NHS
Oxleas
NHS Foundation Trust

Annual Report and Accounts

2017/2018

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

Contents

Oxleas NHS

Our year 2017/18

GOOd

We improved the quality of our services through the year and our Care Quality Commission rating is good across all domains.

We spent **£261m** in 2017/18

Our partnerships continue to flourish

SOUTH LONDON Mental Health and Community Partnership

BEXLEY CARE We're here for you

Qi

In April 2018, we launched our trustwide Quality Improvement programme

3,600

At our annual recognition awards in March 2018, we highlighted the dedication of our inspiring staff across Oxleas. Around 3,600 people work across our physical and mental health services.

Queen Mary's Hospital SIDCUP 100

We celebrated Queen Mary's Hospital centenary in September 2017

Improving lives

Colin and Sonny at the Queen Mary's Hospital, Sidcup, centenary event

Overview

HRH The Princess Royal visiting our occupational therapy services at the Bracton Centre

Overview
This summary aims to give readers enough information about Oxleas to understand our organisation and purpose, how we have performed during the year and any risks to us achieving our objectives.

Our year
Welcome to this report on Oxleas' activity and performance over the year from April 2017 to the end of March 2018. This has been a year of development and we are particularly pleased how our partnerships with local organisations have grown.

Oxleas works across Bexley, Bromley, Greenwich and Kent to provide high quality mental and physical healthcare with the aim of improving people's lives. To achieve this in an increasingly challenging financial environment, we are working closer than ever with partners and aim to work as effectively as possible using technology where we can.

During the year we have had four main priorities – offering good quality services, developing our workforce, managing our finances and working more closely with partners. We have made progress in all these areas and will continue to focus on these in the coming months.

In April 2017, our forensic services were re-inspected by the Care Quality Commission (CQC) following their in-depth inspection across all our services in 2016. The inspection team found our forensic services to be good in four domains – safe, effective, caring and well-led and outstanding in the responsive domain. Our CQC rating dashboard is therefore:

Oxleas Care Quality Commission Ratings Dashboard

	Safe	Effective	Caring	Responsive	Well-led	Overall
1 Community health services for adults	Good	Good	Good	Good	Good	Good
2 Community health inpatient services	Good	Good	Good	Good	Good	Good
3 End of life care	Good	Good	Good	Good	Good	Good
4 Community services for children, young people and families	Good	Good	Good	Good	Good	Good

Overview

Oxleas Care Quality Commission Ratings Dashboard

	Safe	Effective	Caring	Responsive	Well-led	Overall
5 Community mental health services for children, young people and families	Good	Good	Good	Good	Good	Good
6 Community mental health services for working age adults	Good	Good	Good	Good	Good	Good
7 Mental health crisis services	Good	Good	Good	Good	Good	Good
8 Mental health wards for adults of working age	Good	Good	Good	Good	Good	Good
9 Rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
10 Forensic inpatient wards	Good	Good	Good	**Outstanding**	Good	Good
11 Wards for people with a learning disability	Good	Good	Good	Good	Good	Good
12 Community services for people with a learning disability	Good	Good	**Outstanding**	Good	Good	Good

Overview

Oxleas Care Quality Commission Ratings Dashboard

	Safe	Effective	Caring	Responsive	Well-led	Overall
13 Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
14 Community mental health services for older people	Good	Good	Good	Good	Good	Good
Mental Health Services	Good	Good	Good	Good	Good	Good
Community Health Services	Good	Good	Good	Good	Good	Good
Overall Trust Rating	Good	Good	Good	Good	Good	Good

During 2018, we expect further inspections from the CQC and will work with the commission to make any improvements identified.

To keep improving the quality of our services, we have extended the quality improvement programmes we developed in inpatient mental health and forensic mental health services during 2016/17. Last year, we developed plans for a trustwide Quality Improvement (Qi) programme which we launched in April 2018. This will involve comprehensive training for staff across Oxleas, quality improvement projects in all directorates tackling issues identified by staff and sharing of the outcomes of the projects across our services. Some of the initial areas of focus for the Qi projects are:

- Earlier detection of cardiac disease;
- Speeding up referral processes;
- Creating more time for patient care through better caseload management.

We have continued to have a strong focus on health and safety across Oxleas including reviewing our catering arrangements, ensuring we identify and manage ligature risks in our buildings and having comprehensive arrangements to protect our staff when working alone.

Overview

The quality of our services is a major item at every Board of Directors' meeting where data and feedback is reviewed and directors and non-executive directors regularly visit services to talk to staff and patients. A complete review of our quality performance is contained in our Quality Accounts Report which is from page 82 in this document.

We rely on the expertise and dedication of our staff to deliver high quality services and therefore want to ensure that we attract and retain the best staff and support and engage them in developing the care we offer. This year, we have focused on improving recruitment and retention and were part of an NHS Improvement programme to reduce turnover in clinical staff. This work has included speeding up our recruitment processes, increasing awareness of staff benefits and engaging more with colleagues to identify why they choose to work for Oxleas. More details are shared in the Staff Report from 45.

Every year, we recognise the tremendous work of colleagues across Oxleas through our Recognition Awards. This event highlighted a team of the year in each directorate and the governors' award recognising an individual who has gone above and beyond to make a difference to our patients. At our event in March, more than 200 colleagues celebrated how staff across Oxleas have put our values into action.

Our partnership working developed strongly during 2017/18 and what were new relationships in 2016/17 have strengthened and become more established. Bexley Care, the integration of our services with social care services provided by Bexley Council, was formally launched at our annual members' meeting and Queen Mary's centenary event in September 2017 and working in a more integrated way has been developed through the year. This aims to improve collaborative working, avoid duplication and help Bexley residents stay healthy and independent.

The South London Mental Health and Community Partnership, our three-way collaboration with South London and Maudsley NHS Foundation Trust and South West London and St Georges NHS Trust, has shared innovation and expertise and identified ways we can work more efficiently. The forensic mental health pathway across South London has resulted in many patients getting care closer to home and made considerable savings. A similar joint approach in specialist children's mental health services has been established during the year. This is expected to have similar benefits to patients and their families and to make better use of local resources.

Work continues as part of the South East London Sustainability and Transformation Partnership where we are working collaboratively with organisations across South East London. The South London Mental Health and Community Partnership is linked into this work.

In September, we celebrated the centenary of Queen Mary's Hospital in a community event where hundreds of local people joined us to mark the history of the hospital and the services that have been provided there. The joyous occasion was a great success and underlined the strong partnership working that has secured the future of the site.

We continue to seek ways of saving money and have implemented plans across all our services to work more efficiently. This year, we have met our financial targets and continue to have a strong focus on reducing costs particularly around use of agency staff and reducing the use of inpatient beds outside those we provide. More details are in the financial performance report from page 14.

Our Board has developed during the year, we welcomed Meera Nair as our new Director of Workforce and Quality Improvement and said farewell to Simon Hart, Director of Human Resources and Organisational Development and Chief Executive Ben Travis. We expect to have appointed our new Chief Executive by June 2018 and, in the meantime, Helen Smith is our Acting Chief Executive.

Over the coming year, we will continue to build on these developments and partnerships and look forward in particular to celebrating NHS70 and to fully establishing our quality improvement programme across our whole organisation.

Signed by
Helen Smith, Acting Chief Executive
25 May 2018

Section one - Performance report

Overview

Overview

Our purpose
Our purpose is to improve lives by providing the best quality health and social care for our patients and carers.

We do this by putting our values into action:

User focus
We view things through the eyes of our patients and their carers

Excellence
We are never content with a service that is second best

Learning
We constantly review and improve how we do things

Responsive
We avoid unnecessary delays for treatment and care

Partnership
We work with others to ensure our patients get the help they need

Safety
We seek to protect our patients, staff and public from harm

We are organised in six service directorates – Adult Learning Disability, Bexley Care, Bromley Adult Mental Health, Children and Young People, Greenwich Adult, Forensic and Prison – to provide services to the local community as commissioned by clinical commissioning groups, local authorities and NHS England. Our objectives are to provide good quality services, develop our workforce, manage our finances and work more closely with partners.

Increasing demand for health care and financial limitations shape the environment in which we work and we are taking a strategic approach to integrated and collaborative working to help us provide the care people need quickly and effectively.

Our activities
We offer a wide range of health and social care to people living in South East London. This includes community health care such as district nursing and health visiting, care for people with learning disabilities including assessment and therapy and mental health care such as psychiatry, nursing and psychological therapy. Our multidisciplinary teams look after people of all ages and we work closely with other parts of the NHS, local authorities and voluntary organisations. We care for people in many different settings such as hospitals, health centres and in people's homes. We manage hospitals including Queen Mary's Hospital in Sidcup and Memorial Hospital in Greenwich as well as the Bracton Centre, our medium secure unit for people with mental health needs.

We also provide healthcare to prisoners across South East London and Kent. We are one of the largest providers of prison healthcare and work with a range of organisations to give prisoners the physical and mental healthcare they need.

We employ around 3,600 members of staff including nurses, doctors, therapists, healthcare assistants and social workers. We are always seeking caring and enthusiastic staff to join us, visit our **#working4us** page on our website **oxleas.nhs.uk**.

Our history and statutory background
Oxleas NHS Foundation Trust was established in 2006 following many years as a successful NHS trust. We are part of the NHS and are registered with the Care Quality Commission. As a foundation trust, our performance is overseen by the healthcare regulator NHS Improvement (formerly Monitor). Being a foundation trust means we are still part of the NHS but that we are able to include local people more in the decisions we make. Therefore, we have a Council of Governors made up of local people; many of whom use or care for someone who uses our services.

Section one - Performance report

Overview

The key issues and risks that could affect us delivering our objectives are:

Key issue	Risks that could affect this and how we are responding:
Enhance quality and ensure excellence for every patient every time	**safe staffing levels –** we need to ensure that we can recruit and retain sufficient staff to deliver high quality services. We are implementing a trust wide plan to improve recruitment and retention with a specific focus on the development and support of clinical staff **data accuracy issues –** we are working with staff to ensure we collect and share accurate data to measure the quality of our services **implementation of the mental capacity act -** to support consistent application of the mental capacity act we increasing training and practice development in this area
Maintain a skilled and engaged workforce and ensure staff feel valued and are able to make a difference	**work pressures affecting staff morale –** we are investing in supporting staff more - particularly during the first year of working with us. **recruitment difficulties –** we have speeded up our recruitment processes and are trying new ways to attract candidates **staff safety –** we have had a strong focus on ensuring all teams have established lone working arrangements where necessary and that staff are aware of these
Maintain a sustainable organisation and using our resources efficiently challenges.	**ability to manage demand effectively –** we are taking steps to reduce reliance on external providers of in-patient beds by developing more options such as a crisis café, home treatment teams and crisis support. **ability to deliver savings –** we are focused on making our services as efficient as possible **preparation for new General Data Protection Regulation –** we have developed and implemented plans to prepare for the new regulations **Health and Safety Executive action** – we are facing a prosecution from the HSE following the incident at the Bracton Centre in July 2016. We are co-operating with the HSE and acting upon their recommendations.
Work in partnership to deliver better care by working across boundaries	**having a shared vision –** we are working with partners through the South London Mental Health and Community Partnership, Bexley Care and South East London Sustainability and Transformation Partnership to improve pathways across the sector and deliver savings to the local health economy.

Going concern disclosure
After making enquiries, the directors have a reasonable expectation that Oxleas NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, we continue to adopt the going concern basis in preparing the accounts.

Performance analysis

This section provides a detailed performance summary of how we measure our performance.

At each board meeting, we review our performance using key indicators to measure the quality of the services we deliver, the fitness of our workforce and our financial health. This is presented in an integrated board report using information from a variety of sources including our electronic patient information system RiO, our learning support system and national measures such as the Friends and Family Test. We carry out internal audits to ensure the validity of our information and several measures are also audited externally. Each area is assigned to a board sub-committee who review performance, develop mitigation plans as needed and review targets as necessary.

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

Our performance over the past year is outlined below:

Providing quality services

The Board of Directors reviews a range of quality indicators including performance against targets set by NHS Improvement and those internally set. The targets cover the three quality domains of patient experience, patient safety and clinical effectiveness. Our Quality sub-committee had the main oversight of our quality performance and leads in-depth reviews into areas of concern and monitors actions taken in response.

Following a follow-up inspection in April 2017, the current rating by the Care Quality Commission is Good overall and across all domains and all services good or in two cases outstanding.

In our Quality Report, we present our performance against last year's goals which were set through a variety of processes including:

- our annual focus groups with members and governors across Bexley, Bromley and Greenwich
- our regular quality review meetings with our commissioners
- feedback from patients who have used our services
- nationally defined performance targets.

We had 6 quality objectives. These are agreed with our local commissioners and our members to focus on areas of clinical risk, national best practice and involvement of patients and their families. Full details of our performance against our 2017/18 quality objectives are in the Quality Accounts Report from page 82. The report also describes the quality improvement priorities for the year to come.

Supporting our staff

At the centre of our services are qualified and motivated staff who work to improve patients' lives. Ensuring that we have sufficient staff with the right skills and experience to deliver our services is one of our key risks. It is important that our staff feel fully engaged in how our services are run and we have introduced new ways to communicate internally and to improve links between staff and our Executive team. This has included our 'Let's Talk' programme which uses a variety of ways to engage with staff including films, meetings and newsletters. Members of the Board of Directors and Executive Team undertake regular visits to our services to meet with staff so that they can understand their issues and our partnership team holds workshops with staff across the organisation. We have particularly strengthened our support for people joining Oxleas by asking for their feedback and views to ensure we are meeting their needs and expectations. The NHS Staff Survey was undertaken again across our whole workforce. This maintained a similar position to last year where we were better than average in many areas. The key findings from the survey include:

- higher levels than average of staff engagement
- positive feedback on team work and patient feedback
- higher than average levels of staff experiencing abuse from patients and carers

Our staff report outlines the programme of actions we are taking to improve working life at Oxleas. This includes a strong focus on staff engagement, implementing a staff health and wellbeing strategy and supporting clinical teams to manage abusive patients and carers.

Our performance over the past year
Average Sickness Absence over last 12 months – 3.81%

(this was a reduction in absence from the previous year of 4.48%)

Turnover for all reasons 2017/18 – 17.10%
Turnover for all reasons 2016/17 – 17.12%

Our financial health

For the financial year 2017/18, we reported a net deficit of £7.5m on the trust only position within our annual accounts (Group position - a deficit of £7.9m). This includes the following one-off items:-

- Impairment - reductions in the value of a number of assets based upon the amount they are likely to realise when sold on the open market totalled £12.6m (net)
- Disposal of assets - £1.4m profit on the sale of surplus assets during 2017/18
- Sustainability and Transformation Funding (core) - £1.5m
- Sustainability and Transformation Funding (bonus) - £1.6m

When these are excluded from the position, we achieved an underlying surplus of £0.2m, which is marginally ahead of our plan (£0.1m). In order to deliver this surplus, we needed to successfully implement full year effect savings totalling £9.6m between 1 April 2017 and 31 March 2018. Alongside this, we also experienced a number of in-year financial pressures, the most significant being associated with the continued reliance on staff over and above funded establishments to manage levels of acuity and observations, continued usage of additional mental health in-patient beds (where the capacity was not available within the trust) and slippage associated with the mobilisation of savings schemes.

Section one - Performance report

Performance analysis

Performance analysis

'Finance and use of resources' is one of the five themes in the Single Oversight Framework used by NHS Improvement to determine the overall segmentation of NHS Trusts. This theme is underpinned by five equally weighted metrics and the table below sets out our performance against each of these. We attained an overall score of 1 (the 'best'). NHS Improvement's assessment of all five themes resulted in the trust being assigned an overall 'segment' rating of '2'. Segment 1 means complete autonomy and a segment rating of 4 would lead to special measures being instigated

The calculations exclude the one-off items mentioned above and are measuring the 'business as usual' position of the trust.

Financial and use of resource	Measure		YTD	Score
Financial sustainability	Capital Servicing Capacity Rating (times)	Actual	2.35	2
		Plan	1.98	2
	Liquidity Rating (days)	Actual	39	1
		Plan	12	1
Finanical efficiency	I & E Margin (%)	Actual	1.8%	1
		Plan	1.1%	1
Financial controls	Distance from Financial Plan (%)	Actual	0.8%	1
		Plan	0.0%	1
	Agency Spend (%)	Actual	3%	2
		Plan	0.0%	1
Financial and use of resource rating March 18		Actual	1	1
		Plan	1	1

Section one - Performance report

Performance analysis

The table below and subsequent paragraphs set out the financial position in more detail:

	17/18 (£m)	16/17 (Restated) *** (£m)
Reported group deficit (including impairment and profit on asset disposal)	(7.9)	(1.9)
Impairments (land, buildings, major IT)	12.6	5.1
Control Total Performance including Sustainability and Transformation Funding (STF)*	4.7	3.2
Less: STF (Core)	(1.5)	(1.6)
Less: STF (Incentive)	(1.6)	(0.6)
Less gain on asset disposal	(1.4)	(0.6)
Underlying surplus**	**0.2**	**0.4**

* Delivering the assigned 'control total' remains a key condition in receiving sustainability funding. By delivering a 'surplus' of £1.5m we secured £3.0m of sustainability funding.
** Underlying surplus is defined as surplus for the year before impairments and sustainability and transformation funding. This represents the operational performance of the Trust.
*** 16/17 has been adjusted to reflect the gain on asset disposal which was previously included in the underlying surplus.

Key Metrics	17/18 (£m)	16/17 (£m)
Total income	£257.4	£247.0
Total expenditure excluding impairment	(£248.8)	(£240.3)
Impairment charged to operating expenses	£12.6	£5.1
Finance costs	(£4.8)	(£4.0)
Gain from asset disposals	£1.4	£0.6
Revaluation gains	£3.6	£3.0
Underlying surplus	£0.2	£1.1
Underlying surplus margin	0.01%	0.64%
Cash	£60.5	£62.4
Net assets	£153.5	£166.9
NHS Improvement Finance and Use of Resources score	1	2
Efficiencies delivered vs plan (full year effect basis)	**100%**	**100%**

Trust only position, excluding charitable trust funds and Oxleas Prison Services Ltd (100% owned subsidiary of the Trust).

We prepare our accounts in accordance with International Financial Reporting Standards (IFRS). There have been no significant amendments to the accounting standards in 2017/18 and so our accounting policies therefore remain largely unchanged. Our Group deficit of £7.9m includes £0.3m deficit in relation to Oxleas Prison Services Limited.

Performance analysis

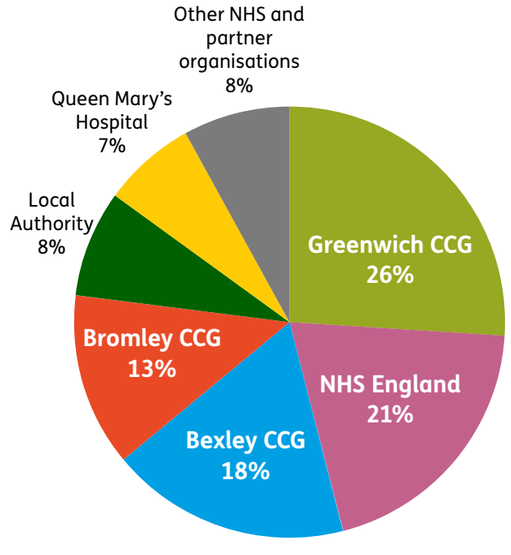
There is no doubt that 2017/18 represented a significant financial challenge for the NHS. The impact of sustained efficiency expectations coupled with continued unrelenting demand; maintaining and improving the quality of care delivered; and achieving financial balance has required efforts across all areas of the organisation. This included the implementation of financial recovery plans where necessary and the decision to limit the number of days of annual leave that could be carried forward from five to two days.

Our partnership working means the role of the trust is far wider than that which is reflected in the financial statements. In 2017/18, Oxleas along with partner organisations in the South London Partnership (South London and Maudsley NHS Foundation Trust and South West London and St Georges Mental Health Trust) led on a number of New Models of Care programmes where the total value of the partnership resource amounted to £83.7m, of which only £18.3m, is included in the financial statements of the trust.

Income
We can confirm that for 2017/18, in accordance with Section 43(2A) of the NHS Act 2006, the income from the provision of goods and services for the purposes of the health service in England was greater than the income from the provision of goods and services for any other purposes. The work required to receive the non-health care income has had no adverse impact on the provision of goods and services for the purposes of the health care.

There was an increase in our total income to £257.4m (2016/17 £247m). The majority of our income comes from NHS England and local Clinical Commissioning Groups for the provision of clinical services. There are a number of other income sources to the trust: education and training income supports the costs of training doctors, nurses and other healthcare professionals and in doing so supports the quality of care provided at the trust; income from local authorities facilitate integrated working across health and social care in our mental health services; rental income; non-contracted activity; and a small sum for research and development.

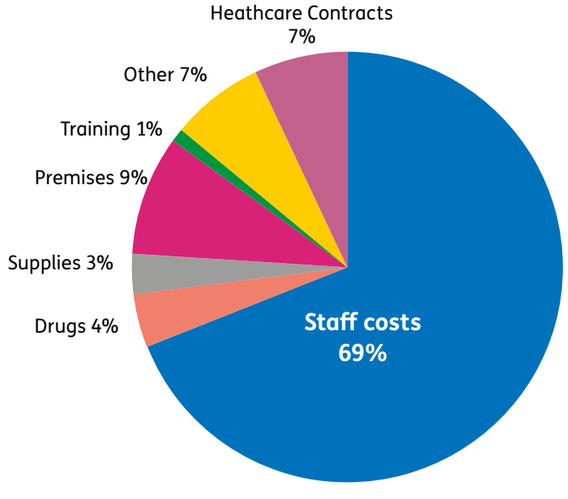
2017/18 Income



Performance analysis

Expenditure
Our total expenditure in the year was £248.8m (before impairment) with staff costs accounting for 69% of operating expenditure. To achieve our planned underlying surplus of £0.1m, we needed to deliver £9.6m of cash releasing efficiencies in the year. All directorates developed detailed schemes to deliver the level of savings required and these were monitored throughout the year with formal reports to the Executive, the Business Committee and the Board. The plans covered a range of themes including service redesign and productivity, rationalisation of the estate in line with our Estates Strategy, continued deployment of new technologies such as iPads and other mobile working initiatives, re-procurement of non-pay goods and services and a review of corporate resources. We delivered £8.0m of the full year effect (86%) in year with the remainder managed through non-recurrent savings.

2017/18 Expenditure



We have complied with the cost allocations and charging requirement set out in HM Treasury and Office of Public Sector information guidance.

Statement of Financial Position
We have continued to invest our cash balances into maintaining and developing the estates and facilities across all our boroughs. In 2017/18, we spent £11.3m on capital expenditure. The trust estate was revalued in 2017/18 and the value at 31 March 2018 was £135.7m – a decrease of £12.5m against 2016/17.

Our journey to redevelop the Queen Mary's site continued in 2017/18. £6.2m was spent on reconfiguring and updating the space for the services delivered from the site which include urgent care, out patients, diabetes, planned care, kidney treatment and cancer care. A further £10.0m will be spent over the next two years on finishing the redevelopment of the site ensuring we achieve our vision of a local 21st century fit for purpose healthcare hub, resulting in local residents being able to access and receive services from redesigned facilities ensuring a better patient experience.

A further £2m was spent on information and communication technology including PC replacement, iPads, transformation projects and metrics. This investment has ensured that healthcare professionals are able to deliver high quality patient care more efficiently.

We closed our accounts on 31 March 2018 with a healthy cash balance of £60.5m. This ensures we do not encounter difficulties in paying our staff and creditors, and can fund our future capital programme of circa £33.4m over the next 2 years.

Better payment practice code and our compliance
We continue to monitor our performance against the Better Payment Practice Code that requires payment of all trade creditor invoices within 30 days of receipt of a valid invoice (unless other terms have been specifically

Performance analysis

agreed with the supplier). The target set is 95% for both value and volume of invoices. We ended the year at 86.4% (value £149m) of invoices were paid (£133m were non-NHS and £16m were NHS) of which £129m (£120m were non-NHS and £9m were NHS) were paid within the target. 90.3% of 58,313 invoices were paid (56,995 were non-NHS and 1,318 were NHS) of which 52,654 (51,705 were non-NHS and 949 were NHS) were paid within the target respectively. No late interest charges were incurred by the Trust. However, the total amount of interest that the trust would be liable to pay had suppliers charged late interest payment would have been £277k. We continue to work towards the Government's initiative to pay small and medium enterprises within 10 working days.

External Audit
Our external auditor is Deloitte and for the year 2017/18 expenditure on external audit fees for statutory audit work was £76k excluding VAT (2016/17 £66k). The quality accounts fees, excluding VAT, was £7k (2016/17 £15k) and the charitable independent examination fee, excluding VAT was £5k (2016/17 £5k).

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

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

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

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

During the year, we implemented the new national guidance on managing conflicts of interest in the NHS. This came into force on 1 June 2017 and aims to ensure that decision-making is not influenced by outside interests or expectations of private gain. We have updated our policies, undertaken an awareness raising campaign with colleagues and made our registers publicly available. We also introduced a new procurement policy which creates a framework for procurement of goods and services in a way that maximises value for money and supports the implementation of the Bribery Act 2010.

Section one - Performance report

Performance analysis

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

Key financial performance indicators
We agree and monitor a number of financial performance indicators to measure our financial success. Some of these form part of the NHS Improvement Single Oversight Framework whilst a number seek to assess and improve performance.

The table below sets out the key indicators and performance against plan.

Metric	17/18 Target	17/18 Actual	Achieved
Underlying Surplus - Year to Date (£m)	0.1	0.2	✔
Cash Position (£m)	47.1	60.5	✔
Capital Plan (revised) - Year to Date (£m)	11.7	11.3	✔
CRE Plans - Full Year Effect (£m)	9.6	8.0 (recurrent) 1.6 (non-recurrent)	✔

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

- generating sufficient income and cash reserves to support on-going operations, fund future capital investment requirements and business development opportunities, and maintaining liquidity
- working in partnership with other agencies, including the third sector, to improve care and delivery efficiencies
- delivering sustainable efficiencies over future years
- drive a refreshed Trust-wide focus on workforce redesign to deliver new ways of working, reduce temporary staffing expenditure and delivering transformation programmes across the South London Mental Health and Community Partnership (joint working between us, South London and Maudsley Foundation Trust and South West London and St Georges NHS Trust) and BexleyCare (health and social care)
- delivering a long-term 'Financial and Use of Resources' score of at least 2
- maintaning our NHS Improvement Single Oversight Framework segmentation of 2
- generating a £0.1m target surplus in 2018/19 and 2019/20 respectively
- capital planning over the next two years of £31.6m to invest in our key priorities of progressing further improvements in our patient environments and use of technology

Performance analysis

- improving our costing capability and understanding of productivity levels to support future sustainability and delivery

The key issues shaping our financial plan include:

- launching our quality improvement initiative to empower staff to 'make the change' and improve care delivery and eliminate waste
- contributing to the development of system-wide working delivering transformation across health and social care (BexleyCare) and being at the forefront of new models of care (South London Mental Health and Community Partnership)
- investing in an alternative acute and crisis service model to ensure patients receive the right care at the right time and in the right setting
- achieving the national mental health and community health service targets
- working with commissioning and acute hospital colleagues to enhance pathways that benefit the patient
- continue to play an active part in the development of the Sustainability and Transformation Partnership for the South East London geographical footprint.

Our environmental performance

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, we have the following sustainability mission statement located in our sustainable development management plan (SDMP) – We aim to improve overall environmental performance. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) which is equivalent to a 28% reduction from a 2013 baseline by 2020. To achieve this target we have already significantly reduced our carbon emissions.

Section one - Performance report

Performance analysis

Policies
In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Travel	Yes
Business Cases	Yes
Procurement environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

We have an approved sustainable development management plan and will continue to focus on this work in the coming year. One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. The last time we used the GCC self assessment was in 2014 when we scored 83%. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff. For example, we promote cycling to work and offer electric charging and electric lease cars to our staff.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The organisation has identified the need to develop a board approved plan for future climate change risks affecting our area.

We aim to reduce the environmental impact of providing our services by efficient use of resources and greener travel where possible. We have a positive social impact by providing jobs and volunteering opportunities locally and supporting the people who use our services to stay in work and to participate fully in their local community.

We comply with the Modern Slavery Act 2015.

Partnerships
The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. For us as a provider, evidence of this commitment is provided in part through contracting mechanisms.

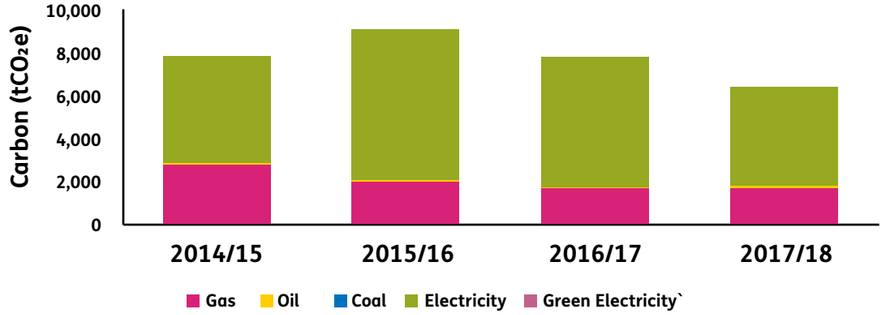
Performance
Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. We now own and manage Queen Mary's Hospital, Sidcup and provide waste and energy services to the wide range of organisations running clinical services on the site 24 hours a day. Therefore, our level of activity has increased.

In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. We have supported this ambition by taking steps in a number of ways such as introducing paperless technology, fitting LED lighting, supporting electric car ownership, and improving heating efficiency where possible.

Performance analysis

Energy use
Our estate profile has changed during the past year and therefore year on year use is not directly comparable as estate size and condition has altered. In 2017/18, we spent £1,623,973 on energy which is an increase on last year's figure (although our consumption reduced) reflecting the rise in energy costs. We continue work to reduce our energy use by introducing more efficient systems and managing our estate. We have undertaken a rolling programme to replace all lighting with LED alternatives where possible. We have installed photo voltaic cells at one of our sites and include carbon reducing specifications on all our major projects.

Carbon Emissions - Enegery Use



Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	13,365,561	9,672,362	8,180,603	8,368,622
	tCO_2e	2,804	2,024	1,710	1,774
Oil	Use (kWh)	159,147	159,157	151,004	151,004
	tCO_2e	51	51	48	49
Coal	Use (kWh)	0	0	0	0
	tCO_2e	0	0	0	0
Electricity	Use (kWh)	8,157,807	12,261,313	11,750,019	10,368,055
	tCO_2e	5,052	7,049	6,072	4,621
Green Electricity	Use (kWh)	0	40	40	40
	tCO_2e	0	0	0	0
Total Energy CO_2e		7,907	9,124	7,830	6,445
Total Energy Spend		£1,341,880	£1,543,061	£1,371,693	£1,623,973

Section one - Performance report

Performance analysis

Waste
Our waste and recycling performance is illustrated below. This reflects the significant amount of work, including building and refurbishment work, that is being undertaken at our sites particularly Queen Mary's Hospital, Sidcup.

Waste		2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	193.00	372.00	214.60	229.67
	tCO_2e	4.05	7.44	4.51	5.00
Other recovery	(tonnes)	175.00	0.00	0.00	509.79
	tCO_2e	3.68	0.00	0.00	11.09
High Temp disposal	(tonnes)	15.00	80.00	204.89	88.34
	tCO_2e	3.30	17.52	45.08	19.43
Landfill	(tonnes)	367.00	120.00	355.00	122.16
	tCO_2e	89.70	29.33	110.05	42.08
Total Waste (tonnes)		750.00	572.00	774.49	949.96
% Recycled or Re-used		26%	65%	28%	24%
Total Waste tCO2e		100.73	54.29	159.63	77.61

Based on ERIC Estates Return Information Collection figures

Although our recycling figure has reduced, our other recovery (energy) has increased. Recycling has reduced due to contamination of recycling waste which will be addressed as part of a waste campaign.

For high temperature waste, 85 tonnes relates to disposal of waste at Queen Mary's Hospital via the onsite incinerator which provides some free heating and hot water for the site.

Performance analysis

Use of water

Water		2016/17	2017/18
Mains Water	m^3	122,000	156,048
	tCO_2e	111	142
Water & Sewage Spend		£ 204,333	£ 222,414

This increased use of water reflects the level of activity at Queen Mary's Hospital together with a substantial leak at the site (now resolved) and intermittent floods. These issues have been addressed. We have restated the cost for 2016/17 due to use of actual costs rather than estimates.

Equality and human rights

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

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

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

We are hosting a placement on the NHS Improvement NExT Director scheme which is supporting people from black, Asian and minority ethnic communities to become non-executive directors in the NHS. We were pleased to be highlighted in the NHS Workforce Race Equality Standard 2017 for being a leading NHS organisation for the diversity of our Board of Directors.

H Smith

Signed by
Helen Smith, Acting Chief Executive
25 May 2018

Directors' report

Board of Directors

There were several changes to the Board of Directors during 2017/18. Simon Hart left his role as Director of Human Resources and Organisational Change in November 2017 and was replaced by Meera Nair as Director of Workforce and Quality Improvement in January 2018. While Chief Executive Ben Travis left Oxleas in March 2018 to take up a new role as Chief Executive of Lewisham and Greenwich NHS Trust. From March 2018, Helen Smith is the Acting Chief Executive while recruitment takes place.

From May 2013 onwards, our Board meetings have been held in public and a quorum of seven is required for the meeting to take place.

The members of the Board of Directors during 2017/18 were:

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

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

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

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

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

Steve James
Non Executive Director
Following 18 years in local authority social work, Steve James has been Chief Executive of the Avenues Group for the past 20 years. Avenues is a charity which pioneers specialist social care supporting people facing significant disadvantage through illness and disability so they can live full lives in their local communities. Previous to his appointment on Oxleas' Board, Steve spent eight years working as a non executive director for NHS Greenwich. He has

Directors' report

an interest in community health services and particularly how they can integrate with social care. Steve has lived in Greenwich for 29 years and is married with two adult children. Steve became our Senior Independent Director in May 2016 and chairs the Quality Improvement and Innovation Committee.

Jo Stimpson
Non Executive Director
Jo joined Oxleas Board of Directors on 1 May 2016 and chairs our Business Committee. She is a law graduate and chartered accountant with senior finance and board level experience gained in the technology and utility sectors, most recently as Finance Director of South East Water. In addition to her role at Oxleas, Jo chairs the South East Water-sponsored pension schemes, is a trustee of Eduserv, a not-for-profit technology services company, serves on the Ravensbourne audit committee and is a school governor. Jo lives in Greenwich with her husband and her two teenage daughters.

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

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

Ben Travis
Chief Executive
Ben joined Oxleas in 2011 from Central and North West London NHS Foundation Trust where he was Deputy Director of Finance. He trained as a chartered accountant with Arthur Andersen and worked for Heineken and Deloitte before moving into the NHS with The Royal Marsden NHS Foundation Trust. Ben left Oxleas in March 2018.

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

Ify Okocha
Medical Director
Dr Ify Okocha qualified in Medicine in 1985 and after training in psychiatry obtained his membership of the Royal College of Psychiatrists in 1992. He was appointed consultant in 1996 and in the same year obtained his Doctor of Philosophy (Ph.D) degree from the Institute of Psychiatry and King's College, London where he did his doctorate and post-doctorate research in psychosis and psychopharmacology respectively. He has received commendations and won many national awards for the high quality care clinical teams working for him deliver. These include: the National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) Team of the Year award; the

Section two - Accountability report

Directors' report

Care Services Improvement Partnership 'Positive Practice' award; commendation by Hospital Doctors Award Committee; award of the British Association of Medical Managers and the Royal College of Psychiatrist Medical Manager/Leader of the Year (2009). He is on the Roll of Honour of the Royal College of Psychiatrists.

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

Simon Hart (until November 2017)
Director of Human Resources and Organisational Development
Simon joined Oxleas in 2006 from Guy's and St Thomas' NHS Foundation Trust. He has worked in a range of human resources roles in acute and mental health trusts and has an MSc in Human Resources Leadership.

Meera Nair (from January 2018)
Director of Workforce and Quality Improvement
After completing an MBA with specialisation in Human Resources, Meera has worked in a range of human resources functions in the private sector in India and the US. She has been working in the NHS since 2002 and has previously worked with Basildon and Thurrock NHS Foundation Trust and University College London Hospital NHS Foundation Trust. She joined Oxleas from Barnet, Enfield and Haringey Mental Health Trust where she was Deputy Director of Workforce.

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

All non executive directors are considered to be independent as they have not been employed by the trust and do not have any financial or other business interest in the organisation. None has close family ties with Oxleas' advisers, directors or senior employees and none has served on the Board of Directors of the foundation trust for more than nine years. Re-appointments of non executive directors are considered at the end of every three-year term to a maximum of nine years in total. There were no significant changes in the external commitments of the Chair over the year. We ensure that the balance of skills, expertise and experience of the Board of Directors provides effective and proactive leadership. The performance evaluation of the Board is by self-assessment and individual appraisal of directors including governor feedback. We have a well established and effective process of governors holding non executive directors to account. The Board of Directors and its sub committees are regularly reviewed to ensure they are effective and well balanced.

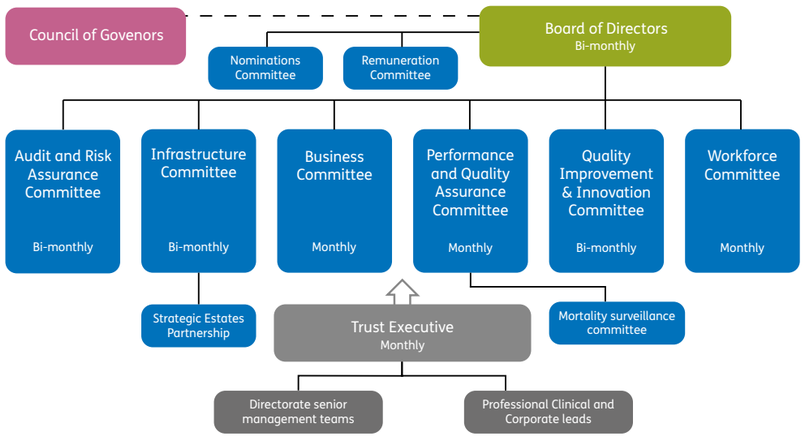
Directors' report

During the Care Quality Commission (CQC) inspection in March 2017, the inspectors carried out a well led review piloting the new well-led framework that brings together the CQC key lines of enquiry and NHS Improvement's framework for leadership and governance. They reported that the trust has robust governance structures in place and a board assurance framework that identifies and monitors areas of risk and links to risk registers across the organisation. The Care Quality Commission report stated that board meetings were well organised and inclusive with a high level of challenge and debate. During 2017/18 we continued to review our governance processes including undertaking an internal audit. This led to changes in our board sub-committee structure and a greater focus on strategy at Board level. During 2018, we are carrying out an internal review against the well-led framework and this will feed into plans for an external review next year. Our annual governance statement on p72 describes in more detail the approaches we take to identify and manage risk within the organisation, our internal control processes and how we work to maintain and improve the quality of our services.

In our Quality accounts from p82, we share how we have sought to increase the feedback we have from patients and their families and to involve families more when planning care. We have improved our services using feedback from patients and their families and, in the Quality Accounts, we highlight areas of good practice across our services sharing case studies on where we have improved outcomes for patients. Our performance against key healthcare targets and how we monitor this is also included in this report.

All board sub-committees are now chaired by non executive directors and the new structure is shown below.

The directors are responsible for preparing the annual report and accounts and have considered the report and accounts as a whole to ensure that they are fair, balanced, understandable and provide the information necessary for patients, regulators and other stakeholders to assess our performance and strategy. We have complied with the cost allocation and charging guidance issued by HM Treasury and we follow the better payment practice code. We comply with Section 43 (2A) of the NHS Act 2006 requiring that income from the provision of goods and services for the purposes of the health service in England is greater than income from the provision of goods and services for any other purpose. More information is included in the financial accounts. A register of directors' interests is available from the Trust Secretary and is published on our website.



How we ensure the quality of our services
Our aim is to ensure that quality is at the forefront of everything that we do and an important aspect of this is to review our performance throughout the year and share how we have performed with staff, patients, members and our commissioners. We have effective structures in place to ensure that quality is monitored and improved across all of our diverse services. The quality of our services is a major focus of every Board meeting and we have developed an integrated dashboard for the Board to track performance in key quality areas including targets set by NHS Improvement. Key risks to the quality of our services are identified in our Board Assurance Framework. Our current Care Quality Commission rating for the organisation is good. Internal and external reports on quality are presented at Board meetings and Board members get further assurance by visiting services and talking direct with patients, carers and staff.

Our quality goals cover the three areas of patient experience, patient safety and clinical effectiveness. Greater detail and examples of how we have improved patient care, how we gather and respond to patient feedback and how we check the quality of our services is included in our Quality Accounts Report from page 82 and assurance on our approach and processes is laid in our Annual Governance Statement on page 72.

Over the year, we have continued to work in partnership with patients, carers, voluntary sector organisations and other providers of health and social care. We liaise with our overview and scrutiny committees, HealthWatch and many local groups and organisations. We seek to involve the people who use our services in shaping not only their own care but also how our services deliver care more widely. We have engaged with members and patients and carers through meetings and stakeholder working groups.

Our partnership working with other health and social care organisations continues to grow. Queen Mary's Hospital in Sidcup is a unique approach to joint healthcare where we enable a wide variety of organisations to provide care to local people. In September 2017, the new cancer and kidney treatment centres on the site were officially opened and plans have been agreed for the next stage of the site's redevelopment.

Our partnership with South London and Maudsley NHS Foundation Trust and South West London and St Georges NHS Trust called the South London Mental Health and Community Partnership continues to flourish. Through this we are providing care in a more efficient way and are enabling many patients to be cared for closer to home. The latest aspect of this partnership is focusing on mental health services for children and is resulting in reducing the distances this vulnerable have to travel for specialist care. We are also part of the local Sustainability and Transformation Partnership which is involving organisations across South East London to develop plans for the sustainable future of health services. More information is available online at **http://www.ourhealthiersel.nhs.uk/.**

Remuneration report

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

In 2017/2018, the committee decided to increase executive salaries by 1% in line with other NHS staff.

Senior Managers' remuneration policy
The remuneration policy for executive directors is based on that established for employees under Agenda for Change and provides an incremental salary scale and pay range for each executive director. Progression through the incremental points is subject to the delivery of appropriate performance targets. As with staff subject to Agenda for Change terms and conditions, incremental progression can be denied where there is sub-standard performance. Performance against agreed objectives is monitored via the annual appraisal process.

The Remuneration Committee includes representation from governors, including a staff governor, and chair of staffside to ensure that views of employees in relation to executive pay are considered. Increases in executive pay are made in line with recommendations by the National Pay Review bodies for Agenda for Change. We regularly benchmark executive pay against other NHS trusts and foundation trusts to ensure a median position. An opinion is sought via NHS Improvement in any instances where executive pay may exceed £150,000.

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

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

Section two - Accountability report

Remuneration report

Future Policy Tables

	Salary and fees	Pension related benefits	Clinical excellence awards
How the component supports the short and long term strategic objectives of the trust	Ensure the recruitment / retention of directors of sufficient calibre to deliver the trust's objectives	Ensure the recruitment / retention of directors of sufficient calibre to deliver the trust's objectives	Recognition of clinical quality and leadership
How the component operates	Standard monthly pay.	Contributions paid by both employee and employer, except for any employee who has opted out of the scheme	Standard monthly
Maximum payment	Basic pay, High Cost Area supplement	Contributions are made in accordance with the NHS Pension Scheme	Standard national rate
Framework used to assess performance	Trust appraisal system	Not applicable	Advisory Committee on Clinical Excellence Awards framework
Performance measures	Based on individual objectives agreed with line manager	Not applicable	Following Advisory Committee framework
Performance period	Concurrent with the financial year	Not applicable	Following Advisory Committee framework
Amount paid for minimum level of performance and any further levels of performance	No performance related payment arrangements	Not applicable	Standard rate
Explanation of whether there are any provisions for recovery of sums paid to directors, or provisions for withholding payments	Any sums paid in error may be recovered	Not applicable	Not applicable

Remuneration report

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

Non Executive Directors
The remuneration of the Chair and non executive directors of the trust is determined by the Council of Governors. Guidance in the setting of non executive director salaries is taken from the NHS Improvement and benchmarking with other NHS foundation trusts. We are reviewing our committee structure for this role with our Council of Governors during 2018.

The terms of office for our non executive directors are three years with a maximum term of office of three successive terms. Appointment of non executive directors is decided by our Council of Governors and the process to remove a non executive director is laid out in the trust's Constitution which is available on our website.

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

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

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

There was one meeting of the remuneration committee in 2017/18. This was attended by all members of the committee. The Committee was supported by Simon Hart, Director of Human Resources and Organisational Development.

Section two - Accountability report

Remuneration report

A) Salaries and allowances (subject to audit)

	APRIL 2017 TO MARCH 2018					APRIL 2016 TO MARCH 2017				
Name and Title	**Salary and Fees (bands of £5000) £000**	**Taxable Benefits Rounded to the nearest £100**	**Clinical Excellence Awards (bands of £5000) £000**	**Pension Related Benefits (bands of £2500) £000**	**Total (bands of £5000) £000**	**Salary and Fees (bands of £5000) £000**	**Taxable Benefits Rounded to the nearest £100**	**Clinical Excellence Awards (bands of £5000) £000**	**Pension Related Benefits (bands of £2500) £000**	**Total (bands of £5000) £000**
Chairman and Non-Executive Directors										
Andy Trotter Chair	55-60				55-60	55-60				55-60
Archibald Herron Non Executive Director (to October 16)	-				-	10-15				10-15
Seyi Clement Non Executive Director	10-15				10-15	10-15				10-15
Steve Dilworth Non Executive Director	15-20				15-20	15-20				15-20
Stephen James Non Executive Director	15-20				15-20	15-20				15-20
James Kellock Non Executive Director	10-15				10-15	10-15				10-15

Remuneration report

A) Salaries and allowances (subject to audit)

Name and Title	APRIL 2017 TO MARCH 2018					APRIL 2016 TO MARCH 2017				
	Salary and Fees (bands of £5000) £000	Taxable Benefits Rounded to the nearest £100	Clinical Excellence Awards (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000	Salary and Fees (bands of £5000) £000	Taxable Benefits Rounded to the nearest £100	Clinical Excellence Awards (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Anne Taylor Non Executive Director (to April 16)	-				-	0-5				0-5
Joanne Stimpson Non Executive Director (from May 16)	10-15				10-15	10-15				10-15
Yemisi Gibbon Non Executive Director (from January 17)	10-15				10-15	0-5				0-5

Section two - Accountability report

Remuneration report

A) Salaries and allowances (subject to audit)

Name and Title	APRIL 2017 TO MARCH 2018					APRIL 2016 TO MARCH 2017				
	Salary and Fees (bands of £5000) £000	Taxable Benefits Rounded to the nearest £100	Clinical Excellence Awards (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000	Salary and Fees (bands of £5000) £000	Taxable Benefits Rounded to the nearest £100	Clinical Excellence Awards (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Board Directors										
Ben Travis Chief Executive (to 16 March 18)	155-160			72.5-75	230-235	150-155			67.5-70	220-225
Helen Smith Deputy Chief Executive & Director of Service Delivery (to 16 March 2018) Acting Chief Executive (From 19 March 2018)	125-130			45-47.5	170-175	125-130			37.5-40	160-165
Iain Dimond Acting Deputy Chief Executive (From 19 March 2018)	110-115			52.5 - 55	110-115	110-115			-	110-115
Jane Wells Director of Nursing & Governance	120-125			35-37.5	155-160	105-110			20-22.5	130-135

Remuneration report

A) Salaries and allowances (subject to audit)

Name and Title	APRIL 2017 TO MARCH 2018 Salary and Fees (bands of £5000) £000	Taxable Benefits Rounded to the nearest £100	Clinical Excellence Awards (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000	APRIL 2016 TO MARCH 2017 Salary and Fees (bands of £5000) £000	Taxable Benefits Rounded to the nearest £100	Clinical Excellence Awards (bands of £5000) £000	Pension Related Benefits (bands of £2500) £000	Total (bands of £5000) £000
Simon Hart Director of HR & Organisational Development (to 23 November 18)	80-85			72.5-75	150-155	120-125			42.5-45	165-170
Dr Ify Okocha Medical Director	170-175		35-40*	120-122.5	330-335	170-175		30-35*	160-162.5	365-370
Jazz Thind Director of Finance	120-125			50-55	175-180	115-120			150-152.5	265-270
Meera Nair Director of Workforce and Quality Improvement (from 15 January 2018)	20-25			-	20-25	-			-	-

	2017/18	**2016/17**
Band of Highest Paid Director's Total Remuneration (bands of £5,000) £'000 **	205-210	200-205
Median Total Remuneration £	30,519	£32,862
Ratio	6.8	6.2

Remuneration report

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in Oxleas NHS Foundation Trust in the year ended 31 March 2018 was £205,000-£210,000**. This was 6.8 times the median remuneration of the workforce which was £30,519.

In the year ended 31 March 2018, no employee received remuneration in excess of the highest paid director. Remuneration of the highest paid employees, who were senior consultants, ranged from £160,000 to £165,000 in the year ended 31 March 2018 (bands of £5,000).

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

For the year ended 31 March 2018, the methodology for calculating the median remuneration involved a detailed analysis of total staff costs which was reconciled to payroll records. Total remuneration figures including salary and allowances, were extracted for the year for permanent staff and bank staff. Staff on maternity pay or sick pay were excluded as they were not deemed to be employed at year end. Where a staff member fulfilled more than one role, the total remuneration received by the employee was apportioned to each role on the basis of the actual total cost incurred for this employee by the Trust.

Amounts were annualised for permanent and bank staff according to their whole time equivalents and total paid hours respectively. The 2016/17 median pay amount was calculated in accordance with these annualised total remuneration figures.

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

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

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

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

** This figure excludes pension related benefits.

Remuneration report

B) Pension Benefits (subject to audit)

Name and title	Real increase in pension at age 60 (bands of £2500)	Real increase in pension lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2018 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Board Directors							
Ben Travis Chief Executive (to 16 March 2018)	2.5-5	2.5-5	25-30	55-60	282	382	99
Helen Smith Deputy Chief Executive & Director of Service Delivery (to 16 March 2018) Acting Chief Executive (From 19 March 2018)	0-2.5	5-7.5	55-60	175-180	1,274	1,354	81
Iain Dimond Acting Deputy Chief Executive (from 19 March 2018)	0-2.5	0-2.5	40-45	60-65	467	553	85
Jane Wells Director of Nursing & Governance	0-2.5	0-2.5	35-40	110-115	600	663	63
Simon Hart Director of HR & Organisational Development	2.5-5	2.5-5	40-45	100-105	518	617	99
Dr Ify Okocha Medical Director	5-7.5	15-17.5	90-95	280-285	1,703	1,909	207
Jazz Thind Director of Finance	2.5-5	0-2.5	40-45	65-70	471	576	106
Meera Nair Director of Workforce and Quality Improvement (from 15 January 2018)	0-2.5	-	15-20	35-40	-	274	-

Section two - Accountability report

Remuneration report

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

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

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

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

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

During the year there were 2 early retirement on the grounds of ill-health (year ended 31 March 2017 - 3). The estimated additional pension liabilities of these ill-health retirements will be £350,028 (year ended 31 March 2017 £172,698). The cost of these ill-health retirements will be borne by NHS Pensions.

Remuneration report

Directors and Governors expenses (not subject to audit)

Mileage reimbursement for directors' travel expenses is processed at HMRC advisory rate of 45 pence per mile for automobiles and 24 pence per mile for motorcycles. Payments for travel claims above the HMRC advisory rate is classed as a benefit-in-kind. For 2017/18 all directors' travel expense claims processed did not exceed the HMRC advisory rates and therefore were not classed as benefit-in-kind. The number of directors who claimed travel expenses during 2017/18 was 9– total value of £10,000 rounded to the nearest £100. The number of governors who claimed travel expenses during 2016/17 was 3 – total value of £1,100 rounded to the nearest £100. A summary of the information in relation to the expenses of the governors and directors is presented in the table below.

	Directors	Governors	Directors	Governors
	2017/18	2017/18	2016/17	2016/17
Total number in office	14	46	15	43
Total number receiving expenses	9	3	7	2
Aggregate sum of expenses paid (to the nearest £100)	£10,000	£1,100	£1,200	£100

H Smith

Signed by
Helen Smith,
Acting Chief Executive
25 May 2018

Staff recognition awards 2018

Providing self-help information

Oxleas NHS
Improving lives

HeadScape - our website for young people to support their mental health and wellbeing. **HeadScape** has been designed for young people by our clinicians and the young people who use our services.

It is a one-stop source of self help about a range of mental health issues and it offers people tailored advice and the opportunity to self refer to our services if necessary. **HeadScape** can be reached at **www.headscapebexley.co.uk** and **www.headscapegreenwich.co.uk**

Staff report

Analysis of staff costs

	Year ended 31 March 2018		
	Total	**Permanently Employed**	**Other**
	£000	**£000**	**£000**
Salaries and wages	**129,367**	128,836	531
Social Security Costs	**13,086**	13,086	0
Apprenticeship Levy	**611**	611	0
Employer contributions to NHS Pension Scheme	**15,372**	15,372	0
Agency/contract staff	**13,676**	0	13,676
Total	**172,112**	**157,905**	**14,207**

	Year ended 31 March 2017		
	Total	**Permanently Employed**	**Other**
	£000	**£000**	**£000**
Salaries and wages	**127,642**	127,526	116
Social Security Costs	**12,849**	12,849	0
Employer contributions to NHS Pension Scheme	**15,206**	15,206	0
Agency/contract staff	**17,747**	0	17,747
Total	**173,444**	155,581	17,863

Total employer's contributions payable to the defined contribution pension scheme in the year ended 31 March 2018 were £15,372,000 (31 March 2017, £15,206,000).

5.2 Average number of employees

	Year ended 31 March 2018 Total Number	Year ended 31 March 2017 Total Number
Medical and dental	**165**	160
Administration and estates	**684**	691
Healthcare assistants and other support staff	**486**	479
Nursing, midwifery and health visiting staff	**1,003**	1,051
Scientific, therapeutic and technical staff	**704**	691
Social care staff	**85**	84
Agency and contract staff	**133**	240
Bank staff	**301**	259
Total	**3,561**	**3,655**

Staff report

Off-payroll arrangements
Oxleas is fully compliant with the HMRC rules in relation to off-payroll arrangements. All agencies that we contract with are aware of our expectations in relation to the application of the regulations and that we would expect tax to be deducted at source, as applicable. There were no off-payroll arrangements in the year 2017/18.

Consultancy expenditure
This is set out in note 4.1 of the accounts

Staff gender analysis

17/18 year end break down:-	Male	Female	Totals
Directors[1]	2	4	6
Other Senior Managers[2]	8	16	24
Employees[3]	743	2952	3695

Annual sickness absence rate	3.81%	
Annual turnover	17.10%	All reasons included

1 Defined as Chief Executive Officer and Executive Directors with voting rights.
2 Defined in accordance with HSCIC's Occupational Code Manual (employees who have been coded in electronic staff record under the Senior Managers G0 occupational code).
3 Presumed definition is those with a permanent contract, excluding those already counted in Director and Senior Manager figures.

Staff engagement is a key part of the trust's workforce strategy. Research shows that high levels of staff engagement have a direct positive impact on the quality of care patients receive so ensuring high levels of staff engagement is very important for Oxleas. Staff engagement in the trust is underpinned by the Partnership agreement which sets out the framework by which we work with trade unions for the best interests of the organisation. We have subsequently extended this agreement to recognise and include the various staff networks including the BME network, LGBT network and Lived Experience (of Mental Health) network. The networks provide the trust with a further opportunity to engage staff and understand staff needs. The networks have been involved in the selection of the Occupational Health Provider, the Staff counselling service and the BME coaching scheme provider. The Chair of the BME network, in partnership with the Head of Employment Relations, scrutinises outcomes of all trust disciplinary processes to ensure that there is no discrimination in either process or outcome. Their conclusions are reported to the Board.

Supporting and engaging with our staff is a key priority for us. A wide variety of communications methods are used to ensure that colleagues are aware of the decisions and actions of the trust and have the opportunity to comment and input. These range from formal consultations relating to organisational change to regular email briefings and focus groups. We have developed our 'Let's Talk' programme which aims to give to colleagues more opportunity to raise issues with senior staff. The chair of staff side is also the Head of Partnership working for the trust and acts as an advocate for all staff irrespective of union membership ensuring that their views are heard and considered. They hold regular feedback sessions with staff across the trust to provide an opportunity to discuss any concerns and raise these with the directorate teams. The two members of the Partnership team also hold the role of Trust Freedom to Speak Up Guardian, a role that fits neatly with their partnership work.

Feedback from staff is gained via the national staff survey, staff Friends and Family test, groups run by the partnership team and visits to teams by service, corporate and non executive directors. Findings from visits are reported directly back to the board and the executive for action. The Head of Partnership presents a report directly to the Trust Board setting out the key themes that staff are raising.

2017 Staff Survey Summary of Key Findings
We take part in the annual National NHS staff survey. The staff survey is an important piece of evidence which demonstrates our compliance with CQC's national standards and targets. The overall response rate to the 2017 survey was 42% (1364 staff) of all staff. The response rate was average when compared with other combined mental health/learning disability and community trusts and was slightly lower than our response rate in 2016 (44%). The report groups the responses of all the questions into 32 key findings with an additional composite finding around staff engagement.

When compared with similar organisations, our comparative scores are as follows:

- 13 key findings were above average
- 8 key findings were average
- 11 key findings were below average

We were rated as better than national average on the composite score for **staff engagement** at 3.84 (out of a maximum of 5). The score is based on a composite of staff responses in relation to three key findings – staff recommendation of the trust as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work.

Staff report

Top 5 ranked scores	2017	2016	National Average 2017	Trust improvement / deterioration
% of staff reporting most recent experience of harassment, bullying / abuse	66%	64%	57%	+2% (improvement)
Quality of non-mandatory training, learning or development	4.15	4.11	4.06	+1% (improvement)
Effective use of patient / service user feedback	3.84	3.85	3.69	-0.3% (deterioration)
% of staff able to contribute to improvements at work	75%	75%	73%	No change
Effective team working	3.90	3.95	3.85	-1% (deterioration)

Bottom 5 ranked scores	2017	2016	National Average 2017	Trust improvement / deterioration
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	34%	33%	26%	+1% (deterioration)
% of staff witnessing potentially harmful errors, near misses or incidents in last month	28%	27%	23%	+1% (deterioration)
% of staff reporting errors, near misses or incidents witnessed in the last month	89%	92%	92%	-3% (deterioration)
% of staff experiencing physical violence from staff in last 12 months	3%	3%	2%	No change
% of staff experiencing discrimination at work in the last 12 months	17%	17%	11%	No change

Section two - Accountability report

Staff report

Oxleas has remained a high performer in comparison to other organisations in terms of overall results. The results have generally remained unchanged reflecting a challenging year with significant organisational change. We are keen to work with our staff to ensure that we achieve the excellence that we have come to expect.

Our directorates are working with their teams on specific local concerns and action plans. We will however embark on organisation wide programmes to address two key areas of concern.

- We are working with all our services to reduce violence and abuse towards our staff. We intend to build on the successes of programmes that have already been instrumental in reducing violence and aggression in specific teams. We will work with staff across a range of teams and organisational hierarchies to ensure that they have clear support and escalation systems to address their concerns. We are also shortly starting a programme applying quality improvement methodology to reduce violence and aggression in inpatient mental health services.
- Working in partnership with our Equality and Diversity leads and Bullying and Harassment advisers we will be working on a programme to address perceptions of discrimination and staff experience of bullying and harassment. We initiated successful programmes in 2016/17, including the BME coaching programme, and expect to take these and new initiatives forward to support our staff and improve their experience of working at Oxleas.

Information to and consultation with employees

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

Trade Union Facility Time Report

Table 1 – Relevant union officials

Number of employees who were relevant union officials during 2017/18	Full-time equivalent employee number
14	13.39 FTE

Table 2 – Percentage of time spent on facility times

Percentage of time	Number of employees
0%	
1-50%	14
51%-99%	
100%	

Staff report

Table 3 – Percentage of pay bill spent on facility time

Total cost of facility time	£6,280
Total pay bill	£572,539
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	1%

Table 4 – Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	100%

This has been collected from existing data and we are awaiting further guidance on reporting for future years. We believe there is a level of under-reporting and are working with our trade union colleagues to address this.

Formal Staff Consultations

Adult Learning Disability Services	Administration (Bromley and Greenwich)
Bexley Care	Twilight
Bexley Care	Community Mental Health Rehabilitation Service
Bromley	Volunteering and Lived Experience Practitioners
Bromley	Bed Management
Children & Young People	Greenwich Specialist Therapy Services
Children & Young People	Children's Community Nursing Teams
Children & Young People	Bromley Universal 0-4 service
Children & Young People	Highpoint House
Children & Young People	Child and Adolescent Mental Health
Corporate	Complaints
Corporate	IT
Corporate	RiO Support Team
Corporate	Estates & Facilities
Corporate	Clinical Audit
Corporate	Mental Health Act and Safeguarding

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Staff report

Formal Staff Consultations contd

Corporate	Quality and Governance
Forensic and Prison Services	Psychological Therapies
Forensics	Integrated Community Team
Greenwich	District Nursing
Greenwich	Chronic Obstructive Pulmonary Disease – Adult Community Services
Greenwich	Neurological - Adult Community Services
Trustwide	Senior Managers
Trustwide	Band 5 Mental Health Inpatient Nurses

Health and safety
The safety of our patients and staff is extremely important and our Health and Safety team supports staff across the organisation to identify and manage risks at work. A programme of environmental risk assessments across the trust is overseen by the team. All sites are required to complete risk assessments in key areas including ligature risk management, security, falls and manual handing and completion of these is routinely monitored by the Health and Safety Committee. During the year, we have had a particular focus on reducing the risks associated with lone working. This has been undertaken through auditing the systems used to protect staff when working alone and ensuring that all staff are aware of the processes teams have in place to protect them. An internal audit has been undertaken to review the processes in place for managing the safety of lone workers and their effectiveness operationally. This gave a rating of significant assurance with minor improvement opportunities.

Countering fraud
We are committed to the elimination of fraud within the trust, and ensure rigorous investigation and disciplinary or other actions are taken as appropriate. We adopt best practice procedures to tackle fraud, as recommended by NHS Protect and by KPMG, who provide us with specialist counter-fraud services.

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

During the year, we implemented the new national guidance on managing conflicts of interest in the NHS. This came into force on 1 June 2017 and aims to ensure that decision-making is not influenced by outside interests or expectations of private gain. We have updated our policies, undertaken an awareness raising campaign with colleagues and made our registers publicly available. We also introduced a new procurement policy which creates a framework for procurement of goods and services in a way that maximises value for money and supports the implementation of the Bribery Act 2010.

Staff report

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

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

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

Off-Payroll arrangements (not subject to audit)
As part of the remuneration report, NHS Foundation Trusts are mandated to report the following data on their highly paid and/or senior off-payroll engagements. This information is presented in the Table 1 and table 2 below.

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Staff report

Table 1: For all off-payroll engagements as of 31 Mar 2018, for more than £245 per day and that last for longer than six months	**2017/18**
	No of engagements
No. of existing engagements as of 31 Mar 2018	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
Confirmation: The trust confirms that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	Not Applicable

Staff report

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Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2017 and 31 Mar 2018, for more than £245 per day and that last for longer than six months	**2017/18**
	0
Number of new engagements, or those that reached six months in duration between 01 Apr 2017 and 31 Mar 2018	0
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
Number for whom assurance has been received	0
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

Exit packages (subject to audit)

During the year there were 6 exit packages (31 March 2017, 27) at a cost of £423,000 (31 March 2017, £792,000).

Year ended 31 March 2018

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

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Staff report

Year ended 31 March 2017

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	5	0	10
£10,001-£25,000	12	0	6
£25,001-£50,000	8	0	4
£50,001-£100,000	1	0	3
£100,001-£150,000	2	0	0
£150,001-£200,000	0	0	0
> £200,000	0	0	0
Total number of exit packages by type	28	0	28
Total resource cost £'000	792	0	792
**** of which***	Number agreed	Total value of agreements (£'000)	
Contractual payments in lieu of notice	0	0	

Code of governance disclosures

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

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

The Board of Directors manages the business of Oxleas NHS Foundation Trust by setting strategy and overseeing performance. The Executive team manages the day to day operational running of the organisation and regularly reports on activity to the Board. The Board also works closely with the Council of Governors and both groups regularly meet and attend each other's meetings.

The Council of Governors have a range of roles and responsibilities. Their general duty is to hold the non executive directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of our members and the public.

The governors' statutory duties are to:

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

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

Our governors also have the right to:

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

None of these rights has been used in 2017/18.

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Code of governance disclosures

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

Attendance at Board meetings

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

Name	Meetings attended
Seyi Clement Non Executive Director	9/10
Steve Dilworth Non Executive Director	10/10
Yemisi Gibbons Non Executive Director	8/10
Simon Hart Director of Human Resources and Organisational Development	6/7
Steve James Non Executive Director	10/10
James Kellock Non Executive Director	8/10
Dr Ify Okocha Medical Director	9/10

Name	Meetings attended
Helen Smith Deputy Chief Executive and Director of Service Delivery	10/10
Jo Stimpson Non Executive Director	10/10
Jazz Thind Director of Finance	9/10
Ben Travis Chief Executive	10/10
Andrew Trotter Chair	10/10
Jane Wells Director of Nursing	10/10

Code of governance disclosures

Audit and Risk Assurance Committee
The members of this committee during the year were:

Stephen Dilworth
Non Executive Director and Chair

Stephen James
Non Executive Director

Jo Stimpson
Non Executive Director

There were 6 meetings between 1 April 2017 and 31 March 2018

	Attendance
Steve Dilworth	6/6
Steve James	4/6
Jo Stimpson	4/6

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

With a membership of non executive directors, the committee uses independent external and internal audit to provide assurance to the Board.

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

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

- NHS revenue recognition and provisioning
- Property valuations
- Capital expenditure particularly at Queen Mary's Hospital
- Impact of South London Mental Health and Community Partnership, Sustainability and Transformation Partnership and new care models
- Management override of controls

KPMG provide internal audit and counter fraud services to Oxleas while Deloitte LLP provide external audit services. Deloitte were re-appointed by our Council of Governors as our external auditors in March 2016 for a period of two years. Our external audit contract was retendered in 2017 and Grant Thornton UK LLP were appointed by our Council of Governors as our external auditor from 1 July 2018 for a period of three years with the option to extend by a further one or two years.

Our internal and external auditors attend our audit meetings as well as relevant trust staff. At these meetings, outcomes of internal and external audits and actions taken as a result

Section two - Accountability report

Code of governance disclosures

were reviewed. Also financial controls, action to reduce fraud and our whistle-blowing and conflict of interest processes were discussed.

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

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

Deloitte are required to make the case to the committee that they are objective and comply with the technical and ethical standards that apply to them as auditors. Part of the audit cycle includes an assessment by the committee of the effectiveness of the audit process.

We incurred audit fees of £76k (excluding VAT) for the accounting period. This was a fee for an audit in accordance with the Audit Code issued by Monitor in 2007. The quality accounts fees, excluding VAT, was £7k (2016/17 £15k) and the charitable independent examination fee, excluding VAT was £5k (2016/17 £5k).

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

Nominations Committee
During 2017/18, our executive Nominations Committee met to appoint our new Director of Workforce and Quality Improvement.

Executive Nominations Committee
Membership

- Andy Trotter, Chair
- Ben Travis, Chief Executive
- James Kellock, Non Executive Director
- Yemisi Gibbons, Non Executive Director
- Sue Read, Staff Governor

The committee met twice during 2017/18 and was supported by our Head of Resourcing and Workforce Development. All members of the committee attended both meetings except for Yemisi Gibbons who could only attend one meeting. Following external advertisement and a range of stakeholder engagement, the committee was pleased to appoint Meera Nair to the post of Director of Workforce and Quality Improvement.

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Other committee attendance
The non executive directors sit on the Board sub-committees and their attendance is detailed below (as the board membership changed during the year, the number of meetings attended differs).

Business Committee

Name	Attendance
Jo Stimpson (Chair)	9/11
James Kellock	10/11
Steve Dilworth	10/11

Quality Committee (to December 2017)

Name	Attendance
Steve James (Chair)	6/6
Seyi Clement	3/6
Yemisi Gibbons	4/6

Performance and Quality Assurance Committee (from January 2018)

Name	Attendance
Yemisi Gibbons (Chair)	3/3
Seyi Clement	2/3
Steve James	1/3

Quality Improvement and Innovation Committee (from January 2018)

Name	Attendance
Steve James (Chair)	2/2
Seyi Clement	2/2
Yemisi Gibbons	2/2

Workforce Committee

Name	Attendance
James Kellock (Chair)	11/12
Yemisi Gibbons	11/12
Jo Stimpson	8/12

Infrastructure Committee

Name	Attendance
Seyi Clement (Chair)	5/6
Steve Dilworth	6/6
Yemisi Gibbons	3/5
Steve James	1/1

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Members of the Council of Governance
The Council of Governors has 42 governors. They represent:

- 13 public governors (four each for Bexley, Bromley and Greenwich boroughs, and one for Rest of England borough)
- 13 service user/carer governors
- 9 appointed governors
- 7 staff governors

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

Service user / carer constituency

Current Governors

Name	Term start	Term end
Lesley Smith	Re-elected 17 September 2016	September 2019
Katherine Copley	Re-elected 17 September 2016	September 2019
Arthur Mars	17 September 2016	September 2019
Fola Balogun	Re-elected 17 Seotember 2016	September 2019
Raja Rajendran	17 September 2016	September 2018
Jacqueline Ashby-Thompson	30 September 2015	September 2018
Irene Badejo	Re-elected 9 September 2017	September 2020
Steve Pleasants	9 September 2017	September 2020
Kulwinder Johal	9 September 2017	September 2020
Joseph Hopkins	9 September 2017	September 2020

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Governors whose term has ended in year

Name	Term start	Term end
Sonia Mars	17 September 2016	10 August 2017
Chris Purnell	Re-elected 24 September 2014	9 September 2017
Hannah Chamberlain	24 September 2014	9 September 2017
Renuka Abeysinghe	15 October 2014	9 September 2017
Mary Stirling	15 October 2014	9 September 2017
Ken Thomas	Re-elected 15 October 2014	9 September 2017

There are three vacant seats in the service user/carer constituency: two in the special interest group of adult community health services and one in older people mental health.

Public constituency

Current Governors

Name	Borough	Term Start	Term Ends
Stephen Brooks	Bexley	Re-elected 30 September 2015	September 2018
Richard Diment	Bexley	Re-elected 30 September 2015	September 2018
Ben Spencer	Bromley	5 February 2016	September 2018
John Crowley	Greenwch	5 February 2016	September 2018
Stuart Dixon	Bromley	17 September 2016	September 2018
Yens Marsen-Luther	Greenwich	Re-elected 9 September 2017	September 2020
Frazer Rendell	Bromley	Re-elected 9 September 2017	September 2020
Trilok Bhalla	Greenwich	9 September 2017	September 2020

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Governors whose term has ended in year

Current Governors

Name	Borough	Term Start	Term Ends
Gabrielle Wain	Greenwich	17 September 2016	15 June 2017
Phoebe Nwobiri	Rest of England	30 September 2015	1 August 2017
Amanda Finlay	Greenwich	Re-elected 24 September 2014	9 September 2017
Elizabeth Anderson	Bexley	30 September 2015	21 September 2017

There are two vacant seats in the Public Bexley constituency, one vacant seat in the Public Bromley constituency and one vacant seat in the Greenwich constituency. The rest of England constituency is also vacant.

Staff constituency

Current Governors

Name	Constituency	Term starts	Term ends
Jacqui Pointon	Children's Services	30 September 2015	September 2018
Sue Read	Adult Community Health Services	30 September 2015	September 2018
Surajsing Persand	Forensic and Prison Health Services	20 April 2016	September 2018
Anna Dube	Older People Mental Health Services	17 September 2016	September 2019
Grace Umoren	Working Age Mental Health Services	17 September 2016	September 2019
Victoria Smith	Corporate and Partner	9 September 2017	September 2020

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Governors whose term has ended in year

Name	Constituency	Term starts	Term ends
Joe Nhemachena	Corporate and Partner	24 September 2014	9 September 2017
Kaye Jones	Learning disability	Re-elected 24 September 2014	9 September 2017

The Staff Learning Disability Services seat is vacant

Appointed governors

Current Governors

Name	Organisation
Cafer Munur	Bexley Council – Local Authority
Judi Ellis	Bromley Council – Local Authority
David Gardner	Greenwich Council – Local Authority
Raymond Sheehy	Bridge – Forensic (Lead Governor)
Mark Ellison	Age UK – Older Adult
Carl Krauhaus	Charlton Athletic Community Trust – Young People
David Palmer	Mind – Adult Mental Health
Steve Davies	Mencap – Learning Disabilities
Brian Sladen	Headway – Adult Community

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

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

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During 2017/18, one election was held. The details are outlined below.

Public

	Number of nominations at deadline of 30/5/17	Outcome of voting (21/6/17 to 14/7/17	When announced	When took up position
Bexley 1 vacancy	No valid nomination received	-	-	-
Bromley 2 vacancies	1	Unopposed 1 elected	30 May 2017	9 September 2017
Greenwich 3 vacancies	2	Unopposed 2 elected	30 May 2017	9 September 2017

Service User/Carer

	Number of nominations at deadline of 30/5/17	Outcome of voting (21/6/17 to 14/7/17	When announced	When took up position
Working Age Adult Mental Health Services **3 vacancies**	4	3 elected	17 July 2017	9 September 2017
Adult Community Health Services **3 vacancies**	1	Unopposed 1 elected	30 May 2017	9 September 2017

Staff

	Number of nominations at deadline of 30/5/17	Outcome of voting (21/6/17) to 14/7/17)	When announced	When took up position
Corporate and partner 1 vacancy	1	Unopposed 1 elected	30 May 2017	9 September 2017
Learning disability Services 1 vacancy	No valid nomination received	-	-	-

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Attendance at Council of Governors' meetings

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

Service user carer

Name	Attendance
Fola Balogun	3/4
Katherine Copley	0/4
Lesley Smith	4/4
Irene Badejo	0/4
Hannah Chamberlain	1/1
Chris Purnell	1/1
Renuka Abeysinghe	1/1
Mary Stirling	1/1
Ken Thomas	1/1
Jacqueline Ashby-Thompson	4/4
Raja Rajendran	2/4
Arthur Mars	3/4
Sonia Mars	0/1
Steve Pleasants	2/3
Kulwinder Johal	1/3
Joseph Hopkins	2/3

Public

Name	Attendance
Frazer Rendell	3/4
Amanda Finlay	0/1
Stephen Brooks	3/4
Richard Diment	4/4
Elizabeth Anderson	0/1
Phoebe Nwobiri	0/1
Ben Spencer	2/4
John Crowley	3/4
Stuart Dixon	3/4
Yens Marsen-Luther	4/4
Gabrielle Wain	0/1
Trilok Bhalla	1/3

Staff

Name	Attendance
Joe Nhemachena	1/1
Kaye Jones	0/1
Jacqui Pointon	1/4
Sue Read	4/4
Surajsing Persand	3/4
Anna Dube	3/4
Grace Umoren	3/4
Victoria Smith	3/3

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Appointed

Name	Attendance
Cafer Munur	1/4
Judi Ellis	0/4
David Gardner	4/4
Raymond Sheehy	4/4
Carl Krauhaus (or representative)	4/4
David Palmer	0/4
Brian Sladen	2/4
Mark Ellison	2/4
Steve Davies	3/4

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

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

Name	Attendance
Seyi Clement Non Executive Director	1/4
Steve Dilworth Non Executive Director	2/4
Yemisi Gibbons Non Executive Director	0/4
Simon Hart Director of Human Resources and Organisational Development	1/2
Meera Nair Director of Workforce and Quality Improvement	1/1
Steve James Non Executive Director	3/4
James Kellock Non Executive Director	2/4
Dr Ify Okocha Medical Director	4/4
Helen Smith Deputy Chief Executive and Director of Service Delivery	2/4
Jo Stimpson Non Executive Director	2/4
Jazz Thind Director of Finance	3/4
Ben Travis Chief Executive	3/4
Andrew Trotter Chair	4/4
Jane Wells Director of Nursing	3/4

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

Membership
Our membership constituencies are:

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

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

Staff: this is open to individuals who are employed by us. Staff working in services contracted by us are also eligible to join.

Constituency	31/3/18	31/3/17
Staff	4373	4176
Public	4983	4652
Service user/carer	1424	1498
Totals	10,780	10326

Membership Strategy
This was our third year of our three year Membership Strategy. Areas of focus in the strategy are:

- Supporting our Council of Governors, including raising their profile
- Supporting our Membership Committee
- Promoting our membership, with particular emphasis on staff engagement to raise awareness, increasing our service user/carer membership, increasing our younger membership and raising the profile of our associate members
- Engaging and involving our members through improved communications and developing member health events.

We have made significant progress in achieving the goals of the Strategy. We have again published a who's who chart for our Council of Governors and a governor review and continued to provide profiles for all governors on our website. The dedicated governor email has been used by members.

Governors report on the work they have been doing to represent their constituency at each Council of Governors. We delivered a very successful Family Fun Day at Queen Mary's Sidcup in conjunction with our Annual Members Meeting in September 2017.

Governors have visited a wide range of services during the year including HMP Belmarsh, HMP Thameside, HMP/YOI Isis and HMP Maidstone. They also visited Adult Learning Disability services at Queen Mary's, Sidcup visiting both the Adult Community Learning Disability Team and the Can You Understand It group. Governors enjoyed a day fishing with our early intervention service users as part of the early intervention programme of activities in partnership with Charlton Athletic Community Trust, toured our Children's Services across the boroughs and our inpatient mental health facilities at Green Parks House. Our governors actively participated in the Board Away Day in February 2018 and attended a South London Partnership Governor event, joining governors from South London and Maudsley NHS FT and South West London and St Georges NHS Trust.

During 2017/18, we increased our overall membership, successfully growing both our public and service user/carer member constituencies. We aim to ensure that our membership is representative of the local populations we

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serve. We have achieved this through public engagement across Bexley, Bromley and Greenwich, held within a range of facilities including our own sites and public libraries. The A-Z of associate members on the staff intranet continues to be a helpful resource for signposting support available within the community. During the past year, we have engaged with members in a number of ways, including:

- Annual Members' Meeting and Family Fun Day. The formal Annual Members' Meeting was attended by 100 people and many more enjoyed the Family Fun Day. Governors were actively involved in the planning of the event and on the day engaged with their members, discussing any issues or ideas members had.
- 115 people attended our Members' Focus Groups held February – April 2018. These were an opportunity for members to have their say about the trust's performance with Oxleas' Board members and governors, and comment on our priorities for the coming year. At each event a governor also talked about their role in more depth and other governors engaged with members during the table-top discussions.
- Publications including Oxleas Exchange and the governor review which reflects the work of our Council of Governors throughout the year and raises their profile.
- Web-based information including www.oxleas.nhs.uk
- Social media such as Facebook and Twitter and emails.
- Voting and governor nomination opportunities.
- Community events, public and targeted such as the Great Get Together in Greenwich, Lark in the Park in Sidcup and the Bromley Dementia Alliance event.
- Membership promotion at trust events such as the joint partnership event with the MS Society (Bexley and Dartford branch) and the volunteering event.
- Membership promotion careers events within schools.
- Members were invited to participate in a focus group to gather the views from service users and carers regarding the SIM - serenity high intensity case management project which is being piloted in Greenwich.
- We have over 119 associate members, representing a broad spectrum of health and social issues across the three boroughs and further afield. A number of associate members took part in the Annual Members' Meeting and Family Fun Day and other trust events such as the Greenwich stakeholder engagement event looking at patient journeys, gaps and coming up with an action plan.

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

Freepost Plus RTTR – GBLX – ASJZ
Membership Office
Oxleas NHS Foundation Trust
Pinewood House Pinewood Place
Dartford
Kent
DA2 7WG

Telephone
0300 123 1541

Email
oxl-tr.governors@nhs.net

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

NHS Improvement's Single Oversight Framework

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

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

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

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

Segmentation
Oxleas NHS Foundation has been placed by NHS Improvement in segment 2. Segment 2 means that providers are offered targeted support which they are not obliged to take up.

This segmentation information is the trust's position as at 25 May 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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

Area	Metric	2017/18 Q4 Score	2017/18 Q3 Score	2017/18 Q2 Score	2017/18 Q1 Score	2016/17 Q4 score	2016/17 Q3 score
Financial sustainability	Capital service capacity	2	2	4	4	2	2
	Liquidity	1	1	1	1	1	1
Financial efficiency	Income and expenditure margin	1	3	4	4	1	2
Financial controls	Distance from financial plan	1	2	3	3	1	1
	Agency spend	2	2	2	2	3	3
Overall scoring		1	2	3	3	2	2

Statement of accounting officer's responsibilities

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

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

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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

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

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

H Smith

Signed by
Helen Smith
Acting Chief Executive and Accounting Officer
25 May 2018

Annual governance statement 2017/18

Scope of responsibility
As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable Officer Memorandum.*

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Oxleas NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Oxleas NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

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

Membership of the committee comprises of three non-executive directors only. In attendance at the committee are the Chief Executive, Director of Finance, Director of Workforce and Quality Improvement, Associate Director of Corporate Affairs and Trust Secretary, Associate Director of Quality and Governance and the Risk and Governance Manager. Clinical representation is provided by the Director of Therapies and a service director. Representatives from internal and external auditors also attend the meeting.

The executive lead for the Audit and Risk Assurance Committee is the Director of Finance.

The responsibilities of all staff in relation to risk management are outlined in the Risk Management Framework; this is updated annually to ensure that is reflects the operational and governance structure of the trust. Our Mandatory and Essential Skills Programme covers risk management training appropriate to the grade, role and location of staff. Examples include safeguarding adults, safeguarding children, resuscitation skills and prevention and management of violence and aggression. All staff are required to complete health and safety, fire safety, infection control and information governance training. The uptake of training is monitored centrally and reviewed through the workforce update to the Board of Directors. Training compliance is also monitored at team level on an on-going basis through live reports on NHS Learn.

We aim to ensure learning from the recommendations of incidents, complaints and claims. This is achieved through the following mechanisms: trustwide embedding learning events; trustwide and local Patient Safety Groups; trustwide and local Patient Experience Groups. Reflective practice is encouraged at ward level and though clinical supervision. The uptake of supervision is monitored regularly by the Board of Directors. The Internal Audit Programme and Clinical Audit Programme are used to evidence that changes in practice have been implemented.

The risk and control framework
Our Risk Management Framework sets out the process for how risk and change in risk is identified, evaluated and controlled. It sets out the responsibilities for individuals and key sub-committees in terms of how risks are reported and escalated through the governance structure. This is regularly reviewed and updated in line with changes to the governance and operational structures.

During 2017/18, our risk management processes were reviewed by Internal Audit, and achieved an outcome of 'significant assurance with minor improvement opportunities.' The audit identified a number of areas of good practice, including central support, the introduction of monthly presentation of risk registers to the Trust Executive and evidence that mitigating actions are being actively performed and progress communicated.

The trust has a single automated system (Datix) for the management of all risks registers across the trust. The internal audit also noted the capacity if this to record, measure and report on its risks in an efficient and effective manner.

We may decide to tolerate certain risks. Patient and staff safety, availability of resources and the impact on the trust's reputation will inform the decision of when to tolerate a risk.

As the committee with delegated responsibility for clinical and non-clinical risk, the Audit and Risk Assurance Committee receives a Board Assurance Framework update as a standing item at every meeting. This includes an overview of new and emerging risks and recommendations on risks to be escalated or de-escalated from the Board Assurance Framework. A report from the Audit and Risk Assurance Committee is a standing item on the Board of Directors' agenda.

The Board Assurance Framework is presented to every meeting of the Board of Directors. Each item on the Board Assurance Framework is tracked against the agenda, to ensure that every risk item is covered during the meeting.

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

The Audit and Risk Committee receives a thematic analysis of risks at every meeting to highlight themes and trends across all services and directorates. From March 2018, the trust commenced a programme of rotational reporting from each of the Board sub-committees to ensure that the Committee is sighted on key strategic and operational risks.

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

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Between April 2017 and December 2018, the Committee with primary responsibility for quality governance was the Quality Committee. This was chaired by a non-executive director, and the Executive Lead was the Medical Director. Membership included clinical directors and other clinical leaders from across the trust. The Quality Committee reported on progress against our quality objectives to every meting of the Board of Directors.

In January 2018, the functions of the Quality Committee were split between the Quality and Performance Assurance Committee and the Quality Improvement and Innovation Committee, so as to ensure a sharper focus on these distinct workstreams.

The remit of the Performance and Quality Assurance Committee is to provide assurance to the Board of Directors on the quality of services provided by the Trust, by agreeing the quality priorities for the trust; and addressing challenges and assessing, monitoring and improving the quality of service provision. This Committee is chaired by a non-executive director and the executive lead is the Director of Nursing.

The remit of the Quality Improvement and Innovation Committee is to provide assurance to the Board of Directors that a culture of continuous improvement and innovation is embedded across the trust; and to have strategic oversight of the delivery of the trust Quality Improvement Programme. This Committee is chaired by a non-executive director and the executive lead is the Medical Director.

The quality of our performance information is also assessed through our Internal Audit Plan; the Data Quality and Performance Audit for 2017/18 achieved an overall outcome of significant assurance with minor improvement opportunities. Further information on the quality of our services and how we monitor this is included in our Annual Quality Accounts and the processes to ensure accuracy of data are laid out later in this statement.

During 2017/18, we continued to use the programme of Board visits as a means of assessing quality at local level. Visits are conducted to at least one team each month to speak with patients, carers and staff about their experience of using the service. Feedback from these visits is reported to Board at every meeting.

The quality impact of savings plans are regularly reviewed through meetings with the Director of Nursing, Medical Director and Director of Therapies who are required to provide assurance to the Board of Directors that saving plans do not impact on the quality of services.

Assurance of compliance with CQC registration requirements is obtained through programme of peer reviews and also through the quality governance process described above. In April 2017, our forensic services were re-inspected by CQC following their in-depth inspection across all our services in 2016 and, as at 31 March 2018, the trust sustained a rating of “good” in all 14 core services and overall rating of “good” trustwide.

Our Short Breaks Service at Bluebell House is registered with both CQC and Ofsted. A full inspection was held in June 2017. No significant concerns were raised and the service retained a rating of ‘good.’

Oxleas has robust information governance systems. It is a mandatory requirement that all staff complete information governance training and there are established processes for identifying and managing breaches in data security, including encryption of all portable storage devices. Oxleas NHS Foundation Trust was not affected by the ‘ransomware’ attack in November 2017, but in response to this, the trust invested in enhanced anti-ransomware software to further improve data security.

During 2017/18, the introduction of the new General Data Protection Regulations (GDPR) regulations was identified as a risk to which the trust needed respond. The trust Information Governance Group has focused on preparation for GDPR including a gap analysis and action plan. These were assessed as part of the wider internal audit of information governance and found to cover the appropriate areas.

There have been no serious lapses of data security.

The major risks faced by Oxleas NHS Foundation Trust in 2017/18 are

- **Legal action from the Health and Safety Executive (HSE) following the incident at the Bracton Centre in July 2016:** Learning from the incident continues to be monitored by the Board and the Executive Team. The trust is working closely with external legal advisors in preparation for the forthcoming prosecution. Financial provision has been made to manage the impact of any fines imposed.
- **Bed management – to ensure demand for inpatient mental health beds is managed effectively:** In response to high demand on our inpatient beds we have introduced new procedures to manage our bed capacity to clear standards and have also invested in improving crisis care, by for example enhancing the role of home treatments teams, mental health liaison teams and opening a Crisis Café in Bexleyheath.
- **Financial sustainability:** across our services we continue to reviewing where we can make efficiencies and are working with partners across South London to support financial viability in the health and social care system.
- **General Data Protection Regulations Preparedness:** A gap analysis has been completed and an action plan has been developed to ensure compliance with the General Data Protection Regulations when they come into force from 25 May 2018.
- **Recruitment and retention of staff:** The trust has developed a detailed retention plan, with a focus on: making first year of employment supportive, nurturing and fulfilling experience, support managers to get the best out of and develop individual staff; and make people feel valued by an organisation that prioritises quality of care. There is an on-going programme of recruitment events, including weekend events and working closely with universities and HEIs and use of social media to raise awareness of job opportunities

During the Care Quality Commission (CQC) inspection in March 2017, the inspectors carried out a well led review piloting the new well-led framework that brings together the CQC key lines of enquiry and NHS Improvement’s framework for leadership and governance. They reported that the trust has robust governance structures in place and a board assurance framework that identifies and monitors areas of risk and links to risk registers across the organisation. The Care Quality Commission report stated that board meetings were well organised and inclusive with a high level of challenge and debate. During 2017/18 we continued to review our governance processes against key areas of the framework including undertaking an internal audit. This gave a

rating of significant assurance with minor improvements and led to changes in our board sub-committee structure and a greater focus on strategy at Board level. During 2018, we are carrying out an internal review against the well-led framework and this will feed into plans for an external review next year.

There are no principal risks to compliance with NHS Foundation Trust condition 4 (FT Governance), other than the risk described elsewhere in this report. We have effective systems in place to ensure the timely and accurate collection of information to provide assurance that we are complying with our licence. Our Integrated Dashboard Report monitors performance against key indicators and targets at every Board meeting.

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

Risk management is well embedded into the activities of the organisation. The Patient Safety Committee reviews all serious incidents, monitors progress against actions plans and ensures that learning takes place through regular trustwide events. The trust openly encourages incident reporting and continues to achieve high levels reporting low-harm incidents and near misses; this is a widely recognised indicator of a positive safety culture. The Mortality Surveillance Group ensures that there are robust systems in place to identify, clinically review and learn from all deaths, not just those reported as serious incidents. This group is chaired by the Director of Nursing. Membership includes a non-executive director and clinical leaders from all service directorates.

Safety risks are also identified and managed though the programme of environmental risk assessments overseen by the Health and Safety Team. All sites are required to complete risk assessments in key areas including ligature risk management, security, falls and manual handing and completion of these is routinely monitored by the Health and Safety Committee.

The trust also organises regular emergency planning exercises to ensure that services are prepared to respond in the event of a major incident. We receive assurance on the robustness of our plans through participation in a NHS England (London region) annual emergency prevention, preparedness and response assurance process.

We actively engage with our governors, membership and key stakeholders in reporting on our performance and planning for the future including managing risks. A key element of this is through the annual focus groups which look at the quality of our services and agree the priorities for the coming year. We are also involved in regular meetings with local partners in health and social care including Overview and Scrutiny Committees, HealthWatch and the wider voluntary sector.

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

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

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.

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

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

Review of economy, efficiency and effectiveness of the use of resources
Service directorate performance is monitored at Board of Directors meetings through the Operational Performance Report. This identifies the top issues of concern that will be the focus of each directorate management team on a month by month basis. Quarterly annual plan review meetings are held with each directorate to monitor progress and discuss any risks to achieving goals. These meetings are chaired by the Chief Executive and are attended by operational managers, clinical leaders and the executive team. Financial performance is monitored through the Business Committee and Audit Committee and reported to the Board of Directors.

The Trust Executive Team also receive detailed operational performance reports from all corporate and service directorates, including a summary of key risks; and new and emerging risks.

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

Internal Audits are undertaken throughout the year on our core financial systems and also on areas where we believe improvements can be made. The Internal Audit Plan is risk based and focuses on the areas where the most benefit is to be gained from Internal Audit input. Over the past year, the key areas covered by our internal audit activity were:

- Freedom to Speak Up - Significant assurance with minor improvement opportunities
- Safeguarding Adults - Partial assurance with improvements required
- Safeguarding Children - Partial assurance with improvements required
- Financial Systems and Reporting - Significant assurance with minor improvement opportunities
- Nurse Revalidation – Significant assurance
- Risk Management - Significant assurance with minor improvement opportunities
- Board Governance - Significant assurance with minor improvement opportunities
- Data Quality and Performance Reporting - Significant assurance with minor improvement opportunities
- Safeguarding Adults Top-up - Significant assurance with minor improvement opportunities
- Safeguarding Children Top-up – Significant Assurance

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- Information Governance – Significant Assurance
- Lone Working – Significant Assurance with minor improvement opportunities

Monitoring progress against recommendations made in these reports is overseen by the Audit and Risk Assurance Committee and the Executive Team. The trust has taken a robust line on ensuring that actions are completed with the agreed timescale, unless there are delays due to circumstances beyond our control.

We also have a contract with counter-fraud services for the proactive prevention and detection, and reactive investigation of fraud. This includes a focus on increasing staff awareness of fraud matters.

The Business Committee, a formal subcommittee of the Board of Directors, is responsible for the consideration of financial and investment risk, the review and approval of the marketing strategy, the review of the Annual Plan in advance of formal approval by the Board of Directors. The Business Committee is chaired by a non-executive director and membership includes non-executive and executive directors. Significant investment decisions are agreed by the Board of Directors and Council of Governors.

The governance framework of the trust, including committee structures, attendance records and the coverage of their work are discussed elsewhere in this report.

Information governance
There have been no serious incidents relating to information governance including data loss or confidentiality breaches.

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

The Board of Directors has assured itself that the Quality Report for 2017/18 represents a balanced view of the quality of our services. Accuracy of data within the Quality Report was ensured via the measures stated below:

1) **Governance and Leadership**
The trust has clear governance and leadership arrangements in place. One of our Non-Executive Directors chairs the Performance and Quality Assurance Committee where all quality indicators are assessed and reviewed, and the quality of our performance is reported back to the Board of Directors. The Performance & Quality Assurance Committee ensures the indicators used within our quality report present a balanced view of the quality of the services provided. Our local clinical directorates also review local clinical quality measures and provide additional assurance to the Committee.

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2) **Policies**
There is comprehensive guidance for staff on data quality, translating the corporate commitment into practice; these are available as policies or guidance or operational procedures, covering data collection, recording, analysis and reporting and are available to staff on the trust intranet. Where new guidance is required such as meeting our CQUIN targets (Commissioning for Quality and Innovation), the trust Quality and Governance team provide implementation guidance and process pathways to ensure all staff are aware of the accurate process for recording and reporting.

3) **Systems and Processes**
There are systems and processes in place to ensure collection, recording, analysis and reporting of data is accurate, valid and reliable. Mechanisms and processes have been put in place to ensure inputs are reported back to staff responsible as well as their supervisors where required to allow for consistent reviews of the quality of the data collected. Mechanisms include reviews by the trust Business Managers, Quality and Governance Managers and the Informatics team to ensure the validity of the data and reports being reviewed. All areas of business development, the annual plan, the quality objectives and management of services are underpinned where possible by information reports provided on a monthly or quarterly basis at team, directorate and at trust level. When new areas of improvement are agreed a robust monitoring method is also agreed to enable us to utilise appropriate information to monitor progress on a regular basis either within a team or throughout the trust.

4) **People and skills**
Roles and responsibilities in relation to quality are clearly defined and documented, and incorporated where appropriate into job descriptions and is integrated to staff appraisal. When new ways of collecting, monitoring or reporting data are agreed within Oxleas, this is circulated to all staff and logged within guidance with essential training provided to ensure that staff have the necessary capacity and skills to implement new ways of working that will improve the quality of our services

5) **Data use and reporting**
We ensure that all quality indicators chosen internally by the Board, and those agreed with our commissioners, are linked clearly back to the trust's Annual Plan priority objectives, national requirements and areas of business development. Data used for reporting to NHS Improvement, commissioning groups and used to populate the Quality Report is taken through an approval process with the Board and Executive before it is submitted. Clear information about the source of information, data quality and analysis is undertaken. Data used to specifically monitor improvements to the quality of our business is agreed within the The Performance & Quality Assurance Committee led by the Non-Executive Director for Quality Assurance. We also take part in national clinical audits which utilises verified data collection tools. These reports are presented to the Clinical Effectiveness Group for approval.

Annual governance statement 2017/18

Reporting of Quality data is achieved via various methods:

- IfOX (Information for Oxleas)– This is our Business Intelligence system which provides all staff access to reports on quality, performance and activity tailored to their way of working. It also gives clinicians access to key data items in the patient records that require updating in a timely fashion.
- Quality dashboards and Quality reports that report on our quality metrics are provided on a monthly basis to the Executive Team, trust and directorate Quality sub-groups, the Board of Directors and the Performance & Quality Assurance Committee.
- We also have in place a data assurance framework which provides us assurance on data quality issues. In addition, a clinical data information group meets monthly, chaired by the Clinical Director for Informatics, this provides a forum to discuss issues related to data, associated risks, accuracy and efficacy of the data provided and reported on.
- Waiting times is an area closely monitored by our Board of Directors. We assure the quality and accuracy of elective waiting time data (which in our case relates to specialist foot surgery) by reviewing and validating the data regularly.

These steps that we have put in place give us an assurance that the Quality Report for 2017/18 presents a balanced view.

Review of effectiveness
As Accountable 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 trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in 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 and the Audit and Risk Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been supported by:

- Regular review of economy, efficiency, effectiveness, strategic risks and the Assurance Framework by the Board of Directors
- The Audit and Risk Assurance Committee completing its audit plan
- The Audit and Risk Assurance Committee and other Board sub-committees evaluation and monitoring of the organisation's risks and mitigation plans including regular review of the operational risk registers from each service directorate.
- Evidence to verify compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009.
- The regular assessment and monitoring of the quality of services provided by Oxleas NHS Foundation Trust, initially through the Quality Committee and then subsequently through the Performance and Quality Assurance Committee.
- The Clinical Effectiveness Group's review of the trust's annual clinical audit programme which reflects compliance with national, CQUIN, trust and local audits. This review encompasses agreement of action plans and ensures implementation of recommendations across the trust's various services.
- The Business Committee's review of new business opportunities and capital developments, contract performance and business planning.

Conclusion
No significant internal control issues have been identified.

Signed by
Helen Smith
Acting Chief Executive and Accounting Officer
25 May 2018

Accountability report signed by

Signed by
Helen Smith
Acting Chief Executive and Accounting Officer
25 May 2018

Part 1

1.0 Chief Executive's Statement on Quality

Providing high quality services and ensuring excellence for every patient has been our focus every year. I am pleased to present to you our Quality Accounts for 2017/18 which give you an insight to our commitment to improve lives by providing the best quality health and social care for patients, their families, carers and those identified as important to them. The following pages demonstrate:

- Our approach to quality improvement,
- Our performance against the quality priorities we set for ourselves in 2017/18,
- Our priorities for 2018/19,
- A showcase of notable and innovative practice that has taken place across our services this year.

We have worked hard across all our services to ensure we achieve our quality priorities. We have achieved 17 of our 19 quality indicators. We are determined to focus on continued improvement in those areas to ensure these are achieved in the year ahead. Our goal is for continuous quality improvement across all services.

Our Board has always been committed to making quality the focus of everything that we do and this year has been no different. We have a 'Board to Floor' programme of monthly visits to clinical areas by every member of the Trust Board accompanied by a clinical and service director. These visits provide our staff and patients the opportunity to directly engage with members of the Board and executive team to share their views on the quality of our services and what it is like to work in Oxleas. Feedback about each visit is also given by non-executive directors at every public Board meeting.

In addition, I am pleased to share that following a re-inspection of our forensic services by the Care Quality Commission in April 2017, that all Oxleas services are now rated as good in the quality domains of safe, effective, responsive, caring and well-led with the exception of Forensic who were rated as outstanding in the quality domain of 'responsive' and our Adult Learning Disability services who were rated outstanding in the quality domain of 'caring'. Further detail is provided in section 2.4.5 of the quality accounts.

Looking forward to the coming year, we have launched an ambitious programme of quality improvement and innovation (Qi). This is a programme that we hope will lead to sustained cultural change within Oxleas ensuring that quality improvement is incorporated into the practice of all our staff and Qi initiatives are routinely implemented, reviewed and learning scaled up across the organisation. This will involve comprehensive training for staff across Oxleas, with quality improvement initiatives undertaken in all directorates tackling issues identified by staff and promoting joy at work. This is an exciting new step for us and we look forward to sharing our quality outcomes with you in 2018/19.

Each year, we work in partnership with staff, patients, carers, members, commissioners, GPs, Healthwatch and other stakeholders and we are grateful to all who have supported and worked with us in reviewing and setting our quality plans. We are proud to have had another successful year and we are determined to maintain these high standards throughout 2018/19.

Section three
Quality Accounts

Declaration
In preparing our Quality Accounts, we have endeavoured to ensure that the information and data presented within is accurate and provides a fair and balanced reflection of our performance this year. However there are a number of inherent limitations in the preparation of the Quality Accounts which may impact the reliability or accuracy of the data reported.

These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits 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, its Board and management team have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognise that it is nonetheless subject to the inherent limitations noted above.

Following these steps, to my knowledge, the information in the document is accurate with the exception of the matters identified in respect of the Early Intervention in Psychosis and Inappropriate out-of-area placements for adult mental health services indicators as described in section 3.1 and
Annex 3 of this report.

H Smith

Signed by
Helen Smith
Acting Chief Executive and Accounting Officer
25 May 2018

Part 2

2.0 Quality Priorities for Improvement

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

Oxleas is committed to delivering good quality care and we have worked in partnership with our staff, patients, carers, members, commissioners, GPs and others to identify areas for improvement. Our annual Quality Account gives us an opportunity to share our performance against our 2017/18 priorities, describe our areas of focus for 2018/19 and showcase notable and innovative practice that has taken place across our services this year.

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

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

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

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

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

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

Green/Achieved
This means the target set has been achieved

Amber/Mostly Achieved
This means our 2017/18 performance is 5% or less below the set target

Red/Not achieved
This means our 2017/18 performance is 6% or more below the set target

Section three
Quality Accounts

2.2 Our performance against our Quality Objectives

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

We have provided summary of our trust-wide performance against each of the 6 quality objectives below however further detail on each objective is provided in sections 2.2.1 to 2.2.6. We have 19 quality goals across the 6 quality objectives::

Table 1

Achieved	17 (89%)
Mostly Achieved)	1 (5%)
Not achieved	1 (5%)
Total	19

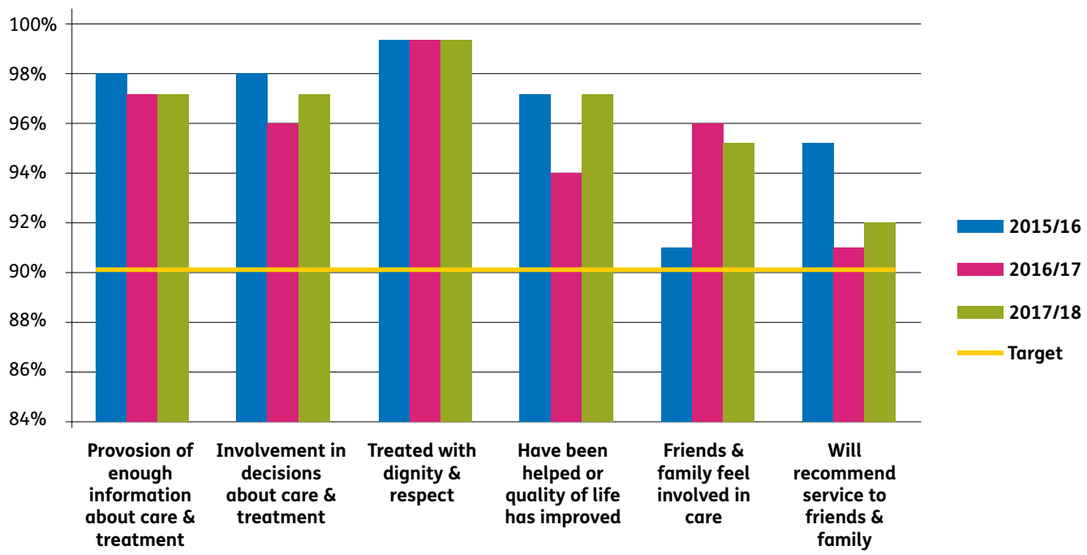
2.2.1 Quality Objective 1 – Meeting our patient promise (Patient Experience)

Our patient promise is the foundation of our patient experience 6 'must ask' questions that must be used in every Oxleas patient survey. We recognise the importance of asking the following questions and ensuring that we respond to what patients tell us about the care, service and treatment that they have received:

1. Patients reporting that they have been provided with enough information about care and treatment
2. Patients reporting that they been involved in decisions about their care and treatment
3. Patients reporting that staff have treated them with dignity and respect
4. Patients reporting that they have been helped/quality of life has improved as a result of the care and treatment they have received
5. Patients who reported that they wanted friends/relatives involved in their care/ treatment did feel that they were involved
6. Patients reporting that they would recommend our service to friends and family if they need similar care or treatment

Our overall Trust performance against all 6 questions over the last 3 years is shown below (the data source is from the results of our internal patient experience surveys):

Chart 1 – Meeting our patient promise – Oxleas Overall Position



The directorate level breakdown is shown in **Table 1** below (***please note that we moved from functional directorates to borough directorates on the 1st of April 2017, hence our data below has been shown according to the new directorates, however the indicators are still the same as per previous years):***

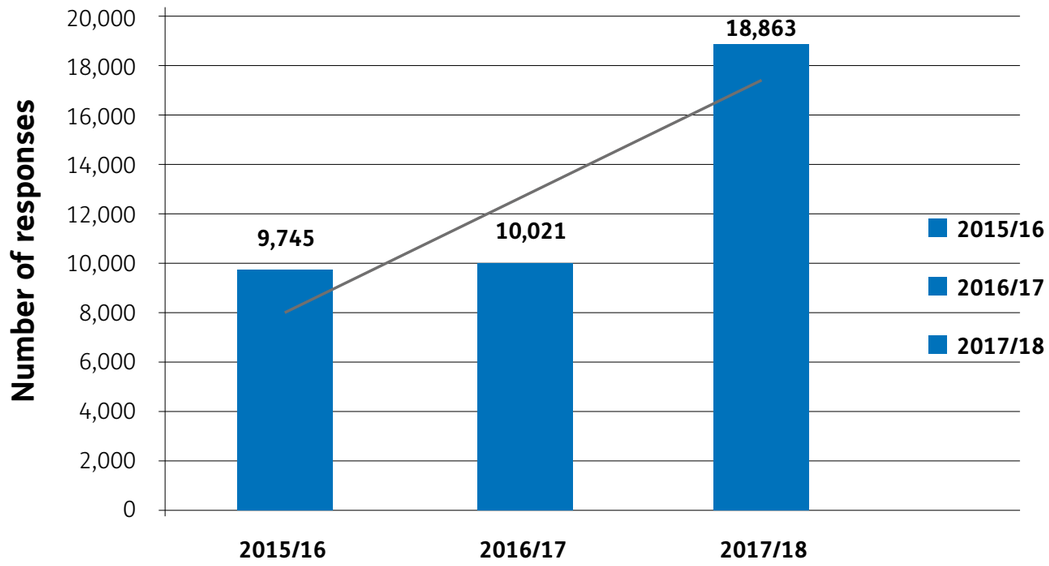
Patient Experience Quality Improwwvvement Goal for 2017/18	Service Directorate Summary for 2017/18					
	Bexley	Bromley	Greenwich	Forensic & Prisons	Adult Learning Disabilities (ALD)	Children & Young People (CYP)
90% of patients surveyed are reporting they have been provided with enough information about care and treatment?	99%	96%	98%	91%	92%	97%
90% of patients surveyed are reporting that they been involved in decisions about their care and treatment?	98%	96%	98%	87%	97%	97%
90% of patients surveyed are reporting that staff have treated them with dignity and respect?	99%	98%	99%	94%	100%	99%
90% of patients surveyed are reporting that they have been helped as a result of the care and treatment they have received	98%	93%	98%	88%	99%	97%
90% of patients who reported that they wanted friends/relatives involved in their care/treatment did feel that they were involved	96%	96%	94%	78%	96%	96%
Friends and Family Test 90% of patients surveyed are reporting that they would recommend our service to friends and family if they need similar care or treatment	96% recommend	89% recommend	92% recommend	73% recommend	81% recommend	88% recommend
	2% not recommend	4% not recommend	2% not recommend	15% not recommend	5% not recommend	2% not recommend
Total number of responses	3729	1114	9617	3076	893	434

Our 2017/18 overall trust performance shows that we have achieved over the 90% target for each of the 6 must ask questions - patients who respond to our surveys reporting that they have been provided with enough information about their care and treatment, have been involved in decisions about their care and treatment, staff have treated them with dignity and respect, that they have been helped as a result of the care and treatment they have received, friends/relatives involved in their care/ treatment feel that they were involved; and that they would recommend our service to friends and family if they need similar care or treatment. However some exceptions are seen in the Forensic & Prisons and Adult Learning Disability Directorates. We will continue to review performance against these goals in the Trust and local directorate patient experience groups, ensuring we focus on what we can do to positively engage and work with patients and those important to them. Identified services also have plans in place to improve on the areas that have been highlighted.

Number of patients who have responded to our surveys

We have made significant effort over the last year to improve the coverage of teams who ask patients to give us feedback as well as to increase the numbers of patients who respond to our patient experience surveys and 6 must ask questions. For 2017/18, we have seen an 88% increase in the number of patients who have responded to our surveys compared to the previous year.

Chart 2 – number of patients providing feedback



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

Please note: *Progress for objective 2 indicator that states ' to ensure 90% of patients who reported that they wanted friends/relatives involved in their care/treatment did feel that they were involved' has been captured in section 2.2.1 above.*

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

In 2016/17, we launched a new carers and support network strategy which took into account our wider range of services; helping us to identify and meet the needs of carers in our community health services as well as in our mental health and learning disability services. One of the outputs from the strategy was to implement a support network engagement tool (SNET) which captured who was important to patient and details recorded within the care record. This assessment tool asks the following questions:

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

Our improvement goal was to ensure 80% of patients have their support network identified and noted within their care record; disappointingly this has not been achieved this year. Our achievement at the end of 2017/18 was 35.2%. This is disappointing to note as we achieved 80% in 2016/17 but this was just specific to our inpatient bedded services and community mental health teams. In 2017/18, this was expanded to include all Oxleas services which was a greater challenge for us.

To help us achieve this next year, there will be continued effort to help our staff move from just thinking about the individual patient presenting for a service, to thinking more widely to also supporting their network, those who are important to them. This is a challenging task for any healthcare provider given the high pace of work required within services.

We will increase the number of reminders to staff including updating the clinicians' task list on Ifox (our information & performance dashboard) to indicate whether the SNET form has been completed as well as ask services to include this indicator as one of the performance areas discussed in their team huddles.

Our aspiration is for all patients/service users and their support networks to be offered the opportunity to be included, involved and engaged; every staff member makes it a priority to ensure that support is provided for the identified network for their patients; and for the inclusion of patients' support networks to become everybody's business. This will continue to be our focus in the coming year and we aim to achieve this across all identified Oxleas services in 2018/19.

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

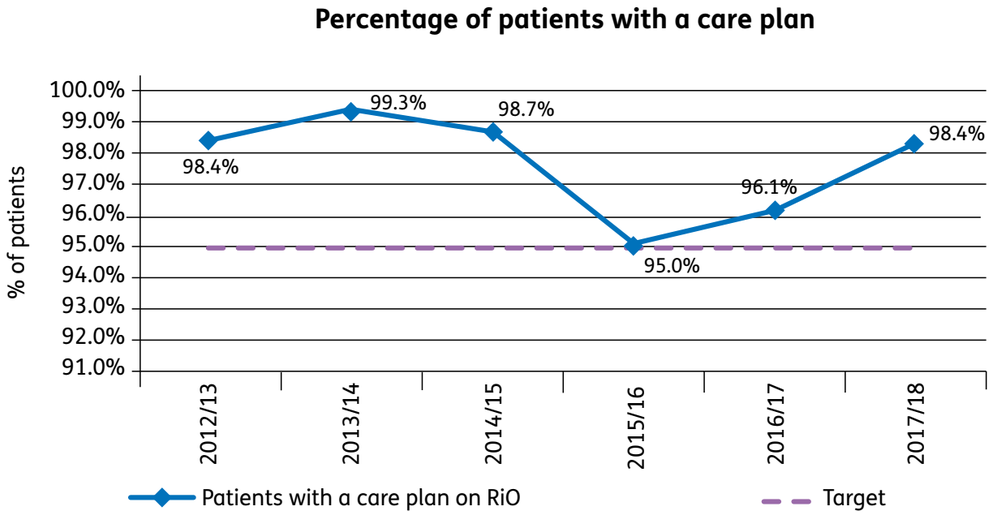
Ensuring that patients are involved in discussions and decisions about their care and have a plan that is personal to them continues to be a key quality priority for Oxleas. We have implemented over the last few years a transforming personalised care planning programme, working with clinicians to understand and resolve issues identified with RiO (our clinical records system), provide essential training that creates confidence and assurance on how to engage patients effectively and worked in partnership with service users to understand the best way to improve engagement.

Objective 3 comes under the clinical effectiveness domain and has two quality goals; we have provided our 2017/18 performance below:

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

This quality indicator had consistently been achieved over the previous four years and we are pleased to see that there is continuous improvement in this area. Our goal is for at least 95% of our patients to have a comprehensive and personalised care plan on RiO and this will continue to be a focus for the Trust and has been added as a priority indicator for the coming year.

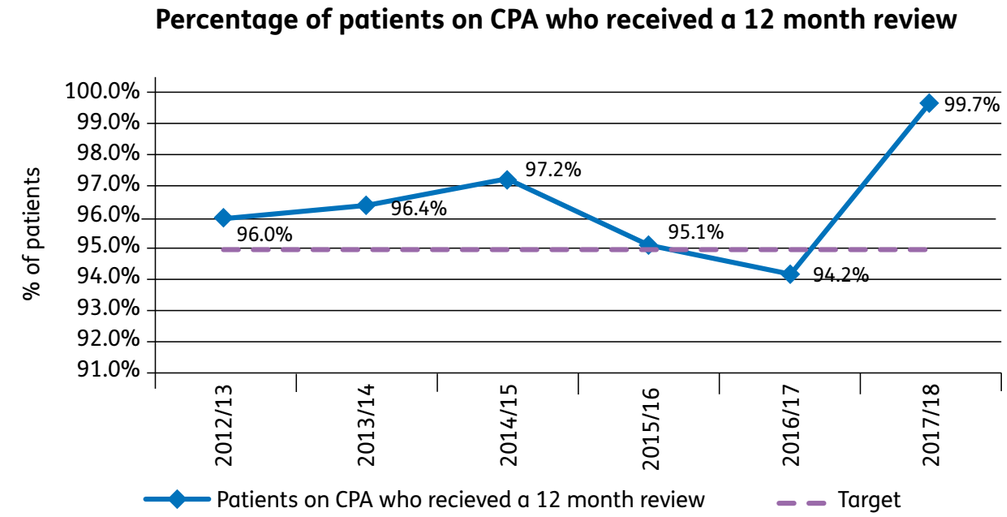
Chart 3
Quality indicator - To ensure 95% of our patients will have a recorded care plan on RiO.



Quality indicator - To ensure 95% of our patients on CPA (Care Programme Approach) will receive a 12 monthly review.

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

Chart 4



In 2016/17, we were 0.8% under the 95% target; we are pleased to note that the 2017/18 status is almost at a 100% with an achievement of 99.7%.

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

For 2017/18, we stated that we will continue our improvement focus on our sign up to safety plan. There are 7 identified areas of focus under the quality objective and we have provided a highlight below on each goal. These have been regularly been reviewed by the Trust Safety Committee.

Please note: The data source for our patient safety goals are from RiO our electronic patient care record, Datix (our incident recording system) and from local clinical audit

- ***Preventing the physical deterioration of people with enduring mental illness***

In 2017, we reviewed and introduced new physical health monitoring forms to the patient's electronic record system to ensure the monitoring of Physical health observations, including blood glucose and blood lipids, BMI, Malnutrition, smoking status and substance and alcohol misuse. This has provided teams with ease of accessibility to record and monitor physical health

We continue to promote Sepsis awareness throughout the trust and are using an e-learn package for staff to access additional training. In June 2017 an electronic version of the Modified Early Warning Score (MEWS) was added to the electronic patient record. This form has an inbuilt sepsis alert tool, which triggers a warning to staff if an abnormal physical health reading is recorded. However we will be moving to NEWS2 in 2018. This is the national early warning scores. We have a robust plan and relevant package of training to be able to successfully and safely roll out NEWS2 to all inpatient wards by the end of 2018.

- ***Supporting an open and honest culture throughout the Trust (duty of candour)***

Duty of candour is about being open, honest and transparent when providing care and treatment at all times. It is also a statutory requirement for all health organisations that are registered with the Care Quality Commission.

It is our legal duty to inform a patient and their family if we have made a mistake in their care or treatment that has led to harm and to provide an apology.

Compliance with Duty of Candour continues to be embedded throughout our services. Staff have shown increased confidence in contacting the Duty of Candour Lead to ask about incidents where it may be applicable and show greater understanding overall. In 2018/19, there will be a Duty of Candour refresh to further improve staff awareness; this will include ward visits by the Duty of Candour Leads. We will continue to work with the Health Innovation Network and colleagues from neighbouring London trusts to focus on learning from deaths and ensuring Duty of Candour.

- ***Suicide prevention***

The Oxleas Suicide Prevention Group was originally set up as a task and finish group to create our Suicide Prevention Strategy: *http://www.oxleasstrategies.com/suicidepreventionstrategy/* which has had almost 20,000 page views.

We have carried out two audits of concordance with the trust's observation policy forms, our results show that further improvement is required and work has been some improvement; however, further improvement is required and we are working in partnership with the South London Partnership partners to deliver e-observations rather than to continue to use paper forms. The e-observations forms will

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synch with our patient electronic record RiO. This will save an enormous amount of admin time scanning and uploading observation forms; it will make recording of observations more accurate, and will stop amended forms being used by wards.

In 2017/18 we also held an embedded learning event for prison staff. The event showcased a film that had been commissioned form prison staff: The aim of the film was to promote awareness of suicide prevention in prison settings.

Work is underway to conduct a trust-wide suicide audit. The aim is to identify any local factors associated with suicide, and any learning that might come from this. The finding of this audit will be reviewed by our Trust Safety Committee in 2018/19.

- ***Reducing risk and harm of violence in our mental health wards/Restrictive Practice***

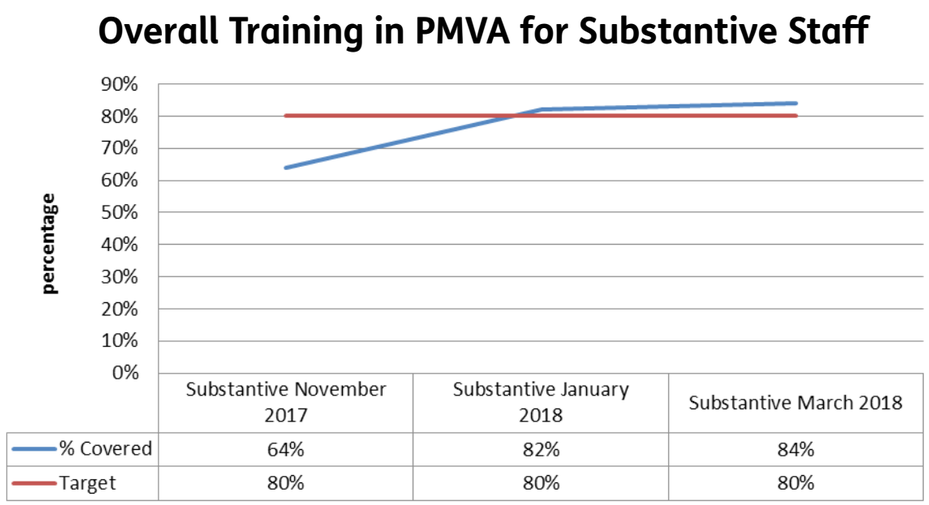
Restraint is the use of force or a threat to use force to make someone do something they are resisting, or the restriction of a person's freedom of movement, whether they are resisting or not. (Mental Capacity Act 2005, section 6(4)). On occasion physical restraint may be necessary either to safeguard a patient from harming themselves or others. In these circumstances staff will need to be able to affect a consistent team approach to physical restraint to ensure effective and safe management of the situation for both staff and service users. Nationally accepted training on physical restraint techniques is provided to Trust staff in accordance with the Training Needs Analysis.

Restraint may take many forms. It may be both verbal and physical and may vary in degree starting from a verbal request to calm down to assisting someone to a safe low stimulus environment

Oxleas aims to reduce incidences of violence and aggression through increased awareness and training and the appropriate management of violent and aggressive behaviour. In its guidance the Department of Health (2014) outlines its aims to develop a culture across health and social care where physical interventions are only ever used as a last resort when all other alternatives have been attempted and only then for the shortest possible time. This means that we aim to only use restraint when absolutely necessary and aim to reduce the use of prone restraint and use a supine option when giving IM emergency medication in the place of prone restraint if required. The Trust's PMVA policy (prevention management of violence and aggression) was updated in September 2017 to include this new option and to ensure new supine training for staff.

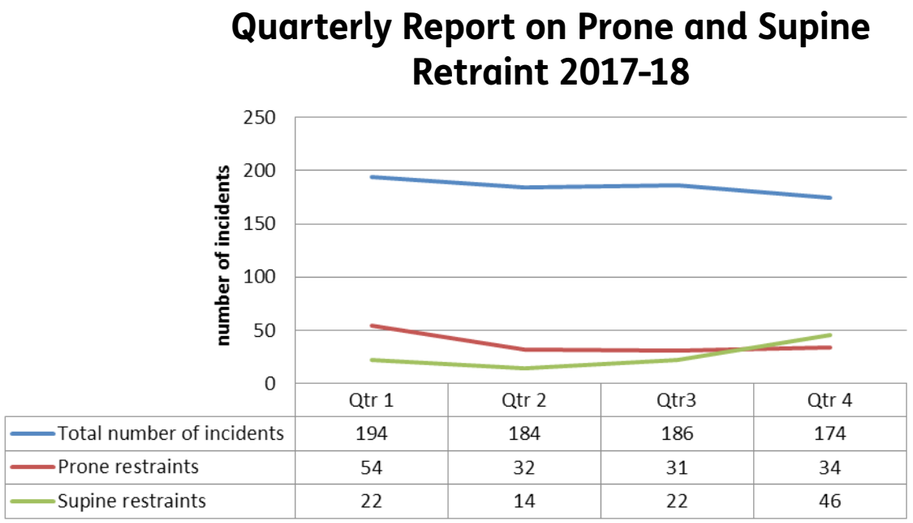
PAMOVA (the trust's PMVA training provider) have included in their PMVA training, risks to airways in respect of prone restraint and are now training staff in supine restraint for the administration of IM rapid tranquilisation. It is our priority that 80% of staff receives the supine restraint training. The overall position for supine training is shown below:

Chart 5



Our restraint data shows that there has been a reduction in prone restraints and an increase in supine restraints, as shown in the chart below. Quarter 4 in 2017/18 was the first time we reported more supine restraints than prone restraints.

Chart 6



We are working in partnership with ResearchNet (a service user group) to co-design a restraint reduction strategy, we continue to roll out the safer wards initiative across all our wards and we are participating in the South London Partnership violence reduction Quality improvement programme.

- ***Ligature management***

We continue to implement a robust programme of ligature risk assessments across all our services. This now includes audits completed in CAMHS, Learning Disabilities and Adult Mental Health community sites.

- ***Falls***

We continue to focus on reducing the incidences of falls on our wards. We conducted a longitudinal study towards the end of 2017/18; this reviewed how many falls a patient had, their falls risk and the use MFRAT (multi factorial falls risk assessment tool) and care plans for every patient admitted in a three month time frame in the following units: Greenwich Intermediate Care Unit, Meadow View Unit and Holbrook Ward. The study aims to develop a deeper understanding of why and how our patients are falling. The results of this study are currently being analysed during the writing of this report. The findings will be presented at the Trust Safety Committee and we aim to share with our CCGs at the Clinical Quality Review Meeting.

- ***Pressure ulcers***

To promote best practice we continue to use our well embedded Pressure Ulcers Prevention Strategy (PUPS). We have PUPS champions across all areas within the directorates and all staff are aware of the strategy and how to put it into practice. We continue to ensure pressure ulcer reviews occur for all incidences of Grade 3 and 4 pressure ulcers. The review meetings ascertain if the pressure ulcers were avoidable, and any learning is identified and embedded.

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

This objective is in line with one of our trust values which is to ensure excellence in everything that we do by providing services and delivering care in line with national best practice and guidelines.

There are 2 quality goals under objective 5:

- We will continue to engage in national audits that permit benchmarking such as POMH UK and the NHS Benchmarking network ***(Data source – national clinical audit utilising data from RiO in line with national guidance)***
- We will participate in the national programme of improving the physical health of patients with SMI and we will achieve the set targets of comprehensive cardio-metabolic risk assessment using the Lester Tool and interventions in patients at high risk. ***(Data source – national clinical audit utilising data from RiO in line with national guidance)***

2.2.5.1 Engagement in National Audits

We have made every effort to participate in national audits that are applicable to the services that we provide. We participated in 14 national audits in 2017/18 as described in section 2.4.1 below. We have provided a summary of one of the national POMH (prescribing observatory for mental health) audits that we participated in last year:

Prescribing high dose and combined antipsychotics national audit
Prescribing high dose and combined antipsychotics is a quality improvement programme that has been running for 11 years.

The audit standards are derived from the NICE Schizophrenia guidelines and the Royal College of Psychiatrists consensus statement for the use of high dose antipsychotics.

The standards are:

- Standard 1 - The dose of an individual antipsychotic should be within its licensed/ BNF limits.
- Standard 2 - Individuals receive only one antipsychotic at a time.
- Standard 3 - Where high-dose antipsychotics are prescribed, there should be a clear plan for regular clinical review including safety monitoring.

In 2017, 58 Trusts participated in the national audit submitting data for 10,072 patients on acute, rehabilitation and forensic wards; the Oxleas sample was for 257 patients.

Summary and key local issues
Nationally, there has been a steady but modest reduction over time in the proportion of patients prescribed high-dose and/or combined antipsychotic medication; Oxleas services benchmark very well compared to the Total National Sample (TNS) both at the baseline and subsequent audits (see the diamonds on the figure below in chart 7).

The reduction seen in the prevalence of combined antipsychotics (antipsychotic polypharmacy) over time seems to be largely attributable to fewer prescriptions for 'as required' antipsychotic medication.

In the 2017 Oxleas sample, regular high-dose antipsychotic medication was prescribed for only 5% of patients. Our practice with respect to ensuring patients have physical health checks and side-effects are monitored was largely better than the national average; however 1 in 4 of our patients in this group had no documented ECG (electrocardiogram) in the last year. Our action plan to improve on this position includes the procurement of hand held ECG machines for teams to use, thus not requiring leads to be attached to the patient which can sometimes be a detriment. This will help to improve ECG screening rates for these patients. As per date of writing this report, hand held ECG machines have been bought and disseminated to all identified teams.

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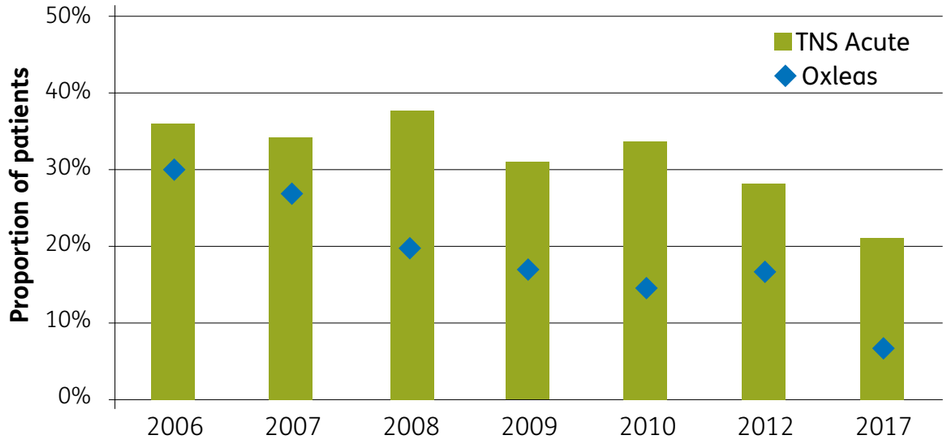
Chart 7 - Practice improved over time for Practice standard 1: National level - Proportion of patients (at each audit) in acute adult/PICU settings (in 2017, n=5159) in the total national sample (TNS) and Oxleas for whom the total daily prescribed dose of antipsychotic drugs including 'as required' is higher than BNF limits.



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

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

Our aim is to improve the physical health care of our patients with SMI by ensuring that they are offered a comprehensive cardio-metabolic risk assessment, have access to the appropriate treatments/interventions and the results are recorded in their electronic record and reviewed regularly as part of their care plan. We continue to ensure that results of screening are shared with the patient's GP and have developed systems to improve the exchange of information with primary care, particularly around physical health.

In terms of our 2017/18 goal, we participated in the national CQUIN which this year was undertaken as part of the National Clinical Audit of Psychosis (NCAP) in December 2017. This included standards on physical health screening and intervention for our patients. Whilst we have submitted data to the national team, the official results are yet to be made available. However we have provided details of our achievement against the national target based on our own internal self-assessment of the data submitted. Please note that these figures are subject to change following publication of results from NHS England.

Table 2
As can be seen from the above table, our results show that the target was not achieved in our community mental health teams. Following our self-assessment we have taken steps to ensure we are better placed to meet the physical hwealth needs of SMI patients in the community going forward. We have undertaken meetings with all community teams to identify and address gaps in processes for physical health screening and interventions; we will be providing a refresh of training and recording in this area as well as update standards for physical health clinics and the roles of physical health leads/champions.

	Total no. of clients in national sample	No. of clients not screened for one or more of the 7 indicators	% screening compliance	No. clients with one or more missing interventions	% Interventions compliance	% Overall compliance	National target 2017/18
Inpatient Services	31	1	97% (30/31)	1	97% (28/29)	97% (30/31)	90%
Community Mental Health Services	55	36	35% (19/55)	15	91% (40/44)	31% (|17/55)	65%
Early Intervention in Psychosis	211	5	98% (206/211)	15	92% (140/155)	90% (190/211)	90%
Total	297	42	86% (255/297)	31	91% (208/228)	90% (237/297)	-

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

Assessing if the clinical care that we have provided has made a difference to patients has been an area of focus for Oxleas over the last two years. We initially started this piece of work as a pilot, looking at various ways to record and measure standardised clinical outcomes but our vision was to extend this to all of our clinical directorates and eligible teams and to make the outcomes data accessible for frontline teams to use to inform clinical care.

We started rolling out routine measurement of clinical outcomes according to the service lines and have provided an update according to each service area; our progress against these are reviewed within local directorate Clinical Effectiveness Groups (CEG) and at the Trustwide CEG:

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- Children & Young People
- Mental Health Services
- Forensic Services
- Adult Learning Disability services
- Adult Community physical health services

Data source is from RiO and manual local databases. Definitions are based on nationally agreed clinical outcome definitions.

Children & Young People's Services
The culture of routine outcome measurement has become embedded across our CYP services. All Health Visiting teams who provide a universal plus service collect goal-based outcomes at the point of taking on a case and they review these at 3 - 6 months to achieve paired outcome data. This is also seen within the public health nursing team in schools across Greenwich.

Speech and Language therapists use Goal-based outcomes (GBOS). GBOS are a way to evaluate progress towards a goal in clinical work with children and young people, and their families and carers. They simply compare how far a young person feels they have moved towards reaching a goal they set at the beginning of an intervention, compared to where they are at the end of an intervention (or after some specified period of input (Law & Wolpert, 2013).

Occupational therapists and physiotherapists use CGAS (the children's global assessment scale) this is like the GBOS but specific to improvements in functioning.

Within our CAMHS services (Family therapy, clinical psychology, child psychotherapy and nursing) goal based outcomes and a range of CYP IAPT clinical measures are recorded at the beginning and end of an intervention. We have provided a case study on CYP IAPT below in section 3.2.7.

Forensic Services
Across our Forensic services, two self-report clinical outcome measures are collected from service users, the CORE-10 and Locus of Control. The CORE-10 is a 10-item outcome measure focussed on psychological distress. The Locus of Control provides a proxy measure of risk to others, by virtue of the extent to which they perceive themselves as irresponsible for events in their lives. It is a 40-item questionnaire and is the only known self-report measure to gauge risk.

The two questionnaires are collected by the psychology teams during the assessment process and the teams encourage service users to complete the measures every three months thereafter. In the inpatient services, assistant and trainee psychologists collect the measures. For outpatients, the lead clinician is responsible collecting the measures.

In addition, we also record HoNOS (Health of the Nation Outcome Scale) for our inpatient services (This is a clinician rated tool developed by the Royal College of Psychiatry to measure the health and social functioning of people experiencing severe mental illness. This is completed at each CPA (3 months and every 6 months thereafter).

Mental Health Services (Adults and Older People)
Our mental health services have used a number of approaches to measure clinical outcomes such as those described above (Core-10 and HoNOS), however HoNOS is the outcome measure that we aim to use consistently across all our services with the flexibility for teams to still continue with the other approaches.

Adult Learning Disability Services
In our ALD services we use a variety of core outcome measures depending on the pathway. For our mental health/challenging behaviour

(MH/CB) pathway we use HoNOS LD and for the complex physical health pathway we use TOMS (the Therapy Outcome Measure which is used to describe the relative abilities and difficulties of a services user in the 4 domains of 'impairment', 'activity', 'participation' and 'wellbeing'. We also use Dementia- QOMID – this is a quality outcome measure that is designed to measure the quality outcomes for an individual with dementia. The measure explores the key areas that ensures that the person with dementia is a experiencing a good quality experience (Dodd and Bush, 2013)

The use of these clinical outcome measures are embedded across all our ALD services.

Adult Community physical health services
In our community physical health services, there are a variety of clinical outcome measures used to cover the wide breath of services that are provided however there are two key clinical outcome measures that have been agreed for consistent use across these are :

- The PHQ-9 which is a patient health questionnaire that screens, diagnoses, monitors and measures the severity of depression. This measure is used within our musculoskeletal, COPD, cardiac and intermediate care services
- The EQ5D-5L – this is a standardised approach to measure health related quality of life and is consistently used in our musculoskeletal services and our community rehabilitation teams

2.3 Our Quality improvement priorities for 2018/19

In the following section, we tell you about our chosen quality priorities for 2018/19. Our priorities reflect the breadth of services we provide as follows: mental health and adult learning disability services across Bexley, Bromley and Greenwich; community health services across Bexley and Greenwich, specialist forensic mental health and prison healthcare across Kent and Greenwich.

Oxleas is committed to delivering quality services and we make every effort to work in partnership with our service users', carers, members, staff and commissioners to identify what our quality priorities should be each year. Every year we hold public meetings in each of our boroughs of Bexley, Bromley and Greenwich to give feedback on progress against our quality goals and invite opinion about potential areas of priority in the coming year. These meetings had a total attendance of 115 people and as per our usual practice, we asked our members and members of the public who attended these forums if we should continue with our 6 quality objectives for 2018/19 and if there were any other areas we should consider. There continues to be overwhelming support for us to continue with our 6 objectives with an additional focus on supporting families, carers and the support network of people who use our services.

Our priority areas have been influenced by our public forums, our engagement with our local and national commissioners, through our quality meetings, our council of governors, patient groups such as Healthwatch, feedback from patient experience surveys and lessons learned from incidents. We also engage with staff at away days, staff meetings and annual planning events. The 2018/19 quality priorities have also been reviewed and agreed by the Trust's Performance & Quality Assurance Committee (a sub-committee of the Board).

Table 3 – Oxleas Quality Priorities 2018/19

Quality Objective	Quality Indicator	rvice area applicable to	Quality Domain	How these will be monitored
Quality Objective 1: Ensure we meet our patient promise	To ensure 90% of patients who respond to our surveys are reporting they have been provided with enough information about care and treatment	All Oxleas Services	Patient Experience	Patient Experience These indicators will be monitored by the Trust Patient Experience Group and monthly by the Trust Performance & Quality Assurance Committee
	To ensure 90% of patients who respond to our surveys are reporting that they have been involved in decisions about their care and treatment	All Oxleas Services		
	To ensure 90% of patients who respond to our surveys are reporting that staff have treated them with dignity and respect	All Oxleas Services		
	To ensure 90% of patients who respond to our surveys are reporting that they would recommend our service to friends and family if they need similar care or treatment	All Oxleas Services		

Table 3 – Oxleas Quality Priorities 2018/19 *contnued*

Quality Objective	Quality Indicator	Service area applicable to	Quality Domain	How these will be monitored
Quality Objective 1: Ensure we meet our patient promise *continued*	To ensure 90% of patients who respond to our surveys are reporting that their quality of life has improved as a result of the care and treatment that they have received	All Oxleas Services	Patient Experience	These indicators will be monitored by the Trust Patient Experience Group and monthly by the Trust Performance & Quality Assurance Committee
	To have a minimum of 10% response rates to our patient experience surveys (single contact with our services)	All Oxleas Services		
Quality Objective 2: Ensure we involve families, carers and people important to our patients	To ensure 90% of patients who respond to our surveys and who reported that they wanted friends/ relatives involved in their care/treatment did feel that they were involved	All Oxleas Services	Patient Experience	
	To ensure 80% of patients have their support network identified and noted within their care record	All Oxleas Services		

Table 3 – Oxleas Quality Priorities 2018/19 *contnued*

Quality Objective	Quality Indicator	Service area applicable to	Quality Domain	How these will be monitored
Quality objective 3: Ensure we involve patients in planning their care and they have a care plan that is personal to them	To ensure 75% of Oxleas eligible teams participate in the care planning audits	All Oxleas Services	Clinical Effectiveness	These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance & Quality Assurance Committee
	To ensure 95% of our patients will have a recorded care plan on RiO	All Oxleas Services		
	To ensure 95% of our patients on CPA will receive a 12 monthly review	Mental Health Services, ALD Forensic & Prisons		
Quality objective 4: Ensure we put the safety of our patients first	We will maintain a trustwide focus on the following safety areas: • Falls • Deteriorating physical health • Violence reduction • Reduce the use of prone restraint by ensuring the following: 1. Increase percentage of staff trained in supine restraint to 80% 2. Increase the use of supine restraint 3. When prone restraint is used, reduce the duration of such restraint	All Oxleas Services	Patient Safety	These indicators will be monitored by the Trust Safety Committee and monthly by the Trust Performance & Quality Assurance Committee

Table 3 – Oxleas Quality Priorities 2018/19 *contnued*

Quality Objective	Quality Indicator	Service area applicable to	Quality Domain	How these will be monitored
Quality objective 5: Ensure we provide care in line with national best practice and guidelines	We will continue to engage in national audits that permit benchmarking of Oxleas services	All Oxleas Services	Clinical Effectiveness	These indicators will be monitored by the Trust Clinical Effectiveness Group and monthly by the Trust Performance & Quality Assurance Committee
	• We will participate in the national programme of improving the physical health of patients with Serious mental illness • We will achieve the set targets of comprehensive cardio-metabolic risk assessment using the Lester Tool and interventions in patients at high risk.	Mental Health		
Quality objective 6: Ensure we routinely measure clinical outcomes so that we know that our care makes a difference to patients	We will undertake a benchmark of Oxleas teams who regularly use clinical outcome measures and increase the coverage to ensure all Oxleas clinical directorates routinely measure the outcome of care delivered to patients	All Oxleas Services	Clinical Effectiveness	

2.4 Statements of Assurance from the Board

This section includes a number of nationally mandated statements of assurances from our trust board

During 2017/18, Oxleas NHS Foundation Trust provided and/or sub-contracted seven relevant health services covering the following directorates:

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

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

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

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Oxleas for 2017/18.

2.4.1 Participation in Clinical Audits

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

During 2017/18, 14 national clinical audits and 27 national confidential enquiry covered NHS services that Oxleas NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that Oxleas was eligible to participate in during 2017/18 are as follows in tables 4 and 5 below.

The national clinical audits and national confidential enquiries that Oxleas participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 4

No.	National clinical audit title 2017/18	Participation (yes/no)	Number of cases submitted	% of cases submitted
1	NCEPOD Young People's Mental Health study	Yes	9	100%
2	National Audit of Psychosis	Yes	150	100%
3	National Parkinsons Audit	Yes	30[1]	100%
4	National Audit of Anxiety and Depression	Yes	N/A[2]	N/A
5	Sentinel Stroke National Audit Programme SSNAP)	Yes	60	56%[3]
6	POMH: 15b: Prescribing valproate for bipolar disorder	Yes	233	100%
7	National Audit of Cardiac Rehabilitation (NACR)	Yes	N/A[4]	N/A
8	Chronic Obstructive Pulmonary Disease (COPD)	Yes	51	100%
9	POMH: 17a: Use of depot/LA antipsychotic injections for relapse prevention	Yes	151	100%
10	POMH: 1g & 3d: Prescribing high dose and combined antipsychotics	Yes	135	100%
11	POMH: 16a: Rapid Tranquilisation	Yes	100	100%
12	Early Intervention in Psychosis National Audit	Yes	289	100%
13	Learning Disability Mortality Review Programme (LeDeR)	Yes	30	100%
14	Maternal, Newborn & Infant Clinical Outcome Review Programme (MBRRACE)	Yes	0	N/A

1 This national audit is in 3 parts: case note audit, patient reported experience measures, and organisational audit. Figures displayed are for the case note audit for Bexley Neuro-Disability Team. Greenwich Neuro-Disability Team did not participate.

2 This audit started in 2017/18 but submission of data to occur during 2018/19 as per audit schedule.

3 Percentage of submitted cases is less than 100% as community teams cannot register patients onto community SSNAP until the discharge hospital have closed their acute SSNAP episode and marked as transferred to community. This is a nationally recognised issue that the SSNAP is working to amend for teams who participate.

4 During 2017/18 Oxleas developed a form for capturing data on our electronic record system specifically tailored to the needs of NACR. The next data upload is scheduled for June 2018.

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Table 5

No.	National Enquiries (2017/18)	Participation (yes/no)	Number of cases submitted	% of cases submitted
1	Mental Health Clinical Outcome Review Programme (National Confidential Inquiry into Suicide and Homicide [NCISH])	Yes	27	100%

The reports of five national clinical audits were reviewed by Oxleas in 2017/18 and we intend to take the following actions to improve the quality of healthcare provided. All national and trust wide priority audits are reviewed at the Trust Clinical Effectiveness Group (a sub-group of the Trust Performance & Quality Assurance Committee) where results are presented and action plans are agreed for each applicable service. We undertake a review of actions to ensure that these are completed in a timely manner and have met the recommendations set; furthermore we participate in re-audits to check compliance with standards. We have provided one example of a national audit reviewed by the Trust Clinical Effectiveness Group in section 2.2.5.1 above (copies of all Trust clinical audit reports are available on request).

2.4.2 Trustwide Clinical Audit Programme

The reports of 48 local clinical audits were reviewed by Oxleas in 2017/18 and we intend to take the following actions to improve the quality of healthcare provided: Recommendations and action plans to improve the quality of healthcare provided have been agreed across each of our directorates. We continue to maintain a focus on improving clinical practice in accordance with national and local guidance. We have provided a summary below on one of our local priority clinical audits.

2.4.2.1 Trustwide Audit of Care Plans (Risk & Service User Involvement)

During financial year 2017/18 we took on a new approach to our annual care planning audit by converting it to a monthly audit and expanded to include a wider variety of teams (for example for the first time our prison services are involved in this audit). Every team within Oxleas is now expected to undertake an audit of a minimum of 5 care plans each month. 280 clinical staff have completed audits since the audit began, this means that approximately 15% of our clinical workforce have participated in the audit as auditors.

To date 115 of teams have participated since July 2017, with over 2200 audits completed. We expect to see this gradually increase and have set a participation target for 2018/19.

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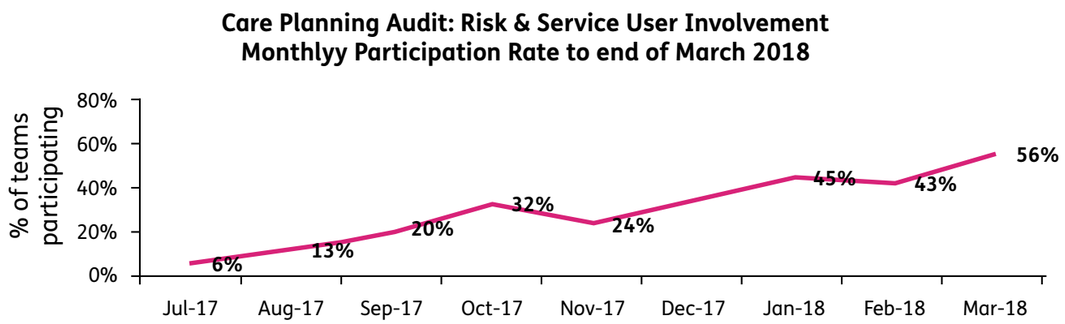
Chart 8



All staff can access their results online, they have the opportunity to see trends, and focus on achieving better results. Care planning workshops have been set up across the Trust and results are reviewed regularly at local Clinical Effectiveness Groups and at Quality Improvement Meetings allowing staff to identify gaps, and drive improvement. Materials such as the Care Planning Strategy with its 7 principles and our 'Writing Good Care Plans Guide' have been distributed, and emphasised. Results of the audit are used during staff supervision, and as part of peer reviews.

Overall results have been positive as shown by the results shown below (data given covers the period to the end of March 2018):

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Table 6

Question*	Yes %
Q1. Has a risk assessment been completed during this episode of care?	85%
Q2. Has the risk assessment been reviewed following significant risk incidents, changes in presentation or within the last 6 months?	97%
Q3. Does the care plan address specific factors identified in the risk assessment associated with increased risk?	86%
Q4. Is there evidence that the service user has been involved in development of their care plan?	85%
Q5. Is there evidence that the service user's support network has been involved in the development of the care plan?	55%
Q6. Has a copy of the care plan been given to the service user?	67%
Q7. Has a copy of the care plan been given to the service user's support network?	34%

* The online audit tool is designed so questions only appear for services that the question is relevant to. There are also options to exclude various patients under certain circumstances e.g. for Q5 above, auditors are able to exclude patients who do not have a support network, or who have stated that they do not want their support network involved in their care. Where these answers are available they have been removed from the denominator for the "Yes %" calculation.

Results vary depending on the services who respond however it is clear that our focus in the coming months of 2018/19 will be on involvement of patients' families, carers and support networks.

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

Quality & Governance Department
Oxleas NHS Foundation Trust
Pinewood House
Pinewood Place
Dartford
Kent
DA2 7WG

Tel: 01322 625770

2.4.3 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Oxleas in 2017/18 that were recruited during that period to participate in national research studies approved by a research ethics committee was 348, which represents a 126% increase on the previous financial year. We have also hosted 49 locally initiated service evaluations and 7 locally initiated formal research studies across our services.

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

2.4.4 Quality Improvement and Innovation Goals agreed with Commissioners

A proportion of Oxleas income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Oxleas and any person or body we have entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically from our Quality and Governance Department (oxl-tr.quality@nhs.net)

Our total 2017/18 CQUIN income conditional on achieving all the quality improvement and innovation goals was £4.13m. The assumed provisional payment dependant on confirmation from our associated commissioners on achieving the goals set by the end of March 2017 is £3.63m. Our total CQUIN income for the previous year 2016/17 was £3.31m.

2.4.5 Registration with the Care Quality Commission (CQC)

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

The Care Quality Commission has not taken enforcement action against Oxleas during 2017/18.

Oxleas has not participated in any special reviews or investigations by the CQC during the reporting period. However our Forensic inpatient/secure wards underwent a comprehensive inspection on the 24th -26th April 2017 and the last Oxleas dashboard, rated by the CQC on the 6th of July 2017 provided below:

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Table 7

Oxleas CQC Ratings Dashboard – last rated 6 July 2017

	Safe	Effective	Caring	Responsive	Well-led	Overall
1 Community health services for adults	Good	Good	Good	Good	Good	Good
2 Community health inpatient services	Good	Good	Good	Good	Good	Good
3 End of life care	Good	Good	Good	Good	Good	Good
4 Community services for children, young people and families	Good	Good	Good	Good	Good	Good
5 Community mental health services for children, young people and families	Good	Good	Good	Good	Good	Good
6 Community mental health services for working age adults	Good	Good	Good	Good	Good	Good
7 Mental health crisis services	Good	Good	Good	Good	Good	Good
8 Mental health wards for adults of working age	Good	Good	Good	Good	Good	Good

Table 7

Oxleas CQC Ratings Dashboard – last rated 6 July 2017 continued

		Safe	Effective	Caring	Responsive	Well-led	Overall
9	Rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
10	Forensic inpatient wards	Good	Good	Good	**Outstanding**	Good	Good
11	Wards for people with a learning disability	Good	Good	Good	Good	Good	Good
12	Community services for people with a learning disability	Good	Good	**Outstanding**	Good	Good	Good
13	Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
14	Community mental health services for older people	Good	Good	Good	Good	Good	Good
	Mental Health Services	Good	Good	Good	Good	Good	Good
	Community Health Services	Good	Good	Good	Good	Good	Good
	Overall Trust Rating	Good	Good	Good	Good	Good	Good

2.4.6 Data Quality

Oxleas submitted records during 2017/18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

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

- 98.5% for admitted patient care
- 99.9% for outpatient care
- 0% for accident and emergency care. (This is not applicable, as Oxleas does not submit data in relation to accident and emergency care. This is an acute trust indicator)

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

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

2.4.7 Information Governance Toolkit

Oxleas Information Governance Assessment Report overall score for 2017/18 was 84% and was graded 'green'.

2.4.8 Clinical Coding

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

2.4.9 Improving Data Quality

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

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

*Ifox – This is the Oxleas Business Information System.

2.5 Learning from deaths

For 2017/18, all NHS Trusts have a requirement to publish learning from deaths data. The Oxleas 2017/18 position is provided below:

2.5.1 Number of patients who died in 2017/18

During 2017/18, 1214 Oxleas patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 292 in the first quarter
- 314 in the second quarter
- 251 in the third quarter
- 357 in the fourth quarter

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

By 31st March 2018, 1182 case record reviews and 32 investigations have been carried out in relation to1214 of the deaths included in item 27.1.

In 1214 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 292 in the first quarter
- 314 in the second quarter
- 251 in the third quarter
- 357 in the fourth quarter

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

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

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter

These numbers have been estimated using the root cause analysis methodology. The panel considered whether the incidents could have been predicted or prevented. Since October 2017, our investigation panels have incorporated structured judgement reviews into the investigation reports to form a view of avoidability. None of the deaths reviewed have been considered avoidable.

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2.5.4 Summary of what Oxleas has learnt from case record reviews and investigations undertaken in 2017/18, actions taken and assessment of impact

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

Lesson 1
Appointments with the Early Intervention in Psychosis Team were not always convenient for services users in full time employment.

- *Action taken:* Appointments are now available out of hours.
- *Assessment of the impact of the actions:* There is now increased engagement and service user satisfaction

Lesson 2
The provision of generic falls prevention training did not always improve staff competencies.

- *Action taken:* Staff now receive falls prevention training in their two week supernumerary induction in the workplace.
- *Assessment of the impact of the actions:* Improved understanding and compliance with falls prevention strategies

Lesson 3
Multidisciplinary team members were not always able to attend ward rounds which could lead to less effective care planning.

- *Action taken:* An inpatient ward round template was developed to enable input by the multi-disciplinary team ahead of the meeting. This included family/carer involvement, service user involvement.
- *Assessment of the impact of the actions:* There is increased multi-disciplinary input into care planning.

Lesson 4
Crisis plans were not always developed with the service user

- *Action taken:* "My Crisis Plan" was developed which is a patient-centred document that is collaboratively devised with the patient, and where appropriate, family and carers.
- *Assessment of the impact of the actions:* This has helped to ensure personalised crisis plans.

Lesson 5
Staff required more specialised training on risk assessing an individual's risk of suicide

- *Action taken:* The trust commissioned STORM training which is a 3 day accredited suicide prevention skills training that encompasses;
  - *Assessment of Risk*
  - Safety Planning
  - Problem Solving
  - Future Safety Planning
- *Assessment of the impact of the actions:* Personalised and competency based risk assessments

Lesson 6
Service users in communal areas without staff supervision may be vulnerable if unsupervised.

- *Action taken:* CCTV has been installed in the gardens of the low security forensic services.
- *Assessment of the impact of the actions:* Improved safety.

Lesson 7
A systematic approach was required to reduce the incidence of pressure ulcers.

- *Action taken:* Staff were trained to use the SSKIN tool kit (Surface, Skin, Keep Moving, Incontinence and Nutrition).
- *Assessment of the impact of the actions:* A systematic approach was in place to reduce the incidence of pressure ulcers.

Lesson 8
There was sometimes a delay in the receipt of information from GP's.

- *Action taken:* Staff now have access to Connect Care which enables identified staff to access the electronic records across GP's.
- *Assessment of the impact of the actions:* Having immediate access to key clinical information in Connect Care, and details about others involved in a person's care has assisted clinicians to:
  - Prevent unnecessary admission/readmission to hospital
  - Prevent delayed discharges
  - Support faster rehabilitation
  - Prevent unnecessary referrals
  - Prevent unnecessary home visits
  - Enable better triage of referrals
  - Support faster and more effective assessment
  - Reduce administrative tasks freeing up time for clinical care
  - Improve patient experience as it reduces repetitive questions

Lesson 9
Information documented in the clinical record was not always used to inform care planning.

- *Action taken:* The electronic record is now able to pull through information into the care plan.
- *Assessment of the impact of the actions:* Increased compliance with the involvement of service user/support network involvement to inform care planning.

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

0 case record reviews and 5 investigations completed after 31st March 2017 which related to deaths which took place before the start of the reporting period.

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

0 representing 0% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number

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has estimated using the root cause analysis methodology. The panel considered whether the incidents could have been predicted or prevented. Since October 2017, our investigation panels have incorporated structured judgement reviews into the investigation reports to form a view of avoidability. None of the deaths reviewed have been considered avoidable.

2.5.7 Revised estimate of the number of deaths in 2017/18 taking account of deaths referred to in section 2.5.6 above

0 representing 0% of the patient deaths during 2016/17 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.6 Performance against National Core Indicators

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

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

Table 8

	National Quality Indicator	Oxleas 2014/15	Oxleas 2015/16	Oxleas 2016/17	Oxleas 2017/18	National Average	Highest Trust Performance	Lowest Trust Performance
1	The percentage of patients on CPA who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	97.5%	99.5%	97.6%	99.0%	95.4%	100.0%	69.2%
2	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.	100.0%	100%	99.2%	99.5%	98.5%	100.0%	84.3%
3	Percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends. (question 21d)	74%	75%	65.4%	67%	67% (combined MH & Community Trusts)	76% (combined MH & Community Trusts)	55% (combined MH & Community Trusts)
4	The trust's 'patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	7.8/10	7.2/10	7.5/10	7.6/10	Not provided	8.1/10	6.4/10

Table 8 *continued*

	National Quality Indicator		Oxleas 2014/15	Oxleas 2015/16	Oxleas 2016/17	Oxleas 2017/18	National Average	Highest Trust Performance	Lowest Trust Performance
5	The number and where available, the rate of patients safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	Rate per 1000 days	27	27	45	24	2,476		
		Severe harm or Death	0.36	0.36	0.59	0.35	4.5 Comparison with Mental Health Trusts Rate per 1000 days - not provided nationally (data shown for England)		

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

Q1: NHS England: Mental Health Community Teams Activity. October – December 2017. Published 9 February 2018

Q2: NHS England: Mental Health Community Teams Activity. October – December 2017. Published 9 February 2018

Q3: National NHS Staff Survey 2017: NHS England, NHS Survey Co-ordination Centre 06/03/2018

Q4: Care Quality Commission: Patient experience of community mental health services. Published 15 November 2017 http://www.cqc.org.uk/content/community-mental-health-survey

Q5: NHS National Reporting and Learning System, Organisation Patient Safety Incident workbook. Published November 2017 Data for incidents 1 October 2016 and 31st March 2017

For indicators 1 and 2 relevant to the services we provide shown in table 8 above:
Oxleas considers that this data is as described for the following reasons:

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

Oxleas intends to take the following actions to improve the percentage of 99%, and so the qualities of its services by continuing our focus of following up patients within 7 days after discharge from psychiatric in-patient care. Our aim is to improve this to 100% although we recognise that there may be occasions when our staff cannot meet this goal for reasons outside their control. In terms of ensuring that all of our admissions to acute wards are gate kept by our Crisis Resolution Home Treatment Teams, we will maintain our focus and improve our position from 99.5% to 100%.

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

- Oxleas considers that this data is as described for the following reasons:
- These are based on our involvement in the National Patient and National Staff Surveys
- It meets the NHS Outcomes Framework domains of enhancing the quality of life for people with long term conditions and ensuring people have a positive experience of care
- The data for these indicators are provided by the CQC and Department of Health

Oxleas intends to take the following actions to improve the percentage of 67% and rate of 7.6 respectively and so the quality of its services, by continuing our focus on the following:

- National Patient Survey - we have put a robust plan in place to tackle areas that require further improvement as identified by the results of the 2017 survey; this is overseen by our Trust Patient Experience Group.
- National Staff Survey - Our 2017 staff survey continues to place us above average and a high performer compared with other organisations. We have engaged with staff to enquire what we can do better and have put in place action plans for the identified areas that require further improvement. Our Workforce Committee will monitor these and report to the Board of Directors.

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

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

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

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

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Part 3 - Other Information

3.0 Other Quality Performance Information

In this section of the Quality Accounts we present other information relevant to the quality of the services provided in 2017/18.

In the earlier part of our report (please see section 2.2), we presented how we have performed against the 2017/18 quality priorities with reference to our performance in previous years where available. No changes have been made to the indicators published in the 2016/17 report, however we have provided directorate level data for objective 1 quality indicators by boroughs instead of by functional directorate (please refer to section 2.2.1 for further detail)

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

3.1 Performance against NHS Improvement's Single Oversight Framework Indicators

In accordance with NHS Foundation Trusts requirements from NHS Improvement (NHSI), we have detailed below our performance against the NHSI indicators that appear in the single oversight framework. There are 6 indicators applicable to the services that we provide and our performances against these are provided below:

Table 9

Single Oversight Framework indicator for disclosure	2017/18 Performance	Threshold
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	70.0%[1]	50%
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a. inpatient wards b. early intervention in psychosis services c. community mental health services (people on care programme approach)	Awaiting publication of national audit results from NHS England (internal self-assessment provided below. This is subject to change) a. 97% b. 90% c. 31%	 90% 90% 65%
Improving Access to Psychological Therapies (IAPT): Proportion of people completing treatment who move to recovery (from IAPT dataset)	57.0%	50%
Improving Access to Psychological Therapies (IAPT): Waiting time to begin treatment (from IAPT minimum dataset) i. Within 6 weeks of referral ii. Within 18 weeks of referral	96.6% 99.9%	75% 95%
Care Programme Approach (CPA) follow up: proportion of discharges from hospital followed up within 7 days	98.0%	95%
Admissions to adult facilities of patients under 16 years old	0	0
Inappropriate out-of-area placements for adult mental health	502 bed days (35 patients) [2] Please note: this figure applies only to quarter 4 2017/18 as per NHSI guidance	

1 EIP Indicator –External audit assurance undertaken by Deloitte has shown limitations in the reliability and accuracy of the published data. Please refer to Annex 3 for further detail

2 Inappropriate Out of area placement indicator - External audit assurance undertaken by Deloitte has shown limitations in the reliability and accuracy of the published data. Please refer to Annex 3 for further detail

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3.2 Oxleas Quality Highlights and Case Studies

Over the course of the year, we are delighted to see evidence of good practice and teams going the extra mile for the benefit of the patient, making sure we make a difference and improve lives. These examples are seen and shared as part of the Board to floor visits or by teams highlighting what they are proud of. In this section of our Quality accounts, we would showcase a few examples of good practice from our services which align to our trust values of having a user focus, excellence, learning, being responsive, partnership and safety.

3.2.1 Partnership working across two different providers

Case for change

Many of the service users of the Oxleas Bromley Community Learning Disability Team have complex physical health problems, which require input from multiple professionals. Some require enteral feeding (tube feeding) or nutritional support and are on Bromley Healthcare's Community Dietetics Team's caseload. People with Learning Disability are known to experience disadvantage when accessing mainstream services (Allerton and Emerson, 2012). This is often due to lack of joint working between different care providers, and mainstream services lacking expertise in making reasonable adjustments and navigating issues such as mental capacity.

One of the most vulnerable groups are people with dysphagia (eating, drinking and swallowing difficulties), who often require support to meet their nutrition, hydration and medication requirements (RCSLT, 2010).

As the community dietetics service are based in Bromley Healthcare (a separate organisation to Oxleas), joint working had proved challenging, leading to breakdown in communication, delays in service users accessing appropriate services and poorer outcomes for patients.

Following a particularly complex case, we reflected on how we can work together to improve outcomes for the patients (Fairclough et al, 2008).

What we did

In March 2017, Clinical Lead Speech and Language Therapist, Kirsty Meehan, arranged an inaugural meeting which has now led to regular, 3 monthly meetings. This meeting involves as many of the members of the Bromley Health Care Dietetics Team as are available to attend and any professionals from the Community Learning Disability Team who are involved with Service users accessing both services. At these meetings, we discuss service updates and our joint cases. Guest speakers attend the meetings such as an Epilepsy Nurse Specialist, who came to talk about their service. This gives an opportunity for all to learn more about each other's roles and how nutrition and hydration can impact on other aspects of health.

We now often carry out joint visits, which ensure a consistent message to the service users, and cuts down on the number of appointments they have. We have implemented a register of all our joint patients; this ensures that information is shared between the two services, to provide more joined up and holistic care. The Clinical Lead Speech and Language Therapist is leading the development of a joint working protocol. When complete, this document will set out the roles and responsibilities of each of the professions, and establish what 'best practice' looks like, to ensure that we continue to work collaboratively.

Results
Knowing each other better has allowed more open channels of communication. We are able to easily seek support and advice, and have increased our knowledge about the roles of the other professions. This has helped to ensure that referrals are appropriate and timely and information is shared consistently. All attendees agree that the meetings have had a positive effect on our practice and look forward to continuing to develop our services.

References
Allerton, L. and Emerson, E. (2012) 'British adults with chronic health conditions or impairments face significant barriers to accessing health services,' Public Health, 126: 920- 927.
Fairclough J., et al (2008) 'Home enteral tube feeding for adults with a learning disability,' British Dietetic Association.
Royal College of Speech and Langauge Therapists (2010) 'Adults with Learning Disabilities Position Paper,' RCSLT.

3.2.2 Developing a Trustwide crisis pathway for people with personality disorder

Case for change
Following the deaths by suicide of two patients with a primary diagnosis of personality disorder who had been under the care of inpatient services, concerns were expressed about the care received by patients with personality disorder during periods of crisis. A project was established with the aim of developing a crisis care pathway for people with personality disorder that considered their needs at every step from assessment by crisis services, during periods of hospital admission, as patients moved back through the pathway into the community and when the patient returned again in crisis. The remit of the project was to develop a model that offered consistently good quality compassionate care, while drawing on resources in a lean and effective manner, with its main emphasis in a community location. The centre of the pathway was to be embedded in three trust day treatment teams. The focus of the pathway was to be on positive relationships, rather than therapy with a shift from "discharge" to "pathway progression"

What has been done differently to improve patient care?
An 18 month service improvement project was agreed and a project team was established consisting of a part-time project lead supported by a clinical psychologist and assistant psychologist. On commencing in role, the project team spoke to patients with a diagnosis of personality disorder about their experiences of care. They clearly described the barriers to accessing early support during periods of crisis and difficult experiences of attending the Emergency Department (ED) during periods of crisis and facing stigma and long waits to see someone from the Mental Health Team. The team also interviewed day treatment staff about their experiences of working with people with personality disorder. The staff spoke of the challenges that they faced, including a feeling that 6-8 weeks was not long enough to support somebody with a personality disorder and that longer term support was needed.

In addition to speaking to patients and staff, the project team visited other London NHS services to ascertain what services currently existed to support people with personality disorder that may be different to what was currently being offered within Oxleas. The team were clear that the model that they wished to develop needed to be patient-centred supporting patients to draw on their own skills and resources, as well as being flexible and rapidly accessible.

The team visited the SUN (service user network) service operated by South London and Maudsley Foundation Trust (SLAM) within Croydon and the SUN service provided at South West London and St Georges NHS Trust. The SUN Project is for people who have longstanding emotional and behavioural problems (personality disorder), and who may feel they do not get adequate support from mainstream services.

The SUN model offers staff-facilitated peer-support groups for people with difficulties associated with personality disorder. The groups run frequently (several times each week) in non-NHS community settings. They are open-access, meaning that the member can attend a group whenever they choose. They offer the members lifelong membership with no threat of discharge "if they get better". The groups are based on the principles of the therapeutic community and cognitive theory and offer members the opportunity to receive support from other group members, as well as offering support to others with any stresses they may be experiencing. The frequent operation of the group enables members to access support rapidly during times of crisis thus helping to prevent an escalation which might in result in the member needing to attend the ED or receive care from home treatment or inpatient services.

Impressed by their visits to other London SUN services, the project team decided to incorporate SUN groups into a personality disorder crisis care pathway, that also included other groups and interventions already operating within the day treatment teams. Nominated staff working within both the day treatment and home treatment teams undertook training in the facilitation of the SUN groups. The groups were then rolled out across the trust, starting in Bromley in July 2017, extending to Greenwich in October 2017 and then to Bexley in January 2018. The groups run twice weekly in each borough and all are sited in church halls.

What have been the benefits in terms of positive outcomes?
The project team are currently evaluating the impact of the crisis pathway, but in particularly the SUN groups, both in terms of patient and staff experience, and use of mental health crisis services. Initial results appear very favourable. Patients speak highly of the groups and how much they value them, an example from one member being "I have been waiting for a group like this for years". Further evaluation of patient feedback is currently being planned by Bromley ResearchNet. Evaluation of the impact of the SUN groups on reducing the use of mental health crisis services is still in its initial stages but again the results appear to be favourable. The project team have looked at the use of mental health crisis services by patients attending the SUN groups in Bromley in the 3 months before and after attending their first group. Attendances at the ED in mental health crisis fell from a collective total of 34 in the 3 months pre-first group attendance to 9 in the 3 months post-group attendance; inpatient episodes fell from 13 to 1 with a reduction in collective bed days from 204 to 6. Referrals to the Home Treatment Team (HTT) also fell from a collective of 43 episodes in the three months pre-first group attendance to 16 in the three months post-first group attendance. This was accompanied by shorter episodes of care with a reduction in the collective number of HTT care days from 389 to 44 and a reduction in the average length of HTT care episode from 15 to 4 days. It is likely that the presence of the SUN groups enabled members to feel able to be discharged earlier from the HTT knowing that they could continue to receive on-going support. Evaluation will continue and it is hoped that the early apparent success in Bromley will be sustained, as well as replicated in Greenwich and Bexley.

The project team hopes that the SUN groups meets the original brief of the project, namely that they offer consistently good quality compassionate care, while drawing on resources in a lean and effective manner, with a main emphasis in a community location, and a focus of on positive relationships, rather than therapy. They move away from the terminology of "discharge" to "pathway progression", and offer the patient-centred, flexible, rapidly-accessible model that patients with personality disorder stated that they valued, and the on-going support that day treatment reported was lacking.

3.2.3 Implementing the Forensic Service Recovery College

Case for Change
Recovery Colleges bring an educational approach to patients learning about their mental health and wellbeing. They provide a sense of empowerment and normality as courses are provided in a classroom style setting, participants are referred to as students and they often assist in the production and facilitation of the courses. This minimises the observable differences between colleagues and students as both provide a different type of expertise.

What We Did
We launched the Oxleas Forensic Recovery College in June 2017. SLAM were invited to help deliver their 'Train the Trainer' programme, resulting in us having several students trained in the production and facilitation of courses.

The courses provided so far have included:

- The **Being a Man and Women of the World** courses involve gender-specific mental and physical wellbeing advice and discussion.
- **Choices for Change** addresses the specific skills we need to bring about changes in our own lives. This can vary from life skills like budgeting and employment, to personal things like relationships and self-esteem.
- **Mood Boost** is an hour long session designed for students and colleagues to attend as much or as little as they would like; either every week, or just when they need a pick-me-up. Each session involves watching pre-approved funny videos to make students laugh, learning different strategies to boost moods outside of session, and guided relaxation exercises.
- The **Mindfulness** course teaches students and colleagues mindfulness skills to use in their everyday lives and through meditation, particularly as a way of managing stress and other difficult emotions.

Results
A new tool named the **Oxleas Forensic Wheel** was developed specifically to assess any particular areas of life that students find challenging, so that specific goals can be set and courses attended can be picked to address these challenges. Students are given a score from 1-5 according to how able they feel to deal manage different areas, with higher scores showing more ability to manage an area. The areas included to be assessed are mental health, moving on, identity and self-esteem, relationships, physical health, managing emotions, skills & activities, substances & addiction, hoping & believing, and risk.

The graph below shows the change in scoring for 15 different students who have attended the Oxleas Forensic Recovery College. Eight students overall scores have increased and three have remained the same, meaning that only four student scores have decreased since they began engaging with the Forensic Recovery College:

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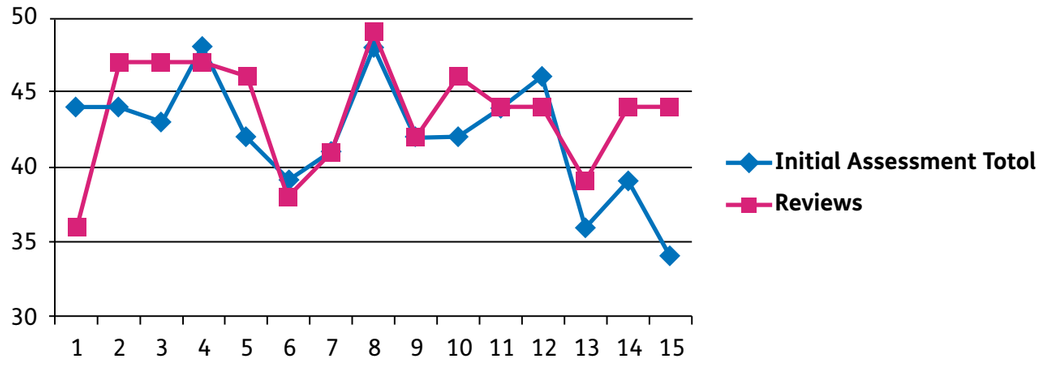
Chart 9



Feedback from participants:

What Next
We currently have three students delivering courses with colleagues a week, one for each session at The Bracton Centre. We are also delivering courses at the two wards at Memorial Hospital and plan to train students to co-produce and co-deliver the courses here too. We are hoping to begin an Unusual Experiences course and a Drama course during the next term.

3.2.4 The Fresh Air Project

Case for Change
The Bracton Centre and Memorial Hospital became a smoke-free environment on the 5th September 2013. The Fresh Air Project had started one year earlier in order to prepare service users for the September smoke-free date. Colleagues received training in smoking cessation support to assist the service users in cutting down and giving up smoking. Increased supplies of nicotine replacement therapy (patches, nasal spray, lozenges, gum and mouth spray) were made available, and Smoking Cessation Advisors began to visit weekly to support the service users giving up. The Fresh Air Project was part of the process preparing to go smoke-free in September. It aimed to support service users in their attempts to become and stay smoke free, by rewarding the service users weekly for their continued efforts as well as providing them with education around smoking related issues.

What We Did
Prior to joining Oxleas in July 2017, the Trust-wide Sports and Fitness Lead had extensive experience of working in smoking cessation across London, in particular working in partnership with East London Foundation Trust and preparing colleagues and service users to go smoke free. Utilising this experience along with the knowledge and expertise in health and fitness, the Trust-wide Sports and Fitness Lead updated, revised and structured the Fresh Air Project sessions around the following areas:

- **The Smokescreen –** How big tobacco companies subtly target people with product placement and mass media to promote smoking
- **Sport Performance –** How the dangers of smoking adversely affects performance in sporting capacity e.g. healing from an injury
- **Physical Fitness -** How smoking impacts the respiratory and cardiovascular systems
- Anatomy – Educating service users a base understanding of the body, for example functions of the skeleton, muscles and energy systems.

Results
Since facilitating the Fresh Air Project on Friday evenings, attendance of service users has risen; average attendance is now around ten each week actively engaging in the session. Carbon monoxide readings remain low (must score below 5 to attend), which indicates whether service users have smoked tobacco either on unescorted leave or within the grounds. When asked if attending the Fresh Air Project had helped them to stop smoking and remain smoke free twenty service users indicated it had, six said it had not and seven were non -smokers (table below).

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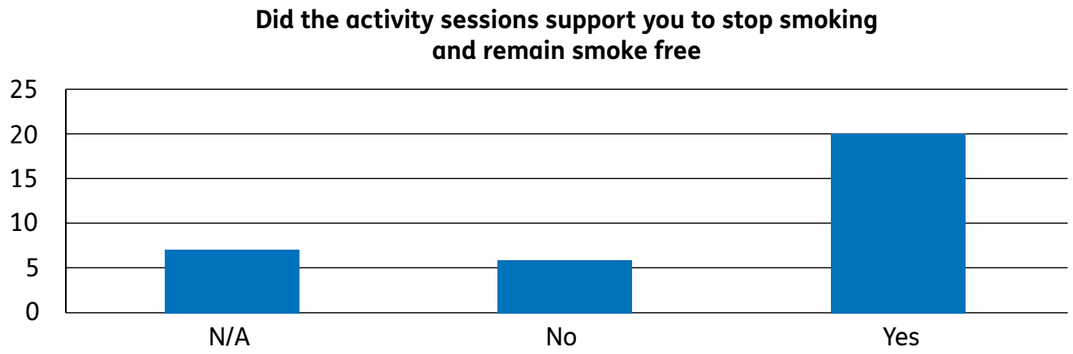
Chart 10



Feedback

- "I like learning about health and fitness and the human body, I find it really interesting" *Joydens service user*
- "Helps give me reasons to stop smoking through learning about the body and how smoking is counterproductive to my health" *Crofton service user*

What Next
To further support the Oxleas' Smoke-Free Policy; it has been agreed by the Trust-wide Sports and Fitness Lead and the Directorate Lead Occupational Therapist to set up a new weekly smoking cessation drop-in clinic, open to all service users and colleagues, similar to what was introduced in the preparation of the service going smoke free in 2013. This now takes place on a Monday afternoon in the GP surgery at The Bracton Centre, which is an additional offshoot of the Fresh Air Project. It gives the opportunity for service users and colleagues to receive one-to-one smoking cessation support, to discuss withdrawal symptoms, craving strategies and nicotine replacement therapy options, similar to the community based module run by local stop smoking services.

3.2.5 Developing an Occupational Therapy Program on the Tarn Ward (PICU)

Case for change
Activities play a vital role in our service users' wellbeing in order to meet their needs (Drew & Rugg, 2001, Kielhofner, 2002 & Law, 2002) and achieve a balanced lifestyle (Kazi et al, 2008). Moreover, by participating in activities, PICU patients can reduce violence, aggression and manage problematic behaviours effectively (Kazi et el, 2008). Providing a weekly activities timetable on the ward, service users have a sense of belonging and safety. They know what to expect during their day and what it is expected from them. Taking gradual steps and participating in the ward's routine service users learn how to build a balanced routine, how to take responsibilities and make healthy choices.

OT practice on the Tarn Ward is underpinned by the Model of Human Occupation (MOHO). An individual assessment is completed on initiating the OT program, and repeated within 2 weeks to revisit and compare original scores. Standardised assessment tools (for example

ACIS, MOHOST, Sensory Profile) and non-standardised assessment tools are used.

Interventions are graded according to service users' functional abilities and aim to support them to reduce problematic behaviours through sensory strategies, to practice communication and interaction skills in a structured environment, to practice process skills by engaging in 2-3 step low demand tasks, to maintain good physical health by engaging in exercise and educational short sessions. All these functional skills are the baseline for the next step in the service users' recovery journey, which is the open ward and community.

What we did
The current OT program was developed based on service users and staff views, PICU OT programs within London NHS Trusts (ELFT & SLAM), recent literature review and National Association of Psychiatric Intensive Care & low secure Units (NAPICU) (2014) guidelines.

The current OT group sessions are:

- **Coffee & chat group:** Service users are encouraged to read newspapers and discuss current affairs topics within a supportive and safe environment.
- **Creative group:** Service users have the opportunity through creative activities to practice alternative ways to deal with their distress, express their feelings and improve their functional skills within a supportive and safe environment.
- **Men's Health group:** Patients have the opportunity through discussion to learn about their illnesses and their symptoms, drug and alcohol misuse, medication, balanced routine, diet, smoking cessation and exercise.
- **Physical Exercise** group is an important activity for acutely unwell patients as it promotes physical and psychological wellbeing and it is a way to channel hyperactivity and aggression constructively.
- **Relaxation group** offers an opportunity for service users to explore various sensory stimuli through relaxing activities and they are assisted to in the development of coping strategies and trigger-recognition.

Qualitative and quantitative data have been collected for each group activity since June 2017 from the evaluation forms that service users have completed anonymously. Also, a questionnaire reflecting on the OT program on the Tarn was handed by fellow OTs on the Greenwich acute open wards to previous service users to complete anonymously. An example statement provided by a patient:

"The OT took my mind off of things that make me sad and stressed and unhappy and even made my mom happy because she likes painting and flowers and the OT got me to paint flowers for my mom"

Outcome

- Professionals from different disciplines are more involved in our therapeutic weekly timetable and thus the levels of engagement with the service users are increased and bridges within MDT and services within and outside Trust have been created.
- We have introduced two new group activities in the weekly timetable.
- We have raised awareness within the ward multi-disciplinary team (MDT) presenting on the role of OT in PICU and relevant assessment tools
- OT input is respected and considered in care planning, MDT reviews, hand overs, MDT assessment and risk management plans promoting a holistic approach within the team.
- Additional funding has been utilised for new leisure activities on the ward.

Next Steps
We aim to evaluate the therapeutic timetable frequently by getting daily verbal and written feedback from our service users and staff and we make amendments accordingly in order to maintain best evidence practice. Our efforts are an on-going progress and will continue to be in order to make sure that we offer the best service to our service users.

References

1 Drew J., Ruggs, S. (2001) Activity use in occupational therapy, British Journal of Occupational Therapy 64(10): 478-486

2 Kazi, F., Flood, B. & Hooton, S. (2008) Therapeutic activities within psychiatric intensive care and low secure units . In: Beer, M.D., Pereira, S. & Paton, C. (eds) Psychiatric intensive care. Cambridge: Cambridge University Press, pp. 149-160

3 Kielhofner, G. 2008. Model of Human Occupation Theory and Application. 4th Ed. Baltimore: Lippincott Williams & Wilkins.

4 Law, M. (2002) Participation in the occupations of everyday life. American Journal of Occupational Therapy 56(6): 640-649

5 National Association of Psychiatric Intensive Care & low secure Units (NAPICU) (2014). National minimum standards for psychiatric intensive care in general adult services. Glasgow: NAPICU Administrative office, www.napicu.org.uk

3.2.6 Bromley Medicines Optimisation Service—helping patients get the best from their medicines

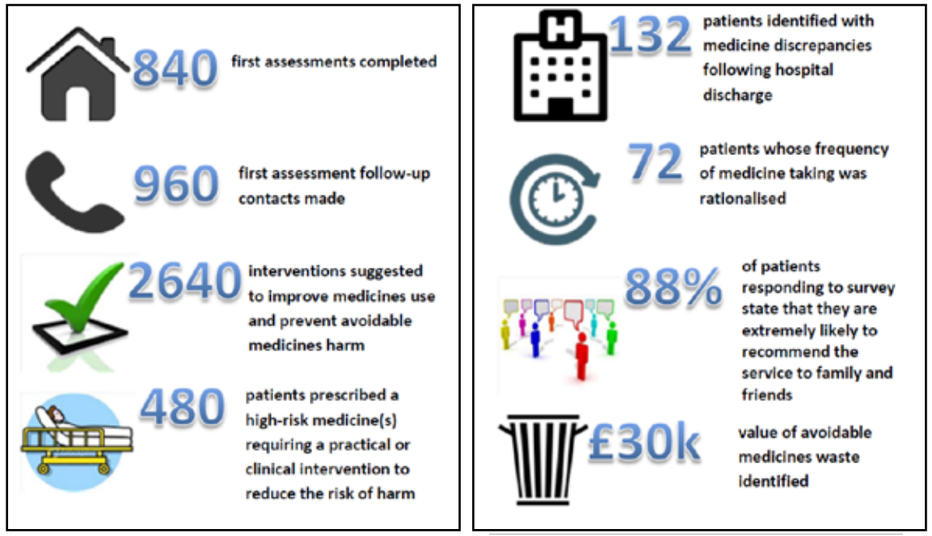
Case for change
One third to a half of medicines prescribed for long-term conditions are not taken as intended, and this is both a lost opportunity for improving health, and a known cause of waste in the NHS. The Bromley Medicines Optimisation Service (MOS) aims to support community-based patients to self-manage their medicines so that the benefits of these medicines can be maximised whilst harms and waste are minimised.

What we did
The MOS team supports patients who are unable to visit their community pharmacy to discuss the problems they have with their medicines. Following a referral from a health or social care professional, a member of the MOS team visits the patient at home. An assessment is conducted to understand the difficulties the patient has in taking their medicines as prescribed, and solutions are put in place that are acceptable to the patient and/or family carers.

The MOS team has worked closely with Bromley CCG to jointly agree key measures that demonstrate the benefits of the service for patients, GPs and commissioners. An expert clinical panel that included a Bromley GP reviewed care plans that had been put in place and this panel agreed that the MOS service delivers a range of positive outcomes.

The figure below provides a summary of the number of patients seen by the MOS service and the ways in which these patients benefit from the service.

A typical year in the MOS service



What a patient said about their experience of the service:
So impressed by the efficient, professional, knowledgeable and friendly support I received. This service has had a positive impact on me and I hope the result will be that I am able to consistently manage my medication and therefore avoid another crisis.

What a GP said about the service:
A really helpful service. I hope it continues.

3.2.7 Improving access to psychological therapies for children and young people

Case for change
Children and Young Peoples (CYP) IAPT (Improving Access to Psychological Therapies) was launched in November 2011 and Greenwich Child and Adolescent Mental Health Service (CAMHS) was a wave 1 site for implementation. The CYP IAPT collaborative is a service transformation programme that aims to improve CAMHS through the following principles:

- Participation
- Delivering evidenced based practice
- Raising awareness
- Clinical outcomes
- Improving access

These principles are co-dependent and applied within a culture of collaboration and shared decision making.

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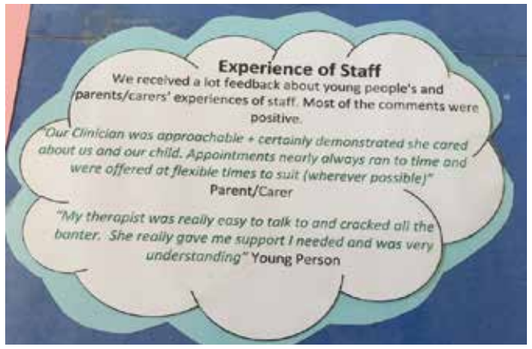
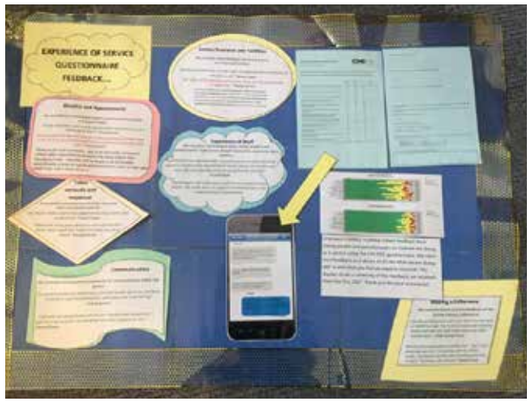
What has been done differently to improve patient care
Changes to the service are predominantly aligned to the five principles detailed above with the addition of governance and leadership. There is a robust Greenwich management team who review and embed the principles of IAPT on a regular basis through management structures and a CYP IAPT lead in the service.

Participation
Parents and carers have been involved in staff training and videos have been created to support this. Young people have also been involved in designing individual support plans for specific symptoms and were involved in the design of the new Greenwich CAMHS base.

Qualitative feedback from the Child Experience of Service questionnaire (CHI-ESQ) demonstrates the positive way in which young people view the service. Comments that are made and actions implemented accordingly are used to create 'You Said, We Did' feedback posters at service user level. All feedback is shared in clinical teams and in the management meetings to ensure an overview.





All feedback, positive and negative is fed back to young people and their families/carers in waiting rooms via a feedback board. These display boards were designed in collaboration with young people from the Bursting Stigma Participation Group.

Evidence based practice
Evidenced based pathways are in place for parenting, Depression, Anxiety, Learning Disabilities, Neurodisabilities and Self-Harm. A number of staff have completed IAPT training in the above evidence based pathways, and all of these have remained working within the service sine the time of training. When posts do become vacant, they are reviewed by the management team and decisions are made on the post based on skill mix, treatment needs and service needs. Staff are supported in training opportunities within the IAPT initiative and decisions are made based on service clinical requirements.

Raising awareness
The CYP IAPT programme supports improved access to services. Early intervention and prevention work is also offered in schools, children's centres and in social care to provide training and supervision, brief intervention and consultation for children and young people presenting with emotional health and well-being concerns.

Clinical outcomes
Greenwich CAMHS has a long history of using outcomes within its services. Clinical outcomes are used at assessment, review, session by session and discharge to help assess a young person's mental health difficulties and review their progress. They are also used within sessions to help track a young person's progress in four key areas: goal tracking, symptom tracking, feedback tracking and impact tracking. Five key outcome reports are produced on an annual basis, these are as follows:

- Goals: Rated by the young person or their family/carer
- SDQ: Mental health outcome reported by the young person or their family carer
- RCADS: Mental health outcome reported by the young person or their family carer
- CGAS: Clinician rated measure of global functioning
- CHI-ESQ: Patient satisfaction questionnaire
- Clinician Complexity Tool: Clinician rating of problem descriptions, complexity factors, contextual problems and attainments/ attendance difficulties

With regards to goal based outcomes for initial assessment and review, Greenwich CAMHS has been over 80% compliant in both areas.

Accessibility
Following feedback from young people, professionals, commissioners, parents and carers Greenwich CAMHS service opening hours changed from 9am – 5pm to 8am – 7pm. Service locations have also been informed by want young people and families have said would be helpful. Services are now delivered at The Point (youth hub), schools, social care, young people's homes and other community settings. This flexibility means that young people who are high risk or who cannot attend a service base can still access Interventions and treatment.

Access targets for assessment to treatment have also changed within Greenwich CAMHS from 12 to assessment and 18 weeks to treatment, to 8 for initial assessment to 12 weeks for treatment. At present the service is in fact averaging six weeks to initial assessment. The management team also regularly reviews waiting lists and if the wait is higher in one part of the service than another, resources will be deployed there to manage this and there are quick waiting list management plans put in place.

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Self-referrals are also accepted via Headscape.

Awards and recognition
Greenwich CAMHS have recently been informed that out of the London and South East CYP IAPT programme, within which are 43 partnerships, they have been rated within the top five. Greenwich CAMHS are now a beacon site for embedding and continuing to deliver an IAPT compliant service. They are the only Community CAMHS Tier 3 service to have been selected as a beacon site. Greenwich CAMHS will be producing a presentation in partnership with the CCG Commissioner that will get submitted to NHS England and be shared with other collaboratives. They will also help to mentor other partnerships to support them in becoming IAPT compliant.

3.2.8 Improving Physical Health Competency in Forensic Services

Case for Change
It was highlighted through observation and discussion with nurses and healthcare assistants, that some of our mental health trained staff lacked basic skills required for physical health assessment and/or the confidence in their abilities to use skills and report effectively. There was also a variety of equipment being used or in situ on wards that staff needed additional competency training in order to use safely and effectively.

What we did
We recruited a nurse with a general nursing/ physical health background to support staff and patients on our Forensic unit and to help improve the areas that we had identified as needing an additional focus.

To improve staff training, the physical health lead nurse initially created a standardised device list that staff required training for. The aim was to have all members of staff on the ward

Feedback from young people and family

"I would recommend Greenwich CAMHS because you can talk about all the bad things and the good things and you will be happy"
Young Person

"I like how in-depth we looked at things that were not obvious to me but which have had an impact on my son's emotional wellbeing"
Parent

"XX really listened about what I had to say and then helped me expand and explain certain problems that I had. I felt really safe and reassured"
Young person

trained to use all in-house devices including ECG Machines and to move the focus away from electronic blood pressure monitors and back onto manual BP monitoring. A training programme was set up on set days commencing with ECG device training and competencies and these sessions were well attended. To work around the issue of staff having to leave the ward, additional training days were provided where the physical health lead nurse attended the wards and provided training on a range of physical health subjects such as Airways (basics), Manual BP, Blood sugar monitoring, and ECG.

Following feedback a decision was made to hold a specific Forensic & Prisons Directorate skills based competency event. We devised a plan to encourage staff to attend to pick up a skill/revise old skills and take back to the ward to practice, the onus would then be on ward doctors/ward managers and senior nurses to ensure that staff were being signed off as competent. The plan focused around a reward card system, the idea was that at each skills station they get their card stamped, they take the card and relevant competency document away with them and practice that skill, they then ask Doctors/ senior nurses to sign them as competent on the ward and the senior nurses add them to the forensic and prisons inpatient spread sheet for competencies. Instructions were printed on the reverse of the reward card so all were aware of what to do and where to find the spread sheet. We had eight tables in total:-

- Manual BP
- GCS (Glasgow coma scale)
- What is in your Drugs box
- What is in your resuscitation bag?
- ECG
- Case Scenarios
- Lifesaver app
- RIO/MEWS

We made each table as interactive as possible for example the resus bag was a game - who can label the items in the quickest time and results were retained so that certificates could be issued at a later time. A similar strategy occurred at the ECG table, we made magnetic counters which correlated to the leads of an ECG machine and staff had to place them on the "patient" in the quickest time possible (like pin the tail on the donkey!). The GCS table used the official website for Glasgow coma scale and staff members were able to have the system explained and test their knowledge. The other tables were much more about facts and skills, for example at the manual BP table, staff needed the practice and the table focused on the skill rather than trying to make this "fun".

We had volunteer trainers from pharmacy, ward doctors/consultants, nurses and healthcare assistants who helped to teach on the day and we all supported one another and worked well as a team to provide the learners with a positive experience.

100% of feedback was that the day was a positive experience and enjoyable with staff using words such as "excellent" or "good"

30 members of staff gained at least 2 new skills and the knowledge to support them and we hope these new skills will be practiced at all given opportunities on the wards.

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Next steps

- To repeat the skills event as a full day event targeting staff on the early and late shifts
- To use the same formula and hold similar events at other sites and directorates across the Trust targeting our staff who work on our acute wards

3.3 Our Staff Survey 2017

We take part in the Care Quality Commission's (CQC) annual national NHS staff survey. The staff survey is an important piece of evidence which demonstrates our compliance with CQC's national standards and targets. The overall response rate to the 2017 survey was 42% (1364 staff) of all staff. The response rate was average when compared with other combined mental health/learning disability and community trusts and was slightly lower than the response rate in 2016 (44%). The Care Quality Commission report groups the responses of all the questions into 32 key findings with an additional composite finding around staff engagement.

When compared with similar organisations, our comparative scores are as follows:

- 13 key findings were above average
- 8 key findings were average
- 11 key findings were below average

We were rated as better than national average on the composite score for staff engagement at 3.84 (out of a maximum of 5). The score is based on a composite of staff responses in relation to three key findings – staff recommendation of the trust as a place to work or receive treatment, staff motivation at work and staff ability to contribute towards improvements at work.

NHS England have requested that Trusts include in the Quality Account Report their results for the following two indicators of the national staff survey:

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion (KF21)

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26)

We have provided our score for 2017, in comparison to the 2017 national staff survey average for combined mental health and learning disability and community trusts and are undertaking key pieces of work with our teams to improve staff perceptions by the next year.

Table 10

Key Finding Indicator	Oxleas 2017 results	National 2017 average for combined MH/LD and community trusts
Percentage of staff believing that the organisation provides equal opportunities for career progression and promotion (Key Finding 21) - **the higher the score, the better**	83%	86%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (Key Finding 26) - **the lower the score, the better**	21%	20%

Oxleas has remained a high performer in comparison to other organisations in terms of overall results. The results have generally stagnated reflecting a challenging year with significant organisational change. We are keen to work with our staff to ensure that we achieve the excellence that we have come to expect.

Our directorates are working with their teams on specific local concerns and action plans. We will however embark on organisation wide programmes to address two key areas of concern.

- We are working with all our services to reduce violence and abuse towards our staff. We intend to build on the successes of programmes that have already been instrumental in reducing violence and aggression in specific teams. We will work with staff across a range of teams and organisational hierarchies to ensure that they have clear support and escalation systems to address their concerns. We are also shortly starting a programme applying quality improvement methodology to reduce violence and aggression in inpatient mental health services.
- Working in partnership with our Equality and Diversity leads and Bullying and Harassment advisers we will be working on a programme to address perceptions of discrimination and staff experience of bullying and harassment. We initiated successful programmes in 2016/17, including the BME coaching programme, and expect to take these and new initiatives forward to support our staff and improve their experience of working at Oxleas.

3.4 Oxleas Complaints Report 2017/18

Complaints received
In 2017/18 there were approximately 960,000 patient contacts with our services; in the same period of April 2017 to March 2018 we received a total of 179 formal complaints (0.02% of overall patient contacts) and 111 informal complaints (0.01% of overall patient contacts).

The Trust reports on all complaints received in writing both formally and informally. We record any complaint that is made in writing to any member of the Trust, CQC or CCG staff,

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or is originally made orally and subsequently recorded in writing. Once this is recorded, we treat it as though it was made in writing from the outset. Complaints and comments/ suggestions that do not require investigation are not included in complaints reporting.

Of the 290 complaints received:-

- 63 (22%) relate to Bexley
- 62 (21%) relate to Bromley
- 89 (31%) relate to Greenwich
- 33 (11%) relate to Children and Young Persons (16 Bexley, 11 Bromley, 6 Greenwich)
- 40 (14%) relate to Forensic and Prison services
- 3 (1%) relate to Corporate services

Complaints investigated
Within the 290 complaints, 780 concerns were raised. Of these 780 concerns raised, 50 are still under investigation. Of the 730 concluded, 101 (14%) were upheld, 160 (22%) partly upheld, 424 (58%) not upheld, and 45 (6%) were indeterminate.

Our review of the concerns raised has identified 3 significant themes:

Table 11

	Investigated	Upheld/ partly upheld	% upheld
Clinical Care	192	60	31%
Attitude of staff	158	43	28%
Communication	114	65	57%

Following the completion of an investigation, when an issue has been upheld or partially upheld, a remedial action must always be identified. Of the 140 actions identified for 2017/18, 13 remain due to be completed, 19 were pending (as they are not yet due), at the time of writing this report and 108 (89%) have been completed.

Complaints handling
In line with the Trust's Complaints Policy the aim is to respond to complaints received within 30 working days, and agree extensions with the complainant when it is not possible to complete the investigation within this time frame. Of the 290 complaints, 170 complaints (59%) were completed within the agreed timescales. This is 5% decrease on last year.

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

This year a rolling programme of Complaints investigation training has been initiated. There have been 51 members of staff trained so far to complete complaints investigations. It is hoped this will mean that, with a greater number of investigating officers, investigations will be completed quicker. A new on-line training programme has also been created to train investigating officers in using Datixweb (the Trust's Risk Management System), with a view to using the system live to complete investigations and build the audit trail of a given complaint within the Complaints procedure. It is hoped this will streamline the process and make the complaint audit trail more robust.

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Work continues to embed and disseminate lessons from complaints across all our services. In addition we have a library of case studies for services to use in embedded learning events, and to share at team meetings to encourage discussion and promote good practice.

We will continue our focus in these areas in 2018/19 to improve the quality of the services we provide.

Parliamentary and Health Service Ombudsman (PHSO)
Complainants who are dissatisfied with the Trust response have the right to ask that the PHSO reconsider their complaint. Since April 2017, five complainants asked for their case to be reviewed by the Ombudsman's Office. One was not upheld, one was referred back to the Trust as a formal complaint, as it had been sent to the PHSO prematurely, and three investigations are currently on-going.

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Glossary of Abbreviations

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

Annex 1:
Feedback from our Stakeholders

Annex 1.1 Greenwich & Bexley CCG Response to Quality Accounts

Greenwich and Bexley CCGs welcome the opportunity to comment on the Oxleas Quality Account 2017/18. The report highlights the work the trust has undertaken over the past year to improve quality and safety for patient/client/service users highlighting the breadth of services delivered to the population they serve. The CCG mechanism to review quality to provide assurance on the services commissioned is through a Clinical Quality Review Group which includes Greenwich, Bexley and Bromley CCGs as part of South East London Commissioning Alliance.

The quality account shows progress in most aspects of service and illustrates some areas for improvement. The CCG notes the increase by 88% (18,863 people) in the number of patients responding to trust surveys; which is encouraging to understand how people view the services which provide their care and treatment. The trust has expanded feedback on involving families, carers and people important to service users to encompass all the trust services and this has reduced the total percentage of feedback the trust received. As the trust is working on this, the CCG would wish to see an improvement in 2018/19 in this important area.

Greenwich CCG fully supports the trust quality objective to increase the use of outcome measures by clinical teams in order to improve the quality of care patients receive and would like to see the expansion of both individual and whole system outcome measures for the future to promote improved service quality.

Care planning is a vital component of quality care for patients and the performance on this measure has declined to 2012/13 levels in the last year. The CCG will continue to work with the trust to ensure the improvement made in previous years is restored for care planning and that the positive steps the trust has made for patients receiving six monthly review of their care plan is maintained.

The identification and early treatment of Sepsis for all patients is paramount for the NHS and CCG. The trust use of Modified Early Warning Score (MEWS) and movement to the National Early Warning Score (NEWS) 2 is an important component of safe and effective patient care fully supported by the CCGs.

The work the trust describes on reducing the use of restraint, implementation of the ligature reduction strategy, reducing the incidence of falls and pressure ulcers and including positive learning all contribute to an improved patient safety environment. In addition, the continued focus on clinical audit to improve quality and the introduction of monthly care plan audits is encouraging. The CCG fully supports the 'joined up approach' to the expansion of the audits and the good practice of closing the audit cycle to ensure more clinical staff are involved in clinical audit to drive improvements thereby enhancing the quality of patient care.

Learning from deaths and the work the trust has undertaken in improving the process is positive, along with dissemination of the learning to improve clinical care for patients.

Overall the trust continues to work on improving the quality of care for patients. The examples of clinical quality in action in clinical teams highlight this approach and the involvement of staff in devising and promoting quality improvements are building blocks for the future.

Greenwich and Bexley CCGs will continue to work with partner CCGs in the South East London Commissioning Alliance and the trust to promote and drive quality initiatives, innovation and improvements to enhance the quality of care commissioned for the population of Greenwich and Bexley. The CCG looks forward to continuing to work in partnership with Oxleas to achieve this aim.

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Annex 1.2: Statement from Local Healthwatch Organisations

healthwatch Bexley healthwatch Bromley healthwatch Greenwich

Joint Healthwatch Response to Oxleas Quality Accounts 2017/18

Areas of success

- Healthwatch is pleased to see that the trust reached their 90% targets across all elements of quality objective 1 and are additionally impressed to see an 88% increase in patients providing feedback across the trust compared to 2016/17. However, it would be useful to see this as a percentage of overall patient feedback, especially given next year's target of receiving 10% response rates for patient experience surveys.
- We were pleased to see a significant increase in those on a CPA receiving their six-monthly review- a 5.5% increase from last year.
- Healthwatch welcome the number of initiatives which were implemented in 2017/18 concerning patient safety. However, we note that while these have been outlined, limited outcomes from these initiatives were recorded in the quality account. It would be interesting to know more about their success/ areas for improvement.
- We were pleased to see Oxleas have proactively engaged in all the national audits they were eligible for over the last year. Positive findings included that physical health checks and side effect monitoring for those on high-dose and/or combined antipsychotic medication is higher than national average; and that initial findings from the National Clinical Audit of Psychosis (NCAP) show met standards for physical health screenings and interventions in inpatient and early intervention in psychosis services.
- We are pleased to see Oxleas are now embedding a culture of routine outcome measurement across an additional five service areas, particularly where goal-based outcomes are being assessed in partnership with the patient. We are particularly glad to see this rolled out with prison and forensic patients, given that they scored between 5-11% lower than all other groups in QO1 for the target of feeling as though their care and treatment has helped them (and narrowly missing the 90% target). We wonder if an additional person-centred goal-based outcome could also be used with this group as is being implemented with Children and Young People, to assess patients' own views of progress and to explore why.

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- We were pleased to read through the report's case studies and quality highlights; these outline several excellent initiatives which have been put in place this year and the wide-ranging, positive effects they have had for patients.
- We were pleased to read the lessons Oxleas has learned from case record reviews and investigations this year and that several significant improvements have been put in place as a result; including the extension of opening hours for the Early Intervention in Psychosis team and the development of a person-centred crisis plan.

Areas for improvement

- We were disappointed to see that prison and forensic patients scored significantly lower than all other groups for the involvement of friends and family members where involvement was desired (78%), as well as for recommending services to friends and family (73%) with 15% not recommending the service. These results are comparable to last years and indicate little improvement in these areas. We would therefore like to see additional attention paid to this demographic going forward in the areas of patient engagement and the involvement of friends and family members.
- We note that adults with learning disabilities scored 81% on the friends and family recommendation test- significantly less than average. Again, we would like to see additional attention paid to this group over the coming year.
- Last year the Trust set a target of achieving 80% of patients to have a support network identified and noted within their care record for 2017/18. We hope the result of 35.2% will be significantly increased next year due to the plans outlined to improve this within the quality account. It would be additionally useful to understand which services are currently managing this better than others, particularly considering the low family and friends' involvement feedback from prisoners and forensic patients in QO1.
- We were disappointed to see a decrease of 6.5% this year in the number of patients with a care plan recorded on RiO, especially as the 95% target has been met every other year since 2012/13. There was no rationale for the decrease offered in the narrative of this quality account; we would be interested to know which specific services are falling behind in this area and why.
- Over the coming year we hope to see improvements in the national physical health screening and intervention standards for patients in community health services, as this was significantly lower than inpatient and early psychosis inpatient results.
- We were disappointed to see that 21% of staff reported experiencing bullying or harassment over the last year from other staff (a slight increase from 20% the previous year), although we recognise this remains close to the national average of 20%.

Response to quality Improvement priorities for 2018-19
Healthwatch are pleased to hear that next year's priorities were discussed and agreed via engagement with patients and the wider community. We note some comments on the following Quality Objectives for the coming year:

QO1
Given that the trust's 90% QO1 targets have been met consistently over the last three years (as an average across all patients), we question whether this target could be increased going forwards.

QO3
It seems that the target 'to ensure 75% of Oxleas eligible teams participate in the care planning audits' has replaced the previous target of ensuring that 95% of all patients have a recorded plan on RiO. Given this target was missed in 2017-18, we would encourage that it stays in as a priority.

QO4
We welcome the target to increase supine restraint in the place of prone restraint. We question whether the wording 'increase supine restraint' ought to be changed to 'increase supine restraint as a percentage of overall restraints'.

Other
Given that 55% of complaints made about communication from the trust were upheld and this remains an issue from 2016/17's account, we wonder whether communications could be an area for quality targets going forwards.

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Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to May 2018
  - papers relating to quality reported to the board over the period April 2017 to May 2018
  - feedback from commissioners dated 21/05/2018
  - feedback from local Healthwatch organisations dated 17/05/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2015/16
  - the internal complaints reports for 2017/18
  - the 2017 national patient survey
  - the 2017 national staff survey
  - the Head of Internal Audit's annual opinion of the trust's control environment dated 22/05/2018
  - CQC inspection reports dated 02/05/2017
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- here are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Signed by
Andrew Trotter
Chair
25 May 2018

Signed by
Helen Smith
Acting Chief Executive
25 May 2018

Annex 3: Criteria applied to mandated indicators

As part of the annual quality report requirements, our external auditors, Deloitte LLP have undertaken work on two mandated core indicators below as described below:

1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral
2. Inappropriate out-of-area placements for adult mental health

The aim of the review is to sample test the mandated indicators and check for accuracy, validity, reliability, timeliness, relevance and completeness. Both indicators require further improvement on the accuracy of the data.

The Early intervention in psychosis indicator - ("people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral") requires accurate recording of start and end times of the indicator. Determining whether the pathway and treatment commenced depends on assessment against criteria as to whether a service user is under the definition of this indicator, and whether the stage of contact with the service user is sufficient to constitute commencement of treatment. In some instances, the application of the guidance has led to pathways being stopped before the national criteria were met, which will in some cases overstate performance against the indicator. The Trust is reviewing its guidance and training for staff to improve recording against these criteria.

Inappropriate out-of-area placements for adult mental health services - Data for this indicator is collected through a series of manual processes operating across each of our three boroughs that we provide services. This is currently a manual process tracked outside of the Trust's reporting IT systems, which inherently has a greater risk of error and of issues in reporting data. The current national guidance includes limited reasons for an "appropriate" placement, which typically do not apply to the Trust's placements. The Trust considers these definitions may not fully reflect the circumstances of use of other providers in a London context. We are reviewing potential process improvements to support reporting in the future.

Annex 4: Independent auditor's report to the council of governors of Oxleas NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Oxleas NHS Foundation Trust to perform an independent assurance engagement in respect of Oxleas NHS Foundation Trust's quality report for the year ended 31 March 2018 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Oxleas NHS Foundation Trust as a body, to assist the council of governors in reporting Oxleas NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Oxleas NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral.
- Inappropriate out-of-area placements for adult mental health services.

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

Respective responsibilities of the directors and 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 NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in specified in section 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

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We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2017 to 25 May 2018;
- papers relating to quality reported to the board over the period April 2017 to 25 May 2018;
- feedback from Commissioners, dated 21 May 2018;
- feedback from local Healthwatch organisations, dated 17 May 2018;
- the latest trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- Care Quality Commission inspection report published on 2 May 2017; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 22 May 2018.

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.

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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.

Bases for qualified conclusion

Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral

The "Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each person's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as a percentage of the number of referrals to and within the trust with suspected first episode psychosis or at 'risk mental state' that start a NICE- recommended package care package in the reporting period within 2 weeks of referral.

We identified the following errors within a sample of 26:

- In 7 cases, the start or end date of treatment was not accurately recorded affecting the calculation of the published indicator;
- In 2 cases, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator.

Inappropriate out-of-area placements for adult mental health services
The "Inappropriate out-of-area placements for adult mental health services" indicator requires that the NHS Foundation Trust accurately record the start and end dates of each person's treatment pathway, in accordance with detailed requirements set out in the national guidance. This is calculated as the total number of bed days patients have spent inappropriately out of area, stated as a monthly average for quarter 4 of 2017/18.

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We identified the following errors within a sample of 30:

- The indicator did not include bed days relating to patients in out-of-area placements during quarter 4 of 2017/18 where the placement commenced prior to the start of the quarter. The calculation did not therefore include all relevant data.
- In 2 cases, the number of bed days was not accurately recorded affecting the calculation of the published indicator;
- In 2 cases, we were unable to obtain sufficient supporting evidence to confirm the details necessary to test the calculation of the published indicator.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "Inappropriate out-of-area placements for adult mental health services" indicator for the year ended 31 March 2018. We are unable to quantify the effect of these errors on the reported indicator.

Annex 3 of the NHS Foundation Trust's Quality Report details the actions that the NHS Foundation Trust is taking to resolve the issues identified in its processes.

Conclusion
Based on the results of our procedures, except for the matters set out in the bases for qualified conclusion section of our report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 here; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP
St Albans
26 May 2018

Independent Auditor's Report to the Board of Governors and Board of Directors of Oxleas NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Oxleas NHS Foundation Trust (the 'foundation trust') and its subsidiaries (the 'group'):

- give a true and fair view of the state of the group's and foundation trust's affairs as at 31 March 2018 and of the group's and foundation trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the Group and Trust Statements of Comprehensive Income;
- the Group and Trust Statements of Financial Position;
- the Group and Trust Statements of Changes in Taxpayers' Equity;
- the Group and Trust Statements of Cash Flows;
- the Accounting Policies and other information; and
- the related notes 1 to 24.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the group and the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our otherethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

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Independent Auditor's report

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: ● NHS revenue recognition; ● Property valuations; and ● Management override of controls. The key audit matters are consistent with the prior year, except for the removal of matters relating to the accounting for spend on the re- development of the Queen Mary Hospital, Sidcup and the provision for non contracted activity provision as explained further, below.
Materiality	The materiality that we used for the group financial statements was £5.0m which was determined on the basis of 2% of the Trust's operating income.
Scoping	The scope of our audit was focussed upon Oxleas NHS Foundation Trust. The Trust makes up substantially all of the Group's total operating income and net assets. Analytic procedures at a group level were performed on Oxleas NHS Foundation Trust Charitable Fund and Oxleas Prison Services Limited, which are exempt from requirements for audit of their statutory financial statements.
Significant changes in our approach	Costs relating to the redevelopment of the Queen Mary Hospital, Sidcup have not been identified as a key audit matter in 2017/18 due to the reduced level of expenditure on the project. The provision for non contracted activity has also not been identified as a key audit matter as the provision has been released in full and the amount of the release is immaterial. As explained further below, we have reassessed the basis for determining materiality.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where: • the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or • the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.	**We have nothing to report in respect of these matters.**

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Section four
Independent Auditor's report

NHS revenue recognition	
Key audit matter description	We have identified risks to NHS revenue recognition in relation to the validity and valuation of deferred income, including deferred QMS transitional funding as the redevelopment of the site progresses. Details of the Group's deferred income of £17.0m (2016/17: £14.4m) is shown in note 13.3 to the financial statements. The Group's description of related critical accounting judgements and key sources of estimation uncertainty is shown in note 1.21 to the financial statements.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of key controls around the validity and valuation of deferral of income (including QMS transitional funding). We reviewed the deferred income balances, including QMS transitional funding, and tested a sample to supporting documentation including correspondence with counterparties where available. We reviewed management's summary of their accounting rationale for the treatment of QMS deferred transitional funding and estimation of the amount to be deferred as at 31 March 2018.
Key observations	We consider the estimates made by the Trust to be relatively conservative.

Property valuations	
Key audit matter description	The Group held £127m of property assets (land and buildings) at 31 March 2018 (31 March 2017: £118m). The Group uses a hypothetical alternative site model. The complexities of this valuation approach mean that there is a risk over the valuation of the property assets because: ● the valuation of the Group's property assets is inherently judgemental; ● the Group holds certain property assets within Property, Plant and Equipment at a "Modern Equivalent Asset" valuation. 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. This includes assumptions on possible "alternative sites" for land values; and ● where existing properties are being modernised, the "Modern Equivalent Asset" valuation rules can lead to a "day one" impairment where the accumulated cost of the asset exceeds the cost of a newly built facility. The Group has had an independent valuation carried out on its estates based on assumptions provided by the Group. The valuation movements on the Group's estate shown in note 9 are an impairment charge to operating expenses of £12.6m (2016/17: £5.1m), impairment charge to the revaluation reserve of £9.8m (2016/17: £nil) and upward revaluation of £3.6m (2016/17: £3.0m). The Group's description of key sources of estimation uncertainty is shown in note 1.21 to the financial statements.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of key controls in place around the property valuation, including controls around the appropriateness of the alternative site use assumption. We used our valuation specialists, Deloitte Real Estate, to review and challenge the appropriateness of the alternative site use assumption used in the year-end valuation of the Group's Land and Buildings. We challenged whether the assumptions made about alternative sites are consistent with the Group's clinical strategy and have been considered and approved at an appropriate level within the Group. We considered the presentation of revaluation movements and impairments, taking into account revaluation reserves for individual assets, and the disclosures included in the financial statements.

Property valuations *continued*	
Key observations	We consider the assumptions made by the Trust to be reasonable.

Management override of controls	
Key audit matter description	We consider that there is a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgments or estimates. This is due to description the increasingly tight financial circumstances of the NHS, the close scrutiny of the reported financial performance of individual organisations, and the incentives to meet or exceed control totals to receive Sustainability and Transformation Funding. All NHS Trusts and Foundation Trusts were requested by NHSImprovement in 2016 to consider a series of "technical" accounting areas and assess both whether their current accounting approach meets the requirements of International Financial Reporting Standards, and to remove "excess prudence" to support the overall NHS reported financial position. The areas of accounting estimate highlighted included accruals, deferred income, bad debt provisions, property valuations, and useful economic lives of assets. The Group's description of critical accounting judgements and key sources of estimation uncertainty is shown in note 1.21 to the financial statements. The Group's £3.0m of Sustainability and Transformation Funding is shown in note 3.1 to the financial statements.

Management override of controls *continued*	
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of controls in relation to journals and key accounting estimates. **Manipulation of accounting estimates** Our work on accounting estimates included considering each of the areas of judgement identified by NHS Improvement. In testing each of the relevant accounting estimates, engagement team members were directed to consider their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS. We tested accounting estimates (including in respect of NHS revenue and property valuations discussed above), focusing on the areas of greatest judgment and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting standards and were appropriate in the circumstances of the Group. **Manipulation of journal entries** We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting, focusing in particular upon manual journals. We traced the journals to supporting documentation, and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. **Significant transactions** We considered whether any transactions identified in the year were material unusual transactions outside the normal course of business.
Key observations	We considered the estimates made by the Group to be within the acceptable range, albeit towards the conservative end.

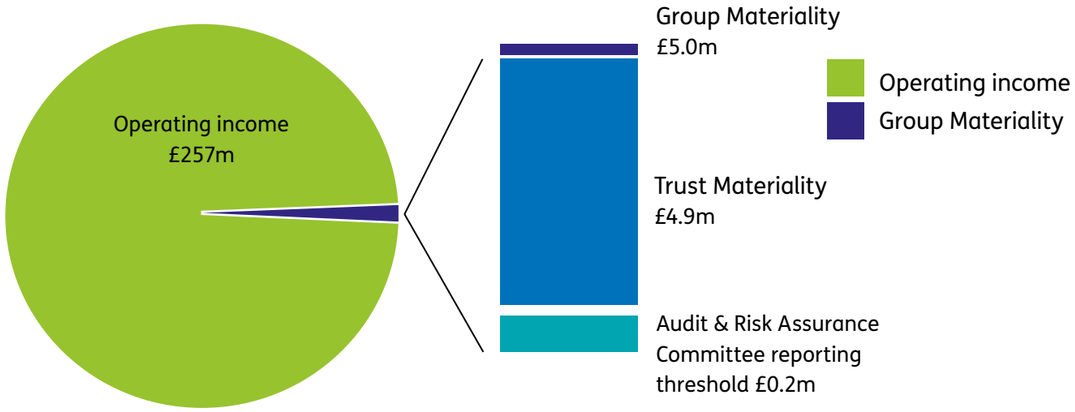
Section four
Independent Auditor's report

Our application of materiality
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	Foundation trust financial statements
Materiality	£5.0m (2017: £3.7m)	£4.9m
Basis for determining materiality	2.0% of operating income (2017: 1.5% of operating income) We reassessed the percentage used in the context of our cumulative knowledge and understanding the audit risks at the foundation trust and our assessment of those risks for this year.	1.9% of operating income (2017: 1.5% of operating income) We reassessed the percentage used in the context of our cumulative knowledge and understanding the audit risks at the foundation trust and our assessment of those risks for this year.
Rationale for the benchmark applied	Operating income was chosen as a benchmark as the foundation trust is a non-profit organisation, and operating income is a key measure of financial performance for users of the group financial statements.	Operating income was chosen as a benchmark as the foundation trust is a non-profit organisation, and operating income is a key measure of financial performance for users of the foundation trust financial statements. foundation trust and our assessment of those risks for this year.

Independent Auditor's report



We agreed with the Audit and Risk Committee that we would report to the Committee all audit differences in excess of £0.2m (2017: £0.185m), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the 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 Group and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Group's head offices directly by the audit engagement team, led by the senior statutory auditor.

Our audit testing focussed upon Oxleas NHS Foundation Trust. The foundation trust makes up substantially all of the Group's total operating income and net assets. Our audit work at the foundation trust was executed at a materiality of £4.9m.

The consolidation process was tested and analytic procedures were performed at a group level on Oxleas NHS Foundation Trust Charitable Fund and Oxleas Prison Services Limited, which are exempt from requirements for audit of their statutory financial statements, to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information.

The audit team included integrated Deloitte specialists bringing specialist skills and experience in property valuations and information technology systems. Data analytic techniques were used as part of the audit testing, in particular to support profiling of populations to identify items of audit interest.

Section four

Independent Auditor's report

Other information
The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, including the performance report and the accountability report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report
that fact.

Responsibilities of accounting officer
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, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the group's and the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the group or the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that

an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability 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

Annual Governance Statement, use of resources, and compilation of financial statements

We have nothing to report in respect of these matters.

Under the Code of Audit Practice, 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 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.

Section four
Independent Auditor's report

Reports in the public interest or to the regulator

We have nothing to report in respect of these matters.

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

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 Code of Audit Practice.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Oxleas 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 foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Ben Sheriff FCA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Statutory Auditor
St. Albans, United Kingdom
26 May 2018

The directors are responsible for the maintenance and integrity of the corporate and financial information included on the Trust's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Foreword to financial statement

These Financial Statements for the year ended 31 March 2018 have been prepared by Oxleas NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Signed by
Helen Smith, Acting Chief Executive, 25 May 2018

Statement of comprehensive income for the year ended 31 March 2018

	NOTE	31 March 2018 TRUST £000	31 March 2018 GROUP £000	31 March 2017 TRUST £000	31 March 2017 GROUP £000
Operating Income	3.1	257,416	255,639	246,979	245,515
Operating expenses	4.1	(261,428)	(260,095)	(245,381)	(244,054)
OPERATING SURPLUS/(DEFICIT)		(4,012)	(4,456)	1,598	1,461
Finance costs					
Finance income	6	146	146	211	211
Finance costs - interest expense	7	(1,071)	(1,071)	(1,067)	(1,067)
PDC dividends payable		(3,949)	(3,949)	(3,183)	(3,183)
Net finance costs		(4,874)	(4,874)	(4,039)	(4,039)
Gain from asset disposals		1,372	1,372	643	643
SURPLUS/(DEFICIT) FOR THE YEAR		(7,514)	(7,958)	(1,798)	(1,935)
Other comprehensive income *					
Impairment losses		(9,790)	(9,790)	0	0
Revaluation gains		3,585	3,585	2,970	2,970
Total Other comprehensive income		(6,205)	(6,205)	2,970	2,970
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		(13,719)	(14,163)	1,172	1,035

The notes on pages 170 to 208 form part of these accounts.
* There are no part of the other comprehensive income that will be reclassified subsequently to income and expenditure.

Statement of financial position as at 31 March 2018

	NOTE	31 March 2018 TRUST £000	31 March 2018 GROUP £000	31 March 2017 TRUST £000	31 March 2017 GROUP £000
NON-CURRENT ASSETS					
Intangible assets	8	3,680	3,680	80	80
Property, plant and equipment	9	129,039	129,039	147,794	147,794
Total non-current assets		132,719	132,719	147,874	147,874
CURRENT ASSETS					
Inventories	10	336	547	287	484
Trade and other receivables	11.1	22,006	21,273	18,458	18,111
Assets held for sale	9	3,140	3,140	220	220
Cash and cash equivalents	12	60,526	61,405	62,419	63,191
Total current assets		86,008	86,365	81,384	82,006
CURRENT LIABILITIES					
Trade and other payables	13.1	(34,968)	(35,124)	(31,742)	(31,719)
Borrowings	13.2	(407)	(407)	(382)	(382)
Provisions	14	(3,512)	(3,512)	(4,334)	(4,334)
Other liabilities	13.3	(17,031)	(17,031)	(14,427)	(14,427)
Total current liabilities		(55,918)	(56,074)	(50,885)	(50,862)
NET CURRENT ASSETS		30,090	30,291	30,499	31,144
TOTAL ASSETS LESS CURRENT LIABILITIES		162,809	163,010	178,373	179,018
NON-CURRENT LIABILITIES					
Borrowings	13.2	(9,305)	(9,305)	(9,713)	(9,713)
Provisions	14	0	0	(1,740)	(1,740)
Total non-current liabilities		(9,305)	(9,305)	(11,453)	(11,453)
TOTAL ASSETS EMPLOYED		153,504	153,705	166,920	167,565
FINANCED BY TAXPAYERS' EQUITY					
Public dividend capital		112,421	112,421	112,118	112,118
Revaluation reserve		41,348	41,348	47,825	47,825
Other reserves		1,218	1,218	1,218	1,218
Merger reserve		141	141	141	141
Income and expenditure reserve		(1,624)	(2,069)	5,618	5,527
Charitable fund reserves		0	646	0	736
TOTAL TAXPAYERS' EQUITY		153,504	153,705	166,920	167,565

The financial statements on pages 166 to 169 were approved by the Board on 25 May 2018 and signed on its behalf by:

Signed by
Helen Smith, Acting Chief Executive, 25 May 2018

Statement of changes in taxpayers' equity

	NOTE	Public Dividend Capital £'000	Revaluation reserve £'000	Other reserves £'000	Merger reserve £'000	Income and expenditure reserve £'000	TRUST £'000	Oxleas Prison Services Limited £'000	NHS Charitable Funds Reserves £'000	GROUP £'000
2017/18										
Taxpayers' equity as at 1 April 2017		**112,118**	**47,825**	**1,218**	**141**	**5,618**	**166,920**	**(91)**	**736**	**167,565**
Deficit for the year		0	0	0	0	(7,514)	**(7,514)**	(354)	(90)	**(7,958)**
Other comprehensive income:										
Impairment losses		0	(9,790)	0	0	0	**(9,790)**	0	0	**(9,790)**
Revaluation gains		0	3,585	0	0	0	**3,585**	0	0	**3,585**
Total other comprehensive income		0	(6,205)	0	0	0	**(6,205)**	0	0	**(6,205)**
Total comprehensive income/(loss) for the year		**0**	**(6,205)**	**0**	**0**	**(7,514)**	**(13,719)**	**(354)**	**(90)**	**(14,163)**
Transfers between reserves		0	(272)	0	0	272	**0**	0	0	**0**
PDC received		303	0	0	0	0	**303**	0	0	**303**
Taxpayers' equity as at 31 March 2018		**112,421**	**41,348**	**1,218**	**141**	**(1,624)**	**153,504**	**(445)**	**646**	**153,705**
2016/17										
Taxpayers' equity as at 1 April 2016		**112,118**	**44,855**	**1,218**	**141**	**7,418**	**165,750**	**(2)**	**782**	**166,530**
Deficit for the year		0	0	0	0	(1,800)	(1,800)	(89)	(46)	(1,935)
Other comprehensive income:										
Revaluation gains		0	2,970	0	0	0	**2,970**	0	0	**2,970**
Total other comprehensive income		0	2,970	0	0	0	**2,970**	0	0	**2,970**
Total comprehensive income/(loss) for the year		0	2,970	0	0	(1,800)	**1,170**	(89)	(46)	**1,035**
PDC received		0	0	0	0	0	**0**	0	0	**0**
Taxpayers' equity as at 31 March 2017		**112,118**	**47,825**	**1,218**	**141**	**5,618**	**166,920**	**(91)**	**736**	**167,565**

Statement of cash flows

for the year ended 31 March 2018

	NOTE	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000	Year ended 31 March 2017 TRUST £000	Year ended 31 March 2017 GROUP £000
Cash flows from operating activities					
Operating surplus from continuing operations		**(4,012)**	**(4,456)**	1,598	1,461
Non cash income and expense:					
Depreciation and amortisation	**4.1**	4,399	4,399	3,330	3,330
Impairments	**4.1**	12,583	12,583	5,130	5,130
Increase in trade and other receivables		(3,548)	(3,171)	(1,522)	(1,455)
(Increase)/decrease in inventories		(49)	(63)	(9)	53
Increase in trade and other payables		4,738	4,891	2,612	2,077
Increase in other liabilities		2,604	2,604	1,282	1,282
Decrease in provisions		(2,562)	(2,562)	(2,410)	(2,410)
NHS Charitable Funds - net adjustments for working capital movements		0	35	0	(30)
Other movements in operating cash flows		(3)	(3)	(1)	22
NET CASH GENERATED FROM OPERATIONS		**14,150**	**14,257**	10,010	9,461
Cash flows from investing activities					
Interest received		146	146	211	211
Purchase of intangible assets		(1,388)	(1,388)		
Purchase of property, plant and equipment		(10,885)	(10,885)	(29,756)	(29,756)
Sales of property, plant and equipment		1,716	1,716	943	943
NET CASH USED IN INVESTING ACTIVITIES		**(10,411)**	**(10,411)**	(28,602)	(28,602)
Cash flows from financing activities					
Public dividend capital received		303	303	0	0
Capital element of Finance Lease		(69)	(69)	(66)	(66)
Capital element of PFI obligations		(312)	(312)	(292)	(292)
Interest element of finance leases	**7**	(57)	(57)	(61)	(61)
Interest element of PFI obligations	**7**	(1,014)	(1,014)	(1,001)	(1,001)
PDC dividend paid		(4,483)	(4,483)	(2,531)	(2,531)
NET CASH USED IN FINANCING ACTIVITIES		**(5,632)**	**(5,632)**	(3,951)	(3,951)
DECREASE IN CASH AND CASH EQUIVALENTS		**(1,893)**	**(1,786)**	(22,543)	(23,092)
Cash and cash equivalents at 1 April	**12**	**62,419**	**63,191**	84,962	86,283
Cash and cash equivalents at 31 March	**12**	**60,526**	**61,405**	62,419	63,191

1 Accounting Policies

NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2017/18 Group Accounting Manual issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) as adopted by the European Union (EU) and HM Treasury's Financial Reporting Manual 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.

1.1 Accounting convention

These accounts have been prepared on a going concern basis and under the historical cost convention modified to account for the revaluation of property, plant and equipment.

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 under contracts from commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the year 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 year is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following year.

1.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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.

Notes to the financial statements
for the year ended 31 March 2018

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Pooled Budgets

The Trust also has pooled budget arrangements with the London Boroughs of Greenwich, Bexley and Bromley. These arrangements are hosted by the London Boroughs of Greenwich, Bexley and Bromley respectively. Under the arrangement funds are pooled under section 75 of the NHS Act 2006 for adult mental health activities.

Payments for services provided by the Trust are accounted for as income from Local Authorities. The Trust accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget arrangements.

1.7 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;
- the cost of the item can be measured reliably;
- each item individually has a cost of at least £5,000; or

- form part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost; or
- where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and 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 revaluation. Equipment assets are valued using depreciated replacement cost as proxy.
- Land and buildings are valued by an independent registered chartered surveyor on a regular basis and in accordance with Royal Institution of Chartered Surveyors' Valuation Standard as required under IAS16 to reflect current value. At 31 January 2018 the land and building asets were revalued.

Current values are determined as follows:
- Land and non-specialised buildings are valued at market value. Non-specialised residential buildings are valued at market value, Land and buildings are not separately valued
- Specialised buildings are valued at depreciated replacement cost based on modern equivalent assets.

Leasehold improvements are not subsequently revalued.
HM Treasury adopts a standard approach to depreciated replacement cost valuations using a modern equivalent asset basis, and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Revaluations are performed annually to ensure that the carrying amounts are not materially different from those that would be determined at the statement of financial position date.

Assets in the course of construction are valued at cost, less any impairment loss. Assets are revalued and depreciation commences when they are brought into use.

Subsequent expenditure
Expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the Statement Of Comprehensive Income in the year in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in a probable increase in the future economic benefits expected to be obtained from the use of an item of property, plant and equipment, and where the cost of the item can be measured reliably, the expenditure is capitalised as an additonal cost of that asset or as a replacement.

Depreciation
Items of property, plant and equipment are depreciated on a straight line basis over their estimated useful economic lives. Freehold land is considered to have an infinite life and is not depreciated.

The useful economic lives of buildings are assessed by the Trust's professional valuers. At 31 January 2018 the useful economic lives were assessed as between the range 1-58 years.

Notes to the financial statements
for the year ended 31 March 2018

Leasehold property, plant and equipment are depreciated over the primary lease term, leasehold improvements are depreciated over the remaining lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

Furniture and fittings - 5 years
Transport equipment - 3 years
IT equipment - 9 years
Mobile tablets - 3 years

If the residual value of an asset is zero at the Statement of Financial Position date, the asset's life will be reviewed annually.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve.The reversal of an impairment loss is credited to operating expenses.

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
Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

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'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Private finance initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-statement of financial position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 39.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the effective interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

1.8 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development."

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset."

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits."

Notes to the financial statements
for the year ended 31 March 2018

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The useful economic lives are shown below:

Development expenditure	7 years
Licences	9 years

1.9 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.10 Inventories
Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula.

1.11 Financial instruments

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

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.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

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 can be categorised as 'fair value through profit or loss', 'loans and receivables', 'held to maturity investments' and 'available for sale financial assets'. The only category applicable to the Trust is 'loans and receivables'.

Financial liabilities can be classified as 'fair value through profit or loss' and 'other'. The only category applicable to the Trust is '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 assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly

Notes to the financial statements
for the year ended 31 March 2018

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.

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 non-current 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 is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets 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 a provision for impairment of receivables.

If, in a subsequent year, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through the Statement of Comprehensive Income to the extent that the carrying amount of the receivable at the date the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.12 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit rate to the outstanding liability and is charged to finance costs in the Statement of Comprehensive Income.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.13 Provisions
The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure 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 HM Treasury's discount rate of 0.1% in real terms for early retirements and injury benefits.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution, which in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in note 14. This is not recognised in these accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Contingencies
Contingent liabilities are not recognised, but are disclosed in note 16, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:
- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Public Dividend Capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less all liabilities, except for

(i) Donated assets (including lottery funded assets);
(ii) Charitable funds (before any consolidation adjustments for charitable funds);
(iii) Average daily cleared balances with the Government Banking Service and National Loans Funds (NLF) deposits, excluding GBS accounts that relate to a short-term working capital facility
(iv) PDC dividend balance receivable or payable;
(v) STF incentive and bonus fund receivable.

The dividend payable is based on the actual average relevant net assets for the year per the ""pre-audit version"" of the annual accounts.

1.16 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Corporation Tax

The Trust has reviewed its operating activities and determined that it has no liability for corporation tax. Group current tax assets and liabilities are measured at the amount expected to be recovered from or paid to the taxation authorities, based on tax rates and laws that are enacted or substantively enacted by the Statement of Financial Position date.

1.18 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in note 21 to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.19 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.20 Other reserves

Other reserves reflect property, plant and equipment written into the accounts on 1 April 2000 resulting from the revaluation exercise carried out by the District Valuer on 1 April 2000.

1.21 Accounting judgements and estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the year in which the estimate is revised if the revision affects only that year, or in the year of the revision and future years if the revision affects both current and future years.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimates (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

The Trust has recognised under IFRIC 12 the need to account for its PFI scheme as a service concession arrangement. The indications of a service concession include the provision of a healthcare service, control over the services and control over the asset at the end of the lease. The PFI arrangement satisfies these conditions. The details of the PFI scheme can be found in note 18.

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The Trust has made judgements for a number of properties as to whether they meet the criteria for treatment as assets held for sale or whether they are surplus assets, and for surplus assets whether there are restrictions which mean that they should be valued at current value in existing use or at market value.

The Trust recognises deferred income relating to QMH. Income in respect of services provided is recognised when, and to the extent that, performance/cost occurs. The Trust prepared a business case for QMH and undertook due diligence of the financials pre October 2013. To minimise risk the Trust agreed that tenants would pay based on the space that they would require in the future (post redevelopment). The gap between income, including transitional funding, and expenditure is closely monitored with the balance held as deferred income being that which is held to support the future costs to closedown, net of delivering a £150k contribution as per the business case.

Part of the space at QMH is occupied and let to third parties. The properties are of a specialised nature and as a result are let substantially to NHS entities with rent determined on a cost sharing basis. The Trust provides ancillary services to its tenants which are more than an insignificant portion of the arrangement. The integrated nature of the QMH site also means that it would not be possible to separately dispose of parts of the site which are not occupied by the Trust. As a result, the Trust has accounted for these properties within Property, Plant and Equipment. As the properties are specialised, they are held at Depreciated Replacement Cost in accordance with the Trust's policies for this category of asset.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement Of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The Trust's estate is valued according to appropriate indices as applied by the Trust's external valuers.

The useful economic lives of buildings are assessed by the Trust's professional valuers who assume that all buildings have a maximum life expectancy from new of 60 years, with the buildings depreciated to on a straight line basis from 100% at completion of construction to zero, once their life span has been met.

When undertaking the valuation of land at 31 January 2018 the Trust's professional valuers have relied on the Trust's opinion that a smaller land area could be appropriate for reproviding services at a number of the Trust's sites. The Trust has also assumed that services could be reprovided on alternative sites, and have valued land having regard to prevailing land values in Kent.

When undertaking the valuation of buildings at 31 January 2018 the Trust's professional valuers have removed the 5% contingency allowance (reflecting the risk of timing delays or cost overruns) which has previously been adopted within the DRC calculations. The effect of this is to reduce the valuation by £4.2m at 31 January 2018. It is impracticable to estimate the effect of this change in accounting estimate on future periods.

The provision for other legal claims is stated subject to uncertainty about the outcome of legal proceedings.

1.22 Accounting standards issued but not yet adopted

The following presents a list of recently issued accounting standards and amendments which have not yet been adopted within the FReM, and are therefore not applicable to DH group accounts in 2017-18.

- IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 14 Regulatory Deferral Accounts - Not yet EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

- IFRS 15 Revenue for Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. This standard will potentially have an impact upon the recognition of revenue disclosed by the trust in 2018/19. The standard requires the trust to recognise revenue when or as it has satisfied performance obligations.
- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

Following the release of the 2018/19 Department of Health and Social Care Group Accounting Manual in May 2018, the Trust is assessing the likely impact of IFRS 9 and IFRS 15 (and the adaptations included in the GAM). Areas the Trust is reviewing include non-contracted income and transitional funding.

Accounting standards issued that have been adopted early

No accounting standards have been adopted early.

1.23 Segmental reporting

IFRS 8 defines the term of Chief Operating Decision Maker (CODM) as a group or individual whose 'function is to allocate resources to and assess the performance of the operating elements of the entity.' For the Trust the most appropriate interpretation is that the Trust Board represents the CODM. Operational performance is monitored at the monthly board meetings and key resource allocation decisions are agreed there.

Information is presented to the Board as nine operating segments as detailed in note 2. This information is prepared in accordance with International Financial Reporting Standards. This has been determined to be sufficient as the Board allocates resources and assesses performance on this basis. This mirrors the information that is submitted to Monitor and enables the Board to make strategic decisions on the Annual Plan.

A reconciliation between the published accounts and the information presented to the CODM for financial years 2017/18 and 2016/17 is shown in note 2 of the accounts.

The Trust generates the majority of its income from healthcare and related services. The information as displayed in the accounts reflects that which is submitted to the Board.

The Trust's major commissioners during the year 2017/18 were as follows:

NHS Greenwich CCG 26%, NHS England 20%, NHS Bexley CCG 18%, and NHS Bromley CCG 13% (2016/17 NHS Greenwich CCG 29%, NHS England 20%, NHS Bexley CCG 18%, and NHS Bromley CCG 14%).

1.24 Interests in other entities

In January 2012 the Trust entered into a joint venture (SARD JV Limited) with Mango Swiss Limited. The Trust owns 51% of the shares in the joint venture and Mango Swiss Limited own 49% of the shares. The Trust holds 51 ordinary shares of £1 each. Joint ventures are separate entities over which the Trust has joint control with one or more other parties. The meaning of control is where the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The Trust provided an initial loan to the joint venture of £40,000 in 2012/13 and provided additional

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funding in 2012/13 of £60,000 which is shown within non NHS receivables within these accounts. Turnover in the joint venture in the year ended 31 March 2018 was £671,175 (Year ended 31 March 2017 £518,167). As this is not a material item in the accounts it has not been accounted for using the equity method as a joint venture but instead has been accounted for at cost less any provision for impairment.

On 5 March 2015, Oxleas Prison Services Limited (OPS Ltd) was set up by the trust as a wholly-owned subsidiary company to provide pharmacy services to prisons in Kent and Greenwich. The income, expenses, assets, liabilty, equity and reserves of this subsidiary are consolidated in full into the appropriate financial statement lines. In year ended 31 March 2018 OPS Ltd made a deficit of £354,048 (year ended 31 March 2017 deficit £89,482), turnover for the period was £3,449,741 (year ended 31 March 2017 £3,246,645). OPS Ltd is domiciled in the UK. The registered address is Bracton Centre (Teambase), Bracton Lane, Off Leyton Cross Road, Dartford, Kent DA2 7AF.

In July 2017 the Trust signed a 10 year partnership agreement with Health Innovations Partners (HIP) as its Strategic Estates Partner (SEP). This is a 50:50 joint venture between the Trust and HIP (Community Solutions and Arcadis JV). The joint venture will work to develop the Trust's estate and surplus assets, helping to reduce costs and maximise revenue for the Trust which can be reinvested into healthcare delivery in South East London.

2 Operating segments

The Chief Operating Decision Maker is the Board of Directors. The Board is presented with monthly management accounts which are split into different segments for income and expenditure. The operating results of expenditure segments are reviewed by the Board to make decisions about resources to be allocated to the segment and to assess its performance.

The Trust has nine reportable segments based on expenditure. Financial performance against budget for each segment is presented to the Board on a monthly basis. The table below summarises the expenditure by each operating segment:

	Year ended 31 March 2018	Year ended 31 March 2017
	£000	£000
Bexley	(29,655)	(30,268)
Bromley	(21,658)	(22,631)
Children & Young People	(26,874)	(28,233)
Greenwich	(39,390)	(38,032)
Adult Learning Disabilities	(4,996)	(4,966)
Prisons	(22,208)	(21,887)
Forensic	(15,727)	(14,706)
Estates & Facilities	(22,149)	(25,271)
HQ Services	(23,723)	(19,138)
Central Income	209,928	207,669
Queen Mary's Hospital (QMS) *	149	150
Trust Surplus	**3,697**	**2,687**
Charitable Trust Funds	(90)	(46)
Oxleas Prison Services Limited	(354)	(89)
Group Surplus	3,253	2,552
IFRS 8: Reconciliation to Deficit for the year		
Impairments	(12,583)	(5,130)
Gain on disposal of land and buildings	1,372	643
SURPLUS/(DEFICIT) FOR THE YEAR	**(7,958)**	**(1,935)**

* The underlying surplus from QMS is analysed as follows:

QMS Operating Statement for the Year Ended 31 March 2018	**31 March 2018 QMS**	31 March 2017 QMS
	£000	£000
Operating Income	18,071	12,719
Operating expenses (excluding impairments)	(15,371)	(11,188)
OPERATING SURPLUS	**2,700**	**1,531**
Finance costs		
Finance costs - interest expense	(420)	(419)
PDC dividends payable	(2,131)	(962)
Net finance costs	(2,551)	(1,381)
UNDERLYING SURPLUS	**149**	**150**

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2 Operating segments (continued)

Estates & Facilities includes depreciation costs.

HQ Services - includes HR & development, nursing & governance, finance, quality & pharmacy, trust management and interest costs

The Trust does not report surplus/deficit, operating income, finance costs or other comprehensive income by segment as part of its management information.

Transactions between reportable segments are accounted for at cost.

The types of products and services that the Trust generates its income from are:

- Bexley - includes Mental Health Inpatient, Mental Health Community and Community Health Services
- Bromley - includes Mental Health Inpatient and Mental Health Community Services
- Children and Young People - includes Child and Adolescent Mental Health services, Specialist community health services, Universal community health services, services for looked after children.
- Greenwich - inlcudes Mental Health Inpatient, Mental Health Community, IAPT and Community Health Services
- Adult Learning Disabilities - includes Community Teams, Day services and Inpatient services
- Forensic and Prisons - includes Medium and Low Secure services, Community Outreach team, Specialist physical and mental health services in Kent prisons.

Most of the Trust's income (more than 75%) is received from Clinical Commissioning Groups (CCGs) and NHS England, the majority of which is through block contracts. The Trust also earns income from cost and volume contracts with CCGs as well as clinical partnerships (S75 agreements) with local authorities. The Trust's income is generated in England.

3.1 Operating Income

	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000	Year ended 31 March 2017 TRUST £000	Year ended 31 March 2017 GROUP £000
Income from Activities				
NHS Foundation Trusts	**1,973**	**1,973**	2,341	2,341
NHS Trusts	**302**	**302**	283	283
CCGs and NHS England	**196,235**	**196,235**	197,296	197,296
Local Authorities	**20,142**	**20,142**	17,402	17,402
Non NHS	**5,066**	**5,066**	3,421	3,421
Total income from activities	**223,718**	**223,718**	220,743	220,743
Being:				
Cost and volume contract income	**2,373**	**2,373**	2,093	2,093
Mental health block contract income	**136,821**	**136,821**	135,929	135,929
Clinical partnerships providing mandatory services (including S75 agreements)	**5,790**	**5,790**	5,900	5,900
Community services block contract income	**58,022**	**58,022**	59,014	59,014
Private patient income	**12**	**12**	0	0
Other non-protected clinical income	**20,700**	**20,700**	17,807	17,807
	223,718	**223,718**	220,743	220,743
Other Operating Income				
Research and development	**39**	**39**	37	37
Education, training and research	**3,771**	**3,771**	3,874	3,874
Sustainability and Transformation Fund income	**3,006**	**3,006**	2,238	2,238
Other income **	**26,882**	**25,058**	20,087	18,530
NHS Charitable Funds: excluding investment income	**0**	**47**	0	93
Total other operating income	**33,698**	**31,921**	26,236	24,772
Total operating income	**257,416**	**255,639**	246,979	245,515
** Analysis of other operating income: Other				
PFI support income	**564**	**564**	0	0
Car parking	**772**	**772**	494	494
Estates recharges	**957**	**957**	1,001	1,001
Pharmacy sales	**6,120**	**6,120**	6,092	6,092
Catering	**80**	**80**	119	119
Property rentals	**7,809**	**7,809**	6,689	6,689
Other	**10,580**	**8,756**	5,692	4,135
	26,882	**25,058**	20,087	18,530

3.2 Commissioner Requested Services

	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000	Year ended 31 March 2017 TRUST £000	Year ended 31 March 2017 GROUP £000
Commissioner Requested Services	203,006	203,006	202,936	202,936
Non Commissioner Requested Services	20,712	20,712	17,807	17,807
Total income from activities	**223,718**	**223,718**	220,743	220,743

4. Operating Expenses

4.1 Operating expenses comprise:

	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000	Year ended 31 March 2017 TRUST £000	Year ended 31 March 2017 GROUP £000
Services from NHS Foundation Trusts	**2,617**	**2,617**	2,233	2,233
Services from NHS Trusts	**1,678**	**1,678**	3,036	3,036
Services from CCGs and NHS England	**680**	**680**	81	81
Purchase of healthcare from non NHS bodies	**12,774**	**12,774**	14,295	14,295
Directors' costs - executive directors	**1,066**	**1,066**	1,055	1,055
Directors' costs - non-executive directors	**153**	**153**	152	152
Staff costs **	**170,975**	**171,046**	172,324	172,389
Drug costs	**9,158**	**7,579**	8,692	7,118
Supplies and services - clinical	**5,621**	**5,631**	6,775	6,785
Supplies and services - general	**1,827**	**1,827**	2,034	2,050
Establishment	**6,648**	**6,648**	7,079	7,079
Transport	**1,173**	**1,173**	1,354	1,354
Premises	**16,422**	**16,422**	14,057	14,057
Bad debts	**720**	**720**	268	268
Movement in other provisions	**(448)**	**(448)**	(1,927)	(1,927)
Depreciation	**4,072**	**4,072**	3,319	3,319
Amortisation	**327**	**327**	11	11
Impairments *	**12,583**	**12,583**	5,130	5,130
Audit services - statutory audit	**91**	**91**	79	79
Audit services - quality accounts	**9**	**9**	17	17
Clinical negligence	**331**	**331**	555	555
Consultancy	**776**	**776**	505	505
Internal audit	**81**	**81**	82	82
Legal fees	**168**	**168**	198	198
Insurance	**217**	**217**	0	0
Training, courses and conferences	**1,615**	**1,615**	1,158	1,162
Patient travel	**372**	**372**	142	142
Car parking and security	**353**	**353**	0	0
Reconfiguration - (not included in staff costs)	**434**	**434**	446	446
Other	**8,935**	**8,963**	2,231	2,255
NHS Charitable funds: Other resources expended	**0**	**137**	0	128
	261,428	**260,095**	245,381	244,054

* Impairments are a result of changes in market price.

** Total staff costs in note 5 of £172,112k (Year ended 31 March 2017 £173,444k) include £1,066k (Year ended 31 March 2017 £1,055k) of executive directors' costs.

4.2 Auditor's remuneration

The Council of Governors appointed Deloitte LLP as external auditor of the Trust for the year commencing 1 April 2018. The audit fee for the statutory audit was £75,500 (2016/17, £65,500) excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011. The quality accounts fee was £7,500 (2016/17 £14,500) excluding VAT. Deloitte LLP also performed an independent examination of the charitable funds for a fee of £4,800 (excluding VAT) (2016/17 £4,800).

The engagement letter signed on 5 April 2018, included a liability cap of £1m for Deloitte LLP, its members, partners and staff (whether in contract, negligence or otherwise) in respect of all such services.

4.3 Profit on disposal of other property, plant and equipment

Profit on disposal all relates to unprotected assets.

4.4 Operating leases

4.4.1 Arrangements containing an operating lease:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Minimum lease payments	**3,614**	3,577

4.4.2 Future minimum lease payments due:

	Year ended 31 March 2018 £000	Year ended 31 March 2017 *Restated £000
Not later than 1 year	**3,361**	3,334
Later than 1 year and not later than 5 years	**7,083**	7,115
Later than 5 years	**18,604**	19,097
Total	**29,048**	29,546

Over 92% of the operating lease commitments are property leases with varying expiring dates.

The Trust also holds a number of operating leases for leased vehicles. The annual commitment for leased vehicles for the year ended 31 March 2018 was £1,173,001 (year ended 31 March 2017, £1,077,301)."

* The 31 March 2017 figures have been restated to exclude 2 buildings which are leased under PFI contracts.

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5 Employee costs and numbers

5.1 Employee costs

	Year ended 31 March 2018		
	Total £000	**Permanently Employed £000**	**Other £000**
Salaries and wages	**129,367**	128,836	531
Social Security Costs	**13,086**	13,086	0
Apprenticeship Levy	**611**	611	0
Employer contributions to NHS Pension Scheme	**15,372**	15,372	0
Agency/contract staff	**13,676**	0	13,676
Total	**172,112**	**157,905**	**14,207**

	Year ended 31 March 2017		
	Total £000	**Permanently Employed £000**	**Other £000**
Salaries and wages	**127,642**	127,526	116
Social Security Costs	**12,849**	12,849	0
Employer contributions to NHS Pension Scheme	**15,206**	15,206	0
Agency/contract staff	**17,747**	0	17,747
Total	**173,444**	155,581	17,863

Total employer's contributions payable to the defined contribution pension scheme in the year ended 31 March 2018 were £15,372,000 (31 March 2017, £15,206,000).

5.2 Average number of employees

	Year ended 31 March 2018 Total Number	Year ended 31 March2017 Total Number
Medical and dental	165	160
Administration and estates	684	691
Healthcare assistants and other support staff	486	479
Nursing, midwifery and health visiting staff	1,003	1,051
Scientific, therapeutic and technical staff	704	691
Social care staff	85	84
Agency and contract staff	133	240
Bank staff	301	259
Total	**3,561**	**3,655**

5.3 Retirements due to ill-health

During the year there were 2 early retirements on the grounds of ill-health (31 March 2017, 3 in total). The estimated additional pension liabilities of these ill-health retirements will be £350,029 (31 March 2017, £172,698). The cost of these ill-health retirements will be borne by NHS Pensions.

5.4 Exit packages

During the year there were 9 exit packages (31 March 2017, 28) at a cost of £480,000 (31 March 2017, £792,000).

Year ended 31 March 2018			
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed ***	**Total number of exit packages by cost band**
<£10,000	1	2	3
£10,001-£25,000	0	0	0
£25,001-£50,000	2	1	3
£50,001-£100,000	1	0	1
£100,001-£150,000	1	0	1
£150,001-£200,000	1	0	1
> £200,000	0	0	0
Total number of exit packages by type	**6**	**3**	**9**
Total resource cost £'000	**423**	**57**	**480**

*** of which**	Number agreed	Total value of agreements (£'000)
Contractual payments in lieu of notice	3	57

Year ended 31 March 2017			
Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	5	0	5
£10,001-£25,000	12	0	12
£25,001-£50,000	8	0	8
£50,001-£100,000	1	0	1
£100,001-£150,000	2	0	2
£150,001-£200,000	0	0	0
> £200,000	0	0	0
Total number of exit packages by type	28	0	28
Total resource cost £'000	792	0	792

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5.5 Directors' remuneration (Key management personnel)

Short-term employee benefits

TThe aggregate remuneration and other benefits receivable by executive and non-executive directors during the year was £1,219,140 (2016/17, £1,206,906). This is made up of aggregate salaries of £919,520 (2016/17, £913,788), other remuneration of £26,031 (2016/17, £21,769), clinical excellence awards of £36,192 (2016/17, £35,832), employer contributions to NHS pensions schemes £115,907 (2016/17, £115,904) and employers national insurance contributions £121,490 (2016/17, £119,613).

The highest paid director's salary in the year was in the band £205,000 - 210,000 (2016/17 £205,000 - 210,000). The highest paid director participated in a defined benefit pension scheme. The total accrued pension at age 60 at 31 March 2018 of this director was in the band £90,000 - 95,000 (2016/17 £85,000 - 90,000) and the lump sum at age 60 related to accrued pension at 31 March 2018 was in the band £280,000 - 285,000 (2016/17 - £265,000 - 270,000).

Post-retirement employee benefits

Employer contributions to NHS pensions schemes in respect of executive and non executive directors in the year were £115,907 (2016/17, £115,904).

The total number of executive and non executive directors to whom benefits are accruing under defined benefit schemes is 7 (2016/17, 6 in total).

6. Finance income

	Year ended 31 March 2018 GROUP £000	**Year ended 31 March 2018 TRUST £000**	Year ended 31 March 2017 GROUP £000	Year ended 31 March 2017 TRUST £000
Interest on loans and receivables	**146**	**146**	211	211
	146	**146**	211	211

Interest on loans and receivables consists of interest earned on the Trust's bank accounts and treasury deposits.

7. Finance costs - interest expense

	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Interest obligations under finance leases	**57**	61
Finance costs in PFI obligations-main finance costs	**571**	592
Finance costs in PFI obligations-contingent finance costs	**443**	409
Unwinding of discount on provisions	**0**	5
	1,071	1,067

8. Intangible assets

	Software Licences	Development Expenditure	Year ended 31 March 2018 £000	Year ended 31 March 2017 £000
Valuation/gross cost brought forward 1 April	**99**	**0**	**99**	99
Additions	**0**	**1,388**	**1,388**	0
Reclassifications	**0**	**2,539**	**2,539**	0
Gross cost at 31 March	**99**	**3,927**	**4,026**	99
Amortisation brought forward 1 April	**19**	**0**	**19**	8
Provided during the year	**11**	**316**	**327**	11
Amortisation at 31 March	**30**	**316**	**346**	19
Net book value at 31 March	**69**	**3,611**	**3,680**	80

9. Property, plant and equipment

2017/18	Land	Buildings excluding dwellings	Assets under construction	Plant & Machinery	Transport equipment	Information Technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	18,434	99,114	26,053	0	86	3,663	1,819	149,169
Additions purchased	0	1,829	7,933	40	0	0	105	9,907
Reclassifications	0	33,207	(33,829)	0	0	(2,208)	0	(2,830)
Impairments charged to operating expenses	(126)	(12,457)	0	0	0	0	0	(12,583)
Impairments charged to the revaluation reserve	0	(9,790)	0	0	0	0	0	(9,790)
Revaluations	3,585	(3,572)	0	0	0	0	0	13
Transfers to/from assets held for sale	(3,088)	98	0	0	0	0	0	(2,990)
Disposals / derecognition	(99)	(174)	0	0	0	0	0	(273)
Cost or Valuation at 31 March 2018	**18,707**	**108,255**	**157**	**40**	**86**	**1,455**	**1,924**	**130,623**
Accumulated Depreciation as at 1 April 2017	0	0	0	0	86	568	720	1,374
Charged during the year	0	3,572	0	2	0	277	221	4,072
Reclassifications	`0	0	0	0	0	(291)	0	(291)
Revaluations	0	(3,572)	0	0	0	0	0	(3,572)
Accumulated Depreciation as at 31 March 2018	**0**	**0**	**0**	**2**	**86**	**554**	**941**	**1,583**
Net Book Value								
Owned	17,374	95,542	157	38	0	901	983	114,995
PFI contracts	1,332	11,584	0	0	0	0	0	12,916
Finance leased	0	1,128	0	0	0	0	0	1,128
Total at 31 March 2018	**18,706**	**108,254**	**157**	**38**	**0**	**901**	**983**	**129,039**

Notes to the financial statements
for the year ended 31 March 2018

9 Property, plant and equipment continued

2016/17	Land	Buildings excluding dwellings	Assets under construction	Plant & Machinery	Transport equipment	Information Technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	18,214	90,501	10,735	0	86	3,451	728	123,714
Additions purchased	0	9,314	18,431	0	0	2,039	879	30,663
Reclassifications	0	5,650	(3,113)	0	0	0	212	2,749
Impairments charged to operating expenses	(200)	(3,103)	0	0	0	(1,827)	0	(5,130)
Revaluations	525	(3,053)	0	0	0	0	0	(2,528)
Disposals / derecognition	(105)	(195)	0	0	0	0	0	(300)
Cost or Valuation at 31 March 2017	**18,434**	**99,114**	**26,053**	**0**	**86**	**3,663**	**1,819**	**149,168**
Accumulated Depreciation as at 1 April 2016	0	0	0	0	86	0	718	804
Charged during the year	0	2,749	0	0	0	568	2	3,319
Revaluations	0	(2,749)	0	0	0	0	0	(2,749)
Accumulated Depreciation as at 31 March 2017	**0**	**0**	**0**	**0**	**86**	**568**	**720**	**1,374**
Net Book Value								
Owned	17,270	83,438	26,053	0	0	3,095	1,099	130,954
PFI contracts	1,164	13,086	0	0	0	0	0	14,250
Finance leased	0	2,590	0	0	0	0	0	2,590
Total at 31 March 2017	**18,434**	**99,114**	**26,053**	**0**	**0**	**3,095**	**1,099**	**147,794**

The Trust's estate was revalued at 31 January 2018 by independent valuers.

The valuation methods used at 31 January 2018 were as follows: Specialised properties-depreciated replacement cost (DRC); Operational Non specialised assets-existing use value (EUV); Investment Properties market value (MV).

DRC is defined as the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation. In general the Trust's valuers have relied upon the floor areas of the existing buildings in assuming modern equivalent assets will require the same floor area, however the Trust has identified that a small number of their existing buildings are inefficient with areas that are not occupied for operational purposes and therefore consider any replacement of those assets would require a reduced floor area. Having derived the modern equivalent replacement cost of the existing buildings the valuers have depreciated these values to reflect age and obsolescence. Each building is assumed to have a maximum life expectancy from new of 60 years with the buildings depreciated on a straight line basis from 100% at completion of construction to zero, once their life span has been met.

The net book value of assets held under PFI agreements and finance leases at the statement of financial position date are as follows:

	Land	Buildings, excluding dwellings	Total
	£000	£000	£000
At 31 March 2018			
PFI	**1,332**	**11,584**	**12,916**
Finance leases	**0**	**1,128**	**1,128**
At 31 March 2017			
PFI	1,164	13,086	14,250
Finance leases	0	2,590	2,590

The total amount of depreciation charged to the Statement of Comprehensive Income in respect of assets held under PFI and finance lease agreements :

Depreciation - 31 March 2018			
PFI	**0**	**402**	**402**
Finance leases	**0**	**82**	**82**
Depreciation - 31 March 2017			
PFI	0	464	464
Finance leases	0	112	112

Assets Held for sale

	Land	Buildings	Total
	£000	£000	£000
Opening at 31 March 2017	77	143	220
Assets classified as held for sale in the year	3,140	0	3,140
Assets no longer classified as held for sale	(53)	(97)	(150)
Disposals in the year	**(24)**	**(46)**	**(70)**
NBV of assets held for sale at 31 March 2018	**3,140**	**0**	**3,140**

Notes to the financial statements
for the year ended 31 March 2018

10 Inventories

	Year ended 31 March 2018 TRUST	Year ended 31 March 2018 GROUP	Year ended 31 March 2017 TRUST	Year ended 31 March 2017 GROUP
	£000	£000	£000	£000
Materials	**336**	**547**	287	484

The inventories figure relates to stocks of drugs.
Expenditure on drugs in the year was £7,579,000 (31 March 2017, £7,118,000). No amounts were written off in the year (31 March 2017, £nil).

11.1 Trade and other receivables

	Year ended 31 March 2018 TRUST	Year ended 31 March 2018 GROUP	Year ended 31 March 2017 TRUST	Year ended 31 March 2017 GROUP
	£000	£000	£000	£000
Current Assets:				
NHS receivables	**13,416**	**13,416**	12,472	12,472
Provision for impaired receivables	**(3,573)**	**(3,573)**	(2,895)	(2,895)
Prepayments	**3,817**	**3,821**	3,494	3,494
Accrued Income	**3,046**	**3,014**	1,445	1,436
VAT receivable	**789**	**890**	1,272	1,308
Non NHS receivables	**4,511**	**3,705**	2,670	2,287
NHS Charitable funds: Trade and other receivables	**0**	**0**	0	9
TOTAL	**22,006**	**21,273**	18,458	18,111
Non Current Assets:				
NHS receivables	279	279	279	279
Provision for impaired receivables	(279)	(279)	(279)	(279)
TOTAL	0	0	0	0

11.2 Provision for impairment of receivables

	31 March 2018	31 March 2017
	£000	£000
At 1 April	**3,174**	3,163
Increase in provision	**2,904**	268
Amounts utilised	**(42)**	(257)
Unused amounts reversed	**(2,184)**	0
At 31 March	**3,852**	3,174
Current assets	**3,573**	2,895
Non current assets	**279**	279
At 31 March	**3,852**	3,174

11.3 Analysis of financial assets

	31 March 2018 £000	31 March 2017 £000
Ageing of impaired financial assets		
0 - 30 days	**1,369**	542
30-60 days	**587**	126
60-90 days	**340**	6
90-180 days	**320**	473
180-360 days	**1,236**	2,027
Total	**3,852**	3,174

	31 March 2018 £000	31 March 2017 £000
Ageing Ageing of non-impaired financial assets past their due date		
0 - 30 days	**0**	0
30-60 days	**2,566**	2,043
60-90 days	**512**	228
90-180 days	**186**	1,421
180-360 days	**108**	905
Total	**3,372**	4,597

The Trust has not provided for these financial assets as there has been no significant change in their credit quality and the amounts are still considered recoverable. Financial assets that are not impaired and are not past their due date are considered recoverable.

12 Cash and cash equivalents

	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000	Year ended 31 March 2017 TRUST £000	Year ended 31 March 2017 GROUP £000
Balance at 1 April	**62,419**	**63,191**	84,962	86,283
Net change in year	**(1,893)**	**(1,786)**	(22,543)	(23,092)
Balance at 31 March	**60,526**	**61,405**	62,419	63,191
Made up of:				
Cash with the Government Banking Service	**20,505**	**20,505**	22,382	22,382
Cash at commercial banks and in hand	**21**	**223**	37	77
Deposits with the National Loan Fund	**40,000**	**40,000**	40,000	40,000
NHS charitable funds	**0**	**677**	0	732
Cash and cash equivalents as in statement of financial position and statement of cash flows	**60,526**	**61,405**	62,419	63,191

13.1 Trade and other payables

	Year ended 31 March 2018 TRUST £000	Year ended 31 March 2018 GROUP £000	Year ended 31 March 2017 TRUST £000	Year ended 31 March 2017 GROUP £000
Current:				
NHS payables	**7,277**	**7,277**	5,088	5,088
Trade payables-capital	**957**	**957**	1,935	1,935
Social security and pension costs	**5,577**	**5,579**	5,310	5,310
Other payables	**6,026**	**6,189**	8,591	8,637
Accruals	**15,086**	**15,046**	10,239	10,165
PDC dividend payable	**45**	**45**	579	579
NHS Charitable funds: Trade and other payables	**0**	**31**	0	5
Total current trade and other payables	**34,968**	**35,124**	31,742	31,719

13.2 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current:		
Obligations under finance leases	**73**	70
Obligations under PFI contracts	**334**	312
	407	382
Non-current:		
Obligations under finance leases	**898**	971
Obligations under PFI contracts	**8,407**	8,742
Total non-current borrowings	**9,305**	**9,713**

13.3 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current:		
Deferred income	**17,031**	14,427

13.4 Prudential borrowing limit

This is no longer a required disclosure for NHS Foundation Trusts.

13.5 Finance lease obligations

	31 March 2018 £000	31 March 2017 £000
Gross lease liabilities of which liabilities are due:		
Not later than 1 year	**127**	127
Later than 1 year and not later than 5 years	**508**	508
Later than 5 years	**1,004**	1,131
	1,639	1,766
Less finance charges allocated to future years	**(668)**	(725)
	971	1,041

Finance lease obligations relate to the lease of buildings at Bridgeways Day Hospital and Wallace Medical Centre. No contingent rent was paid and there is no option in the lease to purchase the asset.

Minimum lease payments are not disclosed at present value as rent increases by RPI annually which is expected to be equal to any inflation and therefore there will not be a significant difference.

13.6 PFI obligations

	31 March 2018 £000	31 March 2017 £000
Gross PFI liabilities of which liabilities are due:		
Not later than 1 year	**883**	883
Later than 1 year and not later than 5 years	**3,534**	3,534
Later than 5 years	**10,716**	11,600
	15,133	16,017
Less finance charges allocated to future years	**(6,392)**	(6,963)
	8,741	9,054

Under IAS 17, disclosure of the net present value of liabilities is required. The figures above are not reported at net present value however note 20.3 discloses the fair value of the finance lease obligations under the PFI contract.

Notes to the financial statements
for the year ended 31 March 2018

14 Provisions

	Pensions early departure costs £000	Legal claims and other £000	Redundancy £000	Total £000
17/18				
At 1 April 2017	1,949	3,642	483	**6,074**
Arising during the year	0	1,162	651	**1,813**
Utilised during the year	(1,629)	(92)	(423)	**(2,144)**
Reversed unused	(275)	(1,925)	(31)	**(2,231)**
Unwinding of discount	0	0	0	0
At 31 March 2018	**45**	**2,787**	**680**	**3,512**
Current	**45**	**2,787**	**680**	**3,512**
Non-current	**0**	**0**	**0**	**0**
	45	**2,787**	**680**	**3,512**
Expected timing of cash flows:				
31 March 2018				
Within one year	45	2,787	680	**3,512**
Between one and five years	0	0	0	**0**
After five years	0	0	0	**0**
	45	2,787	680	**3,512**
31 March 2017				
Within one year	209	3,642	483	**4,334**
Between one and five years	690	0	0	**690**
After five years	1,050	0	0	**1,050**
	1,949	3,642	483	**6,074**

The provision for pensions early departure costs is stated subject to the uncertainty about the length of time and amounts over which this will be payable.

During the year the trust took up the option to capitalise existing premature retirement costs and settled all outstanding cases with NHS Business Services Authority.

Legal claims and other provisions include the following:
Provisions for other legal claims is stated subject to uncertainty about the outcome of legal proceedings.

£nil (31 March 2017, £1,624,084) relating to provisions for overseas income and non contracted income covering activity in 2016/17.

Amounts excluded from total provisions above:
£1,954,863 (31 March 2017, £1,342,270) is included in the provisions in the financial statements of NHS Resolution at 31 March 2018 in respect of clinical negligence liabilities of the Trust.

15 Capital Commitments

Commitments under capital expenditure contracts relating to property, plant and equipment at 31 March 2018 were £596,887 (31 March 2017 £4,536,262).

16 Contingencies

	31 March 2018 £000	31 March 2017 £000
Contingent liabilities	**(46)**	(20)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**(46)**	(20)

Contingent liabilities relate to NHS Resolution legal claims where it is estimated that it is not probable that the Trust will be liable for the excess under the Liabilities to Third parties Scheme and Property Expenses Scheme.

Legal claims under these schemes where it is probable that the Trust will be liable for the excess are included in provisions.

Notes to the financial statements
for the year ended 31 March 2018

Intentionally Blank

Notes to the financial statements
for the year ended 31 March 2018

17 Related Party Transactions

The ultimate controlling party of the Trust is the Department of Health and Social Care of the UK Government. During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Oxleas NHS Foundation Trust other than those set out below. During the year Oxleas NHS Foundation Trust has had material transactions with the following NHS bodies:

	Payments to Related Party 17/18	**Receipts from Related Party 17/18**	**Amounts owed to Related at 31 March 2018**	**Amounts due from Related Party at 31 March 2018**	Payments to Related Party 16/17	Receipts from Related Party 16/17	Amounts owed to Related Party at 31 March 2017	Amounts due from Related Party at 31 March 2017
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Department of Health	**0**	**0**	**117**	**0**	0	0	0	0
NHS Bexley CCG	**542**	**45,849**	**359**	**1,400**	896	44,459	365	861
NHS Bromley CCG	**0**	**34,254**	**0**	**60**	144	34,232	144	18
NHS Croydon CCG	**0**	**565**	**0**	**96**	0	293	0	80
NHS Greenwich CCG	**175**	**65,425**	**175**	**3,006**	721	70,785	495	5,341
NHS Lewisham CCG	**0**	**1,669**	**0**	**550**	0	1,339	0	94
NHS England	**946**	**52,692**	**150**	**5,552**	2	50,142	0	2,284
Kings College Hospital NHS Foundation Trust	**1,235**	**8,767**	**760**	**1,590**	1,271	8,428	1,514	1,659
Dartford and Gravesham NHS Trust	**410**	**5,857**	**211**	**1,386**	514	4,328	250	1,064
Lewisham and Greenwich NHS Trust	**2,957**	**854**	**1,171**	**313**	2,738	770	1,113	14
Health Education England	**1**	**3,714**	**1**	**0**	6	4,172	0	728
The Department of Health is the parent department. In addition, the Trust has had material transactions with the following local Government bodies:								
London Borough of Bexley	**37**	**1,642**	**520**	**59**	106	4,470	1,085	84
London Borough of Bromley	**0**	**3,128**	**464**	**30**	0	1,459	417	0
London Borough of Greenwich	**95**	**15,459**	**497**	**1,165**	250	11,556	342	0

Amounts owed to and from related parties are trade receivable and trade payable balances. Payments from related parties mainly relates to income from contracts for healthcare services.
Payments to related parties are for purchases of healthcare and other services.
The Trust has had transactions with Oxleas NHS Foundation Trust Charitable Fund as follows:

Oxleas NHS Foundation Trust Charitable Fund	**0**	**5**	**0**	**21**	0	11	9	0

The receipts from Oxleas NHS Foundation Trust Charitable Fund relate to a recharge of administrative costs. The Trustees of Oxleas NHS Foundation Trust Charitable Fund are also members of the NHS Foundation Trust Board.
The audited accounts of the Funds Held on Trust are available from the Director of Finance, Oxleas NHS Foundation Trust.
The Trust has had transactions with Oxleas Prison Services Limited as follows:

Oxleas Prison Services Limited	**3,444**	**1,830**	**1**	**811**	3,233	1,560	1	402

The receipts from Oxleas Prison Services Limited relate to a recharge of staff and administrative costs.
The payments to Oxleas Prison Services Limited relate to drugs costs.
The Trust has had transactions with its joint venture SARD JV Limited as follows:

SARD JV Limited	**0**	**0**	**0**	**100**	0	0	0	100

The Trust has provided a loan to the joint venture as disclosed in note 1.24 to the financial statements.

Notes to the financial statements
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18 Private Finance Transactions

Service element of PFI schemes deemed to be on-statement of financial position

The Trust is party to a PFI scheme with Bexley PPP Health Services Ltd ("the partner"). The scheme was implemented in a phased 3 year programme. Three buildings were opened in 1999/2000, two buildings in 2000/2001 and one building in 2001/2002. 2 of the properties - Erith Centre and the Bexleyheath Centre, 4 Emerton Close are used to deliver community mental health and outpatient services and to accommodate Trust offices; the Woodlands Unit is used to deliver acute inpatient services; 3 properties - 42 Oakwood Drive, Somerset Villa and North House are used to deliver residential services for mental health and learning disability clients. The substance of the contract is that the Trust has a finance lease and payments comprise 2 elements - imputed finance lease charges and service charges (see note 1.7). Under IFRIC 12 the assets are treated as assets of the Trust.

The lease period is 50 years commencing in 2000 and expiring in 2050. There are no re-pricing dates in respect of the unitary payment. RPI is applied annually at 1st April based on the table published by the Office for National Statistics. Market testing in respect of maintenance is required 30 years after the commencement date and on a quinquennial basis thereafter. Market testing in respect of items other than maintenance is required 5 years after the commencement date and on a quinquennial basis thereafter.

Ownership of the land and buildings reverts to the Trust at the end of the lease period, i.e. in 2050. Terminal options include those for the following reasons: gross negligence of the partner; insolvency of the partner; non-payment of loan instalments by the partner to the lending bank.

An element of the unitary payments is applied to a "sinking fund" for the purpose of funding significant capital expenditure on the properties as required over the period of the lease.

Following dissolution of South London Healthcare NHS Trust in October 2013 the PFI scheme for Elmstead & Newsland at Queen Marys Hospital, Sidcup, Kent was transferred to the Trust. The partner for the QMH PFI scheme is Bexley PP Health Services Ltd and the lease on the asset expires on 31 March 2029.

	Year ended 31 March 2018	Year ended 31 March 2017
	£000	£000
Amounts included within operating expenses in respect of the 'service' element of PFI schemes deemed to be on Statement of Financial Position	**886**	864
Net charge to operating expenses	**886**	864
Commitments in respect of the service element of the PFI:	**£000**	£000
Within one year	**909**	875
2nd to 5th years (inclusive)	**3,636**	3,501
Later than five years	**18,897**	19,070
Total	**23,442**	23,446

Non current asset values

The following non current assets are held under the PFI schemes:

	Buildings £000	**Land £000**	**Total £000**
31 March 2018			
Erith Centre, Park Crescent, Erith, Kent	**216**	**116**	**332**
42 Oakwood Drive, Barnehurst, Kent	**354**	**191**	**545**
4 Emerton Close, Bexleyheath, Kent	**377**	**203**	**580**
Woodlands Unit, Queen Mary's Hospital, Sidcup, Kent	**10,637**	**352**	**10,989**
North House, 237 Erith Road, Bexleyheath, Kent	**-**	**470**	**470**
Total	**11,584**	**1,332**	**12,916**
31 March 2017			
Erith Centre, Park Crescent, Erith, Kent	214	116	330
42 Oakwood Drive, Barnehurst, Kent	312	168	480
4 Emerton Close, Bexleyheath, Kent	377	203	580
Woodlands Unit, Queen Mary's Hospital, Sidcup, Kent	11,294	352	11,646
Somerset Villa, Goldie Leigh, Lodge Hill, London SE2	876	143	1,019
North House, 237 Erith Road, Bexleyheath, Kent	13	182	195
Total	13,086	1,164	14,250

19. Financial Instruments

Financial Reporting Standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks an entity faces in undertaking its activities.

The Trust is not exposed to significant financial risk factors arising from financial instruments. Because of the continuing service provider relationship that the Trust has with local Clinical Commissioning Groups and the way those CCGs are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Credit Risk

Credit risk is the possibility that other parties might fail to pay amounts due to the Trust. Credit risk arises from deposits with banks as well as credit exposures to the Trust's commissioners and other receivables. Surplus operating cash is only invested in line with the Trust's treasury management policy which allows investments with the Government Banking Service (GBS) and the National Loan Fund (NLF) only. The trust's cash assets at the year end are held with the Government Banking Service and deposits with the National Loan Fund.

The Trust's net operating costs are incurred largely under annual service agreements with local Clinical Commissioning Groups and Local Authorities, which are financed from resources voted annually by Parliament. An analysis of the ageing of receivables and provision for impairment can be found at Note 11.1 "Trade and other receivables".

Market risk
Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. Market risk comprises three types of risk, where the fair value or future cash flows could fluctuate because of movements in the underlying interest rate risk, currency risk, and price risk.

Interest rate risk
The Trust holds short term investments throughout the year in commercial banks as agreed in its treasury management policy. At 31 March 2018, the Trust invests only in the Government Banking Service and National Loan Fund. Other than cash and short term deposits as noted, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash-flows are substantially independent of changes in market interest rates.

Price risk
The Trust has a number of contractual arrangements which are linked to the UK Retail Price Index (RPI) therefore the Trust is exposed to price risk in line with movements in the UK economy.

Liquidity risk
Liquidity risk is the possibility that the Trust might not have funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities.

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20.1 Financial assets by category

Loans and receivables	31 March 2018 TRUST £000	31 March 2018 GROUP £000	31 March 2017 TRUST £000	31 March 2017 GROUP £000
Assets as per statement of financial position				
NHS Receivables - Revenue	**13,416**	**13,416**	12,472	12,472
Provision for impaired receivables	**(3,573)**	**(3,573)**	(2,895)	(2,895)
Accrued income	**3,046**	**3,014**	1,445	1,436
Other receivables - Revenue	**4,511**	**3,705**	2,670	2,287
Cash and cash equivalents	**60,526**	**60,728**	62,419	62,459
NHS Charitable funds - cash & cash equivalents	**0**	**677**	0	732
Total at 31 March	**77,926**	**77,967**	76,111	76,491

20.2 Financial liabilities by category

Financial liabilities at amortised cost	31 March 2018 TRUST £000	31 March 2018 GROUP £000	31 March 2017 TRUST £000	31 March 2017 GROUP £000
Liabilities as per statement of financial position				
NHS payables	**7,277**	**7,277**	5,088	5,088
Other payables	**6,026**	**6,189**	8,591	8,637
Accruals	**15,086**	**15,046**	10,239	10,165
Trade payables - capital	**957**	**957**	1,935	1,935
Obligations under finance leases	**971**	**971**	1,041	1,041
Obligations under PFI contracts	**8,741**	**8,741**	9,054	9,054
Provisions under contract	**0**	**0**	0	0
NHS Charitable funds: trade and other payables	**0**	**31**	0	5
Total at 31 March	**39,058**	**39,212**	35,948	35,925

20.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the Trust's financial assets and liabilities:

	31 March 2018 Book value £000	31 March 2018 Fair value £000	31 March 2017 Book value £000	31 March 20176 Fair value £000	
Financial assets					
NHS Receivables - Revenue	**13,416**	**13,416**	12,472	12,472	
Provision for impaired receivables	**(3,573)**	**(3,573)**	(2,895)	(2,895)	
Accrued income	**3,046**	**3,046**	1,445	1,445	
Other receivables - Revenue	**4,511**	**4,511**	2,670	2,670	
Cash and cash equivalents	**60,526**	**60,526**	62,419	62,419	
TRUST TOTALS	**77,926**	**77,926**	76,111	76,111	
OPS Limited	**(636)**	**(636)**	(352)	(352)	
NHS Charitable funds	**677**	**677**	732	732	
GROUP TOTALS	**77,967**	**77,967**	76,491	76,491	
Financial liabilities					
NHS payables	**7,277**	**7,277**	5,088	5,088	
Other payables	**6,026**	**6,026**	8,591	8,591	
Accruals	**15,086**	**15,086**	10,239	10,239	
Trade payables - capital	**957**	**957**	1,935	1,935	
Obligations under finance leases due < 1 year	**73**	**73**	70	70	
Obligations under finance leases due > 1 year	**898**	**898**	971	971	Note b
Obligations under PFI contracts due < 1 year	**334**	**334**	312	312	
Obligations under PFI contracts due > 1 year	**8,407**	**6,706**	8,742	6,978	Note a
TRUST TOTALS	**39,058**	**37,357**	35,948	34,184	
OPS Limited	**123**	**123**	(28)	(28)	
NHS Charitable funds	**31**	**31**	5	5	
GROUP TOTALS	**39,212**	**37,511**	35,925	34,161	

Notes

a To obtain fair value, cash flows have been discounted at prevailing market interest rates for finance leases for a similar term. As no precise interest rate could be determined the rate has been calculated as the mid point between the base rate at the inception of the lease, plus the risk premium, and the base rate at 31 March 2018, plus the risk premium.

b Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

Book value is assumed to be a reasonable approximation for fair value for current financial assets and liabilities. Fair values for non current liabilities have been estimated using valuation techniques categorised as Level 3 in the fair value hierarchy.

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20.4 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
Less than one year	**29,907**	26,212
In more than one year but not more than two years	**358**	334
In more than two years but not more than five years	**1,572**	1,516
In more than five years	**7,375**	7,863
Total	**39,212**	35,925

21 Third Party Assets

The Trust held £377,586 cash at bank and in hand at 31 March 2018 (31 March 2017, £394,203) which relates to monies held by the Trust on behalf of patients. This has been excluded from cash and cash equivalents reported in the accounts.

22 Losses and Special Payments

There were 17 cases of losses and special payments paid during the year (31 March 2017, 37)

	2017/18 Number	2017/18 £'000	2016/17 Number	2016/17 £'000
Loss of cash - other	**0**	**0**	2	0
Bad debts and claims abandoned - other	**2**	**0**	11	1
TOTAL LOSSES	**2**	**0**	13	1
Special Payments under legal obligation	**11**	**25**	8	59
Ex gratia payments in respect of personal effects	**3**	**1**	16	4
Ex gratia payments in respect of other	**1**	**1**	0	0
TOTAL SPECIAL PAYMENTS	**15**	**27**	24	63
TOTAL LOSSES AND SPECIAL PAYMENTS	**17**	**27**	37	64

During the year there were no cases exceeding £250,000 (31 March 2017, no cases).

Losses and special payments are reported on an accruals basis excluding provisions for future losses.

Notes to the financial statements

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23 Consolidation of charitable funds

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's.

Oxleas NHS Foundation Trust is the Corporate Trustee of Oxleas NHS Foundation Trust Charitable Funds. The charity is deemed to be a subsidiary under the prescriptions of IAS 27. International Accounting Standards dictate that consolidated accounts should be prepared, that include the result and Statement of Financial Position of this subsidiary undertaking.

HM Treasury previously granted dispensation to the application of IAS 27 (revised) by NHS foundation trusts solely in relation to the consolidation of NHS charitable funds. From 2013/14, the Treasury dispensation was no longer available. Consequently in these financial statements the trust has consolidated material NHS charitable funds which are determined to be subsidiaries.

Oxleas NHS Foundation Trust is the sole beneficiary of Oxleas NHS Foundation Trust Charitable Funds. The charity registration number is 1061424 and the registered address is Pinewood House, Pinewood Place, Dartford, Kent DA2 7WG. The charity is domiciled in the UK. Accounts for the charity can be obtained from www.charity-commission.gov.uk.

The charity's total reserves is analysed between restricted and unrestricted funds as below:

	31 March 2018 £'000	31 March 2017 £'000
Unrestricted funds:		
Unrestricted income funds	**315**	377
Restricted funds:		
Restricted income funds	**331**	359
TOTAL CHARITABLE FUND RESERVES		
	646	736

Unrestricted funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds are accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They can also represent capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

24 Events after the reporting period

There are no material events occurring after the reporting period at 31 March 2018