Intelligent Medical Imaging (NCIMI), a collaboration involving multiple NHS trusts and imaging companies nationally.

Our education and training

In 2018-19 there were 825 trainee doctors working at OUH; of these 573 (69%) were tariff-funded and their training was subject to quality management by the local office of Health Education England (HEE). There were 448 educational supervisors at OUH who were all compliant with the GMC 'Recognition of Trainers' policy. All recognised educational supervisors can expect to find this role reflected in their job plans and remunerated at the agreed tariff. In addition, the corporate Practice Development and Education Team continues to support the development and sustainability of education faculty throughout the Trust for non-medical staff. In 2018-19 work has progressed well in support of system working.

In the 2018 General Medical Council (GMC) trainee survey, the majority of trainees at OUH (78%) expressed 'Overall Satisfaction' with their training experience in Oxford; there were only six outliers (clinical oncology, neurosurgery, obstetrics and gynaecology Foundation Year 2 (F2), ophthalmology, paediatric surgery and radiology F2). Workload was only reported as an outlier in three cases: neurosurgery, obstetrics and gynaecology and ophthalmology. Satisfaction with the level of clinical supervision received was reported by trainees in over 92% of the OUH training programmes; outliers were ophthalmology, obstetrics and gynaecology, radiology F2 and renal medicine. This information has been fed back to the relevant departments and those responsible for training. Divisional Education Leads will be responsible for ensuring that 'turn around' action plans are in place and for monitoring progress in the areas of concern listed above.

Neurosurgery is still under GMC Enhanced Monitoring and was visited again by HEE and GMC in February 2019. An updated performance improvement plan has been agreed, actions implemented and a further monitoring period is in progress.

Regarding non-medical training, OUH and Oxford Health NHS Foundation Trust have been successful in becoming a joint Excellence Centre, part of the National Skills for Health and Justice national initiative. In addition, the team is currently working to secure a Quality Kite Mark. The proposal in the immediate term is to standardise Care Certificate training across the local sector, develop system wide career pathways for health and social care for the support workforce, enhance access to and opportunities for training

including apprenticeships and develop a learning culture via leadership development.

The Trust's in-house academic programmes continue to flourish with interest to develop further programmes remaining high. The current programme progressing through to validation is the Post Graduate Certificate in Perioperative Practice, (open to theatre nurses and operating department practitioners). Our latest post graduate programme is Intensive Care which commenced in January 2019 with 14 staff registered. Two masters' level modules from the Renal and Urology Programme - the Deteriorating Patient and Work Based Learning - will be made available to all nurses working in critical care areas as standalone modules from April 2019 together with ten places for staff from the non-medical Foundation Programme as part of a pilot group. This now brings our number of accredited post graduate programmes to six, these include Neuroscience (multi-professional), Ophthalmology (nursing), Leading Compassionate Excellence (nursing and midwifery), and Renal and Urology (nursing).
In January 2019 the Trust celebrated the start of its 50th Cohort of the Care Certificate with over 1200 learners supported since 2015 and our Overseas Nursing Programme, that supports overseas nurses to register in the UK and work within the Trust, grows from strength to strength.

Our peer review programme 2018-19

This year saw the conclusion of phase two of the internal peer review programme. One practice area was reviewed and the outcomes were explored during a quality summit. This year also saw the development, piloting and launch of a bespoke themed peer review programme, the focus of which is adult safeguarding, the Mental Capacity Act and Deprivation of Liberty Standards. Phase one involves the review of 16 practice areas across all four sites and this will conclude in June 2019. The aim of each peer review is to contribute to the continuous quality improvement of patient care. Peer reviews provide a way of further understanding how our services work, a tool to hear the voices of patients and staff, a method to identify what works well and what requires improving, a means of sharing good practice Trust-wide and a means of supporting the delivery of compassionate excellence.

External peer reviews 2018-19

Paediatric Intensive Care Peer Review 12/04/2018

On 12 April 2018 the Southampton and Oxford Retrieval Team (SORT), which is a collaboration between two paediatric intensive care units, underwent a peer view against the Paediatric Intensive Care Society Standards as part of the NHS England Quality Surveillance Programme. This identified seven significant achievements, including outstanding commitment and dedication of every team member and aspects of very robust governance; particularly the reports discussed at the Thames Valley and Wessex PCC Operational Delivery Network meetings. Reviewers noted that retrieval services operating within an intensive care unit allowed the flexibility to use staff where most needed. The leadership team was found to facilitate high quality outreach teaching at the District General Hospitals, which is well-established, and good relationships and mutual respect between the Oxford and Southampton teams were evident. One concern was noted involving processes relating to electronic recording of referrals and transfer communication, which is being managed through local governance processes. Feedback from parents has been sought and quality improvements made as a result of these are displayed visually with a 'tree of improvement'.

This peer review of the Southampton and Oxford retrieval team identified no immediate risks and one serious concern. The compliance self-declaration was scored as 100% whilst the peer review scored this as 63%. The concern was around the lack of electronic recording of referrals and transfer communication. The Trust has responded to this concern stating that it has the technology to support this type of recording, inbound calls are recorded by default but outbound calls were not recorded, all outbound calls are now recorded for this service. Seven significant achievements were noted; this included certain aspects of the governance being robust, outreach teaching being well-established and good relationships and mutual respect between the Oxford and Southampton teams.

Adult and Children's Major Trauma Centre Peer Review 01/11/2018

On Thursday 1 November 2018, the Oxford Major Trauma Centre (MTC) underwent a peer review visit to assess compliance against the national Major Trauma Service Quality Indicators. The Trust was commended for having a cohesive well-led team and a number of clinical services were highlighted as areas of good practice including the MTC psychological medicine services; the paediatric neurorehabilitation service; performance

against the British Orthopaedic Association Standards for Trauma and Orthopaedics (BOAST) for the multidisciplinary team management of patients with open fractures; emergency department nurse training; strong engagement with trauma research; and a high standard of patient discharge documentation. It was noted that the Oxford MTC does not currently meet all of the requirements of the national model for Major Trauma patient care and the Trust promptly produced a detailed action plan to respond to these immediate risks. Additionally there were a number of areas for development which have been included in the MTC business plan for the 2019-20 year. There has been ongoing close collaboration between Directorate, Divisional and Corporate services to progress the action plan resulting in development of numerous business cases for future investment in the MTC service. A paper on the outcomes of the peer review was presented to the Trust Board for assurance purposes in May 2019.

Hepatitis C for Adults Peer Review 03/05/2018

The Operational Delivery Network (ODN) for hepatitis C, led by OUH, underwent peer review which identified many achievements including: a detailed, bespoke service and strategy exists in a complex and varied prison network and a good response rate of patient feedback is in place which demonstrates positive evaluation. Concerns centred on the following: at partner hospitals in the ODN access to diagnosis and referral was unknown and there was limited or no access to local treatment. Actions to address findings at the partner hospitals include: a Clinical Nurse Specialist is to be appointed at one hospital who will prescribe, dispense and manage the hepatitis C drugs to ensure access via agreed systems. Staff at another hospital will prescribe, dispense and manage hepatitis C treatment to prevent patients having to come to Oxford to collect their hepatitis C drugs. Screening for treatment and follow-up treatment remains with the hepatology team at that hospital.

Paediatric Diabetes Peer Review 01/06/2018

A peer review submission was undertaken and assessment documentation submitted for consideration. The Trust is awaiting the outcome.

Haemoglobinopathy Peer Review 18/01/2019

A peer review submission was undertaken and assessment documentation submitted for consideration. The Trust is awaiting the outcome.

Our Human Factors training

In 2018-19 we ran 18 Human Factors courses for 196 staff from all Divisions in the Trust. This year we have responded to the emphasis on embedding LocSSIPs within the Trust and have adapted our teaching materials to focus on the Human Factors issues surrounding the use of Standard Operating Procedures (including checklists) for safe surgery and procedures. Our immersive simulated clinical scenarios incorporate tips on best practice in the use of checklists and our 50 trained Human Factors ambassadors are also delivering this training in their clinical areas. In addition we have provided training in ethnographic observation to allow more meaningful analysis of compliance with the use of LocSSIPs in relevant clinical areas.

We continue to deliver bespoke human factors training for teams after a serious incident has occurred to support and enhance learning and to co-design robust plans for improvement. Feedback from participants remains excellent and we have clear evidence of behavioural change (e.g. continued use of safety critical communication tools) in the workplace after training.

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) five-day Practitioner level course as well as a condensed one-day Fundamentals course. These courses have been developed by NHS Improvement and focus on training frontline staff equipping them with the 'know how' to design and implement more efficient patient-centred services. Other projects included: rolling out a new voice recognition software initially in outpatients to allow letters to be dictated directly into the electronic patient record to reduce time spent transcribing, uniform use of electronic information boards, white boards, in wards to move patients through the hospital more efficiently, further improvement of the gynaecology service to reduce time waiting for treatment, improving patient experience and working with key services on a Trust-wide cancer improvement plan.

Our clinical teams: examples of best practice

OUH's out-of-hours MRI service has been cited as best practice in the national report by the NHS Getting It Right First Time (GIRFT) programme, published on 29 January 2019. The report, which recommends all hospitals provide 24-hour MRI scanning, found good practice at the John Radcliffe

Hospital has resulted in the ability to provide out-of-hours MRI scanning without any incremental cost to existing services.

The Oxford Sepsis Team Strategy was shortlisted for the British Medical Journal 2019 Award for Innovation in Quality Improvement.

The Hip Fracture Team at the Horton General has been ranked as the third best hospital in the 2018 National Hip Fracture Audit – they have now been in the top five hospitals nationally for treatment of hip fracture patients for six years in a row.

OUH was awarded Centre of Clinical Excellence status by Muscular Dystrophy UK for providing outstanding care for people with muscle-wasting conditions.

There was one OUH winner and one member of OUH staff shortlisted at the British Journal of Midwifery Practice Awards.

The Integrated Psychological Medicine Team won the Team of the Year at the Royal College of Psychiatrists Awards.

Patient information videos on anaesthetic procedures for elective caesarean sections and gastroscopy (a procedure in which a thin, flexible tube called an endoscope is used to look inside the oesophagus, stomach and first part of the small intestine) won BMA Patient Information Awards.

Maternity and Newborn Care Unit teams at the John Radcliffe Hospital were awarded the Stage 2 Baby Friendly Initiative (BFI) Accreditation by UNICEF.

Guardian of 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	2018			2019
	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar
Total (approx.)	850	850	825	825
On 2016 TCS (approx.)	710	710	710	710

Oxford University Hospitals NHS Foundation Trust has taken the following actions to ensure compliance with the 2016 TCS, and the quality of its services.

- All Doctors in Training (typically around 700) are provided with compliant 'Work Schedules' and an electronic process to report exceptions when there is variance to rostered hours. Data from exception reporting has been used to amend work schedules.
- The Board receives quarterly and annual reports from the Guardian of Safe Working Hours; the Guardian's reports are informed by workforce data relating to the Doctors in Training as well as feedback from the Junior Doctors Forum.
- The continued implementation of an electronic rostering tool for Doctors in Training.

Exception reporting		**2018**			**2019**	**Total**
		Apr-Jun	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	
Number of exception reports		108	64	107	112	391
Number of doctors reporting		22	30	33	31	88
Specialties receiving reports		12	15	16	12	23
Nature of exception	Education	11	4	8	7	30
	Hours & Rest	100	60	101	109	370
Additional hours worked per exception report		1.4	1.1	1.5	1.9	1.5

Vacancies	**2018**			**2019**	**Tota l**
	Apr-Jun	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	
Unfilled training post	Organisational level data not reliably available as managed at a service level via departmentally commissioned data tools.				
Other					
Total					

Locum shifts		**2018**			**2019**	**Total**
		Apr-Jun	**Jul-Sep**	**Oct-Dec**	**Jan-Mar**	
Total		3295	3547	3497	4186	14525
Agency		1560	1636	1694	2010	6900
Bank		1735	1912	1803	2176	7626
Reason for locum shift	Vacancy	2564	2682	2854	3367	11467
	Non-vacancy	731	865	643	819	3058

Oxford University Hospitals NHS Foundation Trust has recognised that the following actions are required to ensure improved rostering oversight of Doctors in Training.

- A standardised process for the collection, distribution and reporting of data relating to the rostering of Doctors in Training is required to

ensure that those with rostering responsibilities can better match the capacity and capability of Doctors in Training to both service activity and training opportunities.

- Whilst the 2016 TCS clearly describe a number of processes to protect safe working hours for individual Doctors in Training, these TCS are not responsible for assuring safe medical staffing levels. Safe medical staffing levels (e.g. as described by the Royal College of Physicians) not only contribute to a safe medical environment, but also mitigate against some of the risks that cause unsafe working hours.

Focus on nurse retention

Nurse vacancy data demonstrates that the focused UK and international nurse recruitment within OUH is enabling the vacancy position to stabilise with an overall vacancy rate having less than a 1% increase in January 2019 at 14.1% compared to that of January 2018 (13.7%). The nursing turnover position was a key indicator in NHSI's decision to invite OUH to join cohort three of their nurse retention support programme. At the time of the invitation Band 5 nurse turnover sat at 21.5% and this was chosen by the Nursing and Midwifery Recruitment Retention and Education Steering Group (NMRRE) to be the focus for improving nurse retention. An action plan was submitted to Trust Management Executive in June 2018 and approved at Trust Board in July 2018. NHSI wrote to the Associate Chief Nurse in September 2018, acknowledging the action plan and the aim to reduce Band 5 nurse turnover by 2% within 12 months.

Post implementation update on the Nurse Retention action plan

The Nursing and Midwifery Recruitment Retention and Education Steering Group (NMRRE) was set up in April 2018 to drive forward this key work.
The action plan focuses on six key thematic areas.

- Positive engagement
- Improving our intelligence
- Creating a better vision
- A flexible and happy nursing and midwifery workforce
- Internal recruitment
- Employment at the first point of registration

Freedom to speak up

OUH has an up-to-date 'Freedom to Speak Up - Raising Concerns (Whistleblowing) Policy' which is based on the national template recommended by the National Guardian Office. The policy clearly states that staff can raise a concern with their Line Manager, the Freedom to Speak up Guardian, an OUH Executive or Non-Executive Director, a Trade Union Representative or relevant outside body i.e. Care Quality Commission. Concerns can be raised during a meeting, over the phone or in writing. The majority of staff contacting the Freedom to Speak Up (FtSU) team choose a one-to-one meeting to discuss their concerns. The majority of concerns discussed with the FtSU Guardians relate to poor working relationships / dignity and respect issues. A separate Freedom to Speak Up Annual Report is presented to TME and the Trust Board.

Feedback to staff who raise concerns is dependent upon the concern raised and the action the individual wishes to take. Many staff do not wish to take the concern further and are happy with the support and advice given by the FtSU Guardian. However, if the concern is formally raised with the Line Manager, HR or an Executive then feedback is provided, usually by email.

Ensuring staff do not suffer detriment.

If a member of staff raises a concern under the Raising Concerns Policy, they will not be at risk of losing their job or suffering any form of reprisal as a result.

The Trust does not tolerate the harassment or victimisation of anyone raising a concern. Any such behaviour is a breach of the Trust's values and if upheld following investigation, could result in disciplinary action.

The Raising Concerns Policy states that 'Provided a member of staff is acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns'.

Our CQUIN performance

A proportion of Oxford University Hospitals NHS Foundation Trust income in 2018-19 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 2018-19 and for the following 12 month period are available electronically at:
www.ouh.nhs.uk/about/publications/documents/cquins-2018-19.pdf

The monetary total for Oxford University Hospitals NHS Foundation Trust income in 2018-19 is conditional on achieving quality improvement and innovation goals will be known after 31 May 2019.

The monetary total for the associated payment in 2017-18 is as follows: Actual £14,406,000.

Statement regarding how OUH is implementing the priority clinical standards for seven day hospital services

Seven Day Hospital Services Board Assurance Framework

The new Seven Day Hospital Services Board Assurance Framework2 (7DSBAF) has been designed to allow a broader assessment of performance, capturing changes and improvements that the notes' audits may not have included, whilst reducing the administrative burden of reviewing large numbers of patient case notes.

The new measurement system uses a standard template with self-assessments of performance against the seven day services (7DS) clinical standards. The process requires bi-annual assessment and submission of the sign-off board assurance template to the Seven Day Services Regional Team.

At OUH, the 7DSBAF will be implemented gradually with a dry run (November 2018 – February 2019) using data from the April 2018 audit submission followed by full implementation in June 2019.

Data from the trial run will not be made public, but results from the subsequent full implementation will be published on the NHS Improvement (NHSI) and NHS England (NHSE) websites.

NHSI and NHSE have invited feedback on the 7DSBAF template design and process in general.

The bi-annual assurance process will be a requirement of the NHS Standard Contract and a metric based upon this will be included in the next CCG improvement and assessment framework. Furthermore the CQC will use providers' self-assessments of 7DS delivery as supporting evidence in its inspection processes covering 7DS.

Since February 2016 we have been one of 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 priority on the basis of their potential to positively affect outcomes for patients.

- Time to first consultant review (e.g. by a senior level doctor)
- Access to diagnostic tests (e.g. X-rays and heart scans)
- Access to consultant-directed interventions (e.g. interventional radiology and emergency surgeon)
- 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 taken enforcement action against Oxford University Hospitals NHS Foundation Trust during 2018-19; this was a Section 31 enforcement notice in relation to theatres in the JR 2 Theatre Complex.

Oxford University Hospitals NHS Foundation Trust has participated in a special review by the Care Quality Commission relating to the following areas during 2018-19: the follow-up review of 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 January 2019.

The Trust has been subject to a number of recent visits from the CQC they have covered the following.

- Core service reviews: this was an unannounced series of inspections conducted over November and December 2018 and mainly focused on the Maternity, Gynaecology, Urgent Care and Surgery core services. The formal publication of the outcome from this review is still awaited.
- Use of resources (conducted by NHSI using CQC methodology and resources) in December 2018; the outcome from this inspection is still awaited.
- Well-Led Review: the formal publication of the outcome from this review is still awaited.

The Trust uses every opportunity for feedback in a proactive and positive way whenever a report is received an action plan is developed with executive leadership to address the issues. During the core service reviews the Trust received a Section 31 notice in relation to the JR2 Theatres Complex, the action plan is owned by the Director of Clinical Services and is subject to weekly monitoring internally and reported to the CQC on a weekly basis. The issues found within JR2 theatres have been considered more widely by the Trust and any further learning in particular in relation to current practice for storage, cleaning, privacy and dignity and access into all theatre suites are being proactively considered across all theatre suites in all Trust locations. This specific action plan is due to conclude in August 2019.

Our Trust's overall rating to date of 'Good' remains unchanged at present.

- CQC ratings grid is provided below for the Trust overall and by site. There were three separate action plans from the reports addressing multiple actions across the areas previously identified as 'Requiring improvement'. These are overseen by a lead executive and updates are reported to the Clinical Governance Committee. It is likely that these will be reviewed and updated to reflect the results of the most recent inspections with completion dates to be revised accordingly.

Last rated
27 March 2018

Oxford University Hospitals NHS Foundation Trust

John Radcliffe Hospital

Are services

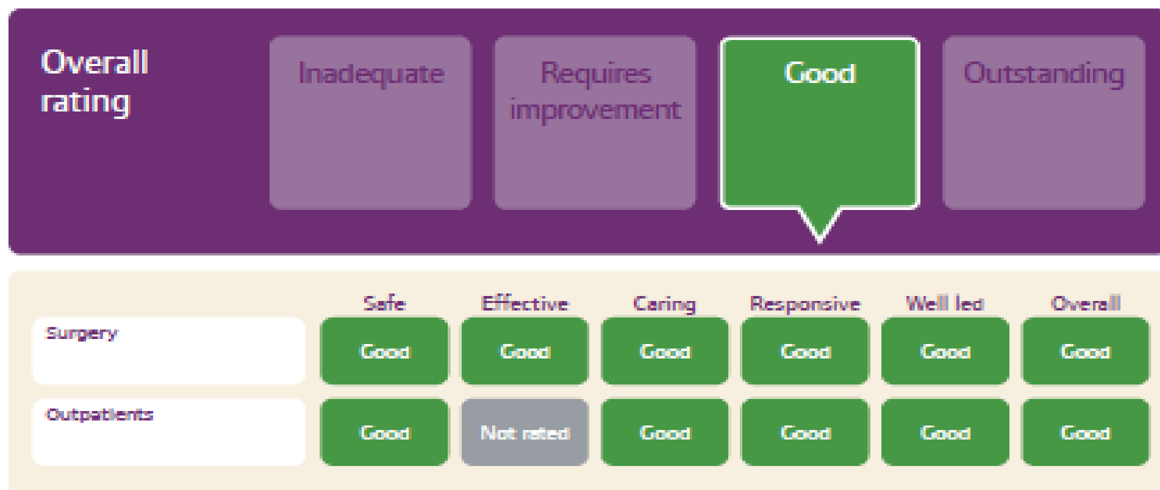
Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Requires improvement
Well led?	Good

Care Quality Commission

Last rated
27 March 2018

Oxford University Hospitals NHS Foundation Trust

Nuffield Orthopaedic Centre



Overall rating: Inadequate | Requires improvement | **Good** | Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

Care Quality Commission

Last rated
14 May 2014

Oxford University Hospitals NHS Foundation Trust

Churchill Hospital

Overall rating: Inadequate | Requires improvement | **Good** | Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

CareQuality Commission

Last rated
14 May 2014

Oxford University Hospitals NHS Foundation Trust

Horton General Hospital

Overall rating: Inadequate | Requires improvement | **Good** | Outstanding

	Safe	Effective	Caring	Responsive	Well led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Urgent and emergency services (A&E)	Not rated	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Intensive/critical care	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good

Our data quality

A vital pre-requisite to robust governance and effective service delivery is the availability of high quality data across all areas of the organisation. This 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 and 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.

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. We have 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 and the Caldicott Guardian.

Oxford University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality.

- Enhance the internal audit programme to include audits to support the use of new functionality within the Electronic Patient Record.
- '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 2018-19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data shows:

SUS dashboards at month 10, 2018-19

Inpatients	OUH	National average
Valid NHS number	99%	99%
General Medical Practice Code	100%	100%

Outpatients	OUH	National average
Valid NHS number	100%	100%
General Medical Practice Code	100.0%	100%

A&E	OUH	National average
Valid NHS number	97%	98%
General Medical Practice Code	100%	99%

Information Governance Toolkit

The Trust submitted its annual Data Security and Protection Toolkit return to NHS Digital on 29 March 2019. The Data Security and Protection Toolkit replaces the Information Governance Toolkit and has been revised following the National Data Guardian's Review, 'Data Security, Consent and Opt Outs - 2016'. The Trust declared compliance against 23 mandatory assertions in its 2018-19 return. Nine assertions have not been met. These have been included as part of an action plan which has been agreed between NHS Digital and the Trust. The action plan is due for completion by the end of October 2019.

Clinical coding error rate

Oxford University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018-19.

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 14 February 2019, for the data period October 2017 to September 2018, 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.
- The Trust takes the following actions to improve the SHMI, and so the quality of its services, by continuing to review the SHMI at the Mortality Review Group. The Trust Mortality Review Group meets monthly under the chairmanship of the Deputy Chief Medical Officer with responsibility for learning from deaths. The Mortality Review Group has multidisciplinary and multi-professional membership with clinical representation from all four clinical Divisions.
- If there is an increase in the SHMI, the Mortality Review Group will task clinical service units to investigate the diagnoses groups contributing to the increase and review the findings from the investigations. If the investigation identifies any care quality concerns, actions will be implemented and monitored by the Mortality Review Group.

Source: NHS Digital	**Jan 17 to Dec 17**	**Apr 17 to Mar 18**	**Jul 17 to Jun 18**	**Oct 17 to Sept 18**
OUH SHMI value	0.93	0.92	0.92	0.92
OUH SHMI banding	2 -as expected	2 -as expected	2 -as expected	2 -as expected
SHMI best performing trust	0.72	0.70	0.70	0.69
SHMI worst performing trust	1.22	1.23	1.26	1.27
OUH % deaths with palliative care coding	45.28	44.80	45.40	46.41

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 2018 to December 2018 indicate that 88% 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 3 2017-18.

During 2018-19, 2,556 OUH patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 624 in the first quarter; 618 in the second quarter; 691 in the third quarter; 623 in the fourth quarter.

Total number of deaths 2018-19	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19	Quarter 4 2018-19
2556	624	618	691	623

By 31 March 2019, 1,037 case record reviews and eight investigations had been carried out in relation to 1,933 of the deaths included above.

In six 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: 325 in the first quarter; 339 in the second quarter; 373 in the third quarter.

	Quarter 4 2017-18	Quarter 1 2018-19	Quarter 2 2018-19	Quarter 3 2018-19
Number of case record reviews (Level 2 comprehensive mortality review or structured review)	367	325	339	373
Number of deaths judged more likely than not to have been due to problems in care	2	0	0	0

0 representing 0% of 1933 of the patient deaths 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.

In relation to each quarter, this consisted of: 0 representing 0% of 624 for the first quarter; 0 representing 0% of 618 for the second quarter; 0 representing 0% of 691 for the third quarter. The reviews of deaths which occurred during the fourth quarter are underway and the summary will be included in the next Quality Account.

These numbers have been estimated using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group.

Summary of learning and impact of the actions from case record reviews and investigations

New protocols and pathways

- The Emergency Department (ED) has improved therapist multidisciplinary team (MDT) working. In particular, physiotherapist rotas will be available to the ED coordinator, physiotherapists will be trained to review X-rays to the same level as the Emergency Nurse Practitioners (ENPs) and the physiotherapist case mix will be reviewed.
- A standard operating procedure for time critical implementation of renal replacement therapy has been developed and implemented.
- An airway proforma has been implemented to support communication from theatres to the Intensive Care Unit (ICU) about difficult airway patients.
- A pathway for patients requiring a colonic stent has been developed with all services (Acute Surgery, Colorectal and Endoscopy) involved in scheduling the procedure.
- EPR discharge summaries have been re-configured to include a section to record incidental findings from investigations and plans for follow-up.
- The review of VTE (venous thromboembolism) risk assessments is included on board rounds which are attended by the ward MDT (multidisciplinary team). The ward pharmacist is allowed time on the board round to raise any medication concerns with the ward MDT.
- To prevent staff of all grades missing Electronic Patient Record (EPR) alerts for venous thromboembolism (VTE) risk assessments the 'soft' pop up alerts, which can be clicked through, have been changed to 'hard' pop up alerts which cannot be bypassed without completing the required action. A preliminary review of this revised system has shown this functionality to be working well.
- The Critical Care and Interventional Radiology teams are developing a specific pathway for the management of massive and sub-massive pulmonary emboli.

Updates to guidance and checklists

- The OUH MIL (Medicines Information Leaflet) on warfarin reversal has been updated to include an isolated Haemoglobin drop < 20g/L in the definition of a major bleed.
- The 'Electronic Foetal Monitoring Antenatal Guideline' has been updated with improved clarity on the interpretation of cardiotocograms (CTG) and the actions for the team to take. This includes the urgency with which midwives should request obstetric reviews and obstetricians should advise delivery.

Clinical audits and service evaluations

- The Trauma Service completed an audit of the care of outlying patients in August 2018 to ensure that the same standard of care is delivered to patients regardless of their ward location. The results from this audit have led to the Clinical Nurse Specialist (CNS) reviewing outlying patients on a daily basis to check that appropriate VTE prophylaxis is being prescribed to all relevant patients who are not based on the trauma wards. The CNS runs a report from EPR each morning and reviews the outliers. During weekends the bleep holder assumes this responsibility.

Training and education

- Staff members in the Upper Gastrointestinal Team have completed Human Factors training focusing on the Track and Trigger Escalation Pathway.
- The 'Standard Operating Procedure (SOP) for Peri-operative Management of Pacemakers and Implantable Cardio-defibrillators' will be provided to the Anaesthetics and Surgery teams. The SOP will be enabled under the search function in the guidelines section of the OUH intranet.
- The Neonatal Unit has disseminated information to the Thames Valley Neonatal Network to raise awareness of patients with duct-dependent congenital anomalies and the need for referral to the Newborn Care Unit with communication between Local, Cardiology and Neonatal teams.

Support for staff

The Critical Care Team has appointed a nurse lead for wellbeing to provide staff with support. The Critical Care Team will be holding its first reflective round in May 2019 as part of a suite of interventions to enhance the wellbeing of staff.

Case record reviews and investigations from Quarter 4 of 2017-18

367 case record reviews and two investigations were completed after 31 March 2018 which related to deaths which took place in the fourth quarter of 2017-18, before the start of the reporting period. Two of the patient deaths representing 0.2% of 793 of the patient deaths reviewed from the fourth quarter of 2017-18 are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the quarterly Divisional mortality reports submitted to the Trust Mortality Review Group

Endocrine Surgery structured mortality review

The level of preparation for a rare but well recognised and potentially life-threatening complication of thyroid surgery was inadequate, both in relation to the location where the patient was cared for after the operation and to the emergency equipment which should have been available.

Following this incident any patient requiring thyroid surgery must be admitted to the Head and Neck Ward. The 'S.C.O.O.P: Acute Management of Post Op Haemorrhage in Thyroid and Parathyroid Surgery' teaching video has been produced and made available to all teams. The protocol has been presented at national forums and disseminated at other hospitals.

The Coroner delivered a narrative conclusion following the Inquest.

Infected heart valve structured mortality review

The structured review found that the death was more likely than not to have been due to problems in the care provided to the patient. If identification of the need for urgent surgery had occurred soon after the patient was reviewed by the Infectious Diseases Team, it is likely that surgery would have been feasible and have taken place in the week prior to the patient's death.

Subsequent to this case, stronger links between the Cardiology and Infectious Diseases teams have been instigated, so that all patients with potential infective endocarditis are discussed, and weekly joint multidisciplinary team meetings are held where difficult or borderline cases are reviewed.

Two representing 0.07% of 2686 of patient deaths during 2017-18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

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 Trust takes the following actions to improve the PROMs, and so the quality of its services, by the Orthopaedic Unit continuing to review the PROMs responses and presenting this to the Trust Clinical Effectiveness Committee.

The national mandatory varicose vein surgery and groin hernia surgery PROMs collections ended on 1 October 2017. The final annual data publication for the half year 2017-18 data was in June 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 2017-18. The final annual data publication for 2018-19 will be available later in 2019 and will be published in our 2019-20 Quality Account.

Repair of a groin hernia – average health gain	2014-15	2015-16	2016-17	2017-18 (Apr to Sept 2017)
OUH	**0.09**	**0.12**	**0.09**	**0.08**
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	0.03

Primary hip replacement – average health gain	2014-15	2015-16	2016-17	2017-18
OUH	**0.44**	**0.42**	**0.43**	**0.45**
National average	0.44	0.44	0.44	0.47
Highest	0.52	0.51	0.54	0.57
Lowest	0.33	0.32	0.31	0.38

Primary knee replacement – average health gain	2014-15	2015-16	2016-17	2017-18
OUH	**0.29**	**0.26**	**0.31**	**0.36**
National average	0.31	0.32	0.32	0.34
Highest	0.42	0.40	0.40	0.42
Lowest	0.20	0.20	0.24	0.23

Varicose veins – average health gain	2014-15	2015-16	2016-17	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	0.03

*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.

The Trust takes the following actions to improve the PROMs, and so the quality of its services.

- If there are negative responses identified in the PROMs returns, these are reviewed by the Orthopaedics Unit to determine if actions are required.
- The actions will be monitored by the Directorate Clinical Governance Team.

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 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.
- The Trust takes the following actions to improve the readmissions rates, and so the quality of its services, by the individual clinical units continuing to review the readmissions rates and including the findings in the monthly quality reports to the Trust Clinical Governance Committee.

Readmissions	2016-17			2017-18			2018-19 (April 2018-September 2018 only)		
	Under 16	16 and over	Total	Under 16	16 and over	Total	Under 16	16 and over	Total
OUH Discharges	**29972**	**164638**	**194610**	**28670**	**160944**	**189614**	**13905**	**80329**	**94234**
OUH 28 day readmissions	**2397**	**14223**	**16620**	**2470**	**14823**	**17293**	**1270**	**7928**	**9198**
OUH 28 day readmission rate	**8.0%**	**8.6%**	**8.5%**	**8.6%**	**9.2%**	**9.1%**	**9.1%**	**9.9%**	**9.8%**
National 28 Day readmission rate average	9.0%	8.0%	8.5%	9.2%	8.3%	9.1%	9.1%	8.7%	8.7%
Highest NHS Trust value	14.5%	10.8%	10.5%	16.5%	11.5%	11.4%	16.3%	11.5%	11.5%
Lowest NHS Trust value	3.7%	5.8%	5.8%	3.3%	5.9%	5.8%	2.5%	6.0%	5.9%

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. The Trust has introduced care pathways whereby a patient is discharged with a scheduled readmission to an ambulatory unit as part of their plan of management. The analysis for readmissions does not exclude these planned readmissions.

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.

The Trust takes the following actions to improve this indicator and so the quality of its services.

- Negative (higher than expected) readmission rates are investigated by the respective Division.
- If the investigation identifies any care quality concerns, actions are implemented and monitored by the Divisional Clinical Governance team and reported to the trust Clinical Governance Committee.

Patient experience

Patient views count and help drive learning and improvement. We listen to patients' views, opinions, feedback and observations about all aspects of our hospitals as they are very important in helping us to continually improve the experience of patients their family and friends that we serve, and of those who use Trust services. 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 are 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	2015-16	2016-17	2017-18
OUH	**72**	**71**	**73**
National average	70	68	69
Highest scoring trust	86	85	85
Lowest scoring trust	59	60	60

Source: Health and Social Care Information Centre website - indicators.hscic.gov.uk/web view - 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 Trust will receive embargoed reports of the 2018 Inpatient survey results on February 2019 and the results will be published by CQC in June 2019.

Patient recommendation of our hospitals to family and friends

Results from the OUH Friends and Family Test (FFT) survey	
FFT: inpatients and day cases	96% of patients were extremely likely or likely to recommend their ward, based on 31,522 responses.
FFT: emergency departments	88% of patients were extremely likely or likely to recommend the care they received in the Emergency Department, based on 23,582 responses.
FFT: outpatients	95% of outpatients were extremely likely or likely to recommend the care they received, based on 74,492 responses.
FFT: maternity	95% of women were extremely likely or likely to recommend the Trust's maternity services (labour and birth only), based on 3,096 responses.

The table below shows the Trust's overall results from the FFT survey for this 12 month period.

April 2018 to March 2019	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know
Number of responses overall	95,945	11,965	2,493	1,544	2,167	639
Percentage	84%	10%	2%	1%	2%	1%

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 Head of Adult Safeguarding or the 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 and maternity services.

- 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.

- 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.

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	2015-16	2016-17	2017-18	2018-19
OUH	**75%**	**79%**	**71%**	**74%**
National average	69%	70%	71%	71%
Highest scoring trust	85%	85%	86%	87%
Lowest scoring trust	46%	49%	47%	40%

Recommendation of the organisation as a place to work:

OUH scores	2015-16	2016-17	2017-18	2018-19
OUH	**60%**	**61%**	**57%**	**57%**
National average	61%	61%	61%	63%
Highest scoring trust	78%	76%	77%	81%
Lowest scoring trust	42%	41%	43%	39%

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.

The action plans from 2017-18 are to be continued along the six key themes.

- Recognising and valuing each other
- Supporting and developing managers
- Empowering teams
- Dignity, respect and fairness
- Meaningful appraisals
- Health and wellbeing at work.

Trust-wide Listening Events are in the process of running to encourage sharing of ideas around what is working well, what could be better and how the Trust can support that to happen. These will be followed by a full set of 25 Directorate-specific and site-specific events which will result in local focused action plans that will feed into the Trust-wide action plan and priorities. Together, this will have a positive impact on these two measures going forward.

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 NHS Foundation Trust, Oxfordshire Clinical Commissioning Group (OCCG) 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**	**2015-16**	**2016-17**	**2017-18**	**2018-19**
OUH attributed (number)	57	53	72	51
Total bed days	394,104	408,361	391,765	Awaiting PHE figure publication date June 2019
Rate per 100,000 bed days (OUH attributed cases)	14.1	13.0	18.1	Awaiting PHE figure publication date June 2019
National average	14.9	13.3	13.7	Awaiting PHE figure publication date June 2019
Best performing trust	0.0	0.0	0.0	Awaiting PHE figure publication date June 2019

C Difficile rates per 100,000 bed days	2015-16	2016-17	2017-18	2018-19
Worst performing trust	41.1	82.7	91.0	Awaiting PHE figure publication date June 2019

End of life care

There have been significant strides in end of life care in OUH over the last two years and the following highlights some of the achievements.

Direct

- There has been a significant increase in overall referrals to the service which equated to over 1,900 patients and over 5,100 patient consultations by the specialist team across all our sites.

Indirect

- There are in excess of 40 projects across OUH to improve care of the dying, many initiated by teams recognising that this is an important area of care for their patients, those important to them and staff. Trust-wide projects include a survey of OUH care offered to all bereaved families, development of EOLC criteria for Structured Judgement Review, grant-sourced for staff education, development of 'what to expect when someone is dying in hospital and at home; rollout of the sunflower logo highlighting that a patient is dying to alert all staff entering the clinical area, and the completion of the National End of Life Care Audit.
- There has been a significant amount and variety of education for all staff groups including masterclasses for specific staff groups, the annual End of Life Care Symposium and Grand Rounds.
- The Palliative Care Service has also gained ethics approval and commenced a prospective cohort research study to look at outcome metrics and cost effectiveness of pro-active palliative care for over 75 year old patients, a unique national NHS study.

Culture

- There has been a definite increase in engagement of all staff groups with regard to end of life care across the organisation, evidenced by the number and breadth of projects and being undertaken and requests for education.
- Greater collaboration and assurance is evident across the Trust, including understanding of all the services involved in and providing

end of life and palliative care to our patients, as well as bereavement support, from neonates to the elderly, expected and sudden deaths.

- There has also been significant investment from charities who support the people of Oxfordshire, including Sobell House Hospice Charity and Ronald McDonald House Charity building new facilities for our patients and their families, and our local hospice charities, Sobell House, Katharine House and Helen and Douglas House supporting clinical posts and providing expertise and resources to enable us to provide excellent palliative and bereavement care to children and adults dying in the Trust.

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 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 National Reporting and Learning System (NRLS).
- Data are compared to peers, highest and lowest performers, and our own previous performance, as below.

	Oxford University Hospitals NHS Foundation Trust			
	2015-16	**2016-17**	**2017-18**	**April-September 2018**
Number of patient safety incidents	**17,788**	**17,121**	**17,002**	**8,577**
National average (acute non-specialist trust)	9,465	7,661	10,714	5,583
Highest reporting trust	24,078	27,991	31,007	23,692
Lowest reporting trust	3,058	2,880	2,444	566
Number of patient safety incidents that resulted in severe harm or death	**44**	**11**	**16**	**10**
National average (acute non-specialist trust)	39	38	37	19
Highest reporting trust	183	190	220	87
Lowest reporting trust	2	3	0	0
Percentage of patient safety incidents that resulted in severe harm or death	**0.20%**	**0.06%**	**0.09%**	**0.12%**
National average (acute non-specialist trust)	0.40%	0.40%	0.37%	0.37%
Highest reporting trust	2.00%	1.38%	1.76%	1.22%
Lowest reporting trust	0.00%	0.02%	0.00%	0.00%

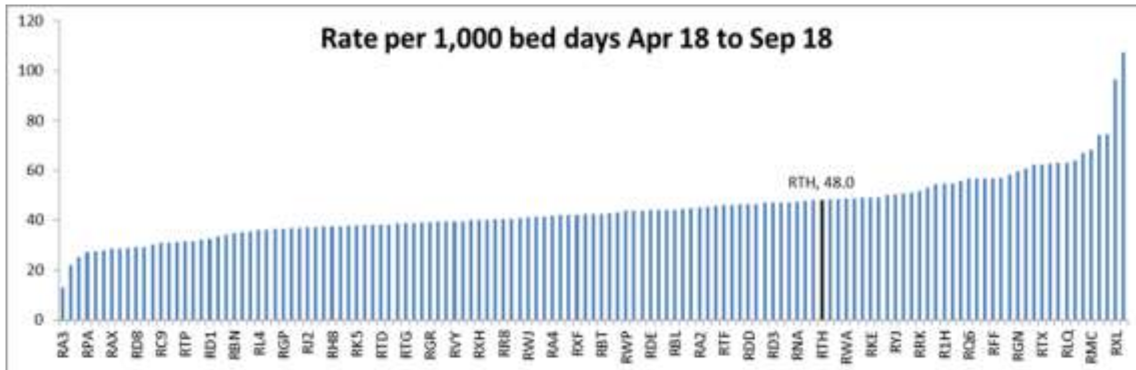
Source: NRLS, Organisation Patient Safety Incident reports which are published six months in arrears.

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 frontline staff, executives and leads for specialist areas such as tissue viability, pharmacy, venous thromboembolism (VTE) and information governance attend as required. During financial year (FY) 18-19 there were 1,486 documented attendees compared to FY 2017-18 where there were 1,537 documented attendees.

During 2018-19 116 SIRIs were declared on the Strategic Executive Information System (STEIS) with five being subsequently downgraded. This is a 23% increase in reported SIRIs on 2017-18, in which 94 SIRIs were identified, with three downgrades. This follows a concerted effort to improve timeliness and extent of escalation of incidents.

Incident rates - acute non-specialist Trust						
	Oct 15 Mar 16	Apr 16 Sep 16	Oct 16 Mar 17	Apr 17 Sept 17	Oct 17 Mar 18	Apr 18 Sep 18
Incident rate (per 1,000 bed days)	**41**	**44**	**40**	**44**	**44**	**48**
National average	40	41	41	43	43	45
Highest reporting rate	76	72	69	112	124	107
Lowest reporting rate	15	21	23	23	24	13



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, although one has been temporarily suspended (undetected oesophageal intubation), and one does not affect acute trusts such as OUH (failure to install collapsible shower or curtain rails).

In 2018-19 OUH reported 11 Never Events compared to eight in 2017-18 and four Never Events in 2016-17. The Never Events in 2018-19 were as follows:

- six wrong site surgery cases*
- five retained foreign object post-procedure cases.

*One incident occurred in 2017-18, but came to light during an investigation, it was reported on STEIS and investigated retrospectively.

The learning stemming from the incidents, with a particular focus on the system changes made to reduce the probability of recurrence is as follows.

- System changes enacted based on learning from these Never Event investigations.
- Creation of a video detailing use of the World Health Organization (WHO) Surgical Safety Checklist, with emphasis on positive patient identification (PPID) elements, for use in Endoscopy induction training.
- Addition of the question “Were any items retained post-procedure that require removal at a later date, and has a plan been documented for their removal?” to the generic WHO Surgical Safety Checklist.
- Campaign to promote PPID and inform patients that staff will ask their name and date of birth at each contact - made a quality priority for the Trust for 2018-19. Including instigation of ‘Wristband Wednesdays;, in which senior staff visit clinical areas to confirm whether PPID is being enacted.
- Development of a revised, robust stock checking and ordering process for Nuffield Orthopaedic Centre (NOC) theatres.
- Creation of a system for prescribing Botox via the electronic patient record (EPR) on an individual patient basis once the clinical decision for its use has been made.
- Change of appointment letters to refer to the Neurological Injection Clinic rather than the Botox Clinic, to reflect the fact that various procedures are completed in this clinic, and to increase patient understanding of their required treatment.
- Implementation of the relevant appendix to the Trust Swabs, Sharps, Instruments and Accountable Items Policy in Gynaecology and Maternity theatres.
- Review of all radiological procedures currently offered, and implementation of the WHO surgical safety checklist where required. Pre-list team briefings being completed before interventional radiology procedure lists.
- The Interventional & Fluoroscopy Modality Manager visited all clinical areas Trust-wide in which interventional radiology procedures are performed to confirm that all equipment requisite to maximise patient safety was available.

- Roll-out of an adapted WHO surgical safety checklist for central venous catheters.
- Development of a formal appendix to the Trust Swabs, Sharps, Instruments & Accountable Items Policy specific to the Orthopaedics service.
- Creation of a standard operating procedure (SOP) to cover all invasive procedures carried out in Neurology Outpatients, involving a standardised checklist and reflecting the 'Stop Before You Block' procedure for local anaesthetic blocks.
- Alteration of the computerised radiology information system to clearly include the site and side of procedures.

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.
- Never Event root cause analysis reports are sent to governance staff in all Divisions, not just that in which the incident occurred, on completion, for immediate consideration regarding sharing learning.
- All SIRI root cause analysis reports are now uploaded to the Trust intranet on completion.
- The Trust has held two Never Event Risk Summits (see below).

Externally

- 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.
- OCCG and NHS England consider all completed root cause analysis reports, and complete assurance visits once action plans are complete to ensure that learning has been sufficiently embedded, before closing the incident on STEIS.
- Representatives from commissioning and regulatory bodies attended the two Never Event Risk Summits (see below).

In response to the high number of Never Events reported, the Trust created a Never Event Improvement Plan during 2018-19. This identified activity to deliver improvements in areas such as Never Event action monitoring, policy content, the National Safety Standards in Invasive Procedures (NatSSIPs) and Local Safety Standards in Invasive Procedures (LocSSIPs), and positive patient identification (PPID). The plan also included engagement with NHS Improvement and the National Patient Safety Team.

The Trust held a Never Event Risk Summit in August 2018. 84 members of Divisional and corporate staff, executive and non-executive directors, patients and external stakeholders attended. Posters were displayed and presentations given concerning the nature of Never Events identified since April 2018, the WHO checklist, NatSSIPs, the Stop Before You Block procedure for local anaesthetic blocks, PPID, and the role of human factors in Never Events.

A second summit was held in January 2019. This was attended by 82 staff members and representatives from our commissioners. Presentations and discussions centred around (NatSSIPs) and the development of LocSSIPs via the Safe Surgery & Procedures Implementation group, positive patient identification (PPID) – including an impactful patient perspective and examples of best practice including a video developed in Endoscopy.

New patient safety strategies introduced by the incoming Medical Director.

- In January 2019 a new weekly Safety Message email, sent to all staff from the Medical Director and Chief Nurse, was launched to raise awareness of important patient safety issues. These continue weekly and cover a variety of areas partly informed by recent incidents, national patient safety alerts and internal quality improvement schemes e.g. the falls prevention initiative 'low before you go'

where relevant patient beds are lowered after a patient has been seen to reduce the impact of a fall should the patient attempt to get out of bed without assistance.

- In March 2019 a Patient Safety Response Team pilot was started on the John Radcliffe Hospital site to review all moderate and above clinical harm incidents daily – this multidisciplinary staff team discusses any incidents in the previous 24 hours and, if required, senior doctors and nurses will visit clinical areas to meet the staff and patient involved to offer support and ensure the safety of all those involved. This process will be evaluated and reviewed prior to potential Trust-wide roll-out.

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. All incidents with outstanding Duty of Candour are tabled for discussion at the weekly SIRI Forum and, once completion is confirmed by Divisional management representatives, this is recorded in the Forum's minutes. Completion of Duty of Candour and wherever possible a copy of the relevant correspondence is recorded both in the Trust incident management system against the reported incident and in the patient's notes.

Compliance with Duty of Candour in the last calendar year is as follows.

	Verbal	Letter
Q1 2018-19	100% (36/36)	100% (36/36)
Q2 2018-19	100% (49/49)	100% (49/49)
Q3 2018-19	100% (52/52)	100% (52/52)
Q4 2018-19	98% (64/65)	98% (64/65)

The single outstanding case from Quarter 4 is being managed: a meeting has been booked for the consultant to meet the deceased patient's family in May, as part of which the Duty of Candour discussion will take place. A letter will be sent thereafter.

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 2018-19.

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	2016-17	2017-18	2018-19
OUH VTE assessment rate	**96%**	**98%**	**97% (Q1-Q4)**
ational average	**96%**	**95%**	**96% (Q1–Q3)**
Best performing Trust (All Acute Trusts)	**100%**	**100%**	**100% (Q1–Q3)**
Worst performing Trust (All Acute Trusts)	**79%**	**74%**	**78% (Q1-Q3)**

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services.

- The VTE Prevention Team and obstetrics have worked closely with the Electronic Patient Record (EPR) team to improve safety with a direct link of the obstetric e-VTE risk assessment 'recommended outcome' to e-prescribing. This was implemented in April 2018. This built on previous work linking medical and surgical e-VTE risk assessments to e-prescribing.

- E-Learning VTE prevention and safe anticoagulation modules are regularly reviewed and are up to date. A bespoke Maternity VTE learning package for midwives went live in January 2019.

- Pharmacy support has enabled a robust independent Trust-wide audit of 'appropriate thromboprophylaxis' since July 2016 and this has continued quarterly. The feedback of good quality data has helped drive improvements in patient safety.

- All hospital associated thrombosis (HAT) incidents are reported. Potentially preventable HATs are discussed in the Serious Incident Requiring Investigation (SIRI) forum and learning outcomes are disseminated.
- Improvements have been made in patient information about hospital acquired venous thromboembolism that is provided on discharge from hospital. 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.
- Implementation of new guidelines from the National Institute for Health and Care Excellence on 'Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism' is in progress.

Part 3: Other information

Progress against priorities for 2018-19

a. Preventing patients deteriorating

Why we chose this priority	How we will evaluate success	Evaluation March 2019
Identifying deterioration early can allow prompt treatment to reduce the duration and severity of subsequent illness. This priority was 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).	**Cardiac Arrest Reduction** • The overall progress against the target set out in the Quality Priority is a 10% decrease overall with a 3% increase in general ward areas when the period 2017-18 is compared with the same period in 2018-19. • The Resuscitation Team continues to observe a number of patients who are subject to a 2222 call and for whom a decision regarding resuscitation status would have been appropriate prior to the point of cardiac arrest. These cases are reviewed and highlighted to the patients' consultants who share the learning with their respective teams.

Cardiac Arrest Reduction

Cardiac arrest numbers Trust wide

Cardiac arrest numbers for general ward areas

*Cardiac arrests which occur in the emergency department are excluded from both graphs.

Not achieved.

Sepsis

- Overall, since April 2018, 504/727 (69%) acute admissions and 976/1,503 (65%) inpatients with sepsis have received antibiotics within one hour.

We have improved to 65% but have not fully achieved this.

	Proportion of patients that received antibiotics within 1 hour										
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-
Adm	42/65 **65%**	38/52 **73%**	39/56 **70%**	50/70 **71%**	41/54 **76%**	41/59 **69%**	36/56 **64%**	38/49 **78%**	49/70 **70%**	45/60 **75%**	43/6 **66%**
Inp	71/105 **68%**	79/124 **64%**	74/113 **66%**	110/155 **71%**	100/156 **64%**	61/105 **58%**	87/138 **63%**	79/121 **65%**	124/172 **72%**	136/196 **68%**	106/1 **64%**

Antibiotics delivered within one hour of a

- Outcomes of patients with sepsis at OUH: Dr Foster data demonstrates a sustained fall in Summary

	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.	Hospital-level Mortality Indicator (SHMI) for sepsis since Trust sepsis work began in July 2015. • The Oxford Sepsis Team strategy has been shortlisted for the British Medical Journal 2019 Award for Innovation in Quality Improvement. Training has been delivered to 197/319 (62%) of regular clinical staff in the Emergency Department (target 50%). ***We have fully achieved this.***
b. Safe surgery and procedures		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
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	Establish a new Safety Standards for Invasive Procedures Group (SSIPG). Develop the remaining key overarching policies from which the specific LocSSIPs will develop. Develop/review LocSSIPs relevant to	• The SSPIG has been established and meets regularly. • The remaining key overarching policies from which the specific LocSSIPs will develop are all either complete or nearing completion. • An implementation plan for LocSSIPs has been developed and reviewed at SSPIG. A small number of LocSSIPs have been completed with work on the others currently underway. • The scoping work for LocSSIPs has been completed before the end of March 2019. F2s (junior doctors)

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. OUH had eight Never Events in 2017-18 and that is why focus on these standards has been chosen to be a Quality Priority.	the eight Never Events that occurred in 2017-18. Scope other surgical and invasive procedural areas across the Divisions where LocSSIPs should be developed.	are supporting clinical areas with the creation of LocSSIPs as part of their Quality Improvement Projects (QIPs). ***We have partially achieved this.***
c. Right patient every time		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
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	**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-	• Final sign-off for the revised PPID policy happened at Clinical Policies Group on 5 March 2019. New 'at a glance' documents will be circulated following this sign-off. • 'Wristband Wednesday' continues however the audit tool is being updated for March 2019 and an associated document "What good looks like" is being produced for the audit. • There has been 1 PPID incident in radiology (in February 2019). This was presented at the serious incident requiring investigation (SIRI) forum and a local investigation is now underway. Learning will be shared once this investigation is complete.

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.	19. The app is being launched for Matron's assurance audits. Achieve a 50% reduction in PPID incidents in Radiology compared to 2017-18	***We have fully achieved this.***

d. War on waste (Clinical effectiveness) - Go Digital

Why we chose this priority	How we will evaluate success	Evaluation
OUH 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.	• The patient portal went live for use on 30 January 2019 as planned. • An eight-week pilot with the Diabetes service will help understand how best to engage with users and provide a baseline prior to roll-out to the rest of the organisation throughout 2019. ***We have partially achieved this.***

e. War on waste (Clinical effectiveness) – Lean Processes

Why we chose this priority	How we will evaluate success	Evaluation
We chose this because we want to increase efficiency	The Transformation Team will train a core team of Divisional staff in Lean Processes.	• From September 2018-February 2019 we will have had 172 staff participate in Quality Service Improvement and Redesign (QSIR) fundamental courses run by the Transformation Team. • Feedback has been outstanding with the most

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.	Each Directorate will then complete a Lean pathway exercise for at least one patient pathway.	describing the course as 'Inspiring'. • Directorates the Transformation Team is supporting, incorporating 'Lean' as one of the improvement tools, include: Gynaecology, Trauma and Orthopaedics, Specialist Surgery, Children's, Renal Transplant and Urology and Oncology and Haematology. ***We have fully achieved this.***
f. Respect for patients and partners (Patient experience) - Partnership working		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
This was 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 2018-19 Winter Plan. Actively participate in the End Pyjama Paralysis campaign and report progress in the 2018-19 Quality report.	• Patients who are ready for discharge are discussed at 12:00hrs Monday to Friday to identify actions that will further support their discharge. This is to reduce their overall length of stay in hospital. • In addition we are working with the community locality teams to provide further support for 'discharge to assess'. • Partners we are working with include the North locality teams, The Order of St John and the continuing healthcare team (CHC). ***We have fully achieved this.*** • All inpatient areas actively participated in the campaign to end pyjama paralysis. This work continues through the wards particularly within the general medical wards. ***We have fully achieved this.***
	Home Assessment	• HART's February 2019 contact time percentage was

	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.	47%, a slight decrease on previous performance. • However the drive to achieve the 55% will continue as HART have recently entered into a subcontract agreement with Oxford Health who are supporting patients in four agreed postcodes across a wide geographical location. ***We have not achieved this.***
g. Respect for patients and partners (Patient experience) – End of life care		
Why we chose this priority	**How we will evaluate success**	**Evaluation**
This was 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.	• There has been learning from the two areas of OUH that have trialled the care plans. • Following review, the care plan will be rewritten into the electronic patient record (EPR) in the next three months. • An advice sheet for staff has been written. • The EOLC care plan is likely to be rolled out initially at sites that are confident with care at the end of life and where there is a strong level of daily support from the Hospital Palliative Care Team. • Continuation of the work has been incorporated into the EOL work plan for 2019-20. ***We have partially achieved this.***

Our 2018-19 performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement February 2019.

	Target		2018-19 Annual	Q1	Q2	Q3	Q4
Rates of Clostridium difficile	<68		51	11	26	40	51
18 Week Incomplete -	>92%		83.73%	85.48%	83.99%	82.38%	82.95%
4 hour Target	>95%		87.19%	88.74%	87.75%	87.82%	84.50%
Maximum wait of 62 days from urgent referral to treatment for all cancers	>85%		72.29%	77.24%	70.06%	73.03%	68.26%
Extended 62-Day Cancer Treatment Targets (following detection via national screening programme of hospital specialist)	>90%		79.42%	84.80%	87.67%	84.00%	60.18%
Supporting measures: number of diagnostic waits <6 weeks - DiagWaits	>99%		97.93%	97.56%	97.67%	98.51%	97.95%

Emergency Department (ED) access: 95% ED patients wait fewer 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	2018-19
No. of four hour Breaches	8,994	14,017	15,893	21,046	26,673	20,588
No. of attendances	132,838	137,883	145,473	151,073	155,352	160,714
Performance	93%	90%	89%	86%	83%	87%
Nat. average	96%	94%	92%	89%	89%	88%
Best performing trust	100%	100%	100%	100%	100%	100%
Worst performing trust	88%	82%	78%	72%	73%	62%

Oxford University Hospitals NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services.

- The Emergency Department has remained very busy in 2018-19 but there have been a number of developments which have helped to support high quality patient care. These include the following.
- The introduction and further development of direct to specialty referrals (streaming) where appropriate.
- The introduction of a GP-led Urgent Care Centre on the JR site to support patients with minor illness.
- We have increased consultant staffing into the late evening seven days a week and added an extra registrar (junior doctor) shift overnight.
- We have developed a cardiac chest pain pathway to improve flow and make early decisions within the ED (especially supporting safe

discharge).

- We have introduced rapid flu testing (bedside result within five minutes) to allow appropriate decision-making and isolation where needed.
- Building works have been undertaken within the JR ED to provide an 'ambulance receiving area' to support early assessment and intervention. This will be further supported with ED resuscitation area build which is currently underway.

Cancer waits

We consistently achieved the two week from GP referral cancer national standard every month through 2018-19. Another four of the standards were achieved for the majority of months across 2018-19. However, the 62 day standard for cancer treatment has provided our biggest challenge throughout the year.

Nationally there has been a decline in achievement of the 62 day standard. This 62 day standard has not been met by the NHS in England in any month since December 2015.

The most significantly challenged tumour sites remained in the urological, head and neck, gynaecological oncology, lung and lower gastrointestinal tumour site groups.

We have developed an action plan for each of the tumour sites and these will form a large part of our improvement plan for 2019-20. We aim to achieve the standard on 62 day cancer treatment by December 2019. The improvement plan will be overseen by a new Cancer Strategy Board which will be chaired by the Chief Executive.

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.

Waits for planned care

Referral to Treatment (RTT) Performance

OUH agreed as part of its plan for 2018-19 two key metrics with regards to the 18 week Referral to Treatment Time (RTT) national metrics. These were as follows:

- reduce the number of people waiting on incomplete elective care pathways for care at OUH to a waiting list size of 50,147 by March 2019;
- halve the number of patients waiting over 52 weeks by the end of March 2019.

On 31 March 2019, 49,706 people were waiting on incomplete elective pathways for care at OUH. This was a decrease of 441 pathways when compared to March 2019, meaning that the agreed target waiting list size of 50,147 was achieved.

The number of patients waiting over 52 weeks reduced from a peak of 203 during 2018-19 to eight by 31 March 2019.

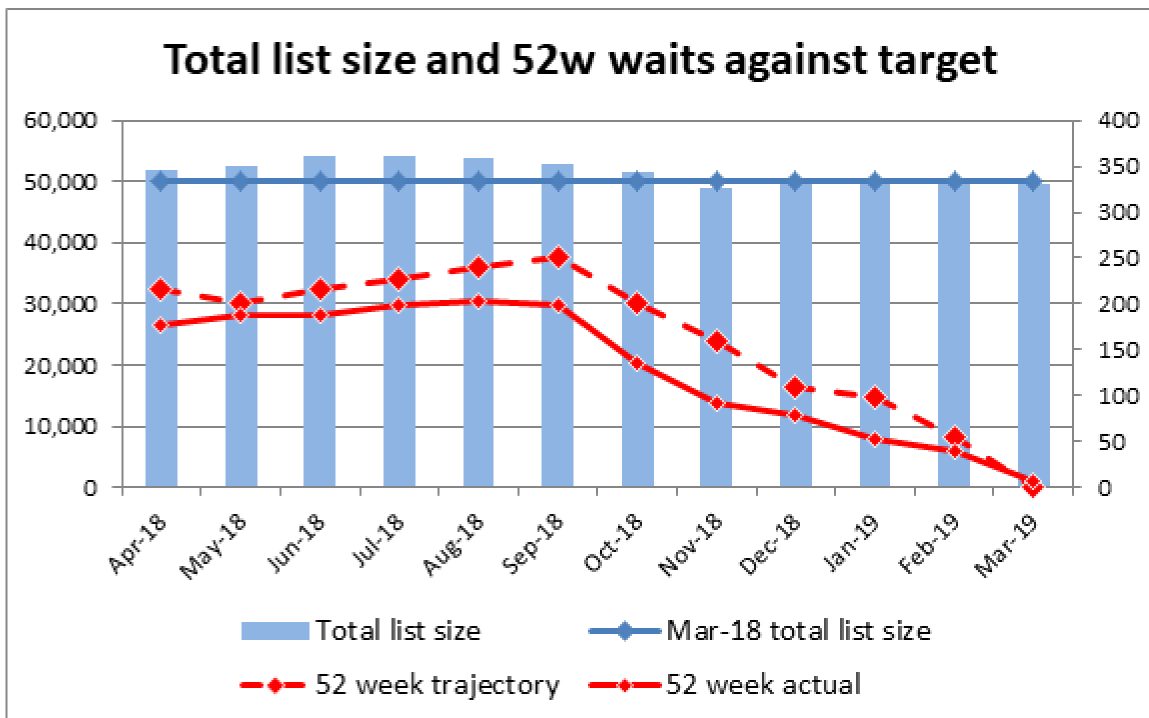


*Figure **5**: RTT incomplete waiting list size and over 52 week waits, OUH, from April 2018*

Statements
Annexe 1: Statements from commissioners, local Healthwatch organisation and Overview and Scrutiny Committees
Statement from Oxfordshire Clinical Commissioning Group (OCCG)

Jubilee House
5510 John Smith Drive
Oxford Business Park South
Cowley
Oxford
OX4 2LH

Telephone: 01865 336795
Email: oxon.gpc@nhs.net

14th May 2019
Dear Colleague,

NHS Oxfordshire Clinical Commissioning Group response to the Oxford University Hospitals NHS Foundation Trust's 2018/19 Quality Account

Oxfordshire Clinical Commissioning Group has reviewed the Oxford University Hospitals NHS Foundation Trust (OUHFT) Quality Account and believed that it provides accurate information. OUHFT is a large NHS organisation that provides many services. OCCG recognises that, as a result, this Account cannot fully provide the public with assurance about the Quality of NHS services provided by the OUHFT. This Quality Account highlights some of the challenges faced by the Trust in 2018/19 and describes areas of quality improvement work which have been undertaken.

The Trust reports a mixed picture in the delivery of 2017/18 quality priorities. The CCG acknowledges the hard work which has gone into the full achievement of half of the priorities. The CCG would like the Trust to consider how areas not fully achieved in 2018/19 could be taken forwards to build on the progress made. The CCG hopes that the adoption of NEWS2 early warning system will assist the Trust in detecting clinical deterioration and acting early, to improve care of patients.

The priorities for 2019/20 have been developed by the Trust in partnership with stakeholders, including patients, the public and the CCG.

This has been a challenging year for the system. The account acknowledges that challenge and that, as a result, NHS Constitution access targets have been missed. Long waits result in a poor experience for patients and OCCG would welcome a clearer statement from the Trust on how it is planning to address access issues in order to minimise the impact on patients.

The Trust is to be commended on its work to reduce the number of patients waiting over 52 weeks. The Trust has put in place a harm review process to understand whether patients are coming to harm as a result of waiting. While the need for the harm review process was unfortunate the process itself has been a positive one, with good collaborative working between the Trust, the CCG and NHSI. The process has led to improvements in patient pathways and has provided a level of assurance.

One area which has been a particular challenge this year is Gynaecology. The Trust has ensured that patients who have been waiting for over a year have now been treated. The temporary suspension of some Gynae-oncology surgery means that some patients have had to travel to other hospitals to be treated.

The number of Never Events at the Trust has continued to present a challenge in 2018/19.
The Trust has given these avoidable patient safety incidents a high priority. It is challenging to learn from and prevent these incidents and to ensure that changes are made across the Trust, not just in the areas where the Never Events have occurred. The Trust's very positive campaign on positive patient identification demonstrates how learning from these incidents can be spread out across a large organisation. Many of the contributory factors in these incidents relate to culture and individual behaviours. The Trust has a programme of work ensuring Local and National Safety Standards for Invasive procedures (LocSSIPs and NatSSIPs) are in place. It is important to recognise that even when the correct policies and procedures are in place human beings do not always follow them. For this reason, OCCG welcomes the Trust's plan to make this a focus of the Human Factors training in the coming year.

The CCG is pleased that the Trust continues to perform very well in SHMI and HSMR measures of mortality.

The impact for patients of the Trust's global digital exemplar status has yet to be demonstrated. This year we have seen a small improvement in the Trust's electronic communication with primary care and with patients. The electronic endorsement of test results continues to present a patient safety challenge. The solution to this issue will be a combination of the right technology with a culture which supports and promotes its consistent use for the benefit of patients.

Recruitment and retention of a highly skilled and motivated workforce is perhaps the greatest challenge facing health care. In Oxfordshire this is particularly challenging. OCCG welcomes the Trust's focus on this area.

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. The Oxfordshire system continues to face significant challenges. It is essential that partners work together to deliver integrated health and social care and that quality and safety remains central. This year there have been some improvements in partnership working – an achievement recognised by the CQC. We believe there is still much to be gained from further integration and we look forward to working closely with the Trust in 2019/20.

Yours sincerely

Louise Patten
Chief Executive

NHS England Specialised Commissioning statement on Oxford University Hospitals NHS Foundation Trust 2018-19 Quality Accounts

NHS England (South)
Specialised Commissioning
60 Caversham Road
Reading
Berkshire
RG1 7EB

Email address: england.speccomm-south@nhs.net

10 May 2019

Dear Clare

Thank you for sharing the Oxford University Hospitals NHS Foundation Trust (OUH) Quality Account with NHS England as the Specialised Commissioner for the Trust. This quality account provides a clear picture of the quality challenges the Trust is addressing and the improvements that have been made during the year.

The initiation of a robust clinical harm review process, which commendably has also attempted to capture psychosocial harm, has been welcomed alongside the considerable achievement in reducing the number of patients waiting over 52 weeks for treatment.

The number, themes and frequency of never events encountered remain a top safety concern. The fact that reducing never events is seen as a top priority for the coming year will give further impetus to the on-going programmes and training focussing on applying the learning from these cases. Correspondingly the continuing work to identify, investigate and respond appropriately to serious incidents is noted.

While 62 day waiting times is seen as the “biggest (cancer) challenge” and there is a key focus on gynaecology services elsewhere perhaps a specific mention could have been made to gynaecology oncology services which has seen some specific challenges and the formation of a taskforce group.

The focus on partnership working under the clinical effectiveness banner is welcomed, however, this could also have explored initiatives around effective team working. As a Tertiary referral centre for many specialities the effectiveness of communication within teams and across teams in other hospitals and for patients with complex care needs across more than one specialty is key to patient outcomes both in timely and appropriate referral and in follow-up. Maybe some of this important work could also have been highlighted.

Participation, follow-up and actions resulting from Peer Reviews, in particular Adult and Children’s Major Trauma Centre, Paediatric Intensive Care and Hepatitis C are noted. Collaboration around understanding and responding to services appearing on Specialised Services Quality Dashboards and in the Quality Surveillance Information System annual declaration will be developed further in 2019/20 and may merit mention in future Quality Accounts.

NHS England Specialised Commissioning endorses this Quality Account and looks forward to building upon the collaborative working arrangements already established in the coming year in order that improvements to the quality of care will continue for patients using OUH specialised services.

Yours sincerely

Wendy Cotterell
Director of Nursing – Specialised Commissioning: NHS England South East and South West Regions

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 2018/19

Thank you for sharing the Oxford University Hospitals Foundation Trust (OUHFT) draft Quality Account with the Oxfordshire Joint Health Overview and Scrutiny Committee (HOSC) for comment. The committee were pleased to receive a presentation of an early view of progress against OUHFT's 2018-19 quality priorities and the emerging priorities for 2019-20 at its meeting on 4th April 2018.

The committee is particularly pleased to note the number of awards that OUHFT have achieved over the 2018-19 period and this is testament to the Trust's eminence. Patient experience is one of the issues in which HOSC takes a keen interest and we are therefore pleased to see that 95% of patients report that they are likely or very likely to recommend OUHFT to others.

HOSC takes a keen interest also in the view and experience of staff; who are the critical interface between the Trust and its patients. Workforce sustainability is the issue which HOSC hears most about for delivering good health and care services in Oxfordshire and are therefore pleased to see that staff satisfaction at OUHFT is good. Despite this, there appears to be a disparity between the proportion of staff recommending the Trust as a place 'to be treated' at 74%, compared to those recommending it as 'a place to work' at 57%. We therefore urge the Trust's curiosity and action around this. It would be helpful for the Trust to understand why staff levels of recommendations with the Trust 'as a place to work' has dropped from 61% since 2016/17, has remained static at 57% for the last two years and is lower than the national average (63%).

With regards to the achievement of priorities for 2018-19, the committee is reassured to understand that where a priority was partially or not achieved, that work will continue to fully achieve the priorities that were set. We note the achievement of actions to improve the early identification of sepsis and encourage you to continue striving to improve the administering of antibiotics within an hour from 74% to meet the identified 90% target.

Similarly, the committee is pleased to note achievement of a priority of 'right first time' patient identification and it encourages continued vigilance in this area to ensure patient safety and identity are protected at all times.

The committee were concerned to learn of the high number of 'never events' which have occurred at OUHFT during 2018/19 and are encouraged to see there is a strong focus on this proposed for 2019/20. The responsibility of the Trust in this area is crucial and we are pleased to note how seriously never events are being managed and would welcome closer HOSC scrutiny of the 'Never Event Improvement Plan' to understand the issues and plans to tackle the issues moving forward.

HOSC is very supportive of the quality priorities identified for 2019/20; particularly the work to prevent deterioration of patients, to improve the care of those with mental health issues and vitally; to reduce still births. We hope that on this last point, the work to address the Secretary of State and Independent Reconfiguration Panel (IRP) on the closure of obstetric services at the Horton General Hospital features heavily in the plans to ensure women and their babies get the right monitoring and care at the Horton to reduce still births.

During the 2018/19 year, the issue of suspension of gynaecology outpatient appointments at the JR came to HOSC's attention. The workforce issues around Oxfordshire are well rehearsed as previously mentioned so HOSC is familiar with the issues and some of the work done to ensure staffing levels are maintained appropriately. However, we would urge the Trust to take a more proactive approach with the management of such situations in future to avoid the need for a complete suspension of services in Oxfordshire. We encourage you to work with Trusts over the Oxfordshire boarder to manage patient flow more effectively to improve patient pathways across the county and avoid unnecessary delays in both diagnosis and treatment.

In addition to these points discussed at the HOSC meeting on the 4th of April, I would like to urge the Trust to prioritise quality improvements in the areas of Emergency Department (ED). The committee recognises there have been improvements in A&E performance, but we encourage a greater and more integrated focus to reduce both patient demand and flow through A&E.

This Quality Account is a valuable tool in helping the public to understand the Trust's performance and priorities for improving the quality of local services. The committee looks forward to seeing how the priorities identified through this process develop through the 2019/20 financial year and would welcome further discussion at a future HOSC meeting about the progress being made.

Yours Sincerely

Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

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:

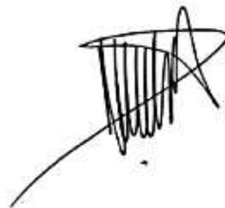
- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018-19 and supporting guidance detailed requirements for quality reports 2018-19.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2018 to May 2019
    - papers relating to Quality reported to the Board over the period April 2018 to May 2019
    - feedback from commissioners dated 14 May 2019 (Oxfordshire Clinical Commissioning Group), 10 May 2019 (NHS England Specialised Commissioning)
    - feedback from Overview and Scrutiny Committee dated 14 May 2019
    - the Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2018
    - the (latest) national and local patient survey dated June 2018 and March 2019 respectively
    - the (latest) national and local staff survey September to November 2018
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 17 April 2019

- CQC inspection report dated January 2019 (System-wide review).

- 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



Sir Jonathan Montgomery	Dr Bruno Holthof
Chair	Chief Executive
22 May 2019	22 May 2019

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 to perform an independent assurance engagement in respect of Oxford University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

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 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance for Quality Reports 2018/19; 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 and supporting guidance and the six dimensions of data quality set out in the Detailed Requirements for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 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:

- Board minutes for the period April 2018 to May 2019;
- Papers relating to Quality reported to the Board over the period April 2018 to May 2019;
- Feedback from Commissioners, dated 14 May 2019 (Oxfordshire Clinical Commissioning Group), dated 10 May 2019 (NHS England Specialised Commissioning);

- Feedback from Overview and Scrutiny Committee, dated 14 May 2019;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2018;
- The (latest) national and local patient survey dated June 2018 and March 2019 respectively;
- The (latest) national and local staff survey September to November 2018;
- The Head of Internal Audit's annual opinion over the trust's control environment, dated 17 April 2019;
- CQC inspection report dated January 2019 (System-wide review).

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, 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 2019, to enable the Council of Governors to demonstrate that it has 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:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- 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 to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

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 impact 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 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.

Basis for modified conclusion

We identified errors in our detailed testing:

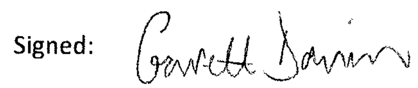
- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; We identified three A&E attendances which contained data quality accuracy errors from a sample of 25 regarding admission and departure times. One of these errors resulted in the patient being misclassified as a non-breach.

As a result of these issues, we are unable to confirm that the above indicator included in the Quality Report for the year ended 31 March 2019 has been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and six dimensions of data quality set out in the Guidance.

Conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for modified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's Detailed Requirements for External Assurance for Quality Reports 2018/19; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Signed: 

Gareth Davies

Partner, for and on behalf of Mazars LLP

Date: 22 May 2019

Chartered Accountants and Statutory Auditor
Tower Bridge House
St Katharine's Way
London
E1W 1DD

FINANCIAL STATEMENTS AND NOTES

FINANCIAL STATEMENTS

These accounts cover the 12 months from 1 April 2018 to 31 March 2019 and have been prepared by Oxford University Hospitals NHS Foundation Trust 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

22 May 2019

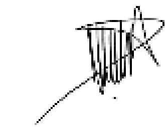
Oxford University Hospitals NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

Oxford University Hospitals NHS Foundation Trust

These accounts, for the year ended 31 March 2019, 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 **22 May 2019**

Statement of Comprehensive Income

	Note	2018-19 £000	2017-18 (Restated) £000
Operating income from patient care activities	3	887,633	863,377
Other operating income	4	185,915	162,590
Operating expenses	7, 9	(1,079,933)	(1,002,649)
Operating surplus/(deficit) from continuing operations		**(6,385)**	**23,318**
Finance costs			
Finance income	12	407	145
Finance expense	13	(22,688)	(21,017)
PDC dividends payable		(6,805)	(6,552)
Net finance costs		**(29,086)**	**(27,424)**
Other gains/(losses)	14	31,868	3,412
Share of profit of associates/joint arrangements	21	-	-
Gains/(losses) arising from transfers by absorption	46	-	-
Corporation tax expense		-	-
Surplus/(deficit) for the year from continuing operations		**(3,603)**	**(694)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	15	-	-
Surplus/(deficit) for the year		**(3,603)**	**(694)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(24,455)	(534)
Revaluations	19	4,245	11,145
Share of comprehensive income from associates and joint ventures	21	-	-
Fair value gains/(losses) on equity instruments designated at fair value through OCI	22	113	-
Other recognised gains and losses		-	-
Re-measurements of the net defined benefit pension scheme liability/asset	38	-	-
Other reserve movements		-	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	14	-	-
Foreign exchange gains/(losses) recognised directly in OCI		-	-
Total comprehensive income/(expense) for the period		**(23,700)**	**9,917**
Supplementary Disclosure Note: Adjusted financial performance (control total basis):			
Surplus/(deficit) for the period		**(3,603)**	**(694)**
Remove impact of consolidating NHS charitable fund		**-**	**-**
Remove net impairments not scoring to the Departmental expenditure limit	8	**21,224**	**(13,299)**
Remove (gains)/losses on transfers by absorption		**-**	**-**
Remove I&E impact of capital grants and donations		**1,313**	**2,427**
Remove I&E impact of asset disposals*			
Prior period adjustments	1.29	**18,390**	**4,242**
Remove non-cash element of on-SoFP pension costs		**-**	**-**
CQUIN risk reserve adjustment (2017-18 only)		**-**	**(2,047)**
Remove 2016-17 post audit STF reallocation (2017-18 only)		**-**	**-**
Adjusted financial performance surplus/(deficit)		**37,324**	**(9,371)**

* Note that gains/(losses) on asset disposal are not excluded from the control total calculation in 2017-18 or 2018-19

Statement of Financial Position

	Note	31 March 2019	31 March 2018 (restated)	31 March 2017 (restated)
		£000	£000	£000
Non-current assets				
Intangible assets	16	10,670	7,285	8,763
Property, plant and equipment	17	513,188	566,345	536,492
Investment property	20	18,135	12,785	12,265
Investments in associates and joint ventures	21	-	-	-
Other investments / financial assets	22	15,510	3,600	295
Receivables	25	6,076	6,134	6,089
Other assets	26			
Total non-current assets		**563,579**	**596,149**	**563,904**
Current assets				
Inventories	24	23,890	22,664	19,969
Receivables	25	64,048	64,868	53,988
Other investments / financial assets	22	-	-	-
Other assets	26	181	503	-
Non-current assets held for sale / assets in disposal groups	27	-	-	-
Cash and cash equivalents	28	53,001	39,910	41,627
Total current assets		**141,120**	**127,945**	**115,584**
Current liabilities				
Trade and other payables	29	(115,470)	(105,201)	(91,501)
Borrowings	32	(3,356)	(11,973)	(11,635)
Other financial liabilities	30	-	-	-
Provisions	34	(3,702)	(1,446)	(4,389)
Other liabilities	31	(4,537)	(4,625)	(4,924)
Liabilities in disposal groups	27	-	-	-
Total current liabilities		**(127,065)**	**(123,245)**	**(112,449)**
Total assets less current liabilities		**577,634**	**600,849**	**567,0390**
Non-current liabilities				
Trade and other payables	29	-	-	-
Borrowings	32	(251,599)	(255,105)	(242,099)
Other financial liabilities	30	-	-	-
Provisions	34	(2,674)	(2,492)	(2,609)
Other liabilities	31	(3,146)	(3,237)	(3,328)
Total non-current liabilities		**(257,419)**	**(260,834)**	**(248,036)**
Total assets employed		**320,215**	**340,015**	**319,003**
Financed by				
Public dividend capital		227,037	223,045	211,950
Revaluation reserve		104,980	125,552	115,172
Financial assets reserve		113	--	-
Other reserves		1,743	1,743	1,743
Merger reserve		-	-	-
Income and expenditure reserve		(13,658)	(10,325)	(9,862)
Total taxpayers' equity		**320,215**	**340,015**	**319,003**

The notes on pages 265 to 331 form part of these accounts.

Name Dr Bruno Holthof

Position Chief Executive

Date 22 May 2019

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve* £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 – brought forward	**223,045**	**125,552**	**-**	**1,743**	**(10,325)**	**340,015**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	(92)	(92)
Surplus/(deficit) for the year	-	-	-	-	(3,603)	(3,603)
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	-	(24,455)	-	-	-	(24,455)
Revaluations	-	4,245	-	-	-	4,245
Transfer to retained earnings on disposal of assets	-	(362)	-	-	362	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	-	-
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	113	-	-	113
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	-	-	-	-	-	-
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	3,992	-	-	-	-	3,992
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 2019	227,037	104,980	**113**	**1,743**	**(13,658)**	**320,215**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	211,950	115,172	-	**1,743**	**(32,494)**	**296,371**
Prior period adjustment	-	-	-	-	**22,632**	**22,632**
Taxpayers' equity at 1 April 2017 - restated	211,950	115,172	-	**1,743**	**(9,862)**	**319,003**
Surplus/(deficit) for the year	-	-	-	-	**(694)**	**(694)**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic	-	-	-	-	-	-
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	-	-	-	-	-	-
Remeasurements 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' equity at 31 March 2018	223,045	125,552	-	**1,743**	**(10,325)**	**340,015**

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 organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care 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.

Financial assets reserve

The reserve comprises the changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

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.

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Statement of Cash Flows

	Note	2018/19 £000	2017/18 (restated) £000
Cash flows from operating activities			
Operating surplus/(deficit)		(6,385)	23,318
Non-cash income and expense:			
Depreciation and amortisation	7.1	30,509	32,425
Net impairments	8	21,227	(13,269)
Income recognised in respect of capital donations	4	(1,081)	(251)
Amortisation of PFI deferred credit		(86)	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase)/decrease in receivables and other assets		1,111	(13,662))
(Increase)/decrease in inventories		(1,226))	(2,695)
Increase/(decrease) in payables and other liabilities		8,786	15,254
Increase/(decrease) in provisions		2,435	(3,066)
Tax (paid)/received		-	-
Operating cash flows movement of discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated from/(used in) operating activities		**55,290**	**38,054**
Cash flows from investing activities			
Interest received		407	145
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(6,416))	(2,470)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(17,156)	(17,852)
Sales of property, plant, equipment and investment property		23,504	350
Receipt of cash donations to purchase capital assets		517	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions / disposals of subsidiaries		(4,788)	(655)
Net cash generated from/(used in) investing activities		**(3,932)**	**(20,482)**
Cash flows from financing activities			
Public dividend capital received		3,992	11,095
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		(790)	(1,405)
Movement on other loans		-	7,500
Other capital receipts		-	-
Capital element of finance lease rental payments		(295)	(832)
Capital element of PFI, LIFT and other service concession payments		(11,134)	(9,979)
Interest on loans		(332)	(57)
Other interest		(52)	-
Interest paid on finance lease liabilities		(61)	(79)
Interest paid on PFI, LIFT and other service concession obligations		(22,201)	(20,815)
PDC dividend paid / (refunded)		(7,394)	(4,717)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from/(used in) financing activities		**(38,267)**	**(19,289)**
Increase/(decrease) in cash and cash equivalents		**13,091**	**(1,717)**
Cash and cash equivalents at 1 April – brought forward		**39,910**	**41,627**
Prior period adjustments		**-**	**-**
Cash and cash equivalents at 1 April – restated		**39,910**	**41,627**
Cash and cash equivalents transferred under absorption accounting	46	-	-
Unrealised gains/(losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	28.1	**53,001**	**39,910**

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 2018-19 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 1.2 Going Concern

The Trust is forecasting a financial surplus in delivering its services in 2019-20 supported as in 2018-19 by material one-off items. 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 and Social Care (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 and Social Care Group Accounting Manual (GAM).

Note 1.3 Interests in other entities

In future accounting periods group accounts will consolidate a number of entities, of which, OUH Commercial Partners Limited and OUH Ventures LLP have taken the exemption in Section 479A of the Companies Act 2006 (the Act) from the requirement in the Act for their individual accounts to be audited.

In order for the audit exemption to be taken, the Trust has guaranteed all outstanding liabilities of those subsidiary entities until those liabilities are satisfied in full. None of the entities are yet to commence trading so are held at cost to the Trust. It is anticipated that the Trust will present group consolidated financial statements in 2019-20.

Subsidiaries

Subsidiaries are entities over which the Trust has the power to exercise control, these entities are consolidated. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position.

Appropriate adjustments are made on consolidation where the subsidiary’s accounting policies are not aligned with the Trust or where the subsidiary’s accounting date is not coterminous.

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.

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

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018-19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for healthcare services. A performance obligation relating to delivery of a spell of healthcare is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a

contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives a proportion of income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. Any actual activity that satisfies the readmission criteria is charged at 81.5% of National Tariff. The actual impact is reflected in the contract baseline and thus in the transaction price.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner and submits evidence to demonstrate achievement of quarterly milestones. Where it has been agreed that a CQUIN scheme has been achieved, the actual impact is reflected in the contract baseline. Where no agreement has been reached, particularly for schemes undertaken in Q4, the Trust reflects this in the transaction price and derecognises any relevant portion of income associated with any risks to achievement of the outstanding CQUIN.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows.

- As per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations as part of a contract that has an original

expected duration of one year or less.

- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. The method adopted to assess progress towards the complete satisfaction of a performance obligation is to review at a contract level which performance obligations are outstanding.

NHS injury cost recovery scheme

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, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 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 1.4.3 Other income

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 in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

The value of the benefit received when the Trust accesses funds from the Government’s apprenticeship service is recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

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 the 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 scheme is accounted for as though it is a defined contribution scheme.

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 Grants payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Trust recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

Note 1.8 Property, plant and equipment

Note 1.8.1 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 a 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.

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 lives.

Note 1.8.2 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. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either frontline services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows.

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

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 and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 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' cease 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.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

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 are 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.

At each financial year end, the Trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.8.3 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 abandoned 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.4 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 1.8.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

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 cost.

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 accrual 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 operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator

Other assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, where these are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. When the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Note 1.8.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below.

	Min life	**Max life**
	years	Years
Land	N/A	N/A
Buildings, excluding dwellings	10	66
Dwellings	14	35
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 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 1.9 Intangible assets

Note 1.9.1 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: it is recognised as an operating expense in the period in which it is incurred. Internally generated expenditure is capitalised if and only if all of the following can be demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its 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 1.9.2 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below.

	Min life years	**Max life** years
Information technology	3	8
Development expenditure	-	-
Websites	-	-
Software licences	3	8
Licences & trademarks	-	-
Patents	3	3
Other (purchased)	-	-
Goodwill	-	-

Note 1.10 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 1.11 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 1.12 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 three 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 1.13 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO_2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO_2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO_2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO_2 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 1.14 Financial assets and financial liabilities

Note 1.14.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office for National Statistics.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.14.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through profit and loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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 below.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through profit and loss.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely

payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On de-recognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has irrevocably elected to measure the following equity instruments at fair value through other comprehensive income.

Equity investment in one private company obtained by the Trust in recognition of its part in establishing the company – this is held as a strategic asset and the Trust is not currently able to liquidise the asset.

Financial assets and financial liabilities at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined by reference to past experience within separate categories of debt, classified by level of risk. Judgement is also applied, where the expectation of future credit losses is anticipated to impact upon the recoverable amount of the asset. The age of a receivable is taken into account and the more overdue a receivable becomes, the higher the value of expected credit loss.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding

NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.14.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.15 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 1.15.1 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 1.15.2 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 1.16 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.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date.

- A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including five years from Statement of Financial Position date.
- A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over five years up to and including ten years from the Statement of Financial Position date.
- A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over ten years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
- All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to 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 NHS Resolution on behalf of the Trust is disclosed at note 34 but is not recognised in the 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 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 1.17 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 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, 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 1.18 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 1.19 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 1.20 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 1.21 Foreign exchange

The functional and presentational currency of the Trust is 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 assets 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.

Note 1.22 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the 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 1.23 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 1.24 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 1.25 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the Trust from another public 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.

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 / 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.

Note 1.26 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's 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 Statement of Comprehensive Income are determined as per the estimation paragraph in section 1.26.1. 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 1.15.

Capitalisation of staff costs

The Trust makes judgements about which of its staff costs are related to capital improvements that meet the definitions in 1.8. These judgements are based on timesheets and the Trust's understanding of what is being achieved by the individuals carrying out the work.

Note 1.26.1 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.

The Trust has used valuations carried out in January 2019 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 and Social Care. The valuation is taken as at 31 January 2019 as being a materially accurate estimate of the value as at 31 March 2019.

Assurance taken from buildings indices in the final quarter of the financial year, showed no material movement.

PFI buildings are valued net of VAT because of certain clauses within the PFI contracts.

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 ten 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 Department of Health and Social Care's financial model as required by the Department of Health and Social Care guidance. The models also provide estimates for interest payable and contingent rent as disclosed in Note 39. 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 39.

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 increases the expected credit loss 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 1.27 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018-19.

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

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. The Trust anticipates that most operating leases will be brought onto the Statement of Financial Position when they fall due for renewal. Transition in itself isn't expected to result in a significant change in accounting, due to IFRS 16 having 'grandfathering' arrangements. Operating lease expenditure in Note 11.2 is not material, the assets associated with this spend will be assessed under IFRS16 in detailed preparation work scheduled to take place during 2019-20 since the decision in November 2018 by the Financial Reporting Advisory Board to defer the implementation of IFRS 16 until the 2020-21 financial year. Some other government departments will still adopt IFRS 16 in 2019-20 as a result of their subsidiary companies needing to adopt IFRS 16, but this will not apply to the Department of Health and Social Care.

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 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Note 1.29 Prior period adjustment

On transition to IFRS15, the Trust examined its accrued and deferred income balances related to long term projects on an individual contract basis. Significant balances existed primarily in the area of Research and Development but also for some hosted bodies including the Oxford Academic Health Science Network (AHSN). The Trust discovered that its previously prudent approach to matching expenditure and income in aggregate meant that some balances were carried forward inappropriately.

The cumulative effect was that £18.4m of income should have been recognised in previous accounting periods. These balances have been removed from the Trust's accounts within the 2018-19 financial year. A prior period adjustment has been made to restate the comparatives as if this error had not occurred.

	Total effect of PPA	31 March 2018	31 March 2017*
	£000	£000	£000
Statement of Financial Position			
Current Assets - accrued income - balances removed	(1,173)	(905)	(268)
Current Liabilities - deferred income - balances removed	13,666	(361)	14,027
Non Current Liabilities - deferred income - balances removed	5,897	(2,976)	8,873
	18,390	(4,242)	22,632
Income and expenditure reserve - more/(less) net income			
Note 4 Other operating income			
Research and development (contract)	14,435	(2,992)	17,427
Other contract income	3,955	(1,250)	5,205
Total more/(less) net income	18,390	(4,242)	22,632

* Note that the effect on the earliest accounting period is cumulative from historical accounting periods

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 Foundation 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 2019 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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)

	£000	£000
Acute services		
Elective income	166,972	160,457
Non elective income	218,858	202,539
First outpatient income	55,408	52,929
Follow up outpatient income	77,542	76,623
A & E income	23,121	21,689
Other NHS clinical income	327,006	337,768
All services		
Private patient income	6,834	7,826
Additional non-tariff income	8,310	-
Other clinical income	3,582	3,546
Total income from activities	**887,633**	**863,377**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:

	2018-19	2017-18
	£000	£000
NHS England	409,167	414,669
Clinical commissioning groups	448,637	426,347
Department of Health and Social Care	8,310	-
Other NHS providers	-	-
NHS other	178	178
Local authorities	10,214	10,087
Non-NHS: private patients	6,834	7,826
Non-NHS: overseas patients (chargeable to patient)	1,459	1,298
Injury cost recovery scheme	2,123	2,248
Non NHS: other	711	724
Total income from activities	**887,633**	**863,377**
Of which:		
Related to continuing operations	887,633	863,377
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018-19	2017-18
	£000	£000
Income recognised this year	1,459	1,298
Cash payments received in-year	843	1,030
Amounts added to provision for impairment of receivables	71	-
Amounts written off in-year	91	162

Note 4 Other operating income

	2018-19 £000	2017-18 Restated £000
Other operating income from contracts with customers:		
Research and development (contract)	58,509	55,296
Education and training (excluding notional apprenticeship levy income)	47,104	47,080
Non-patient care services to other bodies	24,844	23,489
Provider sustainability / sustainability and transformation fund income (PSF / STF)	24,340	5,374
Income in respect of employee benefits accounted on a gross basis	9,950	9,288
Other contract income	17,036	17,895
Other non-contract operating income		
Research and development (non-contract)	-	-
Education and training - notional income from apprenticeship fund	-	-
Receipt of capital grants and donations	1,081	251
Charitable and other contributions to expenditure	500	1,391
Support from the Department of Health and Social Care for mergers	-	-
Rental revenue from finance leases	-	-
Rental revenue from operating leases	2,465	2,526
Amortisation of PFI deferred income / credits	86	-
Other non-contract income	-	-
Total other operating income	185,915	162,590
Of which:		
Related to continuing operations	185,915	162,590
Related to discontinued operations	-	-

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018-19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	3,084
The amount of revenue recognized in 2018-19 from performance obligations satisfied (or partially satisfied) in previous periods was not material	-

Note 5.2 Transaction price allocated to remaining performance obligations

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Due to the significant majority of contracts being annual, the Trust is not disclosing any further material transaction price allocated to remaining performance obligations.

Note 5.3 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.

	2018-19 £000	2017-18 £000
Income from services designated (or grandfathered) as commissioner requested services	879,340	854,253
Income from services not designated as commissioner requested services	8,293	9,124
Total	**887,633**	**863,377**

Note 5.4 Profits and losses on disposal of property, plant and equipment

Oxford University Hospitals currently owns Land and Buildings at the Churchill Hospital which are currently valued on a Modern Equivalent Asset Basis with an alternative site option used. The Trust has developed a Masterplan under which part of the Churchill site will become surplus. Part of this site identified in the Masterplan was sold to Oxford University in March 2019. In order to facilitate the movement of services a short term lease has been agreed with Oxford University in respect of those elements of the site in use by the Trust.

The gross disposal proceeds where £20.5m. The net book value was assessed as the proportion of the MEA that was disposed (Land, Building and External Works) and amounted to £3.045m.

Note 6 Fees and Charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018-19 £000	2017-18 £000
Income	11,777	12,606
Full cost	(7,992)	(9,380)
Surplus /(deficit)	**3,785**	**3,226**

Note that this relates to private patient income of £6.8m (2017-18 £7.8m), car parking income of £3.4m (2017-18 £3.5m) and overseas patient income of £1.5m (2017-18 £1.3m).

Note 7.1 Operating expenses

	2018-19	2017-18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	8,808	8,955
Purchase of healthcare from non NHS bodies and non-DHSC bodies	10,476	7,497
Purchase of social care		
Staff and executive directors costs	570,281	536,982
Remuneration of non-executive directors	154	166
Supplies and services – clinical (excluding drugs costs)	119,899	117,963
Supplies and services - general	7,856	8,084
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	115,795	121,185
Inventories written down	163	2
Consultancy costs	4,160	3,994
Establishment	10,632	9,313
Premises	29,291	28,548
Transport (including patient travel)	4,511	4,246
Depreciation on property, plant and equipment	27,521	28,464
Amortisation on intangible assets	2,988	3,961
Net impairments / (reverse impairments)	21,227	(13,269)
Movement in credit loss allowance: contract receivables / contract assets	(479)	-
Movement in credit loss allowance: all other receivables and investments	-	(556)
Increase/(decrease) in other provisions	-	-
Change in provisions discount rate(s)	(50)	33
Audit fees payable to the external auditor		
audit services- statutory audit	90	108
other auditor remuneration (external auditor only)	11	6
Internal audit costs	342	171
Clinical negligence	31,154	36,516
Legal fees	894	855
Insurance	23	381
Research and development	48,236	44,981
Education and training	8,420	7,419
Rentals under operating leases	1,057	823
Early retirements	-	-
Redundancy	639	155
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	39,189	34,665
Charges to operating expenditure for off-SoFP / LIFT schemes	-	-
Car parking & security	1,380	1,270
Hospitality	27	46
Losses, ex gratia & special payments	18	34
Grossing up consortium arrangements	-	-
Other services, e.g. external payroll	5,522	3,905
Other	9,698	5,746
Total	**1,079,933**	**1,002,649**
Of which:		
Related to continuing operations	1,079,933	1,002,649
Related to discontinued operations	-	-

Note 7.2 Other auditor remuneration

	2018-19	2017-18
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	11	6
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	-	-
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	**11**	**6**

Note 7.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial year 2018-19.

The limitation on auditors' liability for external audit work for the financial year 2017-18 was £2m.

Note 8 Impairment of assets

	2018-19	2017-18
	£000	£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	3	30
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	21,224	(13,299)
Other	-	-
Total net impairments charged to operating surplus / deficit	**21,227**	**(13,269)**
Impairments charged to the revaluation reserve	24,455	534
Total net impairments	**45,682**	**(12,735)**

There are three 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 January 2019 which results in impairments and reverse impairments
iii. changes in the overall footprint assessed by the trust as being its operational space requirement in the MEA.

Note 9 Employee benefits

	2018-19 Total £000	2017-18 Total £000
Salaries and wages	478,737	456,915
Social security costs	42,648	41,053
Apprenticeship levy	2,160	2,069
Employer's contributions to NHS pensions	51,150	48,438
Pension cost - other	11	4
Other post-employment benefits	-	-
Other employment benefits	-	-
Termination benefits	639	155
Temporary staff (including agency)	49,153	38,159
Total gross staff costs	**624,498**	**586,793**
Recoveries in respect of seconded staff		
Total staff costs	**624,498**	**586,793**
Of which		
Costs capitalised as part of assets	2,164	1,864
Temporary staff comprises		
Bank staff	31,107	26,719
Agency staff	18,046	11,440
	49,153	**38,159**

In 2017-18 agency staff included a £0.9m one-off rebate from HMRC in respect of a claim related to prior periods.

Note 9.1 Retirements due to ill-health

During 2018-19 there were 6 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £153k (£209k in 2017-18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social

Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

By 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 (<1%) in this scheme.

Note 11 Operating leases

Note 11.1 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.

	Total £000 2018-19	Total £000 2017-18
Operating lease revenue		
Minimum lease receipts	2,465	2,526
Contingent rent	-	-
Other	-	-
Total	2,465	2,526

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	1,155	2,223
- later than one year and not later than five years;	4,378	4,859
- later than five years.	17,245	22,547
Total	22,778	29,629

Note 11.2 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.

	2018-19 Total £000	2017-18 Total £000
Operating lease expense		
Minimum lease payments	1,057	823
Contingent rents	-	-
Less sublease payments received	-	-
Total	**1,057**	**823**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	1,056	134
- later than one year and not later than five years;	2,805	130
- later than five years.	-	-
Total	**3,861**	**264**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2018-19 £000	2017-18 £000
Interest on bank accounts	400	145
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	7	-
Total	**407**	**145**

Note 13.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018-19	2017-18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	15	55
Other loans	355	62
Overdrafts	-	-
Finance leases	62	79
Interest on late payment of commercial debt	52	-
Main finance costs on PFI and LIFT schemes obligations	14,326	14,208
Contingent finance costs on PFI and LIFT scheme obligations	7,875	6,607
Total interest expense	**22,685**	**21,011**
Unwinding of discount on provisions	3	6
Other finance costs	-	-
Total	**22,688**	**21,017**

Note 13.2 The late payment of commercial debts (interest) Act 1998

	2018-19	2017-18
	£000	£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	52	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 14 Other gains/ (losses)

	2018-19	2017-18
	£000	£000
Gains on disposal of assets	20,051	350
Loss on disposal of assets	(5)	(109)
Total gains/(losses) on disposal of assets	20,046	241
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	4,812	520
Fair value gains / (losses) on financial assets / investments	7,010	2,651
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	-	-
Total other gains / (losses)	**31,868**	**3,412**

The gains and losses on disposal all relate to disposal of property, plant and equipment. No investments were disposed of during the financial year.

Note 15 Discontinued operations

The Trust does not have any operations that are classified as discontinued in the year ended 31 March 2019.

Note 16.1 Intangible assets – 2018-19

	Software licences £000	Patents £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	**3,080**	**9**	**22,697**	**883**	**26,669**
Transfers by absorption	-	-	-	-	**-**
Additions	1,510	-	3,078	1,828	**6,416**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	(53)	-	148	(148)	**(53)**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	(474)	-	(26)	-	**(500)**
Valuation / Gross cost at 31 March 2019	**4,063**	**9**	**25,897**	**2,563**	**32,532**
Amortisation at 1 April 2018 - brought forward	**1,6730**	**9**	**17,702**	**-**	**19,384**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	541	-	2,447	-	**2,988**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	(10)	-	-	-	**(10)**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	(474)	-	(26)	-	**(500)**
Amortisation at 31 March 2019	**1,730**	**9**	**20,123**	**-**	**21,862**
Net book value at 31 March 2019	**2,333**	**-**	**5,774**	**2,563**	**10,670**
Net book value at 1 April 2018	**1,407**	**-**	**4,995**	**883**	**7,285**

Note 16.2 Intangible assets – 2017-18

	Software licences £000	Patents £000	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2017 – as previously stated	**6,730**	**9**	**20,997**	**728**	**28,464**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**
Valuation/gross cost at 1 April 2017 – restated	**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 / de-recognition	(4,278)	-	-	-	**(4,278)**
Valuation/gross cost at 31 March 2018	**3,080**	**9**	**22,697**	**883**	**26,669**
Amortisation at 1 April 2017 - as previously stated	**5,620**	**9**	**14,072**	**-**	**19,701**
Prior period adjustments	**-**	**-**	**-**	**-**	**-**
Amortisation at 1 April 2017 – restated	**5,620**	**9**	**14,072**	**-**	**19,701**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	331	-	3,630	-	**3,961**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	**-**
Disposals / de-recognition	(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 17.1 Property, plant and equipment – 2018-19

	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 2018 - brought forward	**58,831**	**437,703**	**624**	**9,687**	**204,489**	**654**	**12,573**	**3,832**	**728,393**
Additions	-	7,223	-	2,186	6,451	53	3,595	251	**19,759**
Impairments	(16,072)	(53,220)	-	-	-	-	-	-	**(69,292)**
Reversals of impairments	975	10,986	-	-	-	-	-	-	**11,961**
Revaluations	-	3,474	231	-	-	-	-	-	**3,705**
Reclassifications	(538)	1,656	-	(4,138)	2,469	-	61	5	**(485)**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	(1,052)	(2,418)	-	(3)	(480)	-	(1,876)	-	**(5,829)**
Valuation/gross cost at 31 March 2019	**42,144**	**405,404**	**855**	**7,732**	**212,929**	**707**	**14,353**	**4,008**	**688,212**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**-**	**-**	**150,592**	**597**	**7,595**	**3,264**	**162,048**
Provided during the year	-	14,554	31	-	10,698	22	1,993	223	**27,521**
Impairments	-	(11,652)	-	3	-	-	-	-	**(11,649)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(516)	(24)	-	-	-	-	-	**(540)**
Reclassifications	-	-	-	-	-	-	10	-	**10**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	(12)	-	(3)	(475)	-	(1,876)	-	**(2,366)**
Accumulated depreciation at 31 March 2019	**-**	**2,374**	**7**	**-**	**160,815**	**619**	**7,772**	**3,487**	**175,024**
Net book value at 31 March 2019	**42,144**	**403,030**	**848**	**7,732**	**52,114**	**88**	**6,631**	**601**	**513,188**
Net book value at 1 April 2018	**58,831**	**437,703**	**624**	**9,687**	**53,897**	**57**	**4,978**	**568**	**566,345**

Note 17.2 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 – as previously stated	**56,111**	**424,091**	**616**	**4,541**	**187,493**	**654**	**17,745**	**3,668**	**694,919**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 1 April 2017 – restated	**56,111**	**424,091**	**616**	**4,541**	**187,493**	**654**	**17,745**	**3,668**	**694,919**
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 / de-recognition	-	-	-	(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 – as previously stated	**-**	**-**	**-**	**-**	**143,281**	**575**	**11,516**	**3,055**	**158,427**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2017 – restated	**-**	**-**	**-**	**-**	**143,281**	**575**	**11,516**	**3,055**	**158,427**
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 / de-recognition	-	-	-	(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 17.3 Property, plant and equipment financing – 2018-19

	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 2019									
Owned	37,626	171,050	848	7,732	27,492	88	6,607	548	**251,991**
Finance leased	-	-	-	-	1,451	-	-	-	**1,451**
On-SoFP PFI contracts and other service concession arrangements	-	190,543	-	-	21,699	-	-	-	**212,242**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	4,518	41,437	-	-	1,472	-	24	53	**47,504**
NBV total at 31 March 2019	**42,144**	**403,030**	**848**	**7,732**	**52,114**	**88**	**6,631**	**601**	**513,188**

Note 17.4 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 18 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 19 Revaluations of property, plant and equipment

The Trust's land and buildings were revalued as at 31 January 2019 by the District Valuer. The Trust has obtained evidence that the valuation is materially accurate for 31 March 2019 by reference to buildings indices which have not changed significantly. The full movements as a result of revaluations are disclosed at note 17.

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 20.1 Investment Property

	2018-19	2017-18
	£000	£000
Carrying value at 1 April – brought forward	**12,785**	**12,265**
Prior period adjustments	-	-
Carrying value at 1 April - restated	**12,785**	**12,265**
Transfers by absorption	-	-
Acquisitions in year	-	-
Movement in fair value	4,812	520
Reclassifications to/from PPE	538	-
Transfers to/from assets held for sale	-	-
Disposals	-	-
Carrying value at 31 March	**18,135**	**12,785**

Note 20.2 Investment property income and expenses

	2018-19 £000	2017-18 £000
Direct operating expense arising from investment property which generated rental income in the period	(27)	(17)
Direct operating expense arising from investment property which did not generate rental income in the period	-	(3)
Total investment property expenses	**(27)**	**(20)**
Investment property income	1,011	825

Note 21 Investments in associates (and joint ventures)

The Trust is in the process of establishing new joint venture entities, for more information please see note 22.

Note 22 Other investments / financial assets (non-current)

	2018-19 £000	2017-18 £000
Carrying value at 1 April – brought forward	**3,600**	**295**
Prior period adjustment	-	-
Carrying value at 1 April - restated	**3,600**	**295**
Impact of implementing IFRS 9 on 1 April 2018	-	-
Transfers by absorption	-	-
Acquisitions in year	4,787	654
Movement in fair value	7,010	2,651
Movement in fair value through other comprehensive income	113	-
Net impairment	-	-
Transfers to / from assets held for sale and assets in disposal groups	-	-
Amortisation at the effective interest rate	-	-
Current portion of loans receivable transferred to current financial assets	-	-
Disposals	-	-
Carrying value at 31 March	**15,510**	**3,600**

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 £10.1m. During the year, one of the spin-out companies listed on the AIM, the valuation substantially increased as a result, the Trust is not currently able to liquidise the asset and has irrevocably designated it as held at fair value through other comprehensive income.

Other investments also include the Trust's start-up costs of £5.4m 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 commence trading so are held at cost to the Trust. It is anticipated that the Trust will present group consolidated financial statements in 2019-20.

Note 22.1 Other investments / financial assets (current)

The Trust does not have any other investments or financial assets that would be classified as current.

Note 23 Disclosure of interests in other entities

The Trust is in the process of establishing new joint venture entities, for more information please see note 22.

Note 24 Inventories	**31 March 2019**	**31 March 2018**
	£000	**£000**
Drugs	4,877	3,865
Work In progress	-	-
Consumables	17,590	17,508
Energy	319	183
Other	1,104	1,108
Total inventories	**23,890**	**22,664**
Of which:		
Held at fair value less costs to sell	**-**	**-**

Inventories recognised in expenses for the year were £74,988k (2017/18: £73,842k). Write-down of inventories recognised as expenses for the year were £163k (2017/18: £2k).

Note 25.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 restated £000
Current		
Contract receivables *	60,304	
Contract assets*	-	
Trade receivables*		48,327
Capital receivables	-	-
Accrued income *		12,458
Allowance for impaired contract receivables / assets*	(6,833)	
Allowance for other impaired receivables	-	(7,320)
Deposits and advances	-	-
Prepayments (non-PFI)	7,038	4,800
PFI prepayments: Capital contributions	67	67
PFI Lifecycle replacements	402	402
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	3	-
VAT receivable	2,841	2,813
Corporation and other tax receivable	-	-
Other receivables	226	3,321
Total current trade and other receivables	**64,048**	**64,868**
Non-current		
Contract receivables *	5,001	
Contract assets*	-	
Trade receivables*		-
Capital receivables	-	-
Accrued income *		80
Allowance for impaired contract receivables / assets*	-	
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	5	57
PFI prepayments :Capital contributions	1,070	1,137
PFI prepayments: Lifecycle replacements	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	-	4,860
Total non-current trade and other receivables	**6,076**	**6,134**
Of which receivables from NHS and DHSC group bodies:		
Current	38,299	38,069
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS

15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 25.2 Allowances for credit losses – 2018-19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April 2018 – brought forward		**7,320**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	7,412	(7,320)
Transfers by absorption	-	-
New allowances arising	3,672	-
Changes in existing allowances	-	-
Reversals of allowances	(4,151)	-
Utilisation of allowances (write offs)	(100)	-
Changes arising following modification of cotractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 March 2019	**6,833**	**-**

Note 25.3 Allowances for credit losses – 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All other receivables £000
Allowances as at 1 Apr 2017 - as previously stated	**8,093**
Prior period adjustments	
Allowances as at 1 Apr 2017 – restated	**8,093**
Transfers by absorption	-
Increase/(decrease) in provision	(556)
Amounts utilized	(217)
Unused amounts reversed	-
Allowances as at 31 Mar 2018	7,320

Note 25.4 Exposure to 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 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Note 26 Other assets

	2018-19	2017-18
	£000	£000
Current		
EU emissions trading scheme allowance	181	503
Other assets	-	-
Total other current assets	**181**	**503**
Non-current		
Net defined benefit pension scheme asset	-	-
Other assets	-	-
Total other non-current assets	-	-

Note 27 Non-current assets for sale and assets in disposal groups

The assets sold during the year did not meet the criteria to be classified as assets held for sale.

Note 27.1 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 28.1 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.

	2018-19	2017-18
	£000	£000
At 1 April	**39,910**	**41,627**
Prior period adjustments	-	-
At 1 April (restated)	**39,910**	**41,627**
Transfers by absorption	-	-
Net change in year	13,091	(1,717)
At 31 March	**53,001**	**39,910**
Broken down into:		
Cash at commercial banks and in hand	29	30
Cash with the Government Banking Service	52,972	39,880
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**53,001**	**39,910**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**53,001**	**39,910**

Note 28.2 Third party assets held by the NHS foundation trust

The Trust held cash and cash equivalents which relate to monies held by the 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 2019 £000	31 March 2018 £000
Bank balances	-	1
Monies on deposit	-	-
Total third party assets	**-**	**1**

Note 29.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	58,927	54,286
Capital payables	7,028	4,989
Accruals	27,936	24,176
Receipts in advance (including payments on account)	-	-
Social security costs	6,317	5,988
VAT payable	4	28
Other taxes payable	5,845	5,431
PDC dividend payable	-	586
Accrued interest on loans*		63
Other payables	9,413	9,653
Total current trade and other payables	**115,470**	**105,201**
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	12,665	12,525
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 32. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 29.2 Early retirements in NHS payables above

There are no early retirements in NHS payables above

Note 30 Other financial liabilities

The Trust does not have any liabilities classified as other financial liabilities

Note 31 Other liabilities

	31 March 2019 £000	31 March 2018 (restated) £000
Current		
Deferred income: contract liabilities	4,451	4,539
Deferred grants	-	-
PFI Deferred income / credits	86	86
Lease incentives	-	-
Other deferred income	-	-
Total other current liabilities	**4,537**	**4,625**
Non-current		
Deferred income: contract liabilities	532	537
Deferred grants	-	-
PFI Deferred income / credits	2,614	2,700
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**3,146**	**3,237**

Note 32 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Social Care*	-	790
Other loans*	328	67
Obligations under finance leases	252	10
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	2,776	11,106
Total current borrowings	**3,356**	**11,973**
Non-current		
Loans from the Department of Health and Social Care*	-	-
Other loans*	7,273	7,433
Obligations under finance leases	563	1,099
PFI lifecycle replacement received in advance	-	-
Obligations under PFI, LIFT or other service concession contracts	243,763	246,575
Total non-current borrowings	**251,599**	**255,105**

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan

IFRS 9 is applied without restatement therefore comparatives have not been restated, previously interest payable was accrued within the payables note 29.1

Note 32.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Finance leases £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2018	**790**	**7,500**	**1,109**	**257,679**	**267,078**
Cash movements:					
Financing cash flows - payments and receipts of principal	(790)	-	(295)	(11,134)	**(12,219)**
Financing cash flows - payments of interest	(16)	(316)	(61)	(14,332)	**(14,725)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	1	62	-	-	**63**
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	15	355	62	14,326	**14,758**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2019	**-**	**7,601**	**815**	**246,539**	**254,955**

Note 33 Finance leases

Note 33.1 Oxford University Hospitals NHS Foundation Trust as a lessor

The Trust does not have any finance lease receivables as a lessor

Note 33.2 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 2019 £000	**31 March 2018 £000**
Gross lease liabilities	**871**	**1,228**
of which liabilities are due:		
- not later than one year;	292	73
- later than one year and not later than five years;	468	928
- later than five years.	111	227
Finance charges allocated to future periods	(56)	(119)
Net lease liabilities	**815**	**1,109**
of which payable:		
- not later than one year;	252	10
- later than one year and not later than five years;	452	873
- later than five years.	111	226
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. Often 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 34.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Pensions: Injury benefits*	legal claims	other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**1,040**	**1,637**	**82**	**1,179**	**3,938**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	(10)	(40)	-	-	**(50)**
Arising during the year	64	376	65	2,276	**2,781**
Utilised during the year	(102)	(96)	(73)	-	**(271)**
Reclassified to liabilities held in disposal groups	-	-	-	-	**-**
Reversed unused	-	-	-	(25)	**(25)**
Unwinding of discount	1	2	-	-	**3**
At 31 March 2019	**993**	**1,879**	**74**	**3,430**	**6,376**
Expected timing of cash flows:					
- not later than one year;	102	96	74	3,430	**3,702**
- later than one year and not later than five years;	408	395	-	-	**803**
- later than five years.	483	1,388	-	-	**1,871**
Total	**993**	**1,879**	**74**	**3,430**	**6,376**

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 NHS Resolution.

Other provisions reflect commercial claims for which the value carries some uncertainty and the timing is dependent on final resolution.

* In 2018-19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs.

Note 34.2 Clinical negligence liabilities

At 31 March 2019, £555,951k was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Oxford University Hospitals NHS Foundation Trust (31 March 2018: £539,175k).

Note 35 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(50)	(30)
Employment tribunal and other employee related litigation		(50)
Redundancy	-	-
Other	-	-
Gross value of contingent liabilities	**(50)**	**(80)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(50)**	**(80)**
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 £0.05m.

Note 36 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	9,768	312
Intangible assets	-	-
Total	**9,768**	**312**

Note 37 Other financial commitments

The Trust has non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), payments are primarily made based upon usage as opposed to there being contractual commitments irrespective of goods or services provided.

Note 38 Defined benefit pension schemes

The Trust does not operate any material defined benefit pension schemes other than the statutory NHS Pension Scheme

Note 39 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has three PFI schemes being the John Radcliffe West Wing, Churchill Cancer Centre and the Nuffield Orthopaedic Centre. In addition the Trust has service concession arrangements in respect of the John Radcliffe Welcome Centre and the Trust's Carbon Energy Scheme.

The West Wing and Children's Hospital was built in 2006 at an overall cost of approximately £160m as part of a 30 year contract with The Hospital Company (Oxford John Radcliffe) Ltd who built these buildings and operate across most of the site. The West Wing and Children's Hospital are located on the John Radcliffe site and will revert to Trust ownership at the end of the contract period.

The Cancer Centre was completed in 2008 at an overall cost of approximately £150m as part of a 30 year contract with Ochre Solutions Limited who built and operate across most of the site. The Cancer Centre is located on the Churchill site and will revert to Trust ownership at the end of the contract period.

The Nuffield Orthopaedic Centre was built in 2006 at an overall cost of approximately £35m as part of a 30 year contract with Albion Healthcare (Oxford) Ltd who built and operate across most of the site. The Nuffield Orthopaedic Centre will revert to Trust ownership at the end of the contract period.

The John Radcliffe Welcome Centre opened in 2015 following an approximate build project of £3m as part of a 35 year lease with Larkstoke Properties Limited and is recognised as an asset with no liability as there are no payments being made by the Trust, instead a deferred income balance is recognised. The arrangement includes sub-leases where tenants pay rent to Larkstoke and a profit share element that entitles the Trust to an element of surpluses over and above a defined level.

The Trust's Carbon Energy Scheme which was built in 2017 as part of a 25 year lease with Vital Energi Solutions Limited is recognised as an IFRIC12 asset with corresponding liability. The overall cost was approximately £18m. The equipment reverts to Trust ownership at the end of the contract period.

Note 39.1 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 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**409,621**	**435,017**
Of which liabilities are due		
- not later than one year;	16,690	25,424
- later than one year and not later than five years;	90,231	85,792
- later than five years.	302,700	323,801
Finance charges allocated to future periods	(163,082)	(177,338)
Net PFI, LIFT or other service concession arrangement obligation	**246,539**	**257,679**
- not later than one year;	2,776	11,106
- later than one year and not later than five years;	38,738	32,395
- later than five years.	205,025	214,178

Note 39.2 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 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	1,556,397	929,667
Of which liabilities are due:		
- not later than one year;	66,442	43,338
- later than one year and not later than five years;	282,581	178,443
- later than five years.	1,207,374	707,886

Note 39.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2018/19:

	31 March 2019 £000	31 March 2018 £000
Unitary payment payable to service concession operator	64,934	63,229
Consisting of:		
- Interest charge	14,326	14,208
- Repayment of finance lease liability	11,139	9,978
- Service element and other charges to operating expenditure	29,018	28,390
- Capital lifecycle maintenance	2,201	3,302
- Revenue lifecycle maintenance	375	342
- Contingent rent	7,875	6,607
- Addition to lifecycle prepayment	-	402
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	9,796	5,933
Total amount paid to service concession operator	**74,730**	**69,162**

Note 40 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 41 Financial instruments

Note 41.1 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 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 41.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	58,698	-	-	58,698
Other investments / financial assets	-	5,516	9,994	15,510
Cash and cash equivalents at bank and in hand	53,001	-	-	53,001
Total at 31 March 2019	**111,699**	**5,516**	**9,994**	**127,209**

The Trust has irrevocably designated one equity instrument to be held at fair value through other comprehensive income because it is not able to be traded and is held as a strategic asset. The carrying value is £9,994k.

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Trade and other receivables excluding non financial assets	41,539		-	-	**41,539**
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**

Note 41.3 Carrying value of Financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	-	-	-
Obligations under finance leases	815	-	815
Obligations under PFI, LIFT and other service concession contracts	246,539	-	246,539
Other borrowings	7,601	-	7,601
Trade and other payables excluding non financial liabilities	103,304	-	103,304
Other financial liabilities	-	-	-
Provisions under contract	2,433	-	2,433
Total at 31 March 2019	**360,692**	**-**	**360,692**

	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	790	-	**790**
Obligations under finance leases	1,109	-	**1,109**
Obligations under PFI, LIFT and other service concession contracts	257,679	-	**257,679**
Other borrowings	7,500	-	**7,500**
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 2019	**361,416**	**-**	**361,416**

Note 41.4 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 41.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	109,093	106,308
In more than one year but not more than two years	6,378	3,727
In more than two years but not more than five years	34,448	31,402
In more than five years	210,773	219,979
Total	**360,692**	**361,416**

Note 42 Losses and special payments

	2018-19		2017-18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	5	5	16	10
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	35	95	60	174
Stores losses and damage to property	2	169	2	197
Total losses	**42**	**269**	**78**	**381**
Special payments				
Compensation under court order or legally binding arbitration	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	48	18	54	35
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**48**	**18**	**54**	**35**
Total losses and special payments	**90**	**287**	**132**	**416**
Compensation payments received		-		-

Details of cases individually over £0.3m

There were no individual cases in excess of £300k

Note 43 Gifts

There were no gifts in excess of £300k

Note 44.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £1k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £92k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £7,507k.

Note 44.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The Trust has assessed the impact of IFRS15 and this has had trivial impact on the recognition of income within the current financial year. Separately the trust reassed previous years' income recognition under IAS18 and there was a resulting prior period adjustment which has been effected as per note 1.29

Note 45 Related parties

During the accounting period none of the Department of Health and Social Care 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 and Social Care 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

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies.

Statutory payments were made to NHS Pension and HMRC in respect of payroll costs and an outstanding payable balance exists as at 31 March in line with normal business.

The Trust made payments to NHS Professionals in respect of temporary staffing and an outstanding payable balance exists as at 31 March in line with normal business.

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 a company limited by guarantee, independent from Oxford University Hospitals NHS Foundation Trust and therefore the charity is not controlled by the Trust.

Please see note 22 for details of the Trust's sub-entities in partnership with the Oxford University and Mayo Clinic. During the year the Trust invested a further £4.8m in the joint venture.

Note 46 Transfers by absorption

The Trust did not have any transfers by absorption during the accounting period

Note 47 Prior period adjustments

Please refer to note 1.29 for details of prior period adjustments.

Note 48 Events after the reporting date

There have been no material events after the reporting date which require disclosure.

Note 49 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

Opinion on the financial statements

We have audited the financial statements of Oxford University Hospitals NHS Foundation Trust ('the Trust') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and notes to the financial statements, including the 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 interpreted and adapted by the Government Financial Reporting Manual 2018/19 as contained in the Department of Health and Social Care Group Accounting Manual 2018/19, and the Accounts Direction issued under section 25(2) of Schedule 7 of the National Health Service Act 2006 ("the Accounts Direction").

In our opinion, the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006 and the Accounts Direction issued thereunder.

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 section of our report. We are independent of the 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 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.

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 Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust'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.

Key audit matters

Key audit matters are those matters that, in our professional judgement, 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) we identified, including 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 forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Revenue recognition Auditing standards include a rebuttable presumption that there is a significant risk in relation to the timing of income recognition, and in relation to judgements made by management as to when income has been earned. The pressure to manage income to deliver forecast performance in a challenging financial environment increases the risk of fraudulent financial reporting leading to material misstatement and means we are unable to rebut the presumption.	We undertook a range of substantive procedures including: • testing of income around the year-end to ensure transactions are recognised in the correct financial year; • testing year-end receivables to ensure transactions are recognised in the correct financial year; • testing of PSF income by agreement to NHS Improvement year-end funding notification; • review of management's consideration of the introduction of IFRS15 regarding deferred income balances; • reviewing intra-NHS reconciliations and data matches provided by the Department of Health and Social Care as a means of identifying under and over-recorded income and for testing individual mismatches above our trivial threshold; and • with respect to income recognition; review of management oversight of material accounting estimates, review of changes to accounting policies and testing of material accounting estimates relevant to revenue recognition, including income accruals. Our work provided the assurance we sought in respect of this key audit matter.

We consider specific risks in relation to revenue recognition to be in the following areas:

- Recognition of income and receivables around the year end;
- Recognition of Provider Sustainability Fund (PSF) income during the year; and
- Recognition of Research and Development (R&D) deferred income arising from the introduction of IFRS15 during 2018/19.

Property valuations Land and buildings are the Trust's highest value assets. Management engage the District Valuer, as an expert, to assist in determining the current value of property to be included in the financial statements. There is a high degree of estimation uncertainty and changes in the value of property may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Department and Health and Social Care Group Accounting Manual.	We liaised with management to update our understanding on the approach taken by the Trust in its valuation of land and buildings, which included review of the methodology that the Trust uses of valuing an alternative site as part of its modern equivalent asset valuation. Our work also included review of the underlying data, and sample testing to gain assurance of its accuracy. We reviewed and considered: • the scope and terms of the engagement with the District Valuer; and • how management use the District Valuer's report to value land and buildings in the financial statements. We wrote to the District Valuer to obtain information on the methodology and their procedures to ensure objectivity and compliance with professional standards.. Our work provided the assurance we sought in respect of this key audit matter.

Our application of materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures on the individual financial statement line items and disclosures, and in evaluating the effect of misstatements, both individually and on the financial statements as a whole. Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	**Trust**
	£10.799m
Basis for determining materiality	Approximately 1% of operating expenses of continuing operations.
Rationale for benchmark applied	Operating expenses of continuing operations was chosen as the appropriate benchmark for overall materiality as this is a key measure of financial performance for users of the financial statements.
Performance materiality	£7.56m
Reporting threshold	£0.3m

An overview of the scope of our audit
As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and the sector in which it operates. We considered the risk of acts by the Trust which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.
We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.
We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's accounting processes and controls and its environment and considered qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items.
Our tests included, but were not limited to:

- obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by irregularities including fraud or error;
- review of minutes of board meetings in the year; and
- enquiries of management.

As a result of our procedures, we did not identify any Key Audit Matters relating to irregularities, including fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are discussed under 'Key audit matters' within this report.

Other information
The directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.
In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.
We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements
As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting 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 Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

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.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Opinion on other matters prescribed by the Code of Audit Practice
In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2018/19; and

- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • **the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2018/19; or** • **the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.**	We have nothing to report in respect of these matters.
Reports to the regulator and in the public interest	
We are required to report to you if: • **we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a 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; or** • **we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.**	We have nothing to report in respect of these matters.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in this respect.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1)(d) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

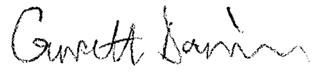
We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

This report is made solely to the Council of Governors of Oxford University Hospitals NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report 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 of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit 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.



Gareth Davies
For and on behalf of Mazars LLP
Tower Bridge House
St Katharine's Way
London
E1W 1DD

22 May 2019

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The following footnote should be added to the audit report when it is published or distributed electronically:

The maintenance and integrity of the Oxford University Hospitals NHS Foundation Trust website 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 website.

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 year:** is a key measure of the overall financial performance of the Trust. The Trust can use any retained surplus to develop its business.

- **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.

- **Total comprehensive income/(expense) for the period:** this is the sum of the surplus/(deficit) for the year and the other comprehensive income.

- **Adjusted financial performance surplus/(deficit):** the surplus/deficit for the period is measured by NHS Improvement and includes Provider Sustainability 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 taxpayer's 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:** 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.

- **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.

- **Financial assets reserve:** the reserve comprises the changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

- **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

NHS Resolution 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 oversees 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 (NHS TDA)

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.

Provider Sustainability Funding (PSF)

The Provider Sustainability Fund (PSF) replaced the Sustainability and Transformation Fund (STF) in 2018 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.

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 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
Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership	www.bobstp.org.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 South	www.hee.nhs.uk/in-your-area/south
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 website	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 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.oxonhealthcaretrasnformation.nhs.uk
Patients' Association	www.patients-association.org.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:
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See our website: www.ouh.nhs.uk