Oxford Health NHS

Foundation Trust

Annual Report and Accounts

2018-2019

Oxford Health NHS

Foundation Trust

Annual Report and Accounts

2018-2019

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

Table of contents

Foreword by Chairman and Chief Executive

Welcome to our 2018/19 Annual Report which sets out our main achievements and some of the challenges we faced over the year which marked the 70th anniversary of the NHS itself.

That provided a timely reminder that the NHS touches all of our lives and was an opportunity to celebrate progress in treatment, care and improved life expectancy.

We hope this report will provide a useful guide to how we are serving communities across Buckinghamshire, Oxfordshire, Swindon, Wiltshire, Bath and North East Somerset, and beyond.

The challenge of recent years, with better treatments and understanding of illness leading to people living longer with more complex health conditions, has been matched by rising expectation and the need for more effective use of resources.

This is true across our services, for community and mental health care, but, with Oxfordshire Clinical Commissioning Group (CCG) we have identified particular issues relating to the legacy of low levels of funding of mental health services which has led to particular pressures.

The last year has seen a great deal of work on this and we have made real progress with our commissioners and other partners in developing a shared understanding of the issues, and what needs to be done about them; it will however take a number of years to improve the situation to the point where we are on a par with other comparable areas.

Specifically, following a joint independent review with the CCG, we have identified the extent of the shortfall in funding for mental health services in Oxfordshire by comparison with other similar areas – in the order of £18-28m.

The review also established that the Trust does make good use of the resources we have (6% more efficiently than the average overall) which offsets the impact of the shortfall to some extent, but this situation has also meant that in recent years our services are in many cases delivering significantly more than they are being funded to do with consequent pressures on teams.

Recognition of this is however a hugely important and welcome first step and work on addressing it has begun.

Not unrelated to that, 2018/19 was a difficult year financially, resulting in an operating deficit of £5.7m against a planned operating deficit of £1.9m.

The significant underinvestment in Mental Health Services in Oxfordshire combined with the high levels of Mental Health activity (exceeding the CCG allocations) was the prime reason for the deficit. The CCG and Oxford Health are working on a three-year plan to redress the funding situation.

The difficulty in recruiting staff across the Trust, which covers a number of areas with a high cost of living, has been an ongoing contributing issue, with agency spend continuing to rise and amounting to £24.6m in the year (10% of total staff costs), adding pressure to costs. In mitigation, the 2018/19 cost improvement programme did result in savings of £8.5m against a target of £6.0m.

The financial and workforce challenge has meant that our regulators NHS Improvement have given us a Single Oversight Framework (SOF) segment rating of 4 for the year ended 31st March 2019, on a 1-4 scale where 1 is best. For comparison we were rated in segment 2 in the previous year.

We can however celebrate that, despite those challenges, the quality of our services remains rated as 'Good' overall by the Care Quality Commission. Our staff continue to recommend Oxford Health as a place to work and to receive care.

Most importantly, our patient feedback shows 94% of people would recommend us to family and friends who needed care or treatment. That is a credit to our staff whose ongoing commitment, from this year additionally supported by our Oxford Healthcare Improvement Centre, continues to deliver improved care.

It has been a great year for National Institute for Healthcare Research (NIHR) funded research associated with the trust. Professor Andrea Cipriani's work on depression through our Biomedical Research Centre and Professor Susan Jebb's work on treating obesity through our Collaboration for Leadership in Applied Health Research and Care, have both attracted international interest and recognition.

In the past year, we have developed a new service model for child and adolescent mental health services in Oxfordshire; new safe havens for people in mental health crisis in Oxfordshire and in Buckinghamshire; and been funded to develop a new learning disability service in Oxfordshire.

We continue to work in partnership with the third sector and other health and social care organisations as we move towards more integrated care and to participate in wider system development as part of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership.

As always, our aspiration is to deliver outstanding care, not to, but with the people who use our services, so that we do things as a joint endeavour between practitioners, patients and carers.

We have seen some important changes in key personnel on our Board. Ros Alstead OBE, our Director of Nursing and Clinical Standards, has retired and will be succeeded by Marie Croft in June 2019.

Non-executive director Alyson Coates has stepped down to begin a new life overseas. And finally, we must acknowledge the great contribution of Martin Howell, who completed his third and final term as chairman of Oxford Health at the end of March

2019. We would like to thank each of them for their highly dedicated and effective service to the trust over many years.

On behalf of the Board of Directors, we thank our staff, governors, volunteers and Foundation Trust members, for their commitment, hard work and support in 2018/19, and we offer all the people in our communities our best wishes for the year ahead.

Signed:
David Walker
Chairman

Signed:
Stuart Bell CBE
Chief Executive

Year at a Glance

April 2018

Oxford Health gives free wifi access first

Oxford Health was one of the first trusts to give free wifi access to patients and the public on our sites, before NHS WiFi was rolled out nationally enabling them to download health apps, browse the internet and access health and care information.

Oxford Health publishes its gender pay gap report

We report our median hourly pay rate is higher for women than for men with a pay gap is -2.77%. However, the mean hourly gender pay gap was 13.62% - the fourth smallest among the 17 NHS trusts reporting figures.

Oxford Centre for Spirituality and Wellbeing launches

Led by Oxford Health and Oxford Brookes University, the centre aims to generate practise-based evidence of an integrated approach to care to underpin the development of training of staff delivering spiritual care.

Oxfordshire NHS trusts launch joint campaign to end "Pyjama Paralysis"

Oxford Health joins forces with Oxford University Hospitals NHS Foundation Trust to get patients on hospital wards out of bed, dressed and active. Just 10 days of bed rest in a community or acute hospital leads to the equivalent of 10 years ageing in the muscles of people 80 and over.

Care worker recruitment campaign attracts thousands

A joint campaign – 'Make a difference every day' – run and funded by Oxford Health with Oxfordshire County Council, Oxfordshire CCG and Oxford University Hospitals NHS Foundation Trust in partnership with the Oxfordshire Association of Car Providers (OACP), saw 130,000 people viewing Facebook adverts and around 200 applications and job registrations for care worker roles.

May 2018

Patients at the end of life are accessing out of hours primary care services

Out-of-hours GPs see almost one third of people who die in Oxfordshire, according to a study in to the extent to which (OOH) GP services play a role in end-of-life care. A collaboration Oxford Health, the University of Oxford and Birmingham University found that almost one third of all people who die in Oxfordshire contact out-of-hours care in the 30 days leading up to their death.

Patient participation group in new video

The work of a patient participation group, set up to provide feedback to our specialist GP services for homeless people in Oxford, is highlighted in a four-minute video produced by Healthwatch Oxfordshire. 'Patient Voices…Our Story' includes interviews with patients and staff at the practice.

Oxford Health's Courtney Hughes to attend the Royal Wedding

A healthcare assistant at Didcot Community Hospital is a guest at the wedding of Prince Harry and Meghan Markle. Courtney Hughes started a Christmas 'Secret Santa' charity collection when she was just 13. Seven years on she raised over £100,000 worth of donations distributed to children and older adults in hospitals.

Oxford Health app part of new national NHS Apps library

A self-harm prevention app developed by Oxford Health's Head of Psychological Therapies, Paul Stallard, will form a key part of a doctor's medical kit in prescribing evidence-based solutions to young patients facing severe mental health challenges, thanks to its inclusion in a new national NHS Apps Library.

Oxfordshire CAMHS makes services easier to access

Mental health services for children and adolescents is now available through a single point of access - a single email and phone number to access any of Oxfordshire's Child and Adolescent Mental Health Services including our mental health services, school and community in-reach support. It can also support parents/carers and professionals who would like to discuss referrals or make an enquiry.

June 2018

Commitment to Carers

Oxfordshire's Commitment to Carers is launched following two years of partnership working between carers and health and social care organisations. It pledges to recognise, value, support and give carers a voice and has been adopted by Oxford Health alongside Oxford University Hospitals NHS Foundation Trust, Oxfordshire CCG and Oxfordshire County Council and partnership organisations.

Child psychiatrist's OBE for services to children and young people

Consultant psychiatrist Dr Wendy Woodhouse is awarded an OBE in the Queen's Birthday Honours for services to children and young people's mental health. Wendy has over 32 years' NHS service, with 22 years in Swindon and Wiltshire, where she continues to practice. For eight years she led Oxford Health's child and adolescent mental health services across five counties.

Oxford Health stages first Carers Conference

Coinciding with the first anniversary of the I Care You Care initiative - how we engage and work with our patients' families, friends and carers to ensure they are at the heart of what we do – the trust holds a Carers Conference to share learning and best practice.

Garden party at Witney Community Hospital kicks off NHS 70 celebrations

Hospital staff hosted a vintage cabaret party complete with costumes, entertainers and cake. Guests listened to live music, sang happy birthday to the NHS and enjoyed timeline cards dotted around the garden highlighting major milestones like the first hip replacement in 1960.

July 2018

A month of NHS 70 celebrations

70th birthday celebrations were in full swing across the Trust, with special teas and special stories. We celebrated the change in focus from mental illness in 1948 to mental health in the 21st century and how our services have developed and evolved. We gave people a glimpse through archive pictures of how our key Warneford and Littlemore sites used to be. Our chief executive Stuart Bell wrote an impactful article on changes he had witnessed through his 36 years in the NHS. And we celebrated other's experience too with focuses on workers - like one of our health visiting teams who together have 100 years' experience. Two lucky staff members attended a national celebratory event at Westminster Abbey.

Oxford Health teams scoop 'placement of the year' awards

Four teams win at the Oxford Brookes University 'Placement of the Year' awards, with six other teams highly commended. Kennet Ward, Littlemore won the Mental Health Placement of the Year, while North Oxfordshire Community Learning Disabilities Team in Banbury scooped both the Placement of the Year for Occupational Therapy and Health Education England's award for Thames Valley. Our Oxford City School Health Nursing team won the 'Return to Practice' category, and the Oxford City Older Adults Community Mental Health Team won the 'Adult and Mental Health Nursing' category.

Oxford Health officially launches new CAMHS model for Oxfordshire

Our new model of care is officially launched allowing young people, families and carers to make direct initial contact with our services for the first time, through a single point of access team (SPA). It also sees the Trust working with a host of charity partners.

Virtual reality delivers automatic psychological therapy for fear of heights

A team led by Professor Daniel Freeman, an Oxford Health consultant psychiatrist and a researcher the University of Oxford's Department of Psychiatry, develops a VR programme in which psychological therapy is delivered by a computer-generated coach to tackle fear of heights – a condition affecting one in five people.

Healthwatch Oxfordshire hails latest efforts to reduced patient discharge delays

Watchdog praises the latest efforts to reduce the number of people stuck in community and acute hospitals. On July 8, eighty eight people were medically fit to leave hospital but were still on wards while waiting for additional care packages, whereas in the previous year 167 people were classed as 'delayed transfers of care'.

August 2018

Peer support workers 'reduce readmissions to mental health crisis units'

Dr Kathleen Kelly, consultant psychiatrist with Oxford Health's emergency department psychiatric service, is a major contributor to a Lancet research paper that shows, following study of more than 400 people, that care from peer support workers with 'lived' mental health experience may help reduce patient readmissions.

Older people wards win Royal College of Psychiatrists accreditation

After 18 months of assessment and peer review, three of Oxford Health's mental health wards for older people are awarded the Royal College of Psychiatrists Accreditation for Inpatient and Mental Health Services (AIMS). The Amber Ward at the Whiteleaf Centre, and the Sandford and Cherwell wards at the Fulbrook Centre get AIMS accreditation.

National award for Oxford Health veterans programme

Our 'Step into Health' programme is one of the 2018 Silver Award recipients of the Ministry of Defence employer recognition scheme designed to celebrate and reward UK employers supporting the principles of the Armed Forces Covenant. Oxford Health has previously been recognised for helping help veterans explore transferable skills and identify NHS career opportunities by winning a bronze award.

Technology Assisted Psychiatry shortlisted for a national award

A ground-breaking video conferencing system in A&E departments that enable psychiatrists to offer speedier consultations and support for patients, gets shortlisted for a national award. The Emergency Department Psychiatry Service's Technology Assisted Psychiatry (TAP) is in the running for the Positive Practice in Mental Health's Innovation in Digital Technology Award. It wins in October.

CQC inspection: Oxford Health NHS Foundation Trust 'Good'

The Care Quality Commission has rated Oxford Health 'good' in four out of five quality measurements – caring, responsive, well-led, effective and 'requiring improvement' for safe. This gives Oxford Health an over-all rating of 'Good' based on weighted scoring across all services inspected.

September 2018

Oxford Health stages first ever Healthfest

Oxford Health opens the doors of our historic Warneford Hospital site to welcome scores of people to our first festival aimed at increasing awareness about the services we and our partners provide. Visitors enjoy 40 exhibition stalls, attend concerts by service users, listen to talks, meet peer support workers. It was held to relaunch Oxford Health Charity and participate in Oxford Open Doors weekend.

Forensic Network New Care Model shortlisted for HSJ award

Our specialist NHS mental health service which prioritises treating long-term hospital patients closer to home is nominated for a national health award. As part of its ground-breaking New Care Model approach, the Thames Valley and Wessex Forensic Network is identifying patients who may not be getting the care that is right for them and close to home. Oxford Health is the lead provider of the network.

New chairman for Oxford Health announced

We reveal David Walker is to become the next chairman of Oxford Health when Martin Howell, who has served since 2010, completes his final term in March 2019. David is deputy chair of Central and North West London NHS Foundation Trust. He is also a member of the Centre for Mental Health's Commission for Equality in Mental Health.

October 2018

Fresh approach to winter

Oxford Health community service director Tehmeena Ajmal is appointed Oxfordshire's first ever Winter Director in a ground-breaking joint system appointment aimed at tackling seasonal pressures across the health and social care system. Leading a central team comprising mental health services, hospitals, ambulance services, GPs, social services and charities, it aims to improve quality and performance of emergency and urgent care.

Oxford Health prepares for winter

The flu jab campaign begins with the aim of vaccinating all workers. Staff and patients collaborate to produce a music video set to the Jackson 5 hit ABC, reminding everyone getting the jab is as 'easy as 1, 2, 3'.

New counselling service available in Buckinghamshire

Kooth, a new online counselling service supporting young people's emotional wellbeing and mental health, launches. Oxford Health, Buckinghamshire County Council and Buckinghamshire CCG commission XenZone o give young people aged 11 to 19 access to professional mental health counsellors.

Bucks Safe Haven for adults in crisis

People experiencing mental health crisis can now self-refer to additional out-of-hours support in Buckinghamshire. Oxford Health expands its partnership with Bucks Mind to the launch a Safe Haven support service in Aylesbury, providing out-of-hours support on Sunday, Monday and Tuesday evenings.

Oxford Health researcher shortlisted for national award

Consultant psychiatrist and associate director of research and development Prof Andrea Cipriani is shortlisted for a 2018 RCPsych Award, the highest level of achievement in psychiatry. He gained international recognition for a ground-breaking antidepressant study published in the Lancet. He wins the award in November.

Oxford Health doctors win research impact award

Oxford Health doctors Agnes Ayton and Ali Ibrahim win the Beat Research Impact Award for their report on the lack of eating disorder training for medical students who receive less than two hours' ED training over four to six years of undergraduate study.

November 2018

Doctor elected divisional vice chair for Royal College of Psychiatrists

Dr Hasanen Al-Taiar, a consultant forensic psychiatrist at Oxford Health providing specialist mental health advice for forensic patients, is elected to the Royal College's executive committee as the mentoring lead in the South East, taking part in various educational committees.

Improving quality of life and reducing agitation in dementia

Wellbeing and Health for people with Dementia (WHELD) training programme for staff is shown to improve the quality of life for people with dementia. A team jointly led by Oxford Health, the University of Exeter and King's College London examine the effectiveness of staff training and medication on 549 people in 69 care homes with significant levels of agitation in dementia compared to standard treatment.

Peer Support Workers graduate

Fourteen trainees with lived experience of mental health issues graduate from their six-month course to became qualified peer support workers. All are offered paid roles with the trust and will help with the treatment and recovery of others in our care.

Staff Recognition Awards 2018

A galaxy of stars from Oxford Health are honoured for their exceptional care, values and performance in the annual awards. More than 100 people representing all areas of the trust – from Wiltshire, Buckinghamshire to Oxfordshire – saw awards in 11 categories celebrating the caring, safe and excellent service being delivered each day by dedicated individuals and teams.

Obesity research wins international acclaim

Professor Susan Jebb, who leads the Oxford's Collaboration and Leadership in Applied Health Research and Care (CLAHRC) on diet and obesity attracted international acclaim for her research work. A study published in the BMJ shows there is evidence that total diet replacement programmes of 810 calories a day, alongside regular sessions with a counsellor is a safe and clinically effective way to treat obesity in primary care. Her work also showed short-term diets can cut weight-related diabetes.

December 2018

Safe Haven launched for people in crisis in Oxford

A specialised safe haven offering a late-night safe space for people experiencing mental health crisis opens. It offers additional out-of-hours support four nights a week for adults and is run by the Oxfordshire Mental Health Partnership, consisting six local mental health organisations from the NHS – including Oxford Health - and the charity sector.

Trust leaders graduate from Leading Together Programme

Senior leaders at Oxford Health graduate from the 2018 Leading Together Programme for learning disabilities. The development course brings together members of the public with healthcare professionals to reflect, learn and work at a strategic level.

Oxford Health new £8.5m learning disabilities low secure unit confirmed

The Department of Health confirms £8.5m funding to develop a new 10-bed low secure inpatient unit to support people with learning disabilities, including those with autism, at Littlemore Mental Health Centre. It will be a regional resource in the South of England to provide safe and responsive services to people with learning disabilities, including those with autism, who need specialist care.

New forensic children and adolescent mental health service launches

Young people, their families and professionals working with children in in Swindon, Wiltshire, Bath & North East Somerset, North Somerset, Bristol and Gloucestershire can now get support from our forensic children and adolescent mental health service (FCAMHS). Launched to support high risk young people, their families and carers, it offers consultation, assessment and interventions for young people.

Oxford Health to lead trailblazing mental health teams into schools

Children and young people in Oxfordshire and Buckinghamshire are to get better access to mental health services after both regions are chosen as NHS 'trailblazers' to pilot improvements to children's mental health services. £7.87m is awarded reduce

CAMHS wait times to four weeks by 2021. A pilot also aims to put new mental health practitioner teams into primary and secondary schools.

January 2019

Open letter to Oxfordshire County Council

Oxford Health, as part of the Oxfordshire Mental Health Partnership, is a signatory to a letter responding to concerns that Oxfordshire County Council is proposing to cut mental health funding by £1.6 million by 2022.

CQC says health and social care services are more joined up

Significant work has been done to join up services across Oxfordshire that is already demonstrating improved outcomes for people, according to a follow-up review by the Care Quality Commission which found key improvements had been made eight months into an 18-month action plan.

Trust welcomes Oxfordshire County Council change of heart

Oxford Health welcomes councillors' decision of to drop proposals for a £1m cut in OCC's contribution to the outcomes-based contract for mental health following an open letter from Oxfordshire Mental Health Partnership. It says it will delay by a year a proposal for a £600,000 saving against mental health social worker funding.

Director backs campaign for all to have a winter plan

Dr Rob Bale, clinical director and consultant psychiatrist urges everyone to have a winter mental health plan to help ease pressures on the health and social care system in Oxfordshire, as part of a system-wide campaign.

February 2019

Witney Community Hospital Extension

A new extension is being built to create a more comfortable environment for people visiting the minor injuries unit, X-ray and outpatients' departments. A new 24-seat waiting area is being constructed in a single-storey extension on hospital land attached to the X-ray department.

Oxford Health Charity backs first Youth in Mind conference

Oxford Health Charity is backs Oxfordshire's inaugural Youth in Mind conference for 400 youth professionals - coming together to raise awareness of mental health. OHC's support and £2,000 in funding will enable the creation of a Youth in Mind directory of services for schools, youth groups, medical professionals and the public.

Mental health funding gap in Oxfordshire – joint statement

Oxfordshire CCG and Oxford Health issue a joint statement following an independent review into the funding of mental health services which found the county is

considerably lower funded than comparator areas. Relative to similar areas, it spends 70 per cent of the average on mental health demonstrating a potential funding gap of up to £28m. It also has the lowest funding allocation per person of any CCG in the country, meaning it spends around 80% of the average.

Oxford Health marks Eating Disorder Awareness Week

A selection of personal testimonies from carers and patients with anorexia who are or have been treated at Cotswold House, Oxford Health's specialist service, garners national media, television and radio coverage.

First overseas nurse completes international programme

Bethany Thompson becomes Oxford Health's first overseas mental health nurse to complete our international programme and gain UK accreditation. Bethany, 27, from Sydney, Australia, completed the six-month programme giving her the essential Nursing and Midwifery Council registration to use her skills to work here. She is now a mental health nurse at the Highfield Unit.

Cannabis smoking in teenage years linked to adulthood depression

Smoking cannabis as a teenager could increase the risk of depression in adulthood by 37 per cent, a study led by Oxford Health's award-winning Professor Andrea Cipriani reveals. The landmark study, which analysed more than 23,000 people, showed the developing brain in 11-15 year olds is at significant risk to cannabis.

March 2019

Under My Skin: Play about self-harm returns to Oxfordshire's schools

A hard-hitting play developed with the guidance of experts from Oxford Health's CAMHS and School Health Nursing teams, that challenges the taboos about self-harm returns for a fourth tour of Oxfordshire schools.

Pilot course of nursing associate trainees graduate

Our first class of nursing associate trainees have completed the course they began in April 2017. More than 20 participants in the course, which ran as a part of the trust's apprenticeship programme, will have graduated in spring and summer 2019 after two years of hard work and dedication. They will now be able to work as nursing associates.

Performance Report

Overview

The purpose of this section of the report is to give a short summary of our organisation, its purpose, the key risks to the achievement of its objectives and how we have performed during the year.

About Oxford Health NHS Foundation Trust

On 1 April 2006, the Oxfordshire Mental Healthcare NHS Trust (created in April 1994) and Buckinghamshire Mental Health Partnership NHS Trust (created in April 2001) merged to establish the Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust. The Trust became the first NHS organisation in either Oxfordshire or Buckinghamshire to be authorised as an NHS foundation trust when it became Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust on 1 April 2008.

On 1 April 2011, as part of the Transforming Community Services programme, the Trust commenced providing community health services in Oxfordshire, which had been previously provided by Community Health Oxfordshire, the provider arm of the Oxfordshire Primary Care Trust. In preparation for this change, the Trust had been renamed Oxford Health NHS Foundation Trust.

Oxford Health NHS Foundation Trust (OHFT) is a public benefit corporation which is a community focused organisation that provides physical and mental health services and social care with the aim of improving the health and wellbeing of all our patients and their families. Our Trust provides community health, mental health, learning disability and specialised health services. We operate across Oxfordshire, Buckinghamshire, Berkshire, Wiltshire, Swindon and Bath and north east Somerset (BaNES).

In Oxfordshire we are the main provider of community health services and deliver these in a range of community and inpatient settings, including eight community hospitals. Our mental health teams provide a variety of specialist healthcare in the community and from inpatient settings across the geographic areas of Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire, Swindon and BaNES.

We also provide a range of specialised health services that include forensic mental health, child and adolescent mental health and eating disorder services across a wider geographic area including support for patients in Berkshire and Wales.

The Trust has been historically organised into three distinct Directorates, Children & Young People, Adults of Working Age and Older Peoples with each Directorate being led by a Service Director and a Clinical Director. During 2018/19, the Operational Directorate structures were realigned to reflect the delivery of all-age services within our regional areas.

We employ more than 6,700 staff (Whole Time Equivalent (WTE) over 4,700) which includes medical staff, therapists, registered nurses, health care workers, support staff and other professionals including psychology, dental staff, social workers and paramedics.

We have in excess of 194 clinical teams and operate services across more than 150 sites. Although we provide mostly community focused services we have a capacity of nearly 400 inpatient mental health beds, and circa 130 community hospital beds with our services treating more than 187,000 people a year. The main services we provide are detailed within the Quality Report.

The Trust is registered with the Care Quality Commission without conditions and is licenced to provide regulated activities by NHS Improvement (NHSI) (previously Monitor) without conditions.

Our aim is to improve the health and wellbeing of all our patients and families, and we work in partnership with a range of organisations to achieve that aim. These include our third sector partners, as well as Oxford University NHS Foundation Trust, Buckinghamshire Healthcare NHS Trust, and the University of Oxford; we work with these partners to promote innovation in healthcare, support research and to train doctors and psychologists.

In addition, Oxford Brookes University, Bath University and the University of Bedfordshire support us to train nurses and allied health professionals, and we work with local authorities, voluntary organisations and GPs across all the locations we serve, to best provide 'joined-up', seamless healthcare.

Strategic Overview of the Trust

Trust Vision

'Outstanding Care delivered by Outstanding People'

Outstanding care

- Focused on patient outcomes, safety and experience
- Continuous improvement culture – Oxford Healthcare Improvement Centre as our centre of excellence
- 'Ward to board' governance to quickly address issues
- Digital to enhance patient care and access
- Building on our 'Good' CQC rating (November 2018) to achieve 'Outstanding'

Outstanding people

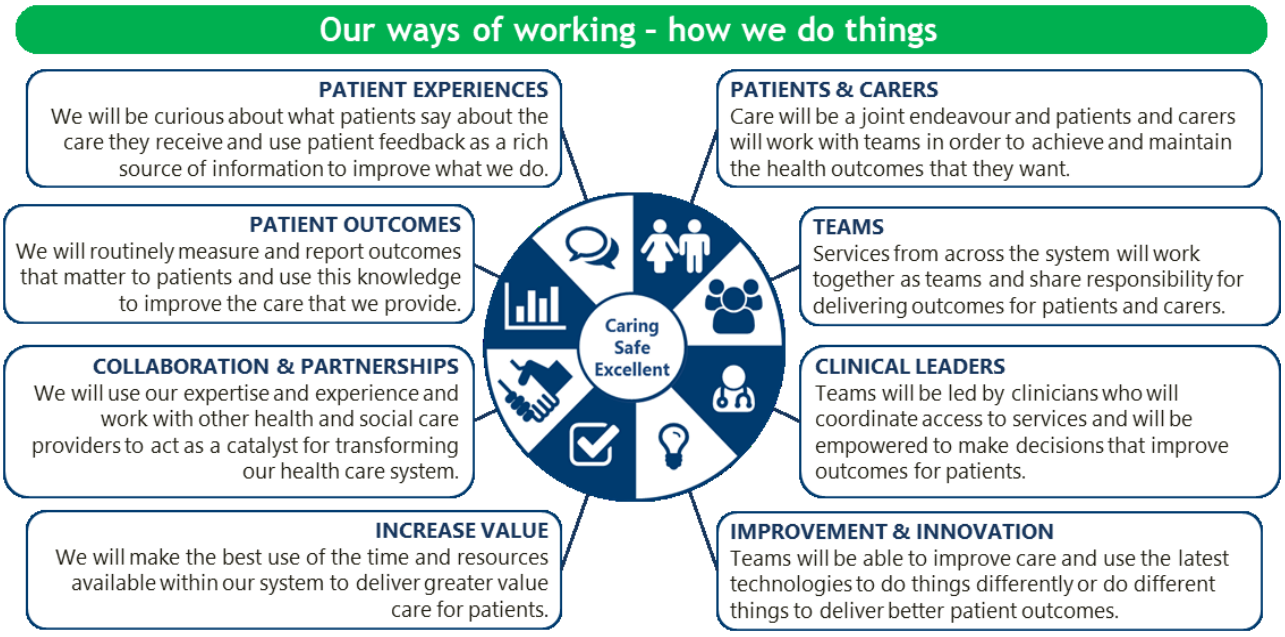
- Staff are passionate about the wellbeing of patients
- Career development – training and accreditation
- Supported staff – understanding the stress and impact of challenging care workloads
- Focus on retention e.g. career advancement, family-friendly employer, rewards and benefits
- Equality and inclusion initiatives

Trust Values

At Oxford Heath NHS Foundation Trust, we have three core values which support everything we do:

- **Safe** – Our services will be delivered to the highest standards of safety; all services will be provided within a safe environment for patients and staff; and we will support our patients and staff with effective systems and processes.
- **Caring** – Privacy and dignity is at the heart of our care; we will treat people with respect and compassion; we will listen to what people tell us and act upon what they say.
- **Excellent** – We will aspire to be excellent and innovative in all we do; we aim to provide the best services and continually improve; we will recognise and reward those who deliver excellence.

Trust Strategy



The Trust has the following strategic priorities to direct activities and planning:

- To improve the quality, safety and efficiency of care by transforming services;
- To make care a joint endeavour between staff, patients, families and carers;
- To support our leaders and develop our culture of continuous innovation and improvement;
- To ensure the Trust is high performing, financially viable, and a great place to work;
- To lead research and adopt evidence that improves the quality and outcomes for patients;
- To maximise the value of digital and technology that enhance the digital health record and improve our efficiency.

The Trust has the following clinical strategies/priorities:

- **Mental Health Transformation**

The Mental Health Transformation programme in 2018/2019 consisted of 6 workstreams, each making progress, and in some cases, fully achieving local and national ambitions.

The number of children and young people accessing mental health services is on the rise and our CAMHS teams across Bucks, Oxfordshire and BaNES, Swindon and Wiltshire have had to transform to meet the new needs of the populations that they serve. OHFT were awarded Trailblazer status for the C&YP Green Paper and have started to roll out Mental Health Support teams in schools across the counties. A new specialist Perinatal service has launched in Oxfordshire and the Buckinghamshire Perinatal service has expanded, expectant and new mothers now have access to specialist community-based interventions. IAPT services have continued to increase access and recovery rates for those with more common mental health disorders such as anxiety and depression.

OHFT was successful in bidding for specialist Individual Placement & Support to get those with severe mental illness (SMI) in to paid employment, full implementation will take place in the coming year. We have increased focus and improved processes relating to inappropriate out of area placements to ensure that individuals in beds outside of our boundaries receive good care and are repatriated as soon as clinically possible. We have led on and participated in many multi agency developments to improve care and support for those with the most complex presentations, and several Safe Haven pilots, staffed by the 3rd sector have taken place throughout Buckinghamshire and Oxfordshire.

The Dementia Strategy has been written for OHFT and will be signed off in the coming year, this also gives us an opportunity to complete a stock take of Older Adult CMHT's. OHFT contributed towards multi agency suicide prevention strategies and plans and also led on an STP bid to develop a standardised psychosocial assessment for those at risk of suicide and/or repeated self-harm.

- **New Care Models**

The New Care Models programme is about redesigning health and care systems to deliver better care for patients. New care models were developed to reduce the gap between patients' needs and resource. They break down the barriers between family doctors and hospitals and between health and social care services in how they provide care. This is intended to result in better care for patients, particularly those with long-term or complex needs. It's an integrated service across the network where care closer to home is maximised, out of area beds are minimised and the patient experience is improved whilst also generating and sharing efficiency savings which will be re invested within the service to aid further improvements. The following points set out work delivered in projects over 2018/19:

Eating Disorders

- Eating disorders (ED) single point of access (SPA) went live July 2018. All ED referrals that require inpatient admission are sent to a centralized inbox. Referrals are reviewed, and patients placed by the clinical activity panel weekly which is made up of Clinical Leads from the various partners within the network.
- The network consists of five inpatient partners and six community teams
- Network Manger has been recruited to support with the running of the Network
- Collaborative working and learning as well as sharing of best practice

Child and Adolescent Mental Health services

- SPA went live April 2019 and clinical partners are engaged.
- The network consists of five inpatient partners and three community teams providing eight units
- Network Manger has been recruited to support with the running of the Network

Thames Valley Wessex Forensic Network (TVWFN)

Over the two years of the TVWFN NCM pilot, 49 patients have been repatriated who were originally placed with out-of-network providers (19 during 2017/18 and 30 during 2018/19). This represents that 40% of patients who were recorded as placed out of network during 2016/17 were supported to return closer to home. At the pilot start up, between 16-24 patients were forecasted to be repatriated over the course of the pilot and so this is an excellent achievement credited to the good work of the network.

Despite the TVWFN covering a very large geography, the NCM partnership has been successfully maintained during the two-year pilot period. The Clinical Activity Panel, which provides clinical oversight of care pathways for network patients, has embedded itself within the NCM governance model well and is functioning successfully – it evidences excellent network collaboration. Consultants from the network have recently agreed to implement the Dundrum assessment tool to support network-wide standardisation of access to services as well as CORE-OM, a tool used to measure patient related outcomes.

When comparing 2018/19 data against pre-pilot data, lengths of stay have reduced by 15% (this being the combined average across network inpatient providers) and have therefore successfully achieved one of the key aims of the NCM. The NCM pilot has extended to a third year whilst it prepares to transition to a Provider Collaborative commissioning model in line with NHSE long-term plan.

This means from 2020/21, Provider Collaborative NCMs will take on more delegated responsibility for pathway and budget management for their network population through a lead provider contracting model.

- **Care Closer to Home**

The Care Close to Home Programme is progressing well against a backdrop of significant change in the Primary and Urgent Care environments and work continues to integrate Primary and Community Care in conjunction with emerging Primary Care Networks and the Oxfordshire Care Alliance. Neighbourhood teams have been established and OHFT is supporting the Clinical Commissioning Group led Frailty pathway trial with OxFed. Patient management through Virtual Wards was successfully piloted over the Winter period and an integrated Single Point of Access was established in July 2018, which is working well.

Oxford Health NHS Foundation Trust, Oxford University Hospitals and Primary Care Partners are continuing to refine the diabetes pathway to improve provider integration and patient outcomes.

On the strategy front the new Community Hospitals, Children's and Young People Community Health, Urgent and Ambulatory Care strategies are undergoing staff review and the Trust is working closely with system partners to take forward the Clinical Commissioning Group led population health framework and place-based commissioning. The development of the Community Directorate has meant that internal and external engagement across the full range of programme initiatives, has been more focussed and meaningful for staff, partners and patients alike.

Statement on performance from our Chief Executive

We continue to be one of the most efficient NHS Foundation Trusts in the country, and benchmarking and the recent Good CQC rating is a testament to the high value care that the Trust delivers. In terms of service delivery, we met the majority of national and locally contracted work and we have good satisfaction ratings from our service users.

This is a significant achievement given the financial and workforce pressures that the Trust and the broader system has experienced throughout the year. Availability of staff continues to be an issue, we are experiencing a significant and sustained increase in the number of referrals, and we are also facing more complex cases and increased acuity. Furthermore, it is recognised that there has been underinvestment in mental health services for several years: with 70% of our revenue derived from mental health services the impact of underinvestment is material.

Improving efficiency and productivity continues to be a priority for OHFT, but the combination of the historically low revenue allocation, the escalating activity, and the increasing complexity of conditions, at a time when it is difficult to fully staff all teams due to regional and national shortages for some specialist roles, makes achievement of a breakeven position ever harder for the years ahead.

I would wish to comment on my appreciation for the way in which Oxfordshire CCG have supported the joint approach between our two organisations to address the issue of mental health funding in Oxfordshire.

Specifically, following a joint independent review with the CCG, we have identified the extent of the shortfall in funding for mental health services in Oxfordshire by comparison with other similar areas in the order of £18-28m. The review also verified that the Trust makes good use of the resources we have (6% more efficiently than the average overall) which offsets the impact of the shortfall to some extent, but this situation has also meant that in recent years our services are in many cases delivering significantly more than they are being funded to do with consequent pressures on teams.

Having established the case and the extent of the issue, we obviously still need to finalise a plan which will get us back on a sustainable footing in the short term and correct the historic underfunding over a two to three-year period.

We should not underestimate the challenge which this poses to the wider Oxfordshire system. In this respect there are some very encouraging discussions taking place about developing a more integrated approach to mental health in the context of wider integrated care system working across Oxfordshire and Buckinghamshire.

The underinvestment described combined with the high levels of mental health activity (exceeding the CCG allocations) was the prime reason for the Trust's financial deficit. The CCG and Oxford Health are working on a three-year plan to redress the funding situation.

The difficulty in recruiting staff across the Trust, which covers a number of areas with a high cost of living, has been an ongoing contributing issue, with agency spend continuing to rise and reaching £24.6m in the year, adding pressure to costs. In mitigation, the 2018/19 cost improvement programme did result in savings of £8.5m against a target of £6.0m.

I am particularly proud of the individuals and teams working and volunteering at the Trust for delivering the great care they have in such challenging circumstances.

Key Issues and Risks

The following operational risk areas are captured in the Trust's current Operational Plan:

Workforce – The high cost of living in Oxford combined with significant increases in workload and caseload make it difficult to attract and retain substantive staff.

These factors, combined with demographics, mean that significant numbers of experienced people are retiring each year, creating risks that patient care and other quality measures will be impacted with increasing severity.

A lack of concerted workforce planning in recruitment and retention, and impacts on staff wellbeing, will result in rising turnover and agency rates, and shortages of staff in some service areas impacting on quality, patient care, and staff morale.

Mitigation actions include: career pathway development (including training accreditation); significant investment in apprenticeships, nursing associates and peer support workers; increased use of bank; benefits and rewards initiatives; new roles and skill mix implementation; proactive recruitment initiatives (e.g. with universities); and retention initiatives (e.g. stay conversations, collaborative work to reduce workplace stress and improve wellbeing and learning from exit interviews).

Demand and Activity - Across the board, data collected by the Trust shows that demand for services is consistently rising yet funded operational and workforce capacity have been constrained at a level significantly below that required to meet it.

In the most challenging services areas, in the absence of progress in resolving historic underfunding, the Trust forecast that it would need to reduce mental health activity across Oxfordshire by approximately 25%.

As this reduction may not be practical in some mental health service areas, reductions may need to be greater in other mental health services where reductions are possible. To scale back services, the Trust would align activity with levels of investment received using capacity and demand models consistent with those promoted nationally by NHS England (NHSE).

Patient flow – failure to care for patients in an appropriate inpatient placement or environment, due to bed pressures or absence of community or social care support, could lead to compromising patient & carer outcomes and experience.

Mitigation actions include: releasing senior matron capacity to work on patient flow; joining system winter calls to raise system awareness of mental health pressures; twice weekly calls led by the Deputy Chief Operating Officer to review every patient out of areas (OAPs) and plans in place; review of staffing pressures; and planning with commissioners on funding for a Crisis Resolution Home Treatment Team (CRHTT) to enable provision of additional intensive home care support.

Financial sustainability - Continued underinvestment places the Trust under significant financial pressure compromising financial stability and its ability to adapt to change. Risks include: not securing additional revenue contribution from commissioners; limited contingency reserve to cover for unplanned events; and non-delivery of cost improvement plans (CIPs).

Mitigation actions include: developing demand and capacity insight to inform demand management and service planning; focus on revenue; and robust delivery (governance) of cost efficiency and productivity work (Cost Improvement Programme schemes).

Going Concern

The Board of Directors is clear about its responsibility for preparing the annual report and accounts. The Board sees the annual report and accounts considered as a whole, as fair, balanced and understandable, and as providing the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business

model and strategy. The Board also describes some of the principal risks and uncertainties facing the Trust in the Annual Governance Statement.

Oxford Health NHS Foundation Trust has prepared its 2018/19 accounts on a going concern basis. After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Performance Analysis

Financial Review

The Trust's financial position is detailed in the Annual Statutory Accounts, which are part of this Annual Report. The Board approved the full audited accounts on 24th May 2019 and the auditor's opinion on the Financial Statements was unqualified, however their report includes a qualification of their value for money conclusion. Historically, the Trust has a strong track record of delivering against financial targets and has consistently performed better than the national average efficiency. During FY19 the Trust had a deficit of £5.7m which was £1.6m worse than the plan. It is important to note that this position included £1.5m of Sustainability and Transformation funding (STF) as follows:

STF	£000
Core	407
Incentive scheme	1,112
Total STF	**1,519**

Although the Statement of Comprehensive Income shows a deficit of £5.7m, excluding STF and other exceptional items (impairments, depreciation on donated assets and non-cash pension costs on SoFP) the underlying position is a deficit of £8.2m, as outlined below:

2018/19 Statement of Comprehensive Income Summary	
	£000
Total Income	337.9
Expenses	(338.4)
Operating Surplus/(Deficit)	(0.5)

Net finance cost and gain on transfer	(5.2)
Surplus/(Deficit) for the year	(5.7)
Exceptional items:	
Net reversal of impairment of assets	(1.2)
Sustainability and transformation funding	(1.5)
Depreciation on donated assets and non-cash pension costs on SoFP	0.2
Surplus/(Deficit) before exceptional items (Underlying position)	(8.2)

Performance against Local and National Indicators

The Trust currently manages performance using a strategic performance framework that provides focus for activity planning, development and performance measurement and comprises four strategic drivers and three enablers;

Strategic drivers:

1. Driving quality improvement
2. Delivering operational excellence
3. Delivering innovation, learning and teaching
4. Developing business through partnerships

Strategic enablers:

5. Developing leadership, people and culture
6. Getting the most out of technology
7. Using our estate efficiently

Annual business plans are created to deliver the Trust strategy with performance measures aligned with the strategic drivers and enablers and progress against the achievement of the plans is reviewed quarterly by the Board.

Within the Strategic Performance Management Framework, Trust performance is measured as follows:

- Performance against locally contracted targets, including Commissioning for Quality and Innovation payments (CQUIN)
- Performance against national targets

- NHSI Improvement Ratings
- Performance in national staff and patient surveys
- Quality measures under the domains of patient safety, clinical effectiveness and patient experience
- Outcomes of quality improvement projects
- Key financial and workforce targets (including CIPs)
- Service user and carer experience
- Outcomes of Care Quality Commission inspections
- Performance against programmes and projects

Progress in these areas is monitored by the receipt and scrutiny of reports at directorate, executive, committee, Board and Council of Governors levels.

Performance of the Trust in 2018/19:

Performance Management: The Trust has adopted a traditional scorecard approach to the management and reporting of performance against local and national indicators. The first graphic overleaf is an example of a monthly report that is provided to the Operational Senior Management Teams, the Board of Directors, Commissioners and on a quarterly basis to the Council of Governors.

The report uses a traditional traffic light reporting scheme and where performance is assessed as red (>10% below target) a special exception report is produced with additional information. By reporting on performance in this way, audiences, including the public are able get a detailed view on what has happened and the actions and timescales for resolution.

In addition to the overall performance scorecard, the Trust also reports on the achievement of indicators over time. The second graphic below is updated on a monthly basis to show the number of indicators that are reported on and the number achieved split simply by met/not met.

This approach to reporting has received significant support all round and continues to be developed. The Trust continues to integrate data to better use information assets for insight, management and reporting.

Performance Scorecard

The tables below show performance as at month 12 with a more detailed breakdown below;

Summary

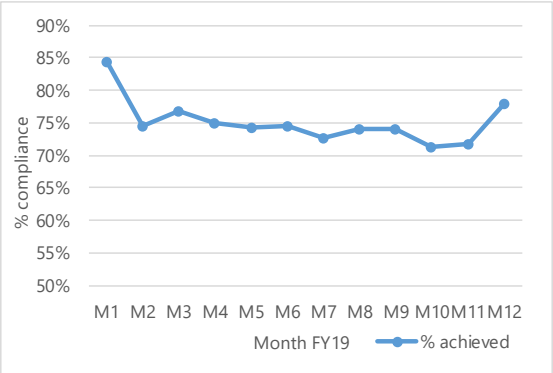
Directorate	Below target >10%	Below Target -1-9%	Target Met	No Target	Total	% Met
National Performance						
(1) Single Oversight Framework	5	1	9	15	15	60%
Local JMG Performance						
(2) Joint Management Groups	0	0	8	111	8	100%
Local Contractual Performance						
(3) Community Services	11	14	94	767	119	79%
(4) All Ages Mental Health Oxon and SWB	27	10	81	360	118	69%
(5) All Ages Mental Health Buckinghamshire	6	10	38	208	54	70%
(6) Specialised Services	2	15	122	116	139	88%
Local Contractual Performance Total	**46**	**49**	**335**	**1451**	**430**	**78%**
Grand Total	**51**	**50**	**352**	**1577**	**453**	**78%**

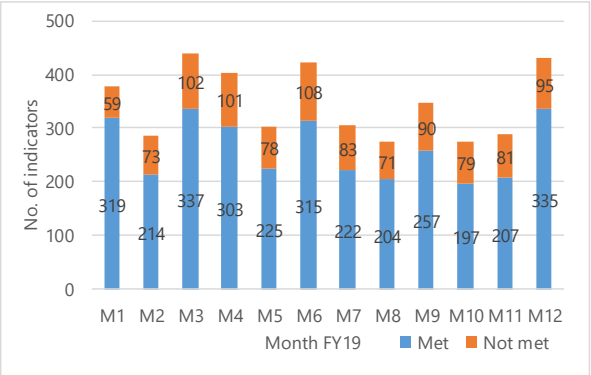
Breakdown

Area	Below target	Below Target	Target Met	No Target	Total	% Met
National Performance						
(1) Single Oversight Framework	5	1	9	15	15	60%
Local JMG Performance						
(2) Joint Management Groups	0	0	8	111	8	100%
Local Contractual Performance						
(3) Community Services	11	14	94	767	119	79%
College Nursing	1	1	7	180	9	
School Health Nursing	0	2	26	159	28	
Health Visiting	2	8	21	83	31	
Immunisations	0	0	7	3	7	100%
Community Adults	3	2	25	266	30	83%
Community Children	3	1	4	15	8	50%
Community Other	0	0	0	0	0	
AQP Podiatry	0	0	3	26	3	100%
Continuing Health Care	2	0	1	35	3	33%
(4) All Ages Mental Health Oxon and SWB	27	10	81	360	118	69%
Outcomes Based Commissioning (OBC) Sch 4 (Oxon)	7	0	5	3	12	42%
OBC Incentivised (Oxon)	2	0	12	87	14	86%
Child and Adolescent Mental Health Service (Oxon)	5	1	6	75	12	50%
Integrated Access to Psychological Therapies (Oxon)	0	0	10	9	10	100%
Wellbeing (Oxon)	0	0	13	0	13	100%
Community & Mental Health Contract Sch 4 (Oxon)	3	1	12	7	16	75%
Child and Adolescent Mental Health Service (SWB)	9	6	18	134	33	55%
Adult Eating Disorders (Wiltshire)	1	2	5	45	8	63%
(5) All Ages Mental Health Buckinghamshire	6	10	38	208	54	70%
Adults & Older Adults CMHTs and Inpatients, IAPT, Perinatal and PIRLS (Bucks)	1	8	22	35	31	71%
CAMHS (Bucks)	5	2	16	173	23	70%
(6) Specialised Services	2	15	122	116	139	88%
Learning Disabilities (OCCG)	0	3	7	0	10	70%
Dentistry (NHSE)	0	0	31	8	31	100%
Forensic MSU (NHSE)	1	5	28	29	34	82%
Forensic LSU (NHSE)	0	5	29	29	34	85%
CAMHS Tier 4 Inpatients (NHSE)	0	1	14	25	15	93%
ED Inpatients (NHSE)	1	1	13	25	15	87%

Performance Trend

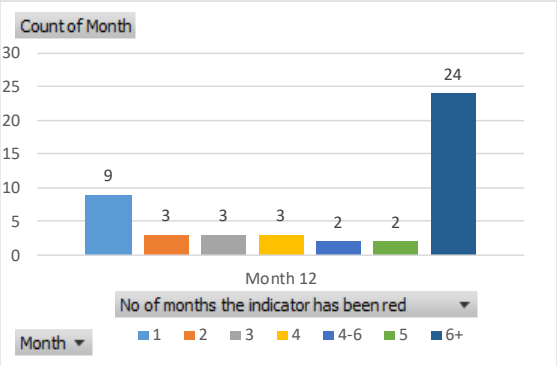
The number of reportable indicators varies each month as while the majority are reportable monthly, some are reportable less frequently (such as quarterly or bi-annually). In month 12, 430 contractual indicators were reportable and of these; 78% were achieved. This is an increase in performance of 6% compared to last month. The number of red indicators this month was 46 which represents 11% of the total number of indicators. Last month it was 13% based on 288 indicators.

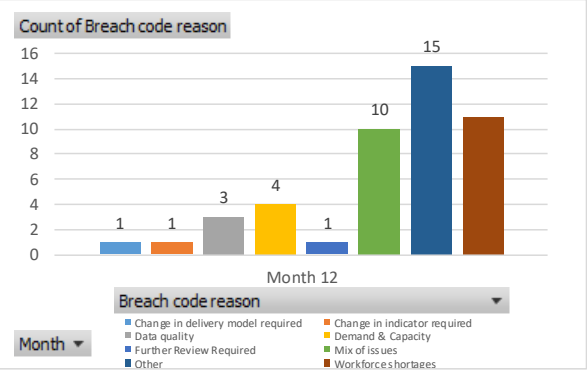


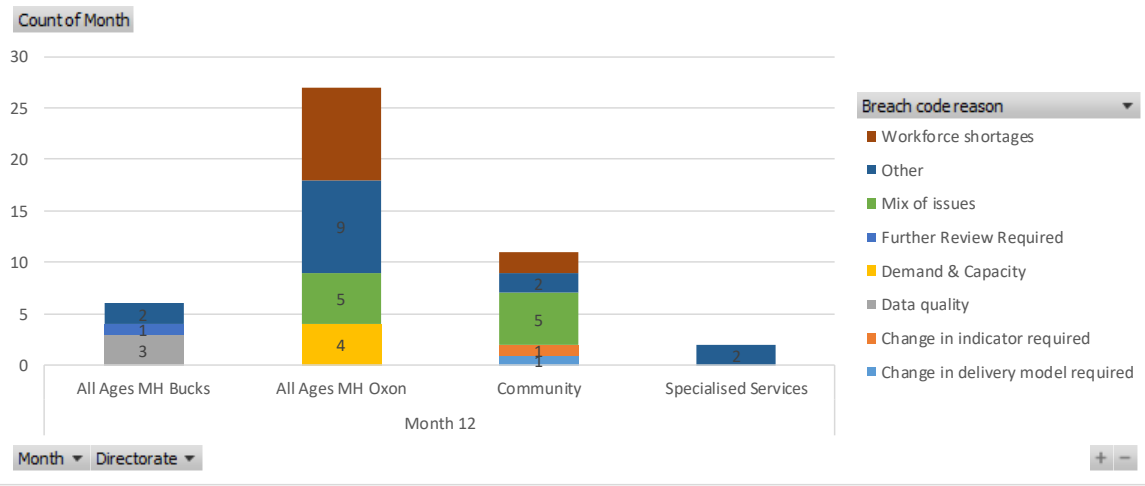


In month 12, there were 24 red indicators that have been red for more than 6 months and 7 indicators red for 4 to 6 months. Last month the figures were 21 for 6 months plus and 3 for 4 to 6 months.

In month 12, the main reason attributed to the non-achievement of local contractual indicators was "other" (e.g. related to patient acuity, indicator introduced this month, issues related to workforce other than lack of workforce); **15 of the 46 red** indicators were not achieved due to this. The graph at the bottom shows the breakdown of reasons by directorate.







Equality and Human Rights

We seek to comply with the requirements of the Public Sector Equality Duty to make sure that we consider the needs of all individuals across our policy development, delivery of services and employment practices. In line with our duties as an employer and provider of NHS services, we also have policies that provides a framework to ensure compliance with the Equality Act 2010 and Human Rights Act 1998. Other sections of the Annual Report cover our work on the Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES) and the Workplace Equality Index (WEI). We continue to work with our staff networks and local community to address discrimination and improve staff and patient experience and outcomes for all.

Modern Slavery

At Oxford Health NHS Foundation Trust, we are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. Our statement which can be accessed here: https://www.oxfordhealth.nhs.uk/about-us/governance/modern-slavery-act-transparency-statement/ sets out actions taken by OHFT to understand all potential modern slavery and human trafficking risks and to implement effective systems and controls.

Anti-Bribery

The Trust has a Conflicts of Interest Policy, which was based on NHS England's model policy. The policy was developed following the issue of new guidance on managing conflicts of interest in the NHS. The new policy incorporates an all-encompassing approach to managing conflicts of interest and has an increased focus on transparency. The Audit Committee oversees counter fraud and anti-bribery activity and more information is provided in the Corporate Governance section.

Environmental matters

As an NHS organisation, we have an obligation to work in a way that has a positive effect on communities. Environmental sustainability means the smart and efficient use of natural resources and building healthy, resilient communities. To fulfil our responsibilities for the role we play, the Trust has the following vision which is located within our Sustainable Development Management Plan (SDMP):

Vision of sustainable health and care: *A sustainable health and care system works within the available environmental and social resources protecting and improving health now and for future generations. This means working to reduce carbon emissions, minimising waste & pollution, making the best use of scarce resources and building resilience to a changing climate.*

To embed this vision of environmental sustainability within the organisation we have a Board approved policy and SDMP. One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Sustainable Development Assessment Tool (SDAT). The SDAT was completed in March

2019, with the trust scoring 34%. In terms of benchmarking, this compares with the national NHS Trust average of 52% and in order to improve will continue to use the SDAT to assist in identifying areas where we can advance our performance and we have plans that aim to support that continuing improvement going forwards.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal as follows:

Sustainability Scorecard 2018/19: As a part of the NHS public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS public health and social care system by 34% by 2020 which is equivalent to a 28% reduction from our 2014 baseline.

A snapshot of some of our achievements is given below:

- Installation of LED Low Energy Consumption lighting
- Ultra-Low Emission Electric vehicle now part of the Estates Maintenance Fleet of vehicles.
- Staff awareness communications strategy regarding reducing Energy Consumption.

Energy: As part of our plans to reduce energy consumption, we achieved 0.5% of our electricity use coming from renewable sources in terms of:

- Highfield Unit – Photo Voltaic (Solar Panels)
- Whiteleaf Centre – Ground Source Heat Pump

As part of our plan and capital investment programme, we have strategies to invest in technology that will enable us to reduce our annual spend on utilities and increase the amount of our electricity that is provided by renewable sources. Our achievement in reducing energy consumption is mainly attributed to improved staff awareness of carbon and energy reduction requirements, and through the oversight and monitoring of performance and activity by the Trust's Sustainable Development Group which is now in place. In addition, investment in energy efficient lighting and high efficiency boilers have supported our aim.

Travel: We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services. We support a culture for active travel to improve staff wellbeing and reduce sickness and are seeing a slow reduction, in business travel through the measure of miles, tCO_2e and cost. We have ambitions to do more to improve this area of environmental sustainability.

Future: We intend to continue to contribute in positive ways to the sustainability of the Trust through the following measures:

- Increase staff awareness with regular communications.

- Secured NHSI funding of £300k to install LED Energy saving lighting.
- Develop Partnership with Oxford Bus Company to reduce staff business mileage.
- Improve monitoring of environment temperatures as part of Energy reduction.
- Introduce Water Monitoring measures and reduction targets.
- Improve SDAT score from 34- 40 %.
- Key Worker transport review with Oxfordshire County Council (EV Car Share).
- Adopt NHS "Clean Air Framework" Monitoring tool.

Signed: **Dated: 24 May, 2019**

Stuart Bell CBE
Chief Executive and Accounting Officer

Accountability Report:

Directors' report

The Board of Directors is focused on achieving long term success for the Trust through the pursuit of sound business strategies, whilst maintaining high standards of clinical and corporate governance and corporate responsibility.

The following statements explain our governance policies and practices and provide insight into how the Board and management run the Trust for the benefit of the community and its members.

The Board of Directors brings a wide range of experience and expertise to its stewardship of the Trust and continues to demonstrate the vision, oversight and encouragement required to enable it to thrive. During the year, the Trust welcomed a new member to the Board with the governors appointing Lucy Weston for a first term of three years, as non-executive director to succeed Alyson Coates who emigrated, leaving the Trust in September 2018; and they concluded the process to appoint the new Chairman, David Walker, succeeding Martin Howell who after nine years of dedication to the Trust, retired on 31st March 2019.

Ros Alstead, OBE retired from the Trust in December 2018 having contributed significantly to the improvement of our services for the benefit of those being cared for by the Trust and to improvements in the experiences of nurses and other heath professionals. Catherine Riddle has been the Acting Director of Nursing since Ros's departure pending the commencement of the successor Chief Nurse, Marie Crofts, in June 2019. Kate has been a most valuable member of the Board during this time.

The Board is especially grateful for Martin's, Alyson's and Ros's dedication and for all of their commitment to the Trust over the years and wishes them well with future endeavours.

At the end of the financial year the Board comprised eight non-executive directors including the chairman (together holding majority voting rights); five voting executive directors including the chief executive; and three non-voting executive directors. Details of all Board directors and their respective membership of committees is included later in the Annual Report.

Chairman, Martin Howell has throughout the year been responsible for the effective working of the Board, for the balance of its membership subject to Board and governor approval and for ensuring that all directors are able to play their full part in the strategic direction of the Trust and in its performance.

The chairman conducted annual appraisals of the non-executive directors and presented the outcomes of such to the governor Nominations and Remuneration Committee. Furthermore, the chairman is responsible for carrying out the appraisal of

the chief executive which was also completed in the year and reported to the respective committee.

Stuart Bell, CBE is chief executive and responsible for all aspects of the management of the Trust. This includes developing appropriate business strategies agreed by the Board; ensuring appropriate objectives and policies are adopted throughout the Trust; and that appropriate budgets are set, and performance effectively monitored.

The chairman, with the support of the company secretary ensures that the directors and governors receive accurate, timely and clear information, making complex information easier to digest and understand.

Directors are encouraged to update their skills, knowledge and familiarity with the Trust's business through their induction; ongoing participation at Board and committee meetings; attendance and participation at development events and board seminars; board member site visits and through meetings with governors. The Board is also regularly updated on governance and regulatory matters.

There is an understanding whereby any non-executive director, wishing to do so in the furtherance of their duties, may take independent professional advice through the director of corporate affairs/ company secretary at the Trust's expense.

The non-executive directors provide a wide range of skills and experience. They bring an independent judgement on issues of strategy, performance and risk through their contribution at Board and committee meetings. The Board considers that throughout the year, each non-executive director was independent in character and judgement and met the independence criteria set out in NHSI's Code of Governance.

The non-executive directors have ensured that they have sufficient time to carry out their duties. Any term beyond six years is subject to rigorous review by the governors' Nominations and Remuneration committee, to include the needs of the organisation in the context of the environment within which it operates.

The non-executive directors through the Nominations Remuneration and Terms of Service Committee are responsible for reviewing the performance appraisal conducted by the chief executive of executive directors and that of the chief executive conducted by the chairman.

During the year, the time spent with the governors has helped the Board to understand their views of the Trust and its strategies, and all Board members attend the Council of Governors' meetings with governors routinely attending the public Board meetings as observers.

Communications with members and service users support our understanding of the things that matter to patients, but we recognise more work needs to be done to make membership more meaningful for those who would wish to be more involved and with that in mind, a new Membership Strategy was approved at the March 2019 Council of Governors' meeting.

We also strive to improve and help patients be more involved in their own care and in service developments. Our membership and patient involvement strategies continue to make a difference and have been revised and enhanced during the year.

During the year covered by this Annual Report the Board of Directors comprised the following individuals who served as Directors in 2018/19:

Executive Directors

V*oting executive director members of the Board:*

Stuart Bell, CBE, Chief Executive

Ros Alstead, Director of Nursing and Clinical Standards to 7th December 2018

Kate Riddle, Acting Director of Nursing from 8th December 2018

Mike McEnaney, Director of Finance

Dominic Hardisty, Chief Operating Officer and Deputy Chief Executive

Dr Mark Hancock from 1st April 2016, Medical Director

Non-voting executive director members of the Board:

Kerry Rogers, Director of Corporate Affairs and Company Secretary

Tim Boylin, Director of Human Resources

Martyn Ward, Director of Strategy and CIO

Non-Executive Directors (*voting non-executive members of the Board*):

Martin Howell, Chairman

Sir John Allison

Sir Jonathan Asbridge (*Vice Chairman)*

Alyson Coates to 30th September 2018

Professor Sue Dopson

Bernard Galton

Chris Hurst *(Senior Independent Director)*

Dr Aroop Mozumder

Lucy Weston from 1st March 2019 *(non-voting associate to 28th February)*

The Chairman and Non-Executive Directors are appointed for a period of office as decided by the Council of Governors at a general meeting, and their terms of office may be ended by resolution of the Council of Governors in accordance with the provisions and procedures laid down in the Trust's Constitution. The current periods

of office of each of the non-executive directors and their respective terms are provided below:

Name	Period of office	Term since FT status
Martin Howell*	31/03/19	3rd *(retired 31st March 2019)*
Sir Jonathan Asbridge	30/06/20	2nd
Sir John Allison	31/03/21	2nd
Alyson Coates	30/09/18	3rd (*resigned early due to relocation overseas*)
Professor Sue Dopson	31/05/21	3rd
Bernard Galton	31/01/21	1st
Chris Hurst	31/03/20	1st
Dr Aroop Mozumder	31/01/21	1st
Lucy Weston	28/02/22	1st

**retired at end of third period of tenure*

Register of interests

The register of interests for all members of the Board is reviewed regularly and is maintained by the director of corporate affairs/company secretary. Any enquiries should be made to the director of corporate affairs/company secretary, Oxford Health NHS Foundation Trust, Trust Headquarters, Warneford Hospital, Warneford Road, Headington, Oxford, OX3 7JX.

Skills and Experience

We are required to describe in the Annual Report each director's skills, expertise and experience and these have been outlined below along with their attendance at each of the Board of Directors' meetings and four Council of Governors' general meetings that took place during the year detailed aside each director's name:

Martin Howell (Chair) 11/12 and 5/5 meetings

Martin enjoyed a long career in the UK steel industry after completing a BSc in Chemistry at the University of Bristol. He retired from Corus as Director of Construction in 2006 and was appointed Chairman of Oxford Health NHS FT in 2010. Prior to this he was a non-executive director of NHS South Central Strategic Health Authority. As well as his work for the Trust, Martin was also a Governor of Oxford Brookes University, a Governor of Oxford University NHS Foundation Trust and a Board member of Thames Valley Crime Stoppers.

Sir John Allison 11/12 and 2/4 meetings

Sir John was appointed to the Board on 1 April 2015, having previously been appointed Associate Non-Executive Director from 1 October 2014. He had a long-distinguished career with the Royal Air Force, retiring with the rank of Air Chief Marshal. Subsequently he was a director of Jaguar Racing Ltd and then a project director for Rolls Royce Plc. He was also a member of the Criminal Injuries Compensation Appeals Tribunal for 13 years. Sir John was elected President of Europe Air Sports in 2004 and served for five years. He was President of the Light Aircraft Association from 2006 to 2015.

Sir John is a Knight Commander of the Order of the Bath and a Commander of the Order of the British Empire. Between December 2005, and March 2013 he served as Gentleman Usher to the Sword of State; the officer of the British Royal Household responsible for bearing the Sword of State on ceremonial occasions.

Sir Jonathan Asbridge (Non-Executive Director) 8/12 and 2/4 meetings

Sir Jonathan was appointed Non-Executive Director on 1 July 2014. He was the first president of the UK's Nursing and Midwifery Council. From early experiences as a St John Ambulance cadet in Cardiff, he went on to become a state registered nurse at St Thomas' Hospital, London. After a career in nursing at Singleton Hospital, he moved to Addenbrooke's Hospital, becoming General Manager, then Director of Clinical Care services. He later became Chief Nurse at Barts and the Royal London Hospitals.

In 2003 he was appointed National Patient Champion for A&E Experience at the NHS Modernisation Agency. He has also worked at Llandough Hospital and the John Radcliffe Hospital in Oxford. He is currently Clinical Director of Healthcare at Home Ltd.

Sir Jonathan is a member of the Royal College of Nursing, Amnesty International, and the Standing Nursing and Midwifery Advisory Committee. He is a trustee of the Nurses Welfare Service and Senior Nursing Editor for the Journal of Clinical Evaluation in Practice. In June 2006, he was knighted in the Queen's Birthday Honours List.

Alyson Coates (Non-Executive Director) 4/6 and 2/2 meetings

Alyson was appointed by the Council of Governors in April 2011. She takes a keen interest in the strategic direction of the Trust and in clinical and financial governance. Originally a biochemist, Alyson spent most of her career as an equity analyst at an international investment bank, specialising in the healthcare sector. Prior to joining the Trust, Alyson was Vice-Chair and Chair of the Audit Committee at South Central Strategic Health Authority. She was a member of the Auditing Practices Board of the national independent financial regulator, the Financial Reporting Council and External Advisor to the Audit Committee of the Olympic Lottery Distributor. Alyson was until recently an independent Governor of Oxford Brookes University where she chaired the Finance and Resources Committee.

Professor Sue Dopson (Non-Executive Director) 6/12 and 2/4 meetings

Sue is Rhodes Trust Professor of Organisational Behaviour and Faculty Dean at Saïd Business School. She is also Fellow of Green Templeton College, Oxford, and Visiting Professor at the University of Alberta, Canada. She is a noted specialist on the personal and organisational dimensions of leadership and transformational change, especially in the public and healthcare sectors.

Sue teaches on the Oxford Advanced Management and Leadership Programme, the Oxford Strategic Leadership Programme, and Consulting and Coaching for Change. She has worked closely with organisations ranging from the UK Department of Health to Roche Pharmaceuticals. As a founding director and current member of the Oxford Health Care Management Institute, she is involved in the development of courses for the NHS. She is also a trustee of the Society for Studies in Organizing Healthcare.

Bernard Galton (Non-Executive Director) 10/12 and 1/4 meetings

Bernard had a long and successful Civil Service career and retired in 2014 from his role as Director General in the Welsh government. He has 15 years' executive board experience and has also been a non-executive director in both an NHS Foundation Trust and a private sector joint venture company.

He led a large corporate services department and was Head of Profession for Human Resources and Organisation Development across all public service bodies in Wales, and responsible for complex multi-million pound contracts with key private sector suppliers across ICT, property and facilities management and learning and development. He is also a Chartered Fellow of the Chartered Institute of Personnel and Development.

He also worked at the highest level in NHS Wales gaining an in depth understanding of key strategic issues facing health and social care services and the professional and operational challenges faced by clinical leaders. He is currently director of a property management and management consultancy.

Chris Hurst (Non-Executive Director) 9/12 and 3/4 meetings

Chris was appointed in April 2017 and is a consultant and executive coach with 25 years' board experience, working in both executive and non-executive roles.

He is a chartered accountant and has worked in the banking and technology sectors, in local and national government and as a Deputy CEO in the NHS.

He was previously a Board Trustee of the Healthcare Financial Management Association (HFMA) and is a non-executive director of a small digital development company and an independent adviser to a healthcare products company.

Dr Aroop Mozumder (Non-Executive Director) 10/12 and 3/4 meetings

Aroop was appointed a Non-Executive Director on 1 September 2017. After qualifying in medicine from Charing Cross Hospital he initially trained in General Practice in the NHS and then spent a couple of years working for Save the Children in famine relief in Africa.

Aroop enjoyed a long career in the Royal Air Force, including being the Inspector General of Defence Medicine, retiring as Director General Medical Services in the rank of Air Vice-Marshal. In the Queens' Birthday Honours List in 2015 he was awarded a Companion of the Order of the Bath.

Currently he works as a Research Fellow at Harris Manchester College Oxford University, is a National Adviser to the Care Quality Commission and is the Academic Dean of the Society of Apothecaries in London.

Lucy Weston (Non-Executive Director from 1st March 2019 (previously 'Associate')) 10/12 and 4/4 meetings

Lucy was appointed as a non-voting associate non-executive in September 2017 and subsequently as voting non-executive director on 1st March 2019. She is a chartered accountant who has spent most of her career in the private and charity sectors. She is a Non-Executive Director (Chair) of Soha Housing and a Governor of Oxford Brookes University.

Stuart Bell CBE (Chief Executive) 11/12 and 3/4 meetings

Stuart was appointed Chief Executive Officer of the Trust on 1 October 2012. Prior to that he was the Chief Executive Officer of South London and Maudsley NHS Foundation Trust for 13 years. He has more than 35 years' NHS experience and has also been Chief Executive of Thameslink NHS Trust and Lewisham and Guy's Mental Health NHS Trust. Earlier in his career he worked at Charing Cross and Whittington hospitals before moving to the South West Thames Regional Health Authority in 1990.

In 2008 Stuart was awarded a CBE for services to the NHS. He is an Honorary Fellow of King's College London and the Royal College of Psychiatrists. He is also Chairman of the Picker Institute Europe and a trustee of Help for Heroes

Ros Alstead OBE (Director of Nursing & Clinical Standards) 8/9 and 1/3 meetings

Ros worked in the NHS for over 35 years, graduating from London University and St George's Hospital with a degree in general nursing, followed by qualifying as a Registered Mental Health Nurse. She had experience as a nurse in both inpatient and community settings before becoming a general manager and completing her MBA at Ashridge Business School. Ros now has more than 20 years' experience at director level.

Ros was Chair of the National Mental Health Nurse and LD Directors and Leads Forum until December 2012. She was a panel member of the Richardson Committee reforming the Mental Health Act and was also the NHS Panel member on the Kerr

Haslam inquiry. In 2017 she was awarded an OBE for services to the NHS. She took retirement in December.

Kate Riddle (Acting Director of Nursing) 3/3 and 1/1 meetings

Kate has a wide range of experience in the NHS and specifically nursing, as a registered nurse, midwife, health visitor and school health nurse. She has worked in the trust area since 1997, has been trust lead for safeguarding for children and young people and was for several years head of nursing for the Children and Young People directorate.

Mark Hancock (Medical Director) 10/12 and 2/4 meetings

Mark was appointed Medical Director in April 2016 and has worked with Oxford Health in several roles since 1999. He has previously been the Deputy Medical Director, since May 2013. In recent years, he has been psychiatric lead for medium secure services (2013-14) and associate clinical director for forensic services (2011-2013).

Mark is Trust lead for Clinical Risk Assessment and Management, the Trust's Caldicott Guardian and Chief Clinical Information Officer. He completed the Nye Bevan programme with the NHS Leadership Academy in 2014.

Dominic Hardisty (Chief Operating Officer) 11/12 and 4/4 meetings

Dominic was appointed Chief Operating Officer and Deputy Chief Executive in February 2016. Dominic was previously Deputy Chief Executive of Northamptonshire Healthcare NHS Foundation Trust.

His background includes 20 years as a leader and entrepreneur in the private sector as well as, since 2009, at several NHS acute and community trusts. These roles have included leading teams to transform services across acute, community, mental health and children's/young people's pathways, as well as leading on responses to CQC inspections and formation of partnerships across primary, acute, community and social care. He holds a degree from Oxford University and an MBA from Harvard Business School. He is also Parish Councillor for East Hendred.

Mike McEnaney (Director of Finance) 12/12 and 3/4 meetings

Mike commenced his financial management career in consumer goods with Hoover adding multinational experience gained in the oil and consumer lubricants sector with Burmah Castrol. He has substantial experience at the executive level gained as Finance Director of Honda's UK manufacturing operations, Avis's UK car rental business and a private equity backed global business. Together with the financial experience gained in manufacturing and commercial organisations, he has experience of managing IT and HR. Mike joined the Trust as Director of Finance in September 2011.

Tim Boylin (Director of Human Resources) 11/12 and 4/4 meetings

Tim Boylin graduated in Law from Leeds University in 1983 before joining the Dowty Group of companies as a Personnel Officer. He spent 15 years in progressively more

senior HR roles in the aerospace and defence sector with Dowty and TI Group, including a five year period based in Toronto leading the HR function for Canadian subsidiaries. He moved into the utilities sector in 1998 and has held operational and corporate HR Director roles in Thames Water and EDF Energy.

In addition to the full range of HR responsibilities, Tim has been Chairman of two large boards of pension trustees. He also has significant merger and acquisition experience, and has led on Health, Safety and Sustainability and is a champion of equality and diversity. Tim joined the NHS in November 2016 and joined the Board of Directors of Oxford Health in January 2018.

Kerry Rogers (Director of Corporate Affairs & Company Secretary) 12/12 and 2/4 meetings

Kerry joined the Board of Directors as a non-voting executive director and Company Secretary on 1 September 2015. Kerry has held Director level roles in the NHS prior to coming to Oxford Health NHSFT, most recently with Sherwood Forest Hospitals NHS Foundation Trust in the Midlands. Until 2010 Kerry was a lay member for the Nursing and Midwifery Council and on the Business Planning and Governance Committee and is a Trustee for Age UK Oxfordshire.

With over 20 years' experience in business and finance in both public and private sectors, Kerry champions good governance and in her company secretary role provides the essential interface between our Board and all stakeholders. Prior to joining the NHS in 2005, her early public sector career was as an Inspector of Taxes. She then went on to be a finance director and company secretary in the private sector, contributing to the strategic direction and operational excellence of the business.

Martyn Ward (Director of Strategy and CIO) 11/12 and 2/4 meetings

Martyn joined the NHS in September 2016 and was appointed to the Board of Directors as Director of Strategy & Performance in January 2018. With a background primarily in IT and information, Martyn has 27 years' public service experience and has served in the Royal Air Force, Thames Valley Police and most recently at Oxfordshire County Council where he led a substantial IT Service from 2012 prior to joining the NHS in 2016.

Martyn brings significant experience of leading service change and transformation and is particularly focused on the development of integrated services with both private and public sector partners.

Non-statutory Board Committees

In addition to the statutory Audit and Nomination/Remuneration Committees the other committees of the Board are detailed below, each of which were chaired by a non-executive director. The terms of reference of the Board committees reflect the required focus on integrated risk, performance and quality management and further detail regarding the work of the Audit, Remuneration, Quality, Finance and Investment

and Charity Committees can be found in the corporate governance section of the Annual Report and are referenced within the Annual Governance Statement and Remuneration Report where relevant.

The Quality Committee which is chaired by non-executive director Sir Jonathan Asbridge, enables the Board to obtain assurance regarding standards of care provided by the Trust and that adequate and appropriate clinical governance structures, processes and controls are in place.

The Committee provides assurance to the Board of Directors that we are discharging our responsibilities for ensuring service quality and that we are compliant with our registration requirements with the CQC. These responsibilities are defined within the CQC's five key questions and their key lines of enquiry and includes assurance that good and poor practice is recognised, understood and being managed through the operational and clinical management structure.

The role of Quality Committee and its sub-committees is to:

- provide assurance that we have in place and are implementing appropriate policies, procedures, systems, processes and structures to ensure our services are safe, effective and efficient;
- provide assurance that the organisation is compliant with regulatory frameworks and legislation;
- approve changes in clinical or working practices or the implementation of new clinical or working practices;
- approve new or amended policies and procedures;
- monitor the quality, effectiveness and efficiency of services and identify any associated risks;
- approve and monitor strategies relating to quality.

The Finance and Investment Committee chaired by non-executive director Chris Hurst, has overseen the development and implementation of the Trust's strategic financial plan and overseen management of the principal risks to the achievement of that plan, including oversight of the Trust's reforecast in year and the associated recovery plan.

The Trust also has a Charity Committee, chaired in the year by the chairman, ensuring the stewardship and effective management of funds which have been donated, bequeathed and given to the Oxford Health Charity.

Enhanced quality governance reporting

At the heart of the Trust's strategy and developments is the ongoing improvement of the quality of services we provide. Improving patient experience and ensuring our services are safe, caring, responsive, effective and well-led, drive the decisions taken by the Board of Directors and the systems established in the Trust. The role of the quality committee in enhancing quality governance is set out above.

The governance framework continues to evolve as the business adapts to changes and currently describes the governance and assurance arrangements for the Trust, supporting integration of clinical and corporate governance, and regular reviews of the Terms of Reference of each committee keep that framework relevant.

The Committees of the Board have been supported by regular reporting against a range of agreed quality metrics including: safety, safeguarding, infection control, clinical effectiveness including National Institute for Health and Care Excellence (NICE) implementation, clinical audit, patient involvement and experience within services and the safety and suitability of the physical estate. Individual Executives led on compliance with CQC standards with assurance drawn from the sub-committees of the Quality Committee.

The directorate and corporate, operational and clinical management structures are accountable to the Board of Directors through the Executive Team. With a clear delineation between governance and management responsibilities it has enabled a stronger focus for reporting into the quality committee.

There are four quality sub-committees that report to the Quality Committee. The sub-committees reflect the five CQC key standards and are composed of: safe; caring and responsive; effective; and well-led. Each of these is responsible for providing assurance to the quality committee that we are compliant with the key lines of enquiry which sit under their key question(s) and any other areas which fall within their responsibility.

Each executive has a clearly defined portfolio and is individually and collectively accountable for the quality and safety of services. The Director of Nursing and Clinical Standards submits reports to the Board on quality and safety and on patient experience matters each on a bimonthly basis which include assessments against CQC requirements and clinical audit results form part of regular updates from the Medical Director.

Further, the Board reviews a range of reports throughout the year which provide an insight into the quality of the services provided and the experiences of patients and service users. The internal audit programme which is reviewed by the Audit Committee provides assurances on a range key governance/control areas.

The Executive team regularly reviews the quality of services through weekly consideration of Serious Incidents Requiring Investigation cases, inquests, claims and complaint trends and themes. The Trust holds performance reviews for each service directorate providing the opportunity for executive directors to review directorate performance against a range of metrics, hold management teams to account for performance and assist directorates in identifying resources to tackle problem areas.

The quality of care provided was independently assessed during the year, and clarity with respect to the focus for improvement since the last inspection has enabled the CQC to assess the subsequent progress. The CQC has rated Oxford Health NHS Foundation Trust ‘good’, and the later Well Led inspection maintained that position. In

the Trust's 2018 inspection we received a rating of 'Good' for four of the five quality domains and an overall rating of 'Good'.

We received a 'Requires Improvement' for the safe domain, although the CQC reported that services were safe. Over the past year many of the actions identified have been completed. More information is included within the Quality Report including a summary of ratings. Any actions required to improve our services will continue to be monitored by the Board.

Although we all have a lot to be proud of at the Trust, we know what we need to do to improve. National inquiries such as CQC reports into mental health and learning disability deaths and other NHS inquiries serve as an important reminder of our professional and personal responsibilities.

We like everyone in the NHS, need to continue to focus on ensuring quality care for all our patients. We will continue to ensure that we have learned from the messages in national reports as well as from inspections of our own services in order to maintain and improve the care we deliver to patients.

Concluding last in June 2017 the Board has in the last 3 years, undertaken a periodic review of board governance including capability and capacity and commissioned an external review into the performance of the Board. This covered the areas previously incorporated in the Quality Governance framework issued by NHS Improvement (and aligned with CQC requirements) and now part of NHSI's broader Well-Led Framework.

Through utilisation of NHS Improvement's well-led framework, we were able to arrive at an overall evaluation of the organisation's performance, internal control and board assurance framework. The Annual Governance Statement and Corporate Governance pages comment also on this positive review and subsequent actions have been monitored to completion by the Well Led sub-committee.

Equality, Diversity and Inclusion

We have been using the NHS Equality Delivery System (EDS2) to develop our equalities work. This framework has helped us to identify our equality priorities and to consolidate the progress we have made to date which can be attributed to a variety of relationships, practices and initiatives involving a diverse range of stakeholders, sector agencies and partnerships.

This year, we have focused our attention and efforts on Disability Equality as part of our wider inclusion agenda to improve the service user provision and the employment experience of our staff.

Some of the key highlights and achievements include:

- Three Linking Leaders Conferences focusing on Disability equality and inclusion held at Oxford, Aylesbury and Swindon which covered a whole range of topics

through presentations, case studies and a new activity called 'The Human Library';

- 'Appointments' of Chairs for the four staff equality network groups:
    - Chair of LGBT+ Equality Staff Network: Alfie Daly (Unit Manager for Out of Hours and Minor Injury Units);
    - Chair of Disability Equality Staff Network: Natasha Shackell (PWP for IAPT Healthy Minds, Bucks);
    - Chair of Race Equality Staff Network (Bucks): Partha Ghosh (CBT Therapist/ Team Lead IAPT Healthy Minds, Bucks);
    - Chair of Race Equality Staff Network (Oxon): Dr Reena Vohora (Course and Academic Tutor);
- New EDI Module delivered on the Level 3 Senior Healthcare Support Worker Apprenticeship programme;
- New 'Religion and Culture' training launched and delivered with Chaplaincy Team;
- 15 team away-days delivered on various subjects across all the counties;
- A staff group took part in the parade and hosting a stall at Oxford Pride;
- More than 60 queries responded to ranging from requests for support and advice to information and guidance;
- The Trust approved its first 'Procedural Guidance for Supporting Transitioning Employees' which sets out the legal obligations in relation to gender reassignment and trans employees in accordance with the Equality Act 2010 and Gender Recognition Act 2004;
- The Trust launched rainbow lanyards to much staff acclaim on 1st February 2019 to coincide with LGBT History Month and within days the 1000 lanyards were gone. The response has been overwhelming and beyond all expectations.

Disclosures

As a foundation trust we are required to make the following disclosures:

Income Disclosures

These can be found in notes 3 and 4 to the Accounts. The income received by the Trust from the provision of goods and services for the purposes of the health service in England are greater than the income from the provision of goods and services for any other purposes, which is in compliance with requirements.

The Better Payment Practice Code

This requires the Trust to aim to pay 95% of the value of all undisputed invoices by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust's compliance with the better payment practice code in respect of invoices received from both NHS and non-NHS trade creditors is shown in the table below:

Measure of compliance	2018/19		2017/18	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the year	68,051	167,895	66,604	147,681
Total Non-NHS trade invoices paid within target	63,872	158,269	60,868	140,225
Percentage of Non-NHS trade invoices paid within target	93.9%	94.3%	91.4%	95.0%
Total NHS trade invoices paid in the year	2,587	14,898	2,899	17,323
Total NHS trade invoices paid within target	2,303	12,229	2,508	15,535
Percentage of NHS trade invoices paid within target	89.0%	82.1%	86.5%	89.7%

There were no **political donations** during the year.

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

Disclosure of information to the auditor

In exercising reasonable care, skill and diligence, each director confirms that so far as they are aware, having made such enquiries of his/her fellow directors and of the company's auditors for that purpose; and taken such other steps (if any) for that purpose, as required by his/her duty as a director, there is no relevant audit information of which the Trust's auditors are unaware. Each director has taken all the steps that they ought to have taken as a director to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information. Relevant audit information is information needed by the auditors in connection with preparing their report.

Remuneration report

Scope of the Report

The Remuneration Report summarises the Trust's Remuneration Policy and particularly, its application in connection with the executive and non-executive directors.

The report also describes how the Trust applies the principles of good corporate governance in relation to directors' remuneration as defined in the NHS FT Code of Governance, in Section 420 to 422 of the Companies Act 2006 in so far as they apply to Foundation Trusts; and the Directors' Remuneration Report Regulation 11 and Parts 3 and 5 of Schedule 8 of the Large and Medium sized Companies and Groups (Accounts and Reports) Regulations 2008 (SI 2008/410) ("the Regulations") as interpreted for the context of NHS Foundation Trusts; Parts 2 and 4 of Schedule 8 of the Regulations and elements of the NHS Foundation Trust Code of Governance.

Details of executive directors' remuneration and pension benefits and non-executives' remuneration are set out in the tables below and have been subject to audit.

Remuneration Committee

The Board appoints the committee to consider remuneration, which is the single committee considering both nominations and remuneration called the Nominations, Remuneration and Terms of Service Committee and its membership comprises only non-executive directors.

The committee meets to determine, on behalf of the Board, the remuneration strategy for the organisation including the framework of executive and senior manager remuneration.

Its remit currently includes determining the remuneration and terms and conditions of the executive and their direct reports, the terms and conditions of other senior managers and approving senior manager severance payments. Employer Based Clinical Excellence Awards are dealt with by the Board of Directors and were approved during the year.

All non-executive directors are members of the committee. During the year, the following non-executive directors have served on the committee as voting core members:

	Attendance:
Martin Howell (Chair)	4/4
Chris Hurst (SID)	0/4
Alyson Coates (to 30/9/18)	2/2
Jonathan Asbridge (Vice)	4/4

John Allison	2/4
Aroop Mozumder	3/4
Bernard Galton	4/4

The committee also invited the assistance of the Chief Executive (Stuart Bell), the Director of Human Resources (Tim Boylin) and the Director of Corporate Affairs/Company Secretary (Kerry Rogers). Other Non-Executive and Associate Non-Executive Directors also assisted the Committee (Sue Dopson NED; Lucy Weston Assoc. NED and substantive NED from 1st March 2019). None of these individuals or any other executive or senior manager participated in any decision relating to their own remuneration.

The Committee has met on 4 occasions during 2018/19.

Gender pay gap

The UK Government introduced legislation making it a statutory requirement for organisations employing 250 or more employees to report annually on gender pay gap. Oxford Health NHS Foundation Trust supports the fair treatment and reward of all staff irrespective of gender or any other protected characteristic. Our published report fulfils the reporting requirements and sets our actions to improve and can be found on https://www.oxfordhealth.nhs.uk/news/gender-pay-gap-report/. Further detail is included in the Staff Report.

Senior Managers' Remuneration Policy

The Trust is committed to the governing objective of maximising value over time. To achieve its goals, the Trust must attract and retain a high calibre senior management team to ensure it is best positioned to deliver its business plans.

The Trust defines its senior managers as those managers who have the authority or responsibility for directing or controlling the major activity of the Trust - those who influence the Trust as a whole. For the purposes of this Report, these are defined as the voting and non-voting members of the Board of Directors.

During the year the Trust adhered to the principles of the agreed pay framework that remunerated the performance of the executive directors and their direct reports based on the delivery of objectives as defined within the Annual Plan.

There are no contractual provisions for performance related pay for executive and direct reports and as such no payments were made relating to 2018/19. The approach to remuneration is intended to provide the rigour necessary to deliver assurance and the flexibility necessary to adapt to the dynamics of an ever-changing NHS.

It is fundamental to business success and is modelled upon the guidance in The NHS Foundation Trust: Code of Governance and the Pay Framework for Very Senior Managers in the NHS (Department of Health).

The key principles of the approach are that pay and reward are assessed relative to the performance of the whole Trust and secondly in line with available benchmarks.

In light of the Trust's financial situation, the remuneration policy for 2018/19 and for the next financial year will not include any performance related pay elements, but all directors' performance will be assessed against delivery of the Annual Plan and associated corporate objectives and kept in line with recognised benchmarks (eg NHS Providers and the wider pay policies of the NHS).

Senior managers' (excluding the Chief Executive who wished to decline an uplift) received an annual inflationary uplift of a flat rate of £2,075 in 2018/19 reflecting the guidance received and published by regulators.

Executive appointments to the Board of Directors continue under permanent contracts and during 2018/19, no substantive director held a fixed term employment contract. The chief executive and all other executive (voting and non-voting) directors hold office under notice periods of 3 or 6 months as detailed within the Annual Report, except when related to conduct or capability.

There were no interim members of the Board of Directors during 2018/19. The Director of Nursing retired in December 2018, succeeded by the Deputy Director of Nursing who took up the position of Acting Director of Nursing pending the commencement of the successor Chief Nurse due to start in post at the beginning of June 2019.

Annual Statement on Remuneration from the chair of the committee

There are no elements that constitute any senior managers' remuneration, including Executive and Non-Executive Directors, in addition to those specified in the table of salaries and allowances. The amounts that are designated salary in the table represent a single contracted annual salary and there are no particular remuneration arrangements which are specific to any senior manager. There were no changes made in the period to existing components of the remuneration package and no components added.

The majority of staff employed by the Trust are contracted on Agenda for Change /terms and conditions and the general policy on remuneration contained within these terms and conditions is applied to senior managers' remuneration (and all other staff employed on non-Agenda for Change contracts), with the exception of the Medical Director, to whom medical and dental terms and conditions apply.

The board members who are each not on Agenda for Change contracts are listed in the table on the next page (their contracts are permanent, and there are no unexpired terms).

Remuneration for senior managers is set, on appointment or following substantial change in responsibilities, with reference to the Incomes Data Services report on NHS senior manager pay and NHS benchmarking data collected by organisations such as NHS Providers. The major consideration for annual pay increases for senior managers

has been the inflationary uplift award made under Agenda for Change and the VSM guidance from regulators.

The Code of Governance submits that the board of directors should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity, nor the chairpersonship of such an organisation.

No executive directors of the trust served as a non-executive director on organisations of comparable size elsewhere during the year. The Chief Executive is serving as an unremunerated non-executive director Chair of the Picker Institute for which limited time is required across the year.

Non-executive directors' remuneration

The remuneration for non-executive directors has been determined by the Council of Governors and is set at a level to recognise the significant responsibilities of non-executive directors in Foundation Trusts, and to attract individuals with the necessary experience and ability to make an important contribution to the Trust's affairs.

They each have terms of no more than three years and are able to serve two concurrent terms dependent on formal assessment and confirmation of satisfactory on-going performance. A third term of three years may be served, subject to on-going positive appraisals and a broader review taking into account the needs of the Board and the Trust.

The maximum period of office of any non-executive director shall not exceed nine years from the time the Trust became a Foundation Trust.

Their remuneration framework as agreed previously by the Council of Governors is consistent with best practice and external benchmarking, and remuneration during 2018/19 has been consistent with that framework. There was a 2% cost of living increase applied for non-executive directors during 2018/19.

None of the non-executive directors are employees of the Trust; they receive no benefits or entitlements other than fees and are not entitled to any termination payments. The entire Council of Governors determine the Terms and Conditions of the non-executive directors.

There was one new non-executive appointment at the end of the year succeeding one non-executive director retiring in 2018/19. The nomination process for the appointment of a new Chairman to succeed the current chairman who retired in March 2019 also concluded during the year.

The Trust does not make any contribution to the pension arrangements of non-executive directors. Fees reflect individual responsibilities including higher rates for chairing the main committees of the Board, with all non-executive directors otherwise subject to the same terms and conditions.

Annual Report on Remuneration

- **Termination Payments**

Notice periods under senior managers' contracts are determined and agreed taking into consideration the need to protect the Trust from extended vacancies on the one hand and the needs of the employee and financial risks to the Trust on the other. The maximum notice period is six months.

Payments to senior managers for loss of office are governed by and compliant with the NHS standard conditions and regulations and all payments are submitted to NHSI for Treasury approval. There were no payments made in the period to any senior manager for loss of office or any payments made to any individual who was not a senior manager in the period but had been a senior manager prior to this financial year.

- **Disclosures**

The Trust is required to disclose the relationship between the remuneration of the highest paid director in the organisation and the median remuneration of the organisation's workforce.

The remuneration of the highest paid director, subject to audit, in the Trust in the financial year 2018/19 was £192,500 (2017/18, £192,500). This was 6.55 times (2017/18, 6.69 times) the median remuneration of the workforce, which was £29,177 (2017/18, £28,746).

The calculation of the highest paid director is based on the full-time equivalent staff of the reporting entity at the reporting period end date on an annualised basis. Termination benefits are excluded from the calculation.

In 2018/19, two employees (none in 2017/18) received remuneration in excess of the highest paid director. Remuneration ranged from £17,460 to £197,446 (2017/18 £15,404 - £191,153). The Medical Director receives a National Clinical Excellence Award, shown as 'other remuneration'.

To achieve its goals, the Trust must attract and retain high calibre and experienced members of the executive team to ensure it is best positioned to succeed. As referenced within this Remuneration Report, the Trust applies the principles of the Code of Governance and NHS guidance on remuneration in addition to a regular review of available benchmark information and consideration of pay and conditions across the wider Trust and the associated pay increases each year.

The governors' Nomination and Remuneration committee includes staff governor representation, and the committee is consulted prior to recommendations to the Council with regard to any changes in non-executive director remuneration.

The Nomination and Remuneration Committee is satisfied that it has taken appropriate steps to ensure where any senior manager is paid more than £150,000 that the level of remuneration is reasonable and proportionate, including benchmarking of job content, responsibility and salary across similar sized organisations. There are currently two senior managers who have been paid above this level for more than three years and there have been no additions to this group in 2018/19.

- **Expenses**

There were 18 directors who served in office during the financial year 2018/19 (2017/18, 18), of which 12 (2017/18, 14) received expenses with a total value of £14,473 (2017/18, £13,974).

During 2018/19, the Trust had 36 governor seats available (2017/18, 36). Full details of the governors in post through the year can be found in other sections of the Annual Report. Whilst the role is voluntary, governors are entitled to claim reasonable expenses. The total value of expenses reimbursed through the year is £3,107 (2017/18, £3,675).

- **Salaries and allowances**

Details of executive directors' remuneration and pension benefits and non-executives' remuneration are set out in the tables below. Remuneration, CETV, exit packages, staff costs and staff numbers are all subject to audit.

Salaries and allowances

2018/19								
Name	Title	Effective Dates if not in post full year.	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (rounded to nearest £00)	Total salary and other remuneration (bands of £5,000)*	Pension-related benefits (bands of £2,500)**	Total including pension-related benefits (bands of £5,000)
			£000	£000	£00	£000	£000	£000
Stuart Bell	Chief Executive		190-195	0	0	190-195	0.0-2.5	190-195
Mike McEnaney	Director of Finance		155-160	0	0	155-160	17.5-20.0	170-175
Dominic Hardisty	Chief Operating Officer		130-135	0	0	130-135	25.0-27.5	155-160
Mark Hancock	Medical Director and Director of Strategy		110-115	15-20	0	125-130	12.5-15.0	135-140
Ros Alstead	Director of Nursing and Clinical Standards	1 Apr 18 to 7 Dec 18	85-90	0	0	85-90	0.0	85-90

Catherine Riddle	Director of Nursing and Clinical Standards	8 Dec 18 to 31 Mar 19	30-35	0	0	30-35	25.0-27.5	55-60
Kerry Rogers	Director of Corporate Affairs and Company Secretary		110-115	0	0	110-115	15.0-17.5	130-135
Tim Boylin	Director of HR		95-100	10-15	0	105-110	0	105-110
Martyn Ward	Director of Strategy and Performance		95-100	0	0	95-100	45.0-47.5	140-145
Martin Howell	Chair		45-50	0	0	45-50	0	45-50
Sue Dopson	Non-executive Director		10-15	0	0	10-15	0	10-15
Alyson Coates	Non-executive Director	1 Apr 18 to 30 Sep 18	5-10	0	0	5-10	0	5-10
Jonathan Asbridge	Non-executive Director		15-20	0	0	15-20	0	15-20
John Allison	Non-executive Director		10-15	0	0	10-15	0	10-15

Chris Hurst	Non-executive Director		15-20	0	0	15-20	0	15-20
Aroop Mozumder	Non-executive Director		10-15	0	0	10-15	0	10-15
Bernard Galton	Non-executive Director		15-20	0	0	15-20	0	15-20
Lucy Weston	Non-executive Director	1 Mar 19 to 31 Mar 19	0-5	0	0	0-5	0	0-5

Salaries and allowances

2017/18								
Name	Title	Effective Dates if not in post full year.	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (rounded to nearest £00)	Total salary and other remuneration (bands of £5,000)*	Pension-related benefits (bands of £2,500)**	Total including pension-related benefits (bands of £5,000)
			£000	£000	£00	£000	£000	£000
Stuart Bell	Chief Executive		190-195	0	0	190-195	25.0-27.5	215-220
Mike McEnaney	Director of Finance		150-155	0	0	150-155	27.5-30	180-185

Dominic Hardisty	Chief Operating Officer		125-130	0	0	125-130	30.0-32.5	160-165
Mark Hancock	Medical Director and Director of Strategy		115-120	10-15	0	125-130	42.5-45.0	170-175
Ros Alstead	Director of Nursing and Clinical Standards		125-130	0	0	125-130	0	125-130
Kerry Rogers	Director of Corporate Affairs and Company Secretary		105-110	0	0	105-110	27.5-30.0	135-140
Tim Boylin	Director of HR	1 Jan 18 to 31 Mar 18	25-30	0	0	25-30	0	25-30
Martyn Ward	Director of Strategy and Performance	1 Jan 18 to 31 Mar 18	20-25	0	0	20-25	0-2.5	20-25
Martin Howell	Chair		40-45	0	0	40-45	0	40-45
Dr Anne Grocock	Non-executive Director	1 Apr 17 to 31 Jan 18	10-15	0	0	10-15	0	10-15

Sue Dopson	Non-executive Director		10-15	0	0	10-15	0	10-15
Mike Bellamy	Non-executive Director	1 Apr 17 to 31 Jan 18	10-15	0	0	10-15	0	10-15
Alyson Coates	Non-executive Director		15-20	0	0	15-20	0	15-20
Jonathan Asbridge	Non-executive Director		10-15	0	0	10-15	0	10-15
John Allison	Non-executive Director		10-15	0	0	10-15	0	10-15
Chris Hurst	Non-executive Director		15-20	0	0	15-20	0	15-20
Aroop Mozumder	Non-executive Director	1 Sep 17 to 31 Mar 18	5-10	0	0	5-10	0	5-10
Bernard Galton	Non-executive Director	1 Sep 17 to 31 Mar 18	5-10	0	0	5-10	0	5-10

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

***The 'pension-related benefits' presented in the tables above represent the annual increase in pension entitlement determined in accordance with the 'HMRC' method. This is calculated as the inflation adjusted in year movement in the lump sum plus the movement in twenty times the annual rate of pension payable to the director if they became entitled to it at the end of the financial year. The 'HMRC' method used above differs from the real increase/(decrease) in cash equivalent transfer value presented in the pension benefits disclosure below.*

Contract Type and Notice Periods

Name	Start date as senior manager	Contract type	Notice period by employee	Notice period by employer
Stuart Bell	01/10/2012	Permanent	6 months	6 months
Dominic Hardisty	22/02/2016	Permanent	3 months	3 months
Ros Alstead	22/03/2011 – 07/12/2018	Permanent	3 months	3 months
Mike McEnaney	15/08/2011	Permanent	3 months	3 months
Mark Hancock	01/04/2016	Five years (as Medical Director)	3 months	3 months
Kerry Rogers	01/09/2015	Permanent	3 months	3 months
Tim Boylin	01/01/2018	Permanent	3 months	3 months
Martyn Ward	01/01/2018	Permanent	3 months	3 months
Kate Riddle	Acting up from 08/12/2018	Permanent	3 months	3 months

With the exception of any members of staff listed above, no senior manager has a contract of employment with a notice period greater than three months.

PENSION BENEFITS								
	Real increase/ (decrease) in pension at pension age (bands of £2,500)	*Real increase/ (decrease) in pension lump sum at pension age (bands of £2,500)*	*Total accrued pension at pension age at 31 March 2019 (bands of £5,000)*	*Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)*	*Cash Equivalent Transfer Value at 1 April 2018*	*Real increase/ (decrease) in Cash Equivalent Transfer Value*	*Cash Equivalent Transfer Value at 31 March 2019*	*Employer's contribution to stakeholder pension*

Title	£'000 a	£'000 b	£'000 c	£'000 d	£'000 e	£'000 f	£'000 g	£'000
Stuart Bell Chief Executive	*0.0-2.5*	*0.0-2.5*	*90-95*	*275-280*	*2,025*	*148*	*2,261*	*0*
Mike McEnaney Director of Finance	*0.0-2.5*	*n/a*	*15-20*	*n/a*	*268*	*39*	*337*	*0*
Dominic Hardisty COO	*0.0-2.5*	*n/a*	*15-20*	*n/a*	*187*	*38*	*250*	*0*
Mark Hancock Medical Director	*0.0-2.5*	*0.0-2.5*	*30-35*	*70-75*	*434*	*66*	*527*	*0*
Ros Alstead Director of Nursing & Clinical Standards (leaver 07/12/18)	*0.0-2.5*	*0.0-2.5*	*70-75*	*215-220*	*1,665*	*0*	*0*	*0*
Kerry Rogers Director of Corporate Affairs	*0.0-2.5*	*0.0-2.5*	*20-25*	*35-40*	*295*	*43*	*363*	*0*
Martyn Ward Director of Strategy / Perf	*2.5-5.0*	*n/a*	*0-5*	*n/a*	*12*	*23*	*48*	*0*
Catherine Riddle Acting Director of Nursing & Clinical Standards (08/12/18 to 31/03/19)	*0-2.5*	*2.5-5.0*	*25-30*	*80-85*	*481*	*42*	*645*	*0*

Analysis of staff costs	2018/19			2017/18
	Total	Permanently Employed	Other	Total
	£000	£000	£000	£000
Salaries and wages	**179,836**	**160,958**	**18,878**	166,883
Social Security costs	**17,047**	**17,047**	**0**	15,770
Apprenticeship levy	**855**	**855**	**0**	789
Employer contributions to NHS pension scheme	**21,302**	**21,302**	**0**	20,305
Other pension costs	**77**	**77**	**0**	25
Termination benefits	**40**	**40**	**0**	383
Bank and agency staff	**24,476**	**0**	**24,476**	22,483
Recoveries in respect of seconded staff	**(1,128)**	**(1,128)**	**0**	(1,036)
	242,506	**199,151**	**43,354**	225,396
Of which				
Capitalised employee costs	**(411)**	**(411)**	**0**	(206)

Analysis of average staff numbers	2018/19			2017/18
Staff Group	Total	Permanently employed	Other	Total
Medical and dental	**246**	**210**	**36**	286
Healthcare assistants and other support staff	**1,087**	**885**	**202**	992
Nursing, midwifery and health visiting staff	**1,530**	**1264**	**266**	1,566
Nursing, midwifery and health visiting learners	**70**	**70**	**0**	62
Scientific, therapeutic and technical staff	**1,049**	**1,005**	**44**	1,005
Social care staff	**70**	**70**	**0**	38
Administration and estates	**1,104**	**1,023**	**81**	1,034
	5,156	**4,527**	**629**	4,983

*WTE - *Whole Time Equivalent. WTE shown is an average throughout the year*

Exit packages	2018/19 Number of compulsory redundancies	2018/19 Number of other departures agreed	2018/19 Total number of exit packages	2017/18 Total number of exit packages
Exit package cost band				
< £10,000	**0**	**8**	**8**	15
£10,000 - £25,000	**1**	**1**	**2**	3
£25,001 - £50,000	**0**	**1**	**1**	3
£50,001 - £100,000	**0**	**0**	**0**	1
£150,001 - £200,000*	**1**	**0**	**1**	0
Total number of exit packages	**2**	**10**	**12**	22
Total resource cost £'000	**182**	**80**	**262**	292

**contractual compulsory redundancy*

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the trust has agreed early retirements, the additional costs are met by the trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

Staff exit packages: other (non-compulsory) departure payments

	2018/19 Number of agreements	**2018/19 Total value of agreements £000**	2017/18 Number of agreements	2017/18 Total value of agreements £000
Contractual payment in lieu of notice	**7**	**16**	17	58
Mutually agreed resignations (MARS) contractual costs	**2**	**57**	3	88
Exit payments following employment tribunals or court orders	**1**	**7**	-	-
Total	**10**	**80**	20	146
Of which: non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	**-**	**-**	**-**	**-**

As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number above will not necessarily match the total number in the exit packages note which will be the number of individuals.

Service contracts obligations

There are no obligations contained within senior managers' service contracts that could give rise to or impact upon remuneration payments which are not disclosed elsewhere in the remuneration report.

Signed:

Date: 24 May, 2019

Stuart Bell CBE
Chief Executive and Accounting Officer

Staff report

Our vision is for *"Outstanding Care Delivered by Outstanding People"* and our staff are central to Oxford Health NHS Foundation Trust's success, directly impacting the lives of our patients and responsible for the quality of experience they receive. Corporately it is the Trust's responsibility to ensure that staff have the best possible training and development opportunities and a good work-life balance to support them in their roles.

The development of the Trust's workforce to ensure delivery of high quality and safe patient care has remained the central focus of our workforce, training and organisational development activities and we recognise the challenges faced by our teams due to increasing workloads and staff recruitment difficulties and are working to tackle this and mitigate adverse impacts on stress, health and wellbeing. Further detail is included in the retention section below.

Workforce profile

At 31st March 2019, the Trust employed:

- Board Directors (executive & non-executive, voting and non-voting): 11 male and 4 female;
- Other senior managers: 57 male and 167 female;
- Employees (excluding the above): 1,198 male and 5,014 female.

At 31st March 2019, the Trust employed 6,729 staff with a contracted WTE (whole time equivalent) of 4,794. This number includes:

- 461 medical staff
- 581 therapists
- 1,686 qualified nurses
- 1,116 health care workers
- 493 other support staff including ancillaries and, care workers
- 568 other professionals including psychology, dental staff and social workers.

(Datasource: ESR – using 'Staff Group')

Permanent Staff

Occupation Code	Description	Total FTE
011	Geriatric Medicine	1.80

021	General Surgery	1.30
051	Psychiatry of Learning Disability	3.00
052	General Psychiatry	108.65
053	Child and Adolescent Psychiatry	36.80
054	Forensic Psychiatry	14.90
055	Medical Psychotherapy	2.60
056	Old Age Psychiatry	17.40
093	Occupational Medicine	0.00
099	Other Specialities	0.80
921	General Medical Practitioner	5.97
971	General Dental Practitioner	20.21
AAA	Emergency Care Practitioner	19.35
G0A	Senior Manager | Central Functions	18.10
G0B	Senior Manager | Hotel, Property and Estates	0.00
G0D	Senior Manager | Clinical Support	7.80
G1A	Manager | Central Functions	86.73
G1B	Manager | Hotel, Property and Estates	15.00
G1C	Manager | Scientific, Therapeutic and Technical Support	4.00
G1D	Manager | Clinical Support	62.51
G2A	Clerical and Administrative | Central Functions	293.77
G2B	Clerical and Administrative | Hotel, Property and Estates	10.00
G2C	Clerical and Administrative | Scientific, Therapeutic and Technical Support	8.19
G2D	Clerical and Administrative | Clinical Support	565.59

G3B	Maintenance and Works | Hotel, Property and Estates	19.80
H1D	HCA | Psychiatry	3.40
H1F	HCA | Community Services	0.80
H2D	Support Worker | Psychiatry	29.36
H2F	Support Worker | Community Services	10.54
H2R	Support Worker | Hotel, Property and Estates	171.20
N0A	Manager | Acute, Elderly and General	4.00
N0B	Manager | Paediatric Nursing	2.80
N0D	Manager | Community Psychiatry	14.20
N0E	Manager | Other Psychiatry	8.00
N0F	Manager | Community Learning Disabilities	9.40
N0G	Manager | Other Learning Disabilities	1.00
N0H	Manager | Community Services	39.65
N0J	Manager | Education Staff	3.00
N0K	Manager | School Nursing	2.00
N1H	Children's Nurse Community Services	0.60
N3H	Health Visitor Community Services	105.63
N4H	District Nurse / CPN / CLDN - 1st level | Community Services	76.03
N5H	District Nurse / CPN / CLDN - 2nd level | Community Services	97.06
N6A	Other 1st level | Acute, Elderly and General	114.30
N6B	Other 1st level | Paediatric Nursing	30.52
N6D	Other 1st level | Community Psychiatry	245.19
N6E	Other 1st level | Other Psychiatry	258.39

N6F	Other 1st level | Community Learning Disabilities	17.10
N6G	Other 1st level | Other Learning Disabilities	10.95
N6H	Other 1st level | Community Services	98.31
N6J	Other 1st level | Education Staff	6.43
N7A	Other 2nd level | Acute, Elderly and General	23.12
N7F	Other 2nd level | Community Learning Disabilities	1.00
N7H	Other 2nd level | Community Services	16.60
N7K	Other 2nd level | School Nursing	11.10
N8H	Nursery Nurse | Community Services	20.17
N9A	Nursing Assistant / Auxiliary | Acute, Elderly and General	143.77
N9B	Nursing Assistant / Auxiliary | Paediatric Nursing	2.60
N9D	Nursing Assistant / Auxiliary | Community Psychiatry	20.88
N9E	Nursing Assistant / Auxiliary | Other Psychiatry	352.77
N9F	Nursing Assistant / Auxiliary | Community Learning Disabilities	3.00
N9G	Nursing Assistant / Auxiliary | Other Learning Disabilities	20.47
N9H	Nursing Assistant / Auxiliary | Community Services	40.30
N9K	Nursing Assistant / Auxiliary | School Nursing	6.21
NAD	Nurse Consultant | Community Psychiatry	2.00
NAE	Nurse Consultant | Other Psychiatry	0.80
NAF	Nurse Consultant | Community Learning Disabilities	1.00
NAJ	Nurse Consultant | Education Staff	1.00
NBK	Qualified School Nurse | School Nursing	38.89
NCE	Modern Matron|Other Psychiatry	14.00

NCH	Modern Matron|Community Services	6.00
NEH	Community Matron	3.00
NFA	Nursing Assistant Practitioner in Acute Elderly & General	0.80
NFE	Nursing Assistant Practitioner in Other Psychiatry	0.80
NFF	Nursing Assistant Practitioner in Community Learning Disabilities	2.00
NFH	Nursing Assistant Practitioner in Community Services	29.00
P1D	Pre-registration Learner | Diploma Nurse Training	17.49
P2B	Post 1st level Registration Learner | Health Visiting	8.60
P2C	Post 1st level Registration Learner | District Nursing	9.00
P2E	Post 1st level Registration Learner | Other Learners	4.00
S0B	Manager | Dietetics	1.80
S0C	Manager | Occupational Therapy	17.23
S0E	Manager | Physiotherapy	9.11
S0J	Manager | Speech and Language Therapy	3.36
S0K	Manager | Multi Therapies	0.60
S0L	Manager | Clinical Psychology	9.00
S0M	Manager | Psychotherapy	2.52
S0P	Manager | Pharmacy	3.79
S0U	Manager | Social Services	23.07
S0X	Manager | Other STT Staff	1.00
S1A	Therapist | Chiropody / Podiatry	34.74
S1B	Therapist | Dietetics	49.29
S1C	Therapist | Occupational Therapy	187.07

S1E	Therapist | Physiotherapy	67.34
S1H	Therapist | Art / Music / Drama Therapy	2.93
S1J	Therapist | Speech and Language Therapy	61.02
S1K	Therapist | Multi Therapies	0.40
S1L	Therapist | Clinical Psychology (Closed)	1.00
S1M	Therapist | Psychotherapy	35.17
S1R	Therapist | Dental	1.00
S1U	Therapist | Social Services	95.77
S1X	Therapist | Other STT Staff	3.30
S2L	Scientist | Clinical Psychology	154.51
S2M	Scientist | Psychotherapy	40.71
S2P	Scientist | Pharmacy	19.33
S4L	Technician | Clinical Psychology	1.00
S4P	Technician | Pharmacy	17.51
S4R	Technician | Dental	29.10
S5C	Assistant Practitioner | Occupational Therapy	5.80
S5E	Assistant Practitioner | Physiotherapy	1.00
S5J	Assistant Practitioner | Speech and Language Therapy	0.50
S5L	Assistant Practitioner | Clinical Psychology	69.69
S5M	Assistant Practitioner | Psychotherapy	76.71
S5U	Assistant Practitioner | Social Services	24.35
S6C	Instructor / Teacher | Occupational Therapy	14.79
S6E	Instructor / Teacher | Physiotherapy	7.41
S6J	Instructor / Teacher | Speech and Language Therapy	5.60

S7J	Tutor | Speech and Language Therapy	1.00
S7R	Tutor | Dental	0.60
S7U	Tutor | Social Services	1.00
S7X	Tutor | Other STT Staff	0.00
S8L	Student / Trainee | Clinical Psychology	57.00
S8M	Student / Trainee | Psychotherapy	14.20
S8P	Student / Trainee | Pharmacy	5.00
S8X	Student / Trainee | Other STT Staff	10.00
S9A	Helper / Assistant | Chiropody / Podiatry	2.85
S9B	Helper / Assistant | Dietetics	3.45
S9C	Helper / Assistant | Occupational Therapy	3.90
S9E	Helper / Assistant | Physiotherapy	17.73
S9J	Helper / Assistant | Speech and Language Therapy	3.00
S9K	Helper / Assistant | Multi Therapies	9.80
S9P	Helper / Assistant | Pharmacy	4.97
S9U	Helper / Assistant | Social Services	9.29
S9X	Helper / Assistant | Other STT Staff	0.95
SAL	Consultant Therapist / Scientist | Clinical Psychology	15.51
SAM	Consultant Therapist / Scientist | Psychotherapy	1.90
Z2E	General Payments | Administration and Non-patient Care Support	8.00

Staff Retention

The central aim of HR's strategy is to promote retention of staff by improving recognition and reward, improving leadership capability, improving career paths and development opportunities, reducing bullying and harassment, reducing stress, violence and aggression (including from patients and carers), and by building on our equality diversity and inclusion work. We aspire to be a truly modern employer in our

policies and in our support to staff, by being flexible and supportive so our workforce thrives and continues to give dedicated and compassionate care to our patients and service users.

We know from staff survey data that the proportion of staff feeling confident that they can give the level of care to which they aspire is reducing year-on-year, as it is across the wider NHS. Our challenge is to reverse this trend and we have a range of strategies in place and being developed.

As referred to elsewhere in the annual report there are formal and structured programmes of work on Equality, Diversity and Inclusion; Stress; Wellbeing and Leadership Development. Some of the other initiatives undertaken in 2018-19 to improve staff retention are as follows:

- Participation in the NHSI Retention Programme, cohort 2;
- Introduction of new Preceptorship programme, called 'Fliers';
- More exit interviews conducted by HR staff to get to the root cause of resignations
- Improved communication of staff benefits so employees are aware of the total job reward including pension value, discounts available, annual leave, development opportunities and salary sacrifice schemes for car leasing or computer purchase;
- Review of long service benefits to re-enforce our gratitude and appreciation for those who stay many years with the Trust and the wider NHS;
- Creation of an intranet-hosted Staff Support Hub showcasing the various ways in which staff can access support;
- A series of 'listening events' to learn more from frontline staff about their concerns and explore solutions to both local and Trust-wide challenges;
- Promotion of our internal Staff Bank as an opportunity for people to work additional shifts and hours – which in turn reduces agency spend.

Staff recognition

- Staff Recognition Awards

There were 380 nominations from staff and the public in 2018 (170 in 2017). The award event was held at the Kassam Stadium, Oxford, and was attended by 220 staff and guests. Executive directors and leads each introduced an award and welcomed the highly commended teams/individuals and winners to the stage to receive their certificates.

Trophies and prizes for the winners consisting of £100 vouchers for individuals and £200 vouchers for teams were presented while photos were taken and the event was reported in the local daily newspaper.

Staff Wellbeing

- **Stress**

The Board of Directors is very concerned at levels of work-related stress in the organisation. Case and workloads are increasing in all clinical and non-clinical areas. This is evidenced in the staff survey, from Board visits to services, from staff representatives, from our occupational health team and other sources.

With strong support from our staff representatives we launched a programme in 2018 to address stress using the Health and Safety Executive's "Management Standards" approach as a guide. Work is underway and likely to be ongoing for up to three more years. We are for this work.

We have formed three sub-groups to address demand, change and control. Each sub-group has HR, staff representatives, senior operational line management and other participants. These three topics were selected as they were identified through a survey (in which around 1,400 staff participated) as being the most significant contributory factors to work-related stress.

- **Royal College of Nursing (RCN) Cultural Ambassadors programme**

Although OHFT's WRES statistics are no worse than comparable Trusts, both senior leadership and staff representatives are concerned at the high proportion of people from a BME background who enter the disciplinary process compared to the number of white staff.

Efforts so far have included unconscious bias training, leadership conferences focusing on Equality and Inclusion and establishing a BME staff network.

The next initiative is to partner with the RCN in deploying their 'cultural ambassadors' programme which identifies people in the Trust from a BME background who will help to proactively consider how race may impact managers decisions/attitudes.

The Trust has agreed to deploy this programme and is seeking volunteers. With RCN backing, the Trust is confident this will help address the challenge.

- **Schwartz rounds**

Recognising the traumatic nature of some of the situations faced by staff, and the more limited time available due to caseload for structured reflective practice and learning, it has been agreed that Schwartz rounds will be trialed in 2019. The Trust has engaged the Point of Care Foundation to ensure deployment is effective.

- **Staff retreats**

The Trust has held two staff retreats, which have had excellent results (e.g. helping staff come to terms with difficult situations and return to work more quickly than otherwise possible). The focus is on people with long term sickness, usually stress related (work related or not) who would benefit from the opportunity to reflect and plan their

recovery in a supportive environment. Further staff retreats will be planned over 2019/20.

- **Employee Assistance Programme**

The Trust is in a procurement phase for an Employee Assistance Programme, having agreed that this is a suitable investment in staff wellbeing and support. Appointment of a chosen programme and supplier is likely to be in Quarter 1 of 2019-20. The Trust continues to offer resilience and mindfulness training to individuals and teams where the case is made that this will add value. In some situations, the Trust's Charity Committee has helpfully funded some of these programmes. The Trust aims to increase access to such funding recognising that workload and caseloads have increased for both clinical and non-clinical staff.

Staff Survey

The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

This year, a total of 2,722 members of staff chose to complete the survey, equivalent to a response rate of 52% compared to 50% in 2017. Scores for each indicator together with that of the survey benchmarking group (Combined Mental Health/Learning Disability and Community Trusts) are presented below.

Summary of results

	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.1	9.2	9.2	9.2	9.2	9.2
Health and wellbeing	6.0	6.1	6.0	6.1	6.1	6.2
Immediate managers	7.1	7.2	7.2	7.1	7.1	7.1
Morale	6.2	6.2	-	-	-	-
Quality of appraisals	5.2	5.5	5.7	5.4	5.6	5.4
Quality of care	7.1	7.4	7.1	7.4	7.1	7.5
Safe environment	8.1	8.2	8.2	8.3	8.2	8.2

– bullying and harassment						
Safe environment – violence	9.5	9.5	9.5	9.5	9.5	9.5
Safety culture	6.8	6.8	6.8	6.7	6.8	6.7
Staff engagement	7.0	7.0	7.0	7.0	7.0	7.0

Future priorities and targets

There are two levels of action that the Trust is taking in response to this year's staff survey results. The first level of action is focused on teams and their individual team responses; the second level being Trust wide and captured within our retention programme.

The programme includes making improvement in the following key areas:

- Health, wellbeing and safety of our employees
- Career opportunities
- Leadership capability and staff development
- Equal Opportunities and fostering good relations
- Reward and recognition

Expenditure on consultancy

We are required to report expenditure on consultancy in 2018/19 which was £114,000 (2017/18, £96,000).

Off-payroll engagements

The Trust's policy on the use of off-payroll arrangements for highly paid staff is first to use the HMRC employment status check to determine the engagement status. The Trust will not directly engage with personal service companies that fall within the IR35 regulations. Individuals classed as employed for tax purposes must either hold a substantive or flexible worker contract with the Trust or be engaged via an agency or umbrella company – these involve tax and National Insurance (NI) deductions at source. The Trust will continue to engage personal service companies that fall outside of the IR35 regulations, or sole traders classed as self-employed, without tax and NI deductions being made.

A purchase order number will be required from the procurement team to engage such services together with the completed HMRC employment status check. In accordance with HM Treasury PES (2017)11 Annual Reporting Guidance, NHS bodies are required to disclose information about 'off-payroll engagements' as follows:

1. **For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months:**

No disclosure required.

2. **For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day band that last for longer than six months:**

No disclosure required.

3. **For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:**

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure includes both off-payroll and on-payroll engagements.	18

Equality, Diversity and Inclusion

We recognise that discrimination and barriers to inclusion can lead to disadvantage and inequalities in accessing services or opportunities in the workplace.

The Trust is committed to inculcating a culture that respects equality and values diversity for our staff and the patients we care for. The programme for staff includes a session on inclusion at the staff induction; EDI modules in the Care Certificate, Apprenticeships and leadership development pathways; and various other workshops, away days, conferences and training.

The Trust's work is led by the Chief Executive with support from the Head of Inclusion, an Equality, Diversity and Inclusion Steering and Delivery Groups and the staff equality network groups.

A strategy for our equality, diversity and inclusion work is in place with four work streams:

- Equal Opportunities – focuses on compliance with legislative, regulatory and accreditation frameworks
- Workforce and Staff – primarily working to ensure policies, training and support is in place for all employees
- Valuing Diversity – includes our approach to staff equality networks and conversations that influence the culture of the organisation
- Patients, service users and carers – working closely with clinical teams and with the delivery of the patient experience and involvement and carer (I care, you care) strategies to ensure that we are sensitive to the different needs of patients and carers.

Each of these work streams has associated action plans to address the findings from the Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES) and Workplace Equality Index (WEI).

In addition, the Oxford Centre for Spirituality and Wellbeing was launched at the end of 2017; the Trust's Head of Spiritual and Pastoral Care is the lead for the centre. The centre supports staff training, development and research into psycho-spiritual care within health and social care contexts.

The Workforce Race Equality Standard (WRES) requires organisations to demonstrate progress against nine indicators around the experience, opportunities and treatment of black & minority ethnic (BME) staff compared to white staff in the workplace. Although we have made good progress across all the WRES indicators, there is still much to do to achieve our aim of total inclusion for everyone.

We have achieved the status of 'Disability Confident Employer' and have a Bronze Award in the Defence Employer Recognition Scheme.

Since April 2016, we have had a Freedom to Speak Up Guardian who provides independent and confidential support to staff who wish to raise concerns and to promote a culture of openness.

Most of the concerns raised with the Guardian have been resolved locally and did not require an investigation. Some bullying and harassment concerns have been raised with the Guardian and in these situations, direct action has been taken.

We have been making progress over the past year with staff locally reporting more positive experiences and feeling more engaged. We need to continue this work and build on what we have achieved to improve patient outcomes and staff experience.

The Workforce Equal Opportunities Policy is the key document which enshrines the Trust's approach and obligation for giving full and fair consideration to applications for employment made by persons with the protected characteristic of disability. The Policy was in place throughout the year and sets out how the Trust supports disabled persons in employment applications, training and career development. The policy states that

the Trust recognises that it has clear obligations towards all its employees and the community at large to ensure people with disabilities are afforded equal opportunities. This includes taking steps to ensure that there is fair consideration and selection of applicants with disabilities and to satisfy their training and career development needs.

The policy also makes clear that there must be ongoing consideration for people with disabilities throughout their employment – this may involve taking any steps which it is reasonable to take to reduce or remove any substantial disadvantage which a physical feature of Trust premises or employment arrangements would cause a disabled employee or job applicant compared to a non-disabled person.

Under the policy, if an employee becomes disabled in the course of their employment reasonable steps will also be taken to accommodate their disability by making reasonable adjustments to their existing employment, consideration of redeployment and through appropriate training. The Trust will support employees remaining in employment where possible.

Counter Fraud Policy

The Trust has a Counter Fraud Policy, which is actively applied and monitored through an annual Counter Fraud Work Plan supported by a Local Counter Fraud Specialist who assists in ensuring information is available on the latest types of fraud activities across the NHS and other businesses, provides training to staff and leads on investigations. The Audit Committee oversees counter fraud and anti-bribery activity and more information is provided in the Corporate Governance section.

The Trust's Disciplinary Procedure lists fraud as being classed as potential gross misconduct. Any allegations of fraud committed by employees would be investigated under this procedure.

Health and Safety

The Trust recognises the importance of ensuring the health and safety of its employees as enshrined within the NHS Constitution. We strive to provide staff with a healthy and safe workplace where we have taken all practicable steps to ensure the workplace is free from verbal or physical violence from patients, the public or staff.

The Trust is supported by a SEQOHS (safe, effective, quality occupational health service) accredited occupational health & wellbeing department which:

- is committed to enabling a planned, supportive approach to providing a safe and healthy working environment which supports and empowers staff to maintain and enhance their personal health and wellbeing at work.
- advises the Trust, employees and managers on the assessment and management of risks, where employees' fitness for work and their health may be of concern in line with current UK and European legislation and best practice;

undertakes employee health assessments, as appropriate; delivers immunisation screening and programmes, contributes to policy review and implementation throughout the Trust, works in partnership with the Infection Prevention and Control team, and with Health & Safety and Human Resources teams.

The introduction of a reviewed skill mix, Musculoskeletal (MSK) case manager and Mental Health specialist within the occupational health & wellbeing team has continued to contribute significantly to the reduction in employees taking long term sick leave, assisting a speedier return to work and supporting employees to continue within the work environment.

Sickness absence

The management of sickness absence serves to reduce costs and maintain the quality of our services. The Trust is maintaining its focus on managing short term sickness absence through collaborative working by the directorates and HR and reviewing sickness absence trends to continually improve sickness rates.

Systems are in place to allow for a timely and professional review of long term sickness, with appropriate referrals to the occupational health service. Managers are expected to make reasonable adjustments for staff to facilitate an early return to their work from long term sickness. Our latest sickness data is as follows:

	2018/19	**2017/18**
Total days lost	**42,615**	42,391
Total staff years	**4,643**	4,548
Average working days lost (per WTE)	**9.18**	9

Trade Unions

For members of staff who are experiencing a problem at work there are specialist advisers and certified trade union reps on hand to help with a wide variety of issues.

The Trust currently has 13 trade union representatives in the organisation with 0.02% of time spent on facility time.

The cost of facility time in the year was £30,067 and the percentage of paid facility time spent on paid trade union activities was 0.04%. Full disclosure details are given below:

Relevant union officials

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
13	12

Percentage of time spent on facility time

Percentage of time	*Number of employees*
0%	0
1-50%	13
51%-99%	0
100%	0

Percentage of pay bill spent on facility time

	Figures
Provide the total cost of facility time	£30,067
Provide the total pay bill	£166.9m
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union	0.04%

activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	

Leadership Development

The trust has increased its apprenticeship offer with 'earn and you learn' courses in business and administration as well as for healthcare support worker roles.

Alongside those we also run nursing associate apprenticeships in partnership with Buckinghamshire New University. On completion of training candidates have skills recognised by the Nursing and Midwifery Council and are able to work alongside registered nurses and perform some of their tasks

More than 20 trainees are about to 'graduate' with a further 130 on the course.

The first two intakes of our Flyer programme have commenced with almost 100 newly qualified healthcare professional participants. This is a two-year programme which includes preceptorship as required by professional bodies and the opportunity to achieve Masters' modules. This programme is one of a range of activities provided to increase retention within the Trust.

We have developed several Masters' modules in partnership with local universities to enable healthcare professionals to access bespoke specialist education relevant to their area of work.

Modules approved so far include Comprehensive Assessment of the Older Adult, Minor Illness and Minor Injury. Further modules in the process of approval include Brief Interventions in Psychosis, Self as an Emerging Practitioner, Reflections on Leadership and Quality Improvement Project.

The Buckinghamshire, Oxfordshire and Berkshire West STP asked the Trust and Oxford University Hospitals Foundation Trust to co-host an Excellence Centre, accredited by the National Skills Academy for Health.

This is a virtual organisation which focuses on the development of the support workforce across the public, voluntary and private sector. A requirement of the host is to achieve the Quality Mark which assures that the Learning and Development offered by the organisation reaches their standards. Both hosts have now achieved the Quality Mark and the formal launch of the Excellence Centre is in late May 2019.

One of the first projects for the Excellence Centre is to organise a Nurse Cadet scheme across the region. School leavers who do not wish to study A- Levels can undertake an apprenticeship programme that will give them the qualifications to go on to nurse

associate training, or, if they apply to Oxford Brookes University, a guaranteed interview for nurse training.

Gender Pay Gap review

Further to reference in the Remuneration Report, the UK Government introduced legislation making it a statutory requirement for organisations employing 250 or more employees to report annually on gender pay gap. As an employer Oxford Health NHS Foundation Trust is required by law to carry out Gender Pay Reporting under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

This involves carrying out six calculations that show the difference between the average earnings of men and women in our organisation. We published the results on our own website and a government website on 30th March 2018 and on 31st March 2019.

We will use these results to assess:

- the levels of gender equality in our workplace
- the balance of male and female employees at different levels
- how effectively talent is being maximised and rewarded.

Oxford Health NHS Foundation Trust supports the fair treatment and reward of all staff irrespective of gender or any other protected characteristic. Our published report fulfils the reporting requirements and sets out an action plan and can be found here https://www.oxfordhealth.nhs.uk/news/gender-pay-gap-report/.

The mean GPG figure for the year to April 2019 deteriorated compared to the previous year's snapshot. Analysis was undertaken to ensure that this change was well understood. The cause of the change was predominantly the inclusion of highly paid (and mostly male) workers who had previously been paid through off-payroll arrangements and who were brought onto the Trust's payroll in 2017 and 2018 to comply with HMRC IR35 requirements. The positions included various part time specialists and Out of Hours GPs.

Corporate Governance (compliance with Code of Governance)

Oxford Health NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Corporate Governance is an important part of the Board's responsibilities. Key decisions and matters are reserved for the Board's approval and are not delegated to management. The Board delegates certain responsibilities to its committees, to assist it in carrying out its functions of ensuring independent oversight. The Board of Directors has a formal schedule of matters reserved for its decision and has terms of reference for the Board's key committees.

The Board receives monthly updates on performance and it delegates management, through the chief executive, of the overall performance of the organisation which is conducted principally through the setting of clear objectives and ensuring that the organisation is managed efficiently, to the highest standards and in keeping with its values.

The Board has had a Vice Chairman and Senior Independent Director (SID) throughout the year. Chris Hurst was SID and Sir Jonathan Asbridge, Vice Chairman. All non-executive directors are considered by the Board to be independent as defined in the Code taking into account character, judgement and length of tenure.

The Nominations, Remuneration and Terms of Service Committee (non-executive directors) and Nominations and Remuneration Committee (governors) are both responsible for succession planning and reviewing Board structure, size and composition, and have taken into account when considering terms and conditions or appointing or reappointing to Board positions in year, the future challenges, risks and opportunities facing the Trust and the appropriateness of the balance of skills, knowledge and experience required on the Board to meet them.

All Directors have confirmed that they meet the criteria for being a fit and proper person as prescribed by our NHSI Licence and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Constitution, standing orders, code of conduct, engagement policy and other governing documents outline the mechanisms by which the Council of Governors and Board of Directors will interact and communicate with each other to support ongoing interaction and engagement, ensure compliance with the regulatory framework and specifically provide for those circumstances where the Council of Governors has concerns about the performance of the Board of Directors, compliance with the Trust's Provider Licence, or other matters related to the overall wellbeing of the Trust.

The Council and the Board approved changes to the Constitution during the year which will be presented to the Annual Members Meeting in September 2019 and thereafter formally adopted.

Code of Governance

The purpose of the Code of Governance is to assist the Board in improving governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice but imposes some disclosure requirements for incorporation into our Annual Report.

As stated, Oxford Health NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors is committed to high standards of corporate governance. For the year ended 31 March 2019, the Board considers that it was, throughout the year, fully compliant with the provisions of the NHS Foundation Trust Code of Governance with the following two exceptions where we have alternative arrangements in place:

1. The Code of Governance requires that (B1.3) **no individual should hold, at the same time, positions of director and governor of any NHS Foundation Trust.**

   As the Trust enters into a growing number of partnership and joint working arrangements within the wider health service economy, it may become expedient for members of the Board to take on formal roles such as that of a governor in another NHS foundation trust. The effectiveness of the Board may be enhanced, and the success of the Trust promoted if the Trust collaborates more widely and formally within the wider health service economy, evidenced already where the Trust has collaborated with local stakeholders.

   As a consequence, in September 2015 the Council of Governors agreed to a change to the Constitution to provide the flexibility for Directors to be governors of other Foundation Trusts, and subsequently to allow the Chairman to become a governor of Oxford University Hospitals NHS FT. The Trust also has on its Council of Governors, a non-executive director of Oxford University Hospitals NHS FT.

2. B7.1 states that **in exceptional circumstances, non-executive directors (NEDs) may serve longer than six years (two three year terms following authorisation of the Foundation Trust but subject to annual reappointment).**

Some of our non-executive directors have been reappointed in previous and in recent years beyond six year terms, to allow for a final third term of three years. The Council of Governors was clear that the performance of the Trust in a strategic climate of

considerable future challenge and expected change, warranted a vital need for stability in the leadership of the Board of Directors.

These non-executives serving beyond six years have not been subject to annual reappointment, but performance appraisals are conducted annually, and the results are presented to the governors' Nominations and Remuneration Committee who would act accordingly in the event of a negative review.

The Trust is compliant with the remaining sections of the Code, with the appropriate disclosures contained within this section of the Report or referenced accordingly, and the Board will continue to look to current and evolving best practice as a guide in meeting the governance expectations of its patients, members and wider stakeholder community.

The Trust has assessed the effectiveness and performance of the Board and its governance through an external well-led assessment by PriceWaterhouseCoopers which concluded in June 2017 as part of the three-yearly assessment of the effectiveness of the Board's performance and governance arrangements. PriceWaterhouseCoopers (PWC) had at that time no other connection with the Trust.

In common with the health service and public sector, the Trust is operating in a fast-changing and demanding external environment, particularly as it understands and responds to the changes through the NHS 10 Year Plan and the potential implications of an EU Exit.

The Trust recognises the need to significantly increase efficiency whilst maintaining high quality care at a time when budgets will become ever tighter, and it will continue to build on improvements through its exceptional staff to respond to these challenges.

During the year the Trust ensured due regard was taken to its legal obligations. To support the governors in fulfilling their own statutory obligations we have continued the governor development programme that accords with and ensures a detailed understanding of the requirements of the Health and Social Care Act 2012, including equipping the governors with the requisite knowledge and skills to undertake their statutory responsibilities.

The roles and responsibilities of the Council of Governors are described in the Constitution together with detail of how any disagreements between the Board and Council of Governors will be resolved which have been expanded upon in our Engagement Policy. The types of decisions taken by the Council of Governors and the Board, including those delegated to subcommittees, are described in the relevant terms of reference.

As previously stated there is a scheme of delegation and reservation of powers which explicitly set out those decisions which are reserved for the Board, those which may be determined by standing committees and those which are delegated to managers.

Members of the Board are invited to attend all meetings of the Council of Governors. Governors have been involved in several events during the year and were consulted by the executive team on matters such as the annual plan, quality report and other relevant strategies and reports.

The Trust has an established role of Senior Independent Director, and also a formally approved role description to ensure full understanding of the role of the Lead and Deputy Lead Governor as set out in an approved Governor Handbook produced with the Trust and led by the Lead Governor and other members of the Council.

In an NHS Foundation Trust, the authority for appointing and dismissing the chairman rests with the Council of Governors. The appraisal of the chairman is therefore carried out for and on behalf of the Council of Governors. During 2018/19, this was undertaken by the senior independent director, supported by the lead governor. They reviewed the chairman's performance against agreed objectives, to include 360-degree feedback from directors and governors and discussed any development needs before reporting the outcome of the appraisal to the Nominations and Remuneration Committee of the Council of Governors. The committee in turn reported the outcome to the Council of Governors.

The executive directors of the Board are appraised by the chief executive who is in turn appraised by the chairman. The Council of Governors does not routinely consult external professional advisors to market test the remuneration levels of the chairman and other non-executive directors. The recommendations made to the Council of Governors are however based on independent advice and guidance as issued from time to time by appropriate bodies such as NHS Appointments Commission in relation to NHS trusts or benchmark data from NHS Providers.

Standards of business conduct

The Board of Directors supports the importance of adoption of the Trust's code of conduct. These standards provide information, education and resources to help staff make good, informed business decisions and to act on them with integrity. In addition, managers should use this resource to foster, manage and reward a culture of accountability within their departments. The Trust believes that working together it can continuously enhance culture in ways that benefit patients and partners, and that strengthen interactions with one another.

The Board has formally constituted committees which support the systematic review of the Trust's risk and control environment and facilitate a more granular view of its systems of governance.

Audit Committee

The Audit Committee provides an independent and objective review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the Trust and plays a pivotal role in supporting

the Board. The committee was chaired by Alyson Coates until September 2018 and then by Bernard Galton and its membership comprises wholly non-executive directors with executives and others in attendance. There were 5 meetings during the year. Attendance at meetings by members is detailed below:

	Attendance
Alyson Coates (Chair)	2/3 *(to end of September 2018)*
John Allison	4/5
Bernard Galton (Chair)	5/5 *(Chair from October 2018)*
Chris Hurst	5/5
Lucy Weston	5/5

Given the skills and experience of the committee members, and through the work of the committee across the year, the Board of Directors is satisfied that the committee has remained effective and that the committee members have recent and relevant financial experience.

The Board commended the work of departing non-executive director, Alyson Coates for her significant contribution to the effectiveness of the Audit Committee throughout her period of tenure.

The committee assists the Board in fulfilling its oversight responsibilities and its primary functions as outlined in its terms of reference are to monitor the integrity of the financial accounting statements and to independently monitor, review and report to the Board of Directors on the processes of governance and the management of risk.

Its key areas of responsibility include corporate and clinical governance, internal control, risk management, internal and external audit and financial reporting. The committee also has a role in relation to whistleblowing/freedom to speak up/management of concerns arrangements to review the effectiveness of those arrangements through which staff may raise concerns in confidence, and ensure measures are in place for proportionate and independent investigation and appropriate follow-up.

In discharging its delegated responsibilities, the committee has reviewed the following non-exhaustive range of matters. A detailed review of the Annual Governance Statement within the context of the wider Annual Report alongside robust scrutiny of the Annual Accounts and Financial Statements has been undertaken.

It has considered the effectiveness of the Board Assurance Framework to include consideration of the internal auditor's report on the corporate governance and risk management arrangements, to gain on-going assurance of the effectiveness of the Trust's risk and internal control processes. The committee also reviewed and approved the internal and external audit plans.

The internal audit plan for 2018/19 was developed in line with the mandatory requirements of the NHS Internal Audit Standards. PriceWaterhouseCoopers were appointed from the beginning of the year as our internal audit service provider and it has worked with the Trust to ensure the plan was aligned to our risk environment.

In line with the internal audit work plan, full scope audits of the adequacy and effectiveness of the control framework in place are complete at the time of this Annual Report.

There has been a regular review of internal audit progress reports including performance indicators and consideration of the effectiveness of internal audit to ensure a systematic review of the systems of internal control to include IT environment; Information Governance; Key Financial Systems, Directorate Review and Partnership Working audits. Additionally, there has been a regular review of single action tender waivers and losses and special payments.

The committee approves and monitors the work-plan of the counter fraud service provided by TIAA. The counter fraud service attends the committee meetings, to present updates on investigations, fraud prevention and deterrent and awareness-raising activities.

The Trust ensures that referrals and allegations of fraud, bribery and corruption are investigated and seeks redress whenever possible so that money recovered can be put back into patient care. The Audit Committee ensures accountability and we do everything in our power to protect the public funds with which we have been entrusted.

The Board of Directors attaches significant importance to the issue of fraud and corruption. Reported concerns have been investigated by our local counter fraud specialists in liaison with the NHS Counter Fraud Authority (CFA) and the police as necessary and as stated, the Audit Committee has paid attention to awareness of bribery and corruption obligations.

We continue to work to maintain an anti-fraud culture and have a range of policies and procedures to minimise risk in this area. There were a number of communications over the year to highlight how staff should raise concerns and suspicions. All investigations are reported to the Audit Committee.

The committee has reviewed whistleblowing arrangements and considered risks around the effective management of concerns. The Freedom to Speak Up Guardian has reported to the Board of Directors on cases of concern and awareness-raising activities which are reviewed by members of the Audit Committee in their capacity as Board members.

The committee is informed by assurance work undertaken by other Board committees, through joint chair membership and also the minutes of the Quality Committee are circulated for scrutiny by the Audit Committee.

The minutes of the meetings of the Finance and Investment, Charity and Quality Committees are also circulated to the Board of Directors and reviewed by members of the Audit Committee in their capacity as Board members. Annual reports are presented to the Audit Committee such that it can review the work of these Board committees to provide relevant assurance to its own scope of work.

In assessing the quality of the Trust's control environment, the committee received reports during the year from the external auditors Grant Thornton, and the internal auditors PWC, on the work they had undertaken in reviewing and auditing the control environment as well as briefing notes on key sector developments. The non-executives routinely hold meetings during the year with both internal and external audit without the executives present.

Through the review of the 2018/19 Annual Report and Financial Statements the committee reviewed and gained assurance from:

- individual internal audit assurance reports including an assessment of the effectiveness of the Board Assurance Framework (BAF)
- head of internal audit opinion on both financial and non-financial matters
- external audit opinion on the accounts, and the external value for money opinion
- management letter of representation to external audit
- a specific review of the evidence supporting preparation of the accounts on a going concern basis.

Grant Thornton were appointed under a three-year contract, taking up the role of external auditor in October 2017. The Council of Governors approved their appointment at a general meeting.

The external auditor engages appropriately with the Trust's Council of Governors and members, providing full reports on audit findings and required opinions at the September Council meeting each year, and at the Annual General Meeting/Members Meeting.

The total audit fee includes £2,500 (Net of VAT) relating to the independent examination of the Oxford Health Charity accounts. We incurred £47,000 (Net of VAT) in audit service fees from Grant Thornton in relation to the audit of our accounts and quality report for the twelve-month period to 31 March 2019 (£47,000 net of VAT from Grant Thornton for the period to 31 March 2018 including £2,500 Charity accounts).

No non-audit services were provided by the external auditors during 2018/19 (none during 2017/18).

During the year, in addition to the coverage already detailed, the committee has examined key risks in detail, including the following:

- Cyber security
- Data Quality
- Fire Safety Management
- Clinical Audit
- General Data Protection Regulation (GDPR)
- Resilience to Terrorism and Emergency Preparedness arrangements

Of the internal audits across the year, the Audit Committee received two Internal Audit reviews which had received a 'high risk' rating in the areas of: IT Environment and a Directorate Review. The Audit Committee discussed the findings in each of the reports and received assurance that appropriate actions were being taken in response to Internal Audit's findings and recommendations. The Board also regularly receives the minutes and escalations of Audit Committee meetings.

Finance and Investment Committee

A further committee of the Board is the Finance and Investment Committee which provides assurance to the Board of Directors on several key financial issues relevant to the Trust. It reviews investment decisions and policy; financial plans and reports, and approves the development of financial reporting, strategy and financial policies to be consistent with obligations and good practice.

The committee was chaired by Chris Hurst, who has extensive commercial and financial expertise as a chartered accountant. The committee is made up of both non-executive and executive directors with other senior managers in attendance. Attendance of core members at the six meetings held in year is detailed below:

	Attendance
Chris Hurst (Chair)	6/6
John Allison	6/6
Stuart Bell	3/6
Martin Howell	5/6
Mike McEnaney	6/6

Some of the key areas of focus included: monitoring of the Estates Strategy and its review in light of the need for account of recent developments such as STP strategies, public estates strategy, and the Carter programme. Also, the annual budget process; the Oxford Pharmacy Store; the inquests and claims annual report; the strategic procurement work plan and key tenders; and options in relation to core IT infrastructure licensing were all matters considered during the year. The Committee also focused on: Sustainability and Transformation Funding and the trajectory to control total achievement; and the ongoing development of service line reporting, in addition to the customary financial reporting which included oversight of liquidity /cashflow; treasury management and the financial plan and recovery plan developed

in year as a result of the declining position against plan. Also, the effectiveness of cost improvement planning and capital programme planning in addition to an assessment of the previous year's committee annual report were also deliberated.

Quality Committee

A further description of the work of the Committee is included in the Accountability Report, the Annual Governance Statement and within the Quality Report. The committee met on 5 occasions and attendance of members at meetings as follows:

	Attendance	Deputised for (deputy counted in quorum)
Jonathan Asbridge (*chair*)	5/5	
Ros Alstead	2/4	2/4
Stuart Bell	4/5	
Tim Boylin	0/5	
Sue Dopson	2/5	
Bernard Galton	3/5	
Aroop Mozumder	5/5	
Mike McEnaney	1/5	
Mark Hancock	5/5	
Dominic Hardisty	3/5	
Martin Howell	5/5	
Kate Riddle	0/1	
Kerry Rogers	4/5	
Martyn Ward	2/5	

Charity Committee

The committee is responsible for ensuring that the Trust fulfils its duties as a Corporate Trustee in the management and use of charitable funds.

Key areas of focus in this year included oversight of slow moving funds and the use of funds and matters which included: development of the Community Involvement Framework including the Fundraising Strategy & Volunteering Services Strategy; a new

charity website development and branding exercise; funding for many initiatives to include Lucy's Room, the resilience training programme and for simulation training in community hospitals; staff retreats to tackle stress and other health and wellbeing issues; Warneford Meadow developments and a new fund for children's' services called the 'positivity pot'.

The committee is also proud to oversee the funds donated by the ROSY fundraisers and the work its members do to support 'Respite for Oxfordshire's Sick Youngsters', raising hundreds of thousands of pounds each year.

The Trust's administrators changed during the previous year following a procurement exercise which saw Kingston Smith appointed. During the year a procurement exercise was undertaken in order to retender management of the charity's investment portfolio. We are grateful to Casenove for their years of support to the Trust and welcome as our new provider, the Standard Life. Committee members and fund advisors came together to consider the charity's strategy which will support its future development in the coming period.

The Committee was chaired during the year by the Trust's Chairman, Martin Howell, with its membership comprising both non-executive and executive directors, and other senior managers in attendance.

It met on 4 occasions during the year and attendance of core members is given below:

	Attendance	Deputised for (deputy counted in quorum)
Martin Howell	2/4	
Ros Alstead	1/3	1/3
Dominic Hardisty	0/0	4/4 *(Dominic's role is represented by service leads)*
Chris Hurst	2/4	
Sue Dopson	0/4	
Bernard Galton	2/2	*Deputised for the Chair on 2 occasions*
Kate Riddle	0/1	

We are also grateful to our lay member Olga Senior who has contributed passionately to enhancements to the charity's governance.

Nominations and Remuneration Committees

As previously stated, the Trust has two committees considering nominations and remuneration regarding executive directors and non-executive directors; the Board of

Directors Nominations, Remuneration and Terms of Service Committee and the Council of Governors Nominations and Remunerations Committee respectively.

Board of Directors' Nominations, Remuneration and Terms of Service Committee

The Board of Directors Nominations, Remuneration and Terms of Service Committee is constituted as a standing committee of the Board of Directors and has the statutory responsibility for identifying and appointing suitable candidates to fill executive director positions on the Board, ensuring compliance with any mandatory guidance and relevant statutory requirements and responsible for succession planning and reviewing Board structure, size and composition.

The Committee was chaired by the Trust's chairman Martin Howell, with membership comprising all non-executive directors. At the invitation of the Committee, the Chief Executive, Director of HR, and Director of Corporate Affairs/Company Secretary attend meetings in an advisory capacity. The Remuneration Report which is a separate section of the Annual Report provides further detail.

As of 31 March 2019, and on-going, the membership comprises all the non-executive directors. The committee's role is also to recommend to the Board the remuneration strategy and framework, giving due regard to the financial health of the Trust and to ensure the executives are fairly rewarded for their individual contributions to the Trust's overall performance. The separate Remuneration Report identifies the work of the committee during the year. The committee approved the process and appointment for the successor Chief Nurse, who succeeds Ros Alstead OBE, who retired from the Trust in December 2018. The Trust paid considerable tribute to Ros for her indefatigable energy and passion for improving the quality and safety of services at the Trust.

The remuneration of the non-executive directors is determined by the Council of Governors via recommendations from its own Nominations and Remuneration Committee, covered further in the Council of Governors' section. The Accountability and Staff Report continue these matters, up to and including the Annual Governance Statement.

Signed: **Dated: 24 May, 2019**

Stuart Bell, CBE
Chief Executive and Accounting Officer

Council of Governors

As an NHS Foundation Trust we are accountable to the Council of Governors, which represents the views of members. The Council of Governors brings the views and interests of the public, service users and patients, carers, our staff and other stakeholders into the heart of our governance.

This group of committed individuals has an essential involvement with the Trust and contributes to its work and future developments to help improve the quality of services and care for all our service users and patients.

The Board of Directors sets the strategic direction of the Trust with participation from the Council of Governors. The principal role of the Council of Governors is to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors, and to represent the interests of the members of the Trust and of the public.

This includes scrutinising the effectiveness of the Board, overseeing that it has sufficient quality assurance in respect of the overall performance of the Trust, making decisions regarding the appointment or removal of the chairman, the non-executive directors and the Trust's auditors, questioning non-executive directors about the performance of the Board and of the Trust, to ensure that the interests of the Trust's members and public are represented.

Keeping informed of Governors' and Members' views

During the year the Board of Directors were kept informed of the views of governors and members in numerous ways including:

- attendance and/or presentations at Council of Governor meetings by Directors;
- attendance by non-executive Directors at Council of Governor Forums;
- attendance by governors at public Board of Directors meetings;
- joint attendance at a governor strategic session to consider the forward plans;
- joint attendance by governors and non-executive directors at governor Sub-Groups (covering finance, quality and patient experience); and
- consultation on the selection of the indicator for auditing re the Quality Report.
- Joint governor/non-executive director development session and reflection

Governors can contact the Senior Independent Director or the Company Secretary if they have concerns regarding any issues which have not been addressed by the Chair, Chief Executive or Executive Officers.

In addition, the Chairman and Company Secretary meet regularly with the Lead Governor. There is an engagement policy which further expands upon how the Board and the Council wish to work together.

Both the Board of Directors and the Council of Governors are committed to continuing to promote enhanced joint working so that they can deliver their respective statutory roles and responsibilities in the most effective way possible to improve services for those that we serve.

Composition of the Council of Governors

The table below shows the composition of the Council of Governors which comprises 28 elected governors and 9 appointed governors (8 following the disestablishment of Chiltern CCG).

The council met in general meeting four times during the year and the meetings were well attended, with wide ranging debate across several areas of interest.

A strategically focussed meeting was held in February 2019 to engage the governors in the development of forward plans. The current list of the Trust's governors is below and can also be found on our website.

Name	Governor Constituency ***	Tenure	Term	Meetings
ELECTED				
Terry Burridge*	Public: Buckinghamshire	01/06/17 – 25/02/19	1	1/3
Matt Bezzant*	Public: Buckinghamshire	01/06/18 – 11/12/18	1	2/3
Paul Miller**	Public: Buckinghamshire	26/02/19 – 31/05/20	1	1/1
Caroline Birch	Public: Buckinghamshire	01/06/16 – 31/05/19	1	4/5
Chris Mace*	Public: Buckinghamshire	01/06/16 – Aug18	1	
Geoff Braham	Public: Oxfordshire	01/06/17 – 31/05/20	1	4/5
Mark Bhagwandin	Public: Oxfordshire	21/01/18 – 31/05/19	1	4/5
Abdul Okoro	Public: Oxfordshire	01/06/17 – 31/05/20	1	3/5
Adeel Arif	Public: Oxfordshire	01/06/16 – 31/05/19	1	0/5
Allan Johnson	Public: Oxfordshire	01/06/17 – 31/05/20	1	2/5
Madeleine Radburn	Public: Oxfordshire	01/06/16 – 31/05/19	1	4/5
Richard Mandunya	Public: Oxfordshire	01/06/17 – 31/05/20	1	2/5
Vacancy	Public: Rest of England & Wales			
Gillian Evans	Patient: Service User: Oxfordshire	01/06/18 – 31/05/21	2	2/5
Tom Hayes	Patient: Service User: Oxfordshire	01/06/18 - 31/05/21	1	3/5
Claire Sessions	Patient: Service User: Buckinghamshire	01/06/18 – 31/03/19	1	2/3
Jacky McKenna	Patient: Service User: Buckinghamshire	01/06/18 - 31/05/21	1	2/5

Name	Governor Constituency ***	Tenure	Term	Meetings
Gillian Randall	Patient: Carer	01/06/16 – 31/05/19	1	5/5
Chris Roberts	Patient: Carer	01/06/16 – 31/05/19	2	5/5
Alan Jones	Patient: Carer	01/06/18 – 31/05/21	2	4/5
Reinhard Kowalski	Staff: Adult Services	01/06/16 – 31/05/19	1	2/5
Kelly Bark **	Staff: Adult Services	01/02/17 – 31/05/19	1	4/5
Karen Holmes	Staff: Older Peoples Services	01/06/16 – 31/05/19	1	4/5
Soo Yeo	Staff: Older Peoples Services	01/06/17 – 31/05/20	3	3/5
Maureen Cundell	Staff: Older Peoples Services	01/06/18 – 31/05/21	2	5/5
Vacancy	Staff: Older Peoples Services			
Neil Oastler	Staff: Children and Young Peoples Services	01/06/17 – 31/05/20	2	3/5
Gordon Davenport	Staff: Children and Young Peoples Services	01/06/18 – 31/05/21	1	2/5
Vicky Drew	Staff: Corporate	01/06/18 – 31/05/21	1	3/5
APPOINTED				
Lawrie Stratford	Appointed: Oxford County Council	01/07/17 – 30/06/20	1	0/5
Astrid Schloerscheidt	Appointed: Oxford Brookes University	01/06/17 – 31/12/18	1	2/3
Dr Mary Malone	Appointed: Oxford Brookes University	01/01/19 - 31/12/21	1	1/1
	Appointed: Oxford University Hospital NHS Foundation Trust	*Currently vacant*		
Andrea McCubbin	Appointed: Buckinghamshire Mind	01/03/18 – 29/02/21	1	2/5
Lin Hazell	Appointed: Buckinghamshire County Council	01/08/17-31/07/20	1	1/5
Davina Logan	Appointed: Age UK Oxfordshire	01/05/16 – 30/04/19	1	4/5
Sula Wiltshire	Appointed: Oxfordshire Clinical Commissioning Group	01/01/18 – 31/12/20	2	2/5
Debbie Richards	Appointed: Chiltern Clinical Commissioning Group****	31/08/17 – 01/09/20	2	1/5

Name	Governor Constituency ***	Tenure	Term	Meetings
Tina Kenny	Appointed: Buckinghamshire Healthcare	01/11/17 – 31/10/20	1	2/5

Key:
* *stood down/ceased to be a governor in year, mid-way through tenure*
** *unexpired term of previous governor (next past post)*
*** *elected governors are public, staff and patient governors*
**** *Chiltern CCG merged with Buckinghamshire CCG*

Lead Governor

The Council of Governors has elected a Lead Governor in line with NHSI guidance. During 2018/19 Chris Roberts, Carer Governor, held this role. Madeleine Radburn, Public Oxfordshire Governor, was elected as Deputy Lead Governor in March 2018.

The Lead and Deputy Lead Governors have been significantly involved in developing working arrangements between the Council of Governors and the Board of Directors, administering and chairing the Council of Governor Forum, developing enhancements to the governor Sub Group structure and improving communication between governors and members.

The role description and process for annual appointment for the Lead Governor was reviewed and approved in March 2019. As Maddy was not to stand again as deputy lead governor she was thanked for her significant contribution to the role and to supporting the Lead Governor.

Register of interests

All governors are asked to declare any interest on the register of governors' interests at the time of their appointment or election and it is reviewed annually thereafter. This register is maintained by the Corporate Governance Officer.

The register is available for inspection on request. Any enquiries should be made to the Director of Corporate Affairs and Company Secretary at the following address: Oxford NHS Foundation Trust, Trust Headquarters, Warneford Hospital, Warneford Lane, Headington, Oxford, OX3 7JX.

Contacting your governor

There is an email address for Members to use to contact their governor. The email address (contactyourgovernor@oxfordhealth.nhs.uk) is promoted to members through Membership Matters Bulletins and other communications they receive.

The inbox is managed by the Corporate Governance Officer who will forward communication onto the relevant governor. Members can also contact their governor by writing to the Corporate Governance Officer or Company Secretary at Oxford NHS

Foundation Trust, Trust Headquarters, Warneford Hospital, Warneford Lane, Headington, Oxford, OX3 7JX.

Council meetings are open to the public and details are published on the website together with the papers and minutes of the meetings. The Council of Governors has the following sub-groups and regular updates were received from each of them including at each Governor Forum meeting:

- Patient and Staff Experience;
- Quality, Safety & Clinical Effectiveness;
- Finance;
- Membership Involvement; and
- Nominations and Remuneration

Council of Governors' Nominations and Remuneration Committee

The Council of Governors' Nominations and Remuneration Committee is responsible for establishing a clear and transparent process for the identification and nomination of suitable candidates for the appointment of the Trust Chairman and non-executive directors for approval by the Council of Governors.

The Committee is chaired by the Trust's Chair with membership comprising the Lead Governor and elected and appointed governors. When considering the terms and conditions of the Chairman, or if on any occasion the Chairman is unavailable to chair, the Vice Chair or one of the other non-executive directors (who is not standing for re-appointment) would take the Chair. The Lead Governor would chair the meeting if all NEDs were conflicted.

The Senior Independent Director presents to the Committee the outcome of the annual performance review given their role with the Lead Governor in determining the Chair's appraisal outcome.

During the year, the Committee undertook a non-executive Chairman appointment process with the support of an external search consultancy and ultimately considered and recommended to the Council of Governors the appointment of David Walker for three years from 01 April 2019 to 31 March 2022 to follow the retirement of Martin Howell on 31st March 2019. The Committee and the Council of Governors also approved the appointment of Lucy Weston from 1st March 2019 for a term of 3 years ending 28th February 2022.

This followed Lucy's tenure as associate non-executive director, a position she had held since September 2017 and a formal interview was conducted as part of succession planning to succeed Alyson Coates who resigned due to a relocation in September 2018.

The Committee during the year also considered and recommended to the Council of Governors an uplift in remuneration of 2% to accord with the average uplift for agenda

for change and very senior managers. This was approved and became effective from 1st April 2018.

Membership

As a foundation trust, we are accountable to our patients and to the general public within the communities that we serve. We aim to engage with people who are interested in the trust and what we do, giving local people, service users, patients and staff influence in how the trust's services are provided and developed. The membership structure reflects this composition and is made up of the categories below:

Membership constituencies

The trust has three membership constituencies:

- public;
- staff; and
- patient

Elected governors		
Constituency	***Class***	***No of governors***
Public	Buckinghamshire Oxfordshire Rest of England & Wales	4 7 1
Patient	Service Users: Buckinghamshire & Other Counties Service Users: Oxfordshire Carers	2 2 3
Staff	*Before directorate restructure:* Adult Services Older Peoples Services Children & YP Services Corporate Services *After directorate restructure:* Mental Health Services Oxfordshire & West class Mental Health Services Buckinghamshire class Community Services class Corporate Services class Specialised Services class	 2 4 2 1 2 2 2 1 2

Public constituency

All people of at least 12 years of age and living in the county of Oxfordshire, or Buckinghamshire or the rest of England & Wales, are eligible to join the trust. Our strategy is to build a broad membership that is representative of the ages and diversity of the people it serves as well as evenly reflecting the geographic reach of our services.

Public membership is for all people who use our services, their carers and families, as well as the broader community. The geographical area that the trust serves is sub-divided using electoral boundaries consisting of the local authority electoral area of Oxfordshire County Council; the local authority electoral area of Buckinghamshire County Council and all other local authority electoral areas in England and Wales not already covered by the local authority areas in Oxfordshire and Buckinghamshire.

Staff constituency

The staff constituency changed during the year. It was until October 2018 divided into four classes: Staff: Adult Directorate, Staff: Older People Directorate, Staff: Children and Young People Directorate, and Staff: Corporate Directorate.

The classes have been amended to reflect changes to staff directorates at the trust which concluded in October 2018. Current staff governors with terms beyond May 2019 will complete their elected term in the old classes with vacancies transferring to the news classes as terms come to an end.

The first staff governors will be elected to the new classes in May 2019. The changes and transitional arrangements have been reflected in the trust's constitution.

Trust employees continue to be registered as members under an opt-out scheme, and the number of employees who choose to opt-out remains extremely low. The staff membership ensures that a l majority of staff are able, through a number of additional channels, to participate in and offer their views on developments at the trust. It is unlikely that we will see significant changes in staff membership given the opt-out rate is already so very low, and due to our work to ensure we retain membership levels.

Patient constituency

There are three classes: Patient: Service Users: Buckinghamshire and other counties; Patient: Service Users: Oxfordshire; and Carers. This constituency is open to patients, service users, or carers who have had contact with the trust in the previous five years on the date of application.

Membership figures at 1st April 2018:

Public: 2,422

Patient: 511

Staff: 6,109

Membership figures at 1st April 2019:

Public: 2,424

Patient: 503

Staff: 6,730

Analysis of Public member demographics at 1st April 2019

		Public members	Eligible base population
Age	0-16	3	256,941
	17-21	16	73,307
	22+	1,866	906,546
	Not stated	589	0
Gender	Male	1,010	611,362
	Female	1,416	623,382
	Unspecified/not stated	48	0
Ethnicity	White	1,832	1,030,674
	Asian	70	74,926
	Black	47	21,914
	Mixed	25	25,593
	Not stated/other	500	8,185

The trust recognises the value of the Council of Governors which is made up of both elected representatives from its membership and appointees from partner organisations. As our governors directly represent the interests of the members and the local communities served, the trust believes that its members have an opportunity to influence the work of the trust and the wider healthcare landscape. The Council of Governors, and by extension the membership is thereby making a real contribution towards improving the health and wellbeing of service users/patients, as well as the quality of services provided.

The Board values the relationship it has with the Council and recognises that its work promotes the strategic aims and assists in shaping the culture of the trust. The newly approved membership strategy sets out a series of objectives for the trust to continue to encourage a broad and diverse membership with its focus on quality engagement activity, including the actions to build and maintain membership numbers with the aim that membership is representative of the population the trust serves; and communicating effectively with members and the public to encourage involvement. The Board and the Council were sorry to lose Chris Mace during the year, who died after a long period of illness. Chris was a great supporter of improvement and collaboration and he will be greatly missed.

Governor Elections

The communication team's structured approach to communicating the election means that the pre-election period, nomination period and voting period are promoted among stakeholders, across trust internal and external channels including social media using #OHFTgetinvolved #OHFTelections, in the media and on community web and social sites.

Communications focus on local communities and the issues and services relevant to them in their geographical area, highlighting the ways governors can make a difference to local healthcare and what they can gain from being a member and governor.

The Membership Team is working with the trust's learning disabilities co-production group which includes five people with a learning disability – experts by experience – and three members of staff, to develop ways to make membership and governorship more accessible and meaningful for people with a learning disability. An Easy Read membership application form, nomination form and membership information leaflet have been developed by the Membership Team to make membership more accessible.

Two 'Becoming a Governor' events were held in Oxfordshire and Buckinghamshire. Thank you to public governors Geoff Braham and Madeleine Radburn for supporting the Director of Corporate Affairs and the Membership Team and meeting prospective governors.

Engagement and recruitment

Members and governors are kept informed of developments at the trust and we work towards creating opportunities alongside our governors to canvass the opinions of the membership. We aim to involve our members from every constituency with our plans, including service objectives and priorities through a combination of:

- regular emails from our membership team;
- the news and member pages on our website;
- using trust social media channels - Facebook, Twitter, Instagram, LinkedIn and YouTube

- the trust magazine *Insight*, which is distributed trust-wide as well as being available online. *Insight* provides up-to-date information and features on the trust including service developments; information on issues relating to mental health, community services and learning disabilities; information about the Council of Governors; and opportunities for members to get involved in surveys;
- our annual general and members meeting which provides an opportunity to hear how the trust performed during the year, the work of the Council of Governors and to meet directors and governors;
- public meetings of the Board of Directors and Council of Governors;
- strategy session of the Board of Directors and Council of Governors to consider forward plans;
- Health Matters events lead by clinicians and trust staff.

The Membership Involvement Group (MIG), comprising governors, public members and trust staff from the membership, volunteering, patient experience and involvement and research involvement teams, has been working to create a more meaningful membership offer which provides members of our foundation trust with genuine opportunities to play a part in the trust, support patient care, improve patient experience and have a say in how services are planned and delivered.

The communications and engagement team has a structured approach to membership communications which means activities, achievements and opportunities re members, governors and Oxford Health Charity are regularly promoted to internal and external audiences to showcase the benefits of membership year-round.

Members were this year invited to take part in an anonymous survey to inform the work of the membership team and MIG to make membership meaningful and communicate well with our members.

Most people told us they joined because they wanted to have a say in their local services and because they felt they have something to contribute to the work of the trust and healthcare in their community. They told us they keep informed about the activity of the trust by reading the monthly membership e-bulletin Membership Matters and by following the trust in the local media.

The majority of respondents said they would like to receive more information about the trust's future plans and be informed about how their views as a member had impacted upon the work of the trust. They also said they would like to be invited to more events.

Staff members highlighted the need for greater information on membership as part of their induction with the trust. The membership team has liaised with the trust's HR and IT department and staff will now automatically receive a staff membership welcome email when they log into their trust IT account for the first time.

The membership website has been refreshed with greater emphasis on engaging imagery and content including information about the work governors do. It features profiles and quotes from our members, volunteers and governors about the value of membership for them. Thank you to members Pat Ross, Claire Sessions, Mark Watts and Paul Hicks for their specific participation.

Media coverage has included our monthly staff Exceptional People Awards nominated by staff and judged by governors; and governor elections. They were publicised internally on the trust intranet and weekly staff e-bulletin, plus externally on the trust website, social media accounts, quarterly magazine, in the press and media, and to members and partners to share in their internal and external communications.

Membership Matters, our monthly round-up of news, information and events of interest to members, this year featured updates from a different governor each month to share news about how they've been representing members and influencing healthcare at Oxford Health.

Thank you to governors who have contributed since April 2018: Caroline Birch, Abdul Okoru, Neil Oastler, Karen Holmes, Soo Yeo, Mark Bhagwandin, Terry Burridge, Vicky Drew, Maureen Cundell, Mary Malone and Paul Miller.

Health Matters, our members-only health-related events programme, relaunched this year, offering members an interactive opportunity to learn about healthcare and the work of the trust. The events drew members to the trust and people became members to attend these events too.

Our first Health Matters event of 2018/19 was a community involvement festival called HealthFest, and with Oxford Open Doors we showcased services and the beautiful Warneford Hospital grounds to the public in September 2018.

Members enjoyed a free cream tea and were encouraged to sign up friends and family as members at the event. Members were also invited to comment on the early stages of an exciting redesign of the Warneford Hospital. Later events in Aylesbury and Oxford looked at Art in Recovery and showcased the work of Artscape, Creating with Care and Shakespearean drama to help children with autism with communication.

As a result of the events the very successful Creating with Care, which enables inpatients to remain active and engaged during their stay in community hospital, is now being rolled out across the trust, supported by Oxford Health Charity. Thank you to Richard Mandunya, Chris Roberts and Paul Miller, governors at the trust, for attending these events.

The events were promoted to members as a benefit to membership and externally, inviting people to sign up as a member to take part. Take-up was high with capacity reached within hours of the event publicity being launched. An additional event was added to the line-up which also 'sold out'.

Insight, the trust's quarterly public and patient-facing magazine, features strategically branded membership content to differentiate and highlight membership and involvement-related information, stories and events and promote membership itself. In addition, the Spring 2018 issue included a dedicated membership and involvement eight page pull out.

The aims and objectives for Oxford Health NHS Foundation Trust's membership in the coming five years have been developed in the past year and a Membership Strategy approved by the Membership Involvement Group and the Council of Governors. An action plan for the year ahead will be overseen by the MIG.

Community Involvement

Since June 2017, the Community Involvement Manager post has been in place for the Trust with a remit to develop and coordinate volunteering, Oxford Health Charity and community group engagement.

These strands of work provide a positive opportunity for increasing resources and support to the Trust moving forward. An additional part-time post has been added to the team on a fixed term contract in March 2019 to provide additional resource, this post is primarily focussed on volunteer recruitment and the delivery of the annual HealthFest event.

To bring together and prioritise activities focussed on increasing community involvement in Oxford Health NHS Foundation Trust, a set of action plans for each area of work have been developed.

In addition to this a toolkit for volunteering has been created and a Charity Strategy is being worked on, both documents utilising best practice from NHS England, Charity Commission, Charity Governance Code and the Investing in Volunteers standard to ensure a high quality of service is delivered throughout.

Volunteering and Community Engagement

Following on from the foundation work carried out in 2017/18, the focus for 2018/19 has included:

- Improved central data management for volunteering (in line with GDPR)
- Volunteer Policy review
- Induction and training reviews
- Production of the Volunteer and Supervisor Toolkit
- Increased promotion of volunteering – internally and externally
- Introduction of new recognition opportunity

- Improved role profile management
- Increased recruitment of new volunteers
- Increased networking across all areas of involvement
- Support for the Peer Support programme
- Development and delivery of a Trust community engagement event - HealthFest

Progress against these activities has been steady through the year with notable successes in recruitment, the Peer Support programme, role development and HealthFest, as detailed below:

- Over 80 new volunteers have joined the Trust during 2018/19
- New roles have been developed for Peer Support trainees (who also jointly won the first Volunteer of the Year award), Creating with Care art programme volunteers, Urgent Care Support volunteers and Stroke Ward engagement volunteers
- The Volunteer of the Year award was created as part of the annual Trust awards and nominations were received from across the Trust for this – joint winners were the Peer Support Trainees and Mary Ward, a Pets as Therapy volunteer.
- Engagement with voluntary and third sector groups in and across Buckinghamshire, Oxfordshire and Swindon, Wiltshire and BaNES to increase awareness and support for volunteers
- Consultation on the new volunteer policy and toolkit across volunteers, staff and supervisors (final sign off being achieved in April 2019)
- An engagement survey across all volunteers took place during Volunteers' Week 2018 (June) with the results highlighted below in Stakeholder Engagement.

Stakeholder Engagement

The Volunteering Stakeholder Group has continued to meet regularly throughout the year with additional meetings and discussions taking place with new supervisors and staff side as necessary.

A volunteer newsletter was launched in early 2019 with the aim of keeping volunteers up to date with Trust activities, opportunities to get involved and events to assist them in their volunteering.

The first newsletter also highlighted the results of the first Volunteer Engagement survey which was carried out during Volunteers' Week 2018 with details on how progress had been made against areas of improvement requested by the volunteers. Notably areas of development and response included:

- **You said, more training would help.** We are currently working on a set of induction training sessions for all new volunteers (and open to anyone who would like to attend). In addition, role specific training can be accessed through the Trust Learning and Development team.

- **You said, more information on volunteer roles across the trust is needed.** We now promote all our open volunteer roles on the Trust website - www.oxfordhealth.nhs.uk/getting-involved - and also provide links to partners like Oxford University Hospitals, Sobell House and OxFed volunteer opportunities.

- **You said, the application process is too lengthy.** We have reviewed the application process in full and reduced the length of application and occupational health forms. We have also moved all DBS checks to a streamlined electronic system.

In addition to the volunteer programme stakeholders, a Steering Group for HealthFest has been developed comprising of volunteers, Governors and staff to assist with the planning and delivery of the 2019 event (more details below).

Communications

The profile for involvement has been traditionally very low with little understanding internally of the role of volunteers and little public awareness of the options for getting involved.

'Getting Involved' pages were created for the Trust website during 2017/18 and these have recently been updated with case studies. Traffic to the pages has been steady throughout the year with 2,500 unique page views for the volunteer opportunities pages alone (according to Google Analytics). In addition to the web pages, promotion of ways to be more involved has taken place at a variety of community events, the Trust AGM and, in print, through Insight magazine and the monthly Membership newsletter.

Community Engagement

Community engagement takes place throughout the Trust at a local level in a variety of forms, from engagement through League of Friends to charity partnerships like the Oxford Mental Health Partnership. In addition, there are commissioned activities like the support of Barnardos in Buckinghamshire CAMHS services where both staff and volunteers are involved or Oxford Health Charity funded posts such as the Creating with Care coordinator post across our community hospitals.

Relationships have been developed with local colleges and schools to increase the involvement of younger volunteers in Trust activities and these have progressed into bank and permanent staff positions in a couple of cases.

To ensure that management of external volunteers (volunteers from outside organisations who support staff or patients on Oxford Health NHS Foundation Trust sites) is at the same level as expected, a Memorandum of Understanding has been drafted and forms part of the Volunteer Policy.

Ongoing support and engagement with community groups like Team Oxford, Healthy Abingdon, Bicester Healthy New Town, Age UK Oxfordshire, the Oxfordshire Good Neighbour Schemes, Age Friendly Banbury and the developing Healthy Witney project has resulted in increased awareness of community activities and opportunities for engagement with community groups by local teams.

In addition, links between healthcare volunteering provision have been forged with OxFed (the federation of Oxford GP services), Oxford University Hospitals Foundation Trust, Sobell House and Buckinghamshire Healthcare Trust.

The Trust is also part of the Helpforce network for NHS Volunteering and will benefit from new volunteers joining as a result of their Christmas 2018 campaign in the coming year.

The first HealthFest event took place in September 2018 at the Warneford site with three main aims:

- To increase awareness of Trust and partner activities
- To reduce stigma associated with mental health
- To increase engagement with the Trust through membership, charity and volunteering opportunities

The event saw over 40 different stall holders from both internal and external teams, multiple talks and music displays as well as approximately 250 attendees.

The Steering Group (as mentioned above) have been meeting since December 2018 and are taking all learning points from the first Healthfest into consideration as part of the planning for the 2019 event, with HealthFest 2019 branded as 'Living Well through Activity'. Initial registration for the event has been successful and communications are already underway to promote it (https://www.facebook.com/events/362502207878163)

Oxford Health Charity (charity number 1057285)

The Oxford Health Charity aims to enhance and support the experience of patients, service users, families and carers accessing services through Oxford Health NHS Foundation Trust and support the staff delivering those services. Funds must be spent on items or experiences which provide a benefit to those groups and are not covered through the normal funding streams of the NHS. For example, in 2018/19 these have included:

- the development of a wildflower meadow at Littlemore, Oxford

- music and arts projects/equipment/resource for wards
- a sensory garden at Amber Ward at the Whiteleaf Centre, Aylesbury
- exercise equipment for wards
- staff Retreats to support wellbeing and return to work following ill health
- support for community projects like Healthy Abingdon and Youth in Mind (https://www.oxfordhealth.charity/News/supporting-oxfordshires-young-people)
- the Creating with Care programme coordination at five community hospitals (https://www.oxfordhealth.charity/news/creating-with-care)

The year has seen continued progress against the aim of increasing awareness and engagement with the charity. This has had both internal and external focus with new guidance being produced on requesting and approving funds, new intranet pages, reviews of fund management structures and the development of the new website (see below for more information).

A strategy development day was held in January 2019 to bring together stakeholders interested in supporting the ongoing development of the charity and the Oxford Health Charity Strategy will be launched in 2019/20. A tender process was undertaken during the year in regard to the charity investment portfolio management and Standard Life were appointed in January 2019, taking over from the long standing team at Cazenove.

The annual report for the charity covering expenditure, financial details and reports will be filed separately under the requirements of the charity commission.

Branding and Communications

The Oxford Health Charity undertook a branding exercise in 2018 and launched this at HealthFest in September 2018. By developing a brand for the charity, it has been easier to promote and engage people with all the activities that are taking place and create a sense of purpose under the charity banner.

The below image shows the main branding:

The tree is also used as a standalone image to represent the charity and will form part of the artwork within the new Community Involvement Hub, promoting the breadth of charitable support.

Alongside the development of the branding, a new website (funded through a grant from the Transform Foundation) was built in 2018 and launched just before Christmas.

The website – www.oxfordhealth.charity – provides a platform to promote and engage the public in the work of the charity as well as enabling fundraising pages and appeals to be created.

The donations through the site can be directed to individual funds or appeals and there is scope to promote events, fundraisers and news stories across the site.

Since it launched, according to the Google Analytics for the site, there have been over 865 new users (approximately double the number of users for the Oxford Health NHS Foundation Trust charity pages in the whole of 2018/19).

News stories generated on the site have been promoted through the Trust social media accounts which have helped increase engagement with both the Trust and the charity as a whole.

One prime example of this has been a news story regarding the fundraising team at Pigments Tattoo Parlour in Newport Pagnell, their story was promoted through the Trust Facebook page and had a reach of over 6,000 people as well as an engagement rate of 12%. (https://www.oxfordhealth.charity/news/pigments-tattoo

Fundraising

Teams and individuals have been fundraising throughout the year, with notable activities including:

- The young people of Marlborough House, Swindon – raising funds through their summer fete and Christmas family event to support the development of their garden and communal space
- The team at Pigments Tattoo Parlour – raising funds to support suicide prevention and mental health support in Milton Keynes, Buckinghamshire
- The ROSY (Respite for Oxfordshire's Sick Youngsters) team – raising funds through their annual Great Estates Walk (https://www.oxfordhealth.charity/news/join-the-great-estates-walk-for-rosy)
- The team at Rick Stein's Café in Marlborough – raising funds for Cotswold House, Marlborough (https://www.oxfordhealth.charity/news/eat-drink-and-be-merry-in-helping-patients-with-severe-eating-disorders)
- The Lucy's Room team – raising funds to provide a music room at the Warneford for adult mental health service users https://www.oxfordhealth.charity/Appeal/lucys-room)
- The team at Sapphire Ward, Whiteleaf – raising funds through a variety of activities for an activity table on the ward

In addition to the above, a set of annual fundraising activities is under development. This will include the staff wellbeing Pedometer Challenge (May), team participation in

the Blenheim Fun Runs (April) and the Oxford Half Marathon (October) as well as the chance for people to tick off bucket list activities like skydiving or overseas treks.

NHS Improvement's Single Oversight Framework

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

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

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Comparative information relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

NHS Improvement has placed the Trust in segment 4 (2017/18: 2) which is for providers in special measures where there is actual or suspected breach of the licence with serious and / or complex issues. This has not resulted in the imposition of any licence conditions nor any enforcement action.

We have monthly telephone conversations and regular meetings with NHS Improvement and we welcome their support and recognition of the impact that mental health under investment is having on the financial health of the Trust despite its strong efficiency performance.

We are working with our commissioners on a multi-year investment programme as referenced elsewhere in the annual report.

This segmentation information is the trust's position as at 24 May 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website. No formal or informal regulatory action was taken by NHSI during the year.

Nevertheless, given the challenging financial environment faced we can continue to expect close monitoring by our regulators as we develop our plans for the years ahead. It is helpful to note the recognition that the Trust is already very efficient in its provision of services against several benchmarking indicators.

NHS Improvement Key Performance Indicators (KPIs)

NHSI Use of Resources Metrics for the year ended 31 March 2019

	Actual	Plan	Variance	Actual rating
Capital Service Cover	0.1	1.9	-1.8	4
Liquidity	-5.9	2.2	-8.1	2
Income & Expenditure Margin	-3.7%	-0.1%	-3.6%	4
I&E Margin Variance from Plan	-3.6%	-0.0%	-3.6%	4
Agency	184.8%	65.2%	119.6%	4
Overall 'use of resources' risk rating				4*

** Note, this is not the same as the segment*

The NHSI Use of Resources Metrics above are based upon the Trust's quarterly submissions to NHSI.

Capital expenditure

During FY18, the Trust has maintained its internal capital funding investment level in its property and infrastructure, reflecting the continuation of a low number of major projects and limited capital funding available. Capital spend in FY19 was £6.7m, compared to £6.9m in the previous year. PDC funding of £2.4m was received, relating to the Global Digital Exemplar (GDE) and Places of Safety.

Investment in FY19 focused on addressing estate rationalisation, condition and compliance issues to ensure that properties from which patient services are provided were fit for purpose. The Trust's main capital investment areas during FY19 were:

Estates: operational and risk management (£4.6m) – including rationalisation, backlog maintenance and other works to address compliance requirements, such as infection control and ligature risks;

IT: GDE, infrastructure and development (£2.1m) – including hardware and software upgrades, GDE infrastructure upgrades and roll out of public Wi-Fi.

Cash flow and net debt

The Trust's cash balance increased by £0.4m during the year and remains strong with a year-end balance of £20.0m. Cash increased during the year because of increased payables and other liabilities, public dividend capital receipts and proceeds from the sale of property, plant and equipment (PPE). This was offset by the operating deficit, increased levels of inventory, capital purchases, public dividend capital (PDC) payments and loan repayments.

The Trust generated £12.9m of cash from operations, down by £0.9m on the previous year, primarily because of the deficit from continuing operations of £1.6m compared to a £0.7m surplus in the previous year.

The Trust's gearing ratio (the percentage of capital employed that is financed by debt and long-term financing) decreased to 17.4% (19.6% in FY18) because of loan repayments reducing the debt balance. Year-end net debt decreased by £2.7m to £23.3m (£26.0m in FY18).

The Trust's liquidity ratio (ability to meet short term obligations on time) is -5.9 per NHSI's definition. This equates to a liquidity risk rating of '2' within NHSI's Use of Resources ratings, which represents a low level of risk.

Total assets employed

Total assets employed increased by £0.8m (0.6%) to £134.4m (£132.5m in FY18), reflecting the increased revaluation of land and buildings and PDC receipts. These increases were offset by the deficit.

Statement of Accounting Officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Oxford Health NHS Foundation Trust

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

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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy, and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS

foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed: **Date: 24 May, 2019**

Stuart Bell CBE
Chief Executive and Accounting Officer

Annual Governance Statement

Scope of responsibility

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

To enable delivery of this, the Board of Directors' governance architecture is supported by a committee structure, reporting through to the Board, to deal with the various elements of governance. A non-executive director (NED) of the Trust chairs each of the Board committees to ensure the appropriate delineation of responsibilities with regard to Board and Executive management.

The Audit Committee reviews the Trust's internal control and risk management systems and monitors the work of Internal Auditors. During 2018/19 the Audit Committee has continued to oversee the direction of the Trust's assurance work carried out by Internal Audit and assured itself and the Council of Governors of the continuing independence of the external auditors to include ensuring that independence of judgment was not compromised. There was no commissioning of non-audit work from the external auditors during the year.

There is a robust system in place to ensure that the Board regularly reviews the effectiveness of its internal controls including the review and oversight of the Board Assurance Framework, which supports determination of the level of assurance the Board requires and its appropriateness in order to satisfy Board on the effectiveness of its internal controls.

The purpose of the system of internal control

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

The system of internal control has been in place in Oxford Health NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

I am responsible for risk management across organisational, clinical and financial activities. I am the chair of the weekly Executive and monthly Extended Executive management meetings and the Quality sub-committee Well Led. The Risk Management Strategy was reviewed, and last approved by the Board at its February 2018 meeting. It continues to provide a framework for managing risk across the organisation which is consistent with best practice and Department of Health guidance. The strategy provides a clear, systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes.

We have begun to consider more closely the risks inherent in being part of an integrated local healthcare system, especially with regard to workforce and demand and activity challenges.

Directorate governance arrangements maintain effective risk management processes across all directorates, maintain directorate risk registers and report routinely through Committee, Executive and performance meetings. These have been reviewed and enhanced as part of the wider Directorate restructures as we move to a more age inclusive service delivery model. The Audit Committee comprising independent non-executive directors, and excluding the Chairman, oversees and has reviewed throughout the year the effectiveness of the system of internal control and overall assurance process associated with managing risk.

The corporate induction programme ensures that all new staff are provided with details of the Trust's risk management policies and processes and is augmented by local induction organised by line managers as appropriate. Mandatory training reflects essential training needs and includes risk management processes such as fire safety, health and safety, manual handling, resuscitation, infection control, safeguarding patients and information governance. Root-cause analysis training is provided to staff members who have direct responsibility for risk and incident management within their area of work.

Lessons learned in the unfortunate event when things go wrong, are shared through directorate and corporate governance systems. Training and guidance are provided in various media formats to staff including e-learning, classroom environment, webinars, information bulletins and seminars to ensure learning from good practice and experience is disseminated quickly and effectively.

The integrated governance framework has successfully delivered a comprehensive integrated governance approach and has supported the wider Trust's service and quality improvement agenda which reinforced activity to achieve an overall 'Good' rating at the last CQC re-inspection.

In Oxford Health NHS Foundation Trust, integrated governance is about the combination of corporate and quality governance, and risk and performance management to give the Board of Directors and key stakeholders assurance regarding the quality and effectiveness of the services that the Trust provides.

Detail regarding the Board's committee structure is included within the Corporate Governance section of the Report along with member attendance records and the scope of Committee remits. The Nominations, Remuneration and Terms of Service Committee remit is included separately within the Remuneration Report. The Trust is required to comply or explain departure from the requirements of the Code of Governance and details are again included within the Corporate Governance section of this Annual Report.

The Quality Committee, a formal committee of the Board, supports the Board in relation to meeting quality standards and the management of corporate risk and in turn is supported by four Quality Sub-committees – well led; caring and responsive; safe; and effective. The Trust has an embedded process for assuring the Board on matters of risk, which enhances the organisation's overall capacity to handle risk. The Board Assurance Framework forms the key document for the Board in ensuring all principal risks are controlled, that the effectiveness of the key controls is assured, and that there is sufficient evidence to support the declarations set out in the Annual Governance Statement.

The Director of Nursing and Clinical Standards takes executive responsibility for clinical risk management in the organisation reporting to the 'Accounting Officer'. The Risk Management strategy clearly sets out the roles and responsibilities of executive directors, managers and staff for risk and clinical risk management across the organisation.

Staff are alerted to both the strategy and supporting policies, including such as the Incident Reporting and Management policy throughout the year but most notably as part of the Trust's improvement activity across the year. In addition to regular updates at relevant Board committee and sub-committee meetings, a formal Board Assurance Framework report is presented to the Board which provides a universal view of the strategic risk profile and a regular opportunity for all directors to review progress against mitigating risks and consider new or emerging risks.

Staff and teams are also supported to learn from good practice to mitigate risks through knowledge sharing workshops that highlight risks identified through such as Serious Incidents Requiring Investigation and actions taken to address these. An external audit of the quality governance arrangements in the Trust including the management of Serious Incidents and national patient safety alerts gave good assurance of the robustness of processes. The Board receives the full investigation report for the most serious of incidents.

The Trust's Counter Fraud Work Plan and Local Counter Fraud Specialist also play a key role in assisting the Trust anticipate and manage risk and regular reporting to each meeting of the Audit Committee ensures board members are frequently apprised of counter fraud prevention and detection activity and any necessary improvements required to the Trust's controls.

The risk and control framework

Risk management requires participation, collaboration and commitment from all staff. The process starts with the systematic identification of risk via structured risk assessments documented on risk registers. These risks are then analysed to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are identified whilst higher scoring risks are managed at progressively higher levels within the organisation. Risk control measures are identified and implemented to support mitigation.

A unified approach to risk management is contained within the Trust's Risk Management strategy and the risk appetite of the various stakeholders has been part of our consideration. The Trust's own appetite for risk is articulated through the boundaries within the risk evaluation matrix that have been defined by the Board of Directors in the Risk Management strategy. Risks assessed as significant are monitored to ensure mitigating actions are undertaken to reduce risks to an acceptable level. The process for the management and monitoring of risk assessments is defined within the Risk Management strategy and supporting procedures.

In order to monitor the Trust's risk profile, local risk registers are in place at corporate (Trust-wide), directorate and department level which contain a summary of risk information. The risk registers enable all risks identified within the Trust to be categorised and recorded and assessed against each other and on a Trust-wide and service basis to facilitate decision-making regarding resource allocation and risk reduction. The risk registers inform the Board Assurance Framework where risks to the attainment of the Trust's strategic objectives are identified.

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

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

I am required to describe the key ways in which the Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place; and how the Trust complies with the 'Developing Workforce Safeguards' recommendations.

- In the FY 18-19 we recruited over 1600 people, mainly replacing leavers.

- We are implementing TRAC to improve our ability to control, manage and report on recruitment activity.

- We are investing considerable time and energy in skill mix work to make sure that the blend of skills in our services is safe, appropriate and affordable.

- We have embraced the Nursing Associates opportunity and have more than 130 in training with the first cohort commencing in their roles from May 2019.

- Our staff turnover figure is now below 14% whereas it had reached 15% in 2016.

- We have a series of initiatives in place to improve retention further and we are part of NHSI's Retention programme.

- The Board monitors recruitment, staff turnover, sickness levels, staff engagement data and agency spend every month.

- The "Weekly Review" meeting led by the Medical Director or Chief Nurse every Monday monitors safe staffing and safety and quality issues arising in our services, issues of concern are then escalated to the Executive Team, usually on the same day.

- We are working collaboratively with our staff side partners to address Stress, which is the Trust's greatest cause of sickness absence, a major factor in retention and a significant issue in our staff engagement scores.

- Short Term gaps are filled by the use of agency staff.

- Medium Term we are working to grow significantly our in-house staff Bank (now over 2000 people registered) by such methods as cutting out agency use on non-registered Health Care Assistant (HCA) roles. We are also actively working on skill mix issues including and beyond the introduction of Nursing Associate roles and other new roles.

- Longer Term our workforce strategy is to further improve retention, to constantly review skill mix and pipelines and to make Oxford Health an employer of choice for all staff groups and all types of worker (full time, part time, Bank, clinical, non-clinical, admin etc).

OHFT is not yet fully compliant with the recommendations in the NHSI publication Developing Workforce Safeguards but recognises many of the themes within it and the benefits of good and effective workforce planning.

The Chief Nurse's team, Operational Leaders, HR, Learning & Development and Finance all own some aspects of our activity on workforce planning and effectiveness and will be working together in the coming year to examine how to embed some of the good practice we have in place and that of other Trusts as highlighted in the NHSI publication. We continue collaborating with other Provider organisations in our STP region and at a more local level.

The trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of *UK Climate Projections 2018 (UKCP18)*. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. More information with regard to the Trust's activities to reduce its carbon footprint is contained earlier in the Report within the Performance Analysis.

I can confirm that the Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission and sections of the annual report explain our systems of assurance in that regard.

The trust has a published register of interests for decision-making staff within the past twelve months, as required by the Managing Conflicts of Interest in the NHS' guidance but we have more work to do to embed this which our reviewed policy will support in the future.

During 2018/19 the Board ensured ongoing assessment of significant risks to the attainment of objectives and maintained oversight of a range of specific risks related to mitigating non-delivery of reforecast financial plans; workforce planning risks to mitigate the inability to fill vacancies/retain staff and reduce reliance upon agencies, improvements in performance frameworks to address risks of variable quality of data and of records; attention on cost control and on the Oxfordshire mental health investment funding gap to support financial sustainability, and ongoing oversight of the implementation of our Electronic Health Record system and its impact on staff and patients.

With continued pressures, particularly on the local mental health systems, we have worked with our commissioners and with our system partners to develop secure financial underpinning for the levels of service required to respond to demand and to ensure that there was a sustainable level of workload across services.

It was helpful that this issue was given public recognition and identified as a national and local priority. Nevertheless, considerable further work is still required to support the right care in the right place and to maintain focus on the need for mental health investment to support our staff who deal day to day with the pressures of caseload and acuity levels.

Oversight of other risks included attention on the elimination of variability in the quality of care and progress on our improvement plan; integration of care pathways internally and between organisations in the system; quality improvement and innovation/adoption and organisation and leadership development.

With regard to new and future risks the Board has considered the risk profile/its risk appetite during its strategic and board development sessions.

As with all NHS organisations, balancing the need to deliver high quality care in the context of increasing demand and complexity, whilst increasing productivity, is a continual challenge in addition to being able to attract and retain staff, and particularly those in specialist roles.

We recognise that strategic and transformational change internally and across geographical health economies will be required to address the risks and the outcome of the CQC Oxfordshire system review and follow up review emphasised the importance of integrated system working which the Trust will support accordingly.

Collaborations and partnerships are increasingly the cornerstone of effective integrated health and care delivery and our Board has paid close attention to the developing Integrated Care Systems (ICS) in Buckinghamshire and Oxfordshire and the priorities nationally and locally underscored within the NHS Long Term Plan.

The future continues to pose increasing risks and challenges for delivering the level of efficiency increases and cost reduction within an extremely challenging financial plan especially in light of the necessity for a reforecast in 18/19, itself a challenging year.

Commissioner affordability with regard to parity of esteem and meeting the required mental health investment including the additional growth in patient demand and acuity across the system will no doubt continue to put additional pressure on our financial plan as it has in 18/19, and on the Oxfordshire system.

The NHS England access standards for mental health services (published early 2019) make it all the more important that we understand fully the scale of the demand we are facing, and the capacity needed to meet that demand, in order to plan for a

sustainable system, particularly given the historically relatively high levels of unmet need across mental healthcare in all developed healthcare systems.

The Trust recognises that managing the risks identified will also involve multiple partners working together across health and social care and adapting our own internal arrangements, so they are sufficiently agile to meet the challenges of working in complex and uncertain circumstances.

Into 2019/20 we will continue to play a key role in the implementation of strategic and transformational change through Sustainability and Transformation Partnerships and Integrated Care Systems and we will engage with our public, staff and stakeholders to agree options together.

The Trust continually assesses compliance with the NHS Foundation Trust Licence Condition 4 (FT Governance). The Board last formally reviewed its assessment in detail in May 2018 (next review May 2019) as part of the Corporate Governance Statement to NHSI and confirmed no material risks had been identified with regard to compliance with its Licence.

The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures to include reporting lines and accountability between the Board, its subcommittees and the executive team
- The responsibilities of directors and sub committees
- The submission of timely accurate information to assess risks to compliance with the Trust's Licence, and
- The degree and rigour of oversight the Board has over the Trust's performance.

Some of these conditions are detailed within the Trust's Corporate Governance Statement the validity of which was assured by the Board prior to submission to NHSI. In order to assure itself of the validity of its statement, required under NHS Foundation Trust condition 4(8)(b), the Trust has assessed the extent with which it complies with the Code of Governance and this is detailed in its own section of the Annual Report.

In June 2017 the Board undertook a review of board governance including capability and capacity and commissioned a review into the performance of the Board covering the areas previously incorporated in the Quality Governance framework issued by NHS Improvement (and aligned with CQC requirements) and now part of NHSI's broader Well-Led Framework. The Board has monitored progress with the action plan through its Quality Sub Committee: Well Led.

The Quality Committee monitors the delivery of the quality priorities for the Trust. The priorities include a number of indicators agreed with stakeholders from our local community together with national indicators of quality, including access to services and patient feedback.

The Executive team and the Quality Committee regularly review assessments against the CQC registration requirements in readiness for our Well Led Review, the last of which concluded in November 2018. Where gaps have been identified, action plans have been monitored for implementation to ensure the board was reasonably assured that CQC standards were being met and improvement plans were effectively delivering the required improvements. The section below on information governance covers the management and control of risks to data security.

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

Financial and non-financial performance is reported through a framework which generates 'dashboard' presentation and analysis at Board, at Executive and at Divisional/Directorate levels. These include local authority indicators in respect of services managed under NHS Act 2006 Section 75 agreements. The Trust reports separately on its performance against Care Quality Commission standards through the Quality Committee and its supporting sub structure and via quality and safety reports to the Board of Directors.

The Trust has a strategic approach to promote economy, efficiency and productivity which aims to ensure that financial benefits are not gained through the erosion of qualitative benefits to patients. The Executive Directors assure themselves of progress with plans and impact on services through such as Divisional Performance Review meetings and exception reporting.

The Trust's Internal Audit plan, which is agreed by the Audit Committee, sets out the full range of audits across the Trust and which reviews the economy, efficiency and effectiveness of the use of resources. The Audit Committee routinely reviews the outcomes and recommendations of the Internal Audit reports, and the management response and progress against action plans.

The Trust's Counter Fraud Work Plan, which is approved by the Audit Committee, demonstrates an embedded counter fraud focus for any assessment process as defined by NHS Protect. The Plan focuses on four key areas: 'Strategic Governance'; 'Inform and Involve'; 'Prevent and Deter' and 'Hold to Account' and more information is included in the Corporate Governance section.

Financially we have seen a net real reduction in income year on year due to a combination of factors detailed in the performance report.

To reiterate, during FY19 the Trust had a deficit of £5.7m which was £7.6m worse than the plan. It is important to note that this position included £1.5m of Sustainability and Transformation funding (STF) and although the Statement of Comprehensive Income shows a deficit of £5.7m, excluding STF and other exceptional items (impairments, depreciation on donated assets and the non-cash element of on-SoFP pension costs) the underlying position is a deficit of £8.2m.

The high cost of agency staff has continued to drive a national focus on reducing reliance on such staff and negotiating nationally to improve procurement frameworks should other staffing options be exhausted.

The Trust has continued to work closely with the NHS Collaborative Procurement Partnership and agency suppliers to negotiate agency rates within the price caps introduced by NHS Improvement but continues to experience significant challenges in reducing its reliance on agency workers and meeting targets set by NHSI.

Where there is significant clinical risk Service Directors are required to authorise over-rides which are reported and scrutinised on a weekly basis by members of the Executive team. The maturation of a e-rostering system and the introduction of the centralised bank has significantly strengthened the Trust's ability to better manage staffing within the agency rules introduced.

All agency use is now managed centrally through this system. The Trust ceased the use of agency for its Health Care Assistant provision during the year.

Cross system working has progressed through our Transformation Board which is looking at how all our health and social care systems can work better together in the longer term and in accordance with our Strategic Transformation Partnership (STP) as part of the Berkshire, Oxfordshire and Buckinghamshire (BOB) footprint. A follow up to CQC Oxfordshire system review in 2017 was conducted in November 2018 and the final report has provided areas of action for senior managers in the NHS, social care and other bodies to act upon to make the whole health and care system work better, but much improvement was recognised since the first review.

We have continued the phased roll out of our new electronic record systems during the year, which will ultimately help us to improve care and involvement in care for everyone, as well as supporting research and audit to understand conditions and develop the best treatments and services. The electronic health record programme is setting a firm foundation that our trust can build on in the coming years.

Despite significant challenges to delivery, we have achieved our cost improvement plan this year but anticipate significant challenge in continuing such efficiencies going forward without appropriate investment in mental health services

To support ongoing attainment of value for money, service line analysis and reporting will provide long-term solutions to the achievement of this aim through a more granular understanding of the areas through which we can drive even greater efficiencies.

Information Governance

The Trust's Integrated Information Governance Policy outlines the management and assurance framework, including key roles and committees that are responsible for managing and monitoring confidentiality and data security.

The Information Management Group, chaired by the Senior Information Risk Owner (SIRO) is responsible for fidelity to the policy and provides management focus and analysis of data security threats and delivers improved data security through the review of incidents, policy development, education of users, highlighting risks and developing risk mitigation action plans.

The Caldicott Guardian is a member of the group as will be the Data Protection Officer (DPO) moving forward. The group oversees compliance with the Freedom of Information Act and receives assurance with respect to subject access requests under the Data Protection Act.

The Data Security and Protection Toolkit (DSPT) is an annual online national self-assessment process overseen by NHS Digital, which enables the Trust to measure its compliance against the National Data Guardian security standards and information governance management, confidentiality and data protection, information security, clinical information, secondary uses and corporate information.

The Trust provides evidence to demonstrate compliance with each of the assertions in the Toolkit, elements of which are independently audited by internal audit. Following the independent audit and sign off by the Trust Caldicott Guardian, and subsequently the Board of Directors, the DSPT assessment is submitted on 31 March each year.

The Trust met all standards and assertions in the DSPT 2018/19. Internal Audit reviewed the key requirements of the DSPT, found no risk and gave reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The Trust requires all information incidents to be reported. Each incident is recorded on the Trust Incident Reporting System and all incidents of Level 1 or less are summarised, reported, analysed and considered by the Information Management Group quarterly. There were no serious confidentiality incidents (level 2) during 2018/19.

The Trust is acutely aware of the growing threat from cyber-crime, i.e. malicious attempts to damage, disrupt or steal our IT-related resources and data. In order to combat this, the IM&T Department continues to step up efforts in all areas to monitor for suspicious activity, with a programme that includes providing awareness education to staff, analysing our infrastructure for potential weaknesses and remediating any issues.

The General Data Protection Regulations (GDPR) came into force on 25th May 2018 replacing the Directive that is the basis for the UK Data Protection Act 1998, and the Trust was able to confirm compliance with the provisions of the GDPR by that date.

The Trust planned for the transition to GDPR and DPA (2018) during 2017/2018, and integrated the new legal framework into policy, procedures and mandatory information governance training ready and for and with effect from 25 May 2018.

An implementation plan was overseen by the Board, which delivered reviews of policy, procedures and training: developed and published new Privacy Notices: changed subject access request procedures to incorporate shorter timescales and digital responses; and established a GDPR working group which continues to develop practice and procedure with respect to GDPR and DPA (2018).

Annual Quality Report and quality governance

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

The Directors of the Trust are required to satisfy themselves that the Trust's Annual Quality Report is fairly stated. In doing so the Trust is required to put in place a system of internal control to ensure that proper arrangements are in place, based on criteria specified by NHSI. The steps which have been put in place to assure the Board that the Quality Report is fairly stated are as follows:

- report specifications are written for each report and take account of any Department of Health rules/guidance on how activity should be counted

- service capacity plans are agreed with each Directorate annually. These plans feed into the contracting process
- monthly activity is monitored against agreed contract targets. Month on month activity is compared to identify any inconsistencies
- quality in this sense is concerned with ensuring that systems are managed to support validity of data, for example that all codes used are nationally recognised codes, or map to national values. Internal data quality also includes maintenance of changeable reference data
- the system support function identifies and corrects inconsistent data
- systems are also managed to enforce data quality where necessary
- production and maintenance of data quality reports that can be run by end users
- specific data quality awareness, including the minimal use of default codes, is included with system training, and training support materials
- monthly monitoring reports produced for the service delivery teams to monitor the quality of the data, raising issues if tolerances are exceeded
- audits of records in the form of spot checks of paper records (where held), and validation of inpatient data entered electronically on a daily basis
- internal audit review of data sources
- external audit review

The Trust has an identified quality and safety department with relevantly qualified and experienced staff to support the execution of quality improvement across the Trust, which was also supported by a dedicated improvement and innovation team, Oxford Healthcare Improvement, during the year.

The Quality Report has been reviewed through both internal and external audit processes and comments have been provided by local stakeholders.

The external audit of the Quality Report did not identify any data quality issues that would have risked a qualified audit opinion.

The reliance on manual intervention whilst it remains, there have been improvements, but ongoing manual scrutiny and review for accuracy and completeness is required. Whilst this ensures data quality, this is a resource intensive and inefficient situation which we continue to work to improve.

In addition, there has been significant progress with implementation of a programme of work to review our structures, methods and resources for performance and contract management which includes a more systematic approach to providing data and information of high quality and integrity with minimal intervention.

The Trust undertook a self-assessment against NHSI's Well Led Framework which has aligned with CQC 'well led' requirements and which is a key focus of the Trust's Well-Led Committee reporting to the Quality Committee.

As previously stated, PriceWaterhouseCoopers concluded their assessment of the Trust's governance arrangements in June 2017 and neither assessment uncovered any significant issues but highlighted areas where improvements could be made. We will consider a further review before June 2020 in accordance with published guidance.

The Trust is proud of its 'good' rating from the CQC for the well led domain and for the Trust overall and the Board will continue its own focus on improvement through a dedicated development programme and the 'good' outcome of its 2018 CQC Well-Led Inspection was most welcomed and supported determination of additional areas on which to focus improvement activity.

The Quality Report as part of this Annual Report describes quality governance and quality improvement in more detail. The Trust has strong quality governance systems in place which support quality improvement and standardised risk assessments (Quality Impact Assessment) of all transformational changes and cost improvement plans.

The Chief Executive has ultimate responsibility for the quality of care across the Trust and the organisation is making quality improvement a part of every manager and leader's role.

The Trust takes a multi-faceted approach to improving quality, including:

- The establishment of a Healthcare Improvement Centre, which is essential to the Trust building capacity and capability to deliver quality improvements;
- A programme of team-to-team peer reviews;
- Achieving more than 20 different external accreditations and network memberships;
- Taking a lead nationally on clinical research with the support of the Oxford Academic Health Science Centre in mental health and dementia;
- Regularly involving patients and service users in the development of services;
- Taking part in national and system collaboratives i.e. virtual community hospital beds, reducing length of inpatient stay for patients with a learning disability, and Lord Carters work on efficiency including e-rostering.
- Establishing formal partnership arrangements with other providers to improve the integration of services and coordination of care

Furthermore, the Trust has robust arrangements in place for patients, staff and the public to raise concerns with respect to the quality of care to include a dedicated Speak

Up Guardian. The Speak Up Guardian has reported to both the Audit Committee and the Board of Directors and the former has also scrutinised the effectiveness of the Trust whistleblowing and speak up arrangements to understand any areas of assurance or for development focus.

Assurance is obtained on compliance with CQC registration requirements through: regular review by the Executive team and the Quality Committee of progress against improvement plans to ensure the CQC outcomes are met; and through a combination of internal peer reviews across the Trust against the CQC framework, and assurance reports to Quality Sub-committees assessing CQC compliance.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. At its last inspection in 2017/18, no enforcement notices were issued and our current rating is 'Good'.

Following the Well-Led inspection mentioned below the Care Quality Commission issued six requirement notices and updates on the progress with all actions has reported to the Executive Team regularly.

As previously referred to, the trust was involved in a local system thematic review in Oxfordshire to look at how health and social care providers and commissioners are working together to care for people aged 65 and older needing physical healthcare. The Quality Report provides further detail regarding CQC inspections.

We have continued our work to enhance safety to ensure that across all Trust services the same high standards are observed. The CQC has also previously noted that some of our older estate, especially inpatient mental health settings at the Warneford Hospital, was outdated for the delivery of modern mental health care.

The Trust has long been aware of the challenge of operating from Victorian buildings and in recent years has developed the Whiteleaf Centre in Buckinghamshire and the Highfield Adolescent Unit in Oxford as exemplars of purpose built 21st century mental health care.

A working group has continued to progress options for future development of the Warneford Hospital to better address modern health care needs.

The Quality Report includes further detail, but the Trust has disappointingly reported two never events in 2018/19, both having had a comprehensive investigation and in both cases, we are grateful that no one was seriously harmed. We are ensuring that we learn from the outcome of the investigations and make improvements to prevent recurrence.

Data quality risks are managed and controlled via the risk management system. Risks to data quality are continually assessed and added to the IM&T risk register.

In addition, independent assurance is provided by the Audit Commission's Payment by Results (PbR) Data Assurance Framework review and the Information Governance Toolkit self-assessment review by Internal Audit.

The Trust initiated improvements in the quality of data on which it relies to assess performance, and key programmes of work have progressed during the year but there remains more to do.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by in particular the Board and the Audit Committee and by the Board's committees/sub-committees and plans to address weaknesses and ensure continuous improvement of the system are in place.

The Trust's Assurance Framework provides me with evidence the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. Internal Audit provides me with an opinion about the effectiveness of the assurance framework and the internal controls reviewed as part of the internal audit plan.

Work undertaken by internal audit is reviewed by the Audit Committee. The Board Assurance Framework/Trust Risk Register provides the Board and me with evidence of the effectiveness of controls in place to manage risks to achieve the organisation's principal objectives.

My review is also informed by External Audit opinion, inspections carried out by the CQC and other external inspections, accreditations and reviews.

Executive Directors who have responsibility for the development and maintenance of the system of internal control provide me with assurance in a variety of ways, including

through reports on the implementation of audit action plans and reports of the work of the Quality Sub-committees.

My review is also informed by processes which are well established and ensure the effectiveness of the systems of internal control through:

- Audit Committee's scrutiny of controls in place
- CQC Registration requirements, the last inspections and CQC (Mental Health Act Commission) reports
- patient and staff surveys; complaints received and outcomes of investigations
- Reviews of serious incidents requiring investigation and whistleblowing investigations and the outcome of the investigations
- internal sources – such as clinical audit, internal management reviews, performance management reports, user and carer involvement activities, benchmarking and self-assessment reports
- assessment against key findings of external inquiries

The Board has monitored progress against the key risks facing the Trust and assured itself that the strategic intent of the Trust appropriately addresses opportunities and the risks facing the Trust and the continual improvement of the totality of its business.

The Audit Committee has sought assurance from the Trust's Internal and External Auditors from the agreed audit programmes which have been developed through consideration of the gross risks, key controls and gaps in assurance as identified by the Board Assurance Framework.

The Quality Committee and the Finance and Investment Committee and their sub-committees have ensured that programmes of work, and the developments of policy and strategy, address identified risk areas.

The committees have also considered the sources of assurance and incorporated the findings of these assurances in future work programmes. The Audit Committee has sought assurance on the design, implementation and review of the Trust's clinical audit programme.

The Accountability Report itself includes further description of the board's committee structure, attendance records and breadth of work, and the Corporate Governance Section of the report outlines compliance with the Corporate Governance Code and explanations of any departures.

By the end of the year, the performance of our teams has resulted in the Trust meeting the majority of its national targets and we have plans in place to improve the quality

of service delivery and our CQC ratings further in the coming years. I and the Board of Directors are very proud of our staff in ensuring delivery against these targets during another very challenging year.

Conclusion

While I recognise we can always improve on our systems, the Board has extensive and effective governance assurance systems in operation. These systems enable the identification and control of risks reported through the Board Assurance Framework and Trust Risk Register. Internal and external reviews, audits and inspections provide sufficient evidence to state that no significant internal control issues have been identified during 2018/19.

There remain potentially significant risks facing the Trust in 2019/20 and beyond with regard to delivery of our plans and the associated cost reduction due to the Trust's already strong efficiency performance, increasing demand and workforce challenges.

The Trust risks being in an unsustainable financial position in light of the severe underfunding of its mental health services. Delivering our current services to meet the population needs in our area sustainably remains dependent upon improving the revenue the Trust receives for its services.

We understand that the best service improvements are those where patients, the wider public and key stakeholders (including local authorities, the voluntary sector, our governors and our social care partners) work together to co-design services based upon the health and care needs of the local population and as we work to break down organisational barriers and work in a much more integrated way to improve care for residents and patients, the developments in, and effectiveness of strong integrated governance arrangements will be paramount.

Signed: **Date: 24 May, 2019**

Stuart Bell CBE
Chief Executive and Accounting Officer

Quality Report and Account

Statement on quality from the Chief Executive

Our vision is: outstanding care, delivered by outstanding people.

Caring for people is at the heart of everything that we do. As Chief Executive I am incredibly proud of what we, at Oxford Health, have achieved so far and with the Board, I am committed to deliver further year-on-year improvements. We hope that you enjoy reading about the many improvements and innovations our staff have made in the last year and our plans for the future.

We continue to be one of the most efficient NHS Foundation Trusts in the country, and benchmarking and the continued 'Good' rating by the Care Quality Commission is a testament to the high value care that Oxford Health delivers. This is a significant achievement given the financial and workforce pressures that the Trust and the broader system has experienced throughout the year.

Availability of staff continues to be an issue, we are experiencing a significant and sustained increase in the number of referrals, and we are also facing a need for the delivery of more complex care. We have started and will continue to transform our workforce to meet the changing health and social care needs of the local population. Furthermore, it is recognised that there has been underinvestment in mental health services for a number of years, we are working closely with our commissioners and the Health and Wellbeing Boards to improve the position going forward.

Despite the difficulties faced by our staff they are inspiring in the way they continue to focus on improving the quality of care and putting the people we treat first. Over the last five years we have seen a year on year improvement on staff reporting they would recommend Oxford Health as a place to work and as a place to receive care. However, we recognise we need to do more to ensure staff never feel bullied or harassed in their workplace with objectives identified for the next year.

We have successfully established a healthcare improvement centre which is enabling us to apply a consistent approach to continuous improvement by developing the capacity and capability of staff to innovate and make improvements to the way we deliver care to people. There are many examples in the Account of the quality improvements, innovations and our contribution to clinical research in 2018/19. With the support of the centre it is our ambition to reach an 'Outstanding' quality rating from the Care Quality Commission.

An integral part of our approach is that care should be a joint endeavor with the people and patients we treat. We want our patients to have a strong voice and to work alongside professionals so that care is centered on their needs.

We are committed to ensuring that the people we treat have a positive experience of care and we continue to prioritise learning from feedback. Feedback shows us that 94% of people would recommend Oxford Health for treatment to their family and friends.

This year we are refreshing our experience and involvement strategy with a focus on inclusion, personalised care and continuing to increase the amount of feedback received, further information is provided within the Account.

Oxford Health has a strong track record of working in partnership with other organisations and developing new models of care, there are many examples of this in the Account. We remain committed to develop new partnerships in 2019/20 so that we can find sustainable solutions to meet the needs of local people.

We are an active partner in the strategic work of the Buckinghamshire, Oxfordshire and Berkshire Sustainability and Transformation Partnership and we are proud to be an active partner in the development of one of the first Integrated Care Systems in Buckinghamshire.

In line with the NHS long term plan, we want to maximise the use of technology in the delivery of care. Oxford Health is one of seven trusts selected as a Global Digital Exemplar and we remain focused in 2019/20 on developing the use of current and emerging technology to improve the care we provide.

We strive to provide caring, safe and excellent care which meets the high standards that people who receive services deserve. I am proud of everything we have achieved in the last year and this is testament to the hard work and dedication of our staff. As we look ahead to the coming year we are commited to achieving both efficiencies and quality improvements and are confident that we can continue to provide high quality care and sustainable services. The Trust's quality improvement plan for 2019/20 is included in the Account.

I am pleased to confirm that the Board of Directors has reviewed the 2018/19 Quality Account and confirm that it is a true and fair reflection of our performance.

Signed

Stuart Bell CBE **Date: 24th May 2019**

Chief Executive

Part 1.1 Who we are

Oxford Health NHS Foundation Trust (OHFT) provide physical health, mental health, social care and learning disability services for people of all ages across Oxfordshire, Buckinghamshire, Bath and North East Somerset, Swindon & Wiltshire.

Our services are delivered at community bases, hospitals, clinics and in people's homes. We focus on delivering care as close to home as possible. We employ around 6,700 staff (head count), deliver services from more than 150 different sites and on average treat more than 44,000 patients a month.

We provide the following services in each county;

Buckinghamshire	Mental health services for children, young people, adults and older people.
Bath and North East Somerset, Swindon and Wiltshire	Mental health services for children and young people and eating disorder services.
Oxfordshire	Physical health, mental health, eating disorder, learning disability and autism services for children, young people, adults and older people.

The main services we provide are listed below.

Physical healthcare services

- Children's integrated therapies
- Children's community nursing
- Looked after children service
- Community dental service
- Family support services
- Health visiting service
- School nursing service
- Luther street GP for homeless people
- Children & adult bladder and bowel service
- Care home support service
- Chronic fatigue service
- Community diabetes service
- Adult community therapy service
- District nursing service
- Tissue viability service
- Emergency multi-disciplinary units/
- Rapid access care unit
- First aid units
- Minor injury units
- Hospital at home service
- GP out of hours' service
- Falls prevention service
- Nutrition & dietetic service
- Heart failure community nursing
- Respiratory & pulmonary rehabilitation service
- Physical disability physiotherapy service
- Podiatry

Mental Health and Learning Disability services

- Children and adolescent mental health community and inpatient service
- Children neuropsychiatry service
- Adult mental health community and inpatient service
- Older people mental health community and inpatient service
- Memory clinics
- Eating Disorder community and inpatient service
- Complex needs service
- Early intervention service
- Forensic mental health community and inpatient service
- Learning disability and autism community service
- Perinatal service
- Emergency psychiatric liaison service
- Improving access to psychological therapies (for mild or moderate conditions)
- Psychological therapy service (for severe/ complex conditions)

In 2018/19 we have developed services for patients by; opening safe havens in Oxfordshire and Buckinghamshire with partner organisations which are late-night spaces for people experiencing a mental health crisis, re-configurating the community hospital wards to open a dedicated stroke rehabilitation unit and we were successful in being chosen as an NHS trailblazer site to pilot improvements to children's mental health services in Oxfordshire and Buckinghamshire.

Part 1.2 Our approach to improving quality

The Chief Executive has ultimate responsibility for the quality of care across the Trust and the organisation is embedding quality improvement as a critical role of every manager and leader.

We take a multi-faceted approach to improving the quality of care with some of the enabling factors described below;

- Regularly involving patients and service users in the development of services,
- Taking part in national and system collaboratives i.e. virtual community hospital beds, reducing length of inpatient stay for patients with a learning disability, and Lord Carters work on efficiency including e-rostering,
- The establishment of a Healthcare Improvement Centre, which is essential to the Trust building capacity and capability to deliver quality improvements,
- A programme of team-to-team peer reviews,
- Achieving more than 20 different external accreditations and network memberships,
- Taking a lead nationally on clinical research with the support of the Oxford Academic Health Science Centre in mental health and dementia,
- Establishing formal partnership arrangements with other providers to improve the integration of services and coordination of care, i.e. the Buckinghamshire Integrated Care System, Thames Valley and Wessex Forensic Network, the Oxfordshire Mental Health Partnership, and a joint enterprise with Oxfordshire GP federations to deliver care to meet local needs. An exciting new partnership is being developed in 2019/20: the first Integrated Dental Care System across Thames Valley in collaboration with NHSE.

response
Connection Support
WE ARE BETTER TOGETHER
NHS Oxford Health
restore
Oxfordshire mind

Your community Your care
Developing Buckinghamshire together

Oxford Healthcare Improvement Centre

The Healthcare Improvement Centre is building capability and capacity for quality improvement to make and sustain change through a layered approach, including:

- Delivery of a three-day quality improvement programme for some of the Extended Executive Team,
- Continuation of a Scholars Programme for senior staff called Leading Quality Improvement to develop an in-depth understanding and to carry out improvement work,
- Provision of an introduction to quality improvement for newly qualified nurses and allied health professionals to increase participation in quality improvement projects,
- Provisions of an introduction to quality improvement on the Trust-wide Leadership Development Programme and an assessment of application in practice,
- Provision of coaching to progress quality improvement projects originating from clinical audits,
- 2019/20 will see the start of a new six-month programme for frontline staff to lead small quality improvement projects in their workplace.

Possible quality risks

The Trust has identified our top risks to the delivery of high-quality care as;

- Staffing recruitment and retention
- Completion of annual appraisals (personal development plans), supervision and mandatory training
- Failure to care for patients in an appropriate inpatient placement due to bed pressures or absence of community or social care support (this can sometimes result in using an out of area placement)
- Historic underfunding of some services in some counties

The Trust's quality improvement plan for 2019/20 starts from page 184

Part 1.3 Innovations in 2018/19

Over the last 12 months there have been many examples of innovative practice by staff, a sample of these are listed below and also shared throughout the Account.

The Minor Injury Unit redesigned the fracture management pathway alongside our acute provider, Oxford University Hospitals NHS Foundation Trust, to deliver definitive care where appropriate at a patient's first contact reducing the need for referral to a secondary trauma clinic. The change has been success with around a 20% reduction in onward referrals.

As part of national dying matters week in May 2018 the Trust alongside partner organisations drove a bus around Oxfordshire to create a friendly space for people to ask questions about end of life care such as making a will, planning a funeral and coping with bereavement.

Four of our teams won at the Oxford Brookes 'Placement of the Year' awards in July 2018, with six other teams being highly commended. The Oxford Brookes Placement of the Year awards celebrate excellent placements and learning environments provided by local health and social care providers.

The Thames Valley and Wessex Forensic Network New Care Model was a finalist for a Health Service Journal award in November 2018. The Trust is the lead provider of the network of NHS trusts and a third sector provider. The new care model provides specialist NHS mental health services, prioritising treating long-term hospital patients closer to home near family and friends. The network has brought over 17 people closer to loved ones and ensured 35 people were placed closer to home on admission.

A film was made called 'Patient Voices…Our Story', by the Patient Participation Group at Luther Street homeless GP, Healthwatch Oxfordshire and a local filmmaker. The film highlighted how patients were being supported to be involved in shaping how services are run. The film was shortlisted and was highly commended at the national Healthwatch network award in October 2018.

An innovative app developed by staff called BlueIce which is a prescribed app designed to help young people to manage urges to self-harm, from May 2018 was included in the national NHS apps library. The library a single resource area for clinicians to access new technical solutions that can help patients.

A series of short films were made featuring young people to promote conversations about mental health issues, to describe what problems might look like, why they might develop and explain what treatments are available. The films were launched on world mental health day in October 2018.

In November 2018 senior leaders at the Trust graduated from the 2018 Leading Together Programme for learning disabilities. The development course is designed to bring together members of the public with healthcare professionals to reflect, learn and work at a strategic level.

'Creating with care' was an initiative developed in partnership with the District Councils to introduce regular creative interventions to the hospital environment. The initiative started at Witney community hospital and has now spread across the community hospital wards. The intention of the initiative is to enhance patient and carer experience and sense of wellbeing through activities such as photograph exhibitions, dance sessions, garden parties, teas dances, concerts, art classes, creating a book of poems and creating a mosaic for the garden.

The Improving Access to Psychological Therapy (IAPT) services in Oxfordshire and Buckinghamshire participated in the Thames Valley evaluation of new integrated treatment teams for patients experiencing long term physical health conditions (LTCs) and co-morbid depression/anxiety. The evaluation of cohort 1 showed both a reduction in healthcare services utilisation and a reduction in healthcare costs for patients who received Integrated IAPT treatment. Patients also experienced considerable therapeutic benefits with a reduction in depression and anxiety symptoms and above national average recovery rates.

The Early Intervention Service have been part of a pilot using a portable device so that clients can have blood tests at home. This means that clients do not have to attend their GP surgery for blood tests and there is less delay in getting any treatment required. We are also able to complete physical health checks with clients, many of whom are at high risk of physical health problems due to mental health problems, their lifestyle choices and medication.

The Trust as part of a project under the NIHR Oxford Health Biomedical Research Centre is piloting an integrated research and clinical assessment centre, known as the Brain Health Centre. This integrated centre will provide high-quality assessments for patients with memory problems, who will have improved access to research opportunities. The research will enable the development of better dementia diagnostic tools and treatments that can be rapidly implemented to provide better care for patients and improve their wellbeing.

See page 181 about the Emergency Multidisciplinary Unit (EMU) which piloted an innovative advanced nurse practitioner outreach service in West Oxfordshire with senior medical support to deliver advanced clinical care in a patient's home to maintain their independence and prevent a hospital admission.

The health visiting service developed and introduced a new pathway in October 2018 for how we support and improve care for families with children with special educational needs and/or disability. The pathway has enhanced the support and care we provide before and after diagnosis or identification.

Part 2: Statements of Assurance/Performance against National Indicators 18/19

Part 2.1: Statements of assurance

This section of the Quality Report follows a standard format and set of words every NHS Trusts is required to report on.

Review of services

During 2018/19, Oxford Health NHS Foundation Trust (OHFT) provided and/or sub-contracted 41 relevant health services covering mental health, learning disabilities and physical health services provided in the community and within an inpatient setting.

The Trust has reviewed all the data available to them on the quality of care in all of these relevant health services. The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of services by OHFT for 2018/19.

Participation in clinical audit

During 2018/19, 10 national clinical audits and three national confidential enquiries covered relevant health services that OHFT provides.

During that period OHFT participated in 100% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The tables below show:

- The national clinical audits and national confidential enquiries that OHFT was eligible to participate in during 2018/19.
- The national clinical audits and national confidential enquiries that OHFT participated in during 2018/19.
- The national clinical audits and national confidential enquiries that OHFT participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audit

Out of the 10 national audits carried out in 2018/19, the reports from two of the clinical audits were reviewed by the provider in 2018/19 and OHFT intends to take action to improve the quality of healthcare provided, as listed in Appendix A. In regard to the other eight national audits we are waiting for the results.

We are pleased to report that the stroke national audit programme (SSNAP) has demonstrated an improvement in the quality of stroke care provided during 2018/19.

Table 1.

Title	Eligible	Participated	Number of cases submitted
NCAAD (National Clinical Audit of Anxiety and Depression)	Yes	Yes	23
NCAAD (National Clinical Audit of Anxiety and Depression) Spotlight 1	Yes	Yes	60
POMH 16 Rapid Tranquilisation	Yes	Yes	38
POMH 18 Clozapine	Yes	Yes	80
POMH 6d Depot Antipsychotic	Yes	Yes	149
POMH 7f Lithium	Yes	Yes	160
NACEL (National Audit of End of Life Care)	Yes	Yes	19
NCAP (Early Intervention spotlight)	Yes	Yes	160
SSNAP (Stroke national audit programme)	Yes	Yes	Ongoing data
National audit of diabetes footcare	Yes	Yes	Ongoing data

Local Clinical Audit

The reports of 11 local clinical audits were reviewed by the provider in 2018/19. Appendix B includes examples of local audits reported and actions taken in 2018/19, the full details can be found in the Trust's 2018/19 annual clinical audit report.

National Confidential Enquiries

Table 2.

Title	Eligible	Participated	% Submitted
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Yes	Yes	Ongoing data
National Confidential Enquiry into Patient Outcome and Death Long Term Ventilation	Yes	Yes	Ongoing data
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	Ongoing data

Participation in clinical research

2,017 patients who are currently receiving or have in the past received health services provided or sub-contracted by OHFT in 2018/19 were recruited during the period to participate in 107 research studies approved by a research ethics committee. These figures include healthy volunteers involved in research. This compares to 143 studies in 2017/18.

The Trust continues to remain within the top three Trusts for recruitment into mental health and dementia studies. Work continues to develop mechanisms to increase the number of community studies relating to physical health services. Along with our

partners in the Oxford Academic Health Science Centre, we are leading the way in research and development. Some examples include:

The National Institute of Health Research Biomedical Research Centre (BRC) which, together with our Clinical Research Facility (CRF), enables us to further contribute to reducing the health inequalities for people suffering mental illnesses and dementia,

- A new National Institute of Health Research Community Healthcare MedTech and in vitro diagnostics Co-operative (MIC) with University of Oxford researchers to lead a medical diagnostics co-operative to develop, foster and evaluate new medical diagnostic technologies to improve outcomes for patients in the community,
- The National Institute of Health Research Collaboration in Leadership and Health Research and Care (CLAHRC), leading research in physical care.

Examples of where research has led to improved outcomes for patients include:

- Improving staff training in care homes to improve quality of life and reduce agitation for older people with dementia. Better staff training reduces reliance on medication, new research has demonstrated. A team jointly led by the University of Exeter, King's College London and Oxford Health NHS Foundation Trust examined the effectiveness of staff training and medication on 549 people in 69 care homes with significant levels of agitation in dementia. The WHELD programme involved training two carer "champions" from each home to deliver person-centred care, which involves individuals in the decisions that affect them. Previous research has found that the average care home resident engages in just two minutes of social interaction in a six-hour period. WHELD increased this to 10 minutes of activity, focussed around the interests of the resident. It also included GP training to reduce prescribing of antipsychotics.
- A study published in *The Lancet Psychiatry* provides first evidence that psychological therapy can be successfully delivered in virtual reality (VR) to treat a fear of heights. A VR programme was developed in which psychological therapy is delivered by a computer-generated virtual coach. Treatment is personalised, with users able to interact with the virtual coach using voice recognition technology
- Using cognitive tests to guide antidepressant treatment, so that patients can be started on effective treatment earlier.
- Undertaking different lines of investigation to establish if certain antibodies may be responsible for psychosis.

For more information, go to the Trust's website at

https://www.oxfordhealth.nhs.uk/research/making-a-difference/

Goals agreed with commissioners; use of the CQUIN[1] payment framework

A proportion of OHFTs income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between OHFT and any person or body that they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework (CQUIN).

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at:
https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf https://www.england.nhs.uk/wp-content/uploads/2019/03/CQUIN-Guidance-1920-080319.pdf

For 2018/19, the baseline value of the CQUIN was £4.9m. This income was conditional on achieving quality improvement and innovation goals. The associated payment for 2017/18 was £4.3m.

Care Quality Commission (CQC)

OHFT is required to register with the Care Quality Commission[2] (CQC) and its current registration status is registered with no conditions. The CQC has not taken enforcement action against OHFT during 2018/19, although following the well-led inspection mentioned below the CQC issued six requirement notices.

Our current rating by the CQC is Good;

OHFT participated in a routine well-led inspection by the CQC covering the whole Trust during 2018/19. The inspection took place over March and April 2018, with results published in August 2018. The Trust maintained our previous rating on quality - Good and identified actions to address the areas for improvement. Six requirements notices were issued by the CQC from the inspection, which we are addressing through an 18-point action plan. So far 10 actions have been completed with the remainder in progress. All actions and progress is reported to the Executive Team. The full results of the CQC inspection are available at http://www.cqc.org.uk/provider/RNU

[1] Commissioning for Quality and Innovation
[2] The CQC is the independent regulator for health and social care services in England.

In November 2018 OHFT was involved in a follow-up CQC local system review in Oxfordshire to look at how health and social care providers and commissioners are working together to provide physical healthcare for people aged 65 and over. Oxfordshire was one of 20 local area systems selected to be part of the review. Details of the outcome of the original review in 2017 and follow-up review in 2018 can be found at https://www.cqc.org.uk/local-systems-review.

The CQC recognised significant improvements, felt good foundations are in place and that the system is committed to making changes. The key areas identified for further improvement across the system are;

- Finalising the refreshed Older Person's Strategy and implementing this at pace
- Better engagement with independent providers to help develop the social care market
- Implementing a joint workforce strategy across organisations
- Developing work on identifying and supporting carers
- Support for self-funders – brokerage service and information
- Continue with work to make cultural changes at senior and frontline levels to better support integrated working
- Review of commissioned care pathways

The CQC started a national thematic review in December 2018 on the use of restraint, seclusion and segregation for people with mental health problems, a learning disability or autism. As part of an initial phase OHFT has provided information to support the review. Further details about the review can be found at https://www.cqc.org.uk/news/stories/cqc-review-use-restraint-prolonged-seclusion-segregation-people-mental-health-problems

NHS number and General Medical Practice code validity

OHFT submitted records during 2018/19 to the secondary user's service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data (as of January 2019):

which included the patient's valid NHS number was:

99.8% for admitted patient care

100% for outpatient care

97% for accident and emergency care

which included the patient's valid Medical Practice Code was:

98.9% for admitted patient care

97.3% for outpatient care

95.1% for accident and emergency care

Information Governance

The Information Governance Toolkit has been replaced in 2018/19 to the Data Security and Protection Toolkit, OHFT has completed an assessment and meets all the national standards. As of 31st March 2019, 95% of staff had completed information governance training.

Clinical coding error rate

OHFT was not subject to the payments by results clinical coding audit during 2018/19 by the Audit Commission.

Data quality

High quality information underpins the effective delivery of improvements to the quality of patient care. Therefore, improving data quality will improve patient care and value for money.

High quality information is:

- ✓ Accurate
- ✓ Up to date
- ✓ Complete
- ✓ Relevant for purpose
- ✓ Accessible
- ✓ Free from duplication

OHFT will be taking the following actions to improve data quality:

- ❖ Using the Trust's staff induction to promote the importance of data quality to new staff.
- ❖ Prioritising data sets to carry out end to end reviews of the data quality
- ❖ Embedding data quality measures into performance reporting and demand forecasting
- ❖ Re-launching a data quality improvement forum
- ❖ Improve the routine oversight of data quality at a senior level through the well-led quality sub-committee

Learning from deaths

Introduction

The Trust provides mostly community care for people of all ages covering both mental health services, learning disability services and physical health services across Oxfordshire, Buckinghamshire, Swindon, Wiltshire and Bath and North East Somerset. We regularly review information on the deaths of current patients, patients discharged

from the Trust who die within six months of their last contact including inpatients and those seen as outpatients. The information provided here is based on the deaths of patients who were currently open to one of our services.

Internal Governance and Oversight

The Trust has implemented a stepped process to the screening, review and then investigation of deaths. Each clinical directorate manages their own mortality review process to identify learning from unexpected and inpatient deaths. If new complaints are received in relation to the care of a bereaved relative a mortality review is automatically triggered. The Trust-wide Mortality Review Group oversees learning across the Trust.

The Mortality Review Group has been overseeing the self-assessments and actions from the following national guidelines published in 2018/19; extended guidance for child deaths reviews (October 2018), learning from deaths guidance: engagement with bereaved families (July 2018) and NHS Resolution thematic review; learning from suicide incident related claims (Sept 2018).

The Trust continues to be involved in the following multi-agency forums including; Oxfordshire vulnerable adult mortality group, Buckinghamshire Integrated Care System learning from deaths group, our neighbouring acute provider's mortality and morbidity group (for community hospital deaths) and the south regional mortality review group.

In 2018/19 the Trust has presented regular reports on the number of deaths, learning and actions to the Board of Directors. To see the detailed reports, go to https://www.oxfordhealth.nhs.uk/about-us/governance/board-papers/

External Oversight

In addition to our own review of deaths, the local coroner will independently review all deaths where the cause of death is unknown, violent, unnatural, or sudden and unexplained.

As a result of the reviews a coroner has issued two Regulation 28 rulings in 2018/19 to prevent any future deaths as they concluded further actions or assurance were required. The rulings related to a death in 2015 and a death in 2017, both had been investigated and the Trust has responded and taken further actions as requested.

All deaths of a person with a learning disability are also reviewed externally through the Learning Disability Mortality Review process (LeDeR) and all deaths of a person aged under 18 are reviewed externally by a child death overview panel.

Number of Deaths

We have seen a static trend in the number of deaths (expected and unexpected) over the last four years in-line with the national data. The majority of deaths relate to people aged over 75 who had received treatment from one of our physical health services, such as the district nursing service.

We saw an increase in deaths in January 2018 (one month) in line with the national picture (the winter period is nationally called the winter excess deaths period when a higher number of deaths is forecasted).

Suicide rates in Oxfordshire and Buckinghamshire are similar to national averages (rates have reduced from 2013-2015 to 2014-2016). In 2018/19 we believe 26 people known to the Trust have taken their own life by suicide, this includes deaths we suspect as being suicides and deaths the Coroner has confirmed are suicides.

Every NHS Trust has been asked to provide the following information in their annual Quality Account. The information shown below is for:

- All ages
- All services provided by the Trust
- Patients currently open to services at the time of their death
- Patients who died whilst they were an outpatient or an inpatient
- Expected and unexpected deaths

The source used for the data is from a weekly trace against the national DBS (demographics batch service) and then this is checked against deaths reported locally by teams.

Table 3. Number of 2018/19 deaths by service

2018/19	Trust-wide total	Learning disability services	Mental health services	Physical healthcare services	Patients open to both physical health and mental health services
Quarter 1	971	4	52	644	271
Quarter 2	985	6	56	654	269
Quarter 3	1054	4	61	671	318
Quarter 4	1083	7	79	703	294

Table 4. Number of 2018/19 deaths by age

2018/19	Trust-wide total	Children (aged 18 and under)	Adults (aged 19-64)	Older People (aged 65 and over)
Quarter 1	971	8	93	870
Quarter 2	985	3	98	884
Quarter 3	1054	6	103	945
Quarter 4	1083	8	101	974

Table 5. Number of 2018/19 deaths by setting inpatient or outpatient

2018/19	Trust-wide total	Inpatient	Outpatient
Quarter 1	971	27	944
Quarter 2	985	17	968
Quarter 3	1054	17	1037
Quarter 4	1083	21	1062

Table 6. Number of 2018/19 deaths reviewed by the Trust

2018/19	Trust-wide total	Case record review completed	Investigation carried out/ underway	Estimate of deaths where learning identified*
Quarter 1	971	50	16	3 (6% of deaths reviewed)
Quarter 2	985	51	15	5 (10% of deaths reviewed)
Quarter 3	1054	58	17	2 (3% of deaths reviewed)
Quarter 4	1083	57	21	0 (0% of deaths reviewed)
TOTAL	4093	216 (5% of all deaths)	69 (2% of all deaths)	10

* These were deaths where we have identified learning in relation to the care provided, but this does not necessarily mean the death was due to problems in care provided to the patient.

Table 7. Deaths in the previous year (2017/18) reviewed in 2018/19

	Case record review completed in 2018/19	Investigation completed in 2018/19	Of those reviewed in 2018/19 - Estimate of deaths where learning identified*	Revised figure for all deaths in 2017/18 – Estimate of deaths where learning identified*
Deaths that occurred in 2017/18	5	8	7	17 (8% of deaths reviewed)

* These were deaths where we have identified learning in relation to the care provided, but this does not necessarily mean the death was due to problems in care provided to the patient.

Themes from deaths reviewed in 2018/19

From the deaths reviewed in 2018/19 we have identified the following overall themes and learning;

- Physical healthcare for patients with a mental illness
- Family and carer involvement and communication
- Communication at points of transition and changes in care between services
- Awareness of sepsis for learning disability patients (also identified in national learning)

Actions

A number of actions have been taken to address the overall themes for learning from deaths, a few are detailed below with our assessed impact of these.

The Trust joined the national quality improvement collaborative called 'closing the gap' to support work to reduce the increased risks for people with a serious mental illness not asking/ getting support with their physical health and then dying prematurely.

There has been significant work completed with adult and older people mental health community teams and inpatient wards to support staff in carrying out the physical health monitoring required for our patients with a serious mental illness aligned with the Lester tool (monitoring diet, exercise, smoking, alcohol and drug use, BMI, Blood pressure and blood tests for lipids and glucose).

This has included; training for all staff, enhanced training for physical health leads in each team, a network for physical health leads has been developed, a physical health handbook was developed, teams were provided with physical health monitoring equipment both in clinics and mobile kits, changes were made to make it easier to document physical health monitoring in a single place on a patient's health record and resources were developed and put on a new physical health page on the staff intranet.

In addition, a pilot has been carried out on point of care testing with five teams carrying out ECG and blood tests rather than referring a person to their GP or another provider for the tests, the teams involved have seen evidence of quicker results and access to treatment.

We have also been part of a pilot of 'sport in mind' to encourage people to be active whereby specialist local groups are set up and people are encouraged to access community resources. Since the first physical health in mental health conference in January 2018 focused on screening we have seen a shift in attitude, staff awareness and levels of screening, however feedback from some staff is that there is a lack of confidence in when to and how to intervene when issues are identified.

A second conference is being planned for June 2019 with a focus on 'don't just screen, intervene'. The Trust has also signed up to the Equally Well UK Charter which is a network of organisations taking coordinated action to improve and priotise physical health for people with mental health problems.

The Trust launched a carers' strategy in 2017 and identified new funding to lead on better engaging and working with carers and families. The aim is to raise awareness and change attitudes on the importance of a carers role and to improve how carers are identified and support provided. The actions taken in 2018/19 include; the development of a library of carer stories to support staff training, the introduction of carer champions in teams, a carer awareness on-line training tool for staff has been co-developed with carers due to be launched shortly, and a new carer handbook has been co-produced with staff and patients for the community hospital wards to share useful information about the service and support available to carers.

We have a transition development group to support the planning for the transition of children to adult mental health services. This was a quality objective identified by the Trust in 2018/19 and an update on the actions and the impact of these can be seen on page 171. The Trust recognises there is scope for further work so has included this as an objective for 2019/20.

Due to a number of deaths linked to sepsis for people with a learning disability we are working on ensuring that we alert patients, care staff and families to the early signs of symptoms. As a service we have reviewed the sepsis information and made this more easily available on the Trust internet for staff, patients and other health professionals to support with making adjustments. We are also co-developing an easy read version of the information. Early indications show a reduction in deaths from sepsis, but continued monitoring will be required in 2019/20.

Additional relevant information can be found under the 2018/19 quality objective about how we continue to improve how we learn from incidents and deaths from page 176.

Part 2.2 Performance against national targets

The Trust aims to meet all national targets and priorities. We have provided an overview of the national targets and minimum standards.

The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatrist inpatient care

Table 6 shows OHFT performance we consider that this data is as described for the following reasons:

- there is a documentary audit trail for the compilation of these figures
- auditors have reviewed the quality of the compilation process

When assessing this criteria, we apply two exclusions in addition to the national guidance for patients who are discharged from inpatient care: those patients who are discharged directly to the care of another mental health provider Trust (whether inpatient or community services) and for discharged eating disorder inpatients who are not funded by Oxfordshire, Buckinghamshire or Wiltshire commissioners and therefore follow-up care is handed back to the GP. Where we have verified that discharge documentation includes clearly set out arrangements for the handover of responsibility for care to the other provider, we have assumed the requirements under the indicator have been met.

Table 8. Performance on % of patients discharged from the ward and followed up within seven days

Reporting Period	Trust Value	National Average	National Target
April-June 2018	94.8%	95.8%	95%
July-Sept 2018	98.2%	95.7%	95%
Oct-Dec 2018	97.6%	95.5%	95%
Jan-March 2019	97%	95.8%	95%

The percentage of admissions to acute wards for which the crisis resolution home treatment team (or equivalent) acted as a gatekeeper

Table 7 shows OHFT performance we consider that this data is as described because there is a documentary audit trail for the compilation of these figures.

When assessing these criteria, we apply two exclusions in addition to the national guidance:

- Admissions via the liaison psychiatry services in Oxfordshire or Buckinghamshire will be deemed to have been considered for home treatment.
- Patients of specialist services (forensic, eating disorders and CAMHS) will be excluded.

Table 9. Performance on % of admissions that a crisis function acted as a gate keeper

Reporting Period	Trust Value	National Average	National Target
April-June 2018	99.6%	98.1%	95%
July-Sept 2018	99.5%	98.4%	95%
Oct-Dec 2018	100%	97.8%	95%
Jan-March 2019	100%	98.1%	95%

The percentage of patients not re-admitted in an emergency to a ward provided by the Trust within 28 days of being discharged (Oxfordshire mental health services only)

Table 10.

	Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19
Trust value	94%	98%	93%	91%	100%	91%	94%	97%	95%	92%	90%
Commissioning Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Numerator	34	45	41	32	33	31	32	36	55	33	37
Denominator	36	46	44	35	33	34	34	37	58	36	41

Patient experience of community health mental health services

The 2018 national survey was sent to a random sample of 850 patients by an external contractor based on national criteria. The criteria includes; patients seen between 1st September to 30th November 2017, aged over 18, not a current inpatient at the time of fieldwork and had received more than one contact by a community mental health team (excluding people in contact with Improving Access to Psychological Therapy services). Our response rate was 27.2%, 225 patients.

The scores are presented in table 11, each section is scored out of a maximum of 10. A higher score indicates better performance: if patients reported all aspects of their care as "very good" we would expect a score of at least 8, while a score of at least 6 indicates "good" patient experience. The section scores are averages based on questions in those sections, while the overall score is the average of all the questions. (defined by NHS England)

In comparison with the other 56 mental health NHS trusts our results are similar. Our results are also similar to last year's survey with fieldwork carried out in 2016.

Table 11.

Survey question sections	Oxford Health NHS FT 2018	Compared with other trusts 2018
Health and social care workers	7.3	About the same
Organising care	8.7	About the same
Planning care	6.7	About the same
Reviewing care	7.5	About the same
Changes in who people see	5.9	About the same
Crisis care	7.2	About the same
Medicines	7.4	About the same
NHS therapies	6.7	Worse
Support and wellbeing	4.7	About the same
Overall views of care and services	7.4	About the same
Overall	7.1	About the same

The full results published in November 2018 can be found at https://www.cqc.org.uk/provider/RNU/survey/6

For more details about the Trust's work around patient experience and involvement and the actions being taken are on page 160

Rate of patient safety incidents[3] (PSI) reported and the number resulting in severe harm or death

Below are the number and rate of patient safety incidents reported by the Trust over the last two years. As a comparator the NRLS (National Reporting and Learning System) figures are shown alongside however these cover only a six-month period (April-September 2018) and are split by provider (mental health and community physical health services).

In general table 12 shows the Trust reports a similar of incidents which caused no harm. However, the Trust does report a higher proportion of incidents which caused severe harm, this partly relates to an internal decision to report all grade 4 pressure ulcers and skin changes at life's end (SCALE) as severe harm, even if there were no

[3] Patient safety incidents are defined as an unintended or unexpected incident which could or did lead to harm to a patient.

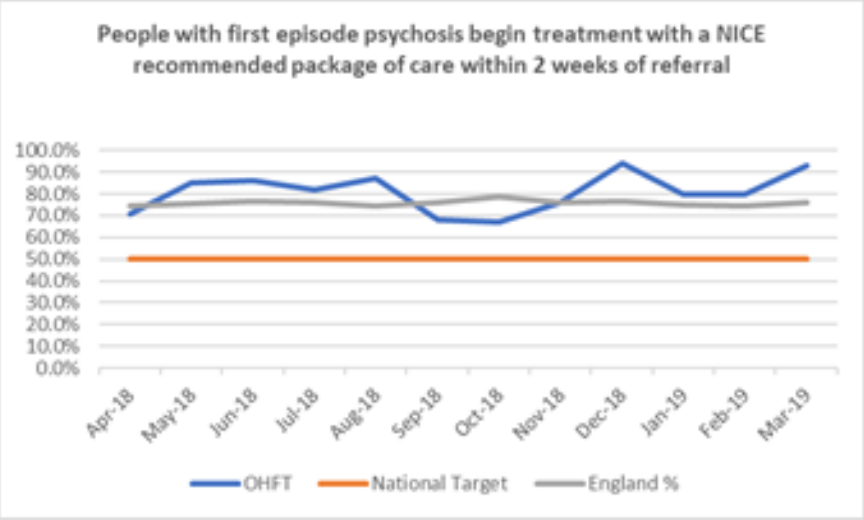
lapses in care. We understand other NHS trusts do not categorise these in the same way. New national guidance was published at the end of June 2018 to standardise pressure ulcers reporting and categorisation which should improve the accuracy of national comparison data once implemented from 1st April 2019.

Table 12.

		No Harm		Low Harm		Moderate Harm		Severe Harm		Death	
		N	%	N	%	N	%	N	%	N	%
Data source: Ulysses incident reporting system	Oxford Health 2018/19	4740	63.2	2239	29.8	367	4.9	102	1.4	47	0.6
	Oxford Health 2017/18	4659	62.1	2338	31.2	346	4.6	122	1.6	33	0.4
Data Source: NRLS	NRLS Mental Health Average (April 18-September 18)	111,454	65.9	47,309	28.0	8,444	5.0	548	0.3	1,286	0.8
	NRLS Community Health Average (April 18 - September 18)	23,583	55.0	16,377	38.2	2,608	6.1	185	0.4	105	0.2

Early intervention in psychosis: people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral

We consider that this data is accurate, and performance is above the national target and improving. Note the national data from NHS England for March 2018 has not been published at the time of writing this report.



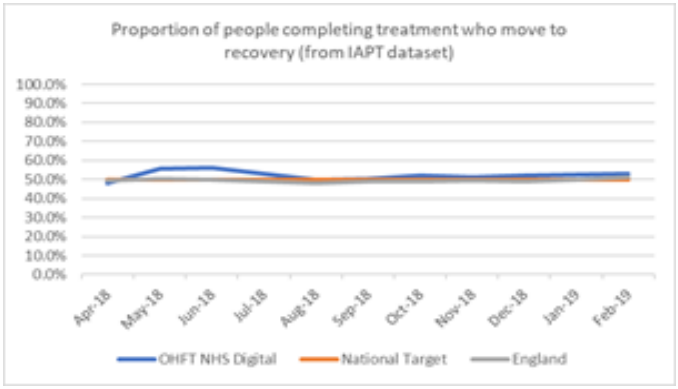
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:

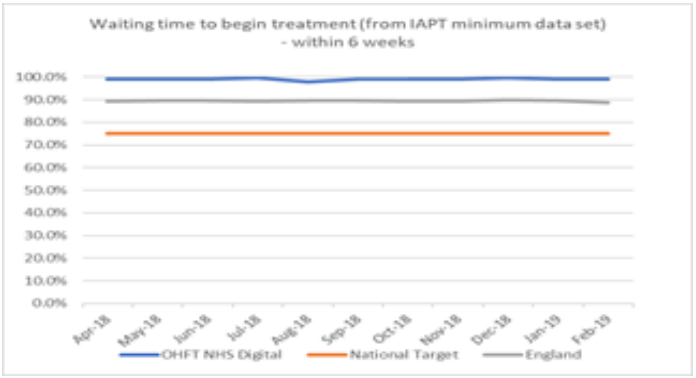
This data is not available at the time of writing the report, the national report is due to be published on 25th June 2019.

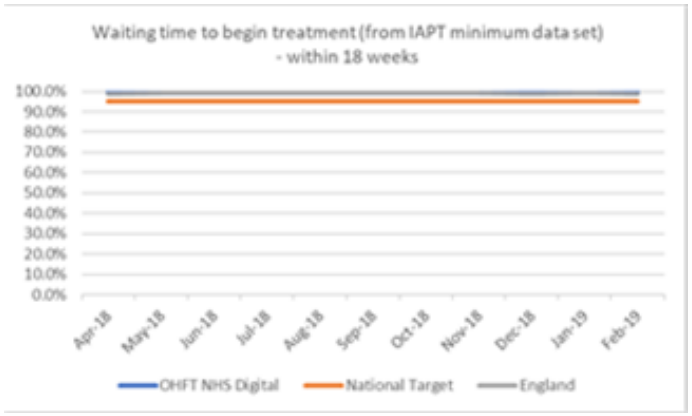
Improving access to psychological therapies[4]:

- **% of people completing treatment who move to recovery**
- **Waiting time to begin treatment**
  - **Within 6 weeks of referral**
  - **Within 18 weeks of referral**

We consider that this data is accurate, and performance is above the national target.







[4] The Improving Access to Psychological Therapies (IAPT) programme began in 2008 and has transformed treatment of mild to moderate anxiety disorders and depression in England.

Admissions to adult facilities of patients under 16 years old

Occasionally a person aged under 16 is admitted to an adult ward this may be for a range of reasons such as care requirements, a lack of support in the community or a lack of available beds. For each admission a safeguarding review is completed and staff experienced in working with children support the persons inpatient stay. We also carry out a review after each admission to identify any learning which is presented to the Trust-wide weekly clinical review meeting.

Table 13.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Trust	0	0	1	1	0	1	0	0	0	0	0	0
NHS England	No national data available											

Inappropriate out of area placement days for adult mental health services (total number of bed days)

Out of area placements mean admitting someone to a ward outside the services provided by the Trust. An out of area placement is categorised as inappropriate if the rationale for placing the person relates to bed pressures or absence of community or social care support. The figures for OHFT are our own internal figures because the monthly data published by NHS Digital is subject to change, due to discharge dates at times being entered at a later stage which will have an impact on the previous monthly reported figures.

The England Average figure is based on the average number of inappropriate out of area placements in days for the reporting month as published by NHS Digital. We consider that this data is accurate and have identified this as a quality improvement objective for 2019/20, **see page 191.**

Table 14.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Trust	223	435	181	518	283	103	398	390	391	380	260	179
NHS England average	348	347	330	366	400	333	358	356	317	344	347	No data

Part 3. Progress on Quality Objectives in 2018/19

In last year's Quality Account, we identified 12 quality objectives which had been developed in discussion with our staff, governors and commissioners. Progress has been made against all of these objectives. The quality objectives were aligned under the following overarching quality priorities;

- Priority 1: Improve staff health and wellbeing
- Priority 2: Improve the experiences of patients, their families and carers
- Priority 3: To continuously and reliably improve patient safety

- Priority 4: Preventing ill-health and promoting self-care

The rest of this section provides a summary of the actions taken, the impact of these actions and any further work being undertaken against each of the quality objectives.

In addition to reporting on our progress against the quality objectives identified for 2018/19 we have also shared below our work this year on;

- Equality, diversity and inclusion (under priority 2)
- Volunteering (under priority 2)
- Infection prevention and control (under priority 3)
- Different ways staff can speak out if they have concerns (under priority 3)

Part 3.1 Summary of Progress

Below is a summary of our progress against the quality objectives set for 2018/19, with more detail on each objective in the following pages. We have fully achieved eight out of the 12 objectives and have made progress and been close to target for four objectives.

Table 15.

	Quality Priority 1 - Improve staff health and wellbeing	Target achieved	Close to target	Not delivered	To be taken into 2019/20 quality account
1.1	Deliver the workforce strategy actions for 2018/19	-			Yes, objectives around staff retention and recruitment will continue as maintaining safe staffing remains a significant risk for the Trust.
1.2	To refine and enhance functionality of the existing electronic patient record to support integrated working		-		No, as development work will continue as part of business as usual.
1.3	Improve the uptake and quality of annual staff appraisals		-		No

	Quality Priority 2 – Improve the experiences of patients, their families and carers	Target achieved	Close to target	Not delivered	To be taken into 2019/20 quality account
2.1	Implement the objectives in the Trust-wide patient experience strategy and carers strategy	-			Yes, in line with new actions identified in the revised strategy.
2.2	Improve transitions between care pathways across ages		-		Yes

	Quality Priority 3 – To continuously and reliably improve patient safety	Target achieved	Close to target	Not delivered	To be taken into 2019/20 quality account
3.1	Reduce patient violence and aggression across the adult acute mental health wards		-		Yes, as there has been minimal change in the number of incidents of violence towards staff.
3.2	Improve the consistency of care processes for the adult acute mental health wards		-		No, although the quality improvement project will continue.
3.3	Continue to improve how we learn from incidents and deaths	-			No

	Quality Priority 4 – Preventing ill-health and promoting self-care	Target achieved	Close to target	Not delivered	To be taken into 2019/20 quality account
4.1	Review the complex needs pathway (for patients suffering with a personality disorder)	-			No
4.2	Develop and introduce a new frailty pathway	-			No
4.3	Continue to develop a joint enterprise with Oxfordshire GP Federations	-			No
4.4	Smoke free work	-			No

Quality priority 1: Improve staff health and wellbeing

(quality domain: safe, effectiveness and patient experience)

We are nothing without the staff we employ; they are the largest and most important resource we have. We employ around 6,700 staff from a range of disciplines. We want to continue to work on improving staff satisfaction and retention, which will also then improve the care and experience we provide to patients and their families. The Trust has achieved the following awards to become an employer of choice;

The Trust's 2018 national annual staff survey results are referenced throughout the document, and the full results can be viewed at http://www.nhsstaffsurveyresults.com/local-benchmarking-organisation-overview/

For this priority we identified three local objectives, progress against each is detailed below;

1.1 Deliver the Workforce Strategy actions for 2018/19.
1.2 To refine and enhance functionality of the existing electronic patient record to support integrated working
1.3 Improve the uptake and quality of annual staff appraisal (also known as personal development plans)

1.1 - Deliver the Workforce Strategy actions for 2018/19

There are significant staff shortages across England, with increasing demand on staff and services. Given the national picture and in addressing our own local context, we are working with our system partners through workforce groups to develop shared strategies and areas of focus. Recruitment and retention is identified as an extreme risk on the Trust wide risk register and Board Assurance Framework. The key risks identified are;

i) pressures on staff having an adverse effect on morale with the possible impact of increased stress related sickness/ difficulties in retaining,
ii) unable to achieve required recruitment of staff to substantive posts which may result in increased usage of agency staff and inability to fill emergency shifts,
iii) not sufficiently promoting and supporting the well-being of staff which may lead to a reduction in staff morale, increase sickness and loss of reputation.

Actions taken this year

- The Trust has become a provider of apprenticeships, enabling us to develop new roles and different entry routes into employment. We employ clinical and non-clinical apprentices. A key one has proven to be, Nurse Associate Trainees. We took on our first trainees in 2017 and 23 are due to qualify in June 2019. Further cohorts started training in June 2018 and October 2018.

- Other alternative employment routes have also been explored including a peer support worker programme developed with 14 people who have 'lived experience' of mental health problems. They graduated from a six-month training course in November 2018 and have been offered paid roles at the Trust – using their own personal experience in tandem with freshy acquired skills to help deliver care to others.

- A recruitment and retention premium introduced for difficult to recruit and retain roles in the Forensic service.

- The Trust is participating in the NHS Improvement 'Retention' Collaborative programme which involves sharing ideas with other NHS trusts and monitoring progress on our objectives. The programme has a particular focus on nurse retention.

- 'Keep in touch' days have been held with University students, followed by joint student nurse recruitment sessions with other local NHS providers from November 2019, which resulted in 38 job offers for students graduating from Oxford Brookes University in the summer of 2019 and 20 job offers for students graduating from the University of Bedfordshire. Allied Health Professionals are expanding and developing their band 5 rotation programmes for Occupational Therapists and Physiotherapists. They have been successful in recruiting to several newly-qualified band 5 posts.

- The decision was made to invest in TRAC, a recruitment and candidate management system which is widely used across the NHS (around 180 other NHS trusts). Implementation begins in April 2019 and the anticipated benefits include improving the candidate experience, a new dedicated recruitment website, automatically generated appointments and reminders, reduced recruitment lead time and better availability of management information in relation to recruitment.

- The Trust took a decision not to use staffing agencies for unregistered healthcare assistants from May 2018, which has been maintained through the year. The rationale for this is based on strong and consistent staff feedback that agency staff are generally less knowledgeable and less able to provide excellent care than our own staff. We have taken steps to strengthen our internal bank called staffing solutions, including better training, improved pay rates, more capacity for supervision, and a more streamlined recruitment process.

- The Trust had previously been recognised for our 'Step into Health' employment programme, which seeks to help veterans of the Armed Forces explore their transferable skills and identify possible training and career opportunities within the NHS. In 2018/19 the Trust moved from a Bronze award to Silver.

- We have strengthened the support for newly-qualified staff, launching a two-year preceptorship programme called the 'Flyer Programme' from October 2018. The programme offers a structured process of extra support to practitioners to develop their confidence and to refine their skills, values and behaviours. It also offers the chance to obtain Masters level modules. The first cohort had 72 staff and the second started in March 2019.

OXFORD HEALTH
FLYER PROGRAMME
DEVELOPING CARING, SAFE & EXCELLENT NURSES & AHPs

- A new nursing and allied health professional's leadership structure is in place with new roles created for a deputy director of nursing for mental health, allied health professional associate directors, nurse consultants and a physical healthcare lead in mental health services. The structure now provides better clinical leadership and clearer defined career pathways to retain and further develop staff.

- Working closely with our staff representatives, the Trust has launched a wide-ranging programme to address work related stress. The framework for this is the Health and Safety Executive's "Management Standards" which sets out the obligations on employers and strategies for creating sustainable improvements. The six management standards are Demand, Support, Control, Role, Relationships and Change. One of the initiatives has been to hold two staff retreats to help staff to come to terms with difficult situations and in some cases had the result of returning to work more quickly. The focus has been on staff with long term sickness, usually stress related (from work or not) who would benefit from the opportunity to reflect and plan their recovery in a supportive environment.

- The Trust has undertaken regular skill mix reviews to start the work to transform the workplace so that it is sustainable for the future.

- The Trust continues to increase and develop the role of Health and Wellbeing Champions who are based within teams and regularly meet to share resources, ideas and changes made locally. Wellbeing initiatives this year have included; bike breakfasts, Sleepio online toolkit, tips on physical activity, workplace wellbeing and how to manage stress, a pedometer challenge, mental health awareness pop up stalls, exercise classes, and mindfulness awareness workshops.

- Monthly Exceptional People Awards and the annual Staff Rrecognition Awards have continued, a group picture of all the winners from the 2018 annual recognition awards is below.

- Work with system partners in Oxfordshire, Buckinghamshire and Berkshire on workforce and capacity management to share resources, actions and ideas.

2018 staff recognition awards ceremony

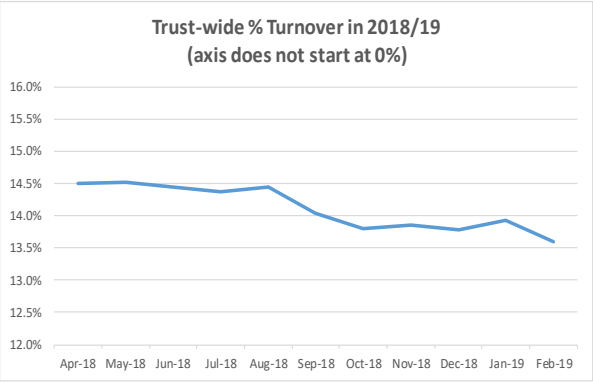
The impact

Aim to reduce **staff turnover** to less than 13.5%. The average turnover for 2018/19 is 14.1% compared with the position in March 2018 at 15%. There has been a slight reduction from September 2018, with the average for this period being 13.8%. Although there has been a sustained reduction we have not achieved the target of less than 13.5% and for some professions there has been no change. Graph below shows performance month by month.

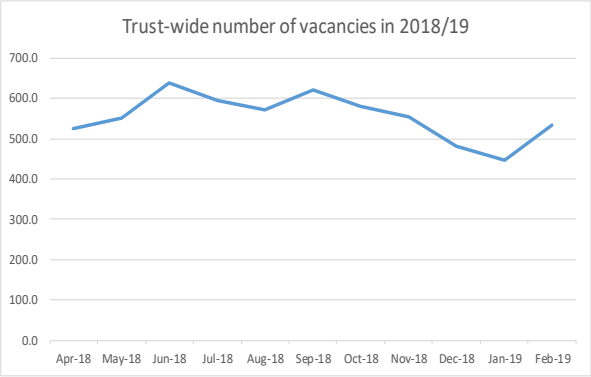
Aim to reduce **vacant posts** to less than 600 WTE. 15.7% of posts were vacant in March 2018 this was reduced to 11.1% by February 2019. In December 2018 and January 2019 there were fewer than 600 vacancies, however by February 2019 the vacancies were up to 619.6 WTE. Although the target was not achieved there was a reduction in vacant posts. Graph below shows performance month by month.

Aim to **Increase flexible staff and reduce use of agency** by 25%. There has been an increase in staff employed through the Trust's internal bank called staffing solutions from 1,550 in March 2018 to 1,921 in March 2019. The use of agency staff on average from April 2018 to February 2019 was 9.8% compared to the position in March 2018 of 12.2%, however this has varied month by month. The target to achieve 25% reduction in agency staff was achieved in four of the 11 months (May, September, January and February). Graph below shows performance month by month.

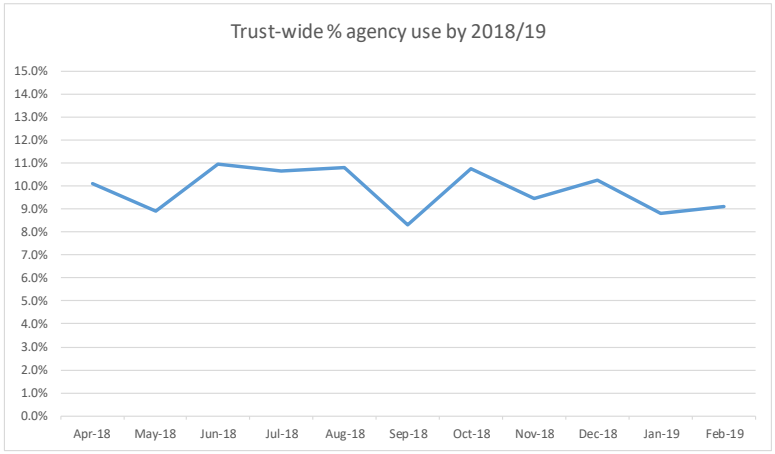
Aim to **improve staff experiences** as measured in the national annual staff survey. The staff engagement score for 2018 was the same as last year at 7.0, which is also the same as the national average. 41.7% of staff in 2018 said they had felt unwell due to work related stress in the last 12 months, this is a worse position from 2017 but similar to the national average. However, we have seen an improvement on staff would recommend the Trust as a place to work (62% in 2018 and above the national average of 59%) and if staff would be happy with the standard of our care for a member of their own family (71% in 2018 above the national average of 66%). Graphs below.



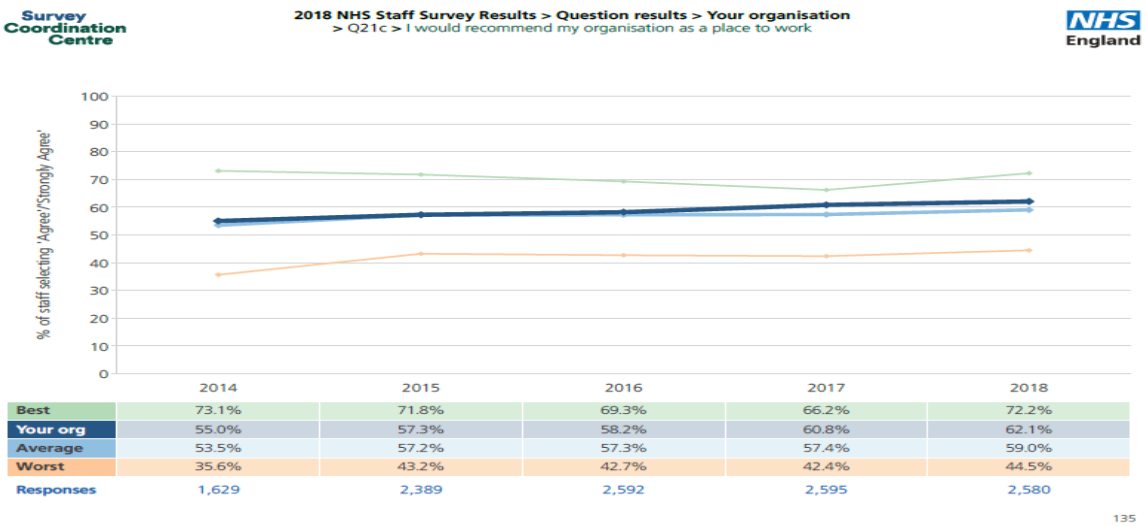
Data source: finance



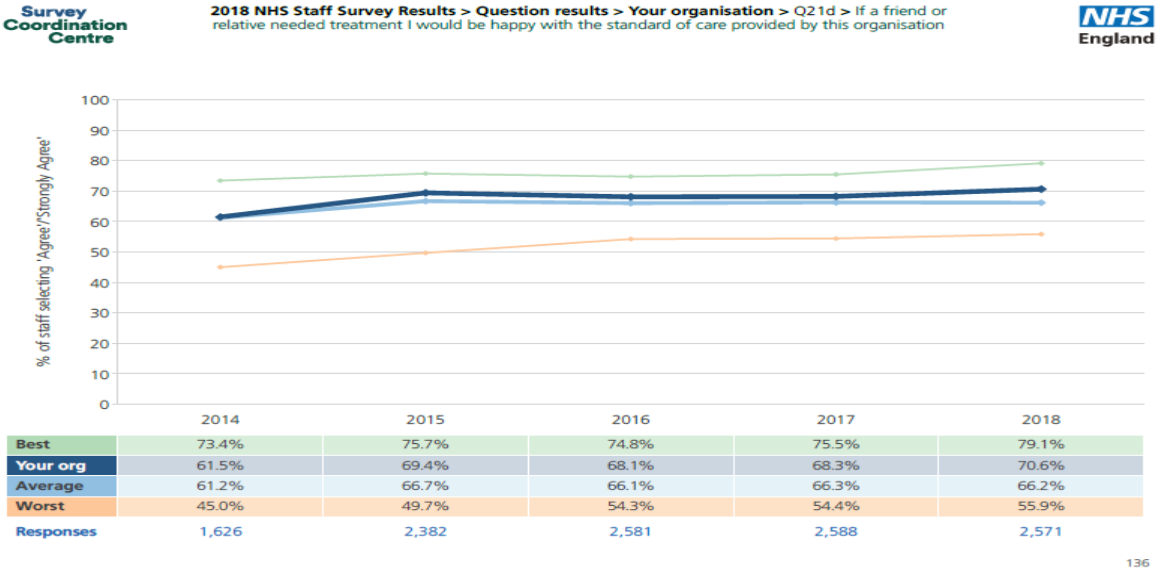
Data source: finance



Data source: finance



Data source: National staff survey results



Data source: National staff survey results

1.2 - To refine and enhance functionality of the existing electronic patient record to support integrated working

Actions taken this year

- Based on the developments we have made with technology; the Trust was one of seven mental health NHS Trusts named a global digital exemplar from July 2017 for innovative use of technology to care for mental health patients. We have continued to use national funding secured to offer remote consultations using video conferencing facilities, make electronic patient notes available via iPad from anywhere at any time, signposting to online wellbeing and mental health therapies, and developing apps such as True Colours to support patients' self-management and recovery.

- The Medical Interoperability Gateway (MIG) - This allows our mental health clinical staff to view GP information via the GP info. Tab. The MIG is currently deployed in Oxfordshire and Buckinghamshire, however connectivity in Wiltshire has not yet been established due to technical connectivity issues between systems. The MIG has been viewed more than 91,000 times over the past year providing our clinicians with key data from the GP surgeries about medications, test results, allergies, diagnosis.

- The Inpatient Interim Discharge Summary (IDS) has been set up to go electronically via Docman from CareNotes to GPs. This is currently only configured for Oxfordshire mental health wards. However, a new technical solution has been found which will be piloted in 2019 that will enable a clinician to select any form (information) they wish to send in CareNotes to go to the patient's GP, regardless of where that GP is located. This is a key part of the global digital exemplar work.

- The docman delivery console solution has been deployed to around 30 clinical teams since October 2018 which gives clinicians, the ability to easily send and track e-correspondence sent from CareNotes to GPs without having to use email or post. Currently more than 6,000 documents have been sent electronically in this way.

- A process has been formalised for clinicians to request and receive training to access Cerner Millenium to view blood results taken at our neighbouring acute NHS Trust, Oxford University Hospitals. The next development will be to enable our staff to request tests of specimens they take and to bring blood test results to be displayed in CareNotes.

- A referral management solution is being piloted with a community mental health team, which will allow them to triage referrals received in one place and then automate recording the appropriate referrals in CareNotes.
- The transfer of health visitor reviews and school immunisations is now automated stopping the manual process which was in place before.
- The Trust has also been exploring options of how to share our data with the wider record sharing solutions across Oxfordshire and Buckinghamshire, once a patient gives their consent. The proposed record sharing solutions are different in each county; HIE and HealtheIntent in Oxfordshire and My Care Record in Buckinghamshire. We hope to run a pilot in Buckinghamshire in May 2019 and we wait for the supplier to have capacity to pilot in Oxfordshire. In terms of Swindon, Wiltshire and Bath & North East Somerset, the Trust has been participating in exploratory sessions with partners in these areas to determine requirements and planned activities.

The impact

Electronic advancements continue to be made particularly for mental health services and urgent care physical health services. There is further work to support the community physical health services to move fully to electronic health records, ensuring the right tools/ templates are available in the system to support them.

1.3 – Improve the uptake and quality of annual staff appraisals

Actions taken this year

- The Trust's policy was reviewed and the process for documenting an appraisal has been simplified, with the new process and forms re-launched in October 2018.
- Monthly team level reports on performance continued to be emailed to every line manager. In addition, a list of all staff with no completed or booked appraisal was sent to the Service Directors to be followed up. Every staff member with no appraisal booked was also emailed individually by the learning and development team.
- A promotion campaign was carried out with tips and support for staff.

The impact

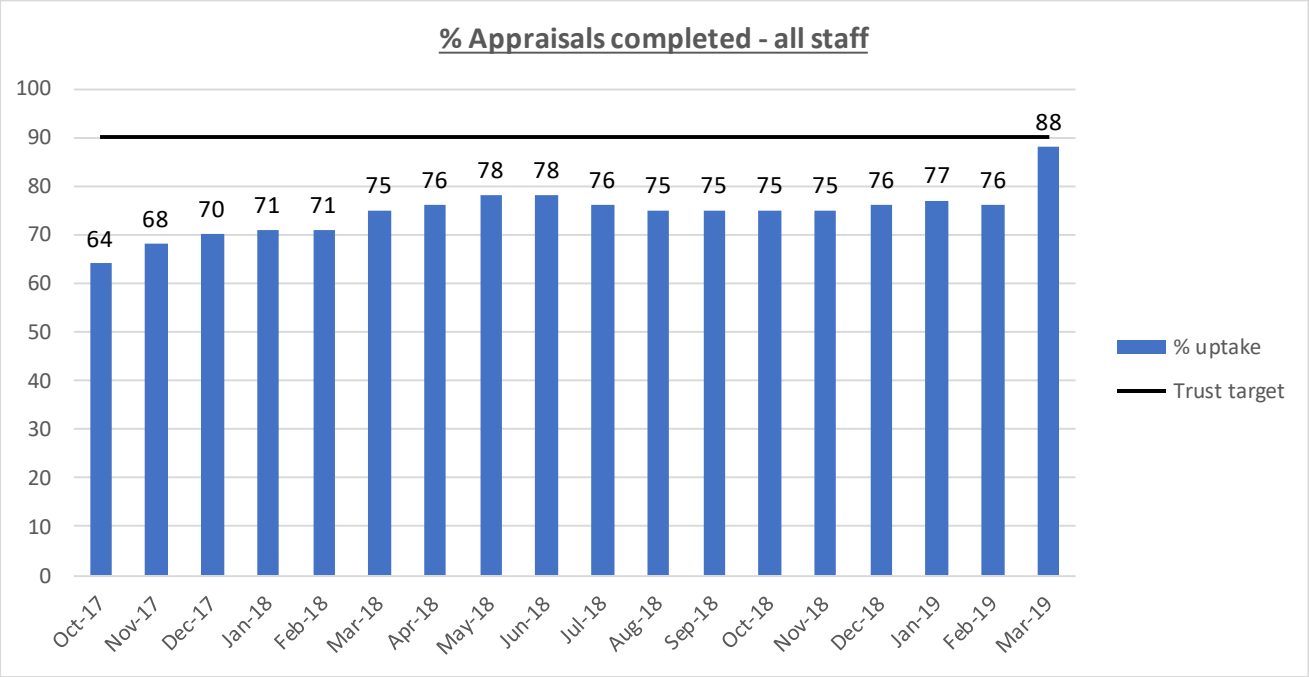
Trust-wide position is 88% of all staff[5] had an appraisal recorded at the end of March 2019 (586 staff had no current appraisal completed). Performance has continued to improve into April and May 2019. This is an improvement on March 2018 when 75% (3566 staff) had a current appraisal. A staff members annual appraisal is based on the day they started working at the Trust, therefore every month appraisals will be carried

[5] Including doctors, dentists and non-clinical staff.

out. Performance has improved in 2018/19 compared to the previous year however it is still below our own expected target, shown below from October 2017 to March 2019.

The national annual staff survey carried out in October 2018 showed 77% of staff said they had received an appraisal in the last 12 months. In relation to staff's assessment of the quality of appraisals this has dropped from 2017 to 2018, scoring 5.7 in 2017 and 5.2 in 2018, with the national average at 5.5 in 2018.

Many of the actions to improve the uptake and quality of appraisals took time to complete and embed. Work will be continued in 2019/20 to further improve the completion and quality of appraisals.



Data source: learning and development system OTR

Quality priority 2: Improve the experiences of patients, their families and carers

(quality domain: patient experience)

The Trust's three-year patient experience and involvement strategy is coming to an end in March 2019. We can demonstrate the positive impact the strategy has had detailed below. In 2018/19 we started to consult and develop a refreshed strategy with patients, staff and partners, the aim is for this to be presented for approval in May 2019.

The new strategy will be focused on personalised care to improve the extent patients and their families feel involved in decisions about their care. The current strategy from 2016-2019 and a draft of the revised strategy is available at https://www.oxfordhealth.nhs.uk/getting-involved-with-oxford-health/patient-involvement/our-strategy/

The Trust has a separate carers' strategy called 'Icareyoucare' to ensure this important area receives sufficient attention. Year two of the strategy in 2018/19 has seen a focus on improving the range and quality of literature available for family, friends and carers, developing our online training tool for staff, and a focus on getting resources in place. A copy of the strategy is available at https://www.oxfordhealth.nhs.uk/support-advice/support-for-carers/

The Trust's annual complaints report will be presented to the Board of Directors in May 2019 and published with the board papers at; https://www.oxfordhealth.nhs.uk/about-us/governance/board-papers/

For this priority we identified two local objectives, progress against each is detailed below;

2.1 Implement the objectives in the Trust-wide patient experience strategy and carers strategy

2.2 Improve transitions between care pathways across ages

Equality, diversity and Inclusion

We recognise that discrimination and barriers to inclusion can lead to disadvantage and inequalities in accessing services or opportunities in the workplace. We continue

to use the NHS Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES) and Workplace Equality Index (WEI) to develop our equalities work and to inform our strategy work plan.

These frameworks help us to identify our equality priorities and to consolidate the progress we have made to date. Our Head of Inclusion is part of the south regional equality, diversity and inclusion group which includes the NHS, county council and police and is a good forum to share good practice and take actions across a system. In 2018/19 we have focused our attention and efforts on disability equality for staff and patients.

The Trust is committed to developing a culture that respects equality and values diversity for our staff and the patients we care for. Training on equality is routinely provided at Trust induction for all new starters and then through e-learning as a refresher, plus training is delivered to unregistered staff through the care certificate course and to current/ potential leaders through the leadership development programme.

Some of the key highlights this year include:

- A series of conferences with team leaders to explore the issues and challenges of being disabled
- The appointment of chairs for the three staff equality network groups:
  - LGBT+ Equality Staff Network
  - Disability Equality Staff Network
  - Race Equality Staff Network
- Delivering staff training on the impact and role of unconscious bias
- New training on equality, diversity and inclusion delivered to apprentices
- New staff training developed and delivered on 'religion and culture'
- The Trust approved guidance for supporting staff to transition gender
- We launched rainbow lanyards in February 2019 to coincide with LGBT History month and within days the 1000 lanyards were gone!
- We celebrated Black History month in October 2018 which included sharing staff case studies including one from Joseph pictured below.
- We have spent 2018/19 working on the action plan from the 2018 Stonewall diversity rating.
- An inclusion award was presented at the annual staff recognition awards in 2018.

The focus in 2019/20 is on gender equality, our teams recently celebrated international women's day in March.

Volunteering

Since June 2017, the Community Involvement Manager post has been in place for the Trust with a remit to develop and coordinate volunteering, the Oxford Health Charity and engagement with our local communities.

In 2018/19 we have:

- Introduced a streamlined and effective recruitment and application process
- Developed a set of role profiles for different volunteering opportunities
- Introduced guidance for volunteers and supervisors
- Better promoted volunteering opportunities across the Trust

Initial baseline data identified the Trust as having approximately 70 volunteers in November 2017, for the most part located in traditional ward support roles within the Community Hospitals. The number of active volunteers now stands at 135, with 105 new people recruited over that time and more than 2,500 people viewing the opportunities pages on the Trust website in 2018/19.

The roles have also increased in scope to reflect the breadth of services delivered across the Trust with volunteers involved in the peer support worker programme in Oxfordshire Mental Health Services, Creating with Care arts programmes across Community Hospitals, Urgent Care volunteers supporting services at locations in

Abingdon, Oxford and Witney as well as more ad hoc roles supporting the development of HealthFest (the Trust's new annual community engagement event). We now promote all our open volunteer roles on the Trust website at www.oxfordhealth.nhs.uk/get-involved

Future developments will be focused around the outcome of the next annual volunteer engagement survey (the first of which took place during Volunteers' Week in 2018).

2.1– Implement the objectives in the Trust-wide patient experience strategy and carers strategy

Actions taken this year

- Permanent dedicated leadership roles have been established to develop our work to improve the experience of patients, carers and families. One of the posts included a Trust-wide carers lead with the person starting in 2018/19.

- All senior leaders' roles (Clinical Directors and Service Directors) include a clear expectation for improving the way our services effectively support and involve patients, carers and families, friends and carers, this was added to job descriptions in 2018/19.

- A series of workshops were held with leaders throughout the Trust around improving shared decision making in June 2018, and carers events in June 2018 (to coincide with national carers week) and February 2019.

- We have reviewed and developed the format and resources available on the Trust's website to provide better information on how to give feedback and how to get involved in different activities within the Trust for example staff interviews, service developments, developing information, teaching at one of the Trust's jointly run recovery colleges.

- We recorded a film with staff called 'we are the patient experience'. More than 60 staff were involved to recognise how everyone, from a gardener to a clinician, plays a role in a patient's experience of a service and therefore we need to improve it together.

- From June 2018 we introduced quarterly team awards to recognise those making improvements to how patients, carers and families experience our services. The awards are also a way to share good practice across the Trust.

- We have developed an extensive library of patient, carer and family stories to support training for staff. Stories are presented in public at almost every Board of Directors meeting.

- Team to team peer reviews have included patients and carers as part of the review team. Some governors have also been trained to take part in peer reviews to help improve the quality of care.

- Throughout the organisation there are staff who are patient and/ or carer champions for their team. This number has grown over the past year and we hope this continues.

- We use regular volunteers to facilitate monthly sessions on wards to listen and gather feedback from patients, carers and families. In addition, a new carer volunteer support role has been developed in 2018/19 and will be piloted at one of the Community Hospital wards in 2019. The role will offer support and information to carers who come into contact with the hospital. It will be as the carer's voice, by sharing feedback, needs and expectations to teams.

- Raising awareness, promoting and supporting staff to use the Trust's single survey mechanism for collecting feedback from patients, carers and families. All teams who use it have access to their own patient experience feedback at all times.

- A peer support worker programme was developed with 14 people with lived experience of mental health problems graduating from a six-month training course in November 2018. All graduates have been offered paid roles to use the knowledge developed through their own experiences in combination with skills learnt to work alongside staff to help with treatment of others in our care.

- A carer awareness online training tool for staff has been co-developed with carers and is undergoing its first review by clinicians in April 2019 with the next stage to be reviewed by family, friends and carers. The training tool allows staff to role play several situations with a fictional family and understand how their actions and behaviours can change outcomes.

- Family, Friends and Carers service handbooks are a way of sharing useful information about the service and a way of providing information to carers as individuals including details on carers' assessments and the local carers organisation and support. In 2018/19 a handbook was developed with patients, carers and staff for community hospital services which will be published shortly.

- The Trust has maintained our external accreditation with the Carers Trust, called Triangle of Care, which involves working to national standards co-produced with carers. A further self-assessment against the national standards was completed by services in 2018/19 to identify priorities for improvement which feeds into the carers strategy (icare,youcare) workplan each year.

- HealthFest 2018 at the Warneford Hospital in September was an all-day event set up to engage with the local community, as well as staff, their families and colleagues. Part of the Oxford Open Doors programme run by the Oxford Preservation Trust it gave people the chance to come 'behind the wall' to breakdown the stigma around mental health. Members of the patient experience team ran a stall alongside a young person from the Oxfordshire CAMHS Participation Group and a carer who both attended for part of the day to talk to visitors about involvement work with the Trust.

- The mental health Complex Needs Service ran a 'Psychoeducational Training weekend' for carers. Over two days 21 people attended enjoying 11 sessions on a range of topics including one session run by ex-service users. The feedback from the event was very positive.

- The Health Visiting Service has written a new pathway for children with Special Educational Needs or Disability which was launched at the 0-5 Conference on 16th October 2018 and is now live. The Health Visiting Service has sought feedback from parents on the new pathway via a survey and has interviewed parents about their experience.

- The first Autism Experience Group was held to better understand the experiences of people with autism using NHS services to help shape how we implement the Autism Strategy to improve their lives. Regular groups meetings will be held.

- The Trust is working with several provider organisations in Oxfordshire as well as people with lived experiences and their families, Oxfordshire Family Support Network, My Life My Choice and our commissioner to improve how we gather feedback about a person's journey and use it together to improve the care for people with a learning disability.

- The Community Dental Service[6] ran a series of focus groups to discuss peoples experience of going to the dentist including any fears or worries and how these might be overcome. These workshops have informed the production of three films

[6] The services provides specialised dental care to a wide range of both **children** and **adult patients**, who are unable to receive care from a general dental practitioner, but do not necessarily need to be seen in a hospital.

currently under development, improvements to easy read appointment letters and information about dental care.

- Three young people were supported to attend the children and adolescent eating disorder community team away day. The young people took an active part in discussions and their feedback has been included in team plans to:
    - Explore the possibility of developing peer support worker roles for the team
    - Reviewing the team's information leaflet and the parent information pack
    - Try new methods to gather feedback from young people post discharge from the service

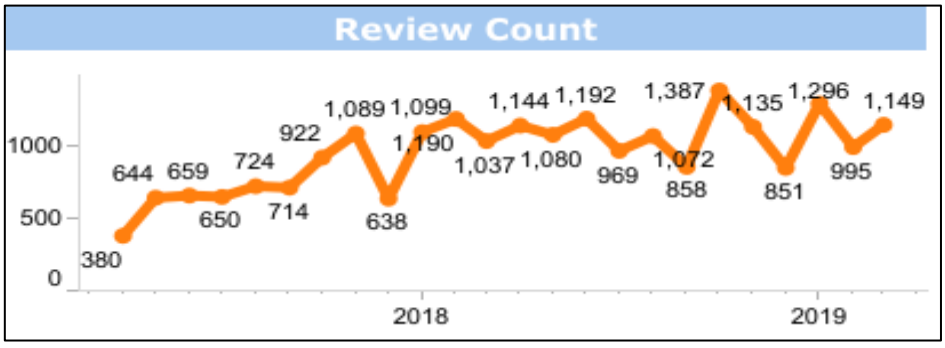
- Boys in Mind project: is a multi-agency alliance of professionals and young people across Bath & North East Somerset and beyond, including representatives from the Local Authority, Public Health, OHFT, schools, voluntary agencies, parents and carers, fostering services, school nurses and many others. Young people involved in the project met to discuss and identify key messages and information they would like to see shared with young men. Members of the Boys in Mind strategy filmed their friends and family talking about a range of issues related to mental health and gender-stereotyping. Part of the concept of the film project was to enable young people to be heard and also to enable those who were filming to listen. Around 25 young people, were involved at different stages of the film project, with the material being used to make short films to promote talking about issues and seeking help.

The impact

Increased awareness and routine collection of patient and carer feedback across a broader range of services. The collection and use of patient, carer and family feedback continues to be high at 13,128 local survey responses received between April 2018 to March 2019. The national annual patient survey, concerns, complaints and compliments are additional sources of feedback we also receive and act on.

Number of local survey responses Trust-wide

Period: March 2017 to March 2019



Data source: iwantgreatcare

Teams have access to their own patient experience feedback which has led to an improvement in the 2018 national annual staff survey results regarding the collection and use of patient feedback. 96% of staff said patient feedback was collected by their team, this compares to 92% in 2017 and the national average of 94%. Going forward we need to ensure the feedback is always used to inform decision making and to make improvements in care.

A quarterly report is presented to the Board of Directors and published by the Trust which details some of the local actions taken by teams following feedback, the reports can be found with the Board papers at; https://www.oxfordhealth.nhs.uk/about-us/governance/board-papers/

The feedback we have received directly from patients and their families as well as the feedback shared by the CQC in 2018 and Healthwatch organisations is overall positive, with patients reporting feeling cared for by staff and that as a result they highly value the service provided.

Overall 94% of patients and carers have told us they would recommend the service, with the quality of care being rated 4.74 out of 5. Compared to the national question, would you recommend the service, physical healthcare services (known as community services) are rated the same as the national average (96% of people would recommend the service in 2018/19), and mental health services are rated higher than the national average (93% of people would recommend the service in 2018/19).

Below is the breakdown of scores by survey question by month for the last two years showing an improvement around information provided, people feeling involved in their care and kindness reported about our staff.

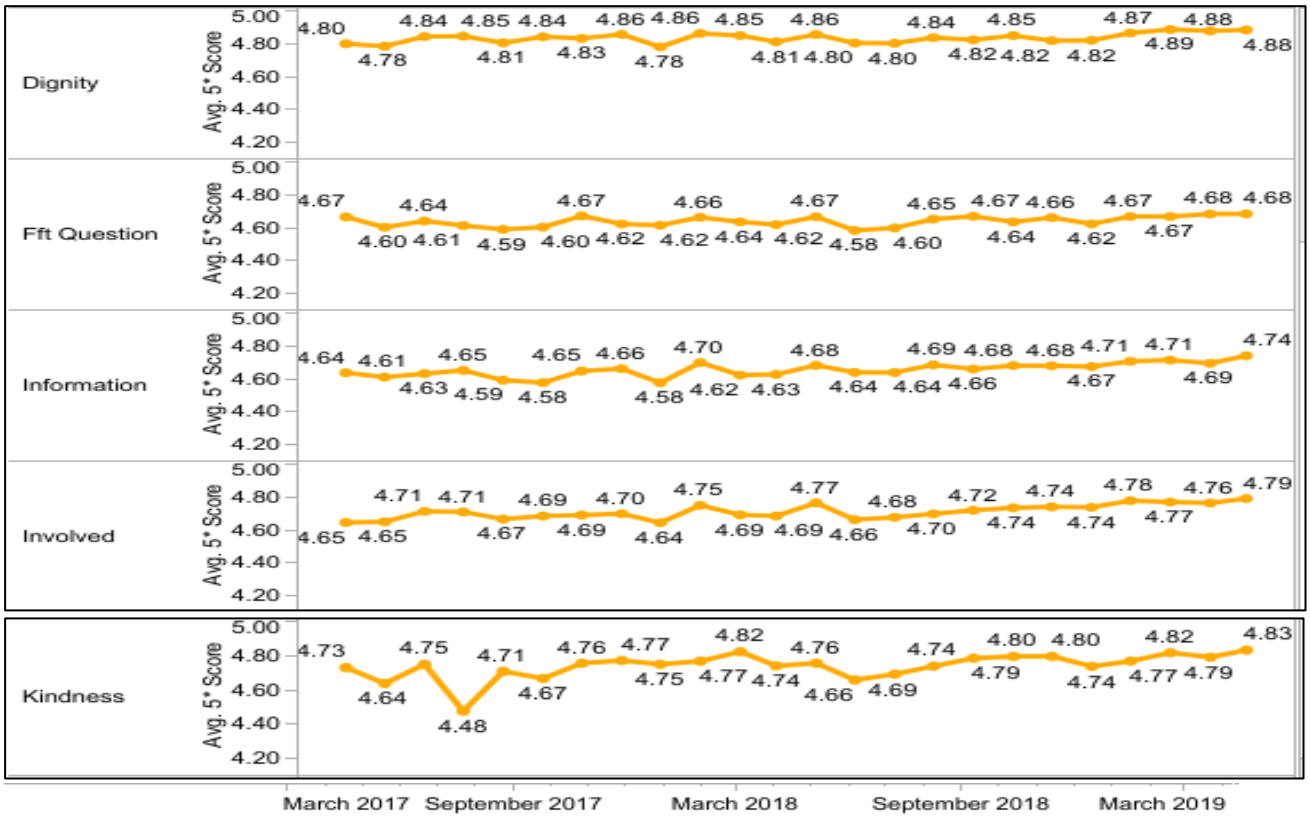
However, some people do not receive the positive experience we expect every person to have, and we therefore have more work to do. In 2018/19 the Trust's Council of Governors raised concerns about the experiences of carers and families when contacting the mental health urgent care service which we have and are taking actions around.

The key themes highlighted from complaints mirror the key areas for further improvement identified from the feedback we receive, and are focused on; waiting times, communication and better information sharing to enable full involvement in care, and the facilities available such as parking.

Rating by local survey question Trust-wide (rating from 0-5)

Period: March 2017 to March 2019

Fft Question = the national question, would the person recommend the service.



Data source: iwantgreatcare

2.2– Improve transitions between care pathways across ages

Actions taken this year

- The management of services was re-configured in the Trust from October 2018 which means child and adult mental health services are now managed and led by the same Clinical Director and Service Director.

- Existing processes remain in place such as a weekly transition panels between children and adult mental health service clinicians to discuss referrals of young people aged 17 ½ onwards and regular transition development groups in each county attended by senior managers and leaders from children and adult mental health services to address issues and improve the quality of transitions. The transition development groups have developed;
  - a leaflet co-designed with and for young people and parents about the transition process,

- the resources available on the Trust's website for young people and parents,
- good practice guidelines and a transition protocol for staff,
- training for staff,
- an agreement the previous care coordinator in the children's mental health service can still be contacted up to three months post transition to facilitate a good transition process,
- identified service transition leads
- a joint workshop between children and adult mental health service clinicians was held in Buckinghamshire in November 2018
- some adult mental health team clinicians have received Dialectical behaviour therapy skills training which is a common therapy used in children's mental health services.

- The Trust asked the national Healthcare Safety Investigation Branch (HSIB) to explore the issue of how well young people are supported in the transition from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) when they turn 18 years old, to gain their expertise and learning from elsewhere in the country. The Trust supported the investigation completed in July 2018.

The full report and recommendations for NHS England, NHS Improvement and Commissioners can be found here, with a recent update on progress; https://www.hsib.org.uk/investigations-cases/transition-from-child-and-adolescent-mental-health-services-to-adult-mental-health-services/

The impact

The number of young people open to children mental health services transitioned to adult mental health services is small (2018/19 – 173 young people) with the majority of young people being discharged back to their GP. The transitions occurred up to the age of 23 when appropriate although most young people transitioned aged 17 (46%) or 18 (36%).

Both the quality of discharges back to GPs and transitions of young people to adult mental health services has been audited as part of a national CQUIN (commissioning for quality and innovation) in 2018/19. The results of the clinical audits each quarter in 2018/19 have been positive showing almost every young people had a named transition coordinator and a clear transition care plan. Although there have been improvements the area for focus in 2019/20 is to ensure there is always a joint planning meeting between the young person, and clinicians from both children and adult mental health services prior to transfer.

The Trust has decided further actions can be taken to improve the quality of transition so this objective will remain for 2019/20.

Quality priority 3: To continuously and reliably improve patient safety (quality domain: safe)

The Trust is committed to making care safer and to prevent errors in healthcare that can cause harm to patients. The errors that occur in healthcare are rarely the fault of individuals, but are usually the result of problems with the systems staff work in. Regardless, patients should be treated in a safe environment and be protected from avoidable harm.

For this priority we identified three local objectives, progress against each is detailed below;

3.1 Reduce patient violence and aggression across the adult acute mental health wards
3.2 Improve the consistency of care processes for the adult acute mental health wards
3.3 Continue to improve how we learn from incidents and deaths

In the Trust's 2018 inspection by the Care Quality Commission (CQC) we received a rating of Good for four of the five quality domains and an overall rating of Good. There were areas within the Safe domain that the Trust was rated as requires improvement for, although the CQC reported that the care provided was safe.

Over the past year many of the actions identified have been completed. Going into 2019/20 we will continue to make improvements in relation to: staff recruitment and retention, improving how patient health records are shared across services and organisations, the monitoring and management of medicines so they are stored at appropriate temperatures, carrying out environmental works to the place of safety facilitates and improving mandatory training levels.

Never Events

Never events are a sub-set of Serious Incidents[7] and are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The trust reported two never events in 2018/19, detailed below, both have had a comprehensive investigation and in both no one was seriously harmed.

- In August 2018 a member of the Community Dental Service by accident extracted the wrong tooth of a child under a general anaesthetic. The tooth was immediately re-implanted which minimised the impact to the patient.
- In August 2018 an adolescent was able to create a ligature whilst on a mental health ward in an ensuite bathroom using a collapsible shower curtain rail as a ligature point. The person was found quickly by staff and not seriously harmed and did not require medical treatment. The anti-ligature magnetic shower track did not collapse. Weight testing before and after the incident showed the rail

[7] A serious incident is when the consequences of an incident or death are so significant to a patient or their family or the potential for learning is so great that a heightened level of response is required.

should have collapsed and would not have been able to take the person's weight. We are in liaison with the manufacturer who is supporting the trust to investigate the circumstances and to identify alternative products. We immediately issued an external alert to inform other mental health trusts of a likely risk.

Infection Prevention and Control

In 2018/19 we had:

- Eight cases of C. Diff however all were deemed unavoidable.
- Zero cases of MRSA bacteraemia. However, in one case a person was transferred from another hospital to one of our older people wards with the bacteraemia. This was investigated and considered unavoidable.
- Zero cases of MSSA bacteraemia.

The Trust was involved in a project to reduce risks for catheter associated urinary tract infections in the community alongside our acute hospital partner. The joint project focused on building staff knowledge through training, standardising the patient pathway and developing a patient catheter passport. We are currently involved in a national collaboration to develop decontamination guidelines for managing toys in healthcare.

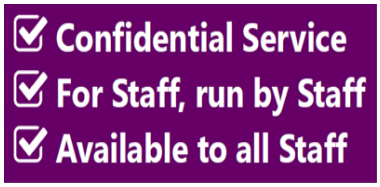
Staff Speaking out

To enable a more open and supportive culture that encourages staff to raise any concerns over the quality of care, patient safety or bullying and harassment we have developed a number of ways staff can speak up, all are promoted on the staff intranet. The ways include speaking to:

- Their line manager to discuss what happened and to agree how they would like to be supported
- The freedom to speak up guardian (pictured right), a dedicated role that offers staff independent and confidential support and a safe way to raise any concerns. The guardian role was introduced from April 2016 and reports directly to the Chief Executive. A part of the role is to promote a culture where staff feel safe to raise concerns without fear of repercussions.

- The guardian of safe working hours for junior doctors, which promotes a culture for trainee doctors to raise concerns and do not fear adverse repercussions. The Trust introduced the role from 2016 following a change in trainee doctor contract negotiations. The guardian reports to the board of directors on a quarterly basis. To see the last report in February 2019, go to https://www.oxfordhealth.nhs.uk/papers/27-february-2019/

- The human resources department, particularly if someone wishes to raise a concern through the whistleblowing process. The Whistleblowing process is overseen by the Executive Team.
- Fair treatment at work facilitators, this innovative role has been introduced across the Trust led by the Equality, Diversity and Inclusion Lead. This is a service made up of 14 staff to provide support to staff who have experiences or have concerns about bullying and harassment in the workplace. The facilitators have received specialist training by the Advisory, Conciliation and Arbitration Service.



- A staff side representative who can offer advice and support.
- An annual report summarising the number of concerns raised, the themes and actions taken with the freedom to speak out guardian is reported to the Board of Directors. The last report was in October 2018 and can be found here, https://www.oxfordhealth.nhs.uk/papers/30-november-2018/.
  No serious patient safety concerns have been raised to date. The 2018 annual national staff survey showed that the majority of staff at the Trust would feel secure to raise a concern about unsafe clinical practice (75%) and would be confident the Trust would address their concern (61%), both above the national average. However, work will continue to improve our openness and curiosity to learn.

3.1– Reduce patient violence and aggression across the adult acute mental health wards

Actions taken this year

- The Trust has more recently started to work in a national collaborative led by NHS Improvement with learning being initially shared across three other trust wards. Elements of the national safewards model have been implemented to improve relationships between staff and patients such as 'know each other' and 'soft words'.
- Positive Engagement and Caring Environment (PEACE) champions have been identified on each ward, who have received enhanced training to help manage violence and aggression and to reduce the use of restrictive practice.
  Regular network days are held for the champions for support and to share good practice. The champions also receive monthly data on incidents and use of restrictive practice on their ward to discuss with colleagues and to identify areas for improvement.
- Work has started on developing a zero-tolerance policy and display material around not accepting inappropriate behaviour towards staff. This work will conclude in 2019/20.

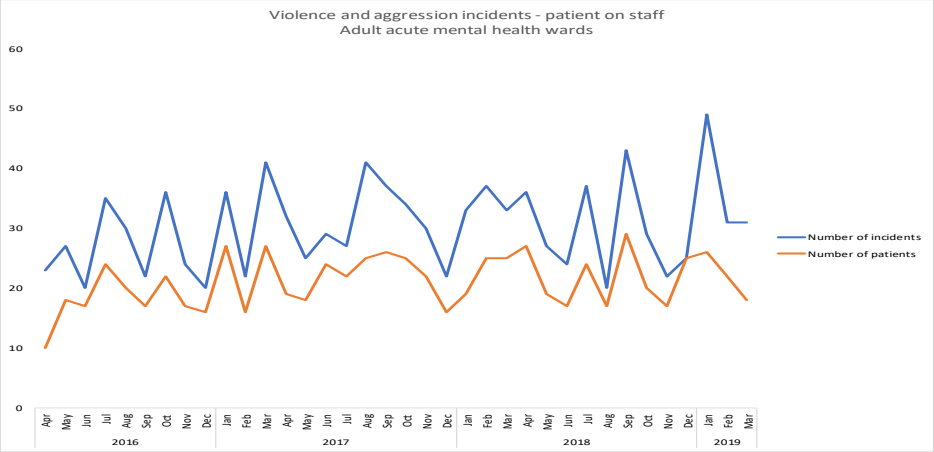
The impact

In 2018/19 there was on average of 31 incidents of violence and aggression each month by patients on staff reported across the six acute wards. The 31 incidents on average were by 21 different patients a month. Of these 82%, n=307 caused no harm, 16%, n=60 minor harm and 2%, n=7 moderate or major harm.

Overall there has been no change, reduction or increase, in the number of incidents although the ward teams report they feel they have been managing more acutely unwell patients over the last 18 months. Graph below shows the number of incidents and number of patients involved for the last three years. However, at ward level, two wards have seen an increase, one ward has had a reduction and three wards have had no change.

The 2018 national annual staff survey shows an improvement from last year with less staff reporting they have experienced violence at work from patients, relatives or members of the public (2018, 12% and 2017, 14%), the Trust is also below the national average. However, the results are Trust-wide and not just for staff working on the adult acute mental health wards.

The Trust has decided further actions can be taken to reduce violence and aggression on staff, so this objective will remain for 2019/20. We believe the number of incidents is under-reported by staff, so further improvement work may see an increase in all levels of harm. However, we would hope to reduce the number of incidents with moderate or major harm. New national reporting should also help to provide a comparison with other mental health NHS Trusts.



Data source: Ulysses incident reporting system

3.2– Improve the consistency of care processes for the adult acute mental health wards

Aim and Objective: to achieve the vision of a high reliability ward by reducing time spent by nurses documenting nursing -related tasks to complete formal admissions by using iPads rather than paper forms by end of 2019.

Actions taken this year

- We documented the current process for admitting formal patients.

- The team introduced a recording template to track the amount of time spent documenting admissions on the paper form. This would serve as a baseline that can be used to track improvements gained by introducing an electronic method through keyboard-equipped iPads. The initial recording template did not capture the information needed, admission forms were not being fully completed, and another recording template was introduced that would capture the baseline information required.

- Whilst the above data was being collected, training was being delivered to ward staff to increase confidence in the use of iPads.

- The ward discovered the paper admission form captured more information than the electronic form currently available on CareNotes (the electronic health record), therefore work has started to expand the electronic form on CareNotes to ensure a complete admission can be documented before moving to the use of iPads.

The impact

The improvement project is at an early stage and cannot progress until the admission form on CareNotes is updated and a complete admission can be captured electronically.

The admission tracker identified fields that were poorly captured in the paper form, such as AWOL risk and 'think family pathway' an approach to ensure any dependents and partners, carers or family members are identified, so work has started to improve how these are being documented prior to moving to an electronic form.

3.3– Continue to improve how we learn from incidents and deaths

Actions taken this year

In 2018/19 a new care plan for end of life care was introduced and the end of life care policy and syringe driver guidelines were reviewed. The local hospice has delivered specialist training sessions to our end of life link nurses and broader training open to all staff has been provided on 'having difficult conversations'. A monthly clinical audit was introduced to review and improve the quality of care plans. We continue to be an active partner in the Oxfordshire end of life care working party.

- The out of hours service developed care pathways including planned reviews of moderate to high risk

patients in line with NICE guidance. The service also developed targeted information for patients relating to early recognition and appropriate timely intervention. Pictured right is the team celebrating World Sepsis Day in September 2018.

- Directorate level and Trust-wide processes to review and learn from deaths have been further strengthened. The Trust is involved in the following multi-agency forums; Oxfordshire vulnerable adult mortality group, Buckinghamshire ICS learning from deaths and the south regional mortality review group. See page 14 for detailed information on the numbers of deaths, themes and actions taken.

- The process for identifying, disseminating and managing actions from national patient safety alerts has been improved. This has included reviewing if past closed actions have been sustained.

- The work in 2017/18 on reducing pressure ulcers developed in service (previously known as acquired) and recognising/ responding to deteriorating patients has been sustained and the number of Serious Incidents[8] has remained small.

- We have made a number of design changes to the incident reporting system to improve ease of reporting for users and to develop our analysis of incidents which has enabled better conversations on how to address concerns and a better shared understanding of the reasons for incidents.

- The training for root cause analysis/ human factors for Serious Incident investigators has been reviewed and revised with four courses ran in 2018/19. There has also been focused work on supporting and training Serious Incident investigators to better engage with bereaved families.

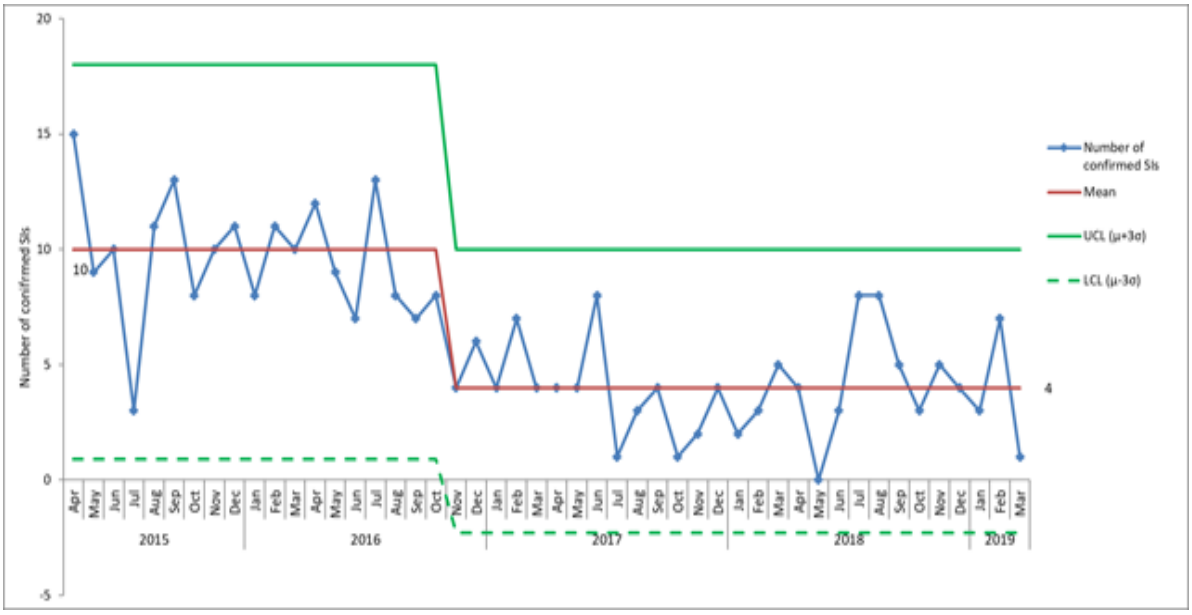
The impact

Incident reporting levels have continued to increase, with the majority causing no harm or minor harm, suggesting the openness of staff to report and learn from incidents.
An external audit of the quality governance arrangements in the Trust including the management of Serious Incidents and national patient safety alerts gave good assurance of the robustness of processes. All national alerts have been closed within the specified timescales.
An internal audit of Serious Incident investigations in November 2018 showed positive results, 75% of initial review reports demonstrated that the patient and or family had been contacted to seek their views of the incident or death and in the remaining

[8] A serious incident is when the consequences of an incident or death are so significant to a patient or their family or the potential for learning is so great that a heightened level of response is required.

instances either family members were not available, or the patient expressed a wish that they were not to be contacted concerning the incident. In reviewing the completed full investigation report, which follows from the initial review report, 100% of investigations demonstrated that either the patients or family members had contributed their concerns to the investigation.

The Trust has seen a sustained decline in the overall number of Serious Incidents particularly around pressure ulcers following focused quality improvement work, demonstrated in the below graph. A statistical process control graph has been used to display the information to be able to identify a positive or adverse trend over time. These types of charts have a central line for the average (red), an upper line for the upper control limit (green) and a lower line for the lower control limit (green), the lines are determined from historical data.



Data source: Ulysses incident reporting system

Quality priority 4: Preventing ill-health and promoting self-care

(quality domain: effectiveness)

The Trust has had a successful year for carrying out clinical research **(see page 135),** it is essential we innovate and use research in practice to get the best possible outcomes for patients. We actively implement NICE guidance and other evidence-based practice to ensure we are delivering the right care that will have positive benefits for patients.

The Trust has achieved and maintained accreditations for more than 20 different external accreditations and network memberships, demonstrating our commitment to raising the standard of care we provide and encouraging external reviews of services. However, we recognise we are only able to improve the quality of care and transform services through working as a system with our partners. There are many examples throughout this report of the partnerships developed.

We have linked with the strategic lead in our region (Buckinghamshire, Oxfordshire and Berkshire) on 'making every contact count'[9] to share good practice on raising awareness and supporting staff and patients to improve their physical and mental health. Making changes such as stopping smoking, increasing physical activity, losing weight to help people to reduce their risk of poor health. We have introduced on-line training on 'making every contact count' which has received positive feedback. The aim for 2019/20 is to roll out the 'making every contact count' training and the smoking cessation training as mandatory for all staff, with more enhanced training available for one or two staff on each ward.

For this priority we identified four local objectives, progress against each is detailed below;

4.1 Review the complex needs pathway (for patients suffering with a personality disorder)
4.2 Develop and introduce a new frailty pathway
4.3 Continue to develop a joint enterprise with Oxfordshire GP Federations
4.4 Smoke free work

4.1– Review the complex needs pathway (for patients suffering with a personality disorder)

Actions taken this year

- Joint system work across Thames Valley providers and commissioners (Oxfordshire, Buckinghamshire and Berkshire) including primary care, clinical commissioning groups, county councils, third sector services with support from NHS England. A programme of work has been agreed which started by mapping what support is currently available and understanding where the gaps in current provision are from patients and carers. Workshops were held in July and November 2018. The key themes identified were; training, reducing risk, information resources and system support. From the workshops we developed guiding principles of the most therapeutic approach but agreed the development of a single pathway would not be the most effective.

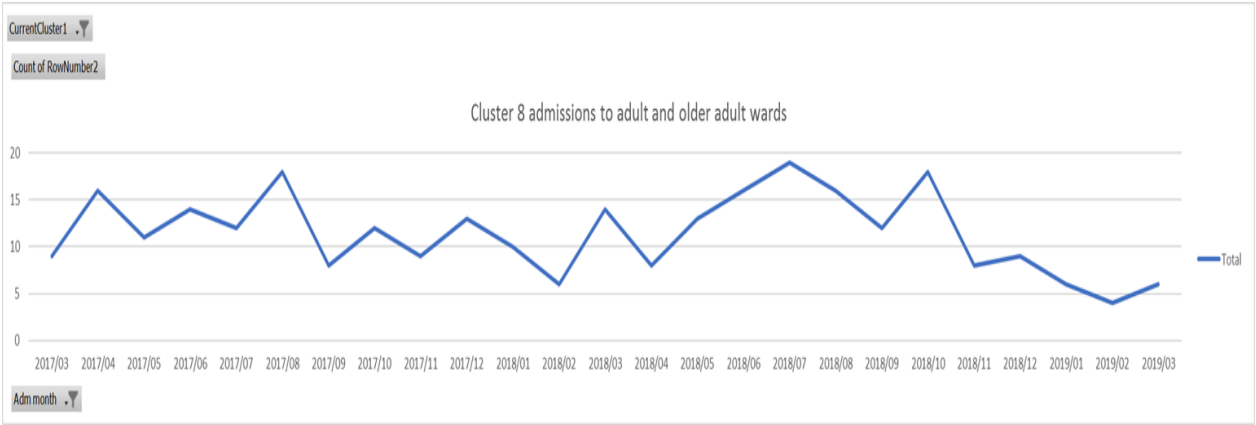
- In December 2018 we submitted a national funding proposal for OHFT to provide training jointly with previous patients of the complex needs service to create a Thames Valley Network of beacon GP practices with enhanced knowledge and skills in personality disorder management. A pilot of the training was completed, and training has been rolled out in Buckinghamshire. Training will start to be delivered in Oxfordshire in 2019/20.

[9] Making every contact count is an approach to behaviour change that utilises the day to day interactions we have with other people to encourage changes in behaviour that have a positive effect on our health and wellbeing.

- We issued guidance to staff about the adverse impact of admissions for patients suffering with a personality disorder and that if a short admission is needed there has to be a clear purpose about what this will achieve. The complex needs service are now providing in-reach to some of the wards to support patients and staff. Alongside this we have been working with community mental health staff about holding greater risk and the benefit of developing safety plans with patients and their families. Structured clinical management supervision delivered by complex needs service staff has been introduced to adult mental health teams, and regular multi-professional complex case panels are held as an opportunity for clinicians to ask for advice and support around the management of cases.

The impact

The Trust has started to see a reduction since October 2018 in the number of admissions of patients suffering with a personality disorder to our adult and older people mental health wards. The graph below shows the number of admissions from March 2017 to March 2019.



Data source: CareNotes, electronic health record

4.2– Develop and introduce a new frailty pathway

Actions and Impact this year

We are working in partnership to improve patient's outcomes and have developed a frailty pathway with primary care, South Central Ambulance Service (SCAS) and OHFT colleagues. Patients with complex physical health needs, frailty or instability requiring a significant level of coordinated care are discussed by a multi-professional team to develop shared care and to help patients stay at home or get back home quickly. Some of the specific initiatives are detailed below:

- The adult community physical health services including district nursing, community therapies, specialist tier 2 services and respiratory service set up a

same day response process that was agreed with SCAS to encourage ambulance crew and paramedics to contact the service via the Single Point of Access (SPA) for suitable patients to consider alternative options of hospital admission. However, this new type of response received low referrals but will continue into 2019/20 with further promotion through the ambulance service.

- The district nursing service received extra training on comprehensive geriatric assessment skills. More than 40 staff received training.

- We also started a pilot to provide an integrated respiratory service in February 2019 in partnership with Oxford Universities Hospital NHS Foundation Trust and GPs in the City and North of Oxfordshire. The pilot is being led by Oxfordshire clinical commissioning group.

- We started a 'getting me home' initiative at Witney community hospital wards to help get patients home sooner so that they can complete rehab in the comfort of their own surroundings. From 1st December 2018 to 31st March 2019, a total of 22 patients were discharged and considered suitable for the initiative. The plan is to expand this model to other community hospital wards in 2019/20.

- In 2018/19 the Emergency Multidisciplinary Units (EMU) piloted an innovative advanced nurse practitioner outreach service in West Oxfordshire with senior medical support to deliver advanced clinical care in a patient's home to maintain their independence and prevent a hospital admission. From 1st December 2018 to 31st March 2019 the service prevented 59 admissions treating people in their home with conditions such as pneumonia, urinary track infection, bacteraemia, heart failure, acute kidney injury and cellulitis.

4.3 – Continue to develop a joint enterprise with Oxfordshire GP Federations, called the Oxfordshire Care Alliance

Actions taken and the impact this year:

- There has been continued development over the last year with four GP Federations in Oxfordshire, we were near final sign off to develop a legal entity called Oxfordshire Care Alliance to facilitate integration between community and primary care services for neighbourhood populations. A plan was agreed for Oxfordshire to be organised into 18 neighborhoods so that local needs can be identified and met. The district nursing service started to reorganise themselves around this.

- However, the NHS long term plan launched in January 2019 with the requirement for new primary care networks to be identified by mid-May 2019 changes the work slightly. The reason for the change is because some of the

populations in the identified 18 neighborhoods do not meet the national requirement of being no larger than 50,000 people but ideally more than 30,000. Each new primary care network will need to appoint a clinical director, have a pharmacist and decide who/ how the network will be hosted.

- The future is still in multi-disciplinary neighborhood teams organised around local GP practices and the preparation work in Oxfordshire has been completed. However, the structural form is now being nationally prescribed.

Celebrating international women's day in March 2019.

4.4– Smoke free work

Actions taken and the impact this year

- We have been smoke-free since 2016 across all our sites, therefore inpatients have been utilising nicotine replacement therapy and support.

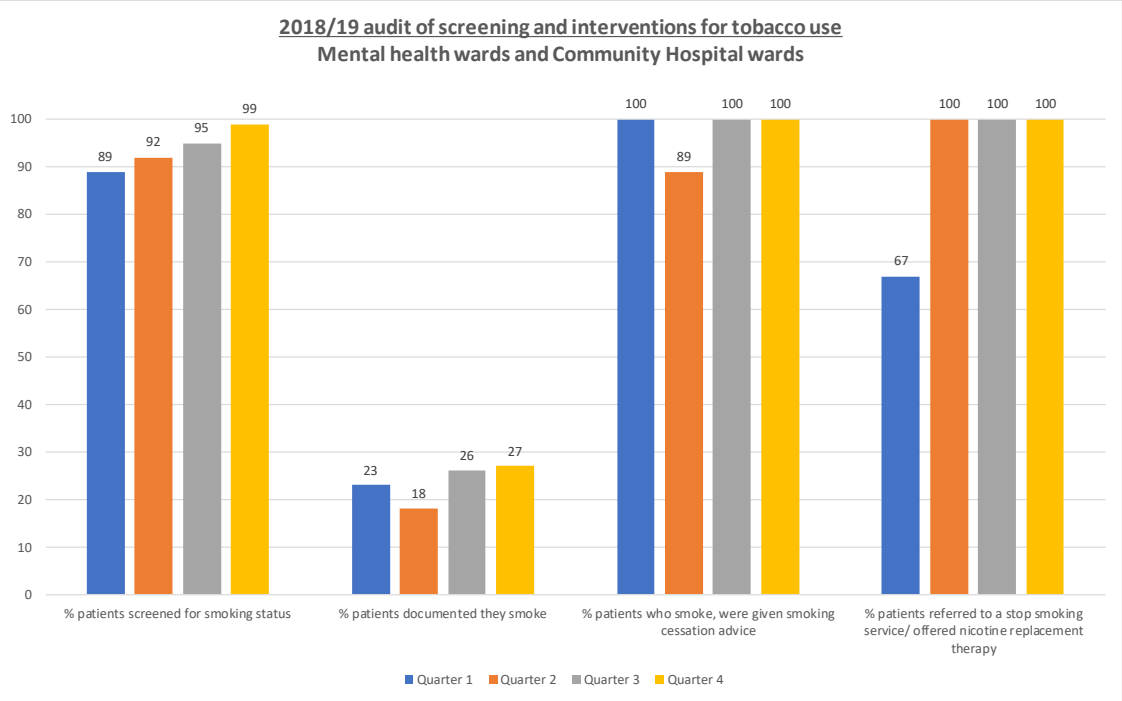
- The previous policy was rewritten and renamed as the nicotine management policy, launched following preparation for implementation in February 2019. There is a change of focus in the policy to reinforce the message of health promotion.

- There is compelling evidence that e-cigarettes are around 95% safer compared to smoking tobacco (Public Health England, 2015). Therefore, the Trust reviewed the different types of e-cigarettes available and agreed to pilot the use of e-burn single use cigarettes on one forensic ward for three months.

- Patients were involved in all aspects of rolling out the pilot. 14 out of 22 patients on the ward trialled the product. The pilot was successful; with positive feedback

from patients and for the majority of patients a reduction in carbon monoxide levels. Although the pilot did not show a reduction or change in smoking habits patients did report that it has helped with their cravings for cigarettes. E-burn cigarettes have since been rolled out across all forensic wards between December 2018 and January 2019 across Oxfordshire, Buckinghamshire and Milton Keynes. In 2019/20 we hope to expand the work to carry out a pilot on two adult acute mental health wards.

- We have been working with the smoking cessation advisors on the adult and older people mental health wards and community hospital wards to ensure every inpatient is screened and supported to stop smoking during their stay. The results are positive with an improvement in awareness/ screening, providing advice and offering interventions, shown in the quarterly clinical audit results in the graph below.



Data source: clinical audit

Part 4. Quality Improvement Plan for 2019/20

Below is the Trust's quality improvement plan for 2019/20, with 14 key objectives identified against the quality domains of; patient and family experiences, patient safety and clinical effectiveness. The plan does not detail all the quality improvements to be carried out across the Trust in the next year but identifies those key areas being addressed.

The objectives have been selected following a review of our risks, performance in 2018/19, self-assessments from recently published national reviews/ guidance, feedback from staff and patients, looking at local and national priorities including the NHS long term plan, the work of the healthcare improvement centre, and findings from the Care Quality Commission's well-led inspection. Some of the objectives from last year (2018/19) are continued into 2019/20 to build on the work already completed.

The objectives have been shared for comment with the Trust Council of Governors, local Clinical Commissioning Groups, Healthwatch Organisations and Health Overview and Scrutiny Committee.

All the objectives are aimed to be completed by 31st March 2020 and progress will be monitored on a quarterly basis by the Trust's Quality Committee and the Board of Directors will be informed of performance against targets. The Trust will report formally on our progress against each objective in our Quality Account next year.

Table 16.

Quality Domain: All - Experiences, Patient Safety and Clinical Effectiveness

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
1. Staff wellbeing and retention. 1a) Schwartz rounds[10] will be trialled 1b) Deploying the Royal College of Nursing 'cultural ambassadors' programme which identifies people in the Trust from a BME background who will help to proactively consider how race may impact managers decisions/attitudes 1c) Implement an employee assistance programme 1d) Develop local workforce plans for each service including resourcing, engagement and retention. 1e) Address bullying and harassment through a programme of work including leadership development, cultural awareness, access and learning from the work of the freedom to speak up champion, intolerance of bullying behaviour, better quality appraisals to identify	All services	1a) Recognising the traumatic nature of some of the situations faced by staff, and the more limited time available due to caseload for structured reflective practice and learning. Aim to reduce work related stress. 1b) Understand and address the relatively high proportion of people from a BME background who enter the disciplinary process, address "unconscious bias", and continue to improve our Workforce Race Equality performance. 1c) This will support employees with personal problems and/or work-related problems that may impact their job performance, health, mental and emotional well-being. Aim to reduce long term sickness. 1d) Improve succession planning and conversations about careers/ retire and return scheme etc. Aim to reduce turnover and therefore further reduce vacancies.	1a) Number of teams using Schwartz rounds regularly, number of trained Schwartz round facilitators as of March 2020 and improvement in staff survey results for those teams using the approach. (baseline 2018 Schwartz rounds are not in use and we have no facilitators trained. Annual staff survey results across the Trust on staff reporting being unwell in last 12 months due to work related stress - 41.7%) 1b) Identify and train at least 10 cultural ambassadors by March 2020 and achieve a reduction in % of BME staff who enter the disciplinary process from Oct 2019 to March 2020. (baseline 2018 0 cultural ambassadors) 1c) Employee assistance programme in place by July 2019 and reduction in long term sickness (baseline YTD 18/19 2.15%) 1d) Reduce vacancies to achieve less than 600 WTE by March 2020 (baseline 619 WTE end of Feb 2019) and better understand turnover information by profession.

[10] Schwartz Rounds are an evidence-based forum for staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients/ service users. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
and address issues, close working with staff representatives and support of staff equity networks.		1e) Improve staff experience, reduce work related stress, improve relationships, improve retention of staff, address unconscious bias, reduce grievances and other forms of complaint about behaviour.	1e) Improvement in staff survey questions related to bullying and harassment from results in 2018, and grievances alleging bullying or harassment are fewer in 2019/20 than in previous years.
2. Staff recruitment. 2a) Train and support a further cohort of nurse associate trainees and nurse cadet schemes 2b) Implement TRAC[11] and carry out the recruitment initiatives to transform the workforce 2c) Grow the internal staff bank and utilise the staff more successfully, including nurses, allied health professionals, healthcare assistance and admin posts.	All services	2a) Shortage of Band 5 nurses, so the aim is to improve the access and entry routes to careers in nursing. 2b) To reduce vacancies, reduce recruitment lead time, promote our Trust more professionally to potential recruits, improve management information, align with other NHS Trusts 2c) Standards are higher for our internal staff bank than those drawn from agencies – this means improved patient care and reduced pressure on our substantive staff	2a) 50 nurse associates recruited and complete training by March 2020, and of those the number who have converted to become employees. 2b) Reduce vacancies to achieve less than 600 WTE by March 2020 (baseline 619 WTE end of Feb 2019), increase flexible workers (baseline 8.3% as of Feb 2019) and an increase in apprenticeships completed in year (129 in 2018/19). 2c) The number of shifts filled by bank workers to be greater than the number filled by agency workers
3. Triangulation of information to improve care. 3a) Develop and implement an advanced business intelligence platform to automate and visualise the triangulation of information for managers and leaders to identify and monitor quality improvements.	All services	3a) Currently information to support quality improvement is held in multiple systems, relying on manually pulling this together. An automated solution would; improve accuracy, analysis would be more sophisticated, triangulated information will be available all the time, and a wider audience will be able to access the platform.	3a) New intelligence platform developed and rolled out with training on how to interpret trends and variations in quality over time.

[11] TRAC is on-line software that supports the recruitment process.

Quality Domain: Patient, carer and family experiences

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
4. Patient, carer and family experiences. 4a) Implement the revised patient experience and involvement strategy workplan for 2019/20 focused on personalising care and shared decision making in care. 4b) Implement the carer and family strategy (icareyoucare) workplan for 2019/20 focused on improving the recognition of carers. 4c) Trial new patient experience measures for children complex care services (children's community nursing and children's integrated therapies) 4d) Patients on the caseload will have a personalised assessment of need informing an up to date care plan	All services All services Children's Community services Learning disability services	4a) and 4b) patient care is the top priority for the Trust and improving patients and their carers/ families' experiences is essential to achieve high quality care. Evidence shows patients who are involved in their care have better outcomes. 4c) Improving the level of feedback and raising the voice from children and families. 4d) Personalised care planning will improve the care people receive and their experiences and outcomes.	4a) Improvement in patients, carers and families telling us they were given the opportunity to be involved in their care and increase the number of responses received. (baseline 2018/19: out of 13,128 responses people rated services 4.74 out of a 5-star rating for involvement in their care. On average we received 1094 responses a month) 4b) Demonstrate improvement in better recognising the needs of carers. The actions being taken are to roll out new carer awareness training trust-wide, host events to value the importance of a carer's role, pilot carer support volunteers, and increase the number of carer champions identified in each service. 4c) Summary of tools trialled and impact on the amount and quality of feedback collected which could be used for quality improvement. 4d) 95% of patients will have evidence of a personalised assessment and care plan.
5. Dementia care. 5a) Implement the dementia strategy workplan for 2019/20, focused on the five	All services	5a) To ensure that people living with dementia, who are in receipt of OHFT services, will have the best dementia care, making best use of all available resources.	5a) We will work with people to live well with dementia. The actions will be taken from the strategy workplan for 2019/20.

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
areas of living well with dementia (known as the five wells).			
6. End of life and palliative care. 6a) To develop the quality of end of life care provided by focusing on embedding the specialist care plan template, delivering enhanced training to staff so that they can offer psychological support to patients and supporting whole system work in Oxfordshire.	Older People Community services	6a) To support people to live as well as possible until they die and to ensure they die with dignity. National and local audits on end of life care have identified areas for improvement.	6a) Demonstrate the national standards in the five priorities for care set out in 'One Chance To Get It Right', NICE Quality Standard 144 (which addresses last days of life) and NICE Quality Standard 13 (which addresses last year of life) are being implemented. Outcome of internal end of life care plan audits and 2019 National Audit of Care at the End of Life, and number of staff who have received enhanced training.
7. Transitions. 7a) Improve the quality of care for a young person when they transition from child to adult mental health services (this objective is linked to the prevention of suicides as transitioning can be a particularly vulnerable time)	Mental health services children and adults	7a) A few young people have to transition between services to complete treatment post turning 18 years old and of these many don't have a positive experience of transition and as a result may disengage from services and put their health and wellbeing at risk. This objective is being carried over from 2018/19.	7a) Young people have a good experience of transitioning. The main focus will be on ensuring every person that transitions has a joint planning meeting with clinicians from both children and adult mental health services prior to transfer.

Quality Domain: Patient Safety

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
8. Suicide Prevention.	Mental health services all ages	8a) To reduce the number of suicides and improve care for users at risk of suicide, this is	8a) Reduce the rates of suicide (suspected or confirmed by a Coroner) of people under our care

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
8a) Implement the self-harm and suicide prevention strategy workplan for 2019/20. Actions will be focused on reducing social isolation, rolling out safety planning, 48 hour follow up after inpatient discharge, training, carer support, support for people bereaved by suicide and work around contagion.		in line with the mental health five year forward view.	contributing to the national objective of a 10% reduction from April 2018 to March 2021*. (Baseline in 2018/19 where were 26 suspected or confirmed cases of suicide for known patients)
9. Restrictive practice. 9a) Review content and frequency of current restrictive intervention staff training and achieve new national training accreditation. (this objective is linked to reducing violence and aggression by patients on staff)	Mental health services all ages	9a) In 2018 there has been a national focus on reducing restrictive interventions around three workstreams; collection and use of data, identifying quality improvements and staff training. In 2019 training provided to staff will need to be accredited by the Restraint Reduction Network.	9a) Trust to apply and achieve certification that our restrictive practice training meets national standards by March 2020.
10. Violence and aggression on wards. 10a) Actions to be identified for each acute ward to reduce violence and aggression from patients. This will include learning from the national collaborative focused on improving the relationships between staff and patients.	Mental health acute inpatient wards	10a) Staff continue to suffer from violence and aggression incidents from inpatients. This has an effect on staff retention and sickness and can lead to more restrictive practice. This objective is being carried over from 2018/19.	10a) Reduce violence and aggression incidents from patients on staff, both those that cause harm and don't. Reduce RIDDOR[12] incidents at work related to violence and aggression for the acute wards. New national reporting requirements from April 2019 will enable the Trust to benchmark levels. (baseline for 2018/19 – average of 31.2* violence and aggression incidents by patients on staff reported per month across 6 wards, of which 82%, n=307 caused no harm, 16%, n=60 minor harm and 2%, n=7 moderate or major harm)

[12] Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
			* the Trust believes incidents are under-reported by staff, so the improvement work may see an increase in all levels of harm however we would hope to reduce the number of incidents with moderate or major harm.
11. Patient falls. 11a) Reduce the number of falls across all wards using the selection of evidence-based interventions i.e. learning from the fallsafe project which used a care bundle approach led by clinical staff	Community Hospitals	11a) The care bundle approach to preventing falls was nationally found to be effective at delivering improvements in processes of care that are important not only for falls prevention but for patient's recovery and wellbeing.	11a) Reduce the amount of harm from inpatients falls. (baseline 456 fall incidents involving 286 different patients in 2018/19 across the 9 wards. Out of 456 incidents, 70.4% resulted in no harm, 27.2% minor harm, 2% moderate harm and 0.4%, 2 patients with major harm)

Quality Domain: Clinical Effectiveness

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
12. Medication for people with a learning disability. 12a) A full self-assessment against the national standards and identification of actions for improvement. National standards are 'Stopping The Over Medication of People with a learning disability and/ or autism' (STOMP) and 'Safe Treatment and Administration of Medicine in Paediatrics' (STAMP)	Learning disability services	12a) It is a national project involving many different organisations which are helping to stop the over use of these medicines. STOMP and STAMPT is about helping people to stay well and have a good quality of life. The aims are to encourage regular check-ups about their medications, ensure professionals involve patients in decisions about medication and inform patients about alternative options to reduce the use of medications.	12a) Completion of self-assessments and action plan. Actions will include closer joint working with specialist teams, pharmacy and primary care to reduce the use of medication. Outcome to show reduction in use of medication. We support STOMP Stopping over-medication of people with a learning disability, autism or both

Objective and Actions	Relevant service(s)	Rationale	Outcome and Measurement (all actions to be achieved by 31st March 2020)
13. Mental Capacity. 13a) Improve the practice and recording of mental capacity. Actions: SOP to be developed for staff so that capacity assessments and best interest processes are recorded clearly and consistently. Training to be reviewed and revised. Leads in each directorate to be identified.	All services	13a) Feedback from the Care Quality Commission and our own understanding of the challenges in this area. We want to ensure patients are supported to make their own decisions wherever possible.	13a) Improvement from clinical audit results and reduction in concerns raised from the Care Quality Commission mental health act visits to the mental health wards.
14. Inappropriate Out of Area Placements.[13] 14a) Reduce the number and length of time adults and older people have to spend in out of area placements by; expanding intensive community provision for people experiencing a crisis, focusing clinical work with patients with a severe mental illness who live in supported accommodation (referred to as living on the recovery campus) to prevent admissions, and to reduce the number of patients struck in hospital waiting to be discharged.	Mental health adults	14a) National evidence shows the experience and outcomes for a patient who has been admitted out of area is worse. The national five year forward view target is to eliminate out of area placements by March 2021.	14a i) Reduce the number of inappropriate adult and older people admissions – achieve from Oct 2019 to March 2020 of 13 or less admissions a month. (baseline 2018/19, median 18 admissions per month and 332 days in placements a month) 14a ii) Funding for crisis resolution and home treatment teams in Oxfordshire and Buckinghamshire secured to provide additional intensive home care.

[13] Out of area placements mean admitting someone to a ward outside the services provided by the Trust. An out of area placement is categorised as inappropriate if the rationale for placing the person relates to bed pressures or absence of community or social care support.

Appendix A. National Clinical Audit; actions to improve quality

The reports of two national clinical audits were reviewed by the provider in 2018/19 and OHFT intends to take the following key actions to improve the quality of care provided.

National Audit of End of Life Care

In 2018/19 a new care plan for end of life care was introduced and the end of life care policy and syringe driver guidelines were reviewed. The local hospice has delivered specialist training sessions to our end of life link nurses and boarder training open to all staff has been provided on 'having difficult conversations'. A monthly clinical audit was introduced to review and improve the quality of care plans. We continue to be an active partner in the Oxfordshire end of led care working party.

We are a partner running a bus tour in Oxfordshire in May 2019 to encourage and remind people to talk about death, dying and bereavement. May is national dying matters week.

We have identified an objective around improving end of life and palliative care in 2019/20 see page 51 for details.

POMH Clozapine 18

Audit results have only just been received and action planning is unfinished.

Appendix B. Local Clinical Audit; actions to improve quality

The reports of 11 local clinical audits were reviewed by Oxford Health NHS Foundation Trust in 2018/19 and listed below are some examples of the actions taken.

Essential Standards bi-monthly audit and Resuscitation annual audit

In 2018/19 additional spare equipment was ordered for one ward and steps taken in one ward to prompt regular checks of equipment are completed and documented.

Care Programme Approach (CPA) quarterly audits

Good practice was shared from one team with others particularly around crisis planning. A working group is developing a checklist for staff to support effective crisis planning.

Personalised care planning training has been delivered to ensure care plans are holistic and include the needs to carers/ families.

Annex 1. Statements from our partners on the quality report and account

Oxford Health NHS Foundation Trust Council of Governors

The Chair of the Governor's Quality and Safety sub-Group has written the following statement following the receipt of comments from the Group.

The Council of Governors consists of active and interested patients, service users and members of the public, as well as representatives from associated agencies, such as the County Council, Universities and Age UK.

The Trust has six Governor sub-Groups of the Council including the Quality and Safety sub-Group. This has met three times during 2018-9, chaired and attended by at least four Governors. Issues relating to safety and clinical effectiveness are discussed here. In addition, the Patient Experience sub-Group (run in the same manner) has been up-dated on all aspects of patient feedback. Key issues from these are taken to the Council of Governors for discussion with the Board. The Governors have been keen to be fully informed about the relevant issues and have read the Quality Account with interest.

In the opinion of the Quality and Safety sub-Group, the account is clear and concise. The contents were scrutinised carefully and several queries were raised. These were all answered fairly and amendments made where requested. Concerns raised by the Governors during the year had been documented clearly. The Group were pleased to note both the arrival of a cohort of Nurse Associates as part of a drive for staff recruitment, and also the achievement of digital connectivity between mental health records and GPs in Buckinghamshire. They appraised the work on the objectives set last year and will be keen to see progress on this year's objectives in due course.

The Quality and Safety sub-Group has appreciated the honesty and openness of the information provided. It is evident that the demands which are being placed on service delivery are not diminishing. The resources with which to meet these demands are stretched to the limit. This situation is not unique to our Foundation Trust which is clearly working very hard to achieve on all fronts. The sub-Group therefore endorses the quality account and quality report and will continue to support and work closely with the Trust in order to maintain and improve services across all the five counties which it serves.

Madeleine Radburn

Chair of the Governors' Quality and Safety sub-Group

May 21st 2019

Oxfordshire

Clinical Commissioning Group

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

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

Buckinghamshire
Clinical Commissioning Group

Second Floor
The Gateway
Gatehouse Rd
Aylesbury
HP19 8FF

Tel: 01296 587220
Email: bucksccgs@nhs.net

17 May 2019

Dear Colleague,

Statement from Clinical Commissioning Groups (CCGs)

NHS Buckinghamshire CCG and NHS Oxfordshire CCG response to Oxford Health NHS Foundation Trust Quality Account 2018/2019

Buckinghamshire Clinical Commissioning Group and Oxfordshire Clinical Commissioning Group have reviewed the Oxford Health Foundation Trust Quality Account against the quality priorities for 2018/2019. There is evidence that the Trust has relied on both internal and external assurance mechanisms, including Care Quality Commission reports to provide a comprehensive Quality Account review.

OHFT participated in a routine well-led inspection by the CQC covering the whole Trust during 2018/19. The inspection took place over March and April 2018, with results published in August 2018. The Trust maintained their previous quality rating of Good and identified actions to address the areas for improvement. Seven requirements notices were issued by the CQC from the inspection, which the Trust is addressing through an action plan with an 18-point action plan. So far 10 actions have been completed with the remainder in progress. The CCGs attended a multi-agency stakeholder event following the Publication of the CQCs report and have been sighted on the CQC action plans.

Furthermore we have provided detailed narrative feedback within the relevant Quality Account sections as part of the feedback process for the Quality Account review by the CCGs. This included narrative related to improvements made and next steps. The CCGs have also provided high level commentary below to recognise achievements and areas in which the CCGs would like to see improvements both from the 18/19 review period and for improvement activities for 19/20.

We additionally recognise the improvements made around Stroke Services as identified in the National Stroke Audit, SSNAP which is an area that would benefit from inclusion to be representative of variety of services provided.

Quality priority 1: Improve staff health and wellbeing

The quality account describes a number of initiatives to improve staff health and wellbeing during 2018/19, it is recognised that 2 of the 3 priorities were achieved for the period, the continued focus on the workforce strategy remains a priority for the organisation, the initiatives implemented to develop career pathways in the Nursing workforce should be commended, in addition to the work completed around the development of apprenticeships. It should also be recognised the innovative work completed related to the use of ex users of services as paid peer development workers.

Quality priority 2: Improve the experience of patients and their families and carers

The quality account describes a number of initiatives to improve patients and carers experiences during 2018/19, the account depicts 1 of the 2 priority areas were achieved and where the activities are close to target such as for transitions these are carried over into the 19/20 priorities.

Quality priority 3: To continuously and reliably improve patient safety

The quality account describes a number of initiatives to improve patient safety during 2018/19, for this priority area 1 of the 3 priorities were achieved, for the areas that are not carried over into 19/20 due to either achieving the objectives or being close to target these will be areas of focus working with OHFT as part of routine activities through our contract and quality monitoring arrangements.

Quality priority 4: Preventing ill-health and promoting self-care

The quality account describes a number of initiatives for improves in preventing ill health and the promotion of self-care during 2018/19, for these areas of priority the trust has achieved all four priorities in this area as reported within the quality account.

Priority areas for 19/20:

The CCGs would like to see included under the established quality priorities for 19/20 the following elements;

We would like to see further focus on the complex needs pathway for patients with a personality disorder to ensure that the revisions to the pathway are fully embedded within the organisation.

A trust wide improvement approach to how patients who have a diagnosis of autism are supported when accessing mental health services, to include partnership working with agencies in the wider Buckinghamshire ICS.

As CCGs we are pleased to see that the transitions work is being carried over, it was acknowledged in the report that there is still work ongoing here. CAMHS have an active engagement group (article 12) based in Buckinghamshire who we would like to see involved in this and for learning to be shared cross counties.

In addition we would also like the trust to focus on discharge as a transition for community mental health patients, patients are sometimes quite critical of their experiences when discharged from hospital. Feedback suggests they were not adequately prepared for discharge and when discharged feeling as though the support has dropped away. We are pleased to see that the 48 hour follow up will be implemented.

For investigations to support Learning from Deaths, the CCGs would like to see wider involvement in the investigation of Serious Incidents, there needs to be consideration of how external agencies for example (substance misuse and primary care as an example) are included in the process of investigation and wider learning.

The CCGs would like to see the continued and sustained improvement around physical health care for patients receiving treatments for their mental health condition.

The Quality Account provides a balanced overview of the Trust's performance over the last 12 months and clearly identifies the achievements within the period reported, but also areas within their service delivery where improvements could be made. The Clinical Commissioning Groups welcome the openness and transparency of this approach and continue to be committed to supporting the Trust in achieving improvement in the areas identified within the Quality Account.

This review of the Quality Account includes comments from Buckinghamshire and Oxfordshire (CCGs) for the services commissioned.

We are grateful to the Trust for working in such an open and transparent way with Commissioners and wider stakeholders. We would also like to recognise the active partnership with the development of the Buckinghamshire Integrated Care System (ICS) and the work commencing for the development of the Oxfordshire (ICS), the Trust continues to demonstrate this commitment to collaborative working with other partner agencies and we will continue to work together to support the Trust on its improvement journey.

Yours sincerely,

Louise Patten

Chief Executive

Oxfordshire and Buckinghamshire Clinical Commissioning Groups

OXFORDSHIRE COUNTY COUNCIL

Date: 14th May 2019

Oxfordshire Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Contact: Sam Shepherd, Senior Policy Officer
Direct Line: 07584 909530
Email: samantha.shepherd@oxfordshire.gov.uk

Jane Kershaw
Head of Quality Governance
Oxford Health NHS Foundation Trust
Jane.Kershaw@oxfordhealth.nhs.uk

Dear Jane,

Re: Oxford Health Quality Account 2018/19

Thank you for sharing the Oxford Health NHS Foundation Trust's (OHFT) draft Quality Account with the Joint Health Overview and Scrutiny Committee (HOSC) for comment. This document is a valuable tool in helping the public to understand the Trust's performance and priorities for improving the quality of local community-based services.

The committee is pleased to note improvements made in a number of areas during 2018/19. In particular, we are pleased that a CQC inspection rated the Trust as 'good' and a subsequent local systems review identified that a number of improvements had been made. The CQC inspection ranked the 'safe domain' category as requiring improvement and as a result the committee is encouraged to see that work has continued from previous years to address staff recruitment and retention.

The increased work by the Trust to support patients and carers is strongly evident in the report including the development of a refreshed patient experience strategy with patients and staff and the introduction of carer champions. The committee also notes the examples of partnership working including the opening of safe havens in the county with partner organisations for those experiencing a mental health crisis.

The committee is pleased that the Trust's access to IAPT has been consistently within six weeks resulting in performance being above the Trust's own target and above the national average. That being said, the committee notes that the report does not distinguish between services delivered by the Trust itself and those delivered by partner organisations such as Oxfordshire Mind and this would be a helpful distinction for clarity in future reports.

The committee would like to recognise the work to develop the 'Oxford Healthcare Improvement Centre' to ensure that quality improvement has a specific focus, particularly in learning from clinical audits. Whilst we are pleased to note that OHFT participated in 100% of national clinical audits that it was eligible to participate in, the committee would encourage the Trust to give consideration to participating in other audits in the future. In particular the National Diabetes Audit, National Respiratory Audit and the MINAP audit of people experiencing myocardial infarction. The committee would also wish that the Trust

gives consideration to increasing the number of local audits from 11 in 2018/19 as a mechanism for care improvement.

In addition to the points raised above, during the 2018/19 year in particular, but for the last three years, the issue of suspension of services at Wantage Community Hospital came to HOSC's attention. As has been identified through HOSC meetings, a 'temporary' closure of a community hospital which lasts more than six months, is no longer temporary and even on the grounds of safety, there is a public and legislative duty to act on a more formal basis. The committee feels as though the handling of Wantage Community Hospital sets a poor example of how claims a closure is 'temporary' are brought forward. As such, the committee is slightly less inclined to have faith in the explanation and proposed management of temporary closures in the future and will seek to scrutinise them in depth. We welcome the holistic approach now planned for examining and planning for health needs access Oxfordshire which is being rolled out in the OX12 locality. However, we urge the Trust to take a far more proactive approach with the management of such situations in future to avoid the need for a complete suspension of services in Oxfordshire's community hospitals. We encourage you to work with HOSC as early as possible to ensure all duties are fully discharged effectively in the future.

In terms of future priorities, HOSC is very supportive of the quality priorities identified for 2019/20; particularly the work to support staff recruitment, wellbeing and retention, which is a critical issue across the country, but particularly for Oxfordshire. We also very much support the focus being brought to patient, family and carer experiences.

The committee would welcome further discussion at a future HOSC meeting about the progress being made against the Trust's 2019-20 priorities.

Yours Sincerely

Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee

Annex 2. Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts/ Reports for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation Trust annual reporting manual 2018/19 and supporting guidance

- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period 1st April 2018 to 24th May 2019
    - papers relating to quality reported to the board over the period April 2018 to 24th May 2019
    - feedback from the commissioners dated 17th May 2019
    - feedback from the governors dated 21st May 2019
    - feedback from Overview and Scrutiny Committed dated 14th May 2019
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25th April 2019
    - the 2018 national patient survey
    - the 2018 national staff survey
    - the Head of Internal Audit's annual opinion over the Trust's control environment dated 24th May 2019
    - CQC inspection report dated 30/08/2018

- the quality report presents a balanced picture of the NHS foundation Trust's performance over the period covered

- the performance information reported in the quality report is reliable and accurate

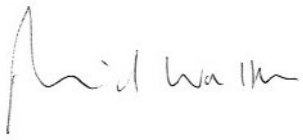
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board.



David Walker

Chairman

Date: 24th May 2019

Stuart Bell CBE

Chief Executive

Date: 24th May 2019

Annex 3. Auditor's statement of assurance

Independent Practitioner's Limited Assurance Report to the Council of Governors of Oxford Health NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Oxford Health NHS Foundation Trust to perform an independent limited assurance engagement in respect of Oxford Health NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with NICE-approved care within 2 weeks of referral; and
- Inappropriate out-of-area placements for adult mental health services.

We refer to these national priority indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS
- Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to 28 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 28 May 2019;
- feedback from commissioners dated 17 May 2019;
- feedback from governors dated 21 May 2019;

- feedback from the Overview and Scrutiny Committee dated 14 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services
- and National Health Service Complaints (England) Regulations 2009, dated 25 April 2019;
- the 2018 national patient survey;
- the 2018 national staff survey;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2019;
- the Care Quality Commission's inspection report dated 30 August 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Oxford Health NHS Foundation Trust as a body, to assist the Council of Governors in reporting Oxford Health NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and Oxford Health NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.
- A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.
The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Oxford Health NHS Foundation Trust.

Our audit work on the financial statements of Oxford Health NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Oxford Health NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Oxford Health NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Oxford Health NHS Foundation Trust's members those matters we are required to state to them in an auditors report and for no other purpose. Our audits of Oxford Health NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Oxford Health NHS Foundation Trust and Oxford Health NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS
- Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP

Chartered Accountants

London

28 May 2019

Health NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Oxford Health NHS Foundation Trust (the 'Trust') for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended;

have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; and

have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

Financial statements audit

- Overall materiality: £5,710,000, which represents 1.7% of the Trust's operating expenses;
- Key audit matters were identified as:

- Contract variations & associated receivables; and
- Valuation of land and buildings.

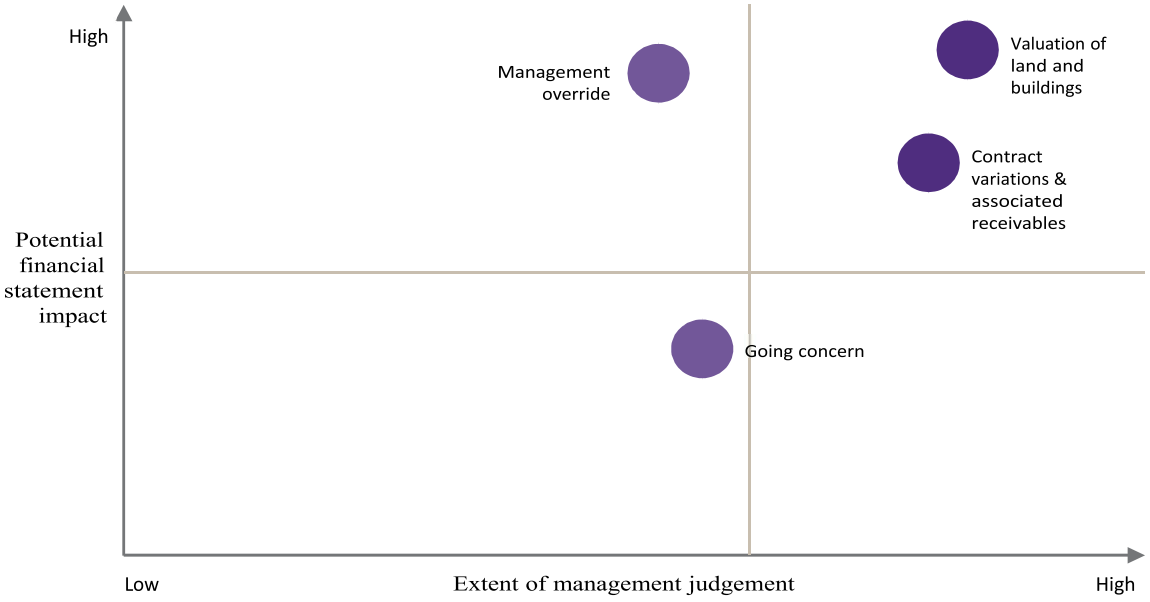
- We have tested all of the Trust's material income streams covering over 99% of the Trust's income, 99% of the Trust's expenditure and the Trust's material assets and liabilities;
- There have been no significant changes in the scope of our audit from the prior year.

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

- We identified one significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources relating to sustainable resource deployment (see Report on other legal and regulatory requirements section).

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter	How the matter was addressed in the audit
Risk 1 - Contract variations & associated receivables Trusts are facing significant external pressure to restrain budget overspends and meet externally set financial targets, coupled with increasing patient demand and cost pressures. The Trust's significant income streams are operating income from patient care activities and other operating income 90.3% of the Trust's income from patient care activities is derived from contracts with NHS commissioners and NHS England. These contracts include the rates for, and level of, patient care activity to be undertaken by the Trust. Any patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement of the completed activity by the Trust's counterparties. The Trust also receives additional patient care and other operating income that is not subject to fixed price contracts There is a risk that income is recognised in the financial statements for these additional services that is not subsequently agreed to by the commissioners. We have therefore identified the occurrence and accuracy of income from patient care and other operating income, excluding those related to block and fixed price contracts, and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: Evaluating the Trust's accounting policies for recognition of income for appropriateness and compliance with the Department of Health and Social Care (DHSC) group accounting manual 2018/19 • Obtaining an understanding of the Trust's system for accounting for income and evaluating the design of the associated controls; and In respect of patient care income: • Using the DHSC mismatch report that details differences in reported income and expenditure and receivables and payables between NHS bodies, investigating unmatched income and receivable balances over £300,000, corroborating the unmatched balances to supporting information; • Agreeing, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from commissioners. In respect of other operating income: • Agreeing, on a sample basis, income and year end receivables to invoices and cash receipts, or other supporting evidence The Trust's accounting policy on income recognition is shown in note 1.4 to the financial statements and related disclosures are included in note 3. **Key observations** We obtained sufficient audit evidence to conclude that: • the Trust's accounting policy for recognition of income complies with the DHSC Group Accounting Manual 2018/19 and has been properly applied; and • patient care income, other operating income and associated receivables are not materially misstated.

Risk 2 - Valuation of land and buildings

The Trust commissioned a desktop valuation of its land and buildings in 2018/19 from an external valuer to ensure that carrying value is not materially different from current value in existing use. This represents a significant estimate by management in the financial statements

In valuing the Trust's estate, management have made the assumption that the Trust's sites, if they needed to be replaced, would be rebuilt to modern conditions on an alternative site.

We therefore identified valuation of land and buildings, including revaluation and impairment, as a significant risk, which was one of the most significant assessed risks of material misstatement.

Our audit work included, but was not restricted to:

- Evaluating management's processes and assumptions for calculation of the estimate, including the instructions issued to the valuation expert and the scope of their work;
- Evaluating the competence, capabilities and objectivity of the valuation expert used by the Trust;
- Enquiring with the valuer about the basis on which the valuations were carried out, challenging key assumptions used by the valuer;
- Challenging the information used by the valuer, including assumptions relating to the Modern Equivalent Asset approach, to assess completeness and consistency with our understanding;
- Testing, on a sample basis, revaluations made during the year to ensure they were recorded accurately in the Trust's asset register; and
- Assessing the overall reasonableness of the valuation movement by reference to general market trends.

The Trust's accounting policy on the revaluations of land and buildings is shown in note 1.7 to the financial statements and related disclosures are included in note 15.

Key observations

We obtained sufficient audit evidence to conclude that:

- the Trust's accounting policy for valuation of land and buildings complies with the DHSC Group Accounting Manual 2018/19 and has been properly applied; and
- the valuation of land and buildings is not materially misstated

Our application of materiality

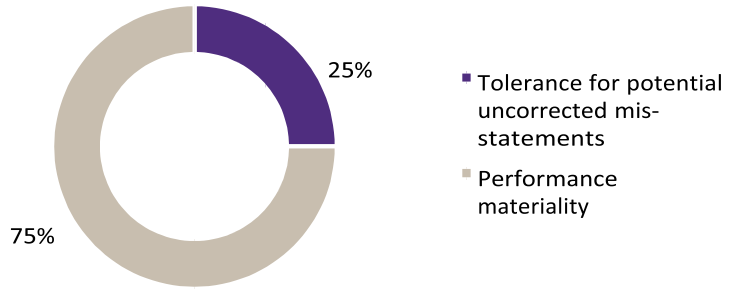
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£5,710,000 which is 1.7% of the Trust's operating expenditure. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is at the same percentage level of operating expenditure as we determined for the year ended 31 March 2018 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Specific materiality	The senior officer remuneration disclosure in the Remuneration Report has been identified as an area requiring specific materiality of £100,000, due to its sensitive nature.
Communication of misstatements to the Audit Committee	£290,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and in particular included:

- an evaluation of the Trust's internal control environment including relevant IT systems and controls over key financial systems;
- obtaining supporting evidence, on a sample basis, for:
    - all of the Trust's material income streams, covering over 99% of the Trust's income;
    - operating expenses, covering over 99% of the Trust's expenditure; and
    - plant, property and equipment and the Trust's other material assets and liabilities.

- there were no changes in the scope of our audit from the prior year.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable **set out on page 107** in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- Audit Committee reporting **set out on pages 79-83** in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2018/19 or is misleading or inconsistent with the information of which we

are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer set out on pages 107 to 108, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2018/19, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of the Trust's services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matters described in the basis for qualified conclusion section of our report we are satisfied that, in all significant respects the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources during the year ended 31 March 2019.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- During the course of 2018/19 the Trust's financial position deteriorated significantly and the Trust incurred a deficit of £6.7 million, compared to a planned surplus of £1.9 million. Due to the deterioration the Trust achieved only £1.5 million of £2.7 million planned Provider Sustainability Fund income. The Trust experienced significant operational pressures and agreed revenues for the year from commissioners fell short of the commissioner revenue levels included in the plan. A joint independent review was commissioned during the year which has identified significant shortfall of funding for some of the Trust's services;
- The Trust achieved savings of £8.5 million in 2018/19, compared to a CIP target of £6.0 million. Of this, only £1.2 million was recurrent;
- For 2019/20, the Trust's forecast outturn is break-even which includes £4.8 million of Provider Sustainability Fund and Financial Recovery Fund income. To receive this income the Trust will need to achieve the £7.6 million of savings included in its financial plan; £6.8 million of these savings are planned for the latter half of the year and are not currently supported by detailed delivery plans.

These matters identify weaknesses in arrangements for setting a sustainable budget within currently available funding, and for identification of recurrent savings plans. They are evidence of weaknesses in proper arrangements for sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks forming part of our qualified conclusion	How the matter was addressed in the audit
Financial position and sustainable resource deployment The original financial plan for the 2018/19 financial year was acknowledged as a highly challenging plan, requiring the Trust to contain the service pressures experienced in 2017/18, deliver £6.0 million of further cost improvement • plans (CIP) savings and achieve £2.6 million of additional income from commissioners. It became clear early in the financial year that the Trust was under considerable pressure to deliver its in year planned deficit of £0.8 million excluding income from the Performance Sustainability Fund (PSF). The Trust reforecast in the second quarter of 2018/19, forecasting a year end deficit of £8.4 million excluding income from the PSF. This increases the risk that the Trust is not able to identify further efficiencies and savings to achieve its financial plan without having an impact on the level of service it is able to deliver.	Our audit work included, but was not restricted to assessing: • the Trust's reforecast and in-year financial performance for the 2018/19 financial year; • the Trust's overall arrangements for achievement of its planned CIPs; • the output of the exercise commissioned by the Trust to benchmark its income against other providers nationally, which has formed part of the Trust's planning negotiations for the 2019/20 year; and • the Trust's plans and assumptions for 2019/20 and beyond with a particular focus on the arrangements in place to achieve planned levels of income and efficiency savings. **Key findings** We have qualified our conclusion in respect of this risk, as set out in the basis of qualified conclusion section of the report.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on

the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Oxford Health NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Iain Murray

Iain Murray, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London
28 May 2019

Oxford Health NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

Oxford Health NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by Oxford Health NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Name ***Stuart Bell***
Job title **Chief Executive**
Date **24 May 2019**

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	282,434	267,141
Other operating income	4	55,473	50,697
Operating expenses	6, 8	(338,419)	(317,187)
Operating surplus/(deficit) from continuing operations		**(513)**	**651**
Finance income	11	154	145
Finance expenses	12	(1,583)	(1,975)
PDC dividends payable		(3,722)	(3,717)
Net finance costs		**(5,151)**	**(5,547)**
Other gains / (losses)	13	-	(14)
Gains / (losses) arising from transfers by absorption	31	-	3,697
Surplus / (deficit) for the year from continuing operations		**(5,663)**	**(1,213)**
Surplus / (deficit) for the year		**(5,663)**	**(1,213)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(900)	(7,939)
Revaluations	16	6,036	4,161
Remeasurements of the net defined benefit pension scheme liability / asset		-	204
Total comprehensive income / (expense) for the period		**(527)**	**(4,788)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(5,663)	(1,213)
Remove net impairments not scoring to the Departmental expenditure limit		(1,172)	5,097
Remove (gains) / losses on transfers by absorption		-	(3,697)
Remove I&E impact of capital grants and donations		89	90
Remove non-cash element of on-SoFP pension costs		91	(142)
Remove 2016/17 post audit STF reallocation (2017/18 only)		-	(419)
Adjusted financial performance surplus / (deficit)		**(6,655)**	**(284)**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	14	2,640	3,133
Property, plant and equipment	15	156,173	150,278
Receivables	18	30	30
Total non-current assets		**158,843**	**153,441**
Current assets			
Inventories	17	3,271	2,533
Receivables	18	24,056	23,037
Non-current assets held for sale / assets in disposal groups	19	9	9
Cash and cash equivalents	20	20,038	19,618
Total current assets		**47,374**	**45,196**
Current liabilities			
Trade and other payables	21	(39,186)	(31,353)
Borrowings	23	(1,836)	(2,224)
Other financial liabilities	22	(254)	(244)
Provisions	24	(1,303)	(1,245)
Other liabilities	22	(4,371)	(3,073)
Total current liabilities		**(46,950)**	**(38,138)**
Total assets less current liabilities		**159,267**	**160,499**
Non-current liabilities			
Trade and other payables	21	-	(801)
Borrowings	23	(21,455)	(23,810)
Provisions	24	(2,795)	(2,863)
Other liabilities	22	(637)	(546)
Total non-current liabilities		**(24,887)**	**(28,020)**
Total assets employed		**134,380**	**132,479**
Financed by			
Public dividend capital		95,226	92,749
Revaluation reserve		27,372	22,706
Income and expenditure reserve		11,783	17,024
Total taxpayers' equity		**134,380**	**132,479**

The notes on pages 9 to 62 form part of these accounts.

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**92,749**	**22,706**	**17,024**	**132,479**
Impact of implementing IFRS 9 on 1 April 2018	-	-	(49)	**(49)**
Surplus/(deficit) for the year	-	-	(5,663)	**(5,663)**
Other transfers between reserves	-	(433)	433	**-**
Impairments	-	(900)	-	**(900)**
Revaluations	-	6,036	-	**6,036**
Transfer to retained earnings on disposal of assets	-	(38)	38	**-**
Public dividend capital received	2,477	-	-	**2,477**
Taxpayers' equity at 31 March 2019	**95,226**	**27,372**	**11,783**	**134,380**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**91,154**	**24,753**	**19,765**	**135,672**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**91,154**	**24,753**	**19,765**	**135,672**
Surplus/(deficit) for the year	-	-	(1,213)	**(1,213)**
Transfers by absorption: transfers between reserves	-	1,716	(1,716)	**-**
Other transfers between reserves	-	(510)	510	**-**
Impairments	-	(7,939)	-	**(7,939)**
Revaluations	-	4,161	-	**4,161**
Transfer to retained earnings on disposal of assets	-	(31)	31	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	204	**204**
Public dividend capital received	1,595	-	-	**1,595**
Other reserve movements	-	556	(556)	**-**
Taxpayers' equity at 31 March 2018	**92,749**	**22,706**	**17,024**	**132,479**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(513)	651
Non-cash income and expense:			
Depreciation and amortisation	6.1	7,575	7,030
Net impairments	7	(1,172)	5,097
Non-cash movements in on-SoFP pension liability		91	(142)
(Increase) / decrease in receivables and other assets		(1,737)	(5,426)
(Increase) / decrease in inventories		(738)	(84)
Increase / (decrease) in payables and other liabilties		8,873	6,709
Increase / (decrease) in provisions		(11)	(2)
Net cash generated from / (used in) operating activities		**12,369**	**13,833**
Cash flows from investing activities			
Interest received		154	145
Purchase of intangible assets		(2,363)	(738)
Purchase of property, plant, equipment and investment property		(4,798)	(3,543)
Sales of property, plant, equipment and investment property		-	1,546
Net cash generated from / (used in) investing activities		**(7,008)**	**(2,591)**
Cash flows from financing activities			
Public dividend capital received		2,477	1,595
Movement on loans from the Department of Health and Social Care		(1,338)	(1,338)
Movement on other loans		(580)	582
Capital element of PFI, LIFT and other service concession payments		(424)	(265)
Interest on loans		(827)	(904)
Interest paid on PFI, LIFT and other service concession obligations		(735)	(1,079)
PDC dividend (paid) / refunded		(3,514)	(4,200)
Net cash generated from / (used in) financing activities		**(4,942)**	**(5,609)**
Increase / (decrease) in cash and cash equivalents		**420**	**5,634**
Cash and cash equivalents at 1 April - brought forward		**19,618**	**13,984**
Cash and cash equivalents at 1 April - restated		**19,618**	**13,984**
Cash and cash equivalents at 31 March	20.1	**20,038**	**19,618**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

After conducting a detailed review, including forecasts over the next 12 months (and projections for 2020/21), the directors have a reasonable expectation that Oxford Health NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. The Trust has agreed/is in the process of agreeing contracts with local commissioners for 2019/20 and services are being commissioned in the same manner in the future as in prior years and there are no discontinued operations.

The 2019/20 financial plan, as agreed by the board of directors, shows a breakeven financial position. This is based on an underlying deficit of £4.7m before PSF/FRF funding of £4.7m. The financial plan for next year also includes a CIP target of £7.6m.

For this reason, the Audit Committee, on behalf of the Board of Directors, resolves to approve the preparation of the accounts on a going concern basis.

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Consideration should be received within the Trust's credit terms once performance obligations have been satisfied. Contract receivable balances are recognised when consideration has not been received.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

Note 1.3.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.3.2 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Income from pharmacy sales is recognised at the point of sale

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies,

allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives."

Note 1.6.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management."

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were carried out at the valuation date of 31 January 2019. Consideration is given to the movement in the valuation between 31 January and 31 March but no adjustments are made where this is not material.

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost (including professional fees), less any impairment loss. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
    - management are committed to a plan to sell the asset
    - an active programme has begun to find a buyer and complete the sale
    - the asset is being actively marketed at a reasonable price
    - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.
Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6.5 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.6.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	1	45
Plant & machinery	5	15
Transport equipment	3	7
Information technology	5	5
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.7 Intangible assets

Note 1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	3	5

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities

Note 1.10.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.10.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are categorised as "fair value through income and expenditure" or loans and receivables.

Financial liabilities are categorised as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. This credit loss will increase further if the credit risk assessed for the financial asset significantly increases.

For financial assets that have become credit impaired since initial recognition, expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.10.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.11.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 24.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in the notes to the accounts where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in the notes, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 Corporation tax

The Trust's activities relate to the provision of goods and services relating to healthcare authorised under Section 14(1) of the HSCA. On this basis the Trust is not liable to corporation tax.

Note 1.17 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.21 Transfers of functions from other NHS or local government bodies

For functions that have been transferred to the trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain or loss corresponding to the net assets or liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS or local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss or gain corresponding to the net assets or liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.22 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

• The Trust's PFI scheme has been assessed as an on Statement of Financial Position PFI under IFRIC 12 because the Trust has judged that it controls the services and the residual interest at the end of the service arrangement.
• The carrying values of property, plant and equipment are reviewed for impairment when there is an indication that the values of the assets might be impaired.
• The Trust determines whether a substantial transfer of risks and rewards has occurred in relation to leased assets, if this is deemed to be the case the lease is treated as a finance lease, all other leases are classified as operating leases.

Note 1.22.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

• Property valuations
Property plant and equipment assets were valued by District Valuer Services as at 31 January 2019. These valuations are based on Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health.

• Estimation of payments for the PFI asset, including finance costs.
The assets and liabilities relating to the PFI scheme have been brought onto the Statement of Financial Position based on estimations from the Department of Health's financial model as required by Department of Health guidance. These estimations were reviewed by external audit as part of the 2008/09 IFRS accounts restatement exercise.

• Estimation of asset lives as the basis for depreciation calculations.
Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets.

• Impairing of receivables.

The majority of the Trust's income comes from contracts with other public sector bodies, hence the Trust has low exposure to credit risk. Following the adoption of IFRS 9 the Trust's exposures as at 31 March 2019 are as disclosed in the trade and other receivables note.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been adopted early in 2018/19.

Note 1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018-19. These standards are still subject to HM Treasury FReM adoption. The government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration. The implementation of IFRS 16 will require a detailed analysis of all lease agreements and is expected to result in a material increase in the value of leases accounted for on the Statement of Financial Position. Aside from IFRS 16, the application of the Standards as revised would not have a material impact on the accounts for 2018/19 were they applied in that year.

- IFRS 16 Leases – Deferred in the public sector until 1st April 2020
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 2 Operating Segments

All of the Trust's activities relate to the provision of healthcare, which is an aggregate of all the individual specialty components included therein. Similarly, the majority of the Trust's income originates with UK Whole-of-Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the provision or support of healthcare activities generally across the Trust together with the related supplies and overheads necessary. The business activities which earn revenue and incur expenses are therefore of one broad combined nature.

The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall foundation Trust Board, which includes non-executive directors. The finance report considered by the Board contains only total balance sheet positions and cash flow forecasts for the Trust as a whole. The Board as chief operating decision maker therefore only considers one segment of healthcare in its decision making process.

The single segment of 'healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities in which the Trust engages and economic environments in which it operates.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
Mental health services		
Cost and volume contract income	3,995	4,440
Block contract income	170,348	160,704
Clinical partnerships providing mandatory services (including S75 agreements)	-	-
Clinical income for the secondary commissioning of mandatory services	5,059	3,475
Other clinical income from mandatory services	1,460	1,795
Ambulance services		
A & E income	-	-
Patient transport services income	-	-
Other income	-	-
Community services		
Community services income from CCGs and NHS England	83,318	81,934
Income from other sources (e.g. local authorities)	14,956	14,666
All services		
Private patient income	96	127
Agenda for Change pay award central funding	3,202	-
Other clinical income	-	-
Total income from activities	**282,434**	**267,141**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	51,254	45,499
Clinical commissioning groups	203,720	196,704
Department of Health and Social Care	3,202	-
Other NHS providers	3,329	3,566
NHS other	1,072	1,015
Local authorities	19,766	19,936
Non-NHS: private patients	91	112
Non-NHS: overseas patients (chargeable to patient)	-	15
Non NHS: other	-	294
Total income from activities	**282,434**	**267,141**
Of which:		
Related to continuing operations	282,434	267,141

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	-	15
Cash payments received in-year	-	15

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	11,064	8,788
Education and training (excluding notional apprenticeship levy income)	12,828	12,157
Non-patient care services to other bodies	3,835	2,518
Provider sustainability / sustainability and transformation fund income (PSF / STF)	1,519	2,274
Other contract income*	26,005	24,704
Other non-contract operating income		
Charitable and other contributions to expenditure	221	256
Total other operating income	**55,473**	**50,697**
Of which:		
Related to continuing operations	55,473	50,697

*Other contract income relates largely to income generated by the Oxford Pharmacy Store for drug sales to other NHS organisations (£23m)

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	3,072

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	-
after one year, not later than five years	-
after five years	-
Total revenue allocated to remainig performance obligations	**-**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	254,974	242,203
Income from services not designated as commissioner requested services	27,460	24,938
Total	**282,434**	**267,141**

Note 6.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,495	2,178
Purchase of healthcare from non-NHS and non-DHSC bodies	8,563	7,135
Staff and executive directors costs	242,053	225,013
Remuneration of non-executive directors	156	168
Supplies and services - clinical (excluding drugs costs)	17,838	14,999
Supplies and services - general	2,265	2,339
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	25,238	23,385
Inventories written down	80	183
Consultancy costs	114	96
Establishment	6,845	5,776
Premises	8,665	7,772
Transport (including patient travel)	3,891	3,548
Depreciation on property, plant and equipment	6,414	6,356
Amortisation on intangible assets	1,161	674
Net impairments	(1,172)	5,097
Movement in credit loss allowance: contract receivables / contract assets	(7)	
Increase/(decrease) in other provisions	359	273
Change in provisions discount rate(s)	-	28
Audit fees payable to the external auditor		
audit services- statutory audit	40	40
other auditor remuneration (external auditor only)	7	7
Internal audit costs	102	95
Clinical negligence	493	430
Legal fees	619	428
Insurance	302	258
Education and training	1,919	1,309
Rentals under operating leases	7,311	6,375
Redundancy	40	383
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	727	598
Car parking & security	141	103
Losses, ex gratia & special payments	26	41
Other services, eg external payroll	584	562
Other	2,152	1,536
Total	**338,419**	**317,187**
Of which:		
Related to continuing operations	338,419	317,187

Note 6.2 Other auditor remuneration

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit-related assurance services	7	7
Total	**7**	**7**

Note 6.3 Limitation on auditor's liability

There is a £2m limitation on auditor's liability for external audit work carried out for the financial years 2018/19 and 2017/18.

Note 7 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(1,172)	5,097
Total net impairments charged to operating surplus / deficit	**(1,172)**	**5,097**
Impairments charged to the revaluation reserve	900	7,939
Total net impairments	**(272)**	**13,036**

In 2018/19 the (£272k) net impairment (£13,036k in 2017/18) arose due to changes in market price. Of the net increase in market price, £900k was charged to the revaluation reserve (£7,939k in 2017/18) and there was a net impairment benefit of £1,172k to comprehensive income (£5,097k charge in £2017/18).

Note 8 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	179,836	166,884
Social security costs	17,047	15,770
Apprenticeship levy	855	789
Employer's contributions to NHS pensions	21,302	20,305
Pension cost - other	77	25
Termination benefits	40	383
Temporary staff (including agency)	24,476	22,483
Total gross staff costs	**243,633**	**226,638**
Recoveries in respect of seconded staff	**(1,128)**	(1,036)
Total staff costs	**242,505**	**225,602**
Of which		
Costs capitalised as part of assets	411	206

Note 8.1 Retirements due to ill-health

During 2018/19 there were no early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £0k (£212k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) **Accounting valuation**
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) **Full actuarial (funding) valuation**
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the

employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Local government superannuation scheme

Buckinghamshire County Council pension scheme

The Trust's obligation in respect of the Buckinghamshire County Council Pension Scheme assets and liabilities is with effect from 1 April 2009, when the staff transferred, and not the period before this date. The net liability applicable is not material to the Trust so the full valuation is not disclosed in these accounts; however the net liability is included in the Statement of Financial Position.

Note 10 Operating leases

Note 10.1 Oxford Health NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Oxford Health NHS Foundation Trust is the lessee.

Operating leases held are simple in nature and relate primarily to buildings

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	7,311	6,375
Total	**7,311**	**6,375**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	6,286	5,582
- later than one year and not later than five years;	3,929	4,163
- later than five years.	883	1,130
Total	**11,098**	**10,875**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	130	54
Interest on other investments / financial assets	-	54
Other finance income	23	36
Total finance income	**154**	**145**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	824	879
Other loans	-	25
Main finance costs on PFI and LIFT schemes obligations	330	608
Contingent finance costs on PFI and LIFT scheme obligations	409	458
Total interest expense	**1,563**	**1,970**
Unwinding of discount on provisions	-	5
Other finance costs	20	-
Total finance costs	**1,583**	**1,975**

Note 13 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Losses on disposal of assets	-	(14)
Total gains / (losses) on disposal of assets	**-**	**(14)**
Total other gains / (losses)	**-**	**(14)**

Note 14.1 Intangible assets - 2018/19

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**4,406**	**4,406**
Additions	668	**668**
Disposals / derecognition	(78)	**(78)**
Valuation / gross cost at 31 March 2019	**4,996**	**4,996**
Amortisation at 1 April 2018 - brought forward	**1,273**	**1,273**
Provided during the year	1,161	**1,161**
Disposals / derecognition	(78)	**(78)**
Amortisation at 31 March 2019	**2,356**	**2,356**
Net book value at 31 March 2019	**2,640**	**2,640**
Net book value at 1 April 2018	**3,133**	**3,133**

Note 14.2 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**2,203**	**2,203**
Prior period adjustments	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**2,203**	**2,203**
Additions	2,433	**2,433**
Disposals / derecognition	(230)	**(230)**
Valuation / gross cost at 31 March 2018	**4,406**	**4,406**
Amortisation at 1 April 2017 - as previously stated	**829**	**829**
Amortisation at 1 April 2017 - restated	**829**	**829**
Provided during the year	674	**674**
Disposals / derecognition	(230)	**(230)**
Amortisation at 31 March 2018	**1,273**	**1,273**
Net book value at 31 March 2018	**3,133**	**3,133**
Net book value at 1 April 2017	**1,374**	**1,374**

Note 15.1 Property, plant and equipment - 2018/19

	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**25,952**	**120,243**	**3,594**	**6,896**	**185**	**5,325**	**8,523**	**170,718**
Additions	-	3,391	1,911	12	-	557	130	**6,001**
Impairments	(300)	(700)	-	-	-	-	-	**(1,000)**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	478	1,036	-	-	-	-	-	**1,514**
Reclassifications	-	257	(3,591)	268	-	967	485	**(1,613)**
Disposals / derecognition	-	-	-	(265)	(45)	-	-	**(310)**
Valuation/gross cost at 31 March 2019	**26,130**	**124,227**	**1,914**	**6,912**	**140**	**6,849**	**9,138**	**175,311**
Accumulated depreciation at 1 April 2018 - brought forward	**0**	**7,790**	**0**	**2,935**	**131**	**3,674**	**5,910**	**20,440**
Provided during the year	-	3,750	-	543	19	1,240	862	**6,414**
Impairments	-	571	-	-	-	-	-	**571**
Reversals of impairments	-	(1,843)	-	-	-	-	-	**(1,843)**
Revaluations	-	(4,522)	-	-	-	-	-	**(4,522)**
Reclassifications	-	(1,613)	-	-	-	-	-	**(1,613)**
Disposals / derecognition	-	-	-	(265)	(45)	-	-	**(310)**
Accumulated depreciation at 31 March 2019	**0**	**4,134**	**0**	**3,213**	**104**	**4,914**	**6,772**	**19,138**
Net book value at 31 March 2019	**26,130**	**120,094**	**1,914**	**3,699**	**35**	**1,935**	**2,365**	**156,173**
Net book value at 1 April 2018	**25,952**	**112,453**	**3,594**	**3,961**	**54**	**1,651**	**2,613**	**150,278**

Note 15.2 Property, plant and equipment - 2017/18

	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**29,978**	**118,671**	**4,150**	**6,676**	**185**	**7,664**	**10,297**	**177,620**

Prior period adjustments	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	**29,978**	**118,671**	**4,150**	**6,676**	**185**	**7,664**	**10,297**	**177,620**
Transfers by absorption	1,760	1,916	-	23	-	-	-	**3,699**
Additions	1	1,196	3,124	28	-	3	110	**4,461**
Impairments	(6,194)	(4,967)	-	-	-	-	-	**(11,161)**
Revaluations	416	660	-	-	-	-	-	**1,076**
Reclassifications	-	2,786	(3,679)	516	-	332	45	**-**
Transfers to / from assets held for sale	(9)	-	-	-	-	-	-	**(9)**
Disposals / derecognition	-	(19)	-	(346)	-	(2,674)	(1,929)	**(4,968)**
Valuation/gross cost at 31 March 2018	**25,952**	**120,243**	**3,594**	**6,896**	**185**	**5,325**	**8,523**	**170,718**
Accumulated depreciation at 1 April 2017 - as previously stated	**0**	**5,249**	**0**	**2,698**	**112**	**5,202**	**6,986**	**20,246**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2017 - restated	**0**	**5,249**	**0**	**2,698**	**112**	**5,202**	**6,986**	**20,246**
Transfers by absorption	-	-	-	2	-	-	-	**2**
Provided during the year	-	3,764	-	581	19	1,146	846	**6,356**
Impairments	-	3,011	-	-	-	-	-	**3,011**
Reversals of impairments	-	(1,136)	-	-	-	-	-	**(1,136)**
Revaluations	-	(3,085)	-	-	-	-	-	**(3,085)**
Disposals / derecognition	-	(13)	-	(346)	-	(2,674)	(1,922)	**(4,955)**
Accumulated depreciation at 31 March 2018	**0**	**7,790**	**0**	**2,935**	**131**	**3,674**	**5,910**	**20,440**
Net book value at 31 March 2018	**25,952**	**112,453**	**3,594**	**3,961**	**54**	**1,651**	**2,613**	**150,278**
Net book value at 1 April 2017	**29,978**	**113,422**	**4,150**	**3,977**	**73**	**2,462**	**3,311**	**157,374**

Note 15.3 Property, plant and equipment financing - 2018/19

	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	26,130	110,609	1,914	3,699	35	1,935	2,365	**146,688**
On-SoFP PFI contracts and other service concession arrangements	-	8,111	-	-	-	-	-	**8,111**
Owned - government granted	-	64	-	-	-	-	-	**64**
Owned - donated	-	1,310	-	-	-	-	-	**1,310**
NBV total at 31 March 2019	**26,130**	**120,094**	**1,914**	**3,699**	**35**	**1,935**	**2,365**	**156,173**

Note 15.4 Property, plant and equipment financing - 2017/18

	Land	Buildings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	25,952	103,249	3,594	3,961	11	1,651	2,613	**141,031**
On-SoFP PFI contracts and other service concession arrangements	-	7,761	-	-	-	-	-	**7,761**
Owned - government granted	-	68	-	-	-	-	-	**68**
Owned - donated	-	1,375	-	-	43	-	-	**1,418**
NBV total at 31 March 2018	**25,952**	**112,453**	**3,594**	**3,961**	**54**	**1,651**	**2,613**	**150,278**

Note 16 Revaluations of property, plant and equipment

Valuations are carried out by the District Valuer (part of the Valuation Office Agency). All work is completed by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last asset valuations were carried out at the valuation date of 31 January 2019. Consideration is given to the movement in the valuation between 31 January 2019 and 31 March 2019 but no adjustments are made where this is not material.

Valuation methodology

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Note 17 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	3,241	2,488
Work In progress	-	-
Consumables	(0)	-
Energy	20	28
Other	9	17
Total inventories	**3,271**	**2,533**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £25,042k (2017/18: £23,175k). Write-down of inventories recognised as expenses for the year were £82k (2017/18: £185k).

Note 18.1 Trade receivables and other receivables

	31 March 2019	31 March 2018
	£000	£000
Current		
Contract receivables*	20,300	
Trade receivables*		14,246
Accrued income*		4,870
Allowance for impaired contract receivables / assets*	(161)	
Allowance for other impaired receivables	-	(121)
Prepayments (non-PFI)	1,771	1,971
PFI prepayments - capital contributions	496	447
PFI lifecycle prepayments	67	81
PDC dividend receivable	285	492
VAT receivable	778	362
Corporation and other taxes receivable	153	22
Other receivables	367	667
Total current trade and other receivables	**24,056**	**23,037**
Non-current		
Other receivables	30	30
Total non-current trade and other receivables	**30**	**30**
Of which receivables from NHS and DHSC group bodies:		
Current	20,552	15,199
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 18.2 Allowances for credit losses - 2018/19

	Total for 2018/19	Contract receivables and contract assets	All other receivables	2017/18
		£000	£000	
Allowances as at 1 Apr 2018 - brought forward	**121**		**121**	**128**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	**49**	170	(121)	
New allowances arising	**90**	90	-	56
Changes in the calculation of existing allowances	**(21)**	(21)	-	
Reversals of allowances (where receivable is collected in-year)	**(76)**	(76)	-	(56)
Utilisation of allowances (where receivable is written off)	**(2)**	(2)	-	(7)
Allowances as at 31 Mar 2019	**161**	**161**	**(0)**	**121**

Note 19 Non-current assets held for sale and assets in disposal groups

	2018/19	2017/18
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**9**	**-**
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**9**	**-**
Assets classified as available for sale in the year	-	9
NBV of non-current assets for sale and assets in disposal groups at 31 March	**9**	**9**

The Asset Held for sale relates to Hill Top Road

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**19,618**	**13,984**
Prior period adjustments	-	-
At 1 April (restated)	**19,618**	**13,984**
Transfers by absorption	-	-
Net change in year	420	5,634
At 31 March	**20,038**	**19,618**
Broken down into:		
Cash at commercial banks and in hand	283	283
Cash with the Government Banking Service	19,755	19,335
Total cash and cash equivalents as in SoFP	**20,038**	**19,618**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**20,038**	**19,618**

Note 20.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Bank balances	264	344
Total third party assets	**264**	**344**

Note 21.1 Trade and other payables

	31 March 2019	31 March 2018
	£000	£000
Current		
Trade payables	6,722	7,534
Capital payables	2,587	2,292
Accruals	25,316	17,208
Social security costs	2,642	2,430
Other taxes payable	1,751	1,716
Accrued interest on loans*		37
Other payables	168	136
Total current trade and other payables	**39,186**	**31,353**
Non-current		
Capital payables	-	801
Total non-current trade and other payables	**-**	**801**
Of which payables from NHS and DHSC group bodies:		
Current	7,187	3,575
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 22 Other financial liabilities

	31 March 2019	31 March 2018
	£000	£000
Current		
Other financial liabilities	254	244
Total	**254**	**244**

Note 22 Other liabilities

	31 March 2019	31 March 2018
	£000	£000
Current		
Deferred income: contract liabilities	4,371	3,073
Total other current liabilities	**4,371**	**3,073**
Non-current		
Net pension scheme liability	637	546
Total other non-current liabilities	**637**	**546**

Note 23 Borrowings

	31 March 2019	31 March 2018
	£000	£000
Current		
Loans from the Department of Health and Scoial Care	1,372	1,338
Other loans	2	582
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	462	304
Total current borrowings	**1,836**	**2,224**
Non-current		
Loans from the Department of Health and Scoial Care	18,737	20,075
Obligations under PFI, LIFT or other service concession contracts	2,718	3,736
Total non-current borrowings	**21,455**	**23,810**

Note 23.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**21,413**	**582**	**4,040**	**26,034**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,338)	(580)	(424)	**(2,342)**
Financing cash flows - payments of interest	(827)	-	(739)	**(1,566)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	37	-	0	**37**
Application of effective interest rate	824	-	330	**1,154**
Other changes	-	-	(27)	**(27)**
Carrying value at 31 March 2019	**20,109**	**2**	**3,180**	**23,291**

Note 24 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2018	**1,191**	**1,150**	**163**	**205**	**1,400**	**4,108**
Arising during the year	62	8	113	38	354	**575**
Utilised during the year	(110)	(59)	(26)	(179)	-	**(373)**
Reversed unused	(62)	(13)	(111)	(26)	-	**(212)**
At 31 March 2019	**1,081**	**1,086**	**138**	**38**	**1,753**	**4,097**
Expected timing of cash flows:						
- not later than one year;	107	59	138	38	960	**1,303**
- later than one year and not later than five years;	427	234	-	-	720	**1,381**
- later than five years.	547	793	(0)	0	73	**1,414**
Total	**1,081**	**1,086**	**138**	**38**	**1,753**	**4,097**

Pension provisions relate to early staff retirements where the Trust is liable. The timing and value of the cash flows are based on known costs and individual demographics.

Injury benefit provisions relate to injury benefit awards where the Trust is liable. The timing and value of the cash flows are based on current costs and individual demographics.

Legal claims relate to outstanding public and employer liability cases. These cases are managed by NHS Resolution on behalf of the Trust.

Other includes dilapidations provisions for the Trust's leasehold premises.

There are no material uncertainties around the timing of these cash flows.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions.

Note 24.1 Clinical negligence liabilities

At 31 March 2019, £1,890k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Oxford Health NHS Foundation Trust (31 March 2018: £1,287k).

Note 25 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	286	2,493
Intangible assets	-	217
Total	**286**	**2,710**

Note 26 Changes in the defined benefit obligation and fair value of plan assets during the year

	2018/19	2017/18
	£000	£000
Present value of the defined benefit obligation at 1 April	**(1,769)**	**(2,183)**
Prior period adjustment		-
Present value of the defined benefit obligation at 1 April - restated	**(1,769)**	**(2,183)**
Transfers by absorption	-	-
Current service cost	(93)	(50)
Interest cost	(82)	(87)
Contribution by plan participants	(9)	(9)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	(64)	147
Benefits paid	26	26
Curtailments and settlements	-	387
Present value of the defined benefit obligation at 31 March	**(1,991)**	**(1,769)**
Plan assets at fair value at 1 April	**1,223**	**1,291**
Plan assets at fair value at 1 April -restated	**1,223**	**1,291**
Interest income	62	62
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets	65	57
- Actuarial gain / (losses)	(1)	-
Contributions by the employer	22	21
Contributions by the plan participants	9	9
Benefits paid	(26)	(26)
Settlements	-	(191)
Plan assets at fair value at 31 March	**1,354**	**1,223**
Plan surplus/(deficit) at 31 March	**(637)**	**(546)**

Note 26.1 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2019	31 March 2018
	£000	£000
Present value of the defined benefit obligation	(1,991)	(1,769)
Plan assets at fair value	1,354	1,223
Net defined benefit (obligation) / asset recognised in the SoFP	**(637)**	**(546)**
Fair value of any reimbursement right	-	-
Net (liability) / asset recognised in the SoFP	**(637)**	**(546)**

Note 26.2 Amounts recognised in the SoCI

	2018/19	2017/18
	£000	£000
Current service cost	(93)	(50)
Interest expense / income	(20)	(25)
Losses on curtailment and settlement	-	196
Total net (charge) / gain recognised in SOCI	**(113)**	**121**

The above pension statement relates to the Local government superannuation scheme

Buckinghamshire County Council pension scheme

The Trust's obligation in respect of the Buckinghamshire County Council Pension Scheme assets and liabilities is with effect from 1 April 2009, when the staff transferred, and not the period before this date. The net liability applicable is not material to the Trust so the full valuation is not disclosed in these accounts; however the net liability is included in the Statement of Financial Position.

Note 27 On-SoFP PFI

Description of the scheme

The Oxford Health PFI scheme provides a centre in Oxford for the secure care of 30 clients with mental health problems and 10 clients with learning disabilities. Many of the clients are offenders who have been referred for treatment through the Courts. The scheme also provides a staff accommodation block. Community Health Facilities (Oxford) Limited have designed, built, financed, maintained and operated the new facility. They are a special purpose company established through three main sponsors:

The Miller Group Limited
Interserve (Facilities Management) Ltd (formerly Building and Property Group Limited)
British Linen Investments Limited

Contract Start Date: 06 September 1999
Contract End Date: 05 September 2049*
* Contract break possible after 25 years, at 05 September 2024. In 2024, the Trust has legal ownership of the asset.

The inflation of the PFI scheme is linked directly to RPI.

The contract involved the lease of Trust land to the operator for nil consideration. The substance of this transaction was that it would result in lower annual payments over the life of the contract, i.e. an implicit reduction in the unitary charge since the operator has not had to lease the land on the open market. Consequently the value of the land is recorded within the Trust's total land value.

Note 27.1 Imputed finance lease obligations

Oxford Health NHS Foundation Trust has the following obligations in respect of the finance lease element of the on-Statement of Financial Position PFI scheme.

The 2018/19 liabilities and commitments are based on an updated PFI accounting model that recalculated the outstanding liabilities at 31st March 2019.

	31 March 2019	31 March 2018
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**4,208**	**6,705**
Of which liabilities are due		
- not later than one year;	753	899
- later than one year and not later than five years;	3,015	4,167

- later than five years.	440	1,639
Finance charges allocated to future periods	(1,028)	(2,665)
Net PFI, LIFT or other service concession arrangement obligation	**3,180**	**4,040**
- not later than one year;	462	304
- later than one year and not later than five years;	2,315	2,401
- later than five years.	403	1,334

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2019	**31 March 2018**
	£000	**£000**
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**13,075**	**15,901**
Of which liabilities are due:		
- not later than one year;	2,213	2,232
- later than one year and not later than five years;	9,417	9,499
- later than five years.	1,445	4,170

Note 27.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19	**2017/18**
	£000	**£000**
Unitary payment payable to service concession operator	**2,159**	**2,148**
Consisting of:		
- Interest charge	330	608
- Repayment of finance lease liability	424	252
- Service element and other charges to operating expenditure	727	543
- Capital lifecycle maintenance	269	287
- Revenue lifecycle maintenance	-	-
- Contingent rent	409	458
- Addition to lifecycle prepayment	-	-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-	55
Total amount paid to service concession operator	**2,159**	**2,203**

Note 28 Financial instruments

Note 28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those organisations are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by regulator review. The borrowings are for 1 – 20 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	20,535	-	-	**20,535**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents at bank and in hand	20,038	-	-	**20,038**
Total at 31 March 2019	**40,573**	**-**	**-**	**40,573**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	20,206	-	-	-	**20,206**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	19,618	-	-	-	**19,618**
Total at 31 March 2018	**39,824**	**-**	**-**	**-**	**39,824**

Note 28.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	20,109	-	**20,109**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	3,180	-	**3,180**
Other borrowings	2	-	**2**
Trade and other payables excluding non financial liabilities	31,622	-	**31,622**
Other financial liabilities	254	-	**254**

Provisions under contract	-	-	-
Total at 31 March 2019	**55,167**	**-**	**55,167**

	Other financial liabilities	**Held at fair value through the I&E**	**Total book value**
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	21,413	-	**21,413**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	4,040	-	**4,040**
Other borrowings	582	-	**582**
Trade and other payables excluding non financial liabilities	25,133	-	**25,133**
Other financial liabilities	244	-	**244**
Provisions under contract	-	-	**-**
Total at 31 March 2018	**51,411**	**-**	**51,411**

Note 28.4 Fair values of financial assets and liabilities

The book value (carrying value) is a reasonable approximation of the fair value

Note 28.5 Maturity of financial liabilities

	31 March 2019	**31 March 2018**
	£000	**£000**
In one year or less	33,712	27,601
In more than one year but not more than two years	1,843	1,770
In more than two years but not more than five years	5,824	5,983
In more than five years	13,788	16,057
Total	**55,167**	**51,411**

Note 29 Losses and special payments

	2018/19		2017/18	
	Total number of cases	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	3	0	3	0
Fruitless payments	229	148	69	13
Bad debts and claims abandoned	1	5	-	-
Stores losses and damage to property	1	0	1	0
Total losses	**234**	**153**	**73**	**13**
Special payments				
Ex-gratia payments	39	27	35	28
Extra-statutory and extra-regulatory payments	1	7	-	-
Total special payments	**40**	**34**	**35**	**28**
Total losses and special payments	**274**	**187**	**108**	**41**
Compensation payments received		-		-

Note 30.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £37k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £49k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £0k.

Note 30.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

IFRS 15 has had no impact for the Trust and revenue is recognised in line with the standards above.

Note 31 Related parties

Oxford Health NHS Foundation Trust is a body corporately established by order of the Secretary of State for Health. The Department of Health and Social Care is regarded as a related party. During the year the Trust had a number of material transactions with the department, and with other entities for which the department is regarded as the parent department. These entities are listed below in order of significance. Oxfordshire CCG, Buckinghamshire CCG and NHS England South Region together account for 84% of the Trusts clinical income:

NHS Oxfordshire CCG
NHS Buckinghamshire CCG
NHS England South Region
Health Education England
Department Of Health
NHS England Hamps, Iow & Thames Valley
Oxford Radcliffe Hospital NHS Foundation Trust
NHS Wiltshire CCG
NHS Bath and North East Somerset
NHS Swindon CCG
NHS Nene CCG
Southampton University Hospitals
Frimley Park Hospital NHS Trust
University Hospital Birmingham
The University Hospital of Leicester
Berkshire Healthcare NHS Trust
NHS Commissioning Board
Buckinghamshire Hospitals NHS Trust
NHS East Berkshire CCG
Royal Berkshire & Battle Hospital

Government bodies outside the Department of Health and Social Care that the Trust has had material transactions with are:

NHS Pension Scheme
HM Revenue and Customs
Oxfordshire County Council
Buckinghamshire County Council
NHS Property Services
Community Health Partnerships
Welsh Health Boards - Cardiff and Vale University Local Health Board

NHS Resolution
Wiltshire County Council

The Trust has also received payments from the Oxfordshire Health Charity, the trustees for which are also members of the Oxford Health NHS Foundation Trust Board. Further details are included in note 32

The Trust manages the Oxford Pharmacy Store, a short line pharmaceutical supplier to other NHS organisations.

The turnover for the year 2018/19 was £23,681K (2017/18 £21,848k)

Stuart Bell, who is the Chief Executive, is Chair of the Picker Institute Ltd and a Trustee of Help for Heroes. Martin Howell, who is the Chairman, is a Governor of Oxford Brookes University and a Governor of Oxford University Hospitals NHS Trust. Ros Alstead who held the role of Director Of Nursing until 7th December 2018 is a Trustee of Young Dementia Homes UK. Alyson Coates who was a Non-Executive Director until 30th September 2018, is a Governor of Oxford Brookes University. Johnathon Asbridge who is a Non-Executive Director is a Clinical Director for Healthcare at Home Ltd. Sue Dopson who is a Non-Executive Director is a Trustee of Society for Studies in Organising Healthcare. Bernard Galton who is a Non-Executive Director is a Director of Bernard Galton Ltd. Chris Hurst who is a Non-Executive Director is a Managing Director of Dorian3d Ltd. Kerry Rogers who is the Director of Corporate Affairs & Company Secretary is a Trustee of Age UK Oxfordshire and a Board member of The Hill. Lucy Weston who is a Non-Executive Director since 1st March 2019 is Chair of Soha Housing, Member of Friends of Larkrise PTA and Governor of Oxford Brookes University

The transactions with bodies outside of Government and the Department of Health, which are considered related parties by virtue of shared director relationships are disclosed below:

	2018/19 £000 Income	**2018/19 £000 Expenditure**	**2017/18 £000 Income**	**2017/18 £000 Expenditure**
Organisation				
Oxford Brookes University	40	161	33	183
Picker Institute Ltd	-	8	-	7
Health Care at Home Ltd	307	-	98	-
Total	**348**	**169**	**131**	**190**

	2018/19 £000 Receivables	**2018/19 £000 Payables**	**2017/18 £000 Receivables**	**2017/18 £000 Payables**
Organisation				

Oxford Brookes University	2	59	-	-
Health Care at Home Ltd	44	-	5	-
Total	**46**	**59**	**5**	**-**

Note 32 NHS Charity

Oxford Health Charity, registered in the UK, is not consolidated within the Oxford Health NHS Foundation Trust accounts. The summary results and financial position for Oxford Health Charity (Charity Registration Number 1057285) are as follows:

Statement of Financial Activities

	2018/19	2017/18
	£000	£000
Total Incoming Resources	324	301
Resources Expended with Oxford Health NHS Foundation Trust	(277)	(265)
Other Resources Expended	(70)	(137)
Total Resources Expended	(347)	(402)
Net (outgoing) resources	(23)	(101)
Gains on revaluation and disposal	31	15
Net movement in funds	**8**	**(86)**

Balance Sheet

	31 March 2019	31 March 2018
	£000	£000
Investments	979	1,076
Cash	529	363
Other Current Assets		16
Current Liabilities	(171)	(126)
Net assets	**1,337**	**1,329**
Restricted / Endowment funds	372	369
Unrestricted funds	965	960
Total Charitable Funds	**1,337**	**1,329**

The 2018/19 Statement of Financial Activities and Balance Sheet are based on unaudited accounts of the Charity.

Note 33 Pooled Budgets

Note 33.1 Oxfordshire County Council Pooled Budgets

Oxford Health NHS Foundation Trust has a pooled budget arrangement with Oxfordshire County Council Oxford Health NHS Foundation Trust is the host. These are treated as agency transactions, and only Oxford Health's proportion is recognised in the Trust's accounts.

Oxfordshire Adults of Working Age and Older Adults Pooled Budget Performance 2018/19

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	6,890	8,299	-1,409
OCC	2,047	2,135	-88
OCC contribution to Trust overheads	0	0	0
Total Pooled Budget	**8,938**	**10,434**	**-1,497**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	OCC Contribution
	£000	£000	£000
Pay Expenditure	10,027	8,042	1,985
Non-Pay Expenditure	481	330	150
Income	-73	-73	0
Contribution to Overheads	0	0	0
	10,434	**8,299**	**2,135**

Note 33.2 Buckinghamshire County Council Pooled Budgets

Oxford Health NHS Foundation Trust has two pooled budget arrangements with Buckinghamshire County Council. Oxford Health NHS Foundation Trust is the host. These are treated as agency transactions and only Oxford Health's proportion is recognised in the Trust's accounts.

Buckinghamshire Adults of Working Age Pooled Budget Performance 2018/19

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	5,263	5,500	238
BCC	2,628	2,751	123
Total Delegated Budget	7,891	8,251	361
BCC contribution to Trust overheads	99	99	-
Total Pooled Budget	**7,990**	**8,351**	**361**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	BCC Contribution
	£000	£000	£000
Pay Expenditure	7,820	5,299	2,521
Non-Pay Expenditure	489	239	250
Income	(57)	(38)	(19)
Contribution to Overheads	99	-	99
	8,351	**5,500**	**2,850**

Buckinghamshire Older Adults Pooled Budget Performance 2018/19

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	2,269	2,096	(173)
BCC	852	784	(68)
Total Delegated Budget	**3,121**	**2,880**	**(241)**
BCC contribution to Trust overheads	41	41	-
Total Pooled Budget	**3,163**	**2,921**	**(241)**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	BCC Contribution
	£000	£000	£000

Pay Expenditure	2,730	2,014	716
Non-Pay Expenditure	151	83	68
Income	(1)	(1)	(0)
Contribution to Overheads	41	-	41
	2,921	**2,096**	**826**

Staff costs

	Permanent	Other	2018/19 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	160,958	18,878	**179,836**	166,884
Social security costs	17,047	-	**17,047**	15,770
Apprenticeship levy	855	-	**855**	789
Employer's contributions to NHS pensions	21,302	-	**21,302**	20,305
Pension cost - other	77	-	**77**	25
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	40	-	**40**	383
Temporary staff	-	24,476	**24,476**	22,483
Total gross staff costs	**200,279**	**43,354**	**243,633**	**226,638**
Recoveries in respect of seconded staff	(1,128)	-	**(1,128)**	(1,036)
Total staff costs	**199,150**	**43,354**	**242,505**	**225,602**
Of which				
Costs capitalised as part of assets	411	-	**411**	206

Average number of employees (WTE basis)

	Permanent	Other	2018/19 Total	2017/18 Total
	Number	Number	Number	Number
Medical and dental	210	36	**246**	286
Ambulance staff	-	-	**-**	-
Administration and estates	1,023	81	**1,104**	1,034
Healthcare assistants and other support staff	885	202	**1,087**	992
Nursing, midwifery and health visiting staff	1,264	266	**1,530**	1,566
Nursing, midwifery and health visiting learners	70	-	**70**	62
Scientific, therapeutic and technical staff	1,005	44	**1,049**	1,005
Healthcare science staff	-	-	**-**	-
Social care staff	70	-	**70**	38
Other	-	-	**-**	-
Total average numbers	**4,527**	**629**	**5,156**	**4,983**
Of which:				
Number of employees (WTE) engaged on capital projects	-	-	**-**	4

Reporting of compensation schemes - exit packages 2018/19

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	8	**8**
£10,000 - £25,000	1	1	**2**
£25,001 - 50,000	-	1	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**2**	**10**	**12**
Total cost (£)	£182,000	£80,000	**£262,000**

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	15	**15**
£10,000 - £25,000	-	3	**3**
£25,001 - 50,000	1	2	**3**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**2**	**20**	**22**
Total cost (£)	£146,000	£146,000	**£292,000**

Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000

Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	2	57	3	88
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	7	16	17	58
Exit payments following Employment Tribunals or court orders	1	7	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**10**	**80**	**20**	**146**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-