Oxford Health NHS
NHS Foundation Trust

Oxford Health NHS Foundation Trust Annual Report and Accounts 2014-15

Oxford Health NHS
NHS Foundation Trust

Oxford Health NHS Foundation Trust Annual Report and Accounts 2014-15

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

Oxford Health NHS Foundation Trust
Annual Report 2014/15

Table of contents

Section Three: Governance, performance and finances	

Foreword by the Chairman and Chief Executive

Welcome to the Oxford Health NHS Foundation Trust Annual Report 2014/15. We hope this report will give you useful insight into our Trust and its major achievements and challenges over the past year.

We continue to set as our top priority providing services that are 'caring, safe and excellent' and meeting the goals of our national and local commissioners, within a very constrained financial environment.

Our population is growing and living longer, with more complex long-term health conditions in patients of all ages and people rightly have high expectations of our health system. With finite resources, we need to meet rising demand in new ways, including better use of technology and finding innovative ways to provide care.

In this landscape we have looked to partnership working and joint endeavours across organisational boundaries, remodelling physical and mental health services to focus ever more closely on patients' needs to help them to achieve the health outcomes they and those who care for them want.

Examples of this include the development of the Oxfordshire Mental Health Partnership with five third sector partners to deliver adult mental healthcare. In Buckinghamshire we have secured the contract for child and adolescent mental health services and developed a new service model in partnership with Barnardos that will be in place next year. Services for older people and those with long-term conditions are benefiting from work on providing more integrated care, through work with GPs and with our acute health partners in Oxfordshire and Buckinghamshire. More of our services, have moved to 24-hour seven-day working, including, our adult community services in both these counties, as well as at centres like our emergency multi-disciplinary unit at Witney.

In the past year we have welcomed distinguished visitors including the Prime Minister, the Rt Hon David Cameron MP, as well as international partners from Hong Kong, mainland China, South Korea and Georgia.

We continue to strive to meet the challenges of 21st century healthcare. Our new Electronic Health Record system has significantly improved our ability to manage and access all of the information staff and patients need to manage their care. We also continue to work closely with our academic partners and through our collaborative networks (of which more inside) to enable research that will benefit our local populations with advances in healthcare, clinical training and practice. The latest development in this area is our work on implementing the CRIS (Clinical Records Interactive Search) tool to support research and clinical audit.

At the heart of our efforts is an ongoing drive for quality improvement in all aspects of our work and our aim to deliver the best clinical outcomes for people using our services, in partnership, in all the communities we serve.

Finally, on behalf of the full Board of Directors, we thank our staff, Governors and Foundation Trust members for their hard work, dedication and support in 2014/15, and offer our best wishes to our patients, their families and communities in the year ahead.

Martin Howell
Chair

Stuart Bell CBE
Chief Executive

Introduction – Our Foundation Trust

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

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, Swindon and BaNES. These include Oxford University Hospitals NHS Trust and Buckinghamshire Healthcare NHS Trust; the University of Oxford to promote innovation in healthcare, support research and to train doctors and psychologists; Oxford Brookes University, Bath University and the University of Bedfordshire 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

Contact us:

Telephone: 01865 901000
Email: enquiries@oxfordhealth.nhs.uk

Trust Headquarters
Warneford Hospital
Warneford Lane
Headington
Oxford OX3 7JX

Strategic Report

This section provides a fair review of the Trust's business and outlines the principal risks, and provides an overview of the work undertaken to achieve our objectives.

Overview

"Driving Quality Improvement" is at the heart of the Trust's strategy which seeks to improve patient safety, clinical outcomes and patient and carer experience. The delivery of the strategy was within the context of a difficult environment. The Trust, like the rest of the NHS, faced an extremely challenging financial environment in 2014/15. The NHS received limited growth funding, small increases in inflation funding and had national efficiency targets of 4% year-on-year. The result of this has been a net real reduction in income year-on-year for the Trust.

Within this context, the Trust focused on delivering patient-centred collaborative care, and continued working to develop a healthcare system that is able to meet patients' health and social care needs in the 21st century. Working with partners is central to achieving these objectives in this climate and the Trust continued to enhance collaborative working arrangements with health and social care partners across the system. The Trust also advanced the adoption of innovative treatments through closer working relationships with academic institutions and industry, and providing transparent and accessible information for patients and carers.

Trust Strategy – meeting our objectives

Our vision is that patients and carers who use Oxford Health NHS Foundation Trust services feel that they receive **"Outstanding Care Delivered by Outstanding People"** and our strategic aims are:

- continuously improve the **quality** of our services so that they are **safe,** provide **excellent experiences** for patients and carers and achieve the **best clinical outcomes**
- working with national and international partners to provide **high quality sustainable services** that meet the **financial challenges** ahead
- making available **accurate and timely information** for patients, carers and people involved in care delivery when and where they need it
- having an **international reputation** for teaching, training and research and for translating **innovation in practice**.

Our Strategic Plan 2013-2016 sets out the work, grouped into seven broad categories, we planned to undertake during 2014/15 to work towards meeting our vision and achieving our aims.

The majority of key targets were met and those that were missed are identified in relevant sections of the Annual Report. As in 2013/14, the cost improvement target was not achieved and the Trust reported a slightly larger deficit than originally planned. Due to reduced income received for services in Oxfordshire, in support of the difficult financial position faced by the health system, and significant cost pressures experienced in relation to agency staff utilisation, out-of-area patient treatments and increased drug costs, the year proved to be challenging financially. This position was worsened by the difficulties encountered in delivering the planned cost improvements in the face of increased activity and patient complexity, for which no additional income is receivable under block contracts.

Summary of achievements

Driving quality improvement

There have been several programmes of work throughout the year which aimed to improve patient safety, clinical outcomes and patient experience. The Safer Care project sought to reduce the number of patient absences without agreed leave (AWOLS) and in areas where it has been implemented we have seen a reduction in numbers. Work will continue to embed the learning further across inpatient and community services. The Making Every Contact Count programme started, which is designed to encourage conversations around behaviour change and healthier lifestyles. Work continued to reduce preventable healthcare-acquired infections (HCAIs) through audits and screening and, following a detailed review of options including listening to the views of patients, a new in-house PVMA (prevention and management of violence and aggression) training package was agreed in 2014/15 and will be implemented throughout 2015/16.

A key goal during the year was to improve patient and carer experience within our services. A values-based behavioural framework linked to our Trust values of 'caring, safe and excellent' was agreed, which will inform our understanding about customer care standards. Alongside this, we have continued to implement our Patient Experience strategy which has seen us expand the range of approaches used to collect feedback from those who access our service. We have also expanded the collection and use of patient stories, culminating in our Board of Directors now hearing patient stories at the start of every meeting. We proactively promote and respond to feedback posted through online forums such as Patient Opinion and NHS Choices and in the coming year a website on patient experience, including information about actions taken following incidents and complaints, will be developed.

Following work looking at what the Care Quality Commission's 'Six Cs' (care , compassion, competence, communication, courage and commitment) means to the nursing workforce, a new Nursing Strategy was developed during 2014/15 and will be implemented during 2015/16. Using the learning from the Francis and Keogh reports, we are working with teams throughout the organisation to embed a caring culture and we launched a major project in the summer of 2014 to align our approach to delivering care within the Care Quality Commission (CQC) domains: safe, caring, effective, responsive and well led.

Finally, during the year, we amended our governance structure to replace the Board of Director's Integrated Governance Committee with the Quality Committee. This new committee, and its sub-committees, reflects the CQC's five domains and ensures that quality improvement is at the heart of decisions taken by the Board of Directors.

Delivering operational excellence

Our three clinical directorates aim to deliver effective and efficient services and have continued to maximise the benefits from the remodelling work carried out in 2013/14.

In 2014/15 our focus was on establishing key partnerships in Oxfordshire which will allow us to deliver the best value care for patients and to benefit the care system as a whole. We are judging our success not by how well we compete with others but by how well we collaborate with them.

The Oxfordshire Mental Health Partnership, a partnership delivering mental health care to adults, was awarded 'most capable provider' status by commissioners. The partnership will see the Trust and five third-sector partners – Oxfordshire Mind, Response, Restore, Elmore community team and Connection Floating Support – work together to develop and implement a model of care – focused on recovery. The partnership will be undertaking a number of projects including the development of the acute to community pathway, supported independent living and the introduction of a recovery college where service users, carers and staff will learn together.

A number of other adult services have been developed during the year including an Asperger's Service in Buckinghamshire. A successful pilot of the Community Psychological Medicines Service and the Street Triage Service took place in Oxfordshire, with the latter resulting in a large reduction in the number of Section 136 detentions alongside a very substantial reduction in the number of people placed in custody.

Within the Children and Young People Directorate, there has been considerable focus during the year on forging partnerships with third sector providers to develop new models of care focused on the needs of patients. During 2014/15, commissioners tendered out the Buckinghamshire CAMH Service and the Trust developed a new model with Barnardos. The Trust/Barnardos partnership was awarded the contract and our innovative model of service will be implemented during 2015/16. The eating disorders pathway for children and young people continued to be developed in collaboration with a voluntary sector partner, BEAT.

The Older People Directorate is developing strong partnerships with acute providers and social care to design a modern, integrated system of care for older people and people with long-term conditions in Oxfordshire. The transformational change that is in progress involves working with GP Federations to deliver locality integration, ambulatory urgent care and acute inpatient care. Work continues with Buckinghamshire County Council and Buckinghamshire Healthcare NHS Trust to take forward the plans for integrated community services in the county.

A key aim of our service remodelling work was to maximise the opportunities and benefits of seven-day working. A lot of progress has been made in this area and a variety of services are now available 24 hours a day, seven days a week, including our

adult mental health teams (AMHTs), children and young people's outreach teams, children's community nursing and the dental services, and all of the older adult community services in both Oxfordshire and Buckinghamshire. Witney Emergency Multi-disciplinary Unit (EMU) extended its opening hours to seven days a week in November 2014.

Innovation, learning and teaching

We continue to maximise the benefits of our strong ties with academic institutions across Thames Valley through the Oxford Academic Health Sciences Network (AHSN), the Oxford Academic Health Sciences Centre (AHSC) and the Collaboration for Leadership in Applied Health Research and Care (CLAHRC), which is hosted by the Trust. These collaborations aim to benefit the health and wellbeing of our local populations and to maximise opportunities to translate research, training and clinical expertise to meet the healthcare challenges of the 21st Century.

We are developing commercial studies with the National Institute for Health Research Clinical Research Facility (NIHR CRF) and are working to increase the recruitment of patient participants into studies. The CRIS (Clinical Records Interactive Search) tool is being implemented in order to expand the Trust's research capability and to assist in clinical audit.

Developing our business

A commercial strategy identified the key areas where we believe our experience and expertise mean we could provide services that are attractive to both patients and commissioners. Ongoing work includes developing a marketing programme for identified specialist services and a strategy for core NHS Services and contracts.

Development of the Trust's international brand continued during the year with the Trust working with partners in Hong Kong, mainland China, South Korea and Georgia. A new internet strategy was developed and will be implemented throughout 2015/16 allowing us to provide more information to patients, carers and other professionals and further strengthen our brand and reputation.

Developing leadership, people and culture

Given the nationwide difficulties in recruitment and the particular issues around the high cost of living we face in Oxfordshire and Buckinghamshire, we worked hard to attract and retain the best staff through improving our recruitment processes. Competence-based questions against core competencies are now being used in our interviews and during 2015/16 our Trust values will be incorporated into all interviews. Our Trust values have also been incorporated into our new online performance development record (PDR) process.

We aim to develop our staff through high-quality performance management and leadership training. Work has progressed this year to prepare for a rollout of virtual classroom training programmes, which reduce the time spent away from the

workplace for patient and personal safety (PPST) training. Team-based working training has continued which is designed to support the development of team-based working which we believe leads to more effective ways of delivering care and improving outcomes for patients.

In order to retain our staff, various projects focused on staff development, engagement, rewards and wellbeing throughout the year. Health and wellbeing work has progressed very well. Ongoing successes include team health challenges (for example the pedometer challenge), support of monthly public health campaigns and wellbeing days. Wellbeing has been successfully incorporated in to the induction process.

Getting the most out of technology

A significant development this year has been the next phase of development for our Electronic Health Record, which contains the information that our staff need to deliver high-quality care, and patients and carers need to manage their own care more effectively. This will also reduce the administrative burden on clinical staff, and contains all the information that staff and patients need to manage their care. A new telephony solution offering a single telephony platform for fixed-line phones at all sites was implemented throughout Oxfordshire and Buckinghamshire. Various upgrades throughout the year were implemented, including Citrix upgrades, a rollout of Windows/Office upgrades and the network upgrades.

Using our estate efficiently

Work has continued to provide suitably located, functional community services accommodation to support home and community care service models. This work is in keeping with the Trust's Estates Strategy, which was developed to support our clinical strategy and service delivery plans. The strategy supports the development of plans that take account of environmental matters including supporting the reduction of the Trust's carbon footprint and implementation of a green travel plan (including better management of Trust car parks). With buildings and travel being the main contributors to the Trust's impact on the environment, the Estates and Facilities department take account of this impact in preparing and implementing the plans under the strategy.

During 2014/2015 we undertook a review of our carbon emissions, taking part in an independent benchmarking exercise undertaken by the Oxford Academic and Science Network. This has helped us to establish those areas of our operations that are responsible for the highest carbon emissions. We have completed a self-audit using the Good Corporate Citizenship tool, to establish our performance against similar Trusts and organisations. Our latest self-audit using the Good Corporate Citizen tool, shows that the work we have been undertaking in 2014/2015 has improved our performance by 10%.

We are currently investigating the option of installing solar panels at some of our sites to generate clean electricity.

We have worked with Oxford City Council to secure the installation of Oxford City Bikes at our key sites within Oxford, to enable us to reduce car usage, and we are hoping to extend the bikes to other sites.

We are exploring the possibility of replacing our current fleet vehicles with electric vehicles, and have installed electric charging points at our main Oxford site.

Social, community and human rights issues

People's social context is a major determinant of mental health and wellbeing. We have been working closely with partner third sector organisations in Oxfordshire to develop a partnership that will develop an acute to community pathway, supported independent living and the introduction of a recovery college where service users, carers and staff will learn together (further details in previous 'Delivering Operational Excellence' section).

The Trust is also working closely with Thames Valley Police on the Crisis Care Concordat and in Oxford city on the Street Triage initiative (discussed in more depth in the 'Service developments' section). Since 1 June 2015, the initiative is now being implemented in Buckinghamshire as well.

Workforce profile

- Directors: 8 male and 5 female (Executive and Non-Executive)
- Other senior managers: 93 female and 53 male
- Employees (excluding the above): 5089 female and 1053 male

Service developments

Throughout 2014/15 we continued with our strategy of developing services that are accessible and integrated to provide the best possible health outcomes and support for patients and their families. In particular, many services moved to seven-day working and extended hours in order to provide care closer to home and from a team that the patient is familiar with. All this helps prevent unnecessary hospital admissions. Following the remodelling of our services, we completed the restructuring of our Clinical Directorates to support the delivery structure with a focus on increasing clinical leadership across the organisation and creating a joint clinical operational leadership model for the Trust. The Trust has three Clinical Directorates – Children and Young People, Adult and Older People Services – and each is led by a Clinical and Service Director.

The Trust recognises that we cannot meet all the needs of our patients working alone and this year has seen the development and formalisation of partnerships between the Trust and key partners, many of whom we have worked with on an informal basis over past years:

- The Oxfordshire Mental Health Partnership (consisting of the Trust, Response, Oxfordshire Mind, Restore, Connection and Elmore) was formed in order to bring mental health services in Oxfordshire together to be able to provide health, housing, care at home and employment support for people with severe mental illness.
- The development of an alliance with Oxford University Hospitals NHS Trust to deliver joined-up urgent care for older people in Oxfordshire.
- The development of mental health urgent care services as part of delivery of the Crisis Concordats in both Oxfordshire and Buckinghamshire which sees us working closely with police, ambulance, acute hospitals and other partners to ensure that people of all ages with a mental health crisis receive the best care as quickly as possible.
- The development of locality-based community services with social care and Primary Care Federations.

Set out over the page are key highlights from each of the Clinical Directorates during 2014/15.

Children and Young People Directorate

This directorate provides:

- integrated mental and physical health services for young people aged 0-18 in Oxfordshire
- mental health services for young people in Buckinghamshire, Swindon, Wiltshire and BaNES and regionally
- specialist eating disorder services in Oxfordshire, Buckinghamshire and regionally for people of all ages
- specialist dental services in Oxfordshire and regionally for people of all ages

Child and Adolescent Mental Health Services (CAMHS) pathway

In Buckinghamshire, ReConnect was developed as an innovative pilot project aimed at improving outcomes for the most vulnerable children under the age of two years. This group will include children (as well as any unborn children) who are at high-risk of developing a disorganised attachment through experiencing parenting breakdown, neglect and abuse, or parental mental health problems that impact on the child's emotional needs.

In Oxfordshire, a youth justice liaison and diversion service was established to organise diversion or provide support for young people under 18 who have come into contact with the police or youth justice system and about whom there are questions regarding mental health, learning disability or other vulnerabilities. The aim is to provide prompt support for young people, with the service offering multi-professional liaison (tracking of young people, advice and formal clinical consultation with families and professionals), assessment and interventions. It is intended to supplement, co-ordinate and support, rather than replicate local general health and CAMHS provision. In Bath and north east Somerset, following the development of a successful emotional resilience pilot in a secondary school, the Clinical Commissioning Group commissioned the Trust to roll-out emotional resilience hubs across all secondary schools.

Complex care pathway

Buckinghamshire's Speech and Language Therapy Service undertook a pioneering project, with funding from Buckinghamshire County Council, to develop a web-based therapy tool, and use Skype for therapy sessions. The website offers information, resources, progress evaluation tools and training to families, staff and others working with the children and young people, and is an important step in helping us deliver personalised care. We are evaluating this project to see the impact on patient outcomes and whether using technology in this way may work for other services.

Dental pathway

In December 2014, the Trust's Oxfordshire Salaried Primary Dental Care Service was awarded the Quality in Dental Service Award by the professional body for dentists. The award was in recognition of the service's high standards in treatment decisions, health and safety, infection control and a number of other requirements. The service provides dental care to patients requiring either special care dentistry, or specialist care, and also provides emergency care for patients requiring urgent dental treatment who do not currently have a dentist of their own.

Public health pathway

The Trust won the contract for Oxfordshire school health nursing, which provides nurses to secondary schools and the school nurse team in primary schools. The service has put in place school health improvement plans which address local health needs and public health issues and work is underway with colleges to develop their personal health improvement plans. Secondary school staff have been very welcoming and appreciative of the new service, which in the month of January 2015 saw over 1200 face-to-face appointments with young people occur in secondary schools. The primary school team have contacted all the head teachers in our 236 primary schools to deliver the service, promoting early intervention to improve outcomes for younger children. The college nurses have embedded their services in three new college sites and now provide a service to all colleges in Oxfordshire.

Children's safeguarding

Over the past year the Trust's safeguarding team has participated in a range of cross-agency developments which relate not only to the issue of child sexual exploitation (CSE) but also to the issue of historical disclosure of sexual abuse. Such developments have been in response, respectively, to criminal prosecutions of adults in areas such as Rochdale, Rotherham and Oxford and in revelations following the death of Jimmy Savile. In addition, the team continues to address a high volume of concerns and dilemmas raised by clinicians within the Trust in response to a wide range of issues concerning children's welfare and also to ensure that a high proportion of Trust staff receive updated safeguarding training.

Adult Directorate

This directorate provides:

- integrated mental and physical health services for adults in Oxfordshire
- mental health services for adults in Buckinghamshire
- primary, specialist and forensic mental health Services for adults aged 18-65 across Oxfordshire, Buckinghamshire and regionally

Street Triage programme

In collaboration with Thames Valley Police (TVP), the Trust supported a 12-month pilot of the Street Triage team in Oxford city, which was one of nine pilot sites across the country. The pilots were established following success in Leicester and the programme sees a trained Registered Mental Health Nurse (RMN) accompany any police callouts where it is suspected that a member of the public might need some mental health support and intervention.

The pilot operated five nights a week from 6pm to 2am and became very successful as evidenced by the significant decrease in inappropriate use of section 136 of the Mental Health Act to admit people. Patients also reported that they felt that they had a better experience during any assessment and subsequent detention. Colleagues from TVP valued having a trained RMN with them as not only did they feel better supported dealing with mental health-related incidents but it also gave the police greater capacity to deal with other calls that required specialist police intervention.

With the success of the pilot, the service increased its operating hours from five to seven nights a week and commissioners agreed to fund the Street Triage team from January 2015. The Trust and TVP have also launched the programme in Buckinghamshire.

Remodelling adult mental health teams

During 2014/15 the Trust completed the remodelling of services to focus on patients rather than team structures. We knew from stakeholder feedback (patients, carers, staff and GPs) that we needed to improve access to our services and ensure that care pathways were clear so people could make informed choices about their care and treatment.

Our previous community mental health teams (CMHTs), crisis services and assertive outreach teams were all integrated to form the new locality-based adult mental health teams (AMHTs). The new AMHTs provide an extended service, operating seven days a week from 7am to 9pm and have both an assessment and treatment function. This reduces the need for patients to be moved from one team to another and supports the development of strong therapeutic relationships. The provision of an integrated treatment and assessment function also ensures that if patients are

discharged but subsequently become unwell again there will be no requirement for them to be formally re-referred into the team, either by their GP, voluntary sector colleagues or another service within the Trust. The treatment functions of the AMHTs are now working in collaboration with colleagues from the voluntary sector and so can support patients housing, employment and wellbeing needs in a more robust and timely manner.

We also wanted to use this new model as an opportunity to provide an enhanced level of staffing on our mental health inpatient wards, which look after our most acutely unwell patients. Now each inpatient ward in both Buckinghamshire and Oxfordshire has a dedicated Consultant Psychiatrist, Modern Matron and two additional Band 6 posts (for any qualified professional). The new model also has a clearly established and accessible pathway between community and inpatient services to improve the handover of care on admission and discharge.

Whilst implementing large-scale change like this is always challenging we have received consistent positive feedback from patients, carers and GPs who have told us that we have improved access to services and that the pathway for patients is more clearly defined now than it has been in the past.

Quality network for forensic mental health services

The Trust has joined the Royal College of Psychiatrists Quality Network for forensic mental health services which aims to promote and achieve quality improvements in medium and low secure forensic mental health services through an iterative cycle of peer review and action planning for improvement against designated standards.

During 2014/15 all of the forensic inpatient wards across the Trust have hosted peer review visits. This has seen the Quality Network co-ordinate a team of clinicians from other member trusts to visit our units and conduct audits against nationally defined standards. The process includes interviews with senior and frontline staff, patients and carers along with information gathering through observation of the environment and scrutiny of local policy and practice guidelines.

Through these reviews we received positive feedback with patients reporting that they valued the relationships with staff and felt that the staff were an important factor in their ongoing recovery and rehabilitation. The visiting teams have also told us that the positive ethos amongst the staff team was particularly evident and this was reflected in their morale and their promotion of a positive patient-centred culture. We were also delighted that both our medium and low secure services scored 100% in six of the standards, with our medium secure units achieving an overall 90% and our low secure services 93%. Where there were areas that the review team felt needed addressing action plans have been developed and put in place.

Older People Directorate

This directorate provides:

- community health services in Oxfordshire
- specialist older people's mental health services across Oxfordshire and Buckinghamshire

Integrating care for older people in community settings

Through the year we have focused on establishing multi-disciplinary 'hubs' in localities in Oxfordshire as the first step in integrating care. This has been achieved by aligning the rapid response capacity of community nurses, therapists and community psychiatric care for older people with complex co-morbidities who would benefit from co-ordinated multi-disciplinary care. Age UK have also played an important role in this development, with their 'Circles of Support' project supporting patients and carers in developing and maintaining social networks based on a range of activities, peer support and opportunities to explore new hobbies. This is an exciting step forward, with clinical teams learning as they work together how we can improve care co-ordination to maximise patient outcomes and give patients and carers better continuity of care through reducing clinical 'hand-offs' and duplicate assessments.

This is the first stage in our wider plans to integrate and co-ordinate care for people with complex needs and we will build on this with primary care and social care over the coming two years.

New buildings and locations: Supporting the integration of care

In Bicester, Oxfordshire, our integration plans have been supported by the long-anticipated move into the new community hospital building which opened in December 2014. This new building provides a modern environment for inpatients, with increased dignity in care through individual patient bedrooms. For the minor injuries unit and GP out-of-hours service, this has provided a welcome move from temporary accommodation into a purpose-built urgent care facility within the hospital which is a pleasant environment for patients. The creation of multi-disciplinary space will help us achieve our goals of integrated locality care.

Similarly the move for older adult mental health into the new Whiteleaf Centre on the Buckinghamshire Health and Wellbeing Campus in Aylesbury has provided modern spacious inpatient facilities. The new £42.8m purpose-built facility for mental health care was opened to patients in 2013/14, and in 2014/15 we were delighted that HRH The Countess of Wessex official opened the centre. The ward staff have worked closely with patients and carers to make best use of the much improved rehabilitation and recreation areas on the ward and the 'dementia-friendly' artwork

on the walls is a talking point that helps creates a relaxing environment for inpatients.

Oxford City Community Hospital moved from its temporary accommodation at the John Radcliffe Hospital into a redesigned ward environment at the Fulbrook Centre in Oxford. This ward is now co-located with the older adult mental health inpatient wards for Oxfordshire. The new ward environment enables each inpatient to have their own bedroom which maximises patient privacy and dignity. The new ward environment also has a bespoke dining room and day room which has prompted much greater socialisation with patients now typically eating meals together (rather than at their bedside) and spending time chatting to each other in communal areas. This minimises the risk of loneliness and social isolation while in hospital, and has created a positive and lively ambience which fosters the therapeutic aims of rehabilitation and recovery.

There have been immediate clinical benefits in the co-location of the older adult mental health inpatient team and the community hospital service through sharing clinical expertise for individual patients. This provides the basis for the next steps in developing an integrated model of care for those patients with dual high acuity mental health and physical health needs.

Looking forward

Over the year ahead there are likely to be a number of key challenges and risks that will affect the Trust's ongoing development and performance. Our forward plans take account of these challenges and seek to mitigate their impact.

The key challenges facing the Trust in the coming years are largely financial. Already recognised as an efficient Trust (national reference cost of 89 against an average of 100), the continued delivery of cost improvements required to offset the national deflation of funding of 4% per annum becomes more difficult to achieve and more dependent on innovation and transformation, often with reliance upon system-wide changes.

As the Trust provides services in areas that receive significantly less than the national average funding from commissioners, the revenue received for our service provision is low and consequently the financial benefits that would be expected to accrue from high levels of efficiency cannot be realised by the Trust.

Added to this is the increasing level of activity and complexity of patient condition which, working within a block contract, leaves the risk residing with the Trust.

Actions have been taken to get an independent review of our cost improvement management and of further opportunities, and the plan for this coming year is conservative but achievable. Particular focus is being put upon integrated working with partners across the health systems to enable transformation and further cost improvements. With this approach to cost improvement - initiatives to reduce specific cost pressures (such as agency staff) and ongoing discussions with commissioners to ensure a fair price for the services - we are confident that we can continue to provide high quality and safe services.

History of the Trust

On 1 April 2006, the Oxfordshire Mental Healthcare NHS Trust and Buckinghamshire Mental Health Partnership NHS Trust merged to create the Oxfordshire and Buckinghamshire Mental Health Partnership NHS Trust. The Oxfordshire Mental Healthcare NHS Trust had been created in April 1994 and Buckinghamshire Mental Health Partnership NHS Trust established in April 2001.

The Trust became the first NHS organisation in either Oxfordshire or Buckinghamshire to be authorised as an NHS foundation trust when it became Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust on 1 April 2008.

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

Going concern and account preparation

The Annual Statutory Accounts are appended to this Annual Report.

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 2014/15 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 2014/15.

After making enquiries, the Directors have a reasonable expectation that Oxford Health NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. The Directors have considered the financial plans for the next few years and the likely risks relating to them, in particular the national assumption of continued income deflation and the consequent requirement to reduce costs and to maintain suitable levels of cash. For this reason, they continue to adopt the going concern basis in preparing the accounts.

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 Quality Committee (formerly the Integrated Governance Committee) and monitors the actions being taken to mitigate risks.

The Board of Directors meets at least ten times a year and meetings are held both in public and in private. At each meeting of the Council of Governors, a report on the Board of Directors' main activities is presented by the Chief Executive. For Board meetings held in public, copies of agendas, minutes and reports are published on the Trust's website.

The membership of the Board of Directors is balanced, complete and appropriate as demonstrated by the biographical details of Board members. The Remuneration 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 Trust has appointed a Senior Independent Director.

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

The Directors have been responsible for preparing this Annual Report and the associated Accounts and Quality Report and are satisfied that taken as a whole they are fair, balanced and understandable, and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Directors during the period and remit

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

Executive Directors

Stuart Bell, Chief Executive
Dr Clive Meux, Medical Director

Ros Alstead, Director of Nursing and Clinical Standards
Yvonne Taylor, Chief Operating Officer
Mike McEnaney, Director of Finance

Non-Executive Directors

Martin Howell, Chair
Sir Jonathan Asbridge
Mike Bellamy
Alyson Coates
Professor Sue Dopson
Dr Anne Grocock
Cedric Scroggs, Vice-Chair and Senior Independent Director
Lyn Williams

Changes in the Board of Directors during the period:

Sir Jonathan Asbridge was appointed Non-Executive Director by the Council of Governors from 1 July 2014. He took on the vacancy created when Cllr Roger Reed's term of office ended in 2013/14.

The Council of Governors re-appointed both Mike Bellamy and Dr Anne Grocock for final three year terms during the year.

In February 2015, Cedric Scroggs sadly passed away whilst in office. His final term of office was due to end on 31 March 2015.

The Council of Governors also appointed Sir John Allison in an associate Non-Executive Director capacity from 1 October 2014 with the expectation that he would take on the full Non-Executive Director role from 1 April 2015. The associate Non-Executive Director role is non-voting and provided an induction opportunity for Sir John Allison.

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
Sir Jonathan Asbridge	30/06/17*
Mike Bellamy	31/01/18*
Alyson Coates	31/03/17
Professor Sue Dopson	31/05/15
Dr Anne Grocock	31/01/18*
Cedric Scroggs	31/03/15
Lyn Williams	31/03/17

Key: * = appointed / re-appointed during 2014/15 by the Council of Governors

Board Director biographies

Martin Howell (Chair)

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.

Sir Jonathan Asbridge (Non-Executive Director)

Sir Jonathan was appointed Non-Executive Director on 1 July 2014. He was the first president of the UK's Nursing and Midwifery Council. From early experiences as a St John Ambulance cadet in Cardiff, he went on to become a state registered nurse at St Thomas' Hospital, London. After a career in nursing at Singleton Hospital, he moved to Addenbrooke's Hospital, becoming General Manager, then Director of Clinical Care services. He later became Chief Nurse at Barts and the Royal London Hospitals. In 2003 he was appointed National Patient Champion for A&E Experience at the NHS Modernisation Agency. He has also worked at Llandough Hospital and the John Radcliffe Hospital in Oxford.

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

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 was a member of the Auditing Practices Board of the national independent financial regulator, the Financial Reporting Council and External Advisor to the Audit Committee of the Olympic Lottery Distributor. Alyson is an independent Governor of Oxford Brookes University where she chairs the Finance and Resources Committee.

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)

The Trust has mourned the sad loss in February of Cedric Scroggs, who was a Non-Executive Director since 2006 and Vice-Chair since 2008. Cedric was a key Board member who played an important role in the Trust gaining NHS Foundation Trust

status and was on the board of its predecessor Oxfordshire Mental Healthcare NHS Trust, serving for a time as its acting Chair.

A former Chair of the South East Oxfordshire Primary Care Trust, Cedric brought a wide range of expertise to this organisation.

Having been a visiting Fellow of Nuffield College, University of Oxford, and a marketing director in various industries, he was also a former Chief Executive of Fisons plc and a former Chairman of Montpellier Group plc.

Cedric passed away on 11 February, aged 74, and is survived by his wife Patricia and children Duncan, Joanna and James. Chief Executive Stuart Bell said: "Cedric made an invaluable and longstanding contribution to this organisation and will be greatly missed by us all."

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 CBE (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 32 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.

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

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

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 32 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, previously 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. Her particular interest is in leadership and leading change. Yvonne is also a Visiting Fellow at the University of Reading where she designed and leads the delivery of the Leadership Programme of Children and Young People's IAPT (improving access to psychological therapies).

Performance review

The Trust supports processes for annual performance reviews for all directors, managers and staff. The Chief Executive undertakes annual appraisals for Executive Directors, and the Chair undertakes annual appraisals for the Chief Executive and Non-Executive Directors. The Council of Governors Nomination and Remuneration Committee oversee the establishment of an appraisal process for the Chair.

Disclosure to Auditor

As directors of the Trust, the directors confirm that, as far as they are aware, there is no relevant information of which the auditor is 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 auditor is aware of that information.

Attendance at Board of Directors' Meetings, 1 April 2014 to 31 March 2015

Director	30 Apr 14	28 May 14	25 Jun 14	30 Jul 14	24 Sep 14	24 Oct 14	26 Nov 14	28 Jan 15	25 Feb 15	25 Mar 15
Ros Alstead	✓✓	✓✓	✓✓	✓✓	✓✓	X	✓✓	✓✓	✓✓	✓✓
Jonathan Asbridge	N/A	N/A	N/A	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Stuart Bell	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	X	✓✓	✓✓	X
Mike Bellamy	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Alyson Coates	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	X	✓✓	✓✓
Sue Dopson	✓✓	✓✓	✓✓	✓✓	X	✓X	✓✓	X	✓✓	✓✓
Anne Grocock	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Martin Howell	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Mike McEnaney	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Clive Meux	✓✓	✓✓	✓✓	X	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
Cedric Scroggs	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	X	✓✓	N/A	N/A
Yvonne Taylor	✓✓	✓✓	X	X	✓✓	✓✓	X	✓✓	✓✓	✓✓
Lyn Williams	✓✓	✓✓	✓✓	✓✓	X	✓✓	✓✓	✓✓	X	✓✓

Key:
✓✓ - attended meeting in public and meeting in private
✓X - attended meeting in public, apologies for meeting in private
X - apologies
N/A - not in post

Committees

Committee meetings between 1 April 2014 and 31 March 2015

The Chair of each Committee is identified in **bold** in each table

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 Board 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, integrated governance, clinical governance and risk management and HR and of external audit updates on governance and quality assurance, including whistleblowing procedures, amongst other matters; regular review of single action tender waivers and losses and special payments; 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 / Quality Committee are regularly presented for information at the Audit Committee).

Through the review of the 2013/14 Annual Report and Financial Statements, the committee was advised by the external auditor that the financial statements were found to be true and fair, and free from material misstatement. Whilst no significant deficiencies in the financial reporting system were bought to our attention, the external auditors made recommendations, all of which had been responded to by management in the report, on:

- extending the process for review of old assets on the fixed assets register
- calculating holiday pay accruals
- segmental reporting

The Audit Committee also considered the key risks identified by the external auditors and used its resources and the internal audit programme to provide assurance around the following areas: revenue recognition; capital expenditure; going concern; and management override of controls.

During the year, specific risks that the committee examined in detail included:

Payroll

As in previous years, the committee continued to review the action being taken to minimise the risk of over and under payments to staff. During the year, the committee noted that sustained improvement had been maintained.

Procurement

The committee requested reporting on the governance of procurement, oversight of estates procurement and consideration of sustainability in procurement.

Clinical audit

The committee received reporting on the development of clinical audit plans and the governance arrangements for reviewing clinical audit results and monitoring action plans. The committee also considered an internal audit report on clinical audit arrangements. The committee requested regular reporting on clinical audit practices whilst noting that the outcomes and ratings of individual clinical audits were separately reviewed by the Integrated Governance Committee / Quality Committee, whose minutes were regularly presented to the committee for information.

New integrated governance structure

The committee reviewed the new Integrated Governance Structure to take effect from 1 January 2015, the reorganised committee structure relating to quality and the proposed new reporting lines and requirements.

Cost improvement plans

The committee requested urgent action in relation to cost improvement outcomes and to implement internal audit recommendations.

The Trust's current external auditors, Deloitte LLP, were appointed for the 2014/15 reporting period under a three-year contract and the tender process took place during the 2011/12 reporting period, during which the Audit Committee reviewed proposals to appoint new external auditors with recommendations to the Council of Governors' (formerly the Members' Council) Audit Sub-Committee, including consideration of the process and scope of appointment. The final decision on appointment was made by the Council of Governors. In March 2015 the Council of Governors agreed to extend the external audit contract for a further two years. In coming to this decision, the Council of Governors took into account the views of the Audit Committee.

During the year, the Trust invited tenders for consultancy services relating to the Cost Improvement Programme. Deloitte LLP was awarded this non-audit consultancy tender and the Audit Committee received appropriate assurance that the independence of the external audit provision would be maintained and that it was appropriate for Deloitte LLP to provide non-audit consultancy services.

Through the presentation of its 2013/14 audit report to the Council of Governors, the role and effectiveness of the external audit process has been discussed.

During 2014/15, the Trust's internal audit function was provided by TIAA which had been appointed through a tender process which took place during 2013/14. The Audit Committee approved the internal audit annual work plan and monitored performance against it.

The members of the Audit Committee regularly meet with both external and internal auditors without the presence of management to discuss issues emerging through audits.

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.

Director	22 April 14	22 May 14	11 June 14 Ext	18 Sept 14	4 Dec 14	5 Feb 15
Alyson Coates	✓	✓	✓	✓	✓	✓
Sue Dopson	✓	X	X	✓	X	X
Anne Grocock	✓	✓	✓	✓	✓	✓
Cedric Scroggs	✓	✓	✓	X	X	✓
Lyn Williams	✓	✓	✓	X	✓	✓

Key: ✓ attended, X apologies, Ext Extraordinary meeting

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.

Director	12 May 14	14 July 14	8 Sept 14	10 Nov 14	3 Feb 15	10 Mar 15
Lyn Williams	✓	✓	✓	✓	✓	✓
Stuart Bell	✓	✓	X	X	✓	✓
Martin Howell	X	✓	✓	✓	✓	✓
Mike McEnaney	✓	✓	✓	✓	✓	✓
Cedric Scroggs	✓	✓	✓	✓	✓	NA

Key: ✓ attended, X apologies, N/A not a member of the committee at this time

Integrated Governance Committee / Quality Committee

The key function of the Integrated Governance Committee has been 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's remit has been to ensure 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 has also been responsible for the development of systems and processes to ensure that the Trust implements and monitors compliance with relevant standards and targets, and with Care Quality Commission Registration. The committee has made 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.

Director	14 May 14	24 July 14	10 Sept 14	13 Nov 14
Martin Howell	✓	✓	✓	✓
Ros Alstead	✓	✓	✓	✓
Anne Brierley[1]	N/A	✓	N/A	N/A
Stuart Bell	✓	X	✓	X
Mike Bellamy	✓p	✓	✓	✓
Anne Grocock	✓	✓	✓	✓
Mark Hancock[2]	N/A	✓	N/A	N/A
Mike McEnaney	✓	✓	X	X
Clive Meux	✓	X	✓	✓
Yvonne Taylor	✓	X	✓	X

Key: ✓ attended, X apologies, N/A not a member of the committee at this time

Following a review of the Trust's governance framework, in October 2014 the Board approved the abolition of the Integrated Governance Committee and its five sub-committees and the creation of a new Quality Committee with four sub-committees with effect from 1 January 2015. The new Quality Committee and its sub-committees focus on the Care Quality Commission's five domains of safe, caring, effective, responsive and well led. The role of the Quality Committee and its sub-committees is to provide assurance that appropriate policies and procedures are in place and implemented to ensure that services provided are safe, effective and efficient; provide assurance that the Trust is compliant with regulatory frameworks and legislation; approve changes in, or implementation of, clinical or working practices; monitor the quality, effectiveness and efficiency of services and identify any associated risks; and approve and monitor strategies relating to quality and risk.

[1] Anne Brierley, Service Director – Older People's Directorate, deputising for Yvonne Taylor, Chief Operating Officer, at Committee
[2] Mark Hancock, Deputy Medical Director, deputising for Clive Meux, Medical Director, at Committee

The key functions of the Quality Committee are to oversee the effective development of the Trust's corporate and clinical governance arrangements and to ensure that there is an objective and systematic approach to the identification and assessment of risk and delivery of the Trust's priorities in the context of all national standards. The committee's remit is to ensure the development and maintenance of the integrated governance framework, taking account of national strategies, priorities and developments concerning governance and risk management. It is also responsible for critically reviewing quality and risk strategies and programmes, monitoring compliance with national requirements and standards and ensuring the Trust's readiness for submission to external governance reviews.

Director	23 Jan 15 Ext	13 Feb 15
Martin Howell	✓	✓
Ros Alstead	✓	✓
Rob Bale	✓	✓
Stuart Bell	✓	✓
Mike Bellamy	✓	X
Anne Grocock	✓	✓
Mike McEnaney	N/A	X
Pete McGrane	X	✓
Clive Meux	✓	✓
Yvonne Taylor	✓	✓
Wendy Woodhouse	✓	X

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

Charitable Funds Committee / Oxford Health Charity Committee

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

In July 2014 the Board approved the supplemental deed of declarations for the charitable funds' change of name from Oxford Health Charitable Funds to Oxford Health Charity. This change was accepted by the Charity Commission and in October 2014 the Board approved a change in the Committee's name from the Charitable Funds Committee to the Oxford Health Charity Committee. The responsibilities of the committee otherwise remained the same.

Member	9 April 14	16 July 14	1 Oct 14	3 Feb 15	25 Mar 15 Ext
Anne Grocock	✓	✓	✓	✓	✓
Ros Alstead	X	✓	X	✓	X
Alyson Coates	✓	✓	✓	✓	✓
Justinian Habner	✓	✓	✓	✓	✓
Gerald Sheeran	X	✓	✓	X	X

Geoff Shepherd[3]	N/A	N/A	X	X	X
Yvonne Taylor	✓	X	✓	✓	✓
Lyn Williams	✓	✓	✓	✓	✓

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

Remuneration Committee

The Remuneration Committee is a sub-committee of the Board of Directors and comprises of Non-Executive Directors. Other directors and officers may attend at the invite of the committee chair. The committee's remit is to recommend the remuneration levels and terms and conditions for Executive Directors and other senior managers not on Agenda for Change conditions. The terms of reference for this committee have been amended in line with changes to the Executive Director structure.

Director	25 June 2014
Mike Bellamy	✓
Alyson Coates	✓
Sue Dopson	✓
Anne Grocock	✓
Martin Howell	✓
Cedric Scroggs	✓
Lyn Williams	✓

Key: ✓ attended, X apologies,

[3] External Committee member

Governance

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

Interests

The register of Directors' interests is available from the Trust Secretary on request.

Council of Governors

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:

- hold the Board of Directors to account for the performance of the Trust
- appoint/remove the Chairman of the Trust and Non-Executive Directors
- decide on the remuneration and terms and 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
- 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 Chair, Martin Howell, chairs the Council of Governors.

During 2014/15 the Council of Governors met quarterly in Thame, Oxfordshire, and on one occasion in Aylesbury, Buckinghamshire.

The Annual General Meeting occurred in September 2014 in Oxford.

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

Lead Governor

The Council of Governors elected a Lead Governor in line with Monitor guidance. During 2014/15 the following Governors held this role:

- Frances Tammer (term of office ended on 30 April 2014)
- Lynda Atkins

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

Governors during 2014/15

First name	Surname	Governor constituency	Tenure	First or second term
Lynda	Atkins	Public: Oxfordshire	01/07/14 – 30/06/17	2
John	Bidston	Public: Oxfordshire	01/07/14 – 30/06/17	1
Tricia	Birchley	Appointed: Buckinghamshire County Council	27/02/15 – 26/02/18	2
Jacqueline	Bourton	Public: Oxfordshire	01/05/11 – 30/04/14	2
Noel	Brown	Appointed Bucks County Council	01/11/13 – 31/10/16*	1
Paul	Cann	Appointed: Age UK Oxfordshire	21/05/13 – 21/05/16*	1
Mandy	Carey	Appointed: Buckinghamshire MIND	01/10/14 – 30/09/17	1
Maureen	Cundell	Staff: Older Peoples Services	02/04/12 – 31/03/15	2
Martin	Dominguez	Patient: Service Users: Buckinghamshire & Other Counties	02/04/12 – 31/03/15	1
Juliet	Dunmur	Public: Oxfordshire	15/07/11 – 14/06/14	1
Carl	Etholen	Appointed: Buckinghamshire County Council	01/08/14 – 31/07/17*	1
Arash	Fatemian	Appointed: Oxfordshire County Council	10/06/13 – 10/06/16*	1
Frances	Finucane	Staff: Adult Services	02/04/12 – 31/03/15*	1
Geoffrey	Forster	Public: Oxfordshire	01/07/14 – 30/06/17	1
Maureen	Ghirelli	Public: Buckinghamshire	01/07/14 – 30/06/17	2
Gary	Gibson	Staff: Corporate Services	01/07/14 – 30/06/17	1
Moira	Gilroy	Staff: Corporate Services	01/06/11 – 31/05/14	1
June	Girven	Appointed: Oxford	01/01/15 –	1

First name	Surname	Governor constituency	Tenure	First or second term
		Brookes University	31/12/17	
Julia	Grinsted	Public: Oxfordshire	01/05/13 – 30/04/16	1
Judith	Heathcoat	Appointed: Oxfordshire County Council	01/04/14 – 31/03/17	1
Taufiq	Islam	Public: Oxfordshire	01/07/14 – 30/06/17	1
William	James	Appointed: University of Oxford	24/11/11 – 24/11/14	1
Sonja	Janeva	Staff: Older Peoples Services	01/07/14 – 30/06/17*	1
Hafiz	Khan	Public: Oxfordshire	01/07/14 – 30/06/17	1
Martha	Kingswood	Staff: Children & Young Peoples Services	01/07/14 – 30/06/17	1
Reinhard	Kowalski	Staff: Children & Young Peoples Services	01/07/14 – 30/06/17	1
Vivian	Lanzon-Miller	Public: Oxfordshire	01/05/11 – 30/04/14	1
Lynda	Lawrence	Staff: Older Peoples Services	01/05/13 – 30/04/16	1
Samantha	Mandrup	Patient: Service Users: Oxfordshire	01/07/14 – 30/06/17	1
David	Mant	Appointed: Oxford University Hospitals NHS Trust	01/01/15 – 31/12/17	1
Rob	Michael-Phillips	Appointed: Buckinghamshire MIND	11/04/14 – 11/04/17*	2
Pam	Norton	Staff: Children & Young Peoples Services	01/05/11 – 30/04/14	1
Neil	Oastler	Staff: Children & Young Peoples Services	15/07/13 – 14/06/14	1
Carol	Penny	Public: Buckinghamshire	01/07/14 – 30/06/17	1
Judith	Randall	Patient: Service Users: Buckinghamshire & Other Counties	01/05/13 – 30/04/16	1

First name	Surname	Governor constituency	Tenure	First or second term
Chris	Roberts	Public: Oxfordshire	01/05/13 – 30/04/16	1
Diana	Roberts	Appointed: Age UK Oxfordshire	07/05/14 – 30/04/17	1
Pat	Ross	Patient: Carers	01/07/14 – 30/06/17	1
Anwar	Soopun	Staff: Adult Services	01/07/14 – 30/06/17	1
Frances	Tammer	Public: Buckinghamshire	01/05/11 – 30/04/14	1
Peter	Tankard	Public: Oxfordshire	01/05/11 – 30/04/14	1
Mark	Tattersall	Public: Rest of England & Wales	01/07/14 – 30/06/17	1
David	Thurston	Staff: Adult Services	01/07/14 – 30/06/17	1
Liz	Turvey	Patient: Carers	01/05/13 – 30/04/16	2
Sula	Wiltshire	Appointed: Oxfordshire CCG	01/01/15 – 31/12/17	1
Soo	Yeo	Staff: Older Peoples Services	15/07/11 – 14/06/14	1

Key: * = resigned mid-way during tenure

Governor details are published on the Trust's website and FT members are encouraged to contact their representatives.

Attendance at Council of Governor Meetings / AGM, April 2014 – March 2015

Governors

First Name	Surname	Jun 2014	Jul 2014	Sep 2014	Nov 2014	Mar 2015
Lynda	Atkins	N/A	✓	✓	X	✓
John	Bidston	N/A	✓	✓	✓	✓
Tricia	Birchley	N/A	N/A	N/A	N/A	✓
Jacqueline	Bourton	N/A	N/A	N/A	N/A	N/A
Noel	Brown	X	N/A	N/A	N/A	N/A
Paul	Cann	X	N/A	N/A	N/A	N/A
Mandy	Carey	N/A	N/A	N/A	✓	✓
Maureen	Cundell	✓	✓	✓	✓	✓
Martin	Dominguez	✓	✓	✓	X	✓
Juliet	Dunmur	✓	N/A	N/A	N/A	N/A
Carl	Etholen	N/A	✓	X	✓	N/A
Arash	Fatemian	N/A	N/A	N/A	N/A	N/A
Frances	Finucane	N/A	N/A	N/A	N/A	N/A
Geoffrey	Forster	N/A	✓	✓	✓	✓
Maureen	Ghirelli	✓	✓	✓	✓	X
Gary	Gibson	N/A	✓	X	X	✓
Moira	Gilroy	N/A	N/A	N/A	N/A	N/A
June	Girven	N/A	N/A	N/A	N/A	X
Julia	Grinsted	✓	✓	X	✓	X
Judith	Heathcoat	X	✓	✓	✓	✓
Taufiq	Islam	N/A	✓	✓	X	X
William	James	X	X	X	X	N/A
Sonja	Janeva	N/A	✓	✓	X	N/A
Hafiz	Khan	N/A	X	✓	X	X
Martha	Kingswood	N/A	✓	✓	✓	✓
Reinhard	Kowalski	N/A	✓	✓	X	✓
Vivian	Lanzon-Miller	N/A	N/A	N/A	N/A	N/A
Lynda	Lawrence	✓	X	✓	✓	✓
Samantha	Mandrup	N/A	X	X	X	✓
David	Mant	N/A	N/A	N/A	N/A	✓
Rob	Michael-Phillips	X	X	X	N/A	N/A
Pam	Norton	N/A	N/A	N/A	N/A	N/A
Neil	Oastler	✓	N/A	N/A	N/A	N/A
Carol	Penny	N/A	✓	X	X	X
Judith	Randall	✓	✓	X	✓	✓
Chris	Roberts	✓	✓	✓	✓	✓

First Name	Surname	Jun 2014	Jul 2014	Sep 2014	Nov 2014	Mar 2015
Diana	Roberts	N/A	✓	✓	✓	✓
Pat	Ross	N/A	✓	✓	✓	✓
Anwar	Soopun	N/A	✓	✓	✓	✓
Frances	Tammer	N/A	N/A	N/A	N/A	N/A
Peter	Tankard	N/A	N/A	N/A	N/A	N/A
Mark	Tattersall	N/A	✓	X	✓	✓
David	Thurston	N/A	✓	✓	✓	X
Liz	Turvey	X	✓	✓	✓	X
Sula	Wiltshire	N/A	N/A	N/A	N/A	✓
Soo	Yeo	X	N/A	N/A	N/A	N/A

Key: N/A = not in post

Directors (Executive and Non-Executive)

First Name	Surname	Jun 2014	Jul 2014	Sep 2014	Nov 2014	Mar 2015
Ros	Alstead	X	X	✓	✓	✓
Jonathan	Asbridge	N/A	✓	X	✓	X
Stuart	Bell	✓	✓	✓	✓	✓
Mike	Bellamy	✓	X	✓	X	X
Alyson	Coates	✓	✓	✓	X	✓
Sue	Dopson	X	X	X	X	X
Anne	Grocock	✓	✓	✓	✓	✓
Martin	Howell	✓	✓	✓	✓	✓
Mike	McEnaney	✓	✓	✓	✓	✓
Clive	Meux	X	X	✓	✓	✓
Cedric	Scroggs	X	X	✓	✓	N/A
Yvonne	Taylor	✓	✓	✓	✓	✓
Lyn	Williams	X	✓	✓	✓	✓

Key: N/A = not in post

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 the Chief Executive gave a presentation the Board's activities and decisions taken alongside the wider strategic issues for the Trust. The Chair presents an oral report on Council business 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.

Board Directors also attend relevant Council of Governor informal seminars which helps enhance the working relationship. Likewise, each Council of Governor sub-group has a Board Director attending.

Governors are explicitly invited to attend and observe the Board of Directors meeting in public and the Chair provided the opportunity for those in attendance to ask questions of the Board.

Key business transacted by the Council during 2014/15 included:

- providing comments on the Trust forward plans and confirming it was satisfied that non-NHS work would not significantly interfere with the Trust's principal purpose and function.
- providing comments on the Quality Report 2013/14 and Quality Account 2014/15.
- receiving the 2013/14 annual reports, accounts and auditor's report.
- agreeing a new sub-committee structure, providing the Council more opportunity to focus on quality, finance and patient experience matters.
- approving amendments to the Trust Constitution.
- appointing and re-appointing Non-Executive Directors.
- approving the appointment of Trust Auditors.

During 2014/15 the Council of Governors and Board of Directors approved changes to the Trust Constitution in relation to FT membership and Governor representation. The changes included:

- Changing staff FT membership classes to reflect the new service directorates.
- Removing the University of Oxford Appointed Governor position and replacing it with an Appointed Governor from Oxford Brookes University.
- Increasing the number of Appointed Governors by four to include the following partners:
    - Oxfordshire CCG
    - Chiltern CCG
    - Oxford University Hospitals NHS Trust
    - Buckinghamshire Healthcare NHS Trust

Interests

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

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 2014/15, the Council of Governors Nominations and Remuneration Committee carried out the following business:

- considering the appointment process for the Non-Executive Director vacancy created by Cllr Roger Reed and the vacancy that would be created when Cedric Scrogg's term of office ended on 31 March 2015.
- recommending re-appointment of three Non-Executive Directors for further terms
- considering the appraisal process for the Chair
- discussing the level of non-executive remuneration

Attendance at Council of Governors Nominations and Remuneration Committee, April 2014 – March 2015

Name	Role	Nov 2014*	Feb 2015
Martin Howell	**Chair**	✓	✓
Lynda Atkins	Governor	X	X
Maureen Cundell	Governor	✓	✓
Martin Dominguez	Governor	X	✓
Geoffrey Forster	Governor	X	✓
Diana Roberts	Governor	X	✓
Liz Turvey	Governor	✓	✓

Key: * = this meeting did not have a quorum and, therefore, no formal business was transacted

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: Buckinghamshire & Other Counties	2
	Service Users: Oxfordshire	2
	Carers	3
Staff	Adult Services	2
	Older Peoples Services	4
	Children & Young Peoples Services	2
	Corporate Services	1
Sub total elected		28
Appointed governors		
Oxfordshire Clinical Commissioning Group		1
Chiltern Clinical Commissioning Group		1
Oxford University Hospitals NHS Trust		1
Buckinghamshire Healthcare NHS Trust		1
Oxfordshire County Council		1
Buckinghamshire County Council		1
Oxford Brookes University		1
Voluntary / Community Organisations - Buckinghamshire Mind - Age UK Oxfordshire		 1 1
Sub total appointed		9
Total number of governors		**37**

In March 2014, the Council of Governors approved amendments to the Trust's constitution which included changes to membership constituencies and governor representation. The changes took effect from 1 April 2014. Further changes to the appointed governor representation were made in November 2014.

Membership activity

Between April 2014 and March 2015 a range of recruitment and engagement activities took place to promote the benefits of NHS FT membership to the Trust's communities. The Trust has a five-year Membership Strategy (2011-2016) which aims 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
- empower members to act as ambassadors for the Trust, to share information about the Trust's services and promote the benefits of membership

Attendance at public and Trust-organised events in order to promote FT membership included:

- Trust Annual General Meeting, September 2014, Oxfordshire
- Hosting, with partners, 'Health Matters' events
- Linking with local higher education partners to support health events
- Linking with local voluntary sector organisations to support health events
- Using events established for other purposes to promote FT membership (for example, the official opening of Whiteleaf building, stakeholder events)

The Trust's newsletter, *Insight*, is sent to all Governors, emailed to all FT members and made available on the Trust website. The newsletter provides information to members, encourages others to join and allows Governors to link with members through articles.

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

Membership recruitment and engagement, and implementing the Membership Strategy are the responsibility of the Trust's Communications and Engagement team. The Trust has had difficulties in substantially growing and engaging its FT membership, despite the implementation of a range of initiatives and approaches. A new Director of Corporate Governance (Trust Secretary) will work with the Head of Communications and Engagement to review FT membership recruitment and engagement activity and will work with Governors to refresh the Membership Strategy and find new ways to enhance FT membership in the year ahead.

Oxford Health NHS FT membership numbers

Public constituency	Last Year
At year start (April 1)	2270
At year end (March 31)	2293
Staff constituency	
At year start (April 1)	6204
At year end (March 31)	6205
Patient constituency	
At year start (April 1)	469
At year end (March 31)	525

Analysis of current membership

Public constituency	Number of members	Eligible members
Age (years):		
0-16	0	11,141,985
17-21	3	2,682,893
22+	1770	38,217,039
Unknown	520	
Ethnicity:		
White	1789	47,520,866
Mixed	25	661,036
Asian or Asian British	50	2,273,736
Other	10	446,704
Unknown	383	
Gender		
Male	966	25,325,925
Female	1327	26,715,992
Unknown	0	

Patient constituency	Number of members	Eligible members
Age (years):		
0-16	0	50,510
17-21	7	5670
22+	452	82064
Unknown	66	

- 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
- 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
- Socio-economic grouping data were analysed by CACI using its ACORN profiling.

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

Staff

There are four classes: Staff: Adult Directorate, Staff: Older People Directorate, Staff: Children and Young People Directorate, Staff: Corporate Directorate. 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.

Enhanced quality governance reporting

At the heart of the Trust's strategy and developments is the ongoing improvement of the quality of services we provide. Improving patient experience and ensuring our services are safe and effective drive the decisions taken by the Board of Directors and the systems established in the Trust. During the year, the Trust's governance framework was reviewed with changes proposed to the arrangements relating to quality.

The Integrated Governance Framework describes the governance and assurance arrangements for the Trust, integrating clinical and corporate governance. From 1 April 2014 to 31 December 2014, five Quality Improvement Committees (QICs) reported in to the Integrated Governance Committee which ultimately reported to the Board. QICs took responsibility for the main areas underpinning the development of quality services:

- clinical effectiveness
- services and estates
- risk, and health and safety
- information management
- human resources

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

From 1 January 2015, the Integrated Governance Committee was reframed and become the Quality Committee. This provides assurance to the Board of Directors that we are discharging our responsibilities for ensuring service quality and that we are compliant with our registration requirements with the CQC. These responsibilities are defined within the CQC's five key questions and their key lines of enquiry and includes assurance that good and poor practice is recognised, understood and being managed through the operational and clinical management structure.

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

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

The decision-making and problem solving related to business as usual and real-time management issues and risks will continue to be managed through the directorate and corporate operational and clinical management structures. These are accountable to the Board of Directors through the Executive Team. With a clearer delineation between governance and management responsibilities it should enable a clearer focus for reporting into the Quality Committee.

There are four new quality sub-committees that will report to the Quality Committee and replace the five QICs. The sub-committees reflect the five CQC key questions. The sub-committees are: safety, caring and responsive, effective, and well led. Each of these will be responsible for providing assurance to the Quality Committee that we are compliant with all of the key lines of enquiry which sit under their particular key question(s) and any other areas which fall within their responsibility.

Each Executive has a clearly defined portfolio and is individually and collectively accountable for the quality and safety of services. The Director of Nursing and Clinical Standards reports monthly to the Board on quality and safety matters, including assessments against CQC requirements and clinical audit results. Further, the Board reviews a range of reports throughout the year which provide an insight into the quality of the services provided. Such reports include complaints annual report, quarterly updates against the Quality Account, and HR workforce key performance indicator reports. Reports, such as the Board Assurance Framework, to the Board of Directors also describe the key risks to the Trust, the mitigating controls and action plans to address gaps. The internal audit programme which is reviewed by the Audit Committee provides assurances on a range key governance areas.

The Executive team regularly reviews the quality of services through weekly consideration of Serious Incidents Requiring Investigation cases, inquest and

complaint trends and themes. The Trust has also established Quarterly Performance reviews for each service division providing the opportunity for Executive Directors to review divisional performance against a range of metrics, hold divisional management teams to account for performance and assist divisions in identifying resources to tackle problem areas. Non-Executive Directors are invited to attend and observe these Reviews.

During 2014/15, the Board undertook a full assessment against the Monitor Quality Governance Framework.

Quality Account and Report

Further detail on the Trust's approach to quality governance and key performance indicators may be found in the Quality Account and Report section from page 71.

Disclosures and regulatory rating

NHS Foundation Trust Code of Governance

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

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 updated Code of Governance sets out the requirement for all NHS foundation trust's to make certain disclosures. In addition the NHS Foundation Trust Annual Reporting Manual sets out certain required disclosures. The table below sets out the disclosures for the Trust.

Provision	Requirement	Trust disclosure
A.1.1	The schedule of matters reserved for board should include a clear statement detailing the roles and responsibilities of the council and governors. This statement should also describe how aboard ony disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors.	The Trust's Scheme of Reservation and Delegation sets out the role and function of the Board and its sub-committees and the Executive function. The role and responsibility of the Council is set out in the Trust's Constitution, Standing Orders and Governor Code of Conduct. The scheme is reviewed on an annual basis and the review in 2014/15 enhanced the references to the Council. Further explanation of the Council's role and function

		and the working relationship between the Board and Council is set out in the Directors' Report.
A.1.2	The Annual Report should identify the Chairperson, the Deputy Chairperson (where there is one), the Chief Executive, the Senior Independent Director and the Chairperson and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those committees and individual attendance by directors.	This information is provided in the Directors' Report.
A.5.3	The Annual Report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The Annual Report should also identify the nominated lead governor.	This information is provided in the Directors' Report.
B.1.1	The Board of Directors should identify in the Annual Report each Non-Executive Director it considers to be independent, with reasons where necessary.	This information is provided in the Directors' Report.
B.1.4	The Board of Directors should include in its Annual Report a description of each director's skills, expertise and experience. Alongside this, in the Annual Report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	This information is provided in the Directors' Report.
B.2.10	A separate section of the Annual Report should describe the work of the Nominations Committee(s), including the process it has used in relation to board appointments.	This information is provided in the Directors' Report.

B.3.1	A Chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report.	Details of candidates' interests and commitments are made available to Council as part of the appointment / re-appointment process. The Trust maintains a Register of Directors' Interests which is publicly available. Further explanation is provided in the Directors' Report.
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	This information is provided in the Directors' Report.
B.6.1	The Board of Directors should state in the Annual Report how performance evaluation of the Board, its committees, and its Directors, including the Chairperson, has been conducted.	This information is provided in the Directors' Report.
B.6.2	Where an external evaluation of the Board and/or governance of the Trust, the external facilitator should be identified and a statement made as to whether they have any other connection with the Trust.	No external facilitator was contracted to undertake governance reviews during 2014/15.
C.1.1	The Directors should explain in the Annual Report their responsibility for preparing the Annual Report and accounts, and state that they consider the Annual Report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients,	This information is provided in the Strategic Report, Directors' Report, Statement of the Chief Executive's Responsibilities, Annual Governance Statement, and Financial Performance,

	regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	Remuneration Report and Income Disclosures.
C.2.1	The Annual Report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	This information is provided in the Annual Governance Statement.
C.2.2	A Trust should disclose in the Annual Report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	This information is provided in the Directors' Report.
C.3.5	If the Council of Governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the Annual Report a statement from the audit committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	The Council of Governors approved the recommendation to extend the current external audit contract by two years.

C.3.9	A separate section of the Annual Report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	This information is provided in the Directors' Report.
D.1.3	Where a NHS foundation trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the Annual Report should include a statement of whether or not the Director will retain such earnings.	Not applicable.
E.1.5	The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the board, and in particular the Non-Executive Directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	This information is provided in the Directors' Report.

E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the Annual Report.	This information is provided in the Directors' Report.
FT ARM	The Annual Report should include a statement about the number of meetings of the Council of Governors and individual attendance by Governors and Directors.	This information is provided in the Directors' Report.
FT ARM	The Annual Report should include a brief description of the length of appointments of the Non-Executive Directors, and how they may be terminated.	This information is provided in the Directors' Report.
FT ARM	The disclosure in the Annual Report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or Non-Executive Director.	No recruitment processes took place during 2014/15.
FT ARM	If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the Annual Report.	The Governors did not exercise this power during 2014/15.
FT ARM	The Annual Report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership • information on the number of members and the number of members in each constituency • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership (see also E.1.6 above), including progress towards any recruitment targets for members	This information is provided in the Directors' Report.

FT ARM	The Annual Report should disclose details of company directorships or other material interests in companies held by Governors and/or Directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of Governors' and Directors' interests which are available to the public, an alternative disclosure is for the Annual Report to simply state how members of the public can gain access to the registers instead of listing all the interests in the Annual Report.	This information is provided in the Directors' Report.

Public interest disclosures

Policies in relation to disabled employees and equal opportunities

Further detail about the Trust's Disabled Workers Policy can be found in the Employee Policies section.

Health and safety performance and occupational health

The Trust is committed to the provision of a safe and healthy working environment for employees, patients, visitors, contractors and members of the public. The Trust accepts fully its duties and responsibilities under the Health and Safety at Work etc. Act 1974 and associated regulations. The Trust recognises that patient care, health, safety, environmental considerations and business objectives are mutually dependent. The Trust aims to develop and promote a positive and effective safety culture throughout the organisation. The safety performance of the Trust is regularly monitored and reviewed to ensure that arrangements for implementing a positive safety culture are reflected within policies and procedures. Monitoring and review are carried out by informal local inspections, Staff Safety Representatives' inspections, formal audits conducted by Health and Safety and Fire Advisors and through the Health and Safety Committee. The Health and Safety Executive, Fire Authorities and Local Authorities may also make inspections and audits from time to time.

During 2014/15 the Health and Safety Executive (HSE) investigated an incident that occurred on the Fiennes Centre in 2013. The incident concerned a patient having fallen from a first floor bathroom window and the HSE investigated the window design and maintenance, and the Trust's procedures relating to the Central Alerting System (CAS) alert. The Trust co-operated fully with the investigation and

implemented a detailed action plan to ensure that the risk of a similar incident occurring at any site was minimised.

The Trust is also supported by an occupational health department which: advises the Trust and managers on the assessment and management of risks, where employees' fitness for work and their health may be of concern; undertakes employee health assessments, as appropriate; delivers immunisation screening and programmes, as appropriate, and works in partnership with the Infection Prevention and Control team; and works in partnership with Human Resources and managers in reducing sickness absence and promoting health and wellbeing.

Relevant Health and Safety policies and procedures include, but are not limited to: Animal Associated Activity policy, Asbestos policy, CAS policy, CCTV policy, Contractors booklet on Health and Safety at Work, Control of Substances Hazardous to Health policy, Display Screen Equipment policy, Fire Safety policy, First Aid policy, Health and Safety policy, Policy and Procedures for reporting and management of incidents including Serious Incidents Requiring Investigation, Manual Handling Operations policy, Personal Safety/Lone Working policy, Risk Management policy and procedure, Smoke-Free policy, Waste Management policy, Workplace Stress policy, Infection Prevention and Control policy and Food Safety and Hygiene policy.

Consultations

We have continued to work with our commissioners to plan and manage changes to the clinical services we provide. These changes are being driven by a number of factors, including service improvement, the need for us to identify more cost-effective ways of working and to respond to reductions in the resources available to our commissioners. We have had discussions with local Overview and Scrutiny Committees on a wide range of issues.

Other public and patient involvement activities

Details of public and patient involvement activities can be found in the Quality Account.

Sickness absence

Average sickness for 2014/15 is 4.19%.

Compliance regarding cost allocation and charging guidance issued by HM Treasury

Further detail about this can be found in the Financial Performance, Remuneration Report and Income Disclosures.

Comply or explain

In addition to the disclosures above, the Code of Governance sets out requirements which NHS foundation trusts must either comply with or explain.

The Board of Directors considers that the Trust is fully compliant with the provisions of the code.

Last year, the Trust explained why it was not compliant with provisions A.4.1 and B.2.2 of the code. Since then the Trust appointed a Senior Independent Director (Cedric Scroggs) and has put in place processes to comply with the fit and proper persons test. All other points of compliance have been maintained from last year.

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 risk ratings. The ratings are designed to indicate the risk of failure to comply with the Provider Licence.

Risk Assessment Framework

The Risk Assessment Framework sets out the process by which Monitor will seek to establish where there is:

1. significant risk to the financial stability of an NHS foundation trust which would put at risk continuity of services
2. poor governance within an NHS foundation trust

Accordingly, NHS foundation trusts will be assigned two ratings:

1. Continuity of services risk rating
2. Governance rating

Continuity of services risk rating

The new continuity of service risk rating replaces the financial risk rating and assesses providers for risk of financial failure using a calculation focused on two metrics.

1. Significant risk
2. Material risk

2*. Level of risk is material but stable

3 Emerging or minor concern potentially requiring scrutiny

4 No evident concerns

Governance rating

The new governance rating has three categories:

- 'Green' rating – where there are no concerns.
- 'Under review' – concerns have been identified but no enforcement action has commenced. Monitor provides a written description stating the issue(s) at hand.
- 'Red' rating – when enforcement action has commenced.

During 2014/15, the Trust's ratings were:

	Annual Plan	Q1	Q2	Q3	Q4
Continuity of Services Risk Rating	3	3	2	3	2
Governance Rating	Green	Green	Under Review	Under Review	Under Review

During 2013/14, the Trust's ratings were:

	Annual Plan	Q1	Q2	Q3	Q4
Financial Risk Rating / Continuity of Services Risk Rating*	3	3	3	4	4
Governance Risk Rating / Governance Rating*	Amber Green	Green	Green	Green	Green

Key: * = the ratings used by Monitor changed from Q3

Performance

During 2014/15, the Trust was not subject to formal regulatory action from Monitor.

In Q2, Monitor changed the Trust's Governance Rating to be 'Under Review' and provided the following written description:

"Monitor is requesting further information following a continuity of services risk rating of 2, before deciding next steps."

This Governance Rating remained in place for Q2, Q3 and Q4.

At the end of Q2 the Trust revised its forecast for the year, in light of income and cost pressures, and informed Monitor that a CoSRR of 2 would be achieved and not 3 as the original plan. After the implementation of a financial recovery plan the Trust did improve upon the forecast although a CoSRR of 3 could not be achieved. The Trust has been in close dialogue with Monitor, providing additional information and regular updates on activities to improve the financial position. It is expected that the Trust's Governance Rating will be considered further by Monitor following review of the 2015/16 Operating Plan.

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.

NHS Staff Survey and Staff Friends and Family Test (SFFT) 2014

The national staff survey is carried out across all NHS trusts in England. It allows staff confidentially to comment on how their trust supports, trains and involves them in delivering high-quality and safe services. NHS trusts delivering similar services are able to compare or benchmark themselves against each other on the basis of whether they are in the top 20%, above average, average, below average or in the bottom 20% of similar trusts.

This survey is important to us as an organisation as it allows the Trust to gather the views of its staff and identify areas where we are doing well and those where some improvements could be made.

2014 was the first time the Trust had the opportunity to survey all 5168 members of staff around the 29 key areas covered by the survey and also the first time for this to be carried out by email. Previous surveys have been carried out on a random sample of 850 staff.

The 2014 survey is the largest number of staff we have ever had providing feedback to the Trust in a survey of this type. The results for the 2014 staff survey are detailed below.

The response rate was 31.84% which was in the lowest 20% of trusts (the average was 44%). OHFT is compared with mental health and learning disability trusts.

Summary of results

We now have 22 key findings that are in the best 20%, better than average or average and seven in the worst 20%, which shows that there are a number of areas where improvements still need to be made.

We had top ranking scores for; fewer staff experiencing physical violence from patients, relatives, the public and staff; staff recommendation of the Trust as a place to work; percentage of staff agreeing feedback from patients/service users is used to make informed decisions in their directorate; and equality of opportunity for career progression.

Our lowest ranking scores were for percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; percentage of staff working extra hours; percentage of staff appraised in the last 12 months and percentage of staff reporting errors, near misses or incidents witnessed in the last month.

The table below shows the Trust response rate and the results of the 2014 staff survey compared to the 2013 results.

	2014		2013		
Response rate	**Trust**	**National average**	**Trust**		**Increase/ decrease in %**
	32%	44%	50%		
	2014		**2013**		
Top 5 ranking scores	**Trust**	**National average**	**Trust**		**Increase/ decrease**
KF16 Percentage experiencing physical violence from patients, relatives or the public in the last 12 months	18%	16%	17%		+1%
KF17 Percentage experiencing physical violence from staff in the last 12 months	3%	3%	3%		=
KF24 Staff recommendation of the Trust as a place to work or receive treatment	3.63	3.57	3.64		-0.01
KF27 Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	88%	86%	93%		-5%
KF29 Percentage of staff agreeing that feedback from patients / service users is used to make informed decisions in their directorate / department	57%	53%	No data		

	2014		2013		
Bottom ranking scores	**Trust**	**National Average**	**Trust**		**Increase/ decrease**
KF1 Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	71%	76%	74%		-3%
KF5 Percentage of staff working extra hours	79%	71%	78%		+1%
KF7 Percentage of staff appraised in the last 12 months	82%	88%	86%		-4%
KF12 Percentage witnessing potential harmful errors, near misses or incidents in the last month	34%	26%	28%		+6%
KF13 Percentage reporting errors, near misses or incidents witnessed in the last month	90%	92%	91%		-1%

Staff engagement

The Department of Health said "motivated and involved staff are better placed to know what is working well and how to improve services for the benefit of patients and the public" in the NHS Operating Framework 2010/11, with the improvement of employee engagement being listed amongst the five national priorities for the NHS.

In high-performing organisations leaders work collaboratively with staff, involving them in decisions and empowering them to make changes in response to patient needs. This includes spending time working with and listening to staff and responding to their concerns. These organisations also focus on understanding the patients' views and placing these at the centre of decisions about services. Evidence shows that organisations with consistently high levels of staff engagement also have better patient experiences and outcomes.

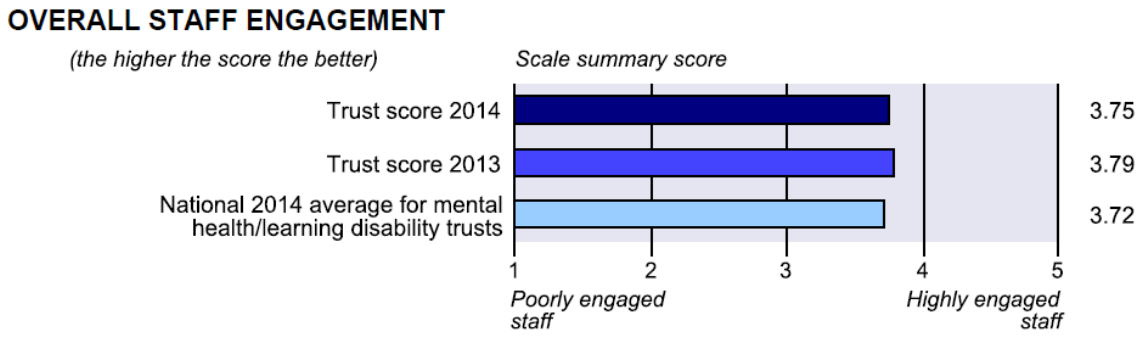
The overall staff engagement score for OHFT is 3.75 which is slightly above average compared with other mental health/learning disability trusts.

NHS Staff engagement score

There are three key findings that make up the NHS staff engagement score and each key finding is made up of three questions from the staff survey as per the table below:

Key finding	Question
Key finding 22 Staff ability to contribute towards improvement at work	7a There are frequent opportunities for me to show initiative in my role
	7b I am able to make suggestions to improve the work of my team / department
	7d I am able to make improvements happen in my area of work
Key finding 24 Staff recommendation of the trust as a place to work or receive treatment	12a Care of patients / service users is my organisation's top priority
	12c I would recommend my organisation as a place to work
	12d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation
Key finding 25 Staff motivation at work	5a I look forward to going to work
	5b I am enthusiastic about my job
	5c Time passes quickly when I am working

The chart below shows how our 2014 staff engagement score of 3.75 was above average compared to other mental health and learning disability trusts (the national average was 3.72) and there is no significant change from our 2013 staff engagement score.



Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged.

Actions going forward

There are two levels of action that the Trust is taking in response to this year's staff survey results. The first level of actions is focused on teams and their individual team scores from the set of 12 staff engagement themes and the individual questionnaire responses, the second level of actions being Trust-wide and being developed around the 12 engagement themes.

Team actions

Below are examples of the actions that teams have taken from this year's results: Discussions with HR to compare against 2013 results and to identify areas for the focus of this year's action plan based on the five CQC domains. Examples from last year were a focus on supporting staff to reduce working excessive hours via modelling best practice, for example prompting staff to leave on time and the management of time-off-in-lieu (TOIL) and also the promotion of positive actions and good clinical outcomes at team meetings to share successes from within the directorate.

Results have been shared with the senior management team and heads of services who are drilling down and focusing on hotspots.

Trust-wide actions

The Trust is revising the current award and recognition scheme by joining up directorate initiatives and organising an annual awards ceremony. A survey was available for staff to complete and give their feedback and suggestions on the type of awards which would be offered, how relevant each award was to them and their team (if applicable) and also what the winners should receive. Staff interest and engagement with this process has been very positive.

The implementation of CareNotes will help to ensure that staffs have the right tools they need to do their roles well.

The staff survey and staff Friends and Family Test are now standing items on the directorates' quarterly performance meeting agendas.

To ensure continuing progress and improvements, the Staff Health and Wellbeing Group incorporates the findings of the 2014 survey in to their annual action plan, which helps to shape the priorities of the group and ensures that they are addressing the key areas that staff feel most strongly about. This year's priorities include taking action to prevent and reduce workplace stress and encouraging and enabling managers to support health and wellbeing at work. The initiatives to be taken forward this year are:

- continue to embed health and wellbeing into the organisational culture at OHFT

- increased access to mindfulness for staff
- continued promotion of health walks schemes at main Trust sites
- increased access to yoga and fitness classes at Trust locations
- link wellbeing results in with HR data
- support staff to make healthy travel choices for short business travel by utilising the OxonBike scheme based at Chancellor Court, Warneford and Littlemore
- pedometer challenge
- increase the number of wellbeing notice boards
- continued programme of public health campaigns, sharing health advice and information with staff
- review management and leadership development activities to incorporate messages about staff health, wellbeing and support

Staff Friends and Family Test (SFFT)

The SFFT was introduced on 1 April 2014 for all trusts providing acute, community, ambulance and mental health services. The aims as announced by the Prime Minister are to encourage improvements in the service delivery – by 'driving hospitals to raise their game' and to increase transparency by enabling patients and the public to readily access and compare scores for different providers and services.

The test is administered every quarter, except quarter three where it is replaced by the NHS Staff Survey.

The test asks two questions with optional comment boxes: 'How likely are you to recommend this organisation to friends and family if they needed care or treatment?' and 'How likely are you to recommend this organisation to friends and family as a place to work?'

The response scale below is used for each of these questions:

Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know

Response rates

Quarter	Response Rate	Average response rate*
1	6%	11%
2	12%	16%
3	NHS Staff survey	
4	18%	16%

*Average response from all NHS organisations that provide acute, community, ambulance and mental health services

The chart on the previous page shows that our response rate has been improving each quarter and that our most recent response rate was ahead of the national average.

Year one summary FFT results

How likely are you to recommend this organisation to friends and family if they needed care or treatment?							
Quarter	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't know	Total no. of staff
1	24%	49%	17%	5%	3%	2%	316
2	21%	48%	22%	5%	2%	2%	723
4	23%	50%	18%	6%	2%	1%	987
Staff survey	61% (based on answer of yes)						1646

How likely are you to recommend this organisation to friends and family as a place to work?							
Quarter	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't know	Total
1	18%	41%	18%	14%	8%	2%	313
2	18%	40%	22%	12%	7%	1%	702
4	17%	40%	22%	13%	8%	1%	963
Staff survey	55% (based on answer of yes)						1646

Responses have been noticeably consistent for each of the three FFT surveys.

Encouraging the involvement of employees in the Trust's performance

The Trust's Head of Strategy and Performance conducted a series of workshops about the Trust's strategy with staff across the organization. He also ran a series of workshops with staff so that they could be equipped with skills to apply the principles of values-based healthcare to the work they do.

A series of conferences with senior leaders also took place over the year that aimed to showcase and share best practice within the Trust with a view to enhancing the organisation's overall performance.

Achieving a common awareness of the financial and economic factors affecting the Trust's performance

In December 2014, a letter was sent to all staff from the Chief Executive outlining the financial and economic factors affecting the Trust's performance. This detailed communication set out plainly the challenges facing the organisation, including the fact that the Trust had recently made significant investments in its adult mental health services, there was increased demand for services and reduced funding from contracts.

Employee policies

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts. Details of senior employees' remuneration can be found where salaries and allowances table 2014/15 starts.

The Trust's Disabled Workers Policy was in place through the year and sets out how the Trust supports disabled persons in employment applications, training and career development.

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

It also makes clear that there must be ongoing consideration for disabled people throughout their employment – this may involve taking any steps which it is reasonable to take to reduce or remove any substantial disadvantage which a physical feature of Trust premises or employment arrangements would cause a disabled employee or job applicant compared to a non-disabled person. Such reasonable adjustments are a way of "levelling the playing field" for disabled people.

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

Quality Report and Account

Part 1: Statement on quality from the Chief Executive

Chief Executive's statement

I am delighted to introduce the Quality Account and Quality Report for Oxford Health NHS Foundation Trust (OHFT) which provides us with the opportunity to reflect on our quality achievements and successes over the past twelve months as well as to identify areas for further improvement, including our quality priorities for the coming year. To the best of my knowledge the information contained in this report is accurate.

In 2014, the Commonwealth Fund identified the NHS as the best healthcare system among eleven other developed nations[4]. This is a testament to the hard work, commitment and compassion of staff across the NHS and I would particularly like to thank everyone here at OHFT for continuing to provide such excellent care.

The challenges we face are not just financial. People are living longer than they used to and often with more complex health needs. Mental health services also continue to influence national policy and funding to ensure parity of esteem. In the long run it is unlikely that we have the right workforce available to meet the changing demands across health and social care systems. This is why we need to find new ways of working. We are developing partnerships with our colleagues working in social care, hospitals and the voluntary sector to come up with system-wide solutions. High quality care that is caring, safe and excellent, that focuses on early intervention and involves patients and those close to them, will achieve the best outcomes and is the best value care.

Last year we set ourselves an ambitious set of quality priorities which have resulted in some quantifiable successes. We have seen an increase in the number of patients who return on time from leave and a reduction in the number of serious incidents resulting in severe harm. Staff have delivered a range of innovations and improvements which are detailed in this report. Community nursing teams are improving assessments and care for patients at risk of pressure damage. We will shortly be implementing our new Electronic Patient Care Support (CareNotes) System which was commissioned with our staff. We have also rolled out the Friends and Family Test to all our services and ensured that all teams have ways of collecting and responding to patient and carer feedback. The whole trust became smoke-free on 2 March 2015, including our new community hospital in Bicester.

Over the last twelve months we have implemented our comprehensive service and pathway remodelling programme in adult and older adult services. The aim was to

[4] Commonwealth Fund report: comparison of 11 countries

ensure our services are patient-centered, that we emphasise family and carer involvement in developing outcome measures and that interventions are evidence-based. This is reflected in the recent move towards outcomes-based contracts, delivery of services in partnership with other providers, and integration of care locally.

In the coming year we have consolidated our quality priorities into four key aspects of quality: a safe and effective workforce supported by effective leadership, working well in teams and focused on continuous improvement; improving quality through service remodelling; striving for a positive patient and carer experience (and acting when this is not the case); and increasing harm-free care.

I should add that to the best of my personal knowledge, the information contained in this document is accurate.

Stuart Bell CBE
Chief Executive

Date: 28 May 2015

Who we are

OHFT is a community-focused organisation that provides physical and mental health services integrated with 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, Milton Keynes, Berkshire, Swindon, Wiltshire, and Bath and north east Somerset (BaNES).

We employ 6172 staff with a contracted WTE of 4743.61[5]. This number includes:

- 306 medical staff
- 686 therapists
- 1837 qualified nurses
- 1026 health care workers
- 354 other support staff including ancillaries and, care workers
- 707 other professional including psychology, dental staff and social workers

In Oxfordshire we are the main provider of the majority of non-GP based community health services for the population of Oxfordshire and deliver these in a range of community and inpatient settings, including eight community hospital sites (ten wards). 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 and BaNES. We also provide forensic mental health and eating disorder services across a wider geographic area including support for patients in Berkshire, the wider Thames Valley and Wales.

We currently operate our services out of 32 freeholds, 45 leased/licenced and 100 informal properties (mainly general medical service and other general practice premises) across around 155 sites in five counties. We have a capacity of 400 inpatient mental health beds, and are also commissioned for 191 community hospital beds.

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 the areas in which we provide services. These include:

- the University of Oxford to promote innovation in healthcare, support research and to advance doctors and psychologists
- Oxford Brookes University, Bucks New University, the University of West London, the University of Bedfordshire, University of Reading, University of Coventry and

[5] numbers correct as of April 2015

Thames Valley Local Education and Training Board to educate nurses and allied health professionals

- local partner NHS organisations, for example Oxford University Hospitals NHS Trust
- local authorities and voluntary organisations
- GPs across all the locations we serve in order to provide joined-up care

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

Executive summary

All NHS Trusts are required to produce annual Quality Accounts to describe past and future activities to improve the quality of the services they provide. In this report (from page 80) we describe our main quality priorities for 2015/16. We are required to include specific data from 2014/15 which we have provided to national bodies such as the Care Quality Commission and the Health and Social Care Information Centre (from page 107). In section 3 (from page 112) we describe all of our achievements against the eight quality priorities we set ourselves for 2014/15. We have explained acronyms and terms in the main text or in footnotes. There is also a full glossary at the end of the report.

Key achievements last year

We set ourselves eight quality priorities in 2014/15 covering workforce, data quality, service remodelling, staff engagement, patient experience and outcomes, and assessing our services using the new five CQC questions (are our services safe, effective, caring, responsive and well led?). Staff across our Trust have spent time reviewing their services against the five CQC questions with the aim of making this business as usual.

We have achieved or exceeded many of our targets and objectives for last 2014/15 and the detailed review of progress can be found in Section 3 (page 112) of this report.

We achieved most of our objectives for our workforce priority. Almost 225 managers have received team effectiveness training and report an improvement. Despite staffing pressures we have maintained levels of access to training. We did not achieve our appraisal target due to significant changes in management structures over the year. Staffing levels are monitored every week and no ward dropped below 92.7% of shifts being fully staffed.

In our 2014 staff survey we had above average scorers for percentage of staff able to contribute towards improvements at work; staff recommendation of the Trust as a place to work; and percentage of staff agreeing feedback from patients and service users is used to make informed decisions in their directorate. We were in the worst for seven (work pressure and harassment). We were shortlisted for the Nursing Times and Award for excellence in supporting staff and wellbeing.

We achieved the objectives we set for quality of data and quality on data. Our quality dashboard will help us to assess where we are doing well and potential areas of vulnerability in terms of quality. We have also approved a standard data quality matrix for use across the Trust to monitor and track data completeness and accuracy. Our data quality audits identify further room for improvement.

We achieved most of our objectives for service remodelling. The planned service changes in adults and older people's services have successfully been implemented, including extended hours, leadership teams, cluster packages, outcome-based

measures, integrated locality teams and the relocation of the City Community Hospital to the Fulbrook Centre. We need to improve some of our Care Programme Approach (CPA) metrics – our new care record system will ensure better documentation of actions.

We achieved our physical health assessment targets but not our venous thromboembolism (VTE) assessment target (however we have not had any VTE events) and we also need to continue work to measure multi-disciplinary assessments for older adults with complex needs. A number of services have a range of locality and ward-based patient forums. We achieved our objectives to review early intervention and complex needs services and a system-wide dementia care strategy has been agreed.

All schools in Oxfordshire now have a health plan. We exceeded our health visitor staffing targets and have delivered a range of activities to improve infant feeding and breastfeeding-friendly access. We describe three pathways where we have worked with patients and those close to them to develop outcomes and then measure progress against these.

We achieved most of our objectives to improve staff engagement. We have substantially reorganised our quality governance structures at a Trust and directorate level. Peer reviews to assess service quality have taken place across all care pathways. Whilst some opportunities were available to bring together staff and Board members, this requires further work to make it more consistent and frequent.

We have developed a framework for values-based recruitment but now need to implement and measure the impact of this. We have developed a new risk management process for the Trust which is working well in some areas. However not all teams have transitioned to the new system.

Staff have delivered a substantial number of improvement activities which have resulted in some quantifiable benefits in terms of increased time to care and reduction in harm.

We achieved some of our objectives for reducing harm. Incident reporting (which demonstrates a strong reporting culture) has increased again this year, with no overall increase in serious incidents. We have improved on last year's number of Clostridium difficile infection (CDI) cases and did not exceed the threshold set by our commissioners. Reported medication incidents have increased since last year reflecting work to improve reporting. The pharmacy team are leading a number of actions to reduce harm from medication incidents.

There have been fewer suspected suicides this year. The overall number of absences without permission (AWOLs) has reduced, but we have not achieved our target of a 50% reduction. There was no harm reported as a result of any AWOL this year.

We have not achieved the reduction in avoidable pressure damage we were aiming for this year. Skin integrity assessment was maintained the same level as last year's

figures, but there has been a drop in nutritional assessments. Our 2015/16 priorities describe the actions we will take as a result.

We have achieved our target for reducing the number of and level of harm from falls in mental health wards. We have not achieved our target for reducing falls on community hospital wards. We plan to improve falls-related assessments in the coming year. The number of incidents relating to violence and aggression has increased. However the number of prone and hyper flexion restraints has reduced (the latter by nearly 75%).

We achieved most of our objectives for implementing our patient experience strategy. This year has seen a change in the range and scope of patient experience feedback. We worked with local organisations including Healthwatch Oxfordshire to improve how we share and respond to feedback and detail a number of actions we have taken as a result. We are still working on the development of a web page to share feedback.

We achieved our objectives for developing outcome measures with patients. We are reviewing outcome measure tools including the outcome star for school health nurses, developing a system for health visitors and using goal-based outcomes with speech and language therapy services in Buckinghamshire.

We achieved our objectives for using the new CQC framework including peer reviews across all of our services using the new CQC standards. Staff now routinely discuss and review their practice against the CQC's five questions.

Examples of good practice include:

- We carried out 35 clinical audits and participated in 100% of the national clinical audits and national confidential inquiries we were eligible to participate in.
- We recruited over 2000 people to participate in approved research.
- Safer staffing is reported and monitored weekly and improved recruitment.
- Safer Care projects are in place in child and adolescent mental health services (CAMHS), school health nursing, inpatient units and community teams.
- OHFT has achieved or is working towards 24 external accreditations and peer reviews.
- Opal Ward (mental health rehabilitation) at the Whiteleaf Centre, Aylesbury, has been accredited as "excellent" by the Royal College of Psychiatrists' Combined Committee for Accreditation and achieved accreditation in mental health inpatient services.
- Two eating disorder wards also achieved an "excellent" rating using national standards.
- Oxfordshire dental services have been awarded the quality in dentistry award by the British Dental Association.
- In Witney, of 33 GPs, 100% were likely or extremely likely to refer a patient within the next month to the Emergency Medical Unit.

- Advanced assessment skills training was rolled out to staff working in the assessment function of the adult mental health teams (AMHTs).
- On one of our adult mental health wards we have set up a physical health clinic which patients can attend to receive advice and support.
- Over the last six months the out-of-hours service has seen a 2.5% increase in home visits to help patients remain in the community.
- Patient satisfaction scores remain high despite pressures on all services.
- We have received the Dignity Plus award for dementia care.
- We have actively involved patients and carers in service remodelling.
- There is 24/7 day working in community mental health and urgent care services and enhanced staffing levels on mental health wards.
- Our Patient Advice and Liaison Service (PALS) visits wards and runs open surgeries for patients to raise concerns at the point at which they are receiving care.
- There are "Have your say" forums to deal with problems as they arise.
- There are 18-25 services for Looked After Children in Wiltshire and BaNES.
- We have implemented transitions clinics with adult mental health services in Wiltshire and BaNES to plan ongoing care post-18 years.
- There is a co-ordinated response to winter pressures to support patients at home.
- We have replaced the East Kent Outcome Scores (EKOS) with the Functional Independence Measurement (FIM) tool in community hospitals.
- The Chiltern Memory Team, South Buckinghamshire, was identified as an excellent example of best practice in memory services across England, seeing people within 40 days from assessment with a 90% response rate.
- There are daily ward rounds to improve discharge, reducing the average length of stay.

Areas for improvement (which are all reflected in our priorities for 2015/16) include:

- Improve how we share learning from incidents and complaints.
- A range of building works to ensure premises are safe and suitable.
- Improve clinical leadership and reduce vacancies in community nursing.
- Some aspects of medicines management, for example management of controlled drugs, medicines reconciliation and learning from medicine incidents.
- Improve nutrition and hydration care in all care settings.
- Improve the number of goals patients achieve through the Recovery Star.
- Improve documentation in patient records supported by the new care record system.
- Improve how patient and family feedback is presented and shared with staff.
- Improve the level of carer satisfaction through the Triangle of Care, carer awareness training for staff and improving our involvement in local carer reference groups.

- Improve how we ask for feedback, for example increase the attendance at local involvement forums, survey along care pathways and develop clinician level feedback.
- Continue to work with patients and their families so they feel they are involved in decisions about their care as much as they would like to be.
- A review of staff musculoskeletal injuries and stress.
- Joint working between our Trust and acute services to share skills and reduce harm.
- Increase our response rate to the national staff survey by 5% and improve our scores.

Quality in 2015/16

Our four quality priorities for the coming year reflect where we need to make further improvement as well as some new areas for inclusion.

1. Enable our workforce to deliver services which are caring, safe and excellent:

Competent staff with regular access to training, working well in teams, and supported by effective leaders deliver safer, more effective care. We want to maintain access to training despite pressure on capacity, to increase the quality of performance development reviews, continue our work to embed effective team working and deliver a comprehensive leadership strategy. We also intend to improve staff wellbeing and ensure good communication between senior managers and staff working directly with patients and those close to them.

2. Improve quality through service remodelling:

We want to ensure service changes have a positive impact on quality and patient experience. We will deliver new projects to improve access and integrate care. We will also deliver a new patient care record to support our work on improving documentation and data quality.

3. Increase harm-free care:

We have made progress on reducing harm, however, we recognise there is an ongoing need to manage and reduce harm from suicide, falls, pressure damage, absence without leave and restraint. Older adults and patients with mental health needs have an increased risk of ill-health and we have added a new priority to improve health promotion and the physical health management of our patients.

4. Improve how we capture and act upon patient and carer feedback:

In the previous year we have made a qualitative and quantitative improvement in capturing and acting upon patient feedback. We recognise, however, that this remains an area for improvement and we have added activities to improve carer involvement in planning and delivery of care.

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

2.1 Priorities for improvement 2015/16

OHFT will focus on four priorities in 2015/16 covering staffing, improving quality through service change, harm reduction and patient and carer experience to enable our services to be caring, safe and excellent. Specific objectives and measures for each priority are detailed from page 83.

1. Enable our workforce to deliver services which are caring, safe and excellent
This will enable the service to be caring, safe, effective, responsive and well led. This builds on last year's workforce priority (page 125) and the staff engagement priority (page 139).

1.1 Ensure we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams.

1.2 Review actions to improve recruitment into vacant positions including implementation of the values-based recruitment framework.

1.3 Improve staff wellbeing (including reduction of harm to staff related to musculoskeletal injury and work related stress), motivation, engagement between patient-facing staff and more senior management and involvement in improvement activities.

2. Improve quality through service remodelling
This will enable the service to be effective and responsive. This builds on last year's service remodelling priority (page 131).

2.1 Continue the service redesign and pathway remodelling programme, specifically focusing on its benefits in terms of quality and outcomes for new pathways of care.

2.2 Monitor specific projects to improve outcomes, for example the extension of the Street Triage project; the work to extend A&E in-reach services; a partnership approach to managing patients frequently accessing services; implementation of the integrated locality teams; improve access for Looked After Children (LAC).

2.3 Monitor the impact of implementation of new Electronic Health Record. Pilot the new quality dashboard at directorate level.

3. Increase harm-free care

This will enable the service to be safe and effective. This builds on last year's harm reduction priority (page 148).

3.1 Prevention of suicide (page 89)

3.2 Reduce the number of patients who are absent without leave (page 90)

3.3 Reduce the number of avoidable grade 3 and 4 pressure ulcers (page 90)

3.4 Reduce harm from falls (page 91)

3.5 Reduce the need for restraint and monitor the use of seclusion (page 92)

3.6 Improve physical health management of patients (page 93).

4. Improve how we capture and act upon patient and carer feedback

This will enable the service to be caring and responsive. This builds on last year's patient experience priority (page 164).

4.1 Capture and demonstrate how we act upon patient and carer feedback and improve our care environments.

4.2 Implement the Triangle of Care to improve carer involvement in planning and delivery of care.

Our quality priorities for 2015/16 were developed in discussion with our clinical directorates, our Governors, commissioners, and Healthwatch. They reflect feedback from patients, carers and staff, a review of themes from incidents, serious incidents requiring investigation (SIRIs), complaints, clinical audit and peer reviews of services, and consideration of local and national changes to service commissioning and provision.

We have retained those priorities from 2014/15 which remain key for us because of the nature of the service we provide (for example prevention of suicide and reduction in the need to use restraint); which had an end date beyond the end of the financial year (for example pathway remodelling); or where we consider we have further improvement to make (for example patient and carer experience and involvement; ensuring staff wellbeing and reducing the number of avoidable pressure ulcers at grade 3 and 4).

They also include some new development objectives across a range of services. These priorities will represent the key areas we monitor and report on through the Quality Account. This list is not exhaustive and work on a wider range of quality and safety initiatives continues across all of our services.

These quality priorities and objectives are being delivered in the context of significant financial, staffing and activity pressures. OHFT considers quality improvement to be a key factor in delivering value, improving effectiveness and efficiency and ensuring better outcomes for patients and those close to them.

Key changes from last year:

- We have reduced from eight priorities last year to four in the coming year.
- We have combined workforce and staff engagement.
- We have combined service remodelling with data quality and improving outcomes.
- We have removed the priority relating to using the new CQC regulatory framework as this has become business as usual.
- We have included a number of new development objectives to show some of the quality improvement plans across the diverse set of services we provide.
- We have expanded the patient experience priority to include carers and the implementation of the Triangle of Care.
- We have created a better balance of physical and mental health priorities to reflect the different patient groups for whom we provide services.

Each measure will have a baseline for 2014/15, where this is available. The completion date for each of the development objectives is 31 March 2016 unless otherwise indicated.

Quality priority 1: Enable our workforce to deliver services which are caring, safe and excellent

There is a direct link between staff capability, capacity and motivation and quality. High performing teams with effective leadership are known to deliver higher quality care with increased patient satisfaction[6]. This priority recognises the need to support, develop and engage all of our staff in whatever role they perform. *This will enable the service to be caring, safe, effective, responsive and well led.*

1.1 Ensure we have the right number of staff with appropriate training and experience, supported by effective clinical and managerial leadership, working effectively within teams

a. Review and measure the impact of the Aston team working model using interviews, impact assessment questionnaires, team stories and repeated effectiveness audits / team temperature checks; and align effective team working into the Trust organisational development strategy.

b. Build effective operational and clinical leadership through trio leadership development[7] and delivery of a collective leadership strategy; monitor using the collective leadership scale and improvement in staff engagement score (staff survey).

c. Maintain existing levels of access to staff training and development, including clinical practice, improvement skills and professional leadership.

d. Monitor safer staffing in inpatient services and report on remedial actions to improve staffing levels and minimise harm arising from pressures on staffing.

[6] http://www.dh.gov.uk/health/2011/08/nhs-staff-management/

[7] Trio leadership development brings together the ward manager, consultant and matron; or team manager, community lead and consultant(s). The programme is aiming to support the trios in providing clear leadership for their respective teams working together to understand the different needs of the services and how these are delivered both operationally and clinically.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
1.1a	Extent to which staff report effective team working	National staff survey	Annual	3.85	3.80 (national benchmark 3.84)
1.1a, 1.1b	Review of five staff stories	Qualitative and semi-structured interview	Quarterly	Stories from all services	n/a
1.1b	Evaluate trio leadership development and assess impact on leadership capability	Feedback from attendees	Six monthly	Improved capability	n/a
1.1b	Performance development reviews completed in last 12 months	Learning and development records	Quarterly	95%	84%
Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
1.1b	staff report having well-structured appraisals in the last 12 months	National staff survey	Annual	75%	38% (41% national benchmark)
1.1c	Skills courses attendance to maintain existing levels	Learning and development records	Quarterly	Maintain 14/15 levels	8671
1.1d	Number of wards unable to staff 90% of shifts	Manual	Quarterly	90% of shifts fully staffed	New indicator

1.2 Review actions to improve recruitment into vacant positions including implementation of the values based recruitment framework

a. Take proactive action on recruitment to vacancies and monitor the impact of the new values-based recruitment framework.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target and lead*	*Baseline 14/15*
1.2a	Reduce vacancies as % of establishment	ESR	Quarterly	Target tba	*5.66%*

1.3 Improve staff motivation and wellbeing (including reduction of harm to staff related to musculoskeletal injury and work- related stress)

a. Implement key actions arising from the national staff survey results to promote staff wellbeing and motivation.

b. Reduce work-related stress through improved access to psychological therapies.

c. Monitor compliance with the working time directive for all Trust staff.

d. Reduce sickness absence due to musculoskeletal injury through the musculoskeletal (MSK) self-referral pilot in older people's services (fast track physiotherapy).

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
1.3a	% staff satisfied with quality of work and patient care they are able to deliver	National staff survey	Annual	75%	71% (national benchmark 76%)
1.3b	% of staff suffering work related stress	National staff survey	Annual	No more than 42%	47% (42% national benchmark)
1.3c	% of staff working extra hours	National staff survey	Annual	No more than 70%	79% (national benchmark 71%)
1.3d	Reduction in absence relating to MSK injury in participating teams	BARM data	Quarterly for 6 months	Target tba	Baseline set Q1

1.4 Increase engagement between patient-facing staff and more senior management and involvement in improvement activities

a. Ensure staff involvement in designing and delivering improvement activities.

b. Improve floor to board engagement and create more opportunities for communication between senior managers, teams and individuals.

c. Implement processes to ensure staff can raise concerns and to monitor actions taken.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
1.4a	% of staff able to contribute towards improvements at work	National staff survey	Annual	75%	73% (national benchmark 72)
1.4b	Overall extent of staff engagement/feeling motivated and engaged[8]	National staff survey	Annual	3.76	3.75 (3.72 national benchmark)

[8] Combines "Ability to contribute to improvements at work"; "Willingness to recommend the organisation as a place to work or receive treatment"; and "Feeling motivated and engaged with their work".

Quality priority 2: Improve quality through pathway remodelling and innovation

The primary aim of our pathway remodelling has been to improve quality through aligning and integrating care for patients, working with patients to develop and deliver outcomes and working in partnership within local health systems. This will help us to meet the changing needs of our patients – a diverse and ageing population living with complex long-term conditions, which require care delivered closer to home. *This will enable the service to be effective and responsive*.

2.1 Continue the service redesign and pathway remodelling programme, specifically focusing on its benefits in terms of quality and outcomes for new pathways of care

a. Evaluate quality improvements relating to new pathways of care, including the impact of the Recovery Star on outcomes, the impact of cluster packages, and the impact of redesigned team structures.

b. Evaluate the integration of physical and mental health pathways for older people and monitor impact on agreed quality measures.

c. Achieve accreditation for memory services (Memory Services National Accreditation Programme).

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 1415*
2.1a	% of patients with a CPA to be in employment or meaningful activity	CPA audit	Quarterly	11.8%	n/a
2.1a	% of patients with a CPA in settled accommodation	CPA audit	Quarterly	78.7%	n/a
2.1a	% of patients involved in setting and achieving goals	CPA audit	Quarterly	100%	88%
2.1a	Qualitative review of 10% of caseloads in AMHTs to	Audit	Annual	100% of audited caseloads in line with cluster allocation	New indicator
Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
2.1b	Number of appropriate older adult patients given early warning score assessment (MEWS)	Audit	Quarterly	tba	Establish baseline Q1
2.1c	Accreditation achieved	manual	Annual	Accreditation achieved	n/a

2.2 Deliver specific projects to improve outcomes

a. Evaluate the goals-based outcomes toolkit and impact of personalised outcomes and circles of support on patients' achievements in speech and language therapy services in Bucks.

b. Work in partnership with commissioners and other providers to develop outcome-based commissioning across a range of services.

c. Introduce a new Cognitive Behaviour Therapy (CBT) pathway for patients with dental anxiety to reduce the need for sedation by rolling out a pilot project to train members of the dental team on CBT approaches and provide individual and group interventions.

d. Reduce the number of frequent attendances[9] to urgent care services and ensure care plans/special notes are available frequent attenders' notes.

e. Reduce incidents of deliberate self-harm in Marlborough House, Swindon.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 1415*
2.2a	Improved achievement of goals	Manual	Annual	tba	n/a
2.2b	Outcome-based commissioning extended	manual	Annual	Increase in OBC	n/a
2.2c	Decrease number of dental patients requiring sedation	Audit	Quarterly	tba	Establish baseline in Q1
2.2d	% of frequent attenders of urgent care where care plan/special notes are available	Adastra	Quarterly	95%	Establish baseline Q1
2.2d	Number of frequent attenders	Adastra	Quarterly	5% reduction	Establish baseline Q1
2.2e	Reduce incidents of deliberate self-harm	Ulysses	Quarterly	Reduce by 50%	Establish baseline Q1

[9] A frequent attender is a patient who contacts the service regularly and consistently presenting with a clinical picture similar to past attendances, more than three times per month over a period of three months. This is different from a repeat caller where the patient may have deteriorated and be calling for a further consultation; these are defined as 2 or more calls within 24 hours.

2.3 Improve access to services

a. Review opportunities for increasing CAMHS in-reach into schools.

b. Evaluate the availability and accessibility of services to Looked After Children (LAC) in partnership with local authorities across Oxfordshire, Buckinghamshire, Swindon, Wiltshire and BaNES including recording parental responsibility and offering health assessments within 20 days of notification.

c. Improve access to services for children and young people with a learning disability implement the dementia strategy with partners.

d. Extend Street Triage to reduce the number of Section 136 admissions through an increase of 5% in the number of contacts made via Street Triage; and extend A&E in-reach services to increase the number of patients seen in A&E by 5%.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 1415*
2.3a	Opportunities for CAMHS in-reach identified	Manual	Annual	tba	n/a
2.3b	Record parental responsibility in clinical records for LAC	Audit	Quarterly	tba	Establish baseline Q1
2.3b	% of initial health assessments offered within 20 days of notification to LAC team (Oxon)	Audit	Quarterly	tba	Establish baseline Q1
2.3c	% of care notes which record patients with LD	Audit	Quarterly	tba	Establish baseline Q1
2.3d	Increase number of Street Triage contacts	EHR	Quarterly	5% increase	Establish baseline Q1
2.3d	Increase number of patients assessed out-of-hours within one hour of referral	EHR	Quarterly	tba	Establish baseline Q1

2.4 Improve information on patient care and quality

a. Monitor the impact of the new Electronic Health Record against planned benefits. This is expected to make significant differences to staff in their ability to deliver accessible and comprehensive recording.

b. Pilot the new quality dashboard at directorate level.

Quality priority 3: Increase harm-free care

Safety remains one of our key priorities. For our patients this means both reducing self-harming behaviour and ensuring we deliver harm-free care. A renewed national emphasis on prevention and health promotion is reflected in a new priority to improve physical health management[10]. As well as six specific harm reduction priorities we will also continue to report on incidents and SIRIs, infection prevention and control, medication incidents and safety thermometer measures for physical and mental health services. *This will enable the service to be safe and effective.*

3.1 Prevention of suicide

a. Implement learning from SIRIs including improved continuity of care, risk assessment and discharge planning, and communicate with and involve carers in care planning.

b. Implement rapid multi-disciplinary consultant-led reviews in clinical teams following a patient (suspected) suicide.

c. Include the interpersonal theory of suicide in the Clinical Risk Assessment Policy and training. In addition, work with relevant universities to ensure the pre-registration mental health nursing curriculum adequately covers suicide awareness, assessment, management and prevention.

d. Develop a suicide prevention strategy, aligned with Bucks and Oxon public health-led suicide risk reduction strategies, to ensure both community services and mental health services are contributing to the wider community activities to reduce suicide.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.1a	Days between probable suicides in individual mental health teams	Ulysses	Quarterly	300 days between in 8 teams	Achieved in 3 teams
3.1a	Days between probable suicides in inpatient services	Ulysses	Quarterly	300 days between	achieved

[10] This also reflects our findings from clinical audit, incidents and SIRIs, and complaints and concerns which suggest that more needs to be done on the assessment and monitoring of physical health both for inpatients and for patients cared for in the community.

3.1b	Rapid review occurred within 10 days of incident	Initial Investigation Report	Quarterly	100% of incidents	n/a
3.1c	Curriculums developed	Manual	Annual	n/a	n/a
3.1d	Strategy developed	Manual	Annual	n/a	n/a

3.2 Reduce the number of missing patients from inpatient services

a. Reduce the number of incidents of patients who fail to return from leave on time, or who abscond from leave or premises by 50%.

b. Due to the low level of harm we will start to measure days between of harm (rated 3, 4 or 5 for impact) to patients or others a result of absence without permission.

objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.2a	Number of incidents where patients do not return on time from approved leave	Ulysses	Quarterly	50% reduction	218
3.2a	Number of patients absent without permission	Ulysses	Quarterly	25% reduction	153
3.2b	Days between harm to patients or other people arising from absence without permission	Ulysses	Quarterly	300 days between	300

3.3 Reduce the number of avoidable grade 3 and 4 pressure ulcers

a. Improved co-ordination of care through the introduction of risk stratification of patients and use of safety rounds for patients on district nursing caseloads.

b. Introduce the SOAPIE[11] model for care planning and the Braden Pressure Ulcer Risk Assessment Tool across all services.

c. Roll out SSKIN[12] bundles to increase reliability of prevention damage prevention and management.

[11] Subjective (patient), Objective (clinician), Assessment, Plan, Intervention, Evaluation.
[12] tool that acts as a prompt to staff to undertake a risk assessment and provide management of the risk with patients

d. Increase staff knowledge and capability through ongoing development of level 4 pressure ulcer prevention and management training.

e. Implement and evaluate the third iteration of the Skintelligence programme to improve partnership working with care homes and use Institute of Healthcare Improvement methodology to reduce avoidable pressure damage across the health and social care system.

f. Implement and review wound care and pressure damage training for children and young people's inpatient units.

objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.3a-e	Days between avoidable pressure damage grade 3 and 4 in community teams and hospitals	Ulysses	Quarterly	300 days between	New indicator
3.3a-e	Reduce avoidable grade 3- 4 pressure tissue damage	Ulysses	Quarterly	10% reduction	12
3.3b/c	SOAPIE, Braden and SSKIN bundles in place	audit	Quarterly	n/a	n/a
3.3d	% of required staff attending level 4 training	L&D	Quarterly	tba	71% of phased target
Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.3e	Evaluate Skintelligence programme	Manual	Annual	n/a	n/a
3.3f	Number of staff attending training in C&YP units	L&D	Quarterly	tba	Baseline set Q1

3.4 Reduce the number of patients harmed by falls

a. Reduce the number of falls by 1000 bed days to 8.6 in physical health and maintain at under 3.8 in mental health.

b. Reduce the level of harm from falls by 1000 bed days (rated 3, 4 or 5 for impact) to 0.2 in physical health and maintain at under 0.2 in mental health.

c. Ensure patients have appropriate risk assessments on admission, after 28 days and after a fall.

objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.4 a/b	Number of falls/number resulting in harm by 1000 bed days	Ulysses	Quarterly	3.5 (0.3 harm) MH 8.6 (0.3 harm) PH	3.7 (0.3 harm) MH 12.6 (0.5 harm) PH
3.4c	% patients in older adult inpatient services to have falls risk assessment on admission	Audit	Quarterly	100%	95% (based on 3 data points)
3.4c	% patients in older adult inpatient services to have a further falls risk assessment after 28 days	Audit	Quarterly	100%	60% (1 quarter's data)
3.4c	% of patients to have a review of care plan after a fall	Audit	Quarterly	100%	69%
3.4c	% patients to be referred to falls service after 2 or more falls	Audit	Quarterly	80% MH 80% CH	37% MH 67% CH

3.5 Reduce the need for restraint and monitor use of seclusion

a. Implement a revised training programme for Prevention and Management of Violence and Aggression (PMVA).[13]

b. Develop and implement children's module as part of PMVA (now known as PEACE) training (piloted in the Highfield Unit) to reduce the number of incidents of violence and aggression (V&A) and harm (rated 3, 4, or 5 for impact) by 25%.

c. Report on and reduce the number of prone restraints (where the person is face down) and use of hyperflexion (holding the arm to restrain).

d. Report on and monitor use of seclusion.

objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline 14/15*
3.5 a/b	Reduce number of reported incidents of V&A resulting in harm (rated 3, 4, 5 impact)	Ulysses	Quarterly	25% reduction	69

[13] This is in line with the DOH publication *Positive and Proactive Care: reducing the need for restrictive interventions* (April 2014). This is part of the government led initiative called *Positive and Safe* which is a two-year project to change the approach to managing challenging behaviours in health and social care settings

3.5c	Number of prone restraints	Ulysses	Quarterly	Towards 0	374/1679
3.5c	Number of restraints involving hyperflexion	Ulysses	Quarterly	Towards 0	39
3.5d	Number of incidents where patients secluded	Ulysses	Quarterly	25% reduction	336

3.6 Improve the physical health management of patients

3.6.1 Improve the management of patients' pre-existing (long-term) physical health conditions (for example diabetes) and monitor the impact of medication and treatment

a. Improve basic physical health monitoring – blood pressure, early warning scores and standard of physical health assessment.
b. Develop a universal monitoring checklist for older adult mental health patients.
c. Develop a physical health policy and implementation and guidance.
d. Improve management of diabetes, and of delirium rather than dementia and monitor administration of clozapine.
e. Ensure timely information is shared with GPs and received from them and that OHFT has relevant information on the physical health and history of patients to whom we are providing care.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.6.1a	% of adult and older adult inpatients to have MEWS, track and trigger, physical health assessment, VTE and MUST within 24 hours of admission	EPR/audit	Quarterly	100%	VTE 92% PHA 99%
Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.6.1a	% of patients have their physical health needs assessed % of those care plans address the PH needs identified	CPA audit	quarterly	95% 95%	New audit 15/16

3.6.1b	Universal monitoring checklist approved	Manual	Annual	n/a	n/a
3.6.1c	Physical health Policy approved	Manual	Annual	n/a	n/a
3.6.1d	% of patients prescribed psychotropic medication are monitored for side effects relating to that medication	CPA audit	quarterly	95%	New audit 15/16
3.6.1e	% of patients prescribed psychotropic medication where their GP has been informed of the need for ongoing monitoring by primary care in the community	CPA audit	quarterly	95%	New audit 15/16

3.6.2 Ensure staff have physical health skills in inpatient settings, community services and sub-acute settings

a. Expansion of the physical health skills course and/or other ways to deliver training effectively for staff in mental health and community/sub-acute settings.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.6.2a	Number of staff attending physical health skills training	L&D	*Quarterly*	tba	n/a

3.6.3 Support patients to reduce risk factors for poor health, for example nutrition and smoking

a. Monitor patient experience of smoking cessation and impact/perceived benefits at six months and twelve months for those in long term care.

b. Ensure baseline monitoring and improve how patients manage their physical health, for example obesity, malnutrition and dehydration and ensure equipment is available for community staff, for example blood pressure (BP) and blood glucose monitors.

c. Monitor the impact of "Making Every Contact Count" (MECC).

d. Map health promotion work in 2015/16 and standardise activities in 2016/17.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
3.6.3a	Patient stories	Manual	Six monthly	5 stories	n/a
3.6.3b	Nutritional needs assessment completed	Essential standards audit	quarterly	tba	n/a
3.6.3c	Evaluation of MECC	Manual	Annual	n/a	n/a
3.6.3d	Health promotion activities mapped	Manual	Annual	n/a	n/a

Quality priority 4: Improve how we capture and act upon patient and carer feedback

Patients and carers (relatives and friends) are experts in their own care and their involvement and feedback is critical to our understanding of when our services do well and where we need to make improvements. The lack of involvement of carers with care planning at the point of discharge from inpatient services has been raised as an issue on a number of occasions in the findings of SIRI investigations and the work to deliver the Triangle of Care recognises that carers are intrinsic to effective care planning. *This enables the service to be caring and responsive.*

4.1 Capture and act upon patient experience

a. Report on domains of patient experience (PE).

b. Monitor improvements made as a result of patient and carer feedback.

c. Monitor themes from complaints and concerns and implementation of actions.

d. Children and Young People (C&YP) to establish patient experience champions and involve service users in service development and recruitment.

e. Development of community hospitals (CH) patient discharge follow-up programme to better understand the patients' experience of discharge and identify improvements.

f. Review how C&YP collect patient experience and feedback, make surveys more engaging and manage communication with patients with communication difficulties to bring this into clinical practice (for example reported outcome measures).

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
4.1a	Review of patient stories	Survey and interviews	Quarterly	5 per quarter	n/a
4.1a&1b	Improve patient satisfaction with services	Friends and Family Test	Quarterly	tba	88%
4.1b	Examples of improvement actions	Manual	Quarterly	5 per directorate	n/a
4.1c	Number (%) of complaints actions outstanding			0 (0%)	
Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
4.1d	Number of PE champions	Manual	Annual	tba	n/a
4.1e	Number of CH patients contacted	Manual	Quarterly	tba	n/a
4.1f	New mechanisms to capture patient experience	Manual	Quarterly	n/a	n/a

4.2 Implement actions from the Triangle of Care to improve carer involvement in the planning and delivery of care

a. Implement actions from our self-assessment using the Triangle of Care and review local carers' strategies to improve communication with and involvement of carers in care planning, and ensure carer queries are responded to while appropriately maintaining confidentiality.

b. Evaluate impact of communication protocol toolkit in the Oxon Integrated Therapy Service on creating joint outcomes for children and improving communication with carers and carer involvement in care planning.

Objective	*Indicator or measure*	*Data source*	*Frequency*	*Target*	*Baseline*
4.2a	Improve patient and carer satisfaction with services	Friends and Family Test	Quarterly	tba	CH +59.6 MIU + 72.5[14]
4.2b	Number of young carers offered support	Audit	Quarterly	tba	n/a

[14] 1. Don't know responses are excluded from the denominator for the net promoter calculation
2. Responses saying likely are excluded from the net promoter calculation (based on old national guidance)
3. The way of displaying the results in this way as a 'net promoter' is no longer supported nationally, figures should be presented as a % to each available answer option

Part 2.2 Statements of assurance from the Board of Directors

The trust has brought together all the mandatory statements required in the Quality Account into the following sections.

Review of services

During 2014/15 OHFT provided and/or subcontracted 58 NHS services. These services are based on the organisation of services within directorates in OHFT during 2014/15.

Children and Young People Directorate

- Buckinghamshire, Oxfordshire and Swindon, Wiltshire and BaNES child and adolescent mental health and specialist services
- Eating disorders (community and inpatient)
- Children's community services, for example health visiting, school nursing, children's nursing
- Oxfordshire Integrated Children's Therapy Service
- Public health services
- Community dental services
- Buckinghamshire Speech and Language Children's Therapy Service

Adult Directorate

- Buckinghamshire and Oxfordshire adult mental health services (community and inpatient)
- Forensic services (community and inpatient)
- Prison health services
- Luther Street homeless GP practice
- Psychological therapies

Older People Directorate

- Buckinghamshire and Oxfordshire older adult mental health services (community/inpatient)
- Eight community hospital sites providing inpatient care in ten wards in Oxfordshire
- District nursing and specialist nursing therapies
- Urgent care services
- Dietetics
- Podiatry
- Musculoskeletal and physical disability physiotherapy
- Re-ablement Service
- Specialist Diabetic Service
- End-of-life care
- Speech and Language Therapy Service

Each of these directorates reviews service provision through quarterly quality and performance meetings, monthly clinical governance meetings, 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.

OHFT has reviewed all the data available to it on the quality of care in all 58 of these services.

The income generated by the relevant health services reviewed in 2014/15 represent 100% of the total income generated from the provision of relevant health services by OHFT for 2014/15.

Activity in 2014/15

The following tables outline the activity delivered by OHFT in 2013/14.

Number of admissions

Admissions	Q1	Q2	Q3	Q4	2014/15 Total
Community hospitals	587	545	532	549	2213
Mental health	400	353	380	331	1464
Trust total	**987**	**898**	**912**	**880**	**3677**

Number of occupied bed days

Occupied bed days	Q1	Q2	Q3	Q4	2014/15 Total
Community hospitals	17019	20911	21108	17356	76394
Mental health	34293	34801	30113	33784	132,991
Trust total	**51312**	**55712**	**51221**	**51140**	**209385**

Face-to-face contacts

Face-to-face contacts	Q1	Q2	Q3	Q4	2014/15 Total
Community	266349	260631	265838	263594	1056412
Mental health	71051	68940	70335	67669	277995
Trust total	**337400**	**329571**	**336173**	**331263**	**1334407**

Service quality and accreditations

OHFT has achieved or is working towards 24 external accreditations and external peer reviews as of the end of 2014/15. These can be found in appendix 1.

Participation in national audit and confidential inquiries

Clinical audit priorities are selected on the basis of national requirements, commissioning requirements and local evidence, including where analysis of incidents and complaints have established specific areas for improvement. The Trust prioritises high risk, high cost or high volume activity. In addition any clinical audit rated as requiring improvement or unacceptable will automatically be returned to the plan for the next year. We operate a three year rolling audit programme. The Trust-wide clinical audit plan for 2014/15 contained a total of 35 audit requirements across the directorates.

The table below provides the rationale for topic selection for the 2014/15 Trust-wide Clinical Audit Plan. Five (22%) of the high priority internal audits were included on the plan as they were previously rated as either requiring improvement or unacceptable.

Rationale for topic selection 2014/15 audit plan	Number of audits	%
Mandatory audit requirements		
National audits	8	23%
Commissioning for Quality and Innovation (CQUIN) Audits	2	6%
Local Commissioning Audit Requirements	2	6%
Trust Priority		
High Priority Internal audits	23	65%
Total	**35**	

Of the 35 Trust-wide audits 12 (34%) were baseline audits and 20 (57%) were re-audits.

Type of audit	Number of audits	%
Baseline	12	34%
Re-audit	20	57%
Annual data submission	1	3%
Point prevalence audit - monthly data collection	2	6%
Total	**35**	

National Audits

During 2014/15, eight national clinical audits and one national confidential inquiry covered relevant health services that Oxford Health NHS Foundation Trust provides. During 2014/15 Oxford Health NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the national confidential inquiries which it was eligible to participate in, as detailed over the page.

	Audit or inquiry	Participation (Yes or No)	Number of cases required by teams	Number of cases submitted	Percentage
1.	Prescribing Observatory for Mental Health (POMH-UK) Topic 14a: Prescribing for Substance Misuse (Alcohol Detoxification)	Yes	n/a	N=42	n/a
2.	POMH-UK Topic 12b: Prescribing for people with Personality Disorder	Yes	n/a	N=76	n/a
3.	POMH-Topic 9 Antipsychotic prescribing in people with a Learning Disability	Yes	n/a	N=62	n/a
4.	Urgent Care telephone triage NQR4	Yes	n/a	N=269	n/a
5.	National audit of Intermediate Care	Yes	n/a	N=70	n/a
6.	Safety Thermometer Classic - reduction in harms (monthly point prevalence audit)	Yes	n/a	n/a	n/a
7.	Safety Thermometer Pilot for Adult Mental Health - reduction in harms (monthly point prevalence audit)	Yes	n/a	n/a	n/a
8.	Stroke Care (SSNAP)	Yes	100%	62	100%
9.	Mental Health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes	34	33	97%

A total of four national audits were reported and reviewed during 2014/15 following data collection in 2013/14. One of the key national audits for the Trust which reported in 2014/15 was the National Audit of Schizophrenia.

The results for Oxford Health NHS Foundation Trust did show an improvement from the baseline audit but a major finding both nationally and for Oxford Health NHS Foundation Trust was:

- poor monitoring of, and intervention for, risk factors for diabetes and cardiovascular disease.

- significant gaps in the availability of cognitive behavioural therapy and family interventions.

Key actions following National Audit of Schizophrenia

It is anticipated that the actions taken in relation to this audit will also address gaps identified in other national audits such as POMH Lithium and POMH attention deficit hyperactivity disorder (ADHD) monitoring which also included aspects of physical health monitoring.

- CP review to be used as the platform to review and monitor physical health by ensuring that GPs are contacted prior to every CPA review for the results of patients' annual health check and any relevant blood tests.
- Increase clinician access to local general hospitals laboratory results to support physical health monitoring.
- Ensure that clinics in the community are equipped with suitable equipment for physical measurements and include up-to-date information (e.g. The Lester Tool).

Examples of some of the actions taken to improve patient care during 2014/15

Audit title	Key actions taken to improve patient care
Audit of care standards for service users not on CPA	Template letter implemented across the Adult and Older Adult mental health teams which will standardise the information provided on all GP letters which includes the following: • Clear indication that the letter is the care plan • State risks or no risks and advise how they should be managed • Address arrangements for management of physical health issues • Include next review date • Include the trust 24 hour contact number
POMH Topic 7d Monitoring of patients prescribed Lithium	Forensic service has implemented a Lithium initiation form and a Lithium monitoring form which will prompt clinicians to undertake relevant physical health monitoring.
Audit of Conditions Relating to Community Treatment Orders (CTOs)	Process reviewed and strengthened by all new CTO1 forms and paper work received by the Mental Health Act office to be checked and active follow-up with teams when documents are missing.
POMH-UK Topic 4b – Prescribing anti dementia drugs	Blood Pressure and Blood Pressure Monitoring machines supplied to all memory clinics to enable nurses to undertake physical health monitoring as part of their assessment
Audit of the prevention and management of pressure ulcers in the District Nursing service	A new role in the District Nursing service was introduced to improve standards generally around tissue viability care – the Tissue Viability Resource Nurse role. This involves registered nurses in each cluster having additional leadership and tissue viability training to enable them to take the lead with improving quality standards around all tissue viability related care in their clusters. They will also serve as an escalation point for ground level staff to escalate Tissue Viability related issues to.

Clinical research

The table below shows the number of studies currently recruiting participants within the trust. Fields containing a * are no longer being monitored.

As of 10 April At 1600	Total number of studies	of total OHFT sponsored	of total students	of Total, clinical psychology trainees	of total funded	of total PICs	of total CTIMPs	of total CCG/OHFT new	of total NIHR UKCRN portfolio	of portfolio via CSP	of portfolio via CSP OHFT lead
Open	89	9	*	*	87	18	38		57	52	
Awaiting approval	19	1	*	*	15	2	6		8	1	

CTIMP Clinical trial of an investigational medicinal product(s) – drug trial
Open Currently recruiting or in analysis within study start and end dates
Awaiting approval Yet to be granted NHS permission
PICs OHFT has agreed to act as a Participant Identification Centre
NIHR National Institute for Health Research
UKCRN United Kingdom Clinical Research Network
CSP Co-ordinated System for gaining NHS Permission – this is nationwide
OHFT Lead OHFT responsible for global (study-wide) governance checks

The number of patients receiving relevant health services provided or sub-contracted by OHFT in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee is 1901 for NIHR portfolio studies, and 369 for non-NIHR portfolio studies.

Commissioning for quality and innovation (CQUIN) payment framework

A proportion of OHFT's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between OHFT and any person or body that they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the CQUIN payment framework.

The income conditional on achieving CQUINs for 2014/15 was £4,900,968 and for 2013/14 was £4,617,249.

Income from CQUINs 2014/15

Commissioner	Service	Amount	% of contract
Oxfordshire CCG	Adult and Older Adult Mental Health	£1,130,976	2.5
Oxfordshire CCG	Community Services	£1,599,848	2.5
Buckinghamshire CCGs	Adult and Older Adult Mental Health	£801,856	2.5
Wessex Area Team	Forensic, Eating Disorders & CAMHS	£834,675	2.5
Buckinghamshire County Council	CAMHS	£62,405	1.15
Wiltshire & BaNES CCG	CAMHS T3	£134,789	2.5
Swindon CCG/BC	CAMHS	£49,530	2.5

Wiltshire CCG	Eating Disorders	£5,844	2.5
Thames Valley AT	Public Health and Health & Justice	£255,150	2.5
Oxfordshire County Council	Harm Minimisation	£23,798	2.0
Swindon CCG	Community Services	£2,097	2.5

Income from CQUINs 2013/14

Commissioner	Service	Amount	% of contract
Oxfordshire CCG	Adult and Older Adult Mental Health	£1,123,694	1.2
Oxfordshire CCG	Community Services	£1,614,510	2.1
Buckinghamshire CCGs	Adult and Older Adult Mental Health	£800,305	2.5
Buckinghamshire CCGs	Speech and Language Therapy	£17,222	2.5
Wiltshire & BaNES CCG	CAMHS T3	£134,789	2.5
Swindon CCG	CAMHS	£51,102	2.5
Wiltshire CCG	Eating Disorders	£5,952	2.5
Wessex Area Team	Forensic	£599,537	2.5
Wessex Area Team	Eating Disorders & CAMHS Inpatients	£207,733	2.5
Buckinghamshire County Council	CAMHS	£62,405	0.4

Care Quality Commission (CQC)

The CQC is the independent regulator of health and adult social care services in England. They make sure that the care provided by hospitals meets government standards to provide people with safe, effective, compassionate and high quality care. The CQC monitors these standards of care through inspections, patient feedback and other external sources of information gathered. They publish which trusts are compliant with all the essential standards of care and which organisations have conditions requiring improvements.

OHFT is required to register with the CQC and its current registration status is "registered without conditions". The CQC has not taken enforcement action against OHFT in 2014/15.

OHFT has not participated in any special review or investigations during 2014/15. We were involved in one themed review on mental health crisis care covering Oxfordshire Local Authority which included an announced visit in January 2015. Oxfordshire was one of fifteen local authorities selected. The review took a care pathway approach to assess how services and agencies work in partnership to provide help, care and support to people during a crisis. The three main pathways reviewed were how people accessed services via the emergency department, the police and through secondary mental health services. Providers will not be rated following the review. The main findings were as follows:

Areas of good practice:

- Strong multi-agency working and a commitment to looking at joint work to encourage positive outcomes for people in mental health crises.

- Consideration of diverse needs of different groups in the local area. For example, students and homeless people
- No groups are excluded from either health based place of safety.
- The Street Triage Service was widely seen as a valuable service. Since being commissioned fewer people had been admitted to a health based place of safety.

Areas for development:

- Improved communication between the two liaison services provided at the John Radcliffe Hospital and development of joint protocols for record keeping and risk assessment.
- Ensuring that monitoring of use of the Mental Health Act Code of Practice is embedded in internal processes so that where there are lapses these are identified and action taken.
- Review availability of AMHP and section 12 doctor resource, particularly out-of-hours, to ensure timely assessments are undertaken.
- Effective engagement with people who use services and carers in the development of services.

The Trust has had seven mental health act (MHA) visits in 2014/15 to our mental health wards: Cotswold House Marlborough, Ruby, Kingfisher, Ashurst, Wenric and Phoenix. From these visits there were a number of positive findings, including:

- caring and helpful nature of staff
- patients reported feeling safe
- availability of food and drinks 24/7
- a programme of environmental improvements completed and in progress
- cleanliness of ward environment
- patients are given the opportunity to raise any issues at weekly ward meetings
- patients can access fresh air within secure outdoor areas when they wish
- patients are having their rights explained and protected
- information about the Independent Mental Health Advocacy (IMHA) services was available on the ward and the advocacy service visited each ward weekly
- risk assessments updated regularly
- de-escalation is used by staff to minimise use of restrictive interventions
- completeness of medication charts

The areas for improvement included:

- Section 17 leave forms: expired copies still in central folder, opportunity to sign.
- Variable quality of care plans with many not fully showing patient and carer involvement.
- When a Second Opinion Appointed Doctor (SOAD) is used those staff consulted with need to record their discussion in the notes as well as the decision of the SOAD.
- Need to better document that patients' rights to an IMHA (independent mental health advocate) have been explained.
- Staffing levels were not always to expected levels, however staffing was always safe and there was evidence actions had and were being taken.
- Completeness of seclusion and S136 records specific to one ward.
- Ensure patients have their rights re-presented (there is initial explanation of rights).

Quality risk profile (QRP)

The QRP no longer exists and the CQC has instead introduced a new intelligence monitoring tool, with the first report published in November 2014. The report shows the CQC's risk assessment for each provider which helps guide them to decide when, where and what areas to inspect. The key sources used for the intelligence include; the NHS Staff Survey, mental health and learning disabilities dataset (MHMDS), MHA visits, Patient-Led Assessments of the Care Environment (PLACE) visits, electronic staff record (ESR), the national community mental health survey and concerns raised by Trust staff. Based on the report the CQC has placed each mental health provider into a priority band from one (high perceived concern) to four (lowest perceived concern). In Oxford Health NHS FT's first report (November 2014) 57 indicators are reported of which one indicator was identified as a risk namely high delayed transfers of care based on data between April-June 2014. No elevated risks were identified. Based on the information the Trust has been placed in priority band four (lowest perceived concern).

OHFT was issued with two Regulation 28 reports/Preventing Future Deaths reports in 2014/15. In the first the Coroner's concern was that the Trust's electronic records system did not make it apparent if we had consent to contact, for example a family member and who we should contact (e.g. family) in the event of a service user entering a period of crisis or heightened risk. In the second the Coroner's concern was that there is no specific Trust protocol or guidance on the use of Clopixol Acuphase; a further concern was the absence of a documented follow-up in terms of physical observations after a Clopixol injection to include consideration of VTE given that the patient was immobile in bed from 20 February 2014.

During 2014/15 the Health and Safety Executive (HSE) investigated an incident that occurred in the Fiennes Centre in 2013, concerning a patient having fallen from a first floor bathroom window. The HSE investigated the window design and maintenance, and the Trust's procedures relating to the Central Alerting System (CAS) alert. The Trust co-operated fully with the investigation and implemented a detailed action plan to ensure that the risk of a similar incident occurring at any site was minimised.

Data quality

OHFT submitted records during 2014/15 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:	which included the patient's valid General Practice Code was:
100% for admitted patient care	97.8% for admitted patient care
100% for outpatient care	99.6% for outpatient care
93.0% for accident and emergency care	97.0% for accident and emergency care

OHFT's Information Governance Assessment Report overall score for 2014/15 was 77% and was graded green (satisfactory).

OHFT was not subject to a payment by results clinical coding audit during 2014/15 by the Audit Commission.

As a result of two data protection breaches the Information Commissioner's Office (ICO) has provided a form of undertaking for the Trust with respect to certain data protection matters. In the last 12 months the trust has had two incidents reported to the ICO.

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

- A data quality work stream is in place to review data quality processes, promote benchmarking and embed the Trust's data quality strategy.
- Data quality indicators for Monitor are reviewed by the Board including data completeness and data outcome indicators. Our process will be reviewed to address recommendations from the Auditors on the Quality Report indicators.
- Training for the new care record has focused on data accuracy and staff ownership of data input to be monitored in 2015/16 as part of the Quality Account priority 2.
- We have developed a data quality dashboard, using business intelligence, which highlights errors or mistakes to target data correction.
- Data quality work stream meets bi-monthly to review data quality, to develop data quality reports and processes for managing data correction with each directorate taking ownership for their data quality via data improvement plans.
- We will pilot a quality dashboard at directorate level in 2015/16.

Part 2.3 Reporting against core indicators (Department of Health mandatory indicators)

This section includes data on nationally specified indicators for the current and previous reporting periods as part of the statutory requirements.

100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital

OHFT 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

OHFT has taken the following actions to improve this percentage, and so the quality of its services:

- all breaches are reviewed and the reason why the patient was not followed-up within seven days is reported to learn any lessons
- the community services were remodelled from February 2014 so that services are now available seven days a week providing extended hours from 7am to 8pm every day
- the community mental health teams, community crisis teams and assertive outreach teams have been brought together so there is a single point of access, a patient's route through services is better defined and co-ordinated

When assessing this criterion, we apply one exclusion 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.

The table below 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.

Reporting Period	Trust Value	National Min	National Max	National Average
Apr-Jun 2014	96.3%	93.0%	100%	97.0%
Jul-Sep 2014	96.6%	91.5%	100%	97.3%
Oct-Dec 2014	96.5%	90.0%	100%	97.3%
Jan-Mar 2015	Data not yet available			
Apr-Jun 2013	96.4%	94.1%	100%	97.4%

Jul-Sep 2013	97.9%	90.7%	100%	97.5%
Oct-Dec 2013	96.6%	77.2%	100%	96.7%
Jan-Mar 2014	96.4%	86.4%	100%	97.4%

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

OHFT considers that this data is as described because there is a documentary audit trail for the compilation of these figures.

OHFT has taken the following actions to improve this percentage, and so the quality of its services:

- The community services were remodelled from February 2014 so that services are now available seven days a week providing extended hours from 7am to 8pm every day.
- The community mental health teams, community crisis teams and assertive outreach teams have been brought together so there is a single point of access, a patient's route through services is better defined and co-ordinated.
- Since February 2014 one dedicated consultant psychiatrist and modern matron has been identified for each adult acute ward and this will be embedded over the next few months.

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 the strategic health authority (SHA) and National Institute for Mental Health in England (NIMHE) under the Fidelity and Flexibilities Framework in 2006.
- Admissions via the liaison psychiatry service in Oxfordshire will be deemed to have been considered for home treatment on the basis that all admissions are arranged through the 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.

The table below 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.

Reporting Period	Trust Value	National Min	National Max	National Average
Apr-Jun 2014	99.1%	33.3%	100%	98.0%
Jul-Sep 2014	99.5%	93.0%	100%	99.5%
Oct-Dec 2014	99.0%	73.0%	100%	97.8%
Jan-Mar 2015	Data not yet available			
Apr-Jun 2013	97.8%	74.5%	100%	97.7%
Jul-Sep 2013	97.6%	89.8%	100%	98.7%
Oct-Dec 2013	98.4%	85.5%	100%	98.6%
Jan-Mar 2014	97.9%	0.0%	100%	98.2%

Patients re-admitted within 28 days of being discharged

This information is not available as the NHS Information Centre website has not published these statistics since 2011/12. 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.

Patient experience of community health mental health services with regard to contact with a health or social care worker (weighted average across four survey questions)

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

- The patient experience survey is a national statutory requirement and co-ordinated for this Trust by an external CQC-approved survey contractor.

Between 2011 and 2014 the Trust has seen an improvement following focused actions which have included:

- the development and use of service user information folders
- each service user being given an information credit card with the care co-ordinator or lead clinician's name and contact numbers and what to do in a mental health crisis
- family engagement training delivered to community mental health staff
- Clear expectations for staff about six-monthly care review meetings with service users, which has included asking service users for their feedback after every review meeting
- All service users receiving treatment have been put on the CPA

- The service has been re-modelled to improve access and co-ordination across services and to deliver a service seven days a week

Further work continues on:

- evaluating and embedding the new service model.
- working closely in partnership with voluntary organisations to increase the provision of services available and to improve the care pathway between statutory and voluntary services.
- continuing to implement the use of the Recovery Star with service users.
- improving the information on the Trust's website for service users and their families or carers.
- working towards the Carers Trust accreditation so that service users, carers and practitioners are working jointly together.

Reporting Period	Trust Value	National Average
2014 survey	79.0 out of 100[15]	79.0 out of 100
2013 survey	84.9 out of 100	85.8 out of 100

Patient safety incidents resulting in severe harm or death

OHFT considers that this data is as described because there is a documentary audit trail for the compilation of these figures.

OHFT has taken the following actions to improve this percentage, and so the quality of its services:

- We continue to review and report every incident quarterly and in addition all serious incidents (including those resulting in severe harm and death) are reviewed weekly and senior clinicians are involved in deciding what level of investigation to commission.
- This trust has continued to set quality priorities each year to reduce suspected suicides and has a target of 300 days between suspected suicides in AMHTs.

The table on the opposite page shows the results of individual reports provided by the NHS from data supplied by the trust throughout the year. The data is provided via the national reporting and learning system (NRLS) in six month periods.

[15] The 2014 score is a composite of 3 questions, whereas the 2013 score was based on 5 questions. There is only 1 question which is the same from 2013 to 2014.

Reporting Period	Number of Patient Safety Incidents Reported	Number/ % of incidents resulting in severe harm	Number/ % of incidents resulting in death
April 2014-Sept 2014	2693	9/0.3%	19/0.7%

Minimising delayed transfers of care (DTOC)

The following table shows the bed days lost to DTOC in mental health inpatient services as a percentage of occupied bed days.

	Q1	Q2	Q3	Q4	FY 14/15
Delayed transfers of care	1.4%	2.3%	1.9%	1.8%	1.9%

Part 3: Achievement against the quality priorities for 2014/15

Introduction

The annual Quality Account details our approach to delivering high quality services which are safe, effective, outcome-focused and in which the experience meets expectations. It describes specific quality activities supported by a number of specific objectives and a range of metrics to measure and evaluate progress over the year. Our eight priorities and summary of actions and progress are detailed below.

We also started using the five questions devised by the CQC to assess the quality of our services: Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led?

Our eight quality priorities for 2014/15 were:

1. **Workforce**
2. **Data on quality and quality of data**
3. **Service remodelling**
4. **Staff engagement**
5. **Reduction in harm from falls, pressure damage, absence without permission, violence and aggression and attempted suicide**
6. **Implementation of our patient experience strategy**
7. **Development of outcome measures**
8. **Using the new CQC regulatory framework**

1. Summary of progress

The CQC has devised five key questions for NHS services. Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led? We have been using these questions to assess the quality of our services over the past twelve months and use them to organise the summary of our progress against our eight quality priorities.

Is the service safe?

Do we monitor incidents, learn when things go wrong and improve safety standards if they do? Do we have reliable systems for medicine management, patient records, infection prevention and control, use of equipment, safety of built environment, safeguarding children and vulnerable adults? Do we plan for potential risks to our services?

We measure safety in a number of ways, through the essential standards audit, the community hospitals assurance tool, the safety thermometer, local safety assessments, clinical audit, reporting and responding to safety incidents and reporting on national and local standards. In 2014/15 our safety thermometer results demonstrate a reduction in harm on those measures. We are making progress on our harm reduction priorities within the Quality Account (*priority 5*), with a reduction in reported absences without leave, fewer probable suicides, a reduction in harm from falls in older adult mental health and a decrease in the use of prone restraints, despite three wards managing some particularly complex patients during this time presenting with very challenging behaviour.

As a Trust we have a strong reporting culture for safety incidents and an effective process for identifying, investigating and learning from serious incidents (*priority 5*). All staff are aware of the online incident reporting system which flags all incidents with our clinical leads via emails to ensure they are aware of incidents; staff are also encouraged to contact the leads directly when a serious incident occurs so that support can be given to the team affected. However, there are a number of teams and professions which report few or no safety incidents and this is an area where we need to do further work.

We share learning in a number of ways, including newsletters, visits to teams, attendance at governance meetings and running learning events. However, we need to strengthen feedback to staff and trend reporting and analysis to teams. We also need to assist them in making sense of a plethora of data and ensuring we are confident our data is consistent and accurate *(priority 2)*. We are now working with services to integrate and prioritise action planning to focus on those actions which will make the biggest difference (*priority 8*).

Each directorate reviews safety information at a senior management, service and team level. This is open to scrutiny during the regular directorate performance reviews with executive and non-executive directors. The Quality Committee and four quality sub-committees provide assurance to the Trust that we have effective processes in place to deliver a safe service and monitor progress against our safety and quality priorities (*priorities 4 and 8*). This is also reported to the Board of Directors at their monthly meetings (which are held in public). The Trust also has a Governors-led quality and safety sub-committee which acts on behalf of the governing body to scrutinise and monitor service quality and safety in detail.

The Trust has a range of policies and procedures which are designed to ensure safe practice. As part of a review of our governance arrangements we are improving our policy review and approval process to ensure policies are kept up-to-date and readily accessible to staff.

We have carried out a complete overhaul of our risk management processes (*priority 4*) and teams have engaged very positively with a simpler reporting format and a

strengthened escalation process linking local risk registers with directorate and corporate risk registers.

In each team (ward and community) a safety board or Patient Status at a Glance (PSAG) boards are in place allowing the teams to monitor the safety of all patients on the team's caseload. These are RAG rated for risks so the team can easily identify any patients for whom safety is a concern. All patients have a risk assessment carried out by the team whether they are in an acute setting or the community. This is regularly reviewed and updated to ensure that patient safety is monitored (*priority 3*). In the forensic wards, the specialised forensic risk assessment is completed for all patients within 72 hours of admission. All teams follow the safeguarding systems in place to record any suspected or actual cases of abuse regarding patients and their families, supported by the Trust's safeguarding leads.

We monitor staffing levels in relation to nursing staffing on a weekly basis to ensure safe staffing levels are available on every shift (*priority 1*) and risk rate wards which are experiencing challenges with, for example, filling vacancies or managing sickness absence. We have a strategic recruitment campaign which has introduced a variety of ways to improve how we attract and retain staff (*priorities 1 and 4*). We are monitoring vacancy levels to ensure that teams can support the number of patients on their caseloads safely and services can be responsive to service demands.

Challenges exist in relation to recruiting and retaining staff in district nursing teams in South Oxfordshire. Elements of this relate to the fact that there is a recruitment premium in neighbouring counties and the impact of increased activity and complexity of patients within the community. We are actively working with partners to match capacity and demand and to model future workforce requirements.

Examples of good practice

- Skintelligence programme continues to improve pressure damage care across the older adult directorate (*priority 5c*).
- Introduction of senior clinical leads across disciplines (*priority 5*).
- Improving the medication management process to reduce errors (*priority 5*).
- More robust management of complaints - themes and learning are shared and triangulated against the five key questions developed by the CQC (*priority 7*).
- Safeguarding, serious incidents requiring investigation and orange incidents are reviewed, initial investigation reports completed, learning and action plans monitored by services (*priority 5*).
- Safer staffing is reported and monitored, which led to the development of a strategic recruitment campaign (*priorities 1 and 4*).

- Safer Care projects in place in CAMHS, school health nursing, inpatient units and community teams (*priorities 4 and 5*).

Areas for improvement

- Reduce incidents of pressure damage (all categories) (*priority 5c*).
- Reduce medication omissions (*priority 5*).
- Improve sharing of learning from incidents (*priority 5*).
- Full rollout of the new risk management strategy to ensure risk registers at all levels and escalation processes in place *(priority 4)*.
- A range of building works to ensure premises are safe and suitable including a programme to minimise ligature points across mental health wards.
- Improve clinical leadership and fill vacancies in community nursing *(priorities 3 and 5)*.
- Some aspects of medicines management for example management of controlled drugs, medicines reconciliation, replacement of drugs cupboards and learning from medicine incidents *(priority 5)*.
- Continue reporting and monitoring of staffing levels across community services.
- Improve workload and capacity in district nursing.

Is the service effective?

Do we properly assess patient needs and deliver appropriate care and treatment? Do we deliver good patient outcomes? Do staff have the skills, knowledge and experience to deliver effective care? How well do staff, teams and services work together? Do staff have access to the patient information they need? Is people's consent to treatment always sought? Do we protect the rights of our patients detained under the mental health act?

We are reviewing our clinical audit process to monitor and report on audits where improvements are required, to ensure actions are implemented so that re-audits show an improvement in practice (*priorities 4 and 6*). We have a process for reviewing our services against NICE guidance and Central Alert System (CAS) alerts. The Research and Development Committee oversees innovations and the use of evidence-based practice. Staff are involved in a range of improvement activities (*priority 4*).

The medical devices group is ensuring we have an up-to-date register of all medical devices equipment, that faults or failures are rapidly rectified and that staff are competent to use medical equipment. There are relatively few incidents relating to medical devices.

Staff are required to attend mandatory training, monitored by the Board of Directors (*priority 1*). We also monitor the percentage of staff who have received a performance development review and had the opportunity to access skills and knowledge training (*priority 1*).

Multi-disciplinary working is promoted through service remodelling (*priority 3*) which is developing locality based teams for older adult services and bringing together physical and mental health practitioners to improve outcomes *(priority 7)*. We work in partnerships to deliver care to patients, and to manage or solve system-wide issues or problems (for example delayed discharges of care or management of pressure ulcers (*priority 5*)). In 2015 we will deliver a new partnership agreement with the third sector in Oxfordshire (*priority 7*).

Non-Executive Directors participate in mental health act hearings and we are subject to a range of monitoring to ensure we are compliant with the mental health act and mental capacity act (*priority 6*). This is reviewed in detail by the effectiveness quality sub-committee. Staff receive training in their responsibilities and in the rights of patients and families in relation to legislation. Areas for improvement relate to the quality of documentation.

We have training placements for various disciplines at undergraduate and postgraduate levels. We work closely with Health Education Thames Valley to ensure trainees get appropriate development and assessment opportunities. With Oxford Brookes University School of Life Sciences we have also developed a successful programme of physical health care training in mental health settings.

Adult services have assessments in place in all settings which are carried out upon the patient's referral to the teams and updates at points of reviews where appropriate. These are monitored through a monthly CPA audit (*priority 3*) involving a quantitative analysis (have requirements been met?) and qualitative (have they been done well?). We use the national benchmarking tool to assess how our Trust compares to others around the country.

Adult mental health services introduced the Recovery Star in 2015 to help patients set goals and assess their progress (*priority 7*). Services are also assessing and managing both physical and mental health needs (*priorities 3 and 5*).

The way in which services are commissioned is also changing, with a focus on outcomes which are measurable and meaningful in an individual's recovery (*priority 7*).

Following feedback from Oxfordshire Clinical Commissioning Group we have added the following:

OHFT will continue to support Multi-Agency Safeguarding Hub developments and continue to work in partnership with other agencies in relation to the identification,

support and risk management of children who are at risk or have experienced child sexual exploitation. These and other areas of work are outlined in the Trust Safeguarding Children action plan which is monitored via the Safe Sub-committee and reported to Trust Board.

Examples of good practice

- Re-ablement is performing at above national average for patients discharged from the service with no ongoing care needs (*priority 6*).
- In Witney, of 33 GPs surveyed 100% were likely or extremely likely to refer a patient within the next month to the Emergency Multi-disciplinary Unit (EMU) (*priority 3*).
- Advanced Assessment Skills training was rolled out to those staff working in the assessment function of the AMHTs (*priority 1*).
- District nurses are receiving diabetes and insulin training (*priority 1 and 5).*
- On one of the adult wards, they have set up a physical health clinic which patients can attend to receive advice and support *(priorities 3 and 5*).
- Personalisation training programme is being delivered across older people's services
- Over last six months the out-of-hours (OOH) service has seen a 2.5% increase in home visits to help patients remain in the community *(priority 3*).
- Good patient outcomes resulting from improved joint working in integrated locality teams (ILTs) *(priority 3*).
- Retendering is providing opportunities for service redesign work including Bucks CAMHS and school health nursing services *(priority 3*).
- Reported Outcome Measures will be completed for CAMHS new referrals *(priority 7*).
- We are reviewing other outcome measure tools for other services; introducing outcome star for school health nurses (SHNs), developing a system for health visitors and using goal-based outcomes with speech and language therapy (SLT) Bucks Services (*priority 7*).

Areas for improvement

- Improve nutrition and hydration care in all care settings *(priorities 3 and 5).*
- Continue to establish holistic physical and mental health care *(priorities 3 and 5).*
- Training for urgent care staff and GPs in urinary tract infections.
- Information sharing and implementation of Oxfordshire Care Summary (*priority 2*).

- Review of pathway between SPA and ILT to further reduce duplication (*priority 3*).
- Training being developed following audit of catheter care (*priority 5*).
- Increase the number of goals patients achieve through the Recovery Star (*priority 7*).
- Improve the end-of-life pathway (*priority 3*).
- Reduce delayed transfers of care in Oxfordshire (community hospitals) *(priority 6)*.
- Increase supervision of staff (*priority 1*).
- Update the resuscitation policy (*priority 5*).
- Strengthen processes for reviewing NICE guidance and CAS alerts.
- Improve documentation supported by the new care record system.

Is the service caring?

Are our patients treated with kindness, dignity, respect, compassion and empathy? Do we involve patients and their carers as partners in their care?

The Trust uses a variety of methods to assess whether patients experience our services and staff as being caring, respectful and compassionate. The National Friends and Family Test is a regular way of capturing a snapshot of patient feedback. We have introduced this test as part of the existing mechanisms we have to gather feedback so we can review quantitative and qualitative information together (*priority 6*). We have also introduced a staff Friends and Family Test including the question "*How likely are you to recommend OHFT to friends and family if they needed care and treatment?*", but response rates are still very low (*priority 1*). One issue staff raise is that pressures on staffing, heavy workload, and increased activity and patient acuity are limiting the ability of staff to spend the time they would like with patients to provide support and reassurance (*priority 6*).

We need to develop more structured ways of developing outcomes measures with patients and those close to them *(priority 7)*. The new care clusters for mental health patients provide some opportunity for this, but we are seeking creative ways of focusing on outcomes, rather than simply processes or inputs across all of our services and care pathways (*priority 3).* All of our wards ensure that the dignity and respect of patients are adhered to through single sex wards. Patients are also given access to cordless phones so they can contact their family and friends within the privacy of their rooms or specific areas on the wards.

Patient and family involvement from the point of referral to discharge is crucial (*priorities 6 and 7*). Where agreed, families are involved in a patient's care planning and their assessments. This provides support to the patient but also offers an

opportunity for families to be supported by the teams. The Trust offers carers' assessments to ensure that the person, whether they are a family member, relative or friend, are supported and their needs identified. In Oxfordshire, we have strong links to Rethink and the Carers Reference Group to understand and gain feedback from families about their experiences of services.

During the remodelling of adult services in 2013/14, families were invited to participate in the local forums to help shape the future services. These meetings provided the directorate with an opportunity to understand how service changes impact on families as well as patients.

Work to achieve the Triangle of Care accreditation will help to ensure that carers and family members are involved in planning and treatment of patients who access services (*priority 6*). We have been working with the local authorities to meet the amendments to the Care Act.

Examples of good practice

- Patient satisfaction scores remain high despite pressures on all services (*priority 6*).
- Feedback from patients and families and observations during peer reviews demonstrate the caring approach and compassionate attitude of staff (*priorities 3 and 6)*.
- Award for dementia care.
- Following dementia training "Knowing Me" documentation passport has been launched across acute, social care and community settings in Oxfordshire *(priority 3)*.
- There has been an increase in the number of circle of support workers plus further funding awarded to continue the training for three further months (*priority 6*).
- Patient experience of pain project completed to improve care (*priority 6*).
- Patient experience survey and national audit of intermediate care survey show service users perceive our staff as caring and respectful of dignity (*priority 6*).

Areas for improvement

- Documentation project pilot by three district nursing teams to support holistic assessment of patients *(priority 5c)*.
- Wider use of "Knowing Me" documentation passport (*priority 3*).
- Improved learning from complaints (*priority 6*).
- Provide opportunity for service users to give immediate feedback to practitioners at the point of discharge (*priority 6*).

- Improve how patient and family feedback is shared with staff (*priority 6*).
- Improve the level of carer satisfaction through the Triangle of Care, carer awareness training for staff and our involvement in local carer reference groups (*priority 6*).
- Improve how we ask for feedback, for example improving the attendance at local involvement forums, surveying along care pathways and clinician level feedback (*priority 6*).
- Integrate human rights and improve accessibility for diverse groups (*priority 6*).

Is the service responsive?

Do we plan and deliver our services to meet the needs of different patients? Do we routinely seek out and learn from patient and carer feedback?

Our services are subject to national and local indicators for responsiveness, which include referral to treatment times, waiting times and accessibility. Our teams have clear targets for responding to referrals whether they are emergency, urgent or routine. We report to commissioners, national reporting bodies and Monitor on a range of such measures, accounting for any failures to meet targets and assurance that remedial actions are in place (*priorities 3 and 6*). We have substantially increased the availability and accessibility (through self-referral) to community, urgent care and in-reach services out-of-hours as part of our service remodelling programme (*priority 3)*.

We have extended our psychiatric liaison into emergency departments in each county. We have also worked alongside other organisations, for example the police, ambulance service, emergency departments and county council to support the implementation of the Crisis Concordat, which is a joint statement about how public services should work together to support individuals with a mental health need in crisis (*priorities 5 and 6*).

Feedback assists us to understand how our services are received by patients and those close to them, and whether they are consistent with our quality aims. We ask for people's views about their experience of care in a number of ways including paper questionnaires handed out or posted directly to someone's home, using handheld electronic devices, stand-alone kiosks and online surveys to get near real time feedback, social media (for example Twitter, Facebook, Patient Opinion), face-to-face forums, focus groups, drop-in surgeries, and one-to-one interviews *(priorities 3 and 6)*.

This year we gathered patient and staff stories through interviews (sometimes filming or recording these) and conversations during peer reviews (*priority 6*). A sample of these stories are regularly heard at quality meetings and the Trust Board. Analysis

shows that patients in general rate the services they receive more highly than the staff who deliver them.

Each directorate works hard to involve patients, parents and their families in their own care as well as asking people their views of how services should develop and change.

We have reviewed the number of patients who have a learning disability as well as a mental health illness to understand any gaps in service delivery. Within Oxfordshire, we have the GP practice at Luther Street providing support to vulnerable or disadvantaged patients who are not otherwise in contact with primary care services. We also work alongside two third sector organisations, Elmore Community Services and Connection Floating Support to meet the needs of patients who may need support in the community.

Our equality and diversity strategy aims to reduce the barriers experienced by some patients and families to accessing services (*priority 6*) and ensure they are culturally appropriate.

Following feedback from Chiltern and Aylesbury Vale Clinical Commissioning Group we have added the following:

The Trust's equality and diversity officer is gathering data for the Race Equality Audit and also developing a plan for the NHS Workforce Race Equality Standard (WRES).

Examples of good practice

- Involvement of patients and carers in service remodelling (*priority 3*).
- 24/7 day working in community mental health and urgent care services (*priority 3*).
- Patient experience strategy (*priority 6*).
- Our governing body includes patient and carer representatives (*priority 6*).
- Governor-led quality and safety sub-committee (*priority 6*).
- Proactive Patient Advice and Liaison Service which visits wards and runs open surgeries for patients to raise concerns at the point they are receiving care (*priority 6*).
- "Have your say" forums receive real time feedback and work with patients to deal with problems or issues they may have (*priority 6*).
- Carers' strategy work is being taken forward to reflect young carers (*priority 6*).
- Implementation of 18-25 services for vulnerable young people. In BaNES and Wiltshire we have done this for Looked After Children (*priorities 5 and 6*).

- Implementation of transitions clinics with adult mental health services in Wiltshire and BaNES to plan ongoing care post-18 years (*priorities 5 and 6*).
- New person friendly web page is in place for Buckinghamshire CAMHS (*priority 6*)
- Enhanced staff levels in older adult inpatient units (*priorities 3 and 6*).
- A co-ordinated response to winter pressures enabling more patients to be supported at home (*priority 3*).
- We have replaced the EKOS with the FIM tool in community hospitals (*priority 7*).
- The Chiltern Memory Team, South Buckinghamshire, was identified as an excellent example of best practice in memory services across England seeing people within 40 days from assessment with a 90% response rate (*priority 3*).
- Urgent Care service access issues have been resolved with no delays (*priority 3*).
- Community mental health teams are providing step-up care to assist with admission avoidance (*priority 3*).
- Inpatient wards and CMHTs have implemented a daily ward round to improve discharge, reducing the average length of stay (*priority 6*).
- Flexible working across urgent care services to meet patient needs (*priority 6*).

Areas for improvement

- Continue to work with patients and their families so that they feel they are involved in decisions about their care as much as they would like to be (*priority 3*).
- Support more people to be able to die at home who choose to do so (*priority 6*).
- Implement the Green Light[16] and audit service accessibility (*priority 6*).
- Ensure emergency medical unit services are well used, accessed into the evening (until 8pm) and better support people with sub-acute needs to remain at home in the evenings (*priority 6 and 7*).
- Continued work on improving adult speech and language therapy response times.
- Improve patient flows to urgent care including via 111 (*priorities 5 and 6*).
- Deliver single assessment process for adult services in Oxon (*priority 6*).
- Improve waiting times in specific services (*priority 6*).

[16] A toolkit to evaluate and improve accessibility of services for people with a learning disability.

Is the service well led?

Do we have a clear vision and strategy for quality of care? Does our leadership and culture support this vision? Do we have effective governance systems? Are we open and honest? Do we strive for continuous improvement?

The Trust has agreed a strategy which includes the strategic objective "Driving Quality Improvement". Specific quality priorities are defined in the annual Quality Account. We have invested in skills and capacity to deliver quality and safety improvement and innovation through our innovation team, our productive team and our safer care team (*priority 4*). They work across the Trust to implement and embed safety projects (*priority 5*).

Board meetings are held in public. We maintain our duty of candour in reporting progress and achievements, and also areas requiring improvement. Directorates reflect on their quality performance with Board members on a regular basis and use this opportunity to identify future risks to service quality as well as to promote innovations and progress (*priority 4*). We have also implemented a patient experience strategy to improve how we act on feedback gathered from patients, parents and their families to improve care (*priority 6*).

The Chief Executive, Executive Directors and Service Directors routinely visit teams and offer drop-in surgeries to enable staff to share concerns and to raise awareness of good practice in their teams or services (*priority 4).* We have a number of initiatives to support staff motivation and improve staff wellbeing (*priorities 1 and 4*).

The Trust has recently reorganised its overall governance structure to reflect the five key questions developed by the CQC and service directorates are similarly reorganising their quality and governance meeting structures (*priority 8*). Directorate leadership teams have been restructured to deliver integrated, clinically led care (*priority 3*). Each Non-Executive Director has an identified lead area to bring independent scrutiny to performance and quality, as part of which they undertake visits and sit on quality committees and groups. We have also established a well-functioning system for peer reviews across our services (*priority 8*). Our new risk management strategy offers a more structured approach to identifying and managing risks at all levels in the organisation (*priority 4*).

Attendance at leadership development events has increased since the same period last year and we provide a range of opportunities for formal and informal leadership development. We hold quarterly senior leadership conferences to bring together our senior management teams. We have recently approved our organisational development strategy and we regularly review organisational development and leadership development at the Board of Directors.

We have also rolled out the Aston teamwork model to improve team functioning and effectiveness (*priority 1*). Mental health wards have strengthened their leadership

teams and older adults have aligned physical and mental health services under a single leader to promote multi-disciplinary working and more seamless care for our patients (*priority 3*).

The Trust has significantly increased its academic profile over the past two years. We are members of the Academic Health Sciences Network (AHSN) and Centre (AHSC). We host the CLARHC (Collaborative Leadership in Applied Health Research) which offers £9 million funding plus £9 million matched funding over five years. We also host the Diagnostic Evidence Collaborative which is our first significant physical health academic development. These partnerships and collaborations help us translate research into clinical practice.

Examples of good practice

- Peer reviews across a range of services (*priority 8*).
- Combined training for nursing, medical and operational leaders (*priority* 1).
- Internal clinical and professional networks (*priority 1*) and external benchmarking.
- Funding identified for a six month staff MSK self-referral pilot to start early next year.
- 'Leading the Way' and 'Planning for the Future' programmes (*priority 1*).
- Consultation with staff and patients on service remodelling (*priorities 3 and 4*).
- Quality leads identified at each management level and in all professions (*priority 4*).
- Staff discuss and review their practice against the CQC's five questions (*priority 8*).

Areas for improvement

- A review of staff musculoskeletal injuries and stress (*priorities 1 and 4*).
- Develop a vision for community nursing and review how community nursing works with primary care for the benefit of the patient (*priority 7*).
- More skills training and clinical supervision for staff (*priority 1*).
- Joint working between OHFT and acute services to enable skill sharing and harm reduction across both settings (*priority 5*).
- Provide a five-day leadership development programme for clinical leaders (*priority 1*).
- Increase our response rate to the staff survey by 5% (*priorities 1 and 4*).
- Improve our staff survey scores and implement actions from feedback (*priority 4).*
- Improve management of policy review and approval process (*priority 5*).
- Ensure staff are able to articulate and meet the requirements of the duty of candour.

Quality priority 1: workforce

Almost 225 managers have received team effectiveness training and report an improvement. Despite staffing pressure we have maintained levels of access to training. We did not achieve our appraisal target due to significant changes in management structures over the year. Staffing levels are monitored every week and no ward dropped below 92.7% of shifts being fully staffed. Our staffing indicators for the quality dashboard have been agreed.

In our 2014 staff survey we had above average scores for percentage of staff able to contribute towards improvements at work; staff recommendation of the Trust as a place to work; and percentage of staff agreeing feedback from patients/service users is used to make informed decisions in their directorate. We were in the worst for seven (work pressure and harassment). We were shortlisted for the Nursing Times award for excellence in supporting staff and wellbeing.

This will enable the service to be caring, safe, effective, responsive and well led.

Agreement of quality-focused workforce indicators as part of a wider quality dashboard by 30 September 2014

The quality dashboard is trialling a number of workforce-related measures which include:

- sickness absence (%)
- vacancies as a proportion of establishment
- number of wards unable to fill 80% of their shifts
- agency staff bill as a percentage of budget for clinical staff
- percentage of staff who have completed patients and personal safety training (PPST) in the last twelve months
- percentage of staff who have been appraised within the last twelve months

Roll-out of the Aston Teamwork model[17] across the organisation to nominated managers

A total of 223 managers have commenced or completed their effective team-based working learning and practice, an increase of 11% in comparison to last year. In addition to the team-based working orientation sessions, 81 teams have received direct support including advice and coaching for the team leader or manager and facilitating team development session and days.

[17] Aston University found that teams working well achieved: improved patient satisfaction; increased effectiveness and innovation; lower patient mortality; reduced error rates; reduced hospitalisation and costs; higher staff satisfaction; reduced staff turnover and sickness absence; increased mental wellbeing of team members. This led to the Aston University team working development programme, an evidence-based facilitated programme with a structured set of tools that aims to improve organisational performance through building effective teams.

Improvements to team effectiveness include:

- Improved understanding of the challenges and issues and increased trust.
- Better communication, both within the leadership team and outside it.
- "The team have become very skilled at problem solving together. They own the issues and then own the solutions which is great to see."
- "There have been thorny issues to resolve … and we are now able to have those difficult discussions without damaging team relationships."

indicator	Data source	purpose	FY 13/14	Q1	Q2	Q3	Q4	FY 1415
a) no. of team leaders trained in Aston teamwork principles – target 250	Improvement and innovation team attendance records	Monitor spread of skills development	178	50	57	98	18	223
b) 100% attendees reporting they are equipped to lead team working effectiveness		Effectiveness of model	86%	90%	86%	89%	98%	91%

Maintain existing levels of access to staff training and development, including clinical practice, improvement skills and professional leadership

The level of performance development review (PDR) has increased over the year but is lower than at the same point last year. This is attributed to the cumulative effect of a year in which significant restructuring created long periods when teams were without settled managers and the continued concern that compressing the PDR into Q1 made it more difficult to meet with all staff in time. Next year we are moving to an incremental date PDR timing. This transition period will reduce the reported level of completed PDRs in year, and may take until end 2016/17 to be fully stabilised. Longer term, however, this will improve the PDR process.

indicator	source	purpose	FY 13/14	Q1	Q2	Q3	Q4	FY 1415
Performance development review completed in last 12 months (target 100%)	Learning and development records	Support staff development, performance review	90%	56%	79%	83%	84%	84%
Skills courses attendance	Learning and development records	Ensure staff develop and update clinical leadership skills	8900	2318	2055	2301	1997	8671

Deliver expected nursing staffing levels on inpatient wards

Staffing levels by ward are reviewed shift by shift by ward staff and immediate managers, daily by Matrons and Heads of Nursing, and weekly by the Director of Nursing and Chief Operating Officer to ensure there is appropriate escalation and that staffing levels match the acuity and needs of patients to provide safe and effective care. There is also a monthly review by the Board of Directors.

The table below shows the percentage of shifts which were fully staffed since May 2014. Using the existing range of quality, safety and workforce measures in our matrix, we have not identified a link between actual staffing levels achieved and adverse outcomes for patients.

	Day time shifts (Early, late and twilight shifts)		Night time shift	
	Registered nurses	Unregistered staff	Registered nurses	Unregistered staff
May 2014	96.20%	94.50%	99.50%	99.80%
June 2014	96.9%	97.3%	95.6%	97.7%
July 2014	98.7%	96.3%	92.5%	98.6%
August 2014	95.1%	93.4%	94.9%	97.5%
September 2014	95.6%	93.9%	95.5%	96.4%
October 2014	96.1%	95.1%	96%	96.3%
November 2014	95.5%	94%	94.8%	98.1%
December 2014	95.1%	94.1%	95.1%	97.3%
January 2015	95.2%	94.7%	96%	97.8%
February 2015	94.7%	93.2%	95.2%	97.9%
March 2015	94.7%	92.9%	95.2%	98.7%

Nursing vacancies are the main reason for under-staffing on the shifts for many wards, related to recruitment difficulties in some geographical areas and some specialties (reflected nationally). The increase in staffing establishment (and therefore expected staffing levels) on a number of wards which is taking time to recruit into. Vacancies are being monitored and managed on a weekly and monthly basis with the Executive Team.

A number of actions were taken specific to each ward to manage capacity, for example:

- managing capacity through a temporary reduction in bed numbers on wards
- considering individual patient level of need when deciding where to admit patients
- staff who are normally supernumerary to the nurse staffing numbers (for example matrons) have worked as part of the nursing shift numbers
- staff were borrowed from other wards to increase the staff to patient ratio

- staff worked flexibly, for example working an extra hour at the beginning or end of a shift
- 'long lines of work' were established with agency staff to improve continuity of care and reliability of temporary staff

Our recruitment action plan outlines attraction and retention activities and career development opportunities. This includes:

- Improvement of external web pages.
- Improvement to advertisements and attachments on NHS jobs.
- Incorporation of values into all recruitment material.
- Promotion of staff accommodation and key worker housing.
- Financial incentives.
- Improving links with universities.

Friends and Family Staff Survey "how likely are you to recommend this organisation to friends and family as a place to work/if they needed care or treatment?"

The Staff Friends and Family Test was introduced on 1 April 2014 and asked two questions:

1. *How likely are you to recommend OHFT to friends and family if they needed care and treatment?*
2. *How likely are you to recommend OHFT to friends and family as a place to work?*

Quarter 1 had a 6% response rate. For Q2 the surveys were emailed to staff who received a unique password to complete the survey. The response rate increased to 12% (compared to a national average of 16%). The Q3 result is taken from the national staff survey.

	Recommend to receive care		Recommend as place to work	
	Result	Response rate	Result	Response rate
Q1	Extremely likely 24% Likely 49% Combined 73%	316, 6%	Extremely likely 18%, Likely 41%, Combined 59%	313 / 6%
Q2	Extremely likely 21% Likely 48% Combined 69%	723, 12%	Extremely likely 18%, Likely 40%, Combined 58%	702 / 12%
Q3	Extremely likely and Likely combined 61%	1646, 32%	Extremely likely and Likely combined 55%	1646 / 32%
Q4	Extremely likely 23%, Likely 50%, Combined 73%	987, 18%	Extremely likely 17%, Likely 40%, Combined 57%	963 / 18%

National staff survey 2014

The national staff survey is carried out across all NHS trusts in England. It allows staff to comment confidentially on how their trust supports, trains and involves them in delivering high quality and safe services. NHS trusts delivering similar services are able to compare or benchmark themselves against each other on the basis of whether they are in the top 20%, above average, average, below average or in the bottom 20% of similar trusts. In 2014 for the first time the trust had the opportunity to survey all 5168 members of staff. Previous surveys have been carried out on a random sample of 850 staff.

The response rate was 31.84% which was in the lowest 20% of trusts (the average was 44%) although the actual number of staff responding was higher. OHFT is compared with mental health and learning disability trusts.

The overall staff engagement score for OHFT is 3.75 which is above average compared with other mental health and learning disability trusts.

This combines:

- staff ability to contribute towards improvement at work; the Trust score was 73% which is above the average of 72%
- staff recommendation of the Trust as a place to work or receive treatment; the Trust score was 3.63 which places it above the average of 3.57
- staff motivation at work; the Trust score was 3.85 placing it above the average of 3.84

We had above average scores for percentage of staff able to contribute towards improvements at work; fewer staff feeling pressure to attend work when feeling unwell; fewer staff experiencing physical violence from patients, relatives, the public and staff; staff recommendation of the trust as a place to work; percentage of staff agreeing feedback from patients and service users is used to make informed decisions in their directorate; and equality of opportunity for career progression.

Our lowest ranking scores were for percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver; percentage of staff working extra hours; work pressure felt by staff; percentage of staff appraised in the last twelve months; percentage of staff reporting errors, near misses or incidents witnessed in the last month; and percentage of staff experiencing harassment, bullying or abuse from staff in the last twelve months.

Implementation of the key actions arising from the national staff survey results to promote staff wellbeing

Action plans for improving areas where we did not score well are now part of the annual requirements for each directorate and are monitored through quarterly performance reviews. They incorporate the specific areas from the staff survey results, which are localised to the directorate and have included:

- tools to enable people to recognise and manage workplace stress.
- initiatives to support staff to take breaks and reduce working of excessive hours
- support after bereavement
- improve opportunities for engagement between staff and senior managers

Quality priority 2: data on quality (and quality of data)

We have agreed a set of quality indicators which, taken together, will allow us to assess where we are doing well and potential areas of vulnerability in terms of quality. This is supported by our standard data quality matrix for use across the Trust to monitor and track data completeness and accuracy. The new Electronic Health Record is being implemented and will improve documentation and access to data.

This will enable the service to be safe, effective and well led.

Agreement of a quality dashboard

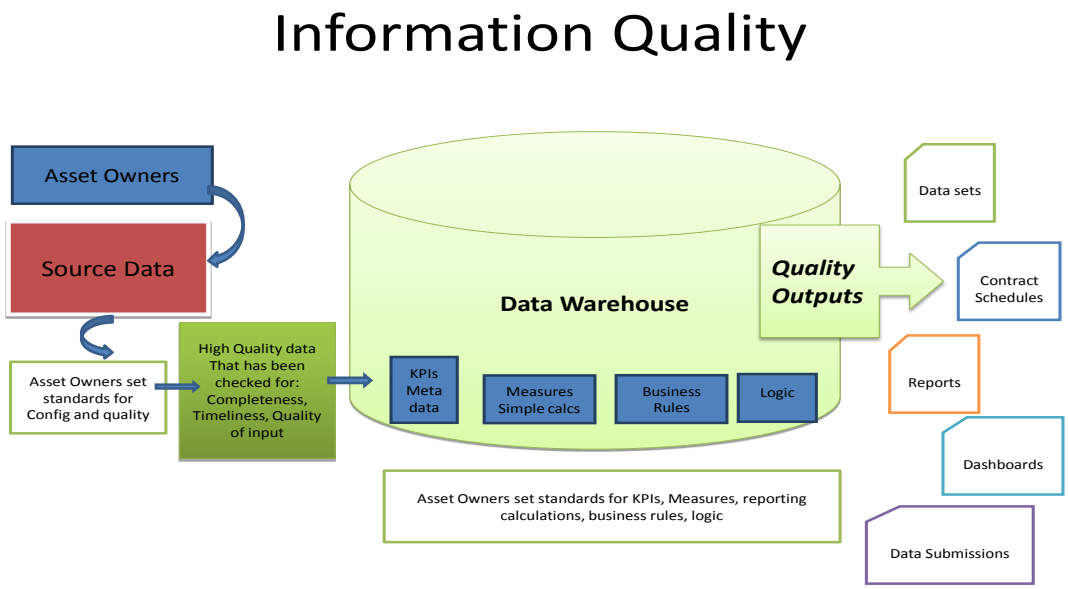
We have agreed a set of indicators (Appendix 2) which include access and waiting times; safety metrics and staffing measures. The project to develop the quality dashboard will continue in 2015/16 as we set up ways to populate the dashboard at a Trust-wide, directorate and service level and begin to use it as part of our quality reporting. We will also align this with the CQC intelligent monitoring dashboard which is still in development.

Development of standard operating procedures for data quality including written controls for quality indicators and a standard process for sourcing, verifying and checking reported data with assigned data leads

The Data Quality Review Group meets every two months to review and monitor the quality of data recorded and reported at the Trust. The group is responsible for implementing standard operating procedures to manage data quality in the Trust. Each directorate has provided details of the reports and process that they follow to review and improve the quality of data. The group has approved a standard data quality matrix for use across the Trust to monitor and track data completeness and accuracy. In addition, an individual healthcare professional version of this matrix has

been completed (My_HCP Dashboard) to provide access to data have entered that is incomplete or inconsistent with Trust standards.

As part of the implementation of the new patient care record, standard operating procedures ensure users of the new system will adhere to consistent data capture methods. Asset owners, who will be allocated at a directorate level, will be required to review, monitor and control the quality of data recorded and reported at the Trust.



Quality priority 3: service remodelling

We have successfully implemented the planned service changes in adults and older adult services, including extended hours, leadership teams, cluster packages, outcome-based measures, integrated locality teams and the relocation of the City Community Hospital to the Fulbrook Centre. We achieved our physical health assessment targets. We have a range of locality and ward-based patient forums, although attendance varies. Early intervention and complex needs reviews are complete. We have a system-wide dementia care strategy.

All schools have a health plan. We have exceeded our health visitor staffing targets and have improved infant feeding and breastfeeding-friendly access. We need to improve some of our CPA metrics in the coming year – the new care record system will ensure better documentation of actions. We did not achieve our target for VTE assessments. We also need to measure multi-disciplinary assessments for older adults with complex needs

This will enable the service to be caring, safe, effective, responsive and well led.

Fully implement a new model of care based on cluster packages[18], care programme approach[19] and the Recovery Star[20]; ensuring patients and their families are clear about who is providing their care, what the care is and what to expect throughout their time in the service; supporting the patient (and/or family) to set their own goals

The new model of care for the AMHTs was implemented in April 2014 across Oxfordshire and Buckinghamshire, working alongside the carers reference group and service user forums.

We implemented the Recovery Star within our service in early 2015. This tool enables us to work with patients to develop their own goals and recovery plans. The star contains a number of domains in which each patient can determine where they are now and where they would like to be; staff can then work with them to reach these goals. The star is being used in conjunction with our care plans. Once the star is available on iPads in the community teams we will be able to link to the new care record system.

Care clustering is now well embedded within the adult teams. All patients are now clustered upon entry to the service.

We are working on improving carers' support through the implementation of the 'Triangle of Care'; this is being led clinically by professional leads in conjunction with Oxfordshire County Council. The purpose of the Triangle of Care is to ensure carer involvement.

Through the partnership with third sector in Oxfordshire, we are developing a Recovery College which will ensure co-design and co-production with service users and carers.

The new model of care for older people's mental health services has been implemented in each county. Benefits include an increased capacity in Oxfordshire memory clinics following service changes. We are now working towards memory clinic accreditation.

Inpatient wards and CMHTs have implemented a daily ward round to proactively confirm which patients are ready for discharge and to prepare for patients returning home. Since Christmas, CMHT and inpatient staff plan together the prioritisation of pending admissions to ensure timely or early discharge; there has been a positive reduction in average length of stay for inpatient services.

[18] A classification of a mental health service user based on their individual characteristics, condition & behaviours.
[19] The Care Programme Approach (CPA) is a national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.
[20] The "Recovery Star" highlights areas to work with individual patients on in identifying and addressing difficulties that they have with core areas of life. These areas are managing health, self-care, trust and hope, living skills, identity and self-esteem, special networks, responsibilities, work, addictive behaviour and relationships.

Outcomes-based clustering is being applied to older adults mental health and the next steps are to embed evidence-based treatment packages in line with clusters.

Involvement in care planning has gradually increased over the year to a high of 93% in Q4. The percentage of patients in employment or settled accommodation has dropped in Q4. This is due to changes in the way data has been collected.

Indicator or measure	*Data source*	*Purpose of measure*	*FY 1314*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
% of patients with a CPA to be in employment or meaningful activity	CPA audit	Measure quality of life goals in care planning	n/a[5]	11.7%	11.6%	11.4%	10.9%	n/a[21]
% of patients with a CPA in settled accommodation	CPA audit	Measure quality of life goals in care planning	n/a[5]	78.6%	77.8%	78.6%	75%	n/a
100% of patients involved in setting and achieving goals	CPA audit	Assess patient involvement in setting and meeting care plans	92%	85%	87%	87%	93%	88%

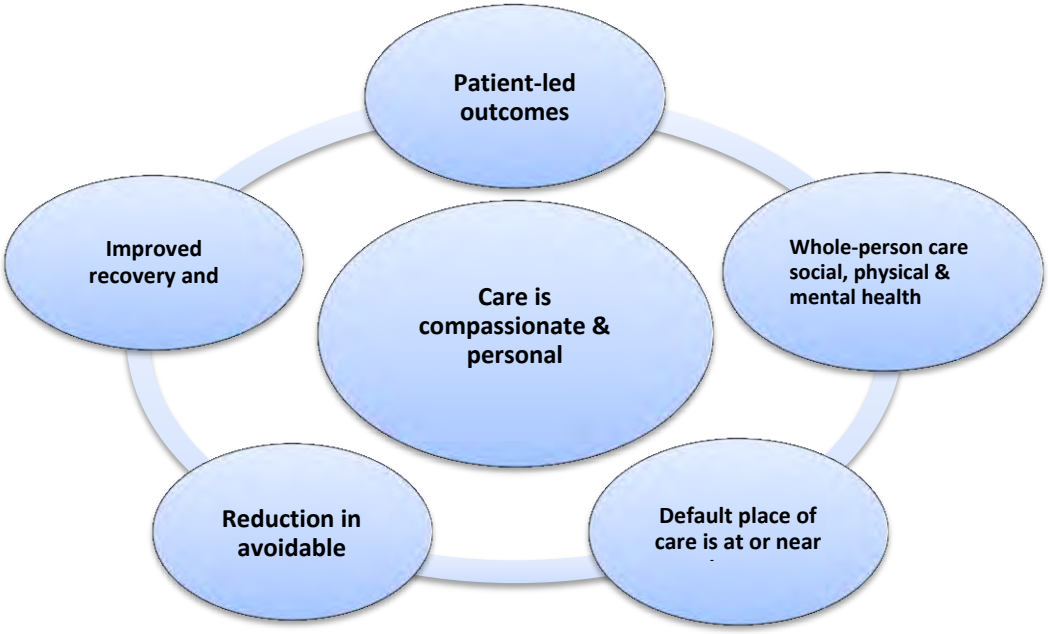
Fully implement the integrated physical and mental health pathways for older people

The Older People Directorate implemented ILTs in Oxfordshire on 1 December 2014. This is part of a whole system programme that will develop over two years. There are six integrated locality teams: north, north east, central, west, south east and south west Oxfordshire.

ILTs are the collective name for community services and professionals working in a locality. This does not mean a change to the way that staff will work within their *specialist* area of expertise but that when required (for example in response to complex, escalating or uncertain referrals for patients requiring multi-disciplinary input), they will work in an integrated or 'joined-up' way with colleagues from other specialties also working in that locality.

This ensures a multi-disciplinary team (MDT) approach to assess and meet a patient's holistic needs and eliminates duplication. Positive effects include enhanced discharge from acute services and discharge planning from mental health (MH) wards, plus improved recognition of MH distress in care home residents.

[21] This is a monthly snapshot figure, a full year figure is therefore not available



VTE assessment has reduced over the year, but there has been an increase in other physical health (PH) assessments. There have been no VTE events. As part of the work to improve physical health management of patients (priority 5f in 2015/16) the quality and frequency of physical health assessments will be improved.

Indicator or measure	*Data source*	*Purpose of measure*	FY 1314	Q1	Q2	Q3	Q4	FY 1415
100% of patients on older adult mental health wards to have MEWS[22] and PH assessment including VTE	audit	Align physical and mental health needs of older adult patients	VTE 96% PHA n/a	VTE 96% PHA 95.75%	VTE 96% PHA 100%	VTE 87% PHA 100%	VTE 87% PHA 100%	VTE 92% PHA 99%

Transfer of the Oxford City Community Hospital to the Fulbrook Centre to support the integrated model of care

The City Community Hospital Ward and the Fulbrook Centre are now co-located providing an integrated model of care for patients and an opportunity to share nursing skills and knowledge. The directorate is working up a joint model of care for people with high physical care needs and bed-based mental health care needs. Due to the co-location there is informal joint working including informal coaching or mentoring for each of the units. The directorate will review the longer term benefits once the ward is established. Delivery of integrated physical and mental health care will be continued in community hospitals.

[22] Compliance with MEWS (early warning system measures) will be audited in 2015

Implement locality and ward-based patient and carer forums

Most localities now have a patient and carer forum which is attended either by the modern matrons or community leads or team members. There is also representation from the wards (modern matrons) attending the AMHT sessions to provide a link between the services and ensure any concerns or issues raised in this forum are fed back appropriately.

The ward forums take the shape of 'Have your say' meetings and meet each week on the wards. Patients are encouraged to participate and raise any concerns they have. Each forum is taking its own approach to the agenda and use of the time; in Aylesbury patients in attendance have been identifying which professionals they would like to meet with and have been thinking about social events to hold. In Chiltern, they have developed a newsletter which feeds back the updates following the forums. The forums have been advertised on the wards and in the AMHTs as well as information being sent to GP practices. The patient forums have on average three to four attendees in Chiltern and Aylesbury saw ten patients attend the last meeting in March 2015. In Oxfordshire, both the north and south have had three to four attendees each time. The groups are looking to see how they can further promote the forums and attract new attendees

The Early Intervention Service now has a carer forum in place. In Oxfordshire this is in partnership with Rethink, which also provides a carer's forum for the wards in conjunction with modern matrons and ward managers.

Implement patient and carer outcome measures

A patient satisfaction questionnaire is undertaken at the point of the patient review to assess satisfaction with setting and achievement of outcomes and care planning. These are anonymous questionnaires which are supported by an external company (Patient Perspective) which collates results and feeds back to the teams. Further work is required to establish a carers' feedback mechanism. Carers outcome measures are under development. The Triangle of Care will improve the engagement of carers in patient treatment.

Review and develop early intervention in psychosis services (EIS)

The review has been completed and the new model is now in place. The service is remaining in the Adult Directorate under the direct management of the Buckinghamshire service manager to provide continuity between the services; an enhanced research function has also been included, supported by the Oxford Academic Health Science Network.

The service have the following research posts: five posts for the AHSN Clinical Network, two for the CLAHRC, two in Oxford Health NHS FT research and development and one for the local clinical research network.

Review and develop the complex needs services with CCG leads

A review of the services commenced with Oxfordshire and Buckinghamshire CCG leads undertaking patient feedback sessions. There are two options awaiting decision: for each county to have the same service model or for each county to have a different service model.

Develop, implement and evaluate new staffing models including seven-day working and extended hours

The new staffing model and seven-day working commenced in April 2014 for adult services.

Extended hours began in Buckinghamshire for older adult mental health services at weekends from 1 September 2014 and on weekday evenings from 1 October 2014. In Oxfordshire teams implemented extended hours on the 1 October 2014.

The CMHTs are providing step-up care to assist with admission avoidance. This is provided through an intensive co-ordinated response from the CMHT to hold people through a period of acute mental illness, therefore avoiding admission to hospital.

The duty system has been introduced into the Oxfordshire ILTs and Buckinghamshire multi-agency groups (MAGs) and multi-disciplinary assessment unit. This enables us to support patients in the community and streamline inpatient processes with partner providers.

The urgent care workforce in Oxfordshire now works flexibly, for example, if the Witney Minor Injury Unit (MIU) service faces high demand, EMU will cross cover to ensure patients' needs are managed promptly. The out-of-hours service manages patients with more assertive (intensive) treatment plans and responds to very unwell patients more quickly. Our staff can provide clinical expertise from illness and minor injury to acute cardiac arrest management.

Implement leadership teams in adult mental health wards

All of the adult inpatient wards now have a leadership team in place comprising the ward-based consultant, modern matron and ward manager. The trio are attending the Planning for the Future (PFTF) programme to help build a strong leadership team for the ward. These sessions have been taking place over the last ten months with experts in the field of leadership.

Agree a health plan for every secondary school in Oxfordshire

Health improvement plan templates are in place and have been completed by school health nurses who have been gathering information on their schools, working together with school staff, referencing School Development Plans. These have now been completed and agreed with the individual schools. They have been submitted

to the commissioners, and with some minor modifications they have now been agreed and are in use in schools. The service has already received some feedback about the positive impact of this.

Increase the number of health visitors in line with the national call for action

Our target is 123.6 WTE and we currently have in post 130.4 WTE, so are above our trajectory however this factors in succession planning in light of forthcoming retirements. This is in line with the National Call to Action and we are staffed to the required numbers.

Support the breastfeeding initiative to promote breastfeeding-friendly areas

All the health visiting teams are receiving training in breastfeeding, with the requirement to provide evidence of competence in supporting women to breastfeed. We now have eight trainers. A two day 'Breastfeeding and relationship building' training was run in November and February. A framework for breastfeeding awareness induction for non-clinical staff has also been developed; this will be rolled out now the updated policy is in place. Breastfeeding information is now included in the health visiting section of the Trust website.

Women are able to breastfeed in the drop-in baby clinics, and in most of the sites there is a private space for them if they do not wish to remain in the public room. An audit is under way for the UNICEF breastfeeding-friendly status and will inform the Trust of how many sites are breastfeeding friendly. It includes all sites used to provide services to include health centres, children's centres, and village halls.

Our infant feeding policy has been reviewed in line with updated Breastfeeding Institute standards, and is now approved for use within the directorate and the health visiting teams, and the application for a certificate of commitment has been submitted. The Nutritional Guidelines for under-5s have also been reviewed to ensure compliance with the updated standards and have been approved and published for staff on the intranet. A question regarding infant feeding is now included in the monthly patient survey.

Agree and implement model to offer multi-disciplinary (MDT) assessment to older adults with physical and mental health needs.

A variety of community therapists, district nurses, re-ablement staff and mental health staff have taken part in shared skills training to facilitate multi-disciplinary working. Topics covered to date have been varied and have included:

- pressure area care and simple wound care
- nutritional assessment (MUST tool) and support with nutrition
- supporting patients with eating challenges who have dementia

- awareness of urinary symptoms and collection of urine specimens
- assessment for toileting equipment and simple mobility aids
- positioning for patients with respiratory problems and post-stroke
- supporting patients who have anxiety

Sessions have also supported skills that staff may need to enable them to work more confidently in other areas than their own locality and this also supports the goal of seven-day working.

As part of this objective we set ourselves a measure of success as the number of appropriate older adults with co-morbidities receiving a multi-disciplinary assessment. It has not been possible to gather meaningful data on this measure in 2014/15.

Further development and agreement of the dementia care strategy with partners

Dementia leaders across various mental and physical health services have attended regular training courses and continue to work with Age UK and Circles of Support to provide extended personalised support for patients and families.

We are part of the Dementia Friendly Communities Project in Buckinghamshire giving advice on how to develop dementia-friendly communities. Stokenchurch was launched as the first dementia-friendly community in February 2015. The local community has come together to be trained to ensure that local resources (for example garages, banks, shops) have awareness of people with dementia and can respond by providing a safe place for people to live.

The "Knowing Me" documentation passport has been rolled out across Oxfordshire and Buckinghamshire. The passport has been well received by patients and carers. Further feedback about the Knowing Me passport is being sought from patients and carers with a view to extending its use outside inpatient services and ideally to be provided at the point of diagnosis in memory clinics across Oxon and Bucks.

We have begun discussions with Buckinghamshire agencies to establish a single dementia passport document. This links to the Dementia Care project in Buckinghamshire which is part of the Integrated Care Programme. We are also part of the Dementia Partnership Board in Buckinghamshire which is delivering the Buckinghamshire Dementia Strategy.

The CMHTs in Buckinghamshire are members of the multi-agency group meetings at more than 40 GP surgeries. This ensures all parties share clinical information on frail elderly or frequent attenders to anticipate and prepare for the next episode or contact.

All community hospitals have been adapted to create a "dementia-friendly" environment. Initial feedback from patients suggests this has made a difference as patients can use the wards more independently. A formal evaluation is being undertaken through the "Dignity First" project.

Improve patient and carer satisfaction with services

Indicator or measure	*Data source*	*Purpose of measure*	*FY 1314*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Improving patient and carer satisfaction with services	Friends and Family Test	Ensuring services meet the needs of patients/people close to them	n/a	+33.3 CH +52.2 MIU	+37.5 CH + 80.0 MIU	+ 66.1 CH + 69.1 MIU	+70.7 CH +71.0 MIU	+59.6 CH + 72.5 MIU

Quality priority 4: staff engagement with the quality agenda

We have substantially reorganised our quality governance structures at a Trust and Directorate level. Peer reviews to assess service quality have taken place across all care pathways. Opportunities have been created to bring together staff and Board members, however this requires further work to make it more consistent and frequent.

Our framework for values-based recruitment is now agreed, but we now need to implement and measure the impact of this. We have developed a new risk management process for the Trust, which is working well in some areas, however not all teams have transitioned to the new system.

Staff have delivered a substantial number of improvement activities which have delivered quantifiable benefits in terms of increased time to care and reduction in harm.

This will enable the service to be caring, safe, effective, responsive and well led.

Review and align governance processes to further develop a safety culture where staff notice, respond to and anticipate quality failures by 30 September 2014

Each operational directorate has reviewed their quality and governance structures to allow a greater degree of assurance and to ensure oversight of quality innovations as well as quality failures. The Older People and the Children and Young People Directorates have organised their meetings to reflect the new CQC questions. The Quality and Risk team is working with individual teams and managers to review the information they receive on safety incidents to support a renewed focus on the management of incidents and the use of information to anticipate areas of risk. The intention is to ensure teams and individuals receive feedback as a result of reporting an incident and understand what actions have been identified as a result. The Quality

and Risk team is also monitoring those teams where no incidents have been reported.

The peer reviews[23], which are being organised to enable teams to assess themselves against the five CQC questions, bring together a range of data to allow a 360° view of each service.

Implement values-based recruitment

Values-Based Recruitment (VBR) is when employers seek to recruit staff and students with personal values and behaviours that fit with their organisation. Recent national reports and enquiries have highlighted a gap between the values of the NHS and the quality of care that people receive. This approach aims to ensure that the NHS has the right workforce, with the right skills, and the right values (aligned to the NHS constitution), to support effective team working to deliver excellent patient care and experience.

Value-Based Interviewing (VBI**)** is a structured way to explore examples of work behaviours, focusing on how and why the individual has made certain choices in their work and the attitudes and reasons underpinning their behaviour. By incorporating this information alongside an applicant's experience, skills and competencies, the recruiting manager can gain a wider and more comprehensive view of them. This will enable the Trust to recruit high-performing, effective staff more closely aligned with our values. Organisations have seen improved morale and job satisfaction and a reduction in turnover and agency costs.

The VBI method builds on good recruitment and safeguarding practice. It is not a substitute for good pre-employment checks and sound general recruitment. We conducted a survey with a cross sample of staff to develop a Behavioural Framework. This will form the basis of the values-based interviewing as well as the PDR process. Interview questions have been developed and training will commence in 2015/16.

Identify and deliver opportunities for staff and board members to meet and discuss quality issues and concerns

A number of surgeries are being organised with Executive Directors to enable staff to speak directly to them and raise concerns. Staff are also invited to speak with Board members on specific topics, and Board members undertake quality visits to clinical areas.

[23] A peer review brings together a range of information about a specific service, supported by a visit or visits to the team and clinical area where services are delivered, to make an assessment against a number of specific standards and questions. It is led by staff working in a similar type of service elsewhere.

Review and redesign the risk management process across the Trust to develop and embed a risk-based approach to quality and safety

The risk management strategy and policy was substantially rewritten and approved in November 2014. Training and briefing has taken place across all directorates and services to support them with using the new process. The response has been extremely positive and teams are developing a range of ways to ensure it remains a live and active document for them. As an example, ward managers in the Whiteleaf Centre (adult mental health) are planning to use the Patient Status at a Glance (PSAG) board to enable a daily review of risks and concerns shift by shift, which will formally be reviewed on a weekly basis by the ward leadership team with a view to transferring to the ward risk register as required. The ward risk registers will be discussed each week with the service manager and any risks escalated to the head of service as necessary.

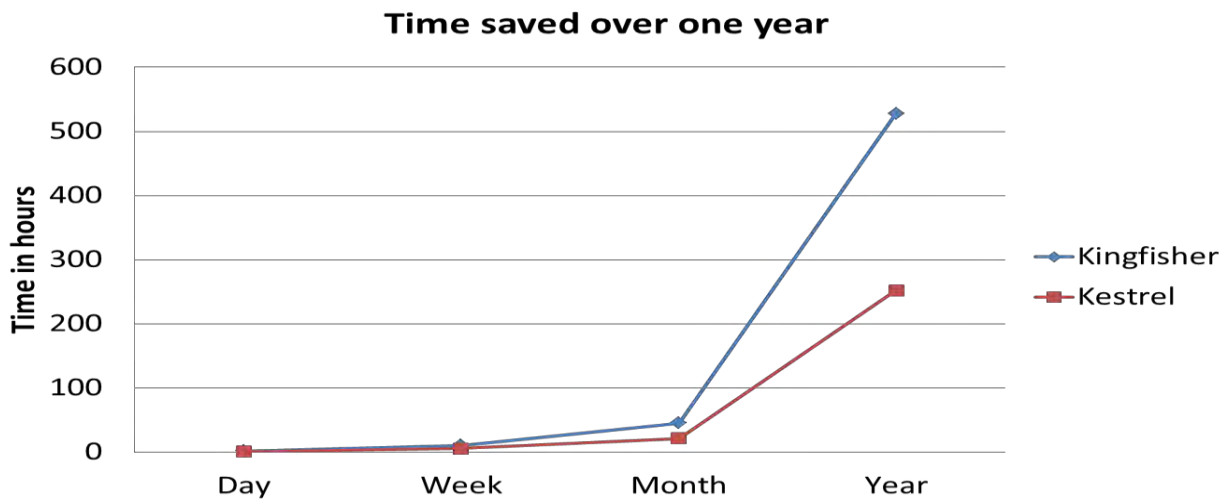
The new process has been the subject of an internal audit process during its initial phase and has been given reasonable assurance. Recommendations have been implemented to further improve how we identify, manage and control risk.

Provide opportunities for staff to engage in improvement activities and projects

Staff have been involved in designing and delivering a vast range of improvement and change projects or schemes some of which are very local and small scale, and some cover a number of areas or teams. Examples include:

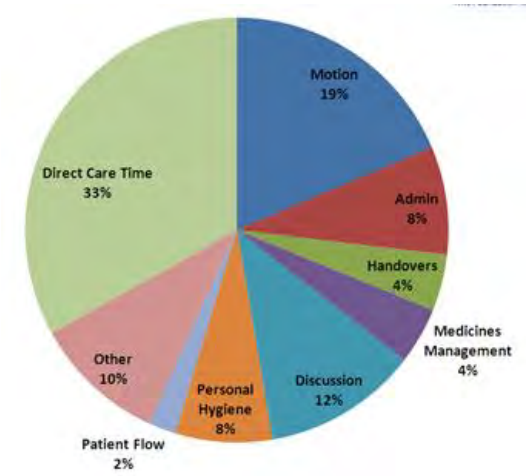
Releasing time to care

Thames House (forensic services) has completed work on improving the efficiency of covering nursing shifts at short notice. The graph below demonstrates the release of time for staff to engage in therapeutic activists with their patients.

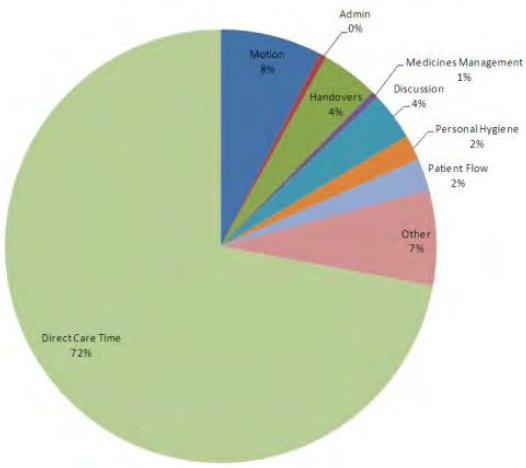


Didcot Community Hospital has achieved the following increase in time to care between 2009 and 2014.

2009



2014



By reviewing all the activities of health care assistants and registered nurses, and finding ways to reduce the time spent on tasks which don't add value, staff on Abingdon Community Hospital Ward 2 managed to increase direct time health care assistants (HCAs) spent with patients by 24% and registered nurses by 5%.

Improving the venous leg ulcer pathway

The community nursing service has adopted PSAG across seven teams in Oxfordshire. At the start of the project venous leg ulcer patients took on average nearly two years to heal from the start of the nursing intervention. The project has achieved:

- 67% of patients are healing by 24 weeks with the aim of reaching and maintaining a healing rate of 70% within 24 weeks
- an improvement in the standard of wound care for all venous leg ulcer patients, quicker, more accurate diagnosis and treatment
- a release of clinical time as fewer district nursing visits are necessary

Improving referral processes

The Continuing Care service has been supported to review all of their processes, enabling a greater clarity of role and a more timely response to referrals and inquiries. This has reduced the average turnaround time for referrals from six working days to two working days.

The District Nurse 'referral into service' form has been reviewed to reduce the number of incomplete referrals and the time spent managing incomplete and inappropriate referrals. Incomplete referrals have been reduced by 68%.

Accreditation of services

Cotswold House, Oxford is working on the Quality Eating Disorders accreditation project. Actions relate to information and communication at all stages of the patient journey.

As part of their work towards AIMS, adult wards are devising a medication competency framework for all registered mental nurses (RMNs). The competency framework is in pilot stage with two wards, with a view to roll-out across all adult wards. The aim of this work is to improve the safety of medication administration and regularly assess the skills of nurses.

Improving the environment and return from leave

Woodlands and Lambourn House have improved the experience of patients returning from leave and the environment for carers and visitors. Lambourn House have introduced an electronic document to record accurately patients returning from leave and have achieved 98% completion. Woodlands secured funds to improve their 'airlock' space and now have a photo board of staff and updated information leaflets for clients and visitors.

Catheter care review

An audit of catheter care was undertaken to identify current practice and levels of knowledge. It was found that there are variations in both areas. As a result the standard operating procedures are being reviewed and a standardised care plan is being developed to support the delivery of care and to ensure best practice guidance is implemented.

Community hospitals medication omissions

A project in community hospitals to investigate medications omissions using root cause analysis techniques has been successful and learning is being shared. Any medication omissions will continue to be monitored.

Urgent care education evenings

The urgent care service is running a programme of education evenings designed to bring services together to discuss best practice and share learning. A recent event focused on urinary tract infection was well attended. The evening was open to all practitioners and providers across Oxfordshire included five presentations from a range of services (including acute, EMU, and GP) considering best practice and management.

Smoking cessation at Cotswold House, Marlborough

Since October 2014, Cotswold House Marlborough Eating Disorders Unit has been completely non-smoking. Previously our patients had the use of a designated smoking shelter in the hospital grounds which presented a number of problems:

- impact on patient health including link to suppressing appetite
- staff time required to accompany patients wishing to smoke
- issues arising from some patients being unable to smoke
- interruptions to care letting patients in and out of the unit

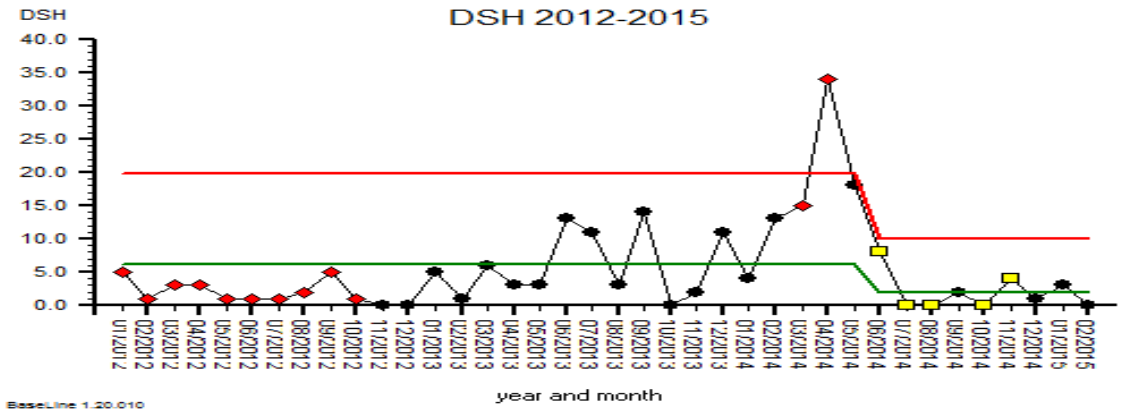
Five members of our team across disciplines trained in smoking cessation and we are able to prescribe appropriate nicotine replacement products. Not all of our patients choose to give up smoking, and they may continue to smoke when on leave, but we provide a high level of support if they do want to quit. Staff time is being used more effectively with a considerable reduction in interruptions. It is easier to manage the amount of time patients have off the ward based on their BMI and physical health, without also needing to consider whether or not they smoke and patients know our guidelines apply equally to all patients.

We extended smoking cessation to all Trust sites on 2 March 2015.

Reducing deliberate self-harm in Marlborough House, Swindon (Tier 4 service)

After reviewing the factors which increased the likelihood of deliberate self-harm, the project tested the impact of having two members of staff in communal areas. This was in response to staff and young people feeling unsafe at times in these areas of the ward. A nurse was rostered 9-5 to attend the case management meetings and to systematically provide feedback to the young person, the family and the ward team within agreed time frames.

Key working and a family nurse role have been introduced and also therapeutic groups for young people who self-harm. The run chart shows a significant reduction in the mean number of self-harm incidents requiring physical intervention since the team commenced their safer care work. Narrative collected from young people during the project has revealed enhanced feelings of safety and that formal observations are now less common on the ward. Staff also report a greater sense of psychological safety.



Implement processes to ensure staff can raise concerns and to monitor actions taken

A revised whistleblowing policy and process has been operating in the Trust since November 2014 and four have been investigated using the new process. All employee relations cases are discussed every week alongside serious incidents, complaints, coroner's reports and other harm reduction information. Outcomes of investigations and any actions are monitored through our governance structure. A review of the whistleblowing policy against the recommendations in Sir Robert Francis' Freedom to Speak Up review will be undertaken through the Well Led Quality Sub-committee.

Implement actions to improve staff wellbeing and motivation at work

The work of the wellbeing group was been shortlisted in the category "**Excellence in Supporting Staff Health and Wellbeing**" as part of the Nursing Times Awards 2014. Some of their activities include:

- **Stress Awareness** - during December including a designated intranet page that signposted staff to useful resources, tips on how to reduce stress and who to contact for further support. Mindfulness sessions and wellbeing days have were held at three sites.

- **Oxfordshire Sports Awards -** the Trust has been named as the most active workplace in Oxfordshire, after becoming a winner at the Oxfordshire Sports Awards, supported by BBC Oxford and Oxford Mail. The award was in recognition of innovation to increase physical activity.

- **OxonBikes -** we entered three bids to Oxfordshire County Council for their Local Sustainable Transport Fund from the Department for Transport in December 2014. We were awarded funding for our main three sites in Oxford: Littlemore, Chancellor Court and Warneford, with a total of 22 bikes being installed. The next steps are to expand the scheme to other sites and look into the addition of electric bikes.

- **Health checks** for 25 members of staff at the Whiteleaf Centre in December with more planned for April. All 25 staff said that they were now more interested in their own wellbeing as a result of their check.
- **Increased access to exercise** over the past twelve months has included health walks which encourage staff to take a break, table tennis tables over the summer, the couch-to-5k running programme and the pedometer challenge.
- **The September pedometer challenge** involved over 450 members and over 50 million steps. Staff feedback shows that they felt it was a great way to have fun with their teams and also made them more aware of increasing the amount of exercise that they do. The next challenge is set for May 2015 (national walking month).
- **Monthly public health campaigns** have included smoking cessation team, oral health and health protection for Stoptober, mouth cancer awareness, stress, and Dry January. Staff have used the campaigns to provide information to patients.
- **H2Go** in January encouraged staff to drink more water and support Dry January (to give up alcohol). The H2Go button signposted staff to useful resources on how much water they should be drinking and tips on how to increase their fluid intake.

Supporting staff through bereavement

Following outcomes of staff surveys and serious incident investigations a working group was established to develop a proposal for supporting staff after critical incidents such as the following:

- acts of actual or threatened violence against staff
- any incident which is particularly poignant or emotionally charged, for example the sudden death of a patient or colleague in adverse circumstances such as suspected suicide
- injury or death to a staff member while on duty
- any incident in which the circumstances are so unusual or the sights or sounds so distressing as to produce a high level of immediate or delayed emotional reactions that overwhelm normal coping mechanisms
- any incident which attracts unusual and intensive media attention

A staff psychological debriefing service, comprising suitably trained staff from all directorates in the Trust was formally launched on 2 March 2015. This service offers facilitated group or individual debriefs between one and two weeks after critical incidents, with an offer of follow-up sessions if required.

Both of the indicators below have dropped since last year and improving engagement and involvement will continue as priorities in the coming year.

indicator	source	frequency	purpose	1314	1415
- ability to contribute to improvements at work	National staff survey	Annual, comparative with previous year's results	Assess staff engagement and motivation	77%	73%
- staff notivation at work				3.90	3.85

Improving access and equality

Using the Equality Delivery System, the following objectives were achieved for 2014/15:

- 'Islam and Wellbeing' Conference with Mind, TalkingSpace and the local Muslim community.
- A 'Bariatric Care' Action Group has been set up to address the diverse range of problems experienced by patients with obesity issues.
- Ensure the patient care record captures data on the nine protected characteristics.
- Raise awareness of psychological therapies available to the community.
- Translation of patient leaflets into twelve community languages.
- A survey of our estate to establish how well it supports accessibility.
- 'Two Ticks' award for a commitment to be positive about disability.
- A new Corporate Accessible Communications Guide.
- A Transgender Equality Guide.

Patient and staff stories

We asked our three directorates to gather a range of patient and staff stories to help us understand what patients value about the care we deliver and what they would like to change. We also wanted to understand how staff feel about what they do, and what helps or makes it more difficult to provide the quality of care they would like to give. This feedback was gathered in a variety of ways: filming patients as they spoke, letters of feedback, surveys and conversations during peer reviews. It is considered alongside all of our other mechanisms for gathering feedback, including audit, FFT, surveys, complaints, concerns and compliments.

Appendix 3 offers a sample of those stories. What is clear is that there are many incidences of kindness, care and compassion from all of our staff which have a significant impact on our patients and those close to them. These include time to

listen to patients and their relatives, recognising when they need support, and patients working with the same clinician or therapist during their therapeutic journey. They also comment that staff seem busy and there are not always enough activities on wards.

Staff feel there is good access to training and development and management and leadership support is improving. However, they reflect that the increase in the number and acuity of patients, and pressures on staffing mean that staff don't always have the time they would like to spend with patients and their families.

Quality priority 5: reduction in harm

Incident reporting has increased again this year, with no overall increase in serious incidents. We did not exceed the commissioner threshold for Clostridium difficile cases. Reported medication incidents have increased since last year reflecting work to improve reporting. The pharmacy team are leading a number of actions to reduce harm from medication incidents.

Suspected and confirmed suicides have reduced by approximately 25% since last year and by 45% since 2011/12. The overall number of AWOLs has reduced but we have not achieved our target of a 50% reduction. There was no harm reported as a result of an AWOL this year. There has been no slight reduction in avoidable pressure damage this year. Skin integrity assessment has maintained last year's figures but there has been a drop in nutritional assessments. There are a range of factors and remedial actions which are detailed below.

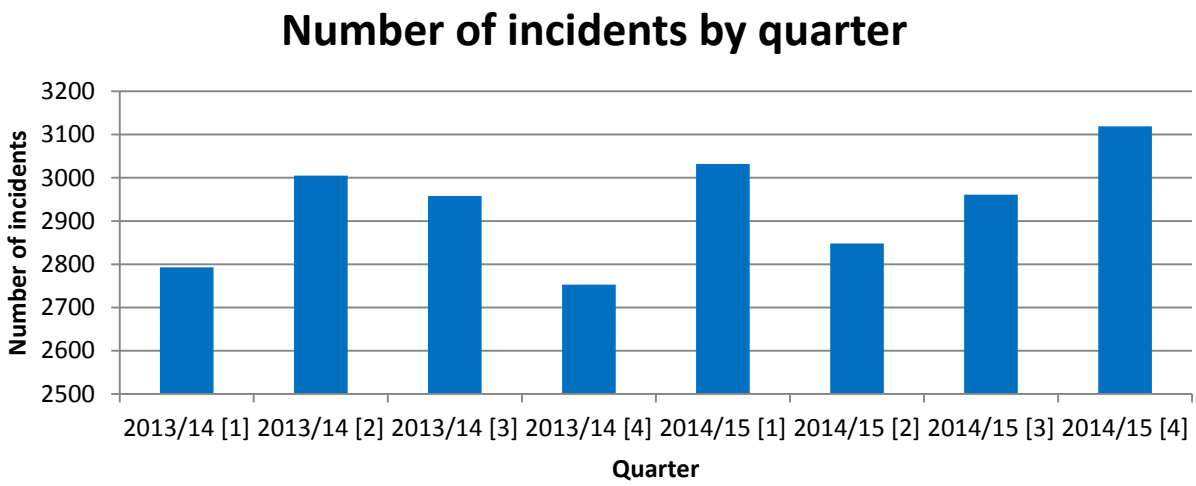
We have achieved our target for reducing the number of and harm from falls in mental health wards. We have not achieved our target for community hospital wards. We plan to improve falls related assessments in the coming year. The number of incidents relating to violence and aggression have increased, however the number of prone and hyper flexion restraints have reduced (the latter by nearly 75%).

This will enable the service to be safe.

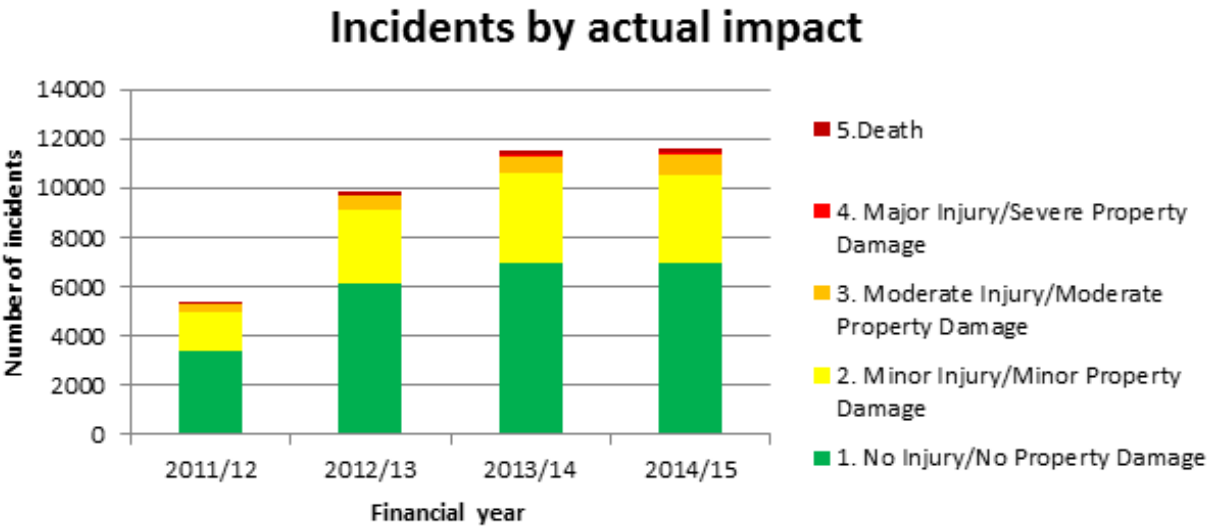
Incident reporting

Over the last four years there has been a steady increase in incident reports. High levels of incident reporting is a key indicator of a positive and open safety culture. Incident reporting has increased from roughly 600 per month in 2011/12 to just over 1000 in 2014/15. The most recent NLRS[24] figures put us in the mid-range for reporting for mental health providers.

[24]National Learning and Reporting System which captures all reported patient safety incidents and provides benchmark data for NHS Trusts



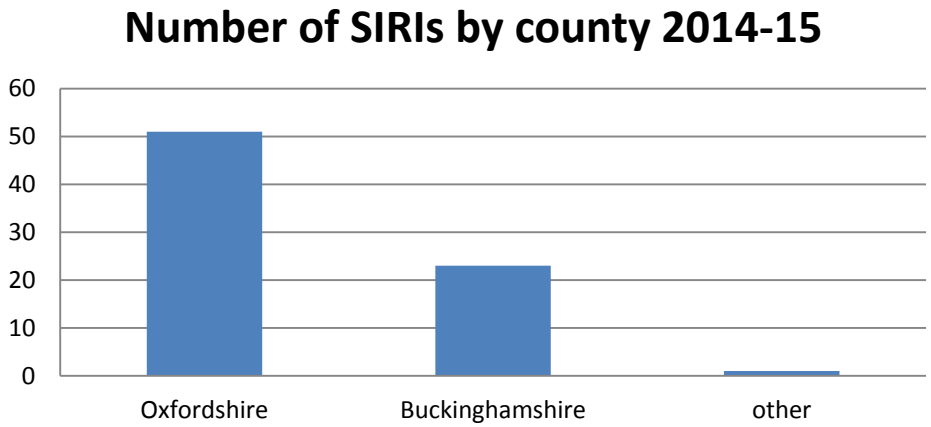
The quarterly reporting figures have ranged from 2717 in quarter 2 to 3119 in quarter 4. The two highest reported incident types were violence and aggression and health (primarily pressure ulcers). Other types of incidents include fall-related, self-harm, security (mainly in relation to patients going AWOL or failure to return to hospital), communication, confidentiality and medication. The numbers of reported green and yellow incidents (low/minor injury or property damage) continues to represent by far the highest proportion of total reported incidents.

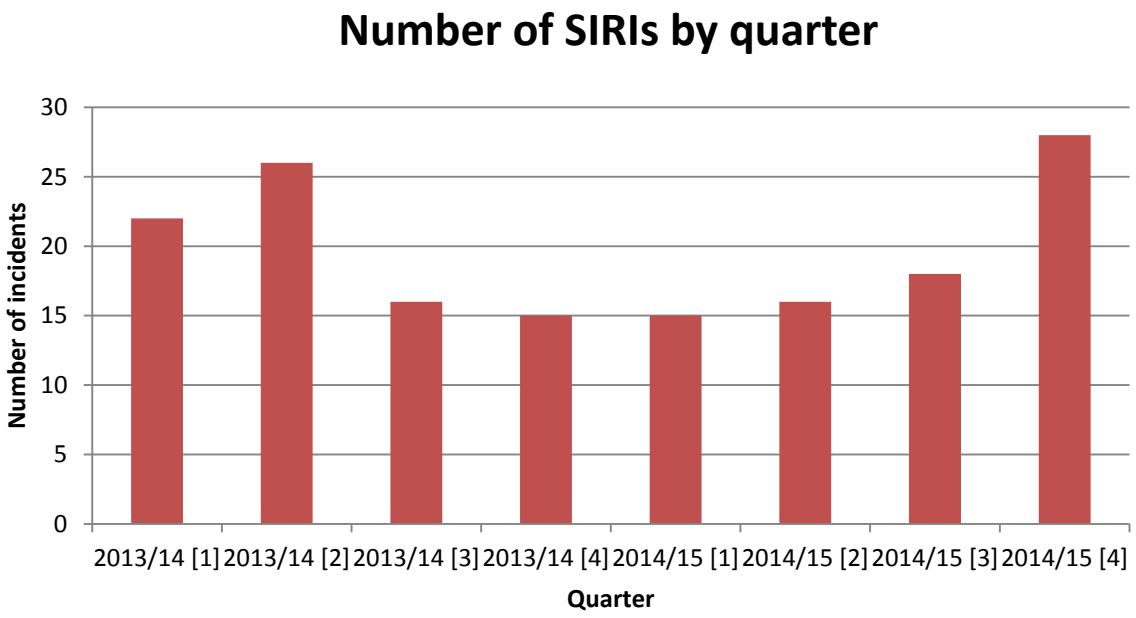


The number of SIRIs we are reporting has remained broadly stable over the last two years sustaining the significant reduction from 2012/13. In 2014/15 there were a total of 75 SIRIs reported with the highest number over the last two years occurring in Q4 2014/15. Both adult and older peoples' directorates saw a spike in these incidents in this quarter. The adult directorate saw the third consecutive quarterly increase and the older people's directorate saw a sharp rise after the previous three consecutive decreases in SIRIs.

There have been no never events or inpatient deaths by suicide.

Oxfordshire services were the highest reporters of SIRIs in 2014/15. This is largely to be expected as all of our community physical health services are located in Oxfordshire and the number of patients using our Oxfordshire-based services is considerably higher. Overall the numbers of SIRIs reported in Oxfordshire were lower and in Buckinghamshire higher than in 2013/14.





Learning from SIRIs

We use a number of approaches to learning from SIRIs including team briefing, local and Trust-wide learning events, and through relevant committees, groups and team meetings. Key themes from 2014/15 which have resulted in improvement actions have included:

- Involvement of carers with care planning at discharge from inpatient services.

- Discharge planning in general and in relation to communication between different parts of the service; also issues with communication and transfers of care.
- Assessment, recording and care planning of risk including crisis and contingency planning.
- Documentation.
- Lack of co-ordinated care, forward planning and communication issues, named nursing, care planning and documentation, training and staffing issues, management of capability, lack of supervision and leadership in community nursing.
- Lack of comprehensive recording of physical observations on the early warning score and noting of patients' refusal to have their observations taken.

We also found many examples of good practice during investigations, including:

- good liaison within and between teams and external agencies and clear evidence of effective multi-disciplinary team involvement in care and multi-agency working.
- timely responses and assessment by AMHTs to referrals from GPs including same day response to GP referrals and thorough assessments.
- collaborative, flexible and responsive working between teams and with patients. This included good practice in relation to timely and consistent step up care, contact with care co-ordinators and effective management of transitions along pathways.
- assertive follow-up following non-attendance for appointments.
- evidence of swift, appropriate and supportive interventions at times of crisis.
- ongoing high levels of community support after discharge.
- good review and management of physical health concerns.
- evidence of good communication with carers with a couple of notable individual interventions by staff.
- strong leadership.
- timely provision of pressure ulcer relieving equipment, involvement of tissue viability and in one case a notable example of whole team engagement in post incident learning with a culture of staff able to escalate concerns in community nursing services.

Improvement actions have included:

- remodelling of mental health services leading to a reduction in transitions from team to team and agreed model of care for inpatients and community services.
- development of Standard Operating Procedures
- revised discharge policy
- improved staff debriefing after serious incidents
- protocol on managing patients found smoking on wards reviewed (forensic).
- standards of documentation.
- identifying what other services the patient is accessing and their key contacts.
- identifying parental responsibility and that patient consent sought and explained.
- ensuring clear information is given to carers regarding patient's medication and risks.
- updating leaflets and website information

Infection Prevention and Control

Indicator or measure	*Data source*	*Frequency of reporting*	*Purpose of measure*	*Baseline 13/14*	*Q1 2014/15*	*Q2 14/15*	*Q3*	*Q4*	*FY 1415*
No more than 8 cases of CDI	Ulysses	Quarterly	Measure preventable infection		1	2	1	3	7
0 MRSA/MSSA	Manual	Quarterly	Measure preventable infection		0	0	0	0	0
E. Coli bacteraemia	Manual	Quarterly	Measure preventable infection		4	7	2	1	14
Bare below the elbow	audit	Quarterly	Prevent infection		96%	97%	97%	97%	97%
Hand hygiene	audit		Prevent infection		97%	96%	96%	97%	97%

The 2014/15 threshold for Clostridium difficile cases in community hospitals has been set at eight. This target contributes to the overall health economy target. Six were in community hospitals in Oxfordshire and one was in an older adult mental health ward in Buckinghamshire; all seven cases have been peer reviewed and assessed as unavoidable.

All E.Coli cases, the vast majority of which are pre-48 hours and community acquired, have had a thorough root cause analysis completed and any learning points identified and discussed within the service. These infections require mandatory reporting but do not have a target.

Cleanliness and infection control is monitored quarterly via the infection prevention and control (IPCT) and governance team. Overall, areas are demonstrating good compliance with this outcome, except the numbers of staff trained in infection prevention and control remain below the target of 90% at 82%. Training is also available via the e-learning programme and work book for staff to access. There are also some concerns regarding audit results and decontamination record keeping.

Environmental audits continue to demonstrate good compliance with infection prevention control standards.

Improving medicines management

NHS England and the MHRA have mandated that organisations must have a nominated individual with responsibility to support medicines incident reporting and learning. This role, the Medication Safety Officer (MSO), is held by the lead pharmacist. The MSO has established the Medicines Safety and Governance Group to focus on implementing and monitoring Patient Safety Alerts, reporting and learning from medicines incidents, education and training needs around medicines safety, medicines policy and practice, and overview of the safe and secure handling medicines audit programme.

The Medication Safety Officer has oversight of all medication incidents in the Trust, and inputs at individual level as well as monitoring trends and patterns which may identify more systematic and underlying factors. Directorate lead pharmacists work with their respective governance teams to improve medicines safety.

The Trust has introduced a medicines management e-learning programme, which is part of staff PPST. This will help ensure safer practice around medicines. Pharmacy is involved in regular audits, for example the controlled drugs audit, medicines management audit and antimicrobial audit. Audits of specific high-risk drugs such as anticoagulants and insulin are also underway.

Pharmacy have recently been successful in securing a small amount of funding from the Patient Safety Federation to develop safe medication pathways between care settings, plus funding from Higher Education Thames Valley (HETV) to evaluate medicines management in urgent care. Initiatives around medicines safety continue within the Safer Care Programme, particularly around reducing delayed and omitted doses and medicines reconciliation.

We are working hard to increase the level of reporting of medication incidents whilst reducing the overall level of harm. We have increased reporting over the year but the proportion of harm has increased by 0.65%.

Indicator or measure	*Data source*	*Frequency*	*Purpose of measure*	*Baseline 13/14*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Number of medication incidents and rating of harm	Ulysses	Quarterly	Measure reporting and reduction in harm	1009 (15 rated 3 and 1 rated 4)	272	303	247	299	1121 (24 rated 3 for impact)

5a: prevention of suicide

Agree suicide awareness and prevention strategies in teams across the trust and review the impact on practice, benchmarking against other providers for common indicators

Suicide awareness training has been delivered to staff across mental health and community health services, using a bespoke model. In addition, training has been provided for mental health nursing students and some health and social care partners. The training covers epidemiology, clinical and social risk factors, lived experience and staff experiences of working with suicide risk. The Interpersonal Theory of Suicide (Joiner 2005)[25] has been introduced in all training to offer a framework to help guide staff thinking, assessment and intervention and to help evolve a shared understanding of suicide across the organisation. Follow-up reflective practice sessions explore practice and complex cases, with which some teams are continuing to engage.

In October Dr Thomas Joiner, the originator of the Interpersonal Theory of Suicide, visited our Trust and delivered lectures to a number of our staff.

Around 400 staff have received training to date (exceeding the target to train ten teams over the year) and it has been agreed that dedicated suicide awareness training should continue to be offered to mental health and community staff. The interpersonal theory of suicide has been incorporated into the clinical risk assessment and advanced assessment skills training.

Evaluation has relied on a self-reported effect of training on knowledge, understanding and confidence in relation to working with suicide and has been positive.

[25] The Interpersonal Theory of Suicide (Joiner 2005 looks at recognising the point or trigger(s) where desire becomes intent and capability in order to help staff differentiate between patients who think about suicide (ideation) and those who are likely to attempt suicide.

Implement recommendations and share learning with safeguarding children's boards from OHFT internal report into children's and young people's suicide

A review was undertaken to examine unexpected deaths by possible suicide of young people under the age of 18 years during the period 1 April 2010 until 31 December 2013 across the geographical area served by OHFT.

During quarters 2 and 3 learning has been shared with all five Local Safeguarding Children Boards with which the Trust works, within the Trust and with our partners in order to increase awareness of risk factors associated with suicide, improve identification of at risk young people and to explore how practice can be improved to increase their safety.

Reduction in probable suicides in community and inpatient services

This year there has been a further reduction in the total number of suspected and confirmed suicides reported. This is the fourth reduction in as many years. The first three quarters were below the median for the last three years, however quarter four has seen an increase in the rate reported. The majority of these deaths are reported in the adult mental health teams, which is to be expected. During this period both Chiltern and Aylesbury AMHTs in Bucks have been reviewed and a number of operational pressures have been identified. Plans are in place within the directorate to help address these concerns.

The table below shows the days between suspected suicides in individual adult mental health (community based) teams where a suspected suicide occurred in 2014/15. There have been no inpatient suicides in 2014/15.

Teams which have achieved 300+ days between suspected suicide	Incident date	Days between incidents
North and West Bucks AMHT	12/05/2014	322
North West AMHT	21/09/2014	439
OA North CMHT	21/02/2015	536
Bucks IAPT (Healthy Minds)	09/03/2015	551
Talking Space	24/11/2014	635
South Oxon PCAMHS	21/08/2014	Over 1238[26]
OA Wycombe CMHT	12/03/2015	Over 1238
Teams which have not achieved 300+ days between suspected suicide	**Incident date**	**Days between incidents**
Community Drug and Alcohol Team	24/03/2015	5
Aylesbury AMHT	20/01/2015	12
Chiltern AMHT	27/03/2015	38
City and NE AMHT	18/01/2015	83
South Oxon AMHT	07/12/2014	125
Prison In Reach Team (HMP Bullingdon)	24/06/2014	162

[26] The teams with over 1238 days between incidents have not reported an incident since the beginning of FY 11/12.

5b: reduction in the number of missing patients from inpatient services

Review and evaluate absence without leave (AWOL) projects in three wards

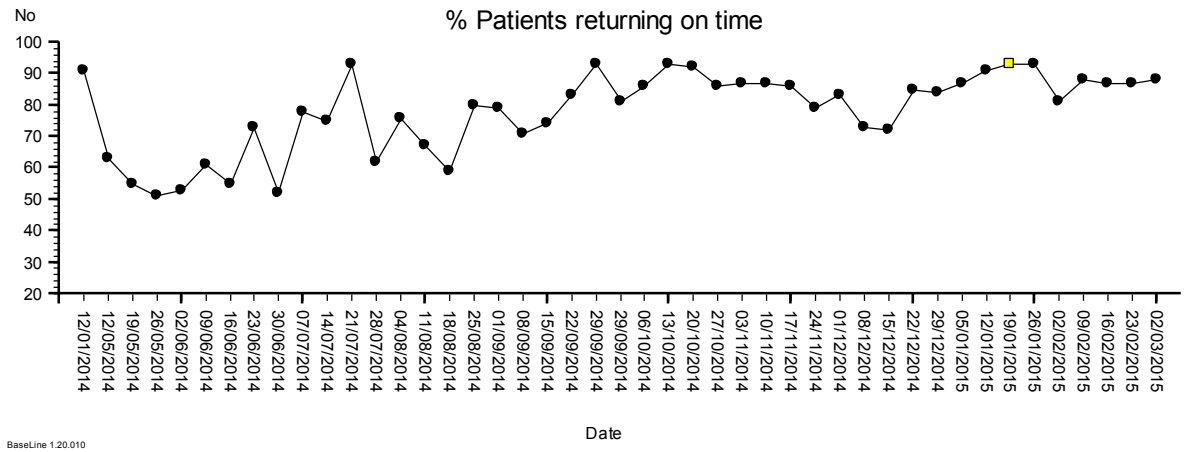
Patients detained under the Mental Health Act who absent themselves from hospital without the written authorisation of the responsible clinician, or who fail to return from authorised leave of absence at the required time (including failure to return within ten minutes following planned leave), or absent themselves from a place where the responsible clinician requires them to reside are deemed to be AWOL.

Patients who fail to return on time from leave and time away project: adult wards

This project continues and has now extended to include all adult acute and rehabilitation wards in the Trust. The focus of the work is to ensure that a philosophy of care and safety underpins the leave and time away process, rather than a security focused process.

Each PDSA[27] cycle has been discussed with patients in ward community meetings. The PDSAs include planning for leave during ward reviews, the provision of patient information for both detained and informal patients developed in collaboration with the CQC, a change to policy guidance, the offer to patients of a ward card with leave details and ward contact numbers, and a range of information posters. A signing in and out book affords nurses and patients the opportunity to discuss their leave or time away agreements and to discuss how leave went upon return. Intentional rounding has been implemented to check the leave status of all patients every hour on the ward. The data chart below shows progress on Allen ward (adult acute).

Allen ward

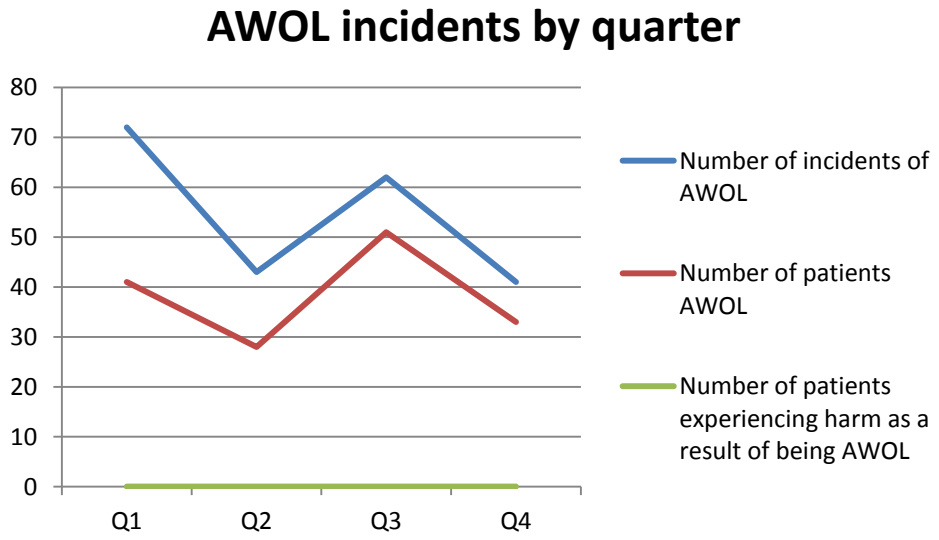


Chaffron Ward is continuing to monitor the days between AWOLs for the safer care project and this stands at 483 from the start of the project. Opal Ward has improved the percentage of patients returning on time to 93%.

[27] Plan, Do, Study, Act (PDSA) is a structured approach to testing out small scale changes and improvements

All adult wards are engaged in the project to test interventions to ensure that patients return from time off the ward at the agreed time, and safe and well. Phoenix Ward provided the first test site and introduced systematic tests of change using Institute for Health Improvement methodology including the use of a signing in and out book, multi-disciplinary discussion with the service user on the therapeutic aims of leave and the time required to achieve these, cards with ward contact details and agreed time of return, and intentional rounding to check safe return. The ward initially improved the rates of return on time from 30% to 74%. With further consolidation, the ward is now sustaining 93% of service users returning to the ward on time.

Overall the number of AWOLs has decreased in 2014/15, both number of incidents and number of patients. While we have achieved a 50% reduction in some areas, we have not achieved our overall target reduction of 50%. There have been no incidents of patients experiencing harm as a result of being AWOL.



Indicator or measure	*Data source*	*Purpose of measure*	*FY 1314*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Number of incidents of AWOL	Ulysses	Measure reduction in AWOLs	229	72	43	62	41	218
Number of patients absent without permission	Ulysses	Measure number of patients generating incidents	174	41	28	51	33	153
0 patients[28] to experience harm (rated 3, 4 or 5 in impact) as a result of AWOL	Ulysses	Measuring reduction in harm from incidents of absence without permission	2	0	0	0	0	0

[28] Three incidents rated as 3 for impact (Q1, 3 and 4) but this was damage to property

5c: reduction in the number of avoidable pressure ulcers

There has been no change in the number of avoidable pressure ulcers reported in 2014/15 compared to the previous year which means we have not achieved the required reduction in avoidable grade 3 and 4 pressure ulcers this year. Prevalence of all pressure damage has reduced recently, as indicated by safety thermometer data. However, the prevalence of new pressure damage remains high in comparison to the national figures for all NHS trusts.

Every category 3 and 4 pressure ulcer is assessed using a regional avoidability tool, which includes a full review of the patient notes and of compliance with procedures and policies. The main themes that have been identified following investigations include:

- missed opportunities to complete in-depth risk assessments and to support risk assessments with comprehensive care plans
- regular and routine review of risk assessments and care plans

Staffing levels and capacity of teams have also been highlighted as contributory factors in avoidable incidents. Improvement actions have included:

- improved 1: 1 supervision and group clinical supervision for teams
- support for new starters with additional assistance from clinical practice educators
- PSAG boards to alert teams to high-risk patients
- documentation audits to encourage ownership of records by teams
- weekly meeting to discuss issues in the caseloads for all clinical staff
- introduction of pressure damage prevention core competencies for registered nurses and assistant practitioners at level 4

Review skin integrity assessment tool and agree options for replacing the Walsall assessment tool

The skin integrity assessment tool was reviewed and the Braden tool[29] which is recommended by NICE and is the most validated and reliable risk assessment tool available was identified as the replacement for the Walsall assessment. The Braden

[29] The primary aim of this tool is to identify patients who are at risk of developing a pressure ulcer and to determine the degree of risk. The Braden Scale is made up of six subscales, which measure elements of risk that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. These are: sensory perception, moisture, activity, mobility, friction, and shear. Each item is scored between 1 and 4, with each score accompanied by a descriptor. The lower the score, the greater the risk. It is being adopted because it is considered to offer better inter-rater reliability and to enable OHFT risk assessments to be consistent with Oxford University Hospitals NHS Trust which currently uses the Braden tool.

assessment is part of the standard documentation for community nursing and this is being supported by a Braden and equipment e-learning package due in May 2015. The Older People Directorate has also developed a tissue viability resource (expert) nurse role within the district nursing service.

The Braden tool was implemented in partnership with Oxford University Hospitals NHS Trust to ensure uniformity in risk assessment and management of care. Prior to discharge a bundle of 'always actions' will be carried out which includes a discussion with the patient and their carers about the pressure ulcer risk and any self-management strategies; sharing a patient information leaflet; ordering equipment and explaining the equipment to the patient.

Skintelligence

The Skintelligence programme commenced in October 2014 utilising methodology from the Institute of Healthcare Improvement service to undertake local interventions that reduce the harm caused to patients' skin as a consequence of pressure. A total of 34 participants, representing twenty teams from a range of older adult services have engaged in activities in partnership with local nursing and residential homes.

Agree and pilot a set of appropriate and reportable indicators to support pressure damage harm reduction projects

During 2014/15 the indicators measured to support the reduction of pressure damage focused on compliance with the completion of appropriate risk assessments. The risk assessments are the skin integrity risk assessment and the nutritional status assessment which when completed indicate appropriate interventions for each patient to prevent pressure damage.

The Fulbrook Ward staff have started collecting data and are using a safety cross to record any skin damage. The random testing of five sets of notes to check all have a risk assessment in place started in October and this will happen weekly to establish a baseline and next steps.

Work has commenced using an initial *Ask five staff* if they know what to do if they see any pressure damage and how they implement further interventions. Each ward has already identified one patient who is at high-risk and are testing out different ways to encourage staff to use the SSKINS model. They are adapting the notes template and a member of staff has created a poster on avoiding skin damage as a prompt for staff. Next year we start to measure days between pressure damage in individual teams.

We have not achieved 100% of patients receiving skin integrity assessments, although in the last two quarters the figure has increased to 97%. We have also not

achieved 100% of patients having a nutritional status assessment and this is generally lower than last year.

Indicator or measure	*Data source*	*Purpose of measure*	*Baseline 13/14*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Number of patients with avoidable pressure ulcers graded 3-4 (target 0)	Ulysses	Measure reduction in avoidable pressure ulcers	13[30]	3[31]	2	4	4	13
100% of patients managed by district nursing service to have skin integrity risk assessment on 1st visit	audit	Reduce risk of avoidable pressure damage	96%	93%	93%	97%	97%	95%
100% of patients managed by district nursing service to have nutritional status assessment on first visit	audit	Reduce risk of avoidable pressure damage	93%	86%	86%	80%	87%	85%

Case study: embedding the use of patient status at a glance (PSAG) to improve venous leg ulcer (VLU) healing rates in district nursing services

A recent pilot of the VLU pathway showed greatly improved healing rates for patients with use of the pathway which in turn reduces their pain and improves their quality of life. As a result of this project five patients were added to the VLU pathway and PSAG:

- One healed within eight weeks
- Two undiagnosed diabetics identified
- Principles of the VLUP followed for 11 mixed aetiology or non-concordant patients leading to:
  - Two patients achieving a 40% reduction in six weeks
  - Three patients healed
  - One patient agreeing to full compression

[30] This figure has changed from last year reflecting the refreshing of data to take account of potential SIRIs which were downgraded by the CCG.
[31] This figure has changed as one SIRI was appropriately reallocated to Q4 1314 when the incident occurred.

5d: reduction in the number of patients harmed by falls

Implement and evaluate a falls harm reduction project in Sandford Ward

Falls risk assessments are completed across the mental health wards on admission, after a fall and after 28 days. We have also introduced:

- two-part falls assessment and agree documentation to be included in falls booklet
- falls awareness training is now available via an e-learning package
- lunchtime falls awareness training delivered across older adult mental health services

When we monitor patient falls, significant contributory factors include cognitive behaviour and decline, the absence of documented effective and in-depth care planning and non-application of appropriate controls following completion of risk assessment.

Local actions taken to address these themes include:

- compliance with falls awareness training within the agreed timeframe
- support to carry out an audit of care planning on the ward
- training in the correct assessment and understanding of the interventions recommended in NICE Guideline for urinary symptoms in females
- all grades of staff have access to the learning around delirium that is planned for ward doctors and nurses

Patients have access to interventions such as Tai Chi classes and physiotherapy support to improve balance. The falls team have promoted the referral process with all teams to raise awareness and ensure consistent referrals are made. Currently an older adult mental health patient is referred to the falls service after one fall, rather than two as is the procedure in community hospitals. This change was implemented to help address the falls rate in older adult mental health wards which has decreased substantially. In addition, all patients are receiving physiotherapy assessment irrespective of mobility issues, which has increased effective screening.

Agree a set of appropriate and reportable indicators to support falls harm reduction projects

The safer care collaborative measure is to reduce harm from falls by 50%. There has been a consistent reduction in harm from falls in the past two quarters, with a 30% reduction in harm since last year in mental health services (Q4 compared with 1314 full year figure). However, the number of falls and level of harm has increased in community hospitals.

Our falls audit collates data on patients in older adult inpatient services to have a falls risk assessment on admission, patients having a falls risk assessment after 28 days and completion of a review of patients' care plans after a fall. This was introduced during Q4. The audit will be carried out quarterly during 2105/16.

Indicator or measure	Data source	Purpose	Baseline 13/14	Q1	Q2	*Q3*	*Q4*	*FY 1415*
Number of falls (with harm rated as 3, 4 or 5 by 1000 mental health bed days (target 3.8/0.2)	Ulysses	Measure reduction in harm from falls	4.8 MH (harm 0.3)	4.4 (0.2 harm)	5.1 (0.6 harm)	4.1 (harm 0.2)	1.2 (harm 0.1)	3.7 (0.3 harm)
Number of falls (with harm rated as 3, 4 or 5) by 1000 physical health bed days target 8.6/0.2	Ulysses		10.6 (harm 0.3)	11.9 (harm 0.5)	10.5 (0.7 harm)	15 (0.4 harm)	12.9 (0.4 harm)	12.6 (0.5 harm)
100% of patients in older adult inpatient services to have falls risk assessment on admission	audit	Reduce the risk of falls	87.75%	99% CH	n/a	95% CH	91%	95% (based on 3 data points)
100% of patients in older adult inpatient services to have a falls risk assessment after 28 days	audit	Reduce the risk of falls	Baseline set Q1	Data from Q4	Data from Q4	Data from Q4	60%	60% based on 1 quarter's data
100% of patients to have a care plan review after a fall	audit	Reduce the risk of falls	Baseline set Q1	74% CH	n/a	68% CH	65% CH+ OAMH	69%
100% of patients to be referred to falls service after 2 or more falls	RiO	Reduce the risk of harm from falls	Baseline set Q1	n/a	MH 30% CH 70%	n/a	MH 43% CH 63%	MH 37% CH 67%

5e: reduction in violence and aggression

Implement a revised training programme for prevention and management of violence and aggression (PMVA)

The project to review the Trust's PMVA (prevention and management of violence and aggression) training has recently been completed. This is in line with the DoH publication *Positive and Proactive Care: reducing the need for restrictive interventions* (April 2014). This is part of the government-led initiative called *Positive and Safe*

which is a two-year project to change the approach to managing challenging behaviours in health and social care settings.

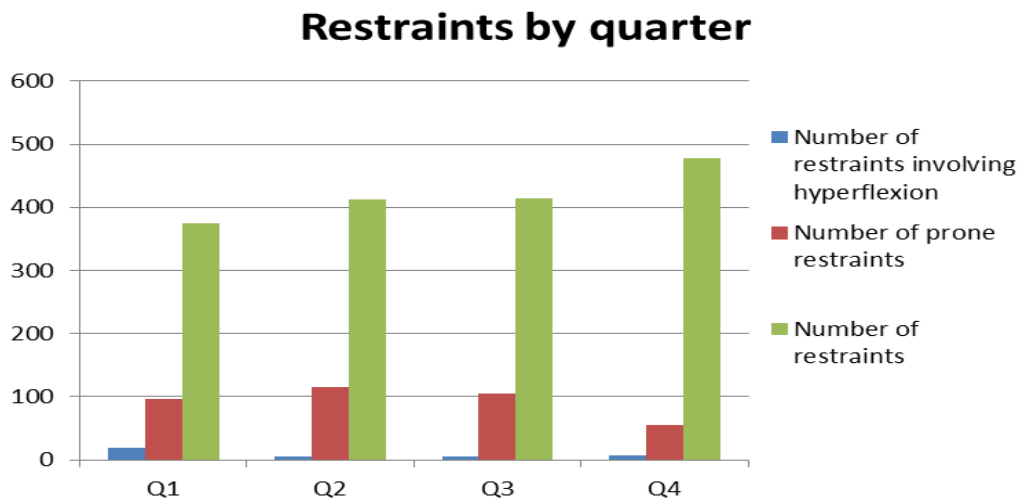
The outcome of this project was to develop a new training programme which has been named positive engagement and calm environments (PEACE). We will start training teams in the summer of 2015. A new group has also been set up to oversee the programme to reduce restrictive interventions, to monitor the use of restraint, seclusion and rapid tranquilisation and initiatives to improve the mental health wards as therapeutic environments.

The Highfield Unit has implemented a project co-ordinated by the Safer Care team to reduce the incidents of serious violence and aggression leading to prone restraints. Their initial target in March 2014 was achieved, and the second target was to reduce incidents of violence and aggression by a further 25% by March 2015. To support this they implemented a sensory assessment and care plan focused on how patients manage when feeling overwhelmed and distressed. The occupational therapist has been involved in assessing new admissions and the case team have been reviewing the assessment, formulating a care plan together and liaising with parents. Patients have welcomed the use of a sensory ladder which communicates to the team how patients are feeling and what may help in that moment. The overall level of prone restraints has steadily decreased.

Sandford Ward is currently completing an audit to measure the number of restraints occurring on the ward, to compare with the numbers reported on incident forms. There has been a successful reduction in incidents of violence and aggression on Watling Ward (medium secure forensic service) as part of safer care work.

Report on and reduce the number of avoidable prone restraints (where the person is face down) and use of hyperflexion (holding the arm to restrain)

The graph below shows the number of restraints per quarter, including the number of restraints involving hyperflexion and prone restraints. Although the overall level of restraints has increased over the four quarters, the proportion of both prone restraint and restraints involving hyperflexion has decreased.



Indicator or measure	*Data source*	*Purpose of measure*	*FY 1314*	*Q1*	*Q2*	*Q3*	*Q4*	*FY 1415*
Reduce by 25% number of reported incidents of violence and aggression with harm (3, impact 3/4/5)	Ulysses	Measure reduction in incidence of violence and aggression	28 (incidents in our inpatient units only)	20 (all incidents)	22	14	13	69
Number of prone restraints/all restraints (target towards 0)	Ulysses	Measure reduction in incidence of prone restraints	392/1464	97/375	116/ 412	105/ 415	56/ 477	374/ 1679
Number of restraints involving hyperflexion (target 0)	Ulysses	Measure reduction in incidence of hyperflexion	146	20	5	6	8	39

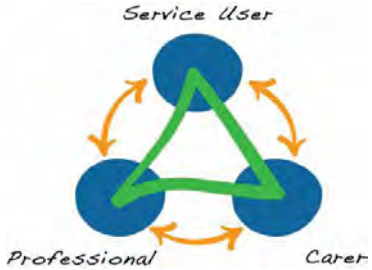
Quality priority 6: implement the patient experience strategy

We achieved the majority of our objectives, with the exception of developing a web page to share feedback. We are working with local organisations including Healthwatch Oxfordshire to improve how we share and respond to feedback and some of the actions we have taken as a result of feedback can be found in the section below.

This will enable the service to be caring and responsive.

"Seeking and acting on patient feedback is key to improving the quality of healthcare services and putting patients at the centre of everything we do."

Our patient experience strategy is co-ordinated through a Trust-wide group. The purpose of the strategy is to deliver a range of quantitative and qualitative approaches to collect and ask for feedback, to collect and share patient stories, and to describe actions taken at a team and clinician level to address patient concerns.



We have also established an organisation-wide carer's strategy forum chaired by the Chief Operating Officer to oversee the achievement of the Carers Trust 'Triangle of Care' external accreditation. The forum is made up of representatives from carers, staff from each directorate, voluntary organisations, and the county councils.

Develop a web page to share feedback and how this has been learned from and acted upon

We have not achieved this objective this year; however we have used a variety of mechanisms to share learning and actions internally. We are also participating in a new quarterly whole system meeting facilitated by Oxfordshire HealthWatch to discuss and share quality issues being raised by patients and the actions each organisation is taking as a result.

90% of teams to be collecting feedback on patient experience feedback and 50% of teams to demonstrate they are listening to and acting on feedback

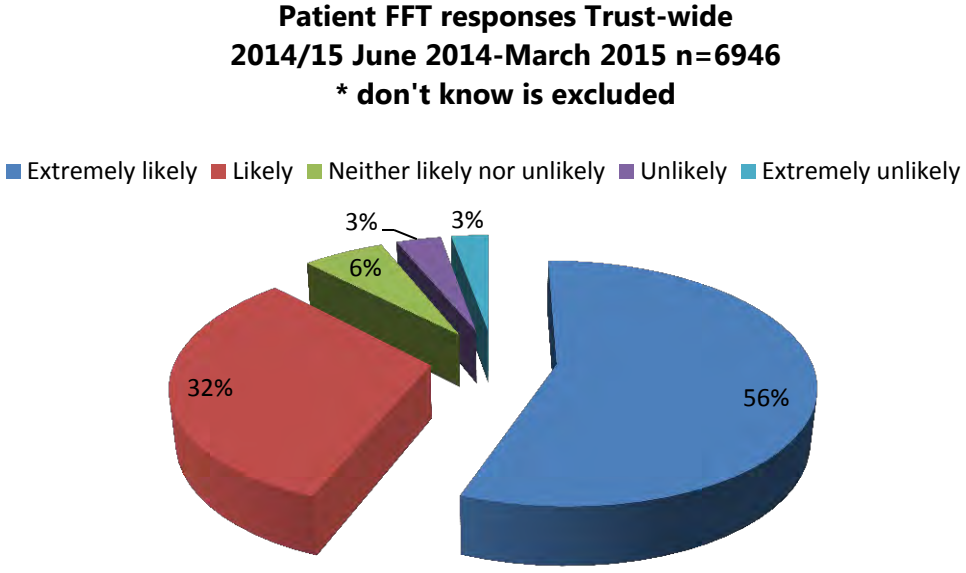
Every service is now collecting feedback and it is possible to evidence the mechanism of this and the action taken as a result. Patient experience leads are reporting on themes and improvement actions through the patient experience group and in reports to the Quality Committee and Board.

In the recent national staff survey (1646 responses, 32% response rate):

- 74% of staff said yes patient experience feedback is collected within their team (national average 79%)
- 55% said they receive regular updates on patient feedback (national average 56%)
- 57% said they feel feedback from patients is used to make informed decisions within their team (national average 53%)

Roll-out of the Friends and Family Test across all services

This year we expanded our Friends and Family Test to include our mental health services. The following chart shows the response to the question *how likely are you to recommend our service to friends and family if they needed similar care or treatment*.



Introduce a system for capturing patient and staff stories

Each of three directorates has spent time speaking to patients and staff to capture their views and experiences of receiving and delivering care. We have filmed patients and staff talking; we have gathered views during care planning and reviews; we have sent anonymous surveys; we have spoken to patients and staff during peer reviews; we have invited patients and carers to training and learning events and we have invited staff to attend Trust Board and committee meetings. Patient stories are now heard at the start of our Board meetings. Some of these stories can be found under Priority 4.

Online feedback forums (iwantgreatcare, Patient Opinion and NHS Choices)

Since the Trust has changed its approach to managing and responding to online feedback forums we have received an increase in the number of postings between July 2014-Feb 2015. The forum most often used has been NHS Choices. From April 2014 to February 2015 (n=34), eighteen postings have been positive, thirteen postings have been negative and three mixed with both positive and negative feedback; no themes have been identified. The majority of postings are about the minor injury units and all postings have been responded to within a week to open a dialogue with people.

Acting on patient feedback

Gathering patient feedback is only the start of the journey. What is important is how we respond to that feedback and what actions we take as a result.

Team	
Adult Acute Wards	**You said** there were a lack of activities across a series of wards. **We have** reviewed and changed the type of activities available and staff are being asked to promote the weekly timetable.
Adult Mental Health Teams	**You said** we want to know about how we can be involved in services. **We have** set up service user forums aligned to each AMHT. The more successful forums have promoted and gained a large representative of service users. Through these forums there has been positive feedback about the recent changes.
Forensic Wards	**You said** it is taking a long time to recruit staff, it is difficult to contact family and friends if mobile phones are not allowed, families live far away and can't visit, curfew time should be extended and you can't order items over the internet as you are unable to use debit cards. **We have** involved patients in recruitment, developed with patients, for patients to have basic mobile phones (no camera or internet access). The pilot is running for six months from Jan 2015 before rolling out to other areas if successful and problem free. Service users can use Skype as a means of contacting loved ones. Curfew time has been extended to 8pm and is regularly reviewed. Payment cards are now available for people that wish to have them.
Psychological Therapy Service	**You said** you were unhappy with waiting times and services accessibility for assessment and treatment and with the choice and availability of these and there were technical problems with appointments by telephone and using electronic

Team	
	education packages. **We have** started monitoring weekly waiting times and monthly DNA rates, informing patients in writing about the expected wait to treatment, offering courses after 6pm, working with the telephone provider to improve call quality and discussing treatment choices with the patient to identify the most appropriate treatment.
Children and Young People's mental health services	**You said** information about services and how to access can be difficult to find and we don't understand some of the terms used by the teams, for example consent and confidentiality. **We have** developed a new website and more user-friendly information in consultation with young people and parents as well as professionals and each service will have a nominated champion who will be responsible for keeping their service information up-to-date on the website. We have also installed TV screens at a number of team bases to improve information for patients waiting for appointments.
Children's therapy services	**You said** as parents you would like to be more in involved in service developments. **We have** developed a new stakeholder's engagement plan and held a parents' information event. We are also implementing a new approach to collect non-verbal feedback from very young people by interviewing a parent or carer as well as watching and recording positive or negative behaviours from the young person whilst therapy is being delivered.
Eating Disorder Service	**You said** there is inconsistency between staff at meal times. **We have** involved patients in making a film for all staff to watch around how to support and encourage people during mealtimes 'induction to meals'. Information resources are being developed for professionals, especially those new to working with patients struggling with an eating disorder.
Community Hospital wards	**You said** there is not enough information, soft meals can be hard to swallow or unpalatable, there are not enough daily activities, wards are not dementia friendly and there should be more home visits before discharge. **We have** set up a daily "walk round" and a regular "clinic" to answer patients' questions and clarify issues, put up posters promoting planned activities, given information on home visits and made changes to the environment to make them more dementia-friendly.
District Nurses (DN)	**You said** you would like times for DN visits to be more specific. **We have** updated the initial assessment sheet to identify if the patient would prefer morning, afternoon or no preference to time of visits.
Physiotherapy services	**You Said** waiting times for appointments are too long. **We have** amended the referral letter to include accurate waiting time predictions, ensure GPs are aware of how to arrange urgent appointments, started to send text reminders to reduce DNAs and increased capacity.
Dietetics Service	**You said** you did not always feel they get sufficient support and information. **We have** set up a Nutritional Action Group created for patients who are malnourished or overweight, supporting carers and families to maintain better nutritional health.
Diabetes service	**You said** you would like to be supported to have increased self-management and independence. **We have** procured MapMyDiabetes online platform procured, allowing patients to upload data, and download information, and allowing Type 2 patients to self-manage.

Case study: using client feedback to improve health visitor clinic services

The health visiting team in Witney spoke to staff and clients to improve their weekly clinics. As a result of feedback they changed the days and times of the clinics, offered time slots to see a health visitor, started a six-weekly health promotion cycle, and changed to a more appropriate room which offered better access, hand washing facilities and more privacy when talking to a health care professional.

Case study: responding to patient experiences of pain

Three patients were filmed talking about their experiences whilst receiving care from district nursing. This was very positive and we have identified where some improvements can be made. Work is underway to improve pain assessment and management. A number of pain assessment tools are being reviewed to be implemented in 2015/16.

Case study: district nursing services

The teams have recently completed making a film which has targeted engaging service users who are difficult to reach. The film is to be used to facilitate changes to practice and care where needed and therefore improve the experience for patients.

Case study: improving the experience of patients in forensic services

Groups of service users have been involved in making a film about their experiences being in hospital and their recovery journey. This has been used to form part of the forensic induction for all new staff. Glyme Ward patients and staff produce a joint newsletter on a monthly basis, this has proven very popular and a positive way to celebrate patient success and keep parties informed of developments. A number of service users have been involved in planning an event across the Littlemore site and a football tournament will take place in August.

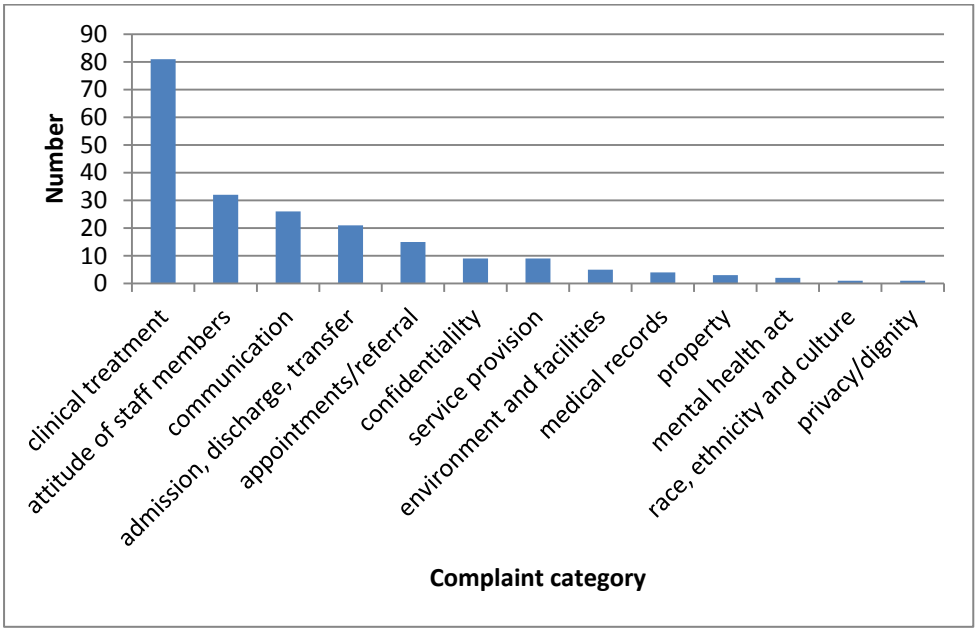
Themes from complaints

The Trust received 209 complaints (excluding withdrawn complaints) in 2014/15. This is an 8% reduction when compared to the 226 complaints received in the previous year. This can be attributed to an increase in PALS dealing with concerns at a local level to resolve problems quickly. During this period of time, 26 complaints were withdrawn by complainants and were resolved informally through PALS.

In 2014/15, 103 (49%) of the 209 complaints received were responded to within the initial timescale agreed with the complainant. 65 (31%) complaints were responded to within an extension agreed with the complainant. 17 (8%) complaints were responded to outside of the agreed timescale. At the time of writing this report, 24 (12%) complaints remain open and under investigation.

Complaints by category

The primary categories of the complaints (upheld and not upheld) received across the Trust in 2014/15 were:



Following investigations, 292 actions have been identified of which 226 (77%) have been completed within time, 38 (13%) actions are overdue and 18 (10%) actions are due to be completed over the next couple of months. Examples of actions include:

- Spot checks by modern matrons for the Buckinghamshire adult mental health wards on the quality of leave planning, leave forms and contact with family around leave. Checklist for monthly spot checking to be created.
- Reviewed handover system on a ward using productive ward tools to ensure that key information is not missed and that essential clinical information is handed over from one shift to another.
- Senior team to develop and agree standards for physical health monitoring, including monitoring for diabetes when prescribing neuroleptic medication.

Healthwatch "independent voice for patients"

We have been sharing feedback and themes received from patients with our local Healthwatch organisations and have supported each other to recruit patients and their family members to be involved in reviewing and improving services, for example PLACE assessments in March 2015. A number of applicable impact studies have been commissioned by Healthwatch in Oxfordshire and Buckinghamshire, based on themes identified locally and nationally by patients. These include access to and experience of health services by a range of groups, personal budgets, young people's mental health, experience of being discharged from hospital, carer experience and dignity in care. The Trust provided an update in January 2015 to the findings and suggested recommendations from the impact studies.

The Older People Directorate is contributing to the Healthwatch Oxfordshire Discharge Quality Review. The project will seek to engage with patients through patient experience questionnaires and visits to services to build a picture of the care provided from the patients' perspective and to test discharge processes to see if they are working as expected.

Healthwatch Oxfordshire and Age UK Oxfordshire are teaming up to try and find out how well national standards on dignity in care are being met in Oxfordshire. Patients, clients and carers will be interviewed about whether the care they are getting matches up to the required standards of dignity in all care settings.

Agree core domains of patient experience to measure and report on

Across our services the key and consistent areas for improvement fed back from service users, patients and carers are:

- Patients want to feel informed, be given options and take part in decisions
- Patients want good information that is tailored to them and is timely
- Patients want staff to communicate clearly with them
- Families and carers want to be involved, listened to and respected

The NQB NHS National Quality Board developed the NHS patient experience framework (2012) which provides an evidence-based list of the elements that patients reported are critical to have a positive experience. We have adopted this as our framework for the domains of patient experience.

Critical elements to a positive experience	Aspect of care
1. **Respect of patient-centred values, preferences and expressed needs** including cultural issues, dignity, privacy and independence and shared decision making	Relational
2. **Co-ordination and integration of care** across and within services	Functional
3. **Information, communication and education** on diagnosis, treatment, progress and processes of care to facilitate autonomy, self-care and health promotion	Relational
4. **Physical comfort** including help with daily living, pain management, and the cleanliness, comfort and safety of the physical environment	Functional
5. **Emotional support** and alleviation of fear and anxiety about diagnosis, treatment, and the impact of illness on their lives	Relational
6. **Welcoming the involvement of family and friends** in decision making and awareness of their needs as care givers.	Relational
7. **Transition and continuity** including co-ordination, planning and support to ease transitions, as well as information that will help patients care for themselves away from a clinical setting	Relational
8. **Access to care** including ease of access and waiting times at each stage through their treatment	Functional

Quality priority 7: development of outcome measures

The three pathways we profile have all seen improvements in patients' settings and in achieving goals and outcomes.

This will enable the service to be effective.

Select two new areas (pathways or services) for development of outcomes measures and report on progress during the year

In 2013/2014, Bucks speech and language therapy (SLT) introduced goal-based outcomes (GBO) for young people in Buckinghamshire. It was designed to measure outcomes following an initial speech language therapy session at start of their school term.

The adult mental health service has been implementing the Recovery Star within the AMHTs and acute inpatient wards over the past twelve months.

Demonstrate that the development process maximises opportunities for involving patients and those close to them in developing and reporting on outcome measures

Bucks SLT

As part of the implementation of outcome measures in SLT, the service developed a standardised tool for assessing outcomes. The tool is used to capture an outcome measure together with the patient at start of school term and to evaluate the patient outcomes against measures at mid and end term. The tool (a questionnaire) is used to make a plan of care that matches the patient's health needs with their therapist which is in turn used to track impact of the care plan on patients' outcomes.

As the tool points out the areas where intervention could improve care and measure progress towards this outcome it influences the relationship between process of care and the outcome. It is hoped that by targeting together (patient and therapist) areas where improvement would yield best results and by working with the tool we are maximising opportunities for involving patients and those close to them in developing and reporting on meaningful outcome measures.

In the 2013/2014 year all the young people seen by Bucks SLT reported an improvement from the first contact to the last contact on their self-selected outcomes and on average reported a perceived 25% improvement against their self-selected outcomes.

In 2014/15 we will start rolling out self-selected goal setting and therapy targets to younger age groups; having successfully piloted GBO with secondary aged pupils . The use of goal-based outcomes will now apply to all children from Y1 to Y13 and we

have revised the toolkit to ensure it's appropriate to developmental needs of the younger cohort.

Recovery Star and clustering in adult mental health services

This is a patient-reported outcome measure which allows the individual firstly to identify where they feel they are and where they would like to be across a number of domains (managing mental health, physical health and self-care, living skills, social networks, work, relationships, addictive behaviour, responsibilities, identity and self-esteem and trust and hope). To date, we have 64 Stars completed across the directorate.

Care clustering has also been underway within mental health services for the last year, which aims to provide treatment and support to patients based upon their needs rather than their diagnosis. We have also implemented clustering in our increasing access to psychological therapies (IAPT) services; we have worked with the local CCGs to develop the appropriate packages of care for these patients. For both the Recovery Star and clusters, we are developing reporting mechanisms to understand how these measures are working and the pathways which patients are taking and whether these are as expected.

Deliver outcome-based care clusters in older adult mental health services

Staff are delivering cluster packages of care for older people within two pathways:
Pathway 1: functional mental health conditions pathway
Pathway 2: dementia conditions or organic mental health pathway

Treatment is provided within these pathways following a specified cluster care package.

- The treatment for people with functional mental health conditions will follow the care packages for clusters 4 to 8 and 10 to 17
- For people with early memory problems where memory assessment and diagnosis is required the care packages for clusters 18 and 19 will followed
- Treatment for people with deteriorating organic mental health conditions will follow clusters 19 to 21 depending upon the stage of the disease and the corresponding care needs

Clustering of patients is being maintained at a good rate within OPMH Services with 90% of all patients clustered.

Systematically monitor, report and share learning from outcomes continuously to improve the quality of care for patients

Cluster outcomes have been set by CCGs for each cluster. Work is ongoing to identify the most effective ways of evidencing these.

Work in partnership with commissioners and other providers to develop outcome-based care across a range of services

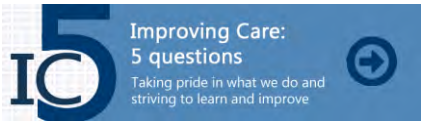
The Trust recognises that we cannot meet all the needs of our patients as a single organisation and this year has seen the development and formalisation of partnerships between the Trust and key partners with which we have worked with more informally for many years.

- The Oxfordshire Mental Health Partnership (OHFT, Response, Oxfordshire Mind, Restore, Connection and Elmore) was formed to be able to provide health, housing, care at home and employment support for people for severe mental illness.
- We have developed an alliance with Oxford University Hospitals NHS Trust to deliver joined-up urgent care for older people.
- We have developed mental health urgent care services as part of delivery of the Crisis Concordats in both Oxfordshire and Buckinghamshire with police, ambulance services, acute hospitals and other partners to ensure that people of all ages with a mental health crisis receive the best care as quickly as possible.
- We have developed high support step down accommodation on the Whiteleaf site in Aylesbury in partnership with Comfort Care and Buckinghamshire County Council.

Quality priority 8: using the new CQC framework

Staff across our Trust have spent time reviewing their services against the five CQC questions with the aim of making this business as usual.

Ensure staff across the organisation are familiar with the changes to the regulatory framework



The project " Improving Care: 5 (IC:5) questions" was launched in June 2014 to develop a sustainable approach for embedding and monitoring the new quality standards being introduced by the CQC. Staff have responded very positively to the new framework and have found the detailed questions helpful and relevant.

Key achievements since project started include:

- a new central Trust-wide clinical service directory for staff
- visits to each clinical service and corporate support team to discuss what the standards mean to each team and how they can ensure these are being met
- information for clinical teams to encourage staff to talk about the standards

- We were a pilot trust consulted on the new mental health intelligence monitoring tool compiled by the CQC and continue to be involved in the development

Adapt the Trust's approach to quality in recognition of changes in regulation

The Trust has recently reorganised its quality governance structure to reflect the five CQC questions. This means that our new Quality Committee (led by the Chairman) and the groups which are accountable to it (led by executive directors) receive information on all aspects of the five questions to identify compliance and good practice, and areas of risk requiring improvement. Local and Trust-wide quality reporting and quality improvement plans are monitored by the weekly clinical governance/senior operational management meeting.

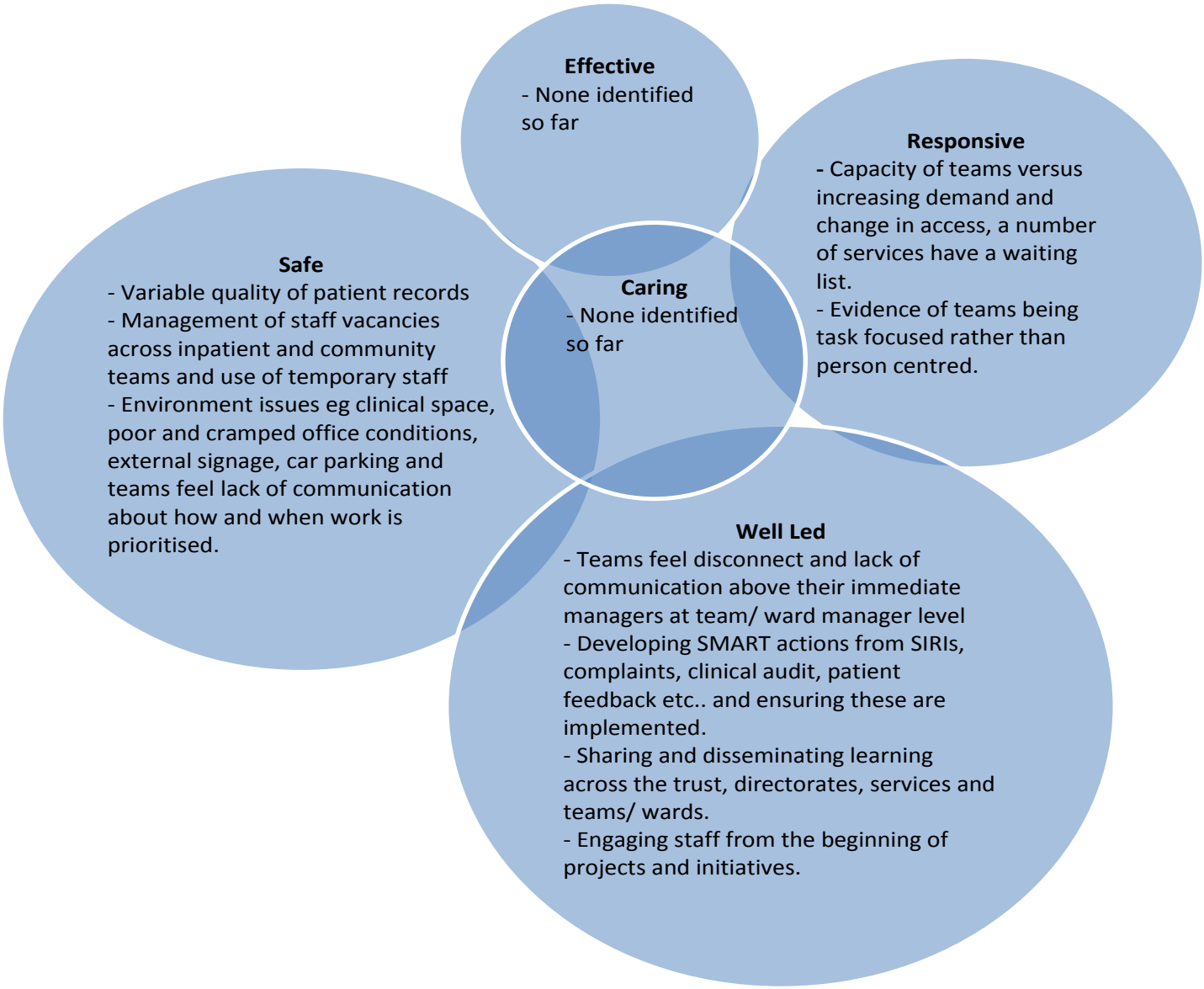
Set up peer reviews across and between different services

We have set up an internal peer review programme which involves teams of staff visiting other services (for example wards, community teams and clinics) to review them against the five CQC questions. The detailed key lines of enquiry and prompts provide a robust set of questions with which to assess our services. Prior to the visit the team reviews a range of information including audits, performance reports, patient feedback, complaints and compliments, incidents and service reviews. During the visit the team assesses the environment, documentation, equipment, safety and quality processes, and speaks to staff and patients about their view of the care provided. We have completed 46 peer reviews to date.

We identified some very good practice during our reviews:

- Overall patients have reported being happy with the care they are receiving.
- Teams demonstrated a caring attitude and compassion for their patients.
- Staff show a good knowledge of the patients on their caseload.
- Good understanding and evidence of adult safeguarding.
- Good management and monitoring of waiting times where they exist.
- Some examples of great visible leadership where staff feel valued and supported.
- Development of pathways with OUH and other partners.
- Some teams are using the five questions as a framework for business meetings.
- Examples of good communication and partnership working across services.

Some areas for improvement include:



Appendix 1 Accreditation			
Accreditation	Body	Service	Comments
Memory Services National Accreditation programme (MSNAP)	The Royal College of Psychiatrists	North Oxfordshire Memory Clinic	Affiliate member only (self assessment and peer visit not completed). See below re. Thames Valley initiative led by AHSM to achieve accreditation.
Electro convulsive therapy (ECT)	The Royal College of Psychiatrists	Whiteleaf Centre, Aylesbury	Accredited to April 2017 (review decision 3.4.15)
ECT	The Royal College of Psychiatrists	Warneford Hospital, Oxford	Accredited to Jan 2017 (review decision 15.1.15)
Quality Network for Inpatient CAMHS	The Royal College of Psychiatrists	Marlborough House, Swindon	Membership is current, checked on 11.11.14.
Quality Network for Inpatient CAMHS	The Royal College of Psychiatrists	Highfield, Oxford	Membership is current, checked on 11.11.14.
Community of Communities	The Royal College of Psychiatrists	Oxfordshire Complex Needs Service	Renewed accreditation from 3.4.15-3.4.17
Community of Communities	The Royal College of Psychiatrists	Buckinghamshire Complex Needs Service	Assessed and accredited in 2009 and 2012. Accreditation completed every 3 years. Re-accreditation due to be completed end of Jan 2015.
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	Marlborough House, MK	Annual peer review (last review Feb 2014)
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	Woodlands, Aylesbury	Annual peer review (last review Feb 2014)
Quality Network for Forensic Mental Health Services	The Royal College of Psychiatrists	The Oxford Clinic, Wenric and Thames House	Annual peer review (last review Feb 2014)
UKMi (UK Medicines Information)	UK Medicines Information	Trusts Medicines Information Department	Awarded following audit in 2009
Quality Network for Eating Disorders (QED)	Royal College of Psychiatrists Centre for Quality Improvement	Cotswold House, Marlborough	Awarded excellent (accredited till Jan 2017)
Triangle of Care member (carers)	Carers Trust	All services	The Trust became a member in June 2014 and is working to achieve 1 star in the next 12 months and 2 stars over 2 years.
Quality in Dental Service Award	British Dental Association (BDA)	Salaried dentist service	Application submitted to BDA in March 2014. Site visit completed in Nov 2014 and

			informed in Dec 2014 achieved accreditation.
Safe Effective Quality Occupational Health Service (SEQOHS)	SEQOHS	Occupational health team at Oxford Health NHS FT	Achieved March 2015
Quality Network for Eating Disorders (QED)	Royal College of Psychiatrists Centre for Quality Improvement	Cotswold House, Oxford	Formal review in Dec 2014.
Quality Network for community CAMHS	The Royal College of Psychiatrists	Oxford City CAMHS	Accredited to Jan 2014. Accreditation possibly has lapsed. Team will go for re-accreditation in next cycle in 2015/16.
Quality Network for community CAMHS	The Royal College of Psychiatrists	Buckinghamshire OSCA	Self-assessment being completed, plan to go for accreditation in next cycle 2015/16.
Quality Network for community CAMHS	The Royal College of Psychiatrists	Buckinghamshire learning disability team	Status to be confirmed.
UNICEF baby friendly breastfeeding status	UNICEF	Health visitors service	In progress.
Psychiatric liaison accreditation network (PLAN)	The Royal College of Psychiatrists	Emergency Department Psychiatric Service Oxfordshire	Application submitted to PLAN. Self-assessment completed in Dec 2014 and visit in Feb 2015. Currently in review stage.
Memory Services National Accreditation programme (MSNAP)	The Royal College of Psychiatrists	Memory service clinics Oxon and Bucks	A Thames Valley initiative led by AHSM has started to support memory service clinics to complete the self-assessment and peer review visit to achieve accreditation.
Accreditation for inpatient mental health services	The Royal College of Psychiatrists	Adult mental health wards	Project established to complete self-assessment and submit application for peer review to achieve accreditation. Initial visits completed in November 2014, final visits planned between Feb-April 15. Waiting to hear outcome.
Imaging Services Accreditation Scheme	UKAS selected to deliver and manage Imaging Services Accreditation Scheme	x-ray services hosted at Abingdon, Bicester, Witney and Henley Community Hospital sites	OUH manage staff and equipment through SLA from April 2014. OUH will apply for external accreditation in June 2016.

Appendix 2
Quality Dashboard: indicators

Quality indicators		
Source	**Domain**	**Indicator**
Manual	Safe	Number of MRSA incidents
Manual	Safe	Number of CDIs
Audit	Caring	CPA % patients involved in setting and achieving goals
F&F test/manual	Responsive	% extremely likely or likely to recommend the service
Audit	Safe	Urinary Tract Infections – new
Ulysses	Responsive	% of upheld complaints
Ulysses	Responsive	% complaints responded to within timeframes
Ulysses	Responsive	% complaints actions awaiting completion
Ulysses	Caring	Number of accolades received
Ulysses	Safe	Number of AWOLs
Ulysses/manual	Safe	Number of falls with harm (1000 bed days)
Ulysses	Safe	Number of medication incidents with harm
Ulysses	Safe	Number of pressure ulcer incidents
Ulysses	Safe	Number of prone restraints
Ulysses	Safe	Number of self-harm incidents
Ulysses	Safe	Number of Orange Incidents
Ulysses	Safe	Number of SIRIs
Ulysses	Safe	Number of suspected suicides
Ulysses	Safe	Number of avoidable grade 3 and 4 pressure ulcers
Ulysses	Responsive	Compliance with Duty of Candour
Ulysses	Safe	Number of Incidents awaiting management review (>15 days)
Ulysses	Safe	Compliance with venous thromboembolism risk assessment
Audit	Safe	No. of venous thromboembolism events
Audit	Effective	Compliance with nutritional risk assessment (%)
Ulysses	Safe	Compliance with Central Alert System alerts (%)
Safety thermometer	Effective	Patients receiving Harm free care (%)
Ulysses	Effective	(%) Scheduled Trustwide clinical audits completed
Ulysses	Effective	(%) Trustwide clinical audits rated good or excellent
Manual	Effective	Gap analyses complete for directly relevant NICE guidance (%)
Manual	Effective	Gap analyses that identify no gaps (%)

Performance indicators		
Source	**Domain**	**Indicator**
Manual	Responsive	% admitted service users RTT within 18 week
Manual	Responsive	% non-admitted Service Users RTT 18 weeks of referral
Ulysses	Responsive	Sleeping Accommodation Breach
Audit	Responsive	CPA % service users followed up within 7 days of discharge
Audit	Responsive	CPA % with a documented risk assessment

Audit	Responsive	CPA % with a documented crisis contingency plan
Manual	Responsive	Emergency readmissions within 28 days of discharge (Adult)
Manual	Responsive	Emergency readmissions within 28 days of discharge
Manual	Responsive	Delayed Transfers of Care MH % of bed days lost
Manual	Responsive	Delayed Transfers of Care MH- Number of patients delayed
Carenote	Responsive	% Clinic letters sent back to GPs within 10 working days
Carenote	Responsive	% Cancellations by services
Carenote	Responsive	% GPs receive discharge letter within 48 hrs of discharge

Workforce indicators

Source	Domain	Indicator
Manual	Safe	Number of wards which were unable to fill 80% of their shifts
ESR	Well led	Vacancies (as a % of establishment)
ESR	Well led	Sickness absence (as a % of establishment)
Manual	Effective	Agency staff bill as a % of budget - clinical staff
L&D/ESR	Effective	Compliance with PPST (%)
L&D/ESR	Effective	% PDRs completed within 12 months
L&D/ESR	Effective	Safeguarding training Level 1

Appendix 3
Patient and staff stories

Service/team	Patient story and feedback	***Staff story and feedback***
District nursing service	"it was the district nurses that made me go to the podiatry - it was the nurses who noticed they [my toes] were going on an uncertain path - they [the nurses] all have their own special qualities." " … She [the nurse] knows all my little worries - you build up a relationship after time" "What they mean to me - reassuring , they have made it possible for life to go on as normal" "... She's so good, so kind... She tells me what she's doing ... She's so kind ..." "If it wasn't for the nurses I wouldn't be able to have this done ... They have worked wonders on my leg ..." "They are all so busy ... They don't have time to sit and talk to you ... They talk to you when they are doing the dressing ... Sometimes it's nice to have someone to talk to."	*"Working in older adult community services for OHFT is challenging and ever evolving. I have been fortunate over the past seven months to have been seconded full-time into the district nursing specialist practitioner course where I have been supported to develop my knowledge and skills surrounding district nursing locally and nationally. Without the support and commitment of OHFT financially to be supernumerary throughout the entire twelve months of the course, the course would be an impossible undertaking.* *Pressure on staff in older adult community services at present is unprecedented and relentless in nature with increased demand for services not being met by the levels of staffing required to meet this demand due to retention challenges. I believe the pressure to deliver care above and beyond on staff new in post exacerbates the retention difficulties being seen in district nursing at present as they feel unsupported to deliver the quality of care they deem appropriate in the time they have available. There is no easy answer to meeting this challenge as the needs of the patient will always be prioritised by district and community staff nurses."* ***District Nurse Specialist Practitioner Student*** *"We must understand that we must respect that we are guests in people's homes and are invited in to support their care. Unlike in a hospital, where they feel that they may have limited choices, we must respect this and work to support them, even though these may not be our choices."* *"This is often the first time where clients are able to be heard and listened to – we often find that patients are not sleeping because of pain or that there may be a psychological impact. We refer many patients to talking health."*

Older adult inpatient ward	"… when I was so poorly and could not even eat for myself, and felt that I could not be of any help for my children, even if they are grown up, the staff on the ward worked with me, my family, and my care co-ordinator and help me to get back on my feet again, they help me to get my confidence back again. I don't know how the staff does it, but they give so much of themselves … it is a good place to be when you are not well'.	
H@H, CCT and Heart Failure Nurses	"I just want to thank everyone who was involved in caring for my aunt … She had severe heart failure, pulmonary hypertension, and her kidneys were failing … [my aunt] came to Oxford and received wonderful care from many people. Hospital at Home is an extraordinary innovation, which enabled [my aunt] to have a Furosemide drip at home, they stopped [her] taking carvedilol and suggested oxygen therapy; all of these transformed her health. Heart failure nurses - thank you to the team who continually fine-tuned her diuretics and she no longer had fluid retention and the Continuing Care team who were so efficient and kind."	
EMU, Community Hospital, CHSS	"Mum was sent by the GP to EMU in November. The GP highly recommended the service for a thorough assessment and had high praise for their patience and understanding of carers coping with older family members (in this case my Dad). Mum was looked after extremely well on the unit, a holistic assessment took place with several clinicians asking many questions over a period of around eight or so hours. They took time to listen to mum waffle on about her past … even though they were clearly very busy and stressed … and they managed to get her to eat, which she hadn't really been doing for weeks. She was admitted to a bed at Witney Linfoot that day and the relief I felt was enormous, reducing me to tears. The EMU lead … quietly removed me from the bay to talk whilst mum and dad chatted on regardless. This is something that really touched me and will remain with me for a long time.	*"I find working for Oxford Health NHS FT very rewarding. I see the patients receiving excellent care on a daily basis despite some of the challenges faced by our organisation. I see the patients' wellbeing and best interest as the focus of the care being given and alongside these patients' families being listened to and included in decision making. I feel supported as a member of staff and have opportunities for further development at various levels. I am kept up-to-date with what is happening in the Trust which in turn leads to a more effective team."* ***Community Hospital Nurse*** *"I am very proud to be working for Oxford health NHS Trust. As a nurse working within a community hospital I feel the care that we provide is excellent. The team that I work in is friendly and hardworking ranging from the nurses, medics, therapists, cleaners and admin staff. The ward shows to be ever dynamic in the way we work to become more efficient in the ever changing world of the NHS and the management team are*

	Mum's stay in Witney was much longer than anticipated … She liked to sit in the day room, calling it the "flower room" when we went to see her, finding it easily identifiable by the mural on the wall. She recognised the toilet by the colours on the door and signposting. She would spend nights pacing and the nurses would allow her to roam constantly reassuring her and trying to keep her calm. We were always updated on how she was after MDTs, quiet spaces were found when we became upset over her deterioration. The ward let me know if dad was looking tired and encouraged him to take a break as much as possible. Mum rang us all often when confused. The nurse in charge would always explain what was happening before putting her on the phone and then take the phone back to make sure we were ok once Mum had had a rant. We all felt very looked after by the ward team a caring bunch of people from the matron to the ladies handing out tea whenever they saw us. The whole team always found time to talk to mum and listen to her stories … and to listen to my dad whilst he reminisced when mum was asleep. I could see how very busy the ward was and I wonder how they manage it!	*approachable. I enjoy going to work and supporting my local community as a nurse, however I do feel the pressures of larger workloads, increasing in responsibilities/duties and caring for the complex patients within the community can at times affect the quality of care I and my team are able to provide at times. Together with caring for individuals who have cognitive impairment and challenging behaviour ever being more frequent in the community hospital setting, I do feel that training needs and support of extra staff are not always met fully, mainly due to time restraints.* ***Community Hospital Nurse***
CMHT	"I would like to thank everyone in the mental health team for the care and support they gave my mum and to the rest of the family. Knowing that there would be somebody visiting regularly and also that there was always somebody we could ring at any time was invaluable. The help given made a very difficult situation much easier to deal with."	
Urgent care		*"I am proud to be part of a team within Oxford Health NHS FT who puts the patient at the heart of their decision making. We are all facing many challenges with staffing and capacity and are often required to discover innovative ways of working at short notice to meet an immediate patient need. The Trust is moving towards locality working which will support colleagues in providing quality care across many services. It is recognised this is a culture change and will be challenging for some; a supportive structure will enable such change. I believe the Trust to be forward thinking and this momentum needs to continue."* ***Clinical Lead, Urgent Care***

CAMHS (Bucks)	Patient A found that the use of a consistent therapist was really important to her. She was worried about trusting people and getting to know people to begin with. A didn't mind having a different person at the assessment, and she didn't mind someone join for the guidance re food, but having the consistent therapist thereafter was crucially important to her. Patient A explained that she has found the service she has received to be excellent, she could not fault it. She is so positive about her experience, the trusting relationship she has with her therapist, and how that has helped her to get better as she believes and trusts what the therapist suggests for treatment, even if it is a bit daunting to her at times. Patient A feels she can tell her therapist anything, she is very grateful for this and it makes a big difference to her quality of life at home and school. In relation to things we could improve on, she said nothing for the service or the quality of work from the CAMHS staff. She did say she was extremely anxious when she first came. She found the waiting area very daunting as there were a lot of children there, some younger and it was very noisy which she found very hard to cope with. She was asked if separate areas or zones might work (specifically a quiet area with more privacy) and she said yes, certainly for people who are very anxious.	
Community CAMHS Swindon	Patient B explained the venue was a good one and she did like going there as she recalled it from an appointment when she was younger for her brother. It was good for her to go to a familiar place and she appreciated seeing a toy dolls house when she first attended, that helped her feel relaxed. She liked the waiting room as there was a section she could sit in that was more private. She really liked always having the same therapist and building a trusting relationship was very important to her recovery. She trusted her therapist completely and felt very safe.	*This was general feedback from a staff wellbeing meeting:* *Staff love their jobs and the work they do. Most have been in post for several years and also within this team for a long time as they love working within the team.* *Staff feel very supported by their local managers and feel they could approach them easily if they had problems or concerns.* *If all staff, led by the most senior, started to change the culture regarding*

	She felt without CAMHS she might have made an attempt on her life as she feels she was very ill and was desperate for help. Patient B was sad that she now had to leave the service as she is approaching 18yrs. She has not left education, she is partially better but not fully, and she worries she will relapse (she is currently not serious enough for adult services). She wishes services in CAMHS went up to 21yrs.	*emails that would be very helpful; therefore work over a six month period to ensure that emails are only sent within working hours (pertinent to your working environment as some do work shift patterns).*
School Health Nursing (SHN) service	Patient C was seen at her secondary school in the North of Oxfordshire. She was well engaged with her SHN who is now based within the secondary school and Patient C found that very helpful. She feels very able to attend regularly for appointments and has done so for some time. She also feels able to ask for help if things suddenly become tricky. Her presentation is now one of a more confident and calmer person with better skills to look after herself, improved self-confidence and an improving relationship with her father. She does feel she can fully trust her SHN although she does know that if the SHN feels she is at risk she might break the confidence (having told Patient C) to keep her safe. She is very pleased she has a confidential relationship with the SHN as she cannot get this with school staff. This helps her find space and time to think about how to change things and keep safe and well in the long run. Patient D was very clear she would never have attended the GP with her worsening anxiety and problems, however after the SHN did an assembly in school (after they became based at school), she realised that the symptoms she had could be helped and that she could talk to the SHN. Patient D texted her and made and appointment to see her, and a referral was immediately made to PCAMHS. Patient D subsequently received treatment for quite serious symptoms at CAMHS and is now fully recovered.	*The SHN felt this was a good development in the end although many had reservations and anxieties initially. Being within the school for her has been a real benefit. She has a supportive school and works well with them and them with her.* *She also explained her concern about lone working as she is based within the school and misses her colleagues who she was sharing an office with and got support from for peer development and shared working. Additionally she explained about difficulties about attending Trust-based training and meetings as she needs to be present in school.* *She explained the managers have been very supportive and communication is hard but they try their best and the monthly newsletter from the operational manager is very well received and helpful.* *She loves her work, feels the change is good and will embed more successfully in due course, but would benefit from more peer support, easier access to meetings and training.*

	Patient D explained that had she not seen the talk from the SHN and been able to access her in school she knows she never would have had the ability to go to the GP with her symptoms, despite being very unwell. She now maintains contact with the SHN to ensure that all remains well especially during exam pressures but she remains on track for high level results and a successful future ahead.	
Health visiting service	Mother explained that she found the Health Visiting Service extremely helpful since she had her baby sixteen weeks ago. She explained it was very helpful to her to have the Child Health clinic at the same venue that her antenatal group had been as this made it easy for her to attend and know where she was going once she had her baby; she felt that was important and things may have been harder if it had been a new venue. The mother of Baby C explained that she found the Health Visitor incredibly helpful, she was there if needed but if all was well she was not inhibiting mum with unnecessary appointments. She had been very helpful with problems with breastfeeding.	*She loves her job and is deeply passionate about health visiting and the opportunity to impact positively upon the life and development of babies and young families. In particularly she is very enthused about the ability to promote attachment in mothers and their young babies, and is acutely aware of the physiological impact upon brain development of this is not achieved.* *She feels they work well with families and work well with the children's centre staff and GP practices.* *She is eagerly awaiting the new EHR as RIO is a terrible system and has made their lives incredibly difficult as practitioners.* *She reports that staff have really valued the iPads they now use.*
Community Children's Nursing		*The staff member explained staff are working way over their hours and this is not sustainable indefinitely. The explained they are very passionate about their work and really enjoy the level of work they can give to patients.* *Staff sometimes feel over managed and there was a suggestion that this pressure could be better 'shared' by allowing more lime management and delegation of responsibility in line with banding and capability, throughout the structure.*
LD CAMHS Buckinghamshire		*Staff feel well led, especially by the team manager in post who provides a quick response and clear actions.* *The client group are well known to them often as they are often with the service for a long time. It can be difficult at times but they do generally*

		love their work, although the increase in workload at the same time as the staff provision has been so vulnerable has made work very challenging. *The building is not the best, it is accessible but it is 'tired' and space for seeing clients is often difficult. However sharing with colleagues is very good and some staff do have their own offices which is very helpful given some telephone calls are highly sensitive and require privacy.*
Adult inpatient mental health	**C is an inpatient in Aylesbury. She experiences psychosis.** I have been in mental health services since I was nineteen. I found it really hard to explain my symptoms and experiences and the Psychiatrist just assumed that I was well. I had to work really hard to convince the doctor that I was not. I shouldn't have had to do this. In my experience with doctors they generalise too much and they need to consider everything before they diagnose. They ask a checklist of questions such as "are you hearing voices?" "Are you low in mood?" yet they need to ask more around those questions and explore more. They shouldn't rule things out. I find it difficult on the ward as we are told to leave our rooms at a specific time and our doors are locked for most of the day. They do this so that we take part in activities but mostly there is nothing to do. They do not use the art room enough and this is only open a couple of times a week. For me distraction is key and we need more to do. Staff are too busy and they spend a lot of time writing notes but they do not talk to us to inform the notes. I think they should prioritise time with patients and organise times more productively. My Psychologist is great, she goes out of her way to help and she really listens. The new occupational therapist is also really good.	***Staff Nurse, Adult Services*** *As a student nurse, Oxford Health NHS FT as a Trust were incredible, the dedication into the training for student nurses was beyond what was expected. Its partnership with university worked well, we had placements three times a year and I personally always felt supported.* *I have only worked within the Trust [as a qualified nurse] for around four months now and no one can prepare you for what you're going to experience. I was given an induction week of training and a week of Prevention in Management of Violence and Aggression training. As a newly qualified nurse however OHFT does not offer any other support or training. We are encouraged to use supervision at work but are not given enough time or enough staff to be able to utilise it.* *During placements on the ward and in the community basis you learn extreme amounts from staff, who can offer you support when you need it; who can offer you guidance; who will push you to learn and be at your best. These are the people that shaped me into the nurse that I am today. As a nurse so much time is spent on paperwork; sitting in an office at a computer making sure that care plans and risk assessments are updated. To me that is not nursing, nursing is about being on the ward, speaking to patients and understanding how they feel. I don't believe that as a Trust they are able to understand what a nurse's job should be about and how much stress people are under to meet the demands and deadlines of the paperwork that has to be completed.*

	M is an Oxfordshire patient receiving care on Opal Ward in Aylesbury. M has a dual diagnosis of schizophrenia and Aspergers. I have been in mental health services for three and a half years. I was admitted to Phoenix Ward at first and this was a very scary time for me. It was demanding on the ward and I lacked confidence which is not good when you are in hospital. I then was moved to Vaughan Thomas ward and then to Mandalay in Aylesbury. I have been on Mandalay and Opal for one and a half years now. I haven't got anywhere to live but the hospital helps me to look for somewhere. I will visit a supported accommodation in Bicester soon. Being in hospital is a helpful process as it gives me time to reflect and I can get involved in activities. I do this because I thrive on activities and I really look forward to them. I don't like it when I have lots of time to think. I am on money management which is brilliant as I have saved about £10,000. Any areas for improvement? It would be good if there was more money for day trips. **A is an inpatient in Aylesbury. A has a diagnosis of schizoaffective disorder** I have been in mental health services since I was twelve. I was seen in Oxford when I was younger at a unit called the Park. I was not diagnosed until I was fourteen-sixteen . At this time we moved to Buckinghamshire. They diagnosed me first as being Bipolar. I have been on many wards including adolescent and adult acute wards. In August 2013 I started hearing voices and was admitted into the Tindal centre. I have been in hospital since then. I am now prescribed Clozapine and a mood stabiliser as well as other drugs.	*Though there are staff shortages and deadlines for teams to meet, the Trust have praised people for all of their hard work and appreciate what we do. Teams work together and from my experience as a nurse, Oxford Health NHS FT work as a team.* ***Preceptee, Adult Services*** *I feel that the provision of training for CPD is great and have been consistently supported in getting on these courses, with management being keen to develop me via training and through formal and informal discussions and supervision.* *Through the preceptorship project I felt that this was a great opportunity for those newly qualified to develop and continue their learning whilst being able to showcase new staff to various people from the Trust: it was good to instil from the start the prospect of service improvement. This time was safeguarded and was helpful in my development. The project was great to have done and a nice way to end - however the preceptorship course was not helpful and did not appear well organised.* *Whilst on the ward, staffing was a consistent issue for around a year yet the team remained supportive and was a great learning environment as well as being a safe and caring environment for patients. I felt that I have been supported to develop well throughout this time by a caring team. A more collaborative approach from management appears to have emerged from over the previous year which has yielded a more supportive and supported team.* *The major difficulties experienced by myself and I believe other clinicians are those of being moved around the wards as it interrupts patient care. I was lucky enough to have been supported in getting a promotion recently and was again supported by the team in preparing for the interview and the role and have found consistent support from the team in terms of development and training.*

	Positive things that I have experienced in this Trust are: • I used to attend groups for service users in Haleacre, these were really good and helped me a lot. Sadly these do not happen anymore. They were stopped. • I once had eight sessions of aromatherapy with massage that was very helpful. • I find my Psychologist really good and this really helps me. I get this on Opal Ward. Things that need improving are: We do not get that much time from staff on the ward as they are always busy with people in seclusion or doing their notes. They can be firm sometimes which I do not think is fair. Leave is stopped sometimes because there is not enough staff to take us out. We are not able to smoke on Opal Ward and this is unfair as the patients on the other two acute wards are allowed smoking breaks. Why is that allowed? We should have more information on medication so that we can understand it better.	*Many issues faced on the wards when I started appear to have dissipated with having one consultant on the ward and having a matron on a ward.*

Annex 1
Statements from our partners on the Quality Report and Account

Oxford Health NHS Foundation Trust Governors

The Quality and Safety Sub-committee has met four times in 2014/15 in a variety of locations to review the quality and safety of services provided by OHFT on behalf of the Council of Governors. Its membership includes Governors, a Non-Executive Director, the Director of Nursing and Clinical Standards, the Trust Secretary and the Head of Quality and Risk. In these meetings the sub-committee has reviewed a number of areas of quality including: patient experience feedback; the service remodelling programme in adult and older adult services; the Quality Account indicators to ensure they reflect the appropriate priorities; the process for investigating and learning from serious incidents; the new requirements from the Care Quality Commission (CQC); an update on the CQC-themed review into crisis services in Oxfordshire; and the peer review process of clinical services and units using the five CQC questions.

The sub-committee, along with other Governor representatives, has reviewed the Quality Report for 2014/15 and the Quality Account for 2015/16. The Quality Account is a good and comprehensive report which reflects the different services provided by OHFT across different counties. The Governors would like to celebrate the achievements made by staff to improve quality and encourage staff to keep working on the areas we did not fully achieve last year.

The Governors are pleased that there are just four main priorities for 2015/16 but note that there are a large number of different objectives. These include objectives carried on from last year as well as some new objectives set by different services in the Trust. OHFT should consider focusing on fewer objectives in future years although we recognise that the quality priorities and objectives reflect suggestions made by our staff and our external stakeholders, which is important.

We are pleased to see that supporting and developing staff will continue to be a key priority. Carer representatives were also pleased to note that more work is planned to improve communication with and involvement of carers, through the Triangle of Care.

However, as Governors we want to ensure that the context for the quality priorities is fully understood. We are asking staff to improve quality and safety at a time when all NHS organisations are having to make cost improvement savings, while demand is increasing. We believe that good quality care is also cost-effective care but we must ensure the cost improvement programme does not prevent us from maintaining the quality improvements we have already achieved.

It is a long document with many facts and figures, and Governor suggestions to help signpost readers and explain terms have been accepted and changes made to the report. The glossary is helpful, however it may also be worth explaining some terms in the text.

The committee has found the trust to be diligent in its presentation of information and willing to be open where improvement is required or objectives have not been achieved. We are pleased, therefore, to endorse the Quality Account and Quality Report and to continue to work with the Trust to improve services for local people across its range of services.

Healthwatch Oxfordshire

Thank you for inviting us to comment on the Trust's Quality Account for 2015/16. The issues raised about OHFT with Healthwatch Oxfordshire this year have primarily related to:

- access to community-based mental health services and psychological therapies for people of all ages
- delayed discharges from hospital
- communication issues
- concerns relating to the district nursing service
- the impact of recruitment and retention problems on effective service delivery

In addition, through the Trust's active involvement in our multi-agency Quality and Patient Experience leads meeting, we have jointly identified with you and other partners a set of eight quality improvement priorities for the whole Oxfordshire health and social care system, based on our collective analysis of service user feedback. These shared priorities, which will be enshrined in the refreshed Health and Wellbeing strategy for 2015/16, are to improve:

- How well care is joined-up, when it is being delivered by a range of health or social care providers.
- Communication between different organisations within the system about individual patients.
- Communication by all parts of the system with patients and carers, both in terms of staff attitudes, involvement of people in decision making about their care and delivery of dignity standards.
- Carer involvement in care planning and care delivery.
- Treatment of patients with physical and mental health needs.
- How well the psychological component of all healthcare is recognised and met.
- How able staff, carers and patients feel to raise concerns or complaints without fear of retribution.

- Public education about how to use the NHS wisely and how to look after oneself when that is the most appropriate thing to do.

Whilst this shared agenda was not explicitly referenced in the 2015/16 Quality Account, Healthwatch Oxfordshire welcomes the commitments you have made to:

- address workforce issues
- improve floor-to-board communication
- improve processes to ensure staff can raise concerns and monitor action taken
- evaluate integration of physical and mental health pathways
- improve the management of patients' long-term physical health conditions
- extend the CAMHS in-reach service in schools
- improve information sharing with GPs
- implement and evaluate the Triangle of Care, in order to improve patient and carer involvement in care planning and communication between the Trust, its patients and their carers

We were also pleased to see in the review of 2014/15 that the Trust was:

- developing partnership-based approaches to improving outcomes for MH patients and older adults with local 3rd sector organisations and Oxford University Hospitals NHS Trust (OUHT)
- adopting a framework for assessing and improving patient experience
- implementing integrated physical and mental health pathways for older people

Whilst we understand that some of the 2014/15 priorities will be rolled forward, we were disappointed not to see a greater emphasis on improving integrated working with OUHT and social services in the 2015/16 priorities in order to reduce delayed discharges and issues associated with transfer of care between organisations.

We would also have welcomed a significantly enhanced focus on improving access to community-based mental health services and psychological therapies.

Finally we would like to have seen the focus on supporting staff to raise concerns to have been extended to include patients and carers and a much more explicit commitment to reporting on the action taken as a result of implementation of the new framework for assessing and improving patient experience.

We have established a good relationship with the Trust in 2014/15 and you have been open to working with us on patients' behalf. We were glad to see this relationship recognised in the Quality Account, and to see your ongoing commitment to working with us. We look forward to continuing to both support and challenge you in the year ahead, in the interest of helping you improve services for local people.

Chiltern and Aylesbury Vale Clinical Commissioning Groups

Chiltern and Aylesbury Vale Clinical Commissioning Groups have reviewed the Oxford Health Foundation Trust Quality Account against the quality priorities for 2014/2015. 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 Mental Health Act visits. 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 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 focused on the mental health services as it is those which are commissioned by the Buckinghamshire CCGs.

Quality Priority 1: Workforce

We, the commissioners acknowledge there has been a drive for managers to receive team effectiveness training. We note that the Trust has been shortlisted for Nursing Times excellence award in supporting staff and wellbeing which reflects the range of activities to improve the staff wellbeing. Workforce is a priority; however, there is nothing on the equality and diversity agenda which we know significantly impacts on quality when representation from top to bottom of organisation is addressed. We also note that the appraisal target has not been met due to changes in the management structure over the year.

We would welcome actions the Trust has identified to address how the appraisal target will be met. We would like to know what the Trust will do to implement the new E&D measure in 2015/2016.

We agree and welcome the key actions identified, such as tools to enable people to recognise and manage workplace stress, following the national survey results to promote staff wellbeing.

Quality Priority 2: Data on quality

It is positive to know that a set of quality indicators have now been agreed that will enable the Trust to assess areas that are working well and any potential areas of vulnerability in terms of quality. The new Electronic Health Record will ensure consistent data capture methods. The Data Quality Review Group that meets regularly implements the standard operating procedures for managing data. As

commissioners, we would welcome some details in the data section about how the Trust are delivering care closer to home, for example to report achievement at locality level.

Quality Priority 3: Service remodelling

The trust highlight a number of successful service changes which have improved the engagement of patients and staff, such as the Recovery Star tool that focuses on patients taking the lead with their own goals and recovery plans. As commissioners we acknowledge the work that has gone into this and that the 'new model of care' for older people's mental health services has been implemented in each county, with the benefit of an increased capacity in Oxfordshire memory clinics following service changes. We support any memory clinic accreditation.

Quality Priority 4: Staff engagement

It is demonstrated that there has been a concerted effort over the last year to address staff engagement. The staff have raised the issue of pressures on their workload, due to increased activity and increase in patients' level of acuity, which has impacted on the amount of time that can be spent with patients providing support and reassurance. Staff have been involved in designing and delivering a number of projects that address their engagement activities. It is welcomed that the Trust have set up a number of surgeries with Executive Directors where staff are able to raise concerns and speak with the Board members on specific topics. We would be interested in knowing the uptake of this by the staff in the future. The achievement made at Didcot Community Hospital, of demonstrating an increase in nursing time to time to care, with more input into therapeutic activities is commendable, and we are interested in knowing if this has been replicated in other sites.

Quality Priority 5: Reduction in harm

There has been an increase in incident reporting this year and this demonstrates a positive and open safe culture. The Trust has a robust mechanism for reviewing SIRIs which encompasses a number of approaches demonstrating inclusivity. We acknowledge that there are also examples of good practice found during the investigations which is also cascaded to other areas in the Trust. The Trust have been transparent and detailed in the areas of improvement that need to be made such as: a regular review of any physical health concerns; revised standard operating procedures; and an overall improvement in the standards of documentation. This with details on medicines management, suicide prevention strategies, and the sharing of learning from safeguarding issues will improve the reduction of harm still further.

Quality Priority 6: 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 work to expand the Family and Friends Test to include the question on

whether the patient would recommend this service, though the response rate at the moment remains low. In addition they have introduced a system to capture patient stories and these are heard at the start of the Board meetings. Every service is now collecting feedback on patient experience. Patient experience leads are reporting on themes and improvement actions through the patient experience group and in reports to the Quality Committee.

The Trust are seeking new ways to develop more structured outcome measures with patients which, where agreed, includes family and friends, such as with the new care clusters. The Trust offers 'carers' assessments, and has strong links to Rethink and the Carers Reference Group, and is working to achieve the Triangle of Care accreditation which will help to ensure that carers and family members are involved in the planning and treatment of patients who access these services. In addition with the Care Act they are working with local authorities to meet the changes. These initiatives can only improve the patients' overall experience of the service.

The future

The 2014/15 priorities contained in the Quality Account are consistent with priorities agreed with both commissioners. We welcome the Trust's reference to increasing partnership with third sector in Oxfordshire and its benefits. It would be useful to know when this will be extended to Buckinghamshire.

We are particularly pleased with the development of the outcome measures as the Recovery Star and clustering in adult mental health services and developing the self-selected goal setting and therapy targets to the younger age groups.

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 and carers.

Oxfordshire Clinical Commissioning Group

OCCG has reviewed the Oxford Health Quality Account and believes that the information it provides is accurate. Oxford Health NHS FT is a large NHS organisation that covers many services across a large geographical area. As a consequence, OCCG recognises that this document will never be able to provide the public with full assurance about the quality of all the NHS services the Trust provides.

OCCG is committed to commissioning high quality care for the population of Oxfordshire. OCCG would therefore like to see a greater acknowledgement within Quality Account priorities of how the Trust interacts with partner organisations. It is

encouraging to see that one of the priorities set by the Trust focuses on staff. OCCG feels that one of the biggest quality challenges facing the Trust is around the staffing of the district nursing service. One of the staff stories in Appendix 2 eloquently states the problems faced by the district nursing service. The priorities selected have some very clear quantitative measures which is encouraging. However, the volume of indicators may be overwhelming. Fewer targets may help the Trust to be more focused.

The Quality Account could make it clearer for readers in stating the location of the services that are being spoken about and whether there is a variation between the same service in different locations. The Quality Account does highlight many of the challenges faced by the Trust whilst highlighting areas of quality improvement work which have been undertaken.

It is essential to identify areas for quality improvement. It is also important to note successful quality improvement within the Trust. This document highlights some successful areas. In partnership with OCC, OCCG has invested in services to support the initiation and maintenance of breastfeeding. We are pleased that OHFT mentions its commitment to UNICEF breastfeeding initiation accreditation. This is an important step towards delivering high quality evidence-based support to improve maternal and infant outcomes.

The section on patient feedback shows that Oxford Health NHS FT is seeking to deliver patient-centred services. OCCG would encourage OHFT to maintain this approach and feedback to patients when improvements have been made.

While acknowledging the size of the document and the challenge of including all issues, OCCG felt that the Account could contain more information about safeguarding issues. In particular, OHFT's response to the recent high profile child sexual exploitation (CSE) case and the Trust's involvement in establishing the multi-agency safeguarding hub (MASH).

The Oxford Health NHS FT Quality Account explains its topics clearly. Overall, it could be improved by better sign posting to allow readers to navigate the document more easily. OCCG look forward to continue to work together with OHFT to deliver high quality care for the patients of Oxfordshire. Overall, OCCG believe that this Quality Account should give readers confidence that the Trust is being open and honest about the quality of services being provided across the organisation and is committed to driving continuous quality improvement.

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 NHS foundation trust Boards should put in place to support data quality for the preparation of the Quality Report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15;
- 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 2014 to June 2015
    - papers relating to quality reported to the Board of Directors over the period April 2014 – June 2015
    - feedback from the commissioners dated May 2015
    - feedback from the Governors dated May 2015
    - feedback from local Healthwatch organisations dated May 2015
    - the Trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, submitted May 2015
    - the latest national patient survey 2014
    - the latest national staff survey issued March 2015
    - the head of internal audit's annual opinion over the trust's control environment dated April 2015
- the Quality Report presents a balanced picture of the NHS foundation trusts 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) as well as the standards to support data quality for the preparation of the Quality Report

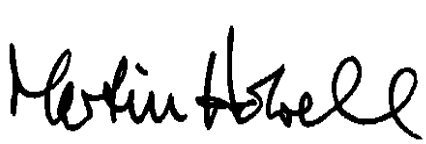
There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. This is because:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in the internal audit programme of work each year.
- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might reasonably have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Trust and its Board of Directors continually strive to improve data quality and validation processes to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.

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



Martin Howell
Chairman

Stuart Bell CBE
Chief Executive

Date: 28 May 2015

Date: 28 May 2015

Annex 3
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 2015 (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 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Oxford Health NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- admissions to inpatient services had access to crisis resolution home treatment teams
- minimising delayed transfers of care (mental health).

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 section 2.1 of the Monitor *2014/15 Detailed guidance for external assurance on quality reports*
- 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

- board minutes for the period April 2014 to 28 May 2015
- papers relating to quality reported to the board over the period April 2014 to 28 May 2015
- feedback from the Commissioners dated May 2015
- feedback from the governors dated May 2015
- feedback from local Healthwatch organisations, dated May 2015
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13/05/2015
- the national patient survey dated 2014
- the national staff survey dated 2014
- Care Quality Commission Intelligent Monitoring Report dated 20/11/2014;
- Care Quality Commission reports
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2015.

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; and
- reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

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 2015:

- 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 2.1 of the Monitor *2014/15 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'.

Deloitte LLP
Chartered Accountants
Reading

28 May 2015

Annex 4
Glossary of terms

A&E Accident and Emergency
ADHD attention deficit hyperactivity disorder
AHSN Academic health sciences network
AHSC Academic health sciences centre
AIMS Accreditation for inpatient mental health services
AMHT Adult Mental Health Teams
Aston teamwork model approach to developing effective team working and team leadership developed by Aston University
AWOL absent without leave, referring to patients who have been allowed out on escorted (with a member of staff) or unescorted (without supervision) leave and who have not returned to their ward within 10 minutes of the agreed time of return
BaNES Bath and north east Somerset
Baseline starting point (to measure improvement)
Bed days measure of a period of time (24 hours)
Benchmark data to compare with another organisation(s)
BHT Bucks Healthcare NHS trust
C&YP Children and Young People
CAS Central alert system
CAMHS Child and Adolescent Mental Health Services
CBT Cognitive Behaviour Therapy
CCG Clinical commissioning group
CDI clostridium difficile infection is a bacterium that is the most serious cause of diarrhoea often associated with taking antibiotics, making people in hospitals particularly susceptible
CH Community Hospital
CIPs cost improvement programme
CLARHC Collaborative leadership in applied health research
CMHT Community Mental Health Teams
CPA Care Programme Approach, a national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery
MH Mental health
MHA Mental health act
MHMDS Mental Health and Learning Disabilities Dataset
MIU Minor injury unit
MRSA/MSSA Two varieties of bacteria which lead to illness and are characterised by being particularly resistant to treatment -its presence in hospitals has therefore led to a concerted campaign to eliminate it from such locations
MSO Medication safety officer
MSK Musculo-skeletal
NAIC National audit of intermediate care
NHS National health service
NICE national institute of clinical effectiveness
CQC Care Quality Commission: the government body that regulates the quality of services from all providers of NHS care
CQUIN Commissioning for quality and innovation
CTO Community treatment order
CUBE Information management system for the trust
DEC Diagnostic evidence collaborative
DoH Department of Health
DTOC delayed transfer of care occurs when a patient or service user is delayed in being discharged from hospital into the community
EKOS East Kent Outcome Scores
EIS early intervention service
EMU Emergency medical unit
ESR Electronic staff record
Essential standards audit tool for mental health inpatient services which measures quality and safety indicators
FFT the Friends and Family Test which was introduced to assess the satisfaction of patients with NHS care and to assess whether they would recommend their local NHS services to friends and family
FIM Functional Independence Measurement
GBO Goal based outcomes
GP General practitioner
HETV Higher education Thames Valley
HR Human Resources
IAPT Increasing access to psychological therapies
ICO Information Commissioner's Office
ILT Integrated locality team
IPCT Infection prevention and control
IMHA Independent Mental Health Advocacy
MAG Multi-agency groups
MDT multi-disciplinary team
LAC Looked After Children
MECC Make Every Contact Count
PSAG patient status at a glance board
QED Quality eating disorders
QRP Quality Risk Profile
RCA root cause analysis
Recovery Star highlights areas to work with individual patients to identify and address their difficulties with core areas of life. These areas are managing health, self-care, trust and hope, living skills, identity and self-esteem, special networks, responsibilities, work, addictive behaviour and relationships.
RiO electronic patient record
RMN Registered mental nurse
Safety Thermometer is a national tool for measuring, monitoring and analysing patient harms and harm-free care using point prevalence (count of the number of incidents at a fixed point time)
SHA Strategic health authority
SHN School health nurse

NIMHE National institute for mental health in England# **NQB** National Quality Board **NRLS** National reporting and learning system **NSPCC** National society for the prevention of cruelty to children **OHFT** Oxford Health Foundation Trust **OOH** Out-of-hours **OUH** Oxford University hospitals NHS trust **PCAMHS** primary children and adults mental health services **PDR** performance development review **PDSA** Plan, Do, Study, Act **PE** patient experience **PEACE** Positive engagement and calm environments **PFTF** Planning for the future **PH** Physical health **PLACE** Patient-Led Assessments of the Care Environment **PMVA** prevention and management of violence and aggression **POMH** Prescribing observatory for mental health **PPST** Patients and personal safety training **Productive care** an improvement programme based on the institute for innovation productive series	**SIRI** serious incident requiring investigation **Skintelligence programme** a skin integrity work stream to improve the management of pressure damage **SLT** Speech and language therapy **SMT** senior management team **SOAD** Second Opinion Appointed Doctor **SOAPIE** Subject (patient), Object (clinician), Assessment Plan, Intervention, Evaluation **SSKIN bundles** a tool that acts as a prompt to staff to undertake a risk assessment and provide management of the risk with patients **ST** Street Triage **UNICEF** United Nations children's fund **V&A** Violence and aggression **VBI** Value based interviewing **VBR** Values based recruitment **VLU** Venous leg ulcer **VTE** venous thromboembolism **WTE** Whole time equivalent

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.

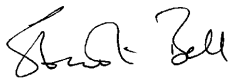
Under the NHS Act 2006, Monitor has directed Oxford Health NHS Foundation Trust to prepare for each financial year a Statement of Accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of 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
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- 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 or 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 CBE
Chief Executive **Date: 28 May 2015**

Annual Governance Statement 2014/15

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 2014/15 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 former Oxfordshire PCT, as part of the Transforming Community Service national initiative. Contracts with Buckinghamshire and Oxfordshire Clinical Commissioning Groups for all mental health services provided by the Trust were in place during 2014/15; these set out the contractual arrangements for services provided by this Trust, including performance, activity and management of Serious Incidents Requiring Investigation. Contracts with the Specialist Commissioning Group for Forensic Mental Health Services, CAMHS and eating disorders were in place during 2014/15. A contract with Oxfordshire Clinical Commissioning Group to provide community services in Oxfordshire was in place during 2014/15.

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 reviewed during 2012/13 and renewed from 1 April 2013 with an annual review. 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 2015 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
- sets out the aims and objectives of governance in the organisation, together with the structures and processes which will be in place to successfully deliver corporate and quality governance in an integrated manner
- enables the Trust to demonstrate continuous improvements in service
- creates an environment in which excellence will flourish
- 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 Integrated Governance Framework was reviewed during 2013/14 and during 2014/15 the Board approved the transition from the Integrated Governance Committee to the Quality Committee.

The Quality Committee, formerly known as 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 four Quality Sub-committees – well led, caring and responsive, safety, and effective. Under the Integrated Governance Committee there were five quality improvement committees: safety, clinical effectiveness, governance and information management, human resources, and service and estates. These sub-committees lead and supervise governance elements within the Trust.

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 Board

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.

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 service directorate has a clinical director and a head of nursing who jointly lead on clinical governance issues. Staff have been alerted to both the strategy and supporting policies, for example Incident Reporting and Management policy. The Risk Management strategy and policy was last reviewed and approved by the Integrated Governance Committee (now known as the Quality Committee) in November 2014. In addition to regular updates at relevant Board sub-committee meetings and Executive Team meetings, a formal quarterly Board Assurance Framework report is presented to the Board which provides a regular opportunity for all directors to review progress against mitigating risks and consider new or emerging risks.

A comprehensive risk management training needs analysis has been completed across the organisation, the results of which influence the design of the Trust's staff training programme. Staff and teams are also supported to learn from good practice to mitigate risks through knowledge sharing workshops that highlight risks identified though Serious Incidents Requiring Investigation and actions taken to address these.

The Executive team and the Quality Committee, formerly known as the Integrated Governance Committee, regularly review a self-assessment against the CQC registration requirements; where gaps are identified action plans are implemented to ensure the CQC Outcomes are met.

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 clear purpose, values and strategic objectives for 2014/15 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 objectives:

- Driving quality improvement.
- Delivering operational excellence.
- Delivering innovation, learning and teaching.
- Developing our business.
- Developing leadership, people and culture.
- Getting the most out of technology.
- Using our estate efficiently.

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 / patients, 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 strategic objectives
- to identify the principal risks that threaten the achievement of the Trust's strategic objectives including achieving satisfactory compliance with national standards and targets

- to ensure that the key controls are in place which are designed to manage the principal risks

Each principal risk has an Executive lead who is responsible for developing action plans 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), and 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 (including self-assessment against CQC registration requirements).

The Board and its sub-committees, including the Audit Committee and the Quality Committee, formerly known as the Integrated Governance Committee, have reviewed the Board 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 Sub-committees, formerly 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. The Board Assurance Framework sets out inherent risks, residual risks (following the application of controls) and target risks. In this way the Board and its sub-committees regularly consider the Trust's risk appetite.

Internal Audit completed 16 audits in 2014/15 of which 0 received a 'no assurance' level assessment and two received a 'limited assurance' assessment; all other audits results were either 'reasonable assurance' or 'substantial assurance'. All audit reports were presented to the Audit Committee and those which received a 'limited assurance' assessment were considered and discussed in a formal meeting of the Audit Committee. The list below identifies the audit areas where urgent recommendations were made which will be addressed as part of the continued development of the system of internal control:

- Estates procurement (three urgent recommendations)
- Cost Improvement Programme (two urgent recommendations)

A system is in place to ensure all recommendations have a management response and, where appropriate, action plans. Internal Audit reports to the Audit Committee on the implementation of actions and the Committee follows-up with the Executive when recommendations have not been implemented by agreed dates.

The Board has been assured through the Quality Committee, formerly known as the Integrated Governance Committee, that effective arrangements are in place to manage and control risks to information and data. An Integrated 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. Since the previous statement, two incidents required reporting to the Information Commissioner. The two incidents concerned:

1. Procurement practice and insufficient data processor provision in contracts.
2. Failure to recover, and make any attempt to recover, a patient letter which had been sent to the wrong address.

The Information Commissioner required the Trust to comply with a formal undertaking, issued in September 2014, to ensure statutory compliance and an action plan was developed. Implementation of that plan was monitored by the Executive team. The Information Commissioner is satisfied that the Trust has taken sufficient action with respect to contract and procurement processes and recovery of personal data to comply with the undertaking and notified the Trust on 7 May 2015.

During the year, one incident required reporting to the Information Commissioner: a document containing un-redacted personal information was posted in a secure portal in support of a tender submission. The information was removed from the secure portal, an Initial Investigation was completed and a Root Cause Analysis conducted. A Standard Operating Procedure was implemented for tender responses: if a redacted example of clinical risk assessment was required in support of a bid then redaction would be completed by the health records staff. The health records department are responsible for subject access requests and experienced in redacting personal clinical information.

Significant assurance has been gained through the annual Information Governance Toolkit self-assessment which assesses process and policies across the following areas: Information Governance Management; Confidentiality and Data Protection; Information Security; Clinical Information; Secondary Use; and, Corporate Information Assurance. The results of the self-assessment are reviewed and confirmed by the Caldicott Guardian and then reported to the Quality Committee (formerly known as the Integrated Governance Committee).

During 2014/15 the Health and Safety Executive (HSE) investigated an incident that occurred on the Fiennes Centre in 2013. The incident concerned a patient having fallen from a first floor bathroom window and the HSE investigated the window design and maintenance, and the Trust's procedures relating to the Central Alerting System (CAS) alert. The Trust co-operated fully with the investigation and implemented a detailed action plan to ensure that the risk of a similar incident occurring at any site was minimised.

As an NHS foundation trust our organisation has a Council of Governors with 37 governors of which 28 are elected from public, patient and staff constituencies. The remaining nine are appointed by stakeholder organisations. The council meets quarterly and the Trust consults with it on future strategy and risks to achieving objectives.

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.

Following review in 2013/14, during 2014/15 the Board implemented a new quality governance element of its Integrated Governance Framework which saw the Integrated Governance Committee and its Quality Improvement Committee replaced by the Quality Committee and its Quality Sub-committees on 1 January 2015. The Quality Committee and its Quality Sub-committees provide assurance to the Board that there are robust systems in place to ensure that essential standards of quality, safety, effectiveness, caring and responsiveness are being met by the Trust and that the organisation is being well led.

The Trust's Corporate Governance Statements are reviewed by the Board alongside evidence which provides assurance that statements are valid. Each statement has an Executive lead who is responsible for ensuring actions are implemented to address any risks to validity.

Assurance is obtained on compliance with CQC registration requirements through: regular review by the Executive team and the Quality Committee of a self-assessment against the CQC registration requirements (where gaps are identified action plans are implemented to ensure the CQC outcomes are met); and through a combination of internal peer reviews across the Trust against the CQC framework, the results of which are assessed by the Executive team, and assurance reports to Quality Sub-committees assessing CQC compliance. In 2015/16 assurance will be based on the outcomes of analysis of the data gathered for internal reviews, the results of internal reviews and other intelligence by service line which will be integrated into Directorate quarterly quality reports and assessed by Directorate Performance Meetings with the Executive team and the Quality Sub-committees. The quality of performance information is assessed, and assurance obtained, through the regular submission of performance reports, including performance exception recovery plans, to the Executive and the Board.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

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.

Information Governance

The Trust Integrated Information Governance Policy outlines the management and assurance framework, including key roles and committees that are responsible for managing and monitoring confidentiality and data security. The Information Management Group, chaired by the Senior Information Risk Owner (SIRO) is responsible for fidelity to the policy and provides management focus and analysis of data security threats and delivers improved data security through the review of incidents, policy development, education of users, highlighting risks and developing risk mitigation action plans. The Caldicott Guardian is a member of the group, produces a report for each committee and is responsible for developing awareness of Caldicott and confidentiality issues throughout the Trust. The Information Management Group monitors implementation of the Integrated Information Governance Policy and actions to improve service user experience in relation to fair, lawful and secure use of their personal confidential information, leading and overseeing the implementation of controls and receiving assurance to maintain service user confidentiality whilst enabling effective and lawful sharing of information. The group oversees compliance with the Freedom of Information Act, and receives assurance with respect to subject access requests under the Data Protection Act.

The Information Governance (IG) Toolkit is an annual online national self-assessment process overseen by the Health and Social Care Information Centre, which enables the Trust to measure its compliance against Department of Health standards of information governance management, confidentiality and data protection, information security, clinical information, secondary uses and corporate information. The Trust provides evidence to demonstrate compliance with each of the standards in the Toolkit, which is independently audited by internal audit. Following the

independent audit and sign off by the Trust Caldicott Guardian, the IG Toolkit assessment is submitted on 31 March each year.

The Trust scored Level 2 or above for all requirements of the IG Toolkit v 11 for 2014-15 that form the Information Governance Statement of Compliance with an overall satisfactory compliance score of 82%. Internal Audit reviewed the key requirements of the Information Governance Toolkit v12 and gave reasonable assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

One serious confidentiality incident (level 2) was reported in 2014-15. Details of the incident are provided in the table below.

Summary of Serious Incident Requiring Investigation involving personal data as reported to the Information Commissioner's Office in 2014-15				
Date of Incident	Nature of Incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
January 2015	A document containing un-redacted personal information was posted in a secure portal in support of a tender submission	Names, part address, telephone number, email address	2	ICO,DH, CCG, Monitor
Action taken	The information was removed from the secure portal, an initial investigation was completed and a root cause analysis conducted. A standard operating procedure was implemented for tender responses: if a redacted example of clinical risk assessment was required in support of a bid then redaction would be completed by the health records staff. The health records department is responsible for subject access requests and experienced in redacting personal clinical information.			
The Trust was subject to an Undertaking issued by the Information Commissioner (reference ENF0498579 & ENF0532683) in September 2014. The Undertaking related to two separate incidents: disclosure of an email list by a website developer contracted by the Trust, and a letter sent in error to an incorrect address. The Information Commissioner is satisfied that the Trust has taken sufficient action with respect to contract and procurement processes and recovery of personal data to comply with the undertaking, and notified the Trust on 7 May 2015.				

The Trust requires all information incidents to be reported. Each incident is recorded on the Trust Incident Reporting System and all incidents of Level 1 or less are summarised and reported to the Trust Extended Executive monthly, and are analysed and considered by the Information Management Group quarterly.

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 (now the Quality Sub-committees reporting to the Quality 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 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'.

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*.

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 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, for example that all codes used are nationally recognised codes, or map to national values. Internal data quality also includes maintenance of changeable reference data
- the system support function identifies and corrects inconsistent data
- systems are also managed to enforce data quality where necessary
- production and maintenance of data quality reports that can be run by end users
- specific data quality awareness, including the minimal use of default codes, is included with system training, and training support materials
- monthly monitoring reports produced for the service delivery teams to monitor the quality of the data, raising issues if tolerances are exceeded
- audits of records in the form of spot checks of paper records (where held), and validation of inpatient data entered electronically on a daily basis
- internal audit review of data sources
- external audit review

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 Board 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 Sub-

committees. The Board 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
- CQC (Mental Health Act Commission) reports
- Monitor quarterly assessment process
- 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
- internal sources – such as clinical audit, internal management reviews, performance management reports, user and carer involvement activities, benchmarking and self-assessment reports
- assessment against key findings of external inquiries.

The Board has monitored progress against the 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 gross risks, key controls and gaps in assurance as identified by the Board Assurance Framework. The Quality Committee, formerly known as the Integrated Governance Committee, and its 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 Audit Committee has sought assurance from the Quality Committee, formerly known as the Integrated Governance Committee, on the design, implementation and review of the Trust's clinical audit programme.

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 2015/16 should the internal control environment not continue to be managed effectively.

The table below sets out the potential significant risks:

Significant risk	Mitigating controls and actions include:	In-year risk	Future risk
Failure to successfully influence, manage and prepare for further changes in commissioning arrangements and the wider health and social care system may compromise the Trust's ability to deliver, maintain and win new contracts.	Ongoing strategic and operational engagement and joint working with CCGs, local authorities and other partners including GP providers. Development of alliances and partnerships with other organisations including the voluntary sector to deliver services into the future. Ability to deliver, maintain and win new contracts supported by service model review and development.	√	√
Failure to deliver financial plan, including Capital Programme, and provide services that meet the Trust's quality standards as a consequence of the inability to generate sufficient savings or obtain new income within the context of the financial resources made available to the Trust by commissioners.	Overall Cost Improvement Programme (CIP) target is set as part of the financial planning process for the annual plan and long term plan. Each Directorate and Corporate Function identifies themes that are developed into project plans and gaps to overall targets are identified and mitigations considered within the overall review of risks and opportunities for the financial plan. Improvements to the management and co-ordination of the CIP are being implemented, including the establishment of a CIP Board, chaired by the Chief Operating Officer with the	√	√

	Medical Director, Director of Nursing and Clinical Standards and Director of Finance as core members.		
Facilities being unsuitable or unfit for purpose may lead to: increased risk to patient safety; lesser quality of care and patient experience; increased cost of operation; and breach of statutory requirements.	Estates Strategy in place including work streams for providing safe and secure environments through risk-based prioritisation of investment, a new CAS alert process and a Planned Preventative Maintenance Programme. Risk register to identify significant risks and levels of investment required and to develop the capital programme. Statutory compliance monitoring and reporting in place. Fire risk assessments, ligature risk assessments, annual Patient-Led Assessments of the Care Environment conducted.	√	√
Inadequate planning for current and future workforce requirements (including number of staff, calibre, skills and training) or ability to respond to changing requirements in a timely manner may lead to: impaired ability to deliver the quantity of healthcare services to the required standards of quality; and inability to achieve the business plan and strategic objectives.	Recruitment processes and analysis of leaving questionnaires. Ongoing staff development through resources such as the Learning and Development training matrix. Performance Framework including the Performance and Development Review Policy and supporting process. Directorate workforce plans linked to Business Plan with regular processes for review. Medical staffing workforce plan.	√	√

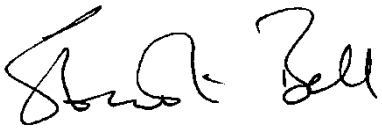
	Workforce planning included as part of service remodelling to inform workforce plans for next three years.		

All major risks are included on risks registers and the Board Assurance Framework. Action plans are implemented and the Board and its sub-committees take a view on the outcomes of actions to mitigate risks based on the evidence provided by the Executive function. Executive Directors take responsibility for managing actions and addressing gaps, and the Executive team reviews progress on implementing actions to mitigate major risks at regular meetings.

Conclusion

The Board has concluded that there are no significant strategic internal control issues facing the Trust in 2014/15 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.

Signed



Stuart Bell CBE
Chief Executive **Date: 28 May 2015**

Financial performance, remuneration report and income disclosures

The Trust's financial position and end of year accounts are detailed here

Financial performance for 2014/15

The Trust's financial position is detailed in the Annual Statutory Accounts, which are appended to this Annual 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 us by telephone 01865 901 000 or email enquiries@oxfordhealth.nhs.uk. These will be made available free of charge.

The Board approved the full accounts on 27 May 2015 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 2014/15 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 2014/15.

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

After making enquiries, 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, they continue to adopt the going concern basis in preparing the accounts.

The Financial year 2014/15 is referred to as FY15, the financial year 2013/14 as FY14, etc.

Financial headlines

The key headlines are as follows:

- an operating deficit of £8.7m, after accounting for asset impairments, compared to an operating deficit of £0.3m the previous year. The underlying position excluding asset impairments was an operating surplus of £2.4m, which represents a decrease of £5.6m compared to the previous year
- surplus margin of -1.3%, compared to 1.0% for the previous year. The surplus margin is the surplus before exceptional items as a percentage of total income

- total income for the Trust increased by £2.3m (0.8%) in FY15 to £288.3m
- income from patient services decreased by £2.4m (1.0%) to £239.6m

During the year, income from the provision of goods and services for the purposes of the health service in England were greater than income from the provision of goods and services for other purposes. Surpluses generated on other income received contribute to the provision of goods and services for the purposes of the health service in England.

Key Performance Indicators (KPIs)

Monitor Continuity of Service Risk Metrics for the year ended 31 March 2015

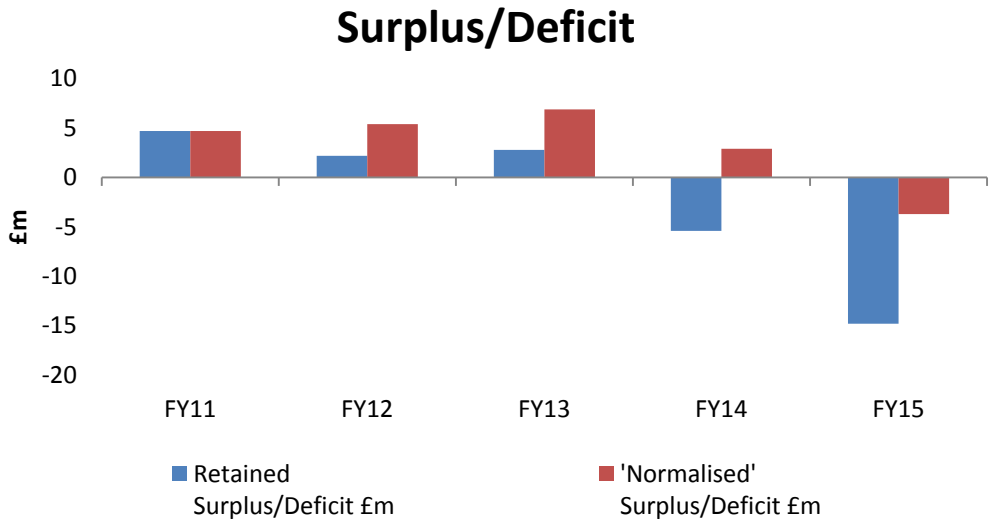
	Actual	Plan	Variance
Capital Service Cover	1.2	1.5	-0.3
Liquidity	-6.6	-3.5	-3.1

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.

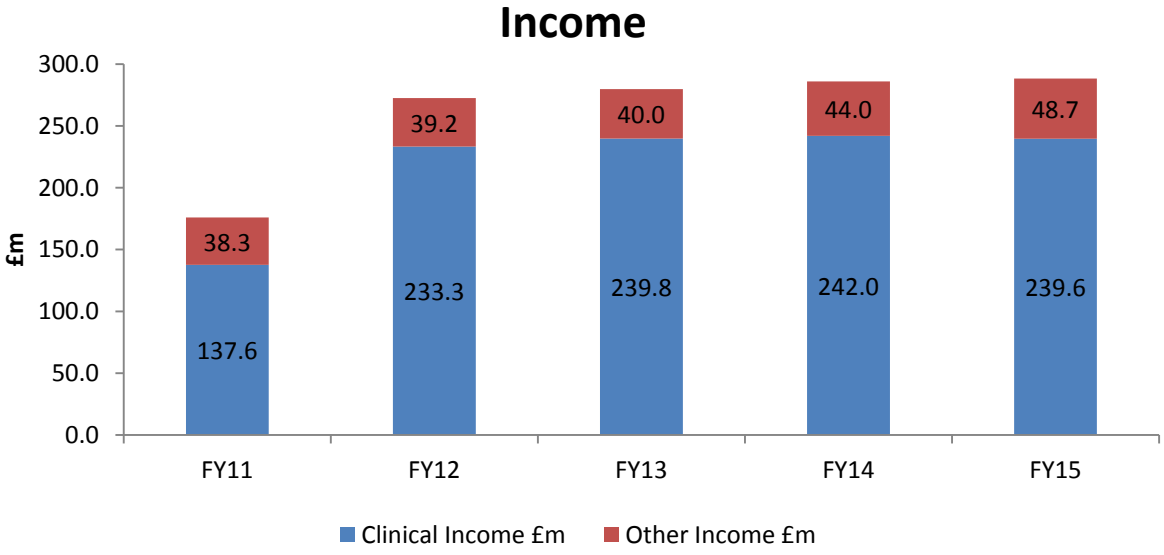
Trust performance

Historically, the Trust has a strong track record of delivering against financial targets. Excluding exceptional items, such as asset impairments, the Trust has achieved a 'normalised' surplus for the last six years prior to FY15. These surpluses are available to invest back into the Trust to improve its services. However, during FY14 and FY15, we invested in and focused on remodelling our services to improve integration and local access to high quality care. Consequently we did not achieve the cost improvement target in the last two years which combined with reduced revenue resulted in a deficit in FY15 rather than the originally planned break-even position.

The income statement is a deficit of £3.7m (before charging impairments of £11.1m), against a plan of break-even. EBITDA was £9.0m against the plan of £12.1m. The main reasons for the adverse position are a shortfall in delivery against the cost improvement plans; reduced revenue for some services, staffing costs pressures with related agency costs due to higher than planned activity levels in community hospitals, community nursing services and mental health inpatient wards, higher than planned cost of out-of-area treatment and higher than planned depreciation charges partly offset by a lower than planned public dividend capital (PDC) liability.



2014/15 Statement of Comprehensive Income Summary	
	£000
Total Income	288,336
Expenses	(297,063)
Operating Deficit	**(8,727)**
Finance income/expense	(2,049)
Dividends paid to Government	(4,071)
Deficit for the year	**(14,847)**
Impairment of assets	11,114
Deficit before exceptional items	**(3,733)**



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 £2.3m (0.8%) in FY15 to £288.3m, compared to the previous year. Income from patient activities decreased by £2.4m (1.0%) to £239.6m, due to the impact of the national deflator on contract values. Contracts totaling £2.4m ceased in FY15 compared to FY14, partly offset by £1.7m of additional income received in respect of other contracts. The Trust's main commissioners in FY15 were the Oxfordshire and Buckinghamshire CCGs and NHS England, which accounted for approximately 87% of clinical activity income. Income from other activities increased by £4.7m (10.7%) to £48.7m, excluding reversal of impairments the increase was £1.4m (3.4%) to £43.5m.

Operating expenses increased by £10.7m (3.7%) to £297.1m, mainly attributable to increased impairment charges included in expenditure as well as increased staff costs.

The majority of operating expenses relate to pay costs, which have increased by £4.4m, 2.2% to £206.6m due to pay inflation and caring for more patients.

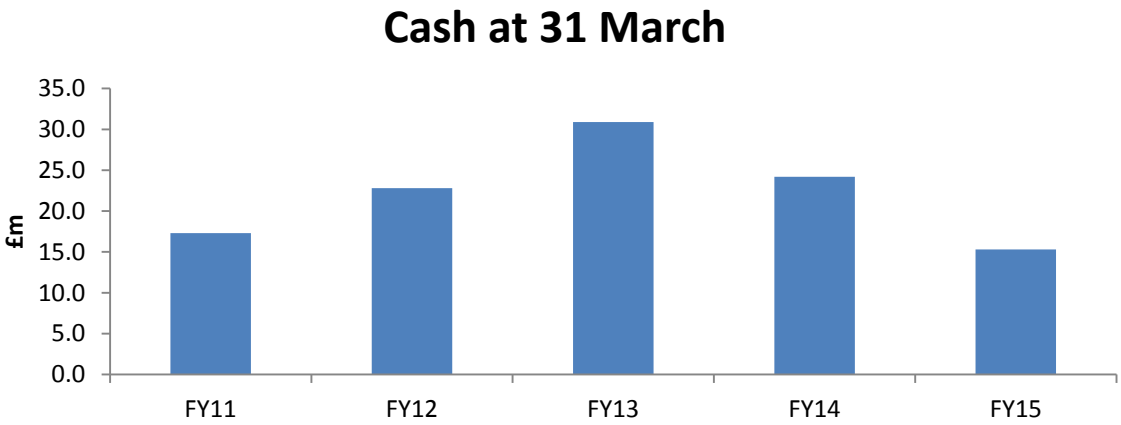
Capital expenditure

During FY15, the Trust has reduced investment in its property and infrastructure, reflecting the completion of the Whiteleaf Centre in FY14 and the deficit position in FY15. Capital spend in FY15 was £9.2m, compared with £21.6m in the previous year. The Trust's main capital investment areas during FY15 were:

- estates operational and risk management (£3.2m) – including backlog maintenance and other works to address compliance requirements, such as infection control and ligature risks
- IT Infrastructure and development (£2.7m) - including £0.6m for the Next Generation Electronic Health Records project
- Windrush Ward, Oxford (£0.9m) – refurbishment works to relocate City Community Centre to this site

Cash flow and net debt

Although the Trust's cash balances decreased by £8.9m during the year they remain relatively strong at £15.3m at the year-end. Cash reduced during the year as a result of the capital investment, decreased deferred income and the deficit position partly offset by proceeds from the sale of Mandalay House and decreased trade and other receivables.



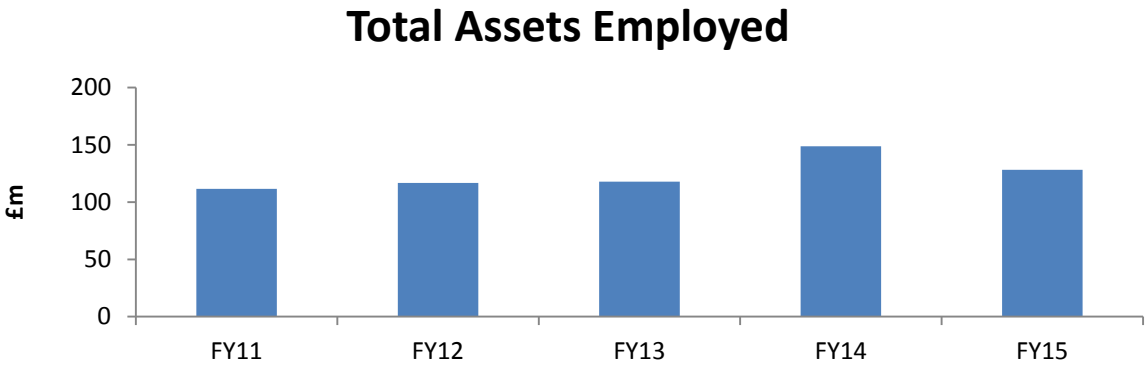
The Trust generated £8.0m of cash from operations, down £6.0m on the previous year, primarily as a result of the operating deficit and decreased deferred income, offset by decreased trade and other receivables.

The Trust's gearing ratio (the percentage of capital employed that is financed by debt and long term financing) increased to 23.4% (21.2% in FY14) as a result of impairments to land and buildings reducing the capital employed. Year-end net debt decreased by £1.5m to £30.0m (£31.5m in FY14).

The Trust's Liquidity Ratio (Trust's ability to meet its short term obligations on time) according to Monitor's Liquidity risk rating calculation is -6.6. This equates to a Liquidity risk rating of '3' within Monitor's Continuity of Service Risk Rating, which represents the second lowest level of risk according to Monitor's metrics.

Total assets employed

Total assets employed decreased by £20.6m (13.8%) to £128.2 m, reflecting the impairments to land and buildings together with the operating deficit.



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 31 March 2015 was as follows:

- Oxfordshire - £10.7m (£10.7m, FY14)
- Buckinghamshire Adults of working age - £8.0m (£8.5m, FY14)
- Buckinghamshire Older Adult - £2.9m (£3.0m, FY14)

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 2014/15

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	**72,922**	**87,028**
Total Non NHS trade invoices paid within target*	**68,695**	**82,039**
Percentage of Non-NHS trade invoices paid within target	**94.2%**	**94.3%**
Total NHS trade invoices paid in the year	**2,693**	**17,358**
Total NHS trade invoices paid within target*	**2,381**	**16,416**
Percentage of NHS trade invoices paid within target	**88.4%**	**94.6%**

*Target - The Better Payment Practice Code requires the Trust to aim to pay 95% of all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. 94.2% of the total number of non-NHS invoices received and processed were paid within the 30 day target, 94.3% 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 absolutely committed to maintaining an honest, open and well-intentioned culture 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 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 (Whistleblowing) Policy. Reports on any counter fraud activity are made to the Audit Committee.

Future finance and performance outlook

As described elsewhere in this Annual Report, the Trust, like the rest of the NHS, is facing an extremely challenging financial future and the associated risks should not be underestimated. We already know that the NHS will continue to receive limited funding growth and is faced with a national efficiency target of at c. 4% per annum that leads directly to reductions in income on existing contracts year-on-year. With the majority of our services being under block contracts, there is no payment for the continued increases in activity which put additional severe strain on our ability to maintain financial sustainability.

In the regions where we provide services the funding allocation to CCGs is significantly below the national average per head of population and this shortfall is borne largely by the non-acute service providers. There has been a further revenue pressure as a consequence of the financial deficit situation in Oxfordshire, which has resulted in a lesser proportion of the health funds being allocated to mental health and community services although demand and activity have increased. During FY14 and FY15, we self-invested in and focused, after consultation with our commissioners, on remodelling our services to improve integration and local access to high quality care. As a result of the shortfall in revenue and the self-investment the Trust did not achieve its cost improvement target and, despite efficiency levels above the national average, incurred a deficit in FY15. The Trust's financial strategy responds to three key challenges of maintaining and improving levels and quality of patient care, integrating and transforming our services for the benefit of the wider care system and reducing cost through improving productivity. However, there is significant financial risk in the FY16 plan, and in the coming years.

The financial strategy for the Trust for FY16-FY17 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 six years since becoming an NHS foundation trust. We will continue to be proactive in responding to the economic recession and the potential impact on public service funding, through:

- robust 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
- securing income that reflects fair price

The Board of Directors approved the FY16 Financial Plan and FY16 budget at its March 2014 meeting.

The key headlines are:

- a normalised deficit (excluding non-recurrent items) of £5.4m, giving a normalised surplus margin of -1.9%
- a normalised EBITDA margin (excluding non-recurring items) of 2.2%
- the requirement for cash releasing efficiency savings of £5.1m
- capital investment of £6.9m
- a Continuity of Service Risk Rating of '2'

The Trust's main contracts in FY16 are with Oxfordshire and two Buckinghamshire CCGs 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. The NHS England Wessex Area Team commission the Trust to provide forensic services, CAMHS and eating disorder inpatient and related day patient services. The Trust also has a contract to deliver child and adolescent mental health services in Swindon, Wiltshire and BaNES.

With the continued downward pressure on income through the annual national efficiency requirement, the Trust will continue to drive increased productivity and quality and deliver cash releasing efficiencies, resulting in a significant reduction in the Trust's cost base over the next two years. 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 productivity, 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 £11.9m over the next two years. Capital investment will be focused on addressing estate condition and compliance issues and maintaining its existing infrastructure to ensure that Trust assets remain 'fit for purpose' to support the provision of high quality services. In addition to its estate infrastructure, the Trust will continue to invest in information technology and information systems to ensure high quality data, and as a way of facilitating improvements and adding value. The capital programme will be financed through cash generated from operations and surplus land sales.

Apart from the challenging economic environment within which the Trust continues to operate, the main risks facing the Trust during FY6 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; and delivering a substantial capital investment programme, particularly in relation to the replacement patient record system, on time and within budget.

Salaries and allowances

2014/15								
Name	Title	Effective dates if not in post full year.	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (rounded to nearest £00)	Total salary and other remuneration (bands of £5,000)	Pension-related benefits (bands of £2,500)	Total including pension-related benefits (bands of £5,000)
			£000	£000	£000	£000	£000	£000
Stuart Bell	Chief Executive		185-190	0	0	185-190	0	185-190
Mike McEnaney	Director of Finance		145-150	0	0	145-150	25-27.5	175-180
Yvonne Taylor	Chief Operating Officer		120-125	0	0	120-125	0	120-125
Clive Meux	Medical Director and Director of Strategy		100-105	35-40	0	135-140	0	135-140
Ros Alstead	Director of Nursing and Clinical Standards		120-125	0	0	120-125	282.5-285	405-410
Martin Howell	Chair		40-45	0	0	40-45	0	40-45
Cedric Scroggs	Non-Executive Director	1 Apr 2014 - 11 Feb 2015	10-15	0	0	10-15	0	10-15
Dr Anne Grocock	Non-Executive Director		10-15	0	0	10-15	0	10-15
Sue Dopson	Non-Executive Director		10-15	0	0	10-15	0	10-15
Lyn Williams	Non-Executive Director		15-20	0	0	15-20	0	15-20
Mike Bellamy	Non-Executive Director		10-15	0	0	10-15	0	10-15
Alyson Coates	Non-Executive Director		15-20	0	0	15-20	0	15-20
Jonathan Asbridge	Non-Executive Director	1 Jul 2014 - 31 Mar 2015	5-10	0	0	5-10	0	5-10
John Allison	Non-Executive Director	1 Oct 2014 - 31 Mar 2015	5-10	0	0	5-10	0	5-10

2013/14								
Name	Title	Effective dates if not in post full year.	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (rounded to nearest £00)	Total salary and other remuneration (bands of £5,000)	Pension-related benefits (bands of £2,500)	Total including pension-related benefits (bands of £5,000)
			£000	£000	£000	£000	£000	£000
Stuart Bell	Chief Executive		185-190	0	0	185-190	0	185-190
Mike McEnaney	Director of Finance		145-150	0	0	145-150	25-27.5	170-175
Yvonne Taylor	Chief Operating Officer		120-125	0	0	120-125	45-47.5	170-175
Clive Meux	Medical Director and Director of Strategy		100-105	35-40	0	135-140	102.5-105	240-245
Ros Alstead	Director of Nursing and Clinical Standards		100-105	0	0	100-105	7.5-10	110-115
Martin Howell	Chair		40-45	0	0	40-45	0	40-45
Cedric Scroggs	Non-Executive Director		10-15	0	0	10-15	0	10-15
Dr Anne Grocock	Non-Executive Director		10-15	0	0	10-15	0	10-15
Sue Dopson	Non-Executive Director		10-15	0	0	10-15	0	10-15
Roger Reed	Non-Executive Director	1 Apr 2013 - 30 Apr 2013	0-5	0	0	0-5	0	0-5
Lyn Williams	Non-Executive Director		15-20	0	0	15-20	0	15-20
Mike Bellamy	Non-Executive Director		10-15	0	0	10-15	0	10-15
Alyson Coates	Non-Executive Director		15-20	0	0	15-20	0	15-20

'Total salary and other 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 or an amount of £26,079 paid to the Medical Director in relation to an external clinical contract.

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

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.

The remuneration of the highest paid director in the Trust in the financial year 2014/15 was £189,260 (2013/14, £189,260). This was 7.69 times (2013/14, 7.69 times) the median remuneration of the workforce, which was £24,599 (2013/14, £24,599).

In 2014/15, no employee (none in 2013/14) received remuneration in excess of the highest paid director. Remuneration ranged from £12,180 to £189,260 (2013/14 £12,180 - £189,260).

The Medical Director receives a National Clinical Excellence Award, shown as 'other remuneration', but this is not a cost borne by the Trust.

There were 15 directors in office during the financial year 2014/15 (2013/14, 13), of which 11 (2013/14, 9) received expenses with a total value of £14,900 (2013/14, £7,400).

During 2014/15, the Trust had 35 Governor seats available at the start of the year and this was increased to 37 in November 2014. Full details of the Governors in post through the year can be found on page 36. Whilst the role is voluntary, governors may claim reasonable expenses and the total value of expenses reimbursed through the year was £1,100 (2013/14, £500).

Annual statement on remuneration from the Chair of the Remuneration Committee

It was agreed, as was the case for the past three years, that there would be no general annual increase applied to senior managers' pay or other elements of remuneration arrangements for the year. There was one substantial change to an individual senior manager's remuneration, the Director of Nursing and Clinical Standards, based upon benchmarked information and to reflect the increased scope of responsibility for learning and development for the Trust. No advice or services

were provided to the committee by any person who was not a member of the committee or an employee of the Trust.

Senior Managers' remuneration policy

There are no additional elements that constitute any senior managers' remuneration, including Executive and Non-Executive Directors, to those specified in the table of salaries and allowances. The amounts that are designated salary in the table represent a single contracted annual salary and there are no particular remuneration arrangements which are specific to any senior manager. The Trust does not operate performance pay or bonus schemes. There were no changes made in the period to existing components of the remuneration package and no components added.

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

The senior managers not on Agenda for Change contracts are listed in the table on the next page (where their contracts are permanent, there are therefore no unexpired terms).

Name	Start date as senior manager	Contract type	Notice period by employee	Notice period by employer
Stuart Bell	01/10/2012	Permanent	6 months	6 months
Yvonne Taylor	02/01/2013	Permanent	3 months	6 months
Ros Alstead	22/03/2011	Permanent	3 months	3 months
Mike McEnaney	15/08/2011	Permanent	3 months	6 months
Clive Meux	01/04/2011	Five years (as Medical Director)	3 months	3 months

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

Service contracts obligations

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

Policy on payment for loss of office

Notice periods under senior managers' contracts are determined and agreed taking into consideration the need to protect the Trust from extended vacancies on the one hand and the needs of the employee and financial risks to the Trust on the other. The maximum notice period is six months. Payments to senior managers for loss of office for loss of office are governed by and compliant with the NHS standard conditions and regulations and all payments are submitted to Monitor for Treasury approval. There were no payments made in the period to senior manager for loss of office nor any payments made to any individual who was not a senior manager in the period but had been a senior manager prior to this financial year.

Statement of consideration of employment conditions elsewhere in the Trust

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

consideration for annual pay increases for senior managers is the award made under Agenda for Change in recent years – no annual increase has been applied to senior managers for three years.

Stuart Bell CBE
Chief Executive  **Date: 28 May 2015**

PENSION BENEFITS								
	Real increase/ (decrease) in pension at age 60/65 (Bands of £2,500)	Real increase/ (Decrease) in pension lump sum at aged 60 (Bands of £2,500)	Total accrued pension at age 60/65 at 31 March 2015 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (Bands of £5,000)	Cash equivalent transfer value at 31 March 2015	Cash equivalent transfer value at 31 March 2014	Real Increase/ (Decrease) in equivalent transfer value as at 31 March 2015	Employer's contribution to stakeholder pension
Title	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Stuart Bell Chief Executive	0-2.5	0-2.5	80-85	245-250	1695	1599	53	0
Mike McEnaney Director of Finance	0-2.5	n/a	5-10	n/a	131	90	38	0
Yvonne Taylor Chief Operating Officer	0-2.5	0-2.5	25-30	75-80	554	509	32	0
Clive Meux Medical Director and Director of Strategy	0-2.5	0-2.5	80-85	240-245	1636	1546	48	0
Ros Alstead Director of Nursing and Clinical Standards	12.5-15	37.5-40	65-70	195-200	1398	1056	313	0

Off-payroll engagements

The Trust's policy on the use of off-payroll arrangements for highly paid staff is to obtain contractual assurance that such staff are liable for payment of income tax and national insurance.

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

1. **For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than six months:**

No disclosure required

2. **For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than six months:**

No disclosure required

3. **For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015 trusts must also disclose:**

No disclosure required

Independent Auditor's report to the Council of Governors and Board of Directors of Oxford Health NHS Foundation Trust

Opinion on financial statements of Oxford Health NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2015 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
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity 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.

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.

Going concern

We have reviewed the Accounting Officer's statement contained within the Financial Performance, Remuneration Report and Income Disclosures on page 221 and the going concern and account preparation statement on page 20 that the Trust is a going concern.

We confirm that:

- we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern.

However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Risk	How the scope of our audit responded to the risk
NHS revenue and provisions There are significant judgements in recognition of revenue from care of NHS service users and in provisioning for disputes with commissioners due to • the judgements taken in evaluating volume related income; and • the judgemental nature of provisions for disputes, including in respect of performance income. Approximately half of the Trust's income, £115m comes from Oxfordshire Clinical Commissioning Group with the rest coming from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. There are NHS debtors of £3.4m at 31 March 2015 with no provision. The accounting policy for income can be found in note 1.2 and further details on the income recognised are in note 5.	We evaluated the design and implementation of controls over recognition of income. We tested the recognition of income through the year, including year-end cut-off, and evaluated the results of the agreement of balances exercise. We challenged key judgements around actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and the results from the Agreement of Balances exercise.
Property valuations The Trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation. The portfolio has been valued at £142m at 31 March 2015. The valuations are by nature significant estimates which are based on specialist and management assumptions and which can be subject to material changes in value. The Trust disclose the accounting policy for property, plant and equipment in note 1.5 and further detail is provided in note 19.	We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Trust to the valuer. We used internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Trust's properties, including comparison of the index values used by the Trust's valuer to our independently obtained figures. We assessed whether the valuation and its accounting treatment were compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.

Accounting for Capital Expenditure The Trust has an extensive capital programme and additions in 2014/15 amounted to £8.4 million. Determining whether expenditure should be capitalised can involve significant judgement as to whether the costs meet the accounting standards criteria for capitalisation. In addition, accounting adjustments may be required to the carrying values of assets that are being replaced or refurbished.	We evaluated the design and implementation of controls around the capitalisation of costs and tested individual transactions on a sample basis to confirm compliance with relevant accounting requirements. We obtained an understanding of key projects and challenged the appropriateness of accounting for significant transactions in connection with the project including whether adjustments to the value of old assets were dealt with as part of the revaluation process. We have assessed whether additions represent valid capital expenditure and have been recognised in the correct period.
Going Concern Assessment The Directors' Going Concern statement is set out on pages 20 and 221 of the Annual Report, and the Trust's principal risks and uncertainties on page 206 of the Annual Governance Statement. The going concern assessment was considered to be an area of audit focus due to the deficit for the year ended 31 March 2015, the deficit forecast for 2015/16, and the uncertainties detailed in the Directors' statement.	We evaluated management's going concern assessment by challenging the key judgements within the Trust's forecasts, including assumptions over activity levels, cost improvement programme savings, and cost of agency staff requirements. We examined the Trust's funding agreements that are in place, reviewed the operational plan and considered how projections compare with other trusts. Our conclusion on the Directors' Going Concern statement is set out above.

The description of risks above should be read in conjunction with the significant issues considered by the Audit Committee discussed on page 30.

Our audit procedures relating to these matters were designed in the context of our audit of the financial statements as a whole, and not to express an opinion on individual accounts or disclosures. Our opinion on the financial statements is not modified with respect to any of the risks described above, and we do not express an opinion on these individual matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

We determined materiality for the Trust to be £2.8m, which is below 1% of income and below 3% of equity.

We agreed with the Audit Committee that we would report to the committee all audit differences in excess of £138k, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control. Audit work was performed at the Trust's head offices in Oxford directly by the audit engagement team, led by the audit partner.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.

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 Strategic Report and 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

Under the Audit Code for NHS Foundation Trusts, we are required 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 is inconsistent with information of which we are aware from our audit;
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters. 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.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements;
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we have considered whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed. We confirm that we have not identified any such inconsistencies or misleading statements.

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 for 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. We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our dedicated professional standards review team.

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.

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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Susan Barratt BA ACA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Reading, United Kingdom
28 May 2015

Annual Statutory Accounts
Year ending 31 March 2015

Annual Statutory Accounts - Year Ending 31 March 2015

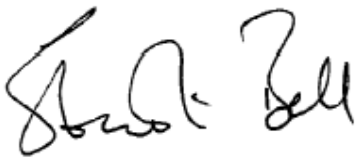
Trust name:	Oxford Health NHS Foundation Trust
This year	2014/15
Last year	2013/14
This year ended	31 March 2015
Last year ended	31 March 2014
This year beginning	1 April 2014
Last year beginning	1 April 2013

FOREWORD TO THE ACCOUNTS

Oxford Health NHS Foundation Trust

The accounts for the year ended 31 March 2015 are set out on the following pages and comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statements 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 2014/15 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 2014/15. The Trust Board has approved the preparation of the 2014/15 accounts on a going concern basis.



Signed: ……

Stuart Bell, Chief Executive

Date: 28 May 2015

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2015

	NOTE	2014/15 £000		2013/14 £000	
Operating income	4,5,6	**288,336**		286,069	
Operating expenses	7	**(297,063)**		(286,373)	
Operating deficit		**(8,727)**		(304)	
Finance costs					
Finance income	16	**76**		78	
Financial expense - financial liabilities	17	**(2,089)**		(2,075)	
Financial expense - unwinding of discount on provisions	17	**(36)**		(50)	
Public Dividend Capital dividends payable	37	**(4,071)**		(3,030)	
Net finance costs			**(6,120)**		(5,077)
Deficit from continuing operations			**(14,847)**		(5,381)
DEFICIT FOR THE FINANCIAL YEAR			**(14,847)**		(5,381)
Other comprehensive income :					
Gain from transfer by absorption from demising bodies	29		**-**		38,974
Revaluation losses and impairment losses property, plant and equipment	20,29		**(6,149)**		(4,209)
Remeasurements of net defined benefit pension scheme asset / liability	11,42		**(343)**		249
Other reserve movements			**-**		(10)
TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR			**(21,339)**		29,623

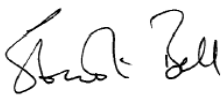
All income and expenditure is derived from continuing operations.
All items in other comprehensive income will not be reclassified subsequently to income and expenditure.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2015

	NOTE	31 March 2015 £000	31 March 2014 £000
NON-CURRENT ASSETS			
Intangible assets	18	**1,216**	630
Property, plant and equipment	19	**158,986**	176,214
Trade and other receivables	22	**30**	30
Total Non-Current Assets		**160,232**	176,874
CURRENT ASSETS			
Inventories	21	**1,804**	1,285
Trade and other receivables	22	**9,571**	10,753
Non-current assets held for sale	23	**3,077**	2,525
Cash and cash equivalents	30	**15,288**	24,213
Total Current Assets		**29,740**	38,776
CURRENT LIABILITIES			
Trade and other payables	24	**(24,649)**	(26,840)
Borrowings	25	**(1,471)**	(1,430)
Other financial liabilities	26	**(357)**	(768)
Other liabilities	27	**(1,838)**	(3,820)
Provisions	28	**(1,600)**	(1,150)
Total Current Liabilities		**(29,915)**	(34,008)
NON-CURRENT LIABILITIES			
Borrowings	25	**(28,574)**	(30,045)
Local government pension scheme	27	**(629)**	(241)
Provisions	28	**(2,620)**	(2,562)
Total Non-Current Liabilities		**(31,823)**	(32,848)
TOTAL ASSETS EMPLOYED		**128,234**	148,794
TAXPAYERS' EQUITY			
Public dividend capital		**90,583**	89,804
Revaluation reserve	29	**20,702**	27,851
Other reserves		**1,317**	1,317
Income and expenditure reserve		**15,632**	29,822
TOTAL TAXPAYERS' EQUITY		**128,234**	148,794

The notes on pages 5 to 47 form part of these accounts.

The financial statements on pages 1 to 47 were approved by the Board and signed on its behalf and authorised for issue by:

Signed:  Date: 28 May 2015

Stuart Bell (Chief Executive)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2014/15

	Total	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2014	**148,794**	89,804	27,851	1,317	29,822
Deficit for the year	**(14,847)**	-	-	-	(14,847)
Transfer to retained earnings on disposal of assets between reserves	**-**	-	(459)	-	459
Revaluation losses and impairment losses on property plant and equipment	**(11,507)**	-	(11,507)	**-**	-
Revaluations - Property, Plant & Equipment	**5,358**	-	5,358	-	-
Actuarial losses on defined benefit pension schemes	**(343)**	-	-	-	(343)
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	**-**	-	(551)	-	551
Movements on other reserves	**-**	-	10	-	(10)
Public Dividend Capital received	**779**	779	-	-	-
Taxpayers' Equity at 31 March 2015	**128,234**	**90,583**	**20,702**	**1,317**	**15,632**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 2013/14

	Total	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve
Taxpayers' Equity at 1 April 2013	117,910	88,543	15,040	6,700	7,627
Deficit for the year	**(5,381)**	-	-	-	(5,381)
Transfers by modified absorption: gains on 1 April transfers from demising bodies	**38,974**	-	-	-	38,974
Transfers by modified absorption: transfers between reserves	**-**	-	14,160	-	(14,160)
Transfer to retained earnings on disposal of assets between reserves	**-**	-	(1,994)	-	1,994
Revaluation losses and impairment losses on property plant and equipment	**(6,200)**	-	(6,200)	**-**	-
Revaluations - Property, Plant & Equipment	**1,991**	-	1,991	-	-
Actuarial gains on defined benefit pension schemes	**249**	-	-	-	249
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	**-**	-	(519)	-	519
Movements on other reserves	**(10)**	-	5,373	(5,383)	-
Public Dividend Capital received	**1,261**	1,261	-	-	-
Taxpayers' Equity at 31 March 2014	**148,794**	**89,804**	**27,851**	**1,317**	**29,822**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2015

	NOTE	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Operating deficit from continuing operations		**(8,727)**	(304)
Operating deficit		**(8,727)**	(304)
Non-cash income and expense:			
Depreciation and amortisation	7	**6,467**	5,022
Impairments	7	**16,377**	10,299
Reversals of impairments	6	**(5,263)**	(2,037)
Non-cash donations/grants credited to income		**-**	(35)
Net loss on disposal of assets		**246**	445
Interest accrued not paid		**-**	-
Dividends accrued and not paid or received		**-**	-
Employer contributions paid less net charge in relation to Local Government Pension Scheme		**45**	55
Decrease/(Increase) in trade and other receivables		**1,167**	(3,045)
(Increase)/Decrease in inventories		**(519)**	270
Increase in trade and other payables		**105**	1,851
(Decrease)/Increase in other liabilities		**(2,373)**	1,548
Increase/(Decrease) in provisions		**473**	(103)
NET CASH GENERATED FROM OPERATIONS		**7,998**	13,966
Cash flows from investing activities:			
Interest received		**76**	78
Purchase of intangible assets		**(757)**	(416)
Purchase of property, plant and equipment		**(10,723)**	(22,042)
Sales of Property, Plant and Equipment		**1,300**	6,882
PFI lifecycle prepayments (cash outflow)		**(94)**	(108)
NET CASH GENERATED USED IN INVESTING ACTIVITIES		**(10,198)**	(15,606)
Cash flows from financing activities:			
Public Dividend Capital received		**779**	1,261
Loans received		**-**	-
Loans repaid		**(1,354)**	(1,371)
Capital element of private finance initiative obligations		**(91)**	(62)
Interest paid		**(1,056)**	(1,064)
Financing element of private finance initiative obligations		**(1,042)**	(1,015)
Public Dividend Capital dividend paid		**(3,961)**	(2,840)
NET CASH USED IN FINANCING ACTIVITIES		**(6,725)**	(5,091)
Decrease in cash and cash equivalents		**(8,925)**	**(6,731)**
Cash and cash equivalents at 1 April		**24,213**	**30,944**
Cash and cash equivalents at 31 March		**15,288**	**24,213**

NOTES TO THE ACCOUNTS

1 Accounting policies and other information

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 FT ARM 2014/15 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 2016/17), 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 Consolidation

NHS Charitable Fund

Oxford Health NHS Foundation Trust is the corporate trustee to the Oxford Health Charity. Oxford Health NHS Foundation Trust has assessed its relationship to the charity and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charity and has the ability to affect those returns and other benefits through its power over the fund.

However, the size of the Oxford Health Charity is not considered material to the accounts of Oxford Health NHS Foundation Trust. On this basis, Oxford Health Charity is not consolidated within the Oxford Health NHS Foundation Trust accounts.

A summary of the financial results and position of Oxford Health Charity is included in note 43.

1.2 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 a subsequent 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.

1.3 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 Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust's accounts, 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 increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.4 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 or current assets such as inventory.

1.5 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.

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 property, plant and equipment 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 as at the valuation date of 31 January 2015.

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 arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating 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. 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. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost 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 charges incurred by the Trust.

1.6 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.

1.7 Government and other grants

Government grants are grants from Government bodies other than income from NHS bodies for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

1.9 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 or loans & receivables.

Financial liabilities are categorised as fair value through income & expenditure or as 'other financial liabilities'.

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 and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Cash and cash equivalents comprise cash on hand and demand deposits, recognisable within three months.

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 or through the use of a bad debt provision.

1.10 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 as 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.

1.11 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 NHS foundation 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.

1.12 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.

1.13 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) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (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.

1.14 Value added tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 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.

1.16 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.

1.17 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* .

1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation 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.

1.19 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. In 2013/14 the net gain corresponding to the net assets transferred from Oxfordshire PCT is recognised within the income and expenditure reserve under the principles of modified absorption accounting which applied to transfers where the transferring body ceased to exist on 1 April 2013.

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.

1.20 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 2014/15. The application of the Standards as revised would not have a material impact on the accounts for 2014/15, were they applied in that year:

IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - adoption delay by HM Treasury. To be adopted from 2015/16
IAS 36 (amendment) recoverable amount disclosures - to be adopted from 2015/16 (aligned to IFRS 13 adoption)
IAS 19 (amendment) employer contributions to defined benefit pension schemes - effective from 2015/16 but not yet EU adopted
IFRS 15 Revenue from contracts with customers - not yet EU adopted but expected to be effective from 2017/18

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 District Valuer Services as at 31 January 2015. 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.

• Impairing of receivables.
The majority of the Trust's income comes from contracts with other public sector bodies, hence the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are as disclosed in the trade and other receivables note.

3 Operating Segments

All of the Trust's activities relate to the provision of healthcare, which is an aggregate of all the individual specialty components included therein. Similarly, the majority of the Trust's income originates with UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the provision or support of healthcare activities generally across the Trust together with the related supplies and overheads necessary. The business activities which earn revenue and incur expenses are therefore of one broad combined nature.

The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board, which includes non-executive directors. The finance report considered by the Trust Board contains only total balance sheet positions and cash flow forecasts for the Trust as a whole. The Board as chief operating decision maker therefore only considers one segment of healthcare in its decision making process.

The single segment of 'healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities in which the Trust engages and economic environments in which it operates.

4 Operating income

	2014/15	2013/14
	£000	£000
Income from activities	**239,627**	242,012
Other operating income	**48,709**	44,057
	288,336	286,069

5 Income from activities

5.1 Income from activities (by activity)

	2014/15	2013/14
	£000	£000
Mental health		
Block contract income	**129,716**	123,299
Cost and volume contract income	**4,668**	10,226
Clinical income for the secondary commissioning of mandatory services	**2,803**	2,857
Other clinical income from mandatory services	**1,084**	1,049
Community services	**101,316**	104,547
Private patient income	**40**	34
	239,627	242,012

All income from activities arises from mandatory services.

5.2 Income from activities (by source)

	2014/15	2013/14
	£000	£000
Commissioner Requested Services		
Clinical Commissioning Groups and NHS England	**213,419**	214,087
Non-Commissioner Requested Services		
Local authorities	**21,730**	22,497
NHS trusts	**2,944**	2,634
Other Central Government bodies	**-**	1,018
Foundation trusts	**106**	260
Health Education England	**-**	142
Bodies external to government	**1,388**	1,340
Private patients	**40**	34
	239,627	242,012

6 Other operating income

	2014/15	2013/14
	£000	£000
Pharmacy sales	**17,283**	15,641
Education and training	**12,493**	11,969
Research and development	**6,769**	6,857
Non-patient care services to other bodies	**4,375**	3,088
Other income	**2,263**	3,623
Profit on disposal of assets held for sale	**-**	46
Reversal of impairments of property, plant and equipment	**5,263**	2,037
Charitable and other contributions to expenditure	**205**	236
Receipt of donations for capital acquisitions	**58**	560
	48,709	44,057

The 2013/14 total remains the same but some figures have been presented in new categories for comparative purposes.

7 Operating expenses

	2014/15	2013/14
	£000	£000
Services from Foundation Trusts	**1,571**	2,797
Services from NHS Trusts	**809**	851
Services from CCGs and NHS England	**2**	-
Purchase of healthcare from non NHS bodies	**3,091**	2,361
Employee Expenses - Executive directors	**909**	875
Employee Expenses - Non-executive directors	**152**	127
Employee Expenses - Staff	**205,015**	200,831
Supplies and services - clinical (excluding drug costs)	**9,061**	9,155
Supplies and services - general	**2,888**	2,902
Establishment	**3,005**	2,621
Transport	**4,272**	5,330
Premises	**8,599**	7,949
Decrease in provision for impairment of receivables	**(34)**	(90)
Increase / (Decrease) in other provisions	**25**	(15)
Change in provisions discount rate	**92**	100
Inventories written down/(back) (net, including inventory drugs)	**42**	(14)
Drug costs (non inventory drugs only)	**2,055**	1,692
Inventories consumed (excluding drugs)	**1,499**	1,475
Drug Inventories consumed	**17,815**	16,251
Rentals under operating leases	**5,331**	5,904
Depreciation of property plant and equipment	**6,296**	4,927
Amortisation of intangible assets	**171**	95
Loss on disposal of property, plant and equipment	**246**	491
Impairment of property, plant and equipment	**16,377**	10,299
Audit services - statutory audit	**68**	68
Other auditor remuneration - non-audit services	**79**	-
Clinical negligence	**300**	327
Professional fees and associated costs	**264**	1,017
Consultancy costs	**1,091**	563
Training, courses and conferences	**1,675**	1,607
Patient travel	**288**	204
Car parking and security	**82**	104
Redundancy (Included in Employee Expenses)	**626**	459
Insurance	**364**	323
Other services, e.g. External payroll	**1,527**	1,517
Losses, ex gratia & special payments	**54**	80
Other	**1,356**	3,190
	297,063	286,373

The Trust has adopted the above operating expenses table in line with Monitor FTC guidance. The 2013/14 total remains the same but some figures have been presented in new categories for comparative purposes.

8 Staff costs and numbers

8.1 Employee expenses

(excluding non-executive directors)

	2014/15 Total	2014/15 Permanently Employed	2014/15 Other	2013/14 Total
	£000	£000	£000	£000
Salaries and wages	163,886	160,566	3,320	163,629
Social Security costs	11,914	11,914	-	12,051
Employer contributions to NHS pension scheme	19,735	19,412	323	19,517
Other pension costs	-	-	-	62
Termination benefits	626	626	-	459
Bank and agency staff	10,522	-	10,522	6,531
Capitalised employee costs	(133)	(133)	-	(74)
	206,550	192,385	14,165	202,175

8.2 Staff numbers

(excluding non-executive directors)

	2014/15 Total	2014/15 Permanently employed	2014/15 Other	2013/14 Total
	WTE	WTE	WTE	WTE
Medical and dental	242	242	-	237
Administration and estates	959	959	-	983
Healthcare assistants and other support staff	1,022	1,022	-	1,068
Nursing, midwifery and health visiting staff	1,553	1,553	-	1,582
Nursing, midwifery and health visiting learners	77	77	-	89
Scientific, therapeutic and technical staff	898	898	-	894
Social care staff	71	71	-	47
Bank and Agency Staff	179	-	179	133
	5,001	4,822	179	5,033

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

8.3 Directors' remuneration and other benefits

	2014/15	2013/14
	£000	£000
Executive and non-executive directors' salaries	888	856
Employers' contribution to executive directors' pensions*	99	100
	987	956

*relates to 5 directors (5 in 2013/14) accruing benefits under the NHS Pension Scheme, a defined benefit scheme

8.4 Staff exit packages

Exit package cost band	2014/15 Number of compulsory redundancies	2014/15 Number of other departures agreed	2014/15 Total number of exit packages	2013/14 Total number of exit packages
< £10,000	**-**	**4**	**4**	5
£10,000 - £25,000	**4**	**3**	**7**	1
£25,001 - £50,000	**4**	**2**	**6**	1
£50,001 - £100,000	**-**	**3**	**3**	0
£100,001 - £150,000	**-**	**-**	**-**	0
Total number of exit packages	**8**	**12**	**20**	7
Total resource cost £'000	**203**	**407**	**610**	71

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

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

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

	2014/15 Number of agreements	2014/15 Total value of agreements £000	2013/14 Number of agreements	2013/14 Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	**-**	**-**	1	38
Mutually agreed resignations (MARS) contractual costs	**10**	**332**	4	29
Non-contractual payments requiring HM Treasury approval	**2**	**75**	2	4
Total	**12**	**407**	7	71
Of which:				
non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	**-**	**-**	**-**	**-**

As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number above will not necessarily match the total number in note 8.4 which will be the number of individuals.

The Remuneration Report provides details of exit payments payable to individuals named in that Report.

One non-contractual payment requiring HM Treasury approval was made in 2014/15, for £66k. Two non-contractual payments requiring HM Treasury approval were made in 2013/14, one for £1k and one for £3k.

9 Employee benefits

The Trust's employees received no material benefits in 2014/15 (none in 2013/14).

10 Retirements due to Ill-health

During 2014/15 there were 6 early retirements (2013/14, 13) from the NHS Foundation Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £158,340 (2013/14, £630,195). 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. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the 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 2012.
The Scheme Regulations 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.

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".

11.1 ***NHS Pension Scheme continued***

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) has been used and replaced 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

Further disclosure of the Buckinghamshire County Council Pension scheme relating to the Trust is shown in note 42.

12 Leases

12.1 Operating lease payments recognised as an expense

	2014/15	2013/14
	£000	£000
Minimum lease payments	**5,331**	5,904
	5,331	5,904

The 2013/14 figure has been restated for comparative purposes as identified in note 7.

12.2 Total future minimum operating lease payments

	Land & Buildings		**Other Leases**		**Employee Car Leases***	
	2014/15	2013/14	**2014/15**	2013/14	**2014/15**	2013/14
	£000	£000	**£000**	£000	**£000**	£000
Payable:						
Not later than one year	**3,814**	4,630	**369**	754	**756**	755
Between one and five years	**2,896**	5,148	**346**	187	**563**	645
After 5 years	**9,385**	11,494	**-**	-	**-**	-
Total	**16,095**	21,272	**715**	941	**1,319**	1,400

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 salaries.

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 Fees paid to external auditor

	2014/15	2013/14
	£000	£000
Audit services - statutory audit	**68**	68
Other auditor remuneration - non-audit services	**79**	-
	147	68

13.2 Limitation on auditor's liability

	2014/15	2013/14
	£000	£000
Limitation on auditor's liability	**-**	-
	-	-

14 Better payment practice code

	2014/15		2013/14	
	Number	**£000**	Number	£000
Measure of Compliance:				
Total Non-NHS trade invoices paid in the year	**72,922**	**87,028**	71,142	88,217
Total Non NHS trade invoices paid within target*	**68,695**	**82,039**	67,452	83,868
Percentage of Non-NHS trade invoices paid within target	**94.2%**	**94.3%**	94.8%	95.1%
Total NHS trade invoices paid in the year	**2,693**	**17,358**	2,669	21,763
Total NHS trade invoices paid within target*	**2,381**	**16,416**	2,448	20,946
Percentage of NHS trade invoices paid within target	**88.4%**	**94.6%**	91.7%	96.2%

* 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

	2014/15	2013/14
	£000	£000
Amounts included within Finance Costs (Note 17) arising from claims made under this legislation	**-**	-
Compensation paid to cover debt recovery costs under this legislation	**-**	-
	-	-

16 Finance income

	2014/15	2013/14
	£000	£000
Bank account interest	**61**	78
Other interest	**15**	-
	76	78

17 Finance expense

	2014/15	2013/14
	£000	£000
Interest on loans	**1,034**	1,048
Financing obligations under PFI contracts:		
- main finance cost *	**717**	723
- contingent finance cost**	**316**	288
Change in discount rate on provisions	**-**	-
Unwinding of discount on provisions	**36**	50
Net finance expense on Local Government Pension Scheme	**22**	16
	2,125	2,125

* 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

	2014/15 £000	2013/14 £000
Gross cost at 1 April	**872**	710
Transfers by modified absorption*	**-**	9
Additions purchased	**757**	417
Disposals	**-**	(264)
Gross cost at 31 March	**1,629**	872
Amortisation at 1 April	**242**	405
Transfers by modified absorption*	**-**	6
Charged during the year	**171**	95
Disposals	**-**	(264)
Amortisation at 31 March	**413**	242
Net book value		
Total at 31 March	**1,216**	**630**

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.

* Assets transferred from Oxfordshire PCT

19 Property, Plant and Equipment

19.1 Property, Plant and Equipment 2014/15

	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 2014	54,322	119,521	85	6,303	5,443	106	6,511	10,767	203,058
Additions purchased	487	4,224	-	1,335	464	3	1,529	253	8,295
Additions donated	-	96	-	-	-	32	-	-	128
Reclassifications	-	5,684	-	(6,301)	525	-	-	92	-
Reclassified as held for sale	(150)	(315)	(85)	-		-	-	-	(550)
Disposals	(195)	(5,790)	-	-	(596)	-	(1,191)	(658)	(8,430)
Revaluation	-	2,484	-	-	-	-	-	-	2,484
Impairments charged to the revaluation reserve	(9,074)	(2,433)	-	-	-	-	-	-	(11,507)
Cost or valuation at 31 March 2015	45,390	123,471	-	1,337	5,836	141	6,849	10,454	193,478
Depreciation at 1 April 2014	5,695	8,748	(2)	3,417	1,090	60	2,797	5,039	26,844
Reclassifications	-	3,417	-	(3,417)	-	-	-	-	-
Reclassified as held for sale	-	-	2	-	-	-	-	-	2
Disposals	-	(4,553)		-	(491)		(1,191)	(651)	(6,886)
Revaluation	-	(2,872)	(2)	-	-	-	-	-	(2,874)
Impairments charged to operating expenses	12,387	3,912	-	-	39	-	-	39	16,377
Reversal of impairments to operating income	-	(5,263)	-	-	-	-	-	-	(5,263)
Charged during the year	-	3,429	2	-	689	8	1,100	1,068	6,296
Depreciation at 31 March 2015	18,082	6,818	-	-	1,327	68	2,706	5,495	34,496
Net Book Value									
Purchased at 31 March 2015	27,309	106,035	-	1,337	4,507	20	4,142	4,962	148,312
Private finance initiatives at 31 March 2015	-	8,813	-	-	-	-	-	-	8,813
Donated and Government Granted at 31 March 2015	-	1,808	-	-	-	53	-	-	1,861
Total at 31 March 2015	27,309	116,656	-	1,337	4,507	73	4,142	4,962	158,986
Purchased at 1 April 2014	48,627	101,458	87	2,457	4,352	21	3,714	5,730	166,446
Private finance initiatives at 1 April 2014	-	7,689	-	-	-	-	-	-	7,689
Donated and Government Granted at 01 April 2014	-	1,625	-	429	-	25	-	-	2,079
Total at 1 April 2014	48,627	110,772	87	2,886	4,352	46	3,714	5,730	176,214

19.2 Property, Plant and Equipment 2013/14

	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 2013	42,510	74,958	765	25,774	2,801	91	10,866	5,241	163,006
Transfers by modified absorption*	16,985	15,400	-	1,744	1,920	-	196	5,694	41,939
Additions purchased	-	14,814	-	2,789	690	21	2,172	681	21,167
Additions donated	-	-	-	-	-	35	-	-	35
Reclassifications	-	22,557	-	(24,004)	1,273	-	-	175	1
Reclassified as held for sale	(1,555)	(454)	(720)	-	-	-	-	-	(2,729)
Disposals	(5)	(5,100)	(120)	-	(1,241)	(41)	(6,723)	(1,024)	(14,254)
Revaluation	-	(67)	160	-	-	-	-	-	93
Impairments charged to the revaluation reserve	(3,613)	(2,587)	-	-	-	-	-	-	(6,200)
Cost or valuation at 31 March 2014	54,322	119,521	85	6,303	5,443	106	6,511	10,767	203,058
Depreciation at 1 April 2013	3,018	6,645	15	3,417	1,561	91	8,482	2,887	26,116
Transfers by modified absorption*	75	256	-	-	417	-	177	2,044	2,969
Reclassifications	-	(2)	-	-	-	-	-	-	(2)
Disposals	-	(4,502)	(22)	-	(1,239)	(41)	(6,723)	(1,003)	(13,530)
Revaluation	-	(1,881)	(17)	-	-	-	-	-	(1,898)
Impairments charged to operating expenses	2,602	7,617	-	-	2	-	-	78	10,299
Reversal of impairments to operating income	-	(2,037)	-	-	-	-	-	-	(2,037)
Charged during the year	-	2,652	22	-	349	10	861	1,033	4,927
Depreciation at 31 March 2014	5,695	8,748	(2)	3,417	1,090	60	2,797	5,039	26,844
Net Book Value									
Purchased at 31 March 2014	48,627	101,458	87	2,457	4,352	21	3,714	5,730	166,446
Private finance initiatives at 31 March 2014	-	7,689	-	-	-	-	-	-	7,689
Donated and Government Granted at 31 March 2014	-	1,625	-	429	-	25	-	-	2,079
Total at 31 March 2014	48,627	110,772	87	2,886	4,352	46	3,714	5,730	176,214
Purchased at 1 April 2013	39,492	59,785	751	22,357	1,240	-	2,384	2,355	128,364
Private finance initiatives at 1 April 2013	-	7,384	-	-	-	-	-	-	7,384
Donated and Government Granted at 01 April 2013	-	1,143	-	-	-	-	-	-	1,143
Total at 1 April 2013	39,492	68,312	751	22,357	1,240	-	2,384	2,355	136,891

* Assets transferred from Oxfordshire PCT which are restricted to healthcare use.

19.3 Economic life of property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
Minimum life years		**1**	**33**	**5**	**3**	**5**	**5**
Maximum life years		**45**	**33**	**15**	**7**	**8**	**10**

19.4 Further comments on property, plant and equipment

All land and buildings were revalued by the District Valuer using Modern Equivalent Asset valuation as at 31 March 2014 and as at 31 January 2015.
Plant and equipment is valued using depreciated replacement cost.

19.5 Loss on disposal of property, plant and equipment

Loss on the disposal of property, plant and equipment is made up as follows:

	2014/15	2013/14
	£000	£000
Loss on disposal of land and buildings	**(131)**	(459)
Loss on disposal of plant and equipment	**(115)**	(32)
	(246)	(491)

£470k of the loss on disposal in 2013/14 relates to the net book value of assets held at the John Hampden Unit, Aylesbury. The services provided from this facility were relocated to the new Whiteleaf Centre in March 2014.

20 Impairment of property, plant and equipment

	2014/15	2013/14
	£000	£000
Property, plant and equipment impairments and reversals taken to SoCI		
Recognised in operating income		
Reversal of Impairments due to changes in market price	**(5,263)**	(2,037)
Recognised in operating expenses		
Impairments due to changes in market price	**16,377**	10,299
Charge to revaluation reserve		
Impairments charged to the revaluation reserve	**11,507**	6,200
Total	**22,621**	14,462

In 2014/15 the £22,621k (2013/14: £14,462k) impairment due to changes in market price was offset by a £5,358k (2013/14: £1,991k) upward revaluation due to changes in market price, resulting in a net impairment of £17,263k (2013/14: £12,471k).
The impairment loss included within other comprehensive income of £6,149k (2013/14: £4,209k) is calculated as the net of the £11,507k (2013/14: £6,200k) impairment loss to revaluation reserve and the £5,358k (2013/14: £1,991k) upward revaluation credited to revaluation reserve.

21 Inventories

21.1 Inventories by type

	31 March 2015	31 March 2014
	£000	£000
Drugs	**1,765**	1,219
Consumables	**0**	10
Energy	**10**	25
Other	**29**	31
	1,804	1,285

Inventories are held at the lower of cost and net realisable value.

21.2 Inventories recognised in expenses

	31 March 2015	31 March 2014
	£000	£000
Inventories recognised as an expense in the period	**19,314**	17,726
Write-down of inventories (including losses)	**339**	210
Reversal of write-downs that reduced the expense	**(297)**	(224)
	19,356	17,712

22 Trade and other receivables

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
NHS receivables	**3,403**	3,156	**-**	**-**
Receivables due from NHS charities - revenue	**86**	57	**-**	**-**
Other receivables with related parties	**969**	2,248	**-**	**-**
Other receivables	**1,244**	1,006	**30**	**30**
VAT	**473**	318	**-**	**-**
Accrued income	**1,869**	2,550	**-**	**-**
PDC dividend receivable	**20**	130	**-**	**-**
Provision for the impairment of receivables	**(141)**	(190)	**-**	**-**
Prepayments other	**1,648**	1,478	**-**	**-**
	9,571	10,753	**30**	**30**

The majority of activity is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2 Impairment of receivables

	Ageing of impaired receivables		Receivables past their due date but not impaired	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Not due	**23**	19		
By up to three months	**26**	16	**1,402**	2,226
By three to six months	**24**	48	**204**	204
By more than six months	**123**	203	**4**	27
	196	286	**1,610**	2,457

22.3 Provision for impairment of receivables

	2014/15	2013/14
	£000	£000
Balance at 1 April	**190**	280
Amount recovered during the year	**(99)**	(179)
Amounts utilised	**(15)**	0
Increase in receivables impaired	**65**	89
Balance at 31 March	**141**	190

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 2014/15

	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 2014	**-**	**2,525**	**-**	**-**	**2,525**
Plus assets classified as available for sale in the year	**-**	**552**	**-**	**-**	**552**
Less assets sold in year	**-**	**-**	**-**	**-**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March 2015	**-**	**3,077**	**-**	**-**	**3,077**

There was a gain recognised on assets sold in the year of £47k

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 2014	**1,555**	**250**	**720**	**-**	**-**	**-**	**2,525**
Plus assets classified as held for sale in the year	150	315	87	-	-	-	552
Less assets sold in the year	-	-	-	-	-	-	-
Balance brought forward at 31 March 2015	**1,705**	**565**	**807**	**-**	**-**	**-**	**3,077**

The non-current assets held for sale at 1 April 2014 relate to land and buildings at the Tindal Centre and part of the remaining Manor hospital site. The loss recognised on becoming classified as held for sale was £5,988k.

The non-current assets held for sale at 31 March 2015 relate to land and buildings at the Tindal Centre and part of the remaining Manor hospital site together with Charter House. The Trust expects the sales to complete in 2015/16.

24 Trade Payables

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
NHS payables - revenue	**1,331**	1,315	**-**	-
Related Parties payables - revenue	**3,667**	2,826	**-**	-
Other trade payables - revenue	**4,492**	2,928	**-**	-
Other trade payables - capital	**416**	1,857	**-**	-
Tax and social security costs	**3,484**	3,644	**-**	-
Accruals	**11,180**	14,071	**-**	-
Other Payables	**79**	199	**-**	-
	24,649	26,840	-	-

25 Borrowings

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Loans from:				
Department of Health	**1,338**	**1,338**	**24,087**	**25,425**
Other entities	**-**	**15**	**-**	**-**
PFI liabilities:				
Main liability	**133**	**77**	**4,487**	**4,620**
	1,471	**1,430**	**28,574**	**30,045**

Department of Health loan facility of £28.1m for the Manor House redevelopment has been fully drawn down. 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 was repaid in full during 2014/15. The Trust received Salix Finance Ltd Energy Efficiency Loans totalling £86k which were repaid in full during 2014/15.

26 Other financial liabilities

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Holiday pay accrual	**357**	768	**-**	-
	357	768	**-**	-

27 Other liabilities

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Deferred Income	**1,838**	3,820	**-**	-
Local Government Pension Scheme	**-**	-	**629**	241
	1,838	3,820	**629**	241

28 Provisions

28.1 Provisions by category

	Current		Non-current	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000	£000	**£000**	£000
Pensions relating to other staff	**93**	99	**976**	1,029
Legal claims	**103**	126	**-**	-
Other - redundancy	**495**	350	**-**	-
Other - pensions to death	**16**	16	**190**	185
Other - injury benefit	**45**	44	**842**	793
Other - employment	**127**	178	**-**	-
Other - dilapidations	**721**	227	**612**	555
Other - onerous lease	**-**	110	**-**	-
	1,600	1,150	**2,620**	2,562

28.2 Analysis of provisions

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Provision at 1 April 2014	**1,128**	**126**	**2,458**	**3,712**
Arising during the year	**38**	**70**	**1,440**	**1,548**
Used during the year	**(95)**	**(47)**	**(674)**	**(816)**
Change in discount	**35**	**-**	**57**	**92**
Reversed unused	**(52)**	**(46)**	**(254)**	**(352)**
Unwinding of discount	**15**	**-**	**21**	**36**
Provision at 31 March 2015	**1,069**	**103**	**3,048**	**4,220**
Expected timing of cash flows:	**£000**	**£000**	**£000**	**£000**
no later than one year	**93**	**103**	**1,404**	**1,600**
later than one year and no later than five years	**361**	**-**	**658**	**1,019**
later than five years	**615**	**-**	**986**	**1,601**

Pensions relating to other staff results from early retirements for which the Trust is liable. Other provisions includes injury benefits to former staff for which the Trust is liable. Also included in other provisions are dilapidations provisions for the Trust's leasehold premises. There are no material uncertainties around the timing of these cash flows.

£542k is included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities of the Trust (31 March 2014: £503k).

29 Revaluation reserve

	2014/15			2013/14		
	Total revaluation reserve	**Revaluation reserve - intangibles**	**Revaluation reserve - property, plant and equipment**	Total revaluation reserve	Revaluation reserve - intangibles	Revaluation reserve - property, plant and equipment
	£000	**£000**	**£000**	£000	£000	£000
Revaluation reserve at 1 April	**27,851**	**-**	**27,851**	15,040	-	15,040
Transfers by modified absorption	**-**	**-**	**-**	14,160	-	14,160
Revaluation (losses) and impairment losses property, plant and equipment	**(6,149)**	**-**	**(6,149)**	(4,209)	-	**(4,209)**
Transfers to the income and expenditure account in respect of asset disposals	**(459)**	**-**	**(459)**	(1,994)	-	(1,994)
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	**(551)**	**-**	**(551)**	(519)	-	**(519)**
Other transfers on reserves	**10**	**-**	**10**	5,373	-	5,373
Revaluation reserve at 31 March	**20,702**	**-**	**20,702**	27,851	-	27,851

On 1 April 2013, Oxford Health NHS Foundation Trust received assets from Oxfordshire PCT. The net assets received were £39.0m. These net assets had an associated revaluation reserve balance in the accounts of the PCT as at 31 March 2013 of £14.2m. The services associated with these assets were previously transferred to the Trust in 2011, hence the historical performance of the function is already included in the Trust's financial statements.

On 1 April 2013, Oxford Health NHS Foundation Trust recognised the £39.0m net assets in its statement of financial position. The corresponding gain of £39.0m was recognised into the income and expenditure reserve. This gain is material therefore is a separate line item in the statement of changes in taxpayers' equity and within other comprehensive income on the face of the statement of comprehensive income.

The Trust transferred £14.2m from its income and expenditure reserve to its revaluation reserve, and reports this transfer in the statement of changes in taxpayers' equity.

30 Cash and Cash Equivalents

	31 March 2015	31 March 2014
	£000	£000
Balance at 1 April	**24,213**	30,944
Net change in year	**(8,925)**	(6,731)
Balance at 31 March	**15,288**	24,213
Consists of:		
Cash with Government Banking Service	**15,029**	23,953
Commercial banks and cash in hand	**259**	260
Cash and cash equivalents as in Statement of Financial Position	**15,288**	24,213

Of the balance classified as cash with commercial banks and cash in hand, £203k (31 March 2014: £203k) is restricted by the requirement for a representative from Buckinghamshire County Council to approve withdrawals.

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 2014/15

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	8,613	8,345	(268)
OCC	2,280	2,205	(75)
OCC contribution to Trust overheads	111	111	-
Total Pooled Budget	**11,004**	**10,661**	**(343)**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	OCC Contribution
	£000	£000	£000
Pay Expenditure	9,834	7,757	2,077
Non-Pay Expenditure	716	588	128
Contribution to Overheads	111	-	111
	10,661	**8,345**	**2,316**

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 2014/15

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	5,651	5,701	50
BCC	2,229	2,238	9
Total Delegated Budget	7,880	7,939	59
BCC contribution to Trust overheads	99	99	-
Total Pooled Budget	**7,979**	**8,038**	**59**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	BCC Contribution
	£000	£000	£000
Pay Expenditure	6,987	5,012	1,975
Non-Pay Expenditure	959	693	266
Income	(7)	(4)	(3)
Contribution to Overheads	99	-	99
	8,038	**5,701**	**2,337**

Buckinghamshire Older Adults Pooled Budget Performance 2014/15

	Plan	Actual	Adjustment to Contribution
	£000	£000	£000
Oxford Health NHS FT	2,269	2,111	(158)
BCC	852	793	(59)
Total Delegated Budget	3,121	2,904	(217)
BCC contribution to Trust overheads	41	41	-
Total Pooled Budget	**3,162**	**2,945**	**(217)**

Analysis of Income and Expenditure within the Pooled Budget

	Total	Trust Contribution	BCC Contribution
	£000	£000	£000
Pay Expenditure	2,748	2,024	724
Non-Pay Expenditure	156	87	69
Income	-	-	-
Contribution to Overheads	41	-	41
	2,945	**2,111**	**834**

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 2014/15 value) is recorded within the Trust's total land value.

Total obligations for on-'Statement of Financial Position' PFI contracts due**:

	31 March 2015	31 March 2014
	£000	£000
Not later than one year	**839**	794
Later than one year, not later than five years	**3,743**	3,568
Later than five years	**4,994**	6,016
Subtotal	**9,576**	10,378
Less: interest element	**(4,956)**	(5,681)
Total	**4,620**	4,697

** 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 £521k (prior year £508k).

The Trust is committed to the following charges:

	31 March 2015	31 March 2014
	£000	£000
PFI scheme expiry date:		
Not later than one year	**534**	521
Later than one year, not later than five years	**2,271**	2,217
Later than five years	**3,174**	3,764
Total	**5,979**	6,502

33 Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2015 were £2,288k (31 March 2014: £4,505k).

34 Events After the Reporting Period

No significant events after the reporting period

35 Contingencies

35.1 Contingent Liabilities

	2014/15	2013/14
	£000	£000
Equal Pay cases	**-**	-
Other	**-**	-
	-	-

35.2 Contingent Assets

	2014/15	2013/14
	£000	£000
Contingent Assets	**-**	-
	-	-

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 CCG, NHS England, Chiltern CCG and Aylesbury Vale CCG together account for 87% of the Trust's clinical income.

NHS Oxfordshire CCG
NHS England
NHS Chiltern CCG
NHS Aylesbury Vale CCG
Health Education England
Oxford University Hospitals NHS Trust
Department of Health
NHS Wiltshire CCG
NHS Bath and North East Somerset CCG
South Central Ambulance Service NHS Foundation Trust
Calderdale And Huddersfield NHS Foundation Trust
NHS Nene CCG
Great Western Hospitals NHS Foundation Trust
Buckinghamshire Healthcare NHS Trust
Frimley Health NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Burton Hospitals NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
NHS Litigation Authority
Southern Healthcare NHS Foundation Trust

Government bodies outside the Department of Health that the Trust has had material transactions with are:
NHS Pension Scheme
HM Revenue & Customs
Oxfordshire County Council
Buckinghamshire County Council
NHS Professionals
Swindon Unitary Authority
NHS Property Services
Community Health Partnerships
Cwm Taf Local Health Board
Wiltshire Unitary Authority

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 2014/15 was £17,251k (2013/14: £15,466k).

Stuart Bell, who is the chief executive, is Chair of the Picker Institute Ltd. Professor Sue Dopson, who is a non-executive director, is an appointed representative of the University of Oxford (Said Business School). Martin Howell, who is the Chairman, is a Governor of Oxford Brookes University. Alyson Coates, who is a non-executive director, is a Governor of Oxford Brookes University. Mike Bellamy, who is a non-executive director, is a non-executive board member of the University of West London.

36 Related Party Transactions (continued)

The transactions with bodies outside of Government and the Department of Health, which are considered related parties by virtue of shared director relationships are disclosed below:

	Income	**Expenditure**	**Receivables**	**Payables**
	£000	**£000**	**£000**	**£000**
University of Oxford	**314**	**4,361**	**79**	**683**
Oxford Brookes University	**42**	**47**	**4**	**-**
University of West London	**-**	**1**	**-**	**-**
Picker Institute Ltd	**-**	**2**	**-**	**-**

37 Public dividend capital rate

For Oxford Health NHS Foundation Trust this dividend is calculated as follows:

	2014/15	2013/14
	£000	£000
Average Relevant Net Assets	**116,302**	86,584
Rate of Dividend (%)	**3.50%**	3.50%
PDC dividend	**4,071**	3,030

38 Financial instruments

38.1 Financial assets

	At fair value through Income and Expenditure	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Receivables	**-**	**7,450**	**-**	**7,450**
Cash at bank and in hand	**-**	**15,288**	**-**	**15,288**
Other financial assets	**-**	**-**	**-**	**-**
Total at 31 March 2015	**-**	**22,738**	**-**	**22,738**
Receivables	-	**8,827**	-	8,827
Cash at bank and in hand	-	**24,213**	-	24,213
Other financial assets	-	-	-	-
Total at 31 March 2014	-	33,040	-	33,040

The majority of receivables relate to agreed debt owing from other NHS bodies. Non NHS receivables have been impaired in accordance with Trust policy.

38.2 Financial liabilities

	At fair value through Income and Expenditure	Other	Total
	£000	£000	£000
Payables	**-**	**18,452**	**18,452**
PFI and finance lease obligations	**-**	**4,620**	**4,620**
Other borrowings	**-**	**25,425**	**25,425**
Provisions	**-**	**-**	**-**
Other financial liabilities	**-**	**357**	**357**
Total at 31 March 2015	**-**	**48,854**	**48,854**
Payables	-	20,536	20,536
PFI and finance lease obligations	-	4,697	4,697
Other borrowings	-	26,778	26,778
Provisions	-	-	-
Other financial liabilities	-	768	768
Total at 31 March 2014	-	52,779	52,779

All financial assets and liabilities are held at fair value.

38.3 Maturity of financial liabilities

	2014/15	2013/14
	£000	£000
In one year or less	**20,280**	22,734
In more than one year but not more than two years	**1,533**	1,471
In more than two years but not more than five years	**5,003**	4,765
In more than five years	**22,038**	23,809
Total	**48,854**	52,779

38.4 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 Trust has with Clinical Commissioning Groups and the way those organisations are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by regulator review. The borrowings are for 1 – 20 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

39 Third party assets

The Trust held £305k cash at bank and in hand at 31 March 2015 (31 March 2014: £307k) 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.

40 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	725	-	6,968	-
Balances with Local Authorities	687	-	471	-
Balances with other NHS Bodies	4,955	-	2,719	-
Balances with Public Corporations and Trading Funds	-	-	-	-
Balances with bodies external to government	3,204	30	14,491	-
Total at 31 March 2015	**9,571**	**30**	**24,649**	**-**
Balances with other Central Government Bodies	468	-	6,599	-
Balances with Local Authorities	2,317	-	1,586	-
Balances with other NHS Bodies	5,432	-	7,155	-
Balances with Public Corporations and Trading Funds	-	-	-	-
Balances with bodies external to government	2,536	30	15,320	-
Total at 31 March 2014	**10,753**	**30**	**30,660**	**-**

41 Losses and special payments

	2014/15		2013/14	
	Total Value of Cases	Total Number of Cases	Total Value of Cases	Total Number of Cases
	£		£	
Losses				
Cash losses	56	3	131	10
Stores losses	-	-	610	1
Special payments				
Extra-contractual payments	-	-	11,190	2
Special severance payments	75,300	2	4,000	2
Ex gratia payments	53,736	33	64,126	34
Total losses and special payments	**129,092**	**38**	**80,057**	**49**

These amounts are reported on an accruals basis, excluding provisions for future losses.

42 *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 2015 22 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, £629k at 31 March 2015 (31 March 2014: £241k).
The Trust commissioned Barnett Waddingham to prepare an actuarial report to provide full pension details in accordance with International Accounting Standard 19 (IAS19) . The report is available on request. The 2013/14 figures have been restated to reflect the revised actuarial report under IAS19.

42.1 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 2015	31 March 2014
RPI Increases	**3.4%**	3.7%
CPI Increases	**2.6%**	2.9%
Salary Increases	**4.4%**	4.7%
Pension Increases	**2.6%**	2.9%
Discount rate	**3.4%**	4.6%

42.2 The estimated Fund asset allocation as at 31 March 2015 is as follows:

	31 March 2015		31 March 2014	
	£000		£000	
Equities	**1,088**	**55%**	1,220	72%
Gilts	**249**	**12%**	85	5%
Other bonds	**258**	**13%**	169	10%
Property	**171**	**9%**	136	8%
Cash	**39**	**2%**	17	1%
Alternative Assets	**29**	**1%**	68	4%
Hedge Funds	**75**	**4%**	-	-
Absolute Return Portfolio	**84**	**4%**	-	-
Total	**1,993**	**100%**	1,695	100%

At 31 March 2014 Hedge Funds were included under Equities and the Absolute Return Portfolio was included under Alternative Assets so the split above at 31 March 2015 provides more detail.

42.3 Amounts recognised in the Statement of Comprehensive Income

	2014/15	2013/14
	£000	£000
Service cost	**(79)**	(101)
Net interest on the defined liability	**(22)**	(16)
Administration expenses	**(6)**	-
Total loss	**(107)**	(117)

42.4 Amounts recognised in the Statement of Financial Position

	2014/15	2013/14
	£000	£000
Oxford Health NHS Foundation Trust liability	(629)	(241)

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	(2,884)	(2,197)
Less fair value of scheme assets (bid value)	1,993	1,694
Deficit in the scheme	(891)	(503)

42.5 Reconciliation of opening and closing Statement of Financial Position balances for Oxford Health NHS Foundation Trust

	2014/15	2013/14
	£000	£000
Deficit in the scheme at 1 April	(241)	(435)
Expenses recognised in the SoCI	(107)	(117)
Contributions paid (Employer)	62	62
Actuarial (losses)/gains in the current year	(343)	249
Deficit in the scheme at 31 March	(629)	(241)

42.6 Change in benefit obligation during the year to 31 March

	2014/15	2013/14
	£000	£000
Opening defined benefit obligation	2,197	2,142
Current service cost	79	101
Interest cost	101	103
Change in financial assumptions	518	-
Change in demographic assumptions	-	-
Experience gain on defined benefit obligation	-	-
Total actuarial gains	-	(164)
Estimated benefits paid net of transfers in	(38)	(12)
Contributions by Scheme participants	27	27
Closing benefit obligation	2,884	2,197

42.7 Change in fair value of plan assets during the year to 31 March

	2014/15	2013/14
	£000	£000
Opening fair value of plan assets	1,694	1,445
Expected return on Fund assets	-	87
Interest on assets	79	-
Return on assets less interest	175	-
Total actuarial gains	-	85
Administration expenses	(6)	-
Contributions by employer including unfunded	62	62
Contributions by fund participants	27	27
Estimated benefits paid plus unfunded net of transfers i	(38)	(12)
Closing fair value of assets	1,993	1,694

43 NHS Charitable Fund

Oxford Health Charitable Funds changed its name to Oxford Health Charity on 30 July 2014.

Oxford Health Charity is not consolidated within the Oxford Health NHS Foundation Trust accounts. The summary results and financial position for Oxford Health Charity (Charity Registration Number 1057285) are as follows:

Statement of Financial Activities

	2014/15		2013/14	
	£000		£000	
Total Incoming Resources	**318**		311	
Resources Expended with Oxford Health NHS Foundation Trust	**(443)**		(213)	
Other Resources Expended	**(74)**		(185)	
Total Resources Expended		**(517)**		(398)
Net (outgoing) resources		**(199)**		(87)
Gains on revaluation and disposal		**84**		33
Net movement in funds		**(115)**		(54)

Balance Sheet

	31 March 2015	31 March 2014
	£000	£000
Investments	**1,269**	1,238
Cash	**41**	100
Other Current Assets	**378**	374
Current Liabilities	**(177)**	(86)
Net assets	**1,511**	1,626
Restricted / Endowment funds	**430**	407
Unrestricted funds	**1,081**	1,219
Total Charitable Funds	**1,511**	1,626

The 2014/15 Statement of Financial Activities and Balance Sheet are based on unaudited accounts of the Charity.