NHS

Oxleas

NHS Foundation Trust

Annual Report and Accounts

2018/2019

Improving lives

oxleas.nhs.uk

Oxleas
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

Contents

Annual Members Meeting and Quality Improvement Showcase

Overview

The purpose of this Performance Overview is to give you a short summary of the history and purpose of Oxleas NHS Foundation, the activities we undertake and how we organise ourselves. Our Chair and Chief Executive will share their views on the trust performance over the last year and the key risks and issues we face.

An introduction to Oxleas NHS Foundation Trust

Oxleas NHS Foundation Trust is a statutory body which became a foundation trust (public benefit corporation) in May 2006. We are part of the NHS, are registered with the Care Quality Commission and have been rated by the commission as Good.

We offer a wide range of health and social care services to people living in south east London and parts of Kent. This includes community health care such as district nursing and health visiting, care for people with learning disabilities and mental health care such as psychiatry, nursing and therapies. Our multidisciplinary teams look after people of all ages and we work in partnership with other parts of the NHS, local councils and the voluntary sector.

Our nearly 3,800 members of staff work in many different settings such as hospitals, clinics, prisons, children's centres, schools and people's homes. We manage hospital sites including Queen Mary's Hospital, Sidcup and Memorial Hospital in Woolwich as well as the Bracton Centre, our medium secure unit for people with mental health needs.

We are organised in six directorates:

- Adult Learning Disabilities
- Bexley Care
- Bromley Mental Health Services
- Children and Young People's Services
- Greenwich Adult Services
- Forensic and Prison Services

At Oxleas, we have six core values which underpin how our staff and volunteers work together to care for our patients. These values are: having a user focus, excellence, learning, being responsive, partnership and safety. Our aim is to improve lives by providing the best quality health and social care for our patients and carers.

Our trust headquarters is based at:

Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG

Tel: 01322 625700
www.oxleas.nhs.uk

Overview

Performance overview from Chair and Chief Executive

This report enables us to share with you how we have made improvements and developed our services over the past year while updating you on how we have performed against national and local standards and in delivering against our plans for 2018/19. We will share a summary with you on how we have put our strategic priorities for the year into action:

- Improving quality,
- Supporting our workforce,
- Maintaining a sustainable organisation
- Working in partnership

More detail is provided in the performance analysis section.

Improving Quality

"The trust had a committed leadership team with strong values and integrity and had delivered consistently high-quality patient care across the services we inspected. Leaders had a good understanding of services, and were visible and approachable," was one of the findings of the Care Quality Commission when their inspection team visited us. The commission carried out a thorough inspection of our services during 2018/19 visiting six of our service lines and undertaking a well led review. They published their report in March 2019 giving Oxleas an overall rating of Good and rating some of our services as outstanding for caring and effectiveness.

We provide care to more than 29,000 people each month and the aim of that care is to improve the lives of the people who use our services and their carers. We ask for feedback on the care we provide and whether it has made a difference. Over the past year, we had more than 25,000 responses to patient experience surveys. This shows us that 97% found that the service was helpful and 92% would recommend Oxleas to their friends and family.

Our Quality Improvement (Qi) programme really took off during 2018/19 with colleagues across Oxleas taking part in training, Qi projects and putting learning from those projects into practice. We showcased the first set of projects at our Annual Members' Meeting in September and the programme continues to go from strength to strength. Alongside improving the quality of our existing services, we are also proud that we have developed new services in the past year to meet the needs of local people better. These include a new specialist perinatal mental health service for women in Bexley, Bromley and Greenwich and a greater focus on services for armed forces veterans. We have also trained more than 60 Lived Experience Practitioners and introduced these individuals, who combine skills and knowledge as a staff member and a service user, into several of our teams.

You can read more about our work to improve the quality of our services in the Quality Report.

Supporting our workforce

During the year, we have had a strong focus on supporting colleagues to deliver the best care possible. Ensuring we have sufficient and engaged staff are key ways of responding to risks around safe staffing and staff morale. We have worked hard to reduce staff vacancies and improve retention. This has resulted in a significant

Overview

reduction in the use of agency staff and vacancies across the organisation. We are part of the NHS Improvement programme to reduce clinical staff turnover and over the past year, our turnover has reduced significantly and is now below average compared to similar organisations.

We have continued our Let's Talk programme to promote engagement between our staff and our senior management team and have worked with colleagues to implement ways to tackle violence and abuse against staff. Our staff networks continue to thrive and our staff survey results show that engagement across the organisation continues to be high. We have also paid attention to staff safety through ensuring effective systems to protect staff when working alone are in place and making sure we learn from incidents. In December 2018, legal action against the trust by the Health and Safety Executive was concluded following an incident at the Bracton Centre in 2016. The trust was fined £300,000 but no systemic health and safety issues at Oxleas were found.

In June 2018, we celebrated the NHS' 70th birthday by recognising the dedication of more than 200 members of staff at our Long Service Awards. Outstanding work and achievements were also celebrated at our annual Recognition Awards where teams and individuals from all directorates received awards.

You can read more about our workforce and how we are performing in this area in the Staff Report from page 128.

Working efficiently

During the year, we faced risks to achieving our objectives through high demand on our services and our ability to deliver savings. We aim to make our services as efficient as possible and work collaboratively with staff and partners to identify savings. Using our in-patient beds as effectively as possible and reducing use of agency staff has helped us to deliver our services within budget. At the end of the 18/19 year, we reported a £5.9m surplus. Details of our performance and key financial indicators are included in the financial performance analysis from page 16.

Working in partnership

The South London Mental Health and Community Partnership, our three-way collaboration with South London and Maudsley NHS Foundation Trust and South West London and St Georges NHS Trust, continues to flourish. Over the past year, joint working in specialist mental health services for children has resulted in better access to local specialist care and better use of resources.

Work continues as part of the South East London Sustainability and Transformation Partnership where we are collaborating with partner organisations to create local care networks.

We have also developed our partnership working with local armed forces and this year were given the Bronze Award in the Defence Employer Recognition Scheme.

To help us put these priorities into action, we use a Board Assurance Framework to identify key risks and implement plans to mitigate these risks. During 2018/19, the key risks to which we were exposed were:

- Insufficient staff recruitment and retention

Overview

- Staff experiencing violence and aggression from service users, carers or members of the public
- Not completing actions from serious incidents in a timely way
- Inaccurate or late data
- The impact of legal action taken by the Health and Safety Executive
- High demand on in-patient beds
- Inability to achieve savings
- Not complying with General Data Protection Regulations
- Lone working arrangements for staff

Our Board Assurance Framework is discussed at every board meeting and is reviewed by sub-committees to ensure that controls and assurances are sufficient and that mitigation plans are being implemented and are taking effect. Further details of our major risks and how they are mitigated are described in the Annual Governance Statement.

Going concern assessment

Oxleas NHS Foundation Trust has prepared the 2018/19 accounts on a going concern basis. After making enquiries, the directors have a reasonable expectation that Oxleas has adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing the accounts. The annual report provides a fair and balanced review of our performance and our strategic developments.

Our Board continued to develop during the year with Matthew Trainer joining as Chief Executive in October 2018 and Nina Hingorani-Crain becoming a Non-Executive Director in November when James Kellock's term of office came to an end. Helen Smith will retire as Deputy Chief Executive in June 2019 when Iain Dimond will take on the role of Chief Operating Officer. Our thanks go to Helen and James for their dedication to Oxleas and our patients.

We are looking forward to the coming year and, in particular, to working with colleagues and partners across the whole organisation to develop the organisation's strategy for the next five years. This is an exciting opportunity to plan how Oxleas will be at the centre of local health services as they develop and adopt new approaches and technologies to meet the changing needs of local people.

On behalf of the Board of Directors, we would like to thank colleagues across the whole organisation for their dedication in 'Improving Lives' for our patients and their families.

Signed by:

Andrew Trotter
Chair
24 May 2019

Matthew Trainer
Chief Executive
24 May 2019

Performance Analysis

To ensure we maintain our performance to enable us to achieve our vision of improving lives, we review key indicators measuring the quality of the services we deliver, the status of our workforce and our financial health at board meetings and board sub-committee meetings. This is presented in an integrated board report using information from a variety of sources including our electronic patient information system RiO, our learning support system and national measures such as the Friends and Family Test. We carry out internal audits to ensure the validity of our information and several measures are audited externally. Each area is assigned to a board sub-committee who review performance, develop mitigation plans as needed and review targets as necessary.

Our key performance indicators are one of the ways we monitor progress of actions to mitigate against our significant risks which are discussed at each board meeting using our board assurance framework. For example, some of our major risks related to the recruitment and retention of staff. Our key performance indicators on vacancies, staff turnover and staff sickness help the Board of Directors and the Workforce Committee to judge how we are managing this risk and the uncertainties that arise in supporting a complex and diverse workforce.

This section of the report analyses our performance in achieving our objectives for 2018/19 and outlines plans for the coming year.

Delivery of the 2018/19 annual plan

During 2018/19, although we have faced financial pressure, performance at Oxleas has been strong and we have made progress across all our priorities.

1. Enhancing quality

Approach to quality improvement, leadership and governance

Enhancing quality by ensuring excellence for every patient is our first strategic priority and our values underpin our commitment to improve the lives of those who need our services.

We have an established quality governance framework which underpins the quality performance processes of:

- Ensuring required standards are achieved
- Investigating and taking action on sub-standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care

Oversight of our framework is through two board sub-committees: The Performance and Quality Assurance Committee and the Quality Improvement and Innovation Committee.

The Performance and Quality Assurance Committee (PQAC) is chaired by a Non-Executive Director and has a key role to define, monitor and drive the quality priorities for the trust. Our performance is monitored across our six quality objectives which fall under the quality domains of patient safety, patient experience and clinical effectiveness. The PQAC triangulates the key quality indicators on the trust and directorate integrated performance dashboard and provides the necessary quality assurance governance for the Board of Directors.

Performance Analysis

In addition to our assurance framework, we have a programme of board visits. This enables board members to visit as least one team a month to learn more about services and speak with patients, carers and staff about their experiences. Feedback from these visits is reported to the Board of Directors at every meeting and actions agreed in response to any issues raised.

Maintaining a Good CQC rating

Our services were re- inspected by the Care Quality Commission (CQC) between 21 November 2018 and 11 January 2019; six core services were visited and a well led inspection also took place. We have maintained our overall 'Good' rating. In their report, the CQC acknowledged our focus on improving quality and found several areas of outstanding practice. The CQC also identified three areas where we must take action:

- In our acute wards for adults of working age and psychiatric intensive care units we must make sure staff consistently carry out physical health checks on patients after they receive rapid tranquilisation in line with trust policy.
- In our community based mental health services for older people we must ensure medicines management is safe and effective.
- In our wards for older people with mental health problems we must ensure that staff complete checks on equipment effectively.

We have responded to this and are also using the feedback from the inspection to improve our services further.

Quality Improvement Programme

We have a vision of creating a culture of continuous quality improvement across the whole organisation. In order to achieve this, we have put in place a systematic Quality Improvement (Qi) Programme that is underpinned by the improvement techniques, systems and practices and Improvement Science. The Oxleas Qi programme was officially launched in April 2018 and aims to:

- Improve access to care at the right location and in a timely manner (and therefore reduce delays)
- Improve reliable adoption of evidence-based care such as personalising care planning and implementing guidance from the National Institute of Health and Care Excellence
- Reduce delays and eliminate inefficiencies and therefore costs attributable to re-work, repeated assessments, repeated checks and addressing concerns and complaints
- Improve patient and carer experience and eliminate harm

In order to make Qi successful in Oxleas and to create a culture of continuous quality improvement and ensure improvement is everyone's business, we have put in place a clear learning/training strategy for Qi. We want a culture whereby Oxleas staff become empowered to focus on where they can make improvements to the work they do: no matter if it be in clinical care or corporate services. Based on this, we have put in place a range of training/awareness options that will cover the whole trust. We expect our Qi programme to help deliver:

- Local teams engaged in locally led and owned improvement processes
- Consistent delivery of our quality priorities and improved outcomes across the organisation

Performance Analysis

- High staff engagement, a valued workforce, joy at work with improved recruitment and retention
- Developed data systems that effectively capture data to drive decision making at clinical and managerial levels
- Improved patient engagement and education
- Reduction in waste across the organisation

During the year, we trained 491members of staff and completed 71 projects. We have shared learning via events both within and outside the organisation.

Quality Plans

During 2018/19, we had six quality objectives.

Objective	Description
1	Ensure we meet our patient promise
2	Ensure we involve families, carers and people important to our patients
3	Ensure we involve patients in planning their care and they have a care plan that is personal to them
4	Ensure we put the safety of our patients first
5	Ensure we provide care in line with national best practice and guidelines
6	Ensure we routinely measure clinical outcomes so that we know that our care makes a difference to patients

We had 19 quality goals across these six objectives and achieved 16 of these completely, achieved one mostly and did not achieve two. More details are provided in the Quality Report.

Performance Analysis

2. Maintaining a skilled and engaged workforce

Recognising the difficulties NHS organisations face recruiting and retaining staff, we have continued to improve our approaches to recruitment although there continue to be roles and services where we need to make further progress. We have introduced new ways to engage with staff members. Our vacancy rate has been improving overall and our use of agency staff has significantly reduced this year to an optimum level and one we will endeavour to maintain.

Our vacancies declined significantly in all staff groups with levels in some clinical staff groups dropping below 3%. Our retention programme has helped us focus on developing a range of work streams that we believe will have a material impact over time in reducing turnover, sickness and temporary staffing spend, as well as improving staff engagement.

The table below sets out some of the key highlights of the work:

Recruitment
• Delivered sustained recruitment campaigns to reduce vacancies from 13% to 8.9% at end of March 2019
• Simplified and streamlined processes and systems • Improved the pace of our recruitment processes
• Successfully capitalised on opportunities through Health Education England to appoint to 100 nursing associates across our South London Mental Health and Community Partnership accessing available apprenticeship pathways
• Reduced the volume of agency spend to 4.2% of overall pay spend remaining well within the NHS Improvement thresholds, and replaced it with increased recruitment to bank and substantive roles
Retention
• As part of the retention programme, initially commenced with support from NHS Improvement, we are working to deliver a range of initiatives to retain and increase the stability of our workforce.

Performance Analysis

- Reviewed our employment 'offer' to our employees
- Launched a health, well-being and benefits portal providing a range of non-pay benefits and support systems recognising and rewarding our staff.

- Launched a series of pulse surveys and in-person feedback mechanisms to improve understanding of why staff choose to stay or leave us, using this intelligence to channel our efforts

- Considered perceptions reported in the staff survey about growing concerns regarding violence and aggression towards staff and launched Quality Improvement programmes to reduce incidents alongside new standardised staff support mechanisms and improved liaison with the police

- Developed rotation programmes with South London Partnership that will provide enhanced career development opportunities
- Reviewed personal development review and supervision processes to support career development and staff engagement

- Improved our preceptorship programme for nurses, and launched new preceptorship models for allied health professionals and therapists
- Launched an internal transfer programme for nurses, with a view to expanding it to the wider clinical workforce

- Used feedback from our staff to maximise the potential for flexible working and variable patterns by implementing longer day working in inpatient areas allowing staff to balance their work and home lives.

- Significant progress on our work to improve the productivity of our workforce with the development of agreed job plans across community-based clinical staff groups

Leadership

- Our leaders are the most powerful influence on our culture. Our revised Leadership Programme is scheduled to launch in April 2019 and is aimed at supporting our leaders across all staff groups and all levels to create environments that will foster engagement and sustain improvement.

Performance Analysis

3. Maintaining a sustainable organisation

We have had a consistent focus on using our resources efficiently and effectively and, at the end of the financial year, achieved our control total. Our 2018/19 plan assumed we would deliver a surplus £2.96m, this was on the basis that we could fully meet the in-year recurrent efficiency challenge of £9.84m and realise a profit on asset sales of £0.77m. In agreeing this plan, the Board of Directors was able to accept NHS Improvement's control total of a £2.96m surplus and was therefore eligible for £2.09m of provider sustainability funding. The latter being 100% linked to the delivery of the financial plan.

The performance for 2018/19 is set out to the right:

Introduction

Our accounts have been prepared accordance with the accounting requirements of the 2018/19 NHS Foundation Trust Annual Reporting Manual agreed with HM Treasury and issued by the NHS Improvement, our regulator. Any changes in the reporting manual have not had a material impact on the accounting policies of the trust and these have therefore, remained largely unchanged. Our Group surplus of £5.8m includes a £0.1m deficit in relation to Oxleas Prison Services Limited (OPS - our wholly owned subsidiary) and £0.1m net expenditure on the Oxleas Charitable Fund.

Overview

This section sets out the financial performance in relation to the 'Trust Only' position (excluding both Oxleas Prison services (wholly owned subsidiary) and Charitable Funds) for the year ended 31 March 2019, which is measured by the Finance and Use of Resources metrics. The 'Finance and Use of Resources' is one of the five themes in the Single Oversight Framework (SOF) and is used by NHS Improvement to determine the overall segmentation of NHS trusts and compare financial performance between NHS trusts. This theme is underpinned by five equally weighted metrics and the table below sets out our performance against each of these. This rating reflects the nature of financial support required, with 4 reflecting the highest level of financial risk (the 'worst') and 1 reflecting the lowest risk (the 'best'). We achieved a rating of 1.

Performance Analysis

Area	Metric		At 31 March 2019	Score
Financial sustainability	Capital Servicing Capacity Rating (times)	**Actual**	3.1	1
		Plan	2.2	2
	Liquidity Rating (days)	**Actual**	36	1
		Plan	27	1
Financial efficiency	I&E Margin (%)	**Actual**	2.2%	1
		Plan	1.2%	1
Financial controls	Distance from Financial Plan (%)	**Actual**	1.0%	1
		Plan	0.0%	1
	Agency Spend (%)	**Actual**	-25.2%	1
		Plan	0.0%	1
Rating March 19		**Actual**		1
		Plan		1

2018/19 has been a challenging year financially for both Oxleas and the wider NHS. This was set against a backdrop of rising inflation; increases in our income of just 0.1% in line with the national tariff inflator; and the need to deliver £9.8m of savings. This led us to look carefully at everything we do; take actions to minimise overspends; develop savings schemes to deliver the savings target; further reduce reliance on our estate by delivering care in a more agile and digitally enabled way; and work with other partner organisations to maximise value.

At the start of the year, we planned to deliver a £3.0m surplus, in line with the Control Total agreed with NHS Improvement. Compared to this target, a £5.9m surplus was achieved, representing an improvement of £2.9m against the original plan. Having delivered and marginally exceeded the control total, the trust was allocated additional Provider Sustainability Funding including incentive and bonus funding totalling £4.9m which reflects the trust's positive financial performance. The control total is calculated before exceptional items i.e. impairments arising from the revaluation of our land and buildings. We make an annual assessment of the valuation of our assets and commissioned an independent external specialist to undertake this review. The impact of the valuation exercise can result in an impairment or a revaluation gain; this has been accounted for accordingly in the accounts. £0.05m was required to be recorded in the Statement of Comprehensive Income as expenditure, with an associated £8.5m net increase in the balances held in the revaluation reserve. When these are taken into account, the total surplus for the year remained at £5.9m.

Performance Analysis

The table below sets out the actual income and expenditure performance as at the 31st March 2019, including comparative information for 2017/18 and tracks this against the trust Control Total:

Statement of Comprehensive Income	2018/19 £m	2017/18 £m
Income	269.1	255.6
Expenditure	(260.2)	(247.4)
Net Gains On Disposals	0.8	1.4
Net Finance Expense	0.4	0.1
Finance Expense	(1.1)	(1.1)
PDC Dividend	(3.1)	(3.9)
Revaluation Gains / (Losses) and Impairment Losses	(0.1)	(12.6)
Surplus For the Year	**5.9**	**(7.9)**

Performance Analysis

Performance Against Control Total	2018/19 £m	2017/18 £m
Surplus For the Year	5.9	(7.9)
Less PSF	(4.9)	(3.0)
Plus Impairments	0.1	12.6
Surplus	**1.0**	**1.7**
Add back		
Core PSF	2.1	1.5
Incentive PSF (Finance)	1.0	0.0
Incentive PSF (General Distribution)	1.0	0.5
Incentive PSF (Bonus)	0.8	1.0
Total Surplus	**5.9**	**4.7**
Control Total	3.0	3.1
Performance Against Control Total	**3.0**	**1.5**

The above includes a number of in-year cost pressures, the most significant of which were: continued reliance on staff over and above funded establishments to manage higher levels of acuity and observations on our wards; ongoing usage of additional mental health beds when capacity was not available within the trust; and slippage in savings schemes. However, through a concerted effort that included the realisation of some of our ambitious savings plans; extra income arising from additional cost and volume activity; significant reduction in the usage of agency staff (25.2% below the NHS Improvement threshold); further non-recurrent actions; and benefits arising from technical accounting adjustments, we were well placed to mitigate these pressures and delivered the improved position against plan.

Our partnership working means the role of the trust is far wider than that which is reflected in the financial statements. In 2018/19, we along with our partner organisations in the South London Mental Health and Community Partnership have continued to embed the New Models of Care programmes, investing a significant share of the savings generated to both develop new care

Performance Analysis

pathways and support improvements in patient care that would otherwise have not been possible. The total value of resources now being managed by the partnership equate to circa £63m with savings of £5.7m generated to date. Of this, only circa £20.8m is included in the financial statements of the trust.

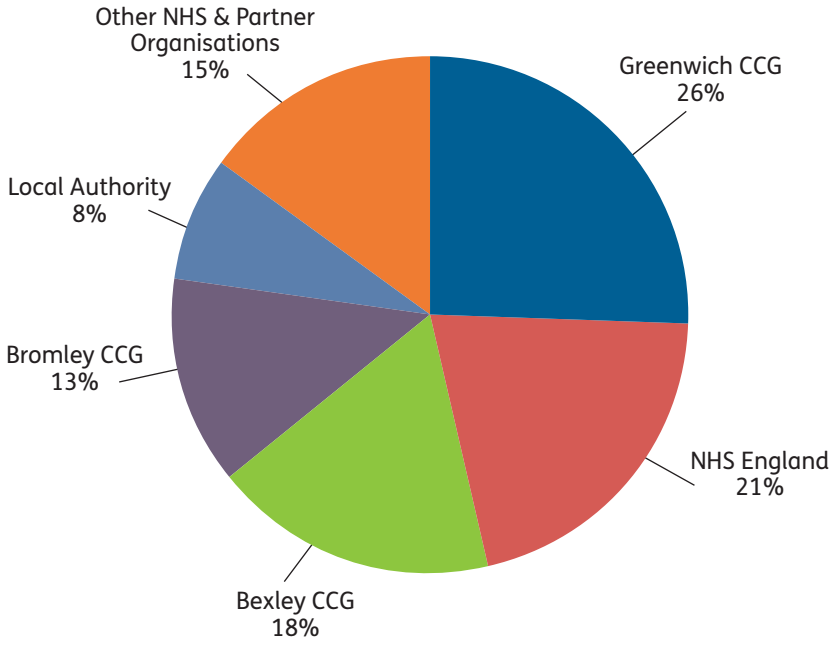
Income

We can confirm that for 2018/19, in accordance with Section 43(2A) of the NHS Act 2006, the income from the provision of goods and services for the purposes of the health service in England was greater than the income from the provision of goods and services for any other purposes. The work required to receive the non-health care income has had no adverse impact on the provision of goods and services for the purposes of the health care.

Our total income amounted to £271.1m for 2018/19 (2017/18 £257.4m). The majority of this was generated from block contracts with NHS England, local Clinical Commissioning Groups and Local Authorities for the provision of clinical services. There are a number of other income sources and these include: education and training income which supports the costs of training doctors, nurses and other healthcare professionals and in doing so supports the quality of care provided at the trust; rental income; non-contracted activity; and a small sum for research and development.

The availability of Mental Health Investment Standards funding (for the first time) provided the us with the opportunity to transform our mental health crisis pathway by expanding our home treatment teams to a 24/7 model as well as embed the provision of a Crisis Line (previously funded from winter pressure monies).

2018/19 Income

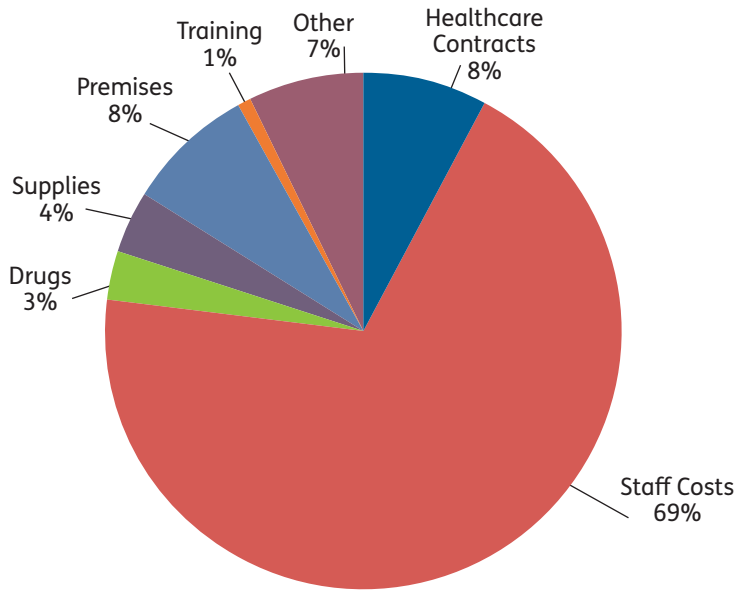


Performance Analysis

Expenditure

Our total expenditure for 2018/19 was £262.2m with staff costs accounting for 69% of this spend. To achieve our planned operational surplus we needed to deliver £9.8m of savings and efficiencies during the year. Schemes to deliver the level of savings required were developed across all service and corporate directorates and these were monitored throughout the year with formal reports to the Executive, Business Committee and the Board. The plans covered a range of themes including service redesign and productivity, rationalisation of the estate in line with our Estates Strategy, continued deployment of new technologies and other mobile working initiatives, re-procurement of non-pay goods and services and a reduction in corporate resources. £7.9m full year effect plans were identified (with an in-year impact of £5.0m), with the balance managed through a number of agreed non-recurrent actions.

18/19 Expenditure



Performance Analysis

Cash

We began the financial year with £60.5m of cash and cash equivalents and closed our accounts on 31 March 2018 with a healthy cash balance of £66.0m. The majority of our cash balance results from surpluses achieved in previous years and the increase reflects the concerted efforts in year to reduce outstanding debts; the award of new funds in relation to the trust attaining Global Digital Fast Follower status; central funding for other digital initiatives. Our cash holdings ensure we do not encounter difficulties in paying our staff and creditors and can afford the funding required to deliver our future capital programme (including completion of the re-development of Queen Mary's Hospital, Sidcup) of circa £48m over the next three years.

Capital Spend Summary	Actual £'000
QMH Redevelopment	5,745
Health & Safety	503
Environmental Sustainability	329
Childrens Services Developments	1,030
IT-infrastructure	1,402
Clinical Transformation	513
Informatics	959
Small Projects	971
Total	**11,453**

Capital Investment Programme

We delivered a sizeable capital programme of £11.4m during 2018/19.The table above provides a summary of the main themes of the capital spend during the year.

Better payment practice code and our compliance

We continue to monitor our performance against the Better Payment Practice Code that requires payment of all trade creditor invoices within 30 days of receipt of a valid invoice (unless other

Performance Analysis

terms have been specifically agreed with the supplier). The target set is 95% for both value and volume of invoices. We ended the year at 88.9% (value £146.6m) of invoices were paid (£128.1m were non-NHS and £18.5m were NHS) of which £130.3m (£120.2m were non-NHS and £10.1m were NHS) were paid within the target. 89.8% of 58,384 invoices were paid (51,711 were non-NHS and 1,673 were NHS) of which 47,941 (46,752 were non-NHS and 1,190 were NHS) were paid within the target respectively. No late interest charges were incurred by the trust. However, the total amount of interest that the trust would be liable to pay had suppliers charged late interest payment would have been £242k. We continue to work towards the Government's initiative to pay small and medium enterprises within ten working days.

External Audit

Grant Thornton are our newly appointed external auditors and the 2018/19 expenditure on external audit fees for statutory audit work was £47.5k excluding VAT (2017/18 £76k). The quality accounts fees, excluding VAT, was £8k (2017/18 £7k) and the charitable independent examination fee, excluding VAT was £4k (2017/18 £5k).

Internal Audit

Our internal audit function is provided by KPMG. KPMG provides us with a comprehensive internal audit service based on our strategic internal audit plan; underpinned by the annual operational audit plan to meet the mandatory standards for NHS internal audit and the reviews linked to our risk register. KPMG also meet the requirements for the provision of the opinion of the Head of Internal Audit on our system of internal control, and provide advice on meeting our corporate governance requirements whilst maintaining the necessary level of professional independence.

Our internal auditors report to our Board of Directors via the Audit and Risk Assurance Committee and have responsibility to our members as well as the wider public in the case of public interest reports.

Local Counter Fraud and Anti-bribery measures

We are committed to providing and maintaining an absolute standard of honesty and integrity in dealing with our assets. We are committed to the elimination of fraud and illegal acts within the trust, and ensure rigorous investigation and disciplinary or other actions are taken as appropriate. We adopt best practice procedures to tackle fraud, as recommended by the NHS Counter Fraud Authority (NHSCFA) and KPMG, who provide us with specialist counter-fraud services.

Over the year, we have widely published our policies and procedures for staff to report any concern about potential fraud and this has been reinforced by a programme of awareness training. Any concerns are investigated by our local counter fraud specialist or the NHSCFA as appropriate with all investigations reported to the Audit and Risk Assurance Committee.

Statement as to disclosure to auditors

So far as the Directors (who held office at the date of approval of this report) are aware, there is no relevant audit information of which our auditors are unaware. They have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that our auditors are aware of that information.

Performance Analysis

Future Financial Plans

Our financial focus remains on long term financial sustainability. To support this vision, our key priorities include:

- generating sufficient income and cash reserves to support on-going operations, fund future capital investment requirements and business development opportunities, and maintaining liquidity
- working in partnership with others to develop integrated care systems to improve care and extract greater value from the resources invested
- delivering sustainable efficiencies over future years
- driving a refreshed trust-wide focus on avoiding overspends
- delivering a long-term 'Financial and Use of Resources' score of at least 2
- maintaining the NHS Improvement Single Oversight Framework segmentation of at least 2
- delivering a breakeven surplus for 2019/20
- investing in our key priorities of progressing further improvements in our patient environments and use of technology
- improving our costing capability and understanding of productivity levels to support future sustainability and delivery
- continuing to embed our quality improvement initiative to empower staff to 'make the change' and improve care delivery and eliminate waste
- securing resources to achieve the national mental health and community health service targets
- working with commissioning and acute hospital colleagues to shift resources into community health services that not only benefit the patient but can be delivered more efficiently

4.0 Working in partnership

We have continued to work collaboratively with our commissioners to align our services with both their priorities and the needs of the local population. In 2018/19 we saw, for the first time, increased investment in our Adult MH Crisis pathway with £2.7m being made available via Mental Health Investment Standards to support the development of a 24/7 Home Treatment Service and a mental health Crisis Line.

Our Healthier South East London is the Sustainability and Transformation Partnership for South East London and has focused on the following objectives:

- Developing community based and primary care services targeted at prevention
- Reducing variation across and improving the quality of both physical and mental health services
- Changing how we work together through a programme of transformation in the delivery of clinical services
- Developing sustainable specialised services
- Reducing cost and increasing productivity through provider productivity collaboration

We have made progress in bringing together the delivery of health and social care services in Bexley under the unified service structure of 'Bexley Care' and, building upon this; we expect to implement significant service changes in 2019/20. The core of this will be the alignment of health and social care services for adults with primary care and the third sector at a local neighbourhood level.

Performance Analysis

There is an embryonic integrated care multi-organisational system being developed in Bromley (One Bromley), and in Bexley Local Care Networks and a provider / commissioner alliance are transforming relationships and ways of working (for example, in musculo-skeletal services).

The South London Mental Health and Community Partnership is well established and has helped to develop stronger relationships and sharing of best practice initiatives; joint working to support challenges regarding workforce; as well as providing the platform to improve patient care nearer to home within ever reducing resources and across a larger geographical footprint (within the areas of Forensic Mental Health and child and adolescent mental health services). As a result, there is better access to services for children and young people in a mental health crisis, and reduced travel times for patients placed in beds out of area.

In partnership with Lewisham and Greenwich NHS Trust and Bexley and Greenwich Local Authorities, The Transfer of Care Collaborative facilitates early discharge, enhanced community capacity and admission avoidance by maximising the wider community input in a co-ordinated way. Access to community therapies and improved support to care homes to reduce attendance at A&E are the next priorities.

Performance Analysis

Environmental matters

Waste

Over the past year, we have focussed on good waste management practices such as diverting waste from the general waste stream through the internal furniture re- use scheme and promoting segregation of waste to ensure we dispose of waste in the most cost effective and least environmentally harmful manner.

In 2018/19, we have continued to increase our percentage of recycling and at the same time decreased our tCO2e emissions as a result of reducing the total amount of waste we create as an organisation. Waste analysis can be found in the table below:

Waste		2017/18	2018/19
Recycling	(tonnes)	128.50	65.54
	tCO2e	2.70	1.42
Other recovery	(tonnes)	365.99	357.40
	tCO2e	7.69	7.77
High Temp disposal	(tonnes)	3.34	4.75
	tCO2e	0.73	0.95
Landfill	(tonnes)	365.50	347.18
	tCO2e	125.75	119.45
Total Waste (tonnes)		863.33	747.87
% Recycled or Re-used		25%	27%
Total Waste tCO2e		**136.87**	**129.39**

Sustainability Report

At Oxleas, we have taken a number of steps to reduce our impact on the environment. During 2017-18, we continued to roll out the installation of LED light fittings within communal and patient areas throughout the estate. This phase has now been completed, our ongoing strategy will encompass the remainder of our offices, plant room and external areas at the earliest opportunity. All project based work will include LED and smart lighting. In addition, we commenced work on replacing windows across our older estate which captured the benefits of reducing solar gain in the summer months and heat retention in the winter months. This work will continue throughout 2019-20.

We are continuing with our strategy of developing one of our largest sites - Queen Mary's Hospital. This development has the reduction of carbon consumption as one of its key strategies. Works include the introduction of smart lighting, water usage reduction, and improved heat recovery.

Over the forthcoming year, we will be reviewing our existing policy and procedure strategy for supplying, installing air conditioning systems and portable heating systems. In addition we will be identifying sites that have ageing building management systems in place with the view of upgrading them to provide better control of the day to day running of the sites.

Performance Analysis

Energy and energy consumption

We are exploring ways to increase engagement on energy efficiency with people who provide services to us. The vision over the next year is to drive forward energy awareness to all service providers to achieve a common goal in reducing our energy footprint within the NHS sector. This will be done through user provider meetings and alignment of energy policy strategy.

Electricity

During 2018-19, electrical energy consumption increased by 6.7% compared to the previous year, this is a concern. However, after carrying out further investigations it was identified that there were a number of contributing factors, which included a 40% increase on permits being issued for electrical car charging point users; and, in addition, due to inclement weather there was an increase in the use of supplying air conditioning units across the estate.

Gas

The trust recognised a decrease in gas usage across the entire estate by 13.9%. Contributing factors include reduced property portfolio as well as closure of departmental wards and buildings to undertake refurbishment works.

Water

We also recognised a significant fall in water usage across the estate compared to previous years. After further investigation, it was established that there was a discrepancy in the figures produced last year, which was due to a sub-check meter being used as part of the calculation. This is a contributing factor. However, there are other factors which also need to be taken into account which include water management awareness and through a decrease in our estate.

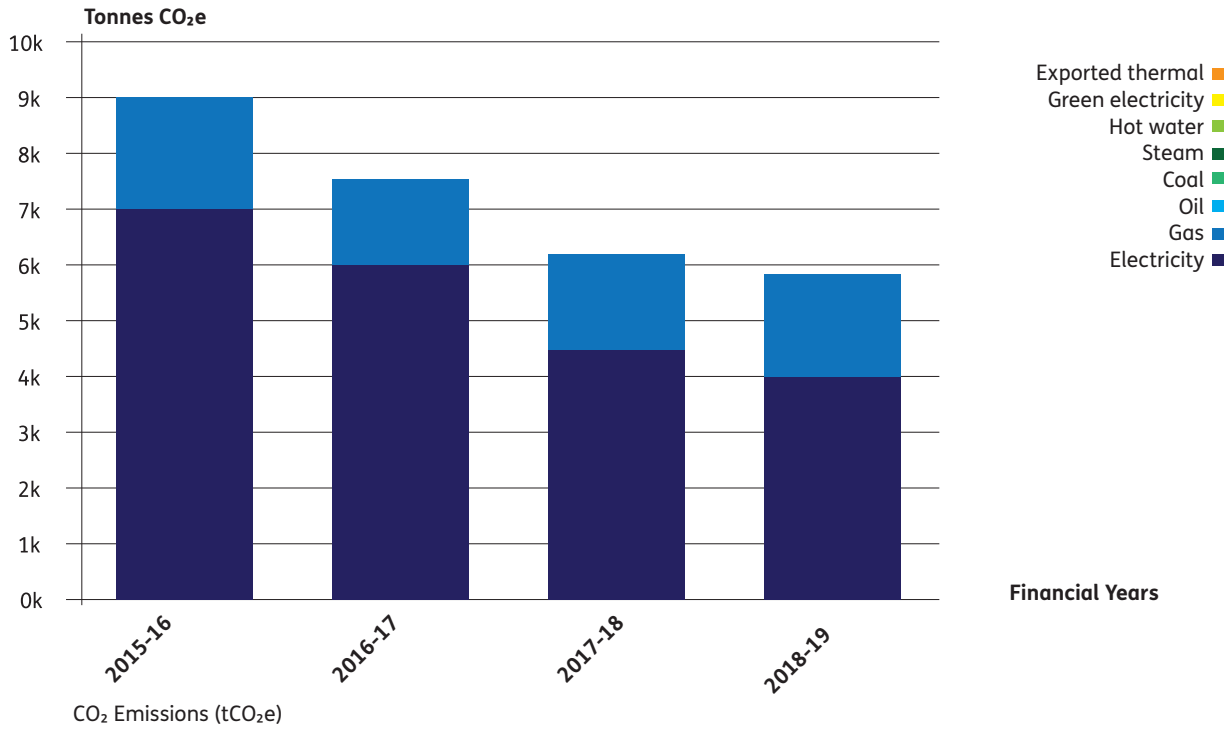
Energy

We have spent £1,733,110 on energy in 2018-19 which is a 6.72% increase on energy spend from last year

Energy consumption In kWh	2015/16	2016/17	2017/18	2018/19
Electricity Consumed	12,261,313	11,750,019	10,368,055	12,002,230
Gas Consumed	9,672,362	8,180,603	8,368,622	7,202,766
Oil Consumed	159,147	159,147	151,004	136,609
Coal Consumed	0	0	0	0
Steam Consumed	0	0	0	0
Hot Water Consumed	0	0	0	0
Green Electricity	40	40	40	40
Total	**22,092,862**	**20,089,809**	**18,887,721**	**19,341,645**

Performance Analysis

Carbon Emissions Resulting



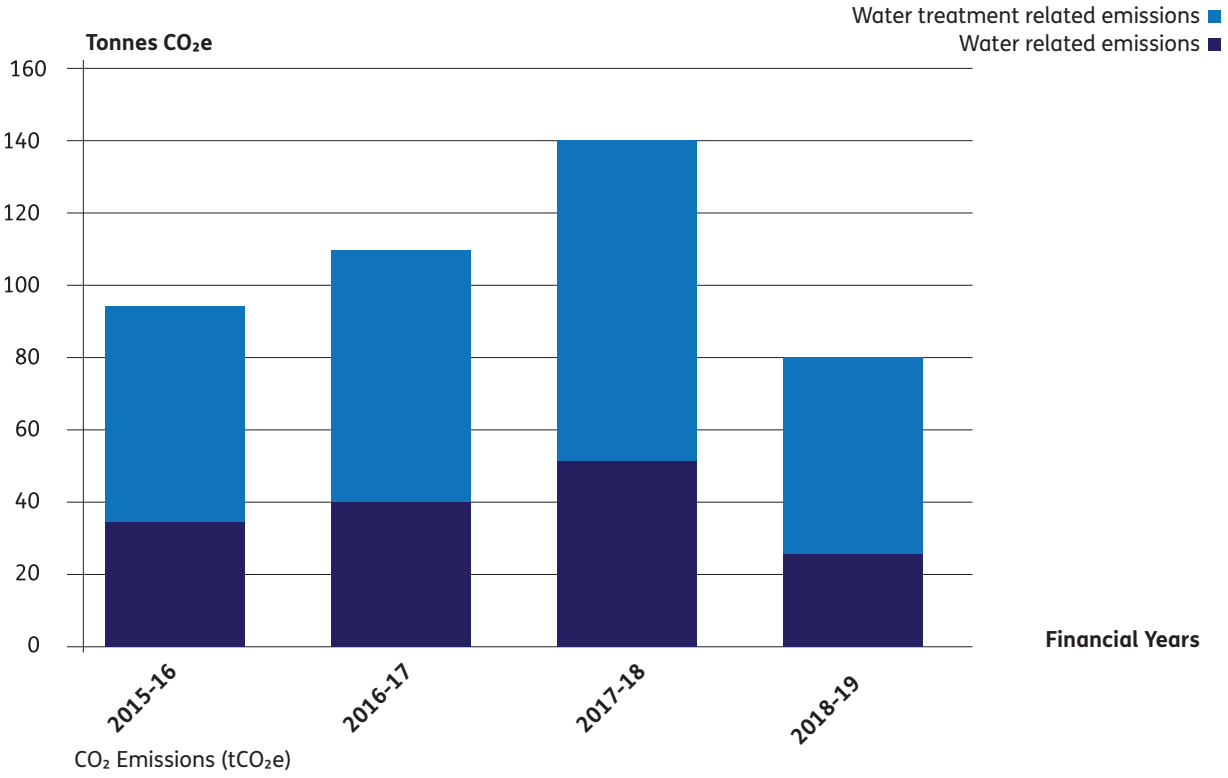
	2015/16	2016/17	2017/18	2018/19
Electricity	7,049	6,072	4,621	4,234
Gas	2,024	1,710	1,774	1,530
Oil	50.8	50.5	49.3	43.6
Coal	0	0	0	0
Steam	0	0	0	0
Hot Water	0	0	0	0
Green Electricity	0	0	0	0
Exported Thermal	0	0	0	0
Total	**9,124**	**7,833**	**6,445**	**5,807**

Electricity usage increased by 6% compared to the previous year whilst gas usage was down by 13% The trust is currently investigating why there has been a significant increase in electricity usage although rt is possible that some contributing factors could include; a 40% Increase in issuing permits for charging electrical vehicles, increased use of air conditioning and portable heating due to inclement weather over the past year. In addition the trust provides direct clinical services to the healthcare service as well as providing clinical space to other service users. With this mix of clientele brings Its own challenges in consistency for driving policies and procedures forward. Projects works include, upgrading buildings with LED light fillings and new window frames across our ageing estate.

Performance Analysis

Finite resource use - Water

	2015/16	2016/17	2017/18	2018/19
Water Volume (m^3)	102,402	122,000	156,048	90,949
Waste Water Volume (m^3)	81,922	97,600	124,838	72,759
Water and Sewage cost (£)	397,249	204,333	222,413	214,505



	2015/16	2016/17	2017/18	2018/19
Water related emissions	35.2	42	53.7	31.3
Water treatment related emissions	58	69.1	69.1	51.5
Total	**93.3**	**111**	**142**	**82.8**

Performance Analysis

Equality and human rights

We are committed to promoting equality and human rights across our services and our workforce. Equality, diversity and human rights is led by our Head of Equality and Human Rights and our quarterly Equality and Human Rights Governance Group, which reports to the Workforce board sub-committee. The role of the group is to lead on equality work and projects, to oversee compliance, to communicate priorities to staff and ensure that plans and actions are implemented.

We have an Equality and Human Rights policy which sets out our expectations for the organisation and a reasonable adjustments policy which sets out the expectations for adjustments in the workplace. We publish an Equality Report, which includes workforce data and examples of our equality work, providing evidence of compliance against the three main headings of the General Duty, which are set out in the Equality Act.

We have an organisational Equality Objective which is published in line with the requirements of the Public Sector Equality Duty. We have published our Workforce Race Equality Standard metrics along with an action plan to address areas for improvement. This has been reviewed during the year. We are working with NHS England on a project to develop Disability as an Asset and the national development of the Workforce Disability Equality Standard. We have undergone assessment against the Equality Delivery System framework and the results are published on our website www.oxleas.nhs.uk

We have a strong Black and Minority Ethnic staff network who organise regular events for colleagues and provide coaching and mentoring. We host a placement on the NHS England NExT Director scheme which is supporting people from black, Asian and minority ethnic communities to become non-executive directors in the NHS. We were pleased to be highlighted in the NHS Workforce Race Equality Standard 2018 for being a leading NHS organisation for the diversity of our Board of Directors.

Looking forward to 2019/20

Each year we work in partnership with our service users, carers, members, staff and commissioners to identify our quality priorities. For 2019/20, we will continue to focus on six quality objectives underpinned by a number of key indicators:

- Quality objective 1 - Ensure we meet our patient promise
- Quality objective 2 - Ensure we involve families, carers and people important to our patients
- Quality objective 3 - Ensure we involve patients in planning their care and they have a care plan that is personal to them
- Quality objective 4 - Ensure we put the safety of our patients first
- Quality objective 5- Ensure we provide care in line with national best practice and guidelines
- Quality objective 6 - Ensure we routinely measure clinical outcomes so that we know that our care makes a difference to patients

Performance Analysis

We will implement the recommendations of our recent Care Quality Commission report and strive to improve the quality of our services even further. A key aspect of this work will be developing an organisation-wide strategy involving staff across Oxleas, service users and members and our partners. Their feedback will help us shape our plans for the coming five years.

The NHS 10 year planning guidance establishes key priorities for local integrated health/care systems. We will be taking forward the following actions to ensure we achieve the next steps in relation to implementing the forward view:-

- Children and Young People – A refresh of programme priorities during 2018/19 established Children & Young People's mental health, urgent care for children and young people with long term conditions and Special Educational Needs and Disability/Autism services as the three priority areas for the South East London system. We anticipate an ongoing focus on children & young people's mental health particularly in relation to the child and adolescent mental health services access standard and the strong emphasis in the Long Term Plan on mental health.
- Community Based Care – we will focus on further developing the work already ongoing around Primary Care Networks (often know as Neighbourhood delivery teams in South East London) as an essential building block of the Integrated Care System approach alongside the development of 'at scale' approaches to prevent ill health and reduce health inequalities.
- Mental health – There will be a continued action to secure a more sustainable mental health workforce with a focus on skill mix and efforts to achieve zero out of area placements. We will continue to work on improving access to psychological therapies and waiting times, increasing access to individual placement support, crisis care and early intervention in psychosis. We will also be undertaking further work on our perinatal mental health services.

We will continue to build on the improvements to recruitment and retention made in 2018/19 and will see the launch of our Leadership Development programme during 2019/20. This will support staff to step up into senior roles and become the future leaders of Oxleas. In the year ahead, we will continue our focus on improving retention of our staff by addressing concerns in relation to development and career progression. We will look to build on earlier successes on creating progression pathways for senior non-medical clinicians by supporting their development and improve uptake of Approved Clinician / Recognised Clinician roles as well as other Advanced Clinical Practitioner roles.

We will be working with our staff, staff-side representatives and staff networks to create a culture that is empowering, supportive and inclusive. We are proud of the composition of our board and its improving balance in terms of gender and race. However, improving equality, diversity and inclusiveness will be a key priority for us, particularly in relation to recruitment and disciplinary processes. We hope to see positive outcomes from our current pilot of the Just Culture methodology and intend to build on this work. A programme of work to address the gender pay gap for doctors will continue with targeted support for female doctors.

Staff perceptions in relation to bullying and harassment from patients, service users and the

Performance Analysis

public as well as colleagues remains a concern and we will be launching a new programme targeted at addressing these behaviours quickly. We intend to learn the lessons from the work to reduce incidents of violence and aggression and improve support post-incident, most particularly that the best solutions will come from our staff, and apply these to our programme for reducing bullying and harassment. We are clear that we need to maintain the momentum on work to reduce violence and aggression and implement radical programmes designed locally, including piloting body worn cameras, CCTV in communal areas, and mobile phone use in medium secure settings.

There is a continued need to deliver efficiencies, and we are working collaboratively with our partners to identify opportunities for efficiencies through joint tendering, harmonisation and, where appropriate, in the delivery of support functions.

The efforts of staff in managing agency spend has seen a marked reduction in agency usage over the course of 2018/19. These improvements will need to be sustained and strengthened and we will continue to seek to use our inpatient beds as efficiently as possible. We will also continue our work on productivity and improving direct patient contact time that is so valued by our staff and our patients and service users.

We are expecting new contracts to develop during 2019 including the delivery of healthcare services to HMP Wandsworth. We will be leading a £12.3M partnership with South London and Maudsley NHS Foundation Trust, Change, Grow, Live and Nacro to provide mental health, substance misuse and resettlement services.

During 2019/20, we will also continue to build upon existing external relationships to deliver innovative partnership approaches to the way services are delivered across Bexley, Bromley and Greenwich. This will enable us to deliver on the expectations of both local sustainability and transformation plans and the ambition of the NHS Long Term Plan. Within this context, we are fully engaged in the Sustainability and Transformation Partnership clinical transformation initiatives. In particular, we will work with partners to focus on urgent and emergency care including maximising patient flow and discharge for patients with both physical and mental health needs.

Signed by:

Matthew Trainer
Chief Executive
24 May 2019

Quality Report

1.0 Chief Executive Statement on Quality

I am pleased to present to you our Quality Accounts for 2018/19 which gives you an insight to our commitment to improve lives by providing the best quality health and social care for patients, their families, carers and those identified as important to them. Our first and foremost organisational priority continues to be enhancing quality - ensuring excellence for every patient across the 3 quality domains of patient experience, patient safety and clinical effectiveness. The following pages demonstrate:

- Our approach to improving quality
- Our performance against the 2018/19 quality priorities both local and national
- Our priorities for 2019/20
- A showcase of notable and innovative practice that has taken place across our services this year

Since taking up the role of Oxleas Chief Executive I have spent considerable time out in services, speaking to frontline staff and to our patients and I am delighted to see how committed our staff are to providing good quality patient care.

The Care Quality Commission (CQC) carried out a thorough inspection of our services in November and December 2018, visiting six of our service lines and undertaking a well led review in January 2019. I am delighted that the results of our latest CQC inspection rate us as 'Good' overall, thus maintaining our previous rating. A number of our services were however, rated as outstanding in some domains: 'Outstanding for caring' in our inpatient mental health services and 'Outstanding for effectiveness' in our community-based mental health services for older people. These latest 'Outstanding' service ratings build on those awarded in 2017 when our forensic inpatient wards were rated 'Outstanding for responsiveness' and our community services for adults with a learning disability received 'Outstanding for caring'. Further detail on areas for improvement and what we aim to do to ensure continuous improvement is provided in section 2 of the quality accounts.

Our Quality Improvement (Qi) programme was launched in 2018/19 with staff across Oxleas taking part in training, Qi projects and putting learning from those projects into practice. The programme continues to grow from strength to strength and we have provided some examples of innovative Qi projects in section 3 of the quality accounts.

In terms of looking back at the previous year, we have not achieved 2 of our 19 quality indicators and slightly underachieved in 1 of them. We will continue to focus our efforts to improve on these areas and have chosen them as priorities again for 2019/20.

Looking forward to the coming year, we have an ambitious programme of quality, improvement and innovation. We will ensure that our focus on patient safety, improved clinical effectiveness and outcomes and positive experience of our care is maintained across all of our services.

Each year, we work in partnership with staff, patients, carers, members, commissioners, GPs, Healthwatch and other stakeholders and we are grateful to all who have supported and worked with us in reviewing and setting our quality plans. We are delighted to have had another successful year and we are determined to maintain these high standards throughout 2019/20 and aim for 'Outstanding'

Declaration

In preparing our Quality Accounts, we have endeavoured to ensure that the information and data presented within is accurate and provides a fair and balanced reflection of our performance this year.

To the best of my knowledge, the information in the document is an accurate and true account of the quality of our services

Signed by:

Matthew Trainer
Chief Executive
24 May 2019

Quality Report

2.0 Quality Priorities for Improvement

In this section, we provide an update on our priorities for improvement and statements of assurance from our trust Board of Directors

Oxleas is committed to delivering good quality care and we have worked in partnership with our staff, patients, carers, members, commissioners, GPs and others to identify areas for improvement. Our annual Quality Account gives us an opportunity to share our performance against our 2018/19 priorities, describe our areas of focus for 2019/20 and showcase notable and innovative practice that has taken place across our services this year.

2.1 Review of our how we did: Progress against 2017/18 priorities

We have highlighted below our performance against last year's goals which cover the three quality domains of patient experience, patient safety and clinical effectiveness. We determine our quality goals through a variety of processes:

- Our annual borough based focus groups across Bexley, Bromley and Greenwich
- Our regular quality review meetings with our commissioners
- Feedback from patients, service users, carers and families of people who have used our services
- Regular review at our Performance & Quality Assurance Committee and associated quality sub-groups

Where available, we have included data from previous years' quality reports for comparison and to evidence progress. With the exception of national surveys or audits, we use information from our electronic patient record, RiO, our staff training database and local audits or surveys to measure achievement of our priorities. We have also included what performance data is determined by local or national definitions.

Our local performance has not been compared to other trusts. Comparable data for national priorities are presented in Table 8, section 2.6. For ease of reference, a glossary of all terms and acronyms used is provided at the end of the report. We also aim to show our performance in comparison to the last 3 years where this data is available.

We have used the following colours to denote how well we performed against the quality priorities:-

Green/Achieved
This means the target set has been achieved

Amber/Mostly Achieved
This means our 2018/19 performance is 5% or less below the set target

Red/Not achieved
This means our 2018/19 performance is 6% or more below the set target

Quality Report

2.2 Our performance against our2018/19 - Quality Objectives

Our quality priorities are split across 6 quality objectives

Objective	Description	Quality Domain
Quality Objective 1	Ensure we meet our patient promise	Patient Experience
Quality Objective 2	Ensure we involve families, carers and people important to our patients	Patient Experience
Quality Objective 3	Ensure we involve patients in planning their care and they have a care plan that is personal to them	Clinical Effectiveness
Quality Objective 4	Ensure we put the safety of our patients first	Patient Safety
Quality Objective 5	Ensure we provide care in line with national best practice and guidelines	Clinical Effectiveness
Quality Objective 6	Ensure we routinely measure clinical outcomes so that we know that our care makes a difference to patients	Clinical Effectiveness

We have provided below a summary of our trust-wide performance against the 6 quality objectives however further detail on each objective is provided in sections 2.2.1 to 2.2.6.

We have 19 quality goals across the 6 quality objectives:

Achieved	16 (84%)	●
Mostly Achieved	1 (5%)	▲
Not Achieved	2 (11%)	■
Total	**19**	

Quality Report

2.2.1 Quality Objective 1 - Meeting our patient promise (Patient Experience)

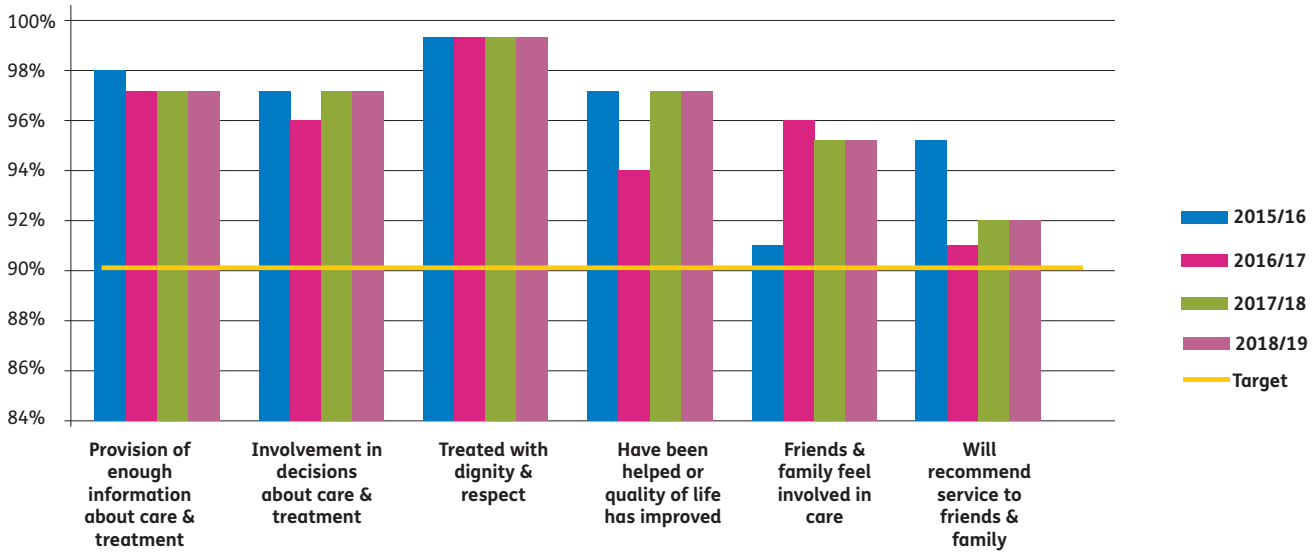
Our first quality priority is to ensure we meet our patient promise; this consists of 6 'must ask' questions that are used in every Oxleas patient experience survey. We ask patients to respond on the following:

- Have you been provided with enough information about your care and treatment?
- Have you been involved as much as you would have liked in decisions about your care and treatment?
- Have staff treated you with dignity and respect?
- Was the service provided helpful?
- Did you want any friends / relatives involved in your care/treatment? if yes, were they involved?
- We would like you to think about your recent experience of this service. How likely would you be to recommend this team to friends and family if they needed similar care or treatment?

Our target for each of the 6 questions is to have at least 90% of patients reporting that we have met our patient promise. We have consistently met our goal of 90% achievement or more since 2015/16 when we started reporting this data as part of our quality priorities.

We are pleased to see that this target has been achieved again in 2018/19 as shown in the chart 1 below.

Chart 1 – Meeting our patient promise – Oxleas Overall Position



We have also provided our patient experience feedback broken down by directorate and it can be seen (as shown below) that we do have some services in the trust where not all patient promise indicators have been achieved. This is the case for our Forensic services, Prison Services and Adult Learning Disability Services and specific to 'friends/relatives involved in care/treatment, 'if they found the service helpful' and the 'will you recommend the service to friends and family' questions. It has been identified that due to the nature of the Forensic services it is unlikely that the patients would select the "Extremely likely" or "Likely" responses.

Quality Report

Some of the comments that service users provide us is that they would not like for their friends or relatives to be "locked up" in a forensic inpatient ward; this is despite the question asking "if they needed similar care or treatment". We survey a wide range of patients who do not choose or want to be in the forensic setting and are detained against their will with often very serious offences and in acute wards ongoing trials and sentencing hearings. However we have put plans in place to make further improvements such as introducing positive events such as 'Bracton's got talent' and holding stalls to provide clearer information to patients about their medication.

In terms of our Adult Learning Disability Services (ALD), the FFT question does not work as well with this client group. Some of the ALD service users select the "Unlikely", "Extremely unlikely" or "Don't know" responses for the FFT question but the comments they provide are very positive. We have shared this with NHS England and provided some examples showing the positive free texts that are not included in the calculations stating that the FFT question does not work as well in these service areas

NHS England have begun work to identify ways to make it a stronger tool to support local service improvement and to also increase the FFTs accessibility to all service users. We expect the revised FFT question and guidance to be published by NHS England early 2019/20 with the plan for trusts to implement in October 2019.

The revised question and guidance will be released by the end of April and the plan is for trusts to implement this in October.

Table 1

'Must Ask' Questions		Bexley	Bromley	Greenwich	CYP	Forensics	Prisons	ALD	Trust wide Position
Enough information about care & treatment		99%	97%	97%	98%	90%	92%	95%	97%
Involved in decisions about care & treatment		98%	95%	97%	98%	95%	87%	96%	97%
Treated with dignity & respect		99%	98%	99%	99%	92%	96%	99%	99%
Friends & relatives involved in care/ treatment (if wanted)		95%	97%	94%	98%	79%	Question not asked	93%	95%
Service was helpful		98%	94%	98%	99%	88%	93%	97%	97%
Friends & Family Test	% Recommend	96%	89%	92%	93%	66%	Question not asked	82%	92%
	% Not Recommend	1%	4%	2%	1%	19%	Question not asked	5%	2%
Response Numbers		5,443	1,513	12,438	4,442	525	709	383	25,453

90%+ target achieved | Less than 5% below target (89-85%) | more than 5% below target (84% or less)

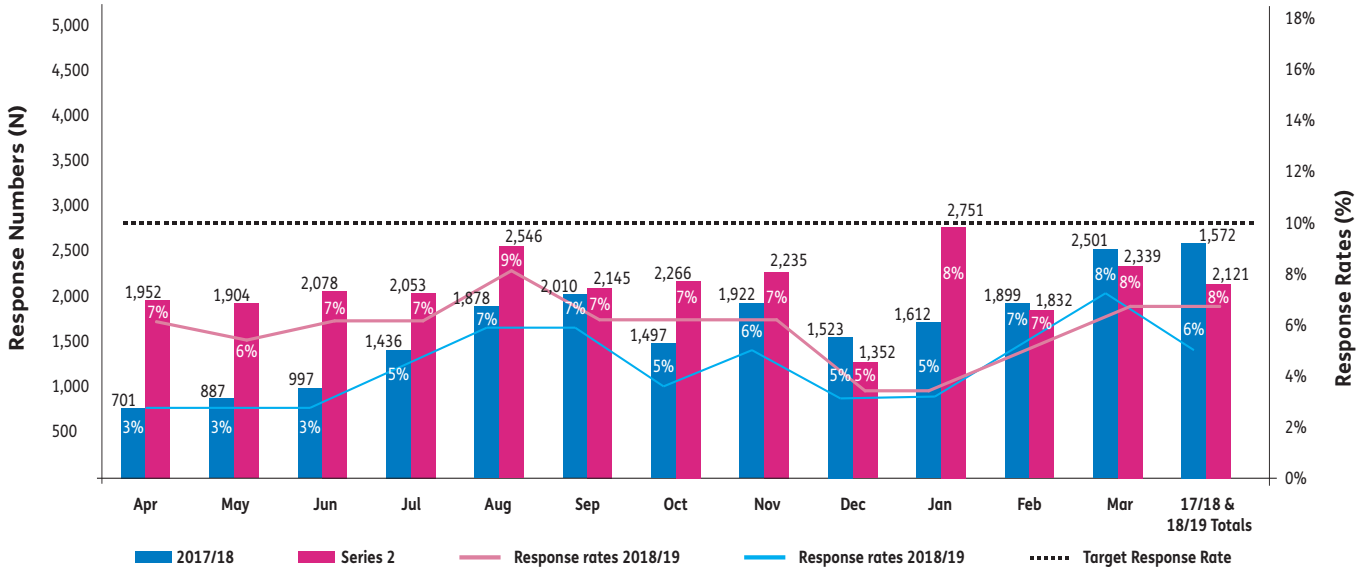
FFT % Not Recommended | 0% – 4% | >5%

Quality Report

Quality indicator – to have a minimum of 10% response rates to our patient experience surveys

The other quality indicator that falls under our patient promise objective is to have a minimum of 10% response rates to our patient experience surveys. As an organisation, we see approximately 29,000 patients in a given month and we aim for at least 10% of those who have been in contact with our services to give us feedback on the 'must ask' questions. We continue to see an increase in the numbers of people who respond but we have not met the 10% mark as shown in the chart below (2018/19 performance is at 8%):

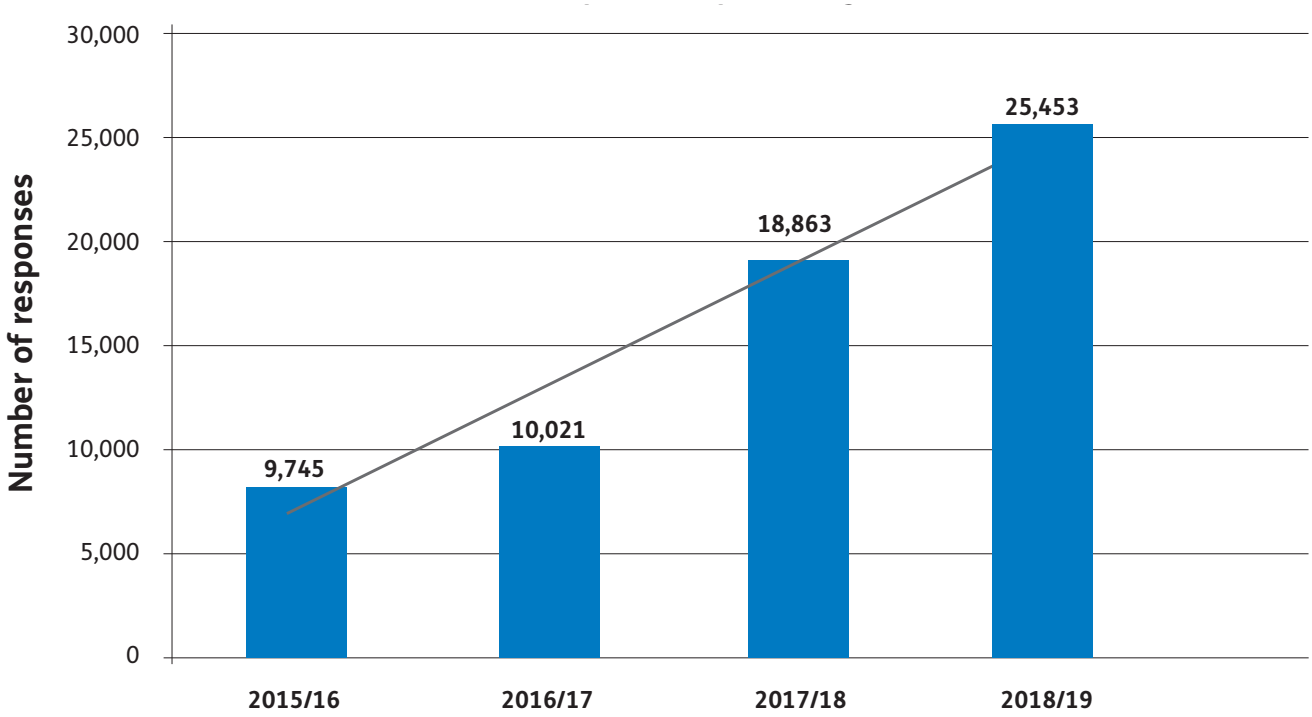
Chart 2 - Patients Experience Feedback Response Rates (2017/18 and 2018/19)



Quality Report

However there has been significant increase on the numbers of patients who do respond to our patient surveys. The chart below shows the annual figures since 2015/16. We continue to work with our teams to encourage patients to give feedback following contact with services. We have also updated our feedback technology making it easier for patients to respond via various methods which include text messaging, online and on paper for those who are homebound and prefer to send in their response via post.

Chart 3 - Number of Patients Providing Feedback



Quality Report

2.2.2 Quality Objective 2 – Involving families, carers and people important to our patients (Patient Experience)

There are two indicators which come under our second quality objective. 2018/19 progress for 'ensuring 90% of patients report that they wanted friends/relatives involved in their care/treatment did feel that they were involved' has been captured in section 2.2.1 above. Progress on the second indicator is provided below.

Quality indicator – to ensure 80% of patients have their support network identified and noted within their care record

Please note: The data source for this objective is from RiO our electronic patient care record and is a local definition.

Our improvement goal for 2018/19 was to ensure that 80% of patients who have been assessed by the relevant services have had their support network identified and noted within the care record. A patient's support network is someone who is important to them and identified by asking the following 4 questions as part of the assessment:

- Who is most important to you at the moment?
- How would you like those identified as most important to be involved in your treatment?
- If there is an emergency, who would you want involved?
- How would you want them to be involved in an emergency?

Our performance at the end of 2018/19 was 37%, with the previous year achievement at 35.2%. This is an area that has been challenging for certain services to achieve and it is disappointing that we have not achieved this improvement goal.

Provided below is the functional service breakdown:

Table 2 - The Functional Service Breakdown

		2018/19		
Metric	**Category**	**Unique Directorate Caseload**	**Support Network Idesntified**	**Compliance**
80% of patients have their support network identified and noted within their care record	Community	60851	11511	18.9%
	Mental Health	39913	25234	63.2%
	Forensic	1719	1195	69.5%
	Total	**102483**	**37940**	**37.0%**

Quality Report

During the year we have undertaken a piece of work to ensure those teams that are expected to complete the tool are clearly identified and specific criteria were adopted to achieve this. This has not yet had a significant impact on reaching the target of 80%, although we have started to see an increase in the number of Support Network Tools (SNETs) completed. A new Patient Experience Co-ordinator has been in post since September 2018 and part of the role is to ensure that the SNET is being completed by teams and that the 80% target is being reached. The Patient Experience Co-ordinator visits teams that are underperforming and reminds them of the importance of asking the 4 questions and recording the outcome in the patient record. A guidance sheet with step-by-step visual instructions on how the tool should be completed has been made available to teams.

Our aspiration remains for all patients/service users and their support networks to be offered the opportunity to be included, involved and engaged in our services. The key to achieving this is for every member of staff to actively identify and involve the support network to ensure better outcomes for their patients. We have seen good performance across our mental health and forensic services but still have a lot to do to embed across our community services. We will continue to focus on this as a quality priority in 2019/20.

2.2.3 Quality Objective 3 – Involving patients in planning their care and that they have a care plan that is personal to them (Clinical Effectiveness)

Our third quality objective for 2018/19 was to ensure we involve patients in planning their care and that they have a care plan that is personal to them. There are 3 quality indicators under this objective and our performance for 2018/19 is shown in the table below:

Please note: The data source for these indicators is RiO our electronic patient care record and is a local definition:

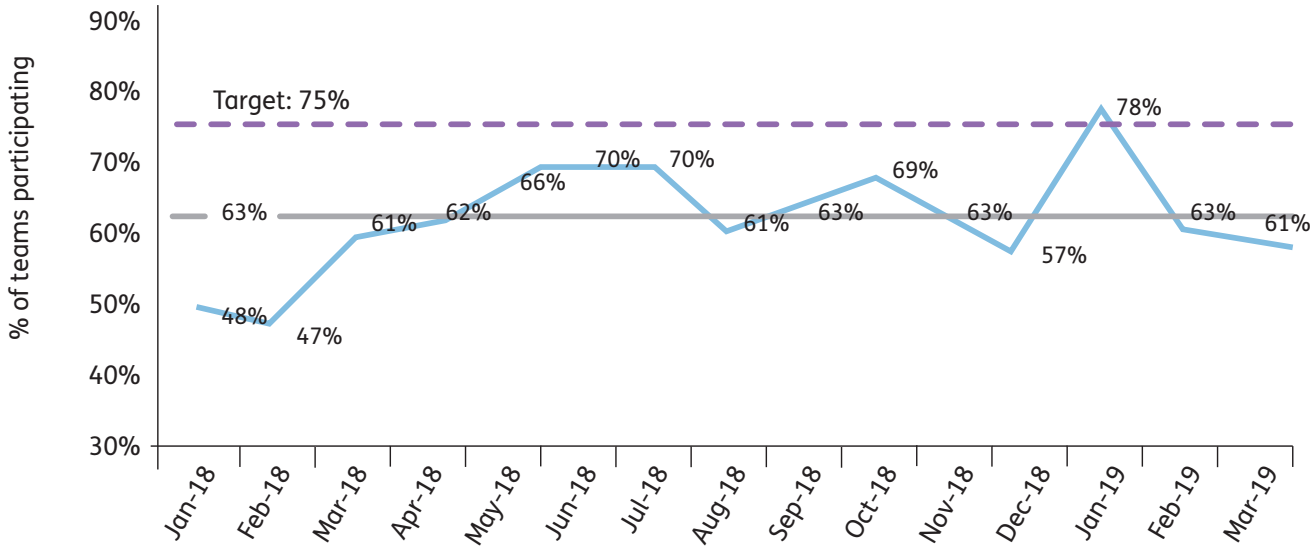
2.2.3.1 Quality indicator – to ensure 75% of Oxleas teams participate in care planning audits

In July 2017, we put in place monthly care planning audits that all services and teams participate in. Teams are expected to complete a minimum of 5 care plans audited per month, with the audit tool and results accessible to all staff via an online portal. The care planning audit is one of our trustwide priority audits and we now have approximately 500 care plans audited per month across 128 teams. This regular data collection means that we are in a better position of understanding the current state of practice and pick up on trends. Teams also have easy access to view their results online and discuss these as part of their monthly team meetings.

Our improvement goal for 2018/19 was to ensure that at least 75% of our teams participate in these monthly audits and as shown in the graph below, we have had an average of 63% of our teams participating in the monthly audits.

Quality Report

Chart 4 - Care Planning Audit: Risk & Service User Involvement Monthly Participation Rate



We are disappointed that despite the increased focus on this in 2018/19 we have been unable to increase the number of teams who participate in the monthly audits and maintain consistency. This has been discussed at the trust's Clinical Effectiveness Group and the Performance & Quality Assurance Board Sub-Committee. A mitigation plan has been put in place to support teams who have not participated in the monthly audits. We have also made this a trust quality priority for 2019/20.

Even though our improvement goal was about participation, we have provided below the results of our care planning audits. As we have been collating care planning audit results consistently over time, we are now in a position to demonstrate statistically significant Oxleas wide improvements.

Quality Report

Table 3

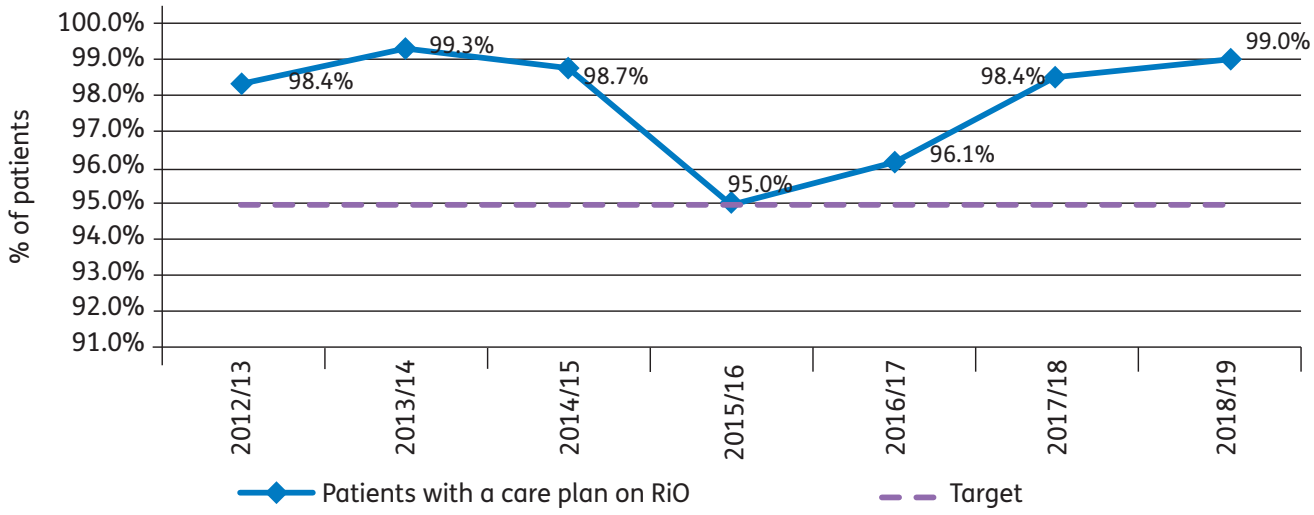
Question	Average Result Per Month (Oxleas wide)
Has a risk assessment been completed during this episode of care?	90%
Has the risk assessment been reviewed following significant risk incidents, changes in presentation or within the last 6 months?	90%
Does the care plan address increased risks that have been identified in the risk assessment?	86%
Is there evidence that the service user has been involved in development of their care plan?	86%
Is there evidence that the service user's support network has been involved in the development of the care plan?	63%
Has a copy of the care plan been given to the service user?	70%
Has a copy of the care plan been given to the service user support network?	40%

Our 2018/19 achievement for the other two indicators under this objective is shown in the graphs below. As can be seen, both of these improvement goals have been achieved.

2.2.3.2 Quality indicator – to ensure 95% of our patients have a recorded care plan on RiO

Please note: The data source for this objective is from RiO our electronic patient care record and is a local definition.

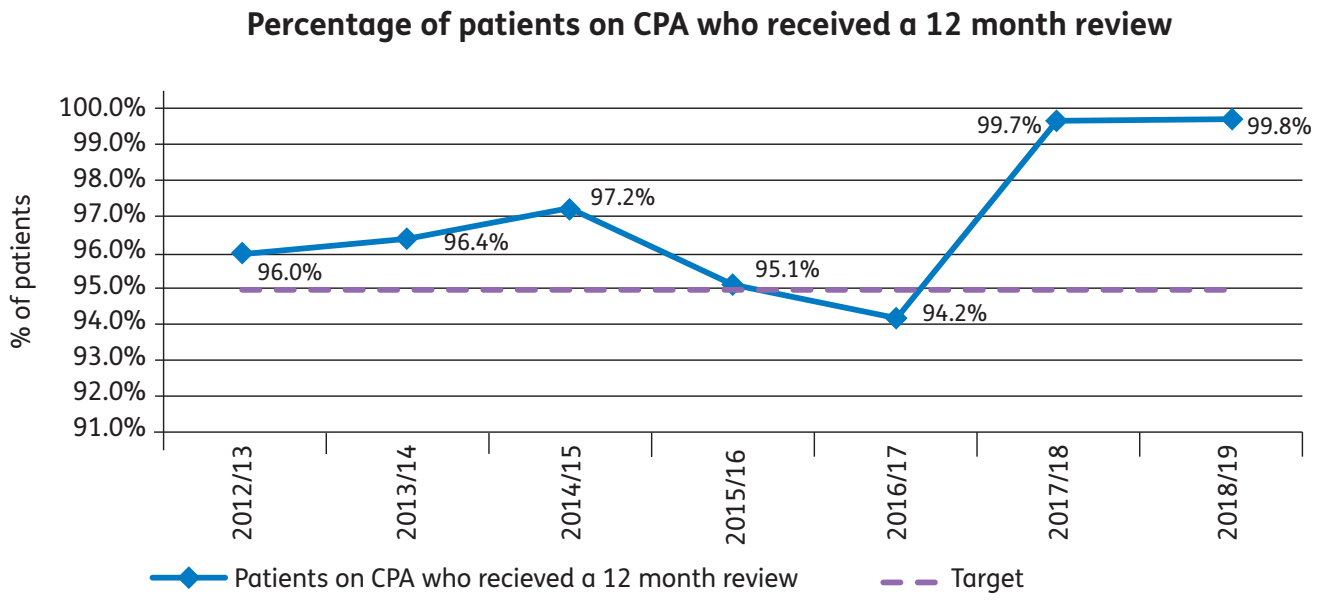
Chart 5 - Percentage of Patients with a care plan on RIO



2.2.3.3 Quality indicator – to ensure 95% of our patients on CPA will receive a 12 monthly review

Please note: The data source for this objective is from RiO our electronic patient care record and is a local definition.

Chart 6 - Percentage of Patients on CPA who received a 12 month review



2.2.4 Quality Objective 4 – Ensure we put the safety of our patients first (Patient Safety)

Our 4th quality objective is to ensure we put the safety of our patients first and the goals linked to this objective are integral to our improvement safety plan. There are four key areas that come under this objective:

- Falls
- Deteriorating physical health
- Violence reduction
- Reducing the use of prone restraint

We have provided progress each safety goal below. Please note, the data source for our patient safety goals are from RiO our electronic patient care record, Datix (our incident recording system) and from local clinical audit.

2.2.4.1 Falls

In 2018/19 we continued our focus on reducing the incidences of falls on our inpatient wards. This focus was founded on the outcomes of the longitudinal study that we conducted at the end of 2017/18 which helped us to gain a deeper understanding of why and how patients fall. As a result we have put in place the following:

- We have updated the Falls Policy and reviewed training, assessment and management of falls. We are also looking to introduce a core group of Falls Champions who will attend training and then roll out the information to colleagues in their specific workplace.
- We have updated the Falls Assessment Tool for in-patient settings and this will be rolled out in 2019/20. This tool gives more direction to Clinicians as to what they should do with the information gathered to help prevent falls. We have also updated the Falls Screening Tool (FSA) for community settings.

We continue to encourage an open and safe culture of reporting of falls and an example of this is to ensure unwitnessed falls in the community will be recorded on Datix (our incident reporting system) within 24 hours of the clinician contact.

In addition and due to our focus on this workstream, we have seen a significant reduction in level 4 falls in our inpatient services in 2018/19 compared to the previous year. There were 3 serious falls in this reporting period compared to 8 in 2017/18; a reduction of 62.5%.

2.2.4.2 Preventing the Deterioration of Physical Health

Since 2017, we have included physical health monitoring forms in the patient's electronic record system to ensure the monitoring of physical health observations, including blood glucose and blood lipids, BMI, Malnutrition, smoking status and substance and alcohol misuse. This enables teams to effectively record and monitor physical health.

All our inpatient wards have been trained in NEWS2 (the National Early Warning System). Training slides have been developed circulated to all wards following training, with the expectation that these are used to train other staff on the wards who are unable to attend the face to face training due to shift patterns.

The Malnutrition Universal Screening Tool (MUST) has been implemented in line with NICE guideline QS24. The MUST enables clinicians to identify patients who are at risk of malnutrition or obesity and to write personalised care plans that address the issues identified. Posters have been designed to support staff with completing the forms and will be circulated to teams. MUST audits measuring the number of patients who have a completed Screening Tool are undertaken regularly by our inpatient wards which are overseen by the trust's lead nurse for practice development. An average of 85% of patients had a completed screening tool completed; there is still further improvement to be done in this area and this is why we have chosen this as a quality

Quality Report

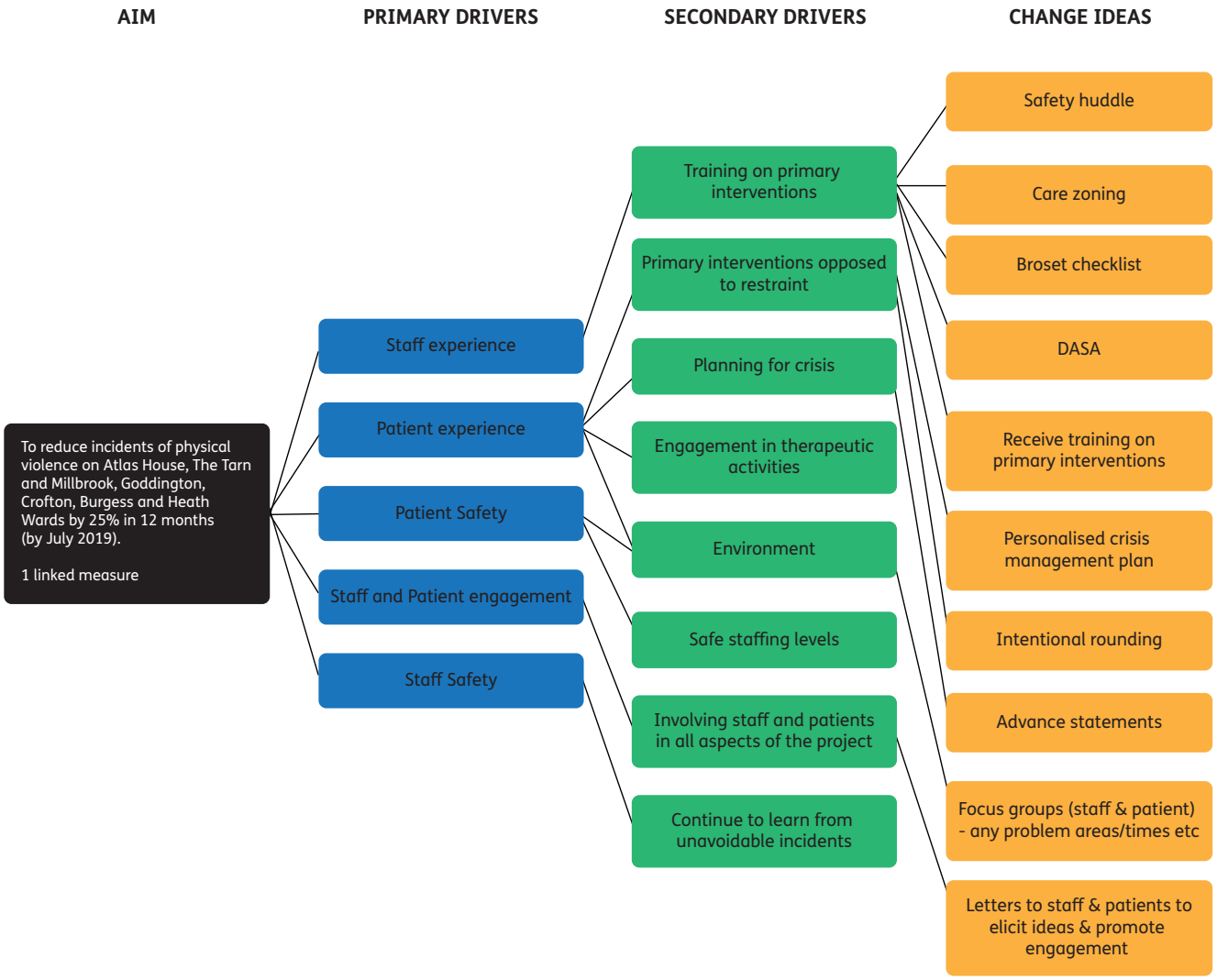
improvement goal for 2019/20 with a target of 100% completion by all wards.

2.2.4.3 Reduction of violence

Reducing the incidents of violence and aggression is one of our quality improvement goals. In the last few years we had seen an increase in the number of incidents recorded in our inpatient units and we took on board feedback staff as seen in our staff surveys and as part of our Board to floor visits to wards. As part of the launch of our Quality Improvement (Qi) Programme we put in place a trustwide reducing violence Qi project with at least one ward from each unit represented as part of the pilot. The aim of the project is to reduce incidents of physical violence by 25% by July 2019.

Provided below is a driver diagram that details our drivers identified for the project and what we want to test and put in place as a result.

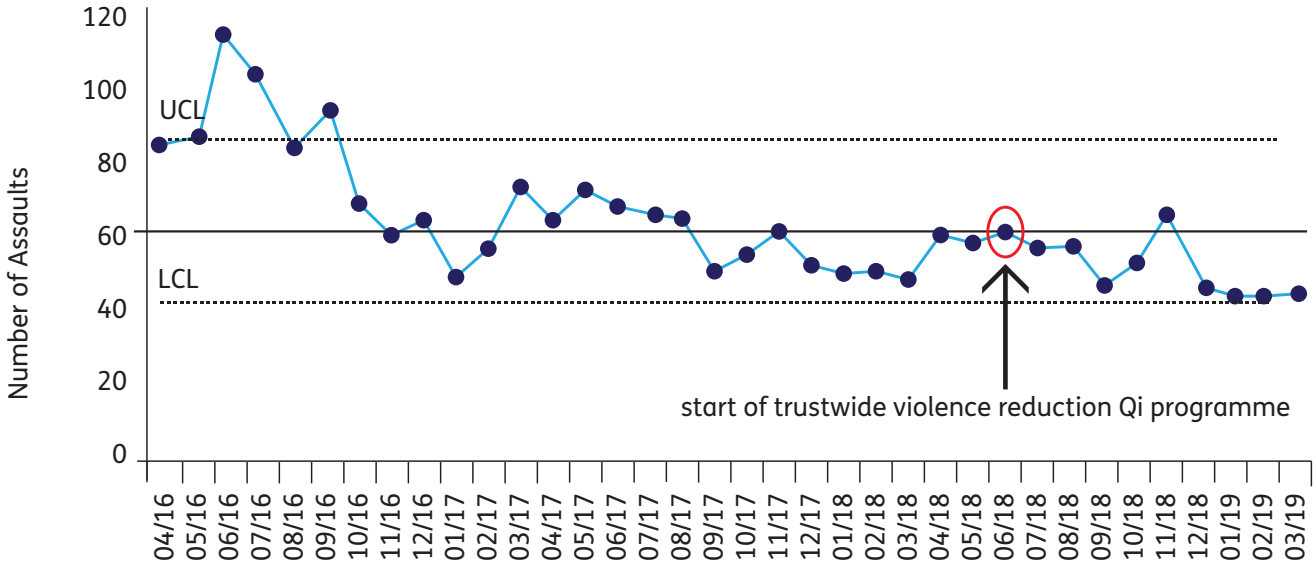
Chart 7



Quality Report

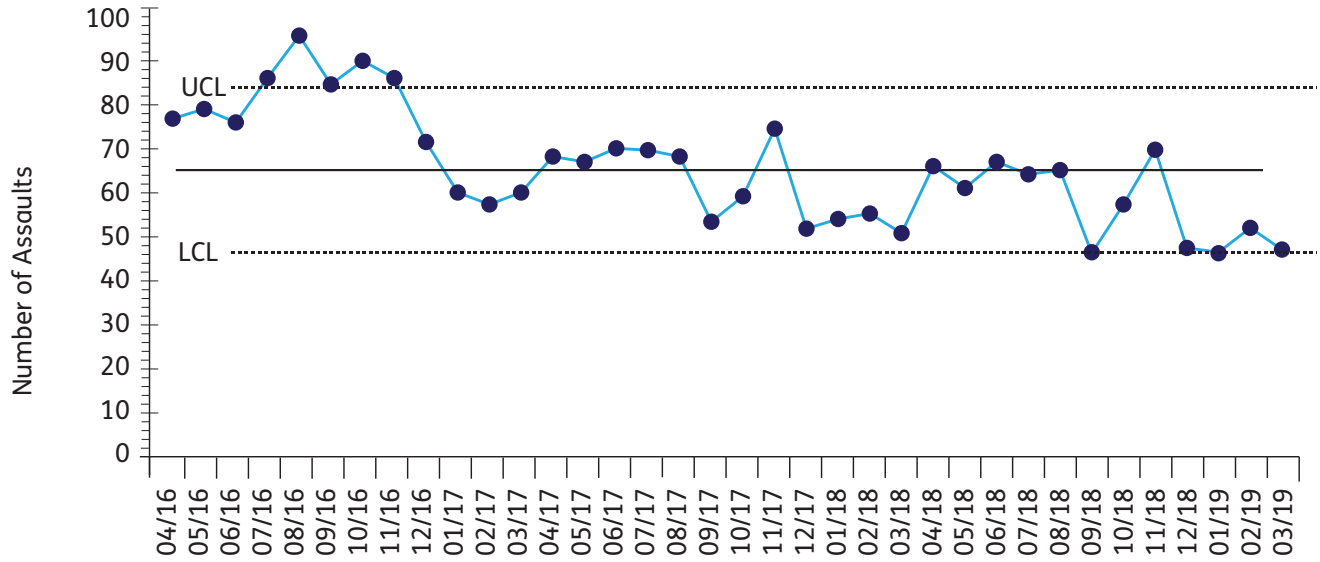
We have seen the incidents of violence and aggression to staff and patients fall since 2016 as shown in the graphs below, this is as a result of the work we have done with the Qi programme and our trustwide staff engagement programme looking at how we can reduce violence and aggression on our inpatient wards.

Chart 8 - Number of Assaults - Patient to Patient (April 2016 - March 2019)



Quality Report

Chart 9 - Number of Assaults - Patient to Staff (April 2016 - March 2019)



We have also provided a Qi project example that has taken place on the Tarn in section 3.3.2. We are aware that this is work in progress and there is more to do to reduce violence and aggression on our wards. We will continue to embed Safe Wards on our inpatient wards and ensure roll-out of best practice from the Qi pilots to other wards.

2.2.4.4 Reducing the use of prone restraint

For the last indicator in our safety first objective, we put forward a goal to reduce the use of prone restraint on our wards.

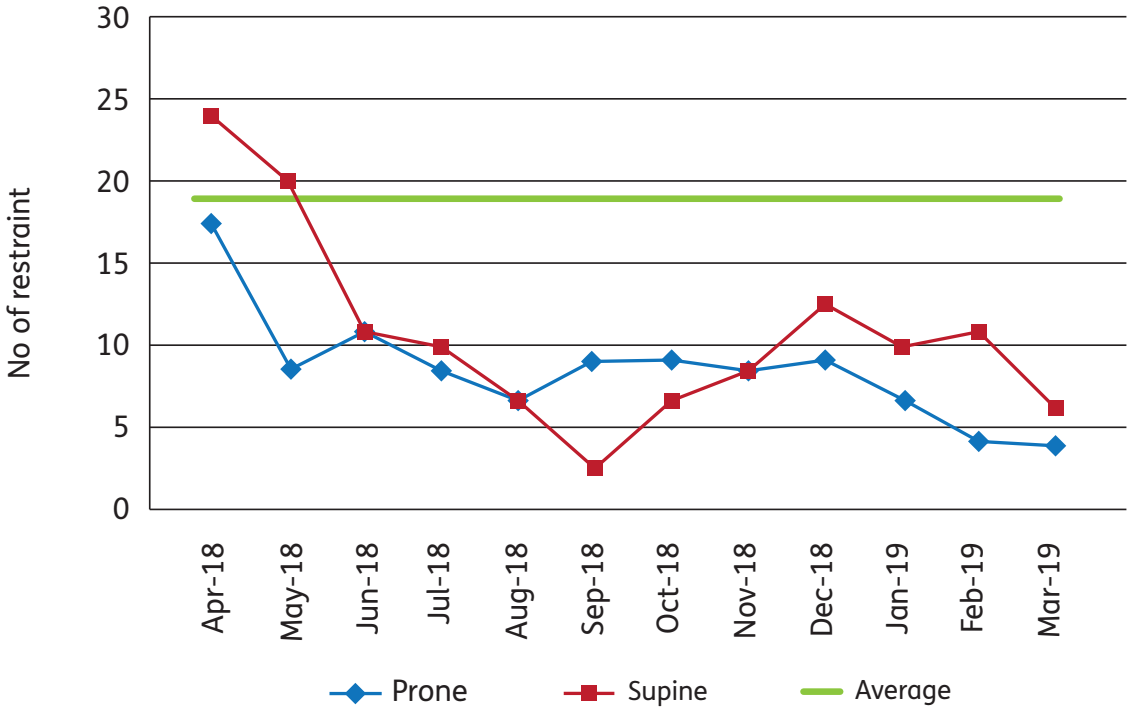
Restraint is the use of force or a threat to use force to make someone do something they are resisting, or the restriction of a person's freedom of movement, whether they are resisting or not (Mental Capacity Act 2005, section 6(4)). There may be occasions where physical restraint is necessary to safeguard a patient from either harming themselves or others. In these circumstances staff will need to be able to adopt a coherent team approach to physical restraint to ensure effective and safe management of the situation for both staff and service users.

Nationally accepted training on physical restraint techniques is provided to trust staff in accordance with the Training Needs Analysis. PAMOVA (the trust's PMVA training provider) have included in their PMVA training, risks to airways in respect of prone restraint and are now training staff in supine restraint for the administration of IM rapid tranquilisation. It is our priority that 80% of staff receives the supine restraint training.

In 2018/19, 90.3% of staff completed training in supine restraint.

There has also been a reduction in the number of prone restraint as shown in chart 10 below:

Chart 10 - Use of prone vs supine restraint 2018/19



The chart shows that not only is there a reduction in the use of prone restraint, there is also a reduction in the use of both prone and supine restraint overall.

The final part of this indicator was to reduce the duration when prone restraint has been unused; unfortunately this was an area that was not regularly completed on Datix by staff who had recorded incidences on the reporting system. This means that

the data available is incomplete and we are unable to report on this however to enable consistent monitoring we have made a new 'length of restraint' field mandatory for 2019/20.

2.2.5 Quality Objective 5 – Providing care in line with national best practice and guidelines

There are two indicators that come under this objective

- To continue to engage in national audits that permit benchmarking of Oxleas services (Data source – national clinical audit utilising data from RiO in line with national guidance)
- To participate in the national programme of improving the physical health of patients with serious mental illness and to achieve the set targets of comprehensive cardio-metabolic risk assessment using the Lester Tool and interventions in patients at high risk (Data source – national clinical audit utilising data from RiO in line with national guidance)

2.2.5.1 Quality Indicator – Engaging in national audits

One of our trust values is to ensure excellence in everything that we do by providing services and delivering care in line with national best practice and guidelines. One of the ways to do this is to engage in national audit. In 2018/19, we have made every effort to participate in national audits applicable to the services that we provide. As described in section 2.4.1 below, we participated in 12 national audits. We are also part of the NHS Benchmarking network and participated in the Mental Health Benchmarking Project and the CAMHS workforce national stocktake.

Highlights of two national audits we participated in during the reporting period is provided in section 2.4.1.

2.2.5.2 Quality Indicator – Participation in the national programme of improving the physical health of patients with Serious Mental Illness

In 2018/19, we participated in the national CQUIN programme of improving the physical health of patients with serious mental illness (SMI). Patients with SMI like schizophrenia, bipolar disorder and schizoaffective disorder die about 15-20 years earlier than the general population due to an increased risk of treatable physical health conditions such as diabetes and coronary heart disease.

Our aim is to improve the physical health care of our patients with SMI by ensuring that they have a comprehensive cardio-metabolic risk assessment, have access to the necessary treatments/ interventions and the results are recorded in their care record and shared appropriately with the patient, the treating clinical teams and the GP. In order to ensure that all patients have ease of access and in the instances where patients have not engaged or attended annual physical health checks with their GPs in primary care, we have put in place physical health clinics. We continue to ensure that results of screening are shared with the patient's GP and have developed systems to improve the exchange of information with primary care, particularly around physical health.

We participated in the national CQUIN which this year was co-ordinated by the Royal College of Psychiatrists in January 2019. This included standards on physical health screening and intervention for our patients. Whilst we have submitted data to the national team, the official results are yet to be made available. However we have provided details of our achievement against the national target based on our own internal self-assessment of the data submitted. Please note that these figures are subject to change following publication of results from NHS England in June 2019.

	Number audited	Number of compliant records	% compliance	National target	CQUIN performance
Inpatient services	50	45	90%	90%	Achieved
Early Intervention in psychosis teams	81	78	96%	90%	Achieved
Community mental health services	100	91	91%	75%	Achieved

2.2.6 Quality Objective 6 – Ensure we routinely measure clinical outcomes (how our care makes a difference to patients) – Clinical Effectiveness

The 6th and final quality objective is to ensure that we can routinely measure clinical outcomes and assess if care delivered to patients have made a difference.

For 2018/19, our improvement goal was to undertake a benchmark of Oxleas teams who regularly use clinical outcome measures and increase the coverage to ensure all Oxleas clinical directorates routinely measure the outcome of care delivered to patients.

We carried out a benchmark of all directorates in November 2018, determining which clinical outcome measures were being used by teams, what outcomes were being recorded electronically and which of these could only be collated manually. Our survey shows that there are 88 Oxleas eligible teams that can adequately use clinical outcome measures, however only 46 (52%) of these teams use clinical outcome measurement as part of routine practice.

The outcome measures that our services routinely use are:

- Adult Mental Health – Clinical Outcomes in Routine Evaluation (CORE-10) and Camberwell Assessment of Need (CANSAS)
- Older People Mental Health – Health of Nation Outcome Scales (HoNOS), CORE-10, Clinical Global Impressions (CGI)
- Forensic – Locus of Control, Core-10
- Adult Community Services – Patient Health Questionnaire – 9 (PHQ-9) and EQ-5D-5L (quality of life pre and post intervention)
- Adult Learning Disability – HoNOS LD, Therapy Outcome Measure (TOM) and Health Equality Framework (HEF)
- Children & Young People – Goal Based Outcomes, Strengths and Difficulties Questionnaire (SDQ) and Children's Experience of Service Questionnaire (Chi-ESQ)

Quality Report

Ensuring we routinely measure clinical outcomes remains an area of ongoing focus for the trust and we have identified quality goals for 2019/20.

Additional resource has also been allocated to this piece of work to improve electronic reporting and to support teams to embed this into practice.

2.3 Our Quality improvement priorities for 2019/20

In the following section, we tell you about our chosen quality priorities for 2019/20. Our priorities reflect the breadth of services we provide as follows: mental health and adult learning disability services across Bexley, Bromley and Greenwich; community health services across Bexley and Greenwich, specialist forensic mental health and prison healthcare across Kent and Greenwich.

Oxleas is committed to delivering quality services and we make every effort to work in partnership with our service users', carers, members, staff and commissioners to identify what our quality priorities should be each year. Every year we hold public meetings in each of our boroughs of Bexley, Bromley and Greenwich to give feedback on progress against our quality goals and invite opinion about potential areas of priority in the coming year. In addition, our priority areas are influenced by our engagement with local and national commissioners, through our quality meetings, our council of governors, patient groups such as Healthwatch, feedback from patient experience surveys, lessons learned from incidents and the outcome of our CQC inspection.

We also engage with staff at away days, staff meetings and annual planning events. Oxleas quality priorities for 2019/20 have also been reviewed and agreed by the trust's Performance & Quality Assurance Committee (a sub-committee of the Board).

Quality Report

Table 5 – Oxleas Quality Priorities 2019/20

Quality Objective	Quality Indicator	Service area applicable to	Quality Domain	How these will be monitored
Quality Objective 1 Ensure we meet our patient promise	To ensure 90% of patients who respond to our surveys are reporting they have been provided with enough information about care and treatment	All Oxleas Services	Patient Experience	These indicators will be monitored by the Trust Patient Experience Group and monthly by the Trust Performance & Quality Assurance Committee
	To ensure 90% of patients who respond to our surveys are reporting that they have been involved in decisions about their care and treatment	All Oxleas Services		
	To ensure 90% of patients who respond to our surveys are reporting that staff have treated them with dignity and respect	All Oxleas Services		
	To ensure 90% of patients who respond to our surveys are reporting that they would recommend our service to friends and family if they need similar care or treatment	All Oxleas Services		
	To ensure 90% of patients who respond to our surveys are reporting that their quality of life has improved as a result of the care and treatment that they have received/ was the service provided helpful?	All Oxleas Services		
	To have a minimum of 10% response rates to our patient experience surveys	All Oxleas Services		
	To ensure 90% of Oxleas teams undertake patient experience surveys	All Oxleas Services		

Quality Report

Quality Objective	Quality Indicator	Service area applicable to	Quality Domain	How these will be monitored
Quality Objective 2 Ensure we involve families, carers and people important to our patients	To ensure 90% of patients who respond to our surveys and who reported that they wanted friends/relatives involved in their care/treatment did feel that they were involved	All Oxleas Services	Patient Experience	These indicators will be monitored by the Trust Patient Experience Group and monthly by the Trust Performance & Quality Assurance Committee
	To ensure 80% of patients receiving care and treatment from our mental health services (inpatients and community) have their support network identified and noted within their care record	All Oxleas Services		
	To ensure 50% of patients receiving care and treatment from our community physical health services have their support network identified and noted within their care record	All Oxleas Services		
Quality Objective 3 Ensure we involve patients in planning their care and they have a care plan that is personal to them	To ensure 75% of Oxleas eligible teams participate in the care planning audits To ensure continuous quality improvement on percentage of the following care planning audit indicators: • 90% of care plans addressing increased risks identified in the risk assessment • 90% of care plans showing evidence of service user involvement in their development	All Oxleas Services	Clinical Effectiveness	These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance & Quality Assurance Committee
	To ensure 95% of our patients will have a recorded care plan on RiO	All Oxleas Services		
	To ensure 95% of our patients on CPA will receive a 12 monthly review	Mental Health Services, ALD Forensic & Prisons		

Quality Report

Quality Objective	Quality Indicator	Service area applicable to	Quality Domain	How these will be monitored
Quality Objective 4 Ensure we put the safety of our patients first	We will maintain a trustwide focus on the following safety areas: **Restraint** • Ensure a 10% reduction on numbers of physical restraint (baseline data - March 2019) • Ensure 95% physical health monitoring is recorded in the care records following rapid tranquilisation • Ensure 95% of patients' debriefing is documented in the care records following a restraint **Physical Health Monitoring** • 100% of wards undertaking NEWS2 monitoring and recording **Falls** • To ensure we achieve 80% of older inpatients in our community intermediate units receive the national three impact actions to prevent falls: - Lying and standing blood pressure recorded at least once. - No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics). - Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit. **Suicide prevention** • Ensure we meet 100% of the year 1 (2019/20) STORM training target for the identified eligible staff	All Oxleas Services	Patient Safety	These indicators will be monitored by the Trust Patient Safety Committee and monthly by the Trust Performance & Quality Assurance Committee

Quality Report

Quality Objective	Quality Indicator	Service area applicable to	Quality Domain	How these will be monitored
Quality Objective 5 Ensure we provide care in line with national best practice and guidelines	We will ensure comprehensive cardio-metabolic risk assessment using the Lester Tool and put in place interventions for patients identified at high risk: • Inpatients – 90% • Community Mental Health – 80% for patients on CPA • Early Intervention in psychosis teams – 90%	Mental Health	Clinical Effectiveness	These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance & Quality Assurance Committee
Quality Objective 6: Ensure we routinely measure clinical outcomes so that we know that our care makes a difference to patients	• We will ensure 60% of the eligible teams in our Children & Young People, Forensic and Adult Learning Services routinely measure and record paired clinical outcomes in the patient record • We will undertake a pilot of the use of DIALOG in our ICMP and EIP community mental health teams • To ensure the use of the Modified Barthel Index (MBI) clinical outcome measure on admission and discharge of patients to our Community intermediate care units to determine level of dependency We will ensure implementation of the following patient experience measures: • 90% of patients who respond to our surveys to report that they would recommend our service to friends and family if they need similar care or treatment • 90% of patients who respond to our surveys to report that their quality of life has improved as a result of the care and treatment that they have received/was the service provided helpful?	• All Oxleas Services	Clinical Effectiveness	These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance & Quality Assurance Committee

2.4 Statements of Assurance from the Board

For this section of the Quality Accounts, we provide a number of nationally mandated statements of assurances from our trust board

During 2018/19, Oxleas NHS Foundation Trust provided and/or sub-contracted seven relevant health services covering the following directorates:

- Greenwich Services (mental health and community physical health)
- Bexley Services (mental health and community physical health)
- Bromley Services (mental health)
- Adult Learning Disabilities Services (inpatient and community)
- Children and Young people Services (mental health, community and specialist children)
- Specialist Forensic Mental Health Services (inpatient and community)
- Prison health care (Kent and Greenwich)

Mental health and adult learning disability services are provided across the London boroughs of Bexley, Bromley and Greenwich; in addition to this, our specialist forensic services also take referrals from any area nationally if clinically appropriate. Community physical health services are provided across Bexley and Greenwich, and community health visiting services are provided across Bromley and Greenwich only.

Oxleas has reviewed all the data available to them on the quality of care in all seven of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Oxleas for 2018/19.

2.4.1 Participation in Clinical Audits

Oxleas NHS Foundation Trust uses participation in national clinical audit programmes and confidential enquiries as a driver for improvements in quality. Initiatives like these not only provide opportunities for comparing practice nationally, they play an important role in providing assurances about the quality of our services. We are committed to ensuring that all clinical professional groups participate in clinical audit.

During 2018/19, 12 national clinical audits and 21 national confidential enquiry covered NHS services that Oxleas NHS Foundation Trust provides.

During this period, Oxleas participated in 100% of the national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Oxleas was eligible to participate in during 2018/19 are as follows in tables 6 and 7 below.

The national clinical audits and national confidential enquiries that Oxleas 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.

Table 6

No.	National clinical audit title 2018/19	Participation (yes/no)	Number of cases submitted	% of cases submitted
1	National Audit of Care at the End of Life (NACEL)	Yes	N/A	N/A
2	Sentinel Stroke National Audit programme (SSNAP)	Yes	116	94%
3	National Audit of Cardiac Rehabilitation (NACR)	Yes	385	56%
4	National Audit of Intermediate Care (NAIC)	Yes	259	62%
5	National Clinical Audit of Psychosis – spotlight audit	Yes	150	100%
6	6D. Assessment of side effects of depot antipsychotics (POMH)	Yes	139	100%
7	7f. Monitoring of patients prescribed lithium (POMH)	Yes	113	100%
8	16B. Rapid Tranquilisation (POMH)	Yes	36	100%
9	National Audit of Anxiety and Depression	Yes	83	100%
10	National Audit of Anxiety and Depression Spotlight Psychological Therapies	Yes	228	100%
11	18a. Use of Clozapine (POMH)	Yes	95	100%
12	Learning Disability Mortality Review Programme (LeDeR)	Yes	15	83%

Table 7

No.	National clinical audit title 2018/19	Participation (yes/no)	Number of cases submitted	% of cases submitted
1	Mental Health Clinical Outcome Review Programme (National Confidential Inquiry into Suicide and Homicide [NCISH])	Yes	21	100%

Quality Report

The reports of 8 national clinical audits were reviewed by Oxleas in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided. All national and trust wide priority audits are reviewed at the trust Clinical Effectiveness Group (CEG - a sub-group of the trust Quality Committee) where results are presented and action plans are agreed for each applicable service. We undertake a review of actions to ensure that these are completed in a timely manner and have met the recommendations set; furthermore we participate in re-audits to check compliance with standards. We have provided two examples of national audits reviewed by the trust Clinical Effectiveness Group below:

2.4.1.1 – National Parkinson's Audit

The Oxleas Neuro Rehabilitation Team is a community based multi-disciplinary service seeing anyone with an acquired neurological condition who would benefit from rehabilitation. The team visits people in their own homes or nursing homes and in addition runs therapy groups. The team is made up of Occupational Therapists, Physiotherapists, Speech and Language Therapists, Neuro nurses, Therapy assistants and a nurse specialist for Multiple Sclerosis and one for Parkinson's.

We participated in 2017 Parkinson's UK audit of services providing care for people with Parkinson's; the review of the findings occurred during the 2018/19 reporting period. The aim of the audit was to outline the current state of Parkinson's services with reference to the new guidelines, Parkinson's disease in Adults (National Institute for Health and Care Excellence, NICE, 2017) and identify areas for quality improvement.

The audit was conducted by therapists and nurses in the Bexley Neuro Rehabilitation Team, with the main data collection via:

- A retrospective notes audit – patients with a confirmed diagnosis of Parkinson's disease open on the team caseload
- Patient Reported Experience Measure (PREM) – a selection of patients were sent a survey to provide feedback on the service provided

The results of the audit showed that we offered a service that met the key areas stipulated in the Parkinson's guidelines however the following areas were highlighted for improvement:

- Identifying Parkinson's specific competencies for completion during team induction
- Referrals to Occupational Therapy for leisure-based goals
- A consistent approach to measures taken at initial assessment and each review point for communication.
- Waiting times for physiotherapy to continue to be monitored and patients to be prioritised on the basis of need
- Ensuring a full assessment of leisure, work and family roles is explored at initial assessment

The results of the audit have been reviewed by the trust Clinical Effectiveness Group (CEG) and we have agreed the following actions:

- We will identify competencies specific to Parkinson's for inclusion at the team induction.
- We will review current documentation and training to ensure referrers and staff within the team are aware of the importance of leisure, work and family roles
- We will continue to monitor & manage the waiting times for physiotherapy to ensure that all patients are seen on the basis of need, meeting the locally agreed standard waiting times
- We will identify minimum communication and swallowing measures to be taken at initial assessment and at each review as appropriate.

2.4.1.2 Prescribing Observatory for Mental Health Audit (POMH) – prescribing valproate for bipolar disorder

Valproate is a medicine used to treat epilepsy and bipolar disorder. There are risks to the foetus if a woman takes valproate when she is pregnant. In women who are prescribed valproate for bipolar disorder and do not have epilepsy, 2-3 babies out of every 100 will be born with a birth defect, for example spina bifida, and around 30-40 out of every 100 may have developmental problems.

The national audit standards state the following:

- Do not routinely prescribe valproate for women of child-bearing age
- If valproate is prescribed for a woman of child-bearing age, there should be documented evidence that the woman:
  - is aware of the need to use adequate contraception, and
  - has been informed of the risks that valproate would pose to an unborn baby.
- Prior to initiating treatment with valproate, the following should be documented in the clinical records: weight and/or BMI, the results of liver function tests (LFTs), and a full blood count (FBC)
- Body weight and/or BMI, blood pressure, plasma glucose and plasma lipids should be measured at least annually during continuing valproate treatment.

In addition to standards around prescribing for women of child-bearing potential, there is the treatment target:

'Serum valproate levels should not be routinely monitored unless there is evidence of ineffectiveness, poor adherence or poor tolerability/toxicity.'

Where we did well:

- For women of child-bearing potential with a diagnosis of bipolar disorder, valproate was prescribed for 23% in the total national sample (TNS) compared to only 18% in the Oxleas sample; for both the TNS and Oxleas there has been virtually no change since the baseline audit.
- When valproate was started in women of child-bearing potential in Oxleas (n=2) there was documented evidence regarding use of contraception and evidence that safety issues were discussed in both cases.
- Of 3 early on-treatment reviews in Oxleas patients, all had therapeutic response documented though with some gaps in adherence assessment, weight, side-effect and blood monitoring (FBC/LFTs).

Where there is room for improvement:

Valproate levels were measured for 16% of the subsample in Oxleas; 10% for non-indicated clinical reasons. This compares to 8% and 4% in the total national sample respectively.

Summary of actions:

- A 'valproate' page on the trust intranet page, explaining the rationale for the new national guidance, with links to all resources required.
- Feedback to teams/trust governance meetings with feedback pamphlet, summarising results.
- Pharmacy newsletter item in December 2018 explaining why valproate plasma levels should not be analysed routinely.

Quality Report

2.4.2 Oxleas Clinical Audit Programme

The reports of 28 local clinical audits were reviewed by Oxleas in 2018/19 and we intend to take the following actions to improve the quality of healthcare provided:

Ensure recommendations and action plans are agreed across each of our directorates to improve the quality of healthcare provided. We will continue to maintain a focus on improving clinical practice in accordance with national and local guidance; and ensure that these form part of our local clinical effectiveness group work plans.

Copies of all Oxleas completed audit reports (inclusive of recommendations and action plans) can be requested from:

Quality & Governance Department
Oxleas NHS Foundation Trust
Pinewood House, Pinewood Place
Dartford, Kent, DA2 7WG
Tel: 01322 625770

2.4.3 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Oxleas in 2018/19 that were recruited during that period to participate in national research studies approved by a research ethics committee was 461, which represents a 32% increase on the previous financial year. We have also hosted 35 locally initiated service evaluations and 6 locally initiated formal research studies across our services.

Our on-going participation in clinical research both national and local demonstrates our commitment to improving the quality of care we offer and our contribution to wider health improvement. It allows our service users and carers access novel treatments that are not available as routine NHS care and also provides an opportunity for our clinical staff to be trained in providing them.

2.4.4 Quality Improvement and Innovation Goals agreed with Commissioners

A proportion of Oxleas income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between Oxleas and any person or body we have 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 from our Quality and Governance Department (oxl-tr.quality@nhs.net)

Our total 2018/19 CQUIN income conditional on achieving all the quality improvement and innovation goals was £4.16m. The assumed provisional payment dependant on confirmation from our associated commissioners on achieving the goals set by the end of March 2019 is £3.4m. Our total CQUIN income for the previous year 2017/18 was £3.5m.

2.4.5 Registration with the Care Quality Commission (CQC)

Oxleas NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'Registered with no conditions applied'.

The Care Quality Commission has taken enforcement action against Oxleas during 2018/19.

Oxleas has participated in investigations relating to services provided at Oaktree Lodge by the Care Quality Commission during 2018/19. Oaktree Lodge is a 17 bed ward providing continuing care to older adults with mental health problems. The ward provides care and treatment to male and female patients, and most patients also have physical health problems. CQC's investigation was a focussed unannounced inspection of Oaktree Lodge which took place on the 9th of April 2018. Oxleas was issued with a S29A Warning Notice in relation to the following areas:

- Person Centred Care – the care and treatment of patients was not always appropriate
- Dignity and Respect – there were incidences where patients were not always treated with dignity and respect
- Safe Care and Treatment – there were incidences where assessment of risks to the health and safety of patients were not done in a timely way
- Good governance – The trust had not effectively assessed, monitored and improved the quality and safety of the service provided.

Oxleas took the following actions to address the requirements reported by CQC:

- We put in place an immediate improvement action plan that was shared with CQC, NHS Improvement, NHS England and our local Clinical Commissioning Group (Greenwich CCG)
- A taskforce group chaired by the Deputy Chief Executive met weekly to oversee progress against each area
- We put in place a staff development and support programme to improve morale, purpose and recognition
- We increased senior leadership and visibility to the unit
- The trust Performance & Quality Assurance committee (a sub-committee of the Board) maintained oversight of the improvement plan.

Oxleas has made the following progress by 31 March 2019. We were disappointed that the above areas had been identified for improvement and worked with staff to ensure that significant changes could be made to improve patient care. We are pleased to report that CQC came back and re-inspected Oaktree Lodge on the 20th of June 2018 and their findings showed that each regulation breach had been resolved and that significant improvements had been made within a 3 month period. As a result the S29A notice has been lifted.

In addition, Oxleas underwent a comprehensive inspection by the Care Quality Commission between 21 November 2018 and 11 January 2018; 6 out of our 14 core services were visited and a well led inspection also took place. Their inspection report was published in March 2019 giving Oxleas an overall rating of Good and rated some of our services as outstanding for caring and effectiveness.

Quality Report

Joint Her Majesty's Inspectorate of Prisons (HMIP) and CQC Inspections

Oxleas provides services to Greenwich and Kent Prisons and during 2018/19, the HMIP and CQC'S Health and Justice Team carried out joint inspections of the following prisons:

- HMP Isis – 23 July to 2 August 2018
- HMP Thameside – 16-17 August 2018
- HMP Maidstone – 8, 9 and 15-19 October 2018
- HMP Rochester – 8 November 2018

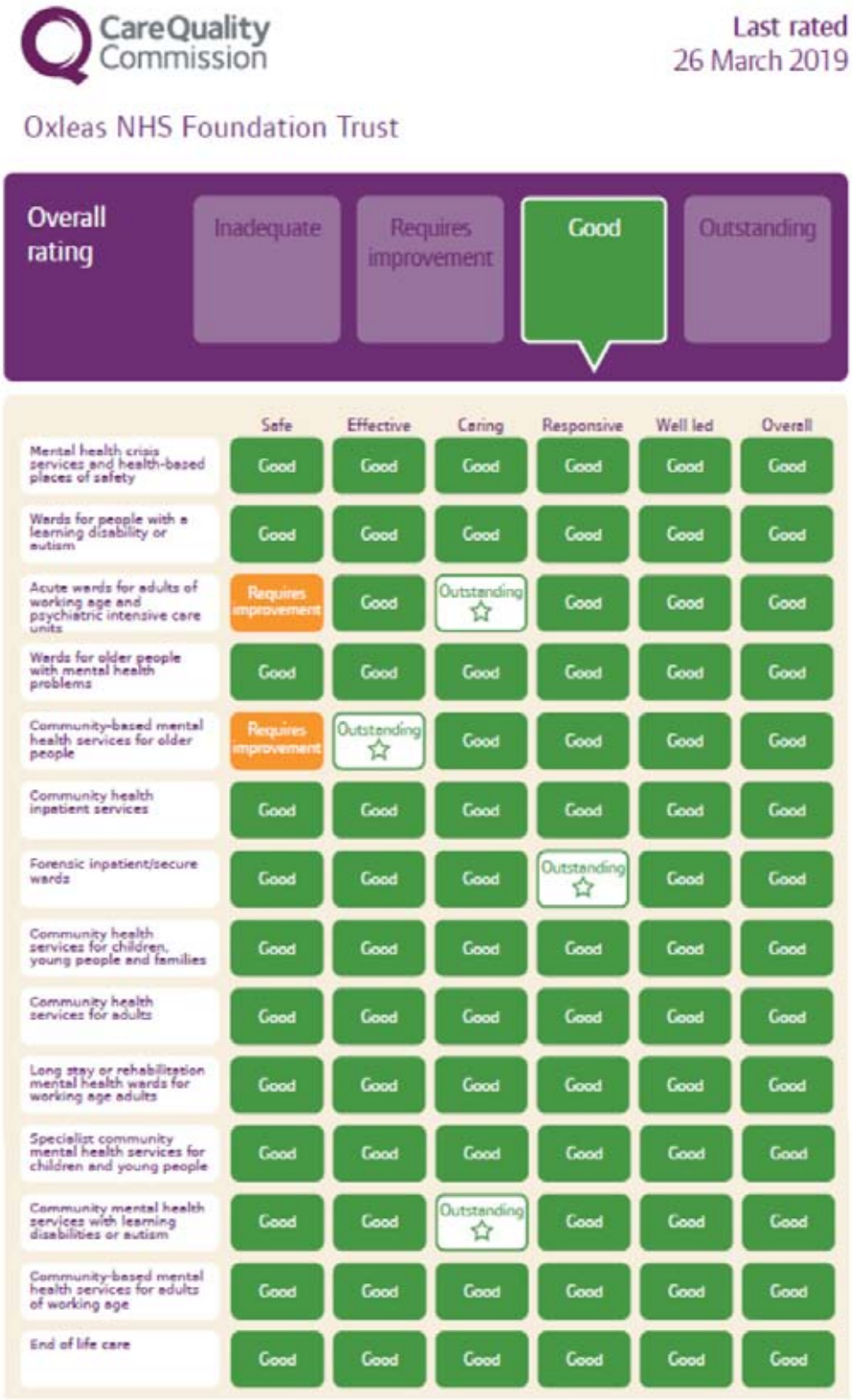
Oxleas has put in place improvement action plans for the following areas where regulations were not met:

- Person-centred care – management of patients with long term conditions
- Good governance – ensuring systematic monitoring of quality and safety of services being provided

Progress against these improvement plans is monitored by the trust Executive and the Performance & Quality Assurance Committee (a sub-committee of the Board)

Provided across is the updated CQC ratings dashboard for the trust:

Quality Report



2.4.6 Data Quality

Oxleas submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data that included the patient's valid NHS Number was:

- 99.23% for admitted patient care
- 99.88% for outpatient care
- 0% for accident and emergency care. (This is not applicable, as Oxleas does not submit data in relation to accident and emergency care. This is an acute trust indicator)

The percentage of records in the published data that included the patient's valid General Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 0% for accident and emergency care. (This is not applicable, as Oxleas does not submit data in relation to accident and emergency care. This is an acute trust indicator)

2.4.7 Information Governance Toolkit

The information governance toolkit has been superseded by the NHS Digital Data Security and Protection (DSP) Toolkit. There are 100 mandatory requirements in the NHS Digital DSP toolkit and Oxleas DSP overall submission for 2018/19 was 'Standards met'.

2.4.8 Clinical Coding

Oxleas NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the National Audit office.

2.4.9 Improving Data Quality

Oxleas will be taking the following actions to improve data quality:

- Continue to ensure all our clinicians are trained to record effectively on RiO (our patient electronic clinical system)
- Use our clinician tasklist on Ifox (Information for Oxleas)* to check completeness of recording information on RiO
- Validate data provided to teams and directorates on a monthly basis to ensure accuracy.
- Continue an ongoing programme of audit through our Clinical Data Governance Group

*Ifox – This is the Oxleas Business Information System.

2.5 Learning from deaths

For 2018/19, all NHS trusts have a requirement to publish learning from deaths data. The Oxleas 2018/19 position is provided below:

2.5.1 Number of patients who died in 2018/19

During 2018/19, 1,068 of Oxleas patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 286 in the first quarter
- 263 in the second quarter
- 263 in the third quarter
- 256 in the fourth quarter

Quality Report

2.5.2 Number of deaths subjected to a case record review or an investigation

By 24th April 2019, 1,021 case record reviews and 47 investigations have been carried out in relation to 1,068 of the deaths included in item 27.1.

In 1,068 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 286 in the first quarter
- 263 in the second quarter
- 263 in the third quarter
- 256 in the fourth quarter

2.5.3 Estimate number of deaths for which a case review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided

17 representing 1.6% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

- In relation to each quarter, this consisted of:
- 1 representing 0.3% for the first quarter;
- 2 representing 0.7% for the second quarter;
- 12 representing 4% for the third quarter;
- 2 representing 0.8% for the fourth quarter

These numbers have been estimated using the root cause analysis methodology. The panel considered whether the incidents could have been predicted or prevented. Since October 2017, our investigation panels have also used The Royal College of Physician's Structured Judgement Review to form a view of avoidability. None of the deaths reviewed have been considered avoidable.

2.5.4 Summary of what Oxleas has learnt from case record reviews and investigations undertaken in 2018/19, actions taken and assessment of impact

We have provided below some examples of what we have learnt from some of the case reviews and investigations undertaken, the actions taken and the assessment of the impact of the actions taken. This covers 27.4, 27.5 and 27.6 of the 'learning from deaths' quality account regulations.

Lesson 1

There continues to be variation in care planning. Care plans do not always adequately reflect current care needs and changing risks, including physical health needs.

- Action taken: All services are expected to complete an audit of 5 patients care plans every month. The results of the audits are shared with the team.
- Assessment of the impact of the actions: All services are expected to complete an audit of 5 patients care plans every month and these are monitored via the CEG.

Quality Report

Lesson 2

In some cases there was a requirement for more robust completion of physical health monitoring during admissions.

- Action taken: Heads of nursing have developed a template to assess and monitor physical health care on the mental health wards.
- Assessment of the impact of the actions: The Heads of nursing now use this template to audit how the physical health of patient's on the mental health wards are monitored each month. This information is then shared with the team and support provided where identified.

Lesson 3

There were instances where carers could have been involved in a discussion about overnight leave. It was also identified that there needs to be better checking and updating of next of kin details on admission to hospital.

- Action taken: This had led to further actions on implementing carers' involvement guidance and carers awareness training in non- CPA outpatient appointments.
- Assessment of the impact of the actions: The CPA policy was recently updated with additional information about carers and what is expected of the care-coordinator. The trust also has a Carers and Support Networks Strategy available on the intranet.

Lesson 4

In one case it was identified that there as poor engagement in outcomes monitoring.

- Action taken: Psychological therapists are developing a protocol for management of poor engagement in evaluating outcome measures. It was agreed that the CORE 10 would now be reviewed as part of psychotherapy sessions.
- Assessment of the impact of the actions: This has been completed and the CORE 10 is now reviewed as part of psychotherapy sessions.

Lesson 5

In a number of incidents the risk assessment did not reflect the current risks, in particular after every significant event.

- Action taken: Risk assessments are to be reviewed with staff during supervision to monitor the quality and accuracy of the assessment.
- Assessment of the impact of the actions: Heads of Nursing continue to review the quality and completeness of risk assessments.

Lesson 6

In two cases The Safe and Therapeutic Observation policy was not adhered to. Staff were not engaging with patients during observations.

- Action taken: The teams have been reminded to engage with service users when carrying out observations.
- Assessment of the impact of the actions: Staff have read 'The Safe and Therapeutic Observation policy' with their manager and sign a competency form.

Lesson 7

Teams are to implement the recently approved trust wide action plan in relation to the management of co-morbid substances misuse.

- Action taken: An embedded learning event on substances misuse and alcohol took place on 22 February 2019. The event focused on joint working with substance misuse services,

expectation of staff, overcoming barriers to engagement, legal highs and key themes from serious incidents.

- Assessment of the impact of the actions: 42 staff attended the Substance Misuse and Alcohol event. The event incorporated 5 sessions; Joint working with substance misuse services, (Not so) legal highs: what you need to know about Novel Psychoactive Substances, The expectation of Adult Mental Health Staff in supporting patient who have substance misuse problems, Overcoming barriers to engagement, and Key Themes from Serious Incidents. The overall event was rated as; Excellent – 50%, Good – 50%.

2.5.5 The number of case record reviews or investigations not included in section 2.5.2

0 case record reviews and 0 investigations completed after 31st March 2018* which related to deaths which took place before the start of the reporting period.

2.5.6 Estimate number of deaths for which a case review or investigation has been carried out in section 2.5.5 above for which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has estimated using the root cause analysis methodology. The panel considered whether the incidents could have been predicted or prevented. Since October 2017, our investigation panels have also tried to use the Royal College of Physician's structured judgement review to form a view of avoidability. None of the deaths reviewed have been considered avoidable.

2.5.7 Revised estimate of the number of deaths in 2018/19 taking account of deaths referred to in section 2.5.6 above

0 representing 0% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.6 Performance against National Core Indicators

One of our requirements as an NHS Foundation Trust is to report our performance against a core set of indicators, which is published by NHS Digital (an arms-length body of the Department of Health and are the national provider of information and data)

There are 5 indicators, which are relevant to the services we provide, and our performance against these indicators is shown below. This is the latest information published by NHS Digital:

Quality Report

Table 8

	National Quality Indicator		Oxleas 2016/17	Oxleas 2017/18	Oxleas 2018/19	National Average	Highest Trust Performance	Lowest Trust Performance
1	The percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period		97.6%	99.0%	97.0%	95.5%	100.0%	81.6%
2	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.		99.2%	99.5%	98.2%	97.8%	100.0%	78.8%
3	Percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. (question 21d)		65.4%	67.0%	66.2%	66.2% (combined MH & Community Trusts)	79.1% (combined MH & Community Trusts)	55.9% (combined MH & Community Trusts)
4	The trust's 'patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.		7.5/10	7.6/10	7.0	Not provided	7.7/10	5.9/10
5	The number and where available, the rate of patients safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	No.	45	24	27	Not available on NHS Digital website		
		%	0.59	0.35	1.5	Not available on NHS Digital website		

Quality Report

Please note: The information published above are taken from differing reporting periods by the NHS Digital, NHS England or the Care Quality Commission

Q1: NHS Digital: Mental Health Community Teams Activity. October – December 2018. Published 15 February 2019

Q2: NHS Digital: Mental Health Community Teams Activity. October – December 2018. Published 15 February 2019

Q3: National NHS Staff Survey 2018: NHS England, NHS Survey Co-ordination Centre http://nhsstaffsurveys2018.com/files/NHS_staff_survey_2018_RPG_full.pdf

Q4: Care Quality Commission: Patient experience of community mental health services. Published November 2018 http://www.nhssurveys.org/Filestore/MH18/MH18_RPG.pdf

Q5: NHS Improvement, National Reporting and Learning System, Organisation Patient Safety Incident workbook. Published 27 March 2018 Data for incidents April to September 2018 https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-march-2019/

For indicators 1 and 2 relevant to the services we provide shown in table 8 above:

Oxleas considers that this data is as described for the following reasons:

- These are NHS Improvement (NHSI) targets that we report on monthly
- It meets the NHS Outcomes Framework domains of preventing people from dying prematurely and enhances the quality of life for people with long term conditions
- The data for these indicators are recorded on RiO and submitted to NHS Digital and NHSI

Oxleas intends to take the following actions to improve the percentage of 97%, and so the qualities of its services by continuing our focus of following up patients within 7 days after discharge from psychiatric in-patient care. Our aim is to improve this to 100% although we recognise that there may be occasions when our staff cannot meet this goal for reasons outside their control. In terms of ensuring that all of our admissions to acute wards are gate kept by our Crisis Resolution Home Treatment Teams, we will maintain our focus and improve our position from and 98.2%% to 100%.

For indicators 3 and 4 relevant to the services we provide shown in table 8 above:

Oxleas considers that this data is as described for the following reasons:

- These are based on our involvement in the National Patient and National Staff Surveys
- It meets the NHS Outcomes Framework domains of enhancing the quality of life for people with long term conditions and ensuring people have a positive experience of care
- The data for these indicators are provided by the CQC and NHS England.

Oxleas intends to take the following actions to improve the percentage of 66.2% and rate of 7.0 respectively and so the quality of its services, by continuing our focus on the following:

- National Patient Survey - we have put a robust plan in place to tackle areas that require further improvement as identified by the results of the 2018 survey; this is overseen by our trust Patient Experience Group.
- National Staff Survey - We have engaged with staff to enquire what we can do better and have put in place action plans for the identified areas that require further improvement. Our Workforce Committee will monitor these and report to the Board of Directors.

For indicator 5 relevant to the services we provide shown in table 8 above:

Quality Report

Oxleas considers that this data is as described for the following reasons:

- This is patient safety information we report to the National Reporting and Learning System (NRLS)
- It meets the NHS Outcomes Framework domains of treating and caring for people in a safe environment and protecting them from avoidable harm
- The data for this indicator is recorded on Datixweb (our local incident reporting database)

Oxleas intends to take the following actions to improve the patient safety incidents that result in severe harm or death and so the quality of its services, by continuing our focus by reviewing trends and themes, learning from events and embedding learning across the trust. We will also review all reported deaths at our Mortality Surveillance Group on a monthly basis.

3.0 Other Quality Performance Information

In this section of the Quality Accounts we present other information relevant to the quality of the services provided in 2018/19.

In the earlier part of our report (please see section 2.2), we presented how we have performed against the 2018/19 quality priorities with reference to our performance in previous years where available. No changes have been made to the indicators published in the 2017/18 report.

We have provided statements of assurance on our national priorities and how we have performed against the relevant indicators. We have also looked forward to 2018/19 and highlighted our quality goals that have been agreed by our Performance & Quality Assurance Committee taking into account the views of our stakeholders to improve the quality of our services. Not all areas of focus have been included in our quality improvement goals as some are aligned to our service development strategy and our internal quality improvement initiatives within the trust. Progress on these will be reviewed through our Performance & Quality Assurance Committee, the Quality Improvement and Innovation Committee and the trust quality sub-groups of Patient Experience, Patient Safety and Clinical Effectiveness.

3.1 Performance against NHS Improvement's Single Oversight Framework Indicators

In accordance with NHS Foundation Trusts requirements from NHS Improvement (NHSI), we have detailed below our performance against the NHSI indicators that appear in the single oversight framework. There are 7 indicators applicable to the services that we provide and our performances against these are provided below:

Quality Report

Table 9

	Single Oversight Framework indicator for disclosure	2018/19 Performance	Threshold
1	Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	75%	50%
2	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a. inpatient wards b. early intervention in psychosis services c. community mental health services (people on care programme approach)	Awaiting publication of national audit results from NHS England (internal self-assessment provided below. This is subject to change) a. 90% b. 96% c. 91%	90% 90% 75%
3	Improving Access to Psychological Therapies (IAPT): Proportion of people completing treatment who move to recovery (from IAPT dataset)	58.9%	50%
4	Improving Access to Psychological Therapies (IAPT): Waiting time to begin treatment (from IAPT minimum dataset) a. Within 6 weeks of referral b. Within 18 weeks of referral	a. 94.2% b. 99.6%	a. 75% b. 95%
5	Care Programme Approach (CPA) follow up: proportion of discharges from hospital followed up within 7 days	96.6%	95%
6	Admissions to adult facilities of patients under 16 years old	0	0
7	Inappropriate out-of-area placements for adult mental health	652.7 average bed days per month	

3.2 Additional NHS Improvement Reporting Requirements

Trusts are required to provide additional information in the 2018/19 Quality Accounts. For Oxleas, these cover our arrangements for 'Freedom to speak up' – how we support staff to openly speak up without blame or suffer of detriment and our improvement plans to reduce gaps in our medical rotas:

3.2.1 Oxleas Freedom to Speak up Approach

The trust undertook a focused programme of work in 2018/19 to encourage staff to speak up and emphasise the fact that no victimisation or harassment would follow concerns being raised. The programme was initiated with publicity on the role of the Freedom to Speak up (FTSU) guardians through videos and poster. 'Let's talk' sessions with the Executive were publicised which allowed any individual in the trust to seek an audience with an Executive Director at any time.

A revised workflow was designed in April 2018 which made it easier for staff to understand the process and clearly highlighted the routes that they could follow to raise concerns within and outside the trust. The role of the guardians and the importance of staff raising concerns is emphasised at all new starter corporate inductions by the FTSU Guardian and the Director of Workforce and Qi as the Executive lead for speaking up. A copy of the workflow is also handed out to every new starter in the trust. In addition, an anonymous reporting portal was launched in January 2019 which allows all employees to raise concerns anonymously but continue to engage in a dialogue on actions taken as a result of raising the concern. These actions resulted in a marked increase in the number of concerns that have been raised in 2018/19 (65 in 2018/19, compared to 0 in the previous year).

An action plan for 2019/20 is in progress to further support these changes, and will include work to embed a culture of speaking up as well as emphasise the need for continued management engagement at all levels.

3.2.3 Improvement Plan for Doctors rota gaps

Trainees in Oxleas NHS Foundation Trust are on a shared training scheme (the Maudsley Training Scheme) with South London and Maudsley NHSFT. Rota gaps inevitably occur from time to time where posts have not been filled.

In this and other instances, the trust will endeavour to fill vacancies and the resulting gaps on rotas firstly through the appointment of NHS locum doctors. In order to ensure services are not disrupted, where positions remain unfilled, gaps in the rotas are covered through the use of trust bank, Medical training Initiative (MTI) or agency doctors.

The trust has participated in Health Education England (HEE) South London meetings to raise awareness of the ongoing implications of late running regional/national recruitment cycles and the adverse impact this is likely to have on our ability to recruit locally to posts unfilled by these recruitment campaigns. We continue to liaise closely with HEE to improve recruitment timescales.

Black History Month Celebrations 2018

Quality Report

3.3 Oxleas Quality Highlights and Case Studies

Each year, in this section of our Quality accounts we showcase a few examples of good practice from our services which align to our trust values of having a user focus, excellence, learning, being responsive, partnership and safety.

We are delighted to continue to see evidence of good practice and teams going the extra mile for the benefit of the patient, making sure we make a difference and improving lives.

3.3.1 Oxleas Quality Improvement Programme

We have a vision of creating a culture of continuous quality improvement across the whole organisation. In order to achieve this we have put in place a systematic Quality Improvement (Qi) Programme that is underpinned by the improvement techniques, systems and practices and Improvement Science. The Oxleas Qi programme was officially launched in April 2018, following investment by the trust Board of Directors. Our Qi programme focuses on the following key areas:

- Improve access to care at the right location and in a timely manner (and therefore reduce delays)
- Improve reliable adoption of evidence-based care such as personalising care planning and implementing NICE guidance
- Reduce (delays) and eliminate inefficiencies and therefore costs attributable to re-work, repeated assessments, repeated checks and addressing concerns and complaints
- Improve patient and carer experience and eliminate harm

The Oxleas Qi framework is the Model for Improvement which asks the following questions:

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

These three fundamental questions are underpinned by the plan, do, study, act (PDSA) cycle.

Qi Training – Building Staff Capability in Qi

In order to make Qi successful in Oxleas, to create a culture of continuous quality improvement and ensure improvement is everyone's business, we have put in place a clear learning/training strategy for Qi. We want a culture whereby Oxleas staff become empowered to focus on where they can make improvements to the work they do: no matter if it be in clinical care, finance, IT, estates and facilities or human resources. Based on this we have put in place a range of training/awareness options that will cover the whole trust. These range from online learning, half day or full day to advanced expert level training. Since the launch of the programme in April 2018, 10% of Oxleas staff have received some form of Qi training and we expect to see a further 17% of staff trained in 2019/20.

We expect our Qi programme to help deliver the following:

- Local teams engaged in locally led and owned improvement processes

- Consistent delivery of our quality priorities and improved outcomes across the organisation
- High staff engagement, a valued workforce, joy at work with improved recruitment and retention
- Developed data systems that effectively capture data to drive decision making at clinical and managerial levels
- Improved patient engagement and education
- Reduction in waste across the organisation

We have provided some case studies of Quality improvement, innovation and best practice examples below.

3.3.2 The Tarn Qi Project – reducing violence, aggression and agency spend

Case for change:
This project was focussed on reducing violence, aggression and agency spend on a 16 bedded Psychiatric Intensive Care Unit (PICU), the Tarn. It was observed that the Tarn was experiencing challenges relating to financial overspend, staff absence and recruitment and retention as well as incidents of violence and aggression and subjecting this to a quality improvement framework was seen as a good way forward.

What we did:

- We made some changes to how staffing was provided on the ward, such as:
- Floating bank staff were offered block bookings of 4 weeks at a time of night shifts to cover vacancies. This encouraged bank staff to work on the Tarn ward instead of other locations / trusts.
- Permanent staff were moved to day shifts, apart from at least one permanent registered nurse on each night shift. This initially caused some upset for permanent staff who were not happy about losing their night shift enhancements, however 12 months later the Tarn saw a reduction in staff sickness and eliminated agency spend. Staff also felt much happier coming to work.
- Occupational Therapy Interventions on the ward: We started a new occupational therapy (OT) programme which was run by our new OT. This involved patients and staff working together to select activities structured around daily routines. These activities included relaxation, physical exercise, creative groups and one-one sessions. A timetable was then created. Service users were encouraged to identify their mood difference before and after an OT session.

Evidence of improvement:
Significant improvement has been made as a result of the Qi programme. We have seen:

- a reduction in the use of agency staff,
- a co-produced OT interventions programme that patients have been involved in
- OT interventions are having a positive impact on service users' mental wellbeing, promoting stability in mental state and recovery. Results show that implementation of a timetable of OT activity had a significant positive impact on the wellbeing of service users.
- Improvement in roster and shift patterns to enable effective staffing levels,
- A reduction in physical violence incidents and a reduction on spend as a result of violence and aggression on the wards.
- A daily community meeting now takes place where service users and staff plan their day.

Quality Report

We have provided below some charts that visually show the improvements made as a result of the work done by the team.

Chart 11 - Tarn - Count of Incidents of Physical Violence reported on Datrix - [C Chart)

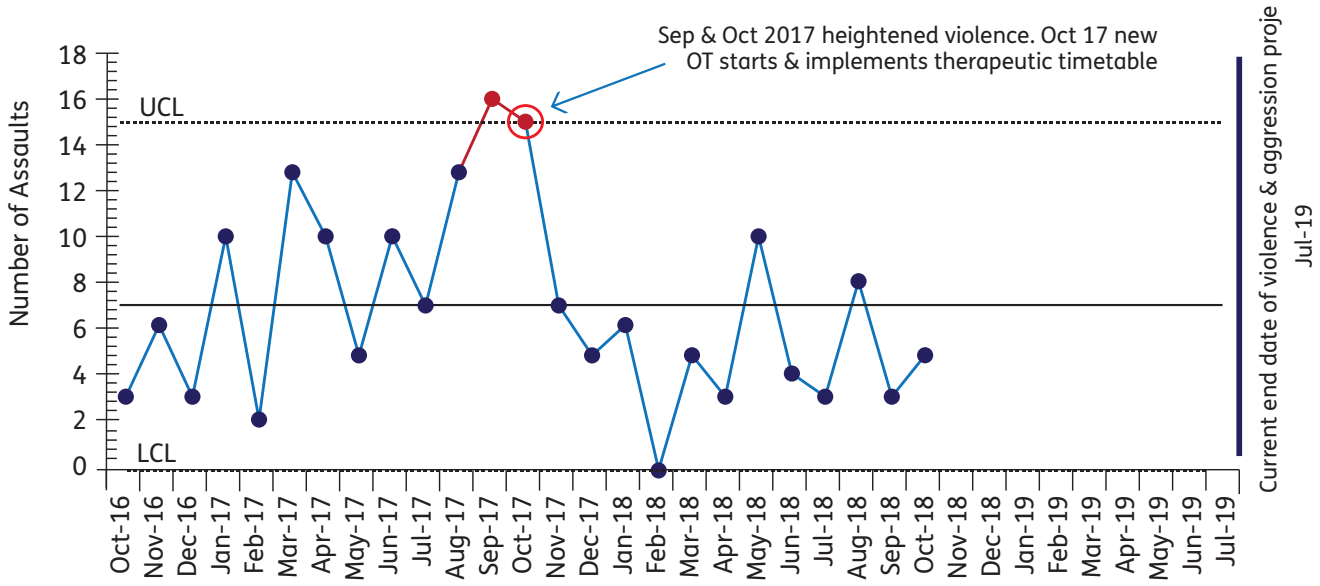
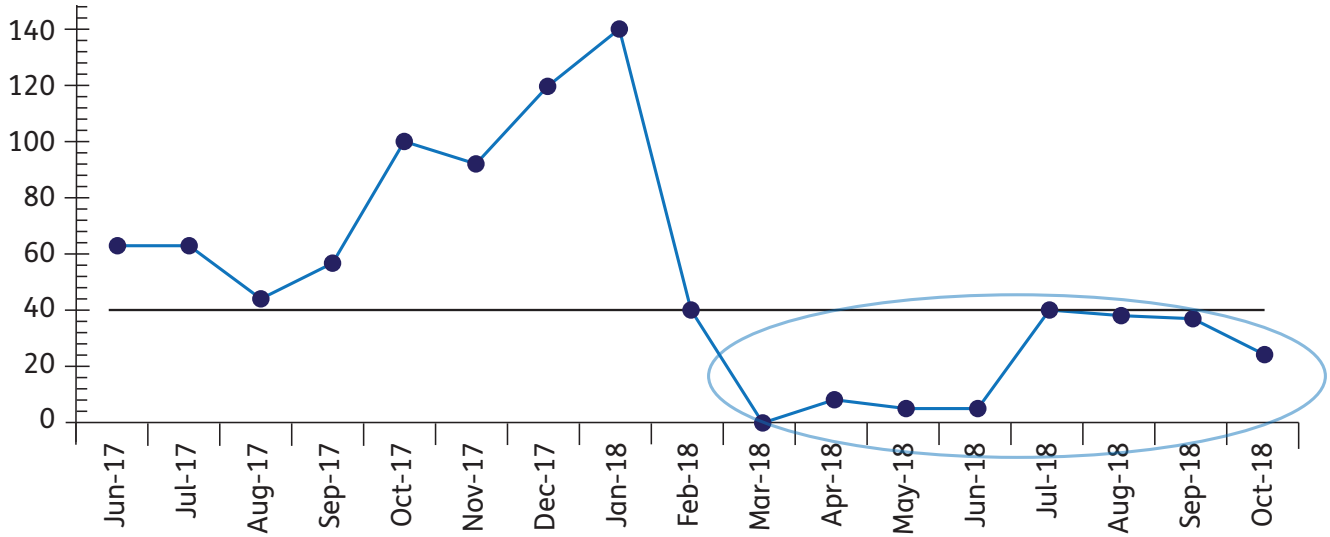
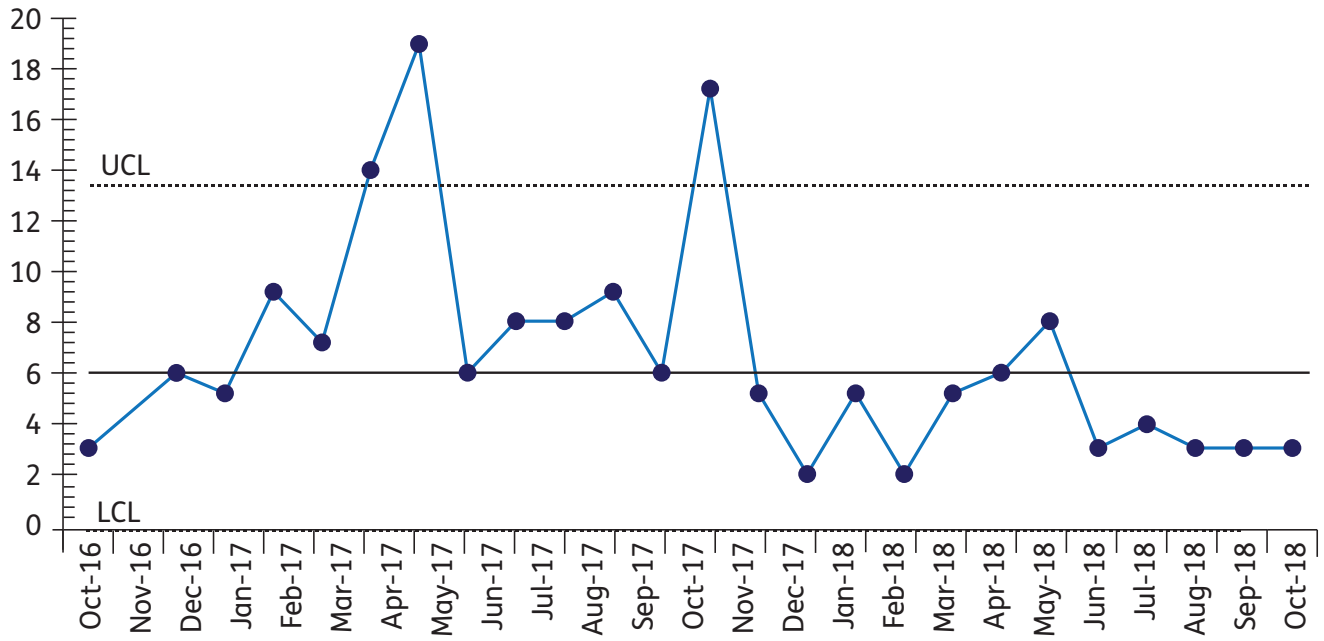


Chart 12 - Staff absence data: count of calendar days lost per month



Quality Report

Chart 13 - Number of incidents of restraint (Tarn)



Feedback from patients

Average of 'mood' scores before and after an occupational therapy timetable was introduced

"Gina (OT) took my mind off things that make me sad, stressed and unhappy. It even made my mum happy because she likes painting and flowers. Gina got me painting flowers for my mum."

Tarn service user

Next steps:

- Share learning with other Oxleas Qi projects focussed on violence reduction
- Plan for more structured activities for weekends to improve patient engagement
- Continue shared learning across London for PICU OT peer meetings

3.3.3 Bexley Intensive Case Management in Psychosis (ICMP) Qi Project – Increasing blood lipid screening for patients with serious mental illness

Case for change

NHS England (2017) state in their national CQUIN guidance that people with severe mental illness (SMI) are at an increased risk of poor physical health, and their life expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking.

Screening cholesterol level is important in the early identification of cardiac disease, and we wanted to increase early identification and management of possible cardiac disease, improve the physical health of patients with SMI and improve patient experience.

Our overall aim was to increase the uptake of lipid monitoring for patients on CPA to 80% within 6 months as this was an area that we were struggling with. Patients were not attending appointments due to fear of needles, they did not see physical health as a priority and majority would only engage in home visits. We also found out that a lot of clinician time was lost on tasks such as booking appointments and sending clinic letters for patients who would not turn up, documentation of DNAs on the patient system or escorting patients to hospital.

What we did:

We trialled the use of a mobile blood lipid testing machine; the machine can test blood lipid levels with a finger prick test rather than a full venepuncture blood test. We also offered patients who declined a full blood test as an alternative.

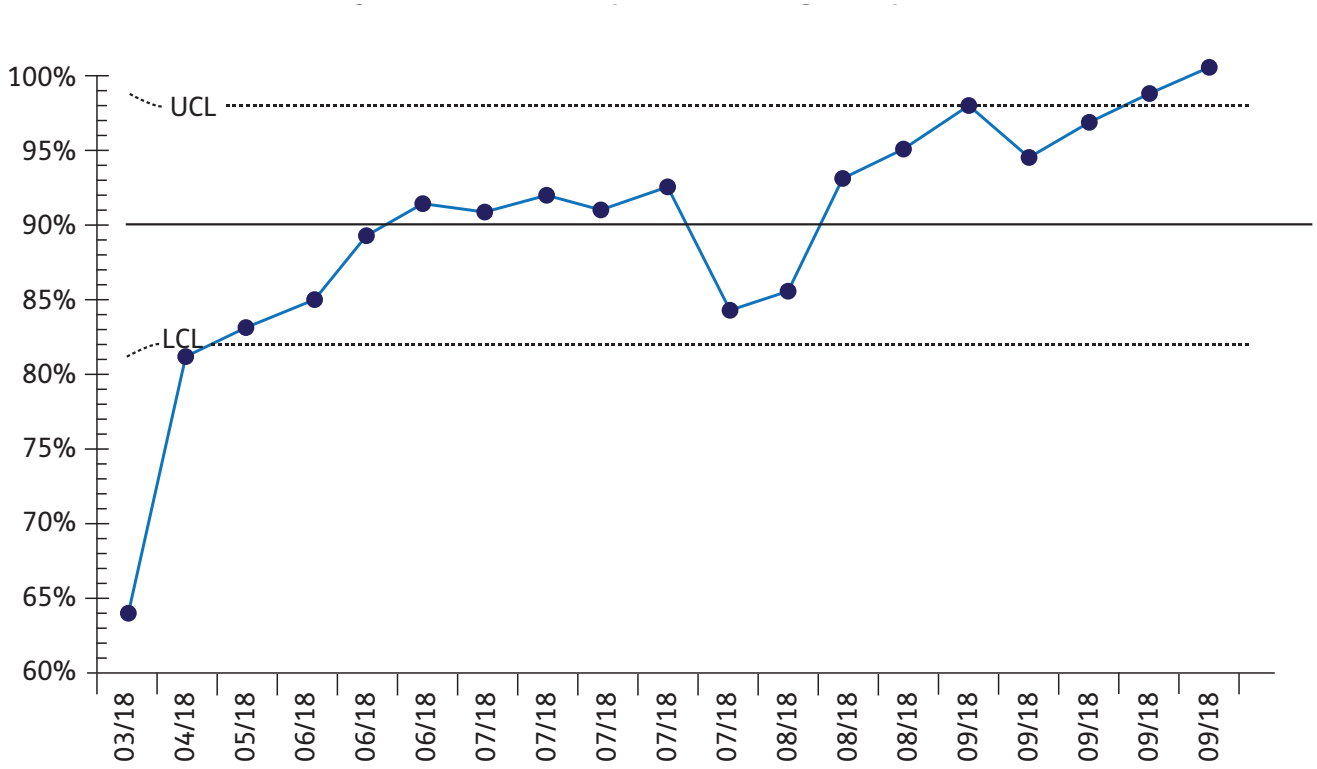
Results of the project:

The table and graph below show the outcome of our improvement project

Physical Health Indicator	Number of Patients for Screening	Number of Patients who had Screening	% of Patients who had Screening
Smoking status screening	108	107	99.07%
Substance use screening	108	108	100%
Alcohol use screening	108	108	100%
Blood lipids screening	108	108	100%
Glucose regulation screening	108	108	100%
BMI screening	108	108	100%
BP screening	108	108	100%

Quality Report

Chart 14 - Bexley ICMP - Blood Lipid Screening Compliance



- By November 2018 the team were reporting 100% compliance for all seven physical health CQUINS
- Blood screening compliance had risen from 64.1% to 100%in a 6 month period
- Of the 42 clients that were screened, 12 were identified as having high cholesterol
- Additional time was also created for staff by reducing the need to book appointments, send letters and complete blood forms
- Feedback from our service users say that the process is much quicker, easier and they were able to get their results in just three minutes

Future plans:

- Share learning with other teams across Oxleas
- Provide advice and training
- Scale up project to other teams within the borough and then across the trust

3.3.4 Improving clinical outcomes in a Musculoskeletal Service

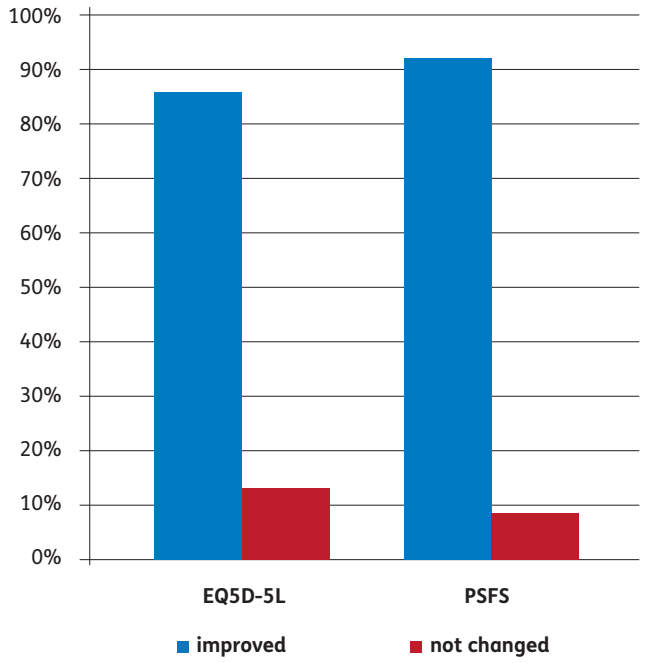
Exercise groups within physiotherapy departments have become increasingly popular in recent years, with the emergence of evidence supportive of therapeutic exercise as an effective treatment modality for many conditions including osteoarthritis, shoulder pathologies and widespread pain syndromes. Group exercises classes have been shown to be a cost effective way of treating people, reducing waitlist and having effective clinical outcomes. The use of supervised exercise therapy use is advocated by a number of NICE Guidance documents and Cochrane reviews.

The introduction of exercise classes also improves patient choice in terms of available treatments and many people find exercising within a supervised group beneficial for reasons such as improving confidence in exercise technique, motivation and adherence to rehabilitation programmes. The following have been comprised from audits of these classes. The classes resulted in the MSK team winning employee of the quarter. This improvement example also showcases one of our quality objectives – ensuring we measure clinical outcomes so that we know that our care had made a difference to patients.

Greenwich Square

12 month review most instruction of group exercise class – all class data has been combined

Chart 15



Between all classes at Greenwich square:

- 124 completed EQ5D-5L scores
- 108 of them had improvements of their EQ5D- 5L score
- 270 PSFS scores were collected 249 of these scores were improved from prior to the class
- 103 out of the 129 recorded patient outcomes (80%) have been discharged to self management
- 1 has been referred to rheumatology, 2 to pain clinic, 1 to orthopaedics and 5 to circle
- 14 has been referred back to their HCP and 3 had phone reviews

Quality Report

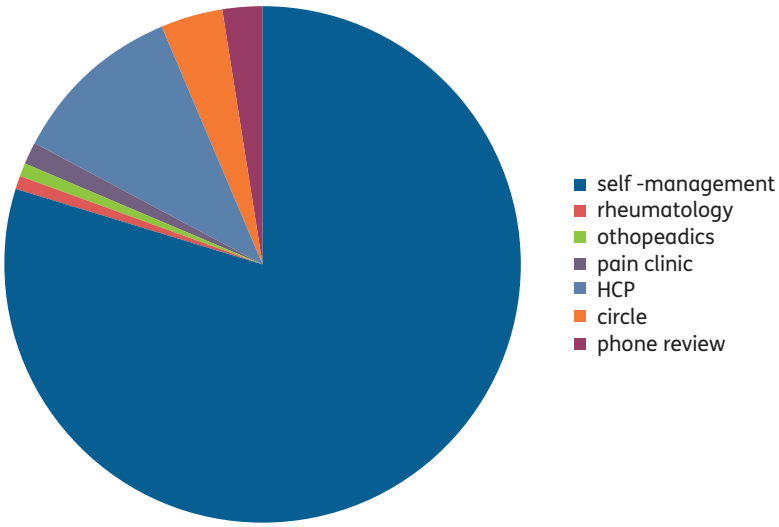
Chart 16

From patient experience questionnaire:

"Very helpful re-motivating me to believe that I can improve my situation"

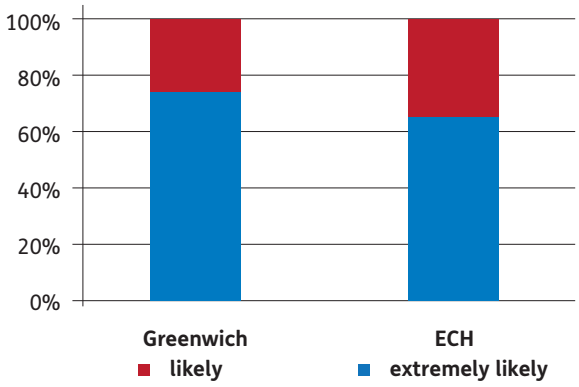
"It was good exercises and I believe I benefited from it and the staff were amazingly professional and helpful"

"I have received all the help and even more of what I needed. I am now returning to the gym. It's something I have not been able to do for a while. I was consulted in every stage of my care"



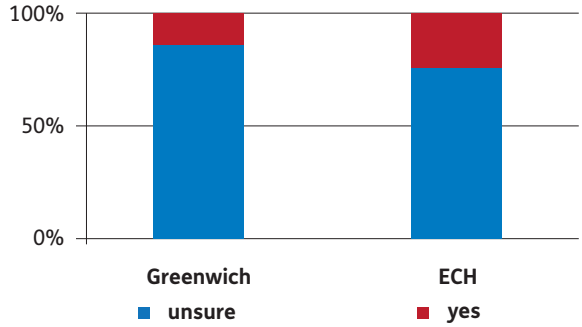
Patient Experience Feedback

We also collated patient experience feedback following attendance at these classes. We have provided a snapshot from two sites (Greenwich Square and Eltham Community Hospital) below.



How likely are you to recommend this service (the group exercise class) to your family and friends?

"The wide range of exercises improve my range of movement, the physio spent time explaining the exercises"



Do you feel you can manage you condition better today as a result of today's consultation (group class)?

"I am very happy with the service I have received so far. Very professional and friendly staff willing to go the extra mile to help me"

3.3.5 Bromley Memory Service Case Study – Improving dementia diagnosis

The Dementia 65+ estimated diagnosis rate indicator compares the number of people thought to have dementia with the number of people diagnosed with dementia. NHS England target is for at least two thirds of people with dementia to be diagnosed. This indicator is updated every month and figures published by NHS England.

Case for change

The Bromley Memory Service was commissioned as a diagnostic service in 2013 in line with NHS England guidelines and the Prime Ministers challenge on Dementia 2020. The service has been MSNAP Accredited since 2014 and we adhere to these standards and in line with the NICE guidelines for dementia. Bromley Memory Service had fallen below the diagnosis rate indicator which was set at 66.7% by NHS England. Early diagnosis helps people to have access to medication, support, information and plan for their future to assist them to live well with dementia.

What we did

We wanted to improve the diagnosis rates for Bromley and the following was put in place

- a Task and Finish group was set up with commissioners
- joint GP visits were conducted to match diagnostic data
- We promoted the memory service to GPs by updating them with services which are available to support people with dementia.

Results

Handheld ECG machines which are set up via the iPad

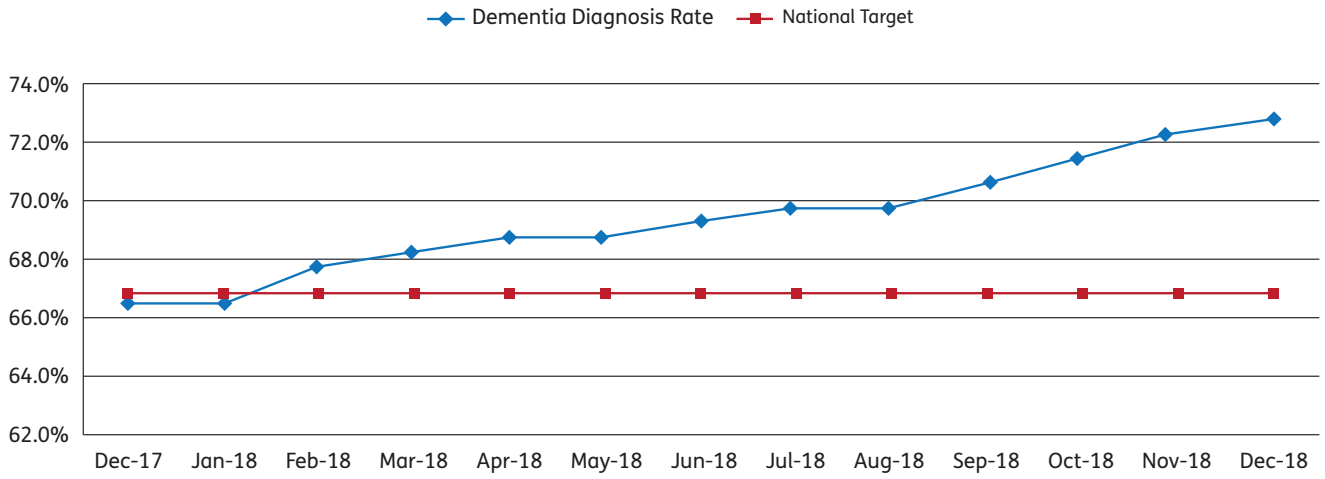
CT Scans are now requested at point of referral

Systems have been set up to access Indigo and Connect Care which gives us quicker result information and allows us to view the images

An A5 laminated sheet has been given on the GP visits of the Read Codes for the top 8 dementia diagnoses as recognised by NHS England and we have now included these in the GP Letters

Quality Report

Chart 19 - Bromley Dementia Diagnosis Rate (Dec '17 - Dec '18)



Clients comments on the Memory Service

I was very apprehensive at going but now I feel very different and feel I have benefitted and will do. I am very grateful thank you

It has been very beneficial and has definitely improved my quality of life

I gained an understanding of my mother's condition

3.3.6 Trimipramine Review —a collaborative approach to medicines management

Case for Change

In 2016 the Bromley CCG Medicines Management (MM) team identified that prescribing of trimipramine, an older tricyclic antidepressant, was higher relative to other CCGs in England, despite more effective, better tolerated, and cost-effective medicines being available. A project began to review and optimise patients' treatment with the aim of reducing trimipramine prescribing when appropriate.

Initial work took place between the MM team and GP practices, providing educational and practical support to identify patients prescribed trimipramine, resulted in a 30% reduction in prescribing. This initial review highlighted a number of more complex patients, some of whom had been prescribed trimipramine for many years. A collaborative service with Oxleas NHS Foundation Trust was commissioned in September 2017 to support GPs review complex patients to improve quality, safety, and patient experience. Soon after guidance from NHS England and NHS Clinical Commissioners was published recommending that patients treated with trimipramine be reviewed and advised that GPs should no longer start this treatment in new patients.

What we did

- 132 patients across 33 GP practices were identified, each case was discussed with their GP to decide if the GP would review or refer to Oxleas specialist pharmacist (complex cases or those requiring additional support with considering changes)
- Referrals to the specialist pharmacist were made September 2017– April 2018
- A specialist pharmacist assessed patients either face-to-face, by telephone consultation, or a case note review. When necessary, the pharmacist discussed the case with a psychiatrist or the GP before an assessment letter, containing treatment recommendations, was sent to the GP

Outcomes:

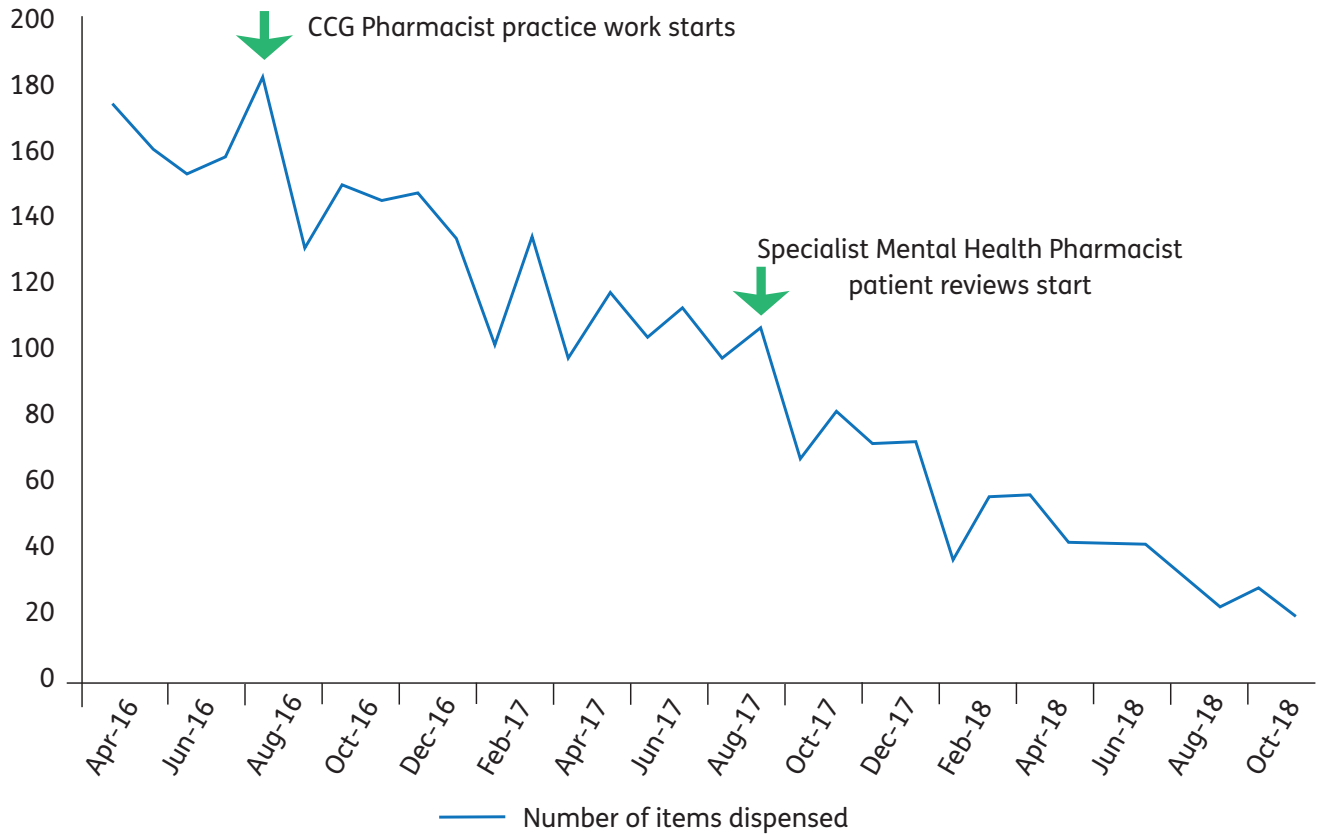
- Improved collaborative working between Oxleas and GP Practices
- Following review and embedding individualised treatment plans, we were able to get a significant proportion of patients to either gradually stop treatment as it was no longer considered necessary or to switch over to other treatments (this was of benefit as we had multiple contacts with patients - pharmacist face-to-face assessments averaged 1 hour, with some patients requiring more than 1 follow-up contact to provide support)

Outcome summary	Proportion of patients reviewed
Patient switched to alternative treatment	41%
Plan to reduce and stop, treatment not indicated	36%
Continue trimpramine	8%
GP to follow-up	15%

Since the initial work started, trimipramine prescribing in Bromley CCG area has reduced by approximately 80% as seen in the chart below.

Quality Report

Chart 20 - Trimipramine dispensing, Bromley CCG area



Our Staff Survey 2018

The results of the National Staff Survey 2018 (conducted between October and December 2018) were published on 26 February 2019. The national staff survey reports have changed significantly this year. Most particularly, the report no longer includes details on key findings. These have now been replaced by 10 themes, all of which are scored on a 0 – 10 scale. The themes include:

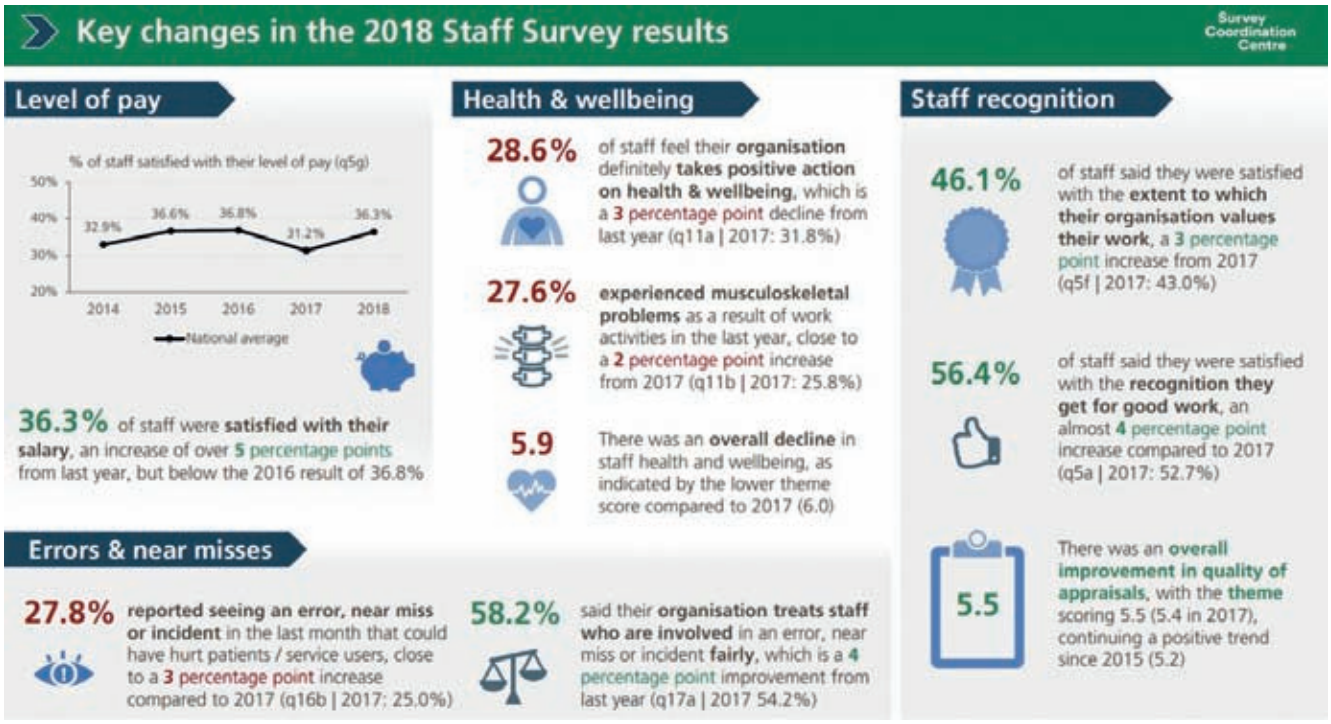
- Equality, diversity and inclusion
- Health and well-being
- Immediate managers
- Morale (new in this year's survey)
- Quality of appraisals
- Quality of care
- Safe environment – bullying and harassment
- Safe environment – violence
- Safety culture
- Staff engagement

Benchmarking data is provided in the report against comparator trusts for each question. Our comparator profile for the national staff survey is Combined Mental Health / Learning Disability and Community Trusts and there are 31 trusts in this comparator pool.

National Highlights

At a national level, all 230 trusts in England participated with an overall average response rate of 46%.

Quality Report



Oxleas results

There was an improved response rate of 49% which was better than our response rate last year of 42%, and also better than the average for our comparator trusts (45%).

We saw significant improvement in two themes: Safe environment – Violence and Safety Culture. Staff perceptions in relation to violence from patients, service users and relatives / public has improved significantly from 16.5% to 19% but this remains below the comparator average. Equally, staff perceptions in relation to the organisation treating staff fairly following incidents, taking action to prevent recurrence and being given feedback have all improved and are better than the average.

Staff Engagement remains above the average. On the new 0-10 scale, the Oxleas scored 7.1, where the best trust scored 7.5 and the average was 7.0. Of the nine questions that feed into the score, there were marginal improvements on all bar one.

Scores were better than the comparator average for themes relating to staff engagement, safety culture, quality of care, quality of appraisals and immediate managers. We were worse than the average for perceptions relating to equality and diversity, health and well-being, bullying and harassment, safe environment – violence.

BME staff (510 staff) generally reported better levels of satisfaction than white staff in most questions relating to their job, support from managers, health and well-being, personal development, appraisals. They had worse perceptions in relation to their experience of violence from patients/service users, bullying and harassment from patients and colleagues/ managers, fairness in career progression. LGBT staff (57 staff) also reported worse perceptions than the average in relation to violence from patients, and bullying from patients and colleagues.

Next Steps

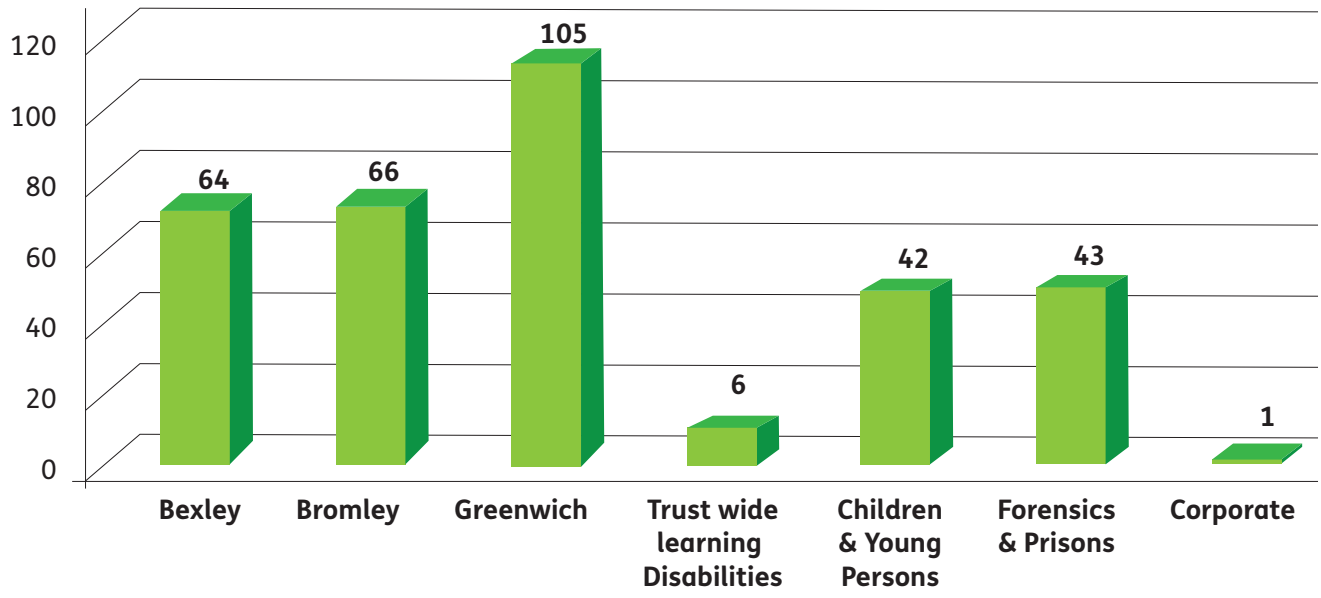
- We will undertake a centrally coordinated programme to address issues perceived by staff in relation to health and well-being. It is recognised that this will have an impact on retention levels and staff recommendation of Oxleas as a place to work. This will be taken forward through senior staff events in the first quarter of 2019/20.
- We will continue to focus on issues affecting poor staff perceptions regarding equality and diversity and bullying and harassment. These programmes will continue to be led centrally by the workforce team with monitoring and oversight through the Executive and Workforce Committee.
- The programme of work undertaken to address concerns relating to violence and aggression at work have started to have an impact on staff perceptions. It will be important to maintain this work and learn lessons from the work that has taken place to date.
- Our Service Directorates will also review their reports and work with their staff to identify issues that need to be addressed at a local level.

3.5 Oxleas Complaints Report 2017/18

In 2018/19 there were 924,371 patient contacts with our services; in the same period of April 2018 to March 2019 we received a total of 223 formal complaints (0.02% of overall patient contacts) and 104 informal complaints (0.01% of overall patient contacts).

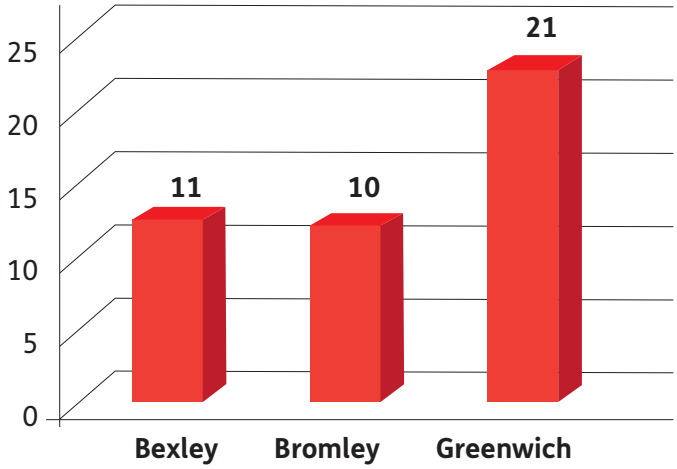
The trust reports on all complaints received in writing both formally and informally. We record any complaint that is made in writing to any member of the trust, CQC or CCG staff, or is originally made orally and subsequently recorded in writing. Once this is recorded, we treat it as though it was made in writing from the outset. Complaints and comments/ suggestions that do not require investigation are not included in complaints reporting.

Chart 21 - The chart below shows the Directorate breakdown of the 327 complaints received



Quality Report

Chart 22 - The chart below shows the breakdown of complaints received by Children and Young Peoples Services by borough.

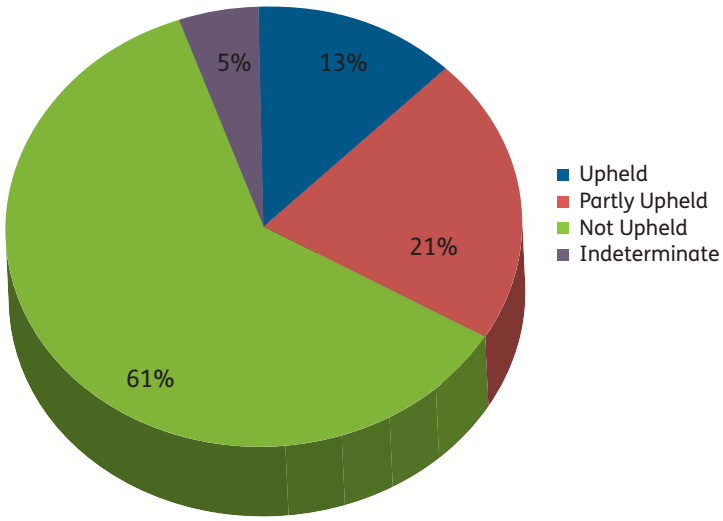


Complaints investigated

Within the 327 complaints, 1024 concerns were raised. Of these 1024 concerns raised, 145 concerns are still under investigation.

The chart below shows the percentage of issues, of the 879 concluded, that were upheld, partly upheld, not upheld and those that were indeterminate.

Chart 23



Quality Report

Our review of the concerns raised has identified 3 significant themes Clinical Care, Attitude and Behaviour of Staff and Communication. The table below shows the number of upheld/partly upheld issues relating to these subjects.

Table 12

	Investigated	Upheld/partly upheld	% upheld
Clinical Care	228	68	30%
Attitude of staff	179	48	27%
Communication	150	83	55%

Following the completion of an investigation, when an issue has been upheld or partially upheld, a remedial action must always be identified. Of the 330 actions identified for 2018/19, 58 remain due to be completed, 16 were pending (as they are not yet due), at the time of writing this report and 256 (82%) have been completed. There are approximately 150 actions that have not been uploaded to Datix following conclusion of investigations had these been included in the data our completion rate would fall to 55%

Complaints handling

In line with the trust's Complaints Policy the aim is to respond to complaints received within 30 working days, and agree extensions with the complainant when it is not possible to complete the investigation within this time frame. Of the 327 complaints, 283 complaints have concluded their investigations (16 complaints are outstanding, 28 were not due to be concluded as at time of writing). Of those 283 concluded, 182 (64%) were completed within the agreed timescales, a 1% decrease on last year.

Robust procedures are in place for following up with the Directorates both those complaints that are overdue with the complainant and those that are due with the complaints team; this is done on a weekly basis. It is hoped this will show an improvement in achieving the target against timescales.

Work continues to embed and disseminate lessons from complaints across all our services with the Complaints team supporting embedded learning events across Directorates. The Complaints and PALS Team will be involved in a series of short videos on learning from complaints using case studies and running sessions during team meetings across Directorates.

We will continue our focus in these areas in 2019/20 to improve the quality of the services we provide.

Parliamentary and Health Service Ombudsman (PHSO)

Complainants who are dissatisfied with the trust response have the right to ask that the PHSO reconsider their complaint. Since April 2018, 9 complainants asked for their case to be reviewed by the Ombudsman's Office. 2 were upheld, 4 were not upheld and three investigations are currently on-going.

Quality Report

4.0 Glossary of Abbreviations

ACS	Adult Community Services
AMH	Adult Mental Health Services
ALD	Adult Learning Disability Services
CAMHS	Children And Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CEG	Clinical Effectiveness Group
CHTT	Crisis and Home Treatment Team
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning For Quality And Innovation
CYP	Children and Young People Services
Datix	Incident Reporting System
DIALOG	a service user rated outcome measure which focuses on the quality of life, treatment satisfaction and care needs
EIP	Early Intervention in Psychosis
F&P	Forensic and Prisons
FFT	Friends And Family Test
HMP	Her Majesty's Prison
HONOS	Health of the National Outcome Scales
HONOSCa	Health of the Nation Outcome Scales Child and Adolescent Mental Health
IAPT	Improving Access to Psychological Therapies
KPI	Key Performance Indicator
LD	Learning Disabilities
NACR	National Audit of Cardiac Rehabilitation
NICE	National Institute for Health And Care Excellence
NHSE	NHS England
NHSI	NHS Improvement
NRLS	National Reporting and Learning System
MDT	Multi Disciplinary Team
MH	Mental Health
MH & LD	Mental Health & Learning Disability
RiO	Electronic Clinical System
OPMH	Older People Mental Health Services
PHSO	Parliamentary and Health Service Ombudsman
POMH	Prescribing Observatory for Mental Health
RAG	Red, Amber, Green rating
RCA	Root Cause Analysis
SMI	Serious Mental Illness
STORM	a self-harm mitigation skills based training in risk assessment and safety planningg

Staff Recognition Awards 2018

Annex 1.1– Feedback from our Stakeholders

Greenwich & Bexley CCG Response to Quality Accounts

Greenwich and Bexley CCGs are responsible for the commissioning of Mental Health services and Community services from Oxleas Foundation Trust. The CCGs works collaboratively with Oxleas to ensure that the services they provide meet the contractual requirements for quality and that they are working to continuously improve the quality of care provided to residents across these varied geographies. The CCGs welcome the opportunity to provide this statement on the Trust's 2018/2019 Quality Account.

Greenwich and Bexley CCGs share the commitment to quality set out by Oxleas NHS Foundation Trust (Oxleas), to deliver good quality care and support the broad vision for quality improvement set out in the annual Quality Account. It is evident within the Quality Account that there is a strong focus on quality assurance and quality improvement though this appears to be more mental health focussed. The CCGs would welcome evidence of priorities particularly for Children and Young People and Community services.

The CCGs were pleased that following a CQC inspection in 2018 the trust was rated as "good" with some services rated as outstanding for caring and effectiveness. We will continue to work with the Trust on maintaining assurances of safe services, driving quality improvement and its ambition to achieve an outstanding CQC rating.

As part of the Trusts commitment to the quality agenda, in April 2018 the trust launched the Trust Quality improvement programme (QI). The CCGs note the excellent work undertaken by this programme particularly in relation to the ability to impact on organisational change and delivery of improved patient outcomes. There have been positive results in reducing incidents of violence and aggression to staff and patients and a reduction on spend as a result of violence and aggression on the wards. We would however welcome more effective activities on mental health wards which will contribute to a reduction in aggression and violence. To create a culture of continuous quality improvement and ensure improvement is everyone's business, the Trust has put in place a clear learning/training strategy for QI. Most importantly the ideas for the quality improvement programme are initiated by front line staff, who are the group of staff that have the most contact with patients.

The National Quality Indicators within the accounts demonstrate a downward trend for 18/19 when compared to 17/18. However the commissioners note that Oxleas remain at or

Quality Report

above the national average in this area. The CCGs would welcome more discussions on this.

The CCGs applauds the progress made with the 19 quality goals developed across the 6 quality objectives with 84% (16) of the goals achieved. The CCGs support the quality priorities for 2019/20, which were developed following a period of staff and user engagement. As part of the commissioning process the CCGs will continue to take an active interest in supporting improvements where the very highest standards have yet to be achieved. We look forward to working with the Trust to achieve these priorities.

The trust are to be congratulated on its staff engagement score which remains above the average. However, we are concerned about the challenges highlighted in the staff survey results on perceptions relating to equality and diversity, health and well-being, bullying and harassment, safe environment and violence. BME staff (510 staff) had worse perceptions in relation to their experience of violence from patients/service users, bullying and harassment from patients and colleagues/managers and fairness in career progression. We are encouraged by the progress made by the Trust CEO and senior management team to address these concerns and look forward to seeing the further improvements in these areas.

It is disappointing to see that the recording of a support network for the patient is recorded in only 37% of records. In addition although work has been undertaken across the trust to increase patient feedback utilising a variety of methods, the CCGs would like to see an improvement in feedback across all areas particularly from currently under-represented groups.

In relation to care planning and risk assessments, the CCGs agree with the trust that it is disappointing that the trust is unable to evidence that all patients have an up to date care plan and where relevant a risk assessment. Given the number of Serious Incidents where this has been identified as a recurrent theme, the CCGs are pleased that this remains a priority for the trust.

The CCGs note the wide range of clinical audit work that Oxleas has engaged with during the year. Clinical audit is a key tool for monitoring and improving the quality of patient care and the CCGs welcome the holistic and joined up approach to developing improvement plans.

We confirm that we have reviewed the information contained within the Quality Account and checked this against data sources where this is available to us as part of existing quality and performance monitoring discussions. We look forward to continuing to work with colleagues at Oxleas to monitor quality and safety and increased service user input in the wide range of service provision across mental health and community services for patients in Greenwich and Bexley.

Yvonne Leese
NHS Greenwich CCG
Deputy Managing Director and Director of Quality

Michael Boyce
NHS Bexley CCG
Deputy Managing Director and Director of Quality

NHS Bexley CCG and NHS Greenwich CCG – members of the NHS South East London Commissioning Alliance (Bexley, Bromley, Greenwich, Lambeth, Lewisham & Southwark CCGs)

Quality Report

NHS
Bromley
Clinical Commissioning Group

Bromley CCG Response to Quality Accounts

Bromley CCG welcomes the opportunity to comment on the Oxleas Quality Accounts 2018/19. The restructure into borough-based teams has continued to enhance closer working relationships between Oxleas and commissioners which is demonstrated this year around the work undertaken with the CCG's medicines management team and the significant improvement in rates of dementia diagnosis in Bromley which the Trust should be congratulated on achieving. In addition sharing of intelligence across Bromley, Bexley and Greenwich continues via the quarterly 3-borough Clinical Quality Review Group.

The CCG notes the focus on putting patients at the centre of service planning and delivery and the good engagement work that has taken place. However, the results around involvement of patients and carers are disappointing and we welcome the continued focus on this area into 2019/20.

Bromley CCG is aware of the emphasis that the Trust has placed on safety of staff and patients and is pleased to note the significant achievements in reduction in incidents of violence and aggression and restraint. The Qi work at the Tarn shows a real commitment which we hope will continue into 2019/20.

The Trust continues to develop and embed robust procedures around Learning from Deaths which will enable the Trust to identify any gaps or service improvement areas in order to drive up clinical care standards.

There are a number of areas that Oxleas can be justifiably proud. For Bromley CCG, we continue to be impressed by the work around supporting service users with personality disorder via community models and the achievements in EIP despite a higher than predicted number of cases. In addition, the significant improvement in dementia diagnosis rates in Bromley is particularly impressive and the work involved in this achievement is recognised.

Bromley CCG would welcome a greater focus on collaborative working with partners across Bromley to include health and local authority partnerships as the Bromley ICS evolves and, in particular, working across Bromley on suicide reduction and around prevention of urgent care admissions.

Bromley CCG looks forward to continuing to work in partnership with Oxleas and South East London CCGs to achieve the Trust's quality aims for 2019/20.

Sonia Colwill
Director of Quality and Governance
Bromley CCG

Bexley Council Communities Overview and Scrutiny Committee
Response to Oxleas NHS Foundation Trust Quality Accounts 2018/19

The Communities Overview and Scrutiny Committee (OSC) welcomes the opportunity to comment on Oxleas NHS Foundation Trust's Quality Accounts 2018/19; the report provides Members of the Bexley Communities OSC with a good overview of the range of work undertaken by the Trust and the measures taken to evaluate the quality and effectiveness of the care given by the Trust to residents in the borough over the last year.

The Committee notes that 16 of the quality goals set for 2018/19 were achieved and that one was mostly achieved and it is hoped that progress will be made in 2019/20 towards achieving the two goals that were not reached.

The Committee are pleased to see further improvement in the percentage of patients with a care plan (on the electronic patient care record- RiO) and the focus of reducing falls and improving physical health for in-patients in mental health wards.

In view of the national concern about the dangers of prone restraints, it is pleasing to see a further reduction in the use of restraint overall and the shift towards supine restraint, where restraint still remains necessary and appropriate.

Participation in the national clinical audits is welcomed as are the targets set for 2019/20; the Committee notes the summary of the latest CQC inspection dashboard that shows that a good or outstanding rating was achieved in 82 of the 84 domains but it is hoped that early progress will be made in improving services in the two domains that require improvement.

The detail provided on the latest Oxleas staff survey is noted, but there is concern that the proportion of staff who feel that the organisation takes positive action on health and wellbeing has declined from 32% to 29%. It is worthy of note that one focus of the developing Bexley System-Wide Prevention Strategy is the role of major local employers, which includes Oxleas NHS Foundation Trust, in maintaining the well-being of the local population, which will be key to achieving positive public health outcomes in the coming years.

Overall, the Committee believes this to be a positive report which recognises that there are areas for improvement, the Communities OSC looks forward to continuing to work collaboratively with Oxleas NHS Foundation Trust over the next year as a key partner of the Council.

Annex 1.2– Statement from Local Healthwatch Organisations

Healthwatch Bromley Response to Oxleas Quality Accounts 2018/19

Healthwatch Bromley is pleased to see that the trust reached their target for quality **objective 1** – "Meeting our patient promise" and that each of the 6 questions were clearly defined as:

1. Have you been provided with enough information about your care and treatment?

2. Have you been involved as much as you would have liked in decisions about your care and treatment?

3. Have staff treated you with dignity and respect?

4. Was the service provided helpful?

5. Did you want any friends / relatives involved in your care/treatment? if yes, were they involved?

6. We would like you to think about your recent experience of this service. How likely would you be to recommend this team to friends and family if they needed similar care or treatment?

The trust attained at least 90% of patients reporting against the criteria and that they have consistently met their goal of 90% achievement or more since 2015/16.

Quality objective 2 focussed on "Involving families, carers and people important to our patients" to ensure 80% of patients have their support network identified and noted within their care record. It is disappointing that this has fallen some way short of target at 37% with no real identification of causation or remedial action. An aspirational target is maintained but there is concern that while the target remains aspirational without substance it will consistently fall short.

Quality objective 3 is defined as involving patients in planning their care and that they have a care plan that is personal to them. The participation figures for this are disappointing at 63% especially as the focus was to improve participation in the audit process but concerning from a Healthwatch perspective under this quality objective is the average results. Significantly a copy of the care plan had been given to the service user in only 70% of cases from a limited audit and only 40% of the user support network had been given a copy. Additionally, being given a copy does not necessarily constitute involving patients in planning their care.

Quality objective 4 is to ensure they put the safety of patients first and the goals linked to this objective are integral to their improvement safety plan. There are four key areas that come under this objective:

- Falls
- Deteriorating physical health
- Violence reduction
- Reducing the use of prone restraint

It is positive to note improvement in all these areas particularly a 62.5% reduction in serious falls and a reduction of incidents of violence.

Quality Report

Quality objective 5 looks to provide care in line with national best practice and guidelines and it is pleasing to note that for audited services in early intervention in psychosis, inpatient services and community mental health services Oxleas compliance was on a par with or exceeded the national standard.

It is positive to note that Oxleas Quality improvement priorities for 2019/20 are undertaken to continue to ensure the patient promise is met and that they ensure families, carers and people important to the patient are involved in their care. However, the aspirational targets attached to quality objective 2 are not made with a clear and concise implementation plan to improve on the previous attained 37% of an 80% target. Without a clear idea of how this result will be obtained Healthwatch are concerned this will result in poor performance against this objective.

Objective 3 continues to focus on involvement in care planning which is positive to view commitment to this however again remedial action to support improvement in this area is not clearly stated.

Finally it is very positive to see suicide prevention identified as a quality objective when putting the safety of patients first.

Mina Kakaiya
Operations Manager
Healthwatch Bromley
Date 15-05-2019

Quality Report

Healthwatch Bexley and Healthwatch Greenwich Response to Oxleas Quality Accounts 2018/19

Areas of success

- Healthwatch is pleased to see that the trust has again reached their 90% target across all elements of quality objective 1 and it is good to see the number of patients providing feedback has increased in 2018/19 by 35%. We are pleased to see that feedback technology has been updated making it easier for patients to respond, however we would like to see more joint working with Healthwatch to offer a greater variety of ways Oxleas patients can comment on the service received.
- We were pleased to see that patients with a care plan on RiO and patients on CPA who receive a 12 month review are both above target at 99% and over.
- Healthwatch welcome the continued focus on reducing the incidence of falls in inpatient wards and the updated falls policy, reviewed training, assessment and management of falls, has led to a significant reduction of serious falls by 62.5% in 2018/19.
- We are pleased to see the reduction of violence and aggression to staff and patients has fallen since 2016 and work is continuing to accelerate further reduction.
- We are pleased to see that in 2018/19 you participated in the national programme of improving the physical health of patients with Serious Mental Illness and that in all 3 areas you exceed the national target.
- We are pleased to see that Oxleas NHS Foundation Trust were rated overall as 'Good' in their last CQC inspection in March 2019, and four areas were rated as 'Outstanding'.
- We were pleased to see a focus on encouraging staff to speak up and share concerns without fear of victimisation or harassment and as a result there has been a significant increase in the number of concerns raised. We welcome further work to embed this approach.
- We are impressed with the results achieved from the introduction of group exercise classes to improve outcomes in musculoskeletal services and the very positive reports from patients.
- We are pleased to see the improvement made in diagnosis rate in the Bromley Memory Service which achieves in excess of national targets.
- We are pleased to see the reduction in trimipramine prescribing in Bromley as a result of improved collaborative working and embedding individualised treatment plans.
- We are pleased to see an improved response rate of 49% in the staff survey for 2018 which is better than the average for comparative trusts (45%) and the national average response rate of 46%.
- We were pleased to see staff perceptions in relation to treating staff fairly following incidents, taking action to prevent reoccurrence and being given feedback have improved and are better then the average for comparative trusts.
- We were pleased to see staff perceptions were better than the comparator average for themes relating to staff engagement, safety culture, quality of care, quality of appraisals and immediate managers.

Quality Report

Areas for improvement

- We were disappointed to see that the overall 10% response rate was not met for quality indicator 1 (8% acheived).
- We were disappointed to see the patient promise indicators were not met in prison, forensic and adult learning disability services. Healthwatch accept there may be additional complexity in gaining favourable ratings from patients who may not choose or want to receive Forensic or Prison services and that comments provided by patients using the Adult Learning Disability contradict the ratings given. However, without comparing against results achieved by other Forensic, Prison and Adult Learning Disability services it is difficult for Healthwatch to have confidence in this explanation. We look forward to the revised FFT question and expect to see improvements in ratings as a result.
- We were disappointed to see that the 80% target for identifying and noting patient's support network within the care record has not been met. Despite improvement (37% in 2018/19 compared with 35.2% in 2017/18) progress is worryingly slow. Indeed, on this trajectory, it will take many decades to reach the 80% target, which is unacceptable. We look forward to seeing a significant improvement in 2019/20 as a result of the work of the new Patient Experience Coordinator and increased awareness of the importance of this task amongst all staff.
- We were disappointed to see that the 75% target for participation in care planning audits has not been met (63%) despite an increased focus on this area in 2018/19. We look forward to seeing this target met in 2019/20 as a result of the mitigation plan now in place.
- We are concerned that HMIP and CQQ joint inspection identified two areas where regulations were not met and we look forward to seeing improvements as a result of the improvement plans in place.
- We were disappointed to see that two areas were highlighted as 'requiring improvement' in the Trusts last CQC inspection in March 2019.
- We were disappointed to see staff perceptions in relation to violence from patients, service users and relatives/public remains below the average when compared to similar trusts.
- We were disappointed to see staff perceptions in relation to equality and diversity, health and well-being, bullying and harassment, safe environment -violence remains below the average when compared to similar trusts.
- We are concerned to see that despite BME staff generally reportingbetter levels of satisfaction than white staff relating to their job, they had worse perceptions in relation to their experience of violence, from patients/service users, bullying and harassment from patients and colleagues/ managers, fairness in career progression.
- We are concerned to see that LGBT staff reported worse perceptions than the average in relation to violence from patients, and bullying from patients and colleagues.
- We are concerned to see the higher level of complaints from Greenwich residents in comparison to Bexley and Bromley and would like further explanation on this issue.
- We note that a higher proportion of complaints on communication were upheld in comparison with complaints on clinical care or attitude of staff and further work is clearly required in this area.

May 2019

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 for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from commissioners dated 15/05/19 and 22/05/19
  - feedback from local Healthwatch organisations dated 15/05/19 and 18/05/09
  - the internal complaints reports for 2018/19
  - the 2018 national patient survey
  - the 2018 national staff survey
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 21/05/19
  - CQC inspection reports dated 26 March 2019
- 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.

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

Signed by
Andrew Trotter
Chair
24 May 2019

Signed by
Matthew Trainer
Chief Executive
24 May 2019

Annex 3: Independent Practitioner's Limited Assurance Report to the Council of Governors of Oxleas NHS Foundation Trust on the Quality Report

Independent Practitioner's Limited Assurance Report to the Council of Governors of Oxleas NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Oxleas NHS Foundation Trust to perform an independent limited assurance engagement in respect of Oxleas 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 a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- 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'.

Quality Report

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 April 2018 to May 2019;
- papers relating to quality reported to the Board over the period April 2018 to May 2019;
- feedback from commissioners dated 15/05/2019 and 22/05/2019;
- feedback from local Healthwatch organisations dated 15/05/2019 and 18/05/2019;
- the Trust's internal complaints reports for 2018/19
- 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 21/05/2019;
- Grant Thornton UK LLP. 2
- the Care Quality Commission's inspection report dated 26 March 2019.

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 Oxleas NHS Foundation Trust as a body, to assist the Council of Governors in reporting Oxleas 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 Oxleas 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 Oxleas NHS Foundation Trust.

Quality Report

Our audit work on the financial statements of Oxleas 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 Oxleas NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Oxleas 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 Oxleas NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Oxleas 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 Oxleas NHS Foundation Trust and Oxleas 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
24th May 2019

Directors' Report

Board of Directors

There were several changes to the Board of Directors during 2018/19. Matthew Trainer joined Oxleas as Chief Executive in October 2018 and Nina Hingorani-Crain became a Non-Executive Director in November 2018 when James Kellock's term of office came to an end.

Our Board meetings are held in public and a quorum of seven is required for the meeting to take place.

The members of the Board of Directors during 2018/19 were:

Andrew Trotter OBE QPM
Chair
Andy has been Chair of Oxleas since November 2015 and is a highly skilled leader in public services, having over 40 years' experience in policing.

His most recent role was a Chief Constable of the British Transport Police and he has also worked with both the Metropolitan and Kent Police Services.

Steve Dilworth
Deputy Chair
Steve chairs our Audit and Risk Assurance Committee. He has extensive experience in financial services, marketing and communications having held senior executive positions in Foresters, Bank of Ireland and Leeds Permanent. Steve has a first class honours degree in economics and history and a degree in financial services. He is a Fellow of both the Chartered Institute of Banking and the Chartered Institute of Marketing. In a voluntary capacity, Steve chairs the Bromley Neighbourhood Police Panel. In 2012, Steve was elected as a Community Champion for the London Borough of Bromley and has been selected as one of Manchester University's Volunteers of the Year. He is married with three children and lives in Bromley.

James Kellock
Non-Executive Director
James joined Oxleas in 2009 after a successful career in the Civil Service where his last role was as Deputy Director of the Serious Fraud Office. James chairs the Workforce Committee. As well as being a non-executive director at Oxleas, he is the director of a charity and has a portfolio of part-time roles in the regulation of professionals in the healthcare and accountancy professions. He has lived with his family in Greenwich for over 25 years. James' term of office with Oxleas ended at the end of October 2018.

Seyi Clement
Non-Executive Director
Seyi is a lawyer and a partner in a law firm based in Bexleyheath. He came to the UK after qualifying as a barrister in Nigeria. He studied Law at the University of Benin in Nigeria. He has previously been secretary of the Independent Healthcare Forum and company secretary to a range of independent healthcare companies, including Three Shires Hospital Limited, Amicus Healthcare Limited and BMI Syon Clinic Limited. He chairs the trust's Infrastructure Committee. Seyi lives in Greenwich with his wife and two sons, one of whom uses our services.

Steve James
Non-Executive Director
Following 18 years in local authority social work, Steve James has been Chief Executive of the Avenues Group for the past 20 years. Avenues is a charity which pioneers specialist social care supporting people facing significant disadvantage through illness and disability so they can live full

Directors' Report

lives in their local communities. Previous to his appointment on Oxleas' Board, Steve spent eight years working as a non-executive director for NHS Greenwich. He has an interest in community health services and particularly how they can integrate with social care. Steve has lived in Greenwich for 29 years and is married with two adult children. Steve became our Senior Independent Director in May 2016 and chairs the Quality Improvement and Innovation Committee.

Jo Stimpson
Non-Executive Director
Jo joined Oxleas Board of Directors on 1 May 2016 and chairs our Business Committee. She is a law graduate and chartered accountant with senior finance and board level experience gained in the technology and utility sectors, most recently as Finance Director of South East Water. In addition to her role at Oxleas, Jo chairs the South East Water-sponsored pension schemes and the Law Society Audit Committee, and is a governor of Ravensbourne University London. Jo lives in Greenwich with her husband and her two daughters.

Yemisi Gibbons
Non-Executive Director
Yemisi joined Oxleas Board of Directors on 1 January 2017. She has been a consultant pharmacist for 17 years and is also CEO of a London-based domiciliary care company. Having studied Pharmacy at Manchester University before completing an MBA, she then entered the primary care sector in medicines management; working with prescribers to ensure clinical excellence to all patients.

Outside of her business commitments, she is also on the fitness to practice and appeals committees within the General Pharmaceutical Council and a member of the Lord Chancellor's advisory sub-committee, contributing to the appointments of new magistrates for a London bench. Yemisi chairs our Quality Assurance and Performance Committee.

Nina Hingorani-Crain
Non-Executive Director
Nina has had a diverse career in the private, public and charity sectors. After almost a decade in corporate finance and consulting, she joined the financial services regulator. Here she spent a varied ten years, including as the Chairman's Principal Private Secretary during the global financial crisis and subsequently as Chief of Staff leading the creation of the new Financial Conduct Authority. Nina also undertook a 6-month secondment to Age UK to inform the authority's strategy of placing consumer needs at the heart of its regulatory mandate. In 2015, she embarked on a Non-Executive career, and is today a Director on the Boards of the Monmouthshire Building Society, Achieving For Children and the Charity Commission. Nina holds an LL.B. (Hons) degree from King's College London, and a Maîtrise en Droit from the Sorbonne Paris. She also qualified as a Chartered Accountant, and has recently completed the Financial Times Non-Executive Director Diploma. She enjoyed a diverse upbringing with spells living in Africa, the Middle East and Europe.

Matthew Trainer
Chief Executive (from 1 October 2018)
Matthew joined us in October 2018 from King's College Hospital NHS Foundation Trust, where he had been managing director of the Princess Royal University Hospital in Bromley since November 2016. He joined King's from NHS England, where

Directors' Report

he was director of commissioning operations for south London.

Matthew previously held senior positions with the MS Society and the Care Quality Commission.

Helen Smith
Deputy Chief Executive/Director of Service Delivery
Acting Chief Executive (until 30 September 2018)
Helen originally trained as a clinical psychologist and practised in a variety of clinical settings. Later she became a senior lecturer at the University of Canterbury and then helped to establish the Centre for Mental Health Services Development at King's College, London. Following a commissioning role at the South East London Health Authority, Helen joined Oxleas in 2000 as Director of Bromley mental health services and became Deputy Chief Executive in 2007. Helen was Interim Chief Executive from March 2018 until end of September 2018.

Ify Okocha
Medical Director
Dr Ify Okocha qualified in Medicine in 1985 and, after training in psychiatry, obtained his membership of the Royal College of Psychiatrists in 1992. He was appointed consultant in 1996 and in the same year obtained his Doctor of Philosophy (Ph.D) degree from the Institute of Psychiatry and King's College, London where he did his doctorate and post-doctorate research in psychosis and psychopharmacology respectively. He has received commendations and won many national awards for the high quality care that is delivered by clinical teams working for him. These include: the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) Team of the Year award; the Care Services Improvement Partnership 'Positive Practice' award; commendation by Hospital Doctors Award Committee; award of the British Association of Medical Managers and the Royal College of Psychiatrist Medical Manager/Leader of the Year (2009). He is on the Roll of Honour of the Royal College of Psychiatrists.

Jane Wells
Director of Nursing
Jane is an experienced registered nurse, district nurse and health visitor. She holds an MSc in Community Health and an MBA with distinction from Henley Business School. Jane's career in nursing began in 1987 at Charing Cross Hospital and she has spent the majority of her working life in community health services. Having been an established director of community health services since 2011, Jane became Director of Nursing for Oxleas in May 2015. Jane is passionate about empowering clinicians, supporting staff and partnering agencies to work together creatively to improve care and make sure services are responsive to the needs of patients and their families and that they are at the heart of everything we do.

Meera Nair
Director of Workforce and Quality Improvement
After completing an MBA with specialisation in Human Resources, Meera has worked in a range of human resources functions in the private sector in India and the US. She has been working in the NHS since 2002 and has previously worked with Basildon and Thurrock NHS Foundation Trust and University College London Hospital NHS Foundation Trust. She joined Oxleas from Barnet, Enfield and Haringey Mental Health Trust where she was Deputy Director of Workforce.

Directors' Report

Jazz Thind
Director of Finance
Jazz is a qualified accountant who joined the NHS in 1993 in a junior finance role. Since then, she has taken up a number of NHS roles across both management and financial accounting functions. Most of these roles have been within provider organisations but Jazz did spend four years with a primary care trust. Post-graduation and prior to joining the NHS, Jazz worked at HMRC in VAT registration.

Iain Dimond
Interim Deputy Chief Executive (until 30 September 2018)
Having worked at Oxleas since 2009, Service Director for Greenwich Adult Services and Trustwide Learning Disability Services Iain stepped up to the role of Deputy Chief Executive during the summer of 2018.

His professional background is in occupational therapy and he has nearly 30 years' clinical experience working in adult mental health, older peoples' mental health and adult learning disability services. He is a member of the NHS England Adult Mental Health Steering Group.

All non-executive directors are considered to be independent as they have not been employed by the trust and do not have any financial or other business interest in the organisation. None has close family ties with Oxleas' advisers, directors or senior employees and none has served on the Board of Directors of the foundation trust for more than nine years. A register of directors' interests is available from the Trust Secretary and is published on our website.

Re-appointments of non-executive directors are considered at the end of every three-year term to a maximum of nine years in total. There were no significant changes in the external commitments of the Chair over the year.

We ensure that the balance of skills, expertise and experience of the Board of Directors provides effective and proactive leadership. The Nominations Committees review skills, capacity and capabilities when appointing to vacancies on the Board. The performance evaluation of the Board is by self-assessment and individual appraisal of directors including governor feedback. The Senior Independent Director conducts the annual appraisal of the Trust Chair while the Chair leads on the appraisal process for the non-executive directors and Chief Executive. The Chief Executive conducts the appraisal process for Executive Board members. We have a well-established and effective process of governors holding non-executive directors to account and a robust re-appointment process for non-executive directors by the Council of Governors. The Board of Directors and its sub committees are regularly reviewed to ensure they are effective and well balanced.

Directors' Report

NHS Improvement's Well Led Framework

During the Care Quality Commission (CQC) inspection from November 2018 to January 2019, the inspectors completed a well led review using the well-led framework that brings together the CQC key lines of enquiry and NHS Improvement's framework for leadership and governance. The overall well-led rating for Oxleas is Good which was based on their inspection of trust management taking into account what they found about leadership in individual services. The CQC rated Oxleas as Good for well-led because:

- Oxleas had managers at all levels with the right skills and experience to a service providing high-quality sustainable care.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff felt well supported by managers and were confident in their leadership approach and direction.
- Services had effective systems for identifying risks, and planning to eliminate or reduce them.
- Oxleas collected, analysed, managed and used information well.
- Oxleas engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The governance systems in place ensured that services were delivered to a good standard.
- Oxleas used a systematic approach to continually improve the quality of services.

Under the well-led domain, the area the CQC would like us to improve is ensuring that all services have effective structures for sharing information and key learning from incidents, complaints and safeguarding concerns cross-borough. The full CQC report on Oxleas is published on the CQC website **www.cqc.org.uk**

During the forthcoming year, we will commission an external well-led review. Our annual governance statement on page 161 describes in more detail the approaches we take to identify and manage risk within the organisation, our internal control processes and how we work to maintain and improve the quality of our services and meet key health care targets. The Quality Report from page 33 describes, in further detail, our approaches to quality improvement, quality governance and how we continue to improve services and patient care.

Directors' Report

Statutory statements required within the Directors' Report

The directors are responsible for preparing the annual report and accounts and have considered the report and accounts as a whole to ensure that they are fair, balanced, understandable and provide the information necessary for patients, regulators and other stakeholders to assess our performance and strategy.

We have complied with the cost allocation and charging guidance issued by HM Treasury and we follow the better payment practice code and performance details are included in financial performance analysis.

We comply with Section 43 (2A) of the NHS Act 2006 requiring that income from the provision of goods and services for the purposes of the health service in England is greater than income from the provision of goods and services for any other purpose.

So far as any of the members of the Board of Directors are aware, there is no relevant audit information of which our auditor is unaware. All directors have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that Oxleas' auditor is aware of that information.

Remuneration Report

Annual statement on remuneration

Changes to pay are considered against the national pay context particularly with the NHS. The remuneration committee aims to balance the need to attract and retain suitably qualified and experienced staff alongside the need for economic efficiency.

In 2018/19, the committee decided to mirror the change within the Agenda for Change pay framework which is the pay and conditions framework for employees elsewhere in the trust. This included merging the lowest two points of each pay scale to reduce the number of points on the scale overall, and varying the percentage increases for the remaining spine points from 1.5% to 2.1% at the maximum point of the scale.

Senior managers' remuneration policy

The remuneration policy for executive directors is based on that established for employees under Agenda for Change and provides an incremental salary scale and pay range for each executive director. Progression through the incremental points is subject to the delivery of appropriate performance targets. As with staff subject to Agenda for Change terms and conditions, incremental progression can be denied where there is sub-standard performance. Performance against agreed objectives is monitored via the annual appraisal process. The remuneration committee includes representation from our governors, including a staff governor, and chair of staff side, to ensure that views of employees in relation to executive pay are considered. Increases in executive pay are made in line with recommendations by the National Pay Review bodies for agenda for change. Consideration is given to compensation commitments director's terms of appointment would give rise to in the event of early termination. We regularly benchmark executive pay in line with other NHS trusts and FTs with a view to ensure a median position. An opinion is also sought via NHS Improvement in any instances where executive pay may exceed £150,000.

The only non-cash elements of executive director remuneration are pension related benefits accrued under the NHS pension scheme. Contributions are made by both the employer and employee in accordance with the rules of the national scheme which is open to all NHS employees. All contracts for executive directors are substantive NHS contracts and are subject to the giving of six months' notice by either party.

The trust's normal disciplinary and performance management policies apply to senior managers, including the sanction of gross misconduct. The trust's redundancy policy is consistent with the NHS redundancy terms for all staff.

Remuneration Report

Future Policy Tables

	Salary and fees	Taxable benefits	Annual performance related bonus	Long term related bonus	Pension related benefits	Clinical excellence awards
How the component supports the short and long term strategic objectives of the trust	Ensure the recruitment/ retention of directors of sufficient calibre to deliver the trust's objectives	None	Not applicable	Not applicable	Ensure the recruitment/ retention of directors of sufficient calibre to deliver the trust's objectives	Recognition of clinical quality and leadership
How the component operates	Standard monthly pay.	None	Not applicable	Not applicable	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme	Standard monthly
Maximum payment	Basic pay, High Cost Area supplement	None	Not applicable	Not applicable	Contributions are made in accordance with the NHS Pension Scheme	Standard national rate
Framework used to assess performance	Trust appraisal system	None	Not applicable	Not applicable	Not applicable	Advisory Committee on Clinical Excellence Awards framework
Performance measures	Based on individual objectives agreed with line manager	None	Not applicable	Not applicable	Not applicable	Following Advisory Committee framework
Performance period	Concurrent with the financial year	None	Not applicable	Not applicable	Not applicable	Following Advisory Committee framework

Remuneration Report

	Salary and fees	Taxable benefits	Annual performance related bonus	Long term related bonus	Pension related benefits	Clinical excellence awards
Amount paid for minimum level of performance and any further levels of performance	No performance related payment arrangements	None	Not applicable	Not applicable	Not applicable	Standard rate
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any sums paid in error may be recovered	None	Not applicable	Not applicable	Not applicable	Not applicable

Annual report on remuneration (of which some elements are subject to audit)

Non-Executive Directors

The remuneration of the Chair and non-executive directors of the trust is reviewed by the Non-Executive Director Nominations Committee. The Council of Governors makes a decision on the recommendation of the committee. Guidance in the setting of non-executive director salaries is taken from the NHS Improvement and benchmarking with other NHS foundation trusts. Levels of remuneration also take into account non-executive directors' time commitments and responsibilities. For example, the senior independent director and deputy chair receive a higher level of remuneration. The Chair's remuneration reflects his time commitment of four days a week.

There was one meeting of the Non-Executive Director nominations committee in 2018/19 where remuneration was discussed. The membership of this committee was:

- Andy Trotter, Chair
- Raymond Sheehy, Lead Governor

Remuneration Report

- Stephen Brooks, elected governor
- Joseph Hopkins, elected governor
- Steve Dilworth, non-executive director

The Chair and non-executive director who are members of the committee were not present when their remuneration was discussed.

We also reviewed the remuneration committee structure with our Council of Governors in 2018/19 and will have a new structure in place for 2019/20 that will mirror best practice suggested by the Institute of Chartered Secretaries for NHS Foundation Trusts non-executive director remuneration committees.

Executive Directors

Remuneration of Executive Directors is decided by the Remuneration Committee. The following are members of the Remuneration committee:

- Andy Trotter, Chair
- Steve Dilworth, non-executive director
- James Kellock, non-executive director
- Wendy Lyon, Head of Partnership and Chair of Staff side
- Lesley Smith, elected governor

The remuneration committee includes the Chair of Staff side and a publicly elected governor to ensure that its processes are transparent and open to scrutiny.

There was one meeting of the remuneration committee in 2018/19. This was attended by all members of the committee.

The committees were supported by the Director of Workforce and Quality Improvement.

Remuneration Report

A) Salaries and allowances (subject to audit)

Chairman and Non-Executive Directors
Andy Trotter – Chair
Seyi Clement - Non Executive Director
Steve Dilworth – Non Executive Director
Stephen James - Non Executive Director
James Kellock - Non Executive Director (to October 18)
Joanne Stimpson – Non Executive Director (from May 16)
Yemisi Gibbons – Non Executive Director (from January 17)
Nina Hingorani –Crain – Non Executive Director (from November 18)
Board Directors
Ben Travis –Chief Executive (to 16 March 18)
Matthew Trainer – Chief Executive (from October 18)
Helen Smith - Deputy Chief Executive and Director of Service Delivery (to 19 March 2018) and Acting Chief Executive (From 17 March 2018 to 30 Sept 2018)
Iain Dimond- Acting Deputy Chief Executive and Director of Service Delivery (From 19 March 2018)
Jane Wells - Director of Nursing
Simon Hart - Director of HR & Organisational Development (to 23 November 17)
Dr Ify Okocha - Medical Director
Jazz Thind – Director of Finance
Meera Nair- Director of Workforce and Quality Improvement (from 15 January 2018)

Remuneration Report

APRIL 2018 TO MARCH 2019					APRIL 2017 TO MARCH 2018				
Salary and Fees (bands of £5000) £000	Taxable Benefits Rounded to the nearest £100	Clinical Excellence Awards (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000	Salary and Fees (bands of £5000) £000	Taxable Benefits Rounded to the nearest £100	Clinical Excellence Awards (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) 000
55-60				55-60	55-60				55-60
10-15				10-15	10-15				10-15
20-25				20-25	15-20				15-20
15-20				15-20	15-20				15-20
5-10				5-10	10-15				10-15
10-15				10-15	10-15				10-15
10-15				10-15	10-15				10-15
5-10				5-10	-				-
-			-	-	155-160			72.5-75	230-235
80-85			-	80-85	-			-	-
145-150			107.5-110	250-260	125-130			45-47.5	170-175
120-125			57.5-60	175-185	110-115			52.5-55	165-170
120-125			130-132.5	250-260	120-125			35-37.5	120-125
-			-	-	80-85			72.5-75	150-155
170-175		35-40*	-	200-215	170-175		35-40*	120-122.5	330-335
130-135			62.5-65	190-200	120-125			52.5-55	175-180
110-115			77.5-80	185-195	20-25			72.5-75	20-25

Remuneration Report

	2017/18	2017/18
Band of Highest Paid Director's Total Remuneration (bands of £5,000) £'000 **	210-215	205-210
Median Total Remuneration £	£32,258	£30,519
Ratio	6.6	6.8

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest-paid director in Oxleas NHS Foundation Trust in the year ended 31 March 2019 was £210,000-£215,000**. This was 6.6 times the median remuneration of the workforce which was £32,258.

In the year ended 31 March 2019, no employee received remuneration in excess of the highest paid director. Remuneration of the highest paid employees, who were senior consultants, ranged from £160,000 to £165,000 in the year ended 31 March 2019 (bands of £5,000).

Total remuneration includes salary and fees, performance-related bonuses, taxable benefits, severance payments and pension related benefits. It does not include employer's national insurance and superannuation contributions.

For the year ended 31 March 2019, the methodology for calculating the median remuneration involved a detailed analysis of total staff costs which was reconciled to payroll records. Total remuneration figures including salary and allowances were extracted for the year for permanent staff and bank staff. Staff on maternity pay or sick pay were excluded as they were not deemed to be employed at year end. Where a staff member fulfilled more than one role, the total remuneration received by the employee was apportioned to each role on the basis of the actual total cost incurred for this employee by the trust.

Amounts were annualised for permanent and bank staff according to their whole time equivalents and total paid hours respectively. The 2018/19 median pay amount was calculated in accordance with these annualised total remuneration figures.

Taxable Benefits are expenses allowances that are subject to UK income tax and paid or payable to the person in respect of qualifying services.

For defined benefit schemes the pension-related benefits figure is the annual increase in pension entitlement determined in accordance with the 'HMRC' method.

Compensation for loss of office paid to senior managers in the year was £nil.

* This relates to an award under the national clinical excellence reward scheme for consultants. This is an award under the terms of the scheme and relates only to medical staff.

** This figure excludes pension related benefits.

Annual Members Meeting and
Quality Improvement Showcase

Remuneration Report

B) Pension Benefits (subject to audit)

Board Directors
Ben Travis –Chief Executive (to 16 March 2018)
Helen Smith - Deputy Chief Executive & Director of Service Delivery (to 16 March 2018) Acting Chief Executive (From 19 March 2018)
Iain Dimond- Acting Deputy Chief Executive (from 19 March 2018)
Jane Wells - Director of Nursing
Simon Hart - Director of HR & Organisational Development
Dr Ify Okocha - Medical Director
Jazz Thind - Director of Finance
Meera Nair- Director of Workforce and Quality Improvement (from 15 January 2018)

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Remuneration Report

Real increase in pension at age 60 (bands of £2500)	Real increase in pension lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2019 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2019	Real Increase in Cash Equivalent Transfer Value	Employer's contribution to shareholder pension
£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
-	-	-	-	382	-	-	-
5-7.5	15-17.5	65-70	195-200	1,354	-	-	21
2.5-5	2.5-5	45-50	65-70	553	702	132	17
5-7.5	12.5-15	45-50	125-130	663	888	205	18
-	-	-	-	617	-	-	0
-	-	90-95	280-285	1,909	2,120	153	2
2.5-5	2.5-5	45-50	70-75	576	731	138	18
2.5-5	5-7.5	20-25	45-50	274	384	101	9

Remuneration Report

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-2005 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

As a part of the NHS, Oxleas offers all staff the opportunity to be part of the NHS Pension Scheme. The terms and conditions and levels of payment for this scheme are determined nationally by the Department of Health in consultation with relevant trade unions.

During the year there were 4 early retirement on the grounds of ill-health (year ended 31 March 2018 - 2). The estimated additional pension liabilities of these ill-health retirements will be £227,059 (year ended 31 March 2018 £350,029). The cost of these ill-health retirements will be borne by NHS Pensions.

Directors and Governors expenses (not subject to audit)

Mileage re-imbursement for directors' travel expenses is processed at: 45 pence per mile where individual utilises their own car (the HMRC advisory rate); 50 pence per mile where the individual has taken up a lease car via the Trust salary sacrifice scheme; and 24 pence per mile for motorcycles. Payments for travel claims above the HMRC advisory rate is classed as a benefit-in-kind. For 2018/19 some director's travel expense claims processed did exceed the HMRC advisory rates and therefore were classed as benefit-in-kind. The number of directors who claimed travel expenses during 2018/19 was 9 – total value of £5,100 rounded to the nearest £100. The number of governors who claimed travel expenses during 2018/19 was 3 – total value of £500 rounded to the nearest £100. A summary of the information in relation to the expenses of the governors and directors is presented in the table overleaf.

Remuneration Report

	Directors	Governors	Directors	Governors
	2018/19	2018/19	2017/18	2017/18
Total number in office	13	38	14	46
Total number receiving expenses	9	3	9	3
Aggregate sum of expenses paid (to the nearest £100)	£5,100	£500	£10,000	£1,100

Off-Payroll arrangements (not subject to audit)

As part of the remuneration report, NHS Foundation Trusts are mandated to report the following data on their highly paid and/or senior off-payroll engagements. This information is presented in the Table 1 and table 2 below.

Table 1: For all off-payroll engagements as of 31 Mar 2019, for more than £245 per day and that last for longer than six months	2018/19 No of engagements
No. of existing engagements as of 31 Mar 2019	1
Of which:	
Number that have existed for less than one year at the time of reporting	1
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
Confirmation: The trust confirms that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Assurance has been sought

Remuneration Report

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2018 and 31 Mar 2019, for more than £245 per day and that last for longer than six months	2018/19 No of engagements
Number of new engagements, or those that reached six months in duration between 01 Apr 2018 and 31 Mar 2019	1
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	1
Number for whom assurance has been requested	1
Of which:	
Number for whom assurance has been received	0
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

Exit packages (subject to audit)

During the year there were 8 exit packages (31 March 2018, 9) at a cost of £47,000 (31 March 2018, £480,000).

Year ended 31 March 2019

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed *	Total number of exit packages by cost band
<£10,000	0	6	6
£10,001-£25,000	2	0	2
£25,001-£50,000	0	0	0
£50,001-£100,000	0	0	0
£100,001-£150,000	0	0	0
£150,001-£200,000	0	0	0
> £200,000	0	0	0
Total number of exit packages by type	**2**	**6**	**8**
Total resource cost £'000	**29**	**18**	**47**

* of which	Number agreed	Total value of agreements (£'000)
Contractual payments in lieu of notice	6	18

Remuneration Report

Year ended 31 March 2018

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed *	Total number of exit packages by cost band
<£10,000	1	2	18
£10,001-£25,000	0	0	0
£25,001-£50,000	2	1	115
£50,001-£100,000	1	0	66
£100,001-£150,000	1	0	131
£150,001-£200,000	1	0	150
> £200,000	0	0	0
Total number of exit packages by type	**6**	**3**	**9**
Total resource cost £'000	**423**	**57**	**480**
* of which	Number agreed	Total value of agreements (£'000)	
Contractual payments in lieu of notice	0	0	

Signed by:

Matthew Trainer,
Chief Executive,
24 May 2019

Staff Report

Analysis of staff costs

Year ended 31 March 2019

	Total £000	Permanently Employed £000	Other £000
Salaries and wages	139,886	139,246	640
Social security costs	14,198	14,198	0
Apprenticeship levy	668	668	0
Pension cost – employer contributions to NHS pension scheme	16,639	16,639	0
Pension cost - other	15	15	0
Temporary staff – agency/contract staff	8,628	0	8,628
Total	180,034	170,766	9,268

Year ended 31 March 2018

	Total £000	Permanently Employed £000	Other £000
Salaries and wages	129,367	128,836	531
Social security costs	13,086	13,086	0
Apprenticeship levy	611	611	0
Pension cost – employer contributions to NHS pension scheme	15,372	15,372	0
Temporary staff – agency/contract staff	13,676	0	13,676
Total	172,112	157,905	14,207

Staff Report

Summary of average staff numbers

At the end of 2018/19, Oxleas NHS Foundation Trust employed 3,791 people. The average number of employees (whole time equivalent) is below.
This table is based on whole time equivalent staffing figures

	2017/18			2018/19		
Staff Group	Fixed term	Permanently employed	Total	Fixed term	Permanently employed	Total
Healthcare Assistants and other support staff	2	486	488	1	533	534
Administrative and Estates	53	684	737	51	693	744
Social care staff	6	85	91	9	83	92
Medical and Dental	21	165	186	16	172	188
Nursing, midwifery and health visiting staff	317	1,003	1,320	282	1,046	1,328
Scientific, Therapeutic and Technical staff	35	704	739	27	741	768
Total	**434**	**3,127**	**3,561**	**386**	**3,268**	**3,654**

Staff gender analysis

At 18/19 year end (Figures related to individual people)

	Female	Male	Total
1. Directors	4	2	6
2. Other senior managers	17	12	29
3. Employees	3028	763	3791

1 Defined as Chief Executive Officer and Executive Directors with voting rights

2 Defined in accordance with HSCIC's Occupational Code Manual (employees who have been coded in electronic staff record under the Senior Managers G0 occupational code)

3 Those with a permanent contract excluding those already counted in Director and Senior Manager figures.

Staff Report

Consultancy expenditure

This is set out in note 4.1 of the accounts

Equality and human rights

Oxleas recognises that delivering on equality and human rights is a driver to achieve the trust's strategic priorities. Equality is embedded within our governance processes and policies which allow for debate, dialogue and escalation. The Executive Lead for equality and human rights is the Director of Workforce and Quality Improvement. There were three key priority areas during 2018/19 – concerns about higher levels of violence, aggression and abuse towards staff (particularly those from minority groups) from patients, carers and service users, gender pay gap with specific reference to clinical excellence awards and the higher numbers of Black and Minority Ethnic staff entering formal disciplinary processes.

A programme of work was undertaken in relation to addressing staff concerns regarding violence, aggression and abuse from patients, service users and carers towards our staff, which disproportionately affected Black and Minority Ethnic staff. Through intensive staff engagement across the whole organisation and with focused quality improvement projects in inpatient areas, perceptions of staff were seen to have improved in the 2018 staff survey.

The Medical Director led multiple focus groups with the medical consultant body and British Medical Association representatives to explore the reasons for the pay gap in relation to clinical excellence awards. Multiple changes were made to the processes, including mentoring for female consultants, refining the template for applications to particularly address the issues experienced by the female workforce in balancing work with family responsibilities, extending the time available for submitting applications etc. The gender pay gap reduced in the data reported for the year ending March 2018. Based on the results of the awards process for 2018/19, we are expecting further marked improvements.

The Equality and Human Rights agreed to focus on the Workforce Race Equality Standard indicator 3, i.e., disproportionate number of Black and Minority Ethnic staff entering a disciplinary process. Despite a review of all casework which provided assurance that all cases in formal processes were appropriate, the indicator had worsened. The committee with representation from the Black and Minority Ethnic staff network and staff-side representatives is piloting the use of 'Just Culture' methodology in all inpatient areas for five months. The pilot is scheduled to end in May 2019.

Future priorities

The priorities for the year have been based on extensive engagement with our partners, including the staff networks, staff side representatives and other stakeholders and work has already commenced on all of them. These are:

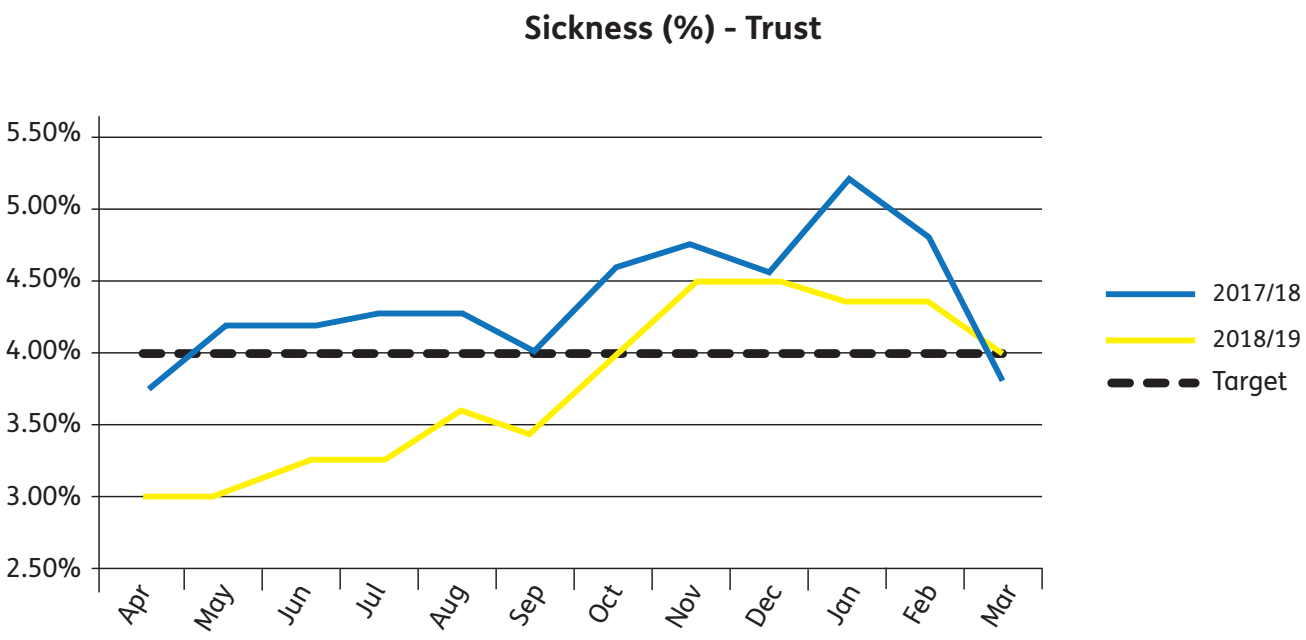
- Improve delivery against the Accessible Information Standard
- Reduce levels bullying and harassment as experienced by various minority groups
- Improve outcomes on the WRES, most particularly levels of representation in senior bands and proportion of BME staff entering formal processes
- Improve outcomes against the pay gap identified in relation to the various minority groups within the workforce

Staff Report

Performance against and monitoring of these targets will be undertaken by the Equality and Human Rights Group and the
Workforce Committee.

Sickness absence

It is our aim to keep sickness absence to below 4%. During 2018/19, absence levels were consistently lower than the previous year. The chart below tracks our performance across the year. We perform well in comparison to our comparator trusts in London.



Staff Report

Oxleas has procedures in place to manage short term and long term absence. Our policy identifies clear points for short term absence that 'trigger' review of absence and allow for targets for improvement to be set. The policy also outlines mechanisms to support staff who are absent for extended periods of time with chronic or long term health conditions, including as appropriate advice from Occupational health, redeployment, phased return to work, and reasonable adjustments.

In addition, our Employee Assistance programme offers confidential support to staff both online and via the telephone. The service is available to staff 24/7, and also provides a range of additional support including legal advice. There is also a fast-track referral process for staff who suffer from musculoskeletal issues.

Oxleas workforce KPI dashboard includes detail on levels of absence within the organisation and is reported on a monthly basis. Data is available by ward/team/department to ensure that all instances of absence are reviewed and supported with appropriate interventions.

Helping our people stay healthy and safe

Oxleas' Health and Safety Committee continues to meet regularly to provide a forum for managers and staff to work together to promote the safety, health and welfare of staff, patients and visitors.

We have developed a new Health & Safety Strategy and associated five year work plan to ensure the Trust maintains a consistently positive health and safety culture, responds to concerns and incidents, and focuses on identified risks to maintain a safe working environment.

We are moving to a software based health and safety auditing system that will greatly enhance our ability to analyse and report on health and safety compliance, and identify areas of necessary focus.

A continued focus on lone working has been a priority, to ensure this potential risk is properly managed. We have been working with all our teams to ensure they have safe systems of work in place, and, where appropriate, have relaunched the use of our chosen lone working device to improve usage. We have doubled the number of teams using this device to enhance staff safety and offered widespread training.

Analysis of incident patterns has led us to begin a careful review of the design of mental health reception areas to minimise risk whilst ensuring premises remain welcoming to patients.

Engaging with our people

Staff engagement is a key part of the trust's workforce strategy. Staff engagement in the trust is underpinned by the Partnership agreement which sets out the framework by which we work with trade unions for the best interests of the organisation. We have subsequently extended this agreement to recognise and include the various staff networks including the Black and Minority Ethnic network, Lesbian, Gay, Bisexual, Transgender plus network and Lived Experience (of Mental Health) network. The networks provide the trust with a further opportunity to engage staff and understand staff needs. The networks have been involved in the selection of the occupational health provider, the staff counselling service and the Black and Minority Ethnic coaching scheme provider. The Chair of the Black and Minority

Staff Report

Ethnic network, in partnership with the Head of Employment Relations, scrutinises outcomes of all trust disciplinary processes to ensure that there is no discrimination in either process or outcome. Their conclusions are reported to the Board.

We systematically provide employees with a range of information on matters that are of concern and/or interest to them as employees:

- Leaders are invited to attend the regular Senior Staff Breakfast to receive briefings of key issues and developments. Messages are then cascaded towards wider teams .
- A fortnightly e-bulletin 'One Oxleas' updating staff on all key matters is circulated to all employees on email.
- Monthly team briefing which provides an update from the executive team.
- The 'Ox', our intranet, pages are updated and curated on a daily basis.
- Professional executives to communicate with all professional leads across Oxleas.
- Our Let's Talk programme which provides a range of ways for the executive to engage with colleagues.
- Opportunities for staff in the first year of employment to meet with the Chief Executive and provide feedback on their experience within the trust.
- Targeted programmes of collaborative work to address areas of concern for staff, e.g., violence and aggression and bullying and harassment, ensuring that staff views are fully considered and included within solution design.
- Several ways for staff to raise concerns, including an anonymous reporting portal.
- Directors including non-executive directors regularly spend time with colleagues in services, providing the opportunity to find out more about the issues that matter most to our colleagues.
- The chair of staff side is also the Head of Partnership working for the trust. She acts as an advocate for all staff irrespective of union membership ensuring that their views are heard and considered, through regular feedback sessions across Oxleas.

2018 Staff Survey - summary of key findings

Oxleas' approach to engaging with our staff is described above. We use a range of mechanisms to monitor and learn from staff feedback, which includes participation in the national NHS staff survey. The 2018 survey was undertaken between October and December 2018 with the results being published in March 2019. This year we used a fully electronic mode for the survey, although previously we had used a mixed mode including paper and electronic surveys. Our comparator group within the staff survey is 31 trusts nationwide that are categorised as combined mental health, community and learning disability trusts.

The survey was sent to all staff. Our response rate of 49% was an improvement over the previous response rate of 42% in 2017. Scores for each indicator together with that of the survey benchmarking group (comparator group of combined mental health, community and learning disability trusts) are presented below.

Staff Report

	2018		2017		2016	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	8.7	9.2	8.8	9.2	8.8	9.2
Health and wellbeing	6.0	6.1	6.1	6.1	6.1	6.2
Immediate managers	7.2	7.2	7.2	7.1	7.2	7.1
Morale	6.1	6.2	N/A	N/A	N/A	N/A
Quality of appraisals	5.6	5.5	5.4	5.4	5.5	5.4
Quality of care	7.4	7.4	7.5	7.4	7.6	7.5
Safe environment – bullying and harassment	7.9	8.2	8.0	8.3	8.0	8.2
Safe environment – violence	9.4	9.5	9.2	9.5	9.2	9.5
Safety culture	6.9	6.8	6.7	6.7	6.9	6.7
Staff engagement	7.1	7.0	7.1	7.0	7.1	7.0
Response Rate	49%	45%	42%	45%	44%	44%

Staff Report

Oxleas has remained a high performer in comparison to other organisations in terms of overall results. The results have generally remained unchanged with significant improvements in two themes: Safe environment – violence and Safety Culture.

Although we remain below the comparator average in relation to violence, staff perceptions have improved significantly. We undertook a focused programme of work in 2018/19 to address staff concerns, develop resilient solutions to support staff in various work settings, improve feedback to staff following incident reporting and build improved relationships with the police. This was paired with a quality improvement programme aimed at reducing violence in inpatient settings. We are hopeful that improvements will be maintained as additional ideas are tested and implemented in 2019/20. Staff perceptions in relation to incident reporting, feedback from incidents as well as improvements in staff perception on ability to report safety concerns have all improved.

Our directorates are working with their teams on specific local concerns and action plans. We will however embark on an organisation wide programme to address staff concerns about health and well-being. We recognise that this will have an impact on retention levels and our goal of making Oxleas the best place to work. Other priorities from the staff survey relate to actions that are already in progress and will continue in 2019/20:

- We are working with our staff networks (Black and Minority Ethnic, Lesbian, Gay, Bisexual, Transgender plus, Disability, Lived Experience), staff side partners and champions to roll-out a new model to address bullying and harassment and increase courtesy and respect in the workplace.
- We will continue the work that is underway in relation to the various equalities strands, including reviewing recruitment processes to ensure that they actively encourage and engage with minority groups, applying the just culture methodology to disciplinary processes. We hope to shortly finalise our equality strategy which will define our priority areas as well as measures for progress.

Our workforce committee, chaired by a non-executive director, will continue to have oversight of these programmes.

Trade Union Facility Time

From 1 April 2017 public sector organisations are required to report on trade union facility time. Facility time is paid time off for union representatives to carry out trade union activities.

We continuously work with our trade union colleagues to improve reporting on facility and trade union time.

Table 1
Relevant union officials

Number of employees who were relevant union officials during the relevant period	Whole time equivalent
23	21.5

Staff Report

Table 2
Percentage of time spent on facility time

Percentage of time	Whole time equivalent
0%	12
1% - 50%	9
51% - 99%	0
100%	2

Table 3
Percentage of pay bill spent on facility time

Total cost of facility time	£109,76
Total pay bill on employees who were relevant union officials % of pay bill spent on facility time	£1,041,106
% of pay bill spent on facility time	10.54%

Table 4
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 activities by relevant union officials during the relevant period/total paid facility time hours) x 100	10.77%

Staff Report

Information to and consultation with employees

Oxleas continues to work in partnership with local trade union representatives on a range of issues. The trust has agreed a formal statement of partnership working with its trade unions which regularises the input and inclusion of staff in the decision making of the trust. This agreement was revised and updated in 2013 to formally recognise the role of the staff networks and their contribution to the trust. Major changes to service provision and roles and responsibilities of staff are accompanied by a formal consultation process to which all affected staff and their trade union representatives are encouraged to contribute. Staff are also able to raise issues and ask questions via the seven elected staff governors. The staff governors are part of the Council of Governors and also attend the Staff Partnership Forum along with trade union stewards and representatives of the staff networks.

Equal Opportunities and Occupational Health

Oxleas has met all of its duties under the 2010 Equality Act and has set and published its objectives to improve equality for those who use our services and those who work in them. We have fully implemented the NHS Equality Delivery System (EDS) which provides a robust assurance framework that allows the trust to identify areas of strength and weakness in relation to how it supports all groups protected under the Act. Progress against the framework is measured independently by patient representatives drawn from HealthWatch and trade union and staff groups. In 2016, we have jointly reviewed all of the outcomes of disciplinary hearings with the chair of the Black and Minority Ethnic network to further ensure transparency and fairness. We have actively supported the development of the National Workforce Race Equality Scheme and have published this data along with a trust action plan in line with the national requirements.

Oxleas is committed to giving full and fair consideration to applications from disabled people. We have been awarded the 'two tick' symbol by Job Centre Plus in recognition of our commitment to the employment of disabled people. We have 'Mindful Employer' status in recognition of our commitment to supporting people with mental health issues into employment. The trust employs a dedicated occupational therapist to support the employment of service users as either employees or via volunteer placements and to further our work as a Mindful Employer.

We support staff who become disabled during their employment and commission an occupational health service. This service has specialist knowledge in supporting staff working in a mental health setting and helps to facilitate disabled employees return to work, either in their own job or alternative employment elsewhere in the organisation. In addition, the service also provides fast track access to physiotherapy and a consultant psychiatrist. We provide an Employment Assistance Programme which gives employees direct and confidential access to a dedicated 24 hour telephone counselling service as well as access to more specialist psychological therapeutic support as required. We have established a staff led Disability Action Group and a Lived Experience Network for staff with personal experience of mental health issues. These groups are actively involved in supporting us to improve how we support our staff.

Code of Governance

Oxleas 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 uses the NHS Foundation Trust Code of Governance as best practice advice to improve our governance practices. We follow the code guidance with exception to the maximum term of office for non-executive directors. In 2011, our membership voted for the extension of the non-executive maximum term of office to 3 x 3 year terms to provide greater continuity through times of change within Oxleas and the wider NHS.

The Board of Directors manages the business of Oxleas NHS Foundation Trust by setting strategy and overseeing performance. The Executive team manages the day to day operational running of the organisation and regularly reports on activity to the Board. The Board also works closely with the Council of Governors and both groups regularly meet and attend each other's meetings. A meeting between governors and non-executive directors is held before every Board meeting to ensure that non-executive directors understand governors' views and any issues of concern.

The Council of Governors have a range of roles and responsibilities. Their general duty 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 our members and the public.

The governors' statutory duties are to:

- Appoint or remove the Chair and non-executive directors (as laid out in the trust constitution)
- Approve the appointment of the Chief Executive
- Decide the remuneration and terms and conditions of non-executives
- Appoint our financial auditor
- Receive the annual accounts
- Provide a view on forward planning
- Approve significant transactions
- Approve mergers and acquisitions
- Approve separations or dissolutions
- Approve an increase or more than 5% of non-NHS activities
- Approve changes to our Constitution (unless it is around the powers and duties of the Council of Governors).

The governors put these duties into action this year in several ways including appointing our financial auditor following a competitive tendering exercise.

Our governors also have the right to:

- Propose a vote on the organisation's or director's performance
- Require one or more directors to attend a meeting to obtain information about the organisation's or director's performance and
- Refer a question to NHS Improvement's advisory panel as to whether the trust has failed or is failing to act in accordance with the Constitution.

None of these rights has been used in 2018/19.

Code of Governance

Should any disagreements arise between our Council of Governors and our Board of Directors, we would follow the procedures laid down in our Constitution. Members of the Board of Directors and Council of Governors both attend our members' focus groups to learn members' views on what our future priorities should be and to gather feedback on our current performance. They also both take part in strategy development days, alongside clinical leaders in the trust.

Attendance at Board meetings

The table below shows the number of meetings attended out of a maximum of eight. As there were changes to the Board membership during the year, not all Board members had the opportunity to attend all meetings.

Name	Meetings attended
Seyi Clement / Non-Executive Director	7/8
Steve Dilworth / Non -Executive Director	7/8
Yemisi Gibbons / Non-Executive Director	7/8
Nina Hingorani-Crain / Non-Executive Director	2/4
Steve James / Non-Executive Director	8/8
James Kellock / Non-Executive Director	4/4
Jo Stimpson / Non-Executive Director	8/8
Iain Dimond / Interim Deputy Chief Executive	4/4
Dr Ify Okocha / Medical Director	6/8
Helen Smith / Deputy Chief Executive and Director of Service Delivery	8/8
Matthew Trainer / Chief Executive	4/4
Jazz Thind / Director of Finance	8/8
Andrew Trotter / Chair	8/8
Jane Wells / Director of Nursing	8/8

Code of Governance

Audit and Risk Assurance Committee

The members of this committee during the year were:

Stephen Dilworth
Non-Executive Director and Chair

Stephen James
Non-Executive Director

Jo Stimpson
Non-Executive Director

There were six meetings between 1 April 2018 and 31 March 2019

Member	Attendance
Steve Dilworth	6/6
Steve James	6/6
Jo Stimpson	6/6

The Audit and Risk Assurance Committee provides the Board of Directors with an independent review of financial and corporate risk management and governance including clinical and non-clinical risks.

With a membership of non-executive directors, the committee uses independent external and internal audit to provide assurance to the Board. The executive lead for the Audit and Risk Assurance Committee is the Director of Finance.

The committee monitors the integrity of our financial statements and ensures we have the right policies and procedures in place to make sure our organisation is run effectively and legally. The committee reviews the adequacy of all risk and control related disclosure statements together with Head of Internal Audit Opinion, External Audit Opinion and other appropriate assurances. It approves the internal audit strategy and considers all the internal audit reports and ensures that the recommendations are put into action. The committee also has oversight of our local counter fraud arrangements. The committee discusses with our external auditors their local evaluation of audit risks and reviews all external audit reports. The committee has oversight of our Board Assurance Framework linking with other board sub-committees to ensure that key risks are identified and plans actioned in response. Each sub-committee presents its risk register annually to the Audit and Risk Assurance Committee. In addition, the committee receives a thematic analysis of risks to highlight trends across the trust.

Significant areas that have been considered by the Audit and Risk Assurance Committee during the year include:

- Property valuations
- Charitable funds
- Internal audit findings
- Salary overpayment comparative analysis
- Lone working arrangements
- Legal claims
- Trust 'whistleblowing' processes

KPMG provide internal audit and counter fraud services to Oxleas while Deloitte LLP provided services until June 2018 and Grant Thornton UK LLP were appointed by our Council of Governors as our provider of external audit services from 1 July 2018 for a period of three years with the option to extend by a further one or two years.

Code of Governance

Our internal and external auditors attend our Audit and Risk Assurance Committee meetings as well as relevant trust staff. At these meetings, outcomes of internal and external audits and actions taken as a result were reviewed. Also financial controls, action to reduce fraud and our whistle-blowing and conflict of interest processes were discussed.

Our internal audit and counter fraud plan includes a number of projects that are designed to review processes and controls where we believe there to be risk and to give appropriate assurance to the Board via the Audit and Risk Assurance Committee that these risks are being addressed. The plan is discussed by the Executive Team and approved by the Audit and Risk Assurance Committee. KPMG present the work they have carried out and provide an update of actions completed. Details of the internal audit report work carried out this year are included in our annual governance statement.

At our Audit and Risk Assurance Committee, Grant Thornton, our external auditor, present updates regarding accounting and business matters that are relevant to our organisation; including their audit plans and reports, for discussion by the committee. As part of this, the committee considers our accounting policies, the implications of new accounting guidance, and whether our financial statements are compliant with the relevant financial reporting standards.

Grant Thornton are required to make the case to the committee that they are objective and comply with the technical and ethical standards that apply to them as auditors. Part of the audit cycle includes an assessment by the committee of the effectiveness of the audit process. Audit fees are reported in the Financial Performance Analysis section.

The Committee engages regularly with the external auditor over the course of the financial year, including private sessions, at which executive management is not represented. The subjects covered include consideration of the external audit plan, matters arising from the audit of the trust financial statements, the review of the trust quality accounts and any recommendations on control and accounting matters proposed by the auditor. Where adjustments are proposed by the auditors, the Audit and Risk Assurance Committee considers both their nature and their materiality to the accounts in deciding whether to record them.

The Audit and Risk Assurance Committee reviews the effectiveness of the external audit process and the quality of its function through a variety of routes. Key aspects include: a review of audit presentations and communications, the planning and scope of the audit and identification of the areas of audit risk; review of the quality of staff and sufficiency of resources provided; execution of the audit; and matters raised in relation to the independence, objectivity and reputation of the firm. Based on this, the Audit and Risk Assurance Committee considers that the performance of the Trust's external auditors (including the quality and value of the work, the timeliness of reporting and the external audit fee) is and has been appropriate over the past year.

NHS foundation trusts should appoint an external auditor for a period of time that allows the auditor to develop a strong understanding of the finances, operations, quality of services and forward plans of the NHS foundation trust. Current best practice recommends a three-to-five-year period of appointment and our regulator, NHS Improvement, recommends that foundation

Code of Governance

trusts undertake a market-testing exercise for the appointment of an auditor at least once every five years. In accordance with this best practice and to ensure that the trust receives a quality service that offers best value for money, the trust commenced a formal market test in June 2017. The tender process involved representatives from the Council of Governors, the Chair of the Audit and Risk Committee Assurance Committee and the Director of Finance. The group evaluated 3 tender submissions which resulted in the Council of Governors approving the appointment of Grant Thornton UK LLP in December 2017. 2018/19 is the first year of the new contract.

Further detail on our risk and control arrangements are described in our Annual Governance Statement.

Code of Governance

Nominations Committee

Executive Nominations Committee

During 2018/19, our Board appointed our new Chief Executive.

Membership

- Chair
- Non-Executive Directors
- Lead Governor

The committee met during 2018/19 and was supported by our Director of Workforce and Quality Improvement. Following external advertisement and a range of stakeholder engagement, the committee was pleased to recommend the appointment of Matthew Trainer as Chief Executive, to the Board. The appointment was approved by the Council of Governors in June 2018.

NED Nominations Committee

Membership

- Andy Trotter, Chair
- Raymond Sheehy, Lead Governor until September 2018
- Richard Diment, Lead Governor from September 2018
- Joseph Hopkins, Elected Governor
- Stephen Brooks, Elected Governor until September 2018
- Janet Kane, Elected Governor from September 2018
- Stephen Dilworth, Non-Executive Director

The committee met during 2018/19 and was supported by our Director of Workforce and Quality Improvement. All members of the committee attended both meetings.

Following external advertisement and a range of stakeholder engagement, the committee was pleased to appoint Nina Hingorani-Crain as Non-executive director (this appointment was approved by the Council of Governors in September 2018).

Other committee attendance

The membership of the board sub-committees is detailed below (as the board membership changed during the year, the number of meetings attended differs).

Business Committee

Name	Attendance
Jo Stimpson	11/11
James Kellock	6/6
Nina Hingorani-Crain	4/5
Steve Dilworth	10/11
Matthew Trainer	5/6
Helen Smith	10/11
Jazz Thind	11/11
Dr Ify Okocha	6/11

Code of Governance

Performance and Quality Assurance Committee

Name	Attendance
Yemisi Gibbons (Chair)	10/10
Seyi Clement	2/10
Steve James	7/10
Jane Wells	10/10
Ify Okocha	9/10
Helen Smith	3/5
Iain Dimond	5/5

Workforce Committee

Name	Attendance
James Kellock (Chair)	6/6
Yemisi Gibbons	9/9
Jo Stimpson	9/9
Meera Nair	9/9
Jane Wells	9/9
Helen Smith	2/4
Iain Dimond	3/5

Quality Improvement and Innovation Committee

Name	Attendance
Steve James (Chair)	6/6
Seyi Clement	1/6
Yemisi Gibbons	5/6
Ify Okocha	5/6
Jane Wells	5/6
Matthew Trainer	1/4
Meera Nair	6/6

Infrastructure Committee

Name	Attendance
Seyi Clement (Chair)	3/6
Steve Dilworth	6/6
Steve James	4/6
Jazz Thind	5/6

Code of Governance

Members of the Council of Governors

The Council of Governors has 37 governors. They represent:

10 public governors (three each for Bexley, Bromley and Greenwich boroughs, and one for Rest of England borough)

11 service user/carer governors

9 appointed governors

7 staff governors

The following tables list the names of the governors, the constituency or organisation they represent and their term of office.

The process to end a governor's term of office early is laid out in the trust constitution. The reasons for ending a governor's term of office include:

- Resignation
- Failure to attend meetings
- No longer being eligible to represent the constituency
- Breaching the code of conduct.

This process is overseen by the Governors' Standards Committee.

Service user / carer constituency

Current Governors

Name	Term start	Term end
Lesley Smith	Re-elected 11 September 2018	September 2021
Katherine Copley	Re-elected 11 September 2018	September 2021
Fola Balogun	Re-elected 17 September 2016	September 2019
Raja Rajendran	26 September 2018	September 2021
Steve Pleasants	Re-elected 11 September 2018	September 2021
Tina Strack	11 September 2018	September 2021
Olivia Church	11 September 2018	September 2021
Claire Wheeler	11 September 2018	September 2021
Frances Murray	26 September 2018	September 2021

Code of Governance

Governors whose term has ended in year

Name	Term start	Term end
Arthur Mars	17 September 2016	11 September 2018
Jacqueline Ashby-Thompson	30 September 2015	26 September 2018
Irene Badejo	Re-elected 9 September 2017	11 September 2018
Kulwinder Johal	9 September 2017	16 May 2018
Joseph Hopkins	9 September 2017	29 June 2018

There are two vacant seats in the Service User/Carer constituency: one in the special interest group of Children and one in Forensic and Prison.

Public constituency
Current Governors

Name	Borough	Term start	Term end
Ben Spencer	Bromley	Re-elected 26 September 2018	September 2021
Yens Marsen-Luther	Greenwich	Re-elected 9 September 2017	September 2020
Frazer Rendell	Bromley	Re-elected 9 September 2017	September 2020
Trilok Bhalla	Greenwich	9 September 2017	September 2020
Sue Hardy	Bexley	26 September 2018	September 2021
Joseph Hopkins	Bexley	26 September 2018	September 2021
Liz Moss	Bromley	26 September 2018	September 2021
Steven Turner	Greenwich	26 September 2018	September 2021
Janet Kane	Rest of England	26 September 2018	September 2021
Sue Sauter	Bexley	8 March 2019	September 2021

Code of Governance

Governors whose term has ended in year

Name	Borough	Term start	Term end
Richard Diment	Bexley	Re-elected 30 September 2015	23 May 2018
Stephen Brooks	Bexley	Re-elected 30 September 2015	26 September 2018
John Crowley	Greenwich	5 February 2016	26 September 2018
Stuart Dixon	Bromley	17 September 2016	26 September 2018

There are no vacant seats.

Staff constituency
Current Governors

Name	Constituency	Term start	Term end
Victoria Smith	Corporate and Partner	9 September 2017	September 2020
Surajsing Persand	Forensic and Prison Health Services	Re-elected 26 September 2018	September 2021
Sue Read	Bexley Adult	Re-elected 11 September 2018	September 2021
Sara Veermah	Bromley Adult	11 September 2018	September 2021
Rebekah Marks-Hubbard	Greenwich Adult	11 September 2018	September 2021
Sharon Rodrigues	Learning Disability	26 September 2018	September 2021
Jo Linnane	Children's Services	26 September 2018	September 2021

Governors whose term has ended in year

Name	Constituency	Term start	Term end
Jacqui Pointon	Children's Services	30 September 2015	26 September 2018
Anna Dube	Older People Mental Health Services	17 September 2016	11 September 2018
Grace Umoren	Working Age Mental Health Services	17 September 2016	11 September 2018

There are no vacant seats.

Code of Governance

Appointed governors
Current Governors

Name	Organisation
Richard Diment	Bexley Council – Local Authority (Lead Governor)
Yvonne Bear	Bromley Council – Local Authority
Averil Lekau	Greenwich Council – Local Authority
Vacant	Bridge – Forensic
Mark Ellison	Age UK – Older Adult
Carl Krauhaus	Charlton Athletic Community Trust – Young People
Dominic Parkinson	Mind – Adult Mental Health
Steve Davies	Mencap – Learning Disabilities
Kate Heaps	Greenwich & Bexley Community Hospice – Adult Community – from 3 August 2018

Governors whose term has ended in year

Name	Organisation
Cafer Munur	Bexley Council – Local Authority
Judi Ellis	Bromley Council – Local Authority
David Gardner	Greenwich Council – Local Authority
Raymond Sheehy	Bridge – Forensic
Brian Sladen	Headway – Adult Community

Code of Governance

Public, staff and user/carer governors are elected by members of their own constituency using the single transferable vote system. Governors are appointed for a fixed term of three years.

For appointed governors, our partner organisations as defined in our constitution were asked to nominate a representative. Appointed governors are appointed for a fixed term of three years.

During 2018/19, two elections were held. The details are outlined below.

Public

	Number of nominations at deadline of 31/07/18	Outcome of voting (20/08/18 to 10/09/18)	When announced	When took up position
Bexley 3 vacancies	3	Unopposed 2 elected (one candidate unable to take up position)	11 September 2018	26 September 2018
Bromley 2 vacancies	4	2 elected	11 September 2018	26 September 2018
Greenwich 1 vacancy	2	1 elected	11 September 2018	26 September 2018
Rest of England 1 vacancy	2	1 elected	11 September 2018	26 September 2018

Code of Governance

Service User/Carer

	Number of nominations at deadline of 31/07/18	Outcome of voting (20/08/18 to 10/09/18)	When announced	When took up position
Bexley Adult 2 vacancies	3	2 elected	11 September 2018	11 September 2018
Bromley Adult 2 vacancies	3	2 elected	11 September 2018	11 September 2018
Greenwich Adult 2 vacancies	3	2 elected	11 September 2018	11 September 2018
Children 1 vacancy	No valid nomination received	-	-	-
Learning Disability 1 vacancy	1	Unopposed 1 elected	11 September 2018	26 September 2018
Carer 1 vacancy	1	Unopposed 1 elected	11 September 2018	26 September 2018

Code of Governance

Staff

	Number of nominations at deadline of 31/07/18	Outcome of voting (20/08/18 to 10/09/18)	When announced	When took up position
Bexley Adult 1 vacancy	2	1 elected	11 September 2018	11 September 2018
Bromley Adult 1 vacancy	1	Unopposed 1 elected	11 September 2018	11 September 2018
Greenwich Adult 1 vacancy	2	1 elected	11 September 2018	11 September 2018
Children 1 vacancy	1	Unopposed 1 elected	11 September 2018	11 September 2018
Forensic & Prison 1 vacancy	1	Unopposed 1 elected	11 September 2018	26 September 2018
Learning Disability 1 vacancy	2	1 elected	11 September 2018	26 September 2018

Code of Governance

By- election

As there were vacancies in both the Public: Bexley constituency and Service User Carer constituency Children special interest group, a by-election was held.

Public

	Number of nominations at deadline of 28/01/19	Outcome of voting (12/02/19 to 07/03/19)	When announced	When took up position
Bexley Adult 1 vacancy	2	1 elected	8 March 2019	3 April 2019

Service User/Carer

	Number of nominations at deadline of 28/01/19	Outcome of voting (12/02/19 to 07/03/19)	When announced	When took up position
Children 1 vacancy	No valid nomination received	-	-	-

Attendance at Council of Governors' meetings

The table below shows the number of meetings attended out of a maximum of four. Several governors changed mid-year, so did not have the opportunity to attend all meetings.

Code of Governance

Service user carer

Name	Attendance
Lesley Smith	4/4
Katherine Copley	2/4
Fola Balogun	4/4
Raja Rajendran	2/4
Steve Pleasants	0/4
Tina Strack	2/3
Olivia Church	2/3
Claire Wheeler	3/3
Frances Murray	0/2
Arthur Mars	0/1
Jacqueline Ashby-Thompson	2/2
Irene Badejo	0/1
Kulwinder Johal	0/0
Joseph Hopkins	1/1

Public

Name	Attendance
Ben Spencer	2/4
Yens Marsen-Luther	2/4
Frazer Rendell	3/4
Trilok Bhalla	2/4
Sue Hardy	1/2
Joseph Hopkins	2/2
Liz Moss	2/2
Steven Turner	2/2
Janet Kane	2/2
Stephen Brooks	2/2
John Crowley	1/2
Stuart Dixon	1/2

Code of Governance

Staff

Name	Attendance
Victoria Smith	1/4
Surajsing Persand	3/4
Sue Read	4/4
Sara Veermah	3/3
Rebekah Marks-Hubbard	3/3
Sharon Rodrigues	2/2
Jo Linnane	2/2
Jacqui Pointon	2/2
Anna Dube	0/1
Grace Umoren	0/1

Appointed

Name	Attendance
Richard Diment	4/4
Yvonne Bear	4/4 (or representative)
Averil Lekau	1/4
Mark Ellison	1/3
Carl Krauhaus	4/4 (or representative)
Dominic Parkinson	3/3
Steve Davies	3/4
Kate Heaps	2/3
Cafer Munur	0/0
Judi Ellis	0/0
David Gardner	0/0
Raymond Sheehy	2/2
Brian Sladen	0/1

Code of Governance

Unfortunately due to work commitments, our partnership governors are not always able to attend Council of Governor meetings but do receive all papers for the meetings.

The table below shows attendance by Directors at Council of Governors meetings. Directors attend the Council of Governors in response to the topics under discussion. There have been several changes mid-year, so not all Board members had the opportunity to attend all meetings.

Name	Meetings attended
Seyi Clement / Non Executive Director	2/4
Steve Dilworth / Non Executive Director	4/4
Yemisi Gibbons / Non Executive Director	0/4
Nina Hingorani-Crain / Non Executive Director	0/2
Steve James / Non Executive Director	2/4
James Kellock / Non Executive Director	2/2
Jo Stimpson / Non Executive Director	1/4
Iain Dimond / Interim Deputy Chief Executive	2/2
Meera Nair / Director of Workforce and Quality Improvement	4/4
Dr Ify Okocha / Medical Director	4/4
Helen Smith / Deputy Chief Executive and Director of Service Delivery	4/4
Jazz Thind / Director of Finance	2/4
Matthew Trainer / Chief Executive	2/2
Andrew Trotter / Chairman	4/4
Jane Wells / Director of Nursing	3/4

Oxleas maintains a register of directors', staff and governors' interests. This is available on our website or from the Trust Secretary.

Code of Governance

Membership

Our membership constituencies are:

Service users/carers: this is open to people aged 14 years and over, who are current service users or carers, or who have been service users or carers within the past five years.

Public: this is open to people aged 14 years and over, living in England.

Staff: this is open to individuals who are employed by us. Staff working in services contracted by us and staff working on our temporary staff bank are also eligible to join.

Constituency	31/3/19	31/3/18
Staff	4593	4373
Public	4800	4983
Service user/carer	1366	1424
Totals	10,759	10,780

Changing our Constitution

Over 50 members joined us on 29 June 2018 for a Special Members' Meeting held to vote on changes to our Constitution and to help us celebrate 70 years of the NHS. The changes had been proposed by our Council of Governors.

Our Chair, Andy Trotter, presented an overview of the proposed changes which were to:

- Re-structure the council and our membership constituencies along similar lines to our service directorates; particularly our staff constituency classes and service user/carer constituency interest groups;
- Reduce our governors from 42 to 37;
- Introduce a new service user/carer constituency interest group for forensic and prison services.

Whilst enjoying a celebratory tea party, members also had the opportunity to watch our new NHS70 film, visit our exhibition showcasing the history of the NHS and Oxleas over the past decades, and vote on the changes to our Constitution. The results of the vote were announced on Monday, 2 July 2018. As members agreed to the changes, constituencies were reconfigured in line with the new structure. This resulted in a number of our existing service user/carer and staff governors being displaced and having to stand in the new constituency interest groups. All members affected by the constitutional changes were contacted to advise their new interest groups with options to change to an alternative interest group if they wished.

Membership Strategy

A new three year Membership Strategy (2019-2021) was agreed by the Council of Governors in December 2018. This strategy aims to take forward the membership activities of the trust focusing on recruitment, communication and engagement.

The strategy will be implemented through an annual work plan of activities led by the Membership Committee. The initial priorities for this are:

- Recruiting young people as members
- Recruiting service user/carer members to represent forensic and prison healthcare services
- Developing more tailored membership materials

Code of Governance

To progress this, governors took part in a membership development session in February 2019 to consider how we can engage more with key groups living in our communities. Governors were able to consider how we are engaging with our current members as well as opportunities to build the membership further, particularly around young people. The session took place at Greenwich and Bexley Community Hospice and was hosted by partnership governor, Kate Heaps. It was chaired by Yens Marsen-Luther, a public governor representing people living in Greenwich, who also chairs our Membership Committee.

Work is underway to build opportunities for member recruitment within our forensic services.

We are also looking at what may interest young people to encourage their engagement with the trust eg work experience, volunteering and apprenticeships.

We have again published a governor review and continued to provide profiles for all governors on our website. We are also developing the membership area on our website.

Governors continue to report on the work they have been doing to represent their constituency at each Council of Governors. In the last year, we have delivered the Special Members' Meeting in June and, in September 2018, our Annual Members' Meeting which followed a Quality Improvement showcase in Bromley. At our Improving Quality event, visitors enjoyed an exhibition showing how we are improving services through our Quality Improvement programme. The exhibition included case studies from a number of projects in progress, giving details of the quality improvement journey colleagues are taking. Our Annual Members' Meeting included a review of the year and our future plans.

Governors have visited a wide range of services during the year including our inpatient services at Green Parks House, forensic services at the Bracton Centre, adult learning disability services at Queen Mary's and have met with the senior management teams of our Greenwich Adult, Bexley Adult and Bromley Adult directorates to learn about the services provided within the directorates and challenges faced. In addition, our Head of Patient Experience has delivered two sessions to help governors understand how the trust collects and uses patient experience feedback. Governors have participated in Board Away Days, inquiry panels and stakeholder events and interview panels for NED and Chief Executive appointments.

In November 2018 governors met with members of the Care Quality Commission team as part of their inspection of the trust. During the focus group, they gave their views on the trust and their role as governors.

During 2018/19, we lost some members through the implementation of practices to comply with new data protection regulations. We continue to aim to ensure that our membership is representative of the local populations we serve. We have undertaken public engagement across Bexley, Bromley and Greenwich, held within our own sites and public spaces. The a-z of associate members has been further developed on our website to become a useful resource for the public.

Code of Governance

During the past year, we have engaged with members in a number of ways, including:

- Special Members' Meeting and Annual Members' Meeting. Governors were actively involved in the planning of the events and engaged with their members on the day.
- We welcomed more than 130 members and colleagues to our Members' Focus Groups, which took place in Bexley, Bromley and Greenwich boroughs. Those who attended were keen to give us feedback on our services and asked some thought provoking questions. They also heard how the NHS Long Term Plan will impact on Oxleas and considered our trust priorities for the coming year. Members were asked to consider what they would like to see developed or done differently in their borough in the next 12 months, and what changes in care they would like to see in five years' time. This feedback will be central to our operational plan going forward.
- Membership Committee meetings followed by public engagement activities at community venues.
- A new member e-bulletin Oxleas Engage was launched in April 2019 in addition to publications including Oxleas Exchange and the governor review.
- Web-based information including www.oxleas.nhs.uk
- Social media such as Facebook and Twitter and emails.
- Voting and governor nomination opportunities.
- Community events, public and targeted such as the Greenwich Get Together and Armed Forces Day, Lark in the Park in Sidcup, and GLLaB Health Fair, Woolwich.
- Membership promotion at trust events such as the Learning Disability Awareness Day at Queen Mary's.
- Membership promotion through careers events within educational establishments.
- Members were invited to participate in focus groups to gather the views from service users and carers regarding Female Psychiatric Intensive Care Unit, Outcomes Star and Perinatal Mental Health. Members were also invited to find out more about Greenwich ResearchNet and to participate in surveys about mobile mental health technologies and engaging young people.
- We have over 100 associate members, representing a broad spectrum of health and social issues across the three boroughs and more widely.

You can contact a governor to ask a question or raise an issue by writing to:

Freepost Plus RTTR-GBLX-ASJZ

Membership Office
Oxleas NHS Foundation Trust
Pinewood House
Pinewood Place
Dartford
Kent DA2 7WG

Telephone
0300 123 1541

Email
Oxl-tr.governors@nhs.net

Staff governors can be contacted at:
Oxl-tr.staffgovernors@nhs.net

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.

Segmentation

Oxleas NHS Foundation has been placed by NHS Improvement in segment 1. Segment 1 means that providers have maximum autonomy and no identified support needs. 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.

Finance and use of resources

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

Area	Metric	2018/9 Q4 Score	2018/9 Q3 Score	2018/9 Q2 Score	2018/9 Score Q1	2017/18 Q4 score	2017/18 Q3 score	2017/18 Q2 score	2017/18 Q1 score
Financial sustainability	Capital service capacity	1	2	2	2	2	2	4	4
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	Income and expenditure margin	1	2	2	2	1	3	4	4
Financial controls	Distance from financial plan	1	2	2	1	1	2	3	3
	Agency spend	1	1	1	1	1	2	2	2
Overall scoring		**1**	**2**	**2**	**1**	**1**	**2**	**3**	**3**

Statement of Accounting Officer's Responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Oxleas 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 Oxleas 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 Oxleas 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**
- 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 an 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 by
Matthew Trainer
Chief Executive
24 May 2019

Annual Governance Statement 2018/19

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxleas 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 Oxleas 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

Oversight of clinical and non-clinical risk is remitted to the Audit and Risk Assurance Committee. This committee has delegated responsibility for monitoring the integrity of the financial statements, assisting the Board of Directors in its oversight of risk management and the effectiveness of internal control, oversight of compliance with corporate governance standards and matters relating to the external and internal audit functions.

Membership of the committee comprises of three non-executive directors only. In attendance at the committee are the Chief Executive, Director of Finance, Director of Workforce and Quality Improvement, Associate Director of Corporate Affairs and Trust Secretary, Associate Director of Quality and Governance, Associate Director of Financial Services and the Risk and Governance Manager. Clinical representation is provided by the Director of Therapies. Representatives from internal audit, external audit and local counter fraud services also attend the meeting. The executive lead for the Audit and Risk Assurance Committee is the Director of Finance.

The responsibilities of all staff in relation to risk management are set out in the Risk Management Framework, which is reviewed annually to ensure that it reflects the operational and governance structure of the trust. Our Mandatory and Essential Skills Programme covers risk management training appropriate to the grade, role and location of staff. Examples include safeguarding adults, safeguarding children, resuscitation skills and prevention and management of violence and aggression. All staff are required to complete health and safety, fire safety, infection control and information governance training. The uptake of training is monitored centrally and reviewed through the workforce update to the Board of Directors. Training compliance is also monitored

Annual Governance Statement 2018/19

at team level on an on-going basis through live reports on NHS Learn. During 2018/19, teams were also offered training on developing team level risk registers, and guidance on this is available to staff on the trust intranet.

The trust has robust arrangements to ensure learning from good practice and learning from experience. These include: embedding learning events, trustwide and local Patient Safety Groups and trustwide and local Patient Experience Groups. The use of reflective practice is encouraged collectively through team meetings and individually through clinical supervision. The uptake of supervision is monitored at team level through NHS Learn, and at Board level through the Integrated Dashboard, which is a standing item at every Board meeting. Internal Quality Assurance visits are used to check that team meetings are used for reflection and learning.

Actions and recommendations from incidents and complaints are recorded on the trust safety management system, Datix. Directorates have responsibility for monitoring progress against the actions and are held to account by the Trust Patient Safety Group and the Trust Patient Experience Group.

The Internal Audit Programme and the Clinical Audit Programme are also used to evidence that changes in practice have been implemented.

The risk and control framework

The trust's Risk Management Framework describes how risk and change in risk is identified, evaluated and controlled. It sets out the responsibilities for individuals and sub-committees in terms of how risks are reported and escalated through the governance structure. The Risk Management Framework is reviewed at least annually to ensure that it aligns with and changes to the governance and operational structures, and also to take account of national guidance and best practice.

The trust has a single automated system (Datix) for the management of all risks registers across the trust. During 2018/19, changes were made to the system to allow managers to add team level risks directly to Datix.

We may decide to tolerate certain risks. Patient and staff safety, availability of resources and the impact on the trust's reputation will inform the decision of when to tolerate a risk. The Risk Management Framework provides guidance on using risk appetite to determine whether or not it is appropriate to tolerate risks.

As the committee with delegated responsibility for clinical and non-clinical risk, the Audit and Risk Assurance Committee reviews the Board Assurance Framework as a standing item at every meeting. This includes an overview of new and emerging risks and recommendations on risks to be escalated or de-escalated from the Board Assurance Framework. A review of the Board Assurance Framework is undertaken at the start of every meeting of the Board of Directors and each risk is referenced to the relevant agenda item to provide assurance that the risk is discussed in context at the meeting.

Each of the Trust board sub-committees holds its own risk register and these are reviewed regularly at these meetings, where new and emerging risks are also discussed. Each of our service directorates also has its own risk register and has developed local arrangements for the identification and review of risks. Support is provided centrally by the Risk and Governance Manager.

Annual Governance Statement 2018/19

The Audit and Risk Assurance Committee receives a thematic analysis of risks at every meeting to highlight themes and trends across all services and directorates.

The Audit and Risk Assurance Committee also receives a risk report from each of the board sub-committees on a rotational basis, to provide assurance that sub-committees are adequately sighted on current and emerging risks. Highlights and exceptions from these reports are reported to the Board of Directors as a standing item.

The board sub-committee with primary responsibility for performance information is the Performance and Quality Assurance Committee, whose role is to provide assurance on the quality of services provided by the trust. The remit of the committee includes agreeing the quality priorities and monitoring the quality of service provision, with a particular focus on ensuring compliance with Care Quality Commission standards. The committee also provides assurance that systems are in place to collect performance data and action plans are in place to address any data quality concerns. The committee is chaired by a non-executive director and the executive lead is the Director of Nursing.

The Integrated Dashboard Report is a standing item on Board of Directors' agenda, with key exceptions and mitigation plans discussed in detail at the meeting. Any data quality issues, including plans to resolve these, are also discussed as part of this item.

The quality of performance information is also assessed through our Internal Audit Plan; the Data Quality and Performance Audit for 2018/19 achieved an overall outcome of significant assurance with minor improvement opportunities. Further information on the quality of our services and how we monitor this is included in our Annual Quality Accounts and the processes to ensure accuracy of data are described later in this statement.

The trust continues to use a programme of Board visits to observe services across the organisation and meet teams delivering these services. Visits are conducted to at least one team each month to give Board members the opportunity to speak with patients, carers and staff about their experience of using or working for the service. Feedback from these visits is reported to Board at every meeting. During 2018/19, the monitoring arrangements where enhanced by ensuring that progress against actions are regularly followed up with service directors; a high level exception report is also provided to the Board.

The quality impact of savings plans are regularly reviewed through meetings with the Director of Nursing, Medical Director and Director of Therapies who provide assurance to the Board of Directors that saving plans do not impact on the quality of services. The arrangements for this are clearly set out in the Financial Approval Limits Policy, which was reviewed in 2018/19 to take account of recommendations from an internal audit on efficiency plans and Quality Impact assessments; this received an outcome of 'significant assurance with minor improvement opportunities.'

Assurance of compliance with Care Quality Commission registration requirements is obtained through the work of the Performance and Quality Assurance Committee described above.

Annual Governance Statement 2018/19

In addition, the trust undertakes peer review visits to all teams as part of routine Quality Assurance activities. These visits are used to check that teams are compliant with the Key Lines of Enquiry, identify areas of good practice for wider sharing and provide assurance that teams are prepared for inspection visits.

The trust was subject to a planned Care Quality Commission inspection between November 2018 and January 2019. The trust maintained its rating of 'Good' in all core services and overall rating of 'Good' trustwide and a rating of 'outstanding' achieved in four specific lines of inquiry. The trust was required to take action in relation to three findings and plans have been put into place to address this. Further detail on the inspection is included in the Performance Analysis section of this report and in the Quality Accounts.

Our Short Breaks Service at Bluebell House is also registered with Ofsted. A full inspection was held in November 2018. No significant concerns were identified and the service retained a rating of 'Good'.

Complementary to the quality assurance workstream is the Quality Improvement programme. The role of the Quality Improvement and Innovation Committee is to provide assurance to the Board of Directors that a culture of continuous improvement and innovation is embedded across the trust; and to have strategic oversight of the delivery of the trust Quality Improvement Programme. This Committee is chaired by a non-executive director and the executive lead is the Medical Director. Further detail on our description of the Quality Improvement Programme has been provided elsewhere in the Performance Analysis section of this report and in the Quality Accounts.

An internal audit of cyber security achieved an outcome of 'significant assurance with minor improvement opportunities' and found that the trust had robust controls in place for the management of data security risks. Our arrangements include: an Information Governance Policy; a Network Security Policy; individual system security policies; the Information Governance Group, which meets bi-monthly to discuss issues relating to data security; a mandatory requirement that all staff complete information governance training; a remote access policy governing access to the network infrastructure; a disaster recovery plan; encryption of all portable storage devices. Any incidents or near misses relating to data security are reported and investigated through the trust incident management process. In addition, to ensure compliance with the GDPR, the trust has appointed a Data Protection Officer, enhanced the content of the mandatory training, produced Privacy Statements, developed an Information Asset Register and reviewed arrangements for reporting information governance incidents to the Information Commissioners Office.

The major risks faced by Oxleas NHS Foundation Trust are recorded on the Board Assurance Framework. The risks that remain on the Board Assurance Framework at year end are:

- **Financial sustainability:** The trust has an on-going focus on making efficiencies, and all services are asked to develop plans to achieve savings targets. The trust shares plans with commissioners to highlight consequences on services of reduced funding. Achievement against plans is monitored by the Business Committee, Executive Team, Board of Directors and at directorate finance meetings on monthly basis. In addition, the trust works

Annual Governance Statement 2018/19

in partnership with other providers to ensure collective responsibility for delivery of south east London Sustainability and Transformation Partnership control total.

- **Financial impact of demand on in-patient service:** The trust has a programme of work to develop alternatives to inpatient admission and ensure that our community teams are functioning at optimum levels. The key work streams include ensuring patients in crisis can access a community based resource; ensuring that each patient admitted to an acute ward has a purposeful admission and that discharge is not delayed; ensuring that care offered in the community is not delayed and that teams are working at optimum
- **Staff recruitment and retention:** The trust has detailed recruitment and retention plans, with a focus on key areas of concern, such as Band 5 nursing staff. This risk is also mitigated through our arrangements for complying with the 'Developing Workforce Safeguards recommendations', which are described elsewhere in this statement.
- **Staff experiencing violence and aggression:** In response to concerns raised in the staff survey, we have had a focus on reducing incidences of violence and aggression and supporting staff affected by such incidents. A detailed, trust wide action plan is in place to ensure we can make improvements in this area, including engagement with staff through focus groups and QI projects in specific teams
- **Timely completion of actions from serious incident inquiries:** A review undertaken by our internal auditors highlighted the need for improved monitoring and reporting of the action plans at both Directorate and Board Level. Performance information is provided to directorate safety groups by the trust Serious Incident Team. The Trust Patient Safety Group monitors progress against and Directorate Patient Safety Groups are held to account by the Trust Patient Safety Committee

During the year, the trust de-escalated a number of risks from the Board Assurance Framework, in recognition of the work undertaken to reduce and mitigate the risk. The de-escalated risks are:

- **Compliance with General Data Protection Regulations (GDPR):** Our arrangements for ensuring compliance with the GDPR are described elsewhere in this statement.
- **Identifying and responding to concerns in service delivery:** The trust reviewed and enhanced its arrangements for monitoring performance and receiving assurance on the quality of services.
- **Legal action from the Health and Safety Executive (HSE) following the incident at the Bracton Centre in July 2016:** The case against Oxleas concluded in December 2018.
- **Lone working:** All teams have identified a Safe System of Work and the trust Health and Safety Team continues to support teams with embedding this.
- **Data accuracy:** In terms of large scale data returns, robust validation processes are in place. The trust has a continued focus on improving individual practice through training, audit and supervision.
- **Agency staff usage:** There has been a significant improvement in agency usage with the Trust now consistently being below the NHSI monthly agency cap

Compliance with the well-led framework was tested as part of the Care Quality Commission inspection. The trust maintained a rating of 'Good'

Annual Governance Statement 2018/19

across all 14 core services. Further detail on this is included elsewhere in this Accountability Report. The trust has plans to undertake an external developmental well-led review in 2019/20.

There are no principal risks to compliance with NHS Foundation Trust condition 4 (FT Governance), other than the risks described elsewhere in this report. The governance structure of the trust is designed to ensure that each of the board sub-committees has a specific remit. The reporting lines and accountabilities between the board, its subcommittees and the executive team are set out in the terms of reference for each of the committees. The scope of the work includes the identification and monitoring of risks relevant to the work of each Committee. The responsibilities of individual directors are set out in job descriptions and are monitored through the trust Performance Development Review process. We have effective systems in place to ensure the timely and accurate collection of information to provide assurance that we are complying with our licence. The Board has oversight of the trust's performance through the Integrated Dashboard Report and the Operational Performance Report, which are standing items at every Board meeting. The responses to concerns or challenges raised by the Board are monitored through an action tracker, which is also a standing item at every Board meeting.

We are able to assure ourselves of the validity of our Corporate Governance Statement through the systems of oversight and scrutiny described in this statement.

Risk management is embedded into the activities of the organisation through a range of processes. The trust openly encourages incident reporting and continues to achieve high levels reporting low-harm incidents and near misses, which is a widely recognised indicator of a positive safety culture.

During 2018/19, the role and remit of the Patient Safety Team and the Patient Safety Committee was substantively reviewed to further enhance how the trust manages risks relating to patient safety. A Serious Incidents Team has been created to focus specifically on the investigation and monitoring of serious incidents. A separate Patient Safety Team focuses on training, committee support and operational matters such as medical device management.

The Mortality Surveillance Group ensures that there are robust systems in place to identify, clinically review and learn from all deaths, not just those reported as serious incidents. This group is chaired by the Director of Nursing. Membership includes a non-executive director and clinical leaders from all service directorates.

Safety risks are identified and managed though the programme of environmental risk assessments overseen by the Health and Safety Team. All sites are required to complete risk assessments in key areas including ligature risk management, security, falls and manual handing; and completion of these is routinely monitored by the Health and Safety Committee. The trust also participates in regular emergency planning exercises to ensure that services are prepared to respond in the event of a major incident.

Our arrangements for ensuring that equality and human rights are integrated into core trust business is described elsewhere in this report.

The trust actively engages with governors, membership and key stakeholders in reporting on our performance and planning for the future

Annual Governance Statement 2018/19

including managing risks. A key element of this is through the annual focus groups which share service developments and quality and agree the priorities for the coming year. We are also involved in regular meetings with local partners in health and social care including Overview and Scrutiny Committees, HealthWatch and the wider voluntary sector.

Our quality improvement targets are agreed with our local commissioners to focus on areas of clinical risk. Our progress against these is covered in more detail in our Quality Accounts.

The trust has resilient mechanisms for workforce planning which are undertaken with active engagement and in collaboration with services, professional leads, finance and workforce teams.

Reviews of the workforce and establishments take place throughout the year with services with key stakeholders for the process in attendance. Rosters are published six weeks in advance to allow managers and staff to be assured of staffing levels and service needs on an operational level through the year. Performance against the target of rosters being published 6 weeks in advance is monitored by the services and is reported to the Board.

We are conscious of the need to maintain levels of staffing that are safe, sustainable and effective. We monitor vacancy levels at directorate and staff group level to ensure that any risks are anticipated and mitigated. Robust induction, supervision and appraisal processes are in place and are tracked and monitored on a monthly basis to ensure that staff are supported at work. There are clear processes to support services with temporary staff of the appropriate levels of skills and competencies should the need arise and to ensure that patient care is prioritised at all times.

In addition, there are annual planning processes led by the services to ensure that the workforce, in relation to establishment, skills and roles are reviewed in light of planned and anticipated local, regional and national changes. This allows us to identify opportunities for transforming services and re-designing roles to best fit new models of care. This includes the use of enabling technologies as well as integrating care across organisational boundaries to support our teams in providing care to our patients and service users in ways that best meet their needs. We are also a year into a programme of work to support and enhance the productivity of our clinical staff and maximise the amount of time that they are able to spend with.

We review our safe staffing levels by triangulating a range of quantitative and narrative sources of information that are tracked over time. Information from benchmarking data, average fill rates for registered nurses and health care assistants, turnover, sickness, bank and agency staff usage, incidents, compliments and complaints, roster key performance indicators, supervision and personal development reviews and professional judgement reviews. The Director of Nursing, Associate Director of Nursing, Director of Therapies, and rostering leads meet with matrons, ward managers, charge nurses, heads of nursing to individually review staffing data for each ward, and consider together the intelligence and themes guided by professional judgement. Alongside these metrics, ward managers and their clinical teams collectively complete a self-assessment and engage in a professional judgement review discussion as in advance of and during the

Annual Governance Statement 2018/19

review meeting. The outcomes from these detailed staffing reviews are presented to the Board on a six-monthly basis.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the Managing Conflicts of Interest in the NHS guidance.

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 time scales 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.

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

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

Directorate performance is monitored through the Executive Team, with the reports alternating between corporate directorates and service directorates on a month by month basis. Service directorate performance is also monitored by the Board of Directors through the Operational Performance Report. This identifies service developments and achievements, as well as the key challenges for each directorate management team. Regular annual plan review meetings are held with each directorate to monitor progress and discuss any risks to achieving goals. These meetings are chaired by the Chief Executive and are attended by operational managers, clinical leaders and the executive team. Financial performance is monitored through the Business Committee and is reported to the Board of Directors.

The Executive Team also receives detailed operational performance reports from all directorates, including a summary of current risks; and new and emerging risks.

The Director of Nursing, Director of Therapies and the Medical Director formally review proposals for cost reducing efficiencies to ensure that saving plans do not adversely impact on quality and safety. Service directors are asked to review plans where concerns are identified.

Internal Audits are undertaken throughout the year to test the robustness of financial and non-financial systems and processes. The Internal Audit Plan is risk based and focuses on the areas where the most benefit is to be gained from Internal Audit input.

Annual Governance Statement 2018/19

Over the past year, the topics covered in our Internal Audit Plan were:

- Financial Systems and Reporting - Significant assurance
- Costing assurance - Significant assurance with minor improvement opportunities
- Partnership Governance – Significant assurance with minor improvement opportunities
- Ligature Risk Assessments - Significant assurance with minor improvement opportunities
- Divisional Quality Governance - Significant assurance with minor improvement opportunities
- Bank and Agency Staffing - Significant assurance with minor improvement opportunities
- Retention and Supervision - Significant assurance with minor improvement opportunities
- Data Quality - Significant assurance with minor improvement opportunities
- CRE Quality Impact Assessment - Significant assurance with minor improvement opportunities
- Responding to Cyber Security Incidents - Significant assurance with minor improvement opportunities

Internal Audit also undertook a proactive review of our Serious Incident process; this was not rated but a number of improvement actions were identified which have been taken forward.

Monitoring progress against recommendations made in these reports is overseen by the Audit and Risk Assurance Committee and the Executive Team, so as to ensure there is an on-going focus on setting of realistic and timely completion dates and closing action within time scale.

The trust has a contract with counter-fraud services for the proactive prevention and detection, and reactive investigation of fraud. Work undertaken in 2018/19 has included raising awareness through training and communication; focused proactive reviews and investigation of reactive referrals. No significant concerns have been identified the year.

The Business Committee, a formal subcommittee of the Board of Directors, is responsible for the consideration of financial and investment risk, the review and approval of the marketing strategy, the review of the Annual Plan in advance of formal approval by the Board of Directors. The Business Committee is chaired by a non-executive director and membership includes non-executive and executive directors. Alongside this, the Infrastructure Committee has a focus on the capital investment programme, IT infrastructure development and estate development. Significant investment decisions are agreed by the Board of Directors and Council of Governors, in line with the trust's approval limits policy.

The governance framework of the trust, including committee structures, attendance records and the coverage of their work are detailed elsewhere in this report

Annual Governance Statement 2018/19

Information governance

During 2018/19, the trust reported five incidents to the Information Commissioner's Office (ICO) and these are summarised in the table.

Trust ref	Date reported to NHS digital	Incident category	ICO Decision
Y Ref: 1389	18/06/2018	Salary information sent to incorrect recipient.	No further action
Y Ref: 1896	20/07/2018	Patient information found in carrier bag by member of the public. A third party reported the data loss to the ICO.	No further action
Y Ref: 4822	04/10/2018	A looked after child was provided with details of siblings in error. This is currently being investigated.	Decision awaited
Y Ref: 7599	07/12/2018	GP had left paper records in a Prison classroom and these were found by a prisoner	No further action
Y Ref: 7600	07/12/2018	Colleague accessed client information inappropriately and made contact with looked after child.	No further action

Annual Quality Report

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 Board of Directors has assured itself that the Quality Report for 2018/19 represents a balanced

Annual Governance Statement 2018/19

view of the quality of our services. Accuracy of data within the Quality Report was ensured via the measures stated below:

1) Governance and Leadership

The trust has clear governance and leadership arrangements in place. As described earlier, the Performance and Quality Assurance Committee is chaired by a non-executive director, and has a specific remit to assess and review the quality of our performance, and this is reported to the Board of Directors. The Performance and Quality Assurance Committee ensures that the indicators used within our quality report present a balanced view of the quality of the services provided. Our service directorates also review local clinical quality measures and provide additional assurance to the Committee.

2) Policies

There is comprehensive guidance for staff on data quality, translating the corporate commitment into practice; these are available as policies, guidance or operational procedures, covering data collection, recording, analysis and reporting, and are available to staff on the trust intranet. Where new guidance is required such as meeting our CQUIN targets (Commissioning for Quality and Innovation), the trust Quality Assurance team provides implementation guidance and process pathways to ensure all staff are aware of the accurate process for recording and reporting.

3) Systems and processes

There are systems and processes in place to ensure collection, recording, analysis and reporting of data is accurate, valid and reliable. Mechanisms and processes have been put in place to ensure inputs are reported back to staff responsible as well as their supervisors where required to allow for consistent reviews of the quality of the data collected. Mechanisms include reviews by the trust Business Managers, Quality Assurance Leads and the Informatics team to ensure the validity of the data and reports being reviewed. All areas of business development, the annual plan, the quality objectives and management of services are underpinned where possible by information reports provided on a monthly or quarterly basis at team, directorate and at trust level. When new areas of improvement are agreed a robust monitoring method is also agreed to enable us to utilise appropriate information to monitor progress on a regular basis either within a team or throughout the trust.

4) People and skills

Roles and responsibilities in relation to quality are clearly defined and documented, and incorporated where appropriate into job descriptions and is integrated to staff appraisal. When new ways of collecting, monitoring or reporting data are agreed within Oxleas, this is circulated to all staff and logged within guidance with essential training provided to ensure that staff have the necessary capacity and skills to implement new ways of working that will improve the quality of our services.

5) Data use and reporting

We ensure that all quality indicators chosen internally by the Board, and those agreed with our commissioners, are linked clearly back to the trust's Annual Plan priority objectives, national requirements and areas of business development. Data used for reporting to NHS Improvement, commissioning groups and used to populate the Quality Report is taken through an approval

Annual Governance Statement 2018/19

process with the Board and Executive before it is submitted. Clear information about the source of information, data quality and analysis is undertaken. Data used to specifically monitor improvements to the quality of our business is agreed within the Performance and Quality Assurance Committee. We also take part in national clinical audits which utilises verified data collection tools. These reports are presented to the Clinical Effectiveness Group for approval.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality 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 the board, the audit and risk assurance committee and the performance and quality assurance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes that have been applied in maintaining and reviewing the effectiveness of the system of internal control have been supported by:

- Regular review of economy, efficiency, effectiveness, strategic risks and the Assurance Framework by the Board of Directors
- The Audit and Risk Assurance Committee completing its audit plan, the results of which are described elsewhere in this report.
- The Audit and Risk Assurance Committee and other board sub-committees evaluation and monitoring of the organisation's risks and mitigation plans including regular review of the operational risk registers from each service directorate.
- Evidence to verify compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009.
- The regular assessment and monitoring of the quality of services provided by Oxleas NHS Foundation Trust, through the Performance and Quality Assurance Committee.
- The Clinical Effectiveness Group's review of the trust's annual clinical audit programme which reflects compliance with national, CQUIN, trust and local audits. This review encompasses agreement of action plans and ensures implementation of recommendations across the trust's various services.
- The Business Committee's review of new business opportunities, contract performance and business planning.

Annual Governance Statement 2018/19

- The Infrastructure Committee's review of the capital investment programme, IT infrastructure development and estates development.
- The Workforce Committees review of recruitment, retention, staff development, workforce health and safety and staff engagement and communication.
- The Performance and Quality Assurance Committee's review of performance against key quality indicators for patient safety, patient experience and clinical effectiveness.
- The Quality Improvement and Innovation Committee's work in implementing quality improvement and sharing and embedding good practice.

Conclusion

No significant internal control issues have been identified.

Signed by
Matthew Trainer
Chief Executive
24 May 2019

Accountability report signed by

Matthew Trainer
Chief Executive
24 May 2019

Independent Auditor's Report

Independent Auditor's report to the Council of Governors of Oxleas NHS Foundation Trust

Report on the Audit of the Financial Statements

Our opinion on the financial statements is unmodified

We have audited the financial statements of Oxleas NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') 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 group and of the Trust as at 31 March 2019 and of the group's expenditure and income and the Trust's 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 group and 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:

Independent Auditor's Report

- 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 group's or 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: £5,202,000 which represents 2% of the group's gross operating expenditure
- Key audit matters were identified as:
  - Valuation of land and buildings
  - Occurrence and accuracy of non-block contract patient care income, other operating income and existence of associated receivables.
- The group consists of three components – the Trust and its two wholly-owned subsidiaries Oxleas Charitable Fund and Oxleas Prison Services.
- We performed full scope audit procedures at Oxleas NHS Foundation Trust and analytical procedures of the two subsidiaries.
- We have tested the Trust's material income and expenditure streams and assets and liabilities, covering 99% of the Trust's income, 99% of the Trust's expenditure, 97% of the Trust's assets and 94% of the Trust's liabilities.

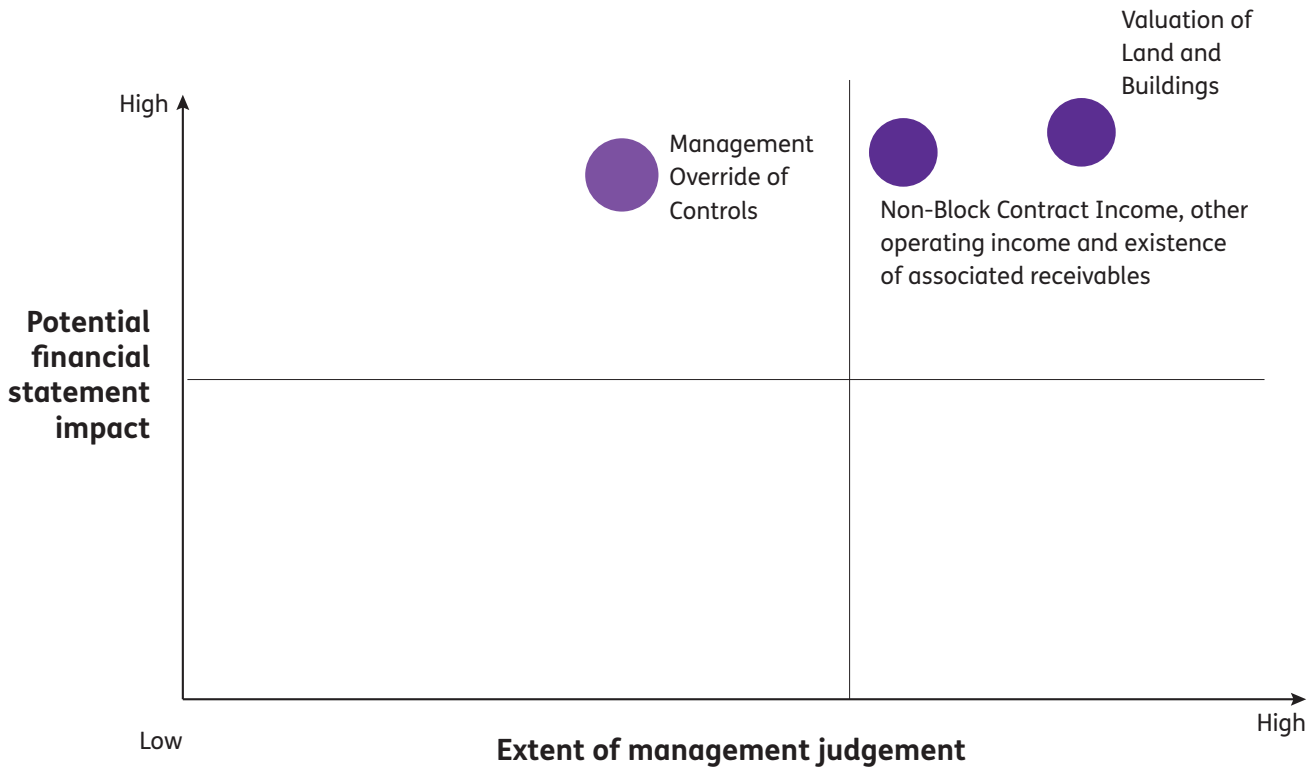
Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- We identified one significant risk in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources regarding the Trust's financial sustainability (see Report on other legal and regulatory requirements section).

Independent Auditor's Report

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.

Independent Auditor's Report

Key Audit Matter – Trust

Risk 1 – Valuation of Land and Buildings

The Trust revalues its land and buildings on a five yearly basis 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.

We therefore identified valuation of land and buildings as a significant risk, which was one of the most significant assessed risks of material misstatement.

How the matter was addressed in the audit – Trust

Our audit work included, but was not restricted to:

- Evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work;
- Evaluating the competence, capabilities and objectivity of the valuation expert;
- Discussing with the valuer the basis on which the valuations were carried out and challenge of the key assumptions;
- Challenging the information used by the valuer to assess completeness and consistency with our understanding;
- Testing revaluations made during the year to ensure they were recorded accurately in the Trust's asset register;
- Evaluating the assumptions made by management for those assets not revalued during the year and assessing how management has satisfied themselves that carrying value is not materially different to current value in existing use.

The group's accounting policy on valuation of property, plant and equipment (which includes land and buildings) is shown in note 1.7 to the financial statements and related disclosures are included in note 10.

Key observations

We obtained sufficient audit assurance to conclude that:

- the basis of the valuation of land and buildings was appropriate and the assumptions

Independent Auditor's Report

Key Audit Matter – Trust	How the matter was addressed in the audit – Trust

Risk 2 – Occurrence and accuracy of non-block contract patient care income, other operating income and existence of associated receivable balances

The Trust's significant income streams are operating income from patient care activities and other operating income.

The Trust recognises income from patient care activities during the year based on the completion of these activities. This includes block contract income which is agreed in advance at a fixed price, and non-block contract income.

Patient care activities provided that are additional to those incorporated in the block contracts with NHS commissioners are subject to verification and agreement of the completed activity by commissioners. As such, 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. Due to the nature of block contracts we have not identified a significant risk of material misstatement in relation to block contracts.

and processes used by management in determining the estimate were reasonable;

- the valuation of land and buildings disclosed in the financial statements is reasonabl

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.

In respect of non-block contract patient care income:

- Obtaining an exception report from the DHSC that details differences in reported income and expenditure and receivables and payables between NHS bodies, agreeing the figures in the exception report to the Trust's financial records and obtaining supporting information for all differences over £300,000 to corroborate the amount recorded in the financial statements by the Trust;
- Agreeing, on a sample basis, non-block contract income from patient care activities to invoices and subsequent cash receipts or, for cases in our sample where cash was yet to be receipted, to alternative evidence;
- Agreeing, on a sample basis, non-block contract receivables at year end to invoices and subsequent cash receipts or, for cases

Independent Auditor's Report

Key Audit Matter – Trust

The Trust also receives other operating income which is predominantly in respect of property rentals, pharmacy sales and Provider Sustainability Funding (PSF). The risk around other operating revenues is improper revenue recognition.

We therefore identified occurrence and accuracy of non-block contract patient care income and other operating income and existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement.

There are no additional significant risks in respect of the group.

How the matter was addressed in the audit – Trust

in our sample where cash was yet to be receipted, to alternative evidence.

In respect of other operating income

- Agreeing, on a sample basis, other income to invoices or alternative evidence.
- • Agreeing PSF income to year end confirmation from DHSC

The group's accounting policy on income recognition is shown in notes 1.2.1 and 1.2.2 to the financial statements and related disclosures are included in note 3.

Key observations

We obtained sufficient audit evidence to conclude that:

- The accounting policies for recognition of income comply with the DHSC Group Accounting Manual 2018/19 and have been properly applied;
- Non-block contract patient care income, other operating income and the associated receivable balances are not materially misstated

Independent Auditor's Report

Our application of materiality

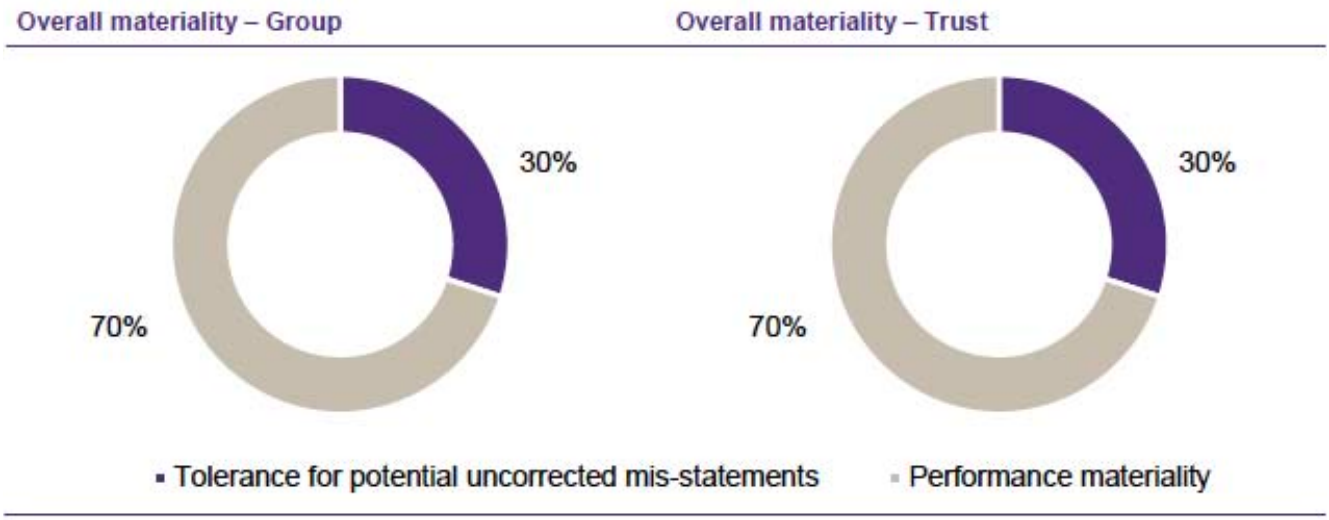
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Group	Trust
Financial statements as a whole	£5,202,000 which is 2% of the group's prior year gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the group has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating costs as was determined for the year ended 31 March 2018 by the predecessor auditors as we did not identify any significant changes in the group or the environment in which it operates	£5,175,000 which is 1.98% of the Trust's prior year gross operating expenses. 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 gross operating costs as was determined for the year ended 31 March 2018 by the predecessor auditors 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	70% of financial statement materiality	70% of financial statement materiality
Specific materiality	N/A	Disclosures of senior officer remuneration in the Remuneration Report and related party disclosures materiality set at £100,000 based on the fact that these are areas of particular interest to the readers of Oxleas' accounts.
Communication of misstatements to the Audit & Risk Assurance Committee	£260,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.	£260,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

Independent Auditor's Report

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was based on a thorough understanding of the group's business, was risk based and included an evaluation of the group's internal controls environment including relevant IT systems and controls over key financial systems.

The scope of our audit included:

- Evaluation of identified components to assess the significance of that component and to determine the planned audit response based on a measure of materiality and significance of the component as a percentage of the group's total assets and income;
- Full scope audit procedures on the Oxleas NHS Foundation Trust, which represents over 99% of the total income and expenditure of the group and 99% of its total net assets;
- Performing analytical procedures on the non-significant components, Oxleas Charitable Fund and Oxleas Prison Services;
- Substantive testing of the Trust's income, expenditure assets and liabilities:
  - obtaining supporting evidence, on a sample basis, for all of the Trust's material income streams covering 99% of the Trust's revenues;
  - obtaining supporting evidence, on a sample basis, for 99% of the Trust's operating costs;
  - obtaining supporting evidence, on a sample basis, for 97% of the Trust's assets including property plant and equipment;
  - obtaining supporting evidence, on a sample basis, for 94% of the Trust's liabilities

Independent Auditor's Report

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 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 group and Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- The Audit & Risk Assurance committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit & Risk Assurance Committee does not appropriately address matters communicated by us to the Audit & Risk Assurance 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.

Independent Auditor's Report

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
- 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, 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 group's and 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 and the group without the transfer of the Trust's services to another public sector entity.

Independent Auditor's Report

The Audit & Risk Assurance 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 resoures

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in respect of the above matter.

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.

Independent Auditor's Report

Significant risk

Financial Outturn and Sustainability

Before the start of each financial year the Trust agrees to a control total set by NHS Improvement (NHSI) which determines the Trust's target financial performance for the financial year. Achievement of the control total also ensures the Trust receives additional Provider Sustainability Funding (PSF).The Trust agreed to a control total for 2018/19 of a £0.1million surplus, increasing to a £3 million surplus with the receipt of PSF and profit on the disposal of assets.

In its budget the Trust forecast that it needed to make savings of £9.8 million in 2018/19 to achieve this control total. £1.5 million of these savings were unidentified halfway through the year. In addition, the Trust has identified that it needs to make £9.4 million of further savings in 2019/20 in order to meet its 2019/20 financial target.

Therefore, the significant risk is whether the Trust has adequate arrangements in place to ensure that it meets its control totals and so receives PSF funding.

How the matter was addressed

Our audit work included, but was not restricted to:

- Monitoring the Trust's performance against its financial plan and achievement of its control total for the financial year 2018/19;
- Evaluating the Trust's forecast position throughout the year and its final outturn against budget;
- Assessing the Trust's overall arrangements for achievement of its control total, including the delivery of planned savings for 2018/19 and the establishment of financial savings plans for 2019/20.

Key findings

Overall, the Trust had adequate arrangements in place to deliver its agreed control total for 2018/19. The Trust recorded a surplus of £5.9 million in 2018/19 achieving its control total for the year and receiving its full PSF allocation.

The Trust has made good progress in its development of savings plans for 2019/20. As at the end of March 2019, the Trust has identified savings plans for £7.4 million full year effect of its £9.4 million savings target.

Independent Auditor's 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 Oxleas 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

Independent Auditor's Report

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.

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
London
24th May 2019

Accounts

Foreword to the Financial Statements

These accounts, for the year ended 31 March 2019, have been prepared by Oxleas NHS Foundation Trust selected in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Matthew Trainer
Chief Executive
24 May 2019

Statement of comprehensive income
for the year ended 31 March 2019

		31 March 2019	31 March 2019	31 March 2018	31 March 2018
	NOTE	TRUST	GROUP	TRUST	GROUP
		£000	£000	£000	£000
Operating Income from patient care activities	3	235,000	235,000	223,718	223,718
Other operating income	3	36,134	34,154	33,698	31,921
Operating expenses	4	(262,196)	(260,391)	(261,428)	(260,095)
Operating surplus/(deficit) from continuing operations		**8,938**	**8,763**	**(4,012)**	**(4,456)**
Finance income	6	386	386		146
Finance expenses	7	(1,098)	(1,098)		(1,071)
PDC dividends payable		(3,107)	(3,107)		(3,949)
Net finance costs		**(3,819)**	**(3,819)**		**(4,874)**
Gain from asset disposals	8	846	846		1,372
SURPLUS/(DEFICIT) FOR THE YEAR		5,965	5,790		(7,514)
Other comprehensive income *					
Impairments		0	0	(9,790)	(9,790)
Revaluations		8,844	8,844	3,585	3,585
Total comprehensive income / (expense) for the period		**14,809**	**14,634**	**(13,719)**	**(14,163)**

The notes on pages p191 to 227 form part of these accounts.
* There are no parts of other comprehensive income that will be reclassified

Accounts

Statement of Financial Position
for the year ended 31 March 2019

		31 March 2019	31 March 2019	31 March 2018	31 March 2018
		TRUST	GROUP	TRUST	GROUP
	NOTE	£000	£000	£000	£000
NON-CURRENT ASSETS					
Intangible assets	9	4,537	4,537	3,680	3,680
Property, plant and equipment	10	145,278	145,278	129,039	129,039
Total non-current assets		**149,815**	**149,815**	**132,719**	**132,719**
CURRENT ASSETS					
Inventories	11	373	614	336	547
Receivables	12	20,952	19,880	22,006	21,273
Non current assets for sale & assets in disposal groups	10	850	850	3,140	3,140
Cash and cash equivalents	13	66,005	66,810	60,526	61,405
Total current assets		**88,180**	**88,154**	**86,008**	**86,365**
CURRENT LIABILITIES					
Trade and other payables	14	(39,318)	(39,266)	(34,968)	(35,124)
Borrowings	14.1	(398)	(398)	(407)	(407)
Provisions	16	(3,234)	(3,512)	(3,512)	(3,512)
Other liabilities	14.2	(18,336)	(18,336)	(17,031)	(17,031)
Total current liabilities		**(61,286)**	**(61,234)**	**(55,918)**	**(56,074)**
TOTAL ASSETS LESS CURRENT LIABILITIES		176,709	176,735	162,809	163,010
NON-CURRENT LIABILITIES					
Borrowings	14.1	(7,591)	(7,591)	(9,305)	(9,305)
Total non-current liabilities		(7,591)	(7,591)	(9,305)	(9,305)
TOTAL ASSETS EMPLOYED		**169,118**	**169,144**	**153,504**	**153,705**
FINANCED BY					
Public dividend capital		113,226	113,226	112,421	112,421
Revaluation reserve		49,856	49,856	41,348	41,348
Other reserves		1,218	1,218	1,218	1,218
Merger reserve		141	141	141	141
Income and expenditure reserve		4,677	4,138	(1,624)	(2,069)
Charitable fund reserves		0	565	0	646
TOTAL TAXPAYERS' EQUITY		**169,118**	**169,144**	**153,504**	**153,705**

The financial statements on pages 188 to 227 were approved by the Board on 24 May 2019 and signed on its behalf by:

Matthew Trainer, Chief Executive, 24 May 2019

Statement of Changes in Equity
for the year ended 31 March 2019

	Public Dividend Capital £'000	Revaluation reserve £'000	Other reserves £'000	Merger reserve £'000	Income and expenditure reserve £'000	TRUST £'000	GROUP £'000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**112,421**	**41,348**	**1,218**	**141**	**(1,624)**	**153,504**	**153,705**
Surplus/(deficit) for the year	0	0	0	0	5,965	5,965	**5,790**
Revaluation gains	0	8,844	0	0	0	8,844	**8,844**
Transfers to retained earnings on disposal of assets	0	(336)	0	0	336	0	**0**
Public dividend capital received	805	0	0	0	0	805	**805**
Taxpayers' equity as at 31 March 2019	**113,226**	**49,856**	**1,218**	**141**	**4,677**	**169,118**	**169,144**

Statement of Changes in Equity for the year ended 31 March 2018

Taxpayers' and others' equity at 1 April 2017 - brought forward	**112,118**	**47,825**	**1,218**	**141**	**5,618**	**166,920**	**167,565**
Surplus/(deficit) for the year	0	0	0	0	(7,514)	(7,514)	**(7,958)**
Impairments	0	(9,790)	0	0	0	(9,790)	**(9,790)**
Revaluations	0	3,585	0	0	0	3,585	**3,585**
Transfers between reserves	0	(272)	0	0	272	0	**0**
Public dividend capital received	303	0	0	0	0	303	**303**
Taxpayers' equity as at 31 March 2018	**112,421**	**41,348**	**1,218**	**141**	**(1,624)**	**153,504**	**153,705**

Accounts

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.

Financial assets reserve / Available-for-sale investment reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevivable election at recognition.

Other reserves

Other reserves reflect property, plant and equipment written into the accounts on 1 April 2000 resulting from the revaluation exercise carried out by the District Valuer on 1 April 2000. The revaluation adjustment was accounted for as a restatement of the 1998/99 Trust Accounts which was included in the 1999/2000 as a prior period adjustment.

Merger reserve

This reserve reflects balances formed on merger of NHS bodies.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 25.

Statement of Cash Flows
for the year ended 31 March 2019

	NOTE	Year ended 31 March 2019 TRUST £000	Year ended 31 March 2019 GROUP £000	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000
Cash flows from operating activities					
Operating surplus from continuing operations		8,938	8,763	(4,012)	(4,456)
Non cash income and expense:					
Depreciation and amortisation	4.1	4,824	4,824	4,399	4,399
Net impairments	4.1	51	51	12,583	12,583
(Increase) / decrease in receivables and other assets		1,915	2,283	(3,548)	(3,171)
(Increase) / decrease in inventories		(37)	(67)	(49)	(63)
Increase / (decrease) in payables and other liabilities		5,302	5,072	7,342	7,495
Increase/(decrease) in provisions		(278)	(278)	(2,562)	(2,562)
Movements in charitable fund working capital		0	(7)	0	35
Other movements in operating cash flows		0	0	(3)	(3)
Net cash flows from / (used in) operating activities		20,715	20,641	14,150	14,257
Cash flows from investing activities					
Interest received		386	386	146	146
Purchase of intangible assets		(1,380)	(1,380)	(1,388)	(1,388)
Purchase of PPE and investment property		(9,500)	(9,500)	(10,885)	(10,885)
Sales of PPE and investment property		0	0	1,716	1,716
Net cash flows from / (used in) investing activities		(10,494)	(10,494)	(10,411)	(10,411)
Cash flows from financing activities					
Public dividend capital received		805	805	303	303
Capital element of finance lease rental payments		(73)	(73)	(69)	(69)
Capital element of PFI, LIFT and other service concession payments		(334)	(334)	(312)	(312)
Interest paid on finance lease liabilities	15.	(54)	(54)	(57)	(57)
Interest paid on PFI, LIFT and other service concession obligations	15.	(1,044)	(1,044)	(1,014)	(1,014)
PDC dividend (paid)/refunded		(4,042)	(4,042)	(4,483)	(4,483)
Net cash flows from / (used in) financing activities		(4,742)	(4,742)	(5,632)	(5,632)
Increase / (decrease) in cash and cash equivalents		5,479	5,405	(1,893)	(1,786)
Cash and cash equivalents at 1 April - brought forward	13	60,526	61,405	62,419	63,191
Cash and cash equivalents at 31 March	13	66,005	66,810	60,526	61,405

Accounts

1.0 Accounting Policies

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

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.

1.2 Going Concern

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. Key assurances on the Going Concern basis adoption include:

- The trust does not have any plans to apply to the Secretary of State for dissolution
- The Trust has agreed its material contracts with both its NHS and Non-NHS commissioners - The Trust is forecasting a cash balance of £66.819m at the 31 March 2019.

1.2.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The trust applies a credit term of 30 days from the invoiced date, which should be when the performance obligation has been met and can be verified. Contract balances over 30 days are overdue.

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

Accounts

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. As a provider that receives its income via a block contracts, recognition of income in relation to incomplete patient care spell is not applicable.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they do not 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. Where CQUIN trajectories have not been met in line with local and national guidance, the commissioner reserves every right to recover this element of income.

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. The Trust is not in receipt of any material revenue from research contracts and therefore this fully recognised in the accounts.

1.2.2 Other income

The performance obligation from the sale of non-current assets is when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recogn period in which the service is received from employees. The Trust policy allows employees to carry forward two days o leave into the following year. However for the year ended 31st March 2019, recognising current vacancy levels and CQ services, the values recognised in the Trust account reflects the cost of annual leave entitlement earned but not taken employees at the end of the period.

1.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits pa rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secreta for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify th the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contributio the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme accounting period.

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 retiremen health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the tru itself to the retirement, regardless of the method of payment.

Accounts

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between form 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 Dep at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunct updated membership and financial data for the current reporting period, and is accepted as providing suitably robust financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 3 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial asse methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury ha used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms pa annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published 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 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 result this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care h recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set follo 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to the valuation process pending conclusion of the continuing legal process.

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 valu goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such plant and equipment.

1.6 Pooled Budgets

The Trust also has pooled budget arrangements with the London Boroughs of Greenwich, Bexley and Bromley. These arrangements are the London Boroughs of Greenwich, Bexley and Bromley respectively. Under the arrangement funds are pooled under section 75 of th 2006 for adult mental health activities.

Payments for services provided by the Trust are accounted for as income from Local Authorities. The Trust accounts for its share of the liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget ar

1.7 Property, plant and equipment Recognition

Property, plant and equipment is capitalised where:

Accounts

- 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;
- each item individually has a cost of at least £5,000; or
- form a group of assets which collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the asse functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and a single managerial control; 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 funct interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single manag or
- form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individu collective cost; or
- where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equ these components are treated as separate assets and depreciated over their own useful lives.

Measurement Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or cons 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 revaluation. Equipment assets are valued using depreciated replacement cost as proxy.

Land and buildings are valued by an independent registered chartered surveyor on a regular basis and in accordance with Royal Institu Chartered Surveyors' Valuation Standard as required under IAS16 to reflect current value. At 31 January 2019 the land and building ass revalued.

Current values are determined as follows:

- Land and non-specialised buildings are valued at market value. Non-specialised residential buildings are valued at market value, Land are not separately valued.
- Specialised buildings are valued at depreciated replacement cost based on modern equivalent assets.

Leasehold improvements are not subsequently revalued.

HM Treasury adopts a standard approach to depreciated replacement cost valuations using a modern equivalent asset basis, and, whe meet the location requirements of the service being provided, an alternative site can be valued.

Assets in the course of construction are valued at cost, less any impairment loss. Assets are revalued and depreciation commences whe brought into use.

Revaluations are performed annually to ensure that the carrying amounts are not materially different from those that would be determ statement of financial position date.

Accounts

Subsequent expenditure
Expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the Statement Of Comprehensive Income in the year in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in a probable increase in the future economic benefits expected to be obtained from the use of an item of property, plant and equipment, and where the cost of the item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement.

Depreciation
Items of property, plant and equipment are depreciated on a straight line basis over their estimated useful economic lives. Freehold land is considered to have an infinite life and is not depreciated. The useful economic lives of buildings are assessed by the Trust's professional valuers. At 31 January 2019 the useful economic lives were assessed as between the range 1-58 years.

Leasehold property, plant and equipment are depreciated over the primary lease term, leasehold improvements are depreciate over the remaining lease term. Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

Furniture and fittings -	5 years
Transport equipment -	3 years
IT equipment -	9 years
Mobile tablets -	3 years
Plant and machinery -	10 years

If the residual value of an asset is zero at the Statement of Financial Position date, the asset's life will be reviewed annually.

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 concerne 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 th 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 i 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.

1.7 Property, plant and equipment (continued)

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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.

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.

Accounts

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.

1.8 Intangible assets

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
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.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Accounts

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The useful economic lives are shown below:

- Development expenditure 7 Years
- Licences 9 Years

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.

1.10 Inventories
Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula.

1.11 Financial instruments Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
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.

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 classified as subsequently measured at amortised cost. Financial liabilities classified as subsequently measured at amortised cost.

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.

Accounts

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.

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 (stage 3).

Lifetime expected credit losses (stage 3) are calculated by assessing historic loss rates adjusted for forward looking macro-economic factors to conclude on apprporiate loss rates. The trust's receivables balances are all judged to have similar risk characteristics and are considered as one group.

1.12 Leases

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 implicit rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit rate to the outstanding liability and is charged to finance costs in the Statement of Comprehensive Income.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses on a straight- line basis over the life of the lease.

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. Leased land is treated as an operating lease.

1.13 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, 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 in note 16. This is not recognised in these 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.

1.14 Contingencies
Contingent liabilities are not recognised, but are disclosed in note 18, 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.

1.15 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.

1.16 Value Added Tax (VAT)
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.

Accounts

1.17 Corporation Tax

The Trust has reviewed its operating activities and determined that it has no liability for corporation tax. Group current tax assets and liabilities are measured at the amount expected to be recovered from or paid to the taxation authorities, based on tax rates and laws that are enacted or substantively enacted by the Statement of Financial Position date.

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 note 23 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

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 NHS foundation 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.

1.20 Accounting judgements and estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the year in which the estimate is revised if the revision affects only that year, or in the year of the revision and future years if the revision affects both current and future years.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimates (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The Trust has recognised under IFRIC 12 the need to account for its PFI scheme as a service concession arrangement. The indications of a service concession include the provision of a healthcare service, control over the services and control over the asset at the end of the lease. The PFI arrangement satisfies these conditions. The details of the PFI scheme can be found in note 18.

The Trust has made judgements for a number of properties as to whether they meet the criteria for treatment as assets held for sale or whether they are surplus assets, and for surplus assets whether there are restrictions which mean that they should be valued at current value in existing use or at market value.

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Accounts

The Trust's estate is valued according to appropriate indices as applied by the Trust's external valuers.

The useful economic lives of buildings are assessed by the Trust's professional valuers who assume that all buildings have a maximum life expectancy from new of 60 years, with the buildings depreciated to on a straight line basis from 100% at completion of construction to zero, once their life span has been met.

When undertaking the valuation of land at 31 January 2019 the Trust's professional valuers have relied on the Trust's opinion smaller land area could be appropriate for re-providing services at a number of the Trust's sites. The Trust has also assumed services could be re-provided on alternative sites, and have valued land having regard to prevailing land values in Kent.

When undertaking the valuation of buildings at 31 January 2018 the Trust's professional valuers have removed the 5% contingency allowance (reflecting the risk of timing delays or cost overruns) which has previously been adopted within the DRC calculation effect of this is to reduce the valuation by £4.2m at 31 January 2018. It is impracticable to estimate the effect of this change accounting estimate on future periods.

The provision for other legal claims is stated subject to uncertainty about the outcome of legal proceedings.

1.21 Accounting standards issued but not yet adopted

The following presents a list of recently issued accounting standards and amendments which have not yet been adopted wit FReM, and are therefore not applicable to DH group accounts in 2018-19.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2020, but not yet adopted by FReM: early adoption is not therefore permitted.

1.22 Accounting standards issued that have been adopted early

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.23 Interests in other entities

In January 2012 the Trust entered into a joint venture (SARD JV Limited) with Mango Swiss Limited. The Trust owns 51% and Mango Swiss Limited own 49% of the shares of the joint venture. The Trust holds 51 ordinary shares of £1 each. Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. The Trust provided an initial loan to the joint venture of £40,000 in 2012/13 and provided additional funding in 2012/13 of £60,000. The outstanding balance of which is shown within the non-NHS receivables section of thess accounts. Turnover in the joint venture in the year ended 31 March 2019 was £878,296 (Year ended 31 March 2018 £670,326). As this is not a material item in the accounts it has not been accounted for using the equity method as a joint venture but instead has been accounted for at cost less any provision for impairment.

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity.

On 5 March 2015, Oxleas Prison Services Limited (OPS Ltd) was set up by the trust as a wholly-owned subsidiary company to provide pharmacy services to prisons in Kent and Greenwich. The results of OPS Ltd have been consolidated in the Group accounts figures presented here for the year ended 31 March 2018.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation. In year ended 31 March 2019 OPS

Accounts

Ltd made a deficit of £94,354 (year ended 31 March 2018 deficit £354,048), turnover for the period was £3,918,367 (year ended 31 March 2018 £3,449,741). OPS Ltd is domiciled in the UK. The registered address is Bracton Centre (Teambase), Bracton Lane, Off Leyton Cross Road, Dartford, Kent DA2 7AF.

In July 2017 the Trust signed a 10 year partnership agreement with Health Innovations Partners (HIP) as its Strategic Estates Partner (SEP). This is a 50:50 joint venture between the Trust and HIP (Community Solutions and Arcadis JV). The joint venture will work to develop the Trust's estate and surplus assets, helping to reduce costs and maximise revenue for the Trust which can be reinvested into healthcare delivery in South East London.

2. Segmental analysis

The Trust does not consider that it has reportable segments as defined by IFRS 8: Operating Segnments. The Trust considers its activities constitute a single segment since they are provided wholly in the UK, are subject to similar risks and rewards and all the assets are managed as one central pot. Furthermore, the majority of the Trust's operating income is secured in the form of block contracts that do not distinguish between divisions, and financial performance to the Board does not devolve income down to operational teams

3 Operating Income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.2.1

Accounts

3.1 Operating Income

	Year ended 31 March 2019	Year ended 31 March 2019	Year ended 31 March 2018	Year ended 31 March 2018
	TRUST	**GROUP**	TRUST	GROUP
	£000	**£000**	£000	£000
Income from Activities				
NHS Foundation Trusts	**2,328**	**2,328**	1,973	1,973
NHS Trusts	**272**	**272**	302	302
CCGs and NHS England	**203,947**	**203,947**	196,235	196,235
Local Authorities	**21,438**	**21,438**	20,142	20,142
Department of Health and Social Care	**2,508**	**2,508**	0	0
Non NHS	**4,507**	**4,507**	5,066	5,066
Total income from activities	**235,000**	**235,000**	223,718	223,718
Being:				
Cost and volume contract income	**3,255**	**3,255**	2,373	2,373
Mental health block contract income	**142,932**	**142,932**	136,821	136,821
Clinical partnerships providing mandatory services (including S75 agreements)	**5,796**	**5,796**	5,790	5,790
Community services block contract income	**58,673**	**58,673**	58,022	58,022
Private patient income	**14**	**14**	12	12
Other non-protected clinical income	**24,330**	**24,330**	20,700	20,700
	235,000	**235,000**	223,718	223,718
Other Operating Income				
Research and development	**42**	**42**	39	39
Education, training and research	**3,878**	**3,878**	3,771	3,771
Provider sustainability fund / Sustainability and transformation fund income (PSF / STF)	**4,919**	**4,919**	3,006	3,006
Other income **	**27,295**	**25,275**	26,882	25,058
NHS Charitable Funds: excluding investment income	**0**	**40**	0	47
Total other operating income	**36,134**	**34,154**	33,698	31,921
Total operating income	**271,134**	**269,154**	257,416	255,639
**** Analysis of other operating income: Other**				
PFI support income	**564**	**564**	564	564
Car parking	**628**	**628**	772	772
Estates recharges	**972**	**972**	957	957
Pharmacy sales	**5,570**	**5,570**	6,120	6,120
Catering	**278**	**278**	80	80
Property rentals	**10,004**	**10,004**	7,809	7,809
Other	**9,279**	**7,259**	10,580	8,756
	27,295	**25,275**	26,882	25,058

3.2 Commissioner Requested Services

	Year ended 31 March 2019	Year ended 31 March 2019	Year ended 31 March 2018	Year ended 31 March 2018
	TRUST	**GROUP**	TRUST	GROUP
	£000	**£000**	£000	£000
Commissioner Requested Services	**210,656**	**210,656**	203,006	203,006
Non Commissioner Requested Services	**24,344**	**24,344**	20,712	20,712
Total income from activities	**235,000**	**235,000**	223,718	223,718

Accounts

4. Operating Expenses

4.1 Operating expenses comprise:

	Year ended 31 March 2019	Year ended 31 March 2019	Year ended 31 March 2018	Year ended 31 March 2018
	TRUST £000	GROUP £000	TRUST £000	GROUP £000
Purchase of healthcare from NHS and DHSC bodies	**6,215**	**6,215**	4,975	4,975
Purchase of healthcare from non-NHS and non-DHSC bodies	**13,509**	**13,509**	12,774	12,774
Purchase of social care	**0**	**0**	0	0
Staff and executive directors costs	**179,926**	**180,034**	172,041	172,112
Non-executive directors	**104**	**104**	153	153
Supplies and services – clinical (excluding drugs costs)	**5,477**	**5,486**	5,621	5,631
Supplies and services - general	**6,045**	**6,045**	1,827	1,827
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs	**10,074**	**7,996**	9,158	7,579
Consultancy	**392**	**392**	776	776
Establishment	**5,332**	**5,332**	6,648	6,648
Premises - business rates collected by local authorities	**1,842**	**1,842**	1,157	1,157
Premises - other	**12,747**	**12,747**	10,765	10,765
Transport (business travel only)	**891**	**891**	1,173	1,173
Transport - other (including patient travel)	**484**	**484**	372	372
Depreciation	**4,301**	**4,301**	4,072	4,072
Amortisation	**523**	**523**	327	327
Impairments net of (reversals) *	**51**	**51**	12,583	12,583
Movement in credit loss allowance: contract receivables/assets	**(680)**	**(680)**	0	0
Movement in credit loss allowance: all other receivables & investments	**0**	**0**	720	720
Provisions arising / released in year	**725**	**725**	(448)	(448)
Change in provisions discount rate	**0**	**0**	0	0
Audit services - statutory audit	**57**	**57**	100	100
Other auditor remuneration (payable to external auditor only)	**10**	**10**	0	0
Charitable fund audit	**0**	**5**	0	0
Internal audit - non-staff	**91**	**91**	81	81
Clinical negligence - amounts payable to NHS Resolution (premium)	**430**	**430**	331	331
Legal fees	**392**	**392**	168	168
Insurance	**314**	**314**	217	217
Education and training - non-staff	**1,557**	**1,557**	1,615	1,615
Operating lease expenditure (net)	**3,788**	**3,788**	3,614	3,614
Redundancy costs - non-staff	**29**	**29**	434	434
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIF	**925**	**925**	886	886
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	**0**	**0**	0	0
Car parking and security	**208**	**208**	353	353
Hospitality	**7**	**7**	0	0
Other services (e.g. external payroll)	**202**	**202**	0	0
Other NHS charitable fund resources expended	**0**	**116**	0	137
Other	**6,228**	**6,263**	8,935	8,963
	262,196	**260,391**	261,428	260,095

4.2 Auditor's remuneration

The Council of Governors appointed Grant Thornton as external auditor of the Trust for the year commencing 1 April 2018. The audit fee for the statutory audit was £47,500 (2017/18, £75,500) excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011. The quality accounts fee was £8,000 (2017/18 £9,000) excluding VAT. Grant Thornton also performed an independent examination of the charitable funds for a fee of £4,000 (excluding VAT) (2017/18 £4,800).

The engagement letter signed on 7 January 2019, included a liability cap of £2m for Grant Thornton, its members, partners and staff (whether in contract, negligence or otherwise) in respect of all such services.

Accounts

4.3 Profit on disposal of other property, plant and equipment

Profit on disposal all relates to unprotected assets.

4.4 Operating leases (Trust as lessee)

4.4.1 Arrangements containing an operating lease:

	Year ended 31 March 2019	Year ended 31 March 2018
	£000	£000
Minimum lease payments	**3,788**	3,614

4.4.2 Future minimum lease payments due:

	Year ended 31 March 2019	Year ended 31 March 2018
	£000	£000
Not later than 1 year	**3,385**	3,361
Later than 1 year and not later than 5 years	**7,049**	7,083
Later than 5 years	**19,075**	18,604
Total	**29,509**	29,048

Over 92% of the operating lease commitments are property leases with varying expiring dates.
The Trust also holds a number of operating leases for leased vehicles. The annual commitment for leased vehicles for the year ended 31 March 2019 was £1,221,194 (year ended 31 March 2018, £1,173,001).

5. Employee costs and numbers

5.1 Employee benefits

	Year ended 31 March 2019	Year ended 31 March 2018
	£000	£000
Salaries and wages	**139,886**	129,367
Social Security Costs	**14,198**	13,086
Apprenticeship Levy	**668**	611
Employer contributions to NHS Pension Scheme	**16,639**	15,372
Pension cost - other	**15**	0
Agency/contract staff	**8,628**	13,676
Total	**180,034**	172,112

5.2 Retirements due to ill-health

During the year there were 4 early retirements on the grounds of ill-health (31 March 2018, 2 in total). The estimated additional pension liabilities of these ill-health retirements will be £227,059 (31 March 2018, £350,029). The cost of these ill-health retirements will be borne by NHS Pensions.

Accounts

6. Finance revenue

	Year ended 31 March 2019	Year ended 31 March 2019	Year ended 31 March 2018	Year ended 31 March 2018
	TRUST	**GROUP**	TRUST	GROUP
	£000	**£000**	£000	£000
Interest on bank accounts	**386**	**386**	146	146
	386	**386**	146	146

Interest on bank accounts consists of interest earned on the Trust's bank accounts and treasury deposits.

7. Finance expenditure

	Year ended 31 March 2019	Year ended 31 March 2018
	£000	£000
Interest obligations under finance leases	**54**	57
Finance costs in PFI obligations-main finance costs	**549**	571
Finance costs in PFI obligations-contingent finance costs	**495**	443
	1,098	1,071

8. Other gains and (losses)

	Year ended 31 March 2019	Year ended 31 March 2018
	£000	£000
Gains on disposal of property, plant and equipment	**846**	1,372
	846	1,372

9. Intangible assets

	Software Licences	Development Expenditure	Year ended 31 March 2019	Year ended 31 March 2018
			£000	£000
Valuation / gross cost at 1 April - brought forward	99	3,927	**4,026**	99
Additions	0	1,380	**1,380**	1,388
Reclassifications	0	0	**0**	2,539
Gross cost at 31 March	99	5,307	**5,406**	4,026
Amortisation brought forward 1 April	30	316	**346**	19
Provided during the year	11	512	**523**	327
Amortisation at 31 March	41	828	**869**	346
Net book value at 31 March	58	4,479	**4,537**	3,680

10. Property, plant and equipment

2018/19	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & Machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	18,707	108,255	0	157	40	86	1,455	1,924	130,623
Additions purchased	0	774	0	7,685	0	0	1,468	0	9,927
Reclassifications	0	791	0	(791)	0	0	0	0	0
Impairments charged to operating expenses	0	(51)	0	0	0	0	0	0	(51)
Revaluations	(1,463)	6,598	0	0	0	0	0	0	5,135
Transfers to/from assets held for sale	1,820	0	0	0	0	0	0	0	1,820
Cost or Valuation at 31 March 2019	**19,064**	**116,367**	**0**	**7,051**	**40**	**86**	**2,923**	**1,924**	**147,454**
Accumulated Depreciation as at 1 April 2018	0	0	0	0	2	86	554	941	1,583
Provided during the year	0	3,709	0	0	4	0	346	242	4,301
Revaluations	0	(3,709)	0	0	0	0	0	0	(3,709)
Accumulated Depreciation as at 31 March 2019	**0**	**0**		**0**	**6**	**86**	**900**	**1,183**	**2,175**
Net Book Value									
Owned	18,201	102,115	0	7,051	34	0	2,023	741	130,165
PFI contracts	862	13,099	0	0	0	0	0	0	13,961
Finance leased	0	1,152	0	0	0	0	0	0	1,152
Total at 31 March 2019	**19,063**	**116,366**	**0**	**7,051**	**34**	**0**	**2,023**	**741**	**145,278**

2017/18	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & Machinery	Transport equipment	Information Technology	Furniture & fittings	Total
	£000	£000		£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	18,434	99,114	0	26,053	0	86	3,663	1,819	149,169
Additions purchased	0	1,829	0	7,933	40	0	0	105	9,907
Reclassifications	0	33,207	0	(33,829)	0	0	(2,208)	0	(2,830)
Impairments charged to operating expenses	(126)	(12,457)	0	0	0	0	0	0	(12,583)
Impairments charged to the revaluation reserve	0	(9,790)	0	0	0	0	0	0	(9,790)
Revaluations	3,585	(3,572)	0	0	0	0	0	0	13
Transfers to/from assets held for sale	(3,088)	98	0	0	0	0	0	0	(2,990)
Disposals / derecognition	(99)	(174)	0	0	0	0	0	0	(273)
Cost or Valuation at 31 March 2018	**18,707**	**108,255**	**0**	**157**	**40**	**86**	**1,455**	**1,924**	**130,623**
Accumulated Depreciation as at 1 April 2017	0	0	0	0	0	86	568	720	1,374
Charged during the year	0	3,572	0	0	2	0	277	221	4,072
Reclassifications	0	0	0	0	0	0	(291)	0	(291)
Revaluations	0	(3,572)	0	0	0	0	0	0	(3,572)
Accumulated Depreciation as at 31 March 2018	**0**	**0**	**0**	**0**	**2**	**86**	**554**	**941**	**1,583**
Net Book Value									
Owned	17,374	95,542	0	157	38	0	901	983	114,995
PFI contracts	1,332	11,584	0	0	0	0	0	0	12,916
Finance leased	0	1,128	0	0	0	0	0	0	1,128
Total at 31 March 2018	**18,706**	**108,254**	**0**	**157**	**38**	**0**	**901**	**983**	**129,039**

Accounts

10. Property, plant and equipment

The Trust's estate was revalued at 31 January 2019 by two partners of Montagu Evans LLP. Both valuers were RICS registered valuers. The valuers opinion was that there had been no material change in market conditions between 31 January 2019 and 31 March 2019.

The valuation methods used at 31 January 2019 were as follows: Specialised properties-depreciated replacement cost (DRC); Operational Non specialised assets-existing use value (EUV); Investment Properties market value (MV).

DRC is defined as the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation. In general the Trust's valuers have relied upon the floor areas of the existing buildings in assuming modern equivalent assets will require the same floor area, however the Trust has identified that a small number of their existing buildings are inefficient with areas that are not occupied for operational purposes and therefore consider any replacement of those assets would require a reduced floor area. Having derived the modern equivalent replacement cost of the existing buildings the valuers have depreciated these values to reflect age and obsolescence. Each building is assumed to have a maximum life expectancy from new of 60 years with the buildings depreciated on a straight line basis from 100% at completion of construction to zero, once their life span has been met.

The net book value of assets held under PFI agreements and finance leases at the statement of financial position date are as follows:

	Land	Buildings, excluding dwellings	Total
	£000	£000	£000
At 31 March 2019			
PFI	**862**	**13,099**	**13,961**
Finance leases	**0**	**1,152**	**1,152**
At 31 March 2018			
PFI	1,332	11,584	12,916
Finance leases	0	1,152	1,152

The total amount of depreciation charged to the Statement of Comprehensive Income in respect of assets held under PFI and finance lease agreements:

Depreciation - 31 March 2019			
PFI	**0**	**351**	**351**
Finance leases	**0**	**32**	**32**
Depreciation - 31 March 2018			
PFI	0	402	402
Finance leases	0	82	82

Non-current assets held for sale - 2018/19

	Land	Buildings	Total
	£000	£000	£000
Opening NBV at 31 March 2019	3,140	0	3,140
Assets sold in year	(470)	0	(470)
Assets no longer classified as held for sale	(1,820)	0	(1,820)
NBV of assets at 31 March 2019	**850**	**0**	**850**

Non-current assets held for sale - 2017/18

	Land	Buildings	Total
	£000	£000	£000
Opening NBV at 31 March 2018	77	144	220
Assets classified as held for sale in the year	3,140	0	3,140
Assets no longer classified as held for sale	(53)	(98)	(150)
Disposals in the year	(24)	(46)	(70)
NBV of assets held for sale at 31 March 2018	**3,140**	**0**	**3,140**

Accounts

11. Inventories

	Year ended 31 March 2019 TRUST £000	Year ended 31 March 2019 GROUP £000	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000
Materials	**373**	**614**	336	547

The inventories figure relates to stocks of drugs.

Expenditure on drugs in the year was £7,579,000 (31 March 2018, £7,579,000). No amounts were written off in the year (31 March 2018, £nil).

12. Trade and other receivables

	Year ended 31 March 2019 TRUST £000	Year ended 31 March 2019 GROUP £000	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000
Current Assets:				
Contract receivables*	**19,408**	**18,334**		
Contract assets*	**0**	**0**		
Trade receivables*	**0**	**0**	17,837	17,031
Accrued Income*	**0**	**0**	3,046	3,014
Allowance for credit losses	**(2,893)**	**(2,893)**	(3,573)	(3,573)
Prepayments (revenue) [non-PFI]	**2,672**	**2,672**	3,817	3,821
PDC dividend receivable	**890**	**890**		
VAT receivable	**762**	**762**	789	890
Other receivables	**115**	**115**	90	90
NHS Charitable funds: Trade and other receivables	**0**	**0**	0	0
TOTAL	**20,954**	**19,880**	22,006	21,273
Non-Current Assets:				
Allowance for credit losses	**(279)**	**(279)**	(279)	(279)
Other receivables	**279**	**279**	279	279
TOTAL	**0**	**0**	0	0
Of which receivable from NHS and DHSC group bodies				
Current		**16,711**	16,422	16,422
Non-current		**0**	0	0

*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

Accounts

12.1 Allowance for credit losses - 2018/19

	TRUST Contract receivables and contract assets £000	TRUST All other receivables £000	**GROUP Contract receivables and contract assets £000**	**GROUP All other receivables £000**
Allowances as at 1 April 2018 - brought forward	0	3,852	0	3,852
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	3,852	(3,852)	3,852	(3,852)
New allowances arising	2,123	0	2,123	0
Reversals of allowances	(2,803)	0	(2,803)	0
At 31 March 2019	**3,172**	**0**	**3,172**	**0**
Of which				
Current assets			**2,893**	
Non current assets			**279**	
At 31 March 2019			**3,172**	

Accounts

12.2 Allowance for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	TRUST	GROUP
	All receivables £000	All receivables £000
At 1 April 2017	3,174	3,174
Increase in provision	2,904	2,904
Amounts utilised	(42)	(42)
Unused amounts reversed	(2,184)	(2,184)
At 31 March 2018	3,852	3,852
Of which		
Current assets	**0**	3,573
Non current assets	**0**	279
At 31 March 2018	**0**	3,852
Non-Current Assets:		
Allowance for other credit losses	(279)	(279)
Other receivables	279	279
TOTAL	0	0

12.3 Exposure to credit risk

	31 March 2019 £000	31 March 2018 £000
Ageing of impaired financial assets		
0 - 30 days	**391**	1,369
30-60 days	**629**	587
60-90 days	**203**	340
90-180 days	**593**	320
180-360 days	**1,355**	1,236
Total	**3,171**	3,852

	31 March 2019 £000	31 March 2018 £000
Ageing of non-impaired financial assets past their due date		
0 - 30 days	**0**	0
30-60 days	**741**	2,566
60-90 days	**273**	512
90-180 days	**57**	186
180+ days	**312**	108
Total	**1,383**	3,372

The Trust has not provided for these financial assets as there has been no significant change in their credit quality and the amounts are still considered recoverable. Financial assets that are not impaired and are not past their due date are considered recoverable.

Accounts

13. Cash and cash equivalents

	Year ended 31 March 2019 TRUST £000	Year ended 31 March 2019 GROUP £000	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000
Balance at 1 April	**60,526**	**61,405**	62,419	63,191
Net change in year	**5,479**	**5,405**	(1,893)	(1,786)
Balance at 31 March	**66,005**	**66,810**	60,526	61,405
Made up of:				
Cash with the Government Banking Service	**25,976**	**25,976**	20,505	20,505
Cash at commercial banks and in hand	**29**	**245**	21	223
Deposits with the National Loan Fund	**40,000**	**40,000**	40,000	40,000
NHS charitable funds	**0**	**589**	0	677
Cash and cash equivalents as in statement of financial position and statement of cash flows	**66,005**	**66,810**	60,526	61,405

14. Trade and other payables

	Year ended 31 March 2019 TRUST £000	Year ended 31 March 2019 GROUP £000	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000
Current:				
Trade payables	**14,170**	**14,094**	13,303	13,232
Capital payables	**1,384**	**1,384**	957	957
Accruals	**17,325**	**17,325**	15,086	15,046
Social security and pension costs	**6,431**	**6,431**	5,577	5,579
PDC dividend payable	**0**	**0**	45	45
Other payables	**8**	**8**	0	234
NHS Charitable funds: Trade and other payables	**0**	**24**	0	31
Total current trade and other payables	**39,318**	**39,266**	34,968	35,124
Of which payable to NHS and DHSC group bodies				
Current	**8,822**	**8,822**	7,322	7,322

Accounts

14.1 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current:		
Obligations under finance leases	**77**	73
Obligations under PFI contracts	**321**	334
	398	407
Non-current:		
Obligations under finance leases	**821**	898
Obligations under PFI contracts	**6,770**	8,407
Total non-current borrowings	**7,591**	9,305

14.2 Other liabilities

	2019 £000	2018 £000
Current:		
Deferred income: contract liaibilities	**18,336**	17,031
	18,336	17,031

15. Reconciliation of liabiliities arising from financing activities

	Finance Leases £000	PFI £000	Total £000
Carrying value at 1 April 2018	**971**	**8,741**	**9,712**
Cash movements:			
Financing cash flows - payments and receipts of principal	(73)	(334)	(407)
Financing cash flows - payments of interest	(54)	(1,044)	(1,098)
Carrying value at 31 March 2019	**844**	**7,363**	8,207

15.1 Finance lease obligations

	31 March 2019 £000	31 March 2018 £000
Gross lease liabilities of which liabilities are due:		
Not later than 1 year	**127**	127
Later than 1 year and not later than 5 years	**508**	508
Later than 5 years	**877**	1,004
Gross lease liabilities	**1,512**	1,639
Less finance charges allocated to future years	**(614)**	(668)
Net lease liabilities	**898**	971

Accounts

Finance lease obligations relate to the lease of buildings at Bridgeways Day Hospital and Wallace Medical Centre. No contingent rent was paid and there is no option in the lease to purchase the asset.

Minimum lease payments are not disclosed at present value as rent increases by RPI annually which is expected to be equal to any inflation and therefore there will not be a significant difference.

15.2 PFI obligations

	31 March 2019 £000	31 March 2018 £000
Gross PFI liabilities of which liabilities are due:		
Not later than 1 year	**777**	883
Later than 1 year and not later than 5 years	**3,109**	3,534
Later than 5 years	**8,006**	10,716
Gross PFI, LIFT or other service concession liabilities	**11,892**	15,133
Less finance charges allocated to future years	**(4,801)**	(6,392)
Net PFI, LIFT or other service concession arrangement obligation	**7,091**	8,741
- not later than one year;	321	334
- later than one year and not later than five years;	1,540	1,596
- later than five years.	5,230	6,811

Under IAS 17, disclosure of the net present value of liabilities is required. The figures above are not reported at net present value however note 22.3 discloses the fair value of the finance lease obligations under the PFI contract.

Accounts

16. Provisions

	Pensions early departure costs	Legal claims and other	Redundancy	Total
	£000	£000	£000	**£000**
18/19				
At 1 April 2018	**45**	**2,787**	**680**	**3,512**
Arising during the year	0	1,307	950	**2,257**
Utilised during the year	0	(830)	(173)	**(1,003)**
Reversed unused	0	(1,253)	(279)	**(1,532)**
Unwinding of discount	0	0	0	**0**
At 31 March 2019	**45**	**2,011**	**1,178**	**3,234**
not later than one year	**45**	**2,011**	**1,178**	**3,234**
later than one year and not later than five years	**0**	**0**	**0**	**0**
	45	**2,011**	**1,178**	**3,234**
Expected timing of cash flows:				
31 March 2019				
Within one year	45	2,011	1,178	**3,234**
Between one and five years	0	0	0	**0**
After five years	0	0	0	**0**
	45	2,011	1,178	**3,234**
31 March 2018				
Within one year	45	2,787	680	**3,512**
Between one and five years	0	0	0	**0**
After five years	0	0	0	**0**
	45	2,787	680	**3,512**

The provision for pensions early departure costs is stated subject to the uncertainty about the length of time and amounts over which this will be payable.

Legal claims and other provisions include the following:
Provisions for other legal claims is stated subject to uncertainty about the outcome of legal proceedings.

Amounts excluded from total provisions above:
£3,026,451 (31 March 2018, £1,954,863) is included in the provisions in the financial statements of NHS Resolution at 31 March 2019 in respect of clinical negligence liabilities of the Trust.

17. Capital Commitments

Commitments under capital expenditure contracts relating to property, plant and equipment at 31 March 2019 were £1,230,235 (31 March 2018 £596,887).

Accounts

18. Contingencies

	31 March 2019	31 March 2018
	£000	£000
Contingent liabilities	(48)	(46)
Amounts recoverable against contingent liabilities	0	0
Net value of contingent liabilities	(48)	(46)

Contingent liabilities relate to NHS Resolution legal claims where it is estimated that it is not probable that the Trust will be liable for the excess under the Liabilities to Third parties Scheme and Property Expenses Scheme.

Legal claims under these schemes where it is probable that the Trust will be liable for the excess, are included in provisions.

19 Related Party Transactions

The ultimate controlling party of the Trust is the Department of Health and Social Care of the UK Government.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Oxleas NHS Foundation Trust other than those set out below. None of the Board Members made any annual declaration of interests in respect of the financial year 2018-19.

During the year Oxleas NHS Foundation Trust has had material transactions with the following NHS bodies:

Department of Health

NHS Bexley CCG

NHS Bromley CCG

NHS Croydon CCG

NHS Greenwich CCG

NHS Lewisham CCG

NHS England

Kings College Hospital NHS Foundation Trust

Dartford and Gravesham NHS Trust

Lewisham and Greenwich NHS Trust

Health Education England

The Department of Health is the parent department. In addition, the Trust has had material transactions with the following local Government bodies:

Accounts

London Borough of Bexley

London Borough of Bromley

London Borough of Greenwich

Payments from the above NHS bodies related parties mainly relate to income from contracts for healthcare services. Payments to these related parties are for purchases of healthcare and other services.

Amounts owed to and from related parties are trade receivable and trade payable balances. Payments from related parties mainly relates to income from contracts for healthcare services. Payments to related parties are for purchases of healthcare and other services.

The Trust has had transactions with Oxleas NHS Foundation Trust Charitable Fund, Oxleas Prison Services Limited and with its joint venture SARD JV Limited as follows:

	Payments to 18/19	Receipts from 18/19	Amounts owed 31 March 2019	Amounts due 31 March 2019	Payments to 17/18	Receipts from 17/18	Amounts 31 March 2018	Amounts due from 31 March 2018
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Oxleas NHS Foundation Trust Charitable Fund	0	0	0	0	0	5	0	21
Oxleas Prison Services Limited	1,926	2,020	0	0	3,444	1,830	1	811
SARD JV Limited	0	0	0	60	0	0	0	100

The receipts from Oxleas NHS Foundation Trust Charitable Fund relate to a recharge of administrative costs. The Trustees of Oxleas NHS Foundation Trust Charitable Fund are also members of the NHS Foundation Trust Board. The audited accounts of the Funds Held on Trust are available from the Director of Finance, Oxleas NHS Foundation Trust.

The receipts from Oxleas Prison Services Limited relate to a recharge of staff and administrative costs. The payments to Oxleas Prison Services Limited relate to drugs costs.

The Trust has provided a loan to the joint venture as disclosed in note 1.23 to the financial statements.

20 Private Finance Transactions

Service element of PFI schemes deemed to be on-statement of financial position

The Trust is party to a PFI scheme with Bexley PPP Health Services Ltd ('the partner'). The scheme was implemented in a phased 3 year programme. Three buildings were opened in 1999/2000, two buildings in 2000/2001 and one building in 2001/2002. 2 of the properties (Erith Centre, Bexleyheath Centre at 4 Emerton Close) are used to deliver community mental health and outpatient services and to accommodate Trust offices; the Woodlands Unit is used to deliver acute inpatient services; 42 Oakwood Drive is leased to a third party to provide learning disability services. Somerset Villa is currently vacant and being reviewed by forensic services. North House which had formerly been used to deliver residential services for mental health and learning disability clients was sold on 25 March 2019. The substance of the contract is that the Trust has a finance lease and payments comprise 2 elements - imputed finance lease charges and service charges (see note 1.7). Under IFRIC 12 the assets are treated as assets of the Trust.

The lease period is 50 years commencing in 2000 and expiring in 2050. There is a break clause in 2025 and the

Accounts

trust has received advice from their solicitors on how the break can be actioned, if required, and this is currently being reviewed.There are no re-pricing dates in respect of the unitary payment. RPI is applied annually at 1st April based on the table published by the Office for National Statistics. Market testing in respect of maintenance is required 30 years after the commencement date and on a quinquennial basis thereafter. Market testing in respect of items other than maintenance is required 5 years after the commencement date and on a quinquennial basis thereafter.

Ownership of the land and buildings reverts to the Trust at the end of the lease period, i.e. in 2050. Termination options include those for the following reasons: gross negligence of the partner; insolvency of the partner; non-payment of loan instalments by the partner to the lending bank.

An element of the unitary payments is applied to a 'sinking fund' for the purpose of funding significant capital expenditure on the properties as required over the period of the lease.

Following dissolution of South London Healthcare NHS Trust in October 2013 the PFI scheme for Elmstead & Newsland at Queen Marys Hospital, Sidcup, Kent was transferred to the Trust. The partner for the QMH PFI scheme is Bexley PP Health Services Ltd and the lease on the asset expires on 31 March 2029.

	Year ended	Year ended
		31 March
	31 March 2019	2018
	£000	£000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on Statement of Financial Position	**925**	886
Net charge to operating expenses	**925**	886
Commitments in respect of the service element of the PFI:	**£000**	£000
Within one year	**872**	909
2nd to 5th years (inclusive)	**3,487**	3,636
Later than five years	**16,800**	18,897
Total	**21,159**	23,442

Non current asset values

The following non current assets are held under the PFI schemes:

	Land	Buildings	Total
	£000	£000	£000
31 March 2019			
Erith Centre, Park Crescent, Erith, Kent	**117**	**216**	**333**
42 Oakwood Drive, Barnehurst, Kent	**191**	**355**	**545**
4 Emerton Close, Bexleyheath, Kent	**203**	**376**	**579**
Woodlands Unit, Queen Mary's Hospital, Sidcup, Kent	**352**	**12,152**	**12,504**
North House, 237 Erith Road, Bexleyheath, Kent	**-**	**-**	**-**
Total	**862**	**13,099**	**13,961**
31 March 2018			
Erith Centre, Park Crescent, Erith, Kent	116	216	332
42 Oakwood Drive, Barnehurst, Kent	191	354	545
4 Emerton Close, Bexleyheath, Kent	203	377	580
Woodlands Unit, Queen Mary's Hospital, Sidcup, Kent	352	10,637	10,989
North House, 237 Erith Road, Bexleyheath, Kent	470	-	470
Total	1,332	11,584	12,916

Accounts

21. Financial Instruments

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The Trust is not exposed to significant financial risk factors arising from financial instruments. Because of the continuing service provider relationship that the Trust has with local Clinical Commissioning Groups and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Financial assets and liabilities are generated by day-to-day operational activities rather than being linked to changes in risks facing the Trust in undertaking its activities.

Credit Risk

Credit risk is the possibility that other parties might fail to pay amounts due to the Trust. Credit risk arises from deposits with banks as well as credit exposures to the Trust's commissioners and other receivables. Surplus operating cash is only invested in line with the Trust's treasury management policy which allows investments with the Government Banking Service (GBS) and the National Loan Fund (NLF) only. The trust's cash assets at the year end are held with the Government Banking Service, Lloyds bank and deposits with the National Loan Fund.

The Trust's net operating costs are incurred largely under annual service agreements with local Clinical Commissioning Groups and Local Authorities, which are financed from resources voted annually by Parliament. An analysis of the ageing of receivables and provision for impairment can be found at Note 12 "Trade and other receivables".

Market risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. Market risk comprises three types of risk, where the fair value or future cash flows could fluctuate because of movements in the underlying interest rate risk, currency risk, and price risk.

Interest rate risk

The Trust holds short term investments throughout the year in commercial banks as agreed in its treasury management policy. At 31 March 2019, the Trust invests in the Government Banking Service, Lloyds bank and the National Loan Fund. Other than cash and short term deposits as noted, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash-flows are substantially independent of changes in market interest rates.

Price risk

The Trust has a number of contractual arrangements which are linked to the UK Retail Price Index (RPI) therefore the Trust is exposed to price risk in line with movements in the UK economy.

Liquidity risk

Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities.

22. 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.

Accounts

Financial assets at amortised cost	31 March 2019 TRUST £000	31 March 2019 GROUP £000
Assets as per statement of financial position		
Receivables (excluding non financial assets) - with DHSC group bodies and other bodies	**16,630**	**15,556**
Cash and cash equivalents	**66,005**	**66,221**
Consolidated NHS Charitable fund financial assets	**0**	**589**
Total at 31 March 2019	**82,635**	**82,366**

Loans and receivables	31 March 2018 TRUST £000	31 March 2018 GROUP £000
Assets as per statement of financial position		
Receivables (excluding non financial assets) - with DHSC group bodies	13,416	13,416
Receivables (excluding non financial assets) - with other bodies	3,984	3,146
Cash and cash equivalents	60,526	60,728
Consolidated NHS Charitable fund financial assets	0	677
Total at 31 March 2018	77,926	77,967

22.1 Carrying values of financial liabilities

Financial liabilities at amortised cost	31 March 2019 TRUST £000	31 March 2019 GROUP £000
Liabilities as per statement of financial position		
Obligations under finance leases	**898**	**898**
Obligations under PFI, LIFT and other service concession contracts	**7,091**	**7,091**
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	**8,822**	**8,822**
Trade and other payables (excluding non financial liabilities) - with other bodies	**24,065**	**23,989**
Consolidated NHS charitable fund financial liabilities	**0**	**24**
Total at 31 March 2019	**40,876**	**40,824**

Financial liabilities at amortised cost	31 March 2018 TRUST £000	31 March 2018 GROUP £000
Liabilities as per statement of financial position		
Obligations under finance leases	**971**	**971**
Obligations under PFI, LIFT and other service concession contracts	**8,741**	**8,741**
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	**7,277**	**7,277**
Trade and other payables (excluding non financial liabilities) - with other bodies	**22,069**	**22,192**
Consolidated NHS charitable fund financial liabilities	**0**	**31**
Total at 31 March 2018	39,058	39,212

Accounts

22.2 Fair Values 2018/19

Set out below is a comparison, by category, of book values and fair values of the Trust's financial assets and liabilities:

	31 March 2019 Book Value £000	31 March 2019 Fair Value £000	
Financial assets			
Trade and other receivables excluding non financial assets	15,556	15,556	
Cash and cash equivalents	66,005	66,005	
TRUST TOTALS	**81,561**	**81,561**	
NHS Charitable funds - cash & cash equivalents	589	589	
GROUP TOTALS	**82,150**	**82,150**	
Financial liabilities			
Obligations under finance leases due < 1 year	77	77	
Obligations under finance leases due > 1 year	821	821	Note a
Obligations under PFI contracts due < 1 year	321	321	
Obligations under PFI contracts due > 1 year	6,770	6,770	Note a
Trade and other payables excluding non financial liabilities	24,065	24,065	
TRUST TOTALS	**32,054**	**32,054**	
NHS Charitable funds - trade and other payables	**0**	**0**	
GROUP TOTALS	**32,054**	**32,054**	

Note

a) Book value is taken to be a reasonable estimate of fair value since the Office of Budget Responsibility Consumer Price combined inflation and discount rates Index apply infation rates of around 2%.

Accounts

22.3 Fair Values - 2017/18

	31 March 2018 Book Value £000	31 March 2018 Fair Value £000	
Financial assets			
NHS Receivables - Revenue	13,416	13,416	
Provision for impaired receivables	(3,573)	(3,573)	
Accrued income	3,046	3,046	
Other receivables - Revenue	4,511	4,511	
Cash and cash equivalents	60,526	60,526	
TRUST TOTALS	**77,926**	**77,926**	
OPS Limited	(636)	(636)	
NHS Charitable funds	677	677	
GROUP TOTALS	**77,967**	**77,967**	
Financial liabilities			
NHS payables	7,277	7,277	
Other payables	6,026	6,026	
Accruals	15,086	15,086	
Trade payables - capital	957	957	
Obligations under finance leases due < 1 year	73	73	
Obligations under finance leases due > 1 year	898	898	
Obligations under PFI contracts due < 1 year	334	334	
Obligations under PFI contracts due > 1 year	8,407	6,706	Note a
TRUST TOTALS	**39,058**	**37,357**	
OPS Limited	123	123	
NHS Charitable funds	31	31	
GROUP TOTALS	**39,212**	**37,511**	

Note

a) To obtain fair value, cash flows have been discounted at prevailing market interest rates for finance leases for a similar term. As no precise interest rate could be determined the rate has been calculated as the mid point between the base rate at the inception of the lease, plus the risk premium, and the base rate at 31 March 2019, plus the risk premium.

Book value is assumed to be a reasonable approximation for fair value for current financial assets and liabilities. Fair values for non current liabilities have been estimated using valuation techniques categorised as Level 3 in the fair value hierarchy.

22.4 Carrying values of financial liabilities 2018/19 and Comparator

	31 March 2019 £000	31 March 2018 £000
Obligations under finance leases	**898**	971
Obligations under PFI, LIFT and other service concession contracts	**7,091**	8,741
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	**8,822**	7,277
Trade and other payables (excluding non financial liabilities) - with other bodies	**23,989**	22,192
Consolidated NHS charitable fund financial liabilities	**24**	31
Total	**40,824**	39,212

Accounts

22.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
Less than one year	**33,233**	29,907
In more than one year but not more than two years	**402**	358
In more than two years but not more than five years	**1,490**	1,572
In more than five years	**5,699**	7,375
Total	**40,824**	39,212

23 Third Party Assets

The Trust held £377,586 cash at bank and in hand at 31 March 2018 (31 March 2017, £394,203) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash and cash equivalents reported in the accounts.

24 Losses and Special Payments

There were 17 cases of losses and special payments paid during the year (31 March 2017, 37)

	2018/19 Number	2018/19 £'000	2017/18 Number	2017/18 £'000
Loss of cash - other	**0**	**0**	0	0
Bad debts and claims abandoned - other	**3**	**0**	2	0
Stores losses and damage to property	**1**	**0**	0	0
TOTAL LOSSES	**4**	**0**	2	0
Compensation under court order or legally binding arbitration award	**9**	**57**	11	25
Ex gratia payments in respect of personal effects	**7**	**3**	4	2
Ex gratia payments in respect of other	**0**	**0**	0	0
TOTAL SPECIAL PAYMENTS	**16**	**60**	15	27
TOTAL LOSSES AND SPECIAL PAYMENTS	**20**	**60**	17	27

During the year there were no cases exceeding £250,000 (31 March 2018, no cases).
Losses and special payments are reported on an accruals basis excluding provisions for future losses.

25. Consolidation of charitable funds

The Trust is the Corporate Trustee of Oxleas NHS Foundation Trust Charitable Funds. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

The charity registration number of Oxleas NHS Foundation Trust Charitable Funds is 1061424 and the registered address is Pinewood House, Pinewood Place, Dartford, Kent DA2 7WG. The charity is domiciled in the UK. Accounts for the charity can be obtained from http://www.charity- commission.gov.uk.

The charity's total reserves is analysed between restricted and unrestricted funds as below:

Accounts

	31 March 2019	31 March 2018
	£'000	£'000
Unrestricted funds:		
Unrestricted income funds	**253**	315
Restricted funds:		
Restricted income funds	**311**	331
TOTAL CHARITABLE FUND RESERVES	**565**	**646**

Unrestricted funds are accumulated income funds that are expendable at the discretion of the Trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds are accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They can also represent capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

26. 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. No cumulative effect arises as an adjustment to reserves on 1 April 2018 from the standard being applied retrospectively.

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.

26.1 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. No cumulative effect of initial application arises as an adjustment to the income and expenditure reserve on 1 April 2018 from the standard being applied retrospectively.

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).

27. Events after the reporting date

There are no material events occurring after the reporting period at 31 March 2019