Oxford Health NHS
NHS Foundation Trust

Oxford Health NHS Foundation Trust Annual Report and Accounts 2012-13

Oxford Health NHS Foundation Trust
Annual Report 2012/13

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Section One – Our Foundation Trust

Who we are

Oxford Health NHS Foundation Trust is a community-focused organisation that provides physical and mental health services and social care with the aim of improving the health and wellbeing of all our patients and their families.

Our Trust provides community health, mental health and specialised health services. We operate across Oxfordshire, Buckinghamshire, Berkshire, Wiltshire, Swindon, Bath and North East Somerset. In Oxfordshire we are the main provider of community health services and deliver these in a range of community and inpatient settings, including eight community hospitals. Our mental health teams provide a range of specialist healthcare in the community and from inpatient settings across the geographic areas of Milton Keynes, Buckinghamshire, Oxfordshire, Wiltshire, Swindon, Bath and North East Somerset (BaNES). We also provide a range of specialised health services that include forensic mental health and eating disorder services across a wider geographic area including support for patients in Berkshire and from Wales.

Our aim is to improve the health and wellbeing of all our patients and families and we work in partnership with a range of other organisations in Oxfordshire, Buckinghamshire, Wiltshire and BaNES. These include the University of Oxford to promote innovation in healthcare, support research and to train doctors and psychologists; Oxford Brookes University, Bucks New University and the University of Bedfordshire and Thames Valley to train nurses and allied health professionals; local authorities and voluntary organisations; and GPs across all the locations we serve in order to provide joined-up care.

Find out more

You can find out more about the many different services we provide and our locations on our website www.oxfordhealth.nhs.uk

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Foreword by the Chairman and Chief Executive

Welcome to the Oxford Health NHS Foundation Trust annual report, the latest review of a year in the life our Trust.

2012/13 was a year characterised by change and innovation at both the local and national level, as we bade farewell to Chief Executive Julie Waldron after 12 years at the organisation's helm.

Julie was an exemplary leader, steering the Trust through a number of changes and most recently our merger with community health services in Oxfordshire when we became a provider of integrated mental and physical healthcare. We wish Julie well in her new endeavours, and thank her for the sound legacy she leaves behind.

We also said goodbye to Graeme Armitage, Director of Human Resources and David Bradley, Chief Operating Officer. Many thanks to both for their commitment to Oxford Health NHS FT. Welcome to new postholders Yvonne Taylor, Chief Operating Officer and our new Non-Executive Director, Sue Dopson.

2012/13 was our second year operating as a combined mental health and community services Trust, and a time when we really started to reap the benefits of such integration. Our work with neighbouring organisations including the county councils, Oxford University Hospitals NHS Trust and Buckinghamshire Healthcare NHS Trust has seen the development of more effective and seamless pathways of care for patients, especially older people.

As people live longer they can have many varied and complex needs, requiring a coordinated response from the acute, community and social care sectors; and our teams have worked hard to develop holistic packages of support to help them remain as independent as possible. We are seeing evidence of a growth in the number of patients accessing services in the community hospitals and closer to home, a rise of over 25 per cent last year. This indicates we are moving towards a position where patients can avoid unnecessary acute hospital admissions wherever appropriate, thanks to better support at home and in community settings.

Significant progress has been made in the discharge arena, but helping patients to avoid the need for admission to hospital in the first place is a pressing objective for 2013/14. Cross-boundary working and strong teams are the key to developing these better pathways of care and we invested in training to support effective team development with Aston University last year. We were delighted to see an improvement in the results of the annual staff satisfaction survey, including positive feedback about the culture of our teams. Our staff are central to the success of the organisation; and we would like to pay tribute to the care, compassion and innovation they show.

We do not take it for granted that excellent patient experience and safe, effective care come as a matter of course – the events at Mid Staffordshire Hospital make clear that Boards must give strong leadership to make sure standards do not slip. The Board has been reviewing the recommendations of the latest report by Robert Francis QC, and has discussed with the Council of Governors how we can learn

from them to improve our ability to realise our core values of being safe, caring and excellent.

That goal is enhanced by our being part of a network of organisations and building strong relationships with neighbouring NHS trusts, councils and voluntary sector services. This is reaping benefits for patients in terms of the care we provide and also looking to the future, new treatments and innovations. We are proud of the Oxford Academic Health Sciences Network, and work closely with the departments of Psychiatry and Primary Care at the University of Oxford. The focus on dementia, which affects over 800,000 people a year, is just one example of the work where we are collaborating. This is helping us to plan and develop better ways of treating and supporting patients with the condition.

We are pleased that we have been able to grow the scope of the work of the Trust, and we are now providing many services outside of our immediate area in the field of child and adolescent mental health care. This is testament to the hard work and progressive approach of the team, who are now supporting children and their families in Bath, North East Somerset and Wiltshire.

Despite the need to review our costs and spending in all areas like every other public sector organisation, we were delighted to perform within budget and still be able to invest in our services during the year. A project we are particularly proud of is the Highfield Unit, the new adolescent inpatient mental health facility in Oxford.

This state-of-the-art environment, which opened to patients in February, is already receiving excellent feedback from clients, their families and staff. Much of its success is down to the active engagement, involvement and creativity of users and staff at every stage of the planning and in November we hosted a music concert to celebrate the development. A number of local bands played for our young people, staff and other stakeholders. This event was also a thank-you to the Oxford Hospitals Charity for their kind donation that enabled the new unit to have a state-of-the-art music studio for young people.

The Highfield Unit is an excellent example of how genuine user involvement adds huge value to the quality of services we provide and we are looking forward to the official opening event later in the year.

Work has also begun on another major capital project – a new £42 million adult and older people's mental health unit in Aylesbury – which should be completed in late 2013. Service users, carers, staff and partners have been involved in the development of this unit since day one. Looking ahead to the coming year we will be consulting with stakeholders on a name for the unit, and planning for patients to move in safely once it is ready.

Structural changes to the way the NHS is organised went live this April, and notable for us will be the difference in the way services are commissioned for our communities in Oxfordshire, Buckinghamshire and beyond. We have been working closely with our three main clinical commissioning groups in their shadow form, and look forward to the even closer connection with GPs offered by the new arrangements.

Lastly, but perhaps most importantly, we want to put on record from the whole Board our thanks to the 6,200 staff, 8,930 members and the dedicated Governors who make up Oxford Health NHS Foundation Trust.

The hard work, compassion and care that they show to patients and their families, year in and year out, is above all the foundation of our success.

With best wishes,

Martin Howell
Chairman

Stuart Bell
Chief Executive
Stuart joined the Trust in October 2012

Directors' report

The role of the Board of Directors

The role of the Board of Directors is to consider the strategic, managerial and performance issues facing the Trust. Directors are accountable for meeting national standards, performance targets, and governance and financial targets.

The executive directors are responsible for the day-to-day running of the organisation and implementing decisions taken at a strategic level by the Board of Directors. The Board reviews key risks regularly at the Audit Committee and the Integrated Governance Committee and monitors the actions being taken to mitigate risks.

The Board of Directors meets 10 times a year and meetings are held in private. At each meeting of the Council of Governors, a formal report on the Board of Directors' activities is presented. In line with changing governance requirements, the Board of Directors will commence meeting in public in 2013/14.

The membership of the Board of Directors is balanced, complete and appropriate as demonstrated by the biographical details of Board members. The Remuneration and Terms of Service Committee for Executive Directors and Nominations and Remuneration Committee of the Council of Governors review the membership of the Board to ensure it remains well balanced and covers the full range of expertise required.

The Trust considers all the non-executive directors to be independent in character and judgement, but it is noted that one of the non-executive directors, Professor Sue Dopson, is an appointed representative of the University of Oxford (Said Business School).

The Board of Directors has assured itself of the robustness of its governance arrangements through its internal auditors.

Directors, changes during the period and remit

The Board of Directors during the year covered by this Annual Report comprised:

Executive Directors

Julie Waldron, Chief Executive – until 31 August 2012
Stuart Bell, Chief Executive – from 1 October 2012
Graeme Armitage, Director of Human Resources – until 31 March 2013
Ros Alstead, Director of Nursing and Clinical Standards
David Bradley, Chief Operating Officer – until 27 July 2012
Yvonne Taylor, Chief Operating Officer – interim from 27 July 2012 and permanent from 1 January 2013
Mike McEnaney, Director of Finance
Dr Clive Meux, Medical Director.

Non-executive directors

Martin Howell, Chairman
Mike Bellamy
Alyson Coates
Professor Sue Dopson – from 1 June 2012
Dr Anne Grocock
Roger Reed
Cedric Scroggs, Vice-Chair
Lyn Williams.

Changes in the Board of Directors during the period:

Julie Waldron retired from the Trust on 31 August 2012 and Stuart Bell was appointed as Chief Executive, taking up post on 1 October 2012.

During the month of September 2012, Clive Meux was appointed Acting Chief Executive in addition to being Medical Director.

David Bradley left the Trust on 27 July 2012 and Yvonne Taylor was appointed to the interim Chief Operating Officer post on 27 July 2012, and then the substantive post on 1 January 2013.

Graeme Armitage, Director of Human Resources and Organisational Development, left the Trust on 31 March 2013.

Following the end of Professor Tom Burns' tenure as Non-Executive Director on 31 October 2011, the Council of Governors appointed Professor Sue Dopson as the University of Oxford's nominated Non-Executive Director from 1 June 2012.

As directors of the Trust, the directors confirm that, as far as they are aware, there is no relevant information of which the auditors are unaware. Each director has taken all of the steps that they ought to have taken as a director in order to make himself or herself aware of any relevant information and to establish that the auditors are aware of that information.

Term of Office and Termination

The Chair and non-executive directors are appointed for a period of office as decided by the Council of Governors at a general meeting, following provisions set out in the Trust's Constitution.

Terms of office may be ended by resolution of the Council of Governors following the provisions and procedures laid down in the Trust's Constitution.

Period of Office

Name	Period of Office End Date
Martin Howell*	31/03/16
Mike Bellamy	31/01/15
Alyson Coates	31/03/14

Professor Sue Dopson	31/05/15
Dr Anne Grocock	31/01/15
Roger Reed	30/04/13
Cedric Scroggs	31/03/14
Lyn Williams	31/03/14

* = re-appointed during 2012/13 by the Council of Governors

Attendance at Board of Directors' meetings, April 2012 – March 2013

Director	25/04/12	30/05/12	26/06/12	25/07/12	26/09/12	31/10/12	28/11/12	30/01/13	27/02/13	27/03/13
Graeme Armitage	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Ros Alstead	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Stuart Bell	N/A	N/A	N/A	N/A	N/A	✓	✓	✓	✓	✓
Mike Bellamy	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
David Bradley	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A
Alyson Coates	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Dopson	N/A	N/A	✓	✓	✓	✓	X	✓	X	✓
Anne Grocock	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Howell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mike McEnaney	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Clive Meux	✓	✓	✓	✓	X	✓	✓	✓	✓	X
Roger Reed	✓	✓	X	✓	✓	✓	✓	✓	X	✓
Cedric Scroggs	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Yvonne Taylor	N/A	N/A	N/A	N/A	✓	✓	✓	✓	✓	✓
Julie Waldron	✓	✓	✓	✓	N/A	N/A	N/A	N/A	N/A	N/A
Lyn Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Key: ✓ - attended X – apologies N/A – not in post Ext – extraordinary meeting

Board Director Biographies

Martin Howell (Chairman)

Martin has enjoyed a long career in the UK Steel Industry after completing a BSc in Chemistry at the University of Bristol. He retired from Corus as Director of Construction in 2006.

Martin was appointed Chairman of Oxford Health NHS FT in 2010. Prior to this he was a Non-executive Director of NHS South Central Strategic Health Authority. As well as his work for the Trust, Martin is currently a Governor of Oxford Brookes University and a Board Member of Thames Valley Crime Stoppers.

Mike Bellamy (Non-Executive Director)

Mike was appointed by the Council of Governors in February 2009 and has taken a particular interest in how the Trust can deliver high quality services in a consistent and reliable way. He worked in the NHS for 32 years including 18 years as a chief executive. Since leaving the NHS, Mike has carried out a variety of projects for organisations including the WHO, National Patient Safety Agency and the Healthcare Commission, as well as working as regional director for the peer review programme of the National Cancer Action Team for six years up to 2010.

He has previously served as a Non-Executive Director of the Blood Services Authority and the Buckinghamshire Hospitals NHS Trust. He was on the Board of Bucks New University for 10 years including three as deputy Chairman up to 2008. He then joined the Board of the University of West London.

Alyson Coates (Non-Executive Director)

Alyson was appointed by the Council of Governors in April 2011. She takes a particular interest in the strategic direction of the Trust and in clinical and financial governance. Originally a biochemist, Alyson spent most of her career as an equity analyst at an international investment bank, specialising in the healthcare sector.

Prior to joining the Trust, Alyson was Vice Chair and Chair of the Audit Committee at South Central Strategic Health Authority. She is a member of the Auditing Practices Board of the national independent financial regulator, the Financial Reporting Council; external advisor to the audit committee of the Olympic Lottery Distributor, and is an independent Governor of Oxford Brookes University.

Professor Sue Dopson (Non-Executive Director)

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

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

Dr Anne Grocock (Non-Executive Director)

Anne was appointed Non-Executive Director in February 2008. She has an MA (BA) in Zoology, and a DPhil from Department of Agriculture, both University of Oxford. She is a Fellow of the Royal Society of Arts (FRSA).

Anne retired as Assistant Registrar in the University of Oxford in February 2010. She is chair of the Nuffield Oxford Hospitals Fund. She is a member of the Standards Committee of the General Optical Council. She has held non-executive posts on the Defence Storage Distribution Agency (MOD) Audit Committee and the Defence Estates (MOD) Audit Committee. Anne was previously Executive Director of the Royal Society of Medicine.

Cedric Scroggs (Non-Executive Director)

Cedric was a visiting Fellow of Nuffield College, Oxford and a marketing director in various industries. Cedric was formerly Chief Executive of Fisons plc, and a former Chairman of Montpellier Group PLC. He was former Acting Chair of Oxfordshire Mental Healthcare NHS Trust and former Chair of South East Oxfordshire Primary Care Trust. Cedric was appointed as Non-Executive Director in 2006 and Vice-Chair of the Trust in 2008.

Councillor Roger Reed (Non-Executive Director)

Roger is a former Non-Executive Director of Buckinghamshire Mental Health NHS Trust and was appointed to the Board of OBMH in 2006. He is an elected member of South Buckinghamshire District Council since 1995 and is Deputy Leader of the Council and Cabinet. Roger was elected to the Buckinghamshire County Council in 2009.

Lyn Williams (Non-Executive Director)

Lyn was appointed in 2006. He has five years' audit experience with constituent firms of Ernst & Young and PwC. He held various senior management positions in Finance, IT and Supply Chain for Unilever PLC. Lyn has a BA (Hons) in German and French from the University of Oxford and is a Chartered Accountant.

Stuart Bell (Chief Executive)

Stuart Bell was appointed Chief Executive Officer of the Trust on 1 October 2012.

Stuart was previously the Chief Executive Officer of South London and Maudsley NHS Foundation Trust and was in post for 13 years. He has 30 years NHS experience. Before working at South London, Stuart was Chief Executive of Thameslink NHS Trust and Lewisham and Guy's Mental Health NHS Trust. Earlier in

his career he worked at Charing Cross and Whittington hospitals before moving to the South West Thames Regional Health Authority in 1990. Stuart has been instrumental in the development of King's Health Partners - the only academic health sciences centre with a major mental health involvement.

In 2008 Stuart was awarded a CBE for services to the NHS and he is an Honorary Fellow of King's College London.

Ros Alstead (Director of Nursing and Clinical Standards)

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

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

Graeme Armitage (Director of Human Resources & Organisational Development)

Graeme is a Chartered Member of CIPD and has a BTEC National Diploma in Business Studies. He has previously been Deputy Director of Human Resources for East Surrey Primary Care Trust and Deputy Director of HR/Training and Development for Surrey Heartlands NHS Trust.

Graeme joined Oxfordshire Mental Healthcare NHS Trust in November 2005. He spent one year managing the project to transform community services in Buckinghamshire and more recently has been the Programme Director for the Oxford Health NHS Foundation Trust Cost Improvement Programme.

Mike McEnaney (Director of Finance)

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

Clive Meux (Medical Director and Director of Strategy)

Clive was appointed Medical Director in April 2011, additionally becoming Director of Strategy in December 2011. He commenced working for the Trust as a consultant forensic psychiatrist in 1999. He was Clinical Director of the Trust's Thames Valley Forensic Mental Health Service from 2005 and Deputy Medical Director from 2010. He has been an Honorary Senior Clinical Lecturer in Forensic Psychiatry, University of Oxford, since 2003.

Clive has worked in the NHS for 29 years, gaining his basic medical degrees (MB BS) at the University of London. He is a registered general and forensic psychiatrist and Fellow of the Royal College of Psychiatrists (FRCPsych). Previous posts include five years as a Senior Lecturer in Forensic Psychiatry at the Institute of Psychiatry, London and seven years as a consultant forensic psychiatrist at Broadmoor Hospital. He has various publications, has taught widely and has substantial expertise in the human rights field at an international level.

Yvonne Taylor (Chief Operating Officer)

Yvonne was appointed as Chief Operating Officer in December 2012 after acting as Interim Chief Operating Officer since July 2012.

Yvonne has worked for the Trust since 2006, most recently as Divisional Director for Children and Families Services, and has a wealth of experience managing operational services over a number of years. Prior to working for the Trust, she worked as a commissioner in Oxfordshire. Yvonne is also a Visiting Fellow at the University of Reading.

Committees

Committee meetings between 1 April 2012 and 31 March 2013:

Audit Committee

The role of the Audit Committee is independently to monitor, review and report to the Board of Directors on the processes of governance and, where appropriate, to facilitate and support through its independence the attainment of effective processes. Its areas of responsibility include governance, internal control, risk management, internal and external audit and financial reporting. The terms of reference of the Audit Committee, including its role and the authority delegated to it by the Board of Directors, are available upon request.

The work of the Audit Committee in the discharge of its areas of responsibility has included: review of the draft Annual Report; review of the draft Annual Accounts and financial statements; review of the Annual Governance Statement; regular consideration of the Assurance Framework to gain ongoing assurance of risk and internal control processes; review and approval of the internal and external audit plans; regular review of internal audit progress reports including internal audit performance indicators and consideration of the effectiveness of internal audit; regular review of external audit progress reports; regular review of internal audit reports on key systems of internal control including finance, clinical governance and risk management and of external audit reports on governance and quality assurance, amongst other matters; regular review of Counter Fraud reports with updates on investigations and awareness raising activities; and review of the work of other committees within the Trust whose work can provide relevant assurance to the Audit Committee's own scope of work, for example, the minutes of the Integrated Governance Committee are regularly presented for information at the Audit Committee.

Cedric Scroggs stepped down as Chair of the Audit Committee in January 2013 and Alyson Coates was appointed by the Board of Directors to take on this role. In addition, the Board of Directors appointed Sue Dopson to join the Audit Committee as an additional member from February 2013.

Given the skill and experience of the current committee members, the Board of Directors is satisfied that the committee has remained effective and that committee members have recent and relevant financial experience.

Finance and Investment Committee

The Finance and Investment Committee provides assurance to the Board of Directors on a number of key financial issues relevant to the Trust. In particular it reviews investment decisions and policy, financial plans and reports; and approves the development of financial reporting, strategy and financial policies to be consistent with the NHS Foundation Trust regime.

As a consequence of stepping down as Chair of the Audit Committee, the Board of Directors appointed Cedric Scroggs as a full member of the Finance and Investment Committee in February 2013.

Integrated Governance Committee

The key function of the Integrated Governance Committee is to lead on the development and monitoring of quality and risk systems within the Trust to ensure that quality, patient safety and risk management are key components of all activities of the Trust. The Committee ensures that appropriate risk management processes are in place to assure the Board that action is taken to identify and manage risks within the Trust. It is also responsible for the development of systems and processes to ensure that the Trust implements and monitors compliance with relevant standards and targets, and with the Care Quality Commission (CQC) Registration. The Committee makes sure that services provided are appropriate, reflect best practice, represent best value for money, are responsive to service user needs and reflect the views and experiences of service users and carers in service delivery.

Charitable Funds Committee

The Charitable Funds Committee is responsible for ensuring that the Trust fulfils its duties as a trustee in the management of the charitable funds.

Executive Directors' Remuneration and Terms of Service Committee

The Remuneration Committee is a sub-committee of the Trust Board, made up of non-executive directors and set up to recommend the remuneration levels for Executive Directors and other senior managers. The committee takes account of Department of Health guidelines and also information available from Capita and IDS.

Council of Governors Nominations and Remuneration Committee

This committee is a formal committee of the Council of Governors and oversees the

development, implementation and review of the composition of non-executive directors. The committee makes recommendations to the Council of Governors on the appointment of the Chair and non-executive directors. The Committee also makes recommendations to the Council of Governors on the terms and conditions, including remuneration and allowances, of the Chair and non-executive directors.

Through the Terms of Reference, the Chair of the Trust is a member of the committee and chairs the meetings. However, the Chair of the Trust does not chair or attend the Committee when it discusses matters specifically relating to the Chair. During 2012/13, the Council of Governors Nominations and Remuneration Committee carried out the following business:

- appointing a new non-executive director and re-appointing the Chairman for a further term
- approving the appointment of the new Chief Executive
- deciding on Chair and non-executive director remuneration (no increase).

Governance

The way the Trust is governed falls under the responsibility of the Trust Secretary, Justinian Habner. Importantly, the Trust Secretary provides advice and support to both the Council of Governors and the Board of Directors.

The NHS Foundation Trust Code of Governance

The Board takes account of the Code with the main and supporting principles being reflected in the Trust's relevant policies and procedures. In particular, the Trust's Constitution and Standing Orders are reviewed on an annual basis with the review taking account of the Code's provisions. The Trust Secretary advises the Board and Council of Governors on the main and supporting provisions of the Code.

The Board considers that the Trust is fully compliant with the provisions of the Code in all but the appointment of a Senior Independent Director. It was agreed with the Council of Governors that this was not appropriate for the Trust at this stage but the decision is kept under review.

Interests

The updated Register of Directors' Interests is available from the Trust Secretary on request.

Membership report

The Trust's Council of Governors plays a central role in the governance of the Trust. The main duties of the Council of Governors are to:

- appoint/remove the Chairman of the Trust and non-executive directors
- decide on the remuneration and terms & conditions of the Chairman and non-executive directors
- approve the appointment of the Chief Executive
- appoint/remove the Auditor
- be consulted in the setting of the Trust's forward business plans and any significant changes to services provided
- receive and approve the Annual Report, Annual Accounts and any Auditor's report on them.

During 2012/13, some parts of the Health and Social Care Act 2012 came into force which gave governors additional responsibilities and powers, including:

- deciding whether the Trust's private patient work would significantly interfere with its principal purpose or the performance of its other functions
- approving proposed increases in private patient income of five per cent or more.

The Council of Governors is made up of governors elected by our Foundation Trust members and appointed by partner organisations. The Trust's Chairman, Martin Howell, chairs the Council of Governors.

During 2012/13 the Council of Governors met quarterly in locations across Oxfordshire and Buckinghamshire. It was at these meetings that the Council of Governors resolved to meet in the same location – Thame, Oxfordshire – for all meetings in the future. Thame was selected given its relative centrality to the areas served by the Trust.

Meetings are held in public with the Board of Directors also in attendance.

Lead Governor

The Council of Governors has appointed a Lead Governor in line with Monitor guidance. During 2012/13 the following Governor held this role:

- Fiona Mackay Perkins – from November 2011 onwards.

In addition to the Lead Governor role set out by Monitor, the Trust's Lead Governor worked with the Chairman to plan meetings and the business of the Council of Governors.

The relationship between the Council of Governors and Board of Directors

The working relationship between the Council of Governors and the Board of Directors continues to grow and develop. Both executive and non-executive directors regularly attend meetings of the Council of Governors to present items on request and answer questions. At each meeting of the Council of Governors a non-executive director has provided a report on the Board's activities and decisions taken. A similar report on council business is presented to the Board of Directors following each Council of Governors meeting. Governors receive regular briefings out-of-session on key items including updates on Board of Director activity.

During 2012/13, the Council of Governors participated in some important business items including:

- appointing a new Non-Executive Director and re-appointing the Chairman for a further term
- approving the appointment of the new Chief Executive
- appointing new Trust auditors.

Informal seminars are also held during the year providing Governors with an opportunity to discuss in depth issues of concern to them and the Trust. One seminar was held jointly with the Board of Directors which provided the opportunity for governors and directors to consider the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Following the 2011/12 review of the way the Council of Governors worked, in addition to the already existing Nominations and Remuneration Committee, the following sub-groups of the council were established and met during 2012/13:

- audit sub-groups
- staff survey sub-group
- quality sub-group
- council information requirements sub-group.

The Trust maintains a Register of Governors' Interests which is available from the Trust Secretary, Justinian Habner, on request.

Membership activity

Between April 2012 and March 2013 a range of recruitment and engagement activities took place to promote the benefits of NHS Foundation Trust membership to the Trust's communities.

Attendance at public and Trust-organised events included:

- Trust Annual General Meeting, September 2012, Oxfordshire
- monthly Health Matters events in Oxfordshire from April 2012
- Health Matters events programme expanded to Buckinghamshire with first event in November 2012
- improving links with local higher education partners to support health events e.g. Oxford Brookes University, Bucks New University
- improving links with voluntary sector organisations to support health events e.g. Buckinghamshire Mind.

The Trust merged the membership newsletter with *Insight*, the Trust newsletter, to share more widely governor and membership news. There is a dedicated section in the newsletter.

Other membership activity throughout the year included:

- interviews with governors about involvement activity and support for engaging with constituents
- increased social networking messages relating to membership
- the use of a revised membership leaflet within mental health services, developed by service users and carers.

Over the five-year period (2011-2016) the Trust hopes to:

- develop a representative membership, with a continued focus on recruiting more service user/patient and carer members;
- develop a more informed and engaged membership;
- develop a more influential Council of Governors, which is closely informed by the Trust's membership;
- ensure membership information is widely and easily accessible; and
- empower members to act as ambassadors for the Trust, to share information about the Trust's services and promote the benefits of membership.

Membership recruitment and engagement is the responsibility of the Communications and Involvement Team.

Service developments

Throughout 2012/13 we continued in our mission to develop services that are accessible and integrated, providing the best possible health outcomes and support for patients and their families. This section outlines the main highlights from across our divisions and the counties.

Children and Families Division

Highfield Unit Oxford

This new Highfield Unit for young people with serious mental illness opened to patients in February 2013. Young people have been involved in the design of the new unit from the beginning and we were able to ensure that patients and their families had a chance to visit the unit prior to the move.

Highfield offers an exceptional therapeutic environment in which young people receive treatment and support for serious mental illness. There are 18 en-suite bedrooms as well as a state-of-the-art music suite, learning zone, gardens and gym. The new unit has two high dependency beds which enable more seriously ill young people to be safely cared for Highfield.

The Right Honourable Norman Lamb, Minister for Health, visited the Trust prior to the opening and was extremely impressed with the thought and planning that had gone into creating the bespoke environment for young people and their families. Young people have been at the heart of developing the new unit – working with the architect, creating and choosing art work and choosing colour schemes and furnishings.

The unit's multidisciplinary team will be enhanced by the first joint academic /clinical consultant psychiatrist post in CAMHS. Nursing staff numbers have also increased and activities across the day / evenings and weekends are planned as part of the wider therapeutic programme.

Health Visiting

The national 'Health Visitor implementation plan' runs from 2010 – 2015 and is the largest single workforce and service growth programme that the Department of Health has ever undertaken. Alongside a pledge to recruit and train more health visitors, it features a strong service transformation mandate aimed at providing better ways of supporting young families.

In Oxfordshire there are 40,000 children aged 0-5 years who will benefit from the new approach. The Trust is an early implementer of the national plan, with a major benefit being that our health visiting workforce will increase by 28% by 2015. The plan includes 'Ages and Stages', a national evidence-based tool for assessing child development at the age of two years. Ages and Stages is now embedded county-wide, and we are proud to be performing in the top quartile with 94% of two-year-olds completing the developmental assessment.

We are also improving the information we provide and promoting our services to help families access them more easily. A new leaflet was developed with the help of families and other key stakeholders to set out clearly what is on offer across Oxfordshire. The leaflet has been well received and an audit will be carried out in the summer to assess its effectiveness.

Our Family Nurse Partnership Service, part of a wider national initiative, is already providing support for 200 families where the mother is under the age of 19 at the time of conception. This is an evidence-based service which provides early intervention to families until their child is two. The programme aims to break familial cycles of deprivation by focusing on supporting a strong and positive attachment between mother and baby. It is based on over 30 years of positive evidence in the USA.

The service continues to cement its position as a leader in the development of health visiting nationwide. Oxford health visitors were chosen to present innovations at a national event hosted by the Department of Health in February. Viv Bennett , DH Director of Nursing and Principal Advisor on Public Health Nursing, also gave her seal of approval and complimented the workforce when she visited the Trust in July 2012 in celebration of 150 years of public health nursing.

For the future, health visiting will be commissioned by the NHS National Commissioning Board from April until 2015, when it will move to being commissioned by local authorities in line with other public health services.

Community Division

Single Point of Access and Discharge Pathway

A key objective for community health services in Oxfordshire is to work with health and social care partners to provide urgent care and support to older people at home at times of crisis. We are also here to support people to recover at home following major illness.

This type of care is aimed at supporting older people to remain independent for as long as possible, by reducing the time spent in acute hospitals when their needs could be met in the comfort and security of their own home.

Trust teams have been working closely with health and social care partners to develop and extend more integrated pathways of care. In the last year this has included:

- Implementing a joint single point of access (SPA) for people with complex and escalating health and social care needs. This means that referring professionals need contact only one service, which then coordinates the different elements of care to implement a plan that meets the individual patient's needs. The SPA also co-ordinates health and social care for adults being discharged from hospital.

- Implementing a supported discharge pathway between our Trust, Oxford University Hospitals NHS Trust and Oxfordshire County Council. This streamlines the processes across the different organisations to enable a better

co-ordinated and timelier discharge from hospital for older people with complex health and social care needs.

- Increasing the number of patients accessing our community hospitals and reablement services by around 25%. This means that more people are benefitting from rehabilitation and recovery at, or closer to, home.

Despite the very high demand on services over the winter because of the freezing weather conditions, these new and integrated ways of working are beginning to demonstrate real improvements for patients.

We will continue to work with local health and social care partners in both Oxfordshire and Buckinghamshire over the coming year to fully embed the changes and develop further the community urgent care pathways.

Choose and Book

From 5 December 2012, GPs have been able to make referrals for first outpatient appointments to the Oxfordshire Podiatry Service using Choose and Book. The Oxfordshire Podiatry Service is one of three pilot sites in our Trust that are implementing Choose and Book. The other pilot services are Muscular Skeletal Physiotherapy and the Dental Service.

The Trust is implementing the directly bookable (DB) method which will mean that patients will be able to leave the GP surgery with an appointment date and time.

The benefits of Choose and Book include:

- A reduction in the amount of time spent by administrative support staff in responding to patients' enquiries about the progress of referrals.
- A reduction in the number of patients not attending for appointments (known as DNAs) because patient's have the opportunity to choose the place, date and time of appointment convenient to them.
- The service can specify/highlight any helpful preliminary investigations/information about the patient to health professionals prior to the appointment.

Mental Health Division

Care clustering

In 2012 the Mental Health Division began the process of developing 'care clustering' for mental health across adult and older adult functional and organic conditions.

Care clustering uses a combination of measures from the Health of the Nation Scale (HoNOS) and the Summary Assessment of Risk and Need Scale (SARN) tools which are used throughout the psychiatric profession. The process involves each patient being clustered according to their psychiatric illness and their care needs.

The work has been supported by commissioners across both Oxfordshire and Buckinghamshire and the cluster specifications (packages of care including inputs, outputs and outcomes as well as predicted durations for treatments) were completed

and piloted in Oxford with City East, City West Community Mental Health Teams, Oxford Assertive Outreach Team and the Early Intervention Service.

The pilot approach involved trialing both care packages and care plans to make sure that they reflect and better meet the full needs of patients within each of the 20 cluster areas.

By December 2012 over 95% of open cases (around 10,000 patients) had a care cluster recorded and care plan templates were developed and saved onto the RiO electronic patient system. They are now acting as templates for staff to access and use to assess future patients' needs.

The pilot roll-out was completed in February 2013 and will be monitored in shadow form with the commissioners in 2014. The work on care clustering has informed a programme of service review and service modelling which commenced mid 2012, and will be completed later in 2013 by the division.

Specialised Services

Substance Misuse Services

A partnership between our Trust and OASIS drug services won a competitive tender to provide harm minimisation services for Oxfordshire as one of eight national 'payment by results' pilot sites in April 2012. This is an innovative national programme aimed at promoting the recovery of drug and alcohol users by incentivising services to motivate people towards complete abstinence.

The collaboration with the voluntary sector is benefiting the Trust by helping to foster a strong ethos of local service user and community involvement. OASIS is developing the 'OASIS republic', a recovery focused user network, which links users to employment, training, confidence-building and mentor training. User involvement was used at all stages of the new service's design, from inception to the plans for ongoing monitoring.

As part of the pilot our range of services has expanded from predominantly shared care clinics with GPs and prescribing focused clinics, to providing targeted outreach for new and designer drug users, hard to reach groups and alcohol related harms clients. A family and carer support programme has also been established.

The payments by results system means that the services are now monitored on tangible clinical outcomes and the transfer of patients to detoxification. This new transparency and information for patients on clinical outcomes is helping staff too, by showing where they are really making a difference.

The Trust continues to provide substance misuse services in Buckinghamshire where we also work closely with OASIS.

Workforce

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

Staff survey 2012

The annual national staff survey is a good indicator of how our staff are feeling, as it asks for their views in a number of important areas. In total a sample of 850 staff were sent the survey, with a 51% response rate which is currently the national average rate. The survey asks staff for their feedback in four main areas that represent pledges in the NHS Constitution. There were 28 key findings this year, compared to 38 key findings last year.

Staff engagement

Staff engagement is a key indicator in the staff survey, and regarded by the Board of Directors as central to delivering outstanding care. During the year a number of initiatives were implemented to provide more opportunities for staff to have their say and become involved in the decision-making of the Trust. The Trust was pleased to see this reflected in an above national average 2012 overall staff engagement score, which is broken down into sub-divisions covering:

- staff ability to contribute to improvement at work
- staff recommendation of the Trust as a place to work
- staff motivation at work.

Summary results table: An improving picture

The table below shows a summary of the 2012 results, which indicate continuing improvements at the Trust. In particular there is now only one area where we fall in the bottom 20% of trusts, which is around staff working additional hours. The key findings are ranked showing our top five and bottom five scores, as compared to national average performance. Out of the top five key findings, four put the Trust in the top performing 20% of organisations nationally for staff satisfaction.

	2012		2011	
Response rate	**Trust**	**National average**	**Trust**	**National average**
	51%	51%	51%	54%

	2012/13		2011/12		Trust improvement / deterioration
Top 5 ranking scores	**Trust**	**National average**	**Trust**	**National average**	**Increase/decrease in %**
KF4 **Effective team working**	3.91	3.83	3.80	3.81	0.11 improvement
KF16 **% of staff experiencing physical violence from patients, relatives or the public in the last 12 months**	15%	20%	8%	12%	7% deterioration
KF17 **% of staff experiencing physical violence from staff in last 12 months**	2%	4%	2%	1%	No change
KF19 **% of staff experiencing harassment, bullying or abuse from staff in last 12 months**	18%	21%	11%	13%	7% deterioration
KF22 **% of staff able to contribute towards improvements at work**	75%	71%	68%	66%	7% improvement
Bottom 5 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	**Increase/decrease in % points**
KF1 **% of staff feeling satisfied with the quality of work and patient care they are able to deliver**	75%	78%	68%	74%	7% improvement
KF3 **Work pressure felt by staff**	3.06	3.02	3.18	3.08	0.12% improvement
KF5 **% of staff working extra hours**	75%	70%	71%	65%	4% deterioration
KF6 **% of staff receiving job-relevant training, learning or development in last 12 months**	81%	82%	83%	80%	2% deterioration
KF9 **Support from immediate managers**	3.73	3.77	3.83	3.79	0.10% deterioration

The action plan

The Trust recognises there is always more to do to improve the working lives of our staff. We manage this agenda through a Wellbeing and Culture Group, with results from their work last year reflected in our improving scores. We were particularly pleased to see an improvement in the team working score, which is directly attributable to the Effective Team Working Initiative. This training programme is being rolled out across all areas of the Trust. Other key actions implemented in 2012 included:

Local surveys – To monitor progress against some of the survey-related challenges, we launched our own local survey in-year. This focused on particular themes to test whether initiatives at corporate and divisional level were having a positive effect.

Divisional action plans – These are now an annual requirement for divisions and incorporate specific issues from the staff survey which relate to individual areas. Action plan implementation is monitored through the Wellbeing and Culture Group and quarterly performance reviews.

Involvement of the governors – The creation of a Council of Governors' Staff Survey Committee was a new initiative for 2012. This involves governor representatives and meets at least quarterly to add an extra level of scrutiny to our planning and progress.

Addressing the problem areas

In 2013/14 the Wellbeing and Culture Group has been tasked with addressing the areas where the Trust's score has deteriorated since 2011. These include:

- Staff working extra hours
- Staff suffering work-related stress in the last 12 months.

New Wellbeing Strategy planned

The Staff Wellbeing and Culture Group has been working on developing a Wellbeing Strategy that will be central to improving staff engagement and satisfaction. The following initiatives were suggested in 2012 and are currently being considered by the group:

- four staff health and wellbeing days a year
- implementation of Mindfulness programmes
- development and trial of health walks schemes at main Trust sites
- increased access to Yoga/fitness classes at Trust locations
- a "Bike to Work'' scheme
- dedicated wellbeing section on the staff intranet
- an annual programme of public health campaigns, to share health advice and information with staff.
- a network of staff health & wellbeing champions
- a review of management and leadership development activities to incorporate messages about staff health, wellbeing and support

- revising the appraisal process to incorporate wellbeing.

Workforce monitoring

Workforce	Target	Actual
Staff sickness rate	3.5%	3.96%
% of staff with personal development reviews	100%	93%
Mandatory training completed in the last 12 months	100%	84% (all)
Use of bank and agency staff	5%	2.48%

The average staff sickness rate for 2012/13 was 3.96%, an increase from the previous year, but below the 2010/11 figure.

Human resources staff are now dedicated to specific areas of the Trust to work intensively on improving sickness rates with managers and Occupational Health. This involves reviewing the causes of absence and supporting staff better for a prompt return to work wherever possible.

We have also held sickness management workshops for staff with team management responsibilities and the sickness absence policy is under review.

Reward and recognition

The Trust is proud of its staff and their commitment to providing excellent care and the best possible experience for patients throughout the many services we run. This section is a round up of key accolades staff and the Trust received in 2012/13.

Recognising Staff Excellence

On 19 July we held our annual awards event which recognises staff members and teams who are working in innovative ways to improve patient care, support quality improvements and help us to achieve our values of caring, safe and excellent. Staff were nominated by colleagues and managers and the winners were:

Chief Executive's Innovation Award Winner
Living with Bipolar Disorder Support Programme – Central West Community Health Team, Buckinghamshire

Community Services Nurse of the Year
Sarah Gardner, Clinical Lead for Community Tissue Viability Service, Oxfordshire

Mental Health Nurse of the Year
Sharon Ryan, Clinical Nurse Lead, Marlborough House Inpatient Unit, Swindon

Therapist of the Year
Jill Higson, Occupational Therapist, Kimmeridge Ward, Buckinghamshire

Community Services Healthcare Assistant of the Year
Geraldine Southgate, Assistant Practitioner, Community Bladder and Bowel Service

Mental Health Healthcare Assistant of the Year
Fiona Johnston, Health Care Assistant, Community Acute Service, Buckinghamshire

Support Services Staff Member of the Year
Yoma Okiti, Domestic Supervisor, Didcot Community Hospital, Oxfordshire

Care Programme Approach Awards
100% Target - Oxford Adult North Community Mental Health Team, Oxfordshire
Most Improved team - Swindon CAMHS Community Mental Health Team, Wiltshire

Chairman's Special Recognition Award
Maureen Cundell, Older Adult Community Psychiatric Nurse, Oxfordshire.

RoSPA Gold Award

The Trust is celebrating winning one of the prestigious RoSPA (Royal Society for the Prevention of Accidents) Occupational Health and Safety Awards for 2012. This is the seventh year running that the Trust has been awarded the Gold Award for occupational health and safety.

The RoSPA Awards are not just about reducing the number of accidents and cases of ill health at work; they are also aimed at ensuring that organisations have good health and safety management systems in place.

Top three trusts for research activity

We were proud to be named as one of the top trusts leading the way in providing opportunities for patients to take part in clinical research studies.

A league table published by the National Institute for Health Research (NIHR) Clinical Research Network details the number of studies undertaken by each individual Trust, and the number of patients they recruit into those studies. For the first time this year the table also categorises NHS trusts into organisations with similar characteristics, which allows comparisons to be made between trusts in similar circumstances.

The Trust currently features in second place in the Mental Health Trusts category having conducted 42 studies, which was an increase of seven studies since the last published results.

Special Commendation – Lifeblood VTE Awards

Dr Brian Murray, Clinical Director - Older Adult Mental Health Services, has led a team which was awarded a “Special Commendation” in the Best VTE (Venous Thromboembolism) Prevention Programme in the Lifeblood VTE Awards 2012.

Brian and team led on the development of a risk assessment form adapted for use in mental health services (less emphasis on surgical risks, but drawing attention to recent research on the use of anti-psychotics and VTE). This form is now used as standard practice with all inpatients, and was launched in tandem with training and education programmes.

Working alongside colleagues from the Community Services Division, the form is helping staff to share their experience and knowledge of managing VTE from a physical health aspect.

Department of Health Nursing Visit

Boundary Brook House played host to a special visit from the Department of Health on 1 February. Viv Bennett, Director of Nursing, and Jane Cummings, Chief Nursing Officer met with teams from across the Children and Families, Community and Mental Health divisions to discuss the innovative ways Oxford Health has been integrating care.

This was part of a wider visit, to see how Oxfordshire is delivering compassionate excellence in healthcare. The visit also included Oxford University Hospitals NHS Trust and Oxford Brookes University, where nursing students who had undertaken placements with the Trust were also included.

Children and Young People’s IAPT visits

The Trust, in partnership with the Charlie Waller Institute at the University of Reading, is running a three-year programme for Children and Young People’s

Improving Access to Psychological Therapies (CYP IAPT). CYP IAPT provides clinical training in therapies for depression, anxiety and behavioural problems.

On 6 February we hosted two high profile visits, one with representatives from the Treasury and the other with the Minister for Care and Support Services, Norman Lamb. Both visits provided an opportunity to showcase the CYP IAPT work so far and included young people who have used services and their families.

Safer Care collects its first award

The Community Acute Services (CAS) in Oxfordshire and Buckinghamshire, part of the Mental Health Division, were formally recognised for their outstanding contribution towards patient safety at the Safer Productive Care Celebratory Conference in 2012.

Community dieticians recognised for their research

Two of the Trust's community dieticians recently attended the British Dietetic Association (BDA) Research Symposium and received awards for their research projects.

Liane Reeves completed her MSc in Allergy, through the University of Southampton, with distinction this year. Her project, completed with the Food Allergy and Intolerance Specialist Group of the BDA and titled 'Learning needs of registered dieticians working with individuals with food hypersensitivities in the UK', won the practice evaluation stream.

Susan Ovington, who is a newly registered dietician, won the best newcomer to research stream as part of her BSc in Nutrition and Dietetics final year research project titled 'A multi-centre randomised trial to assess whether increased dietary fibre intake (using a fibre supplement or high fibre foods), produces healthy bowel performance and reduces laxative requirement in free living peritoneal dialysis patients'. Susan studied at The University of Surrey and completed her project with a distinction.

Equality

Oxford Health NHS Foundation Trust is committed to equality of opportunity for all people and to eliminating unlawful discrimination, harassment and victimisation. We recognise and value the diversity of both the communities we serve and our workforce.

We are using the NHS Equality Delivery System (EDS) to progress our equalities work. This framework helps us to make sure that patients, service users, carers and staff are treated fairly. Using the EDS we identified the following actions for 2012/13:

- The Trust will improve information so that more effective comparisons can be made. This will include improving the quality of data on religion or belief, sexual orientation and disability.
- The Trust will improve information from complaints during the year, including recording how many complaints are received which directly relate to equality issues.
- The Trust will investigate how managers and team leaders support staff to work in culturally competent ways.

The Trust has achieved the following progress against these actions over the last 12 months:

- We established that our patient information systems can be used to record eight out of the nine protected characteristics covered by equality law (age, gender, race, religion or belief, sexual orientation, disability, pregnancy and maternity, and marriage and civil partnership). We discovered however, that we could only report on age, gender, race, and religion or belief. Also we found some gaps in the information across services. To tackle this situation the Trust has improved the information system and developed new ways of reporting. We have also worked with services to improve the collection of equalities information.

- The Complaints Team has entered into their database the known protected characteristics of everyone who has made a complaint since April 2012, so allowing a better analysis of trends. The team has also put in place complaints monitoring for equality issues as part of their weekly reporting processes. During 2012/13 there were six complaints about specific equality and diversity issues.

- The Trust identified that managers and team leaders use a range of tools to support staff to work in culturally competent ways. For example, supervision, attendance on equality and diversity training, completion of equality impact assessments, clinical assessment and admission checklists. We found some good practice, but approaches need to be more consistently applied as part of day-to-day practice.

During 2013/14 the Trust will build on these achievements by working on a new set of actions. The focus for the coming year will be on using equalities information to improve access to our services and health outcomes for the diverse communities we serve. The actions include:

- Continuing to work with services to close gaps in the equalities information we hold.
- Creating an equalities information page on our intranet so that staff have easy access to data that can inform decision-making, policy and service development.
- Completing equality analyses of our service remodelling projects, in order to make sure we shape services around the needs of all patients.
- Completing an equality analysis of the PALS and Complaints Service to identify areas for improvement and take action where needed.
- Delivering the actions set out in our developing staff Health and Wellbeing Strategy.
- Providing deaf awareness training to key teams.

The diversity of our workforce

The Human Resources Department has taken the data below from the Electronic Staff Record system to help show the diversity of our employees:

- The workforce is predominantly female, which reflects the pattern across the NHS.
- Since the integration of community health services and mental health services in Buckinghamshire and Oxfordfordshire, the percentage of male employees has reduced by 0.5%. This reflects the overall increase in staffing within professions that are traditionally female-orientated.
- 46% of staff are aged between 45 and 64 years. In key staffing groups such as qualified nurses, 67% of the current workforce is aged 40 or above. Oxford Health NHS Foundation Trust currently follows the national trend of the potential to lose 16% of its qualified nursing workforce to retirement over the next five years.
- There has been a small increase in staff identifying themselves as 'White: British' of 1.6% and reduction in employees within other ethnic groups.
- The ethnic make-up of the workforce is diverse, with nearly 15% of staff coming from a black or minority ethnic background.
- The number of staff from a 'Black or Black British: African' background is around 4% higher than the percentage of the total population found in both Oxfordshire and Buckinghamshire.
- Although the number of 'undefined' fields for disability has fallen each year, the level of 48.4% in December 2012 remains significant. This may reflect a reluctance amongst staff to declare that they have a disability due to a perception that it may have a negative impact. The level of disability in the general population is around 20%, and the proportion increases with age.
- The number of 'undefined' fields in the Electronic Staff Record for 'religious belief' has gone down by 7.8% over the last three years.
- Oxford Health employs a lower proportion of people of Christian faith than is present in the local population (39% compared to just over 60% of the population in Oxfordshire and Buckinghamshire).
- The next largest identifiable religious belief of our employees is Islam (1.2%).
- There remain a significant percentage of 'undefined' fields for religion or belief.

Contracted staff as at:	31/12/2010		31/12/2011		31/12/2012	
HEADCOUNT	**5819**		**6051**		**6216**	
Gender						
Female	4766	81.9%	4957	81.9%	5107	82.2%
Male	1053	18.1%	1094	18.1%	1109	17.8%
Age Band						
16-24	307	5.3%	262	4.3%	324	5.2%
25-44	2661	45.7%	2814	46.5%	2878	46.3%
45-64	2725	46.8%	2812	46.5%	2862	46.0%
65+	126	2.2%	163	2.7%	152	2.4%
Ethnic Origin						
A White - British	4498	77.3%	4547	75.1%	4772	76.8%
B White - Irish	103	1.8%	109	1.8%	106	1.7%
C White - Any other White background	281	4.8%	300	5.0%	333	5.4%
D Mixed - White & Black Caribbean	19	0.3%	16	0.3%	21	0.3%
E Mixed - White & Black African	16	0.3%	21	0.3%	21	0.3%
F Mixed - White & Asian	18	0.3%	22	0.4%	21	0.3%
G Mixed - Any other mixed background	23	0.4%	19	0.3%	25	0.4%
H Asian or Asian British - Indian	118	2.0%	127	2.1%	145	2.3%
J Asian or Asian British - Pakistani	31	0.5%	36	0.6%	42	0.7%
K Asian or Asian British - Bangladeshi	3	0.1%	5	0.1%	8	0.1%
L Asian or Asian British - Any other Asian background	72	1.2%	74	1.2%	77	1.2%
M Black or Black British - Caribbean	76	1.3%	83	1.4%	86	1.4%
N Black or Black British - African	296	5.1%	328	5.4%	363	5.8%
P Black or Black British - Any other Black background	11	0.2%	16	0.3%	17	0.3%
R Chinese	23	0.4%	25	0.4%	22	0.4%
S Any Other Ethnic Group	60	1.0%	70	1.2%	68	1.1%
Z Not Stated	171	2.9%	253	4.2%	89	1.4%
Disabled						
Yes	92	1.6%	88	1.5%	109	1.8%
No	2238	38.5%	2316	38.3%	2837	45.6%
Not Declared	144	2.5%	232	3.8%	261	4.2%
Undefined	3345	57.5%	3415	56.4%	3009	48.4%

Feedback, complaints and compliments

The Trust takes all feedback – comments, complaints and compliments – very seriously and aims to act on feedback as quickly as possible. Complaints especially are seen as a valuable source of information from which the organisation can learn.

Complaints summary

A summary of the number of complaints received can be found in the Quality Account on page 82.

Trends

The Trust has seen the number of complaints rise, with 278 received in 2012/13 compared to 203 in the previous year, equating to a 37% increase. The NHS Information Centre and Parliamentary Health Service Ombudsman (PHSO) have both reported that complaints to NHS trusts rose between 2010/11 and 2011/12, and the Trust's figures for 2012/13 show this trend continuing.

The top three themes for complaints were:

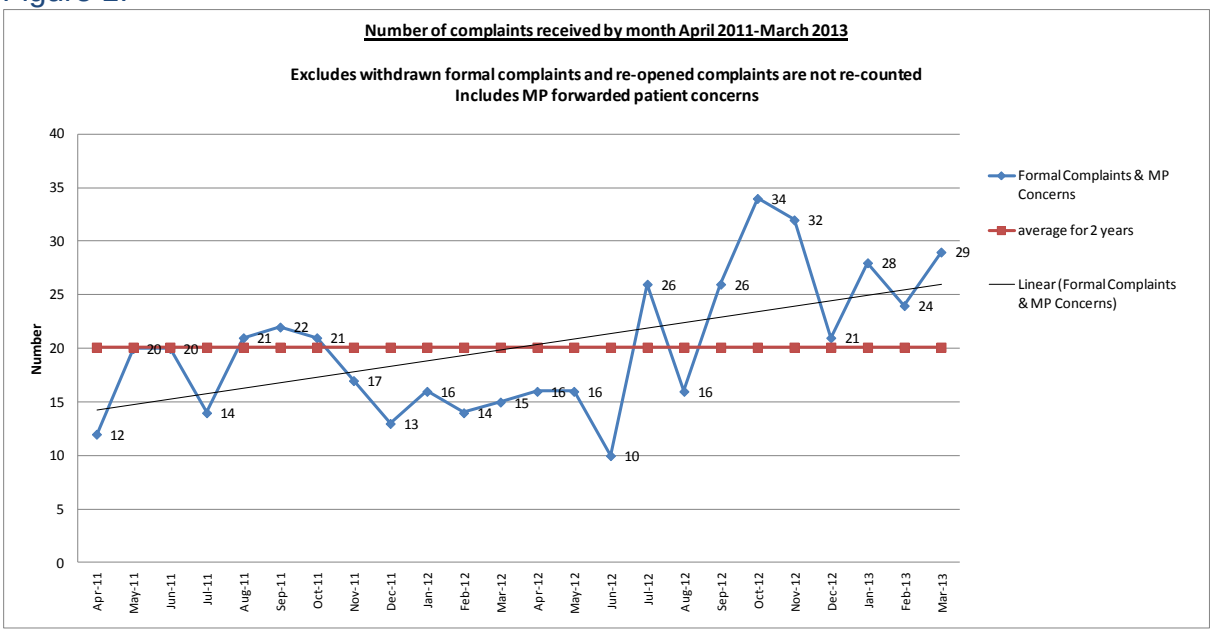
1. Communication, e.g. poor/inappropriate communication on decisions about care, explaining service provision and involving/informing carers and relatives
2. breach of confidentiality
3. inpatient discharge either delayed, too quick or a lack of planning and arrangements.

Of the 225 complaints received and closed (excluding those withdrawn), 118 (52%) had at least one concern (not necessarily the primary concern) well founded.

Referrals to the Parliamentary Health Service Ombudsman (PHSO)

A total of 14 complaints were referred to the PHSO in 2012/13, with the level of review and involvement from the PHSO varying. An additional three cases referred to the PHSO prior to 1 April 2012, have since been closed and one complaint case remains under review. Ten out of the 14 cases referred to the PHSO have been closed, and of the closed cases one has resulted in actions being recommended by the PHSO. The actions have now been completed.

Figure 1.



**The 278 figure excludes cases which are withdrawn by the complainant and resolved informally. If a complaint is re-opened as the complainant is not satisfied with the response and/or outcome then this is not re-counted, but a continuation of the initial complaint is registered. The 278 figure also includes those complaints jointly coordinated and responded to with other NHS or health and social care providers.*

Compliments

In addition to monitoring complaints the Trust logs the number of compliments received, and is pleased to report an increase from 2011/12 to 2012/13. The increase is partially due to a drive to encourage clinical services to always share and report compliments when they receive them.

Some examples of compliments received are shown below.

Inpatient-based services

The following extracts are from mothers who wrote on behalf of their children who received treatment from an older adult mental health ward and the crisis service:

"The treatment he received at A Ward... was extremely competent, professional and sensitive. My son was very impressed by the standard of care he received throughout and feels a deep debt of gratitude to all the staff he engaged with."

"A big thank you to the team for all the help and support the family received with our son while in Crisis. We are very grateful."

These extracts are from wives writing on behalf of their husbands' care on adult acute mental health wards:

"We would like to say a big thank you for your part in helping my husband become well again. And thank you for your kindness and care to both of us. You were and are very supportive."

Patients wrote about the care they received from a child and adolescent mental health inpatient ward and the community hospitals:

"Staff very helpful, go out of their way to help you, really helpful."

"It is excellent here [at the community hospital], staff are as helpful as they possibly can be, even when they are busy they still make time for you."

A sister wrote about the care her brother received:

"We would like to thank you all for your kindness and dedication shown to our brother during his time in your care."

Community-based services

The following extracts are from patients about our:

Eating Disorder Service
"Your reassurance, knowledge and, most of all, your patience have enabled me to believe in myself and to believe in my future. You are wonderful!"

Psychological Therapy Services
"I was very satisfied with my time and experience. It was extremely helpful. My therapist was very kind and easy to talk to."

Community Therapy Reablement Service
"Thank you for motivating me and designing an exercise programme for me, all the best, please keep in touch."

Children's Speech and Language Team
"Your understanding and empathy for us was so appreciated. You have been such a support and we are delighted with the progress."

Out-of-Hours Dental Service
"This has been one of the best dental experiences I have ever had."

Luther Street Medical Centre for homeless people
"...quite literally you did all save my life and for that I will be eternally grateful."

Contraception and Sexual Health Service
"All staff and doctors very kind, friendly, helpful and supportive. Thank you very much!"

For further detail about the themes, outcomes and actions taken following complaints can be found in the Trusts Annual Complaints Report, available from the Complaints Team.

Estates strategy and sustainability

Over the course of the year, work continued on updating our Estates Strategy to make sure it is aligned with the Trust's strategic vision and service requirements.

We adopted a number of guiding principles to inform decisions about premises, and are working proactively toward the creation of better quality inpatient and support environments. The recent structural changes to the NHS as part of the Health and Social Care Act 2012 have meant that the Trust has been transferred 12 properties from Oxfordshire Primary Care Trust. These include a number of community hospitals, which will allow us to make better use of the facilities as part of an integrated and seamless network of services.

Investment

Two new units

We have continued to invest in improving our current buildings and facilities and this year expenditure was over £24 million. Highlights include the opening, in February 2013, of the new Highfield Unit on the Warneford Hospital site (see page 19). This unit provides an 18-bed inpatient ward, along with educational and recreational space for young people with acute mental health needs. The building is widely regarded as among the best of its type, with many aspects of its design developed in consultation with patients to help ensure it provides a supportive environment to aid their recovery.

Construction work on a new replacement hospital in Aylesbury has continued and remains on schedule for completion in later in 2013/14. The old Manor House Hospital in Aylesbury was demolished in 2010 to make way for the development of new dedicated facilities, and work has continued on the environment which will care for adults and older people with mental health needs. This has included increasing the floor space to incorporate more community-based services, the development of an acute day hospital and an outpatient suite, as well as the 80-bed inpatient unit.

The overall budget for the redevelopment of the Manor Hospital site increased to £43 million during the year to reflect enhancements to the plans. Key staff and stakeholders have played an integral part in the development of the overall design by sharing their ideas and views.

Other projects

Other notable works successfully completed in 2012/13 include a new central Pharmacy Unit and the extension of an existing Clinical Trials Unit at the Warneford Hospital site in Oxfordshire, in conjunction with Oxford University. We also launched a three-year programme of improvements to a number of inpatient wards and departments.

Energy and sustainability

Continuing from the previous year, an assessment was made of the benefits of implementing an Environmental Management System, with a view to obtaining accreditation for ISO14001, an internationally recognised standard.

Specialist consultants have been commissioned to complete a scoping study, and the outputs from this study will form an outline business case. This will set out the benefits of implementing the system for the Trust, along with the likely resource and cost implications. At this early stage it is anticipated that the key benefits are likely to include:

- a comprehensive, structured approach to environmental impacts which draw activities from waste management to procurement into one place
- better identification of cost savings from waste disposal, fuel and energy use
- integration of the impacts from working across a diverse estate with other issues, such as energy and waste
- clear traceability of legal compliance with environmental legislation
- clearer information about our impact on the environment for stakeholders.

Carbon Management Plan

Working to the principles of the Carbon Management Plan, the programme to introduce new high efficiency heating plant continued with the commissioning of the new Highfield Unit. The unit uses ground source heating pumps to heat the buildings boosted by high efficiency condensing boilers during times of peak demand; and photo voltaic panels are used to generate electricity.

Engineering designs have also been completed to prepare the way to install combined heat and power generators at the Littlemore Campus site. This is a technology that generates electricity on site and uses the cooling water to provide a heating source. The installation will take place during 2013/14.

Summary of sustainability and energy performance

Area		Non-financial data	Non-financial data	Non-financial data		Financial data cost (£)	Financial data cost (£)	Financial data cost (£)
		2010/11	2011/12	2012/13		2010/11	2011/12	2012/13
Waste minimisation and management	Absolute values for total amount of waste produced by the trust	629 tonnes landfill 89 tonnes clinical waste	1,019 tonnes landfill 120 tonnes clinical waste	850 tonnes landfill 119 tonnes clinical waste	Expenditure on waste disposal (excluding recycling)	113,222	156,561	178,180
Finite resources	Water Electricity Gas	34,052m^3 4,547,340 kwh 14,266,200 kwh	57,482m^3 9,765,090 kwh 25,461,586 kwh	58,808m^3 9,090,296 kwh 22,596,683 kwh	Water Electricity Gas	143,687 579,639 476,304	210,509 1,132,815 984,185	215,237.28 1,093,835.52 903,867.32 *

*2012/2013 financial figures are an estimate based on utility consumption data

Section 2 - Quality Report and Account 2012/13

Part 1. Statement on Quality from the Chief Executive

Chief Executive Statement

As Oxford Health NHS Foundation Trust reaches the end of its second year as a combined mental health and community services Trust, the initial benefits of becoming an integrated mental health and community services organisation are starting to be realised: specifically this has meant becoming an integrated organisation and reducing organisational boundaries to providing integrated care in Oxfordshire. Consequently, it has led to a more ambitious strategy for integrated care with key stakeholders in Oxfordshire, Buckinghamshire, Swindon, Wiltshire and Bath & NE Somerset.

Our core purpose is to ensure that patients have a positive experience of care whilst enhancing outcomes, recovery and quality of life. We set ourselves the expectation of embodying our values to be "*Caring, Safe and Excellent*".

Our staff are skilled in delivering care and treatment to meet increasingly complex health and social care needs in community and hospital settings that must be underpinned by fundamental behaviours such as care and compassion.

Looking back over the year that ended on 31st March 2013, this year's Quality Report details our progress against ambitious and wide-ranging quality improvements. It sets goals for a large number of our services, giving prominence to some for which historically we have little information published, such as with Universal Children's Services. I am pleased to report that the majority of these goals have been met and many exceeded, adding value to the thousands of people who come into contact with our services. For those people who have had less than an optimal experience we shall strive to make further improvements to the care we deliver to ensure we learn from this experience. I should add that to the best of my personal knowledge, the information contained in this document is accurate.

For the forthcoming year 2013/14, we are in transition: setting goals for further quality improvement whilst transforming our models of care and developing new care pathways. Each pathway will have inbuilt standards for quality including measures of patients' experience, clinical outcomes and safety. We intend to publish our performance against these quality standards once the pathways are operating.

We have set out intentions this year to enhance patient and public involvement and to further develop self-management of individuals' care, particularly for people with long-term conditions, supported by care packages that are chosen by the individuals themselves to suit their needs. The routine use of personal health budgets in continuing care has been a major success this year and can be used more widely to benefit more patients.

We have opened a state-of-the-art adolescent mental health inpatient facility, Highfield, in Oxfordshire and we are mid-way through the building of the new mental health facility in Aylesbury, Buckinghamshire.

Over the last year we have begun to integrate care to reduce overlaps and make our care more personalised. We have met all of our statutory and regulatory standards and we are formulating ambitious plans for 2013/14 and beyond to develop integrated care pathways to further improve patients' experience and outcomes in the Trust and its partners.

Executive leadership on the Board has changed entirely over the last two years: Julie Waldron, who was the CEO in Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust for 12 years prior to the formation of Oxford Health NHS Foundation Trust, retired in August 2012; the Chief Operating Officer and the Director of Human Resources & Organisational Development have also both moved to new roles within the NHS; Yvonne Taylor has joined the team as Chief Operating Officer and I joined the Trust in October 2012.

It is clear from the Quality Report that a huge number of quality initiatives have been taken to improve patient safety, experience and outcomes this year. I would like to record my personal gratitude to everyone who has contributed towards these achievements. This is a solid foundation for the formation of models of integrated care next year: building in standards for excellent experience, outcomes and safety. We shall report and publish our quality improvements in detail by the end of 2013/14 as we implement our new models of integrated community and mental healthcare.

Stuart Bell
Chief Executive
30 May 2012

Executive Summary

The following is a summary of the major achievements from last year, on-going problems and the challenges for next year.

Enhancing patient experience

- During 2012/13, we have received a wealth of real time patient experience feedback from patients using a variety of methods: hand held devices, postal and paper surveys, PALS and complaints comments, compliments and PALS Surgeries. We value the feedback and use this rich source of information to make improvements to enhance experience.

- Where individual experience of care or performance at a service level appears to be unsatisfactory, prompt action is taken to address the areas of poor practice down to team level where appropriate. For example, we have developed ward action plans for Fiennes, Sandford, Allen and Portland mental health inpatient wards. These action plans generally arise from reviewing learning from complaints and Serious Incidents. We have responded to Commissioners' feedback regarding the need to further improve the physical estate at Marlborough House, Milton Keynes. We had three serious incidents in the two wards there and we have comprehensive plans to address each of these.

- We also have a programme in place to reduce the incidence of pressure ulcers in the District Nursing Service. Two District Nursing Teams had a small cluster of avoidable pressure ulcers and the whole team caseload was subsequently reviewed. We undertook themed analysis and review in three community mental health teams for which there was more than one apparent suicide during 2012/13.

- The annual CQC community mental health survey results this year were disappointing, showing that patients want to see improvements in "knowing who their care coordinator is" and "knowing what their care plan is". Blue folders with the relevant information in are now being given to every adult mental health patient to address this shortcoming.

- Improving patient experience remains a top priority for the forthcoming year. We expect the remodelling of our services to achieve better integrated care focussed on care pathways to significantly enhance patient experience. Meanwhile, priority areas for improvement - areas where feedback is not as good as we would want it to be – have been identified as community mental health and inpatient services. Working towards external accreditation validated by the Royal College of Psychiatrists such as AIMS (Accreditation for Acute Inpatient Mental Health Services) will provide externally accredited standards to be met which are intended to enhance patients' experience.

- We have improved access to Hospital at Home services significantly this year, which means more people are being cared for at home. District nurses have done well to support an increasing proportion of people who choose to die at home.

Community hospitals have successfully used hourly contacts with patients to ensure their immediate needs are being met.

- In the Children and Young People's IAPT Service (Improving Access to Psychological Therapies), piloting of session-by-session outcome measures has been successful. We are using the You're Welcome accreditation system in Children and Young People's Services. We met 31 out of the 36 criteria in our first year.

- It is our intention to build patient experience measures into every clinical pathway and report and publish patient experience at a service and team level starting in the forthcoming year.

- A new initiative that started last year was to support veterans from the armed forces with the overarching aim to better identify service veterans within our services and assess their needs in relation to their forces experiences to enable appropriate treatment or signposting if required. The resulting programme addresses the issue through a series of workstreams agreed in conjunction with veterans' representatives. This major initiative will be continuing through this current year.

Patients will be protected from harm and treated in safe environments

- Patients' safety has remained a priority to prevent people from dying prematurely. Our safer care programme has made good progress particularly in the Mental Health Division. Safer care work in the Buckinghamshire and Oxfordshire Crisis Resolution and Home Treatment Teams has been successful in reducing community suicides of people using crisis services. Crisis teams are using "Always Events" standards that must happen for every patient and this appears to be improving safety and outcomes. By contrast, suicides of people using crisis services nationally are rising and these outcomes (albeit at an early stage) appear to be significant. The teams have been shortlisted for a national patient safety award for their work.

- We have enhanced our resuscitation training which has led to improvements in our overall practice.

- Upgrading our environments to ensure they are equipped to provide safety, privacy, dignity and well-being has been a priority this year and will continue into 2013/14. We are aware of the need to upgrade our environments, particularly the inpatient mental health wards, with the Warneford Hospital in particular. This year and through to the next, ward environment upgrades are taking place in Wintle, Vaughan Thomas, Phoenix and Marlborough House Milton Keynes. Our new Mental Health Hospital and Community facility for Buckinghamshire in Aylesbury will be open by January 2014, replacing the John Hampden Unit at Stoke Mandeville and the Tindal Centre.

- We remain committed to reducing the rate of serious infections to a minimum in our wards. This year we have had 10 people who have contracted clostridium difficile (C. Diff) infections. Our analysis has shown that our hygiene practices were not a factor and there were no cases of transmission occurring. C. Diff infections can be

influenced by antibiotics and our reviews showed patients were appropriately prescribed antibiotics to treat serious infections. Regrettably, this had an undesirable side effect on some individuals becoming susceptible to C. Diff infections.

- Rapid access for treatment of cardiovascular events has been enabled through the new 111 service.

- The National Patient Safety Thermometer has been introduced in community hospitals and teams, and Older Adults' Mental Health Services. This measures levels of harm and our "Safer Care" programme will ensure we continue to improve outcomes to reduce avoidable harm.

- We set an objective to reduce the number of patient falls by 5% and this has been achieved by ensuring adequate falls assessments and prevention plans.

- We had concerns regarding the number of patients with avoidable pressure ulcers using District Nursing Services and so have developed a new leg ulcer pathway which, in its pilot phase, has much improved healing rates. We plan to roll this out to all teams throughout 2013/14.

The quality of life for people with long-term conditions will improve

- This Quality Account details a wide range of improvement activity that has taken place to improve the quality of life for people with long-term conditions. We have used patient reported outcome measures (PROMS) and observed a reduction in time in hospital for people with long-term illness as a measure of success.

- Notable achievements include:
  - The successful use of the "East Kent Outcomes System" (EKOS) for use in assessing rehabilitation of stroke patients.
  - A self-monitoring system, known as Oxtext 7, led by Oxford University whereby patients take responsibility for continuously monitoring their own conditions.
  - Although significant improvement was made, one of our CQUIN targets not met was to improve the flow of patients through beds to ensure they have the right care quickly. Working collaboratively with our partners at Oxford University Hospitals and Oxfordshire Social Care puts us in a better position for further improvements next year.
  - Another CQUIN target that we did not achieve was the level of breastfeeding that Commissioners set for the Health visiting services. We remain committed to improving this. If breastfeeding is not established within the first 10 days post-delivery, it is difficult to establish subsequently. The Health Visitor's role in maintaining breastfeeding once established is critical, as is the importance of supporting patients to manage their own condition.

- There have been some exciting developments this year with the routine use of personal health budgets (PHB) in continuing healthcare. Everyone is now offered the option of a direct payment, and the accounts from patients are remarkable on how this has significantly improved their quality of life. Next year, routine use of personal health budgets to enable patients to make choices about their lives will be

a core component of our new models of care in order to assist people with long-term conditions having greater control over their healthcare.

- Next year we shall improve patient and public engagement learning from the achievements in our children and family services.

- The publication of the second Francis Report has been discussed and debated within the leadership teams in Oxford Health NHS Foundation Trust and by our Board of Directors and Council of Governors jointly. We have tried to ensure that the quality priorities we have set out for the year take account of the lessons and recommendations of both Francis enquiries. We are focussing on achieving safe, caring and excellent care for every patient.

Part 2a. Looking Forward: Priorities for Improvement 2013/14

Priorities for Improvement 2013/14

Our quality priorities for 2012/13 were intentionally diverse: highlighting quality improvements across the wide range of community and mental health services within Oxford Health NHS Foundation Trust.

Feedback received within the year from the Board of Directors and Governors identified this was too detailed for the Quality Report, hampering clarity and risking loss of focus on a few large priorities. Consequently, we have amended the way in which we identify our main priority areas for 2013/14 in the light of experience.

This year, we have identified a number of discrete priority areas, or "Quality Activities", that link back to the Trust's Strategic Framework. In selecting these priorities, and articulating what we hope to achieve within them, we have been mindful of both the local and national context, as well as feedback from service users, staff, governors and external bodies such as Monitor, the Care Quality Commission, commissioners and LINks.

The improvements in each area were selected by considering the requirements and recommendations from the following sources, some examples of which are shown after each, which we have sought to include within our own priorities given in the following pages:

- Department of Health
    - National priorities
- Care Quality Commission
    - Quality Risk Profiles
    - Feedback from visits
    - National patient and staff surveys
- Monitor
    - Reporting requirements, particularly in the Statement of Directors' Responsibilities towards the Quality Report, Quarterly Governance Declarations and Governance Framework.
- NHS Buckinghamshire and Oxfordshire cluster (lead commissioners)
- Oxfordshire Local Involvement Network (LINk)
    - Personalisation of care, care for people with disabilities and localisation of services
- Oxfordshire Health Overview and Scrutiny Committee (HOSC)
    - In- service integration, access issues, suicide rates, localisation of services
- Buckinghamshire HOSC and Buckinghamshire LINk
    - Importance of community care support
    - Equality of access to services through GPs
- South Central Specialised Services commissioners and Swindon Wiltshire, Bath and North East Somerset and Milton Keynes Commissioners

- Internal assessment of Care Quality Commission (CQC) Outcome compliance
    - Review of Prevention and Management of Violence and Aggression procedures
- Internal audits
    - Improvements in monitoring specific aspects of care
    - Enhancements in training in particular areas
    - Modifications to certain methods of working
- Serious case reviews
- Formal feedback from coroners

The priority Quality Activities, and the link to the Trust's strategic framework, are summarised in Table 1. Details are given for each in the following pages.

Table 1

Strategic Framework	**Quality Framework**
Goals	**Quality Activity**
Improving Patient Safety	1. Specific improvements in patient safety
	2. Prevention of suicides
	3. Infection Control improvements
	4. Environmental Improvements
Improving Clinical Outcomes	5. Develop and implement integrated care pathways for children and young people
	6. Develop and implement integrated care pathways for adults
	7. Develop and implement integrated care pathways for older adults
Improving Patient and Carer Experience	8. Trust-wide improvement of culture of care
	9. Improve patient and public engagement
	10. Measuring and Improving Patient, Carer and Commissioner Feedback
Delivering Efficient and Effective Services	11. Productive Care
	12. Use of technology to support care

Improving patient safety

This is one of the key domains defined by the Department of Health in their document NHS Outcomes Framework 2013/14[1] and has been adopted as one of the main strategic goals of the Trust.

Objectives

The specific objectives associated with this goal are:

[1] http://www.dh.gov.uk/health/2012/11/nhs-outcomes-framework/

- People will not die prematurely.
- Patients will be protected from harm.
- Patients will be treated and cared for in a safe environment.

Measures and targets

Measures and targets that we shall be monitoring to ensure that we are achieving these goals include:

- Unexpected deaths and serious harm in inpatients reduced to 0, or greater than 300 days between deaths over 2 years
- Absence from wards without permission reduced by 50% from 192 detained patients in 2012/13 to 96 in 2013/14
- Reduction of medication adverse events by 50% in 2013/14 to 12
- Harm from falls reduced by 50% from 2.9 per 1,000 bed days in Mental Health Hospitals and 10.1 per 1,000 bed days in Community Hospitals in 2012/13 to 1.5‰ and 5.1‰ respectively in 2013/14[2]
- Pressure ulcers (grade 2-4) reduced to 0, or greater than 300 days between incidents over 2 years
- 95% compliance with VTE (venous thromboembolism) risk assessment and appropriate prophylaxis
- 95% compliance with triggering of physical deterioration intervention
- Catheter associated urinary tract infections (UTIs) with a view to establishing a baseline for targeted reduction in subsequent years
- No inpatients to commit suicide
- Reduction in the number of community suicides
- Number of bacteraemia infections contracted should not exceed last year's
- Number of C. Diff infections contracted by inpatients (a target for this is currently under discussion)
- Number of unsatisfactory environmental infection control audits and number of reaudits with a view to establishing a baseline for targeted reduction in subsequent years
- Level of hand hygiene scores maintained at greater than 95%

The Quality Activities we shall be undertaking to support the strategic goal of Improving Patient Safety are:

Specific improvements in patient safety

Reasons for inclusion
To support the NHS South of England Safety Collaborative Project to reduce harm to patients using community and mental health services, by focussing on four specific areas for improvement.
Aims • Providing senior leadership for safety. • Delivering safe and reliable mental health care. • Getting medicines right. • Improving physical care of patients.

[2] In this document, the symbol ‰ is used to indicate "per mille" i.e. "per thousand", compared to % for "per cent" meaning "per hundred"

Milestones

- Review of progress after 6 months to review future activities.
- Review of targets after 6 months.
- Goals to be achieved within 2 years.

Prevention of suicides

Reasons for inclusion

Suicide is among the top 20 leading causes of premature death globally with nearly one million deaths per year. The new national Suicide Prevention Strategy emphasises a reduction in suicides in high-risk groups, one of which is people in the care of mental health services. We shall support the NHS South of England initiative in understanding the incidence and nature of suicides and attempted suicides in the region with a view to reduce their number.

Aims

- Analyse the occurrences of suicides and attempted suicides.
- Liaise with all interested parties across all units to investigate counter-suicide measures.
- Identify evidence- based and best practice.

Note: although suicide rates will continue to be monitored as part of the overall Trust metrics, there is no direct link between this project and such numbers at this time.

Milestones

- Report with recommendations at the end of 2013/14.

Infection control improvements

Reasons for inclusion

The National Agenda from the Department of Health is to drive down infection rates.

Aims

- Extend the infection control audit programme to include a greater number of community teams.
- Meet the environmental cleanliness standards.
- Ensure best practice for anti-microbial prevention to minimise incidents of C. Diff.

Milestones

- Completion of the annual work programme of infection control by April 2014.

Environmental improvements

Reasons for inclusion

To ensure fit for purpose environments that are compliant with CQC Outcome Standards on Safety and Suitability of Premises.

Aims

- Reduction of ligature points.
- Improvements to privacy, dignity and security in Mental Health inpatient wards and forensic services.
- Completion of the new Buckinghamshire inpatient and community facility in Aylesbury, Buckinghamshire.
- Securing the transfer of the Community Hospital Estate to Trust ownership.

• Addressing community sites with low levels of cleanliness and infection control scores.
Milestones • New hospital to be open by January 2014 for both adults and older adults in Buckinghamshire. • Refurbishment of Vaughan Thomas Ward completed by April 2014. • Refurbishment of Wintle Ward completed by April 2015. • Refurbishment of Phoenix in two phases – 1st phase to be completed April 2014, 2nd phase by April 2015. • Identified risk items addressed on Allen ward due for completion April 2015.

Improving clinical outcomes

Another of the key domains defined by the Department of Health in their document NHS Outcomes Framework 2013/14 is Improving Clinical Outcomes for Patients and this too has been adopted as one of the main strategic goals of the Trust. The main focus of our Quality Activities is in the remodelling of many our services to give a better, more efficient and more rewarding experience for our patients/service users by integrating the separate functions at a much closer level, in particular those of the mental health and community health services.

Objectives

- The quality of life for people with long-term conditions will improve.
- Patients/service users will feel supported to manage their own conditions.
- People with long-term conditions will spend less time in hospital.

Measures and targets

- Number of patients/service users treated in community setting.
- % of adult service users on CPA in settled accommodation.
- % of adult service users on CPA in employment.
- Number of patients/service users with Long Term Conditions receiving. Improvement of Access to Psychological Therapies (IAPT).
- % engagement of patients/service users with care plan.
- Responses to specific survey questions.
- % mental health readmission to community hospitals.
- Number of patients/service users with Personal Health Budgets (PHB).

Develop and implement integrated care pathways for children and young people

Reasons for inclusion To improve the quality of care and efficiency by providing a better integrated service for children and young people rather than having separate discrete services.
Aims • Integration of Children's Services. • Managing transitions for children and young people into adult services. • Development of CAMHS inpatient pathway.
Milestones • Integration by March 2014.

- Completion of transition and inpatient pathway by March 2015.

Develop and Implement Integrated Care Pathways for Adults

Reasons for inclusion
To improve the quality of care and efficiency by providing a better integrated service for adults rather than having separate discrete services.

Aims

- Review and redesign Early Intervention Service.
- Review and redesign Complex Needs Service.
- Improve inpatient experience and outcomes.
- Improve long-term conditions pathways for adults.
- Integrate locality-based community mental health services.
- Develop psychological medicines services care pathway.
- Review of provision and associated estates issues in Forensic Services.
- Develop eating disorders service care pathway.
- Develop integrated psychological therapies pathway.
- Improve inpatient adult mental health pathways.

Milestones

- Milestones being developed as part of the project planning.
- All adult wards to achieve AIMS accreditation by 2015.

Develop and implement integrated care pathways for older adults

Reasons for inclusion
To improve the quality of care and efficiency by providing a better integrated service for older adults and those with long term conditions rather than having separate discrete services.

Aims

- Integration of locality beds.
- Develop integrated pathway for dementia care.
- Implement multidisciplinary assessment unit care pathway.
- Integration of locality teams.
- Develop interface medicine.
- Integration with partnership working in Buckinghamshire.
- Development of rehabilitation therapies care pathway.
- Development of long term conditions care pathway.
- Implement next phase of the Single Point of Access initiative.
- Develop new pathways and processes.

Milestones

- Overall milestones being developed as part of the project planning.
- Completion by March 2015.

Improving patient and carer experience

The third of the key domains defined by the Department of Health in their document NHS Outcomes Framework 2013/14 is Improving User Experience, which we have defined as patients and carers in the strategic goals of the Trust.

Objectives

- Patients' experiences of inpatient/outpatient services will improve.
- Responsiveness to patients' needs will improve.
- Patients' access to community-based services will improve.

Measures and targets

- Number of complaints
- Monthly average number of Delayed Transfers of Care (DTOC).
- Responses to specific survey questions.
- Environmental cleanliness assessments.
- Friends and Family measures.
- Carers' assessments.

Trust-wide improvement of culture of care

Reasons for inclusion We need to ensure that the experience of care for all users of our services feels caring and compassionate. Moreover, we must ensure that the Trust cares for and supports staff to provide a quality service.
Aims • Develop and begin implementing a strategy for caring within the Trust in the professions commencing with nursing. • Develop clear standards and competencies to define care. • Implement values-based recruitment. • Develop a system to affirm values periodically. • Address the weaknesses in the staff survey. • Develop the Trust's Wellbeing and Culture Group.
Milestones • To be determined during the year as the project progresses.

Improve patient and public engagement

Reasons for inclusion Understanding the experiences of all users of our services and all stakeholders in the Trust is essential to identify the strengths and weaknesses of what we provide. We must therefore ensure that the mechanisms by which we communicate with these groups are as effective as possible, whilst at the same time promoting an environment of transparency in what we do.
Aims • Develop and implement a new involvement model within Mental Health. • Implement the Carers' Strategy. • Develop and implement a new model for public and membership involvement.
Milestones • To be determined during the year as the project progresses.

Measuring and improving patient, carer and commissioner feedback

Reasons for inclusion There are many sources of information about the quality of our services and it is necessary to ensure that such data is collated and responded to. It is then important that any resultant actions are properly identified, monitored and implemented.
Aims • Improve the quality and frequency of feedback to clinical teams using real time feedback, PALS information and complaints and productive wards data.
Milestones • To be determined during the year as the project progresses.

Delivering efficient and effective services

One of the major challenges that face every NHS Trust is to improve the overall efficiency and effectiveness of their services in addition to improving the quality of care provided to our patients/service users, carers and families. It is with that end in mind that the Trust has incorporated it into its strategic framework and so is included in this Quality Account as an important quality goal.

Objectives

- Utilisation of resources will be maximised.
- Time spent on patient care will be maximised.
- Patients/service users will progress through the care system in a timely way.

Measures and Targets

- Specific measures on the Productive Dashboard.

Productive Care

Reasons for inclusion To release increasing amounts of time to care, thus improving quality and patient/service user experience.
Aims • Roll out improvement programme to clinical services within the remaining parts of Community Services Division. • Implement the Productive Care foundation module in Universal Services Children and Families Division. • Implement the Productive Care sustainability model in Mental Health Inpatient settings, Community Mental Health Teams (CMHT), Community Nursing Service and community hospitals. • Develop and cascade quality assurance tools along with appropriate measurements for improvement. • Support Specialised Services Division: Forensic Wards and Mental Health services in prisons. • Roll out of e-rostering to designated community services and other areas as appropriate.
Milestones • 100% coverage of Trust-wide clinical teams by end of 2013/14.

- E-rostering in designated community services by end of quarter 2 2013/4.
- E-rostering in other areas to complete by end of 2013/14.

Use of technology to support care

Reasons for inclusion

One of the key methods of improving the efficiency and effectiveness of our services is through judicious use of technology to help redeploy valuable resources to where they are better needed.

Aims

- Improve mobile technology to reduce duplication and cut down travel.
- Develop remote patient monitoring and recording.
- Promote increased self-help and use of on-line or telephone contacts replacing face-to-face contacts where appropriate.
- Roll out of Choose and Book to agreed services.

Milestones

- Choose and Book implemented by end of 2013/14.
- To be determined during the year as the project progresses.

Part 2b. Statements of Assurance from the Board of Directors

Review of Services

During 2012/13, the Oxford Health NHS Foundation Trust provided and/or sub-contracted 26 NHS services.

The Oxford Health NHS Foundation Trust has reviewed all the data available to it on the quality of care in all of these relevant health services.

These services are based on the Divisions within the Trust during 2012/13 that were:

- Mental Health Division
    - Oxfordshire Adult and Older Adult Services
    - Buckinghamshire Adult and Older Adult Services
- Children and Families Services Division
    - Child and Adolescent Mental Health and Specialist Services
    - Eating Disorders
    - Psychological Therapies
    - Children's Services e.g. Health Visiting, School Nursing
    - Children's Therapies
    - Public Health Services
    - Children's Nursing Services
    - Contraception and Sexual Health Services
- Specialist Services Division
    - Forensic Services
    - Drug and Alcohol
    - Prison Health
    - Community Dental
- Oxford Community Health Service
    - 8 Community hospitals providing inpatient care
    - District Nursing and Specialist Nursing Therapies
    - Urgent Care Services
    - Dietetics
    - Speech and Language Therapy
    - Podiatry
    - Musculoskeletal Physiotherapy
    - Rehabilitation Service
    - Reablement Service
    - Care Home Support Service
    - Case Management
    - Crisis Response Service

Each of these divisions reviews service provision through quarterly performance meetings, monthly clinical governance meetings, quarterly performance and quality reports and patient feedback. The data reviewed covers the three dimensions of quality: patient safety, clinical effectiveness and patient experience. The amount of

data available for review has not impeded this objective to effectively review the quality of performance.

Participation in clinical audits and national confidential inquiries

During 2012/13, four national clinical audits and one national confidential inquiry covered relevant health services that Oxford Health NHS Foundation Trust provides.

During 2012/13 Oxford Health NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the national confidential inquiries of the national clinical audits and national confidential inquiries which it was eligible to participate in.

The national clinical audits and national confidential inquiries that Oxford Health NHS Foundation Trust participated in, and for which data collection was completed during 2012/13, are listed below in table 2 alongside the number of cases submitted to each audit or inquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

Table 2

Audit or Inquiry	**Participation (Yes or No)**	**Number of Cases Required by Terms**	**Number of Cases Submitted**
National Audit of Psychological Therapies	YES	n/a	n/a
POMH-UK Topic 2: Screening for metabolic side effects of antipsychotic drugs	YES	n/a	81
POMH-UK Topic 12: Personality Disorder	YES	n/a	49
POMH-UK Topic 11: Prescribing antipsychotics for people with Dementia	YES	n/a	202
POMH-UK Topic 4: Prescribing Anti-Dementia Drugs	NO[3]		
National audit on fever in children (urgent care)	NO[4]		

The reports of four national clinical audits were reviewed by the provider in 2012/13 and Oxford Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (table 3). Other reports have been received and are due to be reviewed.

[3]This audit has been withdrawn by POMH UK and will take place during 2013/14 (Planned for October 2013)

[4]Following submission of 50 cases the Trust was informed that this national audit should be identified as 'not applicable'

Table 3

Title of National Audit	**Agreed actions to improve the quality of healthcare**
POMH-UK Topic 10b: Prescribing antipsychotics for children and adolescents	• Checklist/aide-memoire produced for prescribers summarising the recommended physical monitoring requirements. • Young person's information leaflet produced explaining why blood tests and physical health monitoring are necessary. • Survey has been designed and circulated to gather data on barriers to physical health monitoring.
POMH-UK Topic 2: Screening for metabolic side effects of antipsychotic drugs	• Mental Health Division is proposing to include the physical health monitoring for antipsychotic drugs, produced by Pharmacy as a template on RIO in the CPA section. This should provide a prompt for the required monitoring as part of the CPA process.
POMH-UK Topic 1f and 3c, Prescribing high-dose and combination antipsychotics (Note: Data collection in 2011/12)	• Patients now have access to electronic information regarding their medication regime. • Aide memoire completed for anti-psychotic prescribing – the same is to go onto the help function of RIO. • British National Formulary size versions of the ready reckoner have been made available to clinicians to easily calculate "high-dose" antipsychotic prescribing and facilitate access to information regarding the effect of combining antipsychotics on the percentage maximum dose prescribed. • Green stickers put on the charts by pharmacy as a reminder for high dose monitoring. • High dose form to be completed by consultant before initiation of high dose antipsychotics. Pharmacy ensures this is done. • Pharmacy is in the process of updating high dose guidelines, which are available on the intranet.
POMH-UK Topic 12: Prescribing for people with a Personality Disorder	• Complex Needs Service plan to develop a leaflet for service users to provide information on what to do in a crisis.
National audit of Schizophrenia	• The Prescribing Observatory for Mental Health (POMH) reviewed the data

Title of National Audit	Agreed actions to improve the quality of healthcare
	submissions and published the report in December 2012. An action plan is still in development but the following are in progress: ○ Development of personalised information packs for patients including details of their care co-ordinator and a copy of their care plan. ○ Plans are in place to develop a similar care pack of information for carers. This has been discussed with our Carer Governors and their feedback incorporated to ensure the pack meets their needs. ○ Pilot project at Tindal to review how we can engage more successfully with carers which will review existing groups and provision for carers, review of the present level of information provided to carers and a review of the present level of engagement.

The reports of nine local clinical audits were reviewed by the provider in 2012/13 and Oxford Health NHS Foundation Trust intends to take actions to improve the quality of healthcare provided as identified in Annex 3. Another thirteen local clinical audits were undertaken and will be reported in 2013/14.

Participation in clinical research

The number of people[5] receiving relevant health services provided or sub-contracted by Oxford Health NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee is 1,983 at the time of writing, though around an additional 210 are anticipated before the final year-end figures are received.

The final figure for last year (2011/12) was 2,359 participants.

Use of the CQUIN payment framework

A proportion of Oxford Health NHS Foundation Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Oxford Health NHS Foundation Trust and any person or body they entered into a

[5] Note that this includes patients, staff members, healthy volunteers and anyone else who participated in a research study by this Trust

contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2012/13 and for the following 12-month period are available online at:

http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

There were six separate CQUIN schemes agreed with our commissioners for 2012/13:

- Oxfordshire and Buckinghamshire Adult and Older Adult Services
- Oxfordshire and Buckinghamshire Community Services
- Forensic Specialist Commissioning Group
- Swindon CAMHS
- Buckinghamshire SLT Contract
- Wiltshire and BaNES CAMHS and Eating Disorders.

Details of these CQUIN goals together with our attainment levels are shown in Annex 4. The income from the CQUIN contracts is shown in Table 4 below.

Updates on progress against each goal are reported in the Quality Report presented to the Board of Directors quarterly and available on the Trust Website.

Table 4 Income from CQUINs 2012/13

Commissioner	Mental Health Amount	% of Contract Value	Community Services CQUIN Amount	% of Contract Value
NHS Oxfordshire	£1,055,322	2.5%	£2,017,000	2.5%
NHS Buckinghamshire	£804,642	2.5%	£1,826	1.5%
Wiltshire & BaNES PCT	£159,146	2.5%	n/a	n/a
Northants	£14,159	2.5%	£7,163	1.5%
Swindon PCT	£59,777	1.5%	£3,228	1.5%
East of England SCG	£8,442	1.5%	n/a	n/a
Warwickshire PCT	£228	2.5%	£1,085	1.5%
South Central SCG	£652,150	2.5%	n/a	n/a

Statements from the Care Quality Commission

Oxford Health NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The CQC has not taken enforcement action against Oxford Health NHS Foundation Trust during 2012/2013.

Oxford Health NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during 2012/13.

The CQC undertook 11 unannounced inspections of inpatient mental health facilities across the Trust. Additionally, there was 1 announced visit to review the

arrangements for detained patients in hospital looking at assessment and application for detention, discharge from detention, aftercare and supervised community treatment as part of their normal 3-year cycle of inspections.

The CQC have also conducted 3 routine full essential standard compliance inspections across a number of Trust services in 2012/13. The locations inspected were the John Hampden Unit, Harding and Cromwell Wards in Stoke Mandeville, Wintle Ward at the Warneford Hospital Oxfordshire and Bullingdon Prison. The inspection reports are published by the CQC and can be found on the CQC website using the following link http://www.cqc.org.uk/directory/RNU.

For the 3 formal reports that we have received, 11 different outcomes were assessed; 9 outcomes were found to be fully compliant across all 3 services. The areas of minor concern were: Outcome 20 about the process of notifying the CQC of incidents relating to any abuse or allegation of abuse (the action was completed and the CQC confirmed the area was compliant in Jan 2013); and concerns with Outcome 10 were identified in 2 services regarding the safety and suitability of premises: mitigating actions are in place to minimise the impact on patient safety until building work is completed.

Following each inspection by the CQC the Trust develops an action plan to address the areas of improvement that is submitted to and monitored by the CQC.

The Trust had an announced visit by the CQC in January 2013 to review the arrangements for detained patients in hospital looking at assessment and application for detention, discharge from detention, aftercare and supervised community treatment. The review focused on residents of Oxfordshire County Council.

This is a summary of the feedback from the CQC:

"Throughout the two days of our visit we heard of a considerable amount of good practice some of which we would like to commend services on in this report... In general we received positive feedback from patients about their experiences of the process of assessment and admission under the Mental Health Act (MHA). We learned that, in general, staff were kind and welcoming and made the experience of detention as positive and constructive as possible. Patients were introduced to a member of staff who would be their point of contact for the first few hours of admission...We saw evidence of the effectiveness of the multi agency protocol...we found evidence of good communication between police, ambulance, health and social services... We were also impressed with the level of skills, experience and dedication manifest in the AMHPs we met".

The areas of action identified were to:

- Consider additional options for alternatives to admission
- Consider the challenges of having one Place of Safety facility for assessment
- Improve the environment of the current Place of Safety
- Develop a better understanding of each agencies role; specifically the role of the Crisis Service

- Improve effectiveness and response of transporting patients to mental health services
- Improve the experience of carers during assessment and admission
- Develop a service user group and ensure involvement in strategic and operational levels
- Work with our GPs to improve compliance with Code of Practice 4.73 (at least one of the Section 2 Doctors has previous acquaintance with the patient being assessed)
- Improvement of bed management processes

Quality of Data

Oxford Health NHS Foundation Trust submitted records during 2012/13 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:

- which included the patient's valid NHS Number was:
  - 99.6% for admitted patient care (Mental Health);
  - 100% for admitted patient (Community Health
  - 100% for outpatient care; and
  - 97.4% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was:
  - 67.2% for admitted patient care (Mental Health);
  - 65.2% for admitted patient care (Community Health);
  - 70% for outpatient care; and
  - 4.6% for accident and emergency care.[6]

Oxford Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2012/13 was 82% and was graded green (satisfactory).

Oxford Health NHS Foundation Trust will be taking the following actions to improve data quality:

- We ensure all relevant committees within the committee structure receive sufficient data quality assurance
- The Completeness and Validity report is now generated quarterly
- Continue to improve the clinical coding by ensuring staff refresh their National Clinical Coding Qualification.

[6] This is because most appointments have "GP unknown", which does not register as a valid code

Part 3. Looking Back – Priorities for Improvement 2012/13

Introduction

Last year, 2012/13, our Quality Account for Oxford Health NHS Foundation Trust set out ambitious programmes in the areas of safety, patient experience and outcomes, some of which were to be achieved over the following two to four years. We separated the associated quality measures into five broad areas that matched the NHS' own key quality initiatives and defined them so that they would accurately cover the important and immediate areas of quality improvement. Details of these priorities and the progress we have made are outlined as follows.

User experience

We regard information from surveys, both national and local, and of patients' and service users' experiences, as essential to inform us of the quality of care we provide. Last year we continued to extend our use of such surveys in line with our intentions. Our Governors review progress quarterly and they requested that the Patient Experience Domain is placed at the front of the Quality Report to emphasise its importance.

Patients' experiences of inpatient/outpatient services will Improve

Identified Initiatives

The following is a summary of progress on our actions last year:

- Building the new Highfield inpatient ward for young people and adolescents was completed on time and opened in January 2013. This is a high quality environment for 18 children and young people with mental health problems.

- The building of a new mental health hospital and community facility in Aylesbury, Buckinghamshire on the former Manor House site continued during the year. In anticipation of its opening in December 2013, many new practices have been adopted such as delivery of clinical care models, mobility of community staff and trialling of new IT solutions. The prospect of moving into the new facility has given the Mental Health Division a real and exciting opportunity to explore new and different ways of working for all services that will be based there.

- The wearing of uniforms in CAMHS mental health services was trialled in Swindon and Sandford Ward, Fulbrook Centre to great acclaim. Feedback from service users, family and staff was very positive, with staff feeling a greater sense of belonging and of pride in their appearance.

- New prioritisation methods were introduced into the five prisons and the Young Offenders' Institute in order to improve waiting times for health services. Note

that from 31st March we shall not be providing primary health care to HMP Bullingdon.

- During 2012/13, there has been a 13% increase in referrals received: this growth has mainly been in referrals from acute hospital providers for follow-up rehabilitation. A lot of work over the past two years has been carried out to absorb increases of referrals without increasing waiting times, leading to a small drop in the average waiting times during 2011/12 and early 2012/13, but which subsequently started to creep up with the overall increase in referrals. In the 4th quarter of 2012/13, Choose and Book was introduced and by the end of the year, a GP could book a first appointment for a patient within 5 weeks, however there was an average of 15 weeks wait in referral to treatment across the county.

- Over 300 service users contributed to a survey into alternative user satisfaction measures as part of the health visiting Call for Action programme. This has resulted in the publication of a new Health Visitor service information leaflet and revised patient satisfaction questions for the 2012 patient survey.

- Productive Care is a coordinated programme of work aimed at supporting front line staff to make improvements where they work in order to release time to care for patients and improve patients' experience and outcomes of care. The programme is live across all four clinical divisions and there are many examples of "improvement in action" across services. A celebration conference was held in February 2013 in order to share learning and good practice and reward achievements. A roll out plan for remaining services is in place for 2013/4.

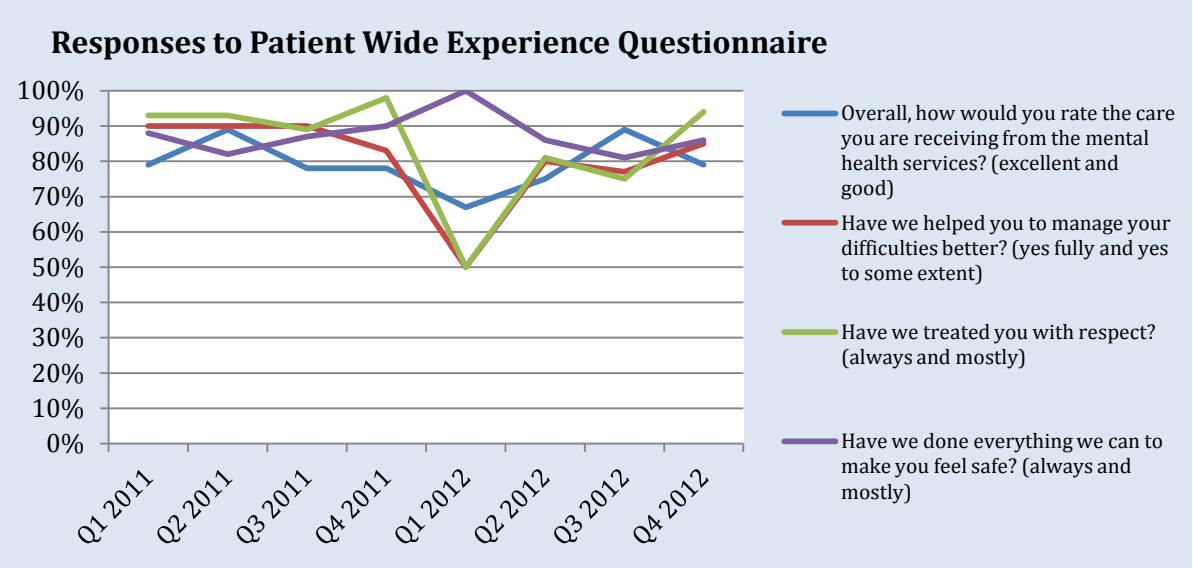
- A new evidence-based developmental assessment tool "Ages and Stages" has successfully been implemented for all children aged 2 years in Oxfordshire this year. This is a universal check of every child undertaken by Health Visitors with the intention of picking up early any developmental or psychosocial issues that may otherwise not be detected until a child starts school and may hamper early educational achievement and social integration. In Child and Family Services, this has led to the development of a new paediatric pathway, increasing integration with Oxfordshire County Council Early Years Services. Audits demonstrate improved user experience and involvement.

- Patient experience surveys in Mental Health and Community Services have used different ways of gathering feedback from patients. In Mental Health Services, hand-held electronic devices have been used. In Community Services, postal and paper-based surveys were used. The results are shown below in the section "Oxfordshire Community Health Services Patient Survey".

Aims

- The results of our own patient-wide questionnaire showed a mixed picture in the four questions asked, although all show at least a high 75% satisfaction level. Note that the figures for the first quarter were anomalous as the hand-held devices were not working to receive feedback. See Chart 1.

Chart 1.



- For mental health patients, the percentage that responded positively in the monthly service users' survey has risen from 78% at the end of last year to 83%.
- The Trust was judged at 6.3 out of 10 for the overall care provided in the 2011 Annual Community Mental Health Services Survey (the same as last year); this was below the average for other Trusts. Further details are given later in the section "Mental Health Community Survey 2012".
- Parental uptake of the 2-year developmental assessments has improved, being currently 94% compared with a target of 90% and baseline of 74% last year. This level of achievement is amongst the highest in England.
- Our target of 90% to measure the height and weight of children in reception and year 6 was exceeded at 92.5% in July 2012. The figures are reported at the end of each academic year and so will not be available for the previous year until July 2013.

"The food is excellent, the nursing care has been great, they talk to each other and it is clear that they get on well as a team"
Community Hospital Patient

Responsiveness to patients'/service users' needs will improve

Identified Initiatives

- It is our intention to enhance the support for people wanting to die at home, a lot of progress was made last year working with District Nurses, and "High Rate" GP practices (those with a higher proportion of palliative patients who die in an acute setting). Early indications suggest that the Trust is performing well against this performance requirement.

- Patient wellbeing checks were implemented in stroke pathway, Emergency Medical Unit patients and Fracture Neck and Femur patients. Further rollouts to other areas within existing pathways continue to be examined.

- Complaints within the Prison Service fell slightly from 12 in 2011/12 to 11 in 2012/13

- A bespoke patient experience survey in the Addictions Harm Minimisation Service was conducted in 2012 and the resulting report is awaited.

- We successfully implemented session-by-session outcome measures for Children and Young People in CAMHS IAPT services.

- One initiative that was introduced this year was an extensive programme to support service veterans from the armed forces with the following aims:
    - To improve awareness of and access to Oxford Health services for veterans and their families.
    - To improve signposting to our services and appropriateness of referrals of veterans by GPs.
    - To improve our engagement with veterans.
    - To improve staff awareness of mental health needs of service families and veterans and equip them with the knowledge and skills to provide high quality, safe and effective services to these groups of service users.
    - To identify and address gaps in services provided to veterans and service families in order to offer a seamless needs-led service to all who require it.

This project is now well underway and will be continuing into 2013/2014

Aims

- 99% of patients on the End of Life Community Matron Caseload have a care plan supporting people's choice to die at home.
- We have been progressing towards our application for the "You're Welcome" accreditation in Children's Therapies and after an initial audit where we achieved 31 of 36 criteria, we produced an action plan that is in the process of being implemented. We anticipate carrying out another audit in 2013, prior to submission for accreditation.

"*...feels that the NHS and Wenric in particular have been excellent and nothing but supportive to her son over the years*."
Patient's Relative, Forensic Ward

Patients' access to community-based services will improve

Identified Initiatives

- The Single Point of Contact (SPOC) and 111 service to improve access to community-based services for referrers was introduced in 2012.

- Community nursing skills were augmented to extend the scope and volume of the Hospital at Home (H@H) initiative, including starting an overnight H@H service, thus allowing sub-acute patients to be managed on a 24 hour, 7 days a week basis.

- Good progress was made in piloting Routine Outcome Measures (ROM) and Self Referral within CAMHS as part of the Young People IAPT project last year. In particular, integrated pathways for delivery for acutely ill children in the community and in hospital have been developed and implemented. OUH paediatric Clinical Decision Unit is now working 8am to 8pm to support this.

- After a successful pilot exercise, home-based community treatments in line with the care clustering packages have been rolled out for all new patients in all Community Mental Health Teams.

Aims

- The number of patients assessed and treated in community settings as part of the Hospital at Home initiative rose from 105 at the end of 2011/12 to 170 by the end of 2012/13.
- Disappointingly, in the National Community Services Survey carried out on behalf of the DH, the responses to the questions showed that we were "about the same" for all questions, except for the first, which was worse than the average (see details in the Mental Health Community Survey 2012 below).

Adult acute mental health ward patient's relative said:
"I recognise that my daughter doesn't fit your usual mould of patient, in that the ward is managing her eating disorder as well as her mood. However, I am impressed with the time staff have spent in trying to understand and learn about this aspect of her care and the empathetic support given to her, especially at mealtimes!"

Patient Safety

People will not die prematurely

The main initiative last year to prevent people in our services dying prematurely was the Leading Improvement in Patient Safety (LIPS) programme, which transformed into the "Oxford Health Safer Care Programme". This programme incorporated the

development of the concept of the Safety Thermometer and ensuring that all divisions have their Head of Nursing as the Safer Care Lead.

Identified Initiatives

- In the Mental Health Division, there is a well-established Crisis Services Workstream that is working towards reducing death by suicide and improving the service for carers. Within PICU (Psychiatric Intensive Care Unit), a review of the use of the Health Development Agency is underway. In Community Mental Health Teams, the Head of Nursing is leading a workstream on Safer Duty Systems.

- Within Specialised Services, the focus has been on implementing a nutritional assessment and care plan for 100% of patients to encourage them to lose body weight. A screening tool for under nutrition and over eating has been introduced. A Safer Restraint project also started last year, starting with the establishment of comprehensive recording of restraint practice.

- The Children's and Families' Division has a Reduction in Restraint workstream on Highfield Unit focussed upon the assessment of, and care planning for, escalation triggers and calming interventions. Work also continues on the inpatient services at Marlborough house on developing and implementing Wellness Recovery Action Plans (WRAP) and standardising admission processes.

- Arrangements to deliver Deliberate Self Harm (DSH) training using multi-agency groups were established in BaNES, Wiltshire and Swindon. We led the development of a multi-agency set of guidelines for self-harm in Swindon that was formally launched in March. We continued to work with our three acute hospitals around their DSH protocols to ensure young people receive care in line with NICE guidance.

- Refurbishment plans completed last year included:
    - New Highfield unit at Warneford Hospital
    - Upgrade to the Special Care Room at Oxford Clinic
    - Clinical Trials Unit
    - Cotswold House, Oxford
    - Thames House extension
    - Wallingford CMHT
    - Rectory Road , Oxford
    - Infrastructure upgrades at Warneford and Car Parking safety works.

- Access to rapid access to treatment for cardio-vascular events was enabled through the new 111 treatment service. There were no emergency cardio-vascular events occurring in the Out of Hours service, indicating that the 111 service is ensuring rapid access to alternative services for these events.

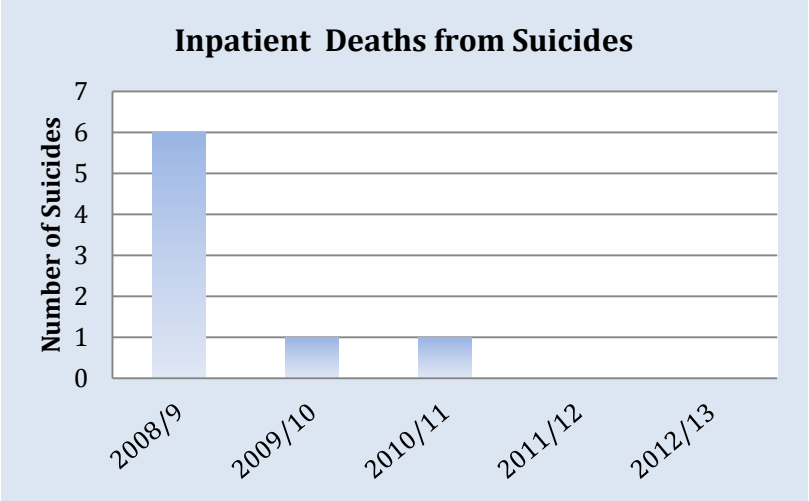
- A protocol was developed for making reasonable adjustments for people with learning disabilities to address the nationally identified excess mortality for this patient group. There is now an associated on-going action plan.

- Oxford Health is an Early Implementer site (supported by DH) in implementing the National actions in respect of Health Visiting strategy. This has entailed establishing a Multiagency Programme Board to monitor the overall progress along with an internal programme board, growing the workforce including associated training and developing an improved Maternity/Health Visiting pathway. Key outcomes are to improve the delivery of the Healthy Child programme and strengthen early intervention and attachment theories into clinical practice. This year we have focussed and improved the maternity and Health Visitor pathway, increased the leadership role of Health Visiting within children centres and improved coverage of key assessments particularly at 2 years of age.

Aims

- There were no suicides by inpatients or patients on leave in the Trust last year or the previous year. There was one death during 2012/13 that might possibly be classed an inpatient suicide but as this depends on the coroner's verdict, it has not been included in Chart 2.

Chart 2



- The number of apparent community suicides was approximately 46 last year, which is a slight rise on the equivalent period last year (44). Note that these are "apparent" suicides, which means that the Coroner has yet to give a judgement so that the actual number of suicides may be lower than appear at present. This increase appears to be in line with national trends (source: National Confidential Enquiry on Suicides).
- It is our aim to be fully compliant with the Access to Healthcare for People with Learning Disabilities standard. An audit in October 2012 gave us a score of 21 out of 24, resulting in key actions being taken in the Carers' Strategy and the Communication and Involvement Strategy.

"...quite literally you did all save my life and for that I will be eternally grateful..."
Medical Centre Service User

Patients will be protected from harm

Identified Initiatives

- We are adopting a phased approach to implementing the Safety Thermometer initiative in Community Hospitals, District Nursing and Older Adult Mental Health teams as defined in the national Commissioning for Quality and Innovation standard (CQUIN). Community Services has an established dashboard for inpatient services and this is being developed for other services in line with the "productives" programme implementation as part of a phased approach. Progress to date has been according to plan.

- The new Child Protection Service Model has been implemented across Divisions. The following actions have been completed:
    - Safeguarding Children Team in place with additional Named Doctors in post
    - New safeguarding children training strategy implemented - delivering integrated locality based training to all staff.
    - Community Contract KPIs achieved.
    - Safeguarding Children advice and support available to all staff and group supervision in place for specific services.
    - Safeguarding work priorities in place for Call for Action Health Visiting programme.

- The Buckinghamshire Children and Adolescent Mental Health Services (CAMHS) model was fully operational at the end of the year.

- The Crisis Services in Oxfordshire were remodelled to improve patient safety. All calls into the Crisis Team are now call handled by the Out of Hours Coordination Centre, in both counties. This team is also able to take referrals for the team – thus creating capacity for the staff in Crisis. The initiatives that the team have been implementing have been recognised nationally by being shortlisted as finalists for the 2013 Patient Safety Awards.

- Pilot exercises have been undertaken in a number of mental health teams for the new care clusters. Care clustering is a framework in which mental health service users are classified by need in order to provide the appropriate care package. The care clusters now have care plans developed, with patient outcome measures to ensure the patient can measure their satisfaction with the care planning and other measurable outcomes of care intervention that will allow us to monitor the interventions being undertaken.

- New management of medicines procedures have been put in place in Bullingdon and Huntercombe prisons.

- The new Addictions Harm Minimisation service, one of the 6 national pilots for addiction services, was implemented and is now in place. Management of the organisation continues to work on joint working and communication.

- A lot of work has been undertaken to reduce the number of drug errors including monthly medicine management training sessions; implementation of competency frameworks for insulin, warfarin and controlled drugs; and reviews of all serious medication incidents.

- Considerable progress has been made in implementing the programme to reduce ward-based falls. Updates on the falls risk screening tool have been incorporated and specific exercise programmes are being provided within Buckinghamshire Older Adults wards. The provision of dedicated physiotherapists to the older adult wards in Buckinghamshire has allowed individual falls prevention work to occur. There has also been close co-operation with Buckinghamshire County Council in their county-wide falls prevention initiative. The pilot National Falls audit is being re-implemented to check progress on completion of falls screening on admission.

- Acquired infections have been subject to close analysis and all actions identified as a result have been implemented.

- The Mortality Global Trigger Tool is now fully embedded in Community Hospitals.

- We have investigated the number and nature of physical restraints and the use of seclusion within mental health wards as part of the LIPS project. The analysis is underway and will be the subject of actions next year.

- Child Health and early detection and intervention to improve the health of young children has been improved with a remodelling of the Health Visiting Service that has included recruiting and training a higher number of health visitors working in Oxfordshire. Strategic growth targets 2012/13 have been met.

- A programme of quality and safety “walkabouts” by executives and directors was piloted in the District Nursing services and will be launched as a corporate approach next year.

- New thresholds on the level of safeguarding referrals are in the process of being agreed with partners and CQC.

- Following the release of a new service leaflet in November 2012, patient satisfaction questions for 2012 patient surveys were reviewed and agreed as part of the Health Visiting Call for Action programme.

Aims

- Table 5 below shows 3% increase in the total number of SIRIs (Serious Incidents that Require Investigation) compared with last year.

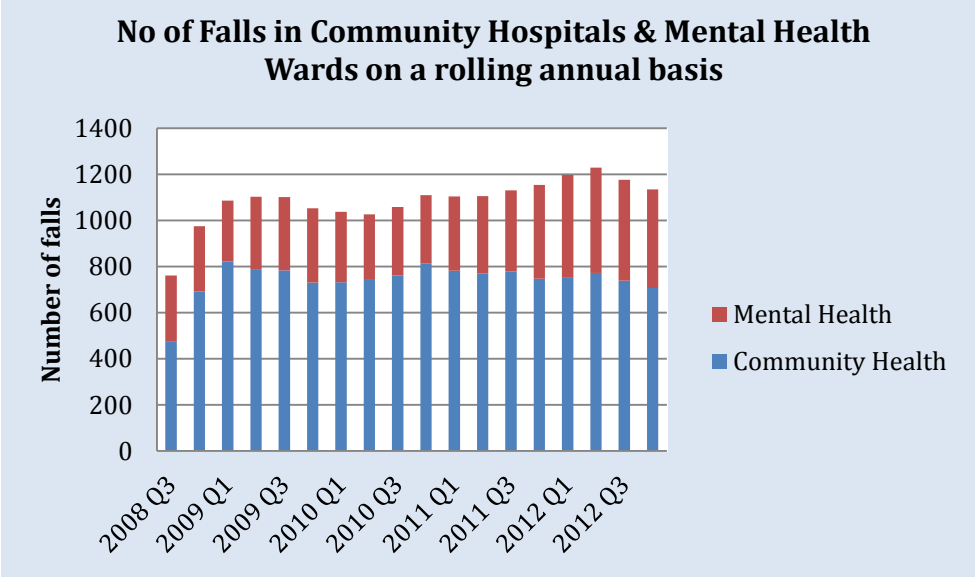
Table 5

Cause	2011/12	2012/13
Apparent Suicide	44	46
Pressure Ulcer	14	19
Unexpected Death	18	7
Falls Related	3	7
Self Harm	3	5
Damage/Assault	3	2
Injury	4	0
Other	12	18
Total	101	104

- Apparent suicides, pressure ulcers, unexpected deaths and falls related incidents are the four main areas of SIRIs.
- It should be noted that these are "apparent" i.e. "possible" suicides. Further investigation or a judgement in the Coroner's Court is needed to confirm this assessment or otherwise.
- The increase in SIRIs is mainly due to us lowering the threshold for what is a SIRI[7] last year, resulting in a widening of the definition to include more incidents of serious assault, some AWOLs, damage to property and patients getting on a rooftop.
- Although the levels of training in Prevention and Management of Violence and Aggression (PMVA) rose to 73% this year from 65% last year, we fell short of our intention to reach 85% coverage.
- We intended to increase the number of staff who have completed the Trust's clinical safe and supportive observations competency training from 65% for new starters; however at the end of the year this was still at 65% of mental health staff.
- There have been 23 potentially serious drug errors in the Community Hospitals this year that were subject to initial investigation reports, compared with 24 last year. All of these were deemed to be near-misses as none caused any harm to patients, but the errors are rated serious as the type of error relates to a near miss never event category e.g. insulin related error.
- We achieved our aim to reduce the overall number of falls by patients/service users in the Trust to below 1,396 (5%) in 2012/13. Chart 3 below shows the number of falls was 1,135. Between the end of 2012/13 and the year before, the number of falls dropped in mental health wards, whilst staying about the same in Community Hospitals.

[7] The risk categories were redefined last year to bring us in line with the NPSA standard model

Chart 3



- Comparing the absolute number of falls can be misleading due to the increase in the number of occupied bed days. A more appropriate target was for us to reduce the falls per 1000 occupied bed days, from 10.1‰ to under 8.6‰. By the year-end, the overall figure was 4.9‰, with Mental Health Wards at 3.1‰ and Community Hospitals at 8.5‰. All appropriate care and actions for falls management were in place.
- An audit in the second quarter of the year showed that 96% of patients admitted to psychiatric wards had a completed physical health assessment compared with our target of 98%. Results for VTE screening are not yet available from the new Essential Standards audit.
- 100% of patients in Community Nursing were assessed for pressure ulcers on their first visit.
- 94% of community hospital patients had a Malnutrition Universal Screening Tool (MUST) nutrition assessment within 3 days of admission, which compares well with our target of 85%. There was evidence of a nutritional assessment with 77% of Older Adult Mental Health service users, however there have been some inconsistencies in how this was recorded and as a result it has not been possible to establish whether this was carried out within 3 days of admission. The issues in measurement are currently being addressed.
- In Community Hospitals, the percentage of community health patients who were physically assessed for Venous Thromboembolism (VTE) within 48 hours of admission or referral to Community Hospitals achieved the target of 85% at 85.2%. There has been a clear improvement since the implementation of safety thermometer and due to greater awareness of the issue.
- Dementia screening results are now available through the safety thermometer, but were not in place to give figures for this report.
- Our aim was to reduce the number of mental health patients who go Absent Without Leave (AWOL) from 237 to fewer than 213 (10%). At the end of the year, there were 247 incidences of AWOL, of which 192 were detained patients. There were a number of environmental works needed (such as fences being heightened, door and windows changed). These were done but were staggered

through the year, so risks remained for some of the year. The joint highest reporter was Mandalay, which is an open rehabilitation ward, and the division has been investigating leave from that ward. This involved multiple AWOLS by the same patients, and patients going AWOL together, so was different in nature to other wards. Reducing AWOLS is a target in the safer care collaborative project. Evidence based interventions will be targeting wards and rolled out across the Trust where successful.

*"***A mother wrote following her sons care from the Crisis Service said:**
"A big thank you to the team for all the help and support the family received with our son while in Crisis. We are very grateful."

Patients will be treated and cared for in safe environments

Identified Initiatives

- In our drive to promote an open culture of reporting safety incidents, we issued three Learning from Incidents newsletters as well as holding six Learning from Incidents events, a one-day externally facilitated Root Cause Analysis (RCA) training programme was delivered to senior staff and a thematic review was compiled, leading to an action plan. Four training sessions have been run on initial investigation report preparation. The overall level of reporting of incidents has risen as a likely consequence (see Aims below).

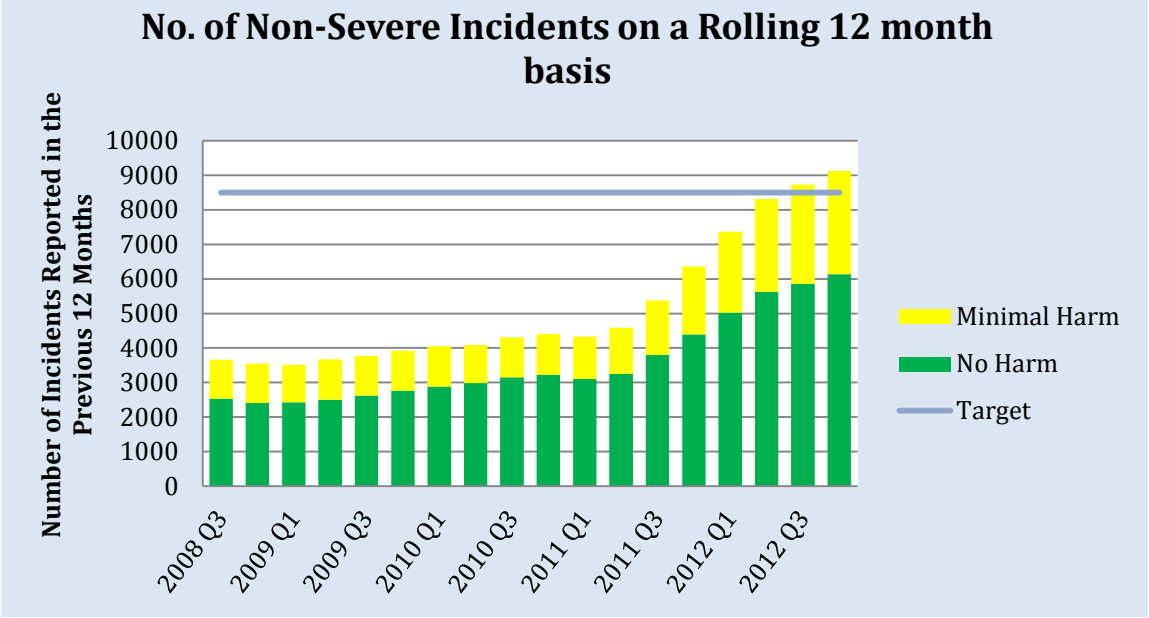
- All actions identified to reduce the incidence of C. Diff. and other acquired infections have been implemented.

- The dental team are currently in the process of completing the portfolio of evidence required for the Quality in Dental Services Award with the remaining items being finalised. Mock dental assessments are being carried out in all dental clinics and sites on a rolling programme and the service will request final assessment when the feedback from the mock assessment concludes that the service is ready. The planned timeframe for assessment is in the first half of 2013.

Aims

- There were 10 instances of C Diff in our hospitals in 2012/13, against a target of 10 and 1 occurrence of bacteraemia (MRSA and MSSA) in a mental health ward.
- We achieved our target of increasing the number of non-severe incidents reported by 27% over the previous year. The actual increase was 9,130 as shown in chart 4 below:

Chart 4



Effectiveness

The quality of life for people with long-term conditions will improve

We had two strands to our strategy to help people manage and live with long term conditions: the first was to improve their quality of life with a range of initiatives measured using tools such as "Patient Reported Outcome Measures" or PROMs; the second was through a series of actions intended to reduce the amount of time people with long-term conditions (LTC) spend in hospital.

Identified Initiatives

- A range of initiatives were undertaken as part of the programme to Improve Access to Psychological Therapies (IAPT), including new marketing materials, improved assessment processes, fast access to low intensity treatments such as stress control and providing alternative methods for delivery of psychological therapies such as large classes and computerised therapy.

- Two significant service developments are being undertaken with the aim of improving access to IAPT for people with LTC and to integrate their physical and mental health care. These services in Buckinghamshire (for patients with Chronic Obstructive Pulmonary Disease) and Oxfordshire (for cardiac patients) were recognised as pilot sites for a Department of Health initiative, working closely with commissioners, acute hospital providers and the Strategic Health Authority. This work will be continuing into 2013/14.

- A self-monitoring system known as Oxtext 7 (led by Oxford University) was started at the end of 2012. This is a research project in which new patients and teams are added to the project at 3-monthly intervals. It allows patients with a

variety of conditions to take more control of their illness and facilitates care interventions to be tailored to the individual.

- PROMs was launched in the Forensic service and by the end of the year, the individual outcome measures were being developed in detail.

- We have improved rehabilitation care for patients with dementia in Oxford Community Services by improving their overall assessment and monitoring, and providing more dementia-friendly environments in our premises.

- We have been implementing the Integrated Care Pathway for people to be supported in dying at home, including liaising with Oxfordshire GPs to work towards better support for these patients. However, the implementation has been hampered by adverse national newspaper reports regarding the use of the Liverpool Care Programme. The practice development facilitators held "surgeries" for those staff that had concerns and several action points emerged from these meetings that are being followed up. Other work has been undertaken to ensure the quality of the care at the end of life and care after death is as good as it can be and that all goals of the Integrated Care Programme are being met. As a result of the audit undertaken at the beginning of 2012, considerable education has been carried out and the rollout of the Advance Care Planning documentation and principles is slowly beginning to be established. The verification of death by nurses is now part of community nursing role and we continue to educate new staff. The "what to do when someone dies policy" is awaiting official ratification.

- Standard operating procedures have been developed for primary nursing, with more being devised in the light of experience. They are currently being rolled out across the district nursing service.

- The "East Kent Outcomes System" (EKOS) for use in assessing rehabilitation of stroke victims was successfully implemented and has gained good feedback from patients.

- Services have been developed to support patients with Long Term Conditions and frail elderly patients in Community Services, featuring a much improved discharge policy.

- The implementation of the Single Point of Access (SPA) and System 111 (the new telephone system for non-emergency calls) has allowed us to support care closer to home through acute hospital avoidance for Community Services patients. Referrals through the SPA have risen from 125 in May 2012 to 183 in March 2013, with a peak of 240 in January 2013, making a total of 2,328 in the year.

- Clear and comprehensive early intervention packages of care for service users with non-psychotic and psychotic high need have been developed and have been implemented within pilot teams.

- People with mental health conditions are being encouraged to improve their wellbeing with initiatives such as “Kick the Habit” manuals and training and clinical support to help people stopping smoking. Training has been provided to help staff talk to patients about their lifestyle and work is advanced to embed the Making Every Contact Count.

Aims

- 77.7% of adult service users on CPA were in settled accommodation at the end of the year, up from 65.2% after the first quarter of the year.
- In addition, 13.1% of adult service users on CPA were in employment at the end of the year compared with 11.0% after the first quarter of the year.
- We were not able to develop a suitable metric to monitor the percentage of service users engaged in meaningful activity, but work on this continues. Similarly, we were unable to develop the metric to measure unplanned admissions and early discharges for Community Children’s Nursing Services.
- The number of people with long-term conditions receiving IAPT rose in Oxfordshire from 124 in quarter 1 of the year to over 300 in quarter 4, and in Buckinghamshire from 76 in quarter 1 to 371 in quarter 4.
- We almost achieved our target of ensuring that 100% of mental health service users on the Care Programme Approach (CPA) had:
    - a current care plan (99.3%);
    - care reviewed in the last 6 months (99.3%);
    - a care coordinator (100%);
    - a risk assessment reviewed in the last 12 months (100%).

At the end of the year, 99.3% had all four elements in place, compared with 90% at the start of the year.

- We aim for 100% of mental health service users to be offered an opportunity to be engaged in the development of their care plans. At the beginning of the year, this was 72% and by the year-end, 78%[8].
- The metric for measuring whether rehabilitation patients admitted to Community Hospitals have been screened for dementia and depression was shown to be impractical; however we have now developed alternative tools that will help us to measure this in future.

People with long-term conditions will spend less time in hospital

Identified Initiatives

- Training has been put in place for Practice Nurses to help their patients with diabetes feel confident in managing their condition

- An urgent care pathway has been developed by the Children’s Community Nursing Service (CCN) in partnership with Oxford University Hospitals (OUH) to prevent admission and planned early discharges for children and young people. As a consequence, the number of referrals to the CCN service from the hospital has increased significantly; the monthly average number of patient episodes

[8] Note that this does not include the results from Forensics Division as a vacancy meant no audit was carried out in the 4th quarter

(face to face visits from the CCN team to provide hospital treatment at home) has risen in 2012/13 from:

- **Pre-project:** 81 (January-June 12) to 121 (July 12-February 13): 49% increase in patient episodes since the project was started.
- **Pre- significant capacity increase**: 83 (January -October 12) to 156 (November 12-February 13): 88% increase in patient episodes since capacity was increased (i.e. since the project implemented significant changes).

The programme is an excellent example of successful partnership working between the Trusts for the benefit of patients.

- Work began last year on a programme to develop pathways of care to integrate physical and mental health care for older people. This extensive piece of work is tied up with the remodelling of the Trust and will continue into 2013/14.

- Preparatory work has been undertaken to provide a new ward to cater for those people with complex enduring mental illness. In addition, a new clinical pathway has been proposed for those patients who need a different provision from those currently available in acute and forensic low secure accommodation.

Aims

- The incidence of emergency readmission in mental health hospitals within 28 days of discharge has been reduced from 10.2% to 7.2% for adults (target 10.3%), but increased from 1.4% to 2.6% for older adults (target 5.3%).
- The average number of Delayed Transfers of Care at any one time during the year was 144 compared to a contracted CQUIN target of 72. Consequently, considerable effort has taken place in partnership with Health and Social Care and OUH, to develop and implement a new discharge policy, which it is anticipated, will succeed in bringing the figures down next year.

"I wanted to contact someone regarding the outstanding treatment I received at Abingdon OOHs. I was seen by a doctor who was very thorough and had excellent patient care. He explained exactly what checks he was doing and why and explained his treatment plan to me really well. I felt he listened to me and was open and friendly."
Out of Hours Service Patient

Patients will be supported to manage their own condition

Identified Initiatives

- Personal Health Budgets (PHB) are now normal operational practice in Continuing Healthcare, so all new referrals are taken through PHB and offered the option of a direct payment. The PHB is being transferred to us from Oxfordshire PCT now that we are a peer-learning hub. A project to achieve this has been started. We have established a peer network and are a learning hub

for South Central SHA. A pilot exercise to extend PHB into mental health services is being planned for next year.

- The self-care programme for Oxfordshire community services patients with long-term conditions has been reviewed by the commissioners and will now form part of the work for 2013/14.

- Following the release of a new service leaflet in November 2012, patient satisfaction questions for 2012 patient surveys were reviewed and agreed as part of the Health Visiting Call for Action programme.

- We started implementing the recommendations from the Oxford Community Service District Nursing Review, now called the "District Nursing Modernisation Programme", including improved supervision and new service delivery hours of 8am to 6.30pm, 7 days a week.

- We continued to look at how we can extend provision on the Trust website of medication details and specific conditions. This is now ready to be launched, subject to approval by the pharmacy team.

- The reablement contract for the Access and Enablement Service was put in place during 2012, resulting in an increase in the numbers seen and eliminating the number of people waiting in community hospitals and acute hospitals for reablement.

Aims

- Last year, the number of people with a personal physical health budget (PHB) were as follows:
    - 50 people have had a direct payment for the Neurological Long Term Condition pilot
    - 2 direct payments have been set up for a children's complex care client

All patients within Community Health Services are routinely offered a PHB.

- We achieved our target of increasing by 20% the number of mental health service users who have Advanced Statements in place as the number rose from 30 instances at the end of 2011/12 to 282 at the end of 2012/13.

"…a huge thank you for your help and guidance over the past year… I'm so pleased I came for help and that I had you as my psychiatrist…thank you so much for fixing me and I am on my way to an exciting future who knows where."
Mental Health Community Services Service User

"My sessions have been of great benefit to me…..It has helped me to become a better parent …and now enjoy my family time….with thanks for everything."
CAMHS Ward Service User

Personal Health Budgets in Action – A Case Study

Carol is in her mid-thirties and lives at home with her mum. She has an illness that limits her activities of daily living and requires almost 24-hour care. Carol was awarded continuing healthcare funding and a traditional package of care was set up for a few hours during the day and several nights a week. The agency that was chosen was able to offer the regular service that all clients can expect.

Carol was happy with the carers that were sent to her, very pleasant people who were able to deliver the care well. However, Carol was not aware of who would be coming to care for her until they arrived at her house. She was sent new carers who did not know her needs well; they would take her to town shopping wearing a uniform, which made Carol feel conspicuous and uncomfortable. Whilst Carol was receiving good care from the agency there was something missing: she was not able to go out without her mum to accompany her unless it was prearranged by the agency and only for the time that was allocated on that day's visit.

Carol was asked if she would like a personal health budget to allow her some control and choice over how her care was being delivered. She was supported through the process by a support broker and her healthcare manager. She made an informed choice to have a managed account with a third party and so she does not handle any money or invoices.
Carol knew of someone who had cared for her previously and approached her to see if she would be interested in being directly employed by her as her personal assistant (PA).

The PA was not contracted at her previous employment so there were no "poaching" fees.
Now, three months on, Carol has two personal assistants who work for her and they manage the rota between themselves so Carol knows who is coming and when. She has the flexibility to ask them to do different hours when she wants to go out and she is now even able to attend a choir with her personal assistant accompanying her. Previously this was not an option as her mum would have had to take her, which, for a young woman in her thirties, was not "normal". Carol and her mum are both now able to live as they wish, still with Carol's disability but knowing she has control over when the care is delivered and by whom.

Quality Risk Profiles

The CQC produces a Quality Risk Profile (QRP) for all organisations that are registered with the CQC. It is seen as an essential tool for gathering key information about us and assists the CQC to monitor how we are complying with the essential standards by identifying any risks from data that CQC receive from many different sources. An assessment of the overall magnitude of the risk for each of the 16 CQC Quality Outcomes for the organisation is then made.

The scale used is: green, yellow, amber and red in increasing risk. Each colour is then subdivided into low (better) and high (worse).

The QRP assists us as an organisation to identify where our performance may be lower than average and may need improvement. This enables us to focus on such issues and to take relevant actions in these key areas.

The year-end QRP (dated 31st March 2013) showed that the position of uncertainty surrounding many of the outcomes last year has been removed as more evidence has been accumulated by CQC (table 6). It is encouraging to note that none of our outcomes is either amber or red, showing that we represent a moderately low risk to the CQC.

Table 6

Outcome	March 2012	March 2013
Section 1 - Involvement and Information		
1. Respecting and involving people who use services	Insufficient Data	High Yellow
2. Consent to care and treatment	No Data	Low Yellow
Section 2 - Personalised Care		
4. Care and welfare of people who use services	Insufficient Data	High Green
5. Meeting nutritional needs	Low Green	High Green
6. Cooperating with other providers	Insufficient Data	High Yellow
Section 3 - Safeguarding and Safety		
7. Safeguarding people who use services from abuse	Insufficient Data	High Yellow
8. Cleanliness and infection Control	Insufficient Data	Low Green
9. Management of medicines	Insufficient Data	High Yellow
10. Safety and suitability of premises	Low Yellow	High Yellow
11. Safety, availability and suitability of equipment	Low Green	Low Yellow
Section 4 - Suitability of Staffing		
12. Requirements relating to Workers	Low Yellow	Low Yellow
13. Staffing	Insufficient Data	High Yellow
14. Supporting staff	Insufficient Data	Low Yellow
Section 5 - Quality and Management		
16. Assessing and monitoring the quality of service provision	Low Yellow	Low Yellow
17. Complaints	Insufficient Data	Low Yellow
21. Records	Low Yellow	Low Green

Oxfordshire Community Health Services patient survey

2011			2012		
Have you been given or offered a care plan?			**Did someone discuss with you a plan for your care and treatment?**		
Yes	27	28%	Yes	78	54%
No	56	57%	No	23	16%
Don't know/Not sure	15	15%	Don't know/Not sure	44	30%
This question was changed to make it clearer, as some patients may not understand the term "care plan". This may have had an effect on the results, which show that 54% of patients are confident that their plan for care and treatment has been discussed with them in October 2012, compared to 28% of patients who were aware that they had a care plan in 2011. However the percentage increase in those who replied "don't know/not sure" is surprising and is being investigated further to find out if there is an underlying reason.					

Do you understand what was in your care plan?			**Did you understand what the plan for your care and treatment was?**		
Yes, definitely	23	46%	Yes, definitely	58	55%
Yes, to some extent	11	22%	Yes, to some extent	29	28%
No, I did not understand it	5	10%	No, I did not understand it	5	5%
Not sure	11	22%	Not sure	13	12%
The question was changed to make it clearer as some patients may not understand the term "care plan". Of patients who responded to this question, 55% now say that they "definitely" understand it, compared to 46% in 2011.					

Do you think your views were taken into account when deciding what was in your care plan?			**Do you think your views were taken into account when deciding a plan for your care and treatment?**		
Yes, definitely	18	39%	Yes, definitely	52	51%
Yes, to some extent	19	41%	Yes, to some extent	47	47%
No	9	20%	No	2	2%
This is the key question for the Quality Account priority and has stayed about the same since last year. The most recent results were reviewed in order to develop action plans. Work related to the "East Kent Outcome System" is expected to provide increased satisfaction when it is fully implemented (see "The Quality of Life for People with Long-Term Conditions will improve" section below).					

We shall be using the full range of methods to gather feedback across our services in the forthcoming year.

Mental Health Community Survey 2012

At the start of 2012, the Care Quality Commission sponsored a questionnaire that was sent to 850 service users in our community based mental health care. Responses were received from 205 service users and the detailed results can be found on the CQC web site at:
http://www.cqc.org.uk/survey/mentalhealth/RNU
A summary of the results taken from the CQC website is shown in table 7 below. Although the overall result of 6.3 was the same as last year, we were disappointed that we were rated as being worse than other Trusts in the Care Coordinator and Care Plan section of questions. Actions have already been taken to address these weaknesses such as developing service folders that include information leaflets, care plans and assessments; staff visiting other Trusts to see how they perform; and developing a mental health forum.

Table 7

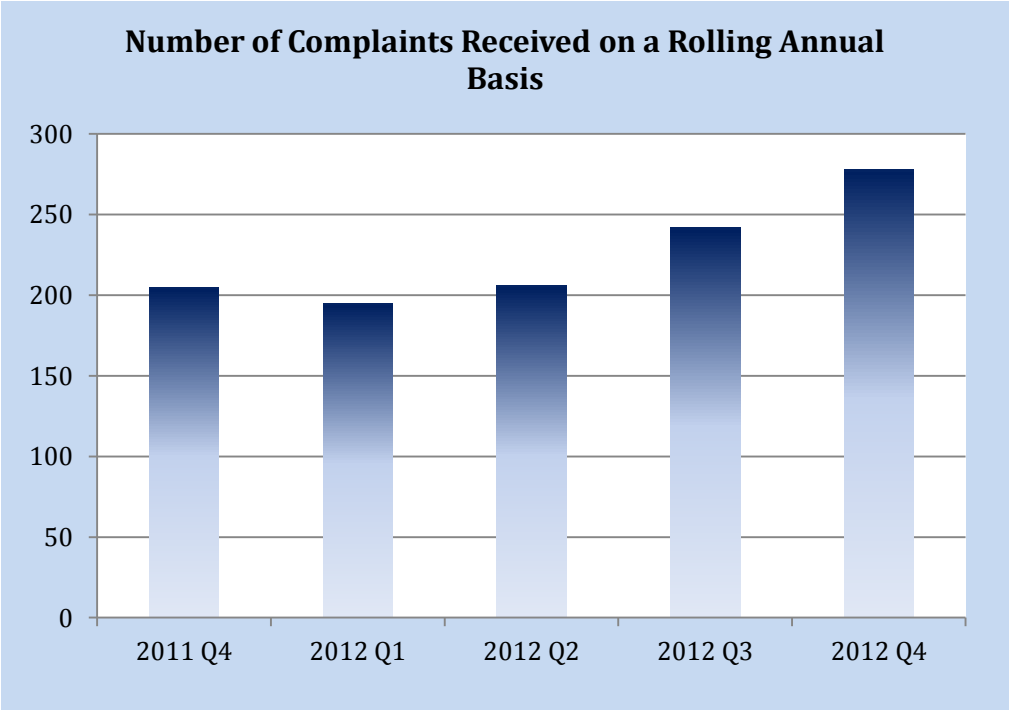
Complaints

The Trust takes complaints very seriously and tries to resolve these as quickly as possible.

During 2012/13, we received 278 complaints of which 46 were concerns received via an MP with a peak in July 2012. This was an increase of 75 (37%) complaints from 2011/12 which is in line with the increasing trend the Trust has seen in the number of complaints received over the last three years. 94% of the 278 complaints were acknowledged within the recommended 3 days timescale. 82% of the 225 complaint cases closed were responded to within a timescale agreed with the complainant, of the 41 complaints responded to later than the agreed time on average the response took a further 5 days. At the time of writing the report 53 cases received in 2012/13 were still open and under investigation.

The steady growth in the number of complaints received during the year can be seen in the chart 5 below. This amounted to a 37% increase in complaints compared to last year. This general increase appears to be mirrored in other Trusts and is likely to be in part a consequence of people's continuing awareness of their rights to complain. There does not seem to be many complaints about the same subject for the same team/ wards, so we regard the rise in the number to be a positive sign as it represents people are better informed of how to raise a complaint and an important opportunity for the Trust to identify early warning signs and a way to learn where improvements can be made.

Chart 5



Examples of actions taken as a result of complaints are:

- The Crisis Team was reminded of the importance of good communication with other relevant parties e.g. with GPs around the management of a patient's crisis.
- A second EpiPen was placed in the emergency bag for the healthcare team at a Prison.
- The out-of-hours doctor has reflected with their supervisor on how they could have improved their communication with a family during a very challenging situation when a patient was at the end of their life.
- Clarification was provided to the CAMHS team to place an alert on a patient's notes if there is a safeguarding concern about sharing information.
- Reviewing the way help with toileting during the evening was being provided within a Community Hospital.
- All staff within the Community Hospital were reminded of the Trust's expectations around care, enabling a discussion with staff about the consequence of not maintaining high standards of care.
- The complaint has been used as a learning case within one of the education evenings and clinical newsletters around palliative care for the out-of-hours service.
- The district nurses are reviewing how they access their messages during the daytime if they are out on visits to improve responsiveness to calls.
- Nursing staff within the Community Hospital have been reminded of the importance of documenting fluid and dietary intake (as well as refusals) and the ward manager is now regularly checking this.
- Staff on the forensic ward have been reminded to take time to explain and involve a patient about a decision and the reasons to transfer from one ward to another, checking the patient's understanding.

Further details about the themes, outcomes and actions taken following complaints can be found in the Trust's Annual Complaints Report.

The Royal College of Psychiatrists

Statement of Participation in National Quality Improvement Projects (non-audit) managed by The Royal College of Psychiatrists' Centre for Quality Improvement

April 1st 2012 – March 31st 2013[9]

CCQI PROGRAMME	Participation by Trust	National Participation
Service accreditation programmes		
ECT clinics	2 ECT clinics	93 ECT clinics
Working age adult wards	1 ward	165 wards
Psychiatric intensive care units	0 PICUs	34 PICUs
Older people mental health wards	0 wards	57 wards
Inpatient learning disability units	0 units	36 units
Inpatient rehabilitation units	0 units	36 units
Memory services	1 services	61services
Psychiatric liaison teams	0 teams	43 teams
Service quality improvement networks		
Inpatient child and adolescent units	2 units	91 units
Child and adolescent community MH teams	1 team	45 teams
Therapeutic communities	2 communities	83 communities
Low secure forensic mental health services	2 services	66 services
Medium secure forensic mental health services	2 services	64 services
Perinatal mental health inpatient units	0 units	15 units

[9] The figures above relate to the last completed cycle or current cycle if recruitment has ended. Oxford Health NHS Foundation Trust also participated in the National Audit of Psychological Therapies with one team taking part.

Statement of Participation in the Prescribing Observatory for Mental Health (POMH UK) managed by The Royal College of Psychiatrists' Centre for Quality Improvement

April 1st 2012 – March 31st 2013

TOPIC	Participation by trust		National participation	
	Number of teams	Number of patients	Number of teams	Number of patients
Prescribing high-dose and combination antipsychotics: acute/PICU, rehabilitation/complex needs, and forensic psychiatric services	22	296	722	9537
Prescribing for people with a personality disorder	11	49	437	2600
Screening for metabolic side effects of antipsychotic drugs	9	81	372	6078
Prescribing antipsychotic medication for people with dementia	11	202	482	12790

Annex 1. Statements from our Partners on the Quality Report and Account

Oxford Health NHS Foundation Trust Governors

During 2012/13 Oxford Health NHS Foundation Trust Governors have formed a Quality Committee to review the Trust's performance on Quality issues. The committee includes several Governors as well as a Non-Executive Director and the Director of Nursing and Clinical Standards.

The Committee meets regularly, at a variety of locations from which the Trust delivers patient services in order to see the facilities (and try the food) first hand. The Quality Account and Quality Key Indicators have been reviewed and discussed at each meeting, and Governors have taken the opportunity to challenge Board members on issues which have arisen. This process has allowed the Quality Committee to take a much more detailed view of relevant issues, and to be able to assure the Council of Governors that the Trust Board is addressing Quality Issues in a systematic and thorough way. There remains much work to be done on improving the Quality of services: the Trust has identified what needs doing and is getting on with delivering the necessary changes.

Both the Governing Body as a whole and the Quality Committee have discussed the findings and recommendations of the Francis Report. In future years, the implementation of much of what is recommended will be reviewed and monitored by the Quality Committee. The 5 key areas highlighted by the Government:

- Preventing problems arising by putting the needs of patients first
- Detecting problems early
- Taking action promptly
- Ensuring robust accountability
- Leadership

are all relevant to the work we expect to do.

The Committee has found the Trust to be diligent in its presentation of information and eager to develop the quality, relevance and accuracy of data and the process further over time, so the form and content is more widely accessible. We are pleased, therefore, to endorse the Quality Account and to continue to work with the Trust to improve services for local people across its range of services.

Oxfordshire Clinical Commissioning Group (CCG)

The Oxford Health NHS FT Quality Account for 2012/13 has been reviewed by the Quality and Performance sub-committee of the OCCG Board. OCCG considers that the report produced contains accurate information and follows the template specified by the Department of Health. The version reviewed by OCCG contained some incomplete sections as some of the targets for key priorities were being finalised.

OCCG is pleased to note that the Trust took into account the comments made by NHS Oxfordshire last year and reduced the number of priorities to four. This approach will lead

to greater clarity. However, in reviewing the priorities, OCCG feels that the priorities do not directly link with the CQUIN objectives agreed with the Trust for 2013/14. While it is not essential that all Quality Account priorities match the CQUIN agreed with commissioner, it would demonstrate that the Trust is taking a coordinated approach to quality. OCCG is happy to note that one of the priorities that Oxford Health has set for 2013/14 is the integration of mental health and community health services. OCCG is disappointed that this benefit of integration has not happened sooner and is glad to see it is now being prioritised.

The language used within the document is an improvement on previous years. The account would benefit from a greater use of data to demonstrate the improvements the Trust has made. The document is written with a greater focus on the mental health services provided by the Trust than on the community services. The document is also focused mainly on Oxfordshire services, when the Trust provides services across several counties.

This report is excellent at stating the achievements made by the Trust in 2012/13. It describes well, for example, the work undertaken by the Trust to reduce the number of cases of clostridium difficile. The Trust has also been open in including some of the areas where they have not reached the standard at which they were aiming, such as the non-achievement of the breastfeeding CQUIN. OCCG feels that the account could have gone further in mentioning a number of areas in which they are seeking to improve, for example the time between GP referral and assessment for mental health services.

The purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they offer. OCCG feels that this document has partially achieved this goal although, it does not cover the full breadth of services offered by the Trust. OCCG looks forward to working with Oxford Health to address many of these issues in the future and that the Trust will benefit from clinical commissioning.

Aylesbury Vale and Chiltern Clinical Commissioning Groups (CCG)

Aylesbury Vale and Chiltern Clinical Commissioning Groups have reviewed the Oxford Health Foundation Trust Quality Account against the three domains of quality: patient experience, patient safety and clinical effectiveness. There is evidence that the Trust has relied on both internal and external assurance mechanisms an example of such being the Care Quality Commission reports and the commissioners are satisfied as to the accuracy of the data contained in the Account.

The report provides a balanced overview of the Trust and clearly identifies their achievements to date, but also areas within their service delivery where improvements could be made. The Clinical Commissioning Group's welcome the openness and transparency of this approach and are committed to supporting the Trust in achieving improvement in the areas identified within the Quality Account through existing contract mechanisms and collaborative working.

One of the purposes of the Quality Account is to support the Trust Board in assessing quality across the totality of the services they offer. This is successfully achieved. We have focussed on the Mental Health services, as it is those that are commissioned by the

Buckinghamshire CCGs. The other purpose is to help patients assess the quality of services and make choices between different providers. The report is less successful in this area and, while we acknowledge that it is difficult to find peer trusts delivering the same profile of care, benchmarking with other specialise services would be possible.

The Trust has understands the need for integrated working, not just across other healthcare providers but also across social care. The commissioners would encourage the Trust to further develop ways of integrating services and we hope that the opening of the new facility in Buckinghamshire will provide a focus for that.

Patient experience

Oxford Health NHS FT clearly demonstrates that it values feedback about the patients' experience and uses this to help shape improvements for the future. There has been particularly strong work done in engaging children and young people in the development of their services.

The Care Quality Commissions (CQC) Community Mental Health survey results were disappointing, identifying that patients wish to see improvements. This has been mitigated to some extent by the monthly local surveys where 83% of patients responded positively about care. Implementing the new blue folders to improve patient's knowledge about their care plan and key worker will improve overall patient experience. However, commissioners would like to see an increase in the percentage of people who think their views were taken into account in planning care.

OHFT have identified the need to improve the patient experience for inpatients and are working towards the Royal College of Psychiatry AIMs accreditation for its wards. The commissioners support this development and the standardisation of quality it will bring.

The Trust has made a commitment to building patient experience measures into every clinical pathway. Monitoring will be at a service and team level, which will develop ownership of the agenda throughout the organisation.

Patient Safety

The Commissioners wish to commend OHFT for being shortlisted for the National Patient Safety Award which recognises their work in reducing suicide rates. We note there were no suicides by in patients or patients on leave in the trust during the year. The use of 'always events' for patients within the service is recognised as a positive development.

Commissioners are pleased to see the provision of a dedicated physiotherapist to the older adults ward to support the falls prevention work in this vulnerable group of patients and the countywide falls prevention initiative.

The report shows that the number of serious incidents reduced from the previous year. The commissioners would have liked to have seen a breakdown in the performance against the 24-hour reporting target as well as the performance showing the number of SIRIs closed within the allotted timescale as these provide a marker for how quickly a provider is in a position to share the learning from an incident.

Clinical effectiveness

Improving the quality of life for patients with long-term conditions is a key initiative for the trust which supports the strategic direction of the commissioners. Of note are the pilots of IAPT for people with Long term Conditions, integrating their physical and mental health care; Oxtext 7 demonstrates a keenness to develop innovative services and making Every Contact Count again links physical and mental health.

We are pleased to see the target of 100% of care plans under the care Programme Approach having all four elements in place.

Commissioning for Quality and Innovation Schemes (CQUIN)

In 2012/13 the trust delivered the majority of their CQUINs and for those that were not met significant progress was made.

For 2013/14 as well as the national CQUIN schemes the local CQUINs will support

- Implementation of the patient held 'blue folder'
- Development of a Psychiatric InReach and Liaison Service
- Implement integrated physical and mental health assessments
- Develop outcomes based commissioning
- Dementia pathway

The Future

The 2013/14 priorities contained in the Quality Account are consistent with priorities agreed with both commissioners and those within the Francis Report. We are particularly pleased that the new facility in Buckinghamshire will give the opportunity to develop new ways of working for both community and inpatient services and will encourage the development of more pathways which integrate physical and mental health.

Conclusion

This Quality Account provides a comprehensive overview of the quality of care within the Trust and commissioners look forward to continuing to work alongside the Trust in meeting the quality aspirations of local users, carers, partners and staff. It is clear that the trust is positively embracing an integrated style of working across the health and social care sectors and welcomes the benefits this will bring to service users and their families/carers.

Buckinghamshire County Council Health Overview and Scrutiny Committee

Thank you for inviting comment from the Buckinghamshire County Council Health Overview and Scrutiny Committee on the trust's 2012/13 quality account.
During 2012/13 staff from the trust contributed to our consultation response to the Better Health Care in Bucks consultation by the Primary Care Trust, and our review into the care of elderly people at hospitals. The area of trust activity the committee has focussed most on in 2012/13 was its Children and Adolescent Mental Health Service (CAMHS).

We think it is important parents/carers are given adequate support and advice from CAMHS and we understand this has improved in recent years with the CAMHS OSCA (Outreach Service) and Crisis Service, as well as the CYP IAPT project that has been piloted. We will follow with interest the quality activity to develop and implement integrated care pathways for children and young people, detailed under the improved clinical outcomes goal.

We look forward to seeing the new mental health hospital and community facility opening in Aylesbury in December 2013.

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.

Monitor 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 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 2012/13;
- 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 2012 to March 2013
  - Papers relating to Quality reported to the Board of Directors over the period April 2012 to March 2013
  - Feedback from the commissioners dated April 2013
  - Feedback from the governors dated 09/05/2013
  - Feedback from Local Healthwatch organisations dated April 2013
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2013
  - The latest national patient survey August 2012
  - The latest national staff survey issued March 2013
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 10/4/2013
  - CQC quality and risk profiles dated 31/03/2013

- 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 Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual**)**.

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

Chairman
30th May 2013

Chief Executive
30th May 2013

Annex 3. Examples of Actions following Internal Clinical Audits 2012/13

Table 9

Title of Audit	Key Actions
Inpatient physical health assessments on admission (including VTE screening)	• Audit findings for mental health wards showed 97% of patients had a physical health assessment on admission. Future audits will focus on more qualitative aspects of physical healthcare activity. • Physical health assessments are being monitored bi-monthly via the Essential Standards audit.
Care Programme Approach Audit	• The standards applied to CPA patients are now being applied to Non-CPA patients in CAMHS, Forensic Services and Eating Disorder Services. • CPA is now being routinely monitored by the Modern Matrons for inpatients in addition to the continued monitoring of key standards monthly and reported to the Board.
Self assessment of mental health wards being family friendly	**Specialised Division** • Service to consult with visitors/families about how to improve facilities. • Review and update play activities for different age groups. • Develop age appropriate information to be available in different formats – booklets/videos. • Staff training to be undertaken to enable staff to provide opportunities for children/young people to talk. • Create reception display area to provide information for family members on how to access support services/groups. • Increase general awareness of importance of 'Thinking Family' by providing staff training and updating policies. **Adult and Older Adult Mental Health** • "Think Family" information (including specific information for young carers) to be made available on Trust intranet, internet and notice boards in clinical areas which will include sign posting to other support agencies. • Review of Children Visiting Wards policy. • The mental health provision in the new Manor building in Aylesbury is designed to meet the standards. • Refurbishment requirements at the Warneford have been identified and await agreement for funding.

	Children and Families Division • There is some age appropriate information available for staff to access but this needs to be developed further to include age appropriate information leaflets in relation to mental health. Development of age appropriate leaflets is being led by the Think Family Champions. Once the leaflets are finalised these will be made available on both the eating disorder units. • The new Highfield Unit opened in January 2013 and is fully compliant with the essential standards including the standard to have a separate area where families can visit with a degree of privacy.
National audit of feverish children (urgent care)	• Provide evening educational sessions for clinicians specifically for paediatric presentations by paediatricians to reinforce guidelines. • Provide urgent care contracted general practitioners access to e-learning and other trust training programmes. • Complete a feasibility study for the implementation of software solutions to support the adherence to antimicrobial guidelines – a program called 'script switch' that prompts clinicians to change if out of guidance.
Transient loss of consciousness ('blackouts') - management in adults and young people presenting to Urgent Care Services	• Explore providing urgent care contracted general practitioners access to e-learning and other trust training programmes. • All staff will be reminded to document a full history of the events of Transient Loss of Consciousness. • Clinicians will be reminded to record and document in all cases: ECG, random blood sugar, other neurological and cardiac signs, full medical history and family medical history, lying and standing blood pressure and vital signs.
Medicines Management Audit Programme	• Work to update clinic room environments is incorporated into ward refurbishments as they arise. • Access to clinical information sources has been achieved. • An e-learning package for medicines management has been agreed to be piloted then rolled out for all qualified staff. • Implementation of "grab-bags" for emergency drugs on mental health units is currently under review.
Infection Control Programme: annual environmental audits and	• Closer collaborative working is in progress between infection prevention and control team and estates and facilities. This includes work and

hand hygiene audits	advice on minimum builds; requirements and standards; and new building and refurbishment projects within the Trust. • High risk areas have maintained good compliance with standards throughout the year therefore audits have been extended in to other clinical services. This has provided a bench mark assessment in order to develop and improve infection prevention and control standards. • An eLearning training package has been developed which will enable staff to complete relevant and appropriate training.
Follow up of service users who did not attend outpatient appointments (Swindon and Bath and North East Somerset CAMHS)	• Monitoring system in place to provide teams with cases for review and updating Risk Assessments following a service user who did not attend their outpatient appointment.
Copying letters to patients, parents and GPs (Swindon and Bath and North East Somerset CAMHS)	• Ensure that a conversation regarding sharing/declining letters takes place and is documented on RiO. • Produce and circulate summary document of copying letters protocol and best practice guidelines to clinicians.

Annex 4. Department of Health Clinical Indicators

Full details of the definitions of the indicators and the targets may be found in Appendix B of the Monitor Document *Compliance Framework 2013/14* at:

http://www.monitor-hsft.gov.uk/sites/default/files/Compliance%20Framework%2030%20March%202012%20FINALv1.3.pdf

CPA Patients receiving follow-up contact within seven days of discharge

The Oxford Health NHS Foundation Trust considers that this data is as described for the following reasons:

- there is a documentary audit trail for the compilation of these figures
- Internal audit review the quality of the compilation process

The Oxford Health NHS Foundation Trust intends/has taken the following actions to improve this percentage, and so the quality of its services, by:

- We are aiming to achieve 100% within 7 days
- We are looking at imposing a 5-day standard rather than 7

When assessing this criterion, we apply two exclusions in addition to the national guidance:

- For patients who are discharged from inpatient care who are discharged directly to the care of another mental health provider Trust (whether inpatient or community services), where we have verified that discharge documentation includes clearly set out arrangements for the handover of responsibility for care to the other provider, we have assumed the requirements under the indicator have been met.
- Patients who have been on Section 17 leave and have been subsequently discharged. All patients on section 17 leave should be followed up within 7 days of going on leave and this will be validated and deemed to meet the requirements for 7 day follow up.

Table 10 shows the results of individual reports provided by the Department of Health and the NHS Commissioning Board from data supplied quarterly by the Trust throughout the year.

At the year end, the results of this indicator were subject to internal data quality review and external audit; the final annual result for 2012/13 being 96.6% and for 2011/12, 97.7%

Table 10

Reporting Period	Trust Value	National Min	National Max	National Average
Apr-Jun 2012	**96.7%**	**94.9%**	**100%**	**97.5%**
Jul-Sep 2012	96.0%	89.8%	100%	97.3%
Oct-Dec 2012	96.5%	92.5%	100%	96.2%
Jan-Mar 2013	96.8%	93.6%	100%	97.3%

Admissions to acute wards had access to crisis resolution home treatment teams acting as gatekeeper

The Oxford Health NHS Foundation Trust considers that this data is as described for the following reasons:

- There is a documentary audit trail for the compilation of these figures.
- Internal audit review the quality of the compilation process.

The Oxford Health NHS Foundation Trust intends/has taken the following actions to improve this percentage, and so the quality of its services, by:

- Building in enhancements during the design and implementation of the programme of service remodelling.

When assessing this criterion, we apply four exclusions in addition to the national guidance:

- Crisis Services in Oxfordshire will include activity of the Crisis Team as well as those responsible for crisis work within the Community Mental Health Teams in line with agreed service specifications signed off by SHA and NIMHE under the Fidelity and Flexibilities Framework in 2006.
- Admissions via Liaison Psychiatry Service in Oxfordshire will be deemed to have been considered for home treatment on the basis that all admissions are arranged through Crisis Team or those responsible for crisis work within the Community Mental Health Teams in line with agreed service specifications signed off by SHA and NIMHE under the Fidelity and Flexibilities Framework in 2006.
- Patients who have had contact with the Crisis Team within three days prior to admission will be deemed to have been considered for home treatment as for the preceding exclusion above.
- Patients of Specialist Services (Forensic, Eating Disorders and CAMHS) will be excluded.

Table 11 shows the results of individual reports provided by the Department of Health and the NHS Commissioning Board from data supplied quarterly by the Trust throughout the year.

At the year end, the results of this indicator were subject to internal data quality review and external audit; the final annual result for 2012/13 being 99.1% and for 2011/12, 98.7%

Table 11

Reporting Period	Trust Value	National Min	National Max	National Average
Apr-Jun 2012	**100%**	**83.0%**	**100%**	**97.8%**
Jul-Sep 2012	99.6%	84.4%	100%	96.6%
Oct-Dec 2012	98.1%	90.7%	100%	98.3%
Jan-Mar 2013	98.9%	84.9%	100%	98.6%

Patients readmitted within 28 days of being discharged

The Oxford Health NHS Foundation Trust considers that this data is as described for the following reasons:

- There is a documentary audit trail for the compilation of these figures.
- Internal audit review the quality of the compilation process.

The Oxford Health NHS Foundation Trust intends/has taken the following actions to improve this percentage, and so the quality of its services, by:

- Improved leadership on the wards, thus ensuring timely appropriate discharges.
- Robust Crisis and CMHT follow up.

The information for Table 12 is not available as the NHS Information Centre web site has not published these statistics for either of the last two years. Also the Department of Health Quality Account Team have informed us that the data is for emergency readmissions only and is not relevant to this Trust.

Table 12

Indicator	2011/12 position	2012/13 position
Patients readmitted within 28 days of being discharged		
i) 0-14 years	N/A	N/A
ii) 15 or over	N/A	N/A

Staff who would recommend the Trust as a provider of care to their family or friends

The Oxford Health NHS Foundation Trust considers that this data is as described for the following reasons:

- The staff survey is an independent exercise under the auspices of the Department of Health.

The Oxford Health NHS Foundation Trust intends/has taken the following actions to improve this percentage, and so the quality of its services, by:

- Producing a detailed action plan, overseen by the Wellbeing and Culture Group to address two of the main areas where our score deteriorated since the last staff survey, namely:
    - Staff working extra hours.
    - Staff suffering work-related stress in the last 12 months.

Table 13

National Staff Survey	2012/13	2011/12	National Average	Highest Score	Lowest Score
% staff who would recommend the Trust as a provider of care to their family or friends	3.59[10]	3.44	3.54	4.06	N/A

Patient experience of community health mental health services with regard to contact with a health or social care worker

The Oxford Health NHS Foundation Trust considers that this data is as described for the following reasons:

- The patient experience survey is an independent exercise under the auspices of the Department of Health.

The Oxford Health NHS Foundation Trust intends/has taken the following actions to improve this percentage, and so the quality of its services, by:

- The development of service user information folders that include information leaflets, care plans and risk assessments.
- Staff visiting other trusts looking at service user involvement.
- Continuing development for a mental health forum.
- Each patient to- be given an information card with the care coordinator/lead clinicians name and contact numbers. This card will also have numbers to contact in a crisis.

Table 14

National Patient Survey	2012/13	2011/12	National Average	Highest Score	Lowest Score
Patient experience of community health mental health services with regard to contact with a health or social care worker	6.3	6.3	n/a	n/a	n/a

Patient safety incidents resulting in severe harm or death

The Oxford Health NHS Foundation Trust considers that this data is as described for the following reasons:

- There is a documentary audit trail for the compilation of these figures.
- Internal audit review the quality of the compilation process.

The Oxford Health NHS Foundation Trust intends/has taken the following actions to improve this percentage, and so the quality of its services, by:

- Continuing to roll out Advanced Assessment Training to reduce the risk of incidents.
- Reviewing the role of the Crisis Teams.

[10] Score is out of a maximum of 5

Table 15 shows the results of individual reports provided by the NHS from data supplied 6-monthly by the Trust throughout the year.

Note:

1. This year is the first time that this indicator has been required to be included within the Quality Report alongside comparative data provided, where possible, from the Health and Social Care Information Centre. The National Reporting and Learning Service (NRLS) was established in 2003 and enabled patient safety incident reports to be submitted to a national database on a voluntary basis to promote learning. It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission as part of the Care Quality Commission registration process. To avoid duplication of reporting, all incidents resulting in death or severe harm should be reported to the NRLS who then report them to the Care Quality Commission. Although it is not mandatory, it is common practice for NHS Trusts to report patient safety incidents under the NRLS' voluntary arrangements.
2. As there is not a nationally established and regulated approach to reporting and categorising patient safety incidents, different trusts may choose to apply different approaches and guidance to reporting, categorisation and validation of patient safety incidents. The approach taken to determine the classification of each incident, such as those "resulting in severe harm or death", will often rely on clinical judgement. This judgement may, acceptably, differ between professionals. In addition, the classification of the impact of an incident may be subject to a potentially lengthy investigation which may result in the classification being changed. This change may not be reported externally and the data held by a trust may not be the same as that held by the NRLS. Therefore, it may be difficult to explain the differences between the data reported by the Trusts as this may not be comparable. The basis of reporting changed in 2012/13 from the number of severe incidents per 1,000 bed days to the % of severe harm and death incidents against the total number of incidents reported
3. No data has been provided by the NHS Information Centre for 2012/13.

At the year end, the results of this indicator were subject to internal data quality review; the final annual result for 2012/13 showed that 2% of the total number of incidents reported to the NRLS related to severe harm or death incidents.

Table 15

Reporting Period	Incidents resulting in severe harm or death ‰ Bed Days	National Min ‰ Bed Days	National Max ‰ Bed Days	National Median ‰ Bed Days
Apr 2011-Sep 2011	0.8‰	0‰	1.1‰	0.2‰
Oct 2011-Mar 2012	0.5‰	0‰	2.3‰	0.3‰
Apr 2012-Sep 2012	N/A	N/A	N/A	N/A

Annex 5. CQUIN Details for 2012-13 with Year End Position

Table 16

	Year End Milestone
Oxfordshire and Buckinghamshire Adult and Older Adult Mental Health	
Patient experience	Partially Met
Results of 2012 NHS Staff Survey	Partially Met
NHS Safety Thermometer	Met
Assistive Technologies	Met
Digital by Default	Met
Improve and Enhance Crisis Service	Met
Mental Health Clustering/ Outcomes	Met
Reduce the use of Physical Restraints	Partially Met
Oxfordshire and Buckinghamshire Community Services	
Improve Responsiveness to Personal Needs of Patients	Partially Met
NHS Safety Thermometer	Met
Adopt the Use of Assistive Technologies	Met
Reducing Unnecessary Face-to-Face Contact through the Use of Electronic Media	Met
Reduce the Number of Patients that Die in an Acute Hospital Setting	Met
Reduce the Number of Admissions of Patients with Cellulitis to an Acute Hospital setting	Partially Met
Roll out and Implement the “Ages and Stages” Assessment Tool	Met
Improve Uptake of Breastfeeding in Oxfordshire	Not met
Reduce the Number of Delayed Transfers of Care in Oxfordshire	Not met
Forensic Specialist Commissioning Group	
Reduction in Average Length of Stay by 30 days	Met
Service User Defined CPA	Met
Payment by Results (PbR)	Met
Shared Pathway – Recovery and Outcomes	Met
Access to Services	Met
Implementing Clinical Dashboards for Specialised Services	Met
CAMHS	
Alignment of Performance Reporting to New CAMHS Structure	Met
Completeness of Performance Reporting for CAMHS Service	Met
Buckinghamshire SLT Contract	
Access to SALT (Speech and Language Therapy) Assessment and Interventions	Met
Wiltshire and BaNES CAMHS and Eating Disorders	
Patients Completing Patient Experience 50% of Caseload	Met
Maintain Reduced Length of Stay (LOS) in Inpatient Setting	Met
Pilot Use of Routine Outcome Measures (ROM)	Met
Medication Review for Children	Met

Annex 6. Auditor's Statement of Assurance

Independent Auditor's Report to the Council of Governors of Oxford Health NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Oxford Health NHS Foundation Trust to perform an independent assurance engagement in respect of Oxford Health NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.
This report, including the conclusion, has been prepared solely for the Council of Governors of Oxford Health NHS Foundation Trust as a body, to assist the Council of Governors in reporting Oxford Health NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Oxford Health NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital; and
- admissions to inpatient services had access to crisis resolution home treatment teams.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.
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;*
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed Guidance for External Assurance on Quality Reports*; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.
We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, 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.*
The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Oxford Health NHS Foundation Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- 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;*

- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed Guidance for External Assurance on Quality Reports*; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

Deloitte LLP
Chartered Accountants
Reading
29 May 2013

Section Three - Governance, performance and finances

Our aim is to maintain an excellent reputation for providing high quality services, specialist services and value for money. A key ingredient to this ambition is the way we govern and monitor the organisation in terms of quality, our operational performance and finances. The following section summarises our performance on all these fronts throughout 2012/13

Statement of accounting officers' responsibilities

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

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

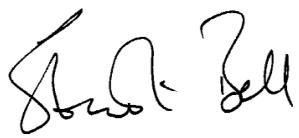
Under the NHS Act 2006, Monitor has directed Oxford Health NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Oxford Health NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, 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* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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



Stuart Bell, Chief Executive

Date: 29 May 2013

Annual Governance Statement 2012/13

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 Audit Committee is responsible on behalf of the Board for seeking evidence and obtaining independent assurance that there is an effective framework of internal control and corporate governance in place.

The Board of Directors (Board), through its Audit Committee, agreed the Trust's 2012/13 Internal Audit Plan with its Internal Auditors. The results of these audits culminated in the Head of Internal Audit's opinion on the system of internal control. This Annual Governance Statement is consistent with findings of the Head of Internal Audit's opinion.

With effect from 1 April 2008, the Trust was authorised as a NHS Foundation Trust by Monitor. From 1 April 2011 the Trust acquired Community Health Oxfordshire (CHO), the provider arm of the Oxfordshire PCT, as part of the Transforming Community Service national initiative. Contracts of at least three years for all mental health services provided by the Trust were in place from 1 April 2010, with both Oxfordshire and Buckinghamshire PCTs, and with the Specialist Commissioning Group for Forensic Mental Health Services, setting out the contractual arrangements for services provided by this Trust, including performance, activity and management of Serious Incidents Requiring Investigation. A contract of at least three years to provide community services in Oxfordshire was in place from 1 April 2011. Oxfordshire and Buckinghamshire PCTs had agreed in 2011/12 to apply a one year extension to the mental health contracts in order to align these with the Oxfordshire community services contract. The Specialist Commissioning contract continued to 31 March 2013 and has been extended in 2012/13 to cover CAMHS and Eating Disorders services. All contracts were reviewed during 2012/13 as part of the changes in the commissioning environment to take place from 1 April 2013.

Section 75 (NHS Act 2006) agreements with Oxfordshire County Council (mental health services for older adults and adults of working age) and Buckinghamshire County Council (mental health services for older adults and adults of working age) are in place. The Oxfordshire agreement was reviewed during 2011/12 and renewed from 1 April 2012 with an annual review. The Buckinghamshire agreement was extended to 31 March 2013 to allow a jointly commissioned independent review of the arrangements to take place during 2012/13; a revised agreement will be put in place in 2013/14. These agreements enable the Trust to exercise various local authority functions relating to the management and delivery of mental health services and local authority staff have been seconded to the Trust.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxford Health NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Oxford Health NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board has in place a comprehensive Integrated Governance Framework which clearly sets out how the organisation:

- safeguards high standards;
- ensures a structured control environment, where risks are identified, assessed and properly managed;
- enables the Trust to demonstrate continuous improvements in service;
- creates an environment in which excellence will flourish; and
- manages and transfers risks, as appropriate, to any organisation providing services on the Trust's behalf.

Assurance on the adequacy of the Trust's governance arrangements has been gained through the work of Internal Audit.

The Trust has an effective and embedded process for assuring the Board on matters of risk, which enhances the organisation's overall capacity to handle risk. The Assurance Framework forms the key document for the Board in ensuring all principal risks are controlled, that the effectiveness of the key controls has been assured, and that there is sufficient evidence to support the declaration set out in the Annual Governance Statement.

The Integrated Governance Committee supports the Board in relation to meeting quality standards and the management of corporate risk and in turn is supported by five quality improvement committees: Safety, Clinical Effectiveness, Governance and Information Management, Human Resources, and Service and Estates. These five committees lead and supervise governance within the Trust. The Board of Directors has also established a Clinical Advisory Board from March 2012 to support it in making informed strategic decisions relating to clinical risk issues.

Under the Trust's Standing Orders and Scheme of Delegation, the Director of Nursing and Clinical Standards takes executive responsibility for risk management (both clinical and non-clinical) in the organisation reporting to the 'Accounting Officer'. The Risk Management policy clearly sets out the roles and responsibilities of executive directors, managers and staff for risk management across the organisation. Each clinical division has a Clinical Director and a Divisional Head of Nursing who jointly lead on clinical governance issues. Staff have been alerted to both the strategy and supporting policies, e.g. Incident Reporting and Management policy. The Risk Management policy was last reviewed and approved by the Board of Directors in December 2011 as part of the approval of the Risk Management policy.

A comprehensive risk management training needs analysis has been completed across the organisation. The Trust is continually looking at new solutions for the delivery of training to ensure that staff are able to undertake training with minimal disruption to services.

The Trust also has a Counter Fraud Work Plan and Local Counter Fraud Specialist who assists in managing risk.

The risk and control framework

The Trust had a clear purpose, values and strategic drivers for 2012/13 as follows:

Our Vision is that the patients, their families and carers who experience Oxford Health NHS FT services feel that our Trust provides "Outstanding Care Delivered by Outstanding People".

Our Values

Caring

- Privacy and dignity is at the heart of our care.
- We treat people with respect and compassion.
- We listen to what people tell us and act upon what they say.

Safe

- Our services are delivered to the highest standards of safety.
- All services are provided within a safe environment for patients and staff.
- We support our patients and staff with effective systems and processes.

Excellent

- We aspire to be excellent and innovative in all we do.
- We aim to provide the best services and continually improve.
- We will recognise and reward those who deliver excellence.

Our Strategic Drivers

- Driving Quality Improvement
- Delivering Operational Excellence
- Delivering Innovation, Learning and Teaching
- Developing our Business

The continued delivery of responsive, high quality services requires the Trust to identify, manage and reduce the effect of events or activities which could result in a risk to our service users, visitors and all healthcare professionals and other employees and contractors deployed in the course of our business. The Risk Management policy covers all aspects of risk management: environmental, clinical and business. All staff are expected to accept the management of risk as one of their fundamental duties. Additionally, every member of staff is expected to be committed to identifying and reducing risks.

The Board believes the management of risk is best achieved through an environment of honesty and openness, where mistakes and untoward incidents are identified quickly and dealt with in a positive and responsive way.

The requirement for all NHS Foundation Trust Chief Executive Officers to sign an Annual Governance Statement, as part of the statutory accounts and annual report,

heightens the need for the Board of Directors to be able to demonstrate that they have been properly informed about the totality of their risks, both clinical and non clinical. To do this the Trust provides evidence to the Board that objectives and principal risks of delivery have been systematically identified through the Trust's assurance framework. The Trust's approach has been:

- to identify the organisation's principal objectives (clinical, financial and generic);
- identify the principal risks that threaten the achievement of the Trust's principal objectives including achieving satisfactory compliance with national standards and targets; and
- ensuring that the key controls are in place which are designed to manage the principal risks.

The Board has in place an Assurance Framework Action Plan to address weaknesses and ensure continuous improvement of the system of internal control.

The Board has implemented a system to gain assurances about the effectiveness of the operation of the controls that are in place to manage the organisation's principal risks. For each key control, risk or control system, the organisation identified potential sources of assurance. The most objective assurances are derived from independent reviewers which include the Care Quality Commission (Mental Health Act Commission), reports by the Internal and External Auditors and these are supplemented by non-independent sources such as clinical audit, performance management and self assessment reports.

The Board and its sub-committees, including the Audit Committee and Integrated Governance Committee, have reviewed the Assurance Framework regularly throughout the year. The Board is informed on a quarterly basis of the top risks facing the Trust in achieving its objectives. The sub-committees and the Quality Improvement Committees review, on a regular basis, the effectiveness of the organisation's system of internal control, covering all of the principal risks and details of positive and adverse assurance of the effectiveness of controls, and significant gaps in control. During the later part of 2012/13, the Trust commissioned a review of its Assurance Framework process alongside transferring responsibility for maintaining the Framework to the Chief Executive's Office. The outcomes of the review will be implemented in 2013/14.

Internal Audit completed 14 audits in 2012/13 of which 5 received a 'limited' assurance level assessment; the remainder were either 'satisfactory', 'good' or 'excellent'. Those which received a 'limited' assessment were formally reported to the Audit Committee. The list below identifies the audit areas where high priority recommendations were made which will be addressed as part of the continued development of the system of internal control:

- Payroll (expenses and travel reimbursements)
- Finance (Single Tender Waivers)
- Oxford Pharmacy Stores (controlled drug stock)
- Estates (Estates Strategy)
- Oxford Cognitive Therapy Centre (contacted hours and income documentation)
- Control Self-Assessment (evaluate if CSA is preferred methodology)

The Trust has mapped user and carer involvement across the organisation and updates this mapping exercise on a six monthly basis. With respect to the public

stakeholder element of risk management, the Trust has aimed to involve the public in minimising risks which impact on them.

The Board has been assured through the Integrated Governance Committee that effective arrangements are in place to manage and control risks to information and data. An Information Governance policy is in place. The Director of Finance is the Senior Information Risk Owner with overall responsibility for information security risk. The Director of Nursing and Clinical Standards has overall responsibility for information governance and data protection. The Caldicott Guardian is responsible directly to the Board of Directors. Significant assurance has been gained through the annual Information Governance Toolkit self assessment. Two serious incidents requiring investigation involving personal data were identified this year that were reported to the Information Commissioner, as set out in guidance on serious untoward incidents involving data. On one case the Information Commissioner informed the Trust that no enforcement action would be taken. On the second case, the Information Commissioner has undertaken a preliminary enquiry and the Trust awaits the Information Commissioner's view.

As an NHS foundation trust the Trust has a Council of Governors with 35 governors of which 28 are elected from public, patient and staff constituencies. The remaining 7 are appointed by stakeholder organisations. The Council meets quarterly and the Trust consults with it on future strategy.

The Trust meets regularly with both statutory and non-statutory partners to brief them, identify areas of concern and facilitate involvement in the development of strategies to address key risk areas. Meetings, or attendance at public meetings, with local Healthwatch bodies, Voluntary Organisations and the Overview and Scrutiny Committees, allow the Trust to raise issues, engage stakeholders in better understanding of concerns and invite debate on potential ways forward. Further involvement is facilitated through the appointment of representatives of such organisations to project boards, responsible for steering projects and recommending future action. Wider engagement in developing solutions to specific risk areas is achieved through the involvement of service users and carers in audit and through consultation on policy and strategy.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). It attained registration with no conditions from 1 April 2010. This was reconfirmed by the CQC following the acquisition of CHO from 1 April 2011.

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

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

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

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

Financial and non-financial performance is reported through a framework which generates 'dashboards' at Board, Executive team and Divisional/Directorate level. These include local authority indicators in respect of services managed under NHS Act 2006 Section 75 agreements. The Trust reports separately on its performance against Care Quality Commission standards through the Quality Improvement Committees reporting to the Integrated Governance Committee.

The Trust has an agreed strategic approach to promote economy, efficiency and productivity which is embedded within development of the cost improvement plan and benefits realisation programmes. This approach aims to ensure that financial benefits are not gained through the erosion of qualitative benefits to patients. The Executive and Non-Executive directors assure themselves of progress with plan and impact on services through quarterly Divisional Performance Review meetings

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

The Trust's Counter Fraud Work Plan, which is approved by the Audit Committee, demonstrates an embedded counter fraud work for any assessment process as defined by NHS Protect. The Plan focuses on four key areas: 'Strategic Governance'; 'Inform and Involve'; 'Prevent and Deter' and 'Hold to Account'. During 2012/13 one significant fraud involving a fraudulent bank mandate was identified and reported for investigation to NHS Protect. The Audit Committee reviewed action taken to ensure such an incident would not happen again.

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. 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 2012/13*.

The Directors of the Trust are required to satisfy themselves that the Trust's annual Quality Accounts are fairly stated. In doing so the Trust is required to put in place a system of internal control to ensure that proper arrangements are in place based on criteria specified by Monitor, the sector regulator for NHS- -funded care. The steps which have been put in place to assure the Board that the Quality Accounts are fairly stated are as follows:

- Report specifications are written for each report and take account of any Department of Health rules/guidance on how activity should be counted.
- Service capacity plans are agreed with each Directorate annually. These plans feed into the contracting process.
- Monthly activity is monitored against agreed contract targets. Month on month activity is compared to identify any inconsistencies.
- Quality in this sense is concerned with ensuring that systems are managed to support validity of data e.g. that all codes used are nationally recognised codes, or map to national values. Internal data quality also includes maintenance of changeable reference data.

- The system support function identifies and corrects inconsistent data.
- Systems are also managed to enforce data quality where necessary.
- Production and maintenance of data quality reports that can be run by end users.
- Specific data quality awareness, including the minimal use of default codes, is included with system training, and training support materials.
- Monthly monitoring reports produced for the service delivery teams to monitor the quality of the data, raising issues if tolerances are exceeded.
- Audits of records in the form of spot checks of paper records (where held), and validation of inpatient data entered electronically on a daily basis.
- Internal Audit review of data sources.

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 Committee and Integrated Governance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an Opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive Directors who have responsibility for the development and maintenance of the system of internal control provide me with assurance in a variety of ways, including through reports on the implementation of audit action plans and reports of the work of the Quality Improvement Committees. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- Work of the Trust's Audit Committee
- CQC Registration requirements
- Assessment against the NHSLA Risk Management standard
- Patient and staff surveys
- Complaints received and outcomes of investigations
- Serious Incidents requiring Investigation and the outcome of the investigations
- CQC (Mental Health Act Commission) reports
- Internal sources – such as clinical audit, internal management reviews, performance management reports, user and carer involvement activities, benchmarking and self-assessment reports
- Monitor quarterly assessment process
- Assessment against key findings of external inquiries

The Board has monitored progress against the top risks facing the Trust and assured itself that the strategic intent of the Trust appropriately addresses the risks facing the

Trust and the continual improvement of the totality of its business. The Audit Committee has sought assurance from the Trust's Internal and External Auditors from the agreed audit programmes which have been developed through consideration of the gaps in assurance as identified by the Assurance Framework. The Integrated Governance Committee and its executive sub-committees have ensured that programmes of work, and the development of policy and strategy, address identified risk areas. These committees have also considered the sources of assurance and incorporated the findings of these assurances in future work programmes.

The Board, supported by the work of its sub committees, has not identified any significant strategic internal control issues. It has, however, identified the potential significant risks facing the Trust in 2013/14 should the internal control environment not continue to be managed effectively. The table below sets out the potential significant risks:

Significant risk	In-year risk	Future risk
Facilities are not suitable or fit for purpose and, therefore, do not support effective service delivery	√	√
Non-delivery of Cost Improvement Plans (CIPs) could cause the Trust to fail in the delivery of its financial plan, including the Trust's Capital Programme	√	√
Breach of NHS England target for the incidence of serious infection (*Clostridium Difficile*) and the application of the financial penalty associated with a breach	√	√

Conclusion

The Board has concluded that there are no significant strategic internal control issues facing the Trust in 2012/13 but has identified the potential risks (as set out in the above table) should the controls not continue to be effectively managed. The Trust's Annual Governance Statement is a balanced reflection of the actual control position.

Chief Executive Date: 29 May 2013

Information governance

Oxford Health NHS Foundation Trust's Information Governance Assessment Report overall score for 2012/13 was 82% and was graded green (satisfactory).

We will be taking the following actions to continue improvement:

- information asset review and risk assessment
- updated information governance training
- continuing to improve the clinical coding by ensuring staff refresh their National Clinical Coding Qualification.

There were four information breaches during 2012/13. The Trust has taken the necessary action to learn from these events and tighten information security processes:

- the Urgent Care team sent special notes to all general practices in Oxfordshire, rather than to a specific individual practice (Community Division)
- electronic staff records were incorrectly reviewed (Human Resources)
- there was a loss of a USB stick which held minimal patient information (Community Division)
- two patient records were sent to Oxford Mail (Nursing and Clinical Standards).

The Board has been assured through the Integrated Governance Committee that effective arrangements are in place to manage and control risks to information and data.

An Information Governance Policy is in place, and was reviewed and updated this year. The Director of Finance is the Senior Information Risk Owner with overall responsibility for information security risk. The Director of Nursing and Clinical Standards has overall responsibility for information governance and data protection.

The Caldicott Guardian is responsible directly to the Board of Directors. Significant assurance has been gained through the annual Information Governance Toolkit self assessment.

One serious incident requiring investigation involving personal data was identified this year that required reporting to the Information Commissioner, as set out in guidance on serious untoward incidents involving data. The Information Commissioner took no enforcement action against the Trust.

Regulatory Ratings

The Board of Directors is required to submit a quarterly report to Monitor. These reports are used by Monitor to assign the Trust with financial, governance, and mandatory goods and service risk ratings. The ratings are designed to indicate the risk of failure to comply with the Terms of Authorisation.

The ratings used by Monitor are described below:

Financial risk rating

1. Highest risk - high probability of significant breach of authorisation in short-term, e.g. less than 12 months, unless remedial action is taken.
2. Risk of significant breach in medium-term, e.g. 12 to 18 months, in absence of remedial action.
3. Regulatory concerns in one or more components. Significant breach unlikely.
4. No regulatory concerns.
5. Lowest risk - no regulatory concerns.

Governance risk rating

Red - concern that issue(s) significantly breaches authorisation
Amber - concerns about one or more aspects of governance
Green - governance arrangements comply with authorisation

During 2012/13, the Trust's ratings were:

	Annual Plan	Q1	Q2	Q3	Q4
Financial Risk Rating	3	4	4	4	4
Governance Risk rating	Amber Green	Green	Green	Green	Green

During 2011/12, the Trust's ratings were:

	Annual Plan	Q1	Q2	Q3	Q4
Financial Risk Rating	3	4	4	4	3
Governance Risk rating	**Amber Green**	**Green**	**Green**	**Green**	**Green**

Performance

The Financial Risk Rating throughout the year was better than plan at '4'.

During 2012/13, the Trust maintained a Green Governance rating.

Financial performance 2012/13

The Trust's financial position and end of year Accounts are detailed in the Summary Financial Statements on pages 129-133 of this report.

The Summary Financial Statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity and the Statement of Cash Flows. Should you wish to obtain a copy of the full annual accounts including the notes to the accounts, please contact enquiries@oxfordhealth.nhs.uk or call 01865 782195. These will be made available free of charge.

The Board approved the full accounts on 29th May 2013 and the auditor's report on the full annual report and accounts was unqualified.

The accounts have been prepared by Oxford Health NHS Foundation Trust in accordance with Schedule 7, Paragraph 24 and 25 of the National Health Service Act 2006 in the form in which Monitor, the Independent Regulator of NHS Foundation Trusts has, with the approval of HM Treasury, directed. The 2012/13 statutory accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) as adopted by the European Union unless directed otherwise within the NHS Foundation Trust Reporting Manual 2012/13.

After conducting a detailed review which included consideration of forecasts covering the next 12 months (and projections for 2014-16) and the progress made in transferring contractual arrangements to our new commissioners, the directors have a reasonable expectation that Oxford Health NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Audit Committee, on behalf of the Board of Directors, resolves to approve the preparation of the accounts on a going concern basis.

The Financial year 2012/13 is referred to as FY13, the financial year 2011/12 as FY12 etc.

Financial highlights

- Total income for the Trust increased by £7.3m (2.7%) in FY13 to £279.8m.
- Income from activities increased by £6.5m (2.8%) to £239.8m.
- Operating surplus increased by £0.6m to £7.6m, after accounting for asset impairments. The underlying position excluding asset impairments was an increase in operating surplus of £1.5m compared to the previous year.
- Surplus margin of 2.4%, an increase of 0.5% compared to the previous year.

Key performance indicators (KPIs)

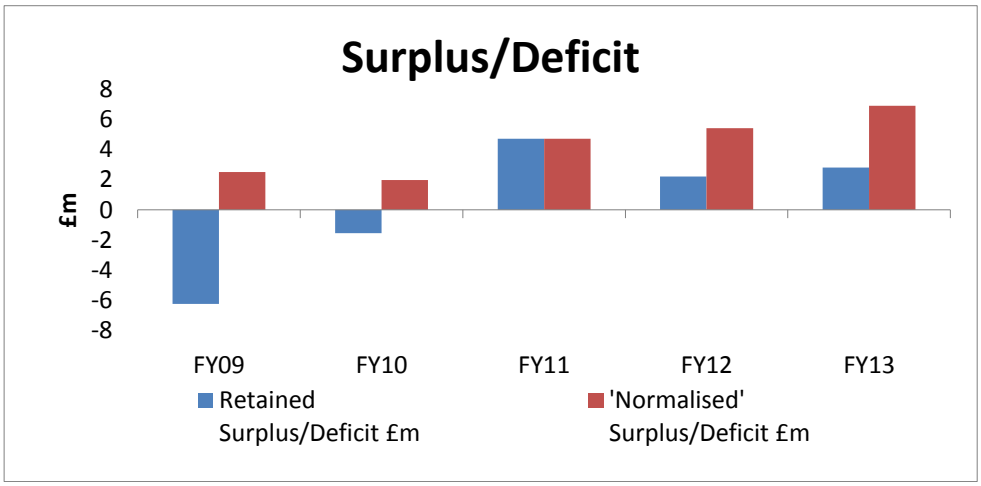
Monitor Financial Risk Metrics for the year ending 31 March 2013

	Actual	Plan	Variance
Underlying Performance:			
EBITDA %	5.3%	4.4%	+0.9%
Achievement of Plan:			
EBITDA % achieved	120.9%	105.8%	+15.1%
Financial Efficiency:			
Net Return after Financing	4.9%	2.6%	+2.3%
I&E Surplus Margin %	2.4%	1.3%	+1.1%
Liquidity:			
Liquid Ratio (days)	36.2	19.4	+16.8

Note -The Monitor Financial Risk Metrics above are based upon the Trust's quarterly submissions to Monitor. These submissions include pooled budget (section 75) income and expenditure and as a result the ratios quoted here are based on different I&E figures to the Trust's annual accounts, which exclude Section 75 balances.

Trust Performance

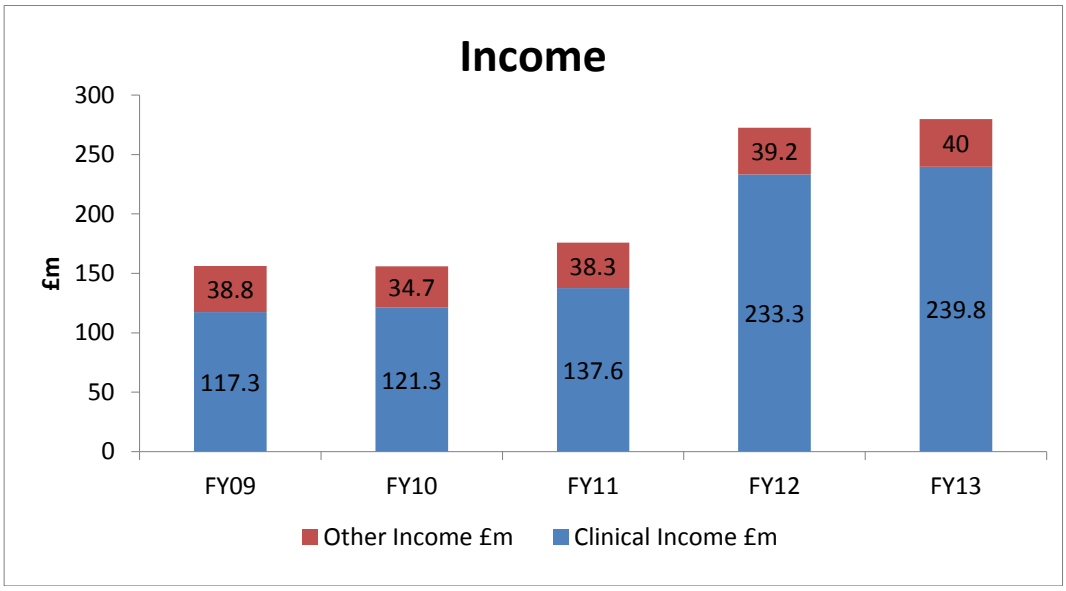
The Trust's full-year results reflect a sound performance. The Trust, and its predecessor trusts, has maintained as a minimum a break-even position for 10 consecutive years and in the last five years, a surplus before exceptional items. These surpluses are available to invest back into the Trust to improve its services.



2012/13 Statement of Comprehensive Income Summary

	£000
Total Income	279,797
Expenses	(272,210)
Operating Surplus	**7,587**
Loss on disposal	0
Finance income/expense	(1,430)
Dividends paid to Government	(3,395)
Surplus for the year	**2,762**
Impairment of assets	4,146
Surplus before exceptional items	**6,908**

** Normalised surplus is net surplus excluding impairments and non-recurring costs.*



In accordance with Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) the amount of income received by the Trust from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purpose.

Total income increased by £7.3m (2.7%) in FY13 to £279.8m. The Trust's main commissioners in FY13 were the Buckinghamshire and Oxfordshire PCTs, which account for approximately 75% of clinical activity income. Income from patient activities increased by £6.5m (2.8%) in FY13 to £239.8m due to additional income from commissioners for caring for more patients, new patient services provided in FY13 and an additional 1% CQUIN funding for quality related improvements. Income from other activities increased by £0.8m (2.0%) in FY13 to £40.0m.

Operating expenses increased by £6.7m (2.5%) to £272.2m, mainly attributable to new patient services and previously contracted out services that were brought in-house and provided by the Trust during FY13.

The majority of operating expenses relate to pay costs, which increased by £8.1m (4.4%) to £191.9m due to new patient services being provided during FY13 and previously contracted out services being brought 'in-house' and provided by the Trust during the year.

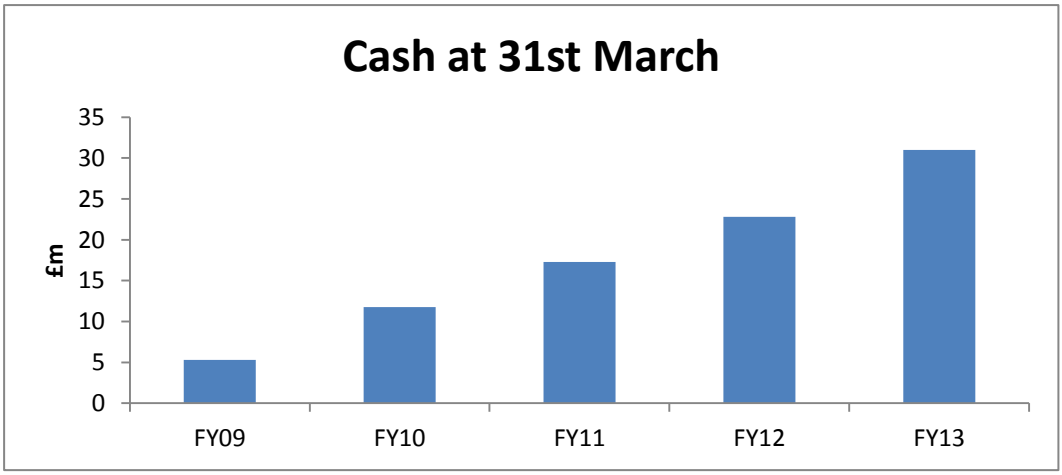
Capital expenditure

Capital spend in FY13 was £23.8m, compared with £13.3m in the previous year. The Trust's main capital investment areas were:

- Manor House, Aylesbury (£14.3m) - preparation for a new hospital due to be completed in autumn 2013;
- Highfield Unit, Oxford (£5.3m) – new inpatient unit for young people which was completed in FY13 and opened in January 2013;
- IT Infrastructure and development (£0.8m).

Cash flow and net debt

The Trust's cash position has improved by £8.2m during the year as a result of an increased operating surplus, external finance received in FY13 in relation to the Manor House capital development and an increase in trade and other payables at year-end.



The Trust generated £17.0m of cash from operations, down £3.7m on the previous year, primarily as a result of the integration of Community Health Oxfordshire in FY12.

The Trust's gearing ratio (the percentage of capital employed that is financed by debt and long term financing) increased to 27.9% (11.7% in FY12) with year-end net debt increasing by £19.2m to £32.9m (£13.7m in FY12) due to the full draw down of the loan for the Manor House capital development.

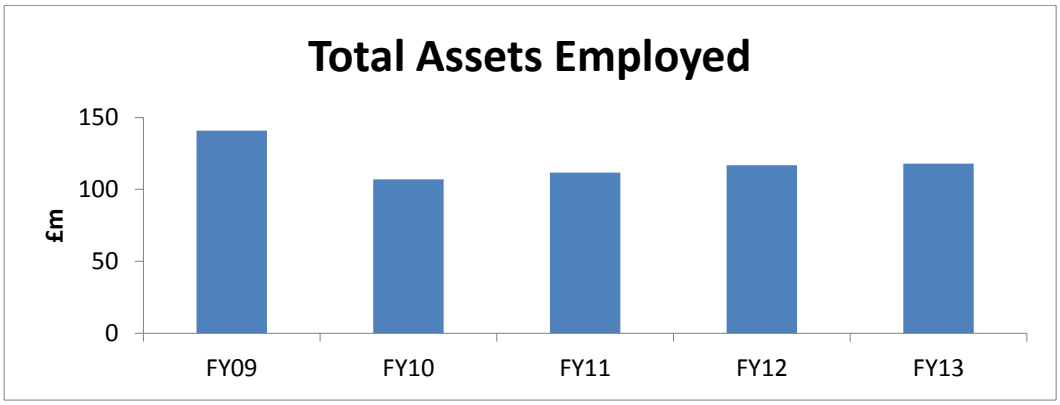
The Trust's Liquidity Ratio (Trust's ability to meet its short term obligations on time) increased to 36.2 days in FY13 from 29 days in FY12, reflecting the improved cash position.

Net Return after Financing

New return after financing was 4.9%, compared to 4.2% the previous year, reflecting the increased operating surplus for FY13.

Total assets employed

Total assets employed increased by £1.1m, 0.9% to £117.9m, reflecting the improved cash position.



Health Act Flexibilities

The Trust operates three provider pooled budgets under Section 75 Health Act Flexibilities, where health and local authority funding is brought together to deliver integrated services and seamless pathways of care. The value of the pools at 31st March 2013 was as follows:

- Oxfordshire - £10.6m (£26.9m, FY12). The decrease in pool value is due to inpatient services and drug and alcohol services no longer being within the scope of the pool
- Buckinghamshire Adults of working age - £8.6m (£9.0m, FY12)
- Buckinghamshire Older Adult – £3.0m (£3.0m, FY12).

The local government contribution to the pooled budgets and spend are excluded from the accounts of the Trust. However, the Board of Directors' performance monitoring of the Section 75 agreements includes local authority targets.

Better Payment Practice Code 2012/13

The Trust's performance against the Better Payment Practice Code is shown in the table below:

	Number	£000
Measure of Compliance:		
Total Non-NHS trade invoices paid in the year	**63,429**	**86,622**
Total Non NHS trade invoices paid within target*	**59,949**	**82,670**
Percentage of Non-NHS trade invoices paid within Target	**94.5%**	**95.4%**
Total NHS trade invoices paid in the year	**2,421**	**22,346**
Total NHS trade invoices paid within target*	**2,280**	**21,687**
Percentage of NHS trade invoices paid within Target	**94.2%**	**97.1%**

*Target - The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. 94.5% of the total number of non-NHS invoices received and processed were paid within the 30 day target, 95.4% by total value. The Trust is continually seeking to improve its invoice payment processes and improve performance against this Code. No interest was incurred under the Late Payment of Commercial Debts (Interest) Act 1998.

Countering fraud and corruption

The Board of Directors is committed to maintaining an honest, open and well-intentioned atmosphere within the Trust. It is therefore committed to eliminating any fraud within the Trust, and to the rigorous investigation of any such cases. Where any acts of fraud or corruption are proven, the Trust will ensure that the culprits are appropriately dealt with, and will also take all appropriate steps to recover any losses in full. The reporting procedures are detailed in the Trust's Counter Fraud policy which is available on the Trust's Intranet along with other useful information about countering fraud. It is the Trust's policy that an employee should not suffer detriment as a result of reporting reasonably held suspicions.

Any reasonably held suspicions should normally be reported to the Local Counter Fraud Specialist (LCFS) or Director of Finance. Serious concerns may also be raised using the Trust's Public Interest Disclosure (Whistle Blowing) Policy. Reports on any counter fraud activity are made to the Audit Committee. The Trust incurred a loss of £121,003.91 in 2012/13 as a result of a single bank mandate fraud; Trust procedures in this area have been reviewed, further strengthened and independently validated.

Future finance and performance outlook

The Trust, like the rest of the NHS, is facing an extremely challenging financial environment.

We already know that the NHS will receive limited growth funding, small increases in inflation funding and be faced with national efficiency targets of 4% year-on-year. The result of this will be a net real term reduction in income year-on-year.

The financial strategy for the Trust for FY14 to FY16 has been produced in response to this challenging economic environment, to find headroom from within existing

resources to maintain and improve existing levels and quality of patient care. It is built on the firm financial foundations laid by the Trust in the previous five years, since becoming a Foundation Trust. The Trust will continue to be proactive in responding to the economic recession and the potential impact on public service funding, through:

- strengthening financial governance
- targeting reductions in overhead costs, including support service functions
- ensuring real health gain in all investments
- driving increased productivity and quality with no net increase in funding
- planning for the delivery of cash releasing efficiency targets at significant levels
- mitigating financial risk through forward planning and contingencies.

The Board of Directors approved the FY14-FY16 Financial Plan and FY14 budget at its March meeting. The key highlights are:

- Normalised* surpluses of £5.5m, £5.3m and £5.3m over the next three years, giving a normalised surplus margin of not less than 1.8% per annum;
- Normalised EBITDA margin of 5.2%, 6.2% and 6.4% over the next three years;
- The requirement for cash releasing efficiency savings of £33.2m during this period;
- Capital investment of £47.6m over the next three years;
- A minimum financial risk rating of '3' over the next three years.

The Trust's main commissioners to the end of FY13 were primary care trusts (PCTs); NHS Oxfordshire and NHS Buckinghamshire. PCTs were abolished at the end of FY13 and clinical commissioning groups (CCG) are now directly responsible for commissioning health services from April 2013, with the exception of certain services commissioned directly by the NHS Commissioning Board; health improvement services commissioned by local authorities and health protection and promotion services provided by Public Health. During the latter part of FY13, PCTs led a process to transfer contracts for the provision of health services to these new commissioners.

The Trust's main contracts from FY14 are now with Oxfordshire CCG and Buckinghamshire CCG to provide mental health services to their respective resident populations, and with Oxfordshire CCG to provide community health services in Oxfordshire. In addition, the Trust has in place with Buckinghamshire and Oxfordshire county councils pooled health and social care budgets under Health Act Flexibilities for the Trust to deliver integrated community mental health services. Under the new commissioning regime, some other services that were previously commissioned by PCTs will move to local authorities. The Trust also has a contract to deliver child and adolescent mental health services in Swindon, Wiltshire, Bath and North East Somerset, and services previously under contract with the South Central Specialist Commissioning Group to provide specialist mental health services has now moved to the NHS Commissioning Board.

In addition to the change in the commissioning environment, the Trust is preparing for the introduction of Payment by Results in mental health, which will lead to the Trust receiving its income based on a national tariff. FY14 is a year of transition; it is

mandatory to contract using care clusters as the contract currency and the Trust will work with its main commissioners on analysing care cluster data and understanding cluster costs in order to move towards a single local price, and assess the potential impact of any national tariff development.

With a real terms reduction in funding, the Trust will continue to drive increased productivity and quality and deliver significant cash releasing efficiencies, resulting in a significant reduction in the Trust's cost base over the next three years. The track record of the Trust in delivering strong financial performance and significant levels of efficiencies provides a sound basis for moving forward, however, the Trust will develop its approach to delivering efficiencies in future years so that it is more transformational in nature. To support the increased focus on costs, the Trust is implementing a patient level information and costing system which will underpin costing work for both pricing and detailed service line reporting in the future.

The Trust recognises the importance of providing services from high quality premises and has a significant capital investment programme of £47.6m over the next three years. The main areas of investment include the completion of the Manor House hospital development. The capital programme will be financed through cash generated from operations and surplus land sales. In addition, the Trust has £28.1m of loan financing towards our new hospital in Aylesbury, Buckinghamshire (the Manor House scheme). In order to make best use of the NHS estate we have taken ownership from 1st April 2013 of the property from which we provide our community services; these properties were previously leased by us by NHS Oxfordshire (which ceased to exist on 31st March 2013).

Apart from the challenging economic environment within which the Trust continues to operate, the main risks facing the Trust during FY14 include: the requirement for the continued delivery of significant efficiency savings; continuing to deliver high quality services to patients in accordance with contracts agreed with commissioners, particularly in the context of the transition to new commissioners from April 2013; and delivering a substantial capital investment programme on time and within budget.

The Trust has plans in place to deliver its financial objectives for FY14 and mitigation plans to manage these risks.

Remuneration report

Salaries and Allowances

		2012/13				2011/12			
Name	Title	Effective Dates if not in post full year.	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (rounded to nearest £00)	Effective Dates if not in post full year.	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind (rounded to nearest £00)
			£000	£000	£00		£000	£000	£00
Julie Waldron	Chief Executive	1 Apr 2012 - 31 Aug 2012	70-75	0	0		165-170	0	0
Stuart Bell	Chief Executive	1 Oct 2012 - 31 Mar 2013	90-95	0	0				
Mike McEnaney	Director of Finance		145-150	0	0	15 Aug 2011 - 31 Mar 2012	95-100	0	0
Gareth Kenworthy	Acting Director of Finance		0	0	0	1 Apr 2011 - 14 Aug 2011	40-45	0	0
Graeme Armitage	Director of Human Resources		200-205	0	0		100-105	0	0
David Bradley	Chief Operating Officer	1 Apr 2012 - 27 Jul 2012	40-45	0	0		125-130	0	0
Yvonne Taylor	Chief Operating Officer	30 Jul 2012 - 31 Mar 2013	75-80						
Clive Meux	Medical Director		100-105	35-40	0		100-105	35-40	0
Ros Alstead	Director of Nursing and Clinical Governance		100-105	0	0		105-110	0	0
Stephen Cass	Director of Infrastructure		0	0	0	1 Apr 2011 - 31 Oct 2011	90-95	0	0
Martin Howell	Chair		40-45	0	0		40-45	0	0
Cedric Scroggs	Non-executive Director		10-15	0	0		15-20	0	0
Professor Tom Burns	Non-executive Director			0	0	1 Apr 2011 - 31 Oct 2011	5-10	0	0
Dr Anne Grocock	Non-executive Director		10-15	0	0		10-15	0	0
Sue Dopson	Non-executive Director	1 Jun 2012 - 31 Mar 2013	10-15	0	0			0	0
Roger Reed	Non-executive Director		10-15	0	0		10-15	0	0
Lyn Williams	Non-executive Director		15-20	0	0		15-20	0	0
Mike Bellamy	Non-executive Director		10-15	0	0		10-15	0	0
Alyson Coates	Non-executive Director		10-15	0	0		10-15	0	0

During 2012/13, a Treasury approved ex gratia payment of £103k was made in relation to the severance of employment to the Director of the Human Resources. Department of Health guidance requires this ex gratia payment to be recorded as salary in the table above.

The Trust is 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. To avoid distortion of the ratio the above ex gratia payment has been excluded from the relationship calculation.

The mid-point of the banded remuneration of the highest paid director in the Trust in the financial year 2012-13 was £147,500 (2011-12, £167,500). This was 6.06 times (2011-12, 6.6 times) the median remuneration of the workforce, which was £24,335 (2011-12, £25,528).

In 2012-13, one employee (none in 2011-12) received remuneration in excess of the highest paid director. Remuneration ranged from £14,009 to £205,000 (2011-12 £13,759 - £167,500)

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

The Medical Director receives a National Clinical Excellence Award, shown as "other remuneration", but this is not a cost borne by the Trust. The Medical Director's salary for 2011-12 has been restated on the same basis.

Stuart Bell, Chief Executive
29 May 2013

PENSION BENEFITS

Title	Real Increase/ (Decrease) in Pension at Age 60/65 (Bands of £2,500) £'000	Real Increase/ (Decrease) in Pension Lump Sum at Aged 60 (Bands of £2,500) £'000	Total Accrued Pension at Age 60/65 at 31 March 2012 (Bands of £5,000) £'000	Lump Sum at Age 60 Related to Accrued Pension at 31 March 2012 (Bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2013 £'000	Cash Equivalent Transfer Value at 31 March 2012 £'000	Real Increase/ (Decrease) in Cash Equivalent Transfer Value as at 31 March 2012 £'000	Employer's Contribution to Stakeholder Pension £'000
Stuart Bell Chief Executive	(2.5) - 0	(2.5) - 0	75-80	230-235	1508	1420	7	0
Julie Waldron Chief Executive	(2.5) - 0	(2.5) - 0	75-80	230-235	n/a	n/a	n/a	0
Mike McEnaney Director of Finance	0-2.5	n/a	0-5	n/a	54	20	33	0
Graeme Armitage Director of Human Resources	(5) - (2.5)	(10) - (7.5)	35-40	105-110	659	656	(31)	0
Yvonne Taylor Chief Operating Officer	0-2.5	5-7.5	20-25	60-65	430	334	53	0
David Bradley Chief Operating Officer	0-2.5	5-7.5	40-45	130-135	783	604	47	0
Clive Meux Medical Director	0-2.5	0-2.5	70-75	215-220	1367	1257	44	0
Ros Alstead Director of Nursing and Clinical Governance	(2.5) - 0	(5) - (2.5)	45-50	145-150	983	931	4	0

Off-Payroll Engagements

In accordance with HM Treasury PES(2012)17 *Annual Reporting Guidance 2012-13* published December 2012, NHS bodies are required to disclose information about 'off-payroll engagements' as follows:

Table 1: For off-Payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012

	Answer
No. in place on 31 January 2012	3
Of which:	
No. that have since come onto the Organisation's Payroll	2
Of which:	
No. that have since been re-negotiated/re-engaged to include to include contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	0
No. that have come to an end	1
Total	3

Table 2: For all new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months

	Answer
No. of new engagements	6
Of which:	
No. of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations	0
Of which:	
No. for whom assurance has been accepted and received	0
No. for whom assurance has been accepted and not received	0
No. that have been terminated as a result of assurance not being received	0
Total	6

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF OXFORD HEALTH NHS FOUNDATION TRUST

We have audited the financial statements of Oxford Health NHS Foundation Trust for the year ended 31 March 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Cash Flow Statement and the related notes 1 to 43. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Oxford Health NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Opinion on other matters prescribed by the National Health Service Act 2006
In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Directors' 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
We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate
We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Susan Barratt, BA ACA (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Reading, United Kingdom
29 May 2013

Appendices

Appendix 1 - Committee Attendance between 1 April 2012 and 31 March 2013

The Chair of each Committee is identified in **bold** in each table
Attendance at Audit Committee Meetings, April 2012 – March 2013

Director	20 Apr 12	24 May 12	20 Sep 12	06 Dec 12	07 Feb 13
Cedric Scroggs*	✓	✓	✓	✓	X
Alyson Coates*	✓	✓	✓	✓	✓
Anne Grocock	✓	✓	X	✓	✓
Roger Reed	✓	X	X	X	✓
Lyn Williams	✓	✓	✓	✓	✓
Sue Dopson**	N/A	N/A	N/A	N/A	X

Key: ✓ - attended Ext – Extraordinary meeting
X – apologies N/A – not a member of the Committee at this time

*Alyson Coates took up the chair of this Committee from December 2012.

**Sue Dopson appointed to Committee in January 2013

Attendance at Finance and Investment Committee Meetings, April 2012 – March 2013

Director	14 May 12	09 Jul 12	10 Sep 12	12 Nov 12	21 Jan 13	13 Mar 13
Lyn Williams	✓	✓	✓	✓	✓	✓
Martin Howell	✓	✓	✓	✓	✓	✓
Mike McEnaney	✓	✓	✓		✓	✓
Roger Reed	✓	✓	✓	X	X	X
Julie Waldron	✓	✓	N/A	N/A	N/A	N/A
Stuart Bell	N/A	N/A	N/A	✓	✓	✓
Cedric Scroggs*	N/A	N/A	N/A	N/A	N/A	✓

Key: ✓ - attended Ext – Extraordinary meeting
X – apologies N/A – not a member of the Committee at this time

*Appointed to Committee in March 2013

Attendance at Integrated Governance Committee Meetings, April 2012 – March 2013

Director	18 Apr 12	31 May 12 (Ext)	26 Jul 12	22 Oct 12	06 Mar 13
Julie Waldron	✓	✓	✓	N/A	N/A
Stuart Bell	N/A	N/A	N/A	✓	✓
Ros Alstead	✓	X	X	✓	✓
Graeme Armitage	✓	✓	✓	✓	✓
Mike Bellamy	✓	✓	✓	✓	✓
David Bradley	✓	✓	X	✓	✓
Anne Grocock	✓	X	✓	✓	X
Martin Howell	✓	✓	✓	X	X
Mike McEnaney	X	✓	✓	✓	✓
Clive Meux	✓	✓	✓	✓	X

Key: ✓ - attended
X – apologies
Ext – Extraordinary meeting
N/A – not a member of the Committee at this time

Attendance at Charitable Funds Committee Meetings, April 2012 – March 2013

Director	30 May 2012	26 Sep 12	28 Nov 12	27 Feb 13
Dr Anne Grocock	✓	✓	✓	✓
Ros Alstead	✓	X	✓	✓
Graeme Armitage	✓	✓	✓	✓
Stuart Bell	N/A	N/A	✓	✓
Mike Bellamy	✓	✓	✓	✓
David Bradley	✓	N/A	N/A	N/A
Alyson Coates	✓	✓	✓	✓
Professor Sue Dopson	N/A	X	X	X
Martin Howell	✓	✓	✓	✓
Mike McEnaney	✓	✓	✓	X
Dr Clive Meux	✓	X	✓	X
Roger Reed	✓	X	✓	X
Cedric Scroggs	✓	✓	✓	✓
Yvonne Taylor	N/A	✓	✓	X
Julie Waldron	✓	N/A	N/A	N/A
Lyn Williams	X	✓	✓	✓

Key: ✓ - attended
X – apologies N/A – not a member of the Committee at this time

Attendance at Executive Directors' Remuneration and Terms of Service Committee, April 2012 – March 2013

Name	13 Nov 12	22 Jan 13
Mike Bellamy	✓	✓
Alyson Coates	X	X
Sue Dopson	X	X
Anne Grocock	✓	✓
Martin Howell	✓	✓
Roger Reed	✓	✓
Cedric Scroggs	✓	✓
Lyn Williams	X	✓

Council of Governors

First Name	Surname	Governor Constituency	Tenure
Patricia	Armstrong	Patient: Carers	01/05/11 – 30/04/14
Lynda	Atkins	Public: Oxfordshire	01/05/11 – 30/04/14
Jacqueline	Bourton	Public: Oxfordshire	01/05/11 – 30/04/14
Karen	Campbell	Staff: Integrated Community Services	01/05/11 – 30/04/14*
Paul	Cann	Appointed: Age UK Oxfordshire	21/05/10 – 21/05/13
Jayne	Champion	Patient: Service Users (Mental Health)	01/04/10 – 31/03/13
Lynda	Colvin	Patient: Carers	15/07/11 – 14/06/14*
Maureen	Cundell	Staff: Mental Health	02/04/12 – 31/03/15
Martin	Dominguez	Patient: Service Users (Mental Health)	02/04/12 – 31/03/15
Juliet	Dunmur	Public: Oxfordshire	15/07/11 – 14/06/14
Arash	Fatemian	Appointed: Oxon County Council	10/06/10 – 10/06/13
Frances	Finucane	Staff: Mental Health	02/04/12 – 31/03/15
Sarah	Gardner	Staff: Integrated Community Services	15/07/11 – 14/06/14*
Stewart	George	Appointed: Bucks PCT	01/02/11 – 01/02/14
Moira	Gilroy	Staff: Corporate Services	01/06/11 – 31/05/14
Gautam	Gulati	Staff: Specialist & Forensic Services	15/07/11 – 14/06/14
William	James	Appointed: University of Oxford	24/11/11 – 24/11/14
Vivian	Lanzon-Miller	Public: Oxfordshire	01/05/11 – 30/04/14
Fiona	Lomas	Patient: Service Users (Mental Health)	01/05/10 – 30/04/13
Fiona	Mackay Perkins	Appointed: Oxon PCT	13/06/11 – 13/06/14
Rob	Michael-Phillips	Appointed: Buckinghamshire MIND	11/04/11 – 11/04/14
Heather	Mintern	Public: Buckinghamshire	01/05/10 – 30/04/13
Pam	Norton	Staff: Children, Young People and Families	01/05/11 – 30/04/14
Neil	Oldfield	Public: Buckinghamshire	15/07/11 – 14/06/14
Paul	Rogerson	Appointed: Bucks County Council	25/07/11 – 25/07/14
Wendy	Stark	Staff: Mental Health	02/04/12 – 31/03/15
Frances	Tammer	Public: Buckinghamshire	01/05/11 – 30/04/14
Peter	Tankard	Public: Oxfordshire	01/05/11 – 30/04/14
Liz	Turvey	Patient: Carers	01/05/10 – 30/04/13
Soo	Yeo	Staff: Integrated Community Services	15/07/11 – 14/06/14

* = resigned mid-way during tenure

Attendance at Members' Council Meetings, April 2012 – March 2013

Governors

First Name	Surname	May 2012	Jun 2012	Sep 2012	Nov 2012	Feb 2013
Patricia	Armstrong	✓	✓	✓	X	✓
Lynda	Atkins	✓	✓	✓	✓	✓
Jacqueline	Bourton	✓	✓	✓	✓	X
Karen	Campbell	X	✓	✓	✓	N/A
Paul	Cann	✓	✓	X	X	✓
Jayne	Champion	X	X	✓	X	X
Lynda	Colvin	X	✓	N/A	N/A	N/A
Maureen	Cundell	✓	✓	✓	X	✓
Martin	Dominguez	✓	✓	✓	✓	X
Juliet	Dunmur	✓	✓	✓	X	✓
Arash	Fatemian	X	X	✓	✓	X
Frances	Finucane	✓	X	✓	✓	X
Sarah	Gardner	X	✓	✓	X	N/A
Stewart	George	✓	X	X	✓	✓
Moira	Gilroy	✓	✓	✓	✓	X
Gautam	Gulati	X	✓	✓	✓	✓
William	James	X	X	X	X	X
Vivian	Lanzon-Miller	X	X	✓	X	X
Fiona	Lomas	X	X	✓	X	X
Fiona	Mackay Perkins	✓	X	X	✓	X
Rob	Michael-Phillips	X	✓	✓	✓	X
Heather	Mintern	✓	✓	✓	✓	X
Pam	Norton	✓	✓	✓	✓	✓
Neil	Oldfield	✓	X	✓	✓	✓
Paul	Rogerson	✓	X	✓	✓	X
Wendy	Stark	X	X	✓	X	X
Frances	Tammer	✓	X	✓	X	✓
Peter	Tankard	✓	✓	✓	X	✓
Liz	Turvey	✓	✓	✓	✓	✓
Soo	Yeo	✓	✓	✓	✓	✓

N/A – not in post

Directors (Executive and Non-Executive)

First Name	Surname	May 2012	Jun 2012	Sep 2012	Nov 2012	Feb 2013
Ros	Alstead	✓	X	✓	✓	✓
Graeme	Armitage	✓	X	✓	✓	X
Stuart	Bell	N/A	N/A	N/A	✓	✓
Mike	Bellamy	✓	✓	✓	✓	X
David	Bradley	✓	X	N/A	N/A	N/A
Alyson	Coates	✓	X	✓	X	✓
Sue	Dopson	N/A	X	✓	X	X
Anne	Grocock	✓	X	✓	✓	✓
Martin	Howell	✓	✓	✓	✓	✓
Mike	McEnaney	✓	X	✓	✓	X
Clive	Meux	✓	X	✓	✓	✓

First Name	Surname	May 2012	Jun 2012	Sep 2012	Nov 2012	Feb 2013
Roger	Reed	✓	X	X	✓	X
Cedric	Scroggs	✓	X	X	✓	X
Yvonne	Taylor	N/A	N/A	✓	X	X
Julie	Waldron	✓	✓	N/A	N/A	N/A
Lyn	Williams	✓	X	✓	X	✓

N/A – not in post

Attendance at Council of Governors Nominations and Remuneration Committee, April 2012 – March 2013

Name	Role	Aug 2012	Oct 2012
Martin Howell	**Chairman**	✓	✓
Lynda Atkins	Public Governor	X	✓
Karen Campbell	Staff Governor	✓	✓
Martin Dominguez	Service User Governor	✓	X
Fiona McKay-Perkins	Appointed Governor	✓	X
Liz Turvey	Carer Governor	✓	✓

Membership Constituencies and Governor Representation

Elected governors		
Constituency	*Class*	*No of governors*
Public	Buckinghamshire	4
	Oxfordshire	7
	Rest of England & Wales	1
Patient	Service Users (Mental Health)	3
	Patients (Community Services)	1
	Carers	3
Staff	Specialist Secondary Mental Health (all disciplines)	3
	Integrated Community Services (all disciplines)	3
	Children, Young People & Families (all disciplines)	1
	Specialist & Forensic Services (all disciplines)	1
	Corporate Services (all disciplines)	1
Sub total elected		28
Appointed governors		
Oxfordshire PCT		1
Buckinghamshire PCT		1
Oxfordshire County Council		1
Buckinghamshire County Council		1
University of Oxford		1
Voluntary / Community Organisations		

- Mind (The National Association for Mental Health) - Age UK Oxfordshire	1 1
Sub total appointed	7
Total number of governors	**35**

Appendix 2 – FT Membership Data

Membership

Public constituency	Last Year
At year start (April 1)	2203
At year end (March 31)	2270
Staff constituency	
At year start (April 1)	6254
At year end (March 31)	6204
Patient constituency	
At year start (April 1)	448
At year end (March 31)	468

Analysis of current membership

Public constituency	Number of members	Eligible members
Age (years):		
0-16	5	11,141,985
17-21	2	2,682,893
22+	1734	38,217,039
Unknown	529	
Ethnicity:		
White	1779	47,520,866
Mixed	22	661,036
Asian or Asian British	47	2,273,736
Black or Black British	33	1,139,575
Other	9	446,704
Unknown	380	
Socio-economic grouping		
ABC1	1637	20,999,815
C2	293	6,149,928
D	258	6,976,630
E	59	6,540,173
Unknown	23	11,375,371
Gender		
Male	953	25,325,925
Female	1317	26,715,992
Unknown		
Patient constituency	Number of members	Eligible members
Age (years):		
0-16	0	50,510
17-21	1	5670
22+	400	82064
Unknown	67	

- Eligible public data for; age, ethnicity and gender, were taken from the Office for National Statistics, 2001 Census analysis.
- Eligible patient data provided by the Information Analysts department within Oxford Health NHS FT, on 9 May 2013
- Eligible social grade data taken from the Office for National Statistics, 2001 Census approximated social grade analysis.
- Current Membership data taken from the Oxford Health NHS FT Membership Relationship Management (MRM) database, on 1 April 2013.
- Socio-economic grouping data were analysed by CACI using its ACORN profiling in May 2013.

Membership commentary

Members belong to one of three Constituencies, which are further sub-divided into classes or groups.
Public
There are three classes: Public: Oxfordshire; Public: Buckinghamshire; and Public: Rest of England & Wales. This Constituency is open to people (excluding staff) who live in either of the counties of Buckinghamshire or Oxfordshire or live in the rest of England or Wales. Patients, service users and carers may also join this Constituency if they wish.

Patient
There are three classes: Patients: Community Services; Service Users: Mental Health; and Carers. This Constituency is open to patients, service users, or carers who have had contact with the Trust in the previous five years on the date of application.

Staff
There are five classes: Staff: Specialist Secondary Mental Health (all disciplines); Staff: Integrated Community Services (all disciplines); Staff: Children, Young People and Families (all disciplines); Staff: Specialised Services (all disciplines); and Staff: Corporate Services (all disciplines). This Constituency is open to all employees of the Trust, including County Council staff employees seconded to the Trust under integrated management arrangements.

Membership for Patient and Public Constituencies is under an ‘opt-in’ system. Membership for the Staff Constituency is under an ‘opt-out’ system.

Annual Statutory Accounts - Year Ending 31 March 2013

Trust name:	Oxford Health NHS Foundation Trust
This year	2012/13
Last year	2011/12
This year ended	31 March 2013
Last year ended	31 March 2012
This year beginning	1 April 2012
Last year beginning	1 April 2011

FOREWORD TO THE ACCOUNTS

Oxford Health NHS Foundation Trust

The accounts for the year ended 31 March 2013 are set out on the following pages and comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and the Notes to the Accounts.

The accounts have been prepared by Oxford Health NHS Foundation Trust in accordance with Schedule 7, Paragraph 24 and 25 of the National Health Service Act 2006 in the form in which Monitor, the Independent Regulator of NHS Foundation Trusts has, with the approval of HM Treasury, directed. The 2012/13 statutory accounts have been prepared in accordance with International Financial Reporting Standards (IFRS) as adopted by the European Union unless directed otherwise within the NHS Foundation Trust Reporting Manual 2012/13. The Trust Board has approved the preparation of the 2012/13 accounts on a going concern basis.

Signed: ……

Stuart Bell, Chief Executive

Date: …. 29-May-13

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2013

	NOTE	2012/13 £000	2011/12 £000
Operating income	4,5,6	**279,797**	272,509
Operating expenses	7	**(272,210)**	(265,483)
Operating surplus		**7,587**	7,026
Finance costs			
Finance income	16	**172**	251
Financial expense - financial liabilities	17	**(1,545)**	(1,326)
Financial expense - unwinding of discount on provisions	17	**(57)**	(43)
Public Dividend Capital dividends payable	37	**(3,395)**	(3,731)
Net finance costs		**(4,825)**	(4,849)
Surplus from continuing operations		**2,762**	2,177
Surplus from discontinued operations		**0**	0
SURPLUS FOR THE FINANCIAL YEAR		**2,762**	2,177
Other comprehensive income :			
Revaluation (losses)/gains and impairment losses property, plant and equipment	20,29	**(1,886)**	3,384
Actuarial gains/(losses) on defined benefit pension schemes	11,43	**42**	(372)
Other reserve movements		**0**	0
TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR		**918**	5,189

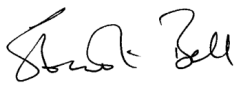
All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2013

	NOTE	31 March 2013 £000	31 March 2012 £000
NON-CURRENT ASSETS			
Intangible assets	18	**305**	292
Property, plant and equipment	19	**136,891**	122,601
Trade and other receivables	22	**30**	30
Total Non-Current Assets		**137,226**	122,923
CURRENT ASSETS			
Inventories	21	**1,555**	1,740
Trade and other receivables	22	**7,791**	7,691
Non-current assets held for sale	23	**6,400**	6,400
Cash and cash equivalents	30	**30,944**	22,788
Total Current Assets		**46,690**	38,619
CURRENT LIABILITIES			
Trade and other payables	24	**(25,864)**	(21,907)
Borrowings	25	**(1,433)**	(103)
Other financial liabilities	26	**(700)**	(607)
Other liabilities	27	**(2,334)**	(4,613)
Provisions	28	**(1,171)**	(1,834)
Total Current Liabilities		**(31,502)**	(29,064)
NON CURRENT LIABILITIES			
Trade and other payables	24	**0**	0
Borrowings	25	**(31,475)**	(13,608)
Other financial liabilities	26	**0**	0
Other liabilities	27	**(435)**	0
Provisions	28	**(2,594)**	(2,040)
Total Non Current Liabilities		**(34,504)**	(15,648)
TOTAL ASSETS EMPLOYED		**117,910**	116,829
TAXPAYERS' EQUITY			
Public dividend capital		**88,543**	88,380
Revaluation reserve	29	**15,040**	15,982
Available for sale financial assets reserve		**0**	0
Other reserves		**6,700**	8,076
Merger reserve		**0**	0
Income and expenditure reserve		**7,627**	4,391
TOTAL TAXPAYERS' EQUITY		**117,910**	116,829

The notes on pages 5 to 46 form part of these accounts.

The financial statements on pages 1 to 4 were approved by the Board and signed on its behalf by:

Signed:  Date: 29 May 2013

Stuart Bell (Chief Executive)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2012/13

	Total	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2012	**116,829**	88,380	15,982	8,076	4,391
Surplus for the year	**2,762**				2,762
Transfer between reserves	**0**		1,376	(1,376)	
Revaluation losses and impairment losses on property plant and equipment	**(1,886)**		(1,886)		
Actuarial gains on defined benefit pension schemes	**42**				42
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	**0**		(432)		432
Movements on other reserves	**0**				
Public Dividend Capital received	**163**	163			
Taxpayers' Equity at 31 March 2013	**117,910**	88,543	15,040	6,700	7,627

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2011/12

	Total	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve
Taxpayers' Equity at 1 April 2011	**111,639**	88,380	12,932	8,076	2,251
Surplus for the year	**2,177**				2,177
Transfer between reserves	**0**				
Revaluation gains on property plant and equipment	**3,384**		3,384		
Actuarial losses on defined benefit pension schemes	**(372)**				(372)
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	**0**		(334)		334
Movements on other reserves	**0**				
Public Dividend Capital received	**0**				
Taxpayers' Equity at 31 March 2012	**116,829**	88,380	15,982	8,076	4,391

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2013

	NOTE	2012/13 £000	2011/12 £000
Cash flows from operating activities			
Operating surplus from continuing operations		**7,587**	7,026
Operating surplus of discontinued operations		**0**	0
Operating surplus		**7,587**	7,026
Non-cash income and expense:			
Depreciation and amortisation	7	**3,515**	3,163
Impairments	7	**4,146**	3,427
Reversals of impairments	6	**0**	(235)
Interest accrued not paid		**(43)**	(23)
Dividends accrued and not paid or received		**(321)**	(63)
Decrease/(Increase) in trade and other receivables		**397**	(563)
Decrease in inventories		**185**	169
Increase in trade and other payables		**3,455**	5,446
(Decrease)/Increase in other liabilities		**(2,257)**	1,038
Increase in provisions		**315**	1,625
Other movements in operating cash flows		**0**	(372)
NET CASH GENERATED FROM OPERATIONS		**16,981**	20,638
Cash flows from investing activities:			
Interest received		**255**	251
Purchase of intangible assets		**(72)**	(171)
Purchase of property, plant and equipment		**(23,246)**	(10,058)
NET CASH GENERATED USED IN INVESTING ACTIVITIES		**(23,063)**	(9,978)
Cash flows from financing activities:			
Public dividend capital received		**163**	0
Loans received		**19,300**	0
Loans repaid		**(34)**	(34)
Capital element of private finance initiative obligations		**(68)**	(64)
Interest paid		**(477)**	(333)
Financing element of private finance initiative obligations		**(995)**	(961)
PDC dividend paid		**(3,652)**	(3,775)
NET CASH GENERATED FROM/(USED IN) FINANCING ACTIVITIES		**14,238**	(5,167)
Increase in cash and cash equivalents		**8,156**	5,493
Cash and cash equivalents at 1 April		**22,788**	17,295
Cash and cash equivalents at 31 March		**30,944**	22,788

NOTES TO THE ACCOUNTS

1 Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012/13 FT ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

After conducting a detailed review which included consideration of forecasts covering the next twelve months (and projections for 2014-16) and the progress made in transferring contractual arrangements to our new commissioners, the directors have a reasonable expectation that Oxford Health NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Audit Committee, on behalf of the Board of Directors, resolves to approve the preparation of the accounts on a going concern basis.

1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.2 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Local government pension scheme

Some employees are members of the Local Government Superannuation Scheme which is a defined benefit pension scheme. The net scheme assets or liabilities attributable to these employees can be identified and are recognised in the trust's accounts, arising from the date of transfer to the Trust. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The current service cost during the year is recognised within operating expenses. The net of the expected gain during the year from scheme assets and the interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance income/costs. Actuarial gains and losses during the year are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.3 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.4 Property, plant and equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

Assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. Costs arising from financing the construction of the fixed assets are not capitalised but are charged to the Statement of Comprehensive Income in the year to which they relate.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*. The last asset valuations were undertaken in 2013 as at the valuation date of 31 March 2013.

The Treasury has decided that the NHS should value its property assets in line with the Royal Institution of Chartered Surveyors (RICS) Red Book standards. This means that specialised property, for which market value cannot be readily determined, should be valued at depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis.

Assets in the course of construction are valued at cost and are valued by professional valuers when they are brought into use.

Operational equipment is valued at depreciated replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or 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 income 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.

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';
  - 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, government grant and other 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. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income. Lifecycle replacement costs are capitalised in line with the operator capital spend.

1.5 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

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

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 fair value. Revaluations gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

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.

1.6 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.7 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

1.8 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as fair value through income & expenditure, loans & receivables.

Financial liabilities are categorised as fair value through income & expenditure or as 'other financial liabilities'.

Financial assets and financial liabilities at 'Fair value through income and expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current and non current assets.

The Trust's loans and receivables comprise: cash at bank and in hand, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of financial position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices, independent appraisals and discounted cash flow analysis.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.9 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
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 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.

1.10 Provisions

The NHS foundation 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
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 28, but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority 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.

1.11 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.12 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation 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 NHS foundation 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) net cash balances held with the Government Banking Services (GBS) and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (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.

1.13 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.14 Corporation tax

The Trust's activities relate to the provision of goods and services relating to healthcare authorised under Section 14(1) of the HSCA. On this basis the Trust is not liable for corporation tax.

1.15 Foreign exchange

The functional and presentational currencies of the Trust are sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of financial position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *Financial Reporting Manual* .

1.17 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 trusts 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.

1.18 Transfers of functions to or from other NHS and local government bodies

For functions that have been transferred to the trust from another NHS or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain or loss corresponding to the net assets or liabilities transferred is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation or Amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the trust has transferred to another NHS or local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss or gain corresponding to the net assets or liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

1.19 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2 Critical accounting estimates and judgements

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 and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

2.1 *Critical judgements in applying accounting policies*

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

• The Trust's PFI scheme has been assessed as an on Statement of Financial Position PFI under IFRIC 12 because the Trust has judged that it controls the services and the residual interest at the end of the service arrangement.

• The carrying values of property, plant and equipment are reviewed for impairment when there is an indication that the values of the assets might be impaired.

• The Trust determines whether a substantial transfer of risks and rewards has occurred in relation to leased assets, if this is deemed to be the case the lease is treated as a finance lease, all other leases are classified as operating leases.

2.2 *Key sources of estimation uncertainty*

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

• Property Valuations

Property Plant and Equipment Assets were valued by the District Valuers as at 31 March 2013. These valuations are based on Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury, the National Health Service and the Department of Health.

• Estimation of replacement of components of the PFI asset during the contract - 'lifecycle replacement'.

PFI lifecycle replacement costs are estimated to take place as planned and at the values included in the operator's financial model as adjusted for indexation.

• Estimation of payments for the PFI asset, including finance costs.

The assets and liabilities relating to the PFI scheme have been brought onto the Statement of Financial Position based on estimations from the Department of Health's financial model as required by Department of Health guidance. These estimations were reviewed by external audit as part of the 2008/09 IFRS accounts restatement exercise.

• Estimation of asset lives as the basis for depreciation calculations.

Depreciation of equipment is based on asset lives, which have been estimated upon recognition of the assets.

• Discount rates for provisions.

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.

3 Operating Segments

The following information segments the results of the NHS Foundation Trust by:

• Oxford Pharmacy Store - Shortline pharmacy store supplying pharmaceuticals to other NHS Trusts in the United Kingdom.

• Healthcare being all the other activities of the NHS Foundation Trust.

	Healthcare		**Oxford Pharmacy Store**		**Total**	
	2012/13 £000	2011/12 £000	**2012/13 £000**	2011/12 £000	**2012/13 £000**	2011/12 £000
Income	**263,588**	255,146	**16,209**	17,363	**279,797**	272,509
Operating surplus/(deficit)	**7,490**	7,156	**97**	(130)	**7,587**	7,026

In line with the HM Treasury, the Trust has chosen to adopt the amendment to IFRS 8. Consequently, the Trust does not need to disclose the total assets attributable to each operating segment as this information is not regularly provided to the Board.

4 Operating income

	2012/13	2011/12
	£000	£000
Income from activities	**239,762**	233,275
Other operating income	**40,035**	39,234
	279,797	272,509

5 Income from activities

5.1 Income from activities (by activity)

	2012/13	2011/12
	£000	£000
Mental health		
Block contract income	**129,022**	129,603
Cost and volume contract income	**1,919**	2,325
Clinical income for the secondary commissioning of mandatory services	**2,861**	2,846
Other clinical income from mandatory services	**2,484**	2,484
Community services	**103,448**	95,998
Private patient income	**28**	19
	239,762	233,275

All income from activities arises from mandatory services.

5.2 Income from activities (by source)

	2012/13	2011/12
	£000	£000
Primary care trusts	**219,535**	214,707
Local authorities	**15,555**	13,853
NHS trusts	**2,782**	2,907
Other WGA bodies	**1,174**	1,108
Foundation trusts	**644**	529
Department of Health	**0**	100
Bodies external to government	**44**	52
Private patients	**28**	19
	239,762	233,275

5.3 Private patient income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statement disclosures that were provided previously are no longer required.

6 Other operating income

	2012/13	2011/12
	£000	£000
Pharmacy sales	**16,250**	17,392
Education and training	**11,249**	11,586
Research and development	**5,030**	3,707
Non-patient care services to other bodies	**4,917**	3,295
Other income	**2,305**	2,825
Reversal of impairments of property, plant and equipment	**0**	235
Charitable and other contributions to expenditure	**218**	194
Receipt of donations for capital acquisitions	**66**	0
	40,035	39,234

7 Operating expenses

	2012/13	2011/12
	£000	£000
Services from Foundation Trusts	**2,610**	1,304
Services from NHS Trusts	**1,008**	2,791
Services from PCTs	**45**	32
Purchase of healthcare from non NHS bodies	**1,131**	1,410
Employee Expenses - Executive directors	**960**	984
Employee Expenses - Non-executive directors	**148**	140
Employee Expenses - Staff	**190,836**	182,743
Supplies and services - clinical (excluding drug costs)	**7,946**	9,378
Supplies and services - general	**2,878**	2,866
Establishment	**7,316**	7,058
Transport	**401**	351
Premises	**10,712**	9,986
Increase in provision for impairment of receivables	**2**	68
Increase in other provisions	**444**	0
Inventories written down (net, including inventory drugs)	**91**	137
Drug costs (non inventory drugs only)	**1,884**	2,184
Inventories consumed (excluding drugs)	**682**	679
Drug Inventories consumed	**17,197**	18,620
Rentals under operating leases	**8,201**	8,397
Depreciation of property plant and equipment	**3,456**	3,124
Amortisation on intangible assets	**59**	39
Impairment of property, plant and equipment	**4,146**	3,427
Audit services - statutory audit	**73**	117
Audit services - regulatory reporting	**0**	15
Audit services - other	**9**	0
Clinical negligence	**396**	490
Legal fees	**420**	452
Consultancy costs	**738**	1,132
Training, courses and conferences	**1,810**	1,490
Patient travel	**117**	74
Car parking and security	**63**	159
Redundancy (Included in Employee Expenses)	**958**	1,631
Insurance	**141**	178
Other services, e.g. External payroll	**1,824**	2,346
Losses, ex gratia & special payments	**295**	53
Other	**3,215**	1,626
	272,210	265,483

The Trust has adopted the above operating expenses table in line with Monitor FTC guidance. The 2011/12 total remains the same but the figures have been presented in the new categories for comparative purposes.

8 Staff costs and numbers

8.1 Employee expenses

(excluding non-executive directors)

	2012/13 Total	2012/13 Permanently Employed	2012/13 Other	2011/12 Total
	£000	**£000**	**£000**	£000
Salaries and wages	**156,153**	**153,869**	**2,284**	147,555
Social Security costs	**11,972**	**11,972**		11,512
Employer contributions to NHS pension scheme	**18,526**	**18,526**		17,834
Other pension costs	**71**	**71**		53
Termination benefits	**1,085**	**1,085**		1,631
Bank and agency staff	**5,158**		**5,158**	6,852
Capitalised employee costs	**(85)**	**(85)**		(79)
	192,880	**185,438**	**7,442**	185,358

8.2 Staff numbers

(excluding non-executive directors)

	2012/13 Total	2012/13 Permanently employed	2012/13 Other	2011/12 Total
	WTE	**WTE**	**WTE**	WTE
Medical and dental	**224**	**224**		198
Administration and estates	**965**	**965**		934
Healthcare assistants and other support staff	**1,005**	**1,005**		972
Nursing, midwifery and health visiting staff	**1,554**	**1,554**		1,412
Nursing, midwifery and health visiting learners	**79**	**79**		0
Scientific, therapeutic and technical staff	**872**	**872**		786
Social care staff	**11**	**11**		72
Bank and Agency Staff	**114**		**114**	132
	4,824	**4,710**	**114**	4,506

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

8.3 Directors' remuneration and other benefits

	2012/13	2011/12
	£000	£000
Executive and non executive directors salaries	**1,063**	994
Employers' contribution to executive directors' pensions*	**110**	112
	1,173	1,106

*relates to 8 directors (7 in 2011/12) accruing benefits under the NHS Pension Scheme, a defined benefit scheme

8.4 Staff exit packages

Exit package cost band	2012/13 Total number of exit packages	2012/13 Number of compulsory redundancies	2012/13 Number of other departures agreed	2011/12 Total number of exit packages
< £10,000	**25**	**0**	**25**	1
£10,000 - £25,000	**31**	**0**	**31**	0
£25,001 - £50,000	**13**	**0**	**13**	0
£50,001 - £100,000	**3**	**0**	**3**	1
£100,001 - £150,000	**1**	**0**	**1**	2
£150,001 - £200,000	**0**	**0**	**0**	1
Total number of exit packages	**73**	**0**	**73**	5
Total resource cost £'000	**1,390**	**0**	**1,390**	523

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

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

9 Employee benefits

The Trust's employees received no material benefits in 2012/13 (none in 2011/12).

10 Retirements due to Ill-health

During 2012/13 there were 6 early retirements (2011/12, 4) from the NHS Foundation Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £411,943 (2011/12, £233,717). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11 Pension Costs

11.1 *NHS Pension Scheme*

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11.2 *Local government superannuation scheme*

Buckinghamshire County Council pension scheme

In 2009-10, 22 members of staff transferred employment from Buckinghamshire County Council. As at 31 March 2013, 15 of these retain active membership of the Buckinghamshire County Council Pension Scheme, which is a defined benefits scheme.

The County Council retains the assets and liabilities relating to this scheme.

The Trust's obligations in respect of pensions liabilities for these staff transferring is with effect from 1 April 2009 and not the period of employment before this date.

The Trust's accounts reflect the liability attributable from this date within Provisions on the Statement of Financial Position, £435,000 at 31 March 2013 (£422,000 at 31 March 2012).

The Trust commissioned Barnett Waddingham to prepare an actuarial report to provide full pension details in accordance with Financial Reporting Standard 17 (FRS17). The report is available on request.

The assets of the Scheme are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets and the interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the Income and Expenditure reserve and reported as an item of other comprehensive income.

Further disclosure of the Buckinghamshire County Council Pension scheme relating to the Trust is shown in note 43.

12 Leases

Memorandum note - operating lease costs are included within operating expenses

12.1 Operating lease payments recognised as an expense

	2012/13	2011/12
	£000	£000
Minimum lease payments	**8,201**	8,397
Contingent rents	**0**	0
Sub-lease payments	**0**	0
	8,201	8,397

12.2 Total future minimum operating lease payments

	Land & Buildings		**Other Leases**		**Employee Car Leases***	
	2012/13	2011/12	**2012/13**	2011/12	**2012/13**	2011/12
	£000	£000	**£000**	£000	**£000**	£000
Payable:						
Not later than one year	**5,129**	6,644	**269**	766	**643**	486
Between one and five years	**7,368**	10,388	**221**	731	**601**	320
After 5 years	**14,908**	14,672	**0**	0	**0**	0
Total	**27,405**	31,704	**490**	1,497	**1,244**	806

Total future sublease payments expected to be received: £Nil

*Leases for employee lease cars are the Trust's liability but not recognised in operating expenses as they are deducted directly from employee salary.

12.3 Finance leases

The Trust has no finance leases, either as lessor or lessee, other than the PFI scheme which is identified separately (see note 32).

13 Audit remuneration

13.1 Audit fees

	2012/13	2011/12
	£000	£000
Audit services - statutory audit	**73**	117
Audit services - audit-related regulatory reporting	**0**	15
Other auditor remuneration	**9**	0
	82	132

£8k of the other auditor remuneration relates to property valuation advice.

13.2 Limitation on auditor's liability

	2012/13	2011/12
	£000	£000
Limitation on auditor's liability	**0**	0
	0	0

14 Better payment practice code

	2012/13		2011/12	
	Number	**£000**	Number	£000
Measure of Compliance:				
Total Non-NHS trade invoices paid in the year	**63,429**	**86,622**	61,851	73,529
Total Non NHS trade invoices paid within target*	**59,949**	**82,670**	58,231	69,966
Percentage of Non-NHS trade invoices paid within target	**94.5%**	**95.4%**	94.1%	95.2%
Total NHS trade invoices paid in the year	**2,421**	**22,346**	2,351	25,409
Total NHS trade invoices paid within target*	**2,280**	**21,687**	2,244	24,718
Percentage of NHS trade invoices paid within target	**94.2%**	**97.1%**	95.4%	97.3%

* The Better Payment Practice Code's target is for the Trust to pay 95% of the value of undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

15 The Late Payment of Commercial Debts (Interest) Act 1998

	2012/13	2011/12
	£000	£000
Amounts included within Finance Costs (Note 17) arising from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
	0	0

16 Finance income

	2012/13	2011/12
	£000	£000
Bank account interest	**172**	250
Net finance income on Local Government Pension Scheme	**0**	1
	172	251

17 Finance expense

	2012/13	2011/12
	£000	£000
Interest on loans	**453**	356
Financing obligations under PFI contracts:		
- main finance cost *	**720**	714
- contingent finance cost**	**270**	247
Change in discount rate on provisions	**84**	9
Unwinding of discount on provisions	**57**	43
Net finance expense on Local Government Pension Scheme	**18**	0
	1,602	1,369

* The interest on the outstanding PFI liability.

** The additional amount payable on the liability due to uncertain factors (i.e. inflation) is treated as a 'contingent finance cost'. IAS17 requires this to be reported separately from the main lease finance cost.

18 Intangible assets

	2012/13 £000	2011/12 £000
Gross cost at 1 April	**638**	467
Additions purchased	**72**	171
Gross cost at 31 March	**710**	638
Amortisation at 1 April	**345**	306
Charged during the year	**59**	39
Amortisation at 31 March	**405**	345
Net book value		
Purchased at 31 March 2013	**305**	**292**
Total at 31 March 2013	**305**	**292**

All intangible assets held by the Trust are software licences which are held at depreciated replacement cost. The useful lives of software assets are finite. The useful remaining life of software licences range from between 1 year and 5 years.

Revaluation reserve balance for intangible assets

	2012/13 £000	2011/12 £000
At 1 April 2012	**0**	0
Changes	**0**	0
At 31 March 2013	**0**	0

19 Property, Plant and Equipment

19.1 Property, Plant and Equipment 2012/13

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2012	42,803	63,844	769	18,117	2,180	91	10,101	4,579	142,484
Additions purchased		6,463		15,999	120		756	374	23,712
Additions donated		66							66
Additions government granted									0
Reclassifications		7,544		(8,342)	501		9	288	0
Reclassified as held for sale									0
Disposals other than by sale									0
Indexation									0
Revaluation	85	2,876	(4)						2,957
Impairments	(378)	(5,835)							(6,213)
Reversal of impairments									0
Cost or valuation at 31 March 2013	42,510	74,958	765	25,774	2,801	91	10,866	5,241	163,006
Depreciation at 1 April 2012	2,864	2,074	10	3,417	1,451	91	7,518	2,459	19,884
Reclassifications									0
Reclassified as held for sale									0
Disposals other than by sale									0
Revaluation		(1,350)	(19)						(1,369)
Impairments	154	3,991							4,145
Reversal of impairments									0
Charged during the year		1,931	24		110		964	428	3,456
Depreciation at 31 March 2013	3,018	6,646	15	3,417	1,561	91	8,482	2,887	26,116
Net Book Value									
Purchased at 31 March 2013	39,492	59,785	751	22,357	1,240		2,384	2,355	128,364
Private finance initiatives at 31 March 2013		7,384							7,384
Donated and Government Granted at 31 March 2013		1,143							1,143
Total at 31 March 2013	39,492	68,312	751	22,357	1,240	0	2,384	2,355	136,891
Purchased at 1 April 2012	39,939	52,459	760	14,700	727		2,583	2,120	113,288
Private finance initiatives at 1 April 2012		8,219							8,219
Donated and Government Granted at 01 April 2012		1,092			2				1,094
Total at 1 April 2012	39,939	61,770	760	14,700	729	0	2,583	2,120	122,601

19.2 Property, Plant and Equipment 2011/12

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2011	43,455	65,512	793	8,021	1,991	91	9,104	4,538	**133,505**
Additions purchased		1,451		10,457	137		997	41	**13,083**
Additions donated									**0**
Additions government granted									**0**
Reclassifications	(652)	961		(361)	52				**0**
Reclassified as held for sale									**0**
Disposals other than by sale									**0**
Indexation									**0**
Revaluation		(7,424)	(64)						**(7,488)**
Impairments									**0**
Reversal of impairments		3,344	40						**3,384**
Cost or Valuation at 31 March 2012	42,803	63,844	769	18,117	2,180	91	10,101	4,579	**142,484**
Depreciation at 1 April 2011	3,517	7,344	52	0	1,366	87	6,645	2,045	**21,056**
Reclassifications	(653)	653							**0**
Reclassified as held for sale									**0**
Disposals other than by sale									**0**
Revaluation		(7,424)	(64)						**(7,488)**
Impairments		10		3,417					**3,427**
Reversal of impairments		(235)							**(235)**
Charged during the year		1,726	22		85	4	873	414	**3,124**
Depreciation at 31 March 2012	2,864	2,074	10	3,417	1,451	91	7,518	2,459	**19,884**
Net book value									
- Purchased at 31 March 2012	39,939	52,459	760	14,700	727		2,583	2,120	**113,288**
- Private finance initiative at 31 March 2012		8,219							**8,219**
- Donated at 31 March 2012		1,092			2				**1,094**
- Total at 31 March 2012	39,939	61,770	760	14,700	729	0	2,583	2,120	**122,601**
- Purchased at 1 April 2011	39,938	49,764	741	8,021	619	4	2,459	2,493	**104,039**
- Private finance initiative at 1 April 2011	0	7,432	0	0	0	0	0	0	**7,432**
- Donated at 1 April 2011	0	972	0	0	6	0	0	0	**978**
- Total at 1 April 2011	39,938	58,168	741	8,021	625	4	2,459	2,493	**112,449**

19.3 Analysis of property, plant and equipment 2012/13

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net Book Value									
Protected assets at 31 March 2013	**38,290**	**54,534**	**565**						93,389
Unprotected assets at 31 March 2013	**1,202**	**13,778**	**186**	**22,357**	**1,240**	**0**	**2,384**	**2,355**	43,502
Total as at 31 March 2013	**39,492**	**68,312**	**751**	**22,357**	**1,240**	**0**	**2,384**	**2,355**	136,891
Protected assets at 1 April 2012	38,696	47,339	565	0	0	0	0	0	86,600
Unprotected assets at 1 April 2012	1,243	14,431	195	14,700	729	0	2,583	2,120	36,001
Total as at 1 April 2012	39,939	61,770	760	14,700	729	0	2,583	2,120	122,601

19.4 Economic life of property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
Minimum life years		**1**	**1**		**5**	**7**	**5**	**7**
Maximum life years		**55**	**31**		**15**	**7**	**8**	**10**

19.5 Further comments on property, plant and equipment

All land and buildings were revalued by the District Valuer using Modern Equivalent Asset valuation as at 1 April 2009, revalued as at 31 March 2010 and as at 31 March 2013.
Plant and equipment is valued using depreciated replacement cost.

19.6 Profit/(loss) on disposal of fixed assets

Profit/(loss) on the disposal of fixed assets is made up as follows:

	2012/13	2011/12
	£000	£000
Profit on disposal of land and buildings	**0**	0
(Loss) on disposal of land and buildings	**0**	0
Profits on disposal of plant and equipment	**0**	0
(Loss) on disposal of plant and equipment	**0**	0
	0	0

20 Impairment of property, plant and equipment

	2012/13	2011/12
	£000	£000
Property, plant and equipment impairments and reversals taken to SoCI		
Recognised in operating expenses		
Impairment of assets in the course of construction	**0**	3,427
Impairments due to changes in market price	**4,146**	(235)
Change to revaluation reserve		
Impairments/(Reversal of impairments) due to changes in market price	**6,213**	(3,384)
Total	**10,358**	(192)

The £10,358k impairment due to changes in market price was offset by a £4,326k upward revaluation due to changes in market price, resulting in a net impairment of £6,032k.

The £3,427k in 2011/12 relates to the impairment of design and professional fees for the development of the Manor House hospital in Aylesbury, following a redesign which will result in a lower operating cost for the hospital.

21 Inventories

21.1 Inventories by type

	31 March 2013	31 March 2012
	£000	£000
Drugs	**1,475**	1,643
Consumables	**18**	36
Energy	**32**	36
Work in progress	**0**	0
Other	**30**	25
	1,555	1,740

Inventories are held at the lower of cost and net realisable value.

21.2 Inventories recognised in expenses

	31 March 2013	31 March 2012
	£000	£000
Inventories recognised as an expense in the period	**17,879**	19,868
Write-down of inventories (including losses)	**187**	137
Reversal of write-downs that reduced the expense	**(95)**	0
	17,971	20,005

22 Trade and other receivables

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS receivables	**2,265**	2,509	**0**	**0**
Receivables due from NHS charities - revenue	**41**	0	**0**	**0**
Other receivables with related parties	**419**	430	**0**	**0**
Other receivables	**1,251**	1,275	**30**	**30**
VAT	**377**	351	**0**	**0**
Accrued income	**2,248**	1,892	**0**	**0**
PDC dividend receivable	**320**	63	**0**	**0**
Provision for the impairment of receivables	**(280)**	(278)	**0**	**0**
Interest receivable	**0**	84	**0**	**0**
Prepayments other	**1,150**	1,365	**0**	**0**
	7,791	7,691	**30**	**30**

The majority of activity is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Impairing of receivables

	Ageing of impaired receivables		Receivables past their due date but not impaired	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
By up to three months	**123**	157	**3,102**	3,401
By three to six months	**141**	107	**38**	77
By more than six months	**172**	152	**19**	5
	436	416	**3,159**	3,483

22.3 Provision for impairment of receivables

	2012/13	2011/12
	£000	£000
Balance at 1 April	**278**	210
Amount written off during the year	**0**	0
Amount recovered during the year	**(196)**	(152)
Increase/(decrease) in receivables impaired	**198**	220
Balance at 31 March	**280**	278

All individual receivables due have been reviewed to reflect fair value.

23 Disposal groups

23.1 Non-current assets held for sale and assets in disposal groups 2012/13

	Intangible assets £000	Property, Plant and Equipment £000	Financial investments £000	Other £000	Total £000
NBV of non-current assets for sale and assets in disposal groups at 1 April 2012	**0**	**6,400**	**0**	**0**	**6,400**
Plus assets classified as available for sale in the year					
Less assets sold in year					
Less Impairment of assets held for sale					
Plus Reversal of impairment of assets held for sale					
Less assets no longer classified as held for sale, for reasons other than disposal by sale					
NBV of non-current assets for sale and assets in disposal groups at 31 March 2013	**0**	**6,400**	**0**	**0**	**6,400**

There was no gain or loss recognised for these non current assets on classification of held for sale

23.2 Analysis of property plant and equipment assets held for sale

	Land £000	Buildings excluding dwelling £000	Dwellings £000	Other property, plant and equipment £000	Intangible assets £000	Other assets £000	Total £000
Balance brought forward at 1 April 2012	**4,600**	**1,800**	**0**	**0**	**0**	**0**	**6,400**
Plus assets classified as held for sale in the year							
Less assets sold in the year							
Less impairment of assets held for sale							
Plus reversal of impairment of assets held for sale							
Less assets no longer classified as held for sale, for reasons other than disposal by sale							
Balance brought forward at 31 March 2013	**4,600**	**1,800**	**0**	**0**	**0**	**0**	**6,400**

The non current assets held for sale at 31 March 2013 relates to Boundary Brook House, formally Park Hospital (Oxford). The Trust have accepted an offer on this property and contracts have been exchanged. The offer is subject to planning consent. The Trust expects the sale to be complete in 2013/14. The terms of the offer include an operating lease arrangement back to the Trust. The sale agreement gives the purchaser the option to purchase an additional piece of land for a fixed price of £254,000 which is approximately equal to its carrying value.

24 Trade Payables

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
NHS payables - revenue	**810**	362	**0**	0
NHS payables - capital	**0**	102	**0**	0
Related Parties payables - revenue	**2,241**	2,681	**0**	0
Other trade payables - revenue	**2,392**	1,883	**0**	0
Other trade payables - capital	**232**	452	**0**	0
Tax and social security costs	**3,724**	3,606	**0**	0
Accruals*	**15,422**	12,473	**0**	0
Other Payables	**1,039**	325	**0**	0
Other	**4**	23	**0**	0
	25,864	21,907	0	0

*Accruals for 31 March 2012 included an accrual for dilapidations (£246k), now moved to provisions.

25 Borrowings

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Loans from:				
Department of Health	**1,338**	**0**	**26,762**	**8,800**
Other entities	**33**	**33**	**16**	**49**
PFI liabilities:				
Main liability	**62**	**70**	**4,697**	**4,759**
Lifecycle replacement received in advance	**0**	**0**	**0**	**0**
	1,433	**103**	**31,475**	**13,608**

DH loan facility of £28.1m for the Manor House redevelopment has been fully drawn down. £19.3m was received in 2012/13 and £8.8m had been received in prior years. This loan will be repaid in full by 2034.

PFI liability will be repaid in full by 2024. The loan in respect of Nuffield Health Centre will be repaid in full by 2015. The Trust has received Salix Finance Ltd Energy Efficiency Loans totalling £86k which will repaid in full by 2014.

26 Other financial liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Holiday pay accrual	**700**	607	**0**	0
	700	607	**0**	0

27 Other liabilities

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Lease incentives	**0**	0	**0**	0
PFI asset – deferred credit	**0**	0	**0**	0
Other - deferred Income	**2,334**	4,613	**0**	0
Local Government Pension Scheme*	**0**	0	**435**	0
	2,334	4,613	**435**	0

* £422k of this 'other liability' has been reclassified from provisions (see note 28)

28 Provisions

28.1 Provisions by category

	Current		Non-current	
	31 March 2013	31 March 2012	**31 March 2013**	31 March 2012
	£000	£000	**£000**	£000
Pensions relating to former directors	**0**	0	**0**	0
Pensions relating to other staff	**97**	94	**1,014**	768
Local government pension scheme*	**0**	0	**0**	422
Legal claims	**200**	126	**0**	0
Agenda for change	**0**	0	**0**	0
Other - redundancy	**534**	1,399	**0**	0
Other - pensions to death	**15**	14	**179**	145
Other - injury benefit	**47**	45	**840**	705
Other - employment	**32**	156	**0**	0
Other - dilapidations	**246**	0	**562**	0
	1,171	1,834	**2,594**	2,040

28.2 Analysis of provisions

	Pensions relating to former directors	**Pensions relating to other staff and Local Government Pension**	**Legal claims**	**Agenda for Change**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Provision at 1 April 2012	**0**	**1,284**	**126**	**0**	**2,464**	**3,874**
Arising during the year		299	120		1,284	**1,703**
Used during the year		(101)	10		(1,464)	**(1,555)**
Change in discount		33			51	**84**
Reversed unused		(10)	(57)		(156)	**(223)**
Transfer from trade payables (accruals)					246	**246**
Transfer to other liabilities		(422)				**(422)**
Unwinding of discount		28			28	**56**
Provision at 31 March 2013	**0**	**1,111**	**199**	**0**	**2,453**	**3,763**
Expected timing of cash flows:	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
no later than one year	0	98	200	0	874	**1,172**
later than one year and no later than five years	0	369	0	0	797	**1,166**
later than five years	0	644	0	0	784	**1,428**

*The £422k provision for the Buckinghamshire County Council pension scheme liability held at the 31 March 2012, has been reclassified as an 'other liability' as at 31 March 2013 (therefore shown as 'reversed unused' in the table above).

£550k is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the Trust (£485k at 31 March 2012).

29 Revaluation reserve

	2012/13			2011/12		
	Total revaluation reserve £000	**Revaluation reserve - intangibles £000**	**Revaluation reserve - property, plant and equipment £000**	Total revaluation reserve £000	Revaluation reserve - intangibles £000	Revaluation reserve - property, plant and equipment £000
Revaluation reserve at 1 April	**15,982**	**0**	**15,982**	12,932	0	12,932
Revaluation gains/(losses) and impairment losses on intangible assets	**0**	**0**	**0**	0	0	0
Revaluation gains/(losses) and impairment losses property, plant and equipment	**(1,886)**	**0**	**(1,886)**	3,384	0	3,384
Revaluation gains/(losses) and impairment losses arising from classifying non current assets as Assets Held for Sale	**0**	**0**	**0**	0	0	0
Fair Value gains/(losses) on Available-for-sale financial investments	**0**	**0**	**0**	0	0	0
Recycling gains/(losses) on Available-for-sale financial investments	**0**	**0**	**0**	0	0	0
Transfers to the income and expenditure account in respect of assets disposed of	**0**	**0**	**0**	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	**(432)**	**0**	**(432)**	(334)	0	(334)
Other transfers between reserves	**1,376**	**0**	**1,376**	0	0	0
Movements on other reserves	**0**	**0**	**0**	0	0	0
Revaluation reserve at 31 March	**15,040**	**0**	**15,040**	15,982	0	15,982

30 Cash and Cash Equivalents

	31 March 2013	31 March 2012
	£000	£000
Balance at 1 April 2012	**22,788**	17,295
Net change in year	**8,156**	5,493
Balance at 31 March 2013	**30,944**	22,788
Consists of:		
Cash with Government Banking Service	**30,705**	7,514
Commercial banks and cash in hand	**239**	15,274
Cash and cash equivalents as in Statement of Financial Position	**30,944**	22,788

31 Pooled Budgets

31.1 Oxfordshire County Council Pooled Budgets

Oxford Health NHS Foundation Trust has a pooled budget arrangement with Oxfordshire County Council. Oxford Health NHS Foundation Trust is the host.

Oxfordshire Adults of Working Age and Older Adults Pooled Budget Performance 2012/13

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	8,161	8,199	39
OCC	2,258	2,269	11
OCC contribution to Trust overheads	111	111	0
Total Pooled Budget	**10,529**	**10,579**	**50**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	OCC Contribution
	£000	£000	£000
Pay Expenditure	9,533	7,344	2,190
Non-Pay Expenditure	935	856	79
Income	0	0	0
Contribution to Overheads	111	0	111
	10,579	**8,199**	**2,380**

31.2 Buckinghamshire County Council Pooled Budgets

Oxford Health NHS Foundation Trust has two pooled budget arrangements with Buckinghamshire County Council. Oxford Health NHS Foundation Trust is the host.

Buckinghamshire Adults of Working Age Pooled Budget Performance 2012/13

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	6,146	6,111	(35)
BCC	2,445	2,428	(17)
Total Delegated Budget	8,590	8,539	(51)
BCC contribution to Trust overheads	99	99	0
Total Pooled Budget	**8,690**	**8,638**	**(51)**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	BCC Contribution
	£000	£000	£000
Pay Expenditure	7,342	5,340	2,002
Non-Pay Expenditure	1,214	781	433
Income	(17)	(10)	(6)
Contribution to Overheads	99	0	99
	8,638	**6,111**	**2,527**

Buckinghamshire Older Adults Pooled Budget Performance 2012/13

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	1,850	1,854	4
BCC	1,085	1,087	2
Total Delegated Budget	2,935	2,941	6
BCC contribution to Trust overheads	41	41	0
Total Pooled Budget	**2,976**	**2,982**	**6**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	BCC Contribution
	£000	£000	£000
Pay Expenditure	2,726	1,771	955
Non-Pay Expenditure	230	89	142
Income	(16)	(5)	(10)
Contribution to Overheads	41	0	41
	2,982	**1,854**	**1,128**

32 Private finance initiatives

32.1 PFI schemes off-'statement of financial position'

The Trust has no PFI schemes off-'statement of financial position'

32.2 PFI schemes on-'statement of financial position'

Description of the scheme

The scheme provides a centre in Oxford for the secure care of 30 clients with mental health problems and 10 clients with learning disabilities. Many of the clients are offenders who have been referred for treatment through the Courts. The scheme also provides a staff accommodation block.

Community Health Facilities (Oxford) Limited have designed, built, financed, maintained and operated the new facility. They are a special purpose company established through three main sponsors:

The Miller Group Limited
Interserve (Facilities Management) Ltd (formerly Building and Property Group Limited)
British Linen Investments Limited

Contract Start Date:	06 September 1999
Contract End Date:	05 September 2049*

* Contract break possible after 25 years, at 05 September 2024. In 2024, the Trust has legal ownership of the asset.

The inflation of the PFI scheme is linked directly to RPI.

The contract involved the lease of Trust land to the operator for nil consideration. The substance of this transaction was that it would result in lower annual payments over the life of the contract, i.e. an implicit reduction in the unitary charge since the operator has not had to lease the land on the open market. Consequently the value of the land (£700K at 2012/13 value) is recorded within the Trust's total land value.

Total obligations for on-'Statement of Financial Position' PFI contracts due**:

	31 March 2013	31 March 2012
	£000	£000
Not later than one year	**773**	777
Later than one year, not later than five years	**3,383**	3,199
Later than five years	**6,849**	7,620
Subtotal	**11,005**	11,596
Less: interest element	**(6,246)**	(6,767)
Total	**4,759**	4,829

** This is the value of the capital liability and future interest liability.

32.3 Charges to expenditure

The total charged in the year to operating expenses in respect of the service element of on-'Statement of Financial Position' PFI contracts was £492k (prior year £473k).

The Trust is committed to the following charges:

	31 March 2013	31 March 2012
	£000	£000
PFI scheme expiry date:		
Not later than one year	**504**	485
Later than one year, not later than five years	**2,147**	2,065
Later than five years	**4,307**	4,795
Total	**6,958**	7,345

33 Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2013 were £13,127k (31 March 2012 £8,259k)
£11,841K of the capital expenditure commitments relate to Manor House scheme which is due to be completed in November 2013

34 Events After the Reporting Period

Under the provisions of The Health and Social Care Act 2012 (Commencement No.4. Transitional, Savings and Transitory Provisions) Order 2013, Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) were dissolved on 1 April 2013. The PCT's/SHA's functions, assets and liabilities transferred to other public sector entities. PCTs and SHAs are related parties to Oxford Health NHS Foundation Trust and where reconfigurations of this nature take place within the public sector, Government accounting requires that the activities concerned are to be considered as continuing operations.

The Department of Health guidance allowed NHS Trusts and Foundation Trusts to be given the opportunity to acquire parts of the PCT estate deemed 'service critical clinical infrastructure'. Oxford Health NHS Foundation Trust assessed the benefit of acquiring these premises and agreed to the transfer of 12 premises on 1 April 2013 from Oxfordshire Primary Care Trust. According to Monitor's Compliance framework, this was deemed a 'significant' transaction, estimated at £41.4m and as such the transaction has been reviewed by Monitor.

35 Contingent Assets and Liabilities

35.1 Contingent Liabilities

	2012/13	2011/12
	£000	£000
Equal Pay cases	**0**	0
Other	**0**	0
	0	0

35.2 Contingent Assets

	2012/13	2011/12
	£000	£000
Contingent Assets	**0**	0
	0	0

36 Related Party Transactions

Oxford Health NHS Foundation Trust is a body corporately established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below in order of significance. Oxfordshire PCT and Buckinghamshire PCT account for 75% of the Trust's clinical income.

Oxfordshire PCT
Buckinghamshire PCT
Hampshire PCT
South Central Strategic Health Authority
Oxford University Hospitals NHS Trust
Wiltshire PCT
Department of Health
Bath And North East Somerset PCT
Northamptonshire Teaching PCT
Milton Keynes PCT
Swindon PCT
University Hospitals Of Leicester NHS Trust
Oxford Learning Disability NHS Trust
Buckinghamshire Healthcare NHS Trust
2Gether NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
South East Essex PCT
South Central Ambulance Service NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
Calderdale And Huddersfield NHS Foundation Trust
Frimley Park Hospital NHS Foundation Trust
NHS Litigation Authority

Government bodies outside the Department of Health that the Trust has had material transactions with are:
Buckinghamshire County Council
Oxfordshire County Council
Swindon Borough Council
Welsh Assembly Government (incl all other Welsh Health Bodies)
NHS Pension Scheme
NHS Professionals

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 Oxford Health NHS Foundation Trust.

The Trust has also received payments from a number of charitable funds, the Trustees for which are also members of the Oxford Health NHS Foundation Trust Board.

The Trust manages the Oxfordshire Pharmacy Store, a shortline pharmaceutical supplier to other NHS organisations. The turnover for the year 2012/13 was £16,209k (£17,363k in 2011/12).

Cedric Scroggs, who is a Non Executive Director of the Trust, is a shareholder of sundry pharmaceutical companies with which the Trust may have business.

Roger Reed, who is a Non Executive Director of the Trust, is a Buckinghamshire County Councillor.

37 Public dividend capital

The Trust is required to deliver a public dividend capital dividend at a rate of 3.5% of average relevant net assets (the average of the opening and closing 2012/13 balance sheet positions). For Oxford Health NHS Foundation Trust in 2012/13 this rate is calculated as follows:

	£000
Opening Relevant Net Assets	**108,233**
Closing Relevant Net Assets	**85,748**
Average Relevant Net Assets	**96,986**
2012/13 PDC dividend	**3,395**
Rate of Dividend (%)	**3.50%**

38 Performance against the prudential borrowing limit

The NHS Foundation Trust is required to comply and remain within a Prudential Borrowing Limit. This is made up of 2 elements :
(1) The maximum cumulative amount of long term borrowing. This is set by reference to the 4 ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term
(2) The amount of any working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code and the Compliance Framework for NHS Foundation Trust's can be found on the website of (or on request from) Monitor, the independent regulator of foundation trusts.

The Trust had a Prudential Borrowing Limit of £62.0m in 2012/13 (£56.1m, 2011/12), against which the Trust had total long term borrowing commitments of £32.9m (£33.0m, 2011/12).

Performance against the Prudential Borrowing Limit (PBL) ratios is shown below:

Financial ratios 2012/13	Actual ratios based on 2012/13 financial performance and standing	Actual ratios based on 2011/12 financial performance and standing	Approved PBL limits (to be read as the Trust must not exceed '<' or go below ' >' the stated value)
Minimum dividend cover	**4.1**	**3.3**	>1
Minimum interest cover	**9.6**	**10.3**	>3
Minimum debt service cover	**9.0**	**9.6**	>2
Maximum debt service to revenue	**0.6%**	**0.5%**	<2.5%

Note that the Trust Prudential Borrowing Code compliance is monitored by Monitor based upon the Trust's annual plan and quarterly monitoring submissions. These submissions include pooled budget (Section 75) income and expenditure and as a result the ratios quoted here are based on different I&E figures to the Trust's annual accounts, which exclude Section 75 balances.

The Trust has a Working Capital Facility of £15.0m in place from 1st April 2013 (£20.0m during 2011/12 and 2012/13) which will be reviewed in line with Monitor Risk Framework guidance.

39 Financial instruments

39.1 Financial assets

	At fair value through Income and Expenditure	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Receivables	**0**	**5,974**	**0**	**5,974**
Cash at bank and in hand	**0**	**30,944**	**0**	**30,944**
Other financial assets	**0**	**0**	**6,400**	**6,400**
Total at 31 March 2013	**0**	**36,918**	**6,400**	**43,318**
Receivables	0	5,942	0	5,942
Cash at bank and in hand	0	22,788	0	22,788
Other financial assets	0	0	6,400	6,400
Total at 31 March 2012	0	28,730	6,400	35,130

The majority of receivables relate to agreed debt owing from other NHS bodies. Non NHS receivables have been impaired in accordance with Trust policy.

39.2 Financial liabilities

	At fair value through Income and Expenditure	Other	Total
	£000	£000	£000
Payables	**0**	**19,671**	**19,671**
PFI and finance lease obligations	**0**	**4,759**	**4,759**
Other borrowings	**0**	**28,149**	**28,149**
Provisions	**0**	**0**	**0**
Other financial liabilities	**0**	**700**	**700**
Total at 31 March 2013	**0**	**53,279**	**53,279**
Payables	0	16,051	16,051
PFI and finance lease obligations	0	4,829	4,829
Other borrowings	0	8,883	8,883
Provisions	0	0	0
Other financial liabilities	0	607	607
Total at 31 March 2012	0	30,370	30,370

All financial assets and liabilities are held at fair value.

39.3 Maturity of financial liabilities

	2012/13	2011/12
	£000	£000
In one year or less	**21,803**	16,762
In more than one year but not more than two years	**1,431**	515
In more than two years but not more than five years	**4,593**	1677
In more than five years	**25,452**	11,416
Total	**53,279**	30,370

39.4 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with primary care trusts and the way those primary care trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Prudential Borrowing Code and Regulator review. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

To mitigate short term liquidity risk the Trust had a Working Capital Facility of £20.0m which was not utilised throughout 2012/13. The Trust has a Working Capital Facility of £15.0m in place from 1st April 2013 which will be reviewed in line with Monitor Risk Framework guidance.

40 Third party assets

The Trust held £355k cash at bank and in hand at 31 March 2013 (£310k at 31 March 2012) which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

41 Intra-Government and other balances

	Receivables: amounts falling due within one year	Receivables: amounts falling due after more than one year	Payables: amounts falling due within one year	Payables: amounts falling due after more than one year
	£000	£000	£000	£000
Balances with other Central Government Bodies	576	0	6,824	0
Balances with Local Authorities	330	0	1,031	0
Balances with other NHS Bodies	4,396	0	5,406	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,489	30	14,935	0
Total at 31 March 2013	**7,791**	**30**	**28,196**	**0**
Balances with other Central Government Bodies	514	0	6,423	0
Balances with Local Authorities	465	0	521	0
Balances with other NHS Bodies	3,986	0	4,832	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,859	30	14,744	0
Total at 31 March 2012	**7,824**	**30**	**26,520**	**0**

42 Losses and special payments

There were 43 cases of losses and special payments totalling £295k paid during 2012/13 (2011/12: 22 payments totalling £52k).

These amounts are reported on an accruals basis, excluding provisions for future losses.

A Treasury approved ex gratia payment of £103k was made in relation to the severance of employment of a former Director of the Trust.

A loss of £121k was incurred in relation to a bank mandate fraud.

43 *Local Government Superannuation Scheme*

Buckinghamshire County Council Pension Scheme

In 2009-10 22 members of staff transferred employment from Buckinghamshire County Council. As at 31 March 2013 15 of these retain active membership of the Buckinghamshire County Council Pension Scheme, which is a defined benefits scheme.

The County Council retains the assets and liabilities relating to this scheme.

The Trust's obligations in respect of pensions liabilities for these staff transferring is with effect from 1 April 2009 and not the period of employment before this date.

The Trust's accounts reflect the liability attributable from this date within Provisions on the Statement of Financial Position, £435,000 at 31 March 2013 (£422,000 at 31 March 2012).

The Trust commissioned Barnett Waddingham to prepare an actuarial report to provide full pension details in accordance with Financial Reporting Standard 17 (FRS17) . The report is available on request.

The assets of the Scheme are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets and the interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the Income and Expenditure reserve and reported as an item of other comprehensive income.

43.1 The main actuarial assumptions used at the date of the Statement of Financial Position in measuring the present value of the defined benefit scheme liabilities are:

	31 March 2013	31 March 2012
RPI Increases	**3.4%**	**3.2%**
CPI Increases	**2.6%**	**2.4%**
Salary Increases	**4.8%**	**4.6%**
Pension Increases	**2.6%**	**2.4%**
Discount rate	**4.7%**	**4.7%**
Expected return on assets (average)	**5.9%**	**6.0%**

43.2 The estimated Fund asset allocation as at 31 March 2013 is as follows:

	31 March 2013		31 March 2012	
	£000		£000	
Equities	**1,011**	**70%**	**762**	**68%**
Gilts	**58**	**4%**	**90**	**8%**
Other bonds	**130**	**9%**	**101**	**9%**
Property	**116**	**8%**	**101**	**9%**
Cash	**14**	**1%**	**22**	**2%**
Alternative Assets	**116**	**8%**	**45**	**4%**
Total	**1,445**	**100%**	**1,121**	100%

43.3 The expected return on the plan assets

The expected return on assets is based on the long-term future expected investment return for each asset class as at the beginning of the period (i.e. as at 1 April 2012 for the year to 31 March 2013). The returns on gilts and other bonds are assumed to be gilt yield and corporate bond yield respectively at the relevant date. The returns on equities and property are then assumed to be a margin above gilt yields.

Asset class	**Expected return at**	
	31 March 2013	31 March 2012
Equities	**6.3%**	**6.6%**
Gilts	**3.0%**	**3.3%**
Other bonds	**4.1%**	**4.7%**
Property	**5.8%**	**6.1%**
Cash	**0.5%**	**3.0%**
Alternative Assets	**6.3%**	**6.6%**
Total	**5.9%**	**6.0%**

43.4 Amounts recognised in the SoCI

	2012/13	2011/12
	£000	£000
Operating expenses - Current service cost	(108)	(76)
Finance costs - Interest on pension obligations	(88)	(78)
Finance costs - Expected return on plan assets	70	79
Other comprehensive income - Actuarial (losses)/gains	42	(372)
Total pension cost recognised	(84)	(447)

43.5 Amounts recognised in the SoFP

	2012/13	2011/12
	£000	£000
Oxford Health NHS Foundation Trust liability	(435)	(422)

Oxford Health NHS Foundation Trust is only liable for the deficit in the scheme from the date of transfer of employees from Buckinghamshire County Council in 2009.

Present value of funded obligations	(2,142)	(1,805)
Less fair value of scheme assets (bid value)	1,445	1,121
Deficit in the scheme	(697)	(684)

43.6 Reconciliation of opening and closing SoFP balances for Oxford Health NHS Foundation Trust

	2012/13	2011/12
	£000	£000
Deficit in the scheme at 1 April	(422)	(28)
Expenses recognised in the SoCI	(126)	(75)
Contributions paid (Employer)	71	53
Actuarial (gains)/losses in the current year	42	(372)
Deficit in the scheme at 31 March	(435)	(422)

43.7 Change in benefit obligation during the year to 31 March

	2012/13	2011/12
	£000	£000
Opening defined benefit obligation	1,805	1,387
Current service cost	108	76
Past service gain	0	0
Interest on pension obligations	88	78
Member contributions	31	26
Past service cost	0	0
Actuarial (gains)/losses on obligations	122	266
Curtailments	0	0
Settlements	0	0
Benefits paid	(12)	(28)
Closing benefit obligation	2,142	1,805

43.8 Change in fair value of plan assets during the year to 31 March

	2012/13	2011/12
	£000	£000
Opening fair value of plan assets	1,121	1,097
Expected return on plan assets	70	79
Actuarial gains/(losses) on assets	164	(106)
Employer contributions	71	53
Member contributions	31	26
Benefits paid	(12)	(28)
Closing fair value of assets	1,445	1,121