Oxford University Hospitals NHS
NHS Trust

Integrated Business Plan
2014/15 – 2018/19

July, 2013

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Chapter 1

Executive Summary

1. Executive summary

1.1. This Integrated Business Plan describes services provided by Oxford University Hospitals NHS Trust (OUH), primarily from four hospitals in Oxfordshire and in a range of settings across a wider area. It describes plans for OUH to provide high quality care as a legally-constituted, financially viable and well-governed NHS Foundation Trust in the five future years to March 2019.

1.2. The period to 2019 is one in which OUH expects to be involved in major change in local health and social care services, driven by a need to adapt care delivery for a growing population of frail, older people and reduce the delays in transfers between services that have been a feature of local care for several years.

1.3. In preparing to function as an NHS Foundation Trust (FT), OUH has focused on achieving and sustaining quality of care for its patients, above all with compassion. Patient safety, clinical outcomes and patient experience are at the core of its work. Its vision for the future is based on values which can be summarised as 'Delivering Compassionate Excellence.' This aim applies to everything the Trust does, from local services to highly specialised care, including teaching and research, and in the partnerships it is developing with providers and commissioners of health and social care.

1.4. Recent years have seen the successful delivery of cost improvements and the repayment of historical debt, creating a financially sound basis for operating as an FT with greater latitude to invest and to take managed risks to deliver the services its patients and commissioners require.

1.5. OUH is working closely with commissioners and with other providers of care to innovate and address areas of rising demand against a backdrop of constrained public funding, to operate as effectively and efficiently as possible and in doing so, to listen carefully to patients, carers and staff to inform its decisions and daily work.

1.6. In providing the required information on services, finances and governance, this IBP sets out an ambition for OUH to be amongst the best providers of quality health care in the NHS through releasing the skills, talents and knowledge of its own staff and those of its teaching and research partners.

Profile

1.7. OUH provides as full as range of acute and general hospital care as almost any other NHS organisation. This range of services supports, and is supported by, strong partnerships with local universities. As an organisation fully committed to its triple functions of patient care, education and reseach, the quality and range of its clinical services are important.

1.8. As local clinical commissioners face the combined challenges of population growth, an ageing population and pressures on funding, OUH is working with other care providers to integrate care, breaking down the boundaries experienced between hospital and non-hospital care and moving care to or near patients' homes as soon as it is safe and possible to do so. Some success has been seen through the provision of social care for people immediately after discharge and detailed work is under way with Oxford Health NHS Foundation Trust and Oxfordshire County Council in particular to find practical ways of enhancing the capacity and capability of services outside hospital to respond to the needs of frail, older people.

1.9. In common with many providers of emergency care in England, OUH's services have operated under great pressure in the early months of 2013. While the Trust has focused on keeping patients safe and providing as good an experience of care as possible, waits in its emergency departments exceeded national standards in the period from January to April.

1.10. Recognising that there are many factors which affect demand for unplanned hospital care and the flow of patients through hospital, OUH has committed to improving its own services and to support continued improvements with partners outside hospital. The Trust has budgeted and staffed its non-elective services at the level it anticipates will be needed to meet the quality and safety requirements

of patient care, but remains committed to supporting care within its own services or those of partner providers that can allow a reduction in its bed capacity.

1.11. As a clinically-led organisation, the Trust has a strong record of achieving improvements in the value of the care it provides. A Cost Improvement Programme developed through the Trust's clinical leadership has delivered a high level of recurrent savings and schemes are closely monitored for any impact they may have on quality of care provided. Against this background, the Trust has delivered the required financial surplus and has completed the repayment of historical debt.

1.12. The past decade has seen major investment in state-of-the-art buildings. OUH plans to make even better use of the facilities on three of its sites which are funded through the Private Finance Initiative (PFI), enabling patients to be treated and staff to work in the best settings supported by the best use of the resources committed to these facilities. PFI unitary charges include repayment of PFI liabilities and interest, estate maintenance and management, 'hard' and 'soft' facilities services including cleaning, portering and catering and at the Churchill Hospital a Managed Equipment Service for the regular upgrade and replacement of radiotherapy and imaging equipment in the Oxford Cancer Centre. These unitary charges accounted for 7.2% of the Trust's turnover in 2012/13 and remain affordable.

1.13. Significant developments have also taken place in several services to strengthen OUH's capability to meet expectations as a provider of specialised care. The creation of its Oxford Cancer Centre and OUH's accreditation as a Major Trauma Centre and as a regional provider of Intensive Care for newborns illustrate the Trust's ability to support a network of providers beyond the Thames Valley area.

1.14. Close work with providers across southern central England has focused on developing networked services which are mutually beneficial – providing the best available care for patients as locally as possible and providing care which is sustainable in terms of quality, cost and OUH's ability to teach and develop the clinicians of the future while supporting the translation of research into clinical practice.

1.15. This network is supported by a strong partnership with the University of Oxford, Oxford Brookes university and with other universities, life science institutions, industries and research bodies, formalised in the Oxford Academic Health Science Network, accredited to operate as one of 15 in England.

Vision, values and strategy

1.16. OUH's mission is the improvement of health and the alleviation of pain, suffering and sickness for the people it serves.

1.17. It will achieve this through providing high quality, cost-effective and integrated healthcare and through the constant quest for new treatment strategies and the development of its workforce.

1.18. The Trust's core values are Excellence, Compassion, Respect, Delivery, Learning and Improvement, summarised in its commitment to 'Deliver Compassionate Excellence.' Collaboration and partnership are also central to its approach in delivering its triple functions of patient care, teaching and research.

1.19. These values determine Oxford University Hospitals NHS Trust's (OUH's) vision to be:

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

1.20. This vision is underpinned by the Trust's founding partnership with the University of Oxford.

1.21. The vision reflects OUH's position as a provider of healthcare both for local people and for a wider population.

1.22. The patient is at the heart of everything the Trust does. OUH is committed to delivering high quality care to patients irrespective of age, disability, religion, race, gender and sexual orientation, ensuring that its services are accessible to all and tailored to the individual.

1.23. Central to the Trust's vision are its staff. OUH aims to recruit, train and retain the best people who embody its values and achieve its vision.

1.24. OUH strives for excellence in healthcare by encouraging a culture of support, respect, integrity and teamwork; by monitoring and assessing its performance against national and international standards; by learning from its successes and setbacks; by striving to improve what it does through innovation and change; and by working in partnership and collaboration with all the agencies of health and social care in the area it serves.

1.25. The Trust is also committed to be an active partner in healthcare innovation, research and workforce education, with the aim of forming an effective bridge between research in basic science and in healthcare service provision, and the delivery of evidence-based, best practice care, translating today's discoveries into tomorrow's care.

1.26. The Trust's vision and values inform its strategic objectives which in turn form the basis of the IBP.

Strategic objectives

1.27. The Trust has six strategic objectives from which its priority work programmes flow.

SO1: To be a patient-centred organisation providing high quality, compassionate care with integrity and respect for patients and staff – *"delivering compassionate excellence."*

SO2: To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – *"a well-governed and adaptable organisation."*

SO3: To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – *"delivering better value healthcare."*

SO4: To provide high quality general acute healthcare to the people of Oxfordshire including more joined-up care across local health and social care services – *"delivering integrated local healthcare."*

SO5: To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist care for the people of Oxfordshire and beyond – *"excellent secondary and specialist care through sustainable clinical networks."*

SO6: To lead the development of durable partnerships with academic, health and social care partners and the life sciences industry to facilitate discovery and implement its benefits – *"delivering the benefits of research and innovation to patients."*

Rationale for NHS Foundation Trust status

1.28. Becoming an FT enables OUH to accelerate progress towards its strategic objectives.

1.29. The Trust's clear focus on quality and value and its ability to invest as an FT will enable it to add to the impact of the clinical and academic networks it is part of, with anticipated innovations as diverse as genomic medicine and technology to support the self-management by patients of their long-term conditions.

1.30. As a membership organisation, it will enable its public and staff members to inform and focus on priority improvements in patient care and experience. Members are involved in patient panels and will be able to contribute in several ways to influence and inform how services develop. The Council of Governors will bring representatives of local people and staff together with commissioners and providers of care to focus on care which is centred on the needs of patients and carers.

1.31. Patient safety, outcomes and patient experience are fundamental to the success of all OUH's services. Transparent governance and scrutiny of quality as an FT will support staff in continuing to strive for the best in healthcare quality, influenced through members' representatives on the Council of Governors.

1.32. There is potential to use new approaches to deliver integrated healthcare and OUH wishes to be at the forefront of doing this in ways which benefit patients, improve quality of care and generate an affordable and sustainable pattern of care that inspires commissioners' confidence. Authorisation to operate as an FT will enable OUH to respond more flexibly to this challenge.

1.33. With the formation of the Oxfordshire Academic Health Consortium and the Oxford Academic Health Sciences Network, the means are being established to translate research into innovative practice.

1.34. With its local and network alliances with other healthcare providers and with a business plan generating financial surpluses to invest, OUH will be able to respond more quickly than as an NHS Trust to needs identified with local service partners and the wider network. Developments will be mutually beneficial for network partners and will support sustained improvements in patient experience and safety.

1.35. Sustained progress against the Trust's strategic objectives requires the freedoms and flexibilities provided by authorisation as an FT. OUH believes that achieving its vision depends on this.

Quality

1.36. As reflected throughout this business plan, quality of care provided is vital to OUH's patients, its membership as a whole and to the future of the Trust.

1.37. A Quality Strategy was agreed in July 2012 which set out ten measurable strategic quality goals in the domains of patients' safety, patients' experience and clinical effectiveness. The Trust has set itself the objective of being one of the safest providers of hospital care, in the top ten per cent of hospitals for patient and staff experience and of providing clinical services that have clinical outcomes in the top ten per cent nationally. Implementation of the Quality Strategy has included:

- Raising awareness of what drives OUH (quality priorities);
- Creating an understanding of the role and contribution every staff member can make;
- Agreeing and promoting quality priorities within services to meet the Trust-wide priorities;
- Promoting leadership at all levels to deliver the quality priorities; and
- Promoting individual responsibility for taking action to improve safety, experience and outcomes for patients, families and staff.

1.38. The National Quality Board published Quality in the New Health System in August 2012, setting a direction of travel for quality in the NHS and asserting that constantly seeking quality improvement is the best way to avoid quality failures. The second report of the Public Inquiry into failures at Mid-Staffordshire NHS Foundation Trust made similar points. In considering the Francis Inquiry with staff, OUH has reinforced the need to continue to focus on compassionate care, on effective teamwork, on enhancing leadership capacity and on seeking and using feedback from patients, carers and staff.

1.39. OUH uses locally-commissioned and national peer reviews to inform its work and during 2013, is reviewing care for patients undergoing surgery and expecting to participate in the national peer review of cancer services.

1.40. OUH is committed to continual quality improvement and to having the skills, systems, reporting and benchmarking in place to sustain this and to provide assurance that it is making a positive difference.

Market assessment and service development

1.41. OUH is relatively unusual in being a teaching trust with a comprehensive portfolio of services and a strong research and educational base, located primarily in a small city with a relatively small catchment.

1.42. OUH provides services to two relatively distinct markets: a local market for general hospital services and a wider market for more specialist care.

1.43. Changes to the national definitions of specialised commissioning have made NHS England the Trust's largest single commissioner in 2013/14.

1.44. Oxfordshire Clinical Commissioning Group (OCCG) is the next largest commissioner and, with 43% of specialised care commissioned from the Trust being for Oxfordshire patients, care for the people of Oxfordshire accounts for 57.5% of OUH's patient care income.

1.45. The Trust also provides local care for surrounding counties, including communities in southern Northamptonshire and Warwickshire.

1.46. The population served by OUH's specialist 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 a larger catchment population, with national and international elements.

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

1.48. OUH is monitoring plans by commissioners to seek tenders for services and has capacity to respond.

1.49. A key feature of the local market is the increasing demand from an ageing population with increasingly complex health and social care needs. OUH's strategic response is to work with local partners, including new commissioners, to develop appropriate care pathways to meet this demand in a way that reflects the needs of patients within the constraints of the current economic climate. A key focus for this within the local health economy is the reduction in delayed transfers of care.

1.50. As local care pathways are redesigned and redirected away from acute hospital settings, the Trust's stategy is to increase its specialist income, with several components:

- consolidation of the existing catchment (e.g. by treating patients more locally who would otherwise have been treated in London);
- extension of current catchment (e.g. through extending operational clinical networks and joint working relationships);
- delivering national and network-driven reconfigurations of specialist services (e.g. Major Trauma, Vascular Surgery and Newborn Intensive Care); and
- responding to the emergence of potential new markets.

1.51. Developments in specialised services are expected to address the specific needs of the network of providers and commissioners OUH serves, with an early focus on cancer care. Business cases for radiotherapy units in Milton Keynes and Swindon are under development, with capital resources reserved.

1.52. Main developments in local acute services are in care pathways rather than buildings, although capital investment is planned to relocate services from 1940s buildings at the Churchill Hospital, to improve outpatient facilities at the Horton General Hospital and to upgrade operating theatres and intensive care facilities at the John Radcliffe Hospital during the five-year period of this IBP.

Performance overview

1.53. Most key performance standards have been met throughout OUH's existence, with progress made on others.

1.54. Work continues to achieve and sustain reduced waits in the Trust's Emergency Departments and to reduce delayed transfers whilst meeting standards in other areas. A&E waits exceeded national standards in Quarter 4 of 2012/13 and in Quarter 1 of 2013/14. Work has taken place to improve pathways into specialties, clinical leadership has been enhanced and additional consultant staff recruited. An action plan is in place and agreed with the Trust's commissioners.

1.55. Delayed transfers of care have been above the expected maximum of 3.5% of acute bed capacity since OUH's formation and Oxfordshire's delays have been the highest in England for several years.

1.56. Reducing delays in transferring patients has proved challenging for local commissioners and providers over a long period. A clear priority for OUH is to participate actively in putting in place new pathways and community provision to deliver this standard and to sustain progress.

1.57. All key cancer standards have been met on a quarterly basis since Q2 of 2011/12 with the single exception of the 62 day standard for GP referral to first treatment in Q2 of 2012/13.

1.58. The proportion of patients waiting more than 6 weeks for diagnostic tests rose above 10% in December 2012. Additional staffing including seven-day operation of scanners was put in place and progress has been made towards achievement of this standard.

1.59. The Trust remained within reduced 'threshold' levels set for cases of MRSA and Clostridium difficile during 2011/12 and 2012/13.

1.60. Nationally reportable breaches of the single sex accommodation standard occurred twice in 2012/13, both related to the need to accommodate patients in the Emergency Admissions Unit (EAU) at the Horton General Hospital.

1.61. OUH has delivered the 18 week referral-to-treatment standard trustwide for both non-admitted and admitted patients since its formation. The small number of specialties not achieving the target has reduced and where problems are identified, action is taken to address issues of capacity or organisation.

1.62. VTE assessments as a percentage of admissions were above the threshold required throughout 2012/13.

1.63. The Trust is registered without conditions by the Care Quality Commission for all regulated activities on each of its sites. It is judged compliant with all 16 essential standards of quality and safety.

1.64. OUH has strengthened its underlying financial position in the past two years. It is focused on continuing to strengthen its financial position and Balance Sheet by delivering a 1% retained surplus in 2013/14 through good financial management and the delivery of cost improvements.

1.65. This base allows it to produce a financial plan that, in an increasingly challenging financial environment, delivers surpluses, with improved liquidity and risk ratings, and finances service improvements in areas of development to support its strategic goals.

Strengths, weaknesses, opportunities and threats

1.66. OUH's key strength is its comprehensive portfolio of services with high levels of subspecialisation. Access to these services is highly valued by the patient population that the Trust serves. Service delivery is underpinned by strong clinical support services and multidisciplinary working. Partnership with the University of Oxford complements and enhances the services offered and supports the delivery of education, training and research.

1.67. Set alongside this, the highest-profile weakness is in waits for access to beds from emergency care and for discharge from hospital, especially for frail, older people. OUH is working closely with local organisations to develop care which is integrated as far as patients and their carers are concerned.

1.68. A range of initiatives have been piloted to provide care closer to home for elderly patients and those with long term conditions. Examples include stroke rehabilitation services in Abingdon and Witney and the establishment of a joint team with Oxford Health NHS FT and Oxfordshire County Council to speed up and rapidly implement decisions on patient discharge.

1.69. The Trust also recognises the importance of addressing the clear threat posed by rising healthcare costs and the availability of funds for healthcare. OUH is committed to work with its commissioners to address this risk, including referral protocols and the establishment of integrated whole care pathways that transfer activity from hospital into primary and community care settings. The Trust is working with local commissioners to develop these proposals, whilst having its own plans to meet cost improvement requirements and preserve quality. For example, OUH has worked with commissioners and community hospitals to provide an accelerated rehabilitation pathway for patients with fragility hip fractures. This generated a shorter length of acute stay for these patients, releasing bed capacity for additional patients coming to the John Radcliffe Hospital as a Major Trauma Centre.

1.70. The Trust is in a good position to benefit from opportunities offered by the national drive towards rationalisation and consolidation of specialist services into designated centres. It has exploited these opportunities to date, with recent service developments in Trauma and Newborn Intensive Care further enhancing its position as a comprehensive provider of specialist care.

1.71. Taking advantage of these opportunities is necessary to support future clinical and financial viability. The Trust has identified that a network approach with surrounding healthcare providers will help mitigate the risk posed by being a specialist teaching centre with a relatively small local catchment population and is actively progressing discussions with neighbouring Trusts to establish and agree partnership arrangements to support the operation of a mutually-beneficial network.

1.72. The centralisation of specialist services may present a threat to those Trust services with a smaller critical mass. For such services, as seen in paediatric cardiac surgery, it will be important for the Trust to develop network arrangements which prevent an adverse impact on remaining services, such as paediatric intensive care. OUH is prepared to work collaboratively as a 'spoke' as well as a 'hub.' This commitment has been demonstrated by an alliance with University Hospitals Southampton NHS FT to support the delivery of paediatric cardiac services.

1.73. The Trust's strategy recognises that intent to centralise or repatriate services to Oxford rely on changes to referral patterns and care pathways. Its strategy is built on clinical network arrangements and relationships with neighbouring hospitals and on developing and extending these.

Risks

1.74. The main risks to achievement of this strategy are described in the IBP as:

Strategic Risk	Principal Indicators	Mitigations
Failure to maintain quality of patient services	▪ Patient experience indicators show a decline in quality ▪ Potential breach of CQC Health and Social Care regulations ▪ Trust Quality Strategy goals are not met ▪ Quality aspects of contracts with commissioners are not met ▪ CIPs impact on patient safety or unacceptably impact on service quality	▪ Focus on patient safety, outcomes and patient experience through delivery of Quality Strategy and Trust values ▪ Staff engagement and awareness of required standards ▪ Collation of evidence at service level ▪ Quality governance ▪ Use of benchmarks to inform analysis of progress ▪ Ongoing quality impact review of CIP schemes ▪ Close liaison with NHSLA and CQC

Strategic Risk	Principal Indicators	Mitigations
Failure to maintain financial sustainability	▪ Required levels of CIP not delivered ▪ Pay costs not adequately controlled ▪ Failure to manage outstanding debtors ▪ Failure to generate income from non-core healthcare activity ▪ Services display poor cost-effectiveness	▪ Two-year rolling cost improvement programme with contingencies ▪ Divisional ownership ▪ Estate strategy
Failure to maintain operational performance	▪ National performance standards for A&E not met ▪ Failure to reduce delayed transfers of care ▪ Necessary level of data quality not achieved	▪ Provider Action Plan ▪ Supported Discharge Service ▪ Collaborative work on care pathways, delivery systems, education and training ▪ Learning from partners across OAHSN ▪ Focus on data quality
Mismatch with commissioner plans	▪ Lack of robust plans across the healthcare system ▪ Loss of commissioner support	▪ Internal performance controls ▪ Effective liaison with commissioners ▪ Strengthened links with commissioners through new partnerships – e.g. OAHC and OAHSN
Loss of share of current and potential markets	▪ Loss of existing market share ▪ Failure to gain share of new markets ▪ Negative media coverage relative to our competitors	▪ Strategy developed with commissioners ▪ Agree assumptions and financial approach with key commissioners ▪ Maintain ability to be nimble in flexing capacity ▪ Contingency plans for withdrawal from services
Failure to sustain an engaged and effective workforce	▪ Difficulty recruiting and retaining high-quality staff ▪ Low levels of staff satisfaction, health & wellbeing and engagement ▪ Insufficient provision of training, appraisal and development	▪ Leadership based on values visible in practice ▪ Improved recruitment and induction materials to set expectations ▪ Strong focus on education and development ▪ Feedback used to inform training ▪ Growing opportunities through the OxAHSC, OAHC and OAHSN
Failure to deliver required transformation of services	▪ Failure to maintain the development of organisational culture ▪ Clinical benefits of EPR are not realised ▪ Low levels of staff involvement in the Trust agenda ▪ Failure to establish robust governance and assurance processes	▪ Delivery of phased programme of change with clear accountability arrangements ▪ Learning from partners across the OAHSN, drawing on expertise of academic and industry partners
Failure to deliver the benefits of strategic partnerships	▪ Failure to establish sustainable regional networks ▪ Adequate support for education is not provided ▪ Research and innovation do not deliver anticipated benefits	▪ Ensure the realisation of benefits of working within Oxford Academic Health Science Network, the OxAHSC and OAHC

1.75. The five-year financial model has been tested by costing each of the risks shown above, combining them into an 'unmitigated downside' and applying proposed actions to address the consequences of the risks materialising. This downside analysis demonstrates that OUH can deliver a sustainable financial position over the five year period with sufficient cash balances.

Conclusion

1.76. This business plan describes how OUH is developing to achieve its vision and the steps it is taking to deliver the best care for local people, for its wider network and to offer the services its commissioners require. It is supported by strategies for estate, information management and technology, membership, quality and workforce.

1.77. The Trust has set itself a clear ambition to deliver compassionate excellence. It is supporting its staff and services to enact its values through the use of visible quality priorities, training and development of managers, actions to support staff engagement and well-being, and values-based recruitment.

1.78. OUH staff have worked hard to provide compassionate care during a period of major pressure on emergency care nationwide in early 2013 and the Trust remains committed to making sustainable improvements to the flow of patients through its emergency services.

1.79. It has strengthened its finances and external relationships, not least through its clinical leadership. These factors provide it with a strong basis from which to redesign and redevelop its services.

1.80. OUH intends to respond creatively to the challenges facing the NHS in the area it serves and, through effective partnerships and harnessing capacity for innovation, to be an organisation that staff are proud to work for, patients choose to be treated by and GPs and other care providers seek to be associated with.

1.81. Operating as an FT is an important next step in the Trust's development.

Chapter 2

Trust profile

2. Trust profile

2.1. Oxford University Hospitals NHS Trust (OUH) provides a wide range of general and specialist health care services, primarily from four hospital sites: the Churchill Hospital, the John Radcliffe Hospital and the Nuffield Orthopaedic Centre in Oxford and the Horton General Hospital in Banbury.

2.2. The Trust provides general hospital services to people in Oxfordshire and neighbouring counties and specialist services on a regional and national basis. As well as Oxfordshire, a significant proportion of OUH's patients come from Buckinghamshire, Berkshire, Wiltshire, Northamptonshire, Warwickshire and Gloucestershire. Chapter 4 provides details of the population served.

2.3. OUH provides services in more than 90 clinical specialties which are grouped into seven clinical Divisions.

2.4. In 2012/13 the Trust provided:

835,448 outpatient consultations and treatments	127,592 attendances at its emergency departments
75,959 day case admissions	88,316 admissions for emergency assessment or treatment
22,312 planned admissions for inpatient care	Delivery of 8,650 babies

2.5. OUH was formed on 1 November 2011 from the integration of the Oxford Radcliffe Hospitals NHS Trust (ORH) and the Nuffield Orthopaedic Centre NHS Trust (NOC). This created synergies and service enhancements based on two complementary and inter-connecting sets of services.

2.6. As well as bringing together the best policy, practice and culture from each trust and delivering financial efficiencies, OUH has been able to develop better integrated care pathways in specialties where the predecessor trusts operated linked services. Integration has also allowed OUH to make more effective use of its total estate, move services from poorer quality buildings and improve productivity. As a new organisation, the Trust has focused on further enhancing quality, focusing on the three domains in its quality strategy of patient safety, patient experience and outcomes.

2.7. OUH had a turnover of £822 million and fixed assets of £693 million in 2012/13.

Financial overview, 2010/11 – 2012/13

	ORH	OUH	
	2010/11	2011/12	2012/13
Turnover (£m)	663.8	788.2	821.7
Fixed Assets (£m)[1]	611.5	708.4	693.2
Reference Cost Index (RCI)	108	108	-
EBITDA (£m)	55.8	69.5	68.8
I&E Surplus/(Deficit) against breakeven duty (£m)	1.3	7.2	3.6

2.8. As well as being a provider of health care, OUH functions as an educator of its own staff and a supplier of services to support the training of the UK's healthcare workforce.

[1] Including tangible and intangible fixed assets and long term debtor balances. A lower figure is given below for tangible fixed assets only (land, buildings and equipment).

2.9. OUH provides a base for training nurses and therapists (with Oxford Brookes University) and medical students and doctors (with the University of Oxford). It launched a Health Care Support Worker Academy during 2012.

2.10. The Trust's postgraduate centres support the training of junior doctors, dentists, GPs and associate specialists. OUH has 400 consultants registered as educational supervisors.

2.11. The Trust's name reflects a formal partnership with the University of Oxford and a commitment to be at the heart of an outstanding, sustainable and innovative academic health science system. The Trust's primary role in the provision of high quality patient care is underpinned by its functions in education, teaching and research.

2.12. Arrangements are in place with Oxford Brookes University to train and develop competent, compassionate non-medical practitioners to provide excellence in care which is sustained through teaching and contributing to the wider research agenda. A joint working agreement is in place to support collaborative work, scholarly activities and other educational initiatives.

2.13. Oxford medical research is focused on "big diseases" where hundreds of thousands of lives can be saved worldwide, including cancer, diabetes and infectious diseases such as malaria and HIV.

2.14. Research themes of particular strength in Oxford are Cancer; Cardiovascular Science; Diabetes, Endocrinology and Metabolism; Infection and Immunology; Musculoskeletal Science; Neuroscience and Cognitive Health; and Reproduction and Development.

Overview of sites and services

2.15. OUH has a comprehensive range of secondary and tertiary services for patients locally and in surrounding counties. It provides supra-regional services (including one of the largest organ transplant programmes in Europe for kidney, kidney/pancreas and small bowel) and is home to several regional networks and centres including major trauma, renal and newborn intensive care.

2.16. Acute services are provided from four hospital sites:

- The Churchill Hospital in Headington, Oxford;
- The Horton General Hospital in Banbury;
- The John Radcliffe Hospital in Headington, Oxford; and
- The Nuffield Orthopaedic Centre in Headington, Oxford.

2.17. The **Churchill Hospital** is the centre for the Trust's cancer services and the base for renal services, transplantation, dermatology, haemophilia, infectious diseases, chest medicine, medical genetics, palliative care and sexual health. The Oxford Centre for Diabetes, Endocrinology and Metabolism is on this site. The hospital, with the adjacent Old Road campus of the University of Oxford's Medical Sciences Division, is a major centre for healthcare research, and hosts a number of academic departments and other major research centres such as the Oxford Cancer Research Centre, a partnership between Cancer Research UK, the Trust and the University of Oxford.

2.18. The **Horton General Hospital** in Banbury provides acute general medicine and general surgery, trauma, obstetrics and gynaecology, paediatrics and critical care. Acute general medicine includes a medical assessment unit, a day hospital as part of specialised rehabilitation services for older people and a cardiology service. The Brodey Centre offers treatment for cancer. Outpatient clinics provide care including input from specialist consultants from Oxford in dermatology, ear, nose and throat (ENT), neurology, ophthalmology, oral surgery, oncology, pain rehabilitation, paediatric cardiology, plastic surgery, radiotherapy and rheumatology. On-site clinical services include dietetics, occupational therapy, pathology, physiotherapy and radiology.

2.19. The **John Radcliffe Hospital** is the largest of the Trust's hospitals. It is the site of Oxfordshire's main accident and emergency service and provides acute medical and surgical services, pathology, trauma,

intensive care and maternity and women's health services. The Oxford Children's Hospital, the Oxford Eye Hospital and the Oxford Heart Centre form part of the hospital. It is the home of many departments of the University of Oxford's Medical Sciences Division, although medical students are educated throughout the Trust and in a network of hospitals beyond Oxfordshire. The West Wing, opened in 2007, is a base for neuroscience services, including neurosurgery and neurology, and specialist surgical services, including ear nose and throat (ENT), plastic surgery and a specialist craniofacial unit. The Oxford Trauma Unit is the designated regional major trauma centre.

2.20. The **Nuffield Orthopaedic Centre** is an internationally-recognised centre of excellence, providing care for people with disabling or long-term musculoskeletal conditions and for those suffering from neurological disability. The hospital includes the Oxford Centre for Enablement which specialises in treating people with severe neuromuscular conditions and provides rehabilitation for those with limb amputation or complex neurological disabilities. It has a wide range of orthopaedic services including orthopaedic surgery, for example hip and knee replacements. Specialist orthopaedic services include limb reconstruction and deformity correction, spinal surgery and treatment of primary malignant bone and soft tissue tumours. Bone infections are treated in the UK's only dedicated unit of its kind.

2.21. The level of outpatient activity provided at each of OUH's main sites in 2012/13 is shown below.

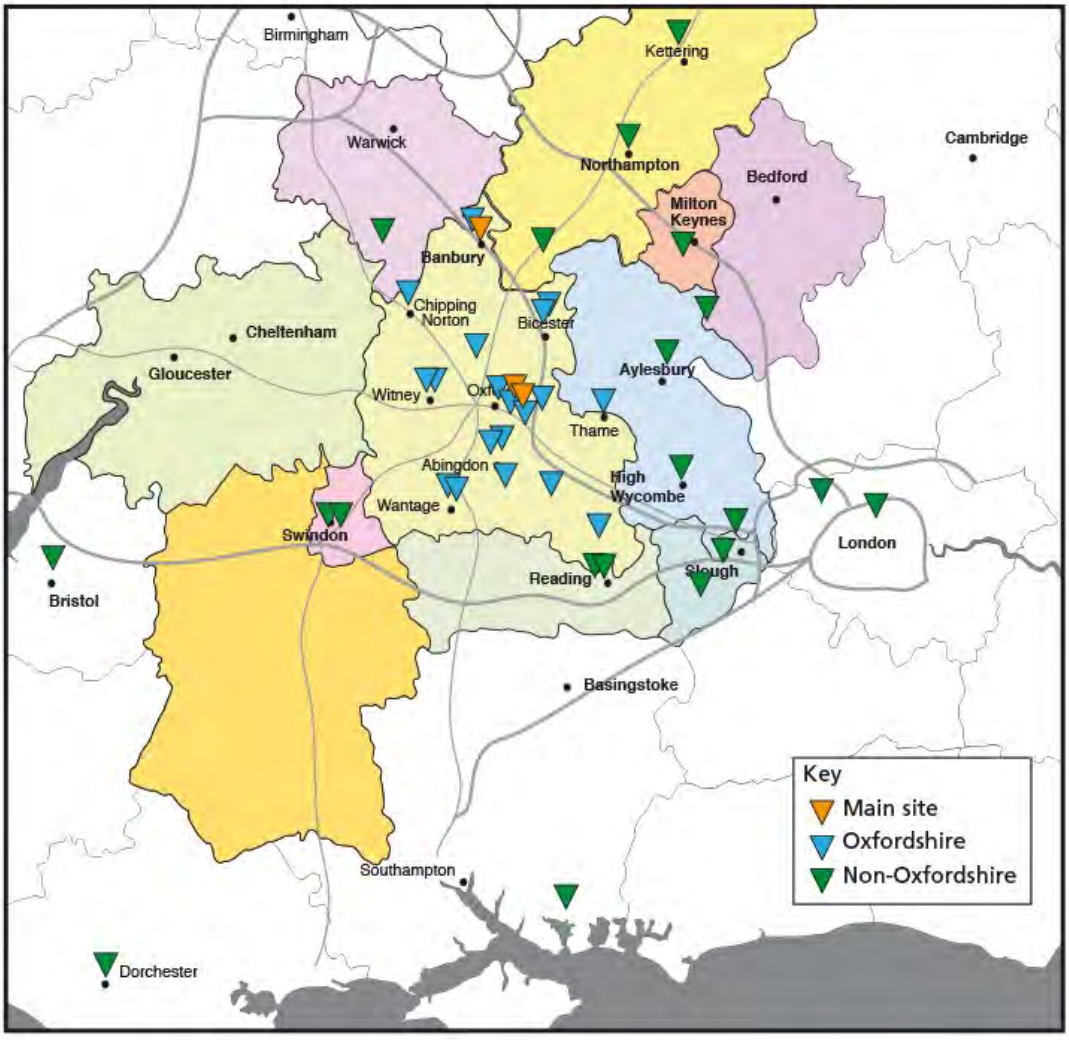
Site	Attendances	% of total
Churchill Hospital	191,124	25.3%
Horton General Hospital	87,610	11.6%
John Radcliffe Hospital	364,572	48.3%
Nuffield Orthopaedic Centre	112,123	14.8%

2.22. The Trust offers private healthcare services across its four sites.

2.23. OUH's pathology service at the John Radcliffe Hospital conducts post mortems on behalf of the Ministry of Defence and receives the bodies of service personnel who have died on operations overseas and are repatriated via RAF Brize Norton.

2.24. Specialist staff provide clinics and services from health facilities operated by other NHS providers. Services are delivered in Oxfordshire and beyond, with outpatient clinics in community settings and satellite outreach services in surrounding hospitals. The Trust runs midwifery-led units in community hospitals in Oxfordshire. It is also responsible for screening programmes, including those for bowel cancer, breast cancer, cervical cancer, chlamydia and diabetic retinopathy. The map overleaf shows the locations from which OUH delivers its services.

Health care sites from which OUH provides services



2.25. 80,000 outpatient episodes (9.58% of the Trust's total) were provided in 2012/13 from 51 non-OUH sites. Locations from which over 1,000 episodes of care were provided are shown below:

Location	Episodes of care
Milton Keynes Hospital	13,491
Wycombe Hospital, Buckinghamshire	11,997
East Oxford Health Centre, Oxford	11,076
Great Western Hospital, Swindon	10,873
Stoke Mandeville Hospital, Buckinghamshire	7,692
Witney Community Hospital, Oxfordshire	3,286
Brackley Community Hospital, Northamptonshire	3,113
Abingdon Community Hospital, Oxfordshire	1,566
Royal Berkshire Hospital, Reading	1,139
Wantage Health Centre, Oxfordshire	1,109
Total	70,731

2.26. Areas of nationally strong clinical performance include:

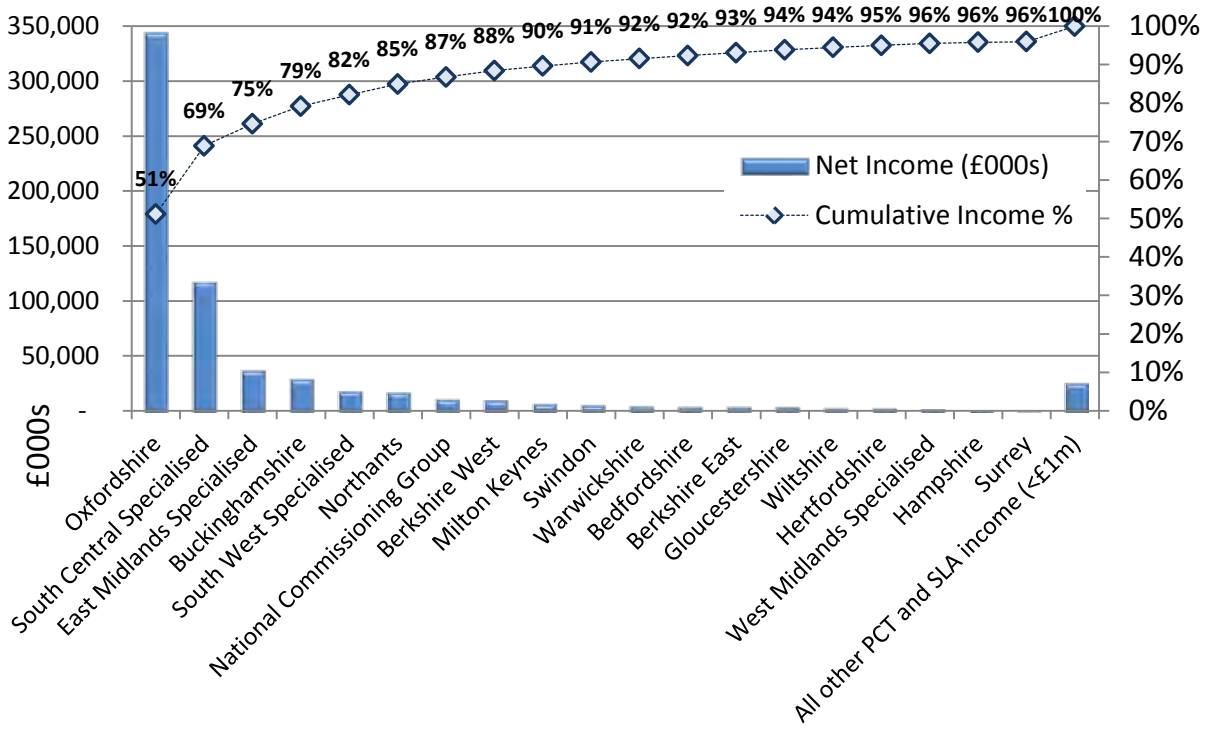
- acute coronary syndrome or acute myocardial infarction, where there has been a 7% year-on-year improvement in the proportion of patients treated within 150 minutes;
- bronchiectasis, where benchmarked performance exceeds the national average and the service provides an innovative multidisciplinary clinic with regular specialist nurse and physiotherapy input and a home intravenous antibiotic service;
- clinical immunology services, in which OUH is recognised as a centre of excellence by the Federation of Clinical Immunology Societies of the US and accredited by the United Kingdom Primary Immunodeficiency Network (UKPIN);
- Chronic Obstructive Pulmonary Disease (COPD) and asthma, in which OUH has led the quality improvement programme for patients since 2011 including a Wellcome-funded Telehealth randomised controlled trial from June 2013 to evaluate a tablet computer with software to support self-monitoring by people with COPD;
- coronary angioplasty, in which Oxford is a top UK percutaneous coronary intervention centre for the number of procedures carried out annually, with low benchmarked mortality and complication rates;
- pain control, in which the Trust's Oxford Pain Relief Unit is a national leader in the use of multi-disciplinary teams as an integral part of care;
- rates of early senior medical review following admission, which are above the national average for adult community-acquired pneumonia.

2.27. OUH has integrated psychiatry into its acute medicine services with a focus on the physical and psychological needs of frail older people. The better management of medical and psychiatric co-morbidity is a theme for the proposed Collaborative Leadership for Applied Healthcare Research Centre (CLAHRC) and includes a significant project to enhance the recognition of psychiatric co-morbidity in physical disease.

Customers and income for patient care

2.28. Clinical Commissioning Groups (CCGs) became the primary commissioners of local health services in 2013/14. Figures reported in this chapter show income from the former Primary Care Trusts (PCTs). New commissioners are shown and further information is given in 4.3.

2.29. Income for providing NHS patient care services in 2012/13 was £672.3m. The chart below shows net income by principal commissioner, distinguishing between services commissioned by former PCTs and specialised services commissioned through consortium arrangements.



2.30. OUH has 26 specialties which each account for 1.5% or more of its NHS patient income. Trauma and Orthopaedics (with services in two Divisions) accounts for the largest single percentage at 9.2%, followed by paediatric medical specialties at 6.9% and General Medicine at 5.6%.

2.31. The tables below show the percentage of the Trust's NHS patient income accounted for by each specialty-based Directorate in 2012/13.

Division	Specialty Description	Net Income 12/13 (£000s)	% of Trust Total
Cardiac, Thoracic and Vascular	Cardiology	28,958	4.3%
	All Cardiothoracic Surgery Grouped	22,394	3.3%
	Vascular Surgery	6,711	1.0%
Cardiac Medicine & Surgery Total		**58,063**	**8.6%**

Division	Specialty Description	Net Income 12/13 (£000s)	% of Trust Total
Children's and Women's	All Paediatric Medical Grouped	46,761	6.9%
	Obstetrics	18,842	2.8%
	All Paediatric Surgery Grouped	15,493	2.3%
	Gynaecology	9,797	1.5%
	Midwifery	12,690	1.9%
Children's & Women's Total		**103,583**	**15.4%**

Division	Specialty Description	Net Income 12/13 (£000s)	% of Trust Total
Critical Care, Theatres, Diagnostics and Pharmacy	All Laboratories Grouped	12,858	1.9%
	Critical Care Medicine	12,604	1.9%
	Radiology & Diagnostic Imaging[2]	12,328	1.8%
	Interventional Radiology	4,100	0.6%
	Pain Management	738	0.1%
	Pharmacy	185	0.0%
	Anaesthetics	123	0.0%
Critical Care, Theatres, Diagnostics & Pharmacy Total		**42,936**	**6.4%**

Division	Specialty Description	Net Income 12/13 (£000s)	% of Trust Total
Emergency Medicine, Therapies & Ambulatory	General Medicine	37,439	5.6%
	Accident & Emergency	18,592	2.8%
	Infectious Diseases	6,423	1.0%
	Genitourinary Medicine	6,316	0.9%
	Clinical Immunology	6,101	0.9%
	Dermatology	5,156	0.8%
	Respiratory Medicine	4,200	0.6%
	Respiratory Physiology	3,116	0.5%
	Geriatric Medicine	2,805	0.4%
	Clinical Genetics	2,440	0.4%
	Endocrinology	2,129	0.3%
	Adult Cystic Fibrosis	1,933	0.3%
	Physiotherapy	1,493	0.2%
	Diabetic Medicine	1,305	0.2%
	Transient Ischaemic Attack	1,017	0.2%
	Podiatry	940	0.1%
	Dietetics	132	0.0%
	Occupational Therapy	3	0.0%
Emergency Medicine, Therapies & Ambulatory Total		**101,541**	**15.1%**

[2] During this period Radiology services provided at the Nuffield Orthopaedic Centre transferred into this Division.

Division	Specialty Description	Net Income 12/13 (£000s)	% of Trust Total
Musculoskeletal & Rehabilitation	Trauma & Orthopaedics	39,518	5.9%
	Rehabilitation	13,395	2.0%
	Rheumatology	9,510	1.4%
	Orthotics	2,766	0.4%
	Medical Oncology	902	0.1%
	Pain Management	156	0.0%
	General Medicine	576	0.1%
	Plastic Surgery	571	0.1%
	Physiotherapy	5	0.0%
Musculoskeletal & Rehabilitation Total		**67,399**	**10.0%**

Division	Specialty Description	Net Income 12/13 (£000s)	% of Trust Total
Neurosciences, Trauma & Specialist Surgery	Neurosurgery	29,012	4.3%
	Trauma & Orthopaedics	21,877	3.3%
	Ophthalmology (Adult & Paediatric)	17,101	2.5%
	Plastic Surgery (Adult & Paediatric)	11,833	1.8%
	ENT (Adult & Paediatric)	10,658	1.6%
	Neurology	9,290	1.4%
	Oral, Maxillofacial & Dental Grouped	7,163	1.1%
	Audiology	1,654	0.2%
	Clinical Neurophysiology	1,478	0.2%
	Orthoptics	829	0.1%
	Optometry	314	0.0%
	Clinical Psychology	210	0.0%
Neurosciences, Trauma & Specialist Surgery Total		**111,419**	**16.6%**

Division	Specialty Description	Net Income 12/13 (£000s)	% of Trust Total
Surgery and Oncology	Medical Oncology	19,416	2.9%
	Transplantation Surgery	19,177	2.8%
	Nephrology	18,835	2.8%
	General Surgery	18,423	2.7%
	Gastroenterology	16,244	2.4%
	Clinical Oncology	15,825	2.4%
	Clinical Haematology	15,246	2.3%
	Haemophilia	14,301	2.1%
	Urology	9,477	1.4%
	Colorectal Surgery	8,046	1.2%
	Palliative Medicine	4,711	0.7%
	Upper Gastrointestinal Surgery	4,299	0.6%
	Blood and Marrow Transplantation	3,708	0.6%
	Breast Surgery	3,051	0.5%
	Gynaecological Oncology	2,089	0.3%
	Anticoagulant Service	1,400	0.2%
	Hepatology	1,252	0.2%
Surgery and Oncology Total		**175,499**	**26.1%**

Divisional totals

Division	Net Income 12/13 (£000s)	% of Trust Total
Cardiac Medicine & Surgery	58,063	8.6%
Children's and Women's	103,583	15.4%
Critical Care, Theatres, Diagnostics & Pharmacy	42,936	6.4%
Emergency Medicine, Therapies & Ambulatory	101,541	15.1%
Musculoskeletal & Rehabilitation	67,399	10.0%
Neurosciences, Trauma & Specialist Surgery	111,419	16.6%
Surgery & Oncology	175,499	26.1%
Trustwide CQUINs and adjustments	11,894	1.8%
Grand Total	**672,334**	**100.0%**

Patient activity

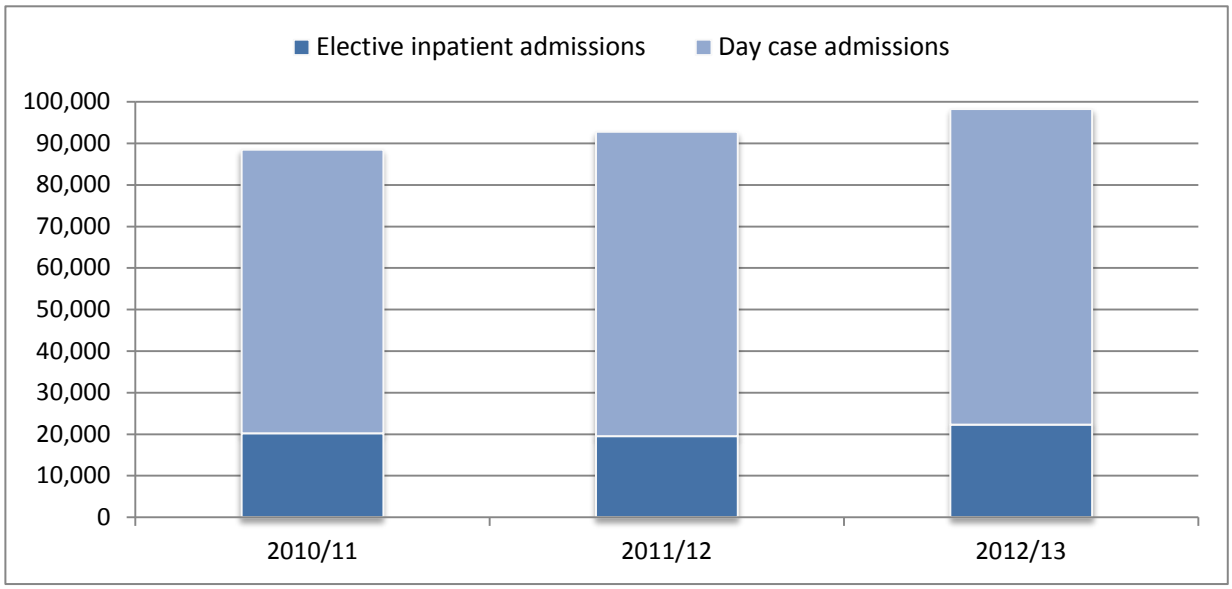
Planned (Elective) Care

2.32. The proportion of surgery carried out on a day case basis grew slightly from 77.2% to 77.3% between 2010/11 and 2012/13.

2.33. Day case activity grew by 11.3% over the two years whilst elective inpatient activity grew by 10.5%, mostly due to the inclusion of activity from the Nuffield Orthopaedic Centre.

2.34. Growth in elective activity at specialty level has been driven by population growth and by targeted reductions in waiting times.

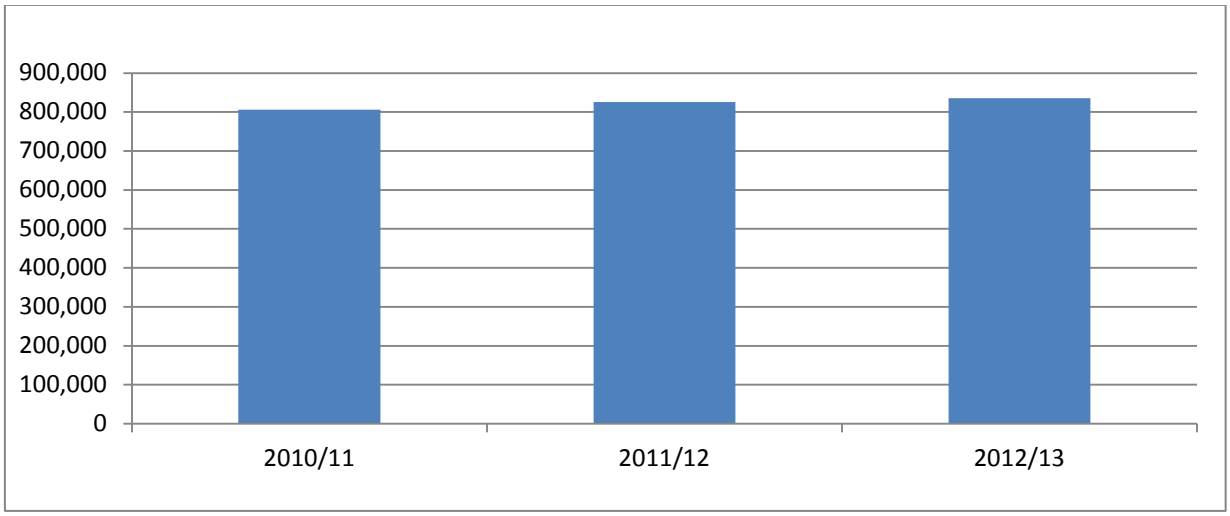
Elective inpatient and day case admissions, 2010/11 – 2012/13



Outpatient care

2.35. Outpatient attendances grew by 3.7% between 2010/11 and 2012/13, again incorporating activity from the Nuffield Orthopaedic Centre.

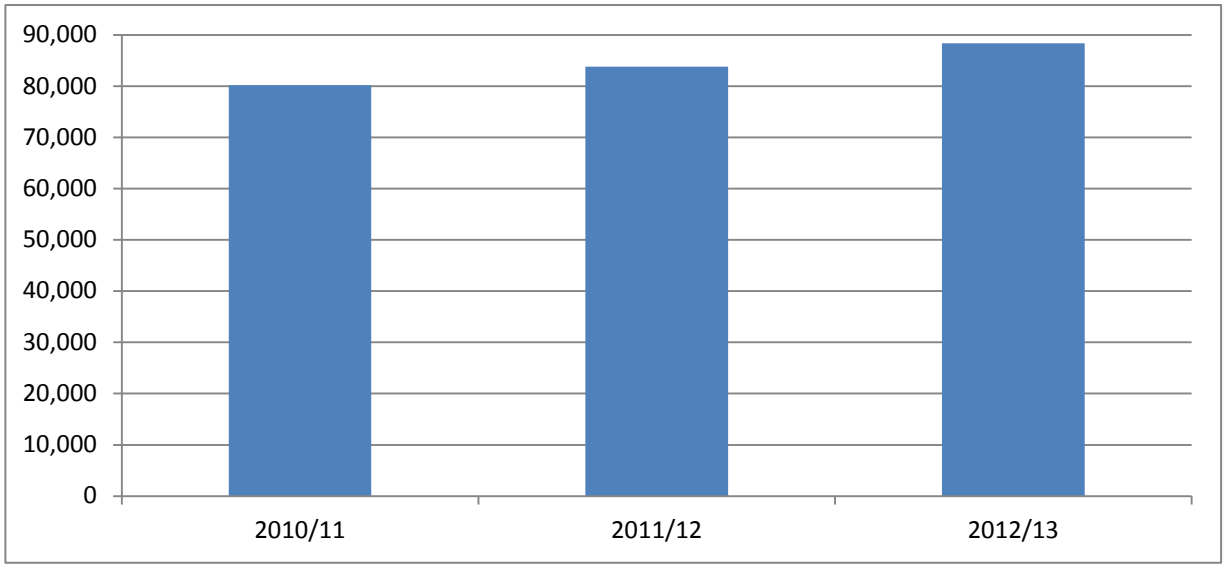
Outpatient attendances, 2010/11 – 2012/13



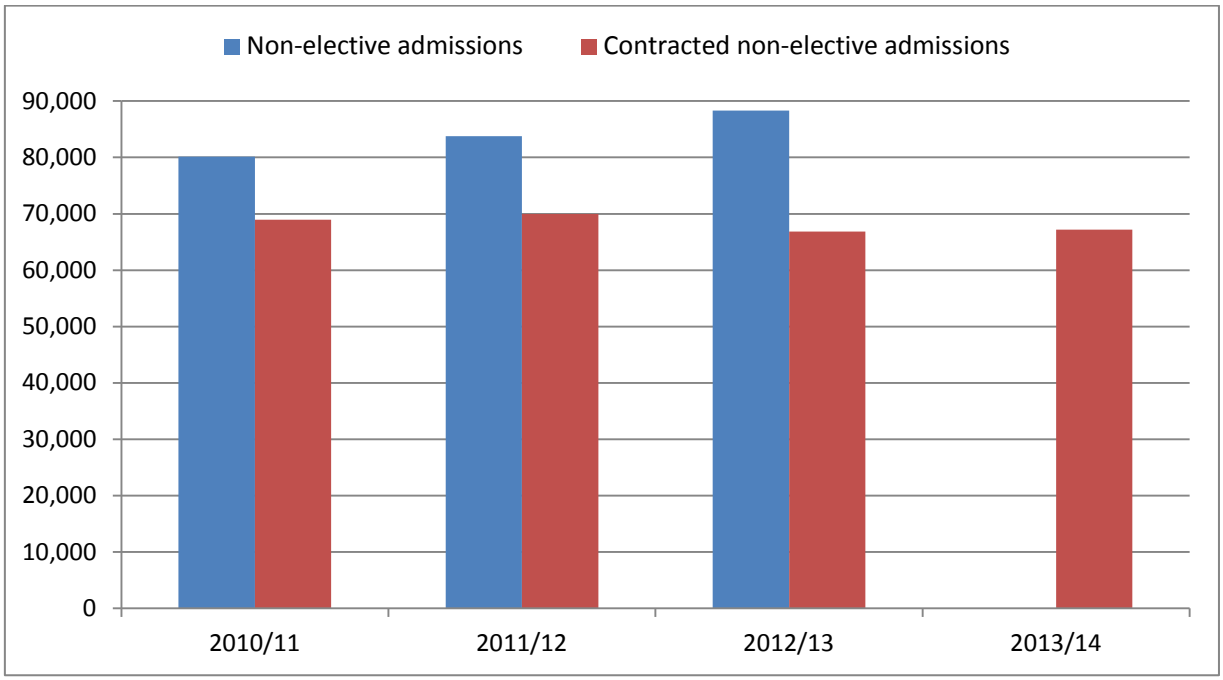
Unplanned and Emergency Care and Assessment

2.36. The number of older people presenting for emergency care has followed demographic trends and an overall growth of 10.2% in non-elective admissions was experienced between 2010/11 and 2012/13.

Non-elective admissions, 2010/11 – 2012/13



2.37. During this period, the level of non-elective care contracted for by NHS Oxfordshire reduced, as shown below.



2.38. As can be seen, the gap between the actual and contracted level of non-elective admissions has grown since 2010/11.

Performance

2.39. Since August 2012 the Trust has reported against a variety of metrics via the FT pipeline self-certification process. This includes the Governance Risk Rating, built on key performance standards contained within Monitor's assurance framework.

2.40. Many of these indicators have been delivered consistently and significant progress has been made to meet others. Work continues to achieve and sustain reduced waits in the Trust's Emergency Departments and to reduce delayed transfers whilst meeting standards in other areas. Developments to achieve and sustain performance in these areas are described in Chapter 5.

18 Week Referral To Treatment

2.41. OUH has delivered the 18 week referral-to-treatment standard trust-wide for non-admitted and admitted patients since its formation.

2.42. The Trust implemented the Cerner Millennium Electronic Patient Record (EPR) in December 2011. This system replaced the entire patient administration system (PAS) and included a strategic solution for managing 18 week RTT for non-admitted and admitted patients.

2.43. With problems experienced in PAS and 18 week functions after implementation, the Trust took a decision to suspend technical implementations until these functions were stabilised, in order to protect patient safety and to minimise the impact on its patients and staff. The stabilisation period allowed OUH to gain greater understanding of patient waits and systems associated with them.

2.44. Trust-wide waiting times of within 18 weeks have been reported for admitted and non-admitted pathways since September 2012, with nearly all specialities achieving this since November 2012.

2.45. The small number of individual specialties not achieving the target has reduced and where problems are identified, action is taken to address issues of capacity or working practice. During 2013 there has been only one specialty-level failure of the non-admitted RTT (General Surgery in January) and only one specialty has breached the admitted RTT (Urology in April and May).

Accident and Emergency standard

2.46. During 2011/12 the Trust achieved overall performance of 95.63% against the standard of seeing, treating and discharging or admitting 95% of patients within four hours.

2.47. Formal reporting was suspended by agreement with NHS South of England during Quarter 4 of 2011/12 following the Trust's introduction of the Cerner Millennium Electronic Patient Record. Performance following the resumption of reporting was as follows:

Period	A&E waits within 4 hours	Period	A&E waits within 4 hours
April-June 2012	89.9%	January 2013	92.91%
July-September 2012	96.1%	February 2013	91.58%
October-December 2012	95.9%	March 2013	85.73%
		April 2013	85.17%
		May 2013	95.23%
		June 2013	96.34%

2.48. During the past twelve months, OUH has completed a review of its Emergency Departments and has invited the Emergency Care Intensive Support Team (ECIST) to examine its services and provide recommendations to ensure their fitness for purpose and sustainability. Acting on these recommendations, work has taken place to improve pathways into specialties, to enhance Emergency Department clinical leadership and to recruit additional consultant staff.

2.49. To enhance senior clinical decision-making, the Trust intends to have on-site consultant grade leadership in place within the Emergency Department for 18 hours a day, seven days a week by December 2013, increasing to 24 hours a day, seven days a week in 2014. The presence of acute general medicine consultants within the Emergency Department is being enhanced and progress is being made towards having a sustained GP presence in the Department.

Cancer standards

2.50. The Trust is monitored on eight key cancer standards under four headings: 31-day maximum waits for second and subsequent treatments (for surgery, anti-cancer drugs and radiotherapy); 62-day maximum waits for first treatment (from GP referral and screening referral); 31-day maximum waits from referral to diagnosis; and waits of within two weeks from referral to first appointment (for all referrals and for symptomatic breast cancer patients).

2.51. Although individual cancer standards have not been met in individual months, all eight of the key cancer standards have been met on a quarterly basis since Q2 of 2011/12 with the exception of the 62 day standard for GP referral to first treatment in Q2 of 2012/13.

Delayed Transfers of Care

2.52. Delayed transfers of care have been above the expected maximum of 3.5% of acute bed capacity since OUH's formation.

2.53. Oxfordshire's delays have been the highest in England for several years.

2.54. Reducing delays in transferring patients has proved challenging for local commissioners and providers over a long period. A clear priority for OUH is to participate actively in putting in place new pathways and community provision to deliver sustainable progress. This is described from 5.30 below.

Diagnostic Waiting Times

2.55. The proportion of patients waiting more than six weeks for diagnostic tests rose above 10% in December 2012. Additional staffing to deliver improvements including the seven-day operation of scanners was put in place and progress has been made towards achievement of this standard.

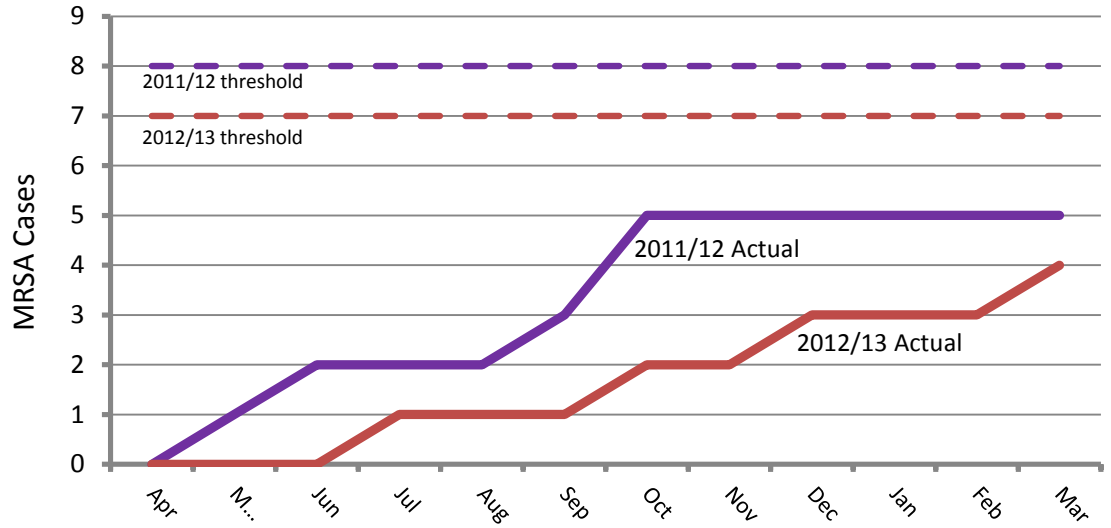
2.56. With an unbundled tariff in place, it is important for OUH and its commissioners that waits within six weeks do not produce or depend upon unaffordable increases in activity.

2.57. The Trust continues to work with Oxfordshire CCG to address changes in demand for musculoskeletal direct access imaging in particular. Clear plans are in place to maintain progress.

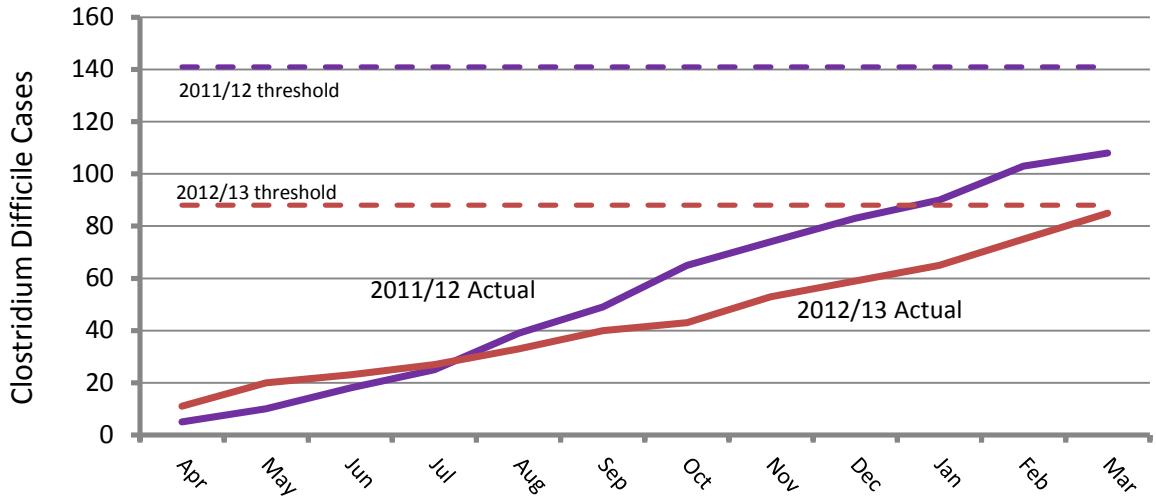
Infection control

2.58. The Trust remained within reducing 'threshold' levels set for cases of MRSA and *Clostridium difficile* in 2011/12 and 2012/13.

Cumulative MRSA cases against threshold



Cumulative *Clostridium Difficile* cases against threshold



Registration with the Care Quality Commission

2.59. OUH is registered without conditions for all regulated activities on each of its sites.

2.60. The Trust is compliant with all 16 essential standards of quality and safety and has systems in place to ensure continued compliance.

Single Sex Accommodation

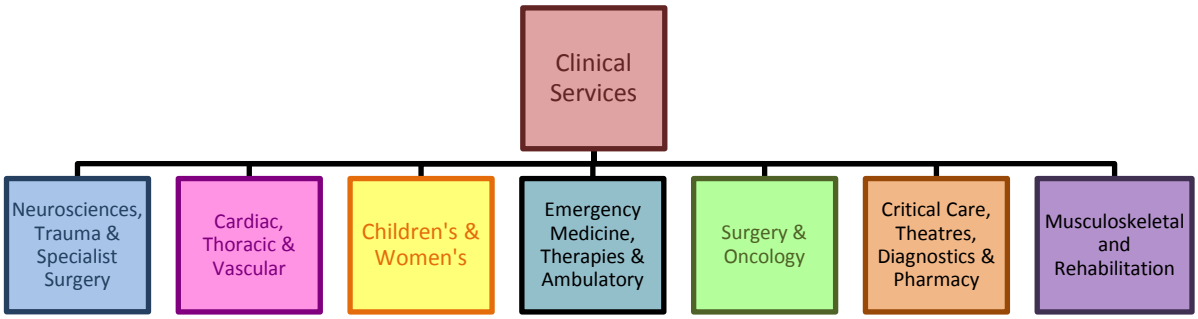
2.61. Breaches of this standard were below 10 per month for most of 2011/12 with peaks in June and January. Nationally reportable breaches occurred twice in 2012/13, both related to the need to accommodate patients in the Emergency Admissions Unit (EAU) at the Horton General Hospital.

VTE Assessment

2.62. VTE assessments as a percentage of admissions showed improvement in 2011/12 and the threshold level was delivered in 2012/13.

Organisational structure

2.63. OUH's clinical services are organised in seven clinically-led Divisions.



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

2.65. Divisions include two or more Directorates, which are broadly specialty-based and contain clinical service units covering specific areas of services. Directorates are led by Clinical Directors who are accountable to the Divisional Director and supported by Operational Service Managers, Matrons and other relevant experts. Directorates include those with services on one or more sites, such as surgery and women's services, and those such as neurosciences which are based on a single site.

Neurosciences, Trauma and Specialist Surgery Division

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

Cardiac, Thoracic and Vascular Division

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

Children's and Women's services Division

- Paediatric medicine, surgery and neonatology: paediatric medicine & specialist medicine; neonatology; community paediatrics; paediatric surgery & specialist surgery, including spinal surgery; paediatric intensive & high dependency care; and
- Women's: obstetrics and midwifery; gynaecology, theatres and anaesthetics.

Emergency Medicine, Therapies and Ambulatory care Division

- Emergency medicine and therapies: emergency medicine; acute general medicine, geratology and stroke medicine; therapies; and
- Specialist and ambulatory medicine: diabetes, endocrinology & metabolism; dermatology; clinical immunology; clinical genetics; chest medicine; infectious diseases & genito-urinary medicine.

Surgery and Oncology Division

- Oncology & haematology: clinical oncology; medical oncology; clinical haematology, haemophilia & thrombosis; medical physics & clinical engineering; palliative medicine;
- Surgery: upper & lower gastrointestinal surgery; acute surgery; breast & endocrine surgery; gynaecological oncology;
- Renal, transplant and urology: transplant & renal; urology; and
- Churchill theatres, endoscopy & GI: Churchill theatres and anaesthetics; gastroenterology; endoscopy.

Critical Care, Theatres, Diagnostics and Pharmacy Division

- Anaesthetics, critical care and theatres: anaesthetics (except as within individual Divisions); adult critical care; pre-operative assessment; resuscitation; pain service; theatres & day case unit (except as within individual Divisions);
- Pathology and laboratories;
- Radiology and imaging; and
- Pharmacy.

Musculoskeletal and Rehabilitation Division

- Orthopaedics (including bone cancer, bone infection, hip and knee, foot and ankle, upper limb, integrated adult spinal surgery, therapies, theatres, high dependency care and TSSU facilities);
- Rheumatology (including paediatric rheumatology and a sports medicine service);
- Metabolic bone disease;
- Chronic pain management with a back pain triage and a functional restoration service;
- Musculoskeletal diagnostic and interventional radiology;
- Musculoskeletal histopathology;
- Gait Laboratory;
- Early and late phase neurological rehabilitation and disability management; and
- Wheelchair, orthotics and prosthetic services.

2.66. Clinical Divisions are supported by corporate and business support functions, including Finance and Procurement, Planning & Information, Human Resources, Estates & Facilities, the Medical Directorate, the Nursing Directorate and the Assurance Directorate; and by other services within corporate directorates, including governance, legal services and research administration.

Trust resources

People

2.67. The Trust employed 11,140 people in 9,154 whole-time equivalent (WTE) posts in March 2013.[3]

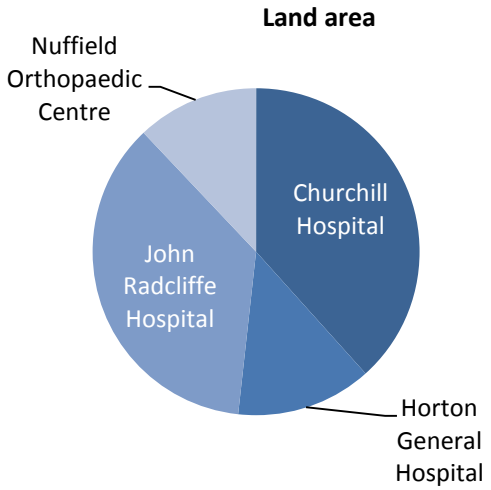
Staff group	% of WTE
Nursing and Midwifery	32
Administration and Estates	18
Medical and Dental	16
Heathcare Assistants	16
Healthcare Scientists	5
Scientific, Therapeutic and Technical Staff	3
Allied Health Professionals	6
Managers and Senior Managers	2
Other	1
Total	100

2.68. Pay accounted for £447.5 million (59%) of OUH's total operating costs of £752.9 million in 2012/13. Management costs made up 1.9% of its total expenditure and 3.1% of its total pay expenditure.

2.69. Details of the Trust's staffing are given in Chapter 8.

Facilities and property

2.70. OUH has 391,000 square metres of internal area on 73.8 hectares of land.



Site	Land area (hectares)
Churchill Hospital	28.3
Horton General Hospital	9.9
John Radcliffe Hospital	26.7
Nuffield Orthopaedic Centre	8.9
Total	**73.8**

[3] This is a snapshot figure of contracted posts. This differs slightly from the LTFM which shows an average worked WTE figure from the finance ledger.

Internal area (m^2)

	Churchill	Horton General	John Radcliffe	NOC	Total	% of total
OUH	53,000	27,500	131,550	8,670	220,720	56.4%
- of which University space in OUH building	2,250	0	11,900	63	14,213	3.6%
University buildings (freehold or leasehold)	5,100	0	11,100	2,320	18,520	4.7%
PFI	35,300	0	58,350	20,350	114,000	29.1%
- of which University space in PFI	360	0	4,300	585	5,245	1.3%
Other	12,300	10,500	15,000	372	38,172	9.8%
Total Gross Internal Area	105,700	38,000	216,000	31,712	391,412	100.0%
% of total	27.0%	9.7%	55.2%	8.1%	100.0%	

2.71. 29.1% of property on OUH's sites has been funded through the private finance initiative (PFI).

2.72. To maintain these facilities the Trust works closely with its PFI partners. For the West Wing and Children's Hospital on the John Radcliffe site, the Special Purpose Vehicle (SPV) for the PFI is The Hospital Company with Carillion Health as service provider. The SPV for the new Churchill Hospital buildings is Ochre Solutions Limited and that for the Nuffield Orthopaedic Centre development is Albion Health Services. Both include G4S as their major service provider. Carillion Health and G4S provide most of the domestic and portering services on the Headington sites. Catering Services are provided by Carillion at the John Radcliffe Hospital and by Aramark at the Churchill and NOC.

2.73. A new Churchill Hospital including the Oxford Cancer Centre opened in April 2009. This development was financed using PFI and offers state-of-the-art facilities and equipment which match the first class expertise of our clinical teams, in a single integrated service centre.

2.74. The £29 million Oxford Heart Centre opened in October 2009, providing additional single rooms, a cardiac intensive care unit and five catheter labs. This development provides state-of-the-art facilities for research and the treatment of people with heart disease and was jointly funded by the NHS and the University of Oxford. Trust staff already work closely with University colleagues and have contributed significantly to advances in the delivery of care to heart patients. Adjacent is a research-funded Acute Vascular Imaging Centre (AVIC), built by the University of Oxford, which puts the University and Trust at the forefront of stroke diagnosis and treatment.

2.75. Bed numbers are flexed where necessary to meet the demands of the service. OUH also has a number of clinical areas which are not staffed on a 24-hour basis, so bed numbers given are indicative and not necessarily a good proxy for capacity.

Relevant assets

2.76. Monitor requires NHS Foundation Trusts, as a condition of their Provider Licence, to maintain an asset register, which indicates which assets are considered 'relevant.'

2.77. Monitor's *Guide for Applicants* (April 2013) states that relevant assets include "any item of property, including buildings, interests in land, equipment (including rights, licences and consents relating to its use), without which the trust's ability to meets its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced."

2.78. This business plan assumes that OUH continues to operate services from its four hospital sites. It therefore intends to regard its four hospital sites as relevant assets.

2.79. The total value of these assets at the end of 2012/13 was £682 million. This comprised NHS and donated tangible fixed assets, including land, buildings and equipment. This sum is a lower figure than the fixed assets figure at 2.7 above as it excludes intangible assets and long-term debtors.

Supplies

2.80. OUH spends £92.6m (12% of its total operating expenses) on clinical supplies, excluding drugs. It invests specialist expertise to support its procurement activity and collaborates with other NHS organisations to obtain an appropriate quality of supplies and services on the most competitive terms.

Finance

2.81. The tables below give illustrative financial data for OUH for 2012/13 and the preceding two years, with figures for 2010/11 being for the predecessor ORH Trust. Further detail is given in Chapter 6.

Income and Expenditure Statement

Income and Expenditure Statement	ORH (000s)	OUH (000s)	
	2010/11	2011/12	2012/13
Income from activities	546,561	638,690	691,048
Other operating income	117,210	149, 530	130,656
Total income	**663,770**	**788,220**	**821,704**
Operating expenses before depreciation and impairments	(608,011)	(718,705)	(752,889)
EBITDA surplus / (deficit)	**55,760**	**69,514**	**68,815**
EBITDA margin %	*8.4%*	*8.8%*	*8.4%*
Retained surplus / (deficit)	**13,207**	**7,603**	**(1,316)**
Adjustments for impairments	(11,618)	(2,327)	4,568
Adjustments for IFRIC12 & donated assets	(300)	1,882	394
Adjusted surplus / (deficit)	**1,289**	**7,157**	3,646
Adjusted surplus / (deficit) %	*0.2%*	*0.9%*	*0.4%*

Balance Sheet

2.82. The 'non-current' liabilities shown below represent liabilities on PFI contracts, with the value of the PFI assets included within the Trust's fixed assets.

Balance Sheet	ORH (000s)	OUH (000s)	
	2010/11	2011/12	2012/13
Fixed assets	611,470	708,366	693,175
Current assets	54,362	92,093	104,063
Current liabilities	(93,018)	(108,189)	(123,663)
Net current assets	(38,656)	(16,096)	(19,601)
Non-current assets	90	90	90
Non-current liabilities	(289,480)	(320,400)	(302,281)
Total net assets	**283,424**	**371,960**	**371,384**
Public dividend capital (PDC)	174,547	206,873	207,673
Revaluation reserve	103,696	147,744	147,360
Donated asset reserve*	68,626	0	0
Other reserves inc government grant reserve	1,815	1,743	1,743
Income & expenditure reserve	(65,260)	15,600	14,608
Total capital and reserves	**283,424**	**371,960**	**371,384**

* Prior to change in donated asset accounting in 2011/12.

Cash Flow

Summary Cash Flow Statement	ORH (000s)	OUH (000s)	
	2010/11	2011/12	2012/13
Net cash inflow/ (outflow) from:			
- operating activities	66,572	86,998	94,077
- returns on investments and servicing of finance	(17,478)	(20,291)	(20,518)
- capital expenditure	(23,096)	(17,438)	(26,239)
- dividend payments	(6,960)	(8,983)	(9,374)
Net cash inflow/ (outflow) before management of liquid resources and financing	19,038	40,286	37,946
Net cash inflow/ (outflow) from financing	(9,924)	(15,879)	(16,174)
Increase/ (decrease) in cash	**9,114**	**24,407**	**21,772**

Historic Reference Cost Index

2.83. The Reference Cost Index figure for ORH was 108 in 2010/11 and was also 108 for OUH in 2011/12. Reference costs are considered further in Chapter 6.

Research partnerships and innovation

2.84. Oxford is one of the largest biomedical research centres in Europe, with over 2,500 people involved in research and more than 2,800 students. Teaching and research span fundamental science through to clinical trials and translation into treatment. Oxfordshire is also a focus for life sciences in the UK, with biomedical research and Science Vale UK based at Harwell, and many life sciences and pharmaceuticals businesses based in the county.

2.85. The Mandate issued to Health Education England in April 2013 included a specific objective for working in partnership, including the development of relationships with AHSCs and AHSNs to align education with research and innovation. OUH and Oxford Health's Chief Executives are members of the Health Education Thames Valley (HETV) Board and both local Universities are members of its Expert Education Reference Group.

2.86. OUH works closely with a range of key partners to:

- Provide high quality NHS and private healthcare services;
- Teach and train healthcare professionals;
- Undertake healthcare research;
- Operate its facilities efficiently; and
- Secure charitable support for appropriate priorities.

2.87. Primary contractual relationships are with:

- Clinical Commissioning Groups and specialised commissioners for the delivery of NHS services;
- PFI partners, for the provision, maintenance, and servicing of part of its estate;
- The University of Oxford and Oxford Brookes University, for teaching and research;
- Suppliers; and
- Other local NHS FTs and NHS trusts, with which it contracts to provide specialist support.

2.88. The Trust works actively with its patients, the public and stakeholder bodies (for example, Oxfordshire's Joint Health Overview and Scrutiny Committee) to gain assurance that its services meet local patients' needs and to test that its plans for service change are well focused and supported.

2.89. The Trust has a strong track record and reputation for research and teaching activities in partnership with the University of Oxford's Medical Sciences Division and with Oxford Brookes University's Faculty of Health and Life Sciences. OUH is committed to bringing the benefits of world-leading research to patients as fast and as effectively as possible.

2.90. Of particular significance amongst the Trust's partnerships is the Joint Working Agreement formalising its links with the University of Oxford. This provides an agreed structure and governance processes for the relationship between the two organisations, enhancing the ability to share thinking and activities and to function as a partnership committed to the pursuit of excellence in patient care, teaching and research.

2.91. The Joint Working Agreement builds on a long history of joint working between the University of Oxford and the NHS hospitals in Oxford, greatly benefitting both patients and the wider community. Existing collaborations include the ambitious research programmes established through the National Institute for Health Research (NIHR)-funded Biomedical Research Centre (BRC) and the Biomedical Research Unit (BRU) in musculoskeletal disease. Each was amongst the first of its type to be designated and a successful bid to extend the programme in 2011 led to the award of funding for a further five years of £63 million for the BRC and £7.9 million for the BRU. These set the standard in translating science and research into new and better NHS clinical care.

2.92. A formal joint working agreement is also in place with Oxford Brookes University (OBU) to support collaborative work, scholarly activities and other educational initiatives. OBU is regularly the top new university in the UK and its Faculty of Health and Life Sciences includes the Departments of Biological & Medical Sciences, Clinical Health Care, Psychology, Social Work & Public Health, and Sport & Health Sciences and the Centre for Rehabilitation and the Clinical Exercise and Rehabilitation Unit. OUH employs significant numbers of new OBU graduates.

2.93. Several OBU research areas are linked to service provision with OUH and other partners, including:

- Cancer care: the impact of cancer care on families; the role of primary care in supporting people with cancer and their families; continuity of care for cancer patients
- Cardiac care: Patient Reported Outcome Measure for fatigue and breathlessness in heart failure; the use of inhaled furosemide in breathlessness
- Maternal & public health: use of birthing pools in labour; women's public health and maternal care strategies
- Drug and alcohol abuse prevention: prevention of risk behaviours in children and young people; drug treatment effectiveness; role of emergency hostels in supporting drug addicts; effects of alcohol advertising and drinking behaviour in young people
- Children & young people: evaluation of Health Visitor Assessments; safeguarding of children delivered through primary care teams

2.94. OUH is a founding and hosting partner of the Oxford Academic Health Science Network (designated in May 2013) for a population of about 3.3 million people across Oxfordshire, Berkshire, Buckinghamshire and Bedfordshire. Oxford AHSN brings together all NHS bodies, nine Universities, NIHR-funded research organisations (e.g. Thames Valley LCRN[4]) and an increasing number of third sector bodies, business networks, SMEs and large life sciences businesses in the region to provide an opportunity for all partners to participate in the provision of evidence-based care for the patients and populations they serve and to develop best care through research and innovation.

2.95. OUH is working with Oxford Health NHS FT, the University of Oxford and Oxford Brookes University to achieve designation as the Oxford Academic Health Science Centre (OxAHSC). The initial prequalification questionnaire has been submitted and it is hoped that OxAHSC will be shortlisted for the next stage. OxAHSC will continue to work collaboratively though the Oxford Academic Health Consortium (OAHC) ensuring that wider cooperation continues with the Oxfordshire Clinical Commissioning Group, Oxfordshire County Council and Southern Health NHS Foundation Trust. OAHC operates as a forum for collaboration on programmes to increase the scale and quality of world-class research and to deliver these benefits more rapidly to patients.

2.96. OUH has also supported a shortlisted bid led by Oxford Health NHS FT to host a new Collaborative Leadership for Applied Healthcare Research Centre (CLAHRC), an NIHR-funded initiative.

2.97. The Trust and the University of Oxford's Medical Sciences Division believe that through working more closely together, they can set and sustain levels of service quality, outcomes and value which will be comparable to the best internationally.

[4] OUH has been shortlisted as host organisation for the new Thames Valley NIHR Local Clinical Research Network (LCRN) from 1 April 2014

Chapter 3

Strategy

3. Strategy

Vision and values

3.1 Our mission is the improvement of health and the alleviation of pain, suffering and sickness for the people we serve.

3.2 We will achieve this through providing high quality, cost-effective and integrated healthcare with compassion and through the constant quest for new treatment strategies and the development of the people who work for us.

3.3 Our core values are Excellence, Compassion, Respect, Delivery, Learning and Improvement.

3.4 Collaboration and partnership are central to our approach in delivering our triple functions of patient care, education and research.

3.5 Summarised as 'Delivering Compassionate Excellence', our values are being used by staff and leaders throughout our organisation and with partner organisations as a basis for improving the quality of the care we provide, not least in terms of our patients' experience of care.

3.6 These values determine Oxford University Hospitals NHS Trust's (OUH's) vision to be:

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

3.7 This vision is underpinned by the Trust's founding partnership with the University of Oxford.

3.8 It reflects OUH's position as a provider of healthcare for local people and for a wider population.

3.9 The patient is at the heart of everything the Trust does. OUH is committed to delivering high quality care to patients irrespective of age, disability, religion, race, gender and sexual orientation, ensuring that its services are accessible to all but tailored to the individual.

3.10 Central to the Trust's vision are its staff. OUH aims to recruit, train and retain the best people to enact its values and achieve its vision.

3.11 OUH strives for excellence in healthcare by encouraging a culture of support, respect, integrity and teamwork; by monitoring and assessing its performance against national and international standards; by learning from its successes and setbacks; by striving to improve what it does through innovation and change; and by working in partnership and collaboration with all the agencies of health and social care in the area it serves.

3.12 The Trust is committed to being an active partner in healthcare innovation, research and education. It aims to be an effective bridge between research in basic science and healthcare provision, turning today's discoveries into tomorrow's care through the use of evidence-based, best practice.

3.13 OUH's vision and values inform its strategic objectives which in turn form the basis of this Integrated Business Plan.

Strategic objectives

3.14 The Trust has six strategic objectives from which its priority work programmes flow.

SO1. To be a patient-centred organisation providing high quality, compassionate care with integrity and respect for patients and staff – *"delivering compassionate excellence."*

SO2. To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – *"a well-governed and adaptable organisation."*

SO3. To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – *"delivering better value healthcare."*

SO4. To provide high quality general acute healthcare to the people of Oxfordshire including more joined-up care across local health and social care services – *"delivering integrated local healthcare."*

SO5. To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialist care for the people of Oxfordshire and beyond – *"excellent secondary and specialist care through sustainable clinical networks."*

SO6. To lead the development of durable partnerships with academic, health and social care partners and the life sciences industry to facilitate discovery and implement its benefits – *"delivering the benefits of research and innovation to patients."*

Measures of strategic success

3.15 OUH is committed to improve and develop its services for local people. These 'local acute' services are vital to each of the Trust's triple functions of patient care, education and research.

3.16 Developments in 'local acute' services are described in Chapter 5 and reflect a clear and constructive response to local demographic change and to the needs faced by local commissioners.

3.17 OUH Executive and Divisional Directors have met with Oxfordshire CCG's six locality groups to strengthen relationships, share respective strategies, discuss issues of shared concern, consider locality-specific issues and discuss how meaningful engagement can be maintained. A proposed work programme is being considered by the Trust's Board in July 2013. The Trust is also working with Oxfordshire County Council's Director of Public Health to support the development of a public health strategy for the county which can help guide the development of the services OUH provides for the people of Oxfordshire. The Trust also recognises a need to work closely with GPs as providers of care. It participates in Oxfordshire Local Medical Committee's liaison group and has invited Oxfordshire LMC to nominate a Governor to the Trust's Council of Governors (see 3.82.1 below).

3.18 During the period of this IBP, distinct changes can be expected in the models of care delivery in which OUH is involved. Integration of care supported by rapid access to expertise will underpin the Trust's services for local people and especially for older and vulnerable adults. OUH is strengthening its clinical liaison with local GPs as it develops improved and new models of local acute care.

3.19 Similar principles support the development of the Trust's specialist services, with a developing network of clinical partners beginning to shape a future where OUH is a partner with a range of providers in delivering high quality and effective care as locally as possible. Chapter 5 describes developments which support and strengthen the value and sustainability of its specialist services.

3.20 Progress against OUH's strategic objectives will be manifested in several ways for different groups:

- **For patients**, through levels of satisfaction and experience that compare well with those of comparable teaching trusts. Patients will experience excellent care delivered in accordance with OUH's values. Patients receiving 'general hospital' care will benefit from better-integrated care closer to home. Across a wider clinical network, patients will be able to access specialised care more locally. Overall, the Trust's patients will benefit from the results of translational research and gain early access to evidence-based treatments and care pathways.
- **For staff**, through raised levels of satisfaction and skills development. Staff will benefit from working in a supportive culture where, consistent with OUH's values, individuals are treated with integrity and respect. Opportunities for personal development will be enhanced through new roles and ways of working, particularly through involvement with research and engagement across both the Oxford Academic Health Science Centre, the wider Consortium and the Oxford Academic Health Science Network.
- **For the trust's public members** who will have the opportunity to influence the Foundation Trust and to be involved with its development.
- **For commissioners** who will be able to access better value healthcare. OUH plans to reshape its services to increase efficiency, enhance quality and where necessary to reduce hospital activity.

3.21 OUH will also measure its success in several other ways:

- **Through choice by referrers** to use OUH, seen through activity levels demonstrating sustained market share and new patterns of referral for specific services;
- **By creating a clinical network** with continued collaboration and partnership;

- **In the Oxford Academic Health Science Network**, through partnership with a strong commitment to deliver the benefits of innovation for patients;
- **In the Oxford Academic Health Science Centre,** through partnership with a strong commitment to the translation of basic research into applied research and patient services;
- **Through innovation in service delivery,** with recent examples including a supportive hospital discharge service delivering social care, and the introduction of a psychological medicine service;
- **By benchmarking**, through demonstrating that the Trust delivers patient safety, patient experience, outcomes and costs that compare well with available comparators; and
- **Through evidence of delivery against plans**, reinforcing confidence in the organisation's capability.

Organisational building blocks

3.22 Delivery of OUH's strategic objectives is founded on organisational building blocks which represent important developments in how it operates. These are:

Board leadership

- Strong and visible leadership across all areas and specifically in terms of values and strategic development;
- Focus on quality and patient experience at the highest level; and
- Leadership within the local and wider health community.

Clinical leadership

- Day-to-day management and delivery of services by clinically-led Divisions; and
- Development of the strategic future for the Trust founded on Divisional involvement.

Staff engagement, wellbeing and development

- Use of a behavioural framework to support the application of the Trust's values in practice; and
- An education and training framework to underpin the Trust's workforce strategy.

Governance and assurance

- Improved systems at directorate, Divisional and trust level to provide assurance to the Board and to regulators of the quality of care and effective systems for the avoidance of harm; and
- Incorporation of learning from other healthcare organisations.

Value for money

- Maximising the service quality and clinical outcomes delivered through a defined resource via visibility of costs at patient level;
- Divisions operating as strategic business units for delivery of service and workforce redesign, informed by benchmarking; and
- Delivery of a divisionally-owned and corporately-supported programme to improve outcomes and reduce costs on a rolling two-year basis.

Enabling strategies

- Progress is supported by OUH's Estate and Workforce strategies. Also relevant are the Trust's strategies for Quality, Information Management & Technology, Membership, Risk and Assurance.

Strategic Objective 1: "Delivering Compassionate Excellence"

3.23 This objective is rooted in three of the Trust's core values and is embedded in its everyday activities. It commits the Trust to the principle of shared-decision making, putting patients at the centre of all that it does.

3.24 Work derived from addressing this objective includes that on learning and development for the clinical workforce. The development of sustainable and patient-focused establishments in wards, theatres and clinics with robust clinical leadership intended to maintain and improve quality whilst containing cost through minimising use of agency and bank staff, is explicitly linked to the Trust's values. Likewise, OUH's work to improve governance, assurance and information systems all support the delivery of the best care.

3.25 Following a process of engagement with staff and the Trust's Patient Panel in autumn 2011, OUH agreed values for use in recruitment, appraisal, training and personal development of its staff and in leadership and management development. The enactment of these values is taking place through initiatives described in 8.65.

3.26 The Trust is developing its mechanisms for gathering and using patient feedback and has a programme of board walk rounds so that Board members are in touch with the views and experience of patients. A scheme based on the concept of "You said… We did…" is intended to demonstrate responsiveness to patients' views.

3.27 The monitoring and benchmarking of outcomes assists the Trust in maintaining a quality focus across its services. Progress is reflected in the Quality Account.

3.28 As well as the attitude of its staff towards its patients, the Trust's ambition to deliver compassionate excellence also reflects the culture to be nurtured in the organisation more widely, with the ethos of integrity and respect amongst staff and in dealings with partners in the delivery of care. OUH aims to engender a culture that expresses commitment and pride in the quality of care it provides, whilst monitoring and assessing performance to provide supportive challenge and to learn from its successes and setbacks and those of others.

Strategic Objective 2: "A Well-Governed and Adaptable Organisation"

3.29 Authorisation as an NHS Foundation Trust will support the achievement of OUH's mission, vision and strategic objectives. Becoming an FT is not an end in itself but a means of creating a clinically and financially sustainable organisation with strong and effective governance arrangements.

3.30 OUH seeks to respond imaginatively to the challenges posed by the economic environment. Operating as an FT will allow the rapid adoption of new ways of working, with greater scope for the delivery of new forms of care in new settings. The potential to use a range of business models with commercial, academic, health or social care partners, individually or in combination, will allow the Trust to provide better value care for the patients of tomorrow in new ways.

3.31 OUH will operate within the context of a clearly stated strategy over several years. It employs a governance framework designed and assessed through external scrutiny as fit to support its delivery and underpinned by appropriate Risk Management and Assurance strategies. Through the Trust's membership and Council of Governors, OUH's patients, public, staff and partner organisations will play a part in guiding this strategy.

3.32 OUH will take steps to ensure meaningful engagement with minority groups and those representing the nine protected characteristics, ensuring that through its membership and the Council of Governors, the communities it serves are able to influence the future of its services.

3.33 Patients will experience care provided by an organisation where they can influence service change and be closely involved in innovation and development from ever-stronger links with world-class research and teaching through the NIHR-funded Oxford BRC and BRU, the Oxford Academic Health Consortium and the Oxford Academic Health Science Network.

3.34 The Trust will grow its membership and, through its Membership Strategy, fulfil its social responsibility as a major local employer and provider of services.

3.35 OUH's systems and processes – from electronic patient records to quality governance – are continuing to develop to respond flexibly and meet emerging standards.

Strategic Objective 3: "Delivering Better Value Healthcare"

3.36 The Trust will continue to change the way it operates to deal with the tensions between the increasing demand for healthcare, both in terms of scale and complexity, and the limitations to the growth of financial resources. It will focus on the value of its healthcare and use innovation to enhance this for the services it offers. This means developing and delivering flexible and sustainable models of care, improving performance against a range of benchmarks and making use of opportunities that exist to make savings from infrastructure.

3.37 Increased value for money is the result of improved outcomes and quality of services linked to improved cost effectiveness in their delivery. Achievement will draw on research already underway on self-care and the use of e-health technologies.

3.38 The Trust is committed to providing high-quality and efficient secondary care services for its local population and to growing its tertiary care services where there are benefits to be gained for patients and commissioners through sharing expertise and costs. Potential developments in cancer services to provide these benefits are described in Chapter 5.

3.39 Some elements of efficiency improvement are linked to the Trust's estate strategy, implementing inter-site service moves between the four hospital locations to make the best use of modern facilities and enable out-of-date property to be vacated, especially on the Churchill Hospital site.

3.40 OUH intends to reshape how its services are delivered in order to achieve the twin goals of improved care and greater efficiency. This will include maximising the use of its physical resources, enabling it to function within a smaller footprint and to close inefficient and time-expired property. This will be achieved by providing more continuous and uninterrupted care and timely access to diagnostics and theatres through enhanced weekend and extended-day working. These changes are intended to enhance patient experience and cost-effectiveness

3.41 Work to strengthen and rationalise out-of-hours site cover across the Trust's hospitals also reflects the improvement of patient safety and value for money.

Strategic Objective 4: "Delivering Integrated Local Healthcare"

3.42 The delivery of high quality healthcare to Oxfordshire's local population is a key focus and responsibility for OUH and requires a flexible and imaginative response to the challenge of managing the growing needs of older patients, those with long-term conditions and those with multiple co-morbidities.

3.43 The Trust is strengthening its work with local GPs to inform a programme of service change that will transform a range of services delivered primarily (though not entirely) for the people of Oxfordshire.

3.44 OUH will redesign its local services, especially in acute medicine, to 'design out' unnecessary and potentially harmful extended stays in hospital and put in place a model of care that is clinically and financially sustainable. This means changing the model of care in particular for vulnerable, older

people by offering more integrated care closer to home, applying acute clinical expertise in the non-hospital setting and 'right-sizing' the Trust's inpatient capacity. Such an approach will result in services that are more responsive to patients' needs, as well as being more cost-effective. This is consistent with the NHS Operating Framework for 2012/13 which emphasises the need for more service delivery to be integrated and organised around the interests of patients.

3.45 The nature and scale of this challenge requires innovative approaches to provide the necessary expertise and care in out-of-hospital settings. The Trust has already begun delivering social care through its Supported Discharge service as part of a package of schemes to deliver acute medical care beyond the hospital site, to allow a safe and sustained reduction in use of inpatient care. This will contribute to reducing delays and fragmentation of care.

3.46 In order to deliver the required level of improvement, the Trust is working in partnership with agencies in the local health and social care system and contributing to a multi-agency action plan on these shared issues. Developments are described in Chapter 5. OUH's work will aim to improve the experience of patients and clinicians at the interface between primary and secondary care.

3.47 Within its hospitals, especially the John Radcliffe and Horton General, OUH will reshape its 'local acute' services, introducing systems to rapidly provide patients with relevant specialist input once their immediate emergency needs have been met. By doing so, patients and GPs will experience the benefits of care coordinated by OUH specialists and thereby the benefits of treatment by an organisation with a wide range of expertise that can be applied quickly to meet assessed needs.

3.48 OUH will work closely with local commissioners as plans develop for the integration of maternity care for Oxfordshire and for the development of integrated care for frail older people.

Strategic Objective 5: "Excellent Secondary and Specialist Care through Sustainable Clinical Networks"

3.49 Partnerships are developing with surrounding trusts to support the delivery of secondary care locally, while consolidating the flow of patients requiring more specialised care to OUH as the local tertiary centre. The intention is that these operational clinical networks continue to support services that are responsive, safe and sustainable. These partnerships will support the provision of secondary care and as much specialist care as possible by acute healthcare providers locally at partner sites, with patients only moving to the tertiary centre at Oxford for necessary components of tertiary care.

3.50 This network of relationships will provide a foundation for OUH investment to establish selected specialist services at designated partner hospitals, leading to a distribution of the provision of these services in a less centrist and more equitable manner. This will, at the same time, increase the service portfolio and secure the sustainability of partner hospitals in the extended health economy. This illustrates a new and emerging leadership role for the Trust.

3.51 This principle has facilitated the significant investment required to provide high quality specialist and tertiary services and concentrated clinical expertise at defined sites with the aim of reducing variability and producing improved outcomes for the populations of local health economies.

3.52 Key to this approach is also the contribution of the Trust to the development and growth of the service profile of partner trusts. In certain partnerships this requires the sharing of OUH expertise and clinical personnel and in others the possibility of financial investment at partner sites.

3.53 Key principles underlying the establishment of such networks include:

- *Patient-focused, population-centred networks* with services delivered for the convenience of patients not providers and the provision of as much care as possible locally at the sites of network partners combined with the withdrawal of clinically and financially unsustainable activity from smaller units in the networks and their concentration at larger units;

- *Mobilisation* of the dormant resource of cooperation between organisations to deal with population health issues in partnership and collaboration, rather than in isolation;
- *Integration of care* by creating network pathways for patient care that eliminate those elements that are uncoordinated, wasteful and potentially harmful;
- *Diversity and synergy in partnership* respecting the different strengths and requirements of partners to deliver win-win arrangements where they engage according to need;
- *Formation of a horizontal secondary care network* to provide appropriate care locally and minimise patient travel;
- *Formation of a tertiary care network* by reconfiguring services to deliver economies of scale and critical mass, using facilities and expertise at the tertiary centre; and
- *The sharing of knowledge, education and training* to standardise and improve the quality and value of care throughout the network.

3.54 Developments are described in Chapter 5.

Strategic Objective 6: "Delivering the Benefits of Research and Innovation to Patients"

3.55 OUH has taken a leading role as a founding partner of the **Oxford Academic Health Science Network** (in line with *Innovation, Health and Wealth,* December 2011) for a population of about 3.3 million people across Oxfordshire, Berkshire, Buckinghamshire and Bedfordshire.

3.56 Authorised in May 2013, Oxford AHSN brings together all NHS bodies, including NIHR-funded bodies, all Universities and a large number of third sector, business networks and life science organisations in an area including Oxfordshire, Berkshire, Buckinghamshire, Milton Keynes and Bedfordshire. OUH is the network's host pending final agreement on governance, hosting and support arrangements.

3.57 The AHSN is intended to provide an opportunity for all partners to participate in the provision of evidence-based care for the patients and populations they serve through innovation, research opportunities and wealth creation.

3.58 The Network's vision is to:

> deliver best care through a sustainable population-centred system that ensures equity of access for our patients using continuous learning and the research-focused Network, which leads to new opportunities to create wealth by healthcare innovation.

3.59 This will be delivered through four programmes (Best Care; Continuous Learning; Research and Development and Wealth Creation and Healthcare Innovation) supported by six cross-cutting themes: Population Healthcare; Patient and Public Engagement and Experience; Integration and Sustainability; Informatics and Technologies; Genomic Medicine and Knowledge Management. Plans for the first year of the Best Care Programme are focused on Adult Critical Care, Cancer, Cardiovascular, Diabetes, Mental Health, Pharmacy, Primary Care, Renal, Trauma and Stroke.

3.60 This approach will support the delivery of OUH's strategic objective for strong clinical networks and for the effective integration of healthcare services.

3.61 Areas in which it is believed that the AHSN can innovate to deliver best care are in the design of population health budgets; the redesign of care pathways to integrate, reduce waste and improve quality; and to design informatics and technologies that reduce face-to-face contacts and increase independence, developing platforms for collaborative working.

3.62 OUH is a founding partner in the **Oxford Academic Health Consortium** (OAHC) with the University of Oxford, Oxford Brookes University, Oxford Health NHS Foundation Trust, Oxfordshire Clinical Commissioning Group, Oxfordshire County Council and Southern Health NHS Foundation Trust.

3.63 OAHC operates as a forum for collaboration on programmes to increase the scale and quality of world-class research and to deliver these benefits more rapidly to patients. A statement of intent has been developed and criteria outlined for the types of projects to be undertaken.

3.64 Areas of collaboration include care pathways such as managing delayed transfers, dementia and cognitive health (agreed as the exemplar) and the care of the older person, nutrition, end of life care and stroke; knowledge transfer and the translation of research; and system issues such as those relating to small District General Hospitals and their implications for collaboration, training and education.

3.65 The identification of dementia as a priority area is consistent with the Operating Framework which identifies dementia and the care of older people as a priority area for 2012/13 and a specific area for joint working with local authorities with the introduction of a new national goal under the CQUIN framework. The dementia project is being supported by the QIPP Right Care Programme and also links into the AHSN Best Care Programme through the Mental Health Network.

3.66 OUH is also a partner with the University of Oxford, Oxford Brookes University and Oxford Health NHS Foundation Trust in applying for the designation of an **Academic Health Science Centre** (OxAHSC) to focus on basic medical research and its translation into applied research and patient services.

3.67 There are many areas where OUH and its partners have an established track record of translating research into practical healthcare developments and have plans for further such innovation. These include:

3.67.1 *Genetic understanding and application in care:* Oxford has a leading track record in understanding the genetic causes of inherited disease and translating this into improved patient care. Investigators at the UK National Haemoglobinopathy Centre at the Churchill Hospital have developed patented assays for the non-invasive, prenatal diagnosis of diseases such as sickle cell anaemia. Oxford researchers discovered new genes underlying cardiomyopathy and sudden cardiac death syndromes and implemented the first national genetic testing services for these disorders, and developed technologies for the diagnosis of new genes causing developmental learning disabilities and neurodegenerative diseases.

3.67.2 *Vaccines:* Oxford Vaccines Group (OVG) has a global track record of novel vaccine development and evaluation, in-house manufacture, and vaccine clinical trials, forming the largest not-for-profit research endeavour in immunisation in Europe. OVG has contributed to the deployment of four of the six vaccines given in the NHS immunisation schedule to age 5. Advances in viral vector-based vaccines and T cell immunity have been translated to clinical studies, exemplified by Tuberculosis (novel vaccine progressed from experimental studies to large-scale efficacy trials); Influenza (a novel universal influenza vaccine has reached Phase 2); HIV (novel vaccine in Phase 2 trials); and Hepatitis C (a novel first-in-class vaccine).

3.67.3 *Novel diagnostic technology applications:* Direct genome sequencing of samples of *Mycobacterium tuberculosis* (TB) from a rapid 'midget' culture of bone and joint fluid and respiratory samples is now actively underway to support early and rapid diagnosis of TB. OBU researchers pioneered the use of monoclonal antibodies to inhibin (a protein hormone) in a wide variety of clinical diagnostic tests, now commercialised worldwide, including the Quad test for Down's Syndrome, infertility testing and ovarian cancer monitoring.

3.67.4 *Medical-psychiatric co-morbidity:* Research is under way to develop interventions which integrate psychiatric and medical care for patients with a combination of a long-term medical condition and a mental disorder. Medical-psychiatric comorbidity worsens outcome, leads to potentially avoidable reduction in quality of life and increases the cost of care. Specific areas

of focus are medical inpatients with distress; patients with poorly-controlled type 2 diabetes and major depression; and those in the last year of life with a long-term condition.

3.67.5 *Patient self-management of long-term conditions:* technology-enabled self-management interventions will be developed and tested including an observational study of weight management behaviour, assessing the influence of lifetime cardiovascular risk information on self-management behaviour in type 2 diabetes, evaluating self-management in COPD with respect to improving co-morbid mood, and pilot trials of the self-management of blood pressure post-delivery by patients with gestational hypertension or bipolar disorder.

3.68 The success of the Oxford Biomedical Research Centre and Biomedical Research Unit provides evidence of OUH's expertise in life sciences research. The OxAHSC, the OAHC and the Oxford AHSN will provide the Oxford BRC and BRU with a vehicle to adopt and spread innovative clinical practice across the health economy and to link this economy with the research and development community.

3.69 By 2016 the Trust aims to be at the core of a visionary and effective network, developing novel methods of care delivery and the new partnerships needed to deliver them.

Support from key commissioners

3.70 The Trust's strategy has been developed with the involvement of Oxfordshire's Clinical Commissioning Group and NHS England specialised commissioners.

3.71 The activity and financial assumptions which underpin this business plan and its associated Long Term Financial Model (LTFM) have also been developed with Oxfordshire CCG and NHS England. These key commissioners confirmed formal confirmation of the Trust's plans with their intentions in late 2012. Since then, the LTFM and business plan have been updated and based as closely as possible on updated contracts agreed for 2013/14.

3.72 Risks for OUH associated with contracting are reduced in comparison with previous years as a result of the early agreement of a 2013/14 contract compliant with national guidance. Dialogue is ongoing with key commissioners to agree and progress actions that also ensure that risks across the healthcare system are managed affectively.

3.73 Detailed work on service redesign for local acute services continues with Oxfordshire CCG. Clinical and managerial leads from OUH participate in each of the relevant programme boards responsible for the CCG's QIPP programme.

3.74 NHS England has produced service specifications for the approximately 70 specialised services they commission. The Trust has responded positively to this, working closely with NHS England's Wessex Area Team to gain designation for its specialist services where required.

Risk and risk management

3.75 Major risks to achievement of this strategy can be seen to be:

Strategic Risk	Principal Indicators	Mitigations
Failure to maintain quality of patient services	▪ Patient experience indicators show a decline in quality ▪ Potential breach of CQC regulations ▪ Trust Quality Strategy goals are not met ▪ Quality aspects of contracts with commissioners are not met ▪ CIPs impact on patient safety or unacceptably impact on service quality	▪ Focus on patient safety, outcomes and patient experience through implementation of Quality Strategy and Trust values ▪ Staff engagement and awareness of required standards ▪ Strengthened quality governance ▪ Use of benchmarks to inform analysis of progress ▪ On-going quality impact review of CIP schemes ▪ Close liaison with CQC and NHSLA
Failure to maintain operational performance	▪ National performance standards for A&E not met ▪ Failure to reduce delayed transfers of care ▪ Necessary level of data quality not achieved	▪ Provider Action Plan ▪ Supported Discharge Service ▪ Collaborative work on care pathways, delivery systems, education and training ▪ Learning from partners across the OAHSN ▪ Focus on data quality
Failure to maintain financial sustainability	▪ Required levels of cost improvement not delivered ▪ Pay costs not adequately controlled ▪ Failure to manage outstanding debtors ▪ Failure to generate income from non-core healthcare activity ▪ Services display poor cost-effectiveness	▪ Two-year rolling cost improvement programme with contingencies ▪ Divisional ownership ▪ Estate strategy
Mismatch with commissioner plans	▪ Lack of robust plans across the healthcare system ▪ Loss of commissioner support	▪ Internal performance controls ▪ Effective liaison with commissioners ▪ Strengthened links with commissioners through new partnerships – e.g. OAHC and OAHSN
Loss of share of current and potential markets	▪ Loss of existing market share ▪ Failure to gain share of new markets ▪ Negative media coverage relative to competitors	▪ Strategy developed with commissioners ▪ Agree assumptions and financial approach with key commissioners ▪ Maintain ability to be nimble in flexing capacity ▪ Contingency plans for withdrawal from services

Strategic Risk	Principal Indicators	Mitigations
Failure to sustain an engaged and effective workforce	▪ Difficulty recruiting and retaining high quality staff ▪ Low levels of staff satisfaction, health & wellbeing and engagement ▪ Insufficient provision of training, appraisal and development	▪ Leadership based on values visible in practice ▪ Improved recruitment and induction materials to set expectations ▪ Strong focus on education and development ▪ Feedback used to inform training ▪ Growing opportunities through the OxAHSC, OAHC and OAHSN
Failure to deliver required transformation of services	▪ Failure to maintain the development of organisational culture ▪ Clinical benefits of EPR are not realised ▪ Low levels of staff involvement in the Trust agenda ▪ Failure to establish robust governance and assurance processes	▪ Delivery of phased programme of change with clear accountability arrangements ▪ Learning from partners across the OAHSN, drawing on expertise of academic and industry partners
Failure to deliver the benefits of strategic partnerships	▪ Failure to establish sustainable regional networks ▪ Adequate support for education is not provided ▪ Research and innovation do not deliver anticipated benefits	▪ Ensure the realisation of benefits of working within Oxford Academic Health Science Network, the OxAHSC and OAHC

Consultation

3.76 Public consultation took place from June to October 2012 on the Trust's strategy and proposed governance arrangements. 16 public meetings were held across population centres in Oxfordshire and south Northamptonshire and meetings took place with stakeholder bodies including Oxfordshire's Joint Health Overview and Scrutiny Committee.

3.77 Feedback informed the Board's agreement of material to form the basis of OUH's FT application, in particular the governance arrangements set out in the IBP and the Trust's Constitution.

3.78 The consultation provided broad support for the Trust's overall vision as well as for its proposed governance arrangements as a foundation trust.

3.79 General themes from consultation were a clearly felt need for the Trust's role to be visibly based on the foundation of high quality services for local people; and a call for effective partnership working, in particular as a prerequisite for the development of service models that will shift care and treatment out of a hospital setting and into the community, closer to patients.

3.80 Consultation also stressed OUH's role in the wider public health agenda as well as the need for ongoing engagement with GPs. The Trust's future vision for the Horton General Hospital was also discussed, with representatives of local people calling for the maintenance of a broad range of services on the Horton General site.

Consultation outcomes

3.81 Seven proposals relating to the Trust's governance as a foundation trust were identified from feedback during the consultation period.

3.82 These informed decisions made by the Board in November 2012 and produced changes to the Trust's draft Constitution.

Nominated Governors

3.82.1 It was proposed that a GP representative nominated by Oxfordshire Local Medical Committee be added to the Council of Governors. This was agreed, recognising the importance of strengthening the Trust's engagement with providers of primary care.

3.82.2 The University of Oxford requested the nomination of a second Governor to the Council of Governors. The Board considered that strong joint arrangements were in place through the Joint Working Agreement between OUH and the University of Oxford and the University would have a right to nominate one Governor and one Non-executive Director. This was therefore not agreed.

3.82.3 The nomination of a Governor for older people via an organisation such as AgeUK was suggested as a large proportion of the people using OUH's services are older people and OUH's proposals specifically include a younger people's Governor. The Board agreed not to support having a Governor nominated specifically to speak for older people, but to ask that the Council of Governors, once established, consider having a member or members who take particular responsibility for liaising with organisations which speak for older people.

Public Governors

3.82.4 Despite overall support for the Trust's proposed arrangements for public constituencies, a number of suggestions were made about changing the balance of Oxfordshire classes within the public constituency. The Board agreed not to change its proposal that two Governors be elected from each District Council area as it was judged to provide the most resilient geographic representation.

3.82.5 A proposal was made that the class within the public constituency for counties surrounding Oxfordshire be split into two to reflect the fact that local general hospital services are provided for the people of Northamptonshire and Warwickshire. The Board agreed on this basis that the previous class electing four Governors should become two classes electing two Governors each: Northamptonshire and Warwickshire; and Berkshire, Buckinghamshire, Milton Keynes, Gloucestershire and Wiltshire.

Staff Governors

3.82.6 Following a proposal from one of the Trust's facilities providers, the Board agreed that staff employed by the Trust but seconded to its PFI providers under retention of employment arrangements would automatically be considered members of its staff constituency unless they chose to 'opt out', and that members of staff employed by the Trust's PFI partners and working on the Trust's sites would be allowed to join the staff constituency on an 'opt in' basis.

3.82.7 Resulting from this agreement, the Board also agreed to alter the balance of clinical to non-clinical staff Governors from 5:1 to 4:2.

3.83 Arrangements for the Council of Governors are shown in Chapter 9 and in the Trust's draft Constitution.

Chapter 4

Market Assessment

4. Market Assessment

Introduction

4.1. Oxford University Hospitals NHS Trust (OUH) is relatively unusual in being a large teaching trust with a comprehensive portfolio of services and a strong research and educational base, located primarily in a city with a relatively small local population.

4.2. This gives OUH two relatively distinct markets: a local market for general hospital services and a wider market for its more specialised services. Specific challenges and opportunities exist in both.

4.3. The map below shows the CCGs which OUH has analysed as forming its catchment.

Clinical Commissioning Groups in the area analysed in this chapter as 'catchment'

Local health economy and market for general hospital services

4.4. OUH provides general hospital services for the population of Oxfordshire and for parts of Buckinghamshire, Northamptonshire and Warwickshire.

4.5. Its three Oxford sites provide a local service for the vast majority of people in Oxfordshire (total population of 655,000) and parts of Buckinghamshire. The Horton General Hospital in Banbury has a catchment population of approximately 150,000 people in northern Oxfordshire and neighbouring communities of south Northamptonshire and south east Warwickshire.

4.6. OUH's local commissioner is Oxfordshire Clinical Commissioning Group (OCCG), which accounts for 37.6% of the Trust's patient care income.

4.7. Nearly one in two of Oxfordshire's residents live in communities of fewer than 10,000 people. The county's rural nature poses challenges and requires innovation in the delivery of care close to home.

4.8. The county's population grew by 50% between 1971 and 2001 compared with 12% for England as a whole. Its population is also predicted to continue to increase rapidly over the next ten years, with the numbers of the 'very old' experiencing the largest percentage growth. This has major implications for providers and commissioners of care, notably in the dependency ratio and the incidence and prevalence of disease, described below in the section on **Demography**.

4.9. Oxford and central Oxfordshire are classed as 'diamonds for growth' – areas in the South East that are expected to deliver significant economic and housing growth. Some 5,000 new homes are due to be built in the county in the period to 2030, in part to alleviate pressure on housing in Oxford, where house prices have affected recruitment for many years.

4.10. Nearly 1,600 new homes are being built on a site in south-west Bicester and up to 1,200 homes are anticipated to be built within two kilometres of the John Radcliffe Hospital site. Combined with demographic change, this can be expected to continue to fuel local demand for healthcare.

4.11. The county's overall affluence masks areas of severe deprivation. Median earnings of Oxford residents are lower than the regional average, despite relatively high earnings for the city as a whole. 18 areas within Oxfordshire are among the 20% most deprived areas in England – 12 in Oxford, five in Banbury and one in Abingdon.[5] Deprivation is closely associated with poor health and need for acute and community healthcare.

4.12. Oxford is more ethnically and culturally diverse than the county as a whole, with the third-highest minority ethnic population in South East England, and is young: at 32%, Oxford's proportion of 16-29 year olds is twice the national average. The city's population grew by 12% between 2001 and 2011, a growth rate equalling London's. At all its sites, OUH must provide care which is appropriate for a diverse population. The Trust's Oxford sites must also respond to the healthcare needs of the city's term-time student population of at least 43,000.[6]

4.13. Oxfordshire is the highest-ranked and fastest-growing region for high-tech services in the EU. The county hosts over 1,400 high-tech companies, employing over 37,000 people. The county contains a concentration of specialised sciences and technology industries, coupled with significant research and development activity linked to the universities, to healthcare and to medical research. The opportunities offered through close links with this sector are described in the section below on Partnerships in care and innovation.

4.14. Oxfordshire has a large military presence with more than 10,000 military personnel (October 2012) and almost 5,000 family members living and working in the county. Two-thirds are members of the

[5] Index of Multiple Deprivation, 2010 data.
[6] Data published by Oxford City Council for 2010/11, accessed 12 June 2013: http://www.oxford.gov.uk/PageRender/decC/University_students_occw.htm

RAF. Bases are located at Abingdon, Benson, Bicester, Brize Norton, Didcot and Shrivenham. Brize Norton is now the UK's largest RAF station, employing nearly 4,000 service personnel and more than 600 civilians. Service personnel use OUH facilities and the Trust trains and benefits from the skills of service healthcare staff.

4.15. Hospitals account for the second-largest share of employment in Oxford after higher education. Public sector jobs account for nearly half of all employment in the city, nearly double the South East England average, and for 30% across Oxfordshire as a whole. OUH's recruitment and turnover are affected by the local and wider employment market, factors described in Chapter 8.

Market for specialised services

4.16. The population served by OUH'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 services are provided for a larger catchment population, with national and international elements.

4.17. Changes to specialised commissioning arrangements, including the redefinition of 'prescribed services' to be commissioned by NHS England, have resulted in NHS England becoming the largest commissioner of the Trust's services and placed OUH's specialised services in a national marketplace.

4.18. The agreement for provision of specialised services is held with NHS England's Wessex Area Team and amounts to £323,567,009 for 2013/14. A separate agreement for 2013/14 with the Thames Valley Area Team for £10,618,386 covers dentistry, offender health and some screening services.

4.19. This share and value of income commissioned by NHS England may decrease slightly in future years as areas commissioned are refined and responsibilities are transferred to local commissioners, but the approach taken for 2013/14 is that prescribed services should be bought from designated providers.

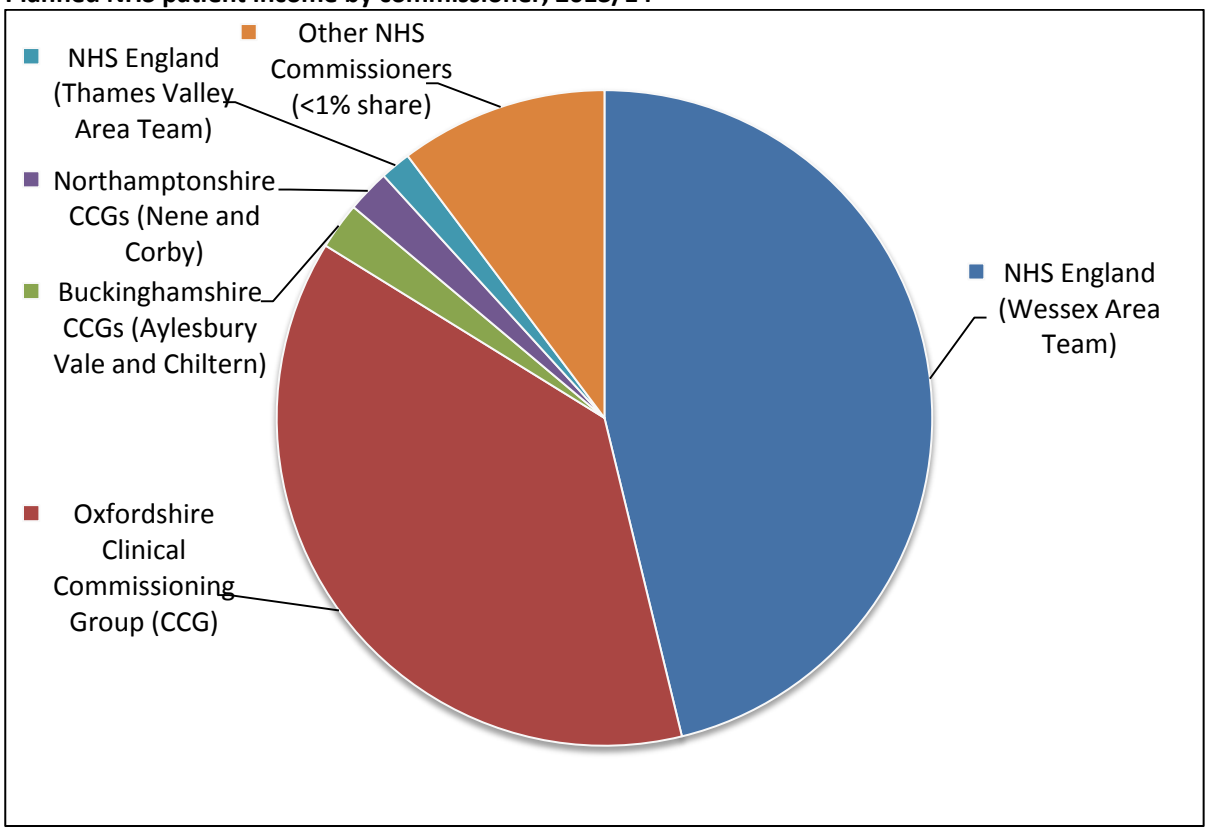
4.20. With specialised treatments forming part of care pathways and with local commissioners regarding the whole service for their patients as important, there will need to be continuing close working between the Trust and its specialised and local commissioners as arrangements evolve.

4.21. The table and chart below show the monetary value of the Trust's agreements with NHS commissioners for local and specialised services.

Planned income for NHS patient care, 2013/14

Commissioner	Service Level Agreement income (£ million)	% of total
NHS England (Wessex Area Team)	323.6	46.2%
Oxfordshire Clinical Commissioning Group (CCG)	263.4	37.6%
Buckinghamshire CCGs (Aylesbury Vale and Chiltern)	16.2	2.3%
Northamptonshire CCGs (Nene and Corby)	14.8	2.1%
NHS England (Thames Valley Area Team)	10.6	1.5%
Other NHS Commissioners (<1% share)	71.8	10.3%

Planned NHS patient income by commissioner, 2013/14



4.22. Approximately 60% of OUH's total patient income is for Oxfordshire patients, as some 43% of the SLA for specialised services held with the Wessex Local Area Team is for Oxfordshire.

4.23. A majority of specialised services income is received for the treatment of non-Oxfordshire residents.

Market requirements

4.24. Market requirements can be summarised as meeting the health needs of the catchment population whilst improving quality and healthcare outcomes, within the context of costs associated with changes in demography, technology and expectations and the economic situation that limits the availability of funding for health services.

Health needs of the Trust's catchment area population

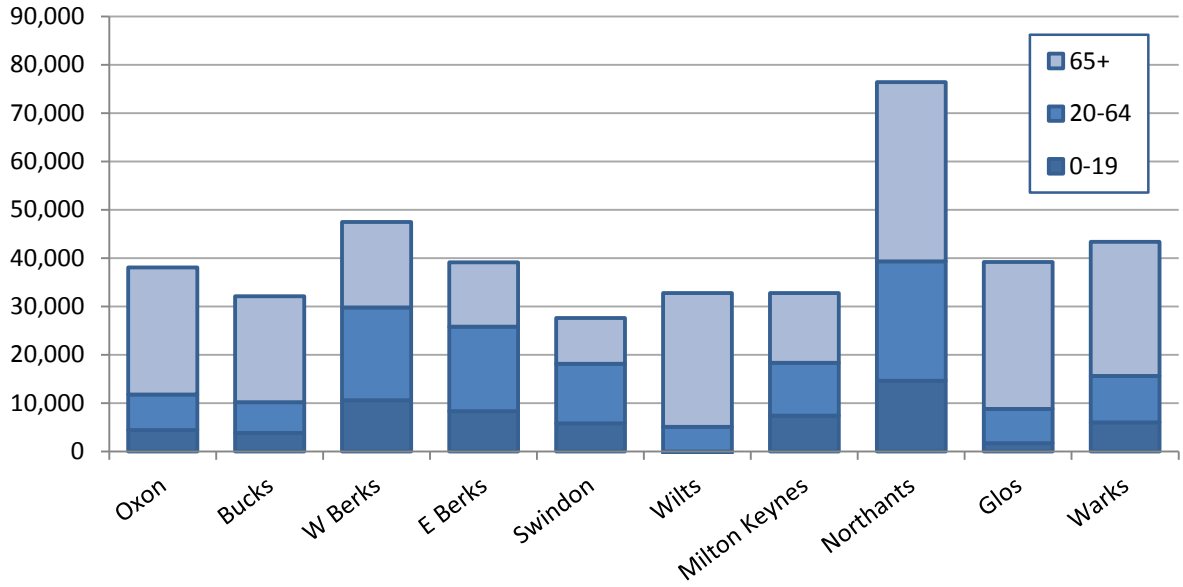
4.25. Population growth in Oxfordshire in the period to 2021 is predicted to be just over 6%, with 8.6% growth over the larger catchment area. High rates of growth are expected in Milton Keynes, Northamptonshire and Swindon.

4.26. Based on Office for National Statistics estimates for 2011 to 2021, figure 4.4 illustrates the impact on population numbers of these changes, showing the variation between age groups.

4.27. Northamptonshire is expected to see the greatest absolute growth, with Oxfordshire, Buckinghamshire, Gloucestershire and Wiltshire in particular seeing a large share of population growth in older people. Milton Keynes sees absolute growth of 14,500 in over-65s compared to Oxfordshire's 26,300 although in relative terms it has double the rate of Oxfordshire's population

growth and nearly double its rate of growth in older people. Growth in the numbers of children and young people is concentrated in Swindon, Milton Keynes, Berkshire and Northamptonshire.

Projected population change in catchment area by PCT population and age group, 2011-2021 [ONS estimates based on 2011 census]



4.28. Life expectancy is above average in Oxfordshire and its neighbouring areas. Growth in the catchment population will be greatest in the oldest population groups between 2011 and 2021. The over-75 population is expected to grow dramatically more quickly than the population as a whole: by nearly 30% in the 75–79 group, just under 20% in the 80–84 group and over 30% in the 85+ group.

4.29. The health of people in Oxfordshire is generally better than the average for England, with rankings by Public Health England of mortality under 75 for cancer, heart disease and stroke, lung disease and liver disease showing Oxfordshire at 22nd best of 151 local authorities in England for 2009-2011.[7]

4.30. Nonetheless, 15,660 children are assessed as living in poverty (almost 12%) and life expectancy is 5.8 years lower for men and 3 years lower for women in the most deprived areas (mostly in Oxford and Banbury) than in the least deprived areas.[8] 15.1% of the county's Year 6 children are classified as obese (below the national average) but levels of physical activity for school age children are significantly below average. Road injuries and deaths are above average and the incidence of malignant melanoma is recorded as above average.

Demography

4.31. The main demographic issues driving demand for health and social care in Oxfordshire and nationally are **firstly**, the increasing age and obesity of the population and **secondly**, the increasing dependency ratio (the proportion of old people to adults of working age).

4.32. These demographic changes alone will cause substantial changes in the incidence and prevalence of illness requiring health care – the key changes being in vascular disease (cardiovascular disease and stroke), diabetes, musculoskeletal failure (osteoarthritis and joint failure) and mental ill health (dementia). Moreover, older and more obese people are at risk of acquiring more than one of these

[7] Public Health England, June 2013 http://longerlives.phe.org.uk/area-details#are/E10000025/par/E92000001
[8] Public Health Observatories Health Profile for 2011/12 http://www.apho.org.uk/resource/view.aspx?RID=105526

problems simultaneously, with this multiple morbidity contributing to a rapid increase in the number of frail older people in particular.

4.33. The increasing dependency ratio is normally seen mainly as a problem for public finance but the associated changes in family and employment structure will also have an impact on available support for the elderly. This substantially changes the market conditions for health care by increasing demand for more institutionally-provided health and social care for people with the chronic conditions of old age, particularly for the frail elderly with multi-morbidity.

4.34. A key treatment issue influencing overall demand is that case-fatality rates for illnesses such as stroke and myocardial infarction have fallen dramatically in recent years (and continue to fall). This "de-coupling of morbidity and mortality" means that people are living longer with their chronic conditions and requiring a different pattern of care – often sporadic acute episodes needing intensive hospital support interspersed with much longer episodes of low-intensity supportive care. OUH is in part addressing this through close liaison and work with Oxford Health and Oxfordshire County Council, particularly for frail older people.

Choice and competition

4.35. The Government's health policy emphasises improvement in quality and healthcare outcomes as the primary purpose of NHS-funded care, with related financial incentives and disincentives through quality and outcome measures reinforcing this as a key market demand.

4.36. The Health and Social Care Act 2012 set out the Government's intention to continue the extension of the patient's role in the market through greater choice and control, encapsulated in the phrase "no decision about me without me."

4.37. Oxfordshire is part of the national scheme piloting personal health budgets for NHS Continuing Healthcare (adults and children); End of Life care and for Adults with Acquired Brain Injury.

4.38. Competition was initially primarily for elective surgery. 'Any Qualified Provider' was then introduced for a growing range of services, creating scope for new market entrants or for existing elective providers to diversify. In 2012/13 Oxfordshire PCT progressed 'Any Qualified Provider' for Podiatry; for Audiology Adult hearing services in the community (as a joint project with Buckinghamshire); and for Assessment for Autistic Spectrum Conditions without a Learning Disability. OUH was seleced as a provider of Audiology: Adult hearing services.

4.39. NHS England has reiterated that choice and competition can be an important lever for commissioners to improve the quality and efficiency of services.[9]

4.40. Competition is also being introduced by Local Authorities who have been responsible for commissioning public health provision since April 2013. Oxfordshire County Council has recently advertised its intention to award a contract for the provision of an Integrated Sexual Health Service for Oxfordshire. The council is seeking to redesign the way in which these services are provided.

4.41. The introduction of competition increases the importance of providing care in a way which will encourage patients and referrers to choose OUH's services and of demonstrating this through the information the Trust publishes. It also means that the Trust will need respond to changes in demand for its services, monitoring activity levels closely and being able to flex capacity, with contingency plans in place for situations where a service is gained or lost through competition.

4.42. OUH began a pilot Musculoskeletal Triage and Tier 2 Treatment service for Oxfordshire in 2010. The Trust successfully bid for a further three-year contract tendered by commissioners which began in April 2013. It intends to use this as an opportunity to examine how this model can be extended to specialties such as General Surgery, Urology and Gynaecology.

[9] NHS England, *Putting Patients First, The NHS England Business Plan for 2013/14-2015/16*, p 14

4.43. The Trust is developing its capability in responding to commercial opportunities and in reconfiguring existing services to meet patient, public and commissioner expectations.

GP-led commissioning

4.44. Downward pressure on public spending and the transfer of commissioning responsibilities and resources to GPs create major risks and opportunities. The risk is that the Trust does not respond flexibly or quickly enough to the changing environment and fails to be part of new models of care delivery and risk-sharing, but this period of major change is an opportunity for OUH to work with GPs in the redesign of local services to create sustainable ways of delivering care locally for the ageing population served by the Trust and its referrers. Work to respond to this opportunity is described in Chapter 5.

4.45. Set alongside the introduction of GP-led commissioning, the opportunity exists for OUH to form a new set of partnerships to deliver care, to conduct research with University and other NHS partners, to spread innovation and add value for patients and commissioners.

Partnerships in care and innovation

4.46. OUH is a partner in the Oxford Academic Health Science Network (AHSN), designated by NHS England as one of fifteen such networks.

4.47. The Oxford AHSN covers a population of 3.3m, including Oxfordshire, Buckinghamshire, Milton Keynes, Berkshire and Bedfordshire. Membership includes:

Oxford AHSN partners
NHS providers in the area, including seven NHS Foundation Trusts and three NHS Trusts
NHS commissioners, including six Clinical Commissioning Groups
NIHR bodies
Nine Universities
Local Authorities
NHS-related bodies including Solutions for Public Health, UK Cochrane Centre, National Spinal Injuries Centre, Oxford Academic Health Consortium and the Oxford Academic Health Science Centre
Third sector bodies, life sciences companies and industry networks and organisations including the Oracle, Cerner, Centre for Sustainable Healthcare, Genetics Alliance UK, OBN (formerly Oxford BioSciences Network), Oracle, Picker Institute, Science Oxford and Special Care Technologies Ltd.

4.48. The AHSN is also affiliated with a growing number of networks and alliances associated with business and commercial organisations, including:

- local enterprise partnerships
- Science Vale UK
- South East Health Technology Alliance
- Association of the British Pharmaceutical Industry
- Association of British Healthcare Industries

4.49. Oxford AHSN's vision is that it will:

> deliver best care through a sustainable population-centred system that ensures equity of access for our patients using continuous learning and the research-focused Network, which leads to new opportunities to create wealth by healthcare innovation.

4.50. Together with Oxford Health NHS FT, the University of Oxford and Oxford Brookes University, OUH has also submitted a pre-qualification questionnaire expressing interest in designation as the Oxford

Academic Health Science Centre (OxAHSC). This is in response to the Department of Health's two-stage competition to designate AHSCs in England. The role of AHSCs will be to increase strategic alignment of NHS providers and their university partners, specifically in world-class research, health education and patient care, in order to improve health and healthcare delivery, including the increased translation of discoveries from basic science into benefits for patients. AHSCs will be able to realise their potential as drivers of economic growth through research partnerships with commercial life science organisations.

4.51. Locally, this builds on the Oxford Academic Health Consortium (OAHC) made up of all NHS organisations within Oxfordshire, Oxford's two Universities and Oxfordshire County Council. Once designated, OxAHSC will continue this wider collaboration and engagement with Commissioners, Public Health and Social Care.

Quality and outcomes

4.52. Specific areas of national focus are set out in the NHS Outcomes Framework. There are also a series of national improvement programmes focused on specific services/groups of services. These programmes take a number of forms including National Service Frameworks, Safe and Sustainable and NICE reviews, but have in common that they review the evidence on what improves clinical outcomes and make recommendations about service standards. These recommendations play a major role in the Trust's market, influencing the demands of both commissioners and patients.

4.53. There is a continued focus on improving care in relation to England's "big killers," particularly those diseases for which England's mortality rate compares unfavourably with that of others. In recent years the Trust has responded with developments in cancer and cardiac services. More recent areas of focus are hyper-acute stroke and trauma services.

4.54. National emphasis in the NHS Outcomes Framework is on the measurement of success in terms of outcomes, such as cancer and stroke survival rates, rather than the previous process targets.

4.55. National policy is clear that, in the context of national fiscal policy, the NHS is expected to make major savings through implementing best practice and increasing productivity in order to afford the investment required for these improvements.

Requirements of local commissioners

4.56. The strategy of Oxfordshire Clinical Commissioning Group (OCCG) is a key part of the Trust's assessment of its market.

4.57. OCCG is developing a commissioning strategy for health services across Oxfordshire, working closely with partners including OUH. The strategy will look at how the CCG would like primary, community and hospital services to be delivered for the county.

4.58. A Joint Executive Group of OUH directors and OCCG Board members meets regularly to consider issues of common interest.

4.59. OUH executive directors and clinicians have strengthened engagement mechanisms with OCCG and its locality groups[10], meeting to discuss the Trust's strategy and issues raised locally by GPs. A joint work programme has been agreed, with five work streams:

- Outpatient appointments
- Sharing information about patients
- Meeting patients' needs following appointment/discharge
- Access for GPs to information and advice

[10] OCCG has formed six localities with each made up of a number of GP practices.

- Making the best use of information entered by GPs on Datix.[11]

4.60. It has been agreed that engagement between OUH and GPs will be improved through ongoing production of a bulletin for GPs; a "buddying" arrangement whereby one executive director and one Divisional Director (clinician) will be nominated by OUH as links to each of OCCG's localities; and an annual series of educational events in each of the six localities.

4.61. OUH clinicians and managers participate in OCCG programme board meetings to develop areas of the QIPP programme for Oxfordshire which are relevant to services the Trust provides.

Oxfordshire Joint Health and Wellbeing Strategy

4.62. As a result of the national reorganisation of commissioning, responsibility for commissioning some public health services, including screening, has passed to local authorities, in OUH's case to Oxfordshire County Council, in the form of the Oxfordshire Health and Wellbeing Board (HWB).

4.63. Oxfordshire's HWB has responsibility for improving the health and wellbeing of people in the county through partnership working. It is a partnership between Local Government, the NHS and the people of Oxfordshire. Members include local GPs, councillors, Healthwatch and senior officers from Local Government.

4.64. Organisations responsible for providing health care are not members of Oxfordshire's HWB.

4.65. Although OCCG has not yet published its own commissioning strategy it is a partner in the HWB which has published a Joint Health and Wellbeing Strategy,[12] linked to a Joint Strategic Needs Assessment. This emphasises the need for organisations providing care in the county to work together to meet the challenges faced in a way that is more "meshed" together.

4.66. This need is emphasised by the fact that Oxfordshire has the highest level in England of delayed transfers of care.

4.67. OUH has an important role to play in five of the Strategy's proposed priorities[13], in particular:

Priority 1 All children have a healthy start in life and stay healthy into adulthood.

4.67.1 Proposed areas of focus include raising the percentage of women who have seen a midwife or maternity health care professional within the first 13 weeks of pregnancy.

Priority 5 Living and working well: adults with long-term conditions, physical disabilities, learning disabilities or mental health problems living independently and achieving their full potential.

4.67.2 Proposed outcomes include increasing the number of people with a long-term condition who feel supported to manage their condition and a reduced number of emergency admissions for people with LTCs.

4.67.3 This priority is reflected in CQUINs agreed with OCCG for 2013/14 (see box).

CQUINs in 2013/14

- Improving the care pathway for people with diabetes-related foot disease.
- Support for young adults with diabetes.
- Identification and care of patients with learning disabilities.

[11] An incident reporting system used by OCCG and OUH.

[12] https://publicinvolvementnetwork.oxfordshire.gov.uk/gf2.ti/f/29474/66693.1/PDF/-/Oxfordshire%20Joint%20HWB%20strategy%20final.pdf accessed 11/6/13

[13] https://publicinvolvementnetwork.oxfordshire.gov.uk/gf2.ti/f/29474/66661.1/PDF/-/JHWBS%20consultation%20document.pdf accessed 11/6/13

Priority 6 Support older people to live independently with dignity whilst reducing the need for care and support.

4.67.4 Proposed outcomes include reducing delayed transfers so that Oxfordshire's performance improves from being in the bottom quarter in England; developing a model to match capacity to demand for health and social care; 60% of the expected population with dementia receiving a recorded diagnosis; improving reablement services; reducing the number of emergency admissions for older people; gathering bereaved carers' views on the quality of care in the last three months of life and raising the proportion of adults using health care who say they receive care in a timely way.

4.67.5 There is a rise in the prevalence in over-65s of stroke, depression and dementia. As these conditions are often diagnosed for the first time on hospital admission, the Trust recognises that it needs to identify and care for an increasingly significant number of patients with dementia, depression or other mental health problems and work with partners to have appropriate care put in place on discharge.

4.67.6 An integrated Psychological Medicine Service has been established by OUH to enable the medical and psychological needs of adult and especially older patients admitted to the Trust to be addressed together.

4.67.7 OUH is working closely with Oxford Health and other local partners to address this very important area of increasing impact and demand.

CQUINs in 2013/14

- Developing the Psychological Medicine Service.
- Establishing baseline data for frail elderly patients and delayed transfers of care.
- Improving medical support for patients undergoing complex surgery.

Priority 7 Working together to improve quality and value for money in the Health and Social Care System.

4.67.8 Proposed outcomes include achieving above the national average of people satisfied with their experience of hospital care; reducing the number of emergency admissions to hospital; reducing emergency admissions for acute conditions that should not usually require hospital admission; and reducing unplanned hospitalisation for chronic, ambulatory care-sensitive conditions.

4.67.9 A CQUIN has been agreed locally to see the introduction of emergency admission navigators, expert nurses to offer a single point of access and help reduce the admission rate for ambulatory care-sensitive conditions.

CQUIN in 2013/14

- Introducing emergency admission navigators.

Priority 8 Preventing early death and improving quality of life in later years.

4.67.10 Proposed outcomes relate to uptake of bowel screening, NHS Health checks and smoking cessation.

Priority 12 Commission safe, high quality, efficient health and social care services.

4.67.11 This new priority includes proposals to use reported outcomes measures and a review of systems and measures used across health and social care services to gauge quality and patient experience.

Oxfordshire Older People's Joint Commissioning Strategy

4.68. Developed from the Joint Health and Wellbeing Strategy, a specific Older People's Joint Commissioning Strategy for 2013-16 has been published by OCCG and Oxfordshire County Council. [14] This recognises the need to respond positively to the growing numbers of older people in the county.

4.69. The strategy has six priorities, ranging from community support to services working well together.

4.70. Priority three covers hospital care and includes several items of feedback from Oxfordshire residents consulted about their experience, summarised below.

"When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and am discharged home when I am ready."

- More work is needed to avoid hospital admission in the first place
- Older people are admitted to care homes too early, particularly from hospital
- It takes too long for people to be supported back home after a period of time in hospital
- Service do not always see older people as part of the care team
- The quality of care in hospitals is variable.
- Outpatient appointments are not always sent out in time for people to attend and there are too many cancelled appointments
- Health and social care teams need to work better together
- We need to ensure we use new medical technologies effectively
- We need to make better use of research and information

4.71. Specific actions in the strategy relate to the training of staff to be more aware of the needs of people with dementia and to enable health and social care services to understand the needs of people with dementia and provide a quality service for them. Action is being taken through the CQUIN agreed with OCCG to respond positively to this need in the context of the Trust's introduction of a Psychological Medicine service.

4.72. Priority six in the strategy is to "see health and social care services working well together." The document states that commissioners will "develop a set of clear commissioning intentions to support the health and social care market to deliver services – this will include a market position statement from June 2013."

Outcomes based commissioning

4.73. Oxfordshire CCG has signalled its intention to introduce outcomes based commissioning.

4.74. Areas of initial focus are maternity, frail elderly and adult mental health.

4.75. This represents a significant development from NHS Oxfordshire's strategic plan which noted that GP commissioners had signalled a wish to commission, based on outcomes, integrated care to support people after hospital admission and to deliver preventive care for people at risk of admission in non-institutional settings.

4.76. Work being done on this agenda is described in Chapter 5.

[14] http://www.oxfordshireccg.nhs.uk/wp-content/uploads/2013/05/2013.05.30-Paper-10-Older-Peoples-Joint-Commissioning-Strategy-with-Report-in-12pt.pdf accessed 3 June 2013

4.77. Priorities set by OCCG align closely with those of the Trust, particularly in developing alternatives to hospital admission, promoting independence and responding to changes in Oxfordshire's population, notably rises in the prevalence of long-term conditions and dementia.

4.78. OUH has the option to respond by adjusting the balance of services it provides in its hospitals and those it provides in non-hospital settings. OUH provides a range of services for local people beyond its four hospital sites as shown in the table, and expects that this range will expand.

Community Paediatric services from settings including East Oxford Health Centre, Orchard Health Centre (Banbury), Deer Park Medical Centre (Witney) and Special Schools.
Community radiology service in Witney, Abingdon, Chipping Norton and Bicester.
Consultant support to community hospitals.
In-reach sexual health services including HIV care to HM Prisons Bullingdon and Huntercombe.
Some midwifery-led maternity care as well as community midwifery teams based in local settings at Abingdon, Bicester, Didcot, Oxford, Witney, Carterton and Thame.
Mobile breast screening.
Musculoskeletal direct access service and other outpatient physiotherapy services at East Oxford Health Centre and Brackley Cottage Hospital.
Oxford Eye Care: ophthalmic services in community settings, initially in Witney.

Specialised commissioning

4.79. NHS England aims to assure the quality of the specialised services it commissions through the designation of providers who meet criteria set out in service specifications.

4.80. A large number of draft specifications were issued for consultation at the end of 2012. OUH undertook a detailed review of these, involving key clinicians. It responded to NHS England's consultation, while internally it identified areas where investment would be required to meet specifications if confirmed. The preparation and finalisation of the specifications is being led by clinical reference groups. OUH clinicians are communicating with these groups and in many cases are members of them.

4.81. The Trust's long term response to specifications may include agreement with network partners of a level of service or infrastructure needed to meet a specification within the available resources or the agreement of plans to meet criteria within a defined time period. In an evolving market for specialised care, this may lead to a change in the portfolio of services that the Trust offers.

4.82. The reorganisation of specialised commissioning is expected to drive further centralisation of specialised care which could provide opportunities for OUH as long as the Trust retains designation for these services. This trend also reinforces the importance of developing and sustaining a strong network with surrounding healthcare providers.

4.83. Clinical networks have important input into specialised commissioning and OUH is involved in clinical networks for Cancer, Cardiovascular care (including cardiac surgery, cardiology, vascular and stroke services), Critical Care, Maternity, Neonatal, Pathology, Renal and Trauma.

4.84. These networks develop responses to the recommendations of national service improvement programmes already identified as playing a major role in the Trust's market. A common feature of the recommendations is the centralisation of specialised services' resources and expertise. Their

recommendations in this respect may involve major service reconfigurations which change the commissioning of services by both specialised commissioners and more local commissioners.

4.85. OUH is well-placed to be a provider of such centralised services as it provides the full matrix of services that acutely ill patients may require, including critical care (with specialised neurological, cardiac and newborn units in addition to general intensive care) and interventional radiology.

4.86. Recent examples of services centralised in OUH for networks are intensive care for newborns and the establishment of a major trauma centre at the John Radcliffe Hospital.

Translating market demands into future potential demand for OUH services

4.87. OUH has used information on market demand to inform the activity model which forms part of its Long-term Financial Model. Areas with high predicted growth are shown in the table below.

Cancer

Incidence is rising, due in particular to the ageing population and in some cases driven by obesity and smoking. Increased survival rates further raise the demand for services. The policy of centralisation of specialised treatments in specialised cancer centres affects OUH. Screening programmes for cancer contribute to demand in, for example, endoscopy, colorectal and lung treatment. OUH's modelling suggests a continuing 5.3% per year growth in colorectal surgery.

OUH is well-placed to attract referrals as a result of this demand. Its Oxford Cancer Centre provides state-of-the art treatment and imaging facilities, reflecting a capital investment of more than £100m. It has over 20 multi-disciplinary teams, including world experts, meeting on a weekly basis to discuss patients referred to them.

Cancer is one of the themes of the Oxford Biomedical Research Centre.

Partnership with the University of Oxford means that patients benefit rapidly from research into improved diagnosis and treatment as well as opportunities to participate in clinical trials. These opportunities will be further enhanced by OUH's membership of the Oxford Academic Health Science Network and the Oxford Academic Health Science Centre with its strong focus on basic medical research (including in genomics and WGS).

As a Cancer Centre in the middle of a network stretching from Swindon in the west to Milton Keynes and Slough in the east, OUH has a catchment area for cancer referrals which is supported through existing oncological presence in surrounding DGHs.

The Trust has modelled the effect of this through, for example, 5% annual growth for both clinical and medical oncology and a similar level of growth for specialties with a high percentage of cancer patients (e.g. 2.7% annual growth is predicted for Upper Gastrointestinal Surgery).

As demand is expected to continue to grow, OUH's strategy is to work with partner Trusts to deliver as much cancer care as possible locally, for example through provision of satellite radiotherapy units and joint appointment of consultants to deliver some elements of specialised care in DGHs. This will benefit patients through reducing travel time, whilst increasing capacity and consolidating the catchment area for specialised treatments available at the Oxford Cancer Centre.

Cardiovascular disease

The UK incidence of coronary heart disease is showing signs of falling, probably through the effects of preventive activity such as the prescription of statins. At the same time, with a growing elderly population there is an increased incidence of heart failure, valvular disease and the need for coronary investigation and intervention.

An increased ability to intervene in heart rhythm defects has meant that demand for electrophysiology is also increasing.

Clinical research in this area is strong, with OUH clinicians working closely with colleagues from the University of Oxford, exemplified in the Heart Theme within the Oxford Biomedical Research Centre (BRC), which aims to achieve translation from basic science to clinical application. For example, research focuses on vascular disease risk factors and the mechanisms that relate 'upstream' disease in the arterial wall to 'downstream' injury manifested as myocardial infarction and stroke, so that new interventions can be targeted to patients more effectively.

These projects extend to investigating patients early after arrival in hospital. The Acute Vascular Imaging Centre (AVIC) opened in 2012 as a unique facility combining MRI in an interventional vascular laboratory for clinical research during emergency treatment of heart attack and stroke patients.

OUH has a particular strength in interventional radiology which is becoming increasingly important in the treatment of vascular disease. It has recently delivered two significant cardiovascular service developments - the centralisation of vascular intervention in Oxford and the repatriation of cardiac surgery from London providers to Oxford.

OUH is designated as a hyper-acute stroke centre, complemented by an active BRC Stroke theme.

The Trust has modelled annual growth of 7% in outpatient cardiology and 4.9% in interventional radiology.

Care of newborns

Oxfordshire's birth rate has risen. With a growing proportion of mothers at risk of complications, demand has also risen for services such as specialised care for newborns.

OUH is a designated provider of level 3 care for newborns and is extending its facilities.

Paediatric subspecialties

The centralisation of specialised care in centres such as OUH, supported nationally by the Safe and Sustainable programme, is increasing demand for paediatric subspecialty services. For example, the Trust's modelling predicts annual growth of 7% for paediatric endocrinology and 5% for paediatric neurology.

As with cancer services, OUH's strategic response is to work with partner Trusts to develop a model which provides as much care as possible locally.

The provision of paediatric ambulatory surgical hubs at partner sites, supported by specialised expertise from OUH will deliver less complex care locally, reducing the travelling requirements for children and their carers, freeing capacity for more complex work on OUH sites and securing the required level of referrals for the sustained development of subspecialised services.

Services for older people and people with long-term conditions

The ageing population is causing demand for health care to grow. Together with lifestyle factors, particularly increased obesity, demographic change is also having an impact on long-term conditions.

People are living longer with their long-term conditions and requiring a different pattern of care: sporadic acute episodes needing intensive hospital support interspersed with much longer episodes of low-intensity supportive care. OUH's strategic response to growth in demand for these services is to work with partners to develop an integrated approach to delivering care for older patients and those with long-term conditions.

Diabetes is one area where research is being prioritised by OUH in partnership with the University of Oxford and is one of the BRC research themes.

The Trust has modelled growth of 9% per annum in diabetes medicine outpatient attendances and 5% per annum in outpatient care for older people.

The development of self-care can be expected to have a particular impact on the pattern of care required for this group of patients and OUH will work closely with researchers developing means of monitoring care and providing advice directly to patients to enable self-care.

Market share

4.88. OUH's catchment area is served by a range of other providers within the NHS and the private sector.

NHS providers

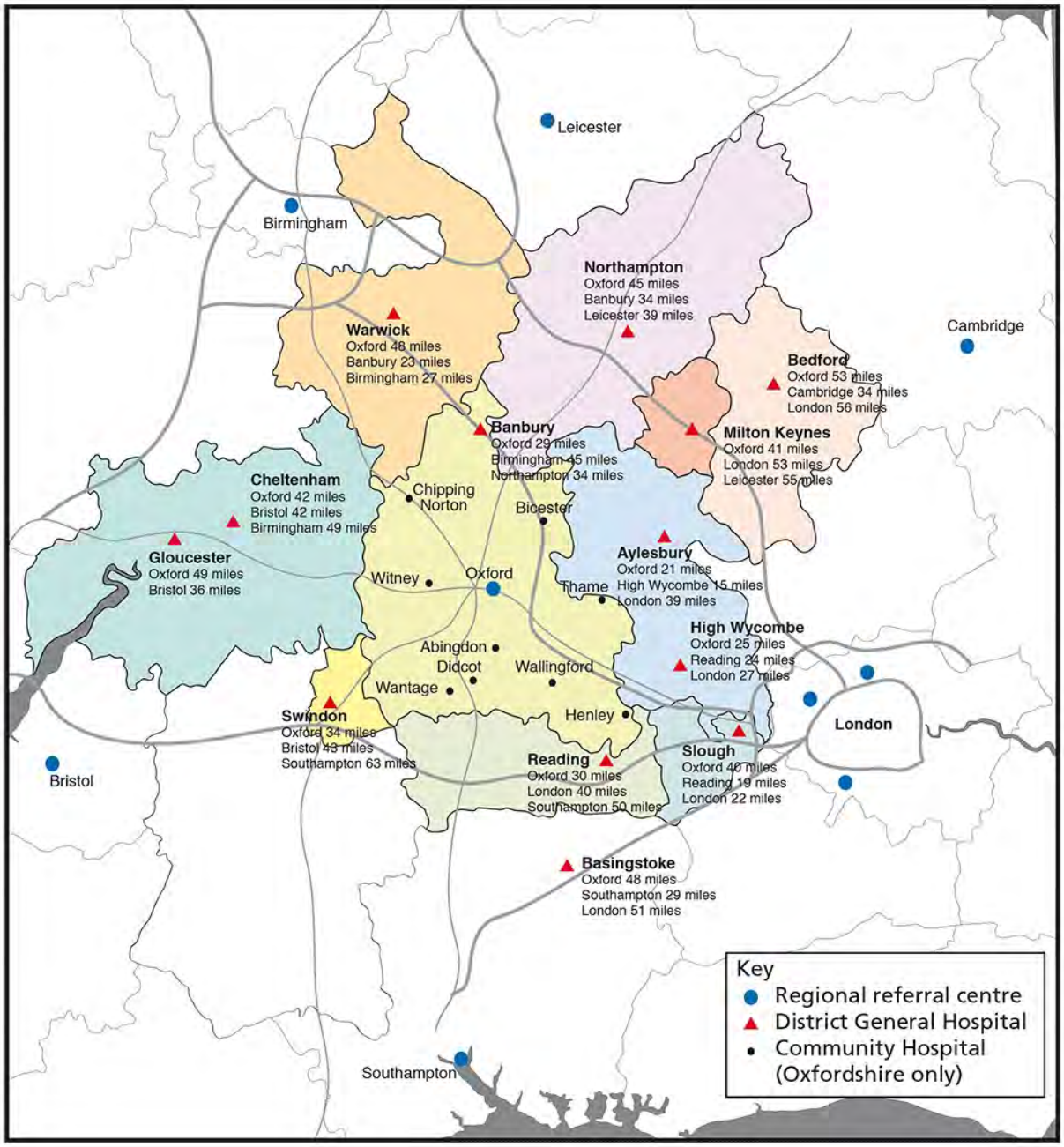
4.89. Sixteen NHS general or acute hospitals are within 50 miles of OUH's Headington sites. Banbury is almost equidistant between Milton Keynes and Oxford, although travel links to Oxford are better.

NHS acute hospitals within 50 miles of OUH's Headington sites

Hospital	Operator	Monitor governance risk rating[15]	Monitor financial risk rating	Road miles from Headington, Oxford	Road miles from nearest town in Oxfordshire
Stoke Mandeville Hospital	Buckinghamshire Healthcare NHS Trust	n/a	n/a	21	11
Wycombe Hospital	Buckinghamshire Healthcare NHS Trust	n/a	n/a	21	15
Royal Berkshire Hospital	Royal Berkshire NHS Foundation Trust	Green	3	24	9
Great Western Hospital	Great Western Hospitals NHS Foundation Trust	Green	3	27	13
Milton Keynes Hospital	Milton Keynes Hospital NHS Foundation Trust	Red	1	28	23
Wexham Park Hospital	Heatherwood & Wexham Park NHS Foundation Trust	Red	1	37	18
Hillingdon Hospital	The Hillingdon Hospitals NHS Foundation Trust	Green	3	41	29
Cheltenham General Hospital	Gloucestershire Hospitals NHS Foundation Trust	Amber-Green	3	42	22
Heatherwood Hospital	Heatherwood & Wexham Park NHS Foundation Trust	Red	1	44	20
Warwick Hospital	South Warwickshire NHS Foundation Trust	Amber-Red	3	46	22
Basingstoke Hospital	Hampshire Hospitals NHS Foundation Trust	Amber -Red	4	47	26
Mount Vernon Hospital	The Hillingdon Hospitals NHS Foundation Trust	Green	3	47	35
Northampton General Hospital	Northampton General Hospital NHS Trust	n/a	n/a	47	36
Northwick Park Hospital	North West London Hospitals NHS Trust	n/a	n/a	47	36
Gloucestershire Royal Hospital	Gloucestershire Hospitals NHS Foundation Trust	Amber-Green	3	48	29
Hammersmith Hospital	Imperial College Healthcare NHS Trust	n/a	n/a	50	38

[15] Monitor ratings as at 20 May 2013

4.90. Oxford is ringed by specialised centres as shown below: London to the south east, Cambridge to the east, Birmingham and Leicester to the north, and Southampton and Bristol to the south and west.



4.91. For OUH to sustain and where possible to extend its catchment, it recognises that it must demonstrate the sustained achievement of high levels of patient safety, outcomes and patient experience; achieve designation where necessary and, underpinning this, sustain good working relationships with referring Trusts and their clinicians.

4.92. To address this need, OUH clinical and strategic leads visit referring hospitals to discuss issues of importance to them and to agree actions. Key elements include the development of network-wide protocols to underpin the standardised delivery of higher quality, financially viable models of care and initiatives to sustain the delivery of services locally wherever possible. Examples include joint consultant urologist and oncologist appointments with Milton Keynes Hospital NHS FT.

Private providers

4.93. Within 50 miles of Oxford, 66 private healthcare sites are registered with the Care Quality Commission. Analysis using data from Dr Foster's Hospital Marketing Manager indicates that NHS Oxfordshire commissioned services from eight private providers during 2011/12, although not all information is available via Dr Foster. The most significant of these were:

- Ramsay Healthcare: operates the Horton NHS Treatment centre at the Horton General Hospital in Banbury. This site provides NHS orthopaedic and imaging services.
- BMI Healthcare: operates the Foscote Hospital adjacent to the Horton General Hospital. This relatively small hospital provides limited NHS work in addition to its core private business.
- Nuffield Health: operates the Manor Hospital adjacent to the John Radcliffe Hospital, providing a range of specialties, with some NHS work carried out.

4.94. Across OUH's wider catchment incorporating Buckinghamshire, Northamptonshire, Berkshire, Milton Keynes, Warwickshire, Swindon, Gloucestershire, Wiltshire and Bedfordshire there are six private providers for which NHS commissioned income of over £1m was recorded by Dr Foster for 2011/12. The income shown in the table relates to activity commissioned by Primary Care Trusts from private providers. Activity sub-contracted to private providers from NHS providers is not included.

Private Providers within catchment recorded by Dr Foster as receiving NHS income, 2011/12

Provider	Commissioner	Income (£m)	Provision
Ramsay Healthcare UK	Oxfordshire	3.04	• Horton NHS Treatment Centre, Banbury (adult elective orthopaedic surgery) • Woodland Private Hospital, Kettering (orthopaedics, physiotherapy, diagnostics including endoscopy, breast screening) • New Hall Hospital, Salisbury (orthopaedics, ophthalmology, general surgery, gynaecology) • Berkshire Independent Hospital, Reading (gastroenterology, general surgery, gynaecology, ophthalmology, orthopaedics, physiotherapy, rheumatology, urology, elderly care) • Blakelands Treatment Centre, Milton Keynes (general surgery, orthopaedics, ophthalmology, gastroenterology) • Winfield Hospital, Gloucester (orthopaedics, general surgery, etc.) • The Dean Neurological and Rehabilitation Centre, Gloucester
	Buckinghamshire	1.11	
	Northamptonshire	5.50	
	Berkshire West	2.57	
	Milton Keynes	1.64	
	Warwickshire	0.48	
	Swindon	15.40	
	Berkshire East	0.75	
	Gloucestershire	3.79	
	Wiltshire	2.32	
	Bedfordshire	0.55	
	Total	**21.77**	

Provider	Commissioner	Income (£m)	Provision
BMI Healthcare	Oxfordshire	0.61	• BMI Foscote Hospital, Banbury • BMI The Shelburne Hospital, High Wycombe • BMI The Chiltern Hospital, Great Missenden • BMI The Paddocks Clinic, Buckinghamshire • BMI The Saxon Clinic, Milton Keynes • BMI Princess Margaret Hospital, Windsor • BMI The Ridgeway Hospital, Wroughton, Swindon • BMI The Meriden Hospital, Coventry • BMI Three Shires Hospital, Northampton • BMI Hampshire Clinic, Basingstoke
	Buckinghamshire	3.67	
	Northamptonshire	2.84	
	Berkshire West	0.55	
	Milton Keynes	0.76	
	Warwickshire	1.33	
	Swindon	2.01	
	Berkshire East	0.58	
	Gloucestershire	0.12	
	Wiltshire	3.40	
	Bedfordshire	0.39	
	Total	**16.25**	
UK Specialist Hospitals Limited	Oxfordshire	20.90	• Treatment Centres in Devizes and Cirencester
	Buckinghamshire	1.40	
	Berkshire West	21.10	
	Milton Keynes	0.02	
	Warwickshire	0.00	
	Swindon	2.24	
	Berkshire East	0.01	
	Gloucestershire	2.26	
	Wiltshire	5.54	
	Bedfordshire	0.00	
	Total	**10.09**	
Spire Healthcare	Oxfordshire	0.08	• Spire Dunedin Hospital, Reading • Spire Healthcare Thames Valley Hospital, Wexham, Slough
	Buckinghamshire	0.39	
	Northamptonshire	0.01	
	Berkshire West	1.31	
	Milton Keynes	0.00	
	Warwickshire	0.11	
	Swindon	0.02	
	Gloucestershire	0.14	
	Wiltshire	0.05	
	Bedfordshire	0.21	
	Total	**2.31**	
Circle	Buckinghamshire	0.00	• CircleBath has 'centre of excellence' for hip surgery • CircleReading opened August 2012, offering cosmetic, plastic & reconstructive surgery, ENT, gastroenterology, general surgery & endoscopy, gynaecology, ophthalmology, orthopaedics, radiology including MRI, rheumatology, urology and vascular surgery
	Swindon	0.01	
	Gloucestershire	0.00	
	Wiltshire	1.64	
	Total	**1.66**	

Provider	Commissioner	Income (£m)	Provision
Nuffield Health	Oxfordshire	0.49	• Nuffield Health The Manor Hospital, Oxford • Nuffield Health Cheltenham Hospital • Nuffield Health Woking Hospital • Nuffield Health Warwickshire Hospital, Leamington Spa
	Buckinghamshire	0.01	
	Northamptonshire	0.01	
	Berkshire West	0.00	
	Milton Keynes	0.01	
	Warwickshire	0.36	
	Swindon	0.02	
	Gloucestershire	0.10	
	Wiltshire	0.01	
	Bedfordshire	0.07	
	Total	**1.07**	

Summary of competitive threats and OUH response

4.95. A summary of competitive threats and OUH's planned response is shown in the table below.

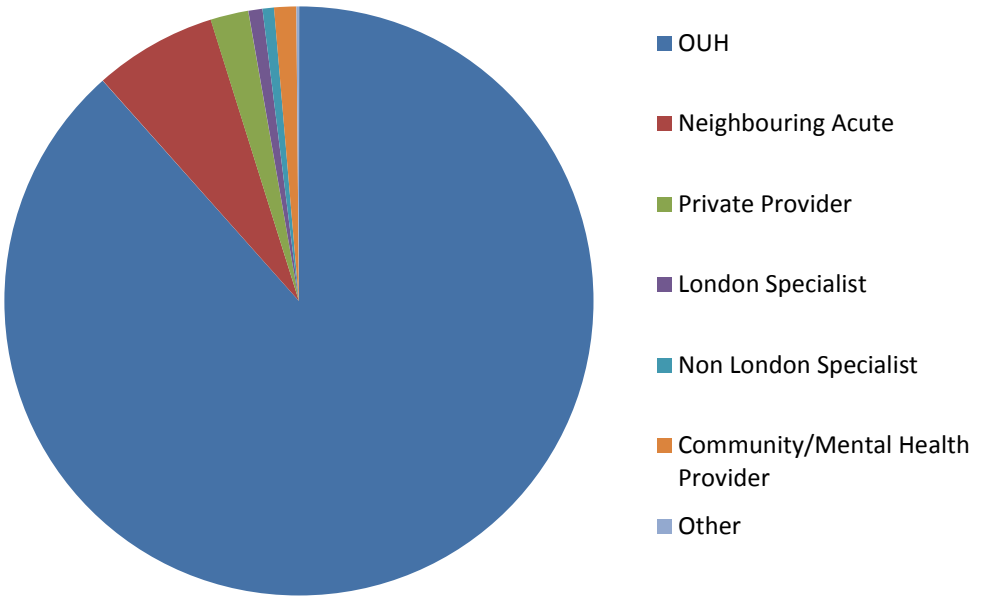
	Issue	Response
Alternative providers	Independent sector treatment centres	OUH is redesigning its services in response to changes at the ISTC in Banbury.
	Any Qualified Provider	OUH will assess the threat posed in selected services and develop an appropriate response.
Other NHS specialised centres	Competition from other teaching hospitals for tertiary work on the boundaries of OUH's specialist catchment area	Work with clinicians and network hospitals to strengthen referral patterns and create supportive clinical networks that help sustain services throughout the geographical patch. Focus on strengthening, sustaining and publicising quality, patient experience and patient recommendation and choice.
	Centralisation of services, particularly national 'Safe and Sustainable' programme	Target investment to build infrastructure and develop networks.
Private Sector	Competition Commission investigating this market, including the need for competition within a geographical area such as Oxford / Headington where, Nuffield Group having bought out BMI's Oxford Clinic, there is one private sector acute hospital provider.	Participation in investigation. Anticipate that market plurality of providers will be necessary around Oxford. Consider OUH capacity to develop its existing private healthcare service and/or form a strategic partnership with another provider.

	Cancer Partners UK poses a specific threat to the Trust's ambition to consolidate the market for its specialised cancer services. It aims to provide new cancer technologies routinely, particularly in radiotherapy. It is developing a site in Oxford and has centres located around OUH's cancer catchment area in London, Birmingham, Southampton and Portsmouth.	OUH's strategy is to partner with other providers in satellite radiotherapy units.
	Private patient market continues to tighten, as does insurers' flexibility to fund care. Strong market remains for private patient work.	Consider OUH capacity to develop its private healthcare service.

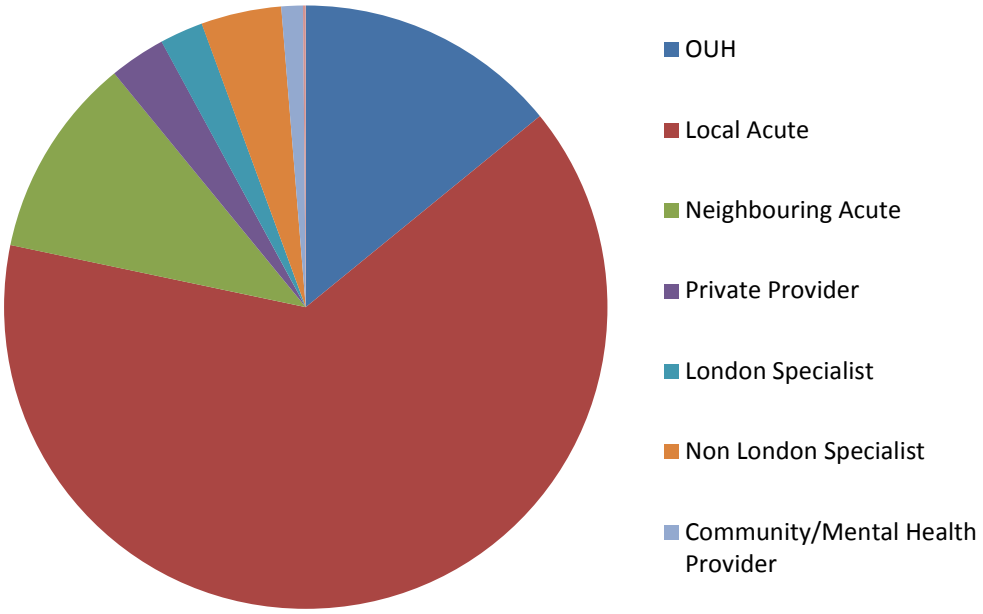
Market segmentation

4.96. Dr Foster's Data Analysis Tool (Hospital Marketing Manager) has been used to analyse market segmentation (by percentage of previous PCT expenditure) across OUH's wider catchment area. This methodology cannot be totally accurate as local prices are not always captured, but the two charts below indicate the division of spending between providers.

Oxfordshire share of NHS spend by provider, 2011-12



Share of spend by provider in 2011-12 for the catchment area shown at paragraph 4.3 above



4.97. When each area previously served by a PCT is analysed separately, market opportunities can be identified as follows.

PCT	Commentary on share of the market[16]
Oxfordshire	• The NHS market as recorded on Dr Foster is worth £201m. • OUH's overall market share is 88.4% (83% of the elective market and 92% of the non-elective market). • 6.7% is accounted for by neighbouring acute trusts, with patients on the periphery going to a closer hospital (Royal Berkshire, Great Western, Buckinghamshire Healthcare, Gloucestershire Hospitals, South Warwickshire, University Hospitals of Coventry and Warwickshire and Heatherwood & Wexham Park). • 5% of elective expenditure goes to private providers, largely Ramsay Healthcare which runs the Horton ISTC (£3m), BMI Healthcare (£606k) and Nuffield Health which runs the Manor Hospital close to the John Radcliffe Hospital (£488k). • £1.5m per annum goes to London specialised hospitals (although this is likely to be an underestimate as Dr Foster does not capture all specialised work) and £1.3m (again a likely underestimate) to non-London specialised hospitals (Southampton, University Hospitals Birmingham, Sheffield, Papworth and Bristol)

[16] Expenditure by PCT as recorded by Dr Foster for 2011/12, showing providers with >0.1%. Market figures based on Payment by Results tariff activity only, i.e. excluding most local prices and specialised commissioning activity.

PCT	Commentary on share of the market[16]
Bedfordshire	• The NHS market recorded by Dr Foster is worth £143m. • OUH has a 1.2% market share. • c.44% of work goes to Bedford Hospital and > 22% to Luton and Dunstable NHS FT • Almost 6% goes to London specialist centres (principally Great Ormond Street, Royal Brompton, Royal National Orthopaedic Hospital, University College London Hospital, Royal Free and Imperial College Healthcare). • >9% goes to non-London specialist centres, mostly Cambridge University Hospitals NHS FT (almost £9m) and Papworth (>£4m) • Private providers account for 2.7% of the elective market
Berkshire East	• The NHS market recorded by Dr Foster is worth £127m. • OUH has a 3.6% market share, with these referrals spread across practices. • Heatherwood and Wexham Park has a 62% market share. • 25% goes to other neighbouring acute hospitals (mainly Frimley Park, the Royal Berkshire Hospital and Ashford and St Peters). • Private providers have a 3.2% share of the elective market. • 7.3% goes to London specialist trusts.
Berkshire West	• The NHS market as recorded on Dr Foster is worth £139m. • OUH has a 6.5% market share. • Over 75% of spending goes to the Royal Berkshire FT. • The private sector has a 7.3% share of the elective market, with an ISTC in Reading. • 3.2% of income goes to London specialist providers. • Just over 1% of income goes to non-London specialist centres including Southampton.
Buckingham-shire	• The NHS market as recorded on Dr Foster is worth £165m. • OUH market share is 12% (14% of the elective market and 11% of the non-elective) • The local acute Trust (Buckinghamshire Healthcare) has a 62% share. • A number of neighbouring acute hospitals account for 17%, with Heatherwood and Wexham Park taking the most work. • Private providers have a 7.4% share of the elective market. • 5.7% (£9.4m) goes to London specialist hospitals. • Very little work (0.5%) goes to non-London specialist Trusts other than OUH.
Gloucestershire	• The NHS market recorded by Dr Foster is worth £231m. • OUH has a 1.2% market share. • 78% goes to Gloucestershire Hospitals NHS FT. • 8.3% (£19m) goes to non-London specialist providers – mainly to Bristol and to a lesser extent Birmingham and Bath. • Private providers account for 6.7% of the elective market.

PCT	Commentary on share of the market[16]
Milton Keynes	• The NHS market recorded by Dr Foster is worth £86m. • OUH has an 11% market share. • 75% of spending goes to Milton Keynes Hospital FT. • Circa £2.3m goes to Northampton General. • The private share of the elective market is 7.4%. • 3.3% goes to London providers including the Royal Brompton & Great Ormond Street.
Northampton-shire	• The NHS market recorded by Dr Foster is worth £252m. • OUH has a 6% market share, predominantly referrals from GP practices in the southwest of the county, close to the Horton General. • 80% of spending is split between Northampton General and Kettering General. • Private providers account for 7.7% of the elective market. • £2.8m goes to London specialist providers with other specialised work going mainly to Leicester (£9m), Cambridge (including Papworth), Nottingham and Birmingham.
Swindon	• The NHS market recorded by Dr Foster is worth £73m. • OUH has a 7.4% market share. • Over 80% of work stays in Swindon at the Great Western Hospital. • The private sector accounts for almost 14% of the elective market. • Less than 1% goes to London. • 4% goes to other specialist providers, mainly in Bristol and Southampton.
Warwickshire	• The NHS market recorded by Dr Foster is worth £198m. • OUH has a market share of 1.7% drawn from three GP practices closest to Banbury. • 86% of spend goes to the county's three acute Trusts (South Warwickshire NHS FT, University Hospitals Coventry and Warwickshire, and George Eliot). • Specialist work goes primarily to Birmingham rather than London. • The private sector accounts for 2.8% of the elective market.
Wiltshire	• The NHS market recorded by Dr Foster is worth £174m. • OUH has a 1.6% market share. • Over 54% of spending is at Salisbury NHS FT and Great Western Hospitals NHS FT. • Almost 26% is at acute Trusts in Bath, Winchester, Dorset, Gloucestershire and Somerset. • Specialist work is mainly at Bristol (>£9m), and Southampton (almost £6m). • Private providers have a 17% share of the elective market.

Competitive factors

Quality

4.98. Quality is the primary focus for OUH.

4.99. A five-year Quality Strategy was agreed by the Board in July 2012, drawing on a wide range of work on patient safety, clinical effectiveness, outcomes and patient experience.

4.100. The Quality Account for 2012/13 was published in June 2013. This reported on the delivery of quality priorities for 2012/13 and identified quality goals for 2013/14, following a patient engagement event in March 2013 which enabled members of the public to contribute to the formulation of these goals.

4.101. Regular reports are brought to the Board covering all aspects of Quality. Divisions prepare their own quality reports for monthly review and present progress to the Clinical Governance Committee.

4.102. OUH is using the national Quality Dashboard as one source of evidence against which to assess its performance in quality terms, with other sources including Dr Foster data and the recently-introduced Summary Hospital-level Mortality Indicator (SHMI).

4.103. OUH is fully registered with the CQC (for all its locations) and is compliant with all 16 essential standards for quality and safety. Its updated statement of purpose as a single, integrated Trust was provided to the CQC in November 2011.

4.104. The CQC's most recent inspection of the Trust was a routine inspection carried out at the John Radcliffe Hospital in February 2013. The CQC reported that the hospital met all the standards inspected and its report said that:

> "Patients were complimentary about the care they received. Patients said 'The nurses here are brilliant and the cleaners are all very friendly'; 'The doctors are very good here' and 'Absolutely wonderful midwives and anaesthetists'. We were also told 'There is a culture of politeness and making sure everyone is looked after here.'
>
> In all areas inspected, patients told us the environment was very clean. One patient said 'The cleanliness is excellent' and another person said 'It's all neat and hygienic.'"[17]

Patient experience

4.105. Patient experience is an important element of service quality. The most recent comprehensive survey of OUH patients is the Inpatient survey conducted by the Picker Institute in late 2012 and published in 2013 by the Care Quality Commission. 156 acute and specialist NHS Trusts were compared in the survey, with results as shown in the table below. 85% of OUH patients rated their overall experience as between 7 and 10 (best) on a scale of 0-10.

Inpatient survey, 2012	OUH
Better than most other trusts on	2 questions
About the same as most other trusts on	58 questions
Worse than most other trusts on	0 questions

4.106. The most recent Outpatient survey was carried out by the Picker Institute in November 2011 and published in 2012. This gave patient feedback as:

Outpatient survey, 2011	OUH
Better than the majority of other trusts on	11 questions
Average on	26 questions
Worse than the majority of other trusts on	2 questions

[17] http://www.cqc.org.uk/sites/default/files/media/reports/RTH_Oxford_University_Hospitals_NHS_Trust_RTH08_John_Radcliffe_Hospital_20130416.pdf accessed 3 June 2013

4.107. The 'Friends and Family Test' has been introduced as a national indicator of patient experience. Using NHS England's methodology for how a net promoter score should be derived from it, the first month of the test's use showed:

Friends and Family test, April 2013	OUH
Overall response rate (n=1,350)	18.3%
Response rate: inpatient wards	21.5%
Response rate: Emergency Department	13.9%
Net promoter score	67
Percentage 'extremely likely' or 'likely' to recommend OUH	93%

4.108. The Trust will monitor Friends and Family scores and comparisons with those of other hospitals once these are available.

4.109. OUH also collects qualitative data alongside the Friends and Family Test through methods including local patient surveys, the use of feedback forms and through its PALS service and the receipt of comments, commendations and complaints. Details are reviewed within Divisions, the Quality Committee and conclusions and priorities reported to the Board of Directors.

Staff experience and perception

4.110. Research shows that the more positive the experiences of staff within an NHS trust, the better the outcomes.[18] Staff engagement has significant associations with patient satisfaction, mortality, infection rates, Annual Health Check scores, as well as with staff absenteeism and turnover. The more engaged staff members are, the better are outcomes for patients and for the organisation generally.

4.111. The 2012 survey of OUH's staff indicated that overall staff engagement had risen to 3.73 (of a maximum 5). The average level for the 142 acute Trusts in England was 3.69.

4.112. The score comprises staff members' perceived ability to contribute to improvements at work, their willingness to recommend the trust as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work.

4.113. Extensive work is being carried out on staff engagement in order to meet the Trust's strategic objective of 'Delivering Compassionate Excellence.' This work has included the introduction of a clear set of values and standards of behaviour, with work undertaken to inform recruitment, induction, appraisal, recognition and management approaches.

4.114. The Trust has also adopted the 'Listening into Action' methodology to involve and engage its staff.

4.115. Further information is given in Chapter 9.

Geography and travel times

4.116. OUH's Oxford sites are within easy reach of the M40 motorway between West London, the M25 and Birmingham and the trunk road network (A34) between the Midlands and Southampton. Swindon, Aylesbury, Cheltenham, High Wycombe, Milton Keynes, Northampton, Reading, Slough and Heathrow Airport are within one hour's journey time.

[18] http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf accessed 3 June 2013

4.117. The Horton General Hospital is close to the M40 and within 45 minutes' journey time of Oxford, Milton Keynes, Northampton and Warwick.

4.118. The development of a new rail link between Oxford and London Marylebone, expected to open in 2015, will create a new Water Eaton parkway station with frequent bus connections to OUH's Headington sites (the John Radcliffe Hospital is 4.5 miles from the station site).

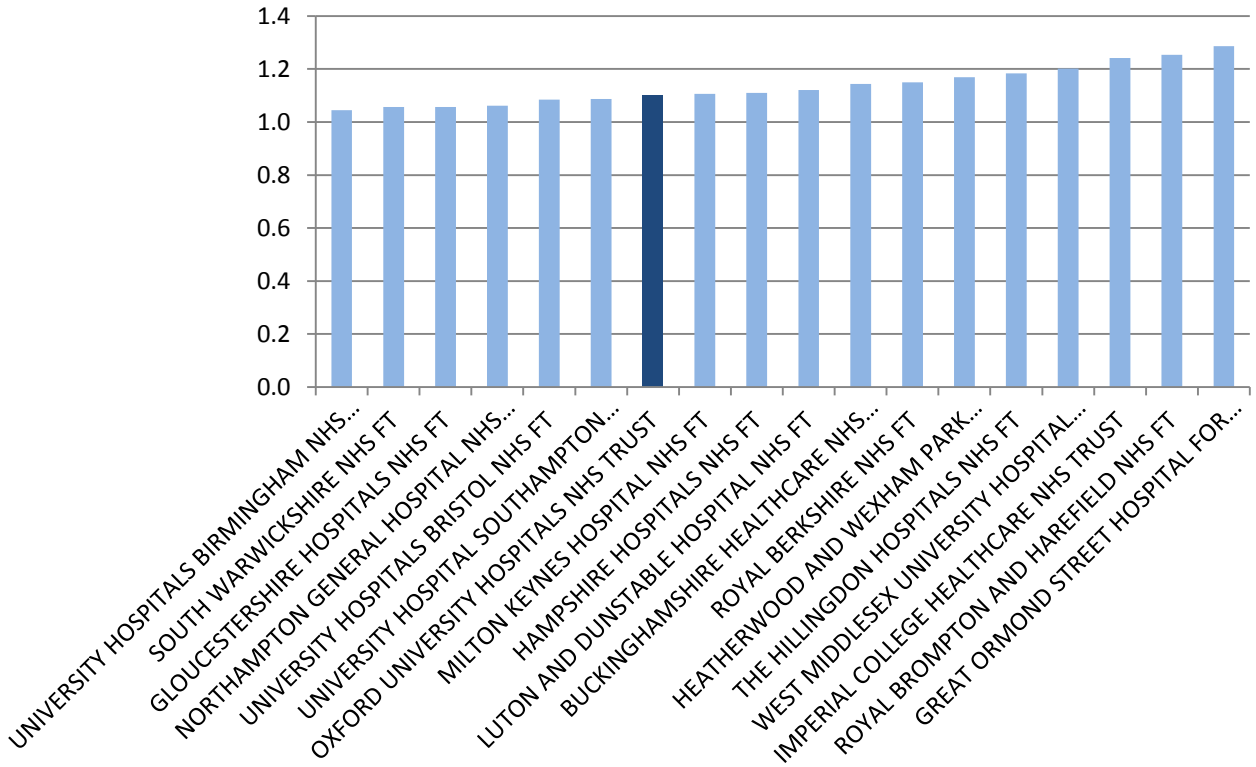
4.119. The subsequent East-West rail link (potentially from 2017/18) will improve access to Oxford and Water Eaton from Milton Keynes, Bedford and Swindon, offering opportunities to extend the services the Trust provides to these growing populations.

Other cost factors

4.120. Reference costs are described in Chapter 6. Benchmarks for 2011/12 showed that OUH had an index of 108, indicating that the Trust's case-mix adjusted activity cost 8% above national benchmarks.

4.121. The Market Forces Factor (MFF) results in commissioners paying different prices to different providers. The visible price difference can influence commissioning, although the Department of Health has signalled its intention to see commissioners stop using MFF as a basis on which to limit patient choice.[19] The chart below shows OUH as fairly well placed compared to its NHS competitors, although the MFF poses more of a challenge if it wishes to pursue specialised activity to the west and north of its catchment. MFF may help to shape the approach taken in developing services on other trusts' sites, as the 'payment index value' shown is driven by property prices rather than pay premia.

Payment Index Value ('Market Forces Factor') for 2013-14, Selected Trusts



[19] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131089.pdf

Conclusions

4.122. The Trust's Board and Divisional Directors have reviewed the political, economic, social, technological, legal and environmental factors which have the potential to affect the Trust. Their impact and the Trust's response are summarised in table form on page 81.

4.123. OUH provides services to a local market for general hospital services and a wider market for more specialised care.

4.124. The Trust provides the majority of acute services for its local market with a small volume of activity going to neighbouring DGHs and to private providers who have contracts, currently for a limited range of orthopaedic and other elective work. It is monitoring plans by commissioners to put services out to tender and developing plans to respond.

4.125. A defining feature of the local market is increasing demand from an ageing population with increasingly complex health and social care needs. The Trust's strategic response is to work with local partners, including new commissioners, to develop new care pathways to meet this demand in a way that reflects the needs of patients within the constraints of the current economic climate. A key focus for this within the local health economy is the reduction in delayed transfers of care.

4.126. As local care pathways are redesigned and redirected away from the acute setting, the Trust's strategy is to increase the proportion of its income that is for specialised care. As commissioning structures have changed, an increased proportion of the Trust's income comes from specialised commissioning. The Trust's strategy to increase its specialised market has three components:

- Consolidate its existing catchment through mutually-beneficial work with local providers and with commissioners, delivering results such as the repatriation of local patients from London.
- Deliver national and network-driven reconfigurations of specialised services, recent examples including major trauma, vascular surgery and newborn intensive care.
- Extend its catchment area through extending clinical networks and joint working relationships into Milton Keynes and Bedfordshire.

4.127. Potential new markets will also be monitored.

4.128. The Trust's ability to deliver its strategies in relation to both local and specialised services requires confidence from patients, GPs, commissioners and referring clinicians that it provides high quality services. OUH has a number of approaches to this:

- Retaining a focus on the quality of care delivered (measuring patient safety and experience, clinical effectiveness and outcomes), gaining assurance of it through its governance systems and demonstrating it by publishing outcomes data and meeting access targets.
- Embedding compassionate excellence in the values and behaviours of the Trust and engaging with patients about what they want and how the organisation can improve.
- Continuing engagement with Oxfordshire Clinical Commissioning Group and its locality groups to understand and respond to local commissioner issues.
- Working with new commissioning bodies to deliver services in line with their strategies, such as local, outcome-based commissioning and national service standards for specialised services.
- Making the most of OUH's unique partnership with the University of Oxford and working through the joint partnership agreement to bring the benefits of excellent research and teaching to the Trust's patients.
- Building wider partnerships (clinical networks, the Oxford Academic Health Science Network and the Oxford Academic Health Consortium) to innovate and deliver benefits more widely.

- Demonstrating that the Trust provides “state of the art” services by making the best use of its new facilities, making targeted investment in new technology, treatments and IT solutions, promoting the work of the Oxford Biomedical Research Centre and Unit and responding to the designation process for Academic Health Science Centres.

4.129. Chapter 5 describes service developments which flow from these factors.

PESTLE analysis

Factor	Impact on OUH	OUH Response
Political		
Centralisation of specialist services	• Centralisation of specific services requested by commissioners, with NHS England beginning to drive this agenda. • Safe and Sustainable Programme reviews (paediatric neurosurgery next). • Programme of designation of specialised services.	• Completion of action from business cases for agreed centralisation in Oxford (Major Trauma, Vascular Surgery, Neonatal, Hyper-acute Stroke) • Deliver paediatric network arrangements for children's heart surgery in collaboration with University Hospital Southampton NHS FT • Develop similar network for paediatric neurosurgery • Review working arrangements with network hospitals, e.g. specialist patient pathways
Continued focus on patient safety.	• Quality Governance Framework assessment. • Continued scrutiny of processes and indicators, including healthcare associated infection standards and Safety Thermometer. • Publication of Francis 2 report heightens expectations of quality governance systems.	• Complete QGF action plan and sustain progress • Development of Patient Safety Framework as part of overarching Quality Strategy • Identified Patient Safety priorities within annual Quality Account • Executive walk rounds
Encouragement of competition and introduction of new providers to market	• Services provided by OUH put out to tender by commissioners.	• Monitor services which could be put out to tender by commissioners and develop plans for gaining/losing activity • Consider tendering for new services • Develop internal capacity and expertise for responding to invitations to tender • Anticipate unmet need and consider joint solutions, e.g. in social care, dementia
Expectations of delivering integrated care	• Requirements of local commissioners. • Potential inclusion by regulators (Monitor duty).	• Deliver redesign of patient pathways and develop new roles.

Factor	Impact on OUH	OUH Response
Extension of patient choice	• Patient choice is influenced by information on outcomes and patient experience • Choice is often influenced by referrers as much as patients • Choice is also influenced by friends and family	• Work with GPs to build relationships of trust • Improve accessibility of Consultants to GPs • Consider establishing new 'gatekeeper' portal, learning from experience in musculoskeletal services • Introduce electronic patient feedback tool • Use of feedback from patients to set priorities in Quality Account • Use Quality Account to demonstrate quality of services to patients • Publicise feedback about the Trust's services
Focus on improving quality whilst reducing cost	• Requirement to deliver CIPs. • Work with partners on QIPP. • Payment by commissioners linked to delivery of quality measures.	• Monitoring and benchmarking of outcomes • Participation in national clinical audits and publication of findings and actions in annual Quality Account • Implementation of Quality Strategy, with positive engagement of staff • Develop robust, granular understanding of costs • Progress towards improvements in quality, e.g. on best practice tariffs
Increased focus on patient experience	• Publication of PROMs for selected procedures and Patient Experience surveys, e.g. for Cancer patients • Link to payment, e.g. Patient Experience CQUIN • Introduction in April 2013 of feedback on whether patients would recommend the service to Friends and Family	• Patient feedback initiatives as above • Prominence within Trust values of compassion and respect, embedded through Listening into Action and associated programmes • OUH's nursing and midwifery standards updated and a set of associated "promises to our patients" developed • Board walk rounds • Individual service developments demonstrate improvements in patient experience, e.g. integrated spinal pathway • 'Friends and Family' test • Introduce "you said… we did…" • Develop discharge questionnaires

Factor	Impact on OUH	OUH Response
National initiatives to promote innovation and translational research in healthcare	• Investment in centres promoting innovation and translational research. • Some funding dependent on introducing best practice, e.g. compliance of six "high impact interventions" pre-condition for receiving CQUIN payments, "Innovation scorecard" and innovation incentives.	• Oxford AHSN focus on innovation, wealth creation and the translation of research benefits • Joint Working Agreement with University of Oxford and (separately) with Oxford Brookes University • Oxford Academic Health Consortium, with formal partnership and agreed priorities for collaboration • Response to Department of Health's competition to designate Academic Health Science Centres (AHSCs)
National strategic focus on specific areas, e.g. • **Cardiovascular and Stroke** • **Cancer** • **Dementia** • **Long-term Conditions**	• Inclusion in NHS Outcomes Framework produces requirements from commissioners with payment implications.	• Oxford Heart Centre developments • Continued development of OUH as Hyper-acute Stroke Centre • Continued realisation of benefits of Oxford Cancer Centre and development of cancer services, e.g. co-location of Head and Neck cancer services and development of radiotherapy • Reflection of national priorities in research initiatives, e.g. BRC Cancer, Heart, Stroke and Diabetes themes *[see also Dementia response below]* • National priorities are reflected in AHSN programmes and themes
Reorganisation of NHS commissioning	• Local Clinical Commissioning Groups and NHS England. • NHS England assumes responsibility for OUH's specialised income. • Local authorities commission some public health services. • Potential lack of clarity in short term about commissioning priorities.	• Develop relationships with new commissioners and emerging GP leaders • Develop clear view with local GP commissioners of priorities for 'local' hospital care • Strengthen clinical networks with surrounding hospitals which can respond to further centralisation of specialist services • Market services to commissioners further afield

Factor	Impact on OUH	OUH Response
Requirement to meet access targets	• Monthly self-certification by Board including access standards. • Achievement of access standards linked to payment by commissioners.	• Integrated Performance Framework • Improved use of resources to flex capacity • Further develop extended day and weekend working, including access to diagnostics. Consider outpatient services beyond current working day • Action plan to reduce delayed transfers • Action plan to improve waits in the Emergency Department
Service reconfigurations	• Reconfiguration of Buckinghamshire hospital care (Wycombe emergency care centre opened 1 October 2013) and future links to Wexham Park: impact on specific services, especially vascular. • SE Midlands Acute Services review and subsequent proposed reconfigurations in Northamptonshire, Milton Keynes and Bedfordshire: some risk to referrals, but opportunities in an area of rapid predicted population growth and with which there are improving transport links. • Joint exercise by Boards of Heatherwood & Wexham Park and Frimley Park NHS FTs to investigate potential benefits to patients of a closer working partnership between the two trusts: may result in reconfiguration of services in East Berkshire and surrounding areas.	• Create and sustain partnerships and network membership and seek to strengthen partnerships with all members of the AHSN, the OAHC and OxAHSC • Pursue joint consultant posts and development of renal and radiotherapy satellite units

Factor	Impact on OUH	OUH Response
Economic		
Changes to NHS payment and pricing mechanisms	• Monitor, NHS England and local commissioners are looking to commission more on the basis of outcomes rather than inputs • Changes to tariffs and tariff structures. • National initiatives to reduce costs (e.g. Carter Review of pathology services) present opportunities and risks involving large amounts of income.	• Engage with GP commissioners on moves towards 'year of life' payments and alternative models of service delivery and funding. • Future shape of pathology services expected to be determined through a link to research with the clinical network within the AHSN.
Offshore economies in growth	• Opportunity to provide training. • Competition in global market.	• Evaluate potential scope (potentially with Saïd Business School).
Reducing personal disposable income	• Impact on health (e.g. diet, expenditure on health promoting activity and loss of mental wellbeing) with consequent effect on demand for services. • Potential reduction in private market.	• Work closely with local commissioners to identify trends as early as possible. • LTFM makes conservative estimates on future private patient income.
Relatively high cost of living around OUH's sites	• Recruitment difficulties, e.g. in lower banded specialist nursing. Cost of Living Supplement no longer part of Agenda for Change terms and conditions.	• Cheap accommodation on Trust sites for a specified period to ease transition. • Relocation package can be offered at discretion of manager. • OUH links with affordable housing schemes. • Comprehensive transport policy to support staff travel.
UK government policy to reduce public spending	• Tariff deflation requires continuing cost reductions to sustain Income & Expenditure surplus. • Reduced social care funding reduces support to vulnerable people, affecting demand for emergency care and efforts to reduce delayed transfers. • Pressure on public sector pay and pensions worsens recruitment, retention and motivation. • Constraint on availability of capital for investment.	• CIP programme on rolling two-year basis with contingencies. • Transformation of service delivery to achieve this. • Action plan with NHS and social care providers to provide targeted support and reduce the impact of 'care boundaries' through service integration. • Continued focus on delivering compassionate excellence. Demonstrate progress on quality strategy. • Affordable capital programme.

Factor	Impact on OUH	OUH Response
Social		
Changing demographics: • **Growing population** • **Ageing population** • **Increasing incidence of dementia** • **Increasing dependency ratio** • **Increasing rates of obesity** • **Increasing numbers with disabilities** • **Growth in range of ethnic minorities**	• Increasing demand for some services, including emergency admissions, patients with chronic conditions, cancer, diabetes and bariatric surgery • Increased complexity of case mix – more co-morbidities, higher risk surgery, more complex after-care required, with lower levels of at-home support and independence • Pressure on social care with associated increase in delayed transfers of care • Increased variability of needs • A growing proportion of the Trust's patients will have dementia • Mortality rates in OUH care may rise	• Demographic factors modelled into activity projections for LTFM • Plans to manage increased demand in specific areas, e.g. radiotherapy • Ensure complexities and co-morbidities captured in clinical coding and monitor whether associated costs reflected in tariffs • Introduction of Integrated Psychological Medicine Service • Introduction of standardised dementia screening • Identification of whole system working and collaboration through Oxford Academic Health Consortium with dementia as the first agreed priority • Reflection of issues in AHSN programmes • Focus on patient-centred care • Plans to develop service integration and reduce delayed transfers
Rising birth rate	• Growing demand for neonatal services	• Expansion of newborn intensive care service
Areas of specific growth with housing developments in Oxfordshire, Milton Keynes and Swindon	• Increased market presents opportunity for OUH services	• Focus on development of partnership working and specific initiatives such as joint posts and business cases for service developments, e.g. satellite radiotherapy provision
Rising expectations of service and customer care	• Demand for outcomes, good experience of care, access and service developments • Demand for information	• Provide timely access, meeting national standards (as above) • Seek and monitor patient feedback (as above) • Improve patient experience (as above)
Cost of litigation	• Rising premia • Changes to NHSLA arrangements	• Deal with dissatisfaction early • Use policies and procedures clearly and visibly to obviate known risks

Factor	Impact on OUH	OUH Response
Technological		
Rapidly developing technology, therapeutic techniques and equipment, including minimally invasive techniques and automation	• Opportunities to increase market share and potentially improve efficiency if capitalise on technological opportunities • Higher-risk patients treated as minimally-invasive procedures develop • Threat to market share if fail to do so	• Investment already made, e.g. da Vinci and dispensing robots • Development of plans to work with academic partners and BRC/BRU to become centre of excellence in specific areas, e.g. radiotherapy and surgical innovation and evaluation. • Use of technologies is an important element of AHSN plans • Develop staff skills to respond well • Build staff confidence in use of information • Forward capital programme
Availability of new drug therapies and treatment regimes	• Rapid translation of new modes of treatment such as future use of genomic therapy • Increased patient and clinician expectations • Effect on costs • "Innovation Scorecard" has impact on patient choice • Staff expectations of most up-to-date equipment	• Therapeutics Advisory Group considers introduction of new procedures/treatment • Move towards being 'data driven' on effectiveness • Develop 'business intelligence unit', perhaps with Saïd Business School, to evaluate and develop 'Oxford USP' • AHSN work stream on informatics and technologies
Information Technology advances	• Potential to improve patient safety, outcomes and patient experience • Improved information to support decision-making • 3 million lives and Digital First High Impact Innovation pre-qualifiers for CQUIN payments • Cost implications and benefits realisation	• IM&T Strategy and associated allocation in capital programme • Benefits realisation as EPR system is rolled out • Prepare and support staff • Use Patient level information and costing system (PLICS) in Divisions • Complete pilot of electronic "track and trigger" early warning system • Develop capabilities of 'data warehouse' • Digital dermatology service introduced to provide e-mail advice for GPs • Pilot remote monitoring of patients using mobile phone technology (mHealth) • Introduction of remote requesting/reporting for direct access diagnostics • Informatics a key element of AHSN plans

Factor	Impact on OUH	OUH Response
Legal		
Health and Social Care Act 2012	• Changes to commissioning structures (as above) • Increased emphasis on competition *and* integration (as above) • Introduction of national and local Healthwatch • Introduction of Joint Health and Wellbeing Board • Changes to regulation	• Develop positive engagement with new commissioners • Incorporate response to Health and Wellbeing priorities into strategy • Work with local Healthwatch to engage with patients and the public, get feedback on services and proposed future priorities and service developments • Demonstrate that governance and assurance systems allow OUH to meet new regulatory requirements

Factor	Impact on OUH	OUH Response
Environmental		
Energy	• Rising energy costs • Penalties for carbon emissions	• Business case for energy investment to address deficiencies in infrastructure and improve efficiency of consumption • Vacate and demolish old and energy-inefficient accommodation
Estate	• Limited space on sites.	• Explore further development of existing building footprint
Transport	• Transport strategy including Park and Ride facilities • New rail links to improve access to OUH's Oxford sites.	• Continued engagement with Oxfordshire County Council to support 'supply' of P&R access to Trust sites • Strategy to expand and consolidate catchment areas to East and North East and consolidate Swindon catchment • Timing of new transport links to be factored into planning and marketing

Chapter 5

Service Development Plans

5. Service Development Plans

Introduction

5.1 OUH recognises that its market assessment and the economic climate within which it operates require it to reduce cost and to improve its use of estate and facilities while continuing to innovate in the delivery of clinical services.

5.2 Significant investment in recent years has enabled many of its services to operate from state-of-the art facilities at the new Churchill Hospital, including the Oxford Cancer Centre; the West Wing, Children's Hospital and Heart Centre at the John Radcliffe Hospital; and the Nuffield Orthopaedic Centre. All provide scope for service development within the building fabric available.

5.3 OUH's Estates Strategy recognises that ongoing investment is required across the Trust's non-PFI estate. The Trust's capital programme provides for developments to improve facilities for care delivery on each site.

5.4 The Trust's focus is on transforming its service delivery through realising benefits from the Electronic Patient Record (EPR), developing increasingly integrated local care in partnership with local providers and commissioners, network partnerships for the delivery of specialised care and, last but not least, a strong partnership with the University of Oxford and other partners to promote healthcare research, healthcare innovation and its rapid adoption into routine clinical practice.

Areas of service development

5.5 Service developments are therefore described in four categories:

a. Improving patient experience and efficiency

5.6 This section describes work taking place to reduce delayed transfers of care. It also lists significant areas of service transformation and capital schemes to improve the environment for care, although none is of sufficient financial value to feature as a distinct service development in the Trust's Long Term Financial Model (LTFM).

b. Activity reduction (QIPP)

5.7 The requirement of commissioners for service redesign which brings reduced hospital activity is recognised through local QIPP programmes. Demographic change and continuing pressure on resources are driving the development of patient pathways to optimise patient experience and the reorganisation of services to promote community-based care. The approach being taken by the Trust is described.

c. Strengthening of specialised services

5.8 The Trust's capability to support comprehensive teaching and research depends in part on its ability to function as a capable provider of specialised care.

5.9 As an established tertiary centre, with strong links to surrounding hospitals, OUH has progressed a series of developments to strengthen its capability to deliver specialised care to national standards.

5.10 Developments made at the request of commissioners in major trauma, newborn intensive care and vascular surgery are summarised. Whilst activity and income from these developments is part of the Trust's Long Term Financial Model (LTFM) and they are not shown separately within it, they do form part of OUH's foundation for service development in specialised services.

d. Strategic development of cancer services

5.11 OUH has made major investment in its cancer services. Market assessment confirms that demand can be expected to continue to rise and that this is an area where development will be required in secondary and tertiary care. The Trust must maintain up-to-date services and technology in an area of care where competitors are entering the local market.

SWOT analysis

5.12 Identification of the Trust's strengths, weaknesses, opportunities and threats has resulted from Board seminars and Divisional and Directorate Business Plans developed through its annual business planning process. The resulting analysis is shown below.

Strengths		
Factor	**Supporting Evidence**	**Implications**
Clinically-led organisation	Clinically-led management structure is embedded. Clinical leaders supported in role by a leadership programme. Demonstrable engagement between the Board and Divisions.	Autonomy and accountability for decision-making is vested in those best placed to balance the drive for improvement in quality, outcome and patient experience with need to improve efficiency.
Comprehensive portfolio of services with high levels of subspecialisation, underpinned by strong clinical support services and multidisciplinary working	Few local referrals are directed outside Oxfordshire. Many services designated for specialised commissioning under Carter review. Good clinical links between paediatric and adult services. On-call interventional radiology and MRI services 24/7. MDTs in all cancer tumour groups.	Comprehensive offer to local commissioners, GPs and patients. Infrastructure in place to support specialised services and ongoing designation.
Established tertiary centre with strong clinical network arrangements with surrounding hospitals	Provision of "in-reach" and "out-reach" services. Jointly funded consultant appointments e.g. in neurology and plastics. Oxford Academic Health Science Network designated and hosted by OUH	Support to referral base for specialised services. Extension of partnership working arrangements with a network including health and social care providers, commissioners, universities and other academic groups, 3rd sector, life science industries, business, the public and patients.
Patients value quality of care and treatment	Comments and PALS contacts. Patient panel feedback. "Let us know your views" leaflets. Picker inpatient survey. Friends and Family survey information.	Encourages patients and GPs to consider OUH provider of choice. Supports the membership drive. Requirement to publish comparative data and feedback will influence choices of patients, carers and GPs.

Strengths		
Factor	**Supporting Evidence**	**Implications**
Performance against access targets, including clinical support services turnaround times	Access standards met in cancer and 18 weeks referral to treatment.	Potential opportunities to positively influence choice of provider for patients and commissioners with delivery exceeding required standards.
Planning processes	Consistent and transparent approach to business planning. Demonstrable implementation review.	Clear justification for investment decisions. Realisation of planned benefits is monitored to ensure delivery.
Reputation for clinical services, many using innovative treatments and techniques, e.g. radio-chemotherapy; robotic surgery	Good clinical outcomes in e.g. cancer, stroke, transplantation.	Strong basis on which to market services to commissioners and patients and to attract research funding/partners.
Reputation for excellence in training and developing research awareness and activity in the non-medical workforce, underpinned by relationship with Oxford Brookes University	Joint Working Agreement with Oxford Brookes University identifies work streams for collaboration.	Able to attract and develop high calibre staff. Increasing non-medical research activity to support innovation, evidence-based practice and research in care.
Reputation for excellence of teaching, training and research, underpinned by relationship with the University of Oxford	Biomedical Research Centre and Biomedical Research Unit status. HEFCE Research Assessment Exercise (HAE) ratings. Top ratings for student experience in Oxford Medical School. Trust brand linked with Oxford brand	Able to attract students and high calibre staff, including recognised clinical leaders, from global market. Translational research informs sustained development of services, leading and embedding innovation in clinical practice. Opportunities for patients to participate in clinical trials.
State-of-the-art facilities including high percentage of single rooms and latest technology	New Churchill Hospital, Nuffield Orthopaedic Centre, West Wing, Children's Hospital, Oxford Heart Centre, Trauma Centre and part of Acute General Medicine. Approximately 50% of patient care estate is under 7 years old. Beam matched linear accelerators; da Vinci robot; core automated laboratory.	Investment made in key service areas. Quality of facilities provides opportunities to attract referrals.

Weaknesses		
Factor	**Supporting Evidence**	**Implications**
Access to care requirements not met in some areas	Delayed Transfers of Care. Diagnostic waits. Emergency Department waits.	Adverse patient experience. Impact on cost and ability to progress Trust's business plan. Impact on choice by patients, GPs and commissioners. Action plans on delayed transfers, diagnostic waits and ED waits. Targeted work to improve flow, strengthen clinical leadership and release downstream beds. System-wide redesign of care for frail older people.
Areas of improvement identified by patients: outpatient booking processes; communication - particularly with older patients; quality of food and helping people to eat; discharge information and arrangements with multi-agency involvement.	Comments, complaints and PALS contacts. Picker Inpatient survey.	Adverse patient experience. Adverse impact on choice by patients, GPs and commissioners. Action on outpatient bookings. Implementation of Trust-wide patient feedback system to identify and prompt timely action on emerging issues.
Capacity in community health and social care services adversely affecting operational and financial performance	Delayed Transfers of Care. Cancelled operations.	Adverse patient experience. Impact on choice by patients, GPs and commissioners. Action to provide alternatives to extended stays in hospital. Collaboration across primary, secondary and social care to provide integrated care pathways.
Finance: achieving Monitor's liquidity rating as part of the Financial Risk Rating	Long-term financial model and historical due diligence.	Strengthened working capital position through proposed loan at the point of authorisation. Cost improvement programme to achieve sustained 1% surplus.
Higher costs associated with new facilities while parts of the estate remain outdated	Some services on the Churchill and Horton General sites are housed in sub-optimal accommodation.	Increase utilisation of PFI facilities. Investment in retained estate through capital programme. Reduction of overall cost of estate through Estates Strategy.
Relatively small local catchment for specialised teaching centre.	Market assessment.	Development of mutually-beneficial partnerships to support the inflow of specialised work.

Weaknesses		
Factor	**Supporting Evidence**	**Implications**
Split site working	Multiple medical rotas.	Rationalisation and simplification of on-call rotas to optimise efficiency and improve value for money whilst ensuring patient safety.

Opportunities		
Factor	**Supporting Evidence**	**Implications**
Electronic Patient Record	Opportunities to deliver improved patient care and service improvements e.g. developing order-communications in the next year, patient prescribing in the next two years, remote monitoring. The recently launched Big Data Institute will create an unrivalled capacity to store and analyse data from large population studies alongside data contained in, for example, the electronic patient record to support a fundamental change in the nature of research and the patient care pathway.	Improved and integrated processes, reduced variation in outcomes and improved availability of clinical information. Wider contribution across academic and research partnerships with associated patient benefit
Extended day and 6-7 day working	Optimises use of assets e.g. in theatres, endoscopy, radiology.	Improved patient experience through timely admission and discharge and improved access. Promotes OUH as provider of choice with improved flexibility and responsiveness. Improves productivity and VFM.
Incentives through developments in commissioning e.g. CQUINs and tariff structures which promote innovation	CQUINs are up to 2.5% of outturn contract value. Payment differential between standard treatment and best practice for specific interventions. e.g. patients with long-term conditions can be remotely monitored, national recognition of EPR for blood product usage.	Development of patient pathways to optimise patient experience and secure value for money.

Opportunities		
Factor	**Supporting Evidence**	**Implications**
Innovation in commissioning and tariff structures to promote integration	Two thirds of annual NHS expenditure relates to patients with long-term conditions. Oxfordshire CCG has signalled intent to commission integrated care for maternity and 'frail elderly.'	Delivery of integrated care across health and social care providers. Strengthening of primary and community-based provision provides opportunity for integration with secondary care expertise and resilience.
National and regional strategies to centralise specialised services	Designation of OUH as Major Trauma Centre, a centre for complex elective and emergency vascular surgery and for newborn intensive care. Further designation processes in train for e.g. severe intestinal failure, specialised burns services.	Activity transferred to OUH with associated transfer of resource. Critical mass of work established to optimise outcomes and maintain expertise and modern technology. Defined standards of service delivery. Scope to strengthen mutually-beneficial partnerships with network hospitals.
Oxford Academic Health Consortium	Statement of Intent agreed and Consortium launched with OUH as a founding member.	Consortium membership of NHS bodies, University of Oxford and Oxford Brookes University and Oxfordshire County Council provides strong local focus to promote integrated working and adoption of innovation in healthcare delivery. Projects in place on dementia and to reduce delayed transfers.
Oxford Academic Health Science Centre	OUH, OH, University of Oxford and Oxford Brookes University in partnership for national designation.	Improved reputation, improved translation of basic research to applied research and patient benefit.
Oxford Academic Health Science Network	Designation in May 2013 with Oxford AHSN hosted by OUH.	Platform for collaborative working across health and social care, academic institutions, biomedical and biotechnology organisations, business and the third sector. Rapid adoption of innovation can be achieved comprehensively where it adds value.

Threats		
Factor	**Supporting Evidence**	**Implications**
Centralisation of specialised services raises the level of 'critical mass' required for some services	"Safe and Sustainable" review of paediatric cardiac and neurosurgical services. Designation of specialised services.	Network arrangements to avoid adverse impact on linked services and patient care.
Changes to commissioning and tariff structures remove resources from hospital care	Two thirds of annual NHS expenditure relates to patients with long-term conditions Pressure on non-elective care nationally and on CCG resources	Close working with commissioners and local partners to find sustainable approach to integration, cost and access.
Competitive tendering by commissioners removes activity and income	Failure to secure contract for Banbury ISTC.	Optimise service quality so that OUH remains the provider of choice for patients and GPs. Develop capability to integrate care across service boundaries. Enhance capability to develop successful tenders. Improve ability to shed costs in response to activity reductions and lost income.
Costs of caring for an ageing population with increasingly complex treatment needs are not adequately funded. Initiatives to manage demand do not realise the planned reductions in activity	Marginal tariffs apply for non-elective and elective referrals above baseline. Activity rising above this baseline is not within acute trusts' control.	Integrated care pathways to reduce duplication across primary, secondary and social care. Risk-sharing arrangements. Collaborative working with primary care and community care to agree a joint approach to demand.
Demand for healthcare increasing with an ageing population and the impact of lifestyle factors	Patients living longer with increasingly complex co-morbidities.	Integrated care pathways, including redesign to support greater self-management. Greater care delivery and resilience within community settings. Support for applied healthcare research if CLAHRC bid is successful.
Recruitment and retention of specific groups of clinical staff is difficult	Demonstrable difficulties in recruiting certain staff groups e.g. pharmacists, cardiac staff, diagnostic and therapeutic radiographers, operating department practitioners, ED middle grades. Reliance on high levels of bank and agency staff, with significant levels of associated expenditure.	Dedicated recruitment campaigns and rolling recruitment programme. Enhanced training and personal development programmes to support retention. Development of in-house training capability. Designation of OAHSN and plans for OxAHSC attract staff.

Threats		
Factor	**Supporting Evidence**	**Implications**
Reductions in social care funding worsen delays in transferring patients	High numbers of delayed transfers of care.	Sub-optimal care for patients. Adverse patient and carer experience. Shortage of usable bed capacity. Delay to elements of Estates strategy. Inpatient costs retained while Trust is paid at below cost.

Implications of the SWOT analysis

5.13 The Trust's key strength is its comprehensive portfolio of services with high levels of subspecialisation. Service delivery is underpinned by strong clinical support services and multidisciplinary working.

5.14 OUH has made significant investment in its infrastructure and services are typically delivered from high quality facilities using latest technology. These strengths are valued by the patient population served by the Trust.

5.15 Partnership with the University of Oxford complements and enhances this reputation, supporting the delivery of excellent education and training and leading-edge research. The range and quality of teaching is linked to the comprehensive portfolio of services provided.

5.16 As the population served ages and the 'very old' increase rapidly in number, demand for healthcare increases as patients live longer with increasing levels of co-morbidity. OUH and its commissioners recognise a need to change patient pathways and models of care for a number of patient groups, notably those described by Oxfordshire Clinical Commissioning Group (OCCG) as 'frail elderly.'

5.17 OUH is working with OCCG and Oxfordshire County Council to develop models of integrated care. Several initiatives have been piloted to provide care closer to home for elderly patients and those with long-term conditions, including the provision of stroke rehabilitation services in Abingdon and Witney. Making integration work at scale will be an important feature of the years covered by this business plan.

5.18 The Trust and the health and social care economy within which it operates experience significant number of delayed transfers of care (DTOCs). Recognition of the need for a system-wide approach, spanning health and social care, has resulted in a formal collaboration of OUH, Oxford Health NHS Foundation Trust (OH), OCCG and Oxfordshire County Council. This collaboration aims to establish care pathways which cut duplication and discontinuity, optimise the experience of patients and their carers and improve value for money. Making progress on this issue is a priority for the Trust.

5.19 OUH recognises the importance of addressing threats that result from the tension between rising healthcare costs and the availability of funding for healthcare. It is therefore committed to working with commissioners on initiatives including referral protocols and the establishment of integrated whole care pathways to transfer activity from hospital into primary and community care settings. It is working with commissioners to develop these proposals under the 'QIPP' heading, whilst having its own plans to improve patient care and meet cost improvement targets. The Trust has, for example, worked with OCCG and OH to implement an accelerated rehabilitation pathway for patients with fragility hip fractures. This has shortened the length of acute stay for these patients, releasing bed capacity for the additional patients coming to the John Radcliffe Hospital as a Major Trauma Centre.

5.20 OUH is in the relatively unusual position as a large, specialised teaching centre that it is not associated with a large local population. The Trust is seeking to consolidate and extend its catchment population and there are several opportunities it plans to use to achieve this.

5.21 The Trust is in a good position to take advantage of opportunities offered by the national drive to rationalise and consolidate specialised services into designated centres. It has already responded to commissioner-led initiatives to reconfigure specialised services, such as in centralising vascular surgery and repatriating cardiac surgery referrals from London providers. Taking advantage of such opportunities is necessary to support future clinical and financial viability by optimising clinical outcomes, using latest technology and techniques and achieving economies of scale.

5.22 The centralisation of specialised services may pose a risk to OUH's services with smaller critical mass. It is important for the Trust to develop network arrangements for these services which prevent an adverse impact on related services. OUH is able and willing to work collaboratively as a 'spoke' as well as a 'hub.' This has been demonstrated through its alliance with University Hospitals Southampton NHS FT to have paediatric cardiac surgery provided in Southampton, with this arrangement supporting the continued provision of paediatric intensive care in Oxford.

5.23 The Trust has adopted a mutually-beneficial network approach with surrounding healthcare providers and is actively progressing discussions with neighbouring Trusts to agree partnership arrangements that will support the operation of this network. This approach will support consolidation of its referral base and facilitate extension of its catchment.

5.24 The Trust's strategy recognises that network strategies to centralise or repatriate services to Oxford rely on changes to referral patterns and care pathways. A key part of this strategy is to build on existing clinical network arrangements and relationships with neighbouring hospitals and to further develop and extend these. OUH is developing its clinical partnerships with Trusts including Royal Berkshire Hospital NHS FT, Bedford Hospital NHS Trust, Buckinghamshire Healthcare NHS Trust, Heatherwood and Wexham Park NHS FT, Milton Keynes Hospital NHS FT, Northampton General Hospital NHS Trust, South Warwickshire Hospitals NHS FT, Great Western Hospital NHS FT and Gloucestershire Hospitals NHS FT. These partnerships will be increasingly important as the Trust increases the range of regional services that it provides.

5.25 The Oxford Academic Health Science Consortium establishes a formal partnership involving all Oxfordshire NHS providers, the two Universities in Oxford and Oxfordshire County Council. This will bring local focus to developing and implementing strategies to strengthen existing academic and clinical partnerships, improve healthcare, conduct translational research and strengthen multi-professional education and teaching, with initial work focusing on dementia care.

5.26 The Oxford Academic Health Sciences Network extends this platform of collaborative working to the wider geography in which OUH operates and includes life sciences industry partners. It strengthens existing clinical and academic partnerships and provides opportunities for new partnerships. The wider network will optimise the development of innovative practice in healthcare delivery and facilitate its rapid adoption where it most adds value and creates wealth.

5.27 Informed by its SWOT analysis, market assessment and continuing work with its commissioners, OUH has identified developments which underpin the delivery of its strategic objectives.

Current and future initiatives

a. Delivering integrated local healthcare and better value healthcare

Integrating care and reducing delays

5.28 The main commissioners and providers of health care for Oxfordshire agreed with Oxfordshire County Council in 2011 to deliver a joint approach to resolve persistent issues affecting care delivery in the county.

5.29 A programme began in March 2012 with the primary objective of reducing Delayed Transfers of Care (DTOCs) in Oxfordshire, creating more appropriate care for the patients and service users affected and bringing performance and financial benefits for commissioners and providers.

5.30 Changes were made to systems and processes in spring/summer 2012, with progress made including:

Actions taken to improve discharge flow and experience, spring/summer 2012
'Discharge to Assess' protocols and policies between hospital, community and primary care.
A Single Point of Access to streamline access between hospital and community services.
A common discharge policy with uniform thresholds for discharge and onward referral.
An integrated assessment tool with improved data sharing.
Improvements to the time taken to conduct social care assessments of people envisaged as requiring residential or nursing home care on discharge.
A partnership approach to improve the flow of patients into domiciliary care.

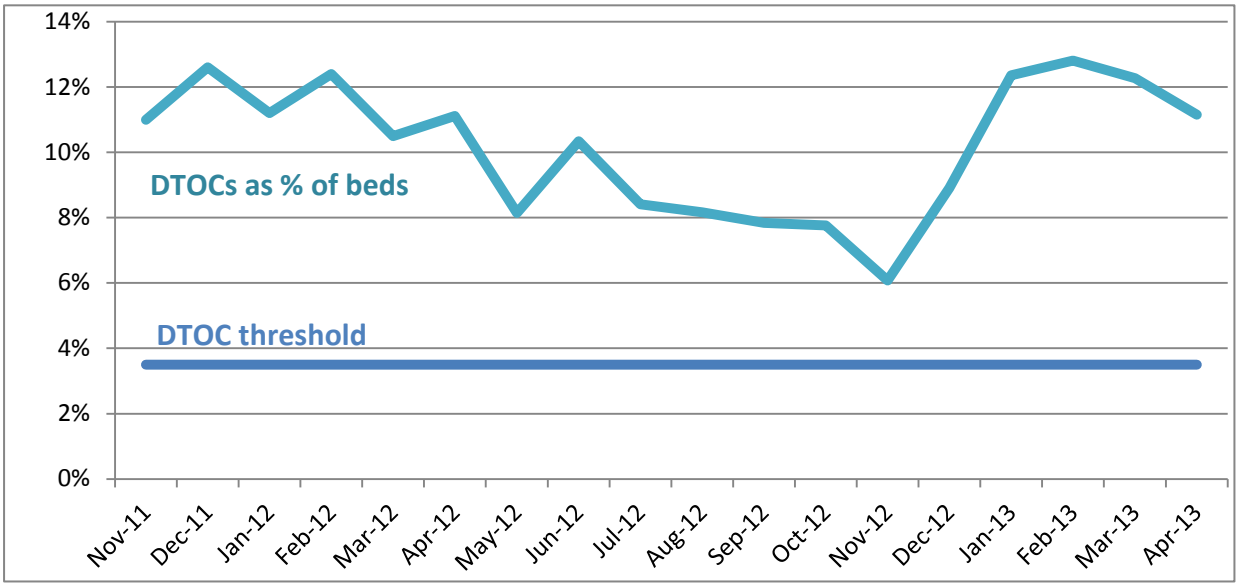
5.31 OUH's Supported Hospital Early Discharge Service (SHEDS) began providing social care in patients' homes in late 2011. SHEDS was managing the care of 60 patients by autumn 2012. The service is provided by OUH to patients at home when they require social care to avoid staying in hospital.

5.32 The reduction in delays improved the availability of OUH bed capacity during 2012, as shown below, but the trend reversed in December, taking bed capacity accounted for by people awaiting transfer to above the 2011/12 peak.

5.33 In response, OUH is expanding its SHEDS service before winter 2013 to increase its caseload by 30 patients per week, extending its hours of operation and adding nursing resources to enable patients to benefit from it earlier.

5.34 Work continues within the Trust's own services to improve processes and make the best use of capacity, including the introduction during 2012 of OUH's Psychological Medicine service, simplification of care pathways, integration of assessments and the provision of a higher level of consultant decision-making input to Emergency Assessment units and faster access to diagnostics.

Delayed transfers as a percentage of OUH beds from November 2011



5.35 The Trust is working closely with Oxford Health in particular to agree practical approaches to put in place before winter 2013 to enable the 'flexing' of capacity to support people at home following unplanned admission and to minimise the boundaries and 'hand offs' that affect the care pathway for frail, older people. It seeks, for example, to agree a single model of medical management of acute and community hospital beds in Oxfordshire to support the urgent care pathway.

5.36 Informing further service development in partnership with local GPs is an academic review to report before winter 2013 on a shared understanding of causal factors.

a. Service transformation

i. Reducing Emergency Department waits

5.37 As reflected in financial plans in Chapter 6, the Board of Directors agreed for 2013/14 to staff wards and to budget at the capacity needed to deliver the anticipated level of non-elective activity, based on assumptions considered with commissioners and the NHS Trust Development Authority (TDA).

5.38 Open dialogue with the TDA, commissioners and the Thames Valley Area Team took place in preparation for the agreement of contracts for 2013/14, which form the basis of the LTFM underpinning this business plan.

5.39 Trust planning to reduce waits for patients attending OUH's Emergency Departments and improve flow has taken account of a report from the King's Fund into urgent care demand and supply in the South of England and from a visit from the Emergency Care Intensive Support Team (ECIST) to examine services provided by the Trust itself. Key themes have been data and information; demand, capacity and patient flow; and clinical decision-making.

5.40 As a result, changes have been made to working arrangements and staffing, systems and processes, including actions to improve flow through Emergency Assessment Units. A further strengthening of senior clinical decision-making presence is under way during 2013 and 2014, as noted on page 28.

5.41 A detailed Emergency Department Action Plan has been developed and shared with commissioners and the Thames Valley Area Team and the Trust continues to work to deliver it. An Urgent Care Taskforce and Urgent Care Programme Board are in place.

5.42 As part of contractual discussions, it has been acknowledged by Oxfordshire CCG that a sustainable and affordable solution to emergency waits requires changes outside hospital. Detailed discussions have also taken place with Oxford Health on actions to improve diversion from admission.

ii. Local hospital care and services provided from Banbury

5.43 OUH sees a strong future for the Horton General Hospital in Banbury.

5.44 The Trust has been developing the key components of a vision for services provided from its Banbury site in collaboration with a Community Partnership Network. These components include:

- Maintaining safe emergency care on site, recognising that major trauma, complex surgery and patients with major acute needs are already taken directly to the John Radcliffe Hospital.
- Strengthening general medicine to provide an enhanced 'clinical backbone' for the hospital, with this service providing continuity of care for most patients on site.
- Expanding diagnostic, outpatient and day case/short stay surgical capacity, transferring activity from Oxford to Banbury to support this and thus enabling patients from a larger area to benefit from dedicated ambulatory care facilities and easier car parking at the Horton General Hospital. In early support of this aim, OUH has set aside resources in its capital programme to improve facilities and support the development of a 'one stop shop' for ambulatory care there, including:

Ambulatory care developments at Horton General Hospital
Improving facilities for outpatient care to ease patient flow and reduce reception areas.
Re-providing interventional ultrasound within radiology to improve privacy and dignity in treatment and waiting areas.
Reviewing and improving existing day surgery facilities to increase capacity for day surgery and provide an integrated day surgery and short stay surgical unit.

- Subject to consultation, permanently transferring emergency general surgical care to the John Radcliffe Hospital to comply with the Royal College of Surgeons' recommendation that emergency general surgical patients should receive the same level of expertise as elective patients.
- Maintaining existing services on site for children and pregnant women.
- Where clinically and financially sustainable, developing the Horton General as a portal to OUH's specialist services. The recent development of a chemotherapy unit and renal dialysis centre on site provide examples of this.

5.45 Oxfordshire CCG plans to consult on its development of an overall commissioning strategy for the county and OUH's vision for services provided from Banbury will be informed by this.

5.46 Continuing to work with stakeholders including the Community Partnership Network, OUH intends to develop a service model for the Horton General Hospital which will allow it be a sustainable local hospital meeting all expected standards and enabling local people to benefit from close connections to specialised and higher-volume services in Oxford.

iii. Outpatient booking

5.47 A major change programme is under way in response to feedback from patients and GPs about difficulties in booking appointments through OUH's call centre.

5.48 A review of outpatient clinics and re-profiling of clinic slots began during 2012/13 with aims to:

- Standardise outpatient clinic template slots and therefore improve booking;
- Reduce routine outpatients timescales so patients can reliably be seen within six weeks;
- Ensure that all urgent patients are seen within two weeks; and
- Reduce the number of follow-ups and non-attendances.

5.49 Work began in ENT and will progress through other specialties in 2013/14, reviewing 17,000 clinics run by 637 consultants.

5.50 Details of the project have been shared with Oxfordshire CCG. New clinic templates and timescales will be rolled out within each specialty according to the project plan and this work will continue to inform discussion with OCCG about the appropriate level of outpatient activity to commission in order to sustain the required waiting times.

5.51 Following successful initial tests in dermatology, the Trust is also developing a means to send all letters electronically to GPs and transfer them electronically into Case Notes. This will require agreement with Cerner and BT as part of the national contract for IT and OUH has requested a solution that is ready to use by the end of December 2013.

iv. Six- and seven-day working

5.52 Feedback from patients and carers and national studies, as well as cost improvement work done within OUH, demonstrate that there are important benefits to be achieved from extending the availability of hospital services across weekends.

5.53 Initial work in OUH indicates that a move to routine six-day elective surgery would be beneficial and that to support non-elective care, enhancement of a range of services across seven days, not least diagnostics, therapies and services to enable discharge, could improve patient experience and improve efficiency. Introduction of seven-day access to scanners has already taken place.

5.54 Work within and across Divisions is under way to find achievable and affordable ways of making this change, recognising its complexity and the need to make it a sustained and affordable change in how services operate. Examples are shown below.

Six- and seven-day working arrangements, 2013
Acute general medicine consultants on site 24/7
Job planning under way to have stroke consultants on site 24/7
Occupational therapy rostered for Saturday and Sunday mornings to actively assess and manage non-elective patients for discharge
Several orthopaedic surgeons are job planned to work Saturday theatre sessions
Physiotherapists rostered to work Saturdays and Sundays to deliver required activity

5.55 Consideration is also being given to extending the hours of services such as outpatient care.

v. Capital programme

5.56 As well as the £1 million OUH has set aside in its capital programme to improve outpatient facilities at the Horton General Hospital, it has allocated £2.9 million to relocate services from parts of the Churchill Hospital which were built in 1942. The latter sum covers the relocation of respiratory, infectious diseases and urology services.

5.57 The capital programme also allocates resources to replace equipment, to maintain or modernise its care facilities and to improve efficiency. Examples are given below.

Scheme	Allocated value (£m)	Year/s
Acute general medicine High Dependency Unit	0.75	2014/15
Adult critical care	5.0	2015/16
Cardiac gamma camera	1.5	2015/16
Estates, including maintenance, utilities, bed replacement	24.8	2014/15-2018/19
Major radiological equipment replacement	3.6	2014/15-2018/19

Medical and surgical equipment	28.4	2014/15-2018/19
General/cardiac theatres upgrade, John Radcliffe Hospital	10.0	2014/15-2015/16
Laboratory IT system replacement	1.5	2014/15-2015/16
Maternity theatres upgrade, John Radcliffe Hospital	5.0	2015/16-2016/17

5.58 OUH continues to invest in developments as part of its IM&T strategy, notably the implementation of the Electronic Patient Record. Resources have been allocated for this purpose across four years.

Scheme	Allocated value (£m)	Year/s
IT strategy and Electronic Patient Record	7.5	2014/15-2018/19

b. Activity reduction (QIPP)

5.59 Oxfordshire's QIPP programme is structured around four key themes: planned care, urgent care, care for long-term conditions and care for complex conditions. It draws upon and develops priorities established by Oxfordshire's Joint Health and Well-Being Strategy for 2012-16.

5.60 The Trust's plans for QIPP delivery draw on the Oxfordshire QIPP programme. Delivery of service changes will be achieved through collaborative working between health and social care partners.

5.61 The Trust's plan consists of three key elements:

- The provider action plan on patient pathways and discharge (to reduce DTOCs), intended to significantly reduce excess bed days and, via the full establishment of the Supportive Hospital Enhanced Discharge Service, further improve rapid discharge from hospital.
- Building on the success of its musculoskeletal hub, the extension of this model to other elective specialties such as General Surgery, Urology and Gynaecology.
- Agreement to reduce follow-up outpatient activity in a variety of specialties.
- Initiatives to manage the use of high-cost drugs.

5.62 Research projects have potential to improve models of care for people with long-term conditions and to contribute to activity reductions sought by commissioners. Self-monitoring by people with diabetes linked to the use of mobile phone technology, for example, may enable changes in the use of outpatient capacity.

5.63 Risks that activity reduction 'under-delivers' against expectations (requiring OUH to provide capacity which commissioners will find it difficult to fund) or that it 'over-delivers' (reducing activity ahead of the Trust's plans and leaving it with stranded fixed costs) are described in Chapter 7 with mitigations.

c. Strengthening of specialised services

5.64 In accordance with its strategy and market assessment, OUH continues to develop its specialised services. This section describes actions taken and nearing completion to enhance the Trust's position as commissioners' provider of choice for key regional services which strengthen its ability to provide other specialised care.

5.65 Three developments are described. The activity, workforce, expenditure and income projections for them are included within the Trust's LTFM without being specified as forthcoming service developments.

i. Major Trauma Centre

5.66 Trauma networks are organised groups of services and personnel who serve a defined population and aim to reduce death and disability following injury. They have been successful in improving the care of patients with major trauma in other countries. Their objective is to deliver patients rapidly and safely to a place that can manage the definitive care of their injuries, either directly or by expedited inter-hospital transfer.

5.67 Each Major Trauma Network has a Major Trauma Centre which works in conjunction with Trauma Units – hospitals that are part of the network and which receive patients because of their strategic geographical position and rapidly assess, resuscitate and transfer to the Major Trauma Centre as appropriate.

5.68 The NHS Operating Framework for 2012/13 supported the establishment of Major Trauma Centres by introducing a "quality increment" which applied to patients treated at regional trauma centres and is designed to reward the associated delivery of high quality care and facilitate the move to trauma care being delivered in designated centres.

5.69 This service development established the John Radcliffe Hospital as the Major Trauma Centre for the Thames Valley Trauma Network. Following formal designation, the service began to operate fully in this capacity in October 2012.

5.70 The planned benefits of this development are:

- 24/7 access to consultant-led clinical teams and specialist clinical support staff
- With access to timely and appropriate intervention, significant reduction in :
  - Preventable mortality by 100%, leading to an overall 20% reduction in major trauma mortality.
  - Long-term debilitating injury and subsequent pressures on long-term health and social care.
- Access to an integrated system of trauma centres to improve patient care across the whole region, such that the needs of patients and their families will be optimally met, through the acute and rehabilitation phase of their treatment, irrespective of where the injury is sustained.
- Provides value for money for commissioners and social care, with a reduced requirement to support patients with long-term injury.
- Improved experience for patients and carers with timely and appropriate interventions throughout the patient pathway. [performance so far?]

ii. Newborn Intensive Care capacity expansion

5.71 OUH provides specialised medical, surgical, and neurosurgical care for newborns for the Thames Valley. A significant number of babies are transferred to the John Radcliffe Hospital (many *in utero*) for immediate surgery and/or intensive care following delivery.

5.72 Lack of capacity for rising demand led to higher than recommended occupancy rates and significant numbers of babies being turned away, meaning that the regional Neonatal Network was unable to achieve its objective of meeting 95% of demand within the Network. Parents and babies had to travel out of the area for the care they needed.

5.73 Support for the expansion of facilities for newborns at the John Radcliffe Hospital to proceed was confirmed by all relevant commissioners and the expanded unit will open during 2013.

5.74 The planned benefits of this service development are that it will:

- Fulfil caseload needs for newborn medical, surgical, cardiological and neurosurgical patients within the north of the South Central region, through providing the capacity for planned activity, thereby meeting the requirements of Specialised Commissioners.
- Improve health outcomes (e.g. by minimising infections and therefore interventions).

- Meet BAPM and Department of Health Estates guidance in relation to the design and staffing of perinatal units.
- Avoid the need for the transfer of mothers, many with high risk pregnancies, from the John Radcliffe Hospital to other hospitals due to a lack of capacity and in particular, avoid separating mothers and babies.
- Improve privacy and dignity and provide the optimum environment for babies and their families, including reaching current standards of cot spacing.
- Allow OUH to be the provider of choice within the region for high risk pregnancies, able to support mother and baby at all levels (obstetrics, foetal maternal, perinatal, medical – including cardiology and surgical) on one site, in line with *Maternity Matters*.
- Replace 40-year-old infrastructure, plant and services.

iii. Vascular surgery centralisation

5.75 Implementation is under way of a three stage process to centralise regional vascular surgery at OUH.

5.76 Following a national review of vascular surgery services which examined evidence showing that hospitals that perform high volumes of vascular surgery have better patient outcomes, use modern technology more frequently and use resources more effectively by working in multidisciplinary teams including interventional radiology, the South Central Cardiovascular Network recommended and commissioners agreed that OUH should become the single centre for all emergency vascular surgery and complex elective vascular surgery for Thames Valley.

5.77 The reconfiguration will deliver 24/7 access to a consultant-led vascular surgery and interventional radiology team associated with provision of an integrated model for the delivery of vascular surgery, combining local assessment and intervention for low risk and short stay surgery, and centralisation for complex high risk surgery. Planned benefits are reductions in preventable patient mortality, long-term debilitating injury and subsequent pressures on long-term health and social care.

5.78 Funding has been reserved in the Trust's capital programme for a vascular interventional radiology room and an anaesthetics room linked to this. These connected developments will provide the physical capacity required to deliver the required specialised activity for the network.

5.79 Joint consultant vascular surgeon posts are being established, with job planning incorporating sessions at network hospitals in order that demand for vascular surgery is met across the network.

d. Strategic development of cancer services

5.80 The Trust's Oxford Cancer Centre provides expertise in the surgical and oncological treatment of a broad range of cancers. Service delivery is underpinned by twenty multi-disciplinary cancer teams and care is provided for patients from Oxfordshire, Buckinghamshire, Berkshire, Wiltshire, Northamptonshire and Milton Keynes.

5.81 The Centre provides access to a number of leading edge treatments, including robotic surgery. It also provides access to early phase and translational research through the Oxford Cancer Research Centre, a virtual partnership between Cancer Research UK, the Trust and the University of Oxford.

5.82 Epidemiological analysis confirms that historical trends of rising demand for cancer treatment can be expected to continue, with the incidence of cancer continuing to rise as a result of the ageing population, coupled with the impact of lifestyle factors.

5.83 OUH has responded to this demand by investing in the Oxford Cancer Centre and a key component of its future development is the consolidation of the benefits of this investment. There are three elements to this:

- Providing services that reflect best practice, delivering the benefits of research and innovation to cancer patients and benefit from the Trust's research partnerships in line with its strategy.

- Working through clinical network arrangements to design cancer care pathways focused on patient need, delivering elements of care locally where possible. This will include the continued creation of joint consultant posts with local hospitals and provision of satellite clinics and services.
- Developing capacity to meet demand.

5.84 The most financially significant development in cancer services addresses each of these elements. The modernisation of radiotherapy, in partnership with the University of Oxford's Department of Oncology which includes the Gray Institute for Radiation Oncology and Biology, includes the increased use of more targeted modalities such as Intensity Modulated Radiotherapy (IMRT), the development of teams of subspecialty, site-specific radiotherapy consultants, the expansion of linear accelerator capacity and the provision of satellite radiotherapy units, subject to the agreement of business cases for the investment involved. Schemes in progress are shown below.

Scheme	Allocated value (£m)	Year/s
IMRT: rapid arc installation and upgrade	2.1	2013/14
Radiotherapy satellite unit: Milton Keynes	8.0	2014/15
Radiotherapy satellite unit: Swindon	11.0	2014/15-2015/16

5.85 Capital allocation to the Milton Keynes scheme is subject to Full Business Case approval. Prior to the Trust's authorisation as a Foundation Trust, proceeding with this scheme will require the approval of the NHS Trust Development Authority.

5.86 Capital allocation to the Swindon scheme is subject to affordability and Full Business Case approval, scheduled for 2014/15.

Conclusions

5.87 Changes to local acute services are a priority and OUH is fully committed to the partnership working required to better integrate services and to resolve the historical causes of high rates of delayed transfers of care within the Oxfordshire health and social care economy.

5.88 The Trust is engaged in developments which enhance its position as a specialised provider working as a key partner within a clinical network. These developments are well aligned with the direction of national strategy for these services.

5.89 OUH will continue to develop its wider networks, strengthening regional partnerships to consolidate activity flows, supporting the reconfiguration of specialised services to repatriate care into the region and extending its network of relationships to sustain and develop its catchment area.

5.90 The Oxford Academic Health Science Network unifies these themes, establishing a coherent structure within which a broad range of clinical and academic partnerships can flourish and which can drive the innovation needed to strengthen the quality and sustainability of services at local and regional level.

Chapter 6

Financial Plans

6. Financial Plans

Introduction

6.1 This chapter:

- Reviews the historical financial performance of the Oxford Radcliffe Hospitals NHS Trust (ORH) for 2010/11, prior to the merger with the Nuffield Orthopaedic Centre NHS Trust (NOC) to create Oxford University Hospitals NHS Trust (OUH) in 2011/12.
- Reviews the historical financial performance of OUH for 2011/12 and 2012/13.
- Outlines in-year financial plans for 2013/14.
- Details the financial plans for the Trust for the five years from 2014/15 to 2018/19.

6.2 Key points in this chapter are that:

6.2.1 Historical financial performance reflects the merger on 1 November 2011 of ORH and NOC to form the new OUH, with combined financial statements under merger accounting for 2011/12.

6.2.2 OUH has used the Long Term Financial Model (LTFM) to forecast its future financial performance over five years to 2018/19. The LTFM incorporates appropriate assumptions on activity, inflation, service development, capital and cost improvement programmes and supports the Trust's strategy as described in Chapter 3.

6.2.3 The LTFM incorporates plans for service expansion in Radiotherapy as part of its strategy to continue developing as a key regional provider of specialist services, as outlined in Chapter 5.

6.2.4 The LTFM reflects the designation and licensing of the Oxford Academic Health Science Network (AHSN) in May 2013, with associated income and expenditure plans of £4.6m in 2013/14.

6.2.5 It demonstrates that the Trust is financially viable and will generate revenue and cash surpluses in the period 2013/14 to 2018/2019.

6.2.6 It shows that the Trust will achieve overall financial risk ratings of at least 3 from 2013/14, rising to a rating of 4 from 2017/18.

Historical financial position

6.3 Tables in this section provide a historical analysis of income and expenditure from 2010/11 to 2012/13. The historical position is shown for the former ORH Trust for 2010/11 prior to the formation of OUH in 2011/12. Information provided includes income and expenditure results, the underlying earnings position, the Balance Sheet and Cash Flows, with narrative on the key changes and movements between each year. The historical delivery of savings each year is also set out here.

Historical financial performance – ORH/OUH

Income and expenditure statement

6.4 The tables below summarise the ORH trading position for 2010/11 and OUH's trading position for 2011/12 and 2012/13, setting out the main components of annual income and expenditure during this period.

Income & Expenditure Statement - ORH Trust / OUH Trust	Actual		
	ORH *	OUH	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Income from activities	546,561	638,690	691,048
Other operating income	117,210	149,530	130,656
Total income	**663,770**	**788,220**	**821,704**
Operating expenses before Depreciation and Impairments	-608,011	-718,705	-752,889
EBITDA surplus/ (deficit)	**55,760**	**69,514**	**68,815**
EBITDA margin %	8.4%	8.8%	8.4%
Depreciation and Amortisation	-28,688	-34,850	-36,758
Operating surplus/ (deficit)	**27,072**	**34,664**	**32,057**
Profit/ (Loss) on the disposal of fixed assets	-293	-159	-17
Fixed Asset impairments	11,618	2,327	-4,568
Surplus/ (Deficit) before interest	**38,397**	**36,832**	**27,473**
Interest receivable	88	135	189
Interest payable and financing costs	-18,691	-20,471	-20,477
Surplus/ (Deficit) for the financial year	**19,794**	**16,497**	**7,186**
Dividends payable on Public Capital	-6,587	-8,894	-8,502
Retained surplus / (deficit)	**13,207**	**7,603**	**-1,316**
Adjustments for impairments	-11,618	-2,327	4,568
Adjustments for IFRIC 12 and Donated asset reserve eliminati	-300	1,882	394
Breakeven duty surplus / (deficit)	**1,289**	**7,157**	**3,646**
Adjusted surplus / (deficit) %	0.2%	0.9%	0.4%

(* 2010/11 is ex-ORH only and excludes the NOC as this was prior to the year of merger in 2011/12)

6.5 In order to compare more easily the 2010/11 performance with OUH after the merger in 2011/12 the table below summarises the trading position from audited restated "OUH" comparative figures for 2010/11 (from the 2011/12 accounts).

Income & Expenditure Statement - audited restated comparatives for 2010/11	Actual		
	OUH restated	ORH	NOC
	2010/11 £000s	2010/11 £000s	2010/11 £000s
Income from activities	618,486	546,561	71,926
Other operating income	124,126	117,210	6,916
Total income	**742,612**	**663,770**	**78,842**
Operating expenses before Depreciation and Impairments	-678,734	-608,011	-70,723
EBITDA surplus/ (deficit)	**63,878**	**55,760**	**8,118**
EBITDA margin %	8.6%	8.4%	10.3%
Depreciation and Amortisation	-32,522	-28,688	-3,834
Operating surplus/ (deficit)	**31,356**	**27,072**	**4,284**
Profit/ (Loss) on the disposal of fixed assets	-293	-293	0
Fixed Asset impairments	11,684	11,618	66
Surplus/ (Deficit) before interest	**42,747**	**38,397**	**4,350**
Interest receivable	108	88	20
Interest payable and financing costs	-21,325	-18,691	-2,634
Surplus/ (Deficit) for the financial year	**21,530**	**19,794**	**1,736**
Dividends payable on Public Capital	-8,498	-6,587	-1,911
Retained surplus / (deficit)	**13,032**	**13,207**	**-175**
Adjustments for impairments	-11,684	-11,618	-66
Adjustments for IFRIC 12 and Donated asset reserve eliminati	233	-300	533
Breakeven duty surplus / (deficit)	**1,581**	**1,289**	**292**
Adjusted surplus / (deficit) %	0.2%	0.2%	0.4%

Income from activities (patient related income)

Changes in Income From Activities	Actual		
	OUH		
	Movement to 2011/12 £000s	Movement to 2012/13 £000s	Total £000s
Activity volume	29,477	53,905	**83,382**
CQUIN	-559	10,585	**10,026**
Developments and other (includes readmission penalties)	-1,172	6,378	**5,206**
NOC income from activities	75,654		**75,654**
National non-elective threshold marginal rates	-1,694	-7,277	**-8,971**
Deflation to national tariffs	-9,576	-11,234	**-20,810**
Total change in income from activities	**92,130**	**52,357**	**144,487**

6.6 Income from activities increased between 2010/11 and 2012/13. The main reasons for this were:

- Increases in volume of activity (£83.4 million), increased CQUIN income (£10.0 million) and developments and other increases (£5.1 million). These were partly offset by the increasing impact of the national non-elective threshold marginal rates rule (£9.0 million) and deflation to national tariffs for PbR (£20.8 million) over the period.
- £75.7m of income included in 2011/12 from the former NOC Trust.

Other operating income

Other Income - ORH Trust / OUH Trust	Actual		
	ORH	OUH	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Education, training and research and development	72,058	87,946	96,154
PFI specific income	560	0	0
Other income	44,592	61,584	34,502
Total other operating income	**117,210**	**149,530**	**130,656**

6.7 Other operating income increased during the period. The main reasons for this were:

- Increasing research and development income (£16.2 million) and £10.2 million of additional income from the former NOC (including £3.7 million education and training income and £3.4 million research and development income). These were partially offset by other income net reductions of £8.4 million. These related to reductions in service level agreements provided to other Trusts (primarily the former NOC) of £5.1 million, loss of drugs sales income (from the former NOC) of £2.0 million, reductions in charitable donations and the end of additional PFI income received from the SHA in the initial period after the new PFI buildings opened.
- A number of non-recurring items included in other income within the financial model. These are set out in the table at 6.12 below, including £18.3m of non-recurrent items in 2011/12.

Operating expenses

Pay costs

Pay Costs - ORH Trust / OUH Trust	Actual		
	ORH	OUH	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Consultants	80,121	90,064	90,904
Junior medical	54,192	59,097	62,871
Nursing and midwifery	115,125	123,922	126,665
Scientific, therapeutic and technical	45,606	55,520	54,858
Other staff	75,386	87,265	94,540
Temporary and agency staff (exc bank)	10,663	12,131	17,617
Total pay costs	**381,093**	**427,999**	**447,455**

6.8 Pay costs increased over the period. The main reasons for this were:

- Pay increases linked to volume growth in activity of £35.1 million.
- Increased research and development pay expenditure (funded by a corresponding increase in income) of £11.3 million.
- Service development investment in pay of £7.9 million.
- Incremental pay increases (and pay awards for staff on the lowest agenda for change pay bands) of £7.4 million.
- Other increases including the investment to deliver the increased CQUIN income and the impact of non-recurrent pay savings from 2010/11 and 2011/12.

6.9 These increases were offset by pay savings of £46.1 million. The figures for 2011/12 include £37.7 million of pay costs from the former NOC Trust.

Non-pay costs

Non-Pay Costs - ORH Trust / OUH Trust	Actual		
	ORH	OUH	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Drugs, blood products and medical gases	67,012	75,893	79,891
Clinical supplies and services	66,856	85,501	92,571
General supplies and services	4,800	7,311	6,274
Establishment costs	6,633	7,428	6,899
Premises costs	22,988	29,505	34,041
PFI operating costs	22,609	29,103	30,739
Depreciation and amortisation of assets	28,688	34,850	36,758
Impairment of fixed assets (non-recurrent)	-11,618	-2,327	4,568
Other operating costs	36,020	55,967	55,020
Total non-pay operating costs in financial statements	**243,988**	**323,230**	**346,759**
Remove impairments and exceptional items	11,618	2,327	-4,568
Total non-pay operating costs (after adjusting impairments)	**255,606**	**325,557**	**342,192**

6.10 Non-pay costs increased during the period. The main reasons for this were:

- Inflationary increases, VAT pressures (in 2011/12), and NICE drugs pressures of £26.5 million.
- Increases linked to volume growth of activity of £22.2 million.
- Increased research and development non-pay expenditure (funded by a corresponding increase in income) of £4.9 million.
- CNST premium increases of £2.6 million.
- Service development investment of £3.2 million.
- Increased depreciation and amortisation (excluding the increase in 2011/12 relating to the former NOC Trust) of £3.3 million.
- Other increases including the investment to deliver the increased CQUIN income and the impact of non-recurrent non-pay savings from 2010/11 and 2011/12.

6.11 These increases were offset by non-pay savings of £36.8 million. 2011/12 included £35.8 million of non pay costs and depreciation from the former NOC. A number of non-recurring items were included in non-pay, as shown in the table overleaf. These included £16.7m of non-recurrent items in 2011/12.

Income and expenditure – normalised earnings

6.12 The Trust improved its underlying financial position, moving from an underlying deficit of £0.8 million in 2010/11 to an underlying surplus of £8.5 million in 2012/13.

Normalised earnings

Normalised Surplus/ (Deficit) - ORH Trust / OUH Trust	Actual		
	ORH	OUH	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Surplus/ (Deficit) reported in the Annual Accounts	**13,207**	**7,603**	**-1,316**
Less impairments	-11,618	-2,327	4,568
IFRIC 12 and Donated asset reserve elimination	-300	1,882	394
Breakeven duty surplus / (deficit)	**1,289**	**7,158**	**3,646**
Profit/loss on asset disposals	293	159	17
Less non recurring income:			
Less non recurring income		-15,200	5,223
Less non recurring income (PFI transitional funding)	-948	-194	0
R&D income		2,000	-2,000
Less non recurring income (in respect of 2009/10)	-1,500		
Less non recurring income (in respect of 2010/11)	1,916	-1,916	
Less non recurring income (in respect of 2011/12)		-1,151	1,151
Less non recurring income (in respect of 2012/13)		-2,000	0
Less non-recurring cost savings	-2,481	-4,215	-4,250
Plus non recurring costs:			
Restructuring costs	1,247	7,206	407
Annual leave accrual		2,943	3,000
Adjustments on stock, provisions and depreciation	502	3,695	-71
EPR implementation costs	809	2,236	373
Merger implementation costs		916	0
PFI legal fees		506	472
Other		220	538
Normalised Surplus/ (Deficit)	**1,127**	**2,363**	**8,505**
Income from donated assets (if normalised) *	-1,944		
Normalised Surplus/ (Deficit) - after donated asset adj	**-817**	**2,363**	**8,505**

* From 2011/12 income from donated asset donations is adjusted out already against the breakeven duty under "IFRIC 12 and Donated asset reserve elimination" in the above table. This followed a mandated accounting policy change by the Department of Health in 2011/12).

Bridge analysis of 2011/12 normalised surplus to 2012/13 normalised surplus

6.13 The bridge analysis overleaf illustrates the main changes in the opening and closing normalised position over the last financial year 2012/13.

Balance Sheet and Cash Flow

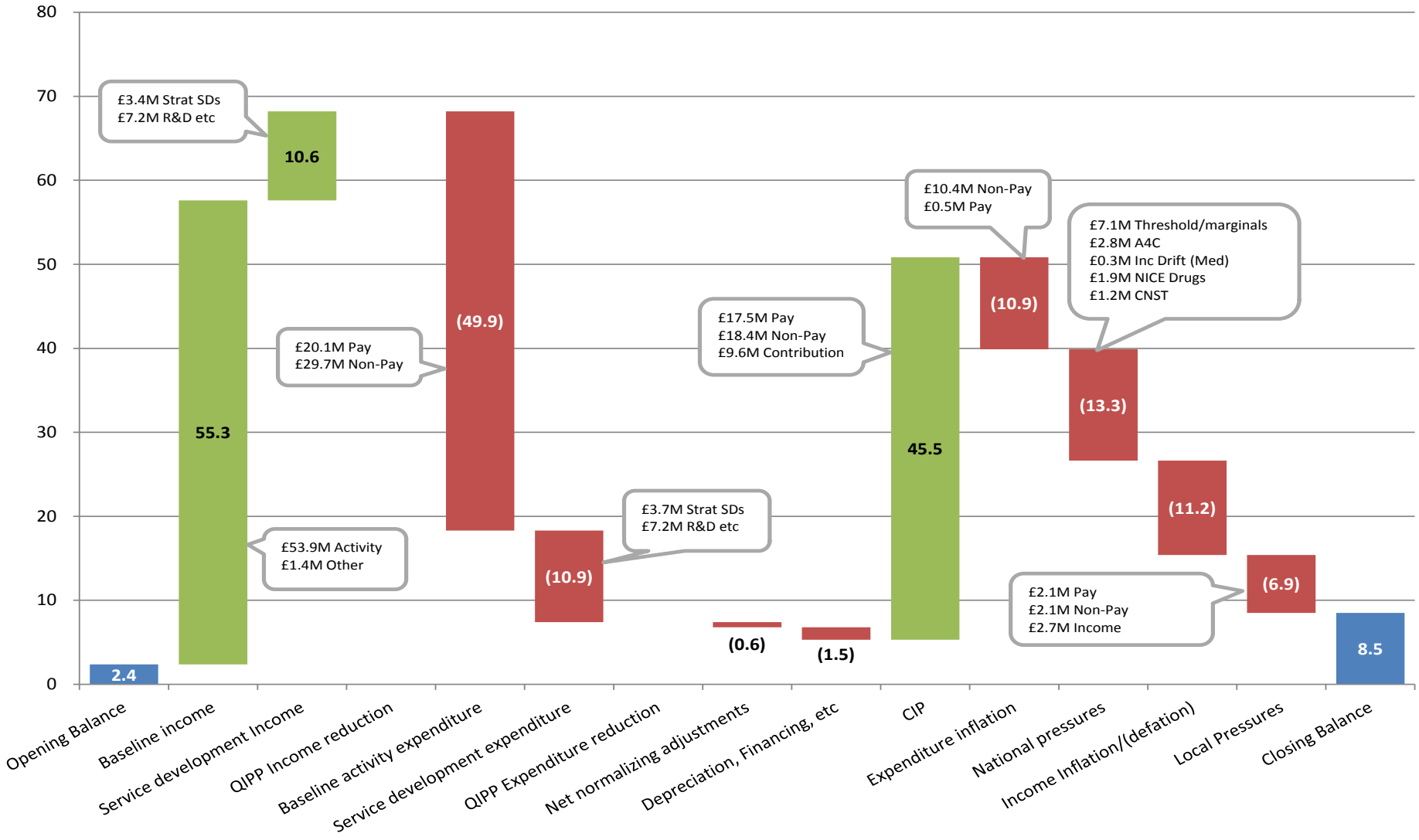
6.14 The table below shows the year-end balance sheets for the period 2010/11 to 2012/13.

Balance Sheet - ORH Trust / OUH Trust	Actual		
	ORH	OUH	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Fixed Assets	**611,470**	**708,366**	**693,175**
Current Assets:			
Stocks	10,834	12,761	11,353
Debtors and prepayments	24,051	35,448	27,054
Cash and cash equivalents	19,477	43,884	65,656
Total Current Assets	**54,362**	**92,093**	**104,063**
Creditors: amounts falling due within one year	-93,018	-108,189	-123,663
Net Current Assets (Liabilities)	**-38,656**	**-16,096**	**-19,601**
Long Term Debtors	90	90	90
Total Assets Less Current Liabilities	**572,904**	**692,360**	**673,665**
Creditors: amounts falling due after more than one year	-271,171	-306,433	-294,272
Provisions for liabilities and charges	-1,032	-1,426	-1,602
Loans	-17,277	-12,541	-6,407
Total Assets Employed	**283,424**	**371,960**	**371,384**
Financed by:			
Public dividend capital	174,547	206,873	207,673
Revaluation reserve	103,696	147,744	147,360
Donated asset reserve *	68,626	0	0
Government grant/other reserve	1,815	1,743	1,743
Income & expenditure reserve	-65,260	15,600	14,608
Total Taxpayers Equity	**283,424**	**371,960**	**371,384**

* Prior to the change in donated asset accounting in 2011/12 which removed the donated asset reserve.

(Loans for 10/11 and 11/12 include amounts due within one year – due to categorisation in the LTFM)

OUH Normalised Surplus Bridge 2011/12 outturn to 2012/13 outturn (£ million)



Fixed assets

6.15 The Trust has invested in recent years in the renewal and improvement of its estate, including a new hospital incorporating the Oxford Cancer Centre on the Churchill Hospital site, a new West Wing, Children's Hospital and Heart Centre on the John Radcliffe Hospital site, and a new hospital on the Nuffield Orthopaedic Centre site. Much of this investment was procured under the Private Finance Initiative (PFI) and was included under fixed assets on conversion to IFRS accounting in 2008/09. There was a fall in value of fixed assets in 2009/10 due to a full revaluation of the Trust's land and buildings by an independent valuer on an open market value using the modern equivalent asset basis of valuation under IFRS accounting, resulting in valuation impairments of £46.6 million, with a consequent impact on the income and expenditure reserve.

6.16 Capital investment has also included an expansion of cardiac and newborn intensive care capacity on the John Radcliffe Hospital site, two additional operating theatres on the NOC site, and investment in medical equipment and the Electronic Patient Record system.

Current assets and liabilities

6.17 Cash balances increased by £46.2 million over the three year period, including £12.1 million from the former NOC Trust (as at 31 October 2011 at the point of merger). Cash increases have been driven by an improved financial position since 2010/11, reduced capital expenditure in 2011/12, and improved cash management in 2012/13, especially around NHS debt and the invoicing and collection of settlements from commissioners.

6.18 The increase in stock in 2011/12 was driven by inclusion of £2.0 million of stock relating to the former NOC. Stock has reduced over the last year by £1.4 million through simplified stock management.

6.19 Debtor balances have increased over the two year period 2010/11 to 2011/12, partly because of the increasing patient care income over that time and due to debtors of £1.8 million relating to the former NOC Trust included within the 2011/12 balances. Debtor balances reduced by £8.4 million in 2012/13, due to factors including prompt billing of all 2012/13 income to avoid legacy debts resulting from commissioning system changes (£2.9 million), and a reduction in sales ledger debts (£1 million) and assets no longer being held as a debtor pending leasing (£2.2 million).

6.20 Creditor and accruals balances have increased due to increases in patient care activity over the three year period as well as increased amounts of research and development income held. The level of this deferred research income is one of the drivers behind the Trust's net current liability position on the Balance Sheet. Creditors and accruals of £10.2 million relating to the former NOC Trust are included within the 2011/12 balances.

6.21 The long term creditors are predominantly the three OUH PFI scheme liabilities which are accounted for under IFRS on the Balance Sheet (with the assets under fixed assets), along with existing medical equipment finance leases that the Trust has in place, deferred income (mainly relating to research), and loans. The long term PFI scheme creditors have reduced gradually each year as capital repayments against the outstanding lease liability are made. The long term creditors include £31.9 million relating to the former NOC within the 2011/12 balances.

6.22 Loan liabilities were for a working capital loan and two capital investment loans. OUH paid the final instalment on its working capital loan in March 2013 and its capital investment loans have reduced as scheduled repayments have been made (see paragraph 6.28 below).

Capital and reserves

6.23 Impairments charged in 2009/10 against income and expenditure (under IFRS) of £46.6 million are the principal factor behind the negative income and expenditure reserve balance in 2010/11. In 2011/12 capital and reserves increased by £70.2 million relating to the former NOC.

Better Payment Practice Code

6.24 The Trust is working to achieve the NHS Better Payment Practice Code expectation of payment of 95% of invoices within 30 days of receipt of invoice. In 2012/13 (on NHS payables) the Trust paid 85% of invoices by value within this time (increased from 81% in 2011/12) and 74% by volume (increased from 72% in 2011/12). The Trust has struggled to achieve this payment record, in part because of the geographical spread of its departments across four sites. It is working to move more purchasing onto its electronic purchase order system to streamline the authorisation process.

Working capital ratios

6.25 In 2012/13 NHS trade receivable days averaged five days for receipt of payment, while non-NHS trade receivable days averaged 27 days.

6.26 Trade payable days averaged 36 days for payment to be made. The stock turnover ratio was six days and therefore this number of days' operating cash was held in stock.

Repaying the working capital and capital loans

6.27 ORH took out a working capital loan of £19.986 million in March 2007 to finance the impact of a deficit accumulated in 2005/06 and 2006/07. The Trust has been repaying this loan over a six year schedule and paid back the final instalments in 2012/13. These repayments have been financed partly by income and expenditure surpluses generated since 2006/07 and partly by constraining the size of the Trust's capital programme.

6.28 Two capital investment loans were taken out to fund capital developments of £6.141 million in 2007/08 and £7.900 million in 2008/09. The capital repayments made on the loans (and the remainder due to be made) are shown in the schedule below.

Loan repayment schedule

Loans - Former ORH Trust £000s	Working capital loan re-payments	Capital loan re-payments	Total loan re-payments
2007/08	3,332	0	3,332
2008/09	3,332	614	3,946
2009/10	3,332	1,404	4,736
2010/11	3,332	1,404	4,736
2011/12	3,332	1,404	4,736
2012/13	3,326	1,404	4,730
2013/14	0	1,404	1,404
2014/15	0	1,404	1,404
2015/16	0	1,404	1,404
2016/17	0	1,404	1,404
2017/18	0	1,405	1,405
2018/19	0	790	790
2019/20	0	0	0
Total	**19,986**	**14,041**	**34,027**

Summary cash flow statement

6.29 The table below details the summary cash flow position for 2010/11 to 2012/13.

Summary Cash Flow Statement - ORH Trust / OUH Trust	Actual		
	ORH	**OUH**	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Net cash inflow/ (outflow) from:			
- operating activities	66,572	86,998	94,077
- returns on investments and servicing of finance	-17,478	-20,291	-20,518
- capital expenditure	-23,096	-17,438	-26,239
- dividend payments	-6,960	-8,983	-9,374
Net cash inflow/ (outflow) before financing	19,038	40,286	37,946
Net cash inflow/ (outflow) from financing	-9,924	-15,879	-16,174
Increase/ (decrease) in cash	**9,114**	**24,407**	**21,772**
Opening cash balance April 1	10,363	19,477	43,884
Closing cash balance March 31	**19,477**	**43,884**	**65,656**

6.30 The level of cash held has increased by £46.2 million over the period; this increase includes £12.1 million of cash balances from the former NOC (as at 31 October 2011 at the point of merger).

6.31 Cash outflows from financing included the interest element of PFI unitary payments as well as interest payable on the Trust's loans.

6.32 Capital expenditure reflected a reduction in capital investment in 2011/12 following a prolonged period of fixed asset investment. Capital expenditure increased in 2012/13, this was driven by increased investment in medical equipment (£1.8 million), developments in Vascular and Trauma (£1.6 million) and increased donated asset expenditure (£2.4 million).

6.33 The dividend level increased by £2.0 million in 2011/12 due to increases in the net relevant asset base from former NOC assets.

6.34 There was a net outflow of cash from financing each year as capital repayments were made on loans and leases and on PFI scheme liabilities.

Capital expenditure

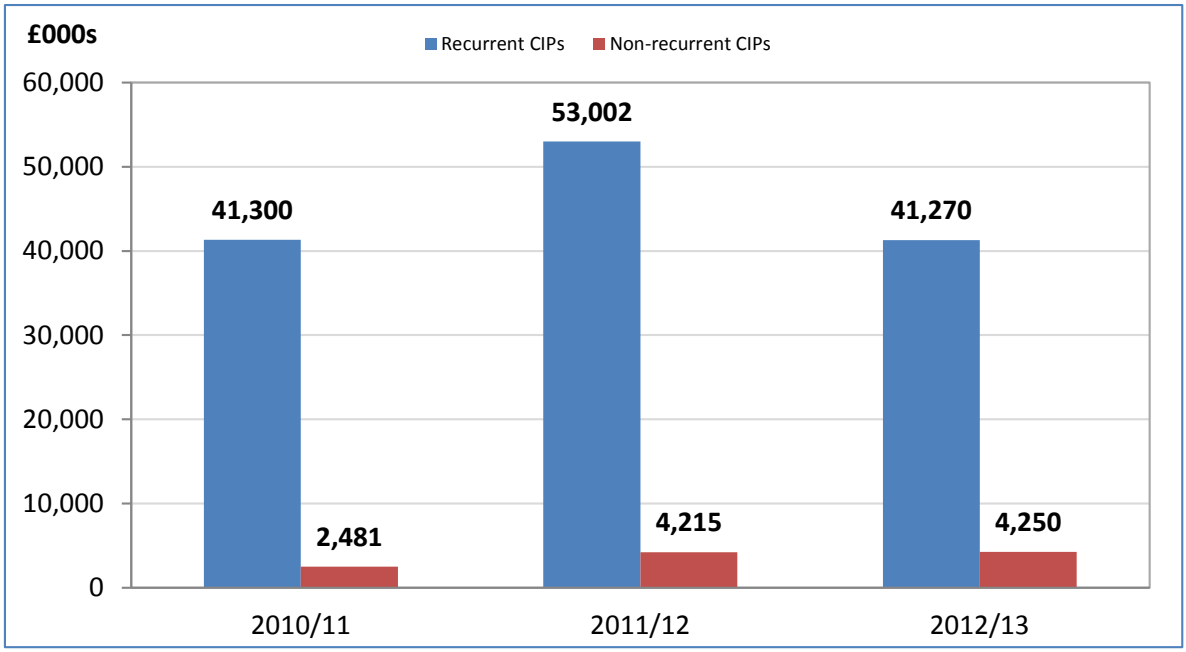
6.35 Historical ORH and OUH levels of capital expenditure are shown in the table below.

Capital Expenditure	Actual		
	ORH	**OUH**	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Maintenance Capex	10,205	6,239	16,787
Non Maintenance Capex	9,961	14,811	10,406
Total Capex	**20,166**	**21,050**	**27,193**

6.36 Maintenance expenditure includes buildings maintenance, medical equipment replacement and IT. The increase in maintenance expenditure in 2012/13 was due to a focus on renewal and replacement of assets in the capital programme, including medical equipment, IT systems to support EPR, the estate and theatres. Non-maintenance expenditure includes strategic expansion of Cardiac, Trauma and Newborn Intensive Care capacity.

Cost improvements 2010/11 to 2012/13

6.37 The level of cost improvement achieved by ORH and OUH since 2010/11 is shown in the graph and table below.



CIPs - ORH Trust / OUH Trust	Actual		
	ORH	OUH	
	2010/11 £000s	2011/12 £000s	2012/13 £000s
Target CIPs	47,146	58,373	49,500
CIPs achieved - recurrent	41,300	53,002	41,270
CIPs achieved - non-recurrent	2,481	4,215	4,250
Variance £	-3,365	-1,156	-3,980
Variance %	-7.1%	-2.0%	-8.0%

6.38 The Trust has sought to generate savings above the nationally expected levels of implied efficiency. This was driven by the need to strengthen the underlying financial position of the Trust, and by cost pressures in addition to those included in the national implied efficiency, for instance the RPI inflation increases on the three PFI schemes.

6.39 In 2010/11, ORH's financial planning process identified a cost improvement requirement of £47.1 million. £41.3 million was delivered recurrently and £2.5 million non-recurrently, with a 7.1% shortfall against target. This shortfall was offset by additional patient activity.

6.40 In 2011/12 OUH delivered a cost improvement programme of £57.2 million, of which £53.0 million was delivered recurrently and £4.2 million non-recurrently, with a 2.0% shortfall against target.

6.41 In 2012/13 OUH delivered a cost improvement programme of £45.5 million, of which £41.3 million was delivered recurrently and £4.2 million non-recurrently, with an 8.0% shortfall against target. The details of this programme are set out in the table below.

Cost improvement summary for 2012/13

CIPs - OUH Trust	Target £000s	Actual £000s	Variance £000s
FYE of 2011/12 schemes	9,400	6,468	-2,932
Divisional General Efficiency	14,500	19,997	5,497
Procurement	4,400	4,051	-349
Energy Management	1,200	0	-1,200
Medicines Management	3,100	1,845	-1,255
Capacity Reductions	3,600	0	-3,600
Adult Ward Nursing	3,200	2,064	-1,136
Consultant Job Planning	2,000	1,030	-970
High Cost Post Review	2,500	1,234	-1,266
Other Pay Cost Initiatives	2,300	0	-2,300
Reduction in Waiting-list Initiatives	2,300	2,300	0
R&D	0	3,349	3,349
Other Income	0	2,884	2,884
Private Patient Joint Venture	1,000	0	-1,000
Theatre / Endoscopy Efficiency	0	298	298
Total	**49,500**	**45,520**	**-3,980**

6.42 The high level of bed occupancy meant that the full level of planned savings from ward closures and other related divisional efficiencies (total of £4.3 million) were not realised during the year. This was partially offset by other Divisional savings and research and other income. The full year effect of savings schemes from 2011/12 included £4.5 million of pay savings, in turn including the full year effect of post-merger pay savings. It also included £1.7 million of non-pay savings, mostly relating to drug savings and radiology, and £0.2 million of income savings in Trauma and Neurosciences.

6.43 Divisional efficiency savings comprised projects delivered by clinical Divisions, including for example:

- Emergency Medicine, Therapies and Ambulatory services: a supported hospital discharge scheme (£0.4 million) and cystic fibrosis investment economies (£0.4 million).
- Children's and Women's: implementing savings to lower the unit cost for additional activity (£1.3 million), development of a new-born outreach and transitional care service from the Horton site (£1.1 million), improved staff utilisation through reduced sickness and agency usage (£0.5 million) and development of a new income stream for new-born hearing screening (£0.3 million).
- Neurosciences, Trauma and Specialist Surgery: improvements in the National Commissioning Group service efficiency (£0.4 million) and a reconfiguration of the specialist registrars in Trauma (£0.2 million).
- Cardiac, Vascular and Thoracic Surgery: changes to the cardiac diagnostic and interventional service pathway (£0.3 million) and the implantable cardiac defibrillator pathway (£0.2 million).

- Critical Care, Theatres, Diagnostics and Pharmacy: removal of pay premia for radiographers (£0.3 million), changes to out of hours rotas in Biochemistry, Haematology and Microbiology (£0.2 million) and changes in shift patterns in West Wing theatres (£0.2 million).
- Surgery and Oncology: including increased activity capture in oral chemotherapy (£0.3 million) and improvements in renal staff sickness and turnover (£0.4 million).
- Musculoskeletal and Rehabilitation Services: including savings from a divisional nurse initiative (£0.3 million) and non-pay efficiency improvements in Rheumatology and Rehabilitation (£0.2 million).

6.44 Other savings included those achieved from reviews of high cost posts (£1.2 million) and of adult ward nursing shift handover efficiency (£2.1 million).

Reference costs index

6.45 Reference costs for the former ORH and for OUH are shown below.

Reference costs index - ORH Trust / OUH Trust	2010/11	2011/12
Reference costs index	108	108

6.46 OUH has taken an active role in initiatives to improve the quality of reference cost submissions, and is one of four Trusts to work with the Department of Health on a national exercise to test changes to the reference cost pools and the reference cost system.

6.47 The Trust uses reference cost information as part of setting savings targets for Divisions. In 2013/14 an element of the target has been applied differentially to each Division according to how it ranks against the others when measured in terms of 2011/12 reference cost scores. This means that Divisions with relatively high reference costs will be asked to find proportionately greater savings relative to their expenditure base than Divisions with lower reference cost scores.

Forward Income and Expenditure Plans – OUH

6.48 This section sets out the Trust's financial performance for the current financial year 2013/14 and its modelled future financial plans for the five subsequent financial years 2014/15 to 2018/19. This is based upon the strategy and service development plans outlined in earlier chapters, to establish OUH as a strong, financially viable foundation trust that is able to continue to develop services and deliver its other objectives. Alongside this long-term model, the Trust sets out its key assumptions and trends, and details of the cost improvement programme upon which these plans are built.

Financial performance in 2013/14

6.49 OUH forecasts achieving its plan of making a £10.9 million surplus (against the breakeven duty), representing a £8.4 million retained surplus, as set out in the table below. This forecast reflects the plans for the year set out in its budgets and financial plans, with updates incorporated to reflect the recent AHSN designation and the disposal of a property on the NOC site.

Income & Expenditure Statement - OUH Trust	Forecast
	2013/14 £000s
Income from activities	704,085
Other operating income	136,577
Total income	**840,662**
Operating expenses before Depreciation	-767,186
EBITDA surplus/ (deficit)	**73,476**
EBITDA margin %	8.7%
Depreciation and Amortisation	-36,171
Operating surplus/ (deficit)	**37,305**
Profit/ (Loss) on the disposal of fixed assets	186
Fixed Asset impairments	0
Surplus/ (Deficit) before interest	**37,491**
Interest receivable	297
Interest payable	-21,235
Surplus/ (Deficit) for the financial year	**16,553**
Dividends payable on Public Capital	-8,184
Retained surplus	**8,370**
Adjustments for impairments	0
Adjustments for IFRIC 12 and Donated asset reserve elimination	2,501
Breakeven duty surplus / (deficit)	**10,871**
Adjusted surplus / (deficit) %	1.3%

6.50 Income from activities includes £690.5 million of NHS clinical activity, and £13.6 million of non-NHS clinical revenue, which includes private patient income and road traffic accident income. NHS clinical activity includes £323.6 million of specialist commissioner activity and £273.7 million of Oxfordshire CCG activity.

6.51 Expenditure budgets for 2013/14 were agreed with the clinically led Divisions to deliver the activity and income levels in contracts. These budgets reflected Divisions' business plans, which were devised to deliver OUH's strategic objectives for the year as set out in the Integrated Business Plan.

Normalised net surplus 2013/14

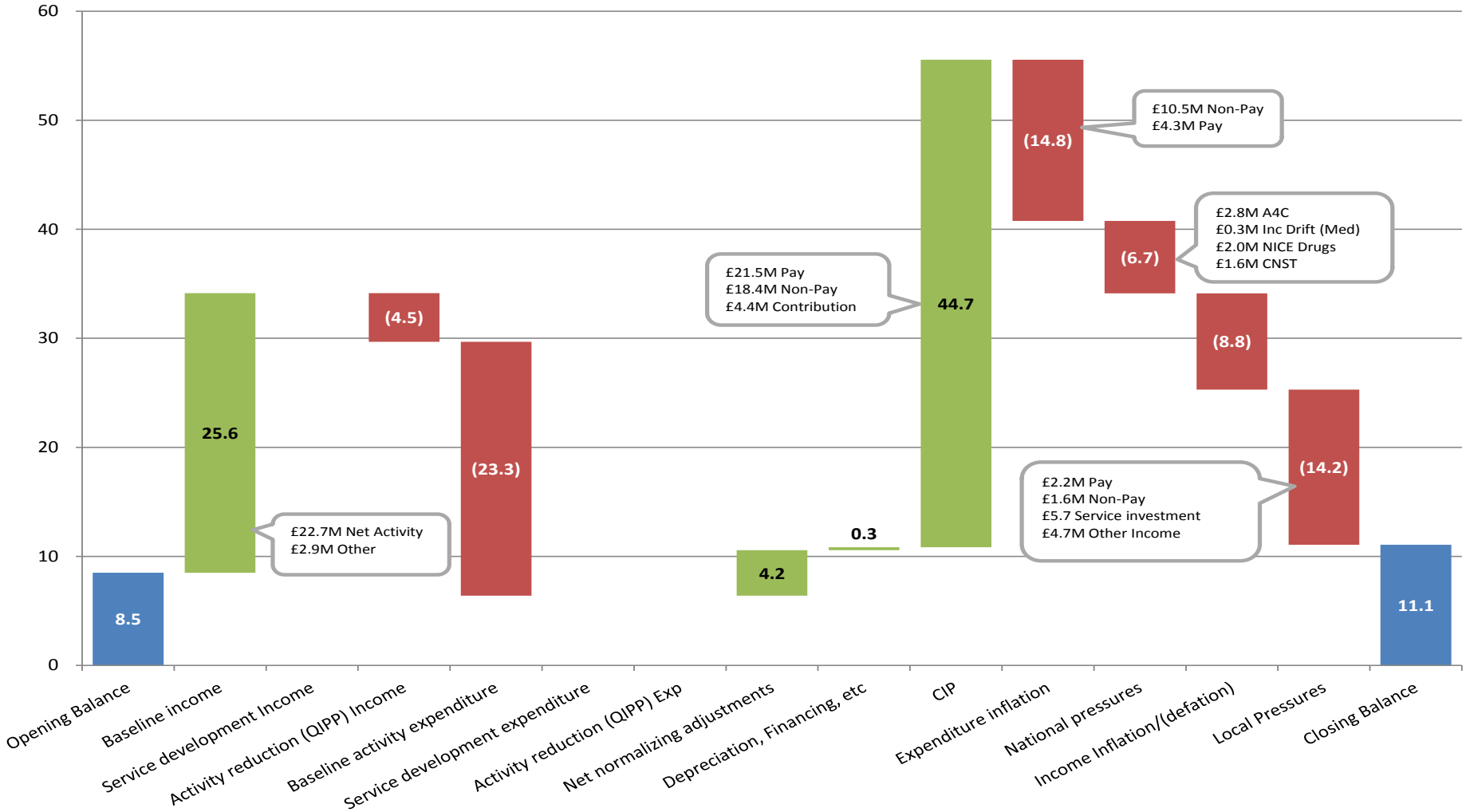
Normalised Surplus - OUH Trust	Forecast
	2013/14 £000s
Retained surplus	**8,370**
Normalising adjustment - profit/(loss) on asset disposals	-186
IFRIC 12 and Donated asset reserve elimination	2,501
Other non-recurrent items (net)	386
Normalised Net Surplus	**11,071**

6.52 The normalised net surplus includes adjusting for the net impact of the change in donated asset accounting of £2.5 million (donations income forecast of £0.3 million, offset by donated depreciation of £2.8 million). The net profit on disposal of £0.2 million (relating to the sale of a property on the Nuffield Orthopaedic Centre site, offset by some anticipated losses on disposal of medical equipment assets) is also adjusted out in the normalised position.

Bridge chart – 2013/14

6.53 The bridge analysis overleaf shows movements between OUH's opening 2013 position and the normalised planned outturn position at the close of 2014.

OUH Normalised Surplus Bridge 2012/13 outturn to 2013/14 plan (£ million)



Balance Sheet and Cash Flow

6.54 The table below sets out the forecast Balance Sheet position at 31 March 2014.

Balance Sheet - OUH Trust	Forecast
	2013/14 £000s
Fixed assets	**678,334**
Current assets:	
Stocks	10,689
Debtors and prepayments	25,054
Cash	96,520
Total Current Assets	**132,264**
Creditors: amounts falling due within one year	-127,413
Net Current Assets (Liabilities)	**4,851**
Long Term Debtors	90
Total Assets Less Current Liabilities	**683,275**
Creditors: amounts falling due after more than one year	-280,532
Provisions for liabilities and charges	-1,787
Loans	-23,003
Total Assets Employed	**377,954**
Financed by:	
Public dividend capital	205,873
Revaluation reserve	147,360
Government grant/other reserve	1,743
Income & expenditure reserve	22,978
Total Taxpayers Equity	**377,954**

Fixed assets

6.55 Fixed assets includes capital expenditure plans of £22.3 million for the current financial year (excluding IFRS impact), in turn including £13.9 million of maintenance expenditure including replacement of medical equipment and IT assets, ward relocations to exit some of the oldest buildings on the Churchill site and investment to improve the facilities. Expenditure is also included on the early phase of planning for the Radiotherapy development in Milton Keynes as detailed in Chapter 5. In addition £1.2 million of expenditure is included for the three PFI schemes lifecycle costs and the managed equipment service within the Churchill Cancer Centre. These investments in fixed assets are offset by forecast depreciation of £36.2 million.

Current assets and liabilities and a new working capital loan

6.56 Cash balances are forecast to be £96.5 million at 31 March 2014. This includes a modelled working capital loan draw down of £20.0 million in March 2014 to strengthen the Balance Sheet net current asset position of the Trust at the planned point of authorisation as a Foundation Trust. This is the forecast loan level necessary to achieve sufficient headroom on the liquidity score on Monitor's Financial Risk Ratings (FRR) in 2014/15 against the base case and downside scenarios (see 6.133 below). This loan is forecast to be repaid over ten years.

6.57 Excluding the planned draw down of the working capital loan, there is a forecast net cash inflow of £10.9 million for 2013/14. This is primarily driven by a £2.6 million favourable overall movement in working capital including plans for continued reductions in debtor levels, sale proceeds of £2.5 million from the property disposal on the NOC site, and a surplus on the internally generated financing available for capital.

Better Payment Practice Code

6.58 The Trust is paying 85% of invoices within 30 days (by value as at March 2013) and is working to improve this, as outlined above.

Non-current liabilities and loans

6.59 Long term creditors are forecast to reduce by £15.0 million in 2013/14 due to capital repayments against the PFI and finance lease liabilities. This is offset by an increase in loans of £18.0 million relating to the non-current element of the planned working capital loan drawdown described at 6.56 above.

Capital and reserves

6.60 The Public Dividend Capital reserve is forecast to reduce by £1.8 million in 2013/14 (relating to a planned repayment of PDC to the Department of Health. The Income and Expenditure reserve is forecast to increase by the planned retained surplus for the year of £8.4 million.

Summary cash flow statement

6.61 The table overleaf sets out forecast cash flow for 2013/14 with a planned closing cash balance of £96.5 million.

6.62 Forecast cash flow for 2013/14 shows a £30.9 million increase in OUH's cash balance during the year. This increase includes the £20.0 million working capital loan, forecast working capital improvements, asset sale proceeds and surplus on the internally generated financing available for capital expenditure as detailed above.

Summary Cash Flow Forecast - OUH Trust	Forecast
	2013/14 £000s
Net cash inflow/ (outflow) from:	
- operating activities	75,994
- returns on investments and servicing of finance	-20,948
- capital expenditure	-20,806
- dividend payments	-7,426
Net cash inflow/ (outflow) before financing	26,814
Net cash inflow/ (outflow) from financing	4,050
Increase/ (decrease) in cash	**30,864**
Opening cash balance April 1	65,656
Closing cash balance March 31	**96,520**

Cost Improvement Programme (CIP) in 2013/14

6.63 The CIP for 2013/14 is designed to deliver savings totalling £44.7m. The programme content was developed by the Trust's clinical Divisions working locally to develop Divisional efficiency schemes and working collaboratively to develop cross-Divisional efficiency improvement plans for Theatres, Outpatients and Non-elective flow.

6.64 Trust support services also worked closely with clinical Divisions developing plans for reduced non-pay costs through procurement and medicines management.

6.65 A combined team of clinical Divisional and corporate leaders designed and agreed workforce initiatives to save on agency, medical and non-medical staffing costs. The programme content is summarised in the table below.

CIPs - OUH	Plan
	2013/14 £000s
Divisional efficiency savings - pay	6,936
Divisional efficiency savings - non-pay	4,388
Divisional efficiency savings - income	3,200
Full Year effect of 2012/13 savings - pay	2,028
Full Year effect of 2012/13 savings - non-pay	1,870
Full Year effect of 2012/13 savings - income	1,232
Workforce initiatives	7,789
R&D and Training & Education	5,700
Procurement	4,279
Medicines Management	1,535
Non Elective Flow	1,200
Theatre Efficiency	1,979
Outpatients Efficiency	500
Waiting List Initiatives	1,000
Blood Product Orders	300
Other initiatives	794
Total CIPs	**44,730**

Quality Impact Assessment

6.66 A tiered assessment process has been put in place to avoid adverse impact on quality from the implementation of the programme.

6.67 All schemes are quality assessed within the clinically-led Divisional management structures.

6.68 After assessment at Divisional level, schemes are assessed for quality impact by the Trust's Chief Nurse, Medical Director and Director of Clinical Services. All schemes are signed off by the relevant clinical lead in the service, the Divisional Director of the relevant clinical division and the Chief Nurse, Medical Director and Director of Clinical Services.

Delivery Process

6.69 The process for ensuring delivery of the programme revolves around the Cost Improvement Programme Steering Group that meets fortnightly. Its membership includes the clinician Divisional Directors, General Managers, Divisional Nurses and Executive Directors of Finance, Clinical Services, Nursing and workforce. The group is chaired by the Director of Clinical Services. A reporting cycle ensures that at each of its meetings the group receives updated forecasts of actual savings against planned schemes. The group agrees actions to address any shortfalls and supports project leads to overcome obstacles to delivery.

6.70 The CIP steering group oversees working groups responsible for delivery of individual schemes within the overall programme. It reports to the Board via the Finance and Performance Committee and provides monthly reports to the Trust Management Executive.

6.71 The programme content consists of a balance of divisional general efficiency, procurement and medicines management savings plans, workforce measures and operational efficiency improvements.

6.72 The Divisional General Efficiency and full year effect of previous year's schemes is the responsibility of individual Divisions. Divisions meet formally as part of the reporting cycle between steering group meetings to take forward their schemes and update forecasts of delivery with support from the programme management office.

Contingency Planning

6.73 Where gaps in delivery of the originally planned schemes are not fully resolvable, the CIP steering group agrees measures to close these gaps through:

- Managing over-delivery against target for some schemes to offset any under-delivery in other schemes. The agency staffing working group is already assessing the possibility of over achieving its target in 2013/14.
- Bringing forward the start date of schemes in the programme to ensure overall delivery. The Trust is aiming to commence reductions in sessional rates earlier than originally planned.
- Bringing forward schemes from the following year 2014/15 to start in 2013/14. Some of the workforce measures planned for 2014/15 may commence before 1 April 2014.

This approach to contingency planning on CIP delivery is supplementary to the approach to risk management and mitigating actions set out in Chapter 7.

Programme Scrutiny and Performance Management

6.74 The Board and its Finance and Performance Committee receive reports on CIP progress at each of their meetings. The savings schemes are reflected in Divisional budgets and Divisions are held to account for performance against these budgets at monthly performance reviews.

Medium term financial plan

6.75 OUH will generate revenue and cash surpluses to achieve a minimum financial risk rating of 3 for all components of the rating for the five-year period 2014/15 to 2018/19. Overall financial risk ratings are initially 3, rising to 4 over the five years. The Trust has made assumptions about activity growth and inflation which recognise the difficult economic climate. This is illustrated by five-year Income and Expenditure projections and the projected bridge analysis to 2018/19.

Five year summary Income and Expenditure projections

6.76 The Trust will continue to strengthen its financial performance:

- Generating retained surpluses of 1% of turnover each year, averaging £8.2 million per year from 2014/15 to 2018/19.
- Increasing its EBITDA margin to 9.1% by 2018/19 driven by planned efficiency improvements.
- Maintaining strong cash balances for each of the five years.

Income & Expenditure Statement - OUH Trust	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Income from activities	704,085	685,304	676,022	675,493	676,367	675,244
Other operating income	136,577	136,825	139,715	141,542	143,428	145,345
Total income	**840,662**	**822,129**	**815,738**	**817,035**	**819,795**	**820,589**
Operating expenses before Depreciation	-767,186	-748,849	-743,536	-744,577	-745,480	-745,548
EBITDA surplus/ (deficit)	**73,476**	**73,280**	**72,201**	**72,458**	**74,315**	**75,042**
EBITDA margin %	8.7%	8.9%	8.9%	8.9%	9.1%	9.1%
Depreciation and Amortisation	-36,171	-36,847	-35,564	-35,822	-36,298	-36,409
Operating surplus/ (deficit)	**37,305**	**36,433**	**36,637**	**36,637**	**38,017**	**38,633**
Profit/ (Loss) on the disposal of fixed assets	186	-200	-200	-200	-200	-200
Fixed Asset impairments	0	0	0	0	0	0
Surplus/ (Deficit) before interest	**37,491**	**36,233**	**36,437**	**36,437**	**37,817**	**38,433**
Interest receivable	297	329	337	291	284	280
Interest payable	-21,235	-20,772	-20,759	-20,232	-21,176	-21,516
Surplus/ (Deficit) for the financial year	**16,553**	**15,789**	**16,016**	**16,495**	**16,925**	**17,196**
Dividends payable on Public Capital	-8,184	-7,482	-7,812	-8,238	-8,702	-8,989
Retained surplus	**8,370**	**8,308**	**8,204**	**8,257**	**8,223**	**8,208**
Adjustments for impairments	0	0	0	0	0	0
Adjustments for IFRIC 12 and Donated asset reser	2,501	2,557	2,373	2,271	2,172	2,077
Breakeven duty surplus / (deficit)	**10,871**	**10,865**	**10,577**	**10,528**	**10,395**	**10,285**
Adjusted surplus / (deficit) %	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%

Normalised Surplus - OUH Trust	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Retained surplus	**8,370**	**8,308**	**8,204**	**8,257**	**8,223**	**8,208**
Normalising adjustment - profit/(loss) on asset dis	-186	200	200	200	200	200
Impairment	0	0	0	0	0	0
IFRIC 12 and Donated asset reserve elimination	2,501	2,557	2,373	2,271	2,172	2,077
Other non-recurrent items (net)	386	0	0	0	0	0
Normalised Net Surplus	**11,071**	**11,065**	**10,777**	**10,728**	**10,595**	**10,485**

Bridge chart – projections to 2018/19

6.77 The first bridge chart below shows forecast movements from 2013/14 forecast outturn normalised surplus to 2014/15 normalised surplus. The second shows the forecast movement over the remaining four future years, from 2015/16 to 2018/19.

6.78 The projections take into account assumptions for inflation and implied efficiency levels, income growth and activity reduction (QIPP), cost pressures and savings, as set out below.

6.79 These projections show that OUH expects to deliver sustainable Retained Surpluses over the period, enabling it to strengthen its balance sheet, improve its underlying liquidity and create capacity for service investment through internally generated resources to deliver its strategic objectives.

6.80 Costs increase during the five year period due to the following factors:

- Pay costs increase £44.9 million. These are associated with activity (£18.6 million), national pressures (incremental drift £15.1 million), local pressures (£10.8 million) and NMET investment (£0.4 million).
- Non-pay costs increase by £29.7 million. These are associated with activity (£9.7 million), national pressures (NICE costs £11.5 million) and local pressures (£8.9 million).
- Cost inflation of £90.9 million. Assumptions on pay, drugs and other inflation rates are shown below; and
- A net increase of £1.3 million relating to depreciation, interest and PDC.

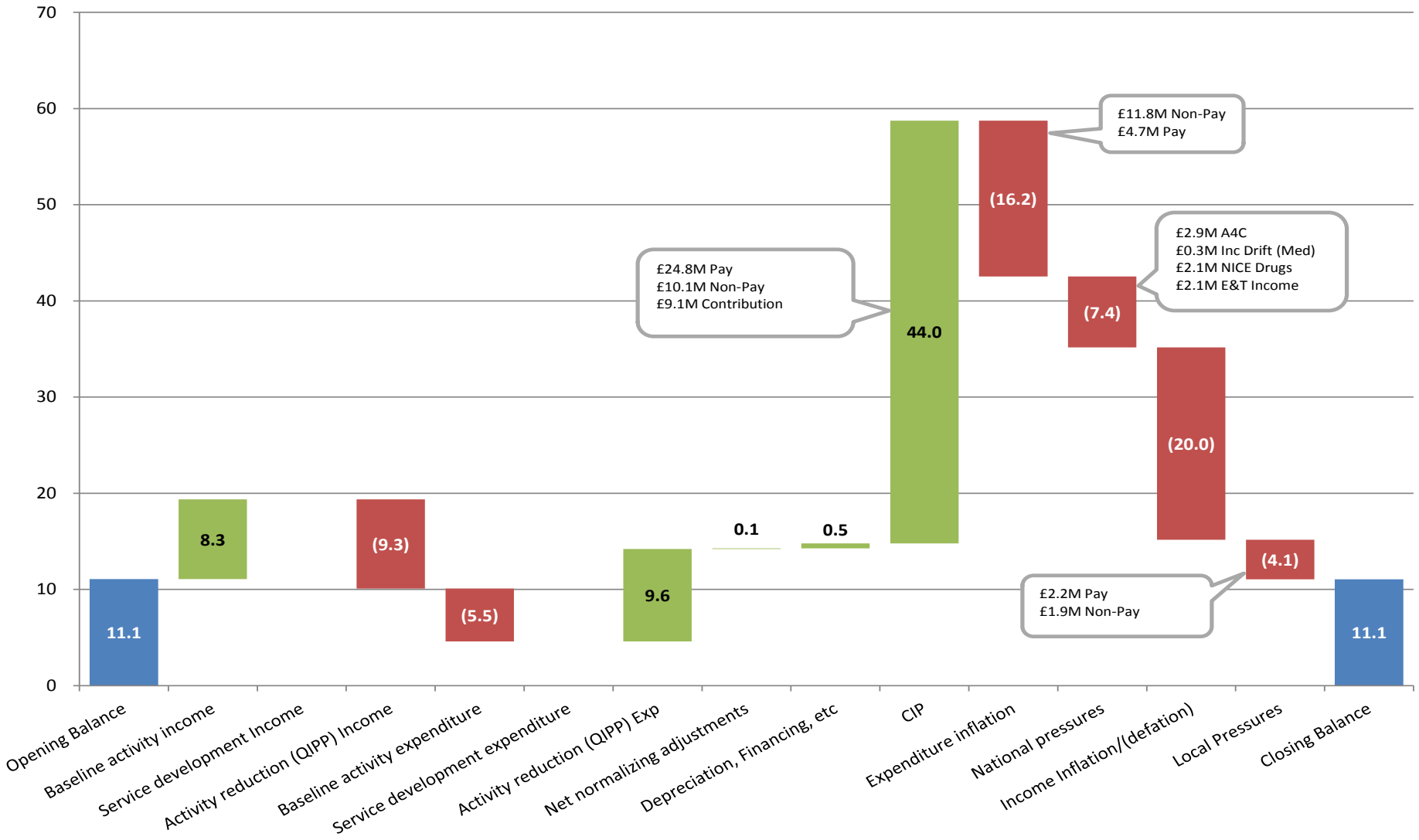
6.81 These cost increases are offset by £23.0 million cost reductions associated with reduced activity from demand reduction plans initiated between 2013/14 and 2015/16, and cost improvement programme savings of £159.5 million (in real terms including agency savings), with costs reducing overall over the period.

6.82 Commissioner income increases during the five year period in relation to the following factors:

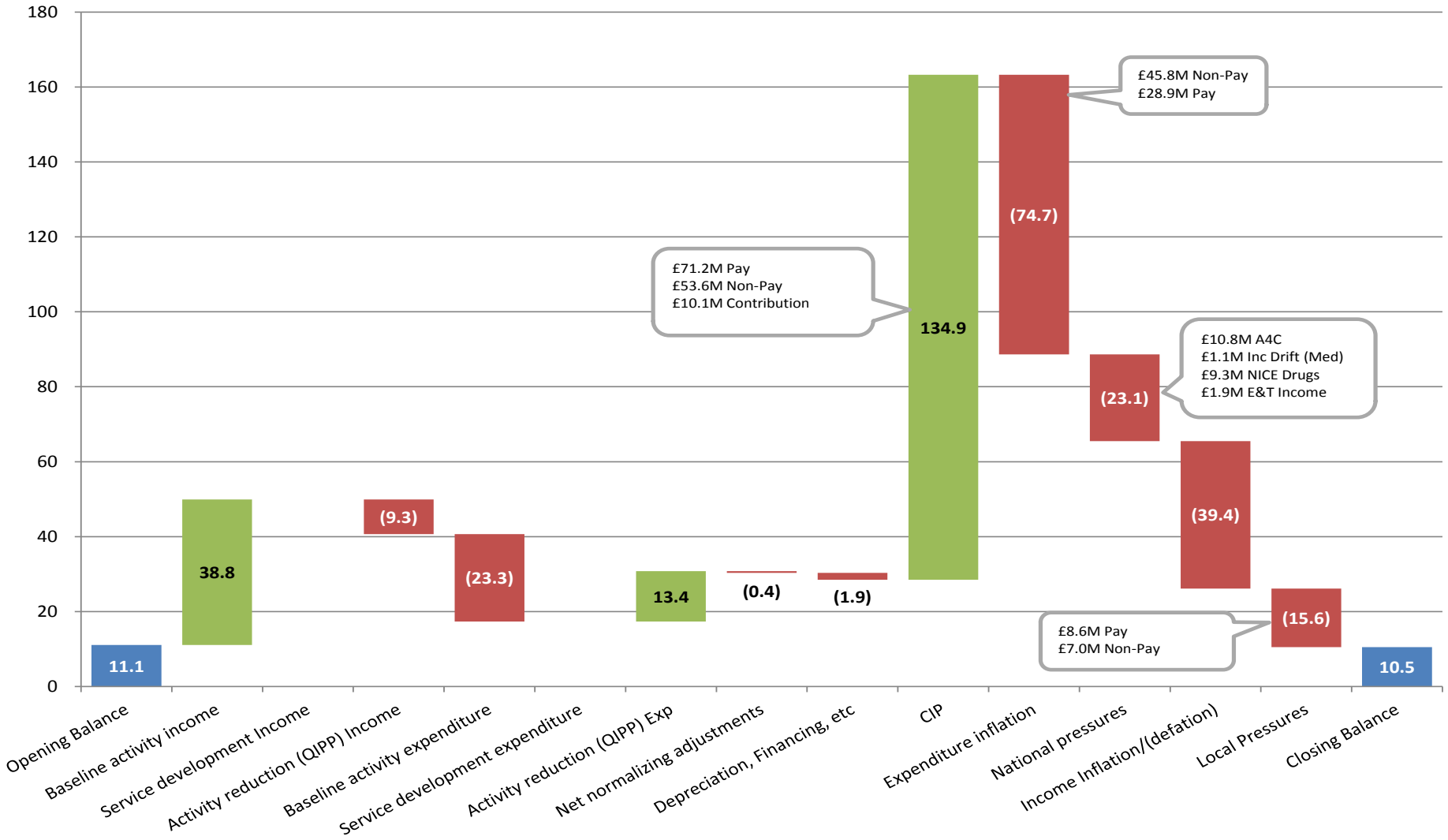
- £46.4 million growth in activity and case-mix income and a £6.7 million increase due to additional contribution derived from income. These are based on the Trust's current activity forecasts and savings plans, and are broken down in the following section 6.77 below.

6.83 These income increases are offset by £18.5 million income reductions from continued activity reduction (QIPP) schemes with Oxfordshire CCG over 2014/15 – 2015/16, and tariff deflation of £67.4 million over the five year period (as part of the on-going implied efficiency requirements in the NHS).

OUH Normalised Surplus Bridge 2013/14 plan to 2014/15 plan (£ million)



OUH Normalised Surplus Bridge 2014/15 plan to 2018/19 plan (£ million)



6.84 The elements of clinical income growth are broken down in the table below (excluding QIPP schemes).

Breakdown of clinical income growth (excluding QIPP) - real terms	Forward Plan				
	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Demographic growth	1,869	1,767	1,684	1,802	1,524
Underlying demand growth	8,958	11,482	8,809	8,663	8,451
KPI - reduction	-1,329	-1,329	-1,329	-1,329	-1,329
Contestability - income reduction	-280	-280	-280	-280	-280
Patients Choice - income growth	183	183	183	183	183
Income efficiency savings	1,238	1,738	1,238	1,238	1,238
Other	-1,500	0	0	0	0
Total	**9,139**	**13,561**	**10,305**	**10,277**	**9,787**

6.85 Private patient and overseas income is planned to increase by £4.0 million over the first two future years, due to planned additional contribution derived from income schemes.

6.86 Education and Training income is planned to reduce in real terms by a net £3.1 million over the first two future years (with a planned further reduction in SIFT and MADEL income of £3.9 million partially offset by NMET income increases of £0.8 million). This follows reductions to these income streams in 2013/14 after changes in education and training funding were implemented by the Department of Health, with overall funding reductions to OUH anticipated to be phased in over a three year period from 2013/14 to 2015/16.

6.87 Research and Development income is planned to increase in real terms by £4.3 million over the first two years due to planned schemes to increase contribution levels from these income streams. Other income is planned to increase by £3.7 million in real terms over the first two years and commercial revenue is planned to increase by £0.5 million in real terms over the first two years, due to planned schemes to increase contribution levels from these income streams. Other operating revenue also rises due to inflation of £8.1 million over the five years. Income inflation assumptions are shown at 6.93 below.

6.88 Cash generated from operating activity surpluses will be used to:

- Fund remaining repayments on the existing two capital loans.
- Fund repayments on the new FT working capital loan proposed to strengthen underlying liquidity.
- Fund annual capital expenditure from internally generated cash, with no plans to draw on interest bearing capital loans.
- Service repayments on lease liabilities.
- Strengthen the balance sheet and liquidity.

Activity assumptions on growth and demand management

6.89 Activity and income projections are underpinned by assumptions which reflect current views on changing demand and market share as well as plans to reduce activity in the acute setting. These assumptions take specific account of:

- Forecast demographic changes based on ONS statistics for the ten most significant commissioners, adding an average £1.7 million per annum.
- Underlying demand changes based upon historical trends, such as increasing cancer survival rates raising activity levels for chemotherapy and radiotherapy. This adds an average £9.3 million per annum. The higher figure of £11.5 million in 2015/16 is related to the phasing in of the planned Radiotherapy development for Bedfordshire and Milton Keynes. The demand projections reflect the Trust's strategy to develop further as a regional centre of specialist acute care, for example including a 5% annual growth in medical oncology, and 5.3% growth each year in colorectal cancer surgery, as treatment continues to be centralised in specialist treatment centres such as the Oxford Cancer Centre. Clinical oncology has been modelled specifically based on current radiotherapy proposals.
- Demand changes take account of increasing demand for cardiology, due to an increase in the incidence of heart failure in the ageing population and increased ability to intervene to treat heart rhythm defects. Annual growth of 7% in cardiology and 4.9% in interventional radiology has been modelled. This reflects current service developments in the centralisation of vascular intervention in Oxford and the repatriation of cardiac surgery from London providers to Oxford.
- Demand changes also reflect OUH's strategic partnership with the University of Oxford, with research activity in areas such as diabetes medicine predicted to drive an annual growth of 9% in diabetes medicine outpatients activity in the Trust.
- The requirement to deliver national performance targets for access is included within the baseline position, with no further income added for this in future years.
- An annual reduction of £1.3 million has been included based upon the delivery of KPIs. This assumes a 5% reduction in bed days (length of stay) across all specialties. A reduction in outpatient follow ups of 2% across all specialties has also been assumed.
- Commissioning plans.
- Activity reductions are planned to continue for Oxfordshire CCG, based upon previous QIPP discussions with local commissioners on anticipated commissioning levels over the period 2014/15 to 2015/16. This reduces income by a further £18.5 million over this period after reductions in 2013/14. Schemes to avoid hospital treatment include plans for long term care closer to home and to transfer services out of the acute trust, such as the current pilots for community ophthalmology and urology services.
- Specific targeted activity growth in Newborn Intensive Care of 3% in 2014/15 and a further 1.5% in 2015/16 (see Chapter 5). The increasing rate of premature and multiple births resulting from delayed childbearing and improvements in the availability of IVF, coupled with improving survival rates for particularly premature babies, is resulting in rising demand for perinatal care. OUH is a designated provider of level 3 care for newborns and is extending its facilities in Newborn Intensive Care.
- Modelling has also incorporated patient choice (focussing on the potential for an increase in activity in surgical specialties based on obtaining a greater proportion of workload from commissioners on the borders of our catchment area) and potential competition from a Treatment Centre in Banbury and an independent endoscopy service in Witney.

6.90 The impact of these factors on activity is shown in the table below.

Activity changes over the five year period

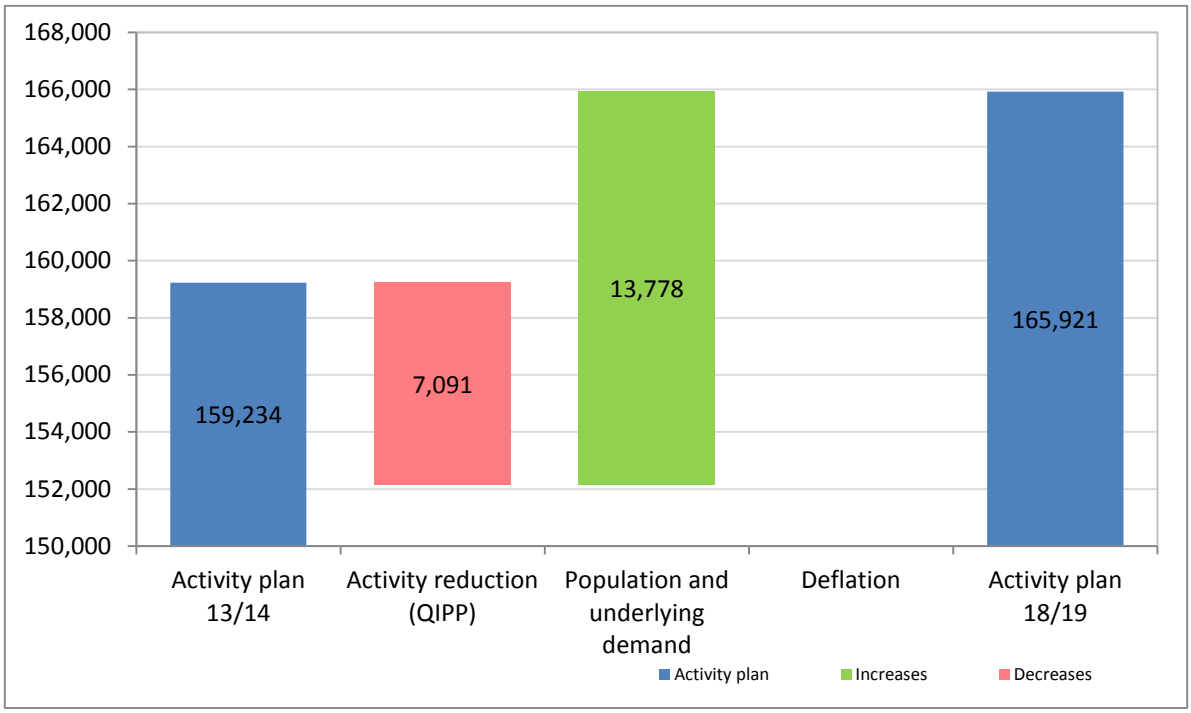
Changes in acute activity - OUH Trust	Forward Plan				
	2014/15	2015/16	2016/17	2017/18	2018/19
Elective - spells (000s)	84.4	84.4	86.4	88.4	90.4
Elective - % change	0.1%	0.1%	2.3%	2.3%	2.2%
Non-Elective - spells (000s)	74.1	73.2	74.0	74.8	75.6
Non-Elective - % change	-1.1%	-1.2%	1.0%	1.0%	1.0%
Outpatient - FA & FU (000s)	715.9	709.0	717.9	726.9	735.7
Outpatient - % change	-1.0%	-1.0%	1.3%	1.2%	1.2%
A&E - attendances (000s)	124.6	122.9	124.0	125.1	126.2
A&E - % change	-1.3%	-1.3%	0.9%	0.9%	0.9%

6.91 The principal reasons for the changes in activity levels modelled are;

- Elective: reflects underlying demand increases based on historical trends and demographic growth. This is partly offset by demand management plans for the first two years.
- Non-elective: reflects underlying demand increases based on historical trends and demographic growth, offset by demand management for the first two years, resulting in an overall decrease in activity during that initial period.
- Outpatients: reflects underlying demand increases based on historical trends and demographic growth, offset by activity reduction for the first two years, resulting in an overall decrease in activity during that initial period.
- A&E: reflects underlying demand increases and demographic growth, offset by demand management for the first two years, resulting in an overall decrease in activity during that initial period.

6.92 The bridge chart below breaks down the movements modelled on elective and non-elective activity spells over the period. Over the first two years, activity growth is offset by the QIPP activity management reductions, with average net reductions of 779 spells each year. From 2016/17 activity then increases by an average of 2,748 spells each year.

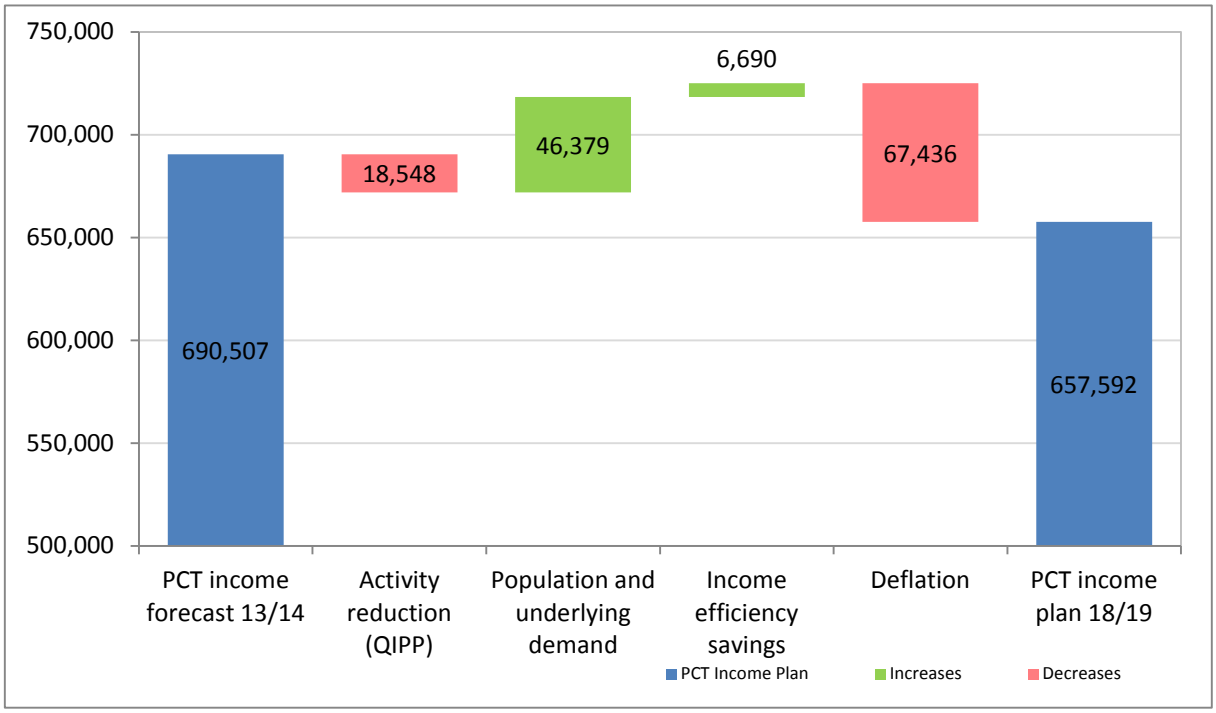
Changes modelled in elective and non-elective spells over the period



Income and expenditure projection trends and assumptions

6.93 The bridge chart and tables below break down the impact of the different components of activity changes modelled upon NHS clinical income levels over the five year period.

6.94 In real terms, income from NHS commissioners is expected to grow by a net £34.5 million over the next five years (including activity reductions (QIPP) of £18.5 million), and tariff deflation is expected to decrease income by £67.4 million.



Total PCT income - OUH Trust	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Total PCT income	690,507	669,254	658,370	657,841	658,715	657,592
Net change (year to year) - all factors	-	-3.1%	-1.6%	-0.1%	0.1%	-0.2%
Total PCT income excluding inflation	690,507	690,372	694,659	704,964	715,241	725,028
Net real terms change (year to year) - all factors	-	0.0%	0.6%	1.5%	1.5%	1.4%

Changes in PCT income - OUH Trust	Forward Plan				
	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Deflation	**-21,118**	**-15,171**	**-10,835**	**-9,403**	**-10,909**
QIPP	-9,274	-9,274	0	0	0
Service Developments	0	0	0	0	0
Demographic and underlying growth	9,139	13,561	10,305	10,277	9,787
Total net real terms growth	**-135**	**4,287**	**10,305**	**10,277**	**9,787**
Overall change in income	**-21,253**	**-10,884**	**-530**	**874**	**-1,122**

Income

6.95 The financial plan includes activity growth with an average financial value of £10.6 million per annum which includes the effect of modelled demographic changes, underlying demand, KPI improvements and efficiency savings.

6.96 This growth is offset by activity reductions with a total financial impact of £18.5 million over the period 2014/15 to 2015/16 (averaging £9.3 million per annum). This reflects discussions held with Oxfordshire commissioners on their intentions to reduce hospital activity commissioned from OUH.

6.97 Income is modelled at 2013/14 tariff levels.

Implied efficiency levels

6.98 The plan makes assumptions on the level of deflation in tariff and non-tariff income and inflation in other income, after taking account of the Trust's cost inflation assumptions set out in the next section. It reflects the implied efficiency levels for acute Trusts issued by Monitor in April 2012 which in turn reflect the continuing difficult economic conditions, particularly in the years 2013/14 and 2014/15. Tariff and non-tariff deflation is included at levels shown in the table below.

Income inflation assumptions	Forward Plan				
	2014/15	2015/16	2016/17	2017/18	2018/19
NHS tariff deflation	-3.7%	-2.9%	-2.2%	-2.0%	-2.3%
NHS non tariff deflation	-3.7%	-2.9%	-2.2%	-2.0%	-2.3%
Non NHS clinical income inflation	0.0%	0.0%	0.0%	0.0%	0.0%
Other income inflation - Education & Training	1.0%	1.0%	2.0%	2.0%	2.0%
Other income inflation - Research & Development	1.4%	1.4%	1.4%	1.4%	1.4%
Other income inflation - Other	-0.4%	0.1%	0.3%	0.3%	0.3%

6.99 The LTFM includes an overall implied efficiency level of 5% for 2014/15, reducing to 4.2% per annum from 2015/16 (excluding local cost pressures). The financial impact of the overall tariff deflation, cost inflation and national cost pressures is shown in the table below, which when compared to total nominal income each year, shows the total implied efficiency built into the LTFM each year as a financial value and a percentage.

Implied efficiency each year in the LTFM	Forward Plan				
	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Tariff Deflation	-21,118	-15,171	-10,834	-9,403	-10,909
Other Income	1,122	1,311	1,827	1,886	1,917
Pay Inflation	-4,438	-4,278	-8,453	-8,216	-7,954
Pay Incremental Drift (national pressure)	-3,175	-3,079	-3,035	-2,947	-2,855
Drugs Inflation	-3,754	-3,895	-4,179	-4,450	-4,739
Drugs NICE (national pressure)	-2,122	-2,203	-2,293	-2,378	-2,466
Clinical Supplies Inflation	-5,012	-5,013	-5,068	-5,100	-5,118
Other Non-Pay Inflation, PFI and below EBITDA	-2,499	-1,647	-2,408	-3,792	-2,226
Total Impact	**-40,996**	**-33,975**	**-34,443**	**-34,400**	**-34,350**
Total Income (nominal)	822,129	815,738	817,035	819,795	820,589
% implied efficiency impact	**-5.0%**	**-4.2%**	**-4.2%**	**-4.2%**	**-4.2%**

Projected clinical income

PCT income - OUH Trust	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Elective	143,415	136,835	131,642	130,469	129,565	128,248
Non-Elective	171,741	163,351	156,596	154,571	152,875	150,712
Outpatient	91,309	88,033	85,541	85,622	85,831	85,722
A&E	13,783	13,100	12,555	12,392	12,254	12,080
Other NHS	270,259	267,935	272,036	274,788	278,189	280,830
Total	**690,507**	**669,254**	**658,370**	**657,841**	**658,715**	**657,592**

Expenditure

6.100 Expenditure projections reflect costs associated with the growth in activity set out above. This cost growth has been calculated from the Trust's PLICS data on marginal cost levels at Point of Delivery (POD) and specialty level, to apply differential marginal costs depending on which POD and specialty the activity growth is in (as set out in the LTFM).

6.101 Cost reductions resulting from activity reductions have been modelled to reflect a twelve month delay before savings against fixed cost headings can be isolated, included in the CIP process and realised.

6.102 Cost pressures have been included for pay incremental drift for staff on Agenda for Change terms and conditions (1% per annum), consultant incremental drift (0.3% per annum), NICE drug cost pressures (2.5% per annum) to reflect funding pressure requirements on new drug developments and local cost pressure (contingencies) at 0.5%.

6.103 Assumptions have been made on expenditure inflation as follows:

- Pay award inflation continuing to be capped at 1% for the next two years (reflecting stated Government public sector pay policy from the Budget statement on 20th March 2013), rising to 2% thereafter.
- Drugs inflation at 4.5% across the period.
- Clinical supplies inflation of 5.4% per annum (twice the forecast RPI level), while other non-pay costs are inflated at 2.7% per annum, based upon RPI forecasts.
- PFI unitary payment inflation is modelled at 2.5% across the period, reflecting future assumptions in the three PFI financial models.

Projected expenditure

Operating expenditure - OUH Trust	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Pay costs	-465,265	-448,240	-442,330	-441,056	-439,409	-437,251
Drug costs	-82,857	-87,169	-90,758	-95,608	-100,828	-106,387
Clinical supplies and services	-95,346	-97,836	-100,416	-103,411	-106,446	-109,470
Other costs	-123,718	-115,604	-110,032	-104,501	-98,797	-92,440
Operating Expenses	**-767,186**	**-748,849**	**-743,536**	**-744,577**	**-745,480**	**-745,548**

Cost Improvement Programme (CIP)

6.104 In nominal (cash) terms annual cost and performance improvements are expected to realise an average of £38.2 million per annum over the five years of the IBP. Savings are higher in 2014/15 than in subsequent years due to the higher implied efficiency requirement in that year, reflecting the challenge for the NHS to save £20 billion by 2015 (see 6.101 above).

CIPs - OUH (nominal terms)	Forward Plan				
	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Staff and pay savings	20,264	14,874	18,634	19,007	19,386
Drugs savings	1,488	3,357	3,118	3,258	3,405
Clinical supplies	2,504	3,245	3,924	4,136	4,359
Other costs	6,463	5,740	7,530	9,291	9,885
Other (including agency and income CIPs)	13,858	7,355	1,882	1,895	1,908
Total CIPs (nominal terms)	**44,577**	**34,570**	**35,088**	**37,587**	**38,942**

CIPs - OUH (real terms)	Forward Plan				
	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Staff and pay savings	20,063	14,580	17,909	17,909	17,908
Drugs savings	1,424	3,074	2,732	2,732	2,732
Clinical supplies	2,376	2,921	3,351	3,351	3,351
Other costs	6,293	5,442	6,952	8,352	8,652
Other (including agency and income CIPs)	13,811	7,336	1,857	1,857	1,857
Total CIPs (real terms)	**43,967**	**33,353**	**32,801**	**34,201**	**34,500**

Cost Improvement Programme (CIP) for 2014/15 and 2015/16

6.105 The table below summarises the expected delivery programme for the period to March 2016.

Saving plans by theme for 2014/15 to 2015/16 (real terms)	Plan	
	2014/15 £000s	2015/16 £000s
Divisional efficiency savings - pay	7,235	7,235
Divisional efficiency savings - non-pay	2,962	2,962
Divisional efficiency savings - income	4,303	4,303
Workforce Initiatives - non-medical	8,393	933
Workforce Initiatives - job planning	2,090	697
Workforce Initiatives - other schemes	2,096	171
Support Service Group	4,575	3,961
R&D & Training & Education	3,225	1,075
Medicines Management	1,350	2,000
Procurement	1,980	2,200
Private Patient Income	1,125	375
Estate savings	1,088	363
Electronic Patient Record	0	4,325
Other savings	3,545	2,753
Total CIPs (real terms)	**43,967**	**33,353**

6.106 The programme for 2014/15 has been subject to a similar planning process as for the 2013/14 CIP, with full project initiation documentation and detailed quality impact assessment in place.

6.107 Programme content consists of divisional and cross divisional schemes. The support services group will develop the Trusts service delivery plans through more strategic partnerships and the EPR scheme will work to realise the benefits of this major modernisation process converting these to cash releasing savings plans by 2015/16. There is also a major focus on efficient deployment of clinical staff through improved job planning and other workforce change. Medicines Management and Procurement will continue to deliver cost reductions.

6.108 The CIP steering group is overseeing the development of mechanisms to deliver these changes to ensure that actions are being taken to a timescale that recognises the lead times for these more significant changes. The CIP steering group receives regular workforce and quality indicator reports.

6.109 The process for designing schemes and agreeing their inclusion in the programme was the same as for 2013/14, with clinical Divisional leaders at the forefront of design and assessment of ideas and deciding which were clinically appropriate for inclusion. Changes have been designed and selected on the basis of positive quality impact assessment.

6.110 The Trust Management Executive and the Trust Board will oversee the progress of the CIP Steering Committee in overseeing the delivery of the schemes including ongoing quality impact assessment.

Key Performance Indicators (KPIs)

6.111 A summary of principal KPI projections is set out below.

6.112 Bed numbers are forecast to reduce by 77 from 1,578 in 2012/13 to 1,501 by 2014/15. This forecast reduction is driven by the non-elective patient flow savings scheme (a reduction of 58 beds) and planned reductions in activity and excess bed days.

6.113 Bed numbers reduce further between 2014/15 and 2015/16 from the 2013/14 forecast level of 1,501 beds, due to activity-related (QIPP) reductions over the first two years. These reductions of 71 beds are offset by capacity resulting from demographic growth, with a small net increase of 6 beds in 2016/17. Average length of stay is forecast to improve as efficiencies are realised from the CIP. Theatre utilisation is also forecast to improve by 5% to 85% in 2014/15 as benefits are realised from further efficiency schemes.

KPIs		Forecast		Forward Projections			
	Units	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Bed numbers	Beds	1,501	1,461	1,433	1,439	1,439	1,439
Average Length of Stay (Elective)	Days	3.9	3.9	3.8	3.8	3.7	3.6
Average Length of Stay (Non Elective)	Days	4.3	4.2	4.1	4.0	4.0	3.9
Theatre Utilisation	%	80%	85%	85%	85%	85%	85%
Catchment population (excluding tourists)	000's	626.6	628.6	630.3	632.0	633.5	635.6

PFI schemes

6.114 OUH has three PFI projects: the West Wing and Children's Hospital at the John Radcliffe Hospital (for which payments started in January 2007), the new Churchill Hospital (for which payments started in January 2009) and the Nuffield Orthopaedic Centre (for which payments started in February 2007). The contracts are for 30 years, except for the NOC contract which is for 37 years. The PFI buildings occupy 29% of the OUH Trust estate.

6.115 As well as the buildings, the contracts include hard and soft facilities management services, including estate management and maintenance and soft facilities management services including domestics, portering, and catering. The Churchill Hospital PFI also includes the provision of a Managed Equipment Service (MES) for regular upgrade and replacement of radiotherapy and radiology equipment in the Oxford Cancer Centre.

6.116 Unitary payments for the three schemes totalled £59.2 million in 2012/13. This sum included the services outlined above, capital repayments of the liabilities and interest. This represented 7.2% of OUH turnover for that year.

Cash flow forecasts

6.117 The table below forecasts the Trust's cash flow to 2018/19. Projections for 2013/14 were described at 6.49 above along with details of an FT working capital loan to strengthen the Balance Sheet liquidity FRR position from 2013/14 as the planned year of authorisation.

6.118 These projections show the Trust maintaining a strong cash position over the period, driven by generation of EBITDA surpluses, and indicate that the Trust will generate a cash balance of £92.9 million by the end of 2018/19.

6.119 This cash position includes funding capital expenditure to address backlog investment requirements. Capital expenditure plans are set out below.

6.120 The Trust has a treasury management policy which provides a framework for managing its cash position and the use of any surplus cash. The Trust has developed a policy to reflect the duties and freedoms of a Foundation Trust which will be approved prior to authorisation.

Summary Cash Flow Forecast - OUH Trust	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
EBITDA	**73,476**	**73,280**	**72,201**	**72,458**	**74,315**	**75,042**
Excluding non-cash I&E items	-260	-270	-281	-292	-304	-316
Movement in working capital:						
(Increase)/decrease in Inventories	664	0	0	0	0	0
(Increase)/decrease in NHS Trade Receivables	-145	-144	-1	0	0	1
(Increase)/decrease in Non NHS Trade Receivable	3,003	1,900	1,401	0	0	-1
(Increase)/decrease in other Receivables	892	792	692	67	67	67
(Increase)/decrease in Other financial assets (e.g.	0	0	0	0	0	0
(Increase)/decrease in Prepayments	312	0	0	0	0	0
(Increase)/decrease in Other assets	0	0	0	0	0	0
Increase/(decrease) in Deferred Income & Paymer	0	0	0	0	0	0
Increase/(decrease) in Provisions	1,222	-1,482	-982	18	18	18
Increase/(decrease) in Trade Payables	-2,501	-1,250	-1,250	-1,250	-1,250	0
Increase/(decrease) in Other Payables	-355	-125	-125	0	0	0
Accruals	-498	-250	-250	-252	-250	-250
Increase/(decrease) in working capital	**2,593**	**-559**	**-515**	**-1,417**	**-1,415**	**-165**
Increase/(decrease) in Non Current Provisions	185	99	99	99	99	99
Net cash inflow from Operating Activities	**75,994**	**72,549**	**71,504**	**70,848**	**72,695**	**74,659**
Capital expenditure	-23,292	-26,096	-29,356	-35,820	-30,251	-31,488
Proceeds on disposals	2,486	0	0	0	0	0
Cash Flow before Financing	**55,188**	**46,453**	**42,148**	**35,029**	**42,443**	**43,171**
Public Dividend Capital received	0	0	0	0	0	0
Public Dividend Capital repaid	-1,800	0	0	0	0	0
Dividends paid	-7,426	-7,482	-7,812	-8,238	-8,702	-8,989
Interest (paid) on Loans and Leases	-21,246	-20,772	-20,759	-20,232	-21,176	-21,516
Interest received on Cash and Cash equivalents	297	329	337	291	284	280
Drawdown of Loans and Leases	20,000	0	0	0	0	0
Repayment of Loans and Leases	-14,150	-16,350	-13,644	-10,619	-13,773	-14,369
Net cash (outflow) / inflow	**30,864**	**2,178**	**271**	**-3,770**	**-923**	**-1,423**
Closing Cash Balance	**96,520**	**98,698**	**98,969**	**95,199**	**94,276**	**92,853**

Capital investment and financing strategy

Capital expenditure plans

6.121 In the period to 2018/19, OUH plans capital investment of £137.5 million. This includes planned expenditure to address the backlog investment required to ensure all buildings and equipment in use are in a good condition and to improve facilities for care delivery on each site. The higher non-maintenance capital expenditure levels planned for 2014/15 and 2015/16 are due to anticipated capital investment in two Radiotherapy satellite units and in adult critical care.

6.122 Maintenance capital expenditure plans include replacement of medical and surgical equipment, IT, increasing estate maintenance expenditure and investment in remodelling and modernising operating theatres on the John Radcliffe Hospital site.

Capital Expenditure Plans - OUH (Nominal)	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Maintenance Capex	13,893	12,268	11,467	22,777	20,179	20,986
Non Maintenance Capex	8,399	12,132	15,159	7,110	7,255	8,215
Total Capex	**22,292**	**24,399**	**26,626**	**29,888**	**27,434**	**29,201**

(Excluding donations)

6.123 The financing strategy is to use cash from depreciation and the annual surpluses generated (after making scheduled loan and lease liability repayments) to finance the five year capital investment plan. This is illustrated in the table below. There is no requirement for new capital investment loans.

Funding of capital investment plans	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Total capital investment	**22,292**	**24,399**	**26,626**	**29,888**	**27,434**	**29,201**
Financed by:						
Retained surplus	8,370	8,308	8,204	8,257	8,223	8,208
Depreciation (inc PFI)	36,171	36,847	35,564	35,822	36,298	36,409
Less: PFI and finance lease repayments of capital	-12,746	-12,946	-10,240	-7,215	-10,369	-11,578
Less: Repayment of loans	-1,404	-3,404	-3,404	-3,404	-3,404	-2,791
Internally generated financing available for capita	**30,391**	**28,804**	**30,124**	**33,460**	**30,749**	**30,247**
Difference	8,099	4,405	3,498	3,572	3,315	1,046

Capital investment criteria applied to developments

6.124 All business cases and associated capital investment requirements go to the Trust's Management Executive for approval. Each is assessed against strict criteria including overall fit with the Trust's strategy, alignment with its business plan, and the requirement to deliver a positive net financial contribution on income and expenditure.

Balance sheet projections

6.125 Balance sheet projections for 2013/14 and the following five years are summarised as follows:

Balance Sheet - OUH Trust	Forecast	Forward Plan				
	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s	2017/18 £000s	2018/19 £000s
Fixed assets	**678,424**	**668,874**	**664,910**	**671,366**	**668,673**	**666,588**
Current assets:						
Stocks	10,689	10,689	10,689	10,689	10,689	10,689
Debtors and prepayments	25,054	24,074	23,049	23,049	23,049	23,049
Cash	96,520	98,698	98,969	95,199	94,276	92,853
Total Current Assets	**132,264**	**133,461**	**132,707**	**128,937**	**128,014**	**126,591**
Creditors: amounts falling due within one year	-127,413	-122,600	-117,468	-119,138	-118,252	-122,497
Net Current Assets (Liabilities)	**4,851**	**10,861**	**15,239**	**9,799**	**9,761**	**4,094**
Total Assets Less Current Liabilities	**683,275**	**679,735**	**680,149**	**681,165**	**678,435**	**670,682**
Creditors: amounts falling due after more than one	-280,532	-271,989	-267,504	-263,567	-255,306	-241,247
Provisions for liabilities and charges	-1,787	-1,886	-1,985	-2,084	-2,183	-2,282
Loans	-23,003	-19,599	-16,195	-12,791	-10,000	-8,000
Total Assets Employed	**377,954**	**386,261**	**394,465**	**402,723**	**410,946**	**419,153**
Financed by:						
Public dividend capital	205,873	205,873	205,873	205,873	205,873	205,873
Revaluation reserve	147,360	147,360	147,360	147,360	147,360	147,360
Government grant/other reserve	1,743	1,743	1,743	1,743	1,743	1,743
Income & expenditure reserve	22,978	31,285	39,489	47,747	55,970	64,177
Total Taxpayers Equity	**377,954**	**386,261**	**394,465**	**402,723**	**410,946**	**419,153**

6.126 The balance sheet projections show:

- Fixed assets reducing overall in net terms over the five years, reflecting the impact of planned capital expenditure (6.121 above) being more than offset by annual depreciation of assets (with the exception of 2016/17 when higher planned PFI Managed Equipment Service expenditure in that year add to the capital expenditure level on fixed assets).
- Working capital: stock levels are projected to remain consistent over the period, in line with forecast stock levels at March 2014.
- Working capital: NHS debtor days are forecast to be broadly constant and consistent with current performance at around five days. Non-NHS debtors days are forecast to reduce over the next two years as collection of private patient debts is improved, bringing these down to around ten days. After this debtors are projected to be consistent over the remaining period.
- Working capital: creditor days are forecast to reduce over the next two years, as payment performance improves, bringing these down to within 30 days. This is driven by planned

improvements to the Accounts Payable systems, including increasing the use of purchase orders and enhancing workflow for creditor invoices.

- Equipment lease liabilities (due within one year) are projected to reduce over the period by £2.5 million as existing leases are paid off with only a low level of new equipment finance leases planned each year (of £0.5 million capital value per annum).
- PFI liabilities (due within one year) are projected to increase over time in line with the planned proportion of unitary payment elements going against repayment of the outstanding liabilities. This is the principal factor driving the increase in creditors falling due within one year after 2015/16.
- Accruals are forecast to reduce over the period reflecting planned improvements to Accounts Payable systems gradually reducing the accruals required.

6.127 Cash balances at each year end are expected to be maintained at between £92.9 million and £99.0 million over the five years, after allowing for the Trust's capital financing strategy.

Private patients

6.128 The Trust expects its private patient income to be stable from 2015/16 at an average of 2.2% of turnover for the remainder of the period after some growth in the next two years.

Development of trading accounts and service line reporting (SLR)

6.129 The Trust has taken steps to develop SLR. These include devolving management responsibility for some theatre areas to the clinical Divisions using those theatres and implementing the Prodacapo costing system to facilitate the production of Patient Level Information Costing (PLICS) and SLR. It is developing internal trading for radiology and pathology services during 2013/14 to support SLR and clinical Divisions in their use of clinical support services.

6.130 SLR reports draw primarily on the same data as reference costs and are reported to managers and clinicians in each of the Trust's clinical Divisions to inform them of the profitability position for each Division and specialty. Reports allow Divisional management to understand the drivers of reference cost benchmarks and to identify areas for cost and productivity improvement and so reduce reference costs and increase financial contributions.

6.131 The Trust has taken steps to promote the use of SLR and reference cost information, including establishing a Clinical Costing Advisory Development Group chaired by a senior clinician. This group takes a lead role in driving the adoption of Service Line Management and the use of PLICS and SLR to improve the understanding of costs and income at a specialty and patient level.

Working capital facility

6.132 OUH has identified its required working capital facility as £61.0 million. This represents an average 30 days of operating expenditure over the period. The Trust does not expect to use this facility during the next five years. The Trust has an action plan for negotiating this facility with a financial institution during the second half of 2013/14 as it nears authorisation.

Loans

6.133 A new FT working capital loan of £20.0 million is included in the modelling to be drawn down in March 2014 and repaid over ten years from 2014/15. This strengthens the liquidity rating on the Balance Sheet at the planned point of authorisation. The balances outstanding on the two existing capital investment loans and the new FT working capital loan are paid down each year.

Financial risk rating and prudential borrowing limit

6.134 The following table summarises the Trust's forecast performance against Monitor's financial risk rating (FRR) for each of the next five years. It illustrates that OUH will generate sufficient revenue and cash surpluses to achieve a minimum risk rating of 3 for all components of the financial risk ratings over the five year period covered by the plan. The overall rating will be a 3 in each year, rising to a 4 from 2017/18, once the EBITDA margin rating rises above 9% required for the score to improve from a 3 to a 4 on that measure.

Financial risk rating

`	2014/15		2015/16		2016/17		2017/18		2018/19	
	metric	score	metric	score	metric	score	metric	score	metric	score
EBITDA margin	8.9%	3.0	8.8%	3.0	8.8%	3.0	9.0%	4.0	9.1%	4.0
EBITDA % achieved	100.0%	5.0	100.0%	5.0	100.0%	5.0	100.0%	5.0	100.0%	5.0
NRAF (Net return after financing)	1.2%	3.0	1.2%	3.0	1.2%	3.0	1.2%	3.0	1.2%	3.0
I&E surplus margin	1.0%	3.0	1.0%	3.0	1.0%	3.0	1.0%	3.0	1.0%	3.0
Liquid ratio	26.5	4.0	29.6	4.0	31.7	4.0	29.0	4.0	29.0	4.0
Weighted average		3.5		3.5		3.5		3.7		3.7
Financial risk rating (FRR)	**3**		**3**		**3**		**4**		**4**	

6.135 The FRR is used to set a Foundation Trust's borrowing capacity, in the form of a Prudential Borrowing Limit (PBL). As previously stated, OUH plans to fund its capital programme using internally-generated resources, with no additional borrowing requirement after the proposed FT working capital loan to strengthen its net current asset position.

6.136 The availability of a working capital facility equivalent to 30 days of operating expenditure (of £61.0 million) is included within the liquidity ratio calculations shown in the FRR table above, as is standard practice within the LTFM.

Conclusion

6.137 The formation of OUH put the combined organisation in a stronger financial position to operate successfully as a Foundation Trust.

6.138 The Trust has strengthened its underlying financial position in the past two years. It is focused on continuing to strengthen its financial position and Balance Sheet by delivering a 1% retained surplus in 2013/14 through good financial management and the delivery of cost improvements.

6.139 This base allows it to produce a financial plan that, in an increasingly challenging financial environment, delivers surpluses, with improved liquidity and risk ratings, and finances service improvements in areas of development to support its strategic goals.

6.140 OUH recognises that there are risks to the delivery of this financial plan. These are examined in Chapter 7 with the measures that the Trust can adopt to control or manage these risks.

Chapter 7

Risk

7. Risk

Introduction

7.1 The Board of Directors has overall responsibility for managing risk. It recognises the importance of monitoring and managing those risks which have the potential to threaten the achievement of its strategic goals proactively.

7.2 The Board has established effective arrangements to do this and to ensure that prompt and proportionate action is taken at the first sign that a risk may be materialising or where there is evidence that the mitigating action it has sanctioned is not proving effective.

7.3 Processes and structures for managing risk have been subject to a rigorous and wide-ranging review as described in Chapter 9.

7.4 OUH aims to operate a mature and structured approach to risk that strikes a balance between being excessively risk averse and exposing the organisation to risks that are insufficiently controlled. The former could prevent the Trust from being able to seize strategic opportunities for improvement, whilst the latter could allow threats to its strategy and performance to materialise. Achieving this balance is based on a process of setting the Trust's level of appetite for a particular risk based on its risk maturity, agreeing an appropriate tolerance for this, delegating the authority to manage within this tolerance and ensuring that appropriate on-going monitoring is in place.

7.5 Risks are clearly linked to the Trust's strategic objectives and, with the progressive implementation of its Risk Management Strategy, the organisation intends to increase the sophistication with which it assesses, manages and monitors risk.

7.6 This chapter sets out OUH's overall approach to risk management and summarises the systems and processes employed. It provides an overview of the latest assessment of key risks facing the Trust's business plan and the sensitivity of its financial projections to these risks if they were to materialise.

Summary of principal risks

7.7 The Trust reviews its strategic objectives each year as part of its business planning cycle. The strategic objectives are supported by a set of annual corporate objectives.

7.8 At Board level, the Trust monitors the principal risks to the delivery of its strategic objectives through its Board Assurance Framework (BAF) and by regular reviews of a Corporate Risk Register (CRR). Divisions and corporate departments monitor and manage risks against the corporate objectives, escalating any risk which may impact at Trust level.

7.9 The eight risk areas identified are outlined below. These relate to the delivery of OUH's business plan following authorisation as a Foundation Trust. Each represents a broad set of related risks which are elaborated upon in text which also describes the mitigating actions which are currently being implemented, planned or considered. All risks are assessed for likelihood and consequence.

7.10 It is important to note that only some of these risks would have a direct impact on income, cost and liquidity. The remaining risks would only be likely to have an adverse financial impact in the medium to long term if no action was taken to address them.

7.11 The table cross-references the identified risks to the strategic objectives that they threaten and to the IBP chapter/s in which content can be found about them, including actions to prevent or mitigate them. This table is split into the three 'principal risks' affecting the Trust and a further five 'secondary risks', effectively those that have a cause, effect or impact on one or more of the principal risks to the extent that the Board agreed that they require describing in their own right.

7.12 The Board has spent time reaching agreement on the articulation of risks contained within the BAF and CRR. It has been agreed that the principal risks identified concern the maintenance of the quality of patient services, operational performance and financial stability; and that the majority of the other risks described in the BAF or CRR have an effect or impact on these principal risks. For example, the Trust's ability to transform services through the positive engagement of its workforce or to engage with its stakeholders and partners has a direct impact on the quality of its services.

	Risk	Principal indicators	Risk Score (L x C)	Objectives threatened	IBP Chapter
	Principal Risks				
R1	**Failure to maintain quality of patient services**	Patient experience indicators show a decline in quality	2x3=6	SO1, SO4, SO5	9
		Potential breach of CQC Health and Social Care regulations	2x3=6	SO1	9
		Trust's Quality Strategy goals and quality aspects of contracts not met	2x3=6	SO1	9
		CIPs impact on patient safety or unacceptably impact on service quality	2x3=6	SO1, SO4, SO5	9
R2	**Failure to maintain financial sustainability**	Required levels of cost improvements not delivered	4x3=12	SO3	6
		Pay costs not adequately controlled	4x3=12	SO3	6, 8
		Failure to manage outstanding debtors	3x3=9	SO3	6
		Failure to generate income from non-core healthcare activity	3x3=9	SO3, SO5,	4, 5, 6
		Services display poor cost-effectiveness	4x2=8	SO3	6
R3	**Failure to maintain operational performance**	National performance standards for A&E not met	3x3=9	SO1, SO2, SO4	4, 5
		Failure to reduce delayed transfers of care	4x4=16	SO1, SO2, SO4	4, 5
		Necessary level of data quality not achieved	2x4=8	SO3	5
	Secondary Risks				
R4	**Mismatch with commission-ers' plans**	Lack of robust plans across the healthcare system	3x4=12	SO3, SO5	5
		Loss of commissioner support	2x4=8	SO3, SO5, SO6	6
R5	**Loss of share of current and potential markets**	Loss of existing market share	2x4=8	SO3, SO5,	4, 6
		Failure to gain share of new markets	3x3=9	SO5,	4, 5, 6
		Negative media coverage relative to competitors	2x2=4	SO5	4, 5, 6
R6	**Failure to sustain an engaged and effective workforce**	Difficulty recruiting and retaining high quality staff	2x4=8	SO1, SO3, SO5	8
		Low levels of staff satisfaction, health & wellbeing and engagement	2x4=8	SO1	8
		Insufficient provision of training, appraisals and development	2x3=6	SO1,SO2, SO4	8

	Risk	Principal indicators	Risk Score (L x C)	Objectives threatened	IBP Chapter
R7	**Failure to deliver the required transformation of services**	Failure to maintain the development of organisational culture	2x4=8	SO2, SO3, SO4, SO6	8
		Clinical benefits of EPR not realised	2x4=8	SO2, SO3, SO4, SO6	5, 9
		Low levels of staff involvement in the Trust agenda	3x3=9	SO2, SO3, SO4, SO6	3
		Failure to establish robust governance and assurance processes	3x3=9	SO2, SO3, SO4, SO6	3
R8	**Failure to deliver the benefits of strategic partnerships**	Failure to establish sustainable regional networks	2x2=4	SO5, SO6	3, 4
		Adequate support for education is not provided	3x2=6	SO5, SO6	
		Research and innovation do not deliver anticipated benefits	2x2=4	SO5, SO6	

Key

SO1	*"Delivering compassionate excellence"*
SO2	*"A well governed and adaptable organisation"*
SO3	*"Delivering better value healthcare"*
SO4	*"Delivering integrated local healthcare"*
SO5	*"Excellent secondary and specialist care through sustainable clinical networks"*
SO6	*"Delivering the benefits of research and innovation to patients"*
L	Likelihood
C	Consequence

7.13 It should be noted that the above chart is not a comprehensive list of every risk within the Trust's Corporate Risk Register. The chart provides a summary of those issues that present a long term risk to the achievement of the Trust's strategic objectives.

7.14 The CRR also includes risks escalated from Divisional or corporate directorate risk registers that have been included for specific implementation and active monitoring of completion by the Trust Management Executive over a short time period. For example, in May 2013 the Trust had a risk relating to the management of its bed and mattress stock included on the CRR, with this risk being actively managed at a corporate level to ensure that the replacement bed stock and works to improve the environment in the bed store were completed within the expected timescale.

Risk 1: Failure to maintain quality patient services

7.15 This represents the risk that agreed patient safety, patient experience and effectiveness priorities as set out in the Quality Strategy are not delivered with a consequent impact on clinical care, patient safety and reputation. Poor service quality would include failure to deliver the quality aspects of contracts with commissioners and a potential breach of CQC regulations. The risk that delivery of cost improvement programmes (CIPs) may impact on service quality has also been considered.

7.16 A related risk would be the failure of the clinically-led organisation to deliver and embed the required cultural changes and associated governance and assurance systems. This is covered in more detail under risk 7.

7.17 Failure to manage risk in this area could also increase the likelihood of other risks being realised. Failures in quality and their impact on reputation could lead to a loss of activity through patient choice if patient experience deteriorates and could impact on the recruitment and retention of staff.

7.18 Mitigations to these risks include a focus on meaningful benchmarks for quality with regular review at Trust and Divisional level. Specifically, the NHS Operating Framework notes the need for Trusts to examine, understand and explain their Summary Hospital Mortality Indicator (SHMI) and act where performance is falling short. The implementation of *Delivering Compassionate Excellence* and *Listening into Action* work to embed change, together with the delivery of the Trust's Quality Strategy, will also mitigate risks to quality along with cultural change to reinforce action and policies that deliver quality. In addition to this the implementation of a Trust-wide patient feedback management system will provide a mechanism to identify and prompt timely action to address emerging issues.

7.19 The Trust requires that an assessment is made of the potential impact of workforce plans and CIPs on quality through review and sign off by the Chief Nurse and the Medical Director to ensure that deleterious proposals are rejected.

7.20 Establishing a network for innovation and operational clinical networks (see Chapter 4) will deliver benefits in maintaining and improving quality of outcomes and patient experience whilst assisting in sustaining and growing specialist services. The Trust has worked with local partners to launch the Oxford Academic Health Consortium to support, enable and facilitate increased partnership working and to facilitate the successful AHSC designation process. In addition, OUH is leading the development of the Oxford Academic Health Science Network.

Risk 2: Failure to maintain financial sustainability

7.21 A significant element of the failure to maintain financial sustainability is that of failing to deliver the required level of CIPs at a level sufficient to make the anticipated financial model viable. This includes a failure to control pay and agency costs and to reduce the workforce sufficiently. There is also the risk of a failure of a sufficient proportion of CIPs to deliver savings recurrently. Furthermore there exists the possibility of increased implied efficiency in tariff requiring additional CIPs.

7.22 There is a risk of lost potential income should commercial opportunities, including the development of private patient work and opportunities in relation to estate management processes, not being progressed.

7.23 A failure to establish a network for innovation may lead to an inability to drive improvements in cost-effectiveness of services through development of pathways and technology.

7.24 Mitigation of these risks is mainly underpinned by ensuring the development of a robust and long-term CIP programme with divisional ownership and sufficient programme office support. This should include service redesign to make pathways more efficient and is likely to move delivery of some services outside of the Trust. This programme is subject to a rigorous performance management regime and the quality impact assessment process as outlined in risk 1.

7.25 Ultimately plans will need to be developed for additional CIPs to be held as contingencies, including 'radical' strategic disinvestments such as site rationalisation and the sale of assets.

Risk 3: Failure to maintain operational performance

7.26 This poses a serious risk to the Trust's financial position because of the effect it has on patient flow, patients' experience and the overall affordability of certain services. The significant impact on the quality of care for patients must not be underestimated.

7.27 The possible failure of CCGs to rapidly develop the required capability and capacity for their new roles would impact on their ability to act as effective partners and to have a shared strategy, potentially affecting the Trust's ability to manage delayed transfers.

7.28 Mitigations include the further development of the Supported Discharge Service, actions as part of the multi-agency Provider Action Plan described in chapter 5, as well as further collaborative work with Oxford Health on integrated care pathways, recruitment, education and training. The ability to ease the flow of patients through the hospital has a direct effect on the Trust's performance in relation to the National A&E target. The Trust is undertaking targeted work to improve patient flow, strengthen leadership and release downstream beds.

Risk 4: Mismatch with commissioners' plans

7.29 A failure to deliver activity levels in line with agreements with commissioners would impact on the assumptions in the LTFM and the affordability of services for the health economy as a whole. Key causes of this would be a lack of robust plans across the healthcare system and the Trust being unable to respond to requirements to flex its capacity up or down.

7.30 Risks associated with contracting are reduced in comparison with previous years as a result of the early agreement of a 2013/14 contract compliant with national guidance. Dialogue continues to identify, agree and progress actions that reduce risks for commissioners.

7.31 Mitigations include internal performance controls and continuing liaison with commissioners to develop contingencies where required. The Trust needs to be prepared to actively remove stranded costs through the development of contingency plans and recognises that delays in taking out stranded fixed costs pose a risk to its own financial performance rather than that of its commissioners.

7.32 The relationship with commissioners is actively monitored through commissioner alignment meetings and a joint strategy has been developed with commissioners to tackle this issue.

Risk 5: Loss of share of current and potential markets

7.33 The Trust's business plan would be put at risk by a loss of activity from referrers and commissioners which could be precipitated by a loss of reputation and poor performance in relation to operational targets and quality (see above). There also exists the risk of future assumptions regarding the market and demand proving incorrect which may include the impact of changes in care models and assumptions made as part of the Trust's market assessment (included in Chapter 4).

7.34 A failure to establish regional networks for services may mean that certain services have insufficient mass to be sustainable and cost-effective. Similarly threats could emerge to arrangements underpinning existing business cases in terms of the scale and timing of delivery.

7.35 As well as the loss of current market share there exists the corresponding risk of failure to gain a share of new markets and to respond rapidly to market demands. The Health and Social Care Act has encouraged the more open tendering of services, as described in Chapter 5, and the Trust's ability to respond to new tendering opportunities and assess the risks of existing services being subject to tender will be important over the coming years.

7.36 OUH could be threatened by a failure of GP/consortium partnerships to develop effectively and by the failure of emerging partnerships to recognise the Trust as a major partner with the resulting impact on future commissioning. The Trust will need to be alert to risks caused by changes in the regional healthcare landscape as a result of mergers or reconfigurations.

7.37 Mitigations to deal with these risks include ensuring that strategy is developed along with commissioners to maintain their support and that assumptions underlying LTFM are agreed with them. It will be important to maintain dialogue with potential partners to develop mutually beneficial clinical linkages through strategic and operational clinical networks and the academic

health science networks. The Trust is enhancing it capability to develop successful tenders and developing a commercial strategy to take business opportunities as they arise.

7.38 The Trust will need both linkages to retain the ability to flex up capacity quickly in response to market demands and to maintain the ability to take costs of investment back out again and vary the composition of the workforce.

7.39 Ultimately contingencies could include the necessity to withdraw from the market for certain services to preserve overall Trust profitability.

Risk 6: Failure to sustain an engaged and effective workforce

7.40 Risks related to workforce include high local employment, staff disengagement and dissatisfaction and the failure to secure a high quality workforce supply in an international job market.

7.41 Failure to manage this will impact on other risks such as the maintenance of quality and the patient experience, the successful delivery of CIPs and the Trust's ability to provide activity levels that meet its income plans. This risk may also have an impact on the reputation of the Trust.

7.42 A further risk relates to the failure to agree a strategy and implement plans for all aspects of in-service and postgraduate education and training which will compromise staff capability, recruitment and retention. This could also have an effect on the level of staff involvement and engagements in the Trust's wider agenda.

7.43 OUH will need to be aware of the risk that a failure to engage staff and trade unions in change management could result in increased industrial action, and so engage in effective communication and partnership working with trade union representatives and staff.

7.44 Mitigation plans to deal with these risks include an active staff engagement programme and the implementation of the Trust's values through recruitment and appraisal processes. Strong Board and Divisional leadership will be supported by leadership development and education to support effective working and change orientation. The adoption of dedicated recruitment campaigns and a rolling programme will also mitigate these risks.

Risk 7: Failure to deliver the required transformation of services

7.45 Transforming the way in which the Trust delivers services will be essential to ensuring its success over the coming years. OUH recognises that there are a range of risks to delivering the required transformation.

7.46 In order to achieve the significant level of change that will be necessary it is required that the Trust develops a flexible and innovative organisational culture, maintains a focus on longer term planning and removes barriers to the implementation of new models of care. It will also be important that the Trust maximises clinical advantages from EPR, where possible.

7.47 These risks impact on the patient experience and on operational performance and would impact on the ability of services to achieve long term sustainability. Mitigation will require the delivery of phased programme of change, with active staff engagement (as mentioned in risk 6 above), with clear accountability and management arrangements built around strong governance and assurance processes.

Risk 8: Failure to deliver the benefits of strategic partnerships

7.48 The Trust's intention to build sustainable partnerships that deliver a range of benefits is essential to its strategy and any failure to establish regional networks could have an impact on the sustainability of specialist services and could lead to the requirement to scale back some services.

7.49 The development of the Oxford Academic Health Science Network will provide opportunities for delivery of innovative services which will enhance the quality of patient care and support the financial sustainability of the Trust through novel and more cost effective treatments. Linkages with

academic partners are also crucial in supporting the education the future of the clinical workforce. There are therefore significant risks in failing to deliver on these opportunities.

7.50 The mitigations for this risk include the active implementation of those benefits contained in the successful AHSN bid and ongoing discussions with partner organisations within the region to continue to strengthen clinical networks.

Financial implications

7.51 The Trust works to mitigate in specific terms each of the key risks described above. Some of the risks have a clear and measurable financial component and therefore have similarly quantifiable mitigations.

7.52 The table below identifies the expected values and mitigations for those risks within the base case which are both measurable and material.

Risk	Mitigation	Intended financial effect	Director responsible	Timescale for applying mitigation if risk materialises	Revised risk rating with mitigation
1. Failure to maintain quality of patient services	Recurrent investment in additional clinical staff and supplies to address quality issues.	Combined additional £12.5 million recurrent expenditure to avoid loss of CQUIN income.	Director of Clinical Services	2014/15 (recurrently)	3 in 2014/15
2. Failure to maintain financial sustainability – due to insufficient CIP delivery or reduced tariffs	Bring forward strategic saving schemes from future years.	Additional £5.8 million of saving schemes brought forward each year (recurrently).	Director of Finance & Procurement	2014/15 to 2018/19	3 in 2014/15
3. Failure to maintain operational performance (delayed transfers and fines)	Invest £3.5 million in clinical resources.	Invest £3.5 million (recurrently) to maintain operational performance standards to avoid fines.	Director of Clinical Services	2014/15 recurrently	3 in 2014/15
4. Mismatch with Commissioners' plans	Invest £10.0 million non-recurrently in 2014/15 in a GP referral hub to deliver activity reductions.	£10.0 million non-recurrent investment in an OUH GP referral hub to deliver activity reductions.	Director of Clinical Services	2014/15 non-recurrently	3 in 2014/15

Risk	Mitigation	Intended financial effect	Director responsible	Timescale for applying mitigation if risk materialises	Revised risk rating with mitigation
5. Loss of share of current and potential markets	Remove costs associated with specialist growth and remove variable costs associated with increased activity reductions.	£2.8 million per annum mitigation through reduction of pay and non-pay costs associated with specialist growth. Further reductions in variable costs (from activity reductions) of £5.3 million by 2015/16.	Director of Clinical Services	2014/15 – 2015/16 recurrently	3 in 2015/16
6. Failure to sustain an engaged and effective workforce	Mitigate additional agency costs incurred by investment in sickness reduction measures.	£0.5 million per annum recurrent investment in measures to reduce sickness rates, to reduce the agency expenditure levels.	Director of Clinical Services	2015/16 recurrently	3 in 2015/16
7. Failure to deliver the required transformation of services	Investment of £1.0 million in 2014/15 to ensure capacity is in place to deliver planned corporate savings.	£1.0 million investment from 2014/15 (£0.5 million recurrently) in transformation team capacity to enable delivery of corporate savings of an additional £3.0 million per annum.	Director of Clinical Services	2014/15 recurrently	3 in 2014/15
8. Failure to deliver the benefits of strategic partnerships	Direct costs will be reduced by £1.5m as income of £3.0m is lost from R&D.	50% mitigation of the potential R&D and education and training income loss through partnership network.	Chief Executive	2015/16 recurrently	3 in 2015/16

Sensitivity analysis on the key risks

7.53 This section examines the potential sensitivity of the Trust's income, cost and cash projections to the risk management of the scenarios set out above. The financial model that underpins this IBP is posited on the base case scenario. This represents the Trust's assessment of the most likely future outlook and is built on:

- Growth and inflation assumptions that seek to recognise the difficult current economic climate.

- Current views on changing demand and market share, including forecast demographic changes, commissioner plans, QIPP demand management, and specific targeted growth in some defining and specialist service developments (as set out in Chapters 5 and 6).

7.54 Several sensitivities have been modelled to examine the eight key risks outlined above. These sensitivities are described in the tables below along with the impact each has, before mitigations are applied, on the income and expenditure position, cash balances, liquidity and the Financial Risk Rating.

Base Case							
		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	8.3	8.2	8.3	8.2	8.2
Cash at bank at year-end	£M	96.5	98.7	99.0	95.2	94.3	92.9
Liquidity	days	14	27	30	32	29	29
Financial risk rating	1–5	3	3	3	3	4	4
I&E surplus margin	%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%

1a. Failure to maintain quality of patient services - partial loss of CQUIN							
Description of sensitivity Failure to deliver quality services results in loss of third of CQUIN funding							
Impact on LTFM Reduced NHS acute activity income of £5.2M each year (real terms) from 2014/15, being one third of full planned value.							
Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	3.2	3.3	3.4	3.5	3.6
Cash at bank at year-end	£M	96.5	93.7	89.0	80.4	74.8	68.7
Liquidity	days	14	27	27	27	22	20
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.4%	0.4%	0.4%	0.4%	0.4%

1b. Failure to maintain qualitiy of patient services - failure to meet CQUIN gateway							
Description of sensitivity Failure to deliver quality threshold results in loss of all CQUIN funding							
Impact on LTFM Reduced NHS acute activity income of £15.7M each year (real terms) from 2014/15.							
Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-6.9	-6.6	-6.2	-6.0	-5.8
Cash at bank at year-end	£M	96.5	83.7	69.2	50.9	35.8	20.4
Liquidity	days	14	27	22	17	8	1
Financial risk rating	1–5	3	3	3	3	2	2
I&E surplus margin	%	1.0%	-0.9%	-0.8%	-0.8%	-0.7%	-0.7%

2a. Failure to maintain financial sustainability - CIP							
Description of sensitivity Failure to deliver Divisional General Efficiency savings							
Impact on LTFM An increase of operating expenditure due to underachievement of CIP programme of £11.5M per annum from 2014/15, accumulating to £57.3M in 2018/19.							
Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-3.4	-15.7	-28.6	-42.3	-56.6
Cash at bank at year-end	£M	96.5	87.1	63.6	23.5	-27.7	-93.7
Liquidity	days	14	26	23	14	-6	-28
Financial risk rating	1–5	3	3	2	2	1	1
I&E surplus margin	%	1.0%	-0.4%	-1.9%	-3.5%	-5.2%	-6.9%

2b. Failure to maintain financial sustainability - Tariff Deflator

Description of sensitivity
Financial failure due to reduced tariffs reflecting Monitor's downside case implied efficiency levels.

Impact on LTFM
An increase in the tariff deflator by up to 0.5% in 2014/15, rising to 0.8% in subsequent years in line with Monitor's downside assessment, resulting in a nominal reduction of NHS acute activity income of £3.8M in 2014/15, rising to a cumulative £27.1M in 2018/19.

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	4.5	-1.6	-6.8	-12.6	-18.2
Cash at bank at year-end	£M	96.5	94.9	85.5	66.7	45.0	17.3
Liquidity	days	14	27	28	25	15	5
Financial risk rating	1–5	3	3	3	3	3	2
I&E surplus margin	%	1.0%	0.5%	-0.2%	-0.9%	-1.6%	-2.3%

3a. Failure to maintain operational performance - DToC

Description of sensitivity
Additional operating costs due to continuing activity from delayed transfers of care

Impact on LTFM
Additional operating costs of £3.6M pa funded at 50% marginal income; additional loss of income due to crowding out of other income (opportunity cost) of £2M pa; additional capital costs of £10M in 2014/15, resulting in additional depreciation of £1M pa from 2015/16

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	3.4	2.1	2.1	1.9	1.7
Cash at bank at year-end	£M	96.5	84.5	79.8	70.9	64.7	57.8
Liquidity	days	14	26	23	22	17	15
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.4%	0.3%	0.3%	0.2%	0.2%

3b. Failure to maintain operational performance - Fines

Description of sensitivity
Reduction of income due to fines

Impact on LTFM
Reduction of income by £14M, around 2% of NHS clinical income

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-5.2	-4.9	-4.6	-4.5	-4.2
Cash at bank at year-end	£M	96.5	85.4	72.5	55.8	42.2	28.3
Liquidity	days	14	27	23	19	10	4
Financial risk rating	1–5	3	3	3	3	2	2
I&E surplus margin	%	1.0%	-0.6%	-0.6%	-0.6%	-0.6%	-0.5%

4. Mismatch with Commissioners' plans

Description of sensitivity
Failure to reduce activity.

Impact on LTFM
Retention of operating costs of £23M due to failure to achieve planned activity reductions from 2014/15 to 2015/16. This is partly offset by payment at marginal rate of 30%.

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	2.4	-6.6	-10.3	-11.2	-12.2
Cash at bank at year-end	£M	96.5	92.9	78.7	57.0	36.6	14.8
Liquidity	days	14	26	26	21	10	1
Financial risk rating	1–5	3	3	3	3	2	2
I&E surplus margin	%	1.0%	0.3%	-0.8%	-1.3%	-1.4%	-1.5%

5a. Loss of share of current and potential markets - Specialist Income

Description of sensitivity
Loss of forward income from Specialist services

Impact on LTFM
Loss of £4M planned additional income from growth in specialist activity from 2014/15.

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	4.5	4.4	4.6	4.6	4.7
Cash at bank at year-end	£M	96.5	94.9	91.4	83.9	79.4	74.4
Liquidity	days	14	27	28	28	24	22
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.5%	0.5%	0.6%	0.6%	0.6%

5b. Loss of share of current and potential markets - overachievement of activity reduction plans

Description of sensitivity
Loss of market share due to overachievement of reduction in elective activity

Impact on LTFM
Additional loss of income through overachievement of elective activity reduction of £4.6M in 2014/15, rising to £7.8M pa from 2015/16, without linked reduction of cost.

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	3.8	0.9	1.0	1.1	1.3
Cash at bank at year-end	£M	96.5	94.2	87.2	76.2	68.2	59.8
Liquidity	days	14	27	27	26	20	16
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.5%	0.1%	0.1%	0.1%	0.2%

6. Failure to sustain an engaged and effective workforce

Description of sensitivity
Increased sickness; absence and turnover due to disengaged staff

Impact on LTFM
Increased premium pay cost to cover absent staff, averaging £6M pa, being 1% of substantive workforce cost (a rise in sickness rates from 3% to 4%) covered by agency staff at a average rate of 140% of substantive costs.

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	1.9	1.8	1.9	1.8	1.8
Cash at bank at year-end	£M	96.5	92.3	86.2	76.1	68.8	61.0
Liquidity	days	14	26	26	25	20	17
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.2%	0.2%	0.2%	0.2%	0.2%

7. Failure to deliver the required transformation of services

Description of sensitivity
Failure to achieve corporate CIP plans

Impact on LTFM
Increased operating costs of £3.0M in 2014/15 accumulatively to £15.2M in 2018/19

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	5.2	1.8	-1.6	-5.2	-9.0
Cash at bank at year-end	£M	96.5	95.7	89.6	76.4	62.2	43.8
Liquidity	days	14	26	28	27	19	13
Financial risk rating	1–5	3	3	3	3	3	2
I&E surplus margin	%	1.0%	0.6%	0.2%	-0.2%	-0.6%	-1.1%

8. Failure to deliver the benefits of strategic partnerships

Description of sensitivity
Loss of R&D and education/training revenue

Impact on LTFM
Loss of £3M annually from 2014/15

Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	5.3	5.1	5.1	5.0	4.9
Cash at bank at year-end	£M	96.5	95.7	92.8	86.0	81.9	77.2
Liquidity	days	14	27	28	29	25	23
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.6%	0.6%	0.6%	0.6%	0.6%

Downside scenario analysis

7.55 The sensitivities set out above to model the impact of the eight key risks are aggregated together to form the downside scenario.

7.56 In aggregating the sensitivities a percentage probability has been applied to each to reflect the Trust's assessment of the likelihood of each risk crystallising in a combined downside scenario. The probabilities against each risk arising in the combined downside scenario are set out below.

Probabilities assigned to each risk in the Downside case	
Risk	**Probability of risk crystalising in downside case (%)**
Failure to maintain quality of patient services - partial loss of CQUIN	90%
Failure to maintain quality of patient services - failure to meet CQUIN gateway	10%
Failure to maintain financial sustainability - CIP	25%
Failure to maintain financial sustainability - Tariff Deflator	100%
Failure to maintain operational performance - DToC	75%
Failure to maintain operational performance - Fines	25%
Mismatch with Commissioners' plans	50%
Loss of share of current and potential markets - Specialist Income	25%
Loss of share of current and potential markets - overachievement of activity reduction plans	0%
Failure to sustain an engaged and effective workforce	50%
Failure to deliver the required transformation of services	50%
Failure to deliver the benefits of strategic partnerships	50%

7.57 This downside case is summarised, before any mitigation, in the following table.

Combined Downside							
Impact before mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-19.4	-34.7	-46.2	-56.3	-65.9
Cash at bank at year-end	£M	96.5	64.3	22.6	-34.0	-98.5	-173.0
Liquidity	days	14	26	12	-5	-32	-61
Financial risk rating	1–5	3	2	1	1	1	1
I&E surplus margin	%	1.0%	-2.4%	-4.3%	-5.8%	-7.1%	-8.3%

7.58 As can be seen, if this downside scenario were to materialise the Trust would need to implement a number of mitigation plans so that it retained:

- its capacity to generate annual surpluses from its operations;
- cash balances at a level allowing it to operate efficiently and meet all of its cash obligations, while maintaining some cash flexibility; and
- a Financial Risk Rating of at least 3 from 2014/15.

7.59 To achieve this, the Trust would implement a set of measures against each key risk. These mitigating actions are shown in the tables below.

1a. Failure to maintain quality of patient services - partial loss of CQUIN

Description of sensitivity
Failure to deliver quality services results in loss of third of CQUIN funding

Impact on LTFM
Reduced NHS acute activity income of £2.6M over the first half of 2014/15, being one third of full planned value. Investment to restore quality of £3.1M increases operating costs from start of 2014/15 and returns CQUIN income to planned level (£15.7M pa) from second half of 2014/15.

Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	2.6	4.9	4.8	4.7	4.6
Cash at bank at year-end	£M	96.5	93.0	90.0	82.8	78.4	73.3
Liquidity	days	14	26	27	27	23	21
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.3%	0.6%	0.6%	0.6%	0.6%

1b. Failure to maintain qualitiy of patient services - failure to meet CQUIN gateway

Description of sensitivity
Failure to deliver quality threshold results in loss of all CQUIN funding

Impact on LTFM
Reduced NHS acute activity income of £7.9M over the first half of 2014/15. Recurrent investment to restore quality of £9.4M increases operating costs from start of 2014/15 and returns CQUIN income to planned level (£15.7M pa) from second half of 2014/15.

Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-9.0	-1.7	-2.0	-2.4	-2.7
Cash at bank at year-end	£M	96.5	81.6	71.9	58.1	46.5	34.2
Liquidity	days	14	26	21	18	11	6
Financial risk rating	1–5	3	3	3	3	3	2
I&E surplus margin	%	1.0%	-1.1%	-0.2%	-0.2%	-0.3%	-0.3%

7.60 The risk relating to failure to deliver quality of patient services has been modelled firstly through a sensitivity assessing failure to deliver all of the CQUIN targets, resulting in a loss of 33% of the

planned CQUIN (£5.2 million), and secondly on a sensitivity assessing failure to meet the CQUIN gateway requirements, leading to the loss of all CQUIN (£15.7 million).

7.61 The failure to deliver all of the CQUIN targets would need to be mitigated by making an investment of £3.1 million in additional staffing and related non-pay to tackle the areas causing the CQUIN targets to be missed. This would then turn around performance from Q3 of 2014/15 to ensure the targets are met from that point.

7.62 The failure to meet the CQUIN gateway would require decisive mitigating action with a recurrent investment of £9.4 million in additional staffing and related non-pay from the start of 2014/15 to improve the quality of patient services. This rapid action would be necessary to decisively tackle the potential reputational risk and associated loss of income at an early stage. This mitigating action would then turn around performance from Q3 of 2014/15 to ensure the targets are met from that point (with associated CQUIN income).

2a. Failure to maintain financial sustainability - CIP

Description of sensitivity
Failure to deliver Divisional General Efficiency savings

Impact on LTFM
An increase of operating expenditure due to underachievement of CIP programme of £11.5M per annum from 2014/15, accumulating to £57.3M in 2018/19. Mitigated by bringing forward strategic saving plans from future years to halve the impact from the second half of 2014/15.

Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-0.5	-3.7	-10.2	-17.0	-24.3
Cash at bank at year-end	£M	96.5	90.0	78.4	56.4	30.3	-3.5
Liquidity	days	14	26	25	21	10	-2
Financial risk rating	1–5	3	3	3	3	2	2
I&E surplus margin	%	1.0%	-0.1%	-0.5%	-1.2%	-2.1%	-3.0%

2b. Failure to maintain financial sustainability - Tariff Deflator

Description of sensitivity
Financial failure due to reduced tariffs reflecting Monitor's downside case implied efficiency levels.

Impact on LTFM
An increase in the tariff deflator by up to 0.5% in 2014/15, rising to 0.8% in subsequent years in line with Monitor's downside assessment, resulting in a nominal reduction of NHS acute activity income of £3.8M in 2014/15, rising to a cumulative £27.1M in 2017/18. No mitigation.

Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	4.5	-1.7	-7.0	-12.8	-18.4
Cash at bank at year-end	£M	96.5	94.9	85.3	66.4	44.6	16.6
Liquidity	days	14	27	28	25	15	5
Financial risk rating	1–5	3	3	3	3	3	2
I&E surplus margin	%	1.0%	0.5%	-0.2%	-0.9%	-1.6%	-2.3%

7.63 Risks relating to failure to maintain financial sustainability have been modelled firstly through a sensitivity on failure to deliver Divisional general efficiency savings (£11.5 million per annum) and secondly on a higher tariff deflator to reflect Monitor's views published in April 2012 on the higher level of implied efficiency requirement within a downside case.

7.64 The savings shortfall would need to be mitigated by bringing forward strategic savings plans from future years. If the downside were to materialise on the tariff deflator then the Trust would need to advance some of the global mitigation plans described at 7.76 below on the mitigated downside case.

7.65 Risk relating to failure to maintain operational performance has been modelled through two sensitivities. Firstly, through additional costs of £3.6 million per annum to operate three wards due to failure to reduce delayed transfers of care (DToC) plus the consequent exclusion of other clinical acute activity of £2.0 million per annum (opportunity cost). The consequence of having to continue running three additional wards to provide care for delayed patients would also require a £10.0 million one-off capital investment in ageing building stock on the Churchill site and consequent revenue implications. This expenditure would be required to maintain patient treatment within a safe ward environment that meets modern standards. No specific mitigation has been modelled against this operational performance relating to DToC, which will be addressed by the global set of mitigation plans outlined at 7.76 below.

3a. Failure to maintain operational performance - DToC							
Description of sensitivity Additional operating costs due to continuing activity re delayed transfers of care							
Impact on LTFM Additional operating costs of £3.6M pa funded at 50% marginal income; additional loss of income due to crow ding out of other income (opportunity cost) of £2M pa; additional capital costs of £10M in 2013/14, resulting in additional depreciation of £1M pa from 2015/16. No mitigation.							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	3.4	2.1	2.1	1.9	1.7
Cash at bank at year-end	£M	96.5	84.5	79.8	70.9	64.7	57.8
Liquidity	days	14	26	23	22	17	15
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.4%	0.3%	0.3%	0.2%	0.2%

7.66 The second sensitivity modelled in relation to the failure to maintain operational performance is the impact of resulting fines in contracts equivalent to 2% of patient care income (£14.0 million). This has been mitigated by an additional investment of £3.5 million in clinical pay and non-pay expenditure in 2014/15 to address the issues leading to fines being triggered in contracts, to avoid further triggering of fines after quarter 2 of 2014/15.

3b. Failure to maintain operational performance - Fines							
Description of sensitivity Reduction of income due to fines							
Impact on LTFM Reduction of income by £7M, around 2% of NHS clinical income, over the first six months of 2014/15. An additional investment in operating costs from start of 2014/15 of £3.5M pa (25% of potential annual loss) restores income from second half of 2014/15.							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-2.0	4.5	4.4	4.3	4.1
Cash at bank at year-end	£M	96.5	88.4	85.0	77.5	72.6	67.1
Liquidity	days	14	26	24	25	20	18
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	-0.2%	0.6%	0.5%	0.5%	0.5%

7.67 The risk shown below of a mismatch with Commissioners' plans and consequent failure to deliver planned activity reductions of £23.0 million over three years has been mitigated by a non-recurrent investment of £10 million in 2014/15 in establishing a GP referral hub to deliver the planned activity reductions from the second half of 2014/15.

4. Mismatch with Commissioners' plans							
Description of sensitivity Failure to reduce activity.							
Impact on LTFM Retention of operating costs of £4.8M due to failure to achieve planned activity reduction in the first half of 2014/15, A non-recurrent investment of £10M over 2014/15 to establish OUH as a referral hub brings the activity reduction back on plan from the second half of 2014/15.							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-4.6	8.2	8.2	8.2	8.2
Cash at bank at year-end	£M	96.5	86.2	86.0	82.2	81.2	79.7
Liquidity	days	14	26	23	25	23	23
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	-0.6%	1.0%	1.0%	1.0%	1.0%

7.68 The risk relating to loss of market share for the Trust has been modelled as two sensitivities. Firstly as a failure to gain a share of new markets by not realising £4.0 million of the planned specialist activity growth in 2014/15 within the base case. This has been mitigated by the removal of the associated marginal costs relating to the additional activity over the same period (£2.8 million).

5a. Loss of share of current and potential markets - Specialist Income							
Description of sensitivity Loss of forward income from Specialist services							
Impact on LTFM Loss of £4M planned additional income from growth in specialist activity from 2014/15. Mitigated by removal of associated marginal costs of £2.8M over the same period.							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	7.3	7.4	7.6	7.7	7.9
Cash at bank at year-end	£M	96.5	97.7	97.2	92.7	91.3	89.5
Liquidity	days	14	27	29	31	28	28
Financial risk rating	1–5	3	3	3	3	4	4
I&E surplus margin	%	1.0%	0.9%	0.9%	0.9%	0.9%	1.0%

7.69 A second sensitivity has been modelled on loss of market share relating to over achievement of planned elective inpatient activity reductions (of £4.6 million in 2014/15, rising to £7.8 million by 2015/16). This is mitigated by the reduction in variable costs associated with that activity. Fixed costs are assumed to remain retained in the Trust.

5b. Loss of share of current and potential markets - overachievement of activity reduction plans							
Description of sensitivity Loss of market share due to overachievement of reduction in elective activity							
Impact on LTFM Additional loss of income through overachievement of elective activity reduction of £4.6M in 2014/15, rising to £7.8M pa from 2015/16, mitigated by reduction in variable costs; fixed costs are assumed to be retained.							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	7.1	6.5	6.9	7.1	7.5
Cash at bank at year-end	£M	96.5	97.5	96.0	90.7	88.7	86.6
Liquidity	days	14	27	29	30	27	27
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.9%	0.8%	0.8%	0.9%	0.9%

7.70 The risk relating to failure to sustain an engaged and effective workforce has been modelled through a sensitivity reflecting a potential financial impact averaging £6.0 million each year relating to increased agency expenditure costs, compared to the base case, caused by increasing sickness rates by 1%.

6. Failure to sustain an engaged and effective workforce							
Description of sensitivity Increased sickness; absence and turnover due to disengaged staff							
Impact on LTFM Increased premium pay cost to cover absent staff, averaging £6M in 2014/15 & 2015/16 being 1% of substantive workforce cost (a rise in sickness rates from 3% to 4%) covered by agency staff at a average rate of 140% of substantive costs. An investment of £500k pa from 2015/16 restores sickness levels to 3% from 2016/17, removing the agency usage.							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	1.9	1.3	7.7	7.6	7.6
Cash at bank at year-end	£M	96.5	92.3	85.7	81.4	79.9	77.8
Liquidity	days	14	26	26	25	22	22
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.2%	0.2%	0.9%	0.9%	0.9%

7.71 This financial risk has been mitigated by a recurrent investment of £0.5 million in implementing an improved sickness management scheme, along with increased training and exit interviews to address the causes of the increase in sickness absence, and therefore reduce agency usage back to previous levels from 2016/17.

7.72 The risk relating to failure to deliver the required transformation of services has been modelled as a sensitivity relating to a lack of capacity to focus on the delivery of the planned corporate efficiency savings (£3.0 million each year from 2014/15). This has been mitigated by a recurrent investment in transformation capacity of £0.5 million (and an additional non-recurrent £0.5 million of expenditure to establish the transformation team in 2014/15). This then ensures the capacity is in place to deliver the corporate efficiency savings of £3.0 million per annum from 2015/16.

7. Failure to deliver the required transformation of services							
Description of sensitivity Failure to achieve corporate CIP plans							
Impact on LTFM Increased operating costs of £3.0M in 2014/15 due to unattained CIP. Investment in Transformation of £500k pa plus an additional £500k non-recurrent set-up cost in 2014/15 restores CIP achievement from 2015/16.							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	4.2	4.5	4.5	4.3	4.2
Cash at bank at year-end	£M	96.5	94.7	91.2	83.7	78.9	73.5
Liquidity	days	14	26	27	28	23	21
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.5%	0.6%	0.5%	0.5%	0.5%

7.73 The risk of failure to deliver the benefits of strategic partnerships has been modelled as a sensitivity regarding the potential resultant loss of research and development and education and training revenue of £3.0 million (recurrently) from 2014/15. This risk has been partially mitigated by scaling back associated pay costs by £1.5 million (recurrently) from 2015/16.

8. Failure to deliver the benefits of strategic partnerships							
Description of sensitivity Loss of R&D and education/training revenue							
Impact on LTFM Loss of £3M annually from 2014/15, mitiagated by reduction in related cost of £1.5M pa from 2015/16.							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	5.3	6.6	6.7	6.6	6.6
Cash at bank at year-end	£M	96.5	95.7	94.4	89.1	86.6	83.5
Liquidity	days	14	27	28	30	26	25
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.6%	0.8%	0.8%	0.8%	0.8%

Mitigated downside case

7.74 The mitigations shown above against each identified risk have then been combined in the mitigated Downside case after applying the percentage probabilities of each risk crystallising (as shown at 7.56 above).

7.75 The mitigated downside case is summarised in the table below.

Combined Downside							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	-23.1	-17.6	-21.6	-28.7	-35.7
Cash at bank at year-end	£M	96.5	60.8	35.8	3.3	-33.7	-78.1
Liquidity	days	14	26	11	1	-15	-32
Financial risk rating	1–5	3	2	2	2	2	1
I&E surplus margin	%	1.0%	-2.8%	-2.2%	-2.7%	-3.6%	-4.5%

7.76 This Downside case (after specific mitigations against each individual risk modelled) leaves a requirement for further more radical recurrent mitigation plans to sustain a surplus each year, and maintain a FRR of at least 3 in each year.

7.77 Any organisation needs to have a set of more radical risk mitigation schemes in reserve, in the event of a downside scenario arising. The Trust is actively pursuing a set of further, more radical risk mitigations, such as extending the review of support services in the Trust, further staffing measures, telemedicine, site rationalisation, reduction in space utilisation and sale of premises.

7.78 These more radical mitigations have been modelled in the combined downside case (after specific mitigations against each individual risk have been included). The result is summarised below.

Combined Downside with Global Mitigations							
Impact after mitigation		2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Retained surplus	£M	8.4	5.8	7.3	7.2	7.3	7.1
Cash at bank at year-end	£M	96.5	89.5	89.5	85.7	84.4	82.8
Liquidity	days	14	27	25	28	25	25
Financial risk rating	1–5	3	3	3	3	3	3
I&E surplus margin	%	1.0%	0.7%	0.9%	0.9%	0.9%	0.9%

7.79 This downside case after global mitigations have been applied shows that OUH can deliver a sustainable financial position over the five-year period, with cash balances of between £82.8 million and £89.5 million, surpluses each year averaging 0.9% of income and maintaining a Financial Risk Rating of 3 each year.

Conclusion

7.80 This analysis presents a prudent set of sensitivities modelling the financial impact of the eight key risks for OUH which are outlined in this chapter. These are combined into a downside case which, when mitigations are applied, illustrates that the Trust will still achieve a financial risk rating of 3 in each year from 2014/15 to 2018/19.

Chapter 8
Leadership and Workforce

8. Leadership and Workforce

Introduction

8.1. OUH's Workforce Strategy for 2013-2018 sets out to enable the Trust to provide a workforce that is appropriately sized, skilled, motivated, informed and engaged to deliver the Trust's vision and strategy.

8.2. Its development included consultation with and the participation of stakeholders including the Board, Trust Management Executive, Workforce Committee, the Joint Personnel Committee (with the University of Oxford), divisional management teams, staff and trade unions.

8.3. It aims to build on OUH's strengths to give it sufficient agility and flexibility to maintain and improve its performance to meet the challenges ahead.

8.4. OUH recognises that new ways of working and new models of care are an essential part of its future success as an organisation. It supports staff to embrace change whilst remaining focused on the needs of patients.

8.5. The Trust is committed to ensuring, in tandem with its improving efficiency and effectiveness, that it is open and transparent and maximises staff engagement. In this way a virtuous circle results, with high value care and efficiency developed through a motivated, skilled but smaller workforce.

8.6. The overarching aims and objectives of the Workforce Strategy are to:

- engage staff so that they feel valued and are proud to work for OUH;
- empower and enable staff to improve quality, services and value;
- contribute to improving patient experience and outcomes through improved staff experience and engagement;
- transform the workforce in terms of improved capability, efficiency, performance and productivity;
- make the best people and the appropriate skills available at the right time, in the right place, at the right cost;
- provide leaders with the capability to transform services and give staff opportunities to deliver to the very best of their ability;
- drive the Trust values, attitudes and behaviours in interactions and performance at all levels;
- encourage a constant quest for learning and improvement so that innovation and research are embraced;
- enable the workforce to respond quickly and flexibly to organisational change;
- facilitate the adoption of partnership working across the health, social care and wider community.

8.7. The Workforce Strategy is built on the core values of Excellence, Compassion, Respect, Delivery, Learning and Improvement which drive attitudes, behaviours, interactions and performance throughout the Trust. These values have been integrated into policies and procedures for recruitment, induction, appraisal, standard setting, customer care, equality and diversity, raising concerns (whistleblowing), performance management and staff recognition.

8.8. Over the next five years the Trust's values will continue to be enshrined in its leadership and the day-to-day behaviours of all staff. In this way, its staff will be able to trace a 'values pathway' during the different aspects of their experience of working at OUH and be aware of their individual role and contribution in achieving its strategic objectives.

8.9. The cumulative effect of this will be the creation of a distinctive, authentic and sustainable values-

based culture giving the Trust a clear employer brand where OUH is recognised as a great place to work, evidenced by improved annual staff and patient survey results. By 2018 the Trust anticipates being in the top 10% of acute Trusts for staff engagement.

Leadership and Management Arrangements

8.10. A key role for the Board is to ensure that proper systems and processes are in place to measure and monitor the effectiveness, efficiency and economy of the Trust's services and the quality of its healthcare delivery (*FT Code of Governance*).

8.11. The Board consists of executive and non-executive directors, led by a non-executive Chairman. The Chairman and Chief Executive have key roles in leading the external and public relationships of the Trust and in establishing the appropriate internal environment.

8.12. The Chairman is responsible for the overall conduct of the Trust, for managing the Board and for appointing and reviewing the performance of the Chief Executive and, jointly with him, of other executive directors.

8.13. The Chief Executive is personally responsible, as Accountable Officer, for ensuring that the organisation works effectively in accordance with national policy and public service values, and maintains proper financial stewardship. The Chief Executive is directly accountable to the Board for ensuring that its decisions are implemented.

8.14. Non-executive directors have a particular responsibility to challenge the performance of the executives and Trust management. All members of the Board contribute to developing and making progress on the Trust's agreed strategic direction. They are also responsible for ensuring that the concerns and interests of the public and outside world are properly integrated into decision-making and, with the Chairman, for monitoring the executive management of the organisation.

8.15. In preparation for authorisation as a Foundation Trust, a Senior Independent Director designate has been appointed to provide an independent voice for non-executive directors and feedback to the Chairman. OUH's non-executive directors have a wide range of experience in the NHS and other industries. A number have clinical backgrounds as well as substantial management experience.

8.16. OUH's executive directors are responsible for the management of the Trust, including the delivery of services, the management of staff and resources and the development of plans and strategies. They have particular responsibilities for the capacity and capabilities of the Trust, which involves working closely with divisional staff, supporting the work of the clinically-led Divisions and their directorates and ensuring that corporate duties and objectives are met.

8.17. The Board has the following membership (*denoting a voting Board member):

- Chairman*
- Six Non-executive Directors*
- Associate Non-executive Director
- Chief Executive*
- Chief Nurse*
- Director of Clinical Services*
- Director of Finance and Procurement*
- Medical Director*
- Director of Assurance
- Director of Development and the Estate
- Director of Planning and Information
- Director of Workforce

8.18. The Board is supported by a Head of Corporate Governance who is an experienced company secretary.

8.19. The roles, skills and experience of Board members are described below.

Dame Fiona Caldicott, Chairman – appointed March 2009 (Non-executive Director from 2002)*

Dame Fiona is an Honorary Consultant Psychiatrist. As President of the Royal College of Psychiatrists from 1993-1996, she was also chairman of the Academy of Medical Royal Colleges from 1995-1996. She was made DBE in 1996 for services to medicine and psychiatry.

From 1996-1997 she chaired the Caldicott Committee on patient identifiable data for the National Health Service Executive, and since June 2011 has been the chairman of the National Information Governance Board. Also from 1996-1998 she chaired a working group of the Nuffield Council on Bioethics that produced a report on Genetics and Mental Disorder.

She was a Trustee of the Nuffield Trust from 1999-2008 and is currently a Trustee of the Daphne Jackson Trust. She is a former President of the British Association for Counselling and Psychotherapy, was Principal of Somerville College in the University of Oxford from 1996-2010, and a Pro-Vice-Chancellor of the University from 2002-2010.

Dame Fiona is the vice-chairman of the Remuneration & Appointments Committee

Sir Jonathan Michael, Chief Executive – appointed April 2010*

Sir Jonathan qualified as a doctor at St Thomas' Hospital Medical School and became a Fellow of the Royal College of Physicians (London) in 1985.

He became increasingly involved in hospital management during the 1990s, being appointed Clinical Director, then Medical Director and finally Chief Executive of the University Hospitals Birmingham NHS Trust. In 2000 he was recruited to the position of Chief Executive of Guy's and St Thomas' Hospitals NHS Trust in London, an organisation that he led to become one of the first wave of Foundation Trusts in the NHS.

He has held regional and national roles including membership of the UK Clinical Research Collaboration Board, Chairmanship of the Board of NHS Innovations (London), and Chairmanship of the Association of UK University Hospitals and Chairmanship of the Board of the NHS Foundation Trust Network. Sir Jonathan was knighted in the New Year's Honours in 2005 for services to the NHS.

In the same year he was elected Fellow of King's College London in recognition of his contribution to the relationship between the health service and higher education. In 2007 he was appointed by the Secretary of State for Health to chair an Independent Inquiry into the access to healthcare for children and adults with learning disabilities. Healthcare For All was published in July 2008.

Before joining the former Oxford Radcliffe Hospitals NHS Trust in 2010, Sir Jonathan was Managing Director of BT Health. He was appointed a Trustee of the King's Fund in 2012.

Professor Sir John Bell, Non-executive Director – appointed November 2009*

Sir John attended Oxford as a Rhodes Scholar to train in medicine and undertook postgraduate training in London and at Stanford University. He returned to Oxford as a Wellcome Trust Senior Clinical Fellow in 1987 and was elected to the Nuffield Professorship of Clinical Medicine in Oxford in 1992.

In 2002 he became the Regius Professor of Medicine at the University of Oxford and in 2008 was made a Fellow of the Royal Society and a Knight Bachelor for his services to Medical Science. He was President of the Academy of Medical Sciences from 2006-2011.

In December 2011 he was appointed as one of two Life Sciences Champions as part of UK Government's announcement of a Life Sciences Strategy and the NHS Chief Executive's Review Innovation, Health and Wealth: Accelerating Adoption and Diffusion in the NHS*.*

Sir John chairs the Remuneration & Appointments Committee.

Mr Alisdair Cameron, Non-executive Director – appointed May 2009*

Alisdair is a Chartered Accountant and was formerly a partner with Arthur Andersen. He is also a trustee of the e-Learning Foundation. He was Finance Director of British Gas, part of Centrica, a FTSE 100 company. Alisdair joined Centrica in 2002, initially as Head of Internal Audit and Risk Management and then as Group Financial Controller.

Alisdair is the Managing Director of SME Energy for British Gas Business, having taken up this appointment on 1 May 2012.

Alisdair is a member of the Audit Committee and the Remuneration & Appointments Committee.

Mr Chris Goard, Non-executive Director and Senior Independent Director (designate) – appointed November 2011*

Chris is Trustee and Honorary Treasurer of the Genetic Interest Group, an umbrella organisation for over 130 charities and represents the interests of their patient groups with the NHS, Government and Pharmaceutical companies.

Until 31 October 2011 he was Chair of the Nuffield Orthopaedic Centre NHS Trust.

He is a Fellow of the Royal Society of Arts and a Fellow of the Institute of Direct Marketing. He is a member of the Quality Committee and of the Audit Committee and Senior Independent Director designate.

Chris chairs the Finance & Performance Committee and is vice-chairman of the Audit Committee. He is also a member of the Quality Committee and the Remuneration & Appointments Committee.

Mr Geoffrey Salt, Non-executive Director and Vice Chairman – appointed May 2009*

Geoff worked for the John Lewis Partnership for 32 years until his retirement in January 2009. He began as a graduate trainee and joined the Waitrose Board in 1999, initially as Supply Chain Director and then as Director of Selling. He now divides his time between management consultancy, assisting in his wife's local catering business and his NHS-related activities. Geoff is a Trustee of the Nuffield Medical Trust and Oxford Kidney Unit Trust.

Geoff chairs the Quality Committee and is a member of the Finance & Performance Committee and Remuneration & Appointments Committee.

Mrs Anne Tutt, Non-executive Director – appointed December 2009*

Anne is a Chartered Accountant with 25 years' experience as an executive member of private sector boards, mainly as Finance Director in sectors including manufacturing and banking.

Since August 2006 she has had a portfolio of Non-executive Directorships and financial consultancy roles across the public, private and social enterprise sectors.

Anne's portfolio includes being Non-executive and chair of the audit committee of the Identity and Passport Service (an Executive Agency of the Home Office), Non-executive and chair of the finance committee of The Social Investment Business and Section 11 Trustee and chair of the audit committee of the ORH Charitable Funds.

Anne chairs the Audit Committee and is vice-chairman of the Finance & Performance Committee. She is also a member of the Remuneration & Appointments Committee.

Mr Peter Ward, Non-executive Director – appointed December 2009*

Peter is a Chartered Engineer and Member of the Institution of Civil Engineers. He is responsible for business development in the healthcare and emergency services sector for John Laing plc. Having managed a number of hospital developments, including the Children's Hospital and West Wing developments at the John Radcliffe Hospital, He joined John Laing in January 2006.

Peter is vice-chairman of the Quality Committee. He is a member of the Finance & Performance Committee and Remuneration & Appointments Committee.

Professor David Mant OBE, Non-executive Director – appointed April 2010

David has been head of the University of Oxford's Department of Primary Health Care and works as a general practitioner in the NHS. His personal research focuses on the prevention and early diagnosis of common diseases in primary care, particularly childhood infection, cardiovascular disease and stroke. He is also responsible for the clinical teaching of University of Oxford medical students in general practice.

In 2011, he was made an OBE for services to medicine.

David is a member of the Quality Committee.

Professor Edward Baker, Medical Director (Deputy CEO) – appointed September 2010*

Ted was previously the Medical Director of Guy's and St Thomas' NHS Foundation Trust, a position he held for seven years. During his time at Guy's and St Thomas' he saw the organisation through accreditation as a Foundation Trust, a Comprehensive NIHR Biomedical Research Centre and an Academic Health Sciences Centre.

He is a paediatric cardiologist by training and led on the development of the Evelina Children's Hospital that opened in 2005. His research interest is in the magnetic resonance imaging of congenital heart disease which he pioneered in the UK.

In 2008 he published a report for the Department of Health on the reconfiguration of tertiary paediatric services and he led on plans to reconfigure these services in London.

Mr Paul Brennan, Director of Clinical Services – appointed February 2010*

Previously Operations Director/Deputy Chief Executive for Operations at the Dudley Group NHS Foundation Trust, Paul has more than 20 years' experience as a Director at Board level in the NHS with a track record of delivering major service change, service improvement, business development and operational performance.

Paul has led the implementation of the clinically-led organisation.

Mr Mark Mansfield, Director of Finance and Procurement – appointed 2010*

Mark has worked as a board member in a number of NHS organisations including acute, non-acute and primary care trusts.

His most recent acute hospital experience was as Director of Finance and Procurement at Nottingham University Hospitals NHS Trust.

Ms Elaine Strachan-Hall, Chief Nurse – appointed February 2007*

Elaine had over ten years' experience as a nurse director prior to appointment. She is a cardiothoracic nurse with general management experience in medicine.

Elaine has a Master's Degree in Nursing (from Brunel University) and in Business Administration (from Cranfield University). She was awarded a leadership scholarship from the Florence Nightingale Foundation in 2007.

She was appointed in 2012 to the governing body of South Warwickshire Clinical Commissioning Group as its registered nurse.

Ms Sue Donaldson, Director of Workforce – appointed November 2008

Sue has worked in the NHS since 2004, starting as Director of Human Resources and Organisational Development at Gloucester PCT, then at Poole NHS Foundation Trust.

Prior to this, Sue had an extensive Human Resources and operational career with The Post Office, most notably leading pay, contractual and organisational change programmes.

She is a Governor at Oxford and Cherwell Valley College.

Mr Andrew Stevens, Director of Planning and Information – appointed 1999

Andrew joined the NHS in 1982 as a national general management trainee. After posts in North Wales and Manchester, he spent two years as Secretary of the Community Health Council in Swindon. Andrew moved to Hampstead Health Authority in 1988 and undertook a variety of senior planning-related roles in the hospital and community sectors.

He project-managed the Royal Free's first wave NHS Trust application before becoming the Trust's Director of Business Planning.

He is the lead executive for the FT application process and for EPR implementation.

Mr Mark Trumper, Director of Development and The Estate – appointed May 2011

Mark joined the NHS in 2009 as a Board Director at Rotherham NHS Foundation Trust, with responsibility for the effective delivery of capital-led, integrated change programmes across infrastructure, technology and service delivery.

Previously he worked for Accenture Business Consulting, providing advice and leadership on Programme Management, Facilities & Asset Management, Systems Implementation, IT Enabled Change Strategy and Public Sector Outsourcing.

Ms Eileen Walsh, Director of Assurance – appointed May 2011

Eileen began with the NHS as a graduate management trainee, following a career in postgraduate academic scientific research. She has a range of NHS management experience, predominantly at Director level, encompassing Clinical Governance, Corporate Governance, Risk Management and Assurance.

Eileen is an active participant in the national governance agenda as an invited speaker on risk, governance and assurance topics and has a strong interest in influencing national policy. She previously held Director-level roles at University Hospitals Birmingham, Heart of England and Guy's and St Thomas'.

Board Development

8.20. Trust Board development has been a continual process which has been regularly informed by independent evaluation of Board effectiveness.

8.21. Professor Stuart Emslie, Visiting Professor of Healthcare Governance at Loughborough University Business School, completed detailed diagnostic work with Board members in November 2011. His findings informed a Board Development Programme which improved the focus on strategy development and enabled improvements in governance arrangements.

8.22. Work with KPMG UK, concluded in February 2013, strengthened the development plan further. In particular, it refreshed the programme to include more time for strategic debate and visioning to build on the compelling future for the Trust, embracing the benefits of Foundation Trust status and Academic Health Science Network designation. Focus has also been placed on the Board's role in modelling the Trust's values and behaviours.

8.23. Each Board member has a comprehensive annual performance review including a requirement for a personal development plan. Whilst these plans are tailored to individual needs, during 2013/2014 all Board members have agreed to participate in a 360^0 feedback process linked to the NHS Leadership Framework. All executive directors are registered on the NHS Top Leaders Programme. Non-executive directors derive particular benefit from training and support available through the Foundation Trust Network.

8.24. As a Foundation Trust the Board will seek regular feedback from key stakeholders including governors and members, clinical commissioning groups, partner trusts and academic institutions, staff and patients to inform future development needs.

Portfolios

8.25. Areas of responsibility for executive directors have been reviewed to ensure that there are clear lines of accountability and that all key areas of responsibility are held unambiguously by an individual. These portfolios are summarised below. The clinical Divisional management structure is shown in 2.63.

Executive Director	Principal areas of responsibility
Chief Nurse	Professional standards and development for non-medical professionals including nurses, midwives, AHPs and healthcare scientists Education and training for all of the above Equality and diversity Management of healthcare libraries Patient safety and information Patient experience, feedback and involvement
Director of Assurance	Assurance systems Regulation and accreditation Corporate governance and company secretary
Director of Clinical Services	Performance and service improvement and redesign Operational management Delivery of access targets Business continuity management, incident and emergency planning

Executive Director	Principal areas of responsibility
Director of Development and the Estate	Commercial and asset development Estates management, capital development and PFI Facilities management Health and safety
Director of Finance and Procurement	Finance Compliance Procurement Fundraising and charitable funds stewardship Cost improvement programme management
Director of Planning and Information	Strategy, planning and marketing Business planning Commissioning and contracts Media and communications Information management and technology
Director of Workforce	Human resources management Employee engagement Organisational development Leadership development Occupational health Non-clinical education and training including statutory and mandatory training
Medical Director	Professional standards for doctors Responsible Officer for medical revalidation Medical leadership, education and training Quality, clinical governance and risk Research and development Director of Infection Prevention and Control

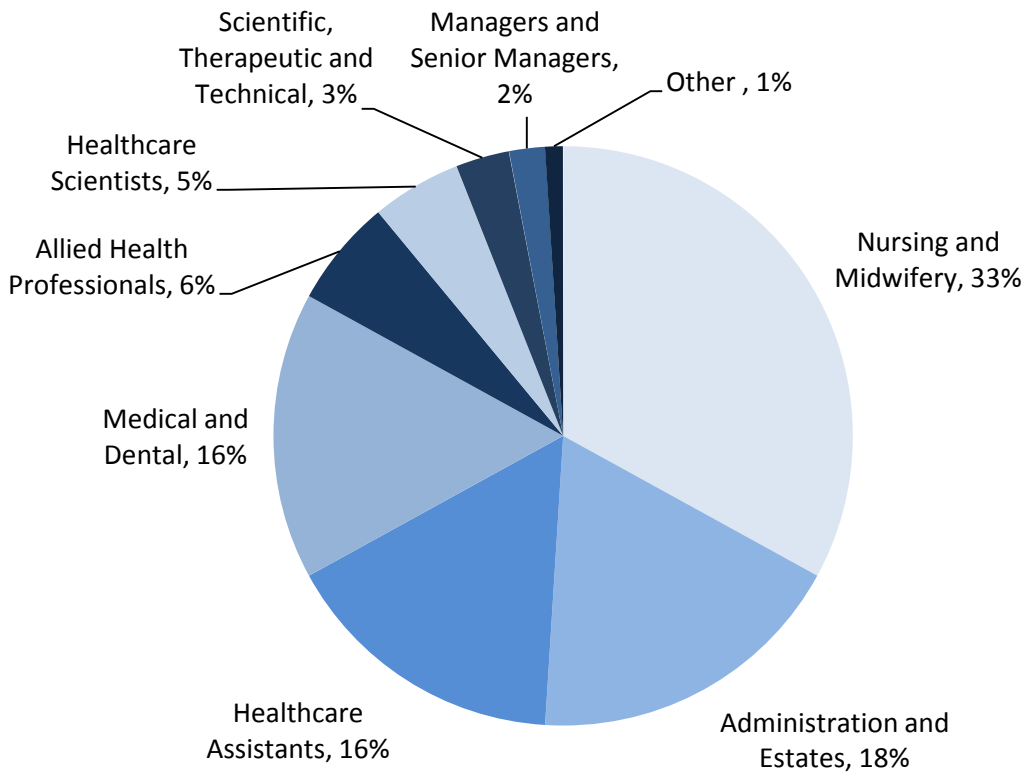
Workforce Profile and Performance Indicators

Profile

8.26. In March 2013, the Trust employed 11,140 people in 9,154 whole-time equivalent (WTE) posts.

8.27. The chart below shows substantive WTEs by staff group.

Staff groups as % of Whole Time Equivalents, March 2013



8.28. OUH benefits from the expertise of academic consultants who are employed by the University of Oxford and hold honorary consultant contracts with the Trust for their clinical contributions.

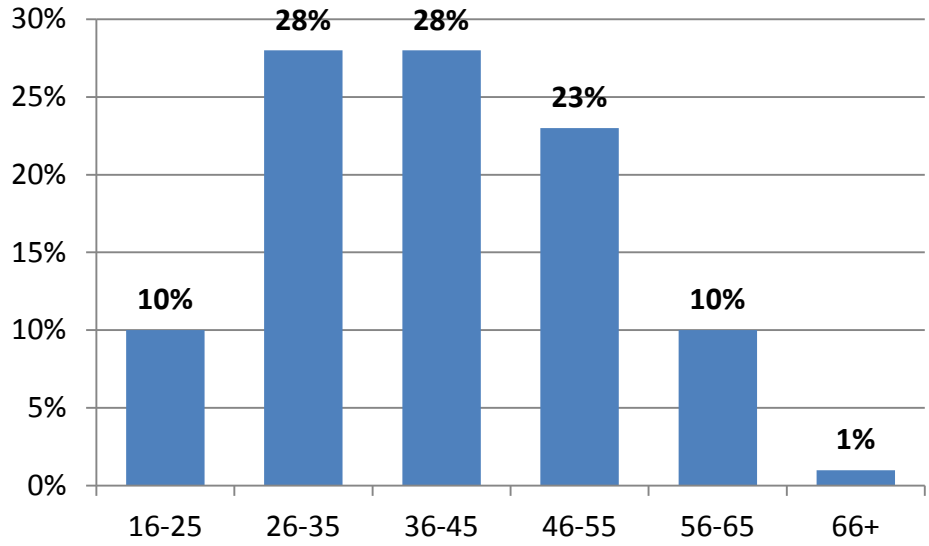
8.29. A similar working agreement with Oxford Brookes University seeks to use the benefits of collaboration to improve patient care.

8.30. 620 facilities staff[20] are employed by the Trust and seconded to third party entities through NHS Retention of Employment (ROE) agreements. These members of staff provide domestic, portering and catering services. The Trust manages the relationship through commercially-based service level agreements.

8.31. The age profile of Trust employees is shown below. It is anticipated that the percentage of employees working beyond the age of 65 years will increase due to demographic changes and modifications to State and NHS pension schemes. This is potentially advantageous to OUH in retaining skills and experience and contributing to a reduction in staff turnover and associated recruitment costs.

[20] Headcount as at 31 March 2013.

Age of Trust employees, March 2013 (Source: ESR)



8.32. Some 62% of staff members are employed full-time and over 77% of members of staff are female.

8.33. The Trust complies with Equality Act 2010 public sector equality duties. OUH has implemented the Equality Delivery System (EDS) to ensure good practice, compliance with legislation, provision of a platform for change and an improvement in demonstrating and realising equality in the workplace.

8.34. Equality objectives have been developed through engagement activities, both internal and external to the Trust and EDS grading activities. Objectives are reviewed at least annually to ensure progress is being made and to determine whether additional objectives should be added. Priorities include:

- 90% of staff members to be assessed as competent in equality and diversity through training and subsequent competency-based assessment;
- Reducing the incidence of bullying and harassment experienced by staff from other staff.

Performance indicators

8.35. In the context of the need for cost reduction, it is important for OUH to have a focus on workforce performance indicators that assist in driving business sustainability.

8.36. In line with expectations for the wider NHS, OUH has committed to reduce and maintain sickness absence at a Trust-wide average of 3% or below. Sickness levels in the Trust fell to 3.1% in 2012/13 from 3.4% in the previous three years. Specific action has been taken through, for example, the introduction of a new sickness absence procedure, improved Occupational Health support, more accurate data for managers, targeted action in directorates and training for managers in dealing with absences.

8.37. Staff Survey findings are used to inform actions by the Trust's Health and Wellbeing Strategy Group. OUH's Health and Wellbeing Strategy has an underpinning philosophy of self-help and individual responsibility, supported by a corporate framework to promote a healthy lifestyle and good practice in relation to workplace health, thereby reducing the risk of absence.

8.38. OUH's target level for sickness absence is below that experienced by comparator trusts. The Health and Social Care Information Centre has reported quarterly sickness levels of just above 4% between April 2012 and December 2012 for the NHS in England. Regional comparators include Southampton at 3.7%, Leicester at 3.4%, Portsmouth at 3.2% and Buckinghamshire Healthcare at 4.2%.

8.39. The pattern of sickness absence is relatively constant within the Trust. 89% of all episodes of sickness and one third of total time lost is due to short term absence of seven days or less. Absence is mainly due to colds/flu (27%), gastrointestinal problems (18%) and headaches/migraines (8%).

8.40. The Trust has experienced an underlying **staff turnover** rate of 11% in previous years, in line with its plans. Some degree of turnover is considered beneficial but excessively high levels are costly in terms of potential disruption to services, especially when some skills are in short supply.

8.41. Generally, in the context of the national economic climate, NHS Trust turnover rates have reduced to within a range of 8-10%. OUH is targeting a reduction in turnover to 10% in 2013/14, reducing to 8% by 2018, to operate within this national range.

8.42. OUH experiences difficulty in recruiting and retaining pharmacists, cardiac staff, diagnostic radiographers, therapeutic radiographers and theatre staff, including operating department practitioners, generally reflecting national staff shortages. Specific recruitment campaigns are undertaken for targeted groups to alleviate shortages. Measures such as the provision of enhanced training and personal development have been introduced to help with retention.

8.43. Nationally and regionally, a review is under way of the number of adult nursing commissions from universities and this has led to an initial increase for OUH of 15% (18 WTE) for 2013/14.

8.44. In the Emergency Department, middle-grade doctors remain a challenge to recruit. International recruitment, a rolling recruitment campaign and a skill mix review of the medical grades employed in the department are some of the current initiatives aimed at ensuring continuity of service provision.

8.45. Actions to improve recruitment and retention in operating theatre roles includes the introduction of a specialist recruitment campaign and a structured development programme for Band 5 and 6 staff, and 'training contracts' are being considered which would require staff to remain in employment for a minimum period during training.

8.46. The Trust has worked to streamline recruitment processes and redesign roles. Improvements have been made to the speed of the recruitment process whilst ensuring compliance with statutory and CQC requirements. Use of a 'time to recruit' KPI plus notice period has been agreed to identify delays in the process. For certain staff groups, a waiting list of successful applicants is maintained with candidates interviewed and pre-employment checks completed such as references, employment eligibility, and professional registration in readiness to offer posts when they become available.

8.47. Values-based interviewing (VBI) has been rolled out in conjunction with the National Society for the Prevention of Cruelty to Children. The development and launch of a values-based induction programme will provide a natural development to support new starters that have been recruited using VBI. These initiatives are intended to help set a positive environment at work and to aid recruitment and retention.

Workforce Plans and Expenditure

8.48. The Trust has aligned workforce plans to the needs of its services.

8.49. Workforce redesign and the development of new roles, which is fundamental to the development of flexible and sustained models of care, have already delivered results and will continue to be introduced. For example:

- As part of its response to delayed transfers of care (DTOC), OUH has developed its Supported Hospital Enhanced Discharge Service. This includes a Community Support Worker role which supports patients after discharge in their homes or other community care settings. Community Support Workers have a local reward package which recognises the need to provide care into night-time hours and to work weekend days without incurring enhanced rates of pay.

- To improve integration of elderly care across organisational boundaries a cultural survey was undertaken, including facilitated discussions with staff from OUH, Oxfordshire County Council and Oxfordshire CCG. This identified barriers on the patient pathway which slowed the discharge of patients. Actions are being taken to remove barriers and improve the patient experience.
- Members of Emergency Department staff have developed new skills and new roles, enabling a more effective distribution of tasks between nursing and medical staff.
- Opportunities have been taken for service-specific clinical nurse specialists to be developed, enhancing the skills available and quality of services provided, e.g. Emergency Nurse Practitioners.
- Expansion is also being sought in the Trust's Assistant Practitioner workforce to enable the management of patient safety and quality with a revised skill mix, linking with the strategic objective of delivering better value healthcare.
- Using the national Modernising Careers programme and based on Benner's model of 'Novice to Expert,' pathways are being developed in each role with associated competencies. The aim is to accelerate service improvements and quality by improving the capability of clinical staff and the consistency of care delivered.
- Job rotation is being considered in specific clinical areas with a view to developing Band 5 nurses in particular to undertake roles in which they can gain skills and experience relevant to areas in which recruitment is more difficult, such as theatres, and to aid retention more generally.

8.50. The Trust has implemented tools to support the management of its key resources. A job planning tool was developed in 2012 in consultation with medical staff. Electronic rostering is being deployed for the majority of clinical staff groups, allowing better planning and reporting of shifts and the assessment of staffing levels across wards, departments and Divisions with the intention of deploying substantive and bank staff most effectively prior to employing more expensive agency workers.

8.51. Whilst growth is anticipated in relation to increased activity and service developments as outlined in Chapter 5, cost improvements and activity reductions (QIPP) are expected to drive a reduction in numbers across staff groups. The cost improvement programme (CIP) has multiple strands which will be realised over the duration of the plan. Specific CIP projects that will result in the removal of posts include changes to working hours and patterns of work; Divisional and departmental restructuring to realise efficiencies; and providing some services through third party entities.

8.52. There are also a number of cost improvements which will be realised through a reduction in pay expenditure which will effectively reduce average pay costs. These include reducing the reliance on premium rate working and use of agency staff through more effective workforce planning and staff rostering; managing attendance and consequently reducing sickness absence costs; improving use of the Trust's nurse bank; managing current flexibilities available within Agenda for Change and other national contracts; managing discretionary leave; salary sacrifice schemes; and plans to promote total reward statements with a choice of benefit selection to retain staff without creating inflationary costs.

8.53. In general, the Trust needs to develop a smaller, more flexible workforce, functioning differently whilst providing continuous care and timely access to services. Workforce plans for skill mix and staff numbers, together with pay expenditure and service changes will be continuously reviewed to make the most effective and efficient use of the Trust's infrastructure and resources without compromising on quality.

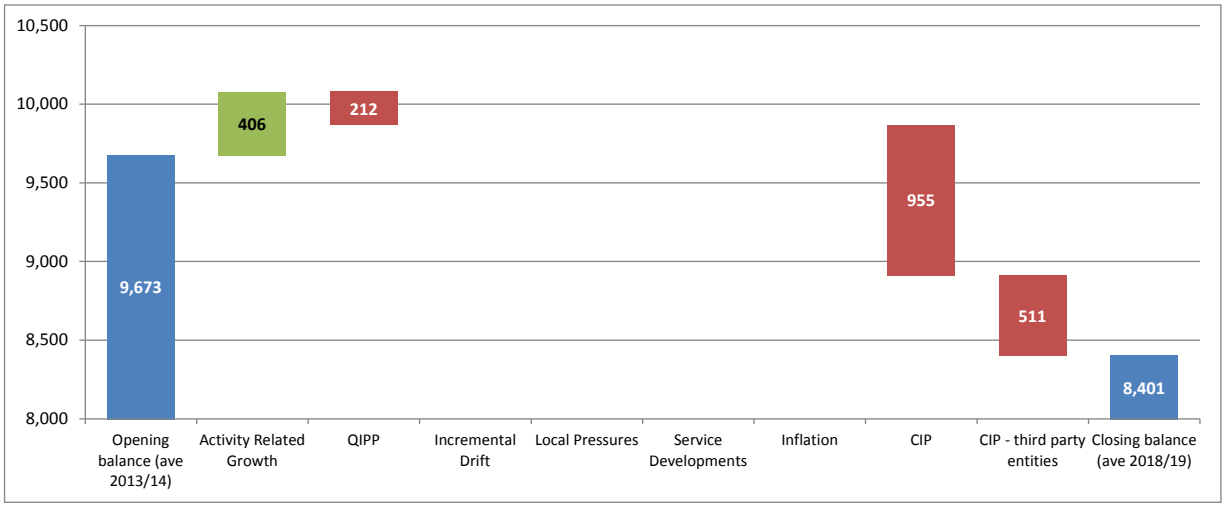
8.54. Work is under way to introduce new shift systems to enhance the seven-day provision of non-elective services and help elective services to provide capacity aligned to demand, with more services operating across the week and over extended periods of the day. Baseline productivity levels, establishing the ratios of clinical staff to patient activity, are being determined and targets for improvements will be agreed.

8.55. Work is also planned to further streamline job plans and provide assurance that nursing establishments and skill mix match levels of patient dependency and service need, especially where patients are frail and elderly or where there is high turnover.

8.56. The Trust continues to work with the local health economy to address delayed transfers of care. The Trust has proposed that in some areas it takes greater responsibility for managing demand in order to deliver local commissioners' activity reduction (QIPP) targets. If achieved, these reductions will reduce the numbers of nurses and clinical support staff.

8.57. The bridge chart below shows the indicative affordable workforce plan based on assumptions described in Chapter 6. It shows that activity-related growth is forecast to increase worked WTE[21] by 406, offset by planned activity reductions (QIPP) of 212 WTE, workforce efficiency schemes of 955 WTE and a reduction of 511 WTE through transfers of staff to third party entities over the five year period. These changes are shown from a forecast average worked WTE of 9,673 in 2013/14.

Bridge chart (Worked WTE)



8.58. The net effect is an anticipated reduction of 1,272 worked WTE by March 2019, broken down below.

Worked WTE by staff group, 2013/14 to 2018/19

Staff group	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Consultant	603	601	596	595	595	594
Junior medical	899	884	871	875	878	882
Nursing, midwifery & health visitors	3,418	3,218	3,126	3,067	3,007	2,946
Other clinical staff	1,317	1,305	1,301	1,285	1,268	1,252
Scientific, therapeutic, & technical	1,458	1,448	1,443	1,384	1,271	1,158
Non clinical staff	1,978	1,814	1,692	1,614	1,591	1,569
Total	**9,673**	**9,270**	**9,029**	**8,819**	**8,611**	**8,401**

8.59. Total expenditure on workforce is monitored routinely to test alignment with agreed workforce plans. Vacancy management and recruitment controls are in place.

8.60. Temporary staffing arrangements (agency, bank and overtime) are used effectively to cover peaks of

[21] Worked WTE include substantive staff and temporary staff but excludes staff on maternity leave, on long term absence or whose pay is fully recharged to other organisations.

activity and/or unexpected staff shortages. Temporary staffing costs are not expected to exceed 5% of total pay budgets.

8.61. Temporary staff are used where there is:

- unexpected and immediate staff shortage e.g. sickness absence;
- staff shortage whilst a vacancy is being filled; or
- a temporary increase in activity, a specific project or initiative.

8.62. Additional activity resulting from delayed transfers of care drove temporary staff bookings during 2012/13. Actions with partners supported by Oxfordshire CCG are expected to reduce such use of temporary staff.

8.63. OUH has also taken the following steps

- Tendering of bank and agency services has been undertaken to ensure economic and efficient arrangements are in place, including active management and reporting on staff utilisation.
- Electronic Rostering has been introduced to enable improved and more accurate planning and reporting of shifts and the assessment of staffing levels across wards, departments and Divisions.
- Booking of bank and agency staff is managed and monitored closely at matron and divisional nurse level via twice-daily meetings to review staffing levels, with the aim of deploying substantive and bank staff most effectively prior to employing more expensive agency workers.

8.64. Medical staff are to be included within the portfolio of rostering and locum control mechanisms.

Staff Engagement

8.65. Staff engagement is central to the delivery of OUH's business plan. Members of staff who are empowered, engaged and well-supported perform better and provide better care. Staff engagement is therefore essential to achieving the strategic objectives of the Trust.

8.66. OUH has participated routinely in the annual NHS Staff Survey to assess levels of staff engagement and the findings of the Staff Survey are used in several ways. Firstly, as a measure of overall staff engagement, informing the Trust at organisational level on what is being done well and where to focus attention on improvement. Secondly, at a directorate and Divisional level, to assess staff experience alongside indicators such as patient surveys, complaints and compliments, so that a holistic view is taken on decisions to improve quality and patient experience. Thirdly, as a way to benchmark with comparable organisations. Its importance is reinforced by the NHS Operating Framework which highlights that the Survey's question regarding whether staff would recommend their hospital to patients should be regarded as a key indicator of quality.

8.67. During 2012/13 the survey was supplemented with localised opportunities for staff to provide feedback as part of a broader staff engagement programme in which OUH is participating as a national pioneer organisation in the Listening into Action (LiA) programme.

Listening Into Action is an approach to engaging and empowering staff around priority outcomes for patients.
Eleven pioneer teams are working on projects including:

- Improving information for patients to reduce anxiety in the endoscopy service
- The role of therapy services in reducing waits in emergency care
- Improving patient experience in the Oxford Eye Hospital
- Shaping the future of day treatment services at the Horton General Hospital

8.68. LiA discussions have contributed to service-specific improvements in areas including pharmacy and therapies, and have generated improvements in staff induction and appraisal.

8.69. The LiA methodology is being used during 2013/14 to support discussions with staff about the alignment of individual and team objectives with those of the Trust.

8.70. Members of staff have, with patients and partners, developed the Trust's values. After agreement of Trust values in January 2012, a 'Values into Action' plan began, with a first phase being to describe clear and measurable standards of behaviour that staff should expect from each other. These behaviours form the basis of appraisal, communication, customer care, induction, performance management, recruitment and recognition approaches throughout the organisation.

8.71. The Trust has introduced a recognition scheme linked to its values, including an annual recognition ceremony, opportunities to generate good ideas and encouragement to provide local feedback to individuals and teams.

8.72. OUH aims to deliver an approach to staff engagement that creates a 'can-do' culture and builds a committed and high-performing workforce focused on achieving OUH's objectives. Priorities are to:

- Deliver communications appropriate to their intended audience;
- Build knowledge and understanding of the Trust, its vision and values and the role the individual plays in the organisation;
- Involve staff in the development of service plans and engage them in change programmes;
- Reinforce an open communications culture across the Trust and provide opportunities for two-way dialogue; and
- Support staff through projects that improve motivation and help the organisation to learn from its employees.

8.73. Progress in staff engagement is illustrated by the improvement made in staff uptake of seasonal influenza immunisation. In 2011 and 2012 OUH performed better than the national average for vaccine uptake despite being one of the largest Trusts and vaccination remaining non-mandatory. This reflected distributed leadership from corporate areas with cascade to clinical Divisions which promoted the vaccine and provided staff to assist with immunisation.

% staff vaccine uptake in year

Organisation	2008	2009	2010	2011	2012
NHS (England and Wales)	16.5	40 (H1N1 pandemic vaccine) / 26.4 (seasonal strain vaccine)	34.4	44.7	45.9
ORH	9.6	48.6/20.4	31.4	51.3	
NOC	No data	53.5/54.1	46.4	61.3	
OUH				52.1	58.6

8.74. Progress in medical staff engagement is illustrated by implementation of medical revalidation and associated appraisal, with Trust processes categorised as showing "significant assurance" in an internal audit in June 2013.

8.75. Having an engaged workforce at every level has benefits in terms of patient safety, patient experience and outcomes, the performance of the Trust more generally and its reputation.

Volunteers

8.76. Volunteers contribute to the activity of the Trust in a range of roles, supporting patients and staff and helping to improve services. Patients and visitors receive help and assistance from volunteers through vulnerable stages of their lives. Examples of the contributions made include receiving and

welcoming patients, mentoring, befriending, and self-help groups.

8.77. With more emphasis within the NHS on better quality and more personalised health care, new opportunities are emerging for volunteers to assist the main workforce in these areas. A voluntary services plan underpins the development of the contribution they are able to provide.

8.78. The health and wellbeing of volunteers from the local community is promoted and factors contributing to this are a chance to gain skills and experience, a pathway into work or an opportunity for volunteers to give something back to the local community/hospital. To build on the positive work already undertaken, the following actions have been agreed as objectives to strengthen the contribution volunteers make to the work of the Trust:

- Increase volunteering opportunities across the four hospital sites to provide extra value and support service delivery, ensuring that volunteering is distinct from paid work;
- Provide clear roles, responsibilities and guidelines for volunteers. The roles that volunteers undertake should complement those performed by trained, paid staff;
- Update and review marketing material, recruitment packs and arrange open days to enhance enrolment;
- Provide appropriate training for volunteers reflecting the area(s) they are placed to enable them to undertake their roles safely and effectively;
- Promote volunteering in partnership with local businesses schools and colleges; and
- Continue to celebrate volunteering – recognising the contribution that volunteers make by showing appreciation and recognition.

8.79. Third sector volunteers not directly managed by the Trust also provide a contribution within its premises including Hospital Radio, League of Friends and the Sobell House Hospice.

Workforce and Organisational Development

Human resources structures and practice

8.80. The Trust's Workforce Committee is a subcommittee of the Trust Management Executive and is a key instrument for the delivery of workforce strategy. The purpose of the Committee is to:

- Oversee the development and implementation of the Trust's Workforce Strategy;
- Provide assurance to the Trust Management Executive on the management of workforce issues, including associated risk; and
- Oversee the development and implementation of organisational change management strategy.

8.81. The Director of Workforce is the executive lead for workforce and ensures organisational arrangements are in place to satisfy legal requirements of the Trust for workforce and is the professional lead for developing the Workforce Strategy. The Director is supported by a corporate human resources department and a dedicated HR consultant post within each of the Divisions.

8.82. The HR consultant in each Division works as part of its multidisciplinary team. Whilst attending to specific divisional needs and initiatives, these post-holders also align outcomes to Trust-wide targets and developments.

8.83. The relationship between OUH and trade unions is good and is based on openness, trust and partnership working. There are occasions when the objectives of the Trust mean that the trade unions take an opposing view. These occasions are dealt with on a basis of mutual respect. During a period in which new ways of working will be an essential feature of the Trust's development, it is particularly important to maintain an ethos of trust and transparency.

8.84. A Trade Union Recognition Agreement integrates existing policies and harmonises the staff side arrangements across all four hospital sites. It provides formal arrangements for consultation and negotiation with management and eight trade unions.

8.85. A Joint Staff Consultation and Negotiation Committee is the main committee for consultation and negotiation between the Trust and its employees which meets every two months. The primary purpose of the Committee is the communication, consultation and negotiation of policies and procedures on staffing issues. It is designed to keep staff representatives informed, able to comment on key issues, and to give them the opportunity to raise matters of concern and interest. Equally, it provides an opportunity for directors to be informed and to discuss issues of concern and interest to staff. The Committee functions so as to anticipate and reduce potential employee relations difficulties and is chaired by the Deputy Director of Workforce.

8.86. There is also a Local Negotiating Committee within which the British Medical Association represents its members on specific matters relating to medical practitioners. This committee meets every two months and is chaired at alternate meetings by the Director of Workforce and by a senior consultant on behalf of the Medical Staff Council.

8.87. OUH's senior human resources team meets regularly with University of Oxford human resources colleagues and workforce matters of mutual interest are considered at a Joint Personnel Committee.

Organisational development

8.88. The clinically-led divisional structure sees the day-to-day management and delivery of services led by clinicians. Development of the strategic future of the Trust is founded on divisional involvement.

8.89. In the future, divisions will increasingly be supported and empowered to operate as autonomous business units.

8.90. The recommendations of the Francis Report have highlighted a number of areas and provided a further opportunity for the Trust to reinforce the importance of staff engagement and associated activities; the overall values, behaviours, openness and culture promoted within the Trust. For example, the Trust's Raising Concerns (Whistleblowing) Policy has been revised and promoted across the Trust.

8.91. The Trust is committed to be an active partner in healthcare innovation, research and workforce education, with the aim of forming an effective bridge between research in basic science and in healthcare service provision, and the delivery of evidence based, best practice care, turning today's discoveries in to tomorrow's care.

8.92. OUH has played a key leadership role in the development of the Oxford Academic Health consortium and the recently-designated Oxford Academic Health Science Network (OAHSN), for which it is the host organisation.

8.93. Clinical staff from OUH lead and contribute to clinical networks (as described in 4.83), which will play an important role in improving outcomes for patients across the network.

8.94. As arrangements for OAHSN are developed, it is expected that there will be secondment opportunities for NHS staff – clinical and non-clinical – in the establishment and delivery of programmes relating to clinical service delivery, patient and public engagement and involvement, cross-cutting themes including informatics and knowledge management, and healthcare innovation and wealth creation.

8.95. Exemplar innovations include work on safer blood transfusion practice.

8.96. The Oxford Biomedical Research Centre and Biomedical Research Unit arrangements developed over a number of years have served the transmission of research from 'bench to bedside' and provide a stimulating environment within which research and clinical staff are able to work and thrive. These will be built upon during the application process for designation of the Oxford Academic Health

Science Centre (OxAHSC), drawing on the skills of clinical researchers across the Trust and working in partnership with Oxford Health NHS FT, the University of Oxford and Oxford Brookes University.

8.97. Partnership with the University of Oxford, formalised in a Joint Working Agreement, occurs at the highest level and is supported through shared committees including a Strategic Partnership Board, Joint Executive Group and Joint Personnel Committee.

8.98. A Joint Working Agreement is also in place with Oxford Brookes University to:

- Increase research and scholarly activity undertaken by non-medical professional staff; and
- Harness research activity to drive up quality across the programme.

8.99. The Trust remains responsive to the fact that developing changes in the care and treatment of patients, through research and technological advancements, can result in changes to the organisation and to the responsibilities and skills required in key roles.

Management and leadership development

8.100. A continued focus on the capacity and quality of leadership within OUH are a vital component of the Workforce Strategy to ensure a quality patient experience.

8.101. As a key NHS Leadership Academy stakeholder and active partner in Health Education England's Thames Valley and Wessex Leadership Academy, the Trust has actively participated in discussions around the creation of delivery models that sustain and promote outstanding leadership at national and local level to improve the quality of services and outcomes for patients. There is an increased focus on developing systems wide leaders to maximise the value of investments and outcomes.

8.102. The Trust has adopted the NHS Leadership Framework and has developed the model further into three levels of management. It has influenced the recent review of the Leadership Framework.

8.103. Local programmes have been introduced in conjunction with the University of Oxford's Saïd Business School, Oxford Brookes University and the NHS Leadership Academy as well as other partners. A leadership programme for ward managers, for example, incorporates content on best practice, peer review, clinical supervision, CQC standards and outcomes linked to the Trust's CQUINs (see also 4.67).

8.104. Participating as a pioneer in the Listening into Action (LiA) programme has provided opportunities for leadership skills to be refreshed and redefined in the organisation. Feedback on the nature of leadership during the development of the Trust's values has helped to align leadership development with the skills, capability and resilience required to deliver improved patient outcomes and experience through the Trust's vision and strategy.

8.105. Clinical and non-clinical leaders and managers are encouraged to lead by example, to articulate a clear and compelling vision, and to live the values of the Trust. They are reviewed against clear competency standards and through 360° feedback and are developed through planned programmes that support talent management and succession planning. The appraisal process is being developed to exploit the use of technology. A new electronic system will incorporate a talent management element to help succession planning and ensure expertise is retained.

8.106. An OUH Leaders Conference series began in early 2013 to bring together OUH's community of leaders to share learning and best practice. Follow-up actions have included a lecture series.

8.107. As part of the Trust's continuing work to engage its staff and to make clear and visible links between strategic objectives and the daily work of teams, the LiA approach is being used during 2013 within Divisions, Directorates and teams across the Trust to raise awareness, provide feedback and improve dialogue with and within the leadership community.

Learning and development

8.108. OUH aims to create an excellent learning environment in which every member of staff makes the

best possible use of their experience, skills, knowledge, capability and capacity.

8.109. All members of staff are expected to receive an annual appraisal in which they discuss and agree a personal development plan. An electronic system is being introduced to support staff members and line managers in conducting and managing appraisals. Employees are encouraged to take ownership of their development supported by their manager and a Learning and Development Team.

8.110. Opportunities for personal development will be enhanced through new roles and ways of working, particularly with respect to involvement with research and engagement across both the Oxford Academic Health Consortium and the Oxford Academic Health Science Network.

8.111. OUH is working closely with Health Education Thames Valley (HETV) on an exercise to inform the next five-year commissioning round with Higher Education Institutions.

8.112. A comprehensive Learning and Development Framework is in place. Resources are maximised through collaboration with education providers including Oxford Brookes University, working in partnership with HETV and other Local Education and Training Boards (LETB); and by using learning technologies based on best practice.

8.113. The Trust anticipates a real terms reduction in Education and Training income in the period to 2015/16 (see paragraph 6.86). It is responding by creating an income and expenditure account for this activity and re-examining the allocation of costs to make more transparent the costs of the infrastructure used to support trainees.

8.114. OUH works closely with the University of Oxford and the Oxford Deanery in the delivery of education and training for doctors. The Trust has over 800 junior doctors in training. Formal educational and clinical supervision processes and structured training programmes are in place which comply with the quality assurance processes of HETV and the General Medical Council. The Trust oversees the quality of this education and through trainee representative groups, including a group of medical educational fellows, gives trainees a voice and an opportunity to learn clinical leadership skills.

8.115. The Trust designs and delivers learning and development programmes including professional pre-registration education and training as set out by professional bodies; continuous professional development; leadership and management training; and the 'Oxford Model', which includes initiatives to support apprenticeships and deliver Foundation Degree Programmes. This aims to support staff who are at the start of their career in the NHS and/or working as Assistant Practitioners. A multi-professional approach to providing learning and development is taken wherever practicable.

8.116. A particular innovation is the Trust's Health Care Support Worker Academy. This brings together the recruitment, selection, induction and ongoing learning and development of Health Care Support Workers (HCSWs). It provides a recruitment and development pathway for HCSWs and a coordinated approach to oversee their development from the moment they enter the Trust. The Academy also supports existing HCSWs through apprenticeship frameworks and portfolios of competence and signposts them to existing bespoke programmes run by in-house teams and to other short courses. This is intended to contribute to improving the quality and consistency of care in services from which the Trust's patients are received and to which they are discharged.

8.117. Following Robert Francis QC's 2013 report into the care of patients at Mid Staffordshire NHS Foundation Trust, a modified programme is being designed for existing HCSWs to generate clearly-evidenced standards of evidence-based best practice and behaviour for this group of staff.

8.118. Provision is made to achieve statutory and mandatory competencies through programmes including e-assessment, e-learning, classroom training and workbooks. Compliance is measured by competence rather than classroom attendance. This approach focuses on the learning outcomes of training. Staff can refresh their capability by competence assessment which negates the need for retraining where it can be demonstrated that skills and knowledge meet latest standards. This competence assessment reduces the time required for refresher training and enables more time to

be spent providing care for patients.

8.119. A web-based learning management system provides a platform for staff to book and undertake classroom learning, e-learning or e-assessment and enables staff to access learning resources 24/7. The system enables staff to review their own compliance and provides automatic reminders when competencies are about to expire. Managers can review training compliance levels at individual, team and organisational level. The system also provides evidence of statutory and mandatory training competencies for staff holding honorary contracts and for volunteers.

Terms and Conditions of Employment

8.120. OUH bases the salaries of its non-medical employees on the Agenda for Change agreement.

8.121. 98% of its medical consultants are employed on the 2003 contract.

8.122. It is the Trust's intention to continue to work within national agreements whilst these meet the needs and ambitions of the organisation. However, where there is a business case to do so, new terms and conditions will be developed. Examples of current variations include terms and conditions for community support workers and 'spot salaries' for senior managers. The successful implementation of local variations have been predicated on clear and strong staff engagement, communication and input from an early stage with all key stakeholders.

8.123. Arrangements are in place for the Trust to meet requirements for medical revalidation. Medical job planning and appraisal are supported by automated systems.

8.124. The Trust remains committed to compliance with European Working Time Directive (EWTD) and New Deal for Junior Doctors. EWTD compliance is verified through a web-based system endorsed by the Department of Health and diary card monitoring exercises are undertaken by junior doctors on a rolling basis throughout the year.

Conclusion

8.125. This chapter has described the arrangements that OUH will use for its leadership and management as a Foundation Trust and how it will develop its workforce through a period of change.

8.126. The delivery of compassionate excellence in care by engaged members of staff working in accordance with an agreed set of values underpins the future of the Trust and its services.

8.127. The challenge presented by reducing cost and improving efficiency whilst keeping patients safe, improving patient experience and sustaining improved outcomes requires innovation in care delivery and in how members of staff are engaged in shaping and delivering future care. Changes to the workforce over the period of this IBP are described and should be read alongside financial plans in Chapter 6 and service development plans in Chapter 5.

8.128. Work has been described to develop and to sustain staff engagement and motivation and the introduction of a systematic approach to leadership development in order to develop and embed good leadership practices and to provide an excellent learning environment for staff.

8.129. OUH intends to sustain and improve its reputation as a great place to work. This intention, founded on its values and supported by its participation in the Oxford AHSN and other work with partner organisations, is closely linked to its ability to innovate, to deliver the best of care and to fulfil its triple functions of care, teaching and research.

Chapter 9

Governance

9. Governance

Introduction

9.1. This chapter gives an account of governance arrangements to provide the required assurances to the Board of Directors across a range of key measures and indicators.

9.2. The overall structures and processes in place are outlined, the areas on which the Board requires assurance are defined and specific measures in place to provide this are indicated.

Council of Governors and Membership

9.3. Upon authorisation as a Foundation Trust, the Council of Governors will be responsible for representing the interests of members and stakeholder organisations in the governance of OUH whilst acting in the best interests of the Trust and adhering to its values and code of conduct.

9.4. It will be chaired by the Trust's chair and has statutory powers to:

- Appoint and, if appropriate, remove the chair;
- Appoint and, if appropriate, remove the other non-executive directors;
- Decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors;
- Approve the appointment of the chief executive;
- Appoint/remove auditors and receive annual accounts and auditors' reports.

9.5. The Health and Social Care Act 2012 has added duties to consider any changes to the constitution proposed by the Board; to consider changes to non-NHS income (to check there is no adverse effect on NHS services); and to consider mergers or acquisitions.

9.6. The Board of Directors will take into account the views of the Council in preparing the Trust's forward plan which must be submitted to Monitor each May.

Constituencies and Governors

9.7. The Board agreed a Membership Strategy in January 2012 based on its commitment to:

- build a substantial and representative membership base to take forward the Trust's strategy, to support public accountability and local engagement, and to develop a more outward-facing organisation; and
- generate a well-informed, motivated and engaged membership which will help the Trust to be a more responsive organisation with an improved understanding of the needs of its patients and local communities.

9.8. Work continues to develop and sustain an active and engaged membership community which in turn will elect public and staff representatives to form a Council of Governors. OUH has over 6,000 public members.

9.9. Public consultation has taken place, informing the Trust's proposed Constitution. Consultation points are summarised in Chapter 3 with the results of decisions made.

9.10. The draft Constitution lists two categories of members:

- **Public members**: members of the general public, patients and carers who live in Oxfordshire and in other geographical areas from which substantial numbers of people come to the Trust for treatment and care.
- **Staff members**: employees of OUH (including those seconded to the Trust's PFI providers), of the University of Oxford's Medical Sciences Division and of the Trust's PFI providers working on the Trust's sites.

9.11. OUH has not designated a separate membership category for patients, as it does not consider it to be helpful to differentiate between patients, carers and members of the public. The Trust expects that within its 'public' membership there will be many people who have been patients of the Trust at some time in the past, and/or are carers. Strong support was expressed for the Trust's proposed governance arrangements during the public consultation in summer 2012.

9.12. Specific steps are being taken to ensure representation from black and minority ethnic, and white non-British communities. Where there are particular ethnic minority groups who seem under-represented in the membership in comparison to their presence in the wider community, every effort is being made to find ways of encouraging members of that particular community to join. Involvement in community meetings could include presentations about health conditions of particular interest for certain ethnic minority groups. As with all Trust leaflets, translations will be made of Foundation Trust membership leaflets and other documents as requested. The current membership form offers translations in many different languages.

9.13. The Trust hopes that as many members as possible will engage fully with its membership programme and will participate in events, in consultation activities and in elections to the Council of Governors. OUH is drawing on strong existing engagement through work with the local community in Banbury and North Oxfordshire through the Community Partnership Network; patient groups such as the Cancer Patient Panel and Diabetes group; consultative meetings with the local community about how to improve services; regular briefings for stakeholders and feedback from patients, carers and the public through a variety of mechanisms.

9.14. Full membership begins at age 16, which means that anyone eligible to become a member is also eligible to stand for election to the Council of Governors (an important principle of governance). Perpetrators of assault or harassment against Trust staff will not be permitted to join the Trust's membership.

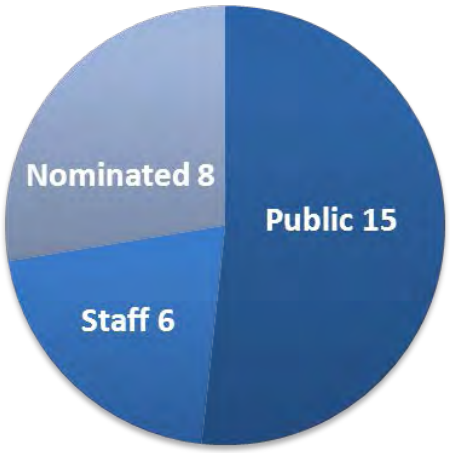
9.15. In shaping the Trust's strategic direction, the proposed Council of Governors will have direct representation from the Trust's public members in geographically-defined constituencies; from its clinical and non-clinical staff classes, including those who hold honorary contracts; and from other nominated representatives as set out below. Governors elected by public members are in the majority, as required by legislation.

9.16. The membership of the Council of Governors (excluding the Chairman) is as shown below.

Public constituency (elected)	*Seats*
Area served by Cherwell District Council	2
Area served by Oxford City Council	2
Area served by South Oxfordshire District Council	2
Area served by Vale of White Horse District Council	2
Area served by West Oxfordshire District Council	2
Northamptonshire and Warwickshire	2
Buckinghamshire, Berkshire, Gloucestershire and Wiltshire	2
Rest of England and Wales	1
Total	***15***

Staff constituency (elected)	*Seats*
Clinical staff	4
Non-clinical staff	2
Total	***6***

Nominated (Stakeholder) Governors	*Seats*
Oxfordshire County Council	1
University of Oxford	1
Oxford Brookes University	1
Oxford Health NHS FT	1
Oxfordshire Clinical Commissioning Group	1
Oxfordshire Local Medical Committee	1
Specialised Commissioner (nominated by NHS Commissioning Board)	1
Young person (nominated by Young People's Executive)	1
Total	***8***



9.17. The arrangement for public constituencies divides Oxfordshire geographically by district council areas. It then splits the surrounding counties who send patients to the Trust for general and specialist services into two, taking account of public feedback that the populations of

Northamptonshire and Warwickshire also receive a local hospital service from OUH from the Horton General Hospital in Banbury. The constituency for the Rest of England and Wales takes account of the fact that some of the Trust's specialised services operate on a national basis.

9.18. OUH staff will be members unless they choose to opt out. Staff constituency proposals are based on the numbers of staff in each employment group, with the 'non-clinical' constituency incorporating staff categorised in the trust's Electronic Staff Record as administrative and clerical, estates and ancillary staff; and the 'clinical' constituency incorporating allied health professionals, additional clinical services, healthcare scientists, medical and dental, nurses and midwives, and professional and technical staff.

9.19. Staff employed by the Medical Sciences Division of the University of Oxford will be able to opt in as staff members, although staff holding honorary consultant contracts with the Trust will be members of the clinical staff class unless they choose to opt out.

9.20. Staff seconded to the Trust's PFI providers under retention of employment agreements will be members of the non-clinical staff class unless they choose to opt out, and employees of the Trust's PFI providers who work on the Trust's sites will be able to opt in to the non-clinical staff class.

9.21. Stakeholder governors from Oxfordshire County Council and the University of Oxford will be appointed as required in legislation. The recognition of partnerships within the local health economy is of particular importance, hence the proposed stakeholder governors from Oxfordshire Clinical Commissioning Group, Oxford Brookes University and Oxford Health NHS Foundation Trust. (Oxfordshire CCG replaces the local Primary Care Trust as the Trust's most significant local commissioner.) The stakeholder governor from specialised commissioning reflects the scale and importance of the Trust's specialist services to its wider catchment population and the wider NHS.

Council of Governors and membership support

9.22. OUH has a Membership Office to communicate with its members, to support potential Governors in preparation for the first elections and to support communications with Governors and members following the formation of the Council of Governors.

9.23. The Trust has now held a series of training sessions for members who might wish to stand as Governors. These have included information about the role of the Council of Governors and the electoral process. Sessions have all had existing foundation trust Governors in attendance to share their experiences and answer questions. They have been held at a variety of times in order to maximise accessibility.

9.24. Induction training will be organised for new Governors. This will draw on governor training commissioned by the Department of Health from the Foundation Trust Network, with bespoke training on OUH and its strategy and forward plans. OUH will maintain training arrangements for governors, responding to specific needs as they arise. OUH will consider a mentoring system to support new Governors.

9.25. The Council of Governors will be responsible for representing the interests of members and stakeholder organisations in the governance of the Trust. In doing so, it should act in the best interests of the NHS Foundation Trust and should adhere to its values and code of conduct. The Board of Directors will work with potential members of the Council and following elections, the Council itself, to explain the direction and strategy for the organisation, its sites and services, and to highlight in particular the roles and responsibilities for the Council towards members and other stakeholders. This will include specific training sessions for Council members on the governance and assurance arrangements, the specific duties and accountabilities of the Council as outlined in the Constitution, including those relating to the appointment of the Chairman and Non–executive Directors.

9.26. Induction for the Council will also include the roles and responsibilities of the Board of Directors, and the Trust's arrangements for governance, performance and risk management.

Membership engagement

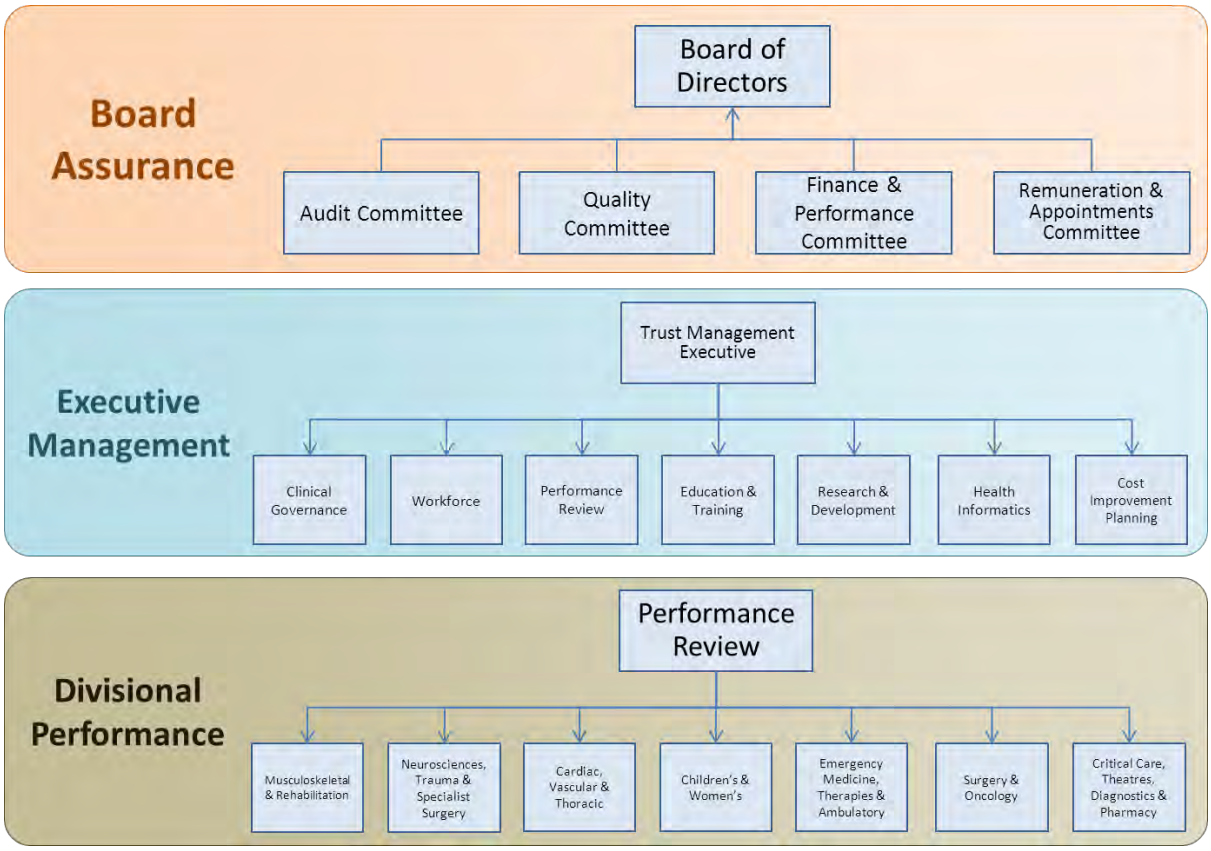
9.27. A lively membership programme is an essential part of creating a motivated and engaged membership. The main elements of the membership programme are as follows:

- An annual members meeting including presentations on developments likely to be of interest to members and providing an opportunity for members to meet with Trust governors.
- Members are invited to the Annual General Meeting and to special events such as a Cancer Centre open day and a Heart Centre open day organised by Charitable Funds. Members have also been invited to attend engagement meetings. Any such event organised in OUH is drawn to the attention of members, particularly those who have expressed an interest in attending events.
- Links with the Oxford Biomedical Research Centre support a continuing programme of presentations on areas of clinical innovation, to which members are invited.
- The Trust aims to widen its network of patient groups as it strengthens its arrangements for patient and public involvement. A close link will be maintained with the Trust's membership through these activities.
- Staff members will be able to participate in all of the above activities in addition to specific staff-related activities.

Structures of corporate governance and management

9.28. The overall organisational structure including assurance and management functions is illustrated below. Board committees provide assurance to the Board, seeking information from the Trust Management Executive (TME) as required. Each of the committees with assurance responsibilities report directly to the the Board but they can also seek further more detailed assurance from the others. They can also seek assurance from the executive management arm of the organisation.

Governance Structure



9.29. At least one non-executive director is a member of both the Finance & Peformance Committee and Quality Committee, ensuring that the assurance functions of the two committees are coordinated where these relate to associated aspects of Trust business. Assurance on workforce issues provides an example of this later in this document.

Board of Directors

9.30. The Board of Directors provides leadership on strategy, the development of policy, and on systems of internal control.

9.31. With its non-executive Directors appointed by the Council of Governors from the date of authorisation as an NHS Foundation Trust, the Board of Directors as a whole is responsible for the quality and safety of healthcare services, education, training and research delivered by the Trust and for applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission and other relevant NHS bodies.

9.32. Prior to authorisation, it is accountable to the Secretary of State, through the NHS Trust Development Authority.

9.33. Having effective Board meetings and committees of the Board is a key part of an effective governance structure and OUH has, as part of its preparation for Foundation Trust status, reviewed its arrangements to ensure that organisational governance is compliant with best practice and supports the objectives of the Trust. This work has included both a review of the Board and its committees and the composition of the Board itself.

9.34. Account has been taken of the Board Governance Assurance Framework and Quality Governance Framework for Aspirant Foundation Trusts.

9.35. The Board's role is largely strategic and supervisory, having as its key functions to:

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

9.36. The work and functioning of the Board is supported by Standing Orders, Standing Financial Instructions, and a Scheme of Reservation and Delegation to the Board.

9.37. The Remuneration and Appointments Committee considered the composition of the Board as part of the development of governance arrangements for Foundation Trust status, drawing on guidance from Monitor's Code of Governance and the principles that:

- the Board should not be so large as to be unwieldy; and
- sufficient skills and experience are present, appropriate to the size of the business.

9.38. The Board has a membership of seven voting non-executive directors (including the Chairman) and five voting executive directors:

- Chairman
- Chief Executive
- Six Non-executive Directors
- Chief Nurse
- Director of Clinical Services
- Director of Finance and Procurement
- Medical Director

9.39. The Board is attended by the following non-voting directors:

- Associate Non-executive Director
- Director of Assurance
- Director of Development and The Estate
- Director of Planning and Information
- Director of Workforce

9.40. In common with authorised foundation trusts, OUH's draft Constitution refers to the voting directors as described above following the date of authorisation.

Divisions and corporate functions

9.41. The Trust's clinical services are grouped into seven clinical Divisions, as shown in Chapter 2, which are accountable for the day-to-day management, delivery and governance of services within their areas, in line with Trust strategies, policies and procedures. Each Division is headed by a Divisional Director, a practising clinician who is supported by a Divisional Nurse and General Manager.

9.42. The seven clinical Divisions and their clinical directorates operate with divisional management executives (DMEs) which meet monthly and comprise both clinical and managerial members. The divisional teams include senior staff from Human Resources and Finance (senior business partners) who are accountable to the Divisional Director whilst their professional accountability remains with the relevant executive director.

9.43. Overall structures and processes of assurance, governance and risk management are developed and overseen by the relevant corporate directorate: Assurance, Clinical Services, Development & the Estate, Finance & Procurement, Medical, Nursing, Planning & Information or Workforce.

9.44. The divisional structure initially introduced in November 2010 was reviewed to take account of:

- the differing requirements of individual Divisions;
- the requirement to embed governance arrangements within Divisions following changes within the portfolios of corporate directors (see below);
- the need to reduce the number of direct reports to Divisional and clinical directors;
- the need to reduce management costs; and
- the need to retain the single point of accountability and leadership held by each Divisional director.

9.45. Corporate directorates have also been reviewed both to optimise the integration of ORH and NOC and to take account of best practice and the requirements for foundation trusts, particularly in relation to financial management, risk, assurance, compliance, clinical governance and quality.

Board Committee structure

9.46. The Board operates with the support of committees. In preparation for assessment against Board Governance and Quality Governance requirements for Foundation Trust applicants, the Board undertook a review of the Board and its sub-committees using the following principles:

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

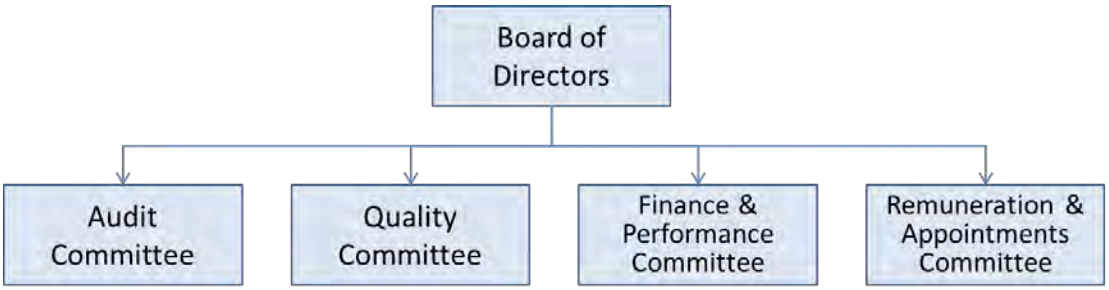
9.47. The following areas were covered during the review:

- statutory duties and good practice guidance;
- balance of committee membership and culture of challenge and scrutiny;
- scope and breadth of committee remits and gaps; and
- preparation and nature of committee papers, scheduling and support arrangements.

9.48. The Board agreed to revise its committees to create the structure shown below. The Finance and Performance Committee was established to focus on the overview and scrutiny of all aspects of performance reporting and the development and determination of financial strategy and plans. The introduction of this committee allowed the Audit Committee to focus on its responsibilities and duties as outlined in the DH Audit Committee Handbook and Monitor's Code of Governance.

9.49. The Board's committee structure is shown below.

Board Committees



Committees

Audit Committee

9.50. The Audit Committee is responsible for providing assurance to the Board of Directors 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.

9.51. The role of the **Audit Committee** takes account of the DH Audit Committee Handbook, Monitor's Code of Governance and other key guidance.

9.52. The Audit Committee will:

- obtain assurance from independent Internal Audit, External Audit and Counter Fraud activities;
- ensure standards are set and compliance with them is monitored in non financial, non clinical areas that fall within the remit of the Committee;
- monitor corporate governance issues such as compliance with NHS regulations, Codes of Conduct, and the maintenance of Register of Interests; and
- monitor and provide oversight of systems of internal control including the Board Assurance Framework and the Risk Register.

9.53. The Committee will receive assurances on the arrangements in place to manage clinical and related risks from the Quality Committee as outlined at 9.57 below.

9.54. Full membership of the Audit Committee is limited to non-executive directors and two of the non-executive directors have recent and relevant financial experience. A non–executive member is also a member of the Quality Committee ensuring the link in relation to internal controls and the management of risks with a specific and potential risk on all aspects of quality. A non-executive member is also a member of the Finance and Performance Committee ensuring the link to the detailed work of this committee is maintained.

9.55. The Audit Committee meets at least five times per year and at each meeting its members also meet privately with the Trust's internal and external auditors. Minutes of the Committee are presented with a covering report to public meetings of the Board by the Chairman of the Committee. An Annual Report on the work and performance of the Committee is provided to the Board.

Quality Committee

9.56. The Quality Committee is responsible for providing the Board with assurance on the standards of quality safety for clinical care and on clinical governance and risk management systems.

9.57. As part of the assurance process on the management of clinical risks, the Quality Committee provides assurance to the Audit Committee at least twice per year on the systems in place through review of non-financial risks on the Corporate Risk Register, Board Assurance Framework and Quality Governance Framework and specifically in relation to the development and completion of the Annual Governance Statement.

9.58. The Committee oversees monitoring of the Trust's compliance with CQC Essential Standards of Quality and Safety and ensures, through work with the Audit Committee, that systems for the management of risks to quality are robust and that assurance upon them can be provided to the Board.

9.59. The Committee is made up of four non-executive directors, the Chief Executive, the Medical Director, the Chief Nurse, the Director of Clinical Services, the Director of Assurance and the Director of Workforce and is chaired by a non-executive director. The Director of Planning and Information attends to discharge responsibilities regarding information governance as the Trust's Senior Information Risk Owner (SIRO).

9.60. The Quality Committee meets at least six times per year and reports to the Board through the presentation of minutes using the same covering paper template as for the Audit Committee, making recommendations to the Board where necessary.

Remuneration and Appointments Committee

9.61. Boards are required to have a Remuneration and Appointments Committee which determines policy on executive remuneration, approves contracts of employment for executive directors and agrees arrangements for termination of contracts, ensuring that appropriate performance management arrangements are in place for executive directors, working with the Chief Executive to relate performance judgements to pay.

9.62. Membership of the Committee is limited to the Chairman and non-executive directors, with the Chief Executive and Director of Workforce in attendance for part of the meetings.

9.63. The Committee meets at least twice per year. Minutes of the Committee are presented with a covering report to public meetings of the Board by the Chairman of the Committee. An Annual Report on the work and performance of the Committee is provided to the Board.

Finance and Performance Committee

9.64. The Finance and Performance Committee is responsible for performance reporting including specific oversight of financial performance and delivery against planned budgets, risks related to finance and performance (as identified from the Corporate Risk Register), CIP targets whilst improving patient safety, experience, clinical effectiveness and outcomes, corporate financial policy, management and reporting, and quality.

9.65. It is chaired by a non-executive director (also a member of the Audit Committee) and includes three additional non-executive members, the Chief Executive, the Director of Finance and Procurement, the Medical Director, the Director of Clinical Services and the Director of Development and the Estate.

9.66. The Committee meets five times per year and reports to the Board through the presentation of minutes and a covering paper in the same way as the Quality and Audit Committees.

Trust management arrangements

9.67. The Trust Management Executive (TME) is the executive management decision-making body for the Trust. It is chaired by the Chief Executive and consists of the Trust's executive directors, the seven Divisional Directors and the University of Oxford Medical Sciences Division's Associate Head of Division (Clinical Affairs).

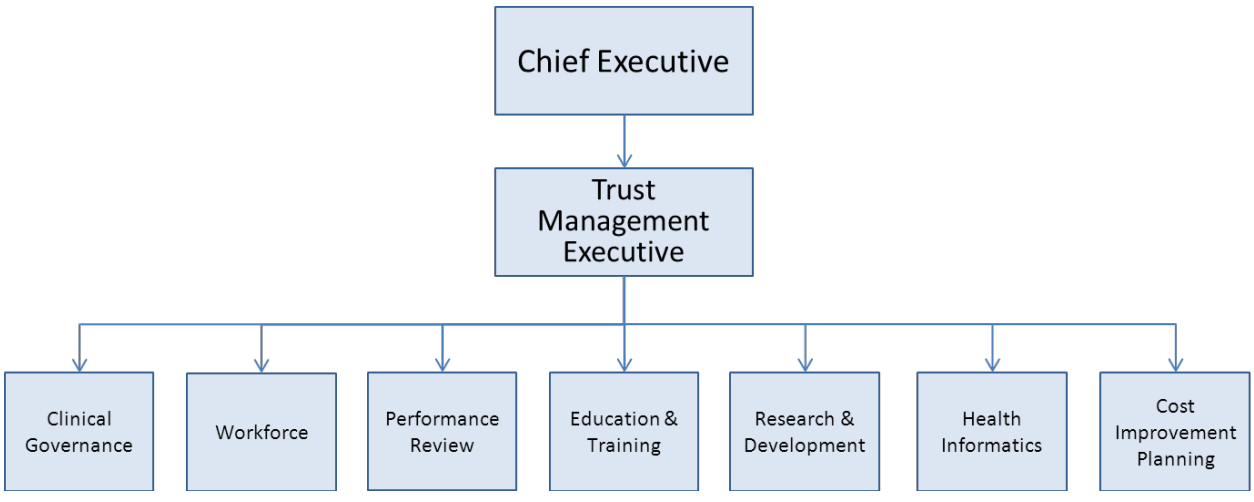
9.68. TME has the following remit:

- to support the Board in setting and delivering the strategic direction for the Trust within the overall context of the university hospital and its partners within the local academic and health and social care system by contributing options for strategic direction, ensuring the integrated and effective delivery of the Trust's agreed strategy and fulfilment of its duties, standards, targets and other obligations;
- to oversee the Trust's management of risk in all aspects of the delivery of its services;
- to ensure that there is always appropriate integration, connection and liaison between individual clinical services, between clinical and corporate functions and between strategic and operational matters: all within the Trust and between all the Trust's partners;
- to support individual directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information, mutual support, resolution of issues and achievement of agreement;
- to ensure the fullest clinical contribution to determining the strategic direction and operational delivery; and to
- approve policies within the delegated authority from the Board of Directors.

9.69. The agenda and minutes of TME are circulated to Board members.

9.70. TME has sub-committees which report to it, focusing on specific areas, shown below. Minutes from sub–committee meetings are presented to TME.

Trust Management Executive Sub-Committees



9.71. Specifically, these sub-committees support TME to conduct the following functions:

- Monitor the effectiveness of clinical governance processes related to patient safety, experience, clinical effectiveness and outcomes and ensure that appropriate actions are taken, as advised by the **Clinical Governance Committee**;

- Monitor the delivery of the Trust's workforce strategy and plans, as advised by the **Workforce Committee**;
- Monitor delivery of the Trust's service activity and financial objectives and agree actions, allocate responsibilities, and ensure delivery where necessary to deliver the Trust's objectives or other obligations, as advised by the **Performance Review Committee**;
- Monitor the delivery of the Trust's education & training strategy and plans, as advised by the **Education & Training Committee**;
- Monitor the delivery of the Trust's R&D strategy and plans, as advised by the **Research & Development Committee**; and
- Monitor the delivery of the Trust's health information management and technology strategy and plans, as advised by the **Health Informatics Committee**.
- Monitor the development and delivery of cost improvement plans, as advised by the **Cost Improvement Committee**.

Governance Processes

Risk management

9.72. The Board of Directors is the accountable body for risk and is responsible for ensuring that the Trust has effective systems for identifying and controlling all risks, whether clinical, financial or organisational.

9.73. The Trust has in place a Risk Management Strategy which defines the system of internal controls in relation to the management of risk, setting out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust. Operational responsibility for the implementation of risk management is delegated to TME. Assurance on risk management activities is monitored via the Board of Directors and its committees.

9.74. The Risk Management Strategy and supporting toolkit for staff set out the key responsibilities for managing risk within the organisation, including ways in which the risk is identified, evaluated, controlled and escalated, where necessary. Risk management is a core component of the job descriptions of senior managers within the Trust. The diagram below summarises the risk management cycle. The risk management process is summarised in the risk cycle diagram below.

The Risk Cycle

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

9.76. The risk management system includes both proactive and reactive processes to support embedding it in day-to-day activities. The Trust learns from good practice though a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and application of evidence based practice.

9.77. The Trust uses the proactive processes of risk assessment and risk registers to identify and evaluate potential risks that may affect achievement of organisational objectives. A risk scoring matrix is used to ensure a consistent approach is taken to assessing and responding to clinical and non-clinical risks and incidents. This relates to the Trust's appetite for risk with clear processes for the management and monitoring of proactive risk assessments defined within the Risk Management Strategy and supporting procedures.

9.78. On a reactive level, the Trust learns from events where things have not gone well. All staff are responsible for responding to incidents, hazards, complaints and near misses in accordance with the appropriate policies. All serious incidents requiring investigation (SIRIs) and serious risks are reported to the Board of Directors via the established committee and reporting structures.

9.79. Risk management by the Board is underpinned by a number of interlocking systems of control. The Board reviews risk through the following related activities:

- the Corporate Risk Register
- the Board Assurance Framework
- the Annual Governance Statement
- tailored reports from the Executive Directors

9.80. Local management teams, via clinical governance groups, are responsible for developing and maintaining local risk registers and overseeing the management of adverse incidents. Management teams are responsible for the review of risk action plans and ensuring they are implemented through the business planning process and other established routes.

9.81. Trust-wide risk processes are monitored and reviewed by Trust Management Executive and subject to independent overview by the Audit Committee. Specific elements are monitored by the Clinical Governance Committee, the Quality Committee and the Finance and Perfomance Committee. The Board reviews the Corporate Risk Register at least twice per year.

9.82. The Board has recognised the need for a consistent approach to three interlinking strategies for risk management, quality and assurance. These strategies, agreed in July 2012, have been developed and publicised in a coordinated fashion. They represent a development in the Trust's risk, quality and assurance processes and a means to support continuous quality improvement.

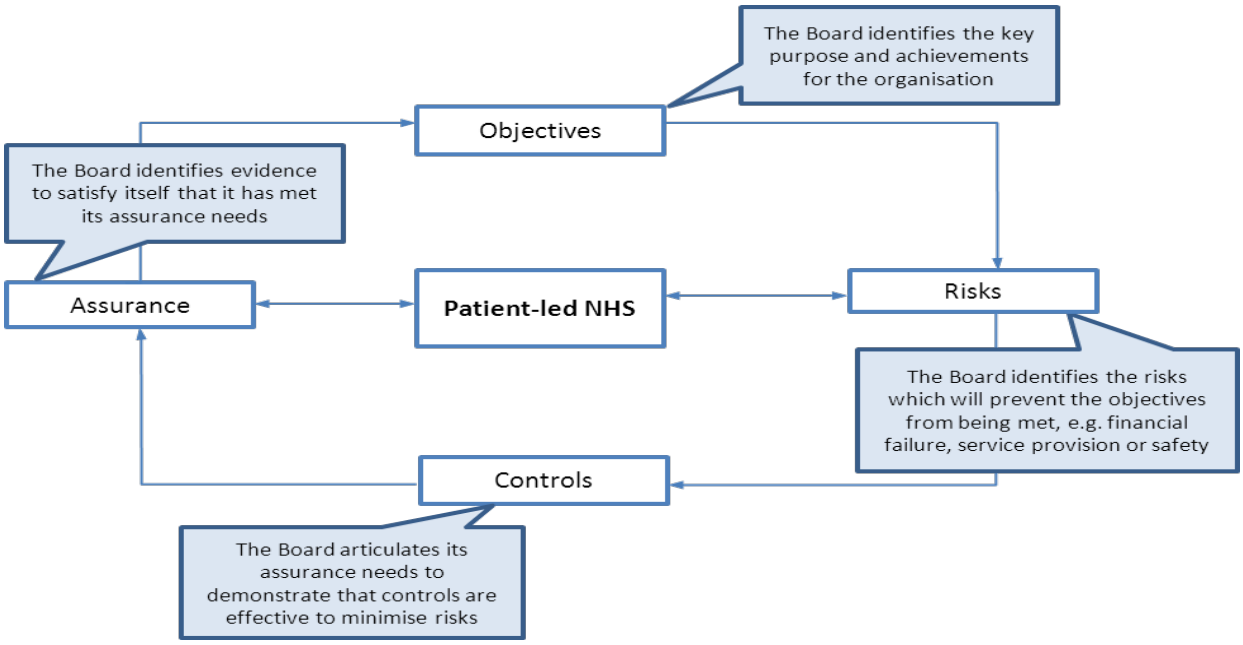
9.83. The Risk Management Strategy and its supporting Toolkit set out the way in which risks are escalated and de-escalated from ward to Board level. the strategy also outlines the high level process used by the Board to consider the Trust's risk appetite and risk tolerence levels. The Board has accepted that it does not have the same appetite and tolerence levels for all risks and has agreed that a tolerence level will be set of each of its strategic risks as part of an annual review of the Corporate Risk Register and Board Assurance Framework.

9.84. Further assurance on the effectiveness of risk management has been received with the achievement of compliance with the Risk Management Standards of the NHS Litigation Authority (NHSLA) at level one for acute and maternity services in September and November 2011 respectively.

Assurance Model

9.85. The Trust has an Assurance Strategy setting out long-term aims in relation to the assurance that the organisation can gain on the delivery of its strategic obectives. This process is set out in diagrammatic form below.

A model for structured assurance. [*Source: Health Care Standards Unit*]



9.86. The Trust receives a range of assurance from mechanisms such as monitoring of compliance by the Care Quality Commission on Essential Standards of Quality and Safety; NHSLA assessments; NICE and National Patient Safety Agency metrics.

9.87. The Trust uses three levels of assurance:

- Level 1: management or operational assurance, for example reports to Board meetings.
- Level 2: oversight functions, for example reports from the Audit Committee.
- Level 3: independent review, for example CQC inspection.

9.88. The three levels reflect the independence of the body providing the assurance with independent review having a higher value than internal management provided assurance. The organisation maintains an evidence-based approach to assurance and the quality and credibility of evidence is assessed to identify and redress any gaps that may exist. Not all assurance is in written form. Some types of assurance are in the form of oral reports or derived from discussions while others are derived from observation, for example board walk rounds.

9.89. In addition to the levels given above the value of assurance received is based on several factors, such as the time that has elapsed since the assurance was obtained and its durability. Some sources of assurance last indefinitely but diminish in relevance over time, for example annual accounts. Others are snapshots in time and need to be current to be of value, for example a clinical audit report. Not all sources of assurance are completely relevant: they may cover only part of a service or be only partially aligned to a particular objective. Some sources of assurance are more reliable than others, while the independence of the source will also affect its value.

9.90. The various mechanisms and tools described in the Assurance Strategy not only enable the assurance information produced to be assessed in terms of value, but also enable any identified gaps in assurance to be reported at an appropriate level and addressed when considered necessary.

Specific Assurance Arrangements

9.91. The sections below provide examples to illustrate the assurance arrangements for a set of key standards, benchmarks and processes. These are by no means exhaustive.

Quality

9.92. The Trust's Quality Strategy, agreed by the Board in July 2012, sets an ambitious five-year quality vision for the organisation. Ten measurable strategic quality goals are grouped into three domains: patients' safety, patients' experience and clinical effectiveness. The Trust has set itself the objective of being one of the safest providers of hospital care, in the top ten per cent of hospitals for patient and staff experience and providing clinical services that have clinical outcomes in the top ten per cent nationally. Quality goals are shown in the diagram below.

Quality goals

9.93. Each clinical service is expected to set annual quality priorities aligned to the Trust's strategic quality objectives. The Board sets annual quality priorities for the Trust, drawing these from locally set priorities and incorporating national standards and CQUIN requirements from contracts.

9.94. The agreed priorities form a framework for Divisional and service level quality priorities and reflect specific to patient needs. These are developed through discussion with clinicians, incuding nursing and medical staff taking into account incidents, risks, complaints and feedback.

9.95. OUH also uses locally-commissioned and national peer reviews to inform its work. During 2013, it is reviewing care for patients undergoing surgery and will participate in the national peer review of cancer services.

9.96. Progress against quality objectives is reviewed locally through Divisional Executive Meetings. Overall delivery of the strategy is monitored through the Trust's committee structure.

9.97. The Quality Committee is responsible for providing the Board with overall assurance on clinical governance systems and standards of quality and safety. Its minutes are seen by the Trust Board, accompanied by the Committee Chair's report. The Medical Director and Chief Nurse also provide topic-specific quality reports on relevant issues to the Trust Board at each of its public meetings. A Quality Account is produced on an annual basis as part of the Trust's Annual Report.

9.98. A range of quality metrics form part of the Integrated Performance Report to the Board and Divisional performance against relevant standards is monitored via the performance review cycle described above.

9.99. The Clinical Governance Committee monitors the effectiveness of clinical governance processes related to patient safety, experience, clinical effectiveness and outcomes and ensures that appropriate actions are taken. It provides a closer scrutiny on these issues than is possible via Divisional performance reviews and, with all Divisions represented, can support consistency of approach across the organisation. Monthly divisional reports are provided to the Clinical Governance Committee and these include assessments of CQC compliance and an analysis of Dr Foster outcome measures. Trends in complaints and incidents as well as lessons from individual instances are tracked to inform progress and future strategy, along with relevant alerts from Dr Foster and the Central Alerting System (CAS). OUH also uses NICE reports and the clinical audit process to proactively explore opportunities for quality improvements. The Clinical Governance Committee reports to the Trust Management Executive on a monthly basis and escalates issues of concern where necessary.

9.100. Regular clinical audit reports go to the Clinical Audit Committee (a subcommittee of the Clinical Governance Committee) for assurance and the outcomes are reported to Quality Committee.

9.101. The Trust has had an external assessment against Monitor's Quality Governance Framework and reassessments against the relevant standards will continue to be made as required and included in its internal audit programme.

9.102. OUH used the East Midlands Quality Dashboard, a forerunner for the National Quality Dashboard, which is reported, with analysis, to the Quality Committee.

9.103. Executive and non-executive directors undertake regular quality walk rounds which are included in Board reports and example patient stories are presented to the Board. Both provide opportunities to triangulate other quality information with the realities of current patient experience.

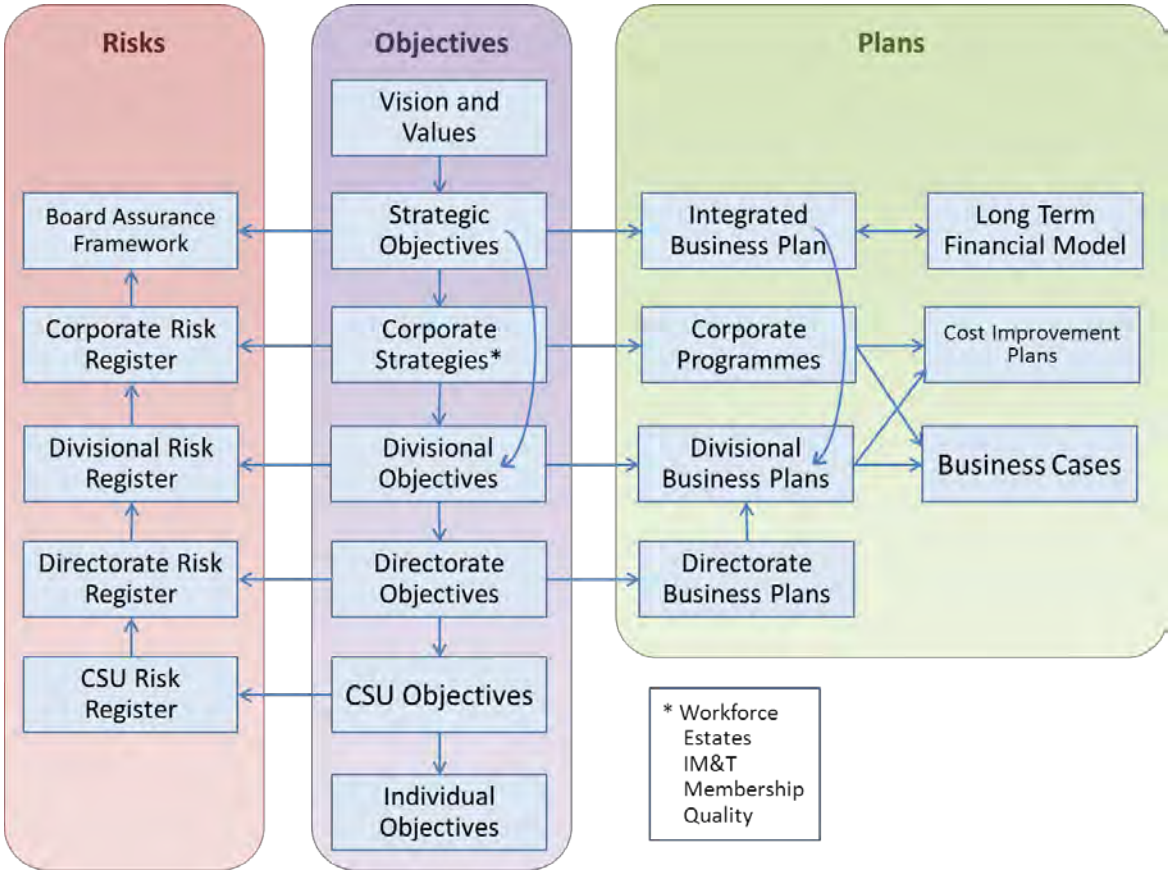
9.104. A Trust-wide Clinical Governance team sets outs and monitors clinical governance arrangements supported by a front line team of clinical governance and risk practitioners, who are allocated to each Division and support activity to deliver the Trust's vision on quality.

Strategy and Business Planning

9.105. The Trust's vision and values have been translated into strategic objectives. To faciliate their delivery a set of corporate strategies has been developed that transform the objectives into sustainable actions. Both the strategic objectives and the complementary strategies have been further translated into individual Divisional, directorate and clinical service unit-level objectives that cascade down through the Trust. Risk to delivery of objectives have been considered at each level and, where relevant, included in the appropriate risk register. Objectives then in turn form an integral part of business plans developed across the Trust.

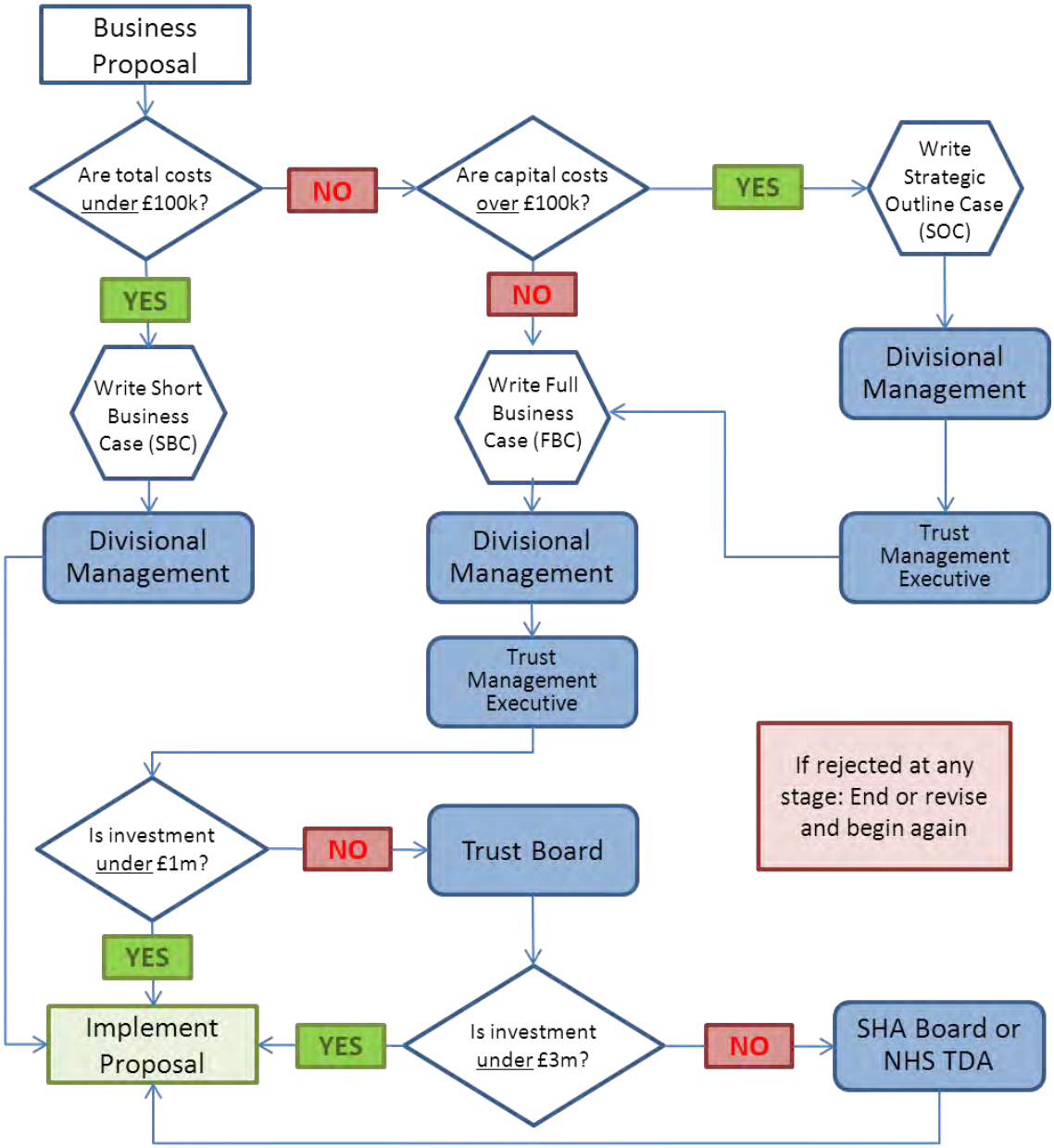
9.106. The diagram below shows schematically how the Trust's overall vision is cascaded and translated into detailed operational planning and actions at the level of Divisions, services and individuals so as to ensure that these are coherent and congruent with the organisation's overall goals.

Vision into actions



9.107. An example of this in action is the development and approval of individual business cases. Business cases are progressed and approved through the process shown below, providing assurance that they receive an appropriate level of scrutiny in relation to the level of resource and capital to be committed and that the Board and TME have opportunity to test their consistency with OUH's overall strategy. The process for developing and assessing cost improvement plans is also outlined from 9.125 below.

Business Case Development



9.108. Once approved, the respective risks are managed and implementation of plans to achieve the relevant objectives is monitored through the Trust's executive management.

9.109. Until authorisation, approval of schemes above the delegated limit for NHS Trusts must be sought from the NHS Trust Development Authority.

Performance Management Framework

9.110. Monitor's Compliance Framework contains performance indicators which are used to judge the performance of FTs. Consultation was recently undertaken on a revised Risk Assessment Framework. Many of the current Compliance Framework's measures reflect existing NHS requirements and these are summarised in the table below.

Area	Indicator	Threshold
Safety	Clostridium Difficile	88
Safety	Methicillin-resistant Staphylococcus Aureus (MRSA)	7
Quality	Maximum 31-day wait for second and subsequent treatment comprising: • Surgery • Anti-cancer drug treatments • Radiotherapy	 94% 98% 94%
Quality	All cancers: Maximum 62-day wait for first treatment from: • Urgent GP referral • Screening service referral	 85% 90%
Quality	All cancers: Maximum 31-day wait from diagnosis to first treatment	96%
Quality	Cancer: Maximum two week wait from referral to appointment for all urgent referrals and for symptomatic breast patients	93% 93%
Quality	A&E: Maximum waiting time four hours from arrival to admission, transfer or discharge	95%
Patient Experience	Maximum 18 weeks referral to treatment - admitted	90%
Patient Experience	Maximum 18 weeks referral to treatment – non-admitted	95%
Patient Experience	Maximum 18 weeks referral to treatment – patients on incomplete pathways	92%
Patient Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A

9.111. The development of the Trust's Integrated Performance Report (IPR) has taken account of Monitor's requirements in the Compliance Framework.

9.112. Performance against the Compliance Framework is also indicated through the Governance Risk Rating (GRR). Performance against both the FRR and GRR is shown within monthly self-certification reports presented to the Board since September 2012.

9.113. A range of elements of the national Planning Guidance need to be monitored appropriately. These include standards that:

- No patient should wait longer than 12 hours on a trolley in Accident and Emergency
- All patients who have operations cancelled on or after the day of admission (including day of surgery) for non-clinical reasons are offered another binding date within 28 days, or the patient's treatment is funded at the time and hospital of the patient's choice
- There is zero tolerance of an urgent operation being cancelled for the second time

9.114. In some cases, such as the rebooking of a cancelled operation, these, like the standards from the Compliance Framework, are incorporated into the IPR. In other cases measures are included in the Trust's SITREP (Situation Report) and reported to the Board on an exception basis. This applies both to 12 hour trolley waits and the cancellation of an urgent operation on a second occasion. The Trust has not breached either of these standards during the 2012/13 financial year.

9.115. The IPR at Trust level is built up from equivalent analysis at Divisional and directorate level and it is therefore possible to drill down into the analysis to review performance within individual areas. The IPR at Divisional level receives evaluation and scrutiny via Divisional performance reviews.

9.116. Monitor's Code of Governance (2010; p26 et seq) sets out requirements for FT boards, saying that:

> "At least annually, the board of directors 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 operations, including clinical outcome data, to allow members and governors to evaluate its performance. Further requirements are included in the *NHS Foundation Trust Annual Reporting Manual…*"

9.117. The Board reviews monthly performance reports covering financial, activity and quality performance data. These include key relevant national priority and regulatory indicators, including Commissioning for Quality and Innovation (CQUIN) targets with additional reports devoted to patient safety, patient experience, clinical effectiveness and outcomes. A monthly qualitative summary is supplemented by more detailed exception reports on any areas of adverse performance.

9.118. An integrated performance report was introduced in July 2012. It provides the Board and Divisions with a comprehensive set of data covering performance indicators within the domains of quality, performance, activity, workforce and finance. Some core indicators stem from the NHS Operating Framework 2012/13, Outcomes Framework 2012/13 and Monitor's Compliance Framework, while others have been identified at an operational level to report on Divisional performance.

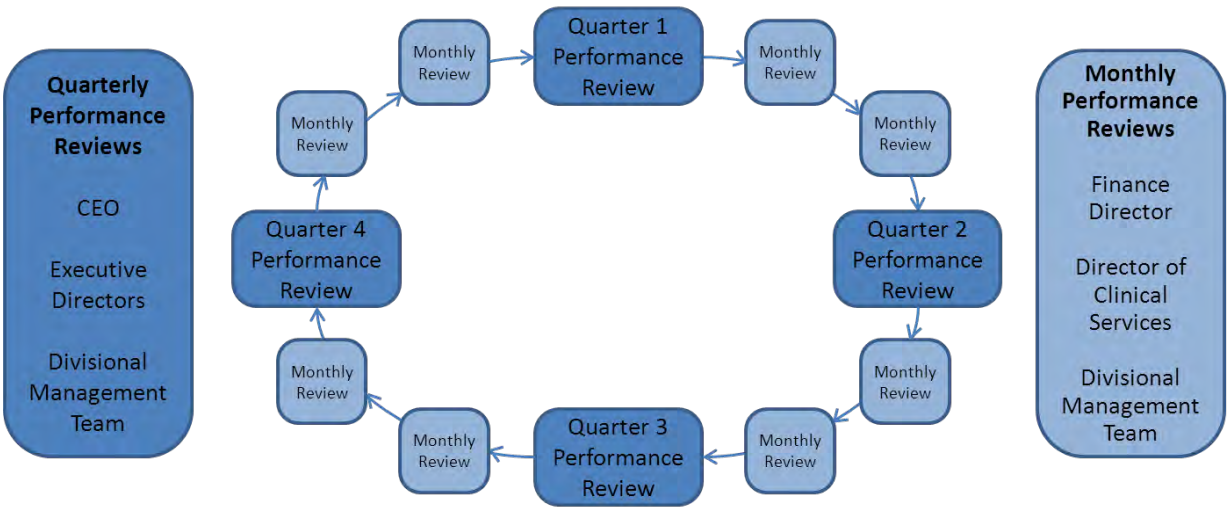
9.119. The selection of appropriate metrics is subject to regular review, with changes in definitions or strategic priorities reflected in the selection. The Finance and Performance Committee's forward plan incorporates an annual review of IPR metrics, tied to the annual business planning process.

9.120. The Board's dashboard is backed up by a cascade of more granular reports reviewed by Board Committees (for example the Quality Committee), directorates and individual services, with analysis at individual practitioner level.

9.121. The Divisional performance review process is shown below. Monthly performance meetings take place with each Division led by the Director of Finance and Procurement.

9.122. At quarterly Divisional performance meetings, financial and non-financial performance measures (of quality, activity and workforce) are reviewed in detail by the Executive Team and actions agreed to mitigate emerging risks and to manage performance. These meetings provide an opportunity for Divisions to explain performance and for corporate functions to offer support where required.

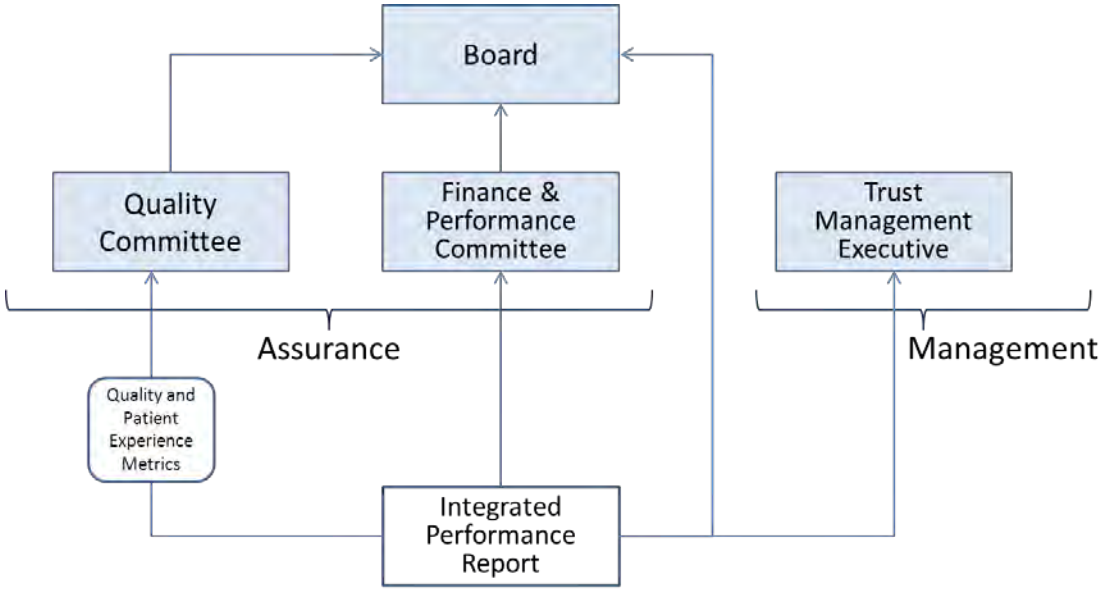
Performance Review Process



9.123. As shown below, the Integrated Performance Report fulfills both management and assurance functions, being reviewed by TME to ensure that appropriate management action is taken where required as well as by Board committees for assurance purposes.

9.124. The Finance and Performance Committee reviews the IPR in its entirety and the quality and patient experience metrics within it are considered by the Quality Committee.

Integrated Performance Report



Financial Controls and Reporting including Cost Improvement Programme

9.125. Detailed monthly financial reports are provided for all Divisions and their directorates. These reports are brought together for review by TME and the Board.

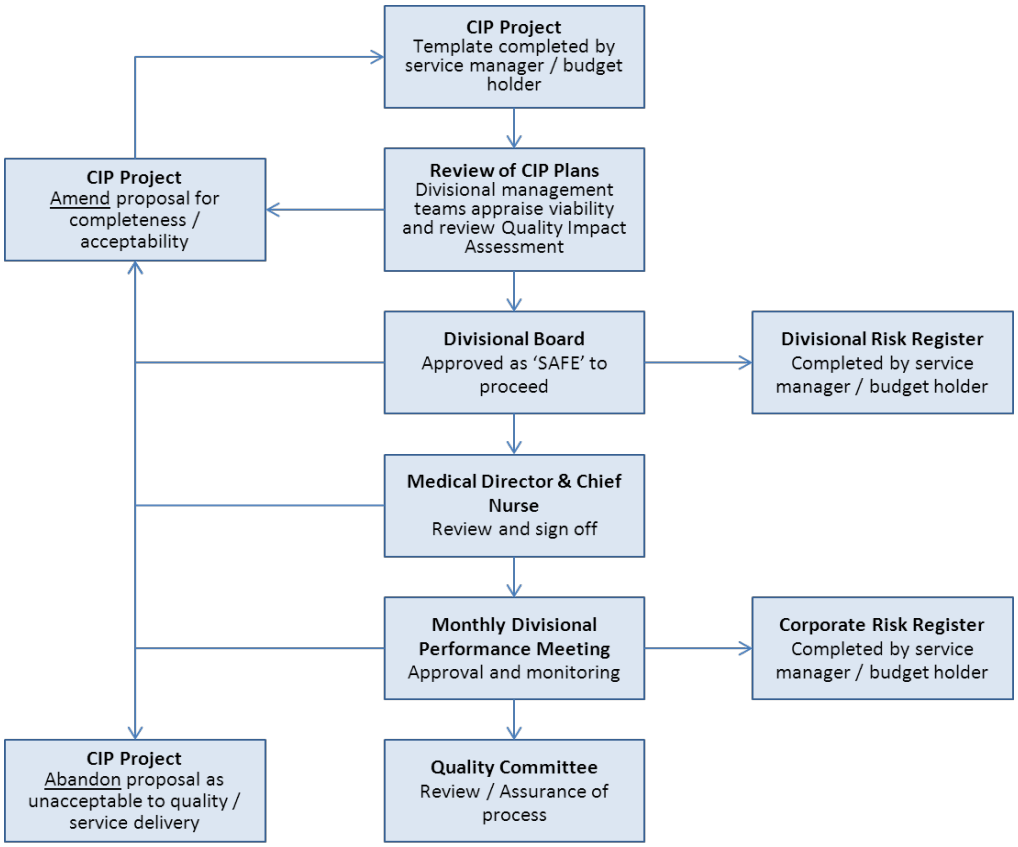
9.126. Board reports include an assessment of the Trust's performance against Monitor's Financial Risk Rating (FRR). The elements that make up the FRR are also visible to the Board so that it can review its performance over time.

9.127. Board reports on finance include the Statement of Comprehensive Income (Income & Expenditure Account); Statement of Financial Position (Balance Sheet); Statement of Cashflows; Financial Risk Rating; Analysis of Income by Commissioner; Analysis of the Capital Programme; Analysis of the Savings Programme; and Risks.

9.128. Controls on expenditure are in place through Standing Orders, Standing Financial Instructions and Budgetary rules.

9.129. OUH has recognised that it must deliver cost improvements which result in a permanent and substantial reduction in its cost base whilst providing safe and effective clinical care. It has an approach to the development and implementation of CIP initiatives that includes an important assurance and oversight role for its Quality Committee. This approach is shown below.

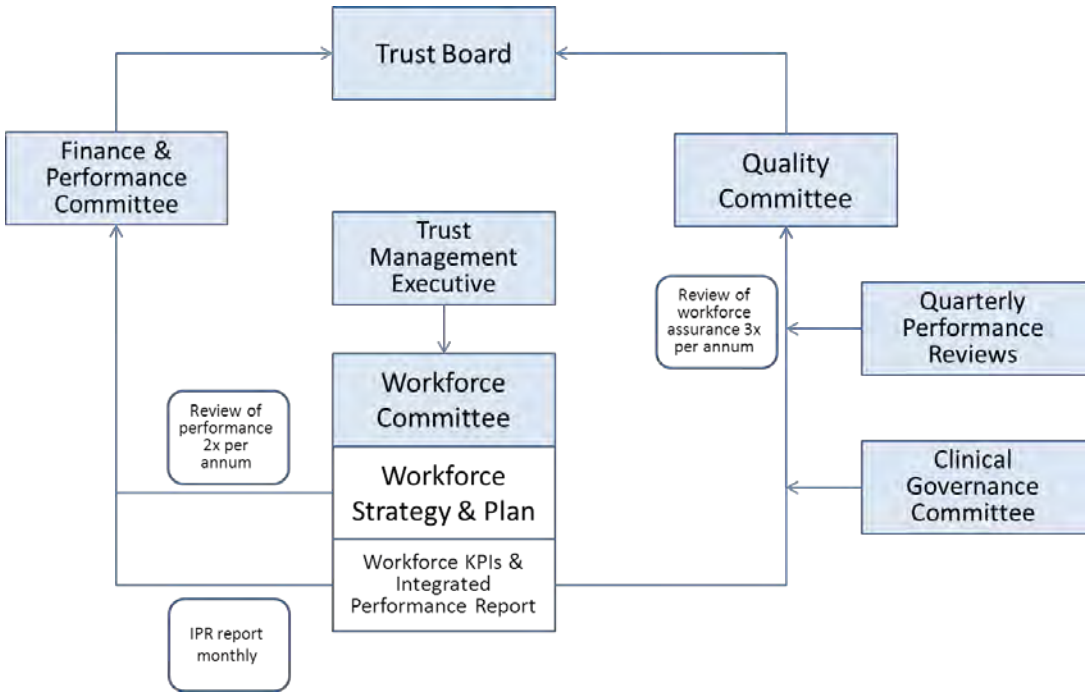
CIP Governance Framework



Workforce

9.130. The process by which workforce metrics and strategy are determined and assurance provided is shown below. This diagram also provides an example of the mechanisms through which the Board committee structure provides assurance for the Trust.

Workforce Governance



9.131. Workforce metrics to be monitored are determined in discussion with Divisions and reviewed by the Workforce Committee and Trust Management Executive (which includes Divisional Directors) to inform the Workforce Plan.

9.132. The Workforce Plan supports and is consistent with the Integrated Business Plan and Long-Term Financial Model agreed by the Trust Board. Workforce KPIs are set and monitored at Trust and Divisional level. KPIs encompass pay expenditure, temporary workforce expenditure, sickness absence rates, turnover rates, compliance with statutory and mandatory training requirements and appraisal rates.

9.133. The Finance & Performance Committee reviews progress against the workforce strategy and plan twice a year. It reviews the IPR report (including workforce metrics) on a monthly basis.

9.134. The Quality Committee triangulates information from Quarterly Reviews at Divisional level, relevant KPIs from the Workforce Committee and CQC outcome data from the Clinical Governance Committee and carries out a review of workforce assurance three times a year. As noted above, at least one non-executive is a member of both committees to ensure that complementary activities are considered.

9.135. The Audit Committee provides annual review of HR governance through the audit cycle.

9.136. Strategic risks to the workforce plan are identified in the Integrated Business Plan and monitored as part of the Board Assurance Framework and Corporate Risk Register, which are routinely reviewed by the Trust Board.

9.137. Risks specific to Divisions are identified and monitored via divisional risk registers, reviewed at Quarterly Performance Meetings and escalated in accordance with the Board Assurance Framework.

9.138. Medical revalidation requirements are managed via an implementation group reporting to the Workforce Committee. Activities in relation to trade unions are reported within the Joint Staff Consultation and Negotiating Committee and Local Negotiating Committee of the BMA and supplied to the Workforce Committee.

Audit

9.139. OUH's External Auditor is Ernst & Young LLP. Its Internal Audit service is provided by KPMG LLP.

9.140. Audit opinions for 2010/11 and 2011/12 are shown below. In each case the Annual Audit Letter was received by the Trust and action taken to address the recommendations.

9.141. The External Auditor indicated in 2010/11 that OUH had adequate arrangements to secure economy, efficiency and effectiveness in its use of resources except in relation to financial resilience. This qualification was a reflection of the degree of progress that the Trust had made at that point towards eliminating the accumulated deficit and the scale of challenges ahead. An unqualified opinion was received on 2011/12.

	ORH	NOC
External Audit (from Annual Audit Letter **2010/11**)	Unqualified opinion on the accounts Value for money opinion qualified in respect of financial resilience	Unqualified opinion on the accounts Unqualified value for money opinion
	OUH	
External Audit (from Annual Audit Letter **2011/12**)	Unqualified opinion on the accounts	
Internal Audit (Head of Internal Audit Opinion, **April 2012**)	Satisfactory Assurance given that there is a generally sound system of internal control in place.	

9.142. The Head of Internal Audit Opinion, notified to the Audit Committee in May 2012, stated that an Assurance Framework had been established which was designed and operating to meet the requirements of the Annual Governance Statement (which had replaced the Statement on Internal Control) for 2011/2012. This provides reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.

9.143. In particular, the Head of Internal Audit provided the following opinions linked to OUH's strategic objectives 2 and 3:

SO2: To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs – *"a well-governed and adaptable organisation."*

SO3: To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services and better value healthcare – *"delivering better value healthcare."*

- satisfactory assurance provided in relation to the report on Financial Management;
- unacceptable assurance provided in relation to a report on Private Patients and Overseas Visitors.

9.144. The Audit Committee reviewed both the above reports, and in relation to the report on private patients, noted significant actions being taken by the private patients team to address the concerns raised. The Audit Committee will follow this work closely.

9.145. Internal Audit reports are received throughout the year and agreed with management. The Audit Committee is rigorous in its follow up of outstanding recommendations: any high or medium priority recommendations which are overdue are followed up with a monthly report to the Executive team and regular reports to the Committee.

9.146. These reports gave the following opinions (for the NOC for the period to 31 October 2011):

Audit Area	OUH
Assurance Framework	Excellent
Human resources, professional registration	Good
Charitable Funds	Good
Payroll	Satisfactory
Estates policies	Limited
Audit Area	**NOC**
Assurance Framework	Excellent
Risk Management	Excellent
Research and Development	Good
Finance	Good

9.147. An Annual Quality Account, with a strong focus on clinical audit and effectiveness, is prepared, reviewed by Internal Audit, and agreed by the Board. It reflects the Board's annual quality priorities (as informed by the Quality Strategy) and drives the development of clinical audit plans within the Trust.

Compliance framework

9.148. Board reports include an assessment of the Trust's performance against Monitor's Financial Risk Rating (FRR). The elements that make up the FRR are also visible to the Board so that it can review its performance over time.

9.149. Performance against Monitor's compliance framework is also indicated through the Governance Risk Rating (GRR). Performance against both the FRR and GRR is shown within monthly self-certification reports presented to the Board since September 2012.

9.150. The development of the integrated performance report has taken account of Monitor's requirements in the Compliance Framework.

Information Management and Technology

Strategy

9.151. OUH's Information Management and Technology (IM&T) Strategy 2012-2017 links IM&T developments into the Trust's objectives and sets out governance arrangements underpinning further investment in IM&T.

9.152. It argues that the implementation of electronic patient record systems is a critical factor in improving efficiency and patient safety and underpins the Trust's overall strategy.

9.153. Information and performance monitoring are of critical importance for the Trust's future development.

9.154. The strategy sets out the developments required and the changes in governance needed to help deliver this.

Electronic Patient Record

9.155. The core clinical solution at the heart of the IM&T strategy is the Electronic Patient Record system implemented during 2012. The introduction of the clinical solution delivering real time information is fundamental to the IM&T strategy's success.

9.156. The ability to develop and enhance the system over time will be at the heart of developments over the next five years. The objective will be to introduce Electronic Document Management and prescribing to enable the Trust to operate in a 'paper light' way, with information available to clinical teams whenever and wherever they need it.

9.157. In this environment it is important that the Trust begins to maximise its use of EPR and over time replaces its legacy systems as EPR gains additional functionality.

9.158. In a period of financial challenge, the strategy focuses on getting the basics right, i.e. the things that must be delivered by any IM&T strategy for an organisation to progress:

- robust, scalable IT Infrastructure that delivers information where staff need it;
- sound governance arrangements;
- high quality management information;
- training and development of IT skills in staff;
- sound project management and procurement; and
- working in collaboration with other NHS organisations.

Priorities to 2014/15

9.159. Key priorities for 2012/13 to 2014/15 are summarised below:

Implementing the Electronic Patient Record clinically across the organisation

- Delivers real-time use of EPR across all OUH services delivering major benefits to all clinical teams.

Making the case and delivering Digitised Notes

- The case for digitising notes is primarily one of safety given the multiple specialist notes that are routinely created for the same patient; the only way a unified record will happen is if the notes are all digitised starting with the specialist libraries.

Data warehouse

- The overarching need for the Trust to co-ordinate, standardise and maximise its use of operational data is articulated in the strategy. A data warehouse will deliver a single place for corporate data to be retrieved from, some standard structured reports defined to enable the organisation at all levels to monitor performance and to support operational service delivery. Over time, data sources from all activity systems, finance, commissioning and other sources will be linked to enable a consistent view of service delivery to be obtained, including service line costing and comprehensive modelling against planned activity. Where appropriate and in conjunction with the research community, options for secondary anonymised use of operational information for research purposes will be explored.

Robust infrastructure including single sign-on and mobile computing

- OUH has built up a technical infrastructure that supports digital imaging across the corporate network as a firm foundation for the future. By 2013/14 key developments are the increased use of vWorkspace; improved mobile bedside access for staff; upgrading of the Trust's storage and continued improvements to the network. A strategy for mobile devices will be explored based on experience of clinical use, combined with the technical assessment on security and cost.

Electronic prescribing

- Plans are being developed through a business case to implement electronic prescribing.

Replacing some legacy systems including pathology and RIS/PACS

- The business case for a pathology replacement system is in preparation and work is also being done to plan the replacement of the RIS and PACS imaging systems. This must be completed before the current contract ends in June 2013.

Working up options for the Trust at the end of the EPR Contract

- Firm plans will be established for the EPR programme at the end of the national contract in June 2015.

Information sharing and whole system working

- The development of agreed ways for working to support information sharing across the health system and facilitate agreed models of working to support new models of care advocated through the commissioning channels.

9.160. An outline plan identifies key milestones and a five-year capital plan identifies IT capital. Further business case development will be completed once the contract reset process has been finished.

Investment

9.161. IM&T is increasing in importance for the Trust as patient care depends increasingly upon network and IT facilities. This is reflected in the Trust's capital investment programme (see Chapter 5).

Standards, Governance and Processes

9.162. Articulated through the IM&T Strategy is the need for appropriate governance arrangements that function within governance and assurance arrangements for the Trust as a whole.

9.163. These are needed to ensure that the organisation moves in a common corporate direction and adheres to common inter-operability standards, common technical standards and common data standards. Without them, systems cannot work together and information cannot be shared.

9.164. The Trust recognises the importance of adhering to corporate standards and of ensuring future system compatibility and will put in place appropriate arrangements to deliver this, working through its Health Informatics Committee, which reports to the Trust Management Executive.

Conclusion

9.165. The Board and its committees have arrangements in place to enable them to drive strategy and oversee the Trust's operational management.

9.166. The Board receives assurance on performance, quality and financial issues via its committees.

9.167. Specific processes are in place to scrutinise all aspects of performance of the clinical Divisions as well as the development of risk registers, cost improvement plans and business cases that link back to the trust's strategic objectives.

9.168. Arrangements are also in place to ensure that key information and metrics are reported to the Board and appropriate committees, with appropriate frequency and to a consistent standard to enable all committees to discharge their duties as set out in the relevant terms of reference.

Glossary

Term	Meaning
A&E	Accident and Emergency
AHP	Allied Health Professional
AHSN	(Oxford) Academic Health Science Network
AQP	Any Qualified Provider
AVIC	Acute Vascular Imaging Centre
BAPM	British Association of Perinatal Medicine
BGAF	Board Governance Assurance Framework
BRC	Biomedical Research Centre
BRU	Biomedical Research Unit
CCG	Clinical Commissioning Group
CIP	Cost Improvement Programme
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation: payment framework linking a proportion of NHS providers' income to the achievement of local quality improvement goals
DGH	District General Hospital
DH	Department of Health
DTOC	Delayed Transfer of Care
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation: a measure of underlying earnings without so-called 'exceptional items'
EDS	Equality Delivery System
EMU	Emergency Medical Unit
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FRR	Financial Risk Rating
FT	NHS Foundation Trust
GP	General (Medical) Practitioner
GRR	Governance Risk Rating
HCSW	Health Care Support Worker
HEE	Health Education England
HETV	Health Education Thames Valley
I&E	Income and Expenditure
IBP	Integrated Business Plan
IM&T	Information Management and Technology
ISTC	Independent Sector Treatment Centre
JSCNC	Joint Staff Consultation and Negotiation Committee
JV	Joint Venture
LiA	Listening into Action

LMS	Learning Management System
LTFM	Long Term Financial Model
MDT	Multi-Disciplinary Team
MES	Managed Equipment Service
MFF	Market Forces Factor
MRI	Magnetic Resonance Imaging
MSD	Medical Sciences Division, University of Oxford
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NHSLA	NHS Litigation Authority
NICU	Newborn Intensive Care Unit
NIHR	National Institute for Health Research
NOC	Nuffield Orthopaedic Centre
OAHC	Oxford Academic Health Consortium
OCCG	Oxfordshire Clinical Commissioning Group
ONS	Office for National Statistics
ORH	Oxford Radcliffe Hospitals NHS Trust
OUH	Oxford University Hospitals NHS Trust
OxAHSC	Oxford Academic Health Science Centre
PACS	Picture Archiving and Communication System
PALS	Patient Advice and Liaison Service
PBC	Prudential Borrowing Code
PESTLE	Political, Economic, Social, Technological, Legal and Environmental analysis
PFI	Private Finance Initiative
QGF	Quality Governance Framework
QIPP	Quality, Innovation, Productivity & Prevention
RAF	Royal Air Force
R&D	Research and Development
RIS	Radiology Information System
SCBU	Special Care Baby Unit
SHMI	Summary Hospital Mortality Indicator
SIRI	Serious Incident Requiring Investigation
SPV	Special Purpose Vehicle
SSNAP	Support for Sick Newborn and their Parents
SWOT	(analysis of) Strengths, Weaknesses, Opportunities and Threats
TIA	Transient Ischaemic Attack
TME	Trust Management Executive
UCLH	University College London Hospitals NHS Foundation Trust
VFM	Value for Money
VTE	Venous Thromboembolism
WTE	Whole Time Equivalent (staff)
YiPpEe	Young People's Executive

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