



Annual report and accounts 2013/14



Improving mental health wellbeing

Birmingham and Solihull
Mental Health NHS Foundation Trust

Annual report and accounts 2013/14

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National Health Service Act 2006*

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Welcome to our Trust

We are pleased to introduce you to the annual report for Birmingham and Solihull Mental Health NHS Foundation Trust for the 12 month period from April 1, 2013 to March 31, 2014.

It was a year of significant changes in the membership of our Board, with five new members joining in the 12 months. We have worked hard to maintain focus and continuity of approach and the changes have been positive in refreshing the way the whole Board interacts with staff throughout the organisation.

The year began with a renewed focus on quality across our Trust, embedded in our corporate strategy for 2013-16, which was launched in April 2013. Throughout 2013/14 the Trust has remained focused on how our vision, values and strategic ambitions will deliver quality care and outcomes for service users, their carers and families and we have continued to work hard to improve the services we provide and the experience of service users and carers. There have been a number of developments during the year that have helped us in this aim and these are highlighted within this report.

Our Service Improvement Programme has led to a new model of care, initially for adult community mental health teams, which will improve the way service users access our services and increase the quality of care they receive by increasing face to face contact time with clinicians and improving transition between and out of services. The new model and ways of working will be embedded during the coming year, with mobile working being piloted which will transform the way our community staff work and enable them to spend more time with service users.

There have also been developments to our estate which have enabled us in turn to develop and improve our services. In December 2013, former Premier League footballer Stan Collymore, who has championed mental health awareness, officially opened the Tamarind male medium secure facility in Bordesley Green. The unit became fully operational during 2013/14 and has allowed some service users to move back to Birmingham from units elsewhere in the country, closer to family and carer support networks. Major developments at our Ardenleigh building in Erdington are providing state of the art accommodation for young people in our Forensic CAMHS service and improving the service we are able to provide in our women's forensic services on the site. Our estates strategy for 2014-19 will continue to support the redesign of services and new ways of working to enable us to provide the best quality care.

We continue to take a partnership approach to delivering services and have demonstrated that this can be a real driver for change. The 'street triage' pilot that we launched in January 2014 with West Midlands Police and West Midlands Ambulance Service has attracted a great deal of interest, with visits from two local MPs and positive media coverage both locally and nationally, including a feature on BBC's The One Show. We are now working with British Transport Police on an innovative pilot to prevent suicides on our railways. Our RAID liaison psychiatry service which we deliver in partnership with acute trusts, was highlighted as good practice in a keynote speech by Deputy Prime Minister Nick Clegg on the national mental health agenda and also in the Department of Health's national suicide report published in January 2014.

Partnership working has also been evident in our work to engage with our communities, with just a few examples of this being our Community Experts Network, our work with Time to Change on engaging with young African and Caribbean men, and our work with Birmingham Repertory Theatre on 'Bedlam, the Festival of Mad Ideas'. We also provide a number of our services in partnership with other agencies, including the addiction services in Wolverhampton which commenced in April 2013, and in Solihull, which we once again won the tender to provide from April 2014.

The 2013 National Patient Survey showed that we have improved against priority areas in relation to giving patients a copy of their care plan and providing information about medication, however there is still work to do on improving the quality of care planning, involving family and support networks and referring to partner agencies. As well as the national survey, we gather a wealth of useful information about where we need to make improvements via our own real time patient feedback. We have now received a total of 4,000 completed surveys, with further expansion of the project planned in the next year.

The year has, however, seen a number of significant challenges for our Trust. These include unprecedented levels of demand with occupancy levels of near 97% in year. This has meant that we have had a number of adult acute patients who we have not been able to admit and have had to place out of area. This is coupled with increasing pressure across the health economy to meet the affordability gap in the NHS and the increasing use of large scale competitive tendering processes by our commissioners.

We have been working hard during the year to ensure that mental health has parity of esteem both locally, for example in the Better Care Fund, and nationally, for example in discussions about the contribution of mental health services to urgent care capacity as evidenced by our RAID service. We negotiated with commissioners a reduction in tariff prices of 1.5 per cent, in line with acute trusts, rather than the planned 1.8 per cent, on the basis that this would enable us to fund the implementation of the Francis Report recommendations, which for our Trust means increasing inpatient staffing. Parity of esteem for mental health services is something we will continue to campaign for in 2014/15.

As a Trust we place a great deal of importance on engaging, involving and developing our staff, as they are key to ensuring we have quality at the heart of everything we do. Our weekly Chief Executive's brief and 'Dear John' mechanism for raising concerns are just two of the new ways in which we are engaging with staff. Teams across the organisation have been involved in the Listening into Action programme which has empowered them to make improvements in their own areas to improve the quality of care for service users and the experience of staff members. We've introduced new learning and development programmes in 2013/14 and have developed a new management and leadership strategy. The introduction of our nursing badge scheme in May 2013 has also helped to embed quality into every day practice. Our staff survey results have shown some significant improvements, for example in staff knowing their responsibilities and feeling satisfied with the quality of care they are able to deliver, however there is still work to be done on issues of equality and diversity, bullying and harassment and physical violence and this will be a focus in the coming year alongside the implementation of a revised staff engagement strategy.

In summary, the past year has seen considerable developments and improvements in our Trust. There is still a lot of work to do to ensure that we are able to provide a consistently high quality of care and service user experience in all of our services across the diverse area of Birmingham and Solihull, but we have a clear strategy to enable us to achieve this.



John Short
Chief Executive



Sue Davis, CBE
Chair

Strategic report

About our Trust

Our Trust was established as Birmingham and Solihull Mental Health NHS Foundation Trust on 1 July 2008. This annual report covers 12 month period from 1 April 2013 to 31 March 2014.

We provide a comprehensive mental healthcare service for residents of Birmingham and Solihull, and to communities in the West Midlands and beyond. We operate out of more than 50 sites and serve a culturally and socially diverse population of 1.2 million spread over 172 square miles, have an annual budget of £236 million and a dedicated workforce of nearly 4,000 staff - making this one of the largest and most complex mental health foundation trusts in the country. Our catchment population is ethnically diverse and characterised in places by high levels of deprivation, low earnings and unemployment. These factors create a higher requirement for access to health services and a greater need for innovative ways of engaging people from the most affected areas.

As a foundation trust we have greater financial flexibility, allowing us to provide even better services and to involve our local communities in the bigger healthcare decisions that we make. It helps us to actively engage our staff in shaping how the Trust is run, make sure the views of service users and their carers and families are central to everything we do, and better understand the different needs of our diverse communities to create services more in tune with local needs.

Our corporate strategy and business model

At the end of 2012/13, the Trust Board met to re-evaluate and refresh the vision, values and strategic direction of the Trust. They frankly considered our current position, drawing upon various information sources and feedback, and confronted some of the difficult issues which have hindered us as a Trust in the past. The Board then collectively thought about where we as a Trust want to be in the future and how we can get there, and most importantly how we will know when we've achieved our ambitions. At the heart of the discussion was ensuring that our vision and ambitions will deliver effective quality care and outcomes for service users, their carers and families. Following consultation with staff and service users, the outcome of this work was a revised Trust strategy from 2013-16, encompassing who we are, what we stand for and where we are going. The strategy was launched in April 2013 alongside a renewed focus on embedding quality throughout the Trust which included a high profile internal communications and engagement campaign about the strategy and values, with the strapline 'quality is at the heart of everything we do'. The campaign is continuing into 2014/15 with a focus on how staff are embedding quality in their every day work.

Our purpose and values

Our purpose is a simple and straightforward one, '**Improving mental health wellbeing**'

Whilst our work covers many areas, and can often be complex, our purpose should be simple, straightforward and meaningful to everyone engaged with our organisation. Our purpose sums up exactly why we are here, and is at the heart of everything we do and every decision we make.

We have established the following as our core values. As an organisation we aim to promote and propagate these values in every element of our work. We put service users at the centre of everything we do by displaying:

Honesty and openness - We will keep each other well informed through regular communication. We will have honest conversations and explain our decisions.

Compassion - We will bring compassion to all our dealings with service users and carers and expect it in our colleagues.

Dignity and respect - We will respect all those whom we deal with at work, especially our service users and staff and take action to address those who do not.

Commitment - We commit to help our colleagues provide the best care services that we can. We will do what we say we will.

Our strategic ambitions

Our strategic ambitions demonstrate how we plan to achieve the Trust purpose, vision and values, and what areas we will be concentrating on in order to make that happen.

1. Continuously improving quality by putting patients at the heart of everything the Trust does to deliver excellence.
2. Developing strong, effective, credible, sustainable relationships with key stakeholders, building the Trust's reputation.
3. To be a well-led, effective and informed organisation.
4. To have a workforce that is innovative, empowered, engaged, fairly rewarded and motivated to deliver the strategic ambitions of the Trust.
5. To achieve long-term financial sustainability.

Our Trust corporate strategy 2013-16 can be found on our website at <http://www.bsmhft.nhs.uk/strategy/>.

Our business model

We are a foundation trust that specialises in mental health, with a large proportion of our income coming from NHS England due to the secure and specialist services we provide.

Our business model is urban and is centred firmly in Birmingham and Solihull due to the large and diverse population we serve and the unique and particular needs of our communities. We aim to provide care as close to home as possible and our services are mainly community based, although we do have a large proportion of inpatient beds.

Our services

We provide a wide range of inpatient, community and specialist mental health services for service users from the age of 16 upwards. These services are located within our five service areas: North, East, West and Addictions; South, Central and Mental Health Services for Older People; Solihull and Youth; Specialist and Complex Care and Offender Health; Specialist Psychological Services.

Together, these services include elements of rehabilitation, crisis and home treatment, assertive outreach, early intervention, addictions, day services and mental health wellbeing. We provide our services on a local, regional and national basis. In addition, our Trust manages the delivery of all healthcare services at HMP Birmingham, in Winson Green, and works closely with the criminal justice system.

Our dedicated, specialist teams work closely with patients, their carers and families to put together a plan of care which suits each individual person and offers different types of support including community, inpatient, outpatient and day services.

We have worked, and will continue to work, hard to support and improve the mental health of people across our patch through a range of locally based inpatient and community services. We also continue to develop close links with partners from education, local authorities and voluntary organisations and work in partnership to provide integrated health and social care - a real benefit for our service users.

The Trust has one wholly owned subsidiary, Summerhill Supplies Limited. This commenced trading on 1 December 2012.

Development and performance of our Trust in 2013/14

A new look Executive Team

There have been a number of changes to the Executive Team during 2013/14. April 2013 saw John Short commence as the Trust's Chief Executive, followed in July 2013 by the appointment of a new permanent Executive Director of Operations, Brendan Hayes, who joined the Trust from Northamptonshire Healthcare NHS Foundation Trust. In December 2013, Dee Roach, Director of Quality Improvement and Patient Experience, left to join Lancashire Care NHS Trust. An interim Executive Director of Nursing, Susan Fairlie, was in post from January to March 2013, when Sue Hartley joined from Walsall Healthcare NHS Trust as our new permanent Executive Director of Nursing.

Service Improvement Programme

The Service Improvement Programme is an initiative that aims to improve the quality and flow of the user journey and experience.

This has involved the development of a new model of care, initially for adult community mental health teams (CMHTs), which builds on existing best practice in adult CMHTs in the Trust. It focuses on evidence based interventions informed by expert assessments. Patients will have the benefit of a robust bio-psychosocial, recovery-focused care plan which is tailored to allow management within primary care where possible. Cost improvements which are clinically appropriate will follow from rationalisation of infrastructure, demand-driven management of resources and increased face to face contact between individual clinicians and patients. Clinicians will have dedicated time to support GPs, facilitating safe transfer back to primary care. A focus on the needs of patients and carers and appropriate deployment of clinicians to support this is the fundamental principle of the model. The programme is set in the national and local context which has seen:

- significant changes in the way the NHS works
- a move towards integrated services
- reduction in budgets.

In developing this programme we consulted with a wide range of people, including individual members of staff, service users, carers, governors, CMHT and other Trust teams, social care, commissioners and Healthwatch. Through this process we identified seven areas to focus on that will really make a difference to the quality of care we provide, these are:

1. Improving patient access to care
2. Improving patients' local access to care services and care closer to home
3. Increasing face to face contact time with patients
4. Patients reaching the right person at the right time
5. Patients having increased evidence based intervention and recovery focused care
6. Patients having improved transition between services and out of services
7. Increasing support for patients from carers, families, friends, referrers and other organisations.

The first element of the model to be implemented is a single point of access for GPs and others to refer people to our services. From April 28, 2014 there is now one number to call for all secondary care mental health referrals from GPs and other referrers. This includes addictions, adults of working age, youth services and older people's services.

The move to a single point of access will improve access to our services by ensuring that patients are seen by the right person at the right time and ensure a consistent, effective and efficient approach to triage with appropriate signposting and referrer management.

We are also piloting mobile working and trialling a number of different devices. The aim is that mobile working will transform the way in which our community staff work, with one of the key benefits being an increase in the proportion of their time that clinicians are able to spend with patients.

Tamarind Centre

December 2013 saw the official opening of The Tamarind Centre, our new 89 bed male medium secure facility in Bordesley Green. Over the preceding 12 months wards had opened on a phased basis, with some service users moving back to Birmingham from units elsewhere in the country where they had been placed as a result of previous issues in the West Midlands of not having enough

secure bed capacity. This means that service users can now be closer to the family and carer support networks.

Developments at our Forensic CAMHS service at Ardenleigh

Our forensic CAMHS unit at Ardenleigh in Erdington has been undergoing a major facelift over the past year. Building work started in May 2013 on a new 18 bed mixed gender unit comprising three six bedded wards which will provide state of the art accommodation for young people. This move is due to take place in spring 2014 and will also improve the service we are able to provide in our women's forensic services on the site.

Summerhill Supplies Limited

This wholly owned subsidiary of the Trust is now fully operational, providing a fully managed service lease for the Tamarind forensic site and pharmacy dispensing services. We plan to generate a small surplus over the next two years.

Embedding the 6Cs of nursing

As part of the Trust's strategy for professional nursing – Proud, Professional, Progressive - launched in 2011, we launched a nursing badge scheme in May 2013 to recognise and celebrate excellence in nursing across our services. To be eligible nurses must have a current registration without restrictions, be fully up to date with fundamental training and provide evidence of how they have reflected the Trust's nursing values in their practice. The application then has to be approved by their lead nurse. An event was held on 9 May 2013 to coincide with International Nurses Day at which 21 nurses from all areas and levels of nursing in the Trust were awarded badges. A second event to mark World Mental Health Day in October saw health care assistants added to the scheme and a total of 37 staff receiving badges. This event included a special video message from NHS England Chief Nursing Officer, Jane Cummings, congratulating the Trust on our work towards embedding the 6Cs of nursing – care, compassion, competence, communication, courage and commitment – into our Trust.

Working in partnership

Street triage: working with West Midlands Police and West Midlands Ambulance Service

Our Trust has joined forces with West Midlands Police and West Midlands Ambulance Service to pilot a new project to ensure people with mental health issues are kept out of police custody and receive the right treatment and care. The West Midlands is one of a number of regions to be selected by the Department of Health to pilot the 'street triage' scheme, which sees mental health nurses and paramedics accompany police officers to incidents where it's believed people need immediate mental health support. Since January 2014, a dedicated car has been operating every day throughout the Birmingham and Solihull area and involves police officers, nurses and paramedics working together. The aim is to ensure people who need mental health care get the right support and at the same time reduce demand on the emergency services.

Working with British Transport Police on suicide prevention

A significant number of fatalities occur on British railways, and it is suspected that a substantial number of these are completed suicides. In addition, the British Transport Police (BTP) respond to a significant number of other incidents – many of which are attempted, 'pre-suicidal behaviour', or incidents close to the railways involving vulnerable people, which give rise to concerns for safety. It is the response to these incidents that provides a real opportunity for positive interventions aimed to prevent loss of life or serious harm. Our Trust is working with the mental health Joint Commissioning Team, and is hosting a pilot scheme funded by the Home Office with BTP. This pilot links BTP and mental health staff – working collaboratively to ensure that people that come to notice of the BTP, or who appear to be in crisis, get access to support, services and interventions. We have recruited four community psychiatric nurses to be based with the BTP at their HQ which covers a significant part of England and all of Wales. Our staff will be able to make direct contact with local mental health services in order to mobilise outreach, action and support.

Solihull Integrated Addiction Services

We are the lead partner for the delivery of drug and alcohol treatment services in Solihull and alongside our partner agencies Aquarius, Welcome and Changes UK, we were successful in winning the tender to deliver these services for a further three years from 1 April 2014. Solihull Integrated Addiction Services (SIAS) partnership has been in operation since 2008. SIAS offers a single point of access for people who suffer with drug and alcohol addictions in Solihull. SIAS was also shortlisted in the best charity partnership category at the national Third Sector Excellence Awards.

Wolverhampton Substance Misuse Service

The contract for Wolverhampton substance misuse service commenced on 1 April 2013. This is delivered in partnership between Nacro, Aquarius and our Trust. In November 2013 a launch event was held for the new service, Recovery Near You. The focus of the three year contract is helping people recover from problems associated with alcohol and or drugs, to move on in their lives, and to improve integration with their own communities.

Rapid Assessment Interface and Discharge (RAID)

During 2013/14 we secured ongoing funding for our innovative and nationally recognised liaison psychiatry service, RAID. This is a specialist multidisciplinary mental health service, working within all acute hospitals in Birmingham, for people aged over 16. RAID has received much attention both regionally and nationally for its innovative approach to liaison psychiatry and in October 2013 the service at City Hospital was visited by Professor Louis Appleby, National Clinical Director for Mental Health, who was very positive about what he saw.

Our Trust's response to Francis

We have placed significant emphasis on learning from the Francis report, reflected through our Quality Governance processes.

Our Board has sought to ensure recommendations were not used as a 'tick box' but that the Board effectively embraces the themes and challenges which the report identifies. In August 2013, the Board received and reviewed an assurance summary against the key recommendations of the following reports:

Francis Inquiry: report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Feb 2013).

Berwick report: Improving the Safety of Patients in England (Aug 2013)

Keogh report: Review into the quality of care and treatment provided by 14 hospital trusts in England: (July 2013)

Following discussion by the Trust Board the assurance summary has been further updated in December 2013 and also reviewed against the Government response to the Francis report ('Hard Truths').

The Trust has taken significant steps over the past year to tackle the themes of the Francis report. These include:

- increasing the visibility of Board members
- developing robust real time feedback systems from service users
- reinforcing requirements for incident reporting and raising concerns
- strengthening the reporting and review of complaints to the Trust Board
- communicating learning from serious incidents
- involving staff as part of the Listening into Action initiative.

In response to Francis, an internal review pinpointed the need to recruit an additional 14.5 full-time nurses and 5.5 health care assistants in order to deliver safe quality care across our adult inpatient beds. This was agreed by our Board in March 2014. The staffing increase has been funded by the trust agreeing a 1.5 per cent tariff cut with CCGs, rather than the planned 1.8 per cent. We are in the process of appointing to these posts and will be considering staffing increases in other inpatient areas in the near future.

Summary financial accounts

This section provides a commentary on our group financial performance for the financial year 2013/14. It provides an overview of our income, expenditure, cash flows and capital expenditure in the year. We ended the year with an operating surplus of £2.0m before exceptional items, compared to a planned surplus before exceptional items of £2.0m. The Continuity of Service risk rating from Monitor is a 3, which is in line with the financial plan we set at the start of the year.

Going concern

The Board of directors considers that the group has adequate resources to continue in operational existence for the foreseeable future and the accounts have been prepared on a going concern basis. In reaching this decision, the board considered the medium term financial plans of the organisation including income and expenditure, the capital programme and associated funding, cash flow and financial performance indicators.

Financial performance

The Trust wholly owns a subsidiary Summerhill Supplies Limited, the results of the subsidiary company have been consolidated with those of the Trust to produce the group financial statements contained in this report and referred to in this commentary.

This has been a challenging year financially for the Trust as well as the wider NHS. We were required to make significant savings of 4% across our organisation but at the same time safeguard the safety and quality of our services and patient experience. This was against a backdrop of rising inflation and reduced income through the national tariff deflator. This has meant we have had to carefully look at all of our services, clinical and corporate, and how they can be provided in the most efficient way. We have also looked at how we work with other healthcare organisations. Our savings plan at the start of the year was to deliver £7m of cost savings, during the year, £4.87m of savings have been delivered and the balance are expected to be delivered early in 2014/15.

Our year end position is better than planned with an operational income and expenditure surplus of £2.0m before taking into account any exceptional items. This is largely due to the release of a provision for redundancy costs which was not required, and a contingency fund that was not needed. These benefits do not bring us any on-going financial benefit for future years however. Exceptional items included a revaluation in our Trust estate which resulted in an increase in the value of £4.9m and termination benefits of £0.9m. After these are accounted for the group is reporting a surplus of £8.0m.

Table 1: Consolidated financial performance 2013/14 and 2012/13

	2013/14 £'000	2012/13 £'000
Income from activities	216,170	204,498
Other operating income	19,834	19,432
Total income	236,004	223,930
Operating expenses	(217,810)	(207,564)
EBITDA	18,194	16,366
Capital financing costs	(15,212)	(14,704)
Revaluation/(impairments)	4,861	(5,324)
Profit/(loss) on asset disposal	(53)	(150)
Surplus/(deficit) including exceptional items	7,790	(3,812)
Exceptional items:		
(impairments)/Revaluation	4,861	(5,324)
Costs of exceptional restructuring	911	(911)
Operating surplus excluding exceptional items	2,018	2,423
Operating surplus margin	0.9%	1.1%
EBITDA margin	7.7%	7.3%

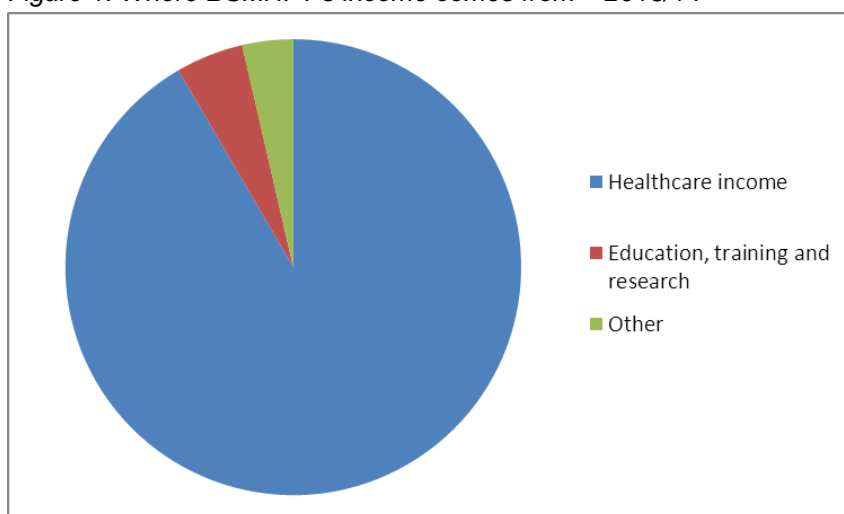
Income

In the financial year 2013/14 the group generated income of £236.0m. We had a reduction in our healthcare income contracts of 1.3 per cent applied by our commissioners. This was in line with all NHS providers. This has been offset by the new income stream delivered by the opening of the Tamarind Centre (men's medium secure) and Japonica (CAMHS) services. This has meant an overall increase in healthcare income of £12.1m (5.4%).

The chart below shows a breakdown of our income. Most of our income (92%) comes from our local and national commissioners for the delivery of healthcare services. We continue to be a major provider of education and training in the West Midlands and so this represents approximately 5% of our income.

The Trust has met the requirement under section 43(2A) of the NHS Act 2006 that the income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and services for any other purposes.

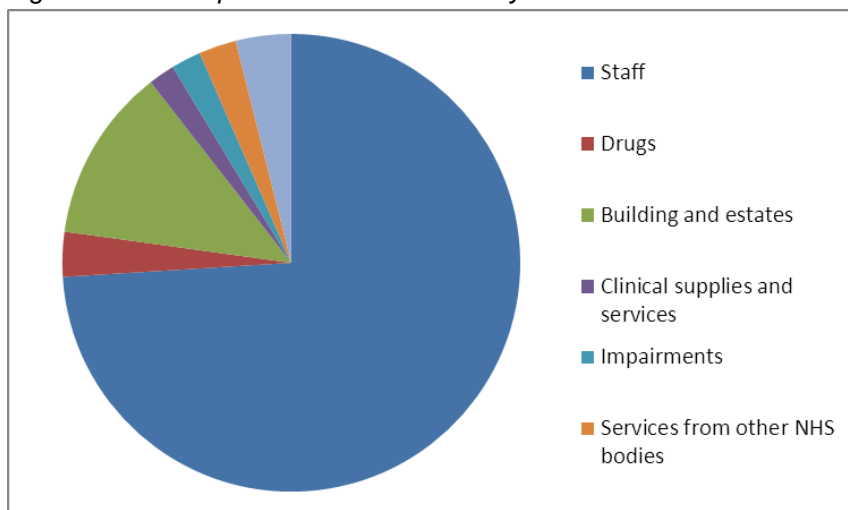
Figure 1: Where BSMHFT's income comes from – 2013/14



Expenditure

The chart shows that our staff are our most valuable and significant part of our expenditure. However we also operate from over 50 sites across Birmingham and Solihull and so the cost of our estate is also a significant proportion of our overall spend. We have reduced our expenditure in year but further work is still needed to fully realise all savings and some plans have been carried forward to 2014/15.

Figure 2: What expenditure was incurred by BSMHFT – 2013/14



Cash flow

At the end of the financial year we have a cash balance of £32.6m. During the year, we have removed the working capital facility of £16m which acted like an overdraft facility as it was costly and was not being utilised. This position means that our liquidity remains strong. In line with our Treasury Management Policy, during the year we invested cash reserves in HM Treasury investments to maximise the interest received.

Overview of capital investment and asset values

We invested £8.1m in our assets in 2013/14. The single largest investment, £3.5m was in the construction of additional ward capacity at the Ardenleigh site.

We also invested £1.2m in our IT infrastructure and new ways of working, £1.1m in backlog maintenance and ensuring our buildings complied with statutory standards, and £1.7m in other projects to modernise our estate and ensure it is fit for purpose.

Our estate has been subject to a full valuation at the year end, resulting in an increase in value of £4.9m. This exercise does not have an impact of our cash and ensures that the true value of the Trust's assets are recorded in the balance sheet and assists in future financial planning.

Management costs

The management costs for the year were £14.2m (2012/13 £12.1m), which represents 6% of income (2012/13 5.4%).

External audit

The Board of Governors appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust for the three years commencing 2010/11. This contract was extended for a further year for 2013/14. The audit fee for the year ended 31 March 2014 was £56k for the Trust's annual report, £10k for the Trust's quality accounts and £6k for Summerhill Supplies Limited (£74k for the year ended 31 March 2013) excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011.

Directors of the Trust have confirmed there is no relevant audit information of which the auditor is unaware and that directors have taken steps to make themselves aware of any relevant audit information and to establish that the auditors are aware of the information. PricewaterhouseCoopers LLP did not carry out any other work for the group in this financial year.

Public sector pay policy

Our Trust adopts a Better Payment Practice Code in respect of invoices received from NHS and non-NHS suppliers. The code requires our Trust to aim to pay all undisputed invoices within 30 calendar days of receipt of goods, or a valid invoice (whichever is later), unless other payment terms have been agreed. To meet compliance with this target at least 95 per cent of invoices must be paid within 30 days, or within the agreed contract term. Our Trust's performance against target is summarised in the table below:

Table 2: Better Payment Practice Code performance

	2013/14 Number	2013/14 £'000	2012/13 Number	2012/13 £'000
Total NHS invoices paid in the period	575	10,242	666	12,395
Total NHS invoices paid within target	550	10,096	589	11,368
Percentage of NHS invoices paid within target	96%	99%	88%	92%
Total non-NHS invoices paid in the period	41,091	51,897	33,982	50,406
Total non-NHS invoices paid within target	39,353	49,925	30,710	47,294
Percentage of non-NHS invoices paid within target	96%	96%	90%	94%

Management of working capital balances, in particular aged balances are reviewed on a regular basis by senior management and escalated where necessary.

Financial risks

The Trust has a treasury management policy which is implemented by the finance department. The Trust has assessed that it is not subject to any significant financial risks in relation to financial instruments:

- Currency risk – the Trust is a domestic organisation with the majority of transactions conducted in £sterling, therefore exposure to currency risk is low.
- Interest rate risk – borrowings are from the Government and interest is fixed for the life of the loan, therefore exposure to fluctuations in interest rates is low.
- Credit risk – majority of our income comes from contracts with other public sector bodies and so there is low exposure to credit risk. Cash deposits are only placed on a short term basis with highly rated UK banks or HM Treasury.
- Liquidity risk – operating costs are incurred under contracts with public sector bodies, financed from the Government. Exposure to liquidity risks are considered to be low.

Looking forward

Looking forward to 2014/15, the challenging financial times will continue. Our healthcare income is reducing by a further 1.5%, rise in inflation of costs will continue and we will need to deliver savings of 4%. We recognise that delivery of savings year on year is tough and delivery of savings while maintaining quality of service is our greatest risk.

Reducing the cost of fraud in the NHS

Fraud in the NHS is a drain on the valuable assets meant for patient care and costs the health service a substantial amount. The situation is improving year on year as recovery of money, prosecution of offenders and awareness of the issue continues to build. However a considerable amount of money is still lost through patient, practitioner and staff fraud. The NHS Counter Fraud Service aims to reduce this to an absolute minimum, and maintain it at that level. BSMHFT has in place a team of Local Counter Fraud Specialists (LCFS) who are the first line of defence against fraud. Their role includes raising awareness of the risk of fraud among staff, reducing the risk through a programme of proactive work and, in the event of suspicion being raised, conducting formal investigations. To find out more, contact one of the Trust's LCFS. Contact: David Fletcher on 0121 695 5162 or email DCFletcher@deloitte.co.uk.

Additional information

The accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006. The accounting policies for pensions and other retirement benefits are set out in note 1 to the accounts and details of senior employees' remuneration can be found in the Remuneration Report on page 56. The NHS Foundation Trust has complied with the cost allocation and charging requirements as set out in the HM Treasury and Office of Public Sector Information guidance.

Summary financial statements

The Annual Report includes summary financial statements. A full set of accounts is available on request by contacting Sandra Betney, Executive Director of Resources, Finance Department, B1, 50 Summer Hill Road, Birmingham, B1 3RB.

Our employees

Our workforce profile at 31 March 2014

Table 3: Workforce profile by staff group and gender at 31 March 2014

Staff Group	Female	% Female	Male	% Male	Grand Total
Add Prof Scientific and Technic	204	74.18%	71	25.82%	275
Additional Clinical Services	775	69.69%	337	30.31%	1,112
Administrative and Clerical	665	75.74%	213	24.26%	878
Allied Health Professionals	121	90.30%	13	9.70%	134
Estates and Ancillary	102	64.97%	55	35.03%	157
Healthcare Scientists	3	75.00%	1	25.00%	4
Medical and Dental	128	45.39%	154	54.61%	282
Nursing and Midwifery Registered	944	70.71%	391	29.29%	1335
Grand Total	2,942	70.43%	1235	29.57%	4,177

Table 4: Staff type by gender at 31 March 2014

Staff Type	Female	% Female	Male	% Male	Grand Total
Directors	5	35.71%	9	64.29%	14
Other Senior Managers	156	51.32%	148	48.68%	304
Employees	2,781	72.07%	1,078	27.93%	3,859
Total	2,942	70.43%	1,235	29.57%	4,177

Table 5: Staff in post: equality and diversity data at 31 March 2014

							2011 Census Data		
Ethnicity		Trust Profile 2009	Trust Profile 2010	Trust Profile 2011	Trust Profile 2012	Trust Profile 31 March 2014	Birmingham Population	Solihull Population	Birmingham & Solihull Population
White	British	54.50%	55.30%	55.20%	55.30%	55.25%	53.10%	85.80%	58.40%
	Irish	3.90%	3.60%	3.50%	3.30%	2.89%	2.10%	1.90%	2.00%
	Gypsy or Irish Traveller	N/A	N/A	N/A	N/A	N/A	0.00%	0.00%	0.00%
	Other White	2.40%	2.50%	2.50%	2.90%	2.92%	2.70%	1.40%	2.50%

							2011 Census Data		
Ethnicity		Trust Profile 2009	Trust Profile 2010	Trust Profile 2011	Trust Profile 2012	Trust Profile 31 March 2014	Birmingham Population	Solihull Population	Birmingham & Solihull Population
Asian or British Asian	Indian	6.00%	5.90%	6.30%	6.70%	6.25%	6.00%	3.40%	5.60%
	Pakistani	2.50%	2.50%	2.70%	2.50%	2.87%	13.50%	1.70%	11.60%
	Bangladeshi	0.50%	0.50%	0.60%	0.50%	0.53%	3.00%	0.30%	2.60%
	Other Asian	1.40%	1.30%	1.30%	1.20%	1.26%	2.90%	0.70%	2.60%
Mixed	White & Black Caribbean	1.20%	1.20%	1.30%	1.40%	1.63%	2.30%	1.20%	2.10%
	White & Black African	0.40%	0.50%	0.50%	0.50%	0.44%	0.30%	0.10%	0.30%
	White & Asian	0.40%	0.40%	0.50%	0.50%	0.51%	1.00%	0.60%	1.00%
	Other Mixed	0.30%	0.40%	0.40%	0.40%	0.49%	0.80%	0.30%	0.70%
Black or Black British	Black Caribbean	9.10%	9.20%	8.90%	8.70%	8.92%	4.40%	0.90%	3.90%
	Black African	6.60%	6.30%	6.70%	6.80%	7.00%	2.80%	0.40%	2.40%
	Other Black	0.90%	1.00%	1.00%	1.00%	1.05%	1.70%	0.20%	1.50%
Chinese	Chinese	0.20%	0.30%	0.30%	0.30%	0.32%	1.20%	0.40%	1.10%
Other Ethnic Group	Other Ethnic Group	1.20%	1.10%	1.00%	1.00%	0.92%	2.00%	1.00%	2.00%
Undefined	Not Stated	8.60%	8.10%	7.30%	7.20%	6.76%	0.00%	0.00%	0.00%
Grand Total		100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Table 6: Workforce age profile at 31 March 2014

Age Range	Headcount	% Headcount
<20	5	0.12%
20-29	607	14.53%
30-39	1,072	25.66%
40-49	1,268	30.36%
50-59	996	23.84%
60-64	177	4.24%
>65	52	1.24%
Grand Total	4,177	100.00%

Table 7: Sexual orientation profile at 31 March 2014

Sexual Orientation	Headcount	% Headcount
Bisexual	15	0.36%
Gay	31	0.74%
Heterosexual	2,227	53.32%
Lesbian	18	0.43%
Undisclosed	1,886	45.15%
Grand Total	4,177	100.00%

Table 8: Gender profile at 31 March 2014

Gender	Headcount	% Headcount
Female	2,942	70.43%
Male	1,235	29.57%
Grand Total	4,177	100.00%

Table 9: Religion or belief profile at 31 March 2014

Religion	Headcount	% Headcount
Atheism	273	6.54%
Buddhism	12	0.29%
Christianity	1,553	37.18%
Hinduism	59	1.41%
Islam	158	3.78%
Jainism	2	0.05%
Judaism	7	0.17%
Other	226	5.41%
Sikhism	76	1.82%
I do not wish to disclose my religion/belief	316	7.57%
Not Declared/Undefined	1,495	35.79%
Grand Total	4,177	100.00%

Table 10: Disability profile at 31 March 2014

Disability	Headcount	% Headcount
No	2,615	62.60%
Not Stated	1,429	34.21%
Yes	133	3.18%
Grand Total	4,177	100.00%

Table 11: Marital status and civil partnership profile at 31 March 2014

Marital Status	Headcount	%Headcount
Civil Partnership	24	0.57%
Divorced	225	5.39%
Legally Separated	59	1.41%
Married	1,733	41.49%
Single	1,381	33.06%
Unknown	731	17.50%
Widowed	24	0.57%
Grand Total	4,177	100.00%

Equality and diversity

To be able to effectively deliver care and support to our service users and their families, we also need to focus on the needs of our staff. Therefore, understanding and valuing the various characteristics our staff bring not only ensures that we can support our staff effectively but, also in turn our service users.

The information above provides an overview of our workforce in terms of some of those protected characteristics identified within the Equality Act 2010.

The Trust recognises the importance of ensuring that all staff are aware of their individual responsibility regarding equality and diversity. This not only relates to the care they deliver to service users and their families but their relationships with colleagues.

Analysis of workforce data suggests that although there have been some improvements in a number of areas, there remain a number of key challenges for the Trust, including:

- retention of BME staff after they have been appointed
- progression and development of BME staff at certain bands
- appropriate systems to capture data on all 'protected characteristics'
- addressing the proportion of 'not stated' or 'unknown'.

Our staff survey results highlight that this is an area in which we need to improve in 2014/15 (see the Staff Survey section of this Annual Report on page 67). Some of the actions we've already taken in 2013/14 are detailed below.

Equalities panel

A Senior Equality and Diversity Lead was appointed in October 2013. Initially with the remit to support the HR function, the role has since developed to support other areas of the equality and diversity agenda to support the Organisational Development and Community Engagement teams and also service delivery teams. Achievements since joining the Trust include:

- review of induction training to reflect the Equality Act and Public Sector Equality Duty
- review and development of the Equality Analysis Guidance and Assessment Tool
- review of the Equal Opportunity in Employment Policy
- publication of an annual equality data report
- development of equality objectives for 2014/15.

The Trust's Equality and Diversity Panel meets bi-monthly to discuss equality and diversity issues and set strategic direction for the Trust in this area. Its agenda includes:

- consideration and setting of objectives to better manage and improve the progression and development of BME staff in the Trust
- the development of a Equality Thermometer, which will take a pulse check of the Trust and establish a baseline of how managers use equality and diversity to influence their planning and decision making processes, identify areas of good practice and actual or potential barriers
- setting up a 'diversity challenge' which will identify equality, diversity or inclusion issues and establish projects to develop good practice to address these issues.

Equality impact assessment

Equality impact assessment (EIA) is key to ensuring that policies, procedures and service developments do not have an adverse effect on any group. We have a mandated approach to assessing equality impact in the form of an assessment which analyses impact changes for each of the nine protected groups as defined by the Equality Act. In addition, our Programme Management Office (PMO) has embedded equality impact assessment in the way it reviews all projects including transformation programmes.

Fundamental training

We provide mandatory training in equality and diversity for all staff. Equality impact assessment training is available for all managers of services. All training is monitored and the data is published on an annual basis. The Senior Equality and Diversity Lead has reviewed the training provided across the organisation and in the coming year plans to further improve this by:

- introducing an e-learning introduction to the Equality Act 2010 and Human Rights
- supporting this with face to face sessions delivered at team meetings
- supporting managers by establishing Action Learning Sets specifically for equality and diversity issues.

Human rights

The Human Rights Act underpins the requirements of the NHS Constitution and speaks directly to the requirements for Freedom, Respect, Equality, Dignity and Autonomy to be provided to all. Our induction training programme has included an introduction to human rights since November 2013, and this is also part of the equality and diversity e-learning programme that is currently in development. The Trust's Equality Analysis Guidance and Assessment Tool gives consideration to human rights and the tool forms part of the Trust's project management system.

Employment and training of disabled persons

In 2013 4.2% of job applicants declared a disability and 1% did not disclose this information. The figures from the previous year were 3.56% and 0.75% respectively. The Trust operates the 'Positive about disabled people' symbol in its recruitment processes. The symbol means the Trust is committed to employing disabled people and that we will guarantee an interview if an applicant declares a disability and meets the essential criteria for a post. During the selection process we will make necessary reasonable adjustments to ensure that a disabled candidate can participate fairly and equitably in the process. If appointed, and following occupational health assessment the Trust will aim to make any reasonable adjustments required for the role to be successfully undertaken.

We actively promote a culture where the talents and experience of all disabled people are valued. We make every effort to ensure that we provide the support and adjustments that all employees and potential employees need to get into, stay in, and get on in employment with our Trust.

If an employee becomes disabled this will in the first instance be managed supportively through Trust policies with the aim of identifying the adjustments with the support of occupational health, that may be necessary to enable the employee to continue working for us.

Staff support networks

There are three staff-led diversity networks. These are the lesbian, gay, bisexual and transgender (LGBT), disability, and black ethnic minority (BME) staff networks. In 2013 LGBT awareness training was made available to our staff and the Trust is proactively engaged with the LGBT network in Birmingham.

Staff engagement

Staff engagement and associated delivery mechanisms are already well established within the Trust. These include:

- a weekly briefing from the Chief Executive which updates staff on key developments and challenges facing the Trust, including financial and economic factors affecting the Trust's performance, and invites staff to feed back and engage with him directly
- The Source, a news and information resource on the intranet enables staff to post news items and comments and responses to specific issues
- Bite Size, a monthly e-bulletin with information about what staff have been up to across the Trust
- Learning Lessons Together, a bi-monthly e-bulletin which shares examples of good clinical practice, and shared learning that could be of benefit for the wider organisation
- Board Challenge, an annual awards scheme and event that recognises innovative team projects
- special thanks and recognition scheme (STAR), which allows staff to recognise when a good job has been done by a colleague by sending an e-card. The team with the most STAR cards in each month then has the opportunity to have 'Tea with the Chair' and spend time talking to our Chair about their work and any issues they have
- visits to teams from non-executive directors
- our Working Better Together initiative, which involves staff directly in the performance of the Trust, through each staff member setting SMART objectives that relate to the objectives stated in the business plan
- involvement of staff across the organisation in the business planning process, with each service and corporate team now developing its own business plan with SMART objectives.

This year we have introduced a number of additional mechanisms to engage with staff, including

- Dear John, introduced in May 2013 this stand alone website can be accessed from any PC inside or outside the Trust and allows staff to raise their quality concerns, anonymously if they wish, direct with our Chief Executive. Since its launch there have been more than 100 submissions to Dear John and each one is read and answered personally by the Chief Executive if contact details are given
- a regular brief from the Director of Operations to operational staff
- operational engagement forums in each area
- face to face sessions for staff to meet non-executive directors and governors
- Quality and Excellence Awards scheme, launched in March 2014 to reward individual staff members for making an outstanding contribution to our services across eight categories. The first annual ceremony will be held in June 2014.

In addition we have run specific consultations for staff on key strategic programmes within the Trust, including the Service Improvement Programme, Care Packages and the staff engagement strategy. These have included the opportunity to directly input into development of these programmes and strategies via face to face sessions and the ability to comment on the intranet or by email.

However, with over 4,000 staff spread over 60 sites, many working shifts, we recognise that staff engagement is not a straightforward issue and we are continually looking for new ways to communicate with staff effectively. With this in mind a revised staff engagement strategy was developed during the year and was agreed by our Trust Board in March 2013 following consultation with staff on the draft strategy. The strategy will be implemented during 2014/15 and the key themes it addresses are:

- enhanced clinical engagement
- engaging and empowering middle managers for them to deliver staff engagement consistently
- engaging and involving more junior staff to feel more a part of the organisation
- increased perceived visibility of Trust Board members
- increased use and developing further, the methods available to staff for two-way communications, for which there is a growing appetite in the Trust

- increased perceived transparency of the Trust and its decision-making
- enhancing our customer service focus to empower staff in how we all contribute to quality and service user experience.

The new strategy will be evaluated through the results of the NHS Staff Survey, Listening into Action pulse check surveys, online polls used in the Trust balanced scorecard, feedback questionnaires from events, submissions to Dear John, including the analysis of content and feedback to Trust Board during site visits.

For more information on the staff engagement strategy please email comms.team@bsmhft.nhs.uk.

Listening into Action

In January 2013, the Trust signed up to a national staff engagement programme called Listening into Action (LiA), which has a great track record in being a vehicle for change in NHS organisations. The essence of Listening into Action is that it puts the views and ideas of frontline staff *at the heart* of how we improve services for patients and the experience of our staff.

Listening into Action is about:

- engaging all the right people around delivering better outcomes for our patients, our staff and our Trust
- overcoming widespread challenges around staff engagement and morale
- developing confidence and capability of our leaders to 'lead through engagement'
- collaborating across the usual boundaries
- engendering a sense of collective ownership and pride.

During 2013/14 the following has been achieved through Listening into Action:

- Five big listening events were held at which staff identified key themes for improvement in the Trust.
- Quick wins achieved included improved catering facilities, better transport for service users and improvements to the Trust telephone directory.
- Other longer term schemes that have been focused on include improvements to our RiO clinical system and infrastructure, looking at minimum staffing levels, reducing the time taken to recruit staff, having service users present at all job interviews and looking at the number and efficiency of meetings.
- Twelve pioneer teams were supported at a local level to identify areas in which their own service could improve, culminating in a 'pass it on' event where they shared their achievements and experiences.
- All senior staff in the Trust attended a Listening into Action masterclass in October 2013 to identify Trust-wide areas for improvement and aid the embedding of LiA across the organisation.
- The second wave of LiA comprising 19 teams commenced in late 2013.
- Focus areas for the teams have included increasing senior management visibility, improving therapeutic activities for service users, looking at shift patterns, improving the physical environment at sites and improving communication within teams.
- A listening event for healthcare assistants was held in February 2014 and was very well attended by staff from across the Trust. Quick wins and actions arising from the discussions at the event are now being implemented.

In order to measure progress, three Listening into Action 'pulse check' surveys of staff have taken place between March 2013 and February 2014 and results for 13 of the 15 questions asked show an improvement between the second pulse check in July 2013 and the third in February 2014.

A commitment to learning and development

The Trust has continued to invest in a number of critical areas.

New learning and development programmes

We want to ensure that our staff are adequately equipped to deliver against the core objectives and business drivers for the Trust, with the ultimate goal of improving the quality of the service user and carer experience. During 2013/14 a number of new learning interventions have been introduced to support both departmental and strategic requirements. These also addressed some of the key issues identified through staff at Listening into Action big listening events:

Bands 1-4 programme

A modular programme offering a variety training packages relating to care and other roles, primarily for staff at band 1-4 level.

Leadership and management development programme

This programme is for both clinical and non-clinical leaders, managers and supervisors at different band levels. There are three cohorts within the LMDP, each one designed on a modular basis for maximum flexibility and aimed at different learning and development needs.

Virtual learning environment

We are developing a new virtual learning environment for the Trust that will provide a single access point for learning and resources. This will enable us to increase the quality of training and staff members' knowledge by providing more up to date information, sharing learning and allowing staff to see their own progress recorded. E-learning means that staff spend less time away from their role, which releases more time back to focus on patient care.

A new strategy for management and leadership

Developing management and leadership capacity and capability has been identified as a Trust priority in line with national findings and recommendations in the wake of the Francis and Berwick reports. A new management and leadership strategy was developed between January and March 2014, involving around 120 people through one to one interviews, focus groups and wider dissemination through our Trust intranet. There was a strand running through the strategy considering equality and diversity.

Six key management and leadership priorities have been identified for the Trust for 2014/15:

- Succession planning and talent management will be developed.
- Capacity of managers and leaders will be better managed, with demands on them being reasonable, coordinated and monitored.
- Use of evidence to make management and leadership decisions.
- Managers and leaders will be clear about their roles.
- There will be clear links between the Trust's strategic ambitions and values and the behaviours of managers and leaders.
- We will have an excellent reputation for management and leadership.

A clear action plan and measures are in place to deliver on these priorities.

Engaging with our communities

As our Trust serves a culturally diverse population in various communities across Birmingham and Solihull, it is vital that we engage with the people we serve. Our community engagement team attend and organise numerous events, ranging from recruitment fairs and workplace seminars, to religious events and carnivals and are involved in a number of important partnerships and initiatives. Some of the highlights of their work within the community during 2013/14 are summarised below.

Community engagement events

During summer 2013 two community engagement events were held, one at Endeavour Court in Erdington and one at Mary Seacole House in Winson Green. These events brought together service users, staff, partner agencies, stakeholders and members of the local community with activities, food and entertainment. The events were a great success and four events at sites across our area are planned for summer 2014.

Mental Health First Aid (MHFA)

The Trust was nominated for the third year in a row in the MHFA Champion category and attended the annual award ceremony at the House of Lords in Westminster in February. This year we have trained 165 people who are now Mental Health First Aiders. We have delivered the shorter half day course, MHFA Lite, to over 30 people. We have had the pleasure of delivering MHFA to people from the following organisations:

University of Birmingham, Nishkam Centre, Yardley Wood Baptist network, the CBSO, Birmingham LGBT Wellbeing Centre, volunteers for the Trust's Spiritual Care service, Shoulder to Shoulder, County Community Partnerships, Service Birmingham, Prevent counter-terrorism initiative and West Midlands Police, Solihull Carers, the Positive Mental Health Group, and Musical Connections.

Birmingham LGBT

The Trust has continued to work in partnership with Birmingham LGBT in order to increase access to culturally competent mental health services for lesbian, gay, bisexual and transgender individuals. All staff have had the opportunity to attend a free training session in order to better understand the needs of LGBT service users and take steps to become an LGBT affirmative and inclusive organisation. These ten training sessions took place in the new Birmingham LGBT Wellbeing Centre that was opened last year. The results of the training sessions will be evaluated by the Director of Birmingham LGBT and used by the Trust to inform future training needs and practice.

Community Experts Network

In January 2014 we launched a network of volunteers who have a deep understanding of their different communities' cultural and faith issues, and who can be accessed by our staff directly. Staff can call or email the individuals in the network with non-emergency enquiries relating to potential cultural issues. They are able to discuss their concerns and issues confidentially with someone who will not judge them negatively and who is competent and networked within their community of interest to enable them to provide authoritative advice. All the Community Experts have undergone Mental Health First Aid Training and an induction to the Trust. Their role is to support staff in dealing with potentially ambiguous and complex scenarios in an open and non-judgemental manner and to signpost staff to relevant individuals/organisations where appropriate.

Time to Change: 300 Voices

The Trust has been working with Time to Change to launch the 300 Voices project that seeks to engage with young African and Caribbean men by enabling them to have their voice heard about their experiences of inpatient care. Over 120 people from the local community, organisations and staff from the Trust came together on 21 January 2014 to celebrate the launch of this exciting new project that aims to address some of the challenges and discrimination faced by service users. During the year-long pilot, 300 men will be interviewed along with 900 staff from our Trust and partner organisations. Following these interviews key themes will be explored and a bespoke model created to address some of the issues raised. Over the next few months our Trust will be working closely with Time to Change to identify service users and staff who will take part in the project, which has been funded by the Big Lottery Fund.

Time to Change and our Trust also sponsored a two day Stereo-Hype Festival in Birmingham on 14/15 March 2014. Stereo-Hype is a unique, inspiring and stimulating festival that challenges mental health discrimination experienced by African and Caribbean Communities through music, theatre, dance and debate.

Birmingham REP: BEDLAM, the festival of mad ideas

The Trust worked in partnership with the Birmingham Repertory Theatre to develop this week long arts festival which was held in November 2013. BEDLAM was living proof that the arts can play an important part in reducing stigma and promoting recovery and wellbeing. People with lived experience of mental health issues helped to shape this exciting programme of drama, theatre, comedy, poetry, spoken word and photography. The specially programmed productions, *The Anatomy of Melancholy* and *Mess*, were surrounded by workshops and debates tackling different aspects of mental health which helped us to challenge the stigma surrounding mental illness. The festival was part of Birmingham Repertory Theatre's re-opening season following its full refurbishment as a result of the new Library of Birmingham development.

Women and Theatre

We have been working with Women & Theatre (W&T), supporting the delivery of their 'Laughing for a Change' project. During 2013/14 there have been four community comedy courses engaging mixed groups of people with and without lived experience of mental ill health, numerous volunteer training sessions, which have been co-delivered by the Trust, and a professional comedy show is now touring nationally. Funded by Time to Change, the project has used comedy as a vehicle for having conversations about mental health with a view to reducing stigma and discrimination. We have also

worked with Women & Theatre to develop an exciting new project, Life Story, a moving and thought provoking participatory project which will increase awareness, challenge taboos and offer opportunities to develop life skills around mental health for participants. The project will bring together relatives and professionals who are caring for someone with memory loss problems. We have engaged with over 150 people through five community and art centres in Birmingham and Solihull. This project supports the National Dementia Strategy and the Government's strategy of building dementia friendly communities. Funding for this came from the Big Lottery Fund's Awards for All programme.

Environmental matters

As in previous years our Trust has continued to demonstrate its commitment to sustainability, reducing its carbon emissions and minimising its impact on the environment and climate change. We continue to demonstrate robust governance for sustainability issues with a lead director and a framework of strategies, policies and procedures to maintain focus and inform decisions. The 2013/14 financial year has seen a number of significant steps forward in delivering against the sustainable development agenda and these are outlined in our separate Sustainability Report which can be found on page 70 of this Annual Report.

The main trends and factors affecting our future development and performance

Increased demand

We have seen unprecedented demand for services, especially adult acute mental health inpatient services. Our occupancy levels have been near 97% in year and averaged over 90% in the last three years. This trend is in line with that reported nationally. Our local CCG commissioners are increasing their activity and expenditure for out of area placements. Coupled with this increase in overall demand, the acuity of the inpatients admitted appears to be increasing if measured by the use of the Mental Health Act.

Financial challenge

There is increasing pressure across the health economy to meet the affordability gap. Nationally as the NHS struggles to meet the £20billion challenge at the end of the 2015 it is forecast that in future year the net efficiency requirements are going to increase across the health economy. NHS England's five year business plan, Putting Patients First, predicts there will be a £30billion funding gap by 2020/21.

Birmingham City Council White Paper

Budget cuts planned at £840m over the next seven years within Birmingham City Council will have an impact, particularly in relation to delayed discharges and bed blocking due to inadequate follow on social care provision.

External environment

There are a number of commissioner plans that will impact in the short term. These include the NHS England moratorium on service development and the challenge to meet IAPT targets and expand services with limited if any investments. Commissioners are re-designing care pathways across traditional boundaries in an attempt to release wider health economy efficiencies. This involves large scale competitive tendering processes which absorb significant corporate and clinical resource and create significant uncertainty for staff and service users.

Better Care Fund

We share a commitment to develop a viable health and social care system which more appropriately responds to the needs of individuals who are vulnerable. The programmes focus upon an aspiration to maximise the opportunities for providing quality care, including mental health, in a variety of community based settings with a focus on preventative and proactive care, only admitting to a hospital bed when it is the right thing to do. This means avoiding non-qualified admissions and

discharging people from acute care at the optimum time into more appropriate alternatives. We are a member of both Birmingham Integration Partnership Board and Integrated Care and Support Solihull, and are therefore influential in developing the delivery plans. As an organisation we are supportive of these plans and they are in line with our own strategy. However we are clear that we continue to have a duty to respond to the need that presents to us and our own plans reflect this mitigation.

Seven day working

We have confirmed to commissioners that we meet the standards for mental health on seven day working through our RAID service. We support the national commitment to seven day working review outlined in "Everyone counts: Planning for Patients".

Patient choice

From April 2014, adults with mental health issues will be given the right to choose which provider and consultant or mental health professional will be in charge of their care when they attend their first outpatient appointment.

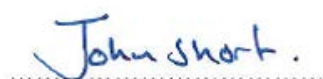
Parity of esteem

Nationally mental health is more frequently referenced than in previous years, for example in seven day working, but guidance to commissioners (and providers) is often less specific and rarely funded as was seen in the assumptions made in relation to Francis recommendations in the national tariff deflator, in which NHS England identified that the Francis and Keogh reports would only impact on staffing in the acute sector. This was despite Robert Francis QC stating that the recommendations he made to improve care in the NHS were "just as applicable" to the non-acute sector. Against this national context we will continue to raise the profile of mental health to achieve parity of esteem both in mental healthcare provision and in parity of physical health outcomes for those with mental health issues. We are working hard to ensure that mental health has parity of esteem both locally, for example in the Better Care Fund, and nationally, for example in discussions about the contribution of mental health services to urgent care capacity as evidenced by our RAID service.

The financing implication of any significant changes in the foundation trust's objectives and activities, its investment strategy or its long-term liabilities

The Trust has developed a five year financial plan, taking into account expected cost pressures on expenditure and changes in income through CRES targets and new service developments through tender bids. A five year capital programme has been developed, which is focused on delivering high quality, fit for purpose buildings to improve patient experience, and information and communications technology to enable staff to focus their time and effort on service users rather than administrative processes. The funding for the capital programme will come from the surplus of income over expenditure that we plan to deliver each year, along with the sale of unused land and building stock.

Signed:



John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust

Date: 21 May 2014

Directors' report

Meet the Board

The Board of directors set the strategic direction of the Trust, overseeing and approving the operational management which is delegated to management within the Trust. The Trust governors are responsible for holding the Board to account.

The Board of directors has resolved that certain powers and decisions may only be exercised by the Board of directors in formal session. These powers and decisions are set out in the *Reservation of powers to the Board of Directors and Scheme of Delegation* and shall have effect as if incorporated into the standing orders. Those powers which it has delegated to officers and other bodies are contained in that document also.

The Board of directors will function as a corporate decision-making body, executive and non-executive directors will be full and equal members. Their role as members of the Board of directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. Trust functions that have not been retained as reserved by the Board of directors or delegated to a committee or sub-committee or otherwise for the purposes of and in accordance with the Mental Health Act 1983, shall be exercised on behalf of the Board of directors by the Chief Executive.

The Chief Executive shall determine which functions he will perform personally and shall nominate officers to undertake the remaining functions for which she will still retain accountability to the Board of directors. The Board of directors includes members with a diverse range of skills, experience and backgrounds in both public and private sectors, which incorporate many of the skills required of the Trust Board by the organisation.

All executive directors and non-executive directors, including the Chair, are appraised annually on their individual performance. Executive directors are permanent appointments, while non-executive directors have a tenure of up to three years, which may be reviewed.

The Board considers that all of the non-executive directors, except for David Boden, are independent as defined in the Code of Governance taking into account, character, judgement and length of tenure. None of the executive directors holds non-executive appointments.

All directors have confirmed that they meet the criteria for being a fit and proper person as prescribed by our Monitor Licence.

Sue Davis CBE, Chair

Sue Davis CBE was appointed as Chair for the Trust in November 2011.

Sue's extensive experience over the past 30 years as a senior non-executive in public bodies began at Shropshire County Council, where she served as a county councillor for 17 years, including eight years as Chair of social services, seven years as Chair of the pension fund, and four as Leader. During her decade at Telford Unitary Authority, Sue served as its first Chair of Education, then as cabinet member for resources. Sue also spent 12 years serving on national local government bodies. In September 2011, she took office as Chair of the National Childminders Association, the first non-childminder to be appointed to this role. Sue was a member of the Shropshire FHSA in the 1980s, served on Shropshire Health Authority from 1998 to 2002, and was Chair of Telford Primary Care Trust from 2002 until she was appointed as Chair for Sandwell and West Birmingham Hospitals NHS Trust in June 2006. Sue is a Governor of Queen's Theological College, Birmingham.

Interests: Chair of Trustees for the National Childminders Association; Governor of Queens College, Edgbaston; Director of West Midlands Constitutional Convention; member of the West Midlands Economic Inclusion Panel; Birmingham City Council, husband is a Councillor; BSMHFT - relatives (by marriage) work for the Trust.

John Short, Chief Executive

John Short has been Chief Executive of the Trust since April 2013.

He began his career as a social worker with local authorities and then moved on to mental health services management in the NHS. John has previously held a number of senior roles including Director of Mental Health and Learning Disability Services at Shropshire Community and Mental Health Services NHS Trust, and latterly at Shropshire PCT. John has also worked at Cheshire and Wirral Partnership NHS Trust as Chief Operating Officer, and was part of the team that took the Trust through its successful foundation trust application.

More recently John was seconded to Leicestershire Partnership NHS Trust as Director of Change Programmes, before taking on the role of Chief Operating Officer. In June 2011 he was then asked to take on the role of interim Chief Executive there, before he was appointed Chief Executive of BSMHFT in April 2013.

Interests: None declared.

Frances Allcock, Director of Organisational Development and Performance Improvement (left May 2013)

Frances, who was appointed to her role within the Trust in February 2010, was previously director for organisational development and change at the BBC. Frances also has a strong record in the private sector, having worked for various blue chip companies including Cable & Wireless, BT Global Services and PricewaterhouseCoopers LLP. She has a BA (Hons) degree in history, an MA in management learning and is a graduate of the Institute of Personnel and Development.

Interests: None declared.

Sandra Betney, Executive Director of Resources

Sandra joined BSMHFT as Executive Director of Resources in February 2013. She brings with her a host of skills and strong experience, and plays a key role in advising our Board on issues around the Trust's fiscal performance, information governance and its estate. Sandra has over 20 years' experience in the NHS. Most recently Sandra was Director of Finance and Commerce and Deputy Chief Executive at 2gether NHS Foundation Trust. Prior to this Sandra was Director of Finance and Procurement at the NHS Information Authority. Sandra has a degree in economics and is a fellow of the Chartered Association of Certified Accountants.

Interests: Director of Summerhill Supplies Ltd.

David Boden, Deputy Chair

David was appointed to the Board as a Non-Executive Director in October 2006, after serving as Chair on the Trust's Patient and Public Involvement Forum. Previously he has served as Senior Independent Director and Chair of the Mental Health Act committee. He is currently Chair of the Planning and Development Committee. At the same time he is the Chief Executive of a small family business and an investor and manager of commercial properties. Prior to this he was a management consultant under the DTI Enterprise Initiative, a Senior Lecturer at Aston University and Marketing Manager at 3M UK dealing in healthcare products. David is also a serving magistrate and was once a Deputy Director of Samaritans Solihull. David has most recently been appointed to the Fitness to Practice Panel for the NMC. He has a BSc in chemistry and an MSc in industrial administration.

Interests: Chief Executive, Company Director and shareholder (bookmaking and property company), magistrate on Walsall Bench, independent member of Misconduct Panel, West Midlands Police, and Director of Summerhill Supplies Ltd, NMC Fitness to Practice Panel and Vice-Chair of the Trust.

Susan Fairlie, Interim Director of Nursing

Susan was appointed as Interim Director of Nursing from 6 January to 31 March 2014. She has significant experience of the NHS and has worked across the health sector from primary care through to tertiary care. Susan was previously Director of Service Development and Executive Nurse at Worcestershire Mental Health Partnership NHS Trust and has recently held interim director roles at Norfolk Community Health and Care Trust, CSH Surrey and United Lincolnshire Hospitals. She has also held several national senior leadership roles including at the Department of Health and the NHS Institute for Innovation and Improvement.

Interests: Managing Director of Mindset Matters Limited.

Sue Hartley, Executive Director of Nursing

Sue joined our Trust as Executive Director of Nursing on 31 March 2014 and was previously Director of Nursing at Walsall Healthcare NHS Trust. She has a strong background in nursing, performance management and service redesign. She is a registered nurse and trained in Birmingham at the Queen Elizabeth Hospital. Sue has held various nursing and management posts and has worked in a number of senior management positions including Deputy Head of Performance at the West Midlands Strategic Health Authority. Sue has a passion for nursing and allied health professional (AHP) leadership, with a focus on the quality of care and experience given to service users and their carers.

Interests: None declared.

Brendan Hayes, Executive Director of Operations/ Deputy Chief Executive Officer

Brendan was appointed to the role of Executive Director of Operations in July 2013. As a qualified nurse with a strong mental health and operational management background, Brendan has a wealth of experience gained in a number of senior NHS roles. Most recently he was Director of Operations and Nursing at Northamptonshire Healthcare NHS Foundation Trust.

Interests: None declared.

Sukhbinder Singh Heer, Non-Executive Director

Sukhbinder was appointed as a Non-Executive Director in 2007. Prior to this, Sukhbinder was the managing partner of RSM Robson Rhodes, the UK member of RSM, one of the world's largest accounting and consulting firms. Sukhbinder is a Chartered Accountant and member of the Institute of Chartered Accountants of England and Wales. He holds a BA Hons in economics and a post-graduate diploma in management, from Harvard University. Sukhbinder is the Chair of the Trust's Audit Committee.

Interests: Partner, Reva Capital LLP; Consultant, Gambit LLP; non-executive director of Hadley Industries plc and Whiting Landscape Limited; member of the Chair's Circle of the Birmingham Symphony and Town Hall, Governor of the King Edward's School Foundation in Birmingham.

Barry Henley, Non-Executive Director

Dr Barry Henley joined us as a Non-Executive Director in July 2013, a role he has previously held at Heart of Birmingham teaching PCT and the Birmingham and Solihull NHS Cluster. Barry brings a wealth of experience and expertise in private industry and the public sector to our Trust. He was Chief Executive of Chubb group companies in the UK, Singapore and Australia, before becoming Chief Executive of the faculty of engineering and computing at Birmingham City University. He was subsequently a knowledge transfer partnership advisor on dozens of innovation projects for the Technology Strategy Board. Barry is also a councillor representing the Brandwood ward on Birmingham City Council and he chairs the Council's conservation and heritage panel, the wholly owned subsidiary Acivico, the ICT joint venture with Capita and the Standing Advisory Council on Religious Education. Barry acts as Chair of the Trust Board's Mental Health Act Legislation Committee and also as Vice-Chair of the Audit Committee.

Interests: Birmingham City Council Councillor for Brandwood, Director Acivico, an arm's length company for the City Council, Director for Service Birmingham, Governor to King David School and Trustee of University of First Age Charity.

Alan Kenny, Interim Executive Director of Operations (until July 2013)

Alan was appointed as the Interim Executive Director of Operations from January until July 2013. Alan has worked for the Trust for many years within the estates team and his current role is Director of Infrastructure and Asset Management.

Interests: Director of Summerhill Supplies Ltd.

Dr Peter Lewis, Executive Medical Director

Dr Peter Lewis was appointed Medical Director for BSMHFT in June 2009. Peter completed his training at the University of the West Indies in 1972, then specialised in psychiatry, gaining his FRCP from the University of Toronto in Canada. Peter joined the Trust as a Consultant Psychiatrist in 2001. Prior to that he was a Consultant Psychiatrist for a mental health trust in north west England, and also had a number of consultant assignments for global organisations including the United Nations and the World Health Organisation.

Interests: Harriet Tubman House, provision of consultant psychiatric services.

Dee Roach, Executive Director of Quality, Improvement and Patient Experience (left December 2013)

Dee was appointed to her role with our Trust in February 2010, having more than 25 years' experience of working in mental health settings. Dee's previous senior roles include Senior Director of Operations for a large health economy in the North West of England, leading service redesign, reconfiguration and developing a range of new services. Latterly, as Deputy Director of Nursing and Director of Clinical Design, she led work to develop the service and workforce models for a major capital scheme to replace mental health inpatient services across Lancashire.

She holds a BSc in nursing studies, a diploma in psychological interventions and is a registered mental nurse. Dee left the Trust at the end of December 2013.

Interests: None declared.

Waheed Saleem, Associate Non-Executive Director

Waheed, who joined as an Associate Non-Executive Director in July 2013, is a management consultant working in the public and voluntary sectors. He graduated from the London School of Economics, is a fellow of the RSA and a member of the Association of Corporate Governance Practitioners. His background includes working at director level in a number of strategic roles in the NHS, most recently as a PCT Locality Commissioning Director in Birmingham. In addition to this NHS experience, he also holds chair and non-executive director positions at a number of major national and regional public and voluntary organisations. Waheed has led significant regeneration programmes, advised the Government on neighbourhood renewal policy and community development, and was instrumental in developing leadership programmes for young people and mentors in inner city schools.

Interests: Waheed is a Trustee of NACRO, Chair of the RCRH and Groundwork West Midlands Charity, Non-Executive Director of Metropolitan Housing, Owner of WS Associates Midlands Limited, Non-Executive Director for Paycare and ACPG and Chair of the Birmingham Lunar Society.

Joy Warmington, Non-Executive Director

Joy Warmington, who was appointed as an Associate Non-Executive Director on 3 January 2012 and appointed as a Non-Executive Director in April 2013, has experience in the public and voluntary sector with particular experience in working with health trusts on issues of service development, equality and human rights issues, regeneration and education. Joy is Chair of the Integrated Quality Committee.

Interests: Chief executive officer, BRAP; vice chair, Gateway Family Services; Governor, Solihull College; and chair CIN (BBC).

Dr Nerys Williams, Non-Executive Director

Dr Nerys Williams - who was appointed as a Non-Executive Director on 1 December 2011 - is a qualified doctor specialising in the field of occupational health medicine. She has worked in both clinical, regulatory and strategy/health policy roles including work for Health and Safety Executive and Department for Work and Pensions. Nerys was appointed as the Senior Independent Director for the Trust in May 2013 and chairs the Trust's Charitable Funds Committee.

Interests: Member of the equality and diversity committee, monitoring committee and examiner for the Royal College of Physicians; Disability assessment medicine examiner and chair of promoting occupational health in medical schools group at the Faculty of Occupational Medicine, London; Independent remuneration panel of Solihull Metropolitan Borough Council; Honorary Senior Lecturer, University of Birmingham; Honorary associate professor, University of Warwick; Specialty doctor, Heart of England NHS Foundation Trust; Performance assessor and examiner PLAB, General Medical Council; Member of the editorial board, Society of Occupational Medicine; and medical advisor, Capita.

The Board met 12 times during 2013/14. Attendance of these meetings is set out in the table overleaf.

Table 12: Trust Board attendance 2013/14

	24/04/13	29/05/13	26/06/13	07/08/13	28/08/13	25/09/13	30/10/13	27/11/13	18/12/13	29/01/14	26/02/14	26/03/14
Sue Davis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Short	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brendan Hayes			✓	✓	O	✓	✓	✓	✓	✓	✓	✓
Peter Lewis	✓	✓	✓	O	✓	✓	✓	✓	✓	✓	✓	✓
Sandra Betney	✓	✓	O	O	✓	✓	✓	✓	✓	✓	✓	✓
Susan Fairlie										✓	✓	✓
Dee Roach	✓	✓	✓	✓	✓	✓	✓	✓				
Alan Kenny	✓	✓	✓	✓								
Sukhbinder Singh Heer	O	O	✓	O	O	✓	✓	✓	✓	✓	✓	✓
David Boden	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nerys Williams	✓	✓	✓	✓	O	✓	✓	✓	✓	✓	✓	✓
Joy Warmington	✓	✓	✓	✓	✓	✓	O	O	✓	✓	✓	✓
Barry Henley			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Waheed Saleem			O	✓	✓	✓	✓	✓	✓	✓	✓	✓

O = apologies given ✓ = attended meeting

Audit committee

The audit committee's function is to review integrated governance, risk management and internal control across the whole of our organisation's activities, both clinical and non-clinical, which supports the achievement of our objectives.

Its membership comprised the following non-executive directors: Sukhbinder Singh Heer (Chair), Barry Henley, David Boden, and Dr Nerys Williams and associate non-executive director, Waheed Saleem. It receives advice from both internal and external audit. David Boden stepped down from the audit committee in March 2014 leaving three independent non-executive directors.

The role of the audit committee is to provide assurance to the Board that systems and processes are in place and effective for the effective management of the Trust. The audit committee aligns its work programme to the assurance framework to ensure that the major risks facing the Trust are mitigated.

The committee meets quarterly, when at least two of its members are required to be present. The Executive Director of Resources, Medical Director, and Executive Director of Nursing also attend these meetings as required, as do appropriate internal and external audit representatives. The directors are responsible for preparing the accounts. Finally the committee also meets at least once a year in private with the external and internal auditors. The audit committee will consider any additional work that may be performed by external auditors and determine if there is a conflict of interest before any work commences.

Audit committee attendance

The table overleaf details attendance at the audit committee meetings, which were held every two months between 1 April 2013 and 31 March 2014.

Table 13: Audit committee attendance 2013/14

	22/05/13	21/08/13	20/11/13	19/02/14
Sukhbinder Singh Heer	✓	✓	✓	✓
David Boden	✓	✓	✓	✓
Nerys Williams	✓	✓	✓	✓
Barry Henley	✓	✓	✓	✓
Waheed Saleem	✓	✓	✓	✓

O = apologies given ✓ = attended meeting

Significant issues considered by the committee in relation to the financial statements

The Audit Committee in discharging its responsibilities has considered on several occasions the draft accounts prior to approving them on 21 May 2014.

It should be noted that the Trust had a trading surplus on the income and expenditure account of £2m. The draft annual accounts had reported a surplus of £3.2m and the difference related to an exceptional item relating to termination benefits of £0.9m which is included in the surplus before impairment in the management accounts. Further, there are two adjustments to the accounts which were amended prior to audit:

- An adjustment has been made of £110k relating to payments in respect of two service areas.
- A redundancy payment for 2013/14 of £99k was notified late.

The Audit Committee also noted the following exceptional items:

- A reversal of impairment losses of £5.4m following a revaluation of the estate.
- A reversal of the previous year's provision for termination benefits of £0.9m
- An impairment of the Trust's accounts relating to the Tamarind Centre of £0.5m.

The committee also considered the ISA 260 opinion received from the external auditors noting that they offered an unqualified opinion on the accounts. The auditors did identify some significant audit and accounting matters which were considered by the committee, as follows:

Consolidated Accounts

The accounts included consolidation of both the Trust's accounts and the accounts of Summerhill Supplies Limited (SSL). The committee is aware in one material difference in accounting policies in respect of both fixed assets. The Audit Committee, has considered and is satisfied that the lease between SSL and the Trust in respect of the Tamarind Centre continues to meet the requirements of an operating lease and that this has been appropriately accounted for. The committee agreed not to consolidate the accounts of the Trust's charitable funds.

Estates/ Impairments Valuations and new projects

The Audit Committee have noted the significant changes in the value of the Trust estate due to the volatility of the property market. A valuation of the estate was undertaken in February 2014 and the Audit Committee has noted the approach taken by the District Valuer and accepted this approach.

Accounting for Termination Benefits

The Audit Committee noted the redundancy provision relating to redundancy payments; leading to £1.8m being released back to the statement of comprehensive income.

Other Provisions

The Audit Committee has noted that the Trust has increased its injury allowance provision by £1.6m as at 31 March 2014 to £1.7m. In the previous financial year the provision was £0.1m. The Committee was satisfied with the basis of the revaluation provision.

Misstatements and Significant Audit Adjustments

The Audit Committee noted that there had been reclassification related to £0.5m of impairment of the Tamarind centre which had been accounted for within operating expenditure rather than as an exceptional item.

Judgments and Accounting Estimates

It was also recognised that the bad debt provision has an inherent level of judgement and noted that this was £0.4m as at 31 March 2014. The Audit Committee also noted that this was the same level of bad debt provision in the previous financial year.

The Audit Committee noted that significant testing on levels of deferred income undertaken by the auditors did not identify any matters to bring to the attention of the committee.

The Audit Committee considered that there were no material issues arising after the end of the financial year which would have any issues on the accounts.

Finally, the Audit Committee considered as to whether the financial accounts represented that the Trust was a going concern and was satisfied that it is.

Summerhill Supplies

In November 2012 our Trust Board approved plans to establish a subsidiary company, wholly owned by BSMHFT, called Summerhill Supplies Limited. The subsidiary company operates on a commercial basis, providing the Trust with the ability and capacity to identify appropriate opportunities within and outside the NHS, which are beneficial to the Trust.

The scope of services offered enables the Trust to maximise its expertise, resources, skills and significant assets, in turn the company will be able to manage and deliver services with the flexibility needed in an increasingly competitive environment.

While this is an innovative initiative, this way of working is becoming more commonplace within the NHS and other public sector organisations.

Summerhill Supplies currently provides outpatient dispensing services to the Trust. The company also owns the building and operates facilities management services at one of our medium secure units, the Tamarind Centre.

Meet the Governors

Governance of a Foundation Trust is prescribed by legislation, to comprise members, governors and the Board of directors. The members may be patients, staff or the general public who have an interest in the Trust and its work. The governors are appointed by the members to represent them across a number of constituencies, such as staff governor, stakeholder governors (local authority, education, Police Commissioners, third sector) as well as public governors appointed from the general membership, and those representing patients or carers. Governors have a number of statutory functions including: appointment and removal of the Chair and non-executive directors, setting allowances for the Chair and non-executive directors, approve the appointment of the Chief Executive, scrutiny of the annual plan and appointment of auditors, as well as receiving the annual audit report.

Composition of the Council of Governors

The composition of the Council of Governors shall be in accordance with the constitution of the Foundation Trust. The Chair is not a governor. However under the Regulatory Framework, she will preside at Council of Governor meetings and holds the casting vote. Where the Chair of the Trust has died or has ceased to hold office, or where she has been unable to perform her duties owing to illness or any other cause, the Deputy Chair shall act up until the existing Chair resumes her duties or a new appointment is made.

Role and responsibilities of the Council of Governors

The roles and responsibilities of the Council of Governors, to be undertaken in accordance with the Trust's constitution, are to:

- appoint and remove the Chair and other non-executive directors of the Foundation Trust at a general meeting
- approve at a general meeting the appointment by the non-executive directors of the Trust
- appoint or remove the auditors at a general meeting
- be consulted by the Trust's Board of directors on forward planning and have the Council of Governors' views taken into account within the primary care system
- be presented with the Trust's annual report and accounts, and the auditor's report on the accounts at a general meeting.

The 2006 Act provides that all the powers of the Foundation Trust are to be exercised by its directors. The Council of Governors does not have the right to veto decisions made by the Board of directors.

The Council of Governors, and individual governors, are not empowered to speak on behalf of the Trust and must seek the advice and views of the Chair concerning any contact from the media or any invitations to speak publicly about the Trust or their role within it.

For the avoidance of doubt, in this context the Chair acts as the Chair of the Trust, not the Council of Governors, and in her absence governors should seek the advice of the Deputy Chair of the Trust, or the Senior Independent Director.

The specific role of Trust Governors

All NHS Foundation Trusts must have a Council of Governors to represent Trust members' interests in the development of their organisation.

Our Trust is served by 22 governors across Birmingham and Solihull, comprising five from public constituencies, four representing service users, three carers, three staff and seven for partner organisations. Our governor constituencies are Birmingham, Solihull and rest of England and Wales. Birmingham is represented by three public governors and two service user governors; and Solihull and rest of England and Wales are represented by one service user governor and one public governor each.

Governors are a key link with the communities our Trust serves, who feed back to the Board of directors on issues their constituents feel need to be addressed, as well as ideas for service development or improvement. Part of their role is to ensure the views of service users, stakeholders and local communities are taken into account when plans for services are being drawn up. They are also ambassadors for the Trust who champion initiatives to tackle the stigma associated with mental illnesses.

The governors' relationship with the Board of directors is also critical as they also have a strategic role, helping to set priorities for change and improvement. A major responsibility is the appointment of the Trust's Chair and non-executive directors, and to approve the appointment of the Chief Executive. Their role also includes holding the Trust's Board to account, and ultimately they have the ability to terminate the Chair's or non-executive directors' contracts. However, our governors are not involved in the day-to-day running of the organisation, nor can they inspect its services or overrule decisions made by the Board of directors, as they are not employed by the Trust. It is also not an appropriate platform for those who wish to pursue political agendas or represent lobby or pressure groups, as they must represent their constituency's range of views.

Since the Health and Social Care Act 2012, our governors have been discharging their new powers. Whilst the majority of the new powers came into force in April 2013, training and networking with other foundation Trust governors has taken place to share and identify best practice. Following the implementation of specific parts of the Health and Social Care Act in October 2012, our Council of Governors and Board of directors approved amendments to our Constitution to take account of the changes to legislation.

All governors have confirmed that they meet the criteria for being a fit and proper person as prescribed by our Monitor Licence.

Governors are expected to maintain regular contact with members within their constituencies, which at a minimum involves briefing them on the outcome of Council meetings. We are seeking to improve our engagement between our governors and membership; in some areas we already have positive relationships established but further work is required to embed this with all of our governors. Our work to date has included governors attending celebration events or participating in our annual general meeting at which members attend. In 2014 we are holding membership seminars which will be hosted by governors, allowing an opportunity for members to approach members directly.

Members can contact their governor by sending email messages to contact.governors@bsmhft.nhs.uk, calling the Governor Liaison Office on 0121 301 1096, or by writing to the governor c/o: Governor Liaison Office, BSMHFT, 50 Summer Hill Road, Birmingham, B1 3RB.

During the last year our Trust has led and delivered two different networking groups, the Midlands and East Mental Health Governor Network and the Pan Birmingham Provider Network. These brought together a large number of Governors from different Trusts to network, receive briefings and share ideas.

Nomination and Remuneration Committee

As of the 31 March 2014, the committee's membership is made up of the Trust's Chair and six governors:

- Darren Cooper (Lead Governor, staff constituency)
- Peter Brown (service user constituency)
- Peter Tinsley (public constituency)
- Maureen Johnson (carer constituency)
- Tessa Griffiths (stakeholder constituency)
- Maureen Smojkis (stakeholder constituency)

The Governors' Nomination and Remuneration Committee met three times between 1 April 2013 and 31 March 2014.

At the meeting on 29 August 2013, Darren Cooper, Peter Tinsley, Maureen Johnson and Peter Brown were in attendance.

At the meeting on 21 November 2013, Darren Cooper, Peter Tinsley, Maureen Johnson, Peter Brown and Tessa Griffiths were present.

At the meeting on 13 February 2014, Darren Cooper, Peter Tinsley, Maureen Johnson and Peter Brown were in attendance.

The committee met to agree the process for conducting appraisals for the Chair of the Trust and the non-executive directors, they have also participated in the appraisal of the Chair and fed the results back to the whole Council of Governors. The members of the committee are involved in the appraisals of the non-executive directors and Chair.

The committee considered the reward packages of the Chair and the non-executive directors, taking into account benchmarking data, as well as the requirements for the non-executive director vacancies arising from an existing non-executive director's term ending.

The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the chair of the Trust and the other non-executive directors. Removal of the chair or another non-executive director shall require the approval of three-quarters of the members of the Council of Governors.

Governor elections

This year has seen four governor elections in three different constituencies. The term for the Carer, Solihull and the Non-Clinical Staff Governor seats came to an end in February 2013, and as there was more than one candidate standing, these were decided by an externally verified ballot in May 2013. The Carer, Solihull seat had two candidates and went to ballot on May 10, 2013. Maureen Johnson was announced as the chosen Governor in May 2013. There was also an election for the Service User Governor for the Rest of England and Wales, on the first attempt no candidates stood, on the second occasion John Stone was appointed unopposed. A vacancy arose in the Non-Clinical Staff Governor, which led to six candidates standing, leading to a ballot being held on 8 October, 2013 with Lucy Okill being appointed Non-Clinical Staff Governor.

Due to the resignation of Sandra George from the Public constituency, Solihull, there is currently one vacancy, for which an election process is being undertaken.

Our Governors

Public Birmingham

Pat Hemmings - elected in October 2011

Peter Tinsley - elected in November 2011

Khalid Ali – elected in November 2011

Public Solihull

Dr Sandra George – elected January 2013 – resigned March 2014

Public rest of England and Wales

Mary Jones – elected in April 2012

Carer

Lawrence Innis – elected in October 2011

Anne McKenzie – elected in October 2011

Maureen Johnson – elected May 2013

Service User Birmingham

Faheem Uddin – elected October 2011

Lynda Smith – elected October 2011

Service User Solihull

Peter Brown - elected unopposed March 2012

Service User rest of England and Wales

John Stone – elected unopposed August 2013

Staff

Darren Cooper (Clinical non-medical) - elected unopposed October 2011

Dr Asaf Khan (Clinical medical) - elected unopposed April 2011, elected unopposed March 2014

Non-clinical - Lucy Okill elected October 2013

Stakeholder

Steve Wordsworth (Birmingham City University) - appointed May 2013

Maureen Smojkis (Birmingham University) - appointed July 2011

Cllr Mick Brown (Birmingham City Council) - reappointed September 2013

Dr Peter Lea (Solihull Metropolitan Borough Council) - reappointed July 2011

Tessa Griffiths (Council for Voluntary Services) - reappointed July 2011

CI Sean Russell (West Midlands Police) – appointed September 2013

Dr Aqil Chaudary (Cross City Clinical Commissioning Group) - appointed December 2013

Our Board are committed to the views of our governors and members. The governors are invited to attend monthly Trust Board meetings to hear the views of the Board and comment on Trust business. governors also receive papers of the Board meetings including private items. Furthermore our executive and non-executive directors endeavour to attend Council of Governor meetings in order to network and collaborate with the governors on a regular basis and in order to gain their valuable insight. Other ad-hoc governor meetings are attended by various executive and non-executive directors in order to ensure a wide spread of knowledge when discussing strategic issues.

A list of the declarations of interests of the Governors of the Trust is available from Gill Harrad, Company Secretary and Head of Legal Services (gill.harrad@bsmhft.nhs.uk or telephone 0121 301 1085).

Our Lead Governor

Darren Cooper is the governor representing the staff constituency (nursing). Darren was appointed as Lead Governor since authorisation. Governors will generally communicate with Monitor, our regulator, via our Chair. However, there may be instances where it would not be appropriate for the Chair to contact Monitor, or for Monitor to contact the Chair (for example, in relation to the appointment of the Chair). In such situations, it would be the Lead Governor that would communicate with Monitor.

Darren has been a governor in the Trust since July 2008. Darren works in the Trust as a Team Manager at our healthcare facilities at Birmingham Prison. Darren is also a Councillor and Council Leader for Sandwell Borough Council.

Attendance at Council of Governors meetings

Details of the number of Council of Governors meetings attended by each governor and directors are as follows:

Table 14: Attendance at Council of Governors meetings

	16/05/13	11/07/13	12/09/13	AGM 26/09/13	14/11/13	16/01/14	13/03/14
Khalid Ali	✓	✓	✓	✓	✓	✓	✓
Mick Brown				O	O	✓	✓
Peter Brown	✓	✓	O	✓	✓	✓	✓
Aqil Chaudary						O	✓
Darren Cooper	✓	✓	✓	✓	✓	✓	✓
Sandra George	O	✓	O	O	O	O	
Tessa Griffiths	✓	✓	✓	O	✓	✓	✓
Pat Hemmings	O	✓	✓	O	O	O	O
Lawrence Innis	✓	✓	✓	✓	✓	O	O
Maureen Johnson	✓	✓	✓	✓	✓	✓	✓
Mary Jones	✓	✓	✓	✓	✓	✓	✓
Asaf Khan	✓	✓	✓	O	✓	✓	✓
Peter Lea	✓	✓	✓	O	✓	O	✓
Anne McKenzie	✓	O	✓	O	✓	O	✓
Lucy Okill					✓	✓	✓
Sean Russell			✓	O	O	✓	✓
Lynda Smyth	✓	✓	✓	O	✓	✓	✓
Maureen Smojkis	✓	O	O	O	✓	✓	✓
John Stone			✓	O	✓	✓	✓
Peter Tinsley	✓	✓	✓	✓	✓	✓	✓
Faheem Uddin	✓	O	✓	✓	✓	O	✓
Steve Wordsworth		✓	✓	O	O	O	O

O = apologies given ✓ = attended meeting

A busy year for our governors

Under the direction of Sue Davis, and in the spirit of the NHS reforms, governors have maintained a high level of involvement in the running of the Trust, helping shape Trust strategies and offering input into other aspects such as how we can engage more effectively with our members.

Governors play an important part in the strategic direction of our Trust and their input is extremely valuable. Governors are invited to feed their views into the annual business plan and to comment on the Trust's strategic direction, whether that be through formal meetings, ad hoc seminars or one-to-one meetings with the Chair.

Our governors attend joint sessions with our Board of directors (twice a year) for discussions on future strategy.

Actively engaging members to gather their thoughts, our governors have been out and about for the past year, attending carers and service user groups, representing the Trust on a number of issues.

As well as membership, governors also take a keen interest in staff engagement and staff recognition. Many governors were involved in judging last year's Board Challenge, and went on to present the awards and even assisted in organising the evening event which was held on the same evening as our Long Service Awards.

Governors also played an active role in the recruitment of our new external auditors. Four governors sat on the evaluation panel and the rest of the Council of Governors received a recommendation to appoint at the November Council of Governors meeting.

The Health and Social Care Act 2012 has seen a change in Governor responsibilities. In keeping with this, governors attend the private board session, have undertaken training and regularly attend conferences such as those held by the Foundation Trust Network, or by the local health economy within the West Midlands. These conferences help governors develop within their role, and also offer networking opportunities. They have also undergone a name change and are now known as the Council of Governors rather than the Assembly of Governors.

Likely future developments at our Trust

Our estate

We have produced a draft estates strategy for 2014-19, a key objective of which is to support the re-design of services and the development of new ways of working. Emerging priorities to be addressed are:

- relocation of three stand alone inpatient units
- a development that will allow services to be relocated from a site unsuitable for mental health provision
- development to address shortfalls associated with two inpatient units
- development of two new community hubs
- new ways of working for IAPT services workers.

Tenders

There are various tender opportunities for our Trust identified or planned at present.

Corporate review

Our plan is to deliver productivity gains across the corporate function. This will take the form of reviewing back office processes to determine the most effective way of supporting operational services.

Significant activities in research and development

Our Trust's reputation is enhanced through our research and innovation work. We enjoy partnerships with the Universities of Birmingham and Warwick, work with many other universities and NHS mental health trusts throughout the United Kingdom, and we continue to host the Heart of England Mental Health Research Network. This enables us to both lead and participate in high quality research that has both a local and national impact. Some examples of our work in 2013-14 are:

Neuropsychiatry research programme

The last year has seen further growth in our neuropsychiatry research. Dr Hugh Rickards (programme lead) is the national lead for Huntington's Disease (HD) Research for the Dementia and Neurodegenerative Disorders Research Network (DeNDRoN) and is chair of the United Kingdom HD research network. He has developed an international role as part of the European Clinical Trials Taskforce for HD and sits on the ENROLL-HD scientific planning committee. We have set up a successful collaboration with Cardiff University for clinical trials in exercise therapy for HD. Researchers in the department have published agenda-setting papers on social cognition in HD and the role of carers in research in HD. We have pioneered the role of physiotherapy and occupational therapy research within the Trust. We are now one of the major research sites in the UK for HD research, enjoying a European and global reputation for our work.

Addictions research programme

The addictions research programme has had outstanding success in securing funding for a number of studies. Most recently, we have received a grant for a multi-centred trial to adapt and test a family and social intervention for young people with substance misuse problems based on previous work conducted within the programme. Another NIHR trial of a brief intervention for substance use in Trust inpatient units is well over half way and is providing a much needed evaluation of a service provided to the high numbers of patients with alcohol and cannabis problems admitted to Trust inpatient units. In addition, all the five drug service Hubs are part of the National Study of Contingency Management approaches to the treatment of drug problems. This study will have important implications for the

future management of addiction treatment in the UK. Finally, programme lead Professor Alex Copello has this year led and developed an international network to promote research into the impact of families and addiction (AFINET).

Neurodegenerative disorders and cognitive impairment

The research programme continues to be at the forefront of dementia research. We were delighted that one of our programme research nurses (Analisa Smythe) was awarded £200k by the Burdett Trust to develop and evaluate a dementia skills training intervention for nursing staff in care homes. Analisa and Dr Paul McDonald (Research Manager) are also leading the NIHR ENRICH project across the West Midlands, encouraging care homes to participate in NIHR research in dementia, stroke and diabetes. Programme Lead Dr Peter Bentham is currently analysing data collected to evaluate the effectiveness of brain training on cognitive function in people with Alzheimer's Disease. Dr Bentham is also principle investigator in two NIHR Health Technology Assessment trials and two commercial studies.

Early intervention and prevention research programme

The early intervention theme is central to the next five years of the Collaboration for Leadership in Applied Health Research and Care in the West Midlands (CLAHRC-WM), which was recently refunded. Mental health was the best performing theme in the outgoing CLAHRC and forms a central pillar of CLAHRC-WM in its focus on youth mental health and prevention; and is a priority for the new West Midlands Academic Health Network (AHN). Our Youthscape pathway and its linked research led directly to the CCG re-commissioning of a new 0-25 pathway for Birmingham. A new programme grant 'PARTNERS', has recently started and is a collaboration with primary care in Birmingham to find new ways of supporting people with serious mental illness in primary care through collaborative care and specialist support. Our MRC 'COMMAND' trial will report soon (expected publication in Lancet Psychiatry). The study shows that harmful compliance in individuals with commanding hallucinations who have acted on their voices with disastrous consequences for themselves and others, is reduced by nearly a half following intervention. This is the first such demonstration of an intervention that reduces risk.

Ethnicity and mental health research programme

Throughout 2013/14 the implications of a range of NIHR funded studies (ENRICH, AMEND, ENDEAVOUR) are still being disseminated and discussed both locally and nationally. Over time the programme lead professor Swaran Singh has focussed more upon youth and minority mental health problems and in particular upon the transition from child to adult mental health care. Subsequently, Professor Singh has secured funding through the European Union for the MILESTONE project which aims to strengthen the transition experienced in a number of countries across Europe. Additionally, he is working with Dr Doug Simkiss (University of Warwick) on the NIHR LYNC study evaluating how to improve the mental health and wellbeing of young people leaving public care.

Research PPI programme

During 2013/14 we have continued to ensure that we involve our service users, carers and members of the public at the early stages of all the work we undertake and continue to involve them throughout the process.

The MHRN has continued to support service users and carers involved in research. There is now an established database of individuals and organisations that provide support and guidance to those who require PPI involvement. We now have research-trained members who can review grant applications and ethics submissions, provide support in developing questionnaires, leaflets and information sheets, and host focus groups and conduct interviews. We also have developed resources on how researchers can engage with service users, carers and members of the public. We have developed a 'budget calculator' providing future service users, carers and researchers with a means of calculating what funding would be required for PPI.

West Midlands Academic Health Science Network (WMAHSN)

Following the publication of Innovation Health and Wealth in December 2011, academic health sciences networks were established throughout England. The goal is to improve the identification, adoption, spread and speed of innovation and good practice in the NHS. The West Midlands AHSN selected mental health as one of the three clinical priority areas. Our Medical Director is a Board member of the WMAHSN with specific responsibilities for the mental health component of the network. BSMHFT has been successful in receiving support for the following projects:

- Medically Unexplained Symptoms (MUS).
- RAID.
- Youth Pathway.

Staff wellbeing

The wellbeing of our staff is of paramount importance to us and, as such, we have various policies and support services in place to assist them in maintaining a healthy work-life balance. These include:

- an occupational health service
- flexible working options
- physiotherapy services
- Resolve staff support
- tax free cycle scheme
- reduced membership at a number of local gyms
- childcare voucher scheme
- access to a physical therapies service.

At an individual level we continue to support staff, through a number of policies and procedures that are in place to ensure that if they have any concerns regarding the conduct, behaviour or ability of a member of staff that these issues can be fairly investigated.

We acknowledge and understand that conflict at work can have a significant impact on staff and have a number of different support mechanisms in place to support staff including a Resolve staff care (in-house confidential counselling service), occupational health, bullying and harassment advisors and advice and guidance from human resources team. The bullying and harassment advisors act as independent advocates who provide confidential advice/support and often support and enable staff to resolve issues informally where appropriate.

Sickness absence

Working on the frontline in mental health services can be demanding and requires resilience. The Trust employs a range of measures to support staff in accessing the right support and guidance when they are unwell to aid their recovery and assist them in returning to work as quickly as possible. The management of attendance (sickness absence) policy encourages managers to recognise when staff may require specific support. Staff are able to access professional advice and support via our occupational health provider, confidential staff support (Resolve) and physiotherapy service.

We are continuing to work towards achieving our stated sickness absence target of 3.39%. We ran two training sessions with managers in January 2014 in conjunction with occupational health, physiotherapy, Resolve staff care and the employee relations team. They were aimed at supporting managers in managing the health and wellbeing of their staff.

Sessions explored best practice guidance and the importance of early intervention. Our trades union lead representatives were also present throughout both workshops and feedback from staff was positive. More of these sessions are planned throughout the year.

In addition we are also reviewing our sickness absence policy so that managers have the right tools and guidance available to them to manage absence.

Table 15: Staff sickness absence 2013/14

Month	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
	4.01%	4.40%	4.40%	4.67%	4.13%	4.48%
	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
	4.87%	5.09%	5.30%	5.45%	5.45%	5.43%

Working in a healthy, safe and secure environment

Our commitment to providing a safe, secure and healthy environment for our staff is unwavering. As part of this commitment, every member of staff receives mandatory training in a number of areas including health and safety and fire safety. Our specialised health and safety staff make regular assessments providing assurance that all standards of health and safety legislation are adhered to. Occupational health services are provided to all staff by an external provider, Team Prevent.

Managing violence and aggression

We believe that any incident involving violence and/or abuse is unacceptable and we take prevention and management of these issues extremely seriously. Our Trust continues to deliver a programme of such measures which are implemented by our local security management specialist, who supports any individual who has been affected by such incidents, with a specific emphasis on liaising with the appropriate criminal justice agencies to ensure sanctions are imposed on the aggressor when appropriate. Our local security management specialist is part of the risk management department and is available to provide advice and support to clinical teams, individuals and in some areas, service users across our Trust in relation to tackling violence against staff and reducing the impact of crime on staff and service users.

Information about employment and training of disabled persons is covered in the equality and diversity section of the Strategic Report on page 20.

Information about how we engage with our staff can be found in the Strategic Report on page 22. This includes actions taken during the year to:

- provide employees systematically with information on matters of concern to them
- consult employees so their views can be taken into account
- encourage the involvement of employees in the Trust's performance
- achieve a common awareness of the financial and economic factors affecting the Trust's performance.

Financial risk management

Our financial risk management and exposure to price risk, credit risk, liquidity risk and cash flow risk are explained in the summary financial accounts in the Strategic Report on page 16.

How we govern service quality

Our Board established an Integrated Quality Committee which provides assurance to the Board on the effectiveness of quality and safety across all services. The committee has a clear programme of work including the following reports:

- Quarterly themed review of serious incident recommendations.
- Progress against the Trust Quality Strategy and Quality Governance Assurance Framework.
- Themes from external reviews and internal quality assessments.
- Regular team to Board monitoring report.
- Performance report, service profile and benchmarking reviews of services.
- HR dashboard.
- Key risks identified in Trust risk registers.

Each service area has a monthly Service Area Integrated Quality Committee chaired by their Clinical Director, to support and co-ordinate effective clinical governance arrangements and to demonstrate high standards and a commitment to service improvement.

Improvements in quality are overseen by the Integrated Quality Committee through the Operational Clinical Governance structure.

The role of the Clinical Governance group which reports to the Integrated Quality Committee and is jointly chaired by the Medical and Nursing Directors includes:

- a systematic and co-ordinated approach to the provision of good quality clinical care
- continuous improvement of clinical services
- assessment and management of patient safety and risks.

There are various workstreams that report to the Clinical Governance group and report quarterly against defined work programmes. The Audit Committee reviews the effectiveness of our systems of integrated governance, risk management and internal control. The Mental Health Legislation committee ensures we meet the requirements of all relevant mental health legislation.

The Board monitors quality at each meeting including quality goals, quality account priorities and serious incidents. A service user and carer experience report reviews complaints received, trends in issues identified and learning. The report also includes feedback and data from our real time feedback monitoring system which monitors service user and carer views across the organisation

The Trust has continued to apply Monitor's Quality Governance Assurance Framework which contributed to the development and implementation of the Trust's Quality Strategy.

In order to further support progress, in February 2013 we commissioned a review of compliance against Monitor's Quality Governance Framework using a limited version of standard methodology adopted for aspirant Foundation Trusts. The review was commissioned for internal purposes to enable continuous improvement to services and embed quality. A further review conducted by in July 2013 identified a significant improvement and reduced the score to 6. The report reinforced actions being undertaken to move towards a score below 4, the expected standard for aspirant Trusts. Progress on this work is reviewed through the Integrated Quality Committee and reported to Trust Board.

More information about how we govern service quality can be found in the Quality Report on page 76 and Annual Governance Statement on page 125.

The role of internal audit

The Trust has an internal audit function, provided by Deloitte, which develops an annual audit plan based on the following criteria:

- **Delivers a risk focused audit programme** – through informed risk assessment across the organisation and at a component level (review of key documentation, meeting with key members of staff).
- **Is proactive and forward looking** – by looking at the risks the Trust faces and trying to minimise these through our work.
- **Adds value** – through practical and commercial recommendations, working with other functions, for example, clinical audit, and trying to make effective use of resources where possible.
- **Engages stakeholders** – thereby ensuring commitment across the Trust.
- **Supports the Audit committee** – as one of the key stakeholders, we will work with the Audit Committee in supporting its work for the year.

Internal audit plans are based upon a risk assessment, which ensures the programme reflects key risks faced by the Trust, cross referenced to the Trust Assurance Framework. Deloitte use a business risk model to assess and understand a wide range of risks, and inform our plan. Key areas include:

- environmental risks
- operational risks
- information and decision making risks.

Our internal audit plans consider the national context of the health economy and current developments in the regulatory environment. This includes changes in the Care Quality Commission's assessment framework. We have held discussions with Trust senior management to support us in developing our audit plans. We have also reviewed the work that has been undertaken over the previous three years, to inform the development, and the outcome of those reviews.

In accordance with NHS Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (ie the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit committee.

Patient care

2013 National Patient Survey

The national patient survey highlighted that we had improved against our priority areas in relation to giving patients a copy of their care plan and explaining the side effects of medication, however we still need to do more to improve the quality of our care planning arrangements, how we involve family and support networks and also referring to partner agencies.

Friends and Family Test

Our Trust has been part of the NHS England consultation group which has advised on how the Friends and Family Test will work in mental health. Our contribution has been particularly valued due to our experience in having peripatetic teams and in areas such as prison mental health.

Real Time Patient Feedback

Since January 2013, our Trust has been asking our service users and carers about their experiences and actively using their responses in our services. We operate real time feedback across our Trust so that patients' and carers' views can be swiftly collected and collated, to make real improvements in the services they receive.

In March 2014 we reached the landmark of 4,000 surveys completed, which has given us a wealth of useful information to guide service improvements and show our service users that we really are taking their opinions seriously. Having this amount of data allows us to make meaningful comparisons between teams and over time.

We are still expanding the project to include all Trust services by the end of this year. We have over 40 feedback devices - and kiosks with screens at our busiest sites. Screens have also been installed at our Trust headquarters and the Uffculme centre so that staff can also use this valuable data to guide their service developments.

Actively participating in staff recruitment

As well as contributing to every induction programme for all new staff to the Trust, service user representative are now part of every interview panel for staff at all levels in the organisation, from frontline to the most senior management and clinical posts.

Responding to changes in the external environment

A number of external factors have led to developments in our work around service user and carer experience. Changes in the benefits system for service users and carers have led us to introduce benefits training for staff. There has been an increasing demand for information about physical health, benefits and other non-Trust services and activities available to service users and carers. In response to this we have further strengthened our partnership working with external agencies so we are able to signpost people to agencies who are able to help. The development of a Partner Zone on our Trust intranet has enabled staff to provide information to service users and carers about the external support available.

More information about service user and carer experience and involvement, improvements in the quality of care we provide, progress against key targets, as well as complaints, can be found in the Quality Report from page 76.

Engaging with our stakeholders

Our Trust is a transparent and forward thinking organisation which believes open and trustworthy communication can support the creation of a positive working environment, cement working relationships with external parties, and set the tone for the entire organisation. We recognise that improving communication with our stakeholders is key to ensuring effective mental health services which meet the needs of the people accessing them.

To us good communication is more than a simple exchange of information or messages, we believe it involves attitude and behaviour too. We are committed to fostering an environment of openness and honesty, and have a number of initiatives which assist the establishment of effective, robust communications.

Trust Talk

Our quarterly magazine Trust Talk is the main way we communicate with our members and service users. It celebrates the achievements of our staff, service users and partners and also provides news and useful information from partner organisations in our area. The magazine highlights the work we do with partners, includes articles submitted by governors, members and service users, and tells readers about the work we are doing to improve patient experience. Copies of each issue are available at all Trust sites, and personal copies are posted to every Trust member twice a year. Electronic copies are also available via email or can be downloaded from the Trust's website. www.bsmhft.nhs.uk.

BSMHFT website

Our website www.bsmhft.nhs.uk is a virtual portal into the Trust and includes useful information for patients and carers with dedicated pages covering everything from latest Trust vacancies, how to become a member of the Trust, and details on the services we provide.

Electronic copies of board papers, minutes and board summaries are also available on the website, for people to read and download. Visitors are encouraged to communicate with us via a two-way email system, while members have access to a special members-only area which includes details of member seminars and events. We are currently gathering feedback from staff, service users and other stakeholders such as GPs, and during 2014/15 will be reviewing the website with a view to refreshing the style and content to reflect the changing needs of our users.

Social media

Over the past 12 months, our Trust has increased its presence on social networking sites such as Twitter and Facebook, and other social media platforms such as YouTube.

Social media is a useful tool for engaging with service users, stakeholders, partner organisations and members of the public. It not only helps us raise awareness of our Trust and its services, keeping interested parties informed of events and other relevant Trust news, but also helps us raise awareness about mental health issues in general.

Twitter especially is now used as a forum to discuss current affairs, and by having a presence on this site, our Trust can increase its national presence and comment on pertinent issues. Through active usage, we now have more than 1,250 Twitter followers (up by more than 700 from this time last year) and our Facebook page has more than 370 'likes', an increase of more than 300. This is an area we will be developing further in the coming year.

YouTube is being used increasingly to post videos about our Trust, virtual tours of sites and general information films which are also signposted from our website and other social media channels. We have increased the number of videos on our YouTube channel during the year and this will continue to be developed over the coming year as part of our social media strategy.

Details of significant partnership and alliances, development of services with other local services/agencies and involvement in local initiatives are described in the Strategic Report, on pages 8 to 27 of this Annual Report.

Our membership

The Trust recognises the importance of an effective membership to the successful governance of an NHS Foundation Trust and the delivery of a good quality service. Becoming a member of BSMHFT is a great way of challenging the stigma and discrimination that people with mental health difficulties can sometimes face. The public membership constituencies are defined by residence, being Birmingham, Solihull or rest of England and Wales.

Members are also categorised by their interests and are categorised into the following groups: public members, service user members and carer members. Each group of members is represented by a governor.

Our Trust actively recruits members, engages with them and is committed to creating a dialogue with our communities. We currently have 12,641 members.

We have now adopted a fresh approach to improve membership recruitment, retention and engagement. We continue to be proactive and consistent in engaging our members with a range of programmes that form our community engagement work plan.

Our aim is for our members to become active, engaged and representative of local communities, staff, and the wider population our trust serves and our overarching aims are to:

- ensure governors are enabled to play a key role in the recruitment retention and engagement of members
- increase the overall membership of the Trust, to ensure it is more closely representative of the community it serves
- retain current members by engaging them on a level suitable for them, and working with members to address Trust priorities such as improved services, patient experience and anti-stigma messages
- develop a highly engaged membership
- establish a cohort of active members who will act as ambassadors for our Trust in our communities.

The main focus of the membership strategy has moved away from being merely about the growth in number of new members and more on continuing to engage and involving our current members, depending on their interests and level they wish to become involved in the Trust.

Recruitment activities during the year have included: Attending meetings with partner organisations; participating in voluntary sector events; publicity on the Trust website and intranet for online and downloadable applications; targeted work with communities perceived as hard to reach; dedicated members area of the Trust website; and free member seminars on a number of mental health and Trust related topics such as caring for a loved one with dementia, finding your spirituality, mental health first aid and an overview of mental health.

Individuals (other than staff) may choose which constituency they belong to if they meet either the residence or service user/carers definition. Staff must be within the staff constituency within one of the three subgroups depending upon their role; namely medical, nursing or non-clinical.

Members can join the Trust online via the website or through filling out a membership form which are distributed across Trust sites and are also given out widely at events the Trust attends.

The membership for each constituency is as follows:

Public: 7,074
Service user (including carer): 1,417
Staff: 4,150
Total: 12,641

We regularly monitor how representative our membership is and the latest analysis by age, gender, ethnicity and socio-economic group is shown in the tables below.

Table 16: Membership age profile

Age	Public	Patient	Staff	Total
0-16	6	0	0	6
17-21	84	10	12	106
22-29	1,042	175	528	1,745
30-39	1,396	217	1,053	2,666
40-49	1,333	252	1,280	2,865
50-59	1,002	266	1,015	2,283
60-74	761	190	262	1,213
75+	217	63	0	280
Not stated	1,233	244	0	1,477
Total	7,074	1,417	4,150	12,641

Table 17: Membership gender profile

Gender	Public	Patient	Staff	Total
Unspecified	100	18	291	409
Male	2,574	540	1,147	4,261
Female	4,400	858	2,712	7,970
Transgender	0	1	0	1
Total	7,074	1,417	4,150	12,641

Table 18: Membership ethnicity profile

Ethnicity	Public	Patient	Staff	Total
Asian	1,919	359	421	2,699
Black	804	166	643	1,613
Mixed	177	39	115	331
Other	1,378	77	611	2,066
White	2,796	776	2,360	5,932
Total	7,074	1,417	4,150	12,641

Table 19: Membership socio-economic profile

Acorn Socio-Economic Category	Public	Patient	Staff	Total
Affluent Achievers [1]	1,383	165	866	2,414
Rising Prosperity [2]	429	33	248	710
Comfortable Communities [3]	1,564	268	1,156	2,988
Financially Stretched [4]	2,173	550	1,144	3,867
Urban Adversity [5]	1,151	349	699	2,199
Not Private Households [6]	318	48	18	384
Not available [NA]	56	4	19	79
Total	7,074	1,417	4,150	12,641

Our membership database allows us to now engage with our members in a more targeted way. Members can keep in touch with their governor by sending messages to a dedicated email address contact.governors@bsmhft.nhs.uk, calling the governor liaison office (0121 301 1096).

Going forward, we will work closely with governors to ensure that they have opportunities to encourage new members and engage with existing members through our community engagement programme and other Trust activities. We will ensure governors are given the opportunity to host and open events as appropriate. A 12 month rolling programme of monthly education seminars is being developed.

Engaging with GPs

With the move towards GP commissioning the Trust has been working on further strengthening its relationship with GPs and clinical commissioners. Our strategic ambition is to develop effective, credible, sustainable relationships with these key stakeholders.

The objectives of our Trust are to:

- ensure we are the first choice provider for patients and GPs in the services we provide, and continue to grow our organisation
- Educate and share good practice with GPs in mental health to raise their understanding of conditions and the ways patient experience can be improved
- listen and build partnerships with GP clinical commissioning groups to allow them to fully actively contribute, and take a partnership approach in developing mental health services in Birmingham and Solihull
- increase the positive visibility and reputation of the Trust amongst GPs and clinical commissioners.

The Trust has a dedicated GP and Stakeholder Manager who co-ordinates day to day liaison with GPs and commissioners by bringing together the work of corporate departments and clinical colleagues.

A comprehensive service directory is available which provides vital information about our services, where they are provided and who to contact to commission them. It is designed to complement an area on our website dedicated to GPs and commissioners where information can be found about our clinical directors, forthcoming seminars, the GP Matters bulletin and much more. The GP hub allows GPs to share their general feedback, comments or complaints, although not patient specific information. Cross City CCG also send feedback from GPs about our services to which we respond.

Our monthly e-bulletin, GP Matters, provides GPs with valuable updates on community mental health teams, Birmingham Healthy Minds, forthcoming GP seminars and useful pharmacy updates. The Trust also provides information for the regular local CCG bulletins.

A series of GP events and seminars have taken place over the year at Trust sites, GP surgeries and larger venues. We are committed to supporting primary care education programmes across the city and have worked with local CCGs to provide GP training sessions for both Cross City CCG and Birmingham South Central CCG. We also provide teaching support for City and Sandwell and North Birmingham vocational training schemes for GP trainees.

Consultation

The Trust has well established arrangements in place to ensure effective consultation and engagement with communities, staff, service users and other stakeholders. We involve key stakeholders and those who are likely to be affected by proposed policies or service change. A core part of our communications strategy is to engage with service users and staff in all areas of the work we do.

Serious incidents involving data loss or confidentiality breach

The table below lists serious incidents requiring investigations, involving personal data as reported to the Information Commissioner's Office in 2013-14

Table 20: Serious incidents involving personal data

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
May 2013	Disclosed in error	Name, address, disciplinary details	1	Individual notified
Further action on information risk	In future addresses for letters will be sourced direct from ESR (staff database) rather than relying on copying from previous correspondence.			

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
May 2013	Unsecure email route	Name, age, issues regarding substance misuse	13	Individuals notified
Further action on information risk	Greater communications regarding secure methods for transferring information to all staff.			
June 2013	Unsecure email route	Name, date of birth, NI number, salary, address and pension details for some.	136	Individuals notified by letter
Further action on information risk	Training and review of the processes within the function that led to the incident. Training was delivered to the whole team by the Head of Information Governance.			
July 2013	Breach of confidentiality	Name, address, psychiatric history	1	Data Subject not informed as they had since passed away.
Further action on information risk	Staff member underwent formal disciplinary action and have been reported to their professional governing body.			
July 2013	Breach of confidentiality	Name, NHS Number date of birth, psychiatric details	1	Individual spoken to and informed of incident
Further action on information risk	Ensure that copies of information that is provided to service users is clearly marked 'Patient Copy'. Trust project to provide service users with a folder to store their copy correspondence in.			
August 2013	Breach of confidentiality	Psychiatric report	1	Following a clinical review the data subject was not informed regarding incident as it was felt it would be detrimental to their mental wellbeing.
Further action on information risk	Communications to team regarding faxing and checking numbers by senior management. Links to Trust guidance, Safe Haven, issued.			
September 2013	Unsecure email route	Name, age, ethnicity, pay grade, disability, sexual orientation, marital status.	445	Letter sent to all individuals who were affected by the incident.
Further action on information risk	Training and review of the processes within the function that led to the incident. Training was delivered to the whole team by the Head of Information Governance.			
September 2013	Breach of confidentiality	Name, address, results of psychiatric assessment	1	Consultant contacted data subject and relative regarding breach.
Further action on information risk	Team spoken to with regard to ensuring that the correct service user details are used when sending correspondence and taking due care and attention.			

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
October 2013	Breach of confidentiality	Name, risk information, index offences	10	Data subjects informed of breach by clinical team.
Further action on information risk	Ward spoken to regarding the need to ensure that confidential material is always kept secure in the nurse's office. Processes were amended so that less personal data is included in observation folders from now on.			
October 2013	Breach of confidentiality	Name, address, DOB, NHS number and assessment notes	1	Following a clinical review the data subject was not informed regarding incident.
Further action on information risk	Records were recovered. Processes altered so that staff to not carry clinical information into public areas when collecting service users for appointments and use trust approved secure devices if there is a clear need.			
October 2013	Breach of confidentiality.	Name, address, age, medication relating to mental health, doctors signature and stamp identifying from a mental health trust	5	Letter sent to data subjects informing them of the breach.
Further action on information risk	Ensure that pharmacy address is in full on all correspondence.			
October 2013	Breach of confidentiality	Name, address. Mental health details	1	Letter sent to data subject informing them of the breach.
Further action on information risk	Double check correspondence prior to being sent to ensure correct address is used, and does not use previous letters which already contain an address.			
November 2013	Breach of confidentiality	Name, address, assessment	1	Data Subject informed of the breach.
Further action on information risk	All staff told to double check correspondence prior to being sent to ensure that the correct attachment is put the letter when required.			
November 2013	Breach of confidentiality	Complete set of psychiatric notes	1	Data subject informed of the breach.
Further action on information risk	All staff told to double check correspondence prior to being sent to ensure that the correct attachment is put the letter when required.			
November 2013	Breach of confidentiality	Full psychiatric records	10	Data Subjects informed of breach.
Further action on information risk	Full internal investigation undertaken and individual reported to their professional governing body. Internally the starters and leavers process has been reviewed and amended to rectify the process failings that were identified from this incident. This includes changes to the IT process, control room process and management process.			

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
January 2014	Unsecure email route	Name, personnel number, start/ leaving date	2,000	N/A- although an insecure route no breach of confidentiality as a legitimate relationship existed.
Further action on information risk	Head of function where incident occurred undertook a complete review of all processes in the function where personal data is required to be sent externally to the Trust and ensure the routes were secure. Communications were issued to the Team on how to send information in a secure way. This was carried out in consultation with the Head of Information Governance.			
February 2014	Breach of confidentiality	Name, address, details of medication	1	Data subject informed of breach
Further action on information risk	All staff advised to double check correspondence prior to being sent to ensure correct address is used.			
February 2014	Breach of confidentiality	Name, address, outcome of telephone assessment.	1	Data subject informed of breach
Further action on information risk	All staff advised to double check correspondence prior to being sent to ensure correct address is used.			
February 2013	Breach of confidentiality	Name, address, disciplinary action	1	Data Subject aware of the breach
Further action on information risk	Internal investigation currently underway.			
March 2014	Unsecure email route	Name, consultant's name, synopsis of care	40	Unknown
Further action on information risk	Internal investigation currently underway.			

Additional Information

In light of the above incidents, the Trust has implemented an internal technical solution which monitors outbound emails and reviews the content for potential personal data. Staff are then provided with the ability to review the email prior to confirming release to assist with preventing breaches. The Trust has also undertaken a voluntary audit by the Information Commissioner's Office in order to seek both assurance and recommendations in relation to the Trust's information governance approach and processes. A report is due in June 2014.

Statement as to disclosure to auditors

For each individual who is a director at the time this report is approved, so far as the director is aware, there is no relevant audit information of which our Trust's auditor is unaware and the director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of that information.

Policies for pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1 to the accounts and details of senior employees' remuneration can be found in page 56 of the Remuneration Report.

Statement on the Annual Report and Accounts

The directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Important events since the end of the financial year

There have been no significant events since the end of the financial year affecting our Trust.

Remuneration report

Remuneration committee

The committee monitors and evaluates the performance of the Chief Executive and the Executive Directors as well as setting terms of appointment and or termination for those staff. The Remuneration Committee over the last 12 months have been busy in terms of recruitment of a new Executive Director of Operations and both an interim and substantive Director of Nursing (to replace the former Executive Director of Quality Improvement and Patient Experience). The Remuneration Committee involved a variety of stakeholders including staff, Governors and external partners in the recruitment process. In addition to the substantive appointments, the Committee was also involved in and approved the interim appointment for the new Director of Nursing.

The committee met five times in 2013/14.

- On 24 April 2013, Sue Davis (Chair), David Boden, Non-Executive Director, Alison Lord, Non-Executive Director, Dr Nerys Williams, Non-Executive Director, Joy Warmington, Non-Executive Director were present.
- On 26 June 2013, Sue Davis (Chair), Joy Warmington (Non-Executive Director, David Boden Non-Executive Director, Dr Nerys Williams Non-Executive Director, Sukhbinder Singh Heer Non-Executive Director and Barry Henley Non-Executive Director were present.
- On 18 September 2013, David Boden, Non-Executive Director Chaired the meeting, Joy Warmington Non-Executive Director, Barry Henley Non-Executive Director, Waheed Saleem, Associate Non-Executive Director and Dr Nerys Williams Non-Executive Director were present.
- On 27 November 2013, Sue Davis, Chair, Joy Warmington, Non-Executive Director, David Boden, Non-Executive Director, Sukhbinder Singh Heer, Non-Executive Director and Waheed Saleem Associate Non Executive Director were present.
- On 18 December 2013, Sue Davis Chair, Joy Warmington Non-Executive Director, Dr Nerys Williams Non-Executive Director, Sukhbinder Singh Heer Non-Executive Director, David Boden Non-Executive Director, Barry Henley, Non-Executive Director and Waheed Saleem, Associate Non-Executive Director were present.

The committee has also conducted a review of salaries, considering benchmark data of other trusts and foundation trusts, in order to consider the reward packages of our executive directors. Having considered the data, the current economic environment, as well as the challenges facing our staff, the Committee determined that executive directors should not receive any increase to their salary over the following 12 months. The Committee also considered the appointment of the Executive Director of Operations, as Deputy Chief Executive and that a Deputy Chief Executive role would attract a small level of remuneration in addition to the executive's salary.

In considering the remuneration of senior executives, the committee considers any guidance or best practice issued by the Secretary of State for Health as well as the affordability of any increases. We have also taken into consideration the pay of our wider workforce.

The Committee formulates pay based upon benchmarking data from local and comparable Trusts. During the year the Committee approved salary bands for each executive post based upon the benchmarking data.

There are no performance related elements to remuneration. This will be reviewed on an annual basis. All appointments as executive directors are made as permanent appointments, unless appointed on acting basis, in which case a three or six month notice period is expected, and will only be terminated on resignation of the employee or a fundamental breach of their employment contract. there is no provision for compensation for early termination of their contracts. The Chief Executive has a six month notice period.

Reasons for termination may include where a member of the Trust Board of directors has been adjudged bankrupt or whose estate has been sequestered and not, in either case, been discharged. Individual Board members may also be disqualified if: a) a person as made a composition or arrangement with, or granted a Trust deed for, his/her creditors and has not been discharged in

respect of it, or b) if they have been convicted of any offence in the past five years and received a prison sentence of at least three months (whether suspended or not).

All non-executive directors' appointments are for up to three years and their contracts of service can be terminated for the same reasons that apply to executive directors, set out above, plus if three-quarters of members of the Trust's governors, at a general meeting of the Council of Governors approve the removal of non-executives, including the Chair.

The Nomination and Remuneration Committee and Remuneration Committee have considered, during 2013/14 the balance, completeness and membership of the Board.

The Committee has refreshed its terms of reference, taking into account the Monitor Code of Governance.

All members of the Trust Board subscribe to the Code of Conduct for NHS Managers. Our directors, managers and staff are required to adopt high standards of corporate and personal conduct in respect of offers of hospitality, declaration of interests and prevention of fraud and corruption. Policies relating to these matters are available from the Executive Director of Resources.

Our Chief Executive, John Short, and executive directors were appointed via rigorous nationwide recruitment processes in line with national and local guidance.

Table 21: Appointments and tenures of non-executive directors

Name and title			Date of first appointment / re-appointment tenure
Sue	Davis	Chair	28/11/2011 Reappointment 28/11/14 – 27/11/17
David	Boden	Non-Executive Director	12/10/2006 – 31/08/2015 (various renewals)
Sukhbinder	Heer	Non-Executive Director	13/08/2007 – 31/08/2014 (various renewals)
Barry	Henley	Non-Executive Director	01/07/2014 – 30/06/2017
Alison	Lord	Non-Executive Director	01/09/2007 – 03/04/2013 (various renewals)
Waheed	Saleem	Associate Non-Executive Director (no voting rights at Board)	01/07/2014 – 30/06/2017
Joy	Warmington	Non-Executive Director: Associate (No voting rights at board) Appointed Non-Executive Director	03/01/2012 – April 2013 01/05/2013 – 30/04/2017
Nerys	Williams	Non-Executive Director	01/12/2011 - 30/11/2014

Table 22: Salary and pension entitlements of senior managers – salaries and allowances

Name and Title	Year Ending 31 March 2014					Year ending 31 March 2013				
	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total
	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Paul Jennings (Acting Chief Executive Officer) (Appointed 3 December 2012, Resigned 31 March 2013)	-	-	-	-	-	60-65	-	-	-	60-65
Sue Turner (Chief Executive Officer) (Resigned 30 November 2012)*	-	-	-	-	-	195-200	-	-	-	160-165
John Short (Chief Executive Officer) (Appointed 1 April 2013)	160-165	-	-	47.5-50	210-215	-	-	-	-	-
Sandra Betney (Executive Director of Resources) (Appointed 1 February 2013)	120-125	-	-	60-62.5	180-185	20-25	-	-	-	10-15
Andrew Lee (Acting Executive Director of Resources) (Appointed 22 October 2012, Resigned 28 February 2013)	-	-	-	-	-	85-90	-	-	-	85-90

Name and Title	Year Ending 31 March 2014					Year ending 31 March 2013				
	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total
	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Martin Sheldon (Acting Executive Director of Resources) (Appointed 21 May 2012, Resigned 31 October 2012)	-	-	-	-	-	55-60	-	-	-	55-60
Georgina Dean (Acting Executive Director of Resources) (Resigned 2 December 2012)	-	-	-	-	-	60-65	-	-	10-12.5	50-55
Peter Lewis (Executive Medical Director)	105-110	60-65	-	20-22.5	190-195	100-105	60-65	-	20-22.5	185-190
Frances Allcock (Executive Director of Organisational Development and Performance Improvement) (Resigned 31 May 2013)	15-20	-	-	-	15-20	115-120	-	-	12.5-15	125-130
Denise Roach (Executive Director of Quality, Improvement and Patient Experience) (Resigned 29 December 2013)	80-85	-	-	-	70-75	105-110	-	-	-	90-95

Name and Title	Year Ending 31 March 2014					Year ending 31 March 2013				
	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total
	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Susan Fairlie (Interim Director of Nursing) (Appointed 6 January 2014, Resigned 31 March 2014)	45-50	-	-	-	45-50	-	-	-	-	-
Glynis Markham (Executive Director of Strategic Delivery) (Resigned 31 March 2013)	-	-	-	-	-	95-100	-	-	5-7.5	100-105
Alan Kenny (Interim Director of Operations) (Appointed 11 January 2013, Resigned 30 June 2013)	30-35	-	-	10-12.5	40-45	95-100	-	-	-	90-95
Brendan Hayes (Executive Director of Operations / Deputy CEO) (Appointed 15 July 2013)	75-80	-	-	22.5-25	95-100	-	-	-	-	-
Sue Davis (Chair) *	60-65	-	-	-	60-65	45-50	-	-	-	45-50
David Boden (Non-Executive Director)*	15-20	-	-	-	15-20	15-20	-	-	-	15-20
Sukhbinder Heer (Non-Executive Director)	15-20	-	-	-	15-20	15-20	-	-	-	15-20
Nerys Williams (Non-Executive Director)	15-20	-	-	-	15-20	15-20	-	-	-	15-20

Name and Title	Year Ending 31 March 2014					Year ending 31 March 2013				
	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total	Salary	Other remuneration	Benefits in kind	Pension - Related Benefits	Total
	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £5,000)	(rounded to nearest £100)	(Bands of £2,500)	(Bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Joy Warmington (Non-Executive Director)	10-15	-	-	-	10-15	10-15	-	-	-	10-15
Waheed Saleem (Non-Executive Director) (Appointed 01 July 2013)	5-10	-	-	-	5-10	-	-	-	-	-
Dr Barry Henley (Non-Executive Director) (Appointed 01 July 2013)	10-15	-	-	-	10-15	-	-	-	-	-
Alison Lord (Non-Executive Director) (Resigned 30 April 2013)	0-5	-	-	-	0-5	10-15	-	-	-	10-15
Jeff Herdman (Non-Executive Director) (Resigned 31 March 2013)	-	-	-	-	-	15-20	-	-	-	15-20
Stan Baldwin (Non-Executive Director) (Resigned 28 September 2012)	-	-	-	-	-	5-10	-	-	-	5-10

For both 13/14 and 12/13 there were no annual performance related bonuses or long term performance related bonuses

* Sue Turner resigned from the Board on 30 November 2012. In her capacity as Chief Executive Officer of Birmingham and Solihull Mental Health NHS Foundation Trust Sue Turner earned a salary of £109,643 during 2012/13 and was paid £86,288 in lieu of notice.

* David Boden salary includes remuneration for acting as the Chairman between October and November 2011.

* Sue Davis salary includes remuneration for One off payment of £15,000 due to increased workload during CEO Handover.

* Susan Hartley did not have membership in the NHS Pension Scheme with this organisation until 8 April 2014, hence there is no disclosure.

Band of Highest Paid Directors Total Remuneration (£'000)	165-170	195-200
Median Total Remuneration	26,811	28,713
Ratio	6.3	6.80

Median Pay - Method of Calculation

The payroll data was examined, exceptional items that would distort the calculation were excluded, such as pension related benefits, the normalised data was used to derive an annualised pay figure, and the median calculation was determined from the resultant data-set.

Table 23: Pension benefits 2013/14

Name and Title	Real Increase In Pension at Age 60	Lump Sum at Age 60 Related To Real Increase In Pension	Total Accrued Pension at Age 60 Ending 31 March 2014	Lump Sum at Age 60 Related To Accrued Pension at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2014	Real increase in accrued pension during year
	(Bands of £2,500) £'000	(Bands of (£2,500) £'000	(Bands of £5,000) £'000	(Bands of £5,000) £'000	£'000	£'000	£'000
John Short (Chief Executive Officer) (Appointed 1 April 2013)	2.5-5	7.5-10	50-55	160-165	921	1,027	85
Sandra Betney (Executive Director of Resources (Appointed 1 February 2013)	2.5-5	7.5-10	30-35	100-105	460	550	80
Peter Lewis (Executive Medical Director)	0-2.5	5-7.5	20-25	70-75	-	-	-
Frances Allcock (Executive Director of Organisational Development and Performance Improvement) (Resigned 31 May 2013)	0-2.5	0-2.5	10-15	0-5	171	175	1
Denise Roach (Executive Director of Quality, Improvement and Patient Experience) (Resigned 29 December 2013)	0-2.5	0-2.5	35-40	115-120	601	632	13

Name and Title	Real Increase In Pension at Age 60	Lump Sum at Age 60 Related To Real Increase In Pension	Total Accrued Pension at Age 60 Ending 31 March 2014	Lump Sum at Age 60 Related To Accrued Pension at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2014	Real increase in accrued pension during year
	(Bands of £2,500) £'000	(Bands of (£2,500) £'000	(Bands of £5,000) £'000	(Bands of £5,000) £'000	£'000	£'000	£'000
Brendan Hayes (Executive Director of Operations / Deputy CEO) (Appointed 15 July 2013)	0-2.5	2.5-5	30-35	90-95	460	519	35
Alan Kenny (Interim Director of Operations) (Appointed 11 January 2013, Resigned 30 June 2013)	0-2.5	0-2.5	35-40	110-115	719	770	9

Table 24: Pension benefits 2012/13

Name and Title	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 ending 31 March 2013	Lump sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in accrued pension during year
	(Bands of £2,500) £'000	(Bands of £2,500) £'000	(Bands of £5,000) £'000	(Bands of £5,000) £'000	£'000	£'000	£'000
Sue Turner (Chief executive officer) (resigned 30 November 2012)	(0-2.5)	(0-2.5)	60-65	185-190	-	1150	-
Sandra Betney (Executive director of resources (appointed 1 February 2013)	(0-2.5)	(0-2.5)	30-35	90-95	460	444	(1)
Georgina Dean (Acting executive director of resources) (resigned 2 December 2012)	0-2.5	0-2.5	5-10	15-20	81	67	7
Peter Lewis (Executive Medical Director)	0-2.5	2.5-5	20-25	60-65	-	-	-
Frances Allcock (Executive Director of Organisational Development and Performance Improvement)	0-2.5	0-2.5	10-15	0-5	171	142	22

Name and Title	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 ending 31 March 2013	Lump sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2012	Real increase in accrued pension during year
	(Bands of £2,500) £'000	(Bands of £2,500) £'000	(Bands of £5,000) £'000	(Bands of £5,000) £'000	£'000	£'000	£'000
Denise Roach (Executive Director of Quality, Improvement & Patient)	(0-2.5)	(0-2.5)	35-40	115-120	601	561	11
Glynis Markham (Executive director of strategic delivery) (resigned 31 March 2013)	0-2.5	0-2.5	10-15	30-35	-	-	-
Alan Kenny (Interim director of operations) (appointed 11 January 2013)	0-2.5	0-2.5	35-40	105-110	719	656	6

* Martin Sheldon was employed between 21/05/12 and 31/10/2012 and was not employed at 31/03/2013 therefore no pension data has been disclosed.

Off Payroll Engagements

Table 25: For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months

No of existing arrangements as of 31 March 2014	6
Of which...	
No. that have existed for less than one year at time of reporting	1
No. that have existed between one and two years at time of reporting	1
No. that have existed between two and three years at time of reporting	
No. that have existed between three and four years at time of reporting	
No. that have existed for more than four years at time of reporting	4

Confirmation 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.

Table 26: For all new off payroll arrangements, or those that reached six months in duration between 1 April 2013 and 31 March 2014, for more than £220 per day

No of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	24
No. of the above that include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	21
No. for whom assurance has been requested	3
Of which...	
No for whom assurance has been received	2
No for whom assurance has not been received	1
No. that have been terminated as a result of not being received	

Table 27: For any off-payroll engagements of Board members or senior officials with significant financial responsibility, during the financial year

No. of off-payroll engagements of Board members and / or senior officials with significant financial responsibility, during the year	1
No of individuals that have been deemed Board members or officials with significant financial responsibility during the financial year. (Includes all on and off-payroll engagements)	23

Trust Board and Governor Expenses

Table 28: Executive director expenses 2013/14

Executive Directors		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Short	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Hayes	B	-	-	-	-	-	-	-	-	262	-	-	113	375
Betney	S	169	19	-	98	-	50	-	-	49	79	65	42	571
Allcock	F	-	-	-	-	-	-	-	-	-	-	-	-	-
Roach	D	-	-	-	-	-	-	-	-	-	-	-	-	-
Kenny	A	78	33	-	-	-	-	-	-	-	-	-	-	111
Lewis	P	130	80	57	96	-	29	166	-	-	-	270	47	875
Fairlie	S	-	-	-	-	-	-	-	-	-	470	308	265	1,043
Total		377	132	57	194	-	79	166	-	311	549	643	467	2,975

Table 29: Non-executive director expenses 2013/14

Non-Executive Directors		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Davis	S	-	39	40	93	-	47	-	-	114	129	61	53	576
Heer	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Boden	DP	46	231	70	-	49	217	133	302	-	-	106	92	1,246
Williams	N	72	363	-	-	376	407	299	260	51	-	-	220	2,048
Warmington	J	-	112	9	28	-	-	-	-	-	-	-	-	149
Saleem	W	-	-	-	-	-	-	-	-	-	-	-	-	-
Henley	BS	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		118	745	119	121	425	671	432	562	165	129	167	365	4,019

Table 30: Governor expenses 2013/14

Governors		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
McKenzie	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Chaudary	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Khan	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Cooper	D	-	-	-	-	-	-	-	-	-	-	-	-	-
Uddin	F	-	-	-	-	-	-	-	-	-	-	-	-	-
Stone	J	-	-	-	-	-	-	-	-	-	-	-	-	-
Ali	K	-	-	-	-	-	-	-	-	-	-	-	-	-
Smith	L	-	-	-	50	-	-	-	-	-	-	38	-	88
Innis	L	-	-	-	-	-	-	-	-	-	-	105	-	105
Okill	L	-	-	-	-	-	-	-	-	-	-	-	-	-
Jones	M	-	-	-	196	-	-	-	-	-	-	203	-	399
Johnson	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Brown	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Smojkis	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Brown	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Hemmings	P	-	-	-	284	-	-	-	-	-	-	-	-	284
Tinsley	P	-	-	-	-	-	-	131	-	-	-	-	-	131
Lea	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Russell	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Wordsworth	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Poller	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Illingworth	P	-	-	-	-	-	-	-	6	-	-	-	-	6
George	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Griffiths	T	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		-	-	-	530	-	-	131	6	-	-	346	-	1,013

Governor Election Expenses were £1,957 during the year

Table 31: Executive director expenses 2012/13

Executive Directors		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Turner	S	455	66	-	-	-	-	-	-	-	-	-	-	521
Jennings	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Dean	G	126	-	-	-	-	-	-	-	459	-	-	-	585
Lee	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Sheldon	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Betney	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Allcock	F	-	-	-	-	-	-	-	-	-	-	-	-	-
Roach	D	-	106	-	-	155	51	47	-	-	-	-	-	359
Lewis	P	81	93	164	146	96	-	-	-	280	83	156	-	1,099
Kenny	A	249	-	-	622	-	157	130	209	216	232	-	545	2,360
Markham	G	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		911	265	164	768	251	208	177	209	955	315	156	545	4,924

Table 32: Non-executive director expenses 2012/13

Non-Executive Directors		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Davis	S	-	38	241	-	61	-	38	92	37	-	21	57	585
Lord	A	-	-	-	-	-	-	-	-	-	-	-	1,163	1,163
Baldwin	WS	-	-	-	-	-	-	-	-	-	-	-	-	-
Heer	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Boden	DP	112	-	242	84	89	70	28	129	-	55	189	46	1,044
Herdman	J	154	69	85	102	-	-	-	-	105	35	-	989	1,539
Williams	N	-	111	-	178	45	-	34	102	-	128	-	43	641
Warmington	J	48	11	-	-	-	21	-	-	-	19	28	37	164
Total		314	229	568	364	195	91	100	323	142	237	238	2,335	5,136

Table 33: Governor expenses 2012/13

Governors		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Uddin	F	-	-	-	-	-	-	-	-	-	-	-	-	-
Smith	L	-	-	-	-	-	-	-	-	-	-	-	-	-
Brown	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Innis	L	-	-	-	-	-	-	-	-	-	-	-	-	-
McKenzie	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Fleetwood-Walker	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Jones	M	-	-	-	-	-	-	-	-	-	180	-	-	180
Ali	K	-	-	-	-	-	-	-	-	-	-	-	-	-
Hemmings	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Tinsley	P	320	69	-	-	-	-	-	-	-	-	-	-	389
George	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Cooper	D	-	-	-	-	-	-	-	-	-	-	-	-	-
Khan	A	-	-	-	-	-	-	-	-	-	-	-	-	-
Anderson	S	-	-	-	-	-	-	-	-	-	-	-	-	-
Lea	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Griffiths	T	-	-	-	-	-	-	-	-	-	-	-	-	-
Smojkis	M	-	-	-	-	-	-	-	-	-	-	-	-	-
Illingworth	P	-	-	-	-	-	-	-	-	-	-	-	-	-
Total		320	69	-	-	-	-	-	-	-	180	-	-	569

Signed:



John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust

Date: 21 May, 2014

III health retirements

During the year there were two early retirements due to ill health. The costs of these were borne by the NHS Business Services Authority (Pensions division). The value of these retirements was £179k.

Non-financial reporting

National staff survey 2013/14

Table 34: Summary of performance

	2012/13		2013/14		Difference
	Trust	National Average	Trust	National Average	Trust
Response Rate	45%	51%	50%	48%	5%

Table 35: Top 5 Ranking Scores¹

		2012/13		2013/14		Difference
		Trust	National Average	Trust	National Average	
1	Work pressure felt by staff ²	3.00	3.02	2.92	3.07	0.08
2	% of staff feeling satisfied with the quality of work and patient care they are able to deliver	81%	78%	83%	77%	2%
3	% of staff having well-structured appraisals in the last 12 months	43%	41%	50%	42%	7%
4	% of staff agreeing that their role makes a difference to patients	88%	90%	92%	90%	4%
5	% of staff appraised in the last 12 months	87%	87%	93%	87%	6%

Table 36: Bottom 5 Ranking Scores³

		2012/13		2013/14		Difference
		Trust	National Average	Trust	National Average	
1	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	41%	30%	41%	30%	0%
2	% of staff experiencing discrimination at work in the last 12 months	20%	13%	23%	13%	3%
3	% of staff experiencing physical violence from staff in last 12 months	8%	4%	6%	4%	-2%
4	% of staff believing the trust provides equal opportunities for career progression or promotion	80%	90%	81%	89%	1%
5	% of staff feeling pressure in the last 3 months to attend work when feeling unwell	28%	22%	26%	22%	-2%

¹ Top 5 ranking scores are the five key findings where the Trust is ranked closest to 1 when compared to all mental health & learning disability trusts in England

² Scale summary scores are calculated by assigning numbers to the responses available e.g. strongly agree would score 5 & strongly disagree would score 1. Scores for each question used to calculate the key finding are added together and then divided by the number of questions, the lower the score the better.

³ Bottom 5 ranking scores are the five key findings ranked closest to 57 when compared to all mental health and learning disability trusts in England

Table 37: Top 4 Areas of Improvement⁴

		2012/13	2013/14	Difference
1	Team members often meet to discuss the team's effectiveness	63%	68%	5%
2	I always know what my work responsibilities are	80%	85%	5%
3	We are given feedback about changes made in response to reported errors, near misses and incidents	40%	45%	5%
4	I am satisfied with the quality of care I give to patients / service users	85%	89%	4%

Future priorities and targets

We have made some significant improvements in our staff survey results this year. Our Trust is in the top five mental health trusts and top 30 NHS organisations in the country in terms of staff feeling satisfied with the quality of patient care they are able to deliver. In addition we are in the top 20 mental health trusts for overall staff engagement. There are significant increases in the percentage of staff being appraised and having well-structured appraisals, which is an indication that our Working Better Together initiative is having a positive impact.

However, the survey results show that the Trust has a significant challenge in relation to staff experiencing bullying and harassment from patients, relatives and the public, being the second worst mental health trust in England for this indicator. Similarly the Trust is in the top ten worst mental health trusts for staff experiencing physical violence from other staff despite a 2% decrease from the 2012 survey.

Addressing issues relating to equality and diversity will be a priority for the Trust over the next 12 months. Some of these have already been identified by the Equality and Diversity Panel as a priority and are a key objective in the Trust's 2014/15 business plan.

We will be carrying out a more detailed analysis of concerns raised by service area in order to identify service specific and wider organisational issues requiring attention and action, including cross referencing the staff survey results with serious incident reporting and HR casework.

There will also be specific engagement events as part of our Listening into Action approach to explore the issues of bullying, harassment and abuse from patients, relatives or members of the public, physical violence, and equality and diversity.

More information about our staff engagement strategy and how it is evaluated can be found in the Strategic Report on page 22.

For more information about the staff survey or to request a copy of our 2013/14 survey please e-mail. hr.support@bsmhft.nhs.uk.

⁴ Top 4 areas of improvement are the individual questions that have seen the biggest improvement compared to the 2012 staff survey.

Regulatory ratings

Table 38: Analysis

	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
Under the Compliance Framework					
Financial risk rating	3	3	3		
Governance risk rating	Amber-Red	Amber-Red	Green		
Under the Risk Assessment Framework					
Continuity of service rating				3	3
Governance rating				Green	Green*

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial risk rating	3	3	3	4	3
Governance risk rating	Amber -Red	Amber -Red	Green	Green	Green

*The Trust has submitted a Green rating for Q4, however we are awaiting confirmation of this from Monitor

Commentary

2012/13

The Trust's planned GRR rating submitted to Monitor for 2012/13 was 'amber-red'. This was due to the known outcomes of the CQC responsive review regarding the safety of healthcare provision across three of the trust's sites, adult psychiatric intensive care units at Eden, Meadowcroft and the Caffra unit during quarter 4 2010/11. In line with Monitor's Compliance Framework, any Foundation Trust with a 'major' concern identified by the CQC is automatically 'amber-red' rated. This can only then be lifted by a CQC re-inspection confirming assurance.

The Trust took actions to address the concerns identified at the time and during quarter 1 of 2011/12, local assurance of compliance was confirmed via the Trust's Clinical Governance Committee. Further local assurance of compliance was also undertaken through an internal audit review and re-assessment of the safeguarding standard using the CQC's audit tool. However, feedback from Monitor indicated that irrespective of local assurance, the Trust's 'amber-red' rating was fixed until the CQC repeated its assessment and confirmed compliance.

This approach resulted in the Trust continuing to declare an 'amber-red' rating for subsequent quarter's Governance Risk Rating (GRR) until quarter 2 of 2012/13. During quarter two 2012/13, the CQC re-inspected the three sites and lifted the major concern which enabled the Trust's GRR to move to 'green'.

2013/14

At the time of submitting the Governance Risk Rating (GRR) plan for 2013/14, the following issue contributed to the Trust submitting an 'amber-red' rating for Governance as part of its 2013/14 plan.

The CQC had undertaken an inspection of the Eden Unit, one of the Trust's adult psychiatric intensive care units on 30 April 2013. The related CQC report received on 24 May 2013 identified that the standard on staffing was not being met with 'major impact' identified for people who use the service. Immediate actions were taken by the Trust to address the concerns highlighted, including confirmation to the CQC of the actions taken and that as a result the Trust's view that it was then compliant.

However, in line with Monitor's Compliance Framework, the 'amber-red' GRR could only be lifted by a CQC re-inspection. As this had not been completed in quarter 1, the Trust's GRR remained at 'amber-red'.

The CQC conducted a follow-up inspection during quarter 2, with a confirmation of compliance confirmed on 10 September 2013. This enabled the Trust's GRR move to 'green' for quarter 2. This was sustained for quarter 3, with quarter 4 compliance yet to be confirmed.

Sustainability Report

As in previous years our award winning Trust has continued to demonstrate its commitment to sustainability, reducing its carbon emissions and minimising its impact on the environment and climate change. Our Trust continues to demonstrate robust governance for sustainability issues with a lead director and a framework of strategies, policies and procedures to maintain focus and inform decisions. Indeed our CEO is an advocate for sustainability using a bike to travel to and from his many appointments.

This financial year (2013/14) has seen a number of significant steps forward in delivering against the Sustainable Development agenda.

Headlines include:

- The Trust has been recognised nationally for delivering best practice in sustainability reporting. In fact the Trust was one of only three mental health trusts in the country to be recognised in this way.
- The Trust has developed a sustainable procurement policy which requires both the Trust itself but also its suppliers within the full supply chain to consider environmental and carbon impacts of a product or service as part of the procurement process.
- The Trust has developed a draft Green / Active Transport Plan for all of its sites. This plan, along with a supporting action plan, will be used to influence decisions made and it is hoped help to deliver both environmental and carbon savings.
- We have invested in energy efficiencies including a combined heat and power plant and LED lighting replacements at specific sites.

The Trust is pleased that the NHS Sustainable Development Unit has released (January 2014) the new Sustainable Development Strategy for the NHS entitled 'Sustainable, Resilient, Healthy People and Places'. The Trust's Sustainable Development Carbon Management steering group have already received this strategy and will over the coming months be assessing what needs to be done and what challenges or opportunities this strategy brings.

The Trust is also pleased that the NHS Good Corporate Citizen self-assessment model has been revised in light of the new strategy. This self-assessment tool allows Trusts to measure their own performance against key sustainability themes and to map or benchmark their performance against others. We will be completing the revised version during quarter 1, 2014/15.

Managing finite resources, minimising and mitigating wastage is an embedded priority for the Trust. Indeed the Trust, led by Estates and Facilities, has also been heavily involved in a pilot study focusing on waste minimisation within the health sector. This is a DEFRA led pilot study with initial findings due in May 2014.

The Trust has continued to:

- raise awareness of the need to manage resources more effectively, reducing consumption, waste, emissions and expenditure. Indeed a campaign has been re-launched focusing on energy reduction. A competition has been held to develop a slogan for energy saving and this slogan has been used on merchandise / posters to support the turn off /switch off and save messages. The Trust has also supported another local Trust in moving forward with its sustainability objectives
- invest in new buildings, plant, equipment and technology to improve efficiency, and provide more with less
- adopt procurement practices which promote sustainable development, consciously specifying, procuring and re-cycling materials from sustainable sources
- promote the need to embed sustainability in / as part of the day-day business of the Trust - this being an integral part of the Green Travel Plan.

Trust performance analysis

Carbon Management

Table 39: Carbon management

Year	Electricity, Gas and Oil (tCO ₂) - (Taken from properties where actual data is available)	Transport (inc Taxi, Grey Fleet Vehicles and Fleet Vehicles) - (tCO ₂)	Waste (tCO ₂)	Total (tCO ₂)
Baseline year of 2007/08 including Waste, Energy and Transport				12,353 (estimated)
2008/9	10,647	980	175	11,647
2009/10	10,231	938	134	11,303
2010/11	10,852	926	91	11,843
2011/12	10,195	900	90	11,185
2012/13	10,550	893	91	11,534
2013/14	10,542	857	75	11474

As the above table clearly shows the carbon tonnage associated with energy, waste and transport has dropped again in 2013/14. Overall the Trust is emitting 8% less carbon than in the 2007/08 baseline year, this being just 2% off the 2015 target of a 10% reduction. It is also to be recorded that the above figures (2013/14) include the Tamarind Centre which by very nature of its size and facilities is the site that uses the most energy across the Trust estate.

Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

At the time of writing the report our Trust is in negotiations with both Consort, University Hospital Birmingham and as necessary the Environment Agency with a view to either inclusion or exclusion from the CRC energy efficiency scheme. If the Trust is to be included in the scheme then this will mean that the Trust has a RPIX linked recurring levy associated with Carbon to the value of circa £180K per annum. Prudent financial planning and communications have enabled this sum to be ring-fenced.

Waste Management (domestic, clinical, electrical and confidential)

Our Trust recognises the importance of good waste management. As already detailed we have volunteered to be part of a waste minimisation pilot study look at reducing waste and improving re-use and recycling.

The amount of waste to landfill decreased in 2013/14 against the last four years of management information and the percentage of all waste recycled by the Trust reached over 80% (achieved 82%) for the first time on record. Increasing recycling and avoiding landfill along with improved clinical waste segregation has seen the annual cost of our waste management decrease. The total cost of the waste management service for 2013/14 was £173,302.

Table 40: Waste management

Waste	Non-Financial data	Non-Financial data	Non-Financial data	Non-Financial data
	2010/11	2011/12	2012/13	2013/14
Total Waste Arising	1229 Tonnes	1186 Tonnes	1191 Tonnes	1247 Tonnes
Waste sent to Landfill	263 Tonnes	249 Tonnes	267 Tonnes	208 Tonnes
Waste Recycled	958 Tonnes	931 Tonnes	907 Tonnes	1027 Tonnes
% of Waste Recycled	77%	79%	77%	82%
Waste Incinerated	8 Tonnes	6 Tonnes	7 Tonnes	12 Tonnes

Table 41: Expenditure on waste disposal

	Financial Data (£)	Financial Data (£)	Financial Data (£)	Financial Data (£)
	2010/11	2011/12	2012/13	2013/14
Total Expenditure on Waste Disposal	£217,678	£217,922	£197,428	£174,302

Finite Resources (electricity, gas and water)

The Financial Year 2013/14 included the first full operational year of the Tamarind Centre, figures for which have been included within the consumption and financial summary. This year also gave us one of the longest and warmest summers on record along with one of the wettest but warmest winters on record. The degree day analysis work undertaken suggests that the gas costs for the Trust would have been in the region of £120K greater should a normal / cold winter have been experienced.

The table and supporting graphs below / overleaf demonstrate how:

- **energy consumption** across the Trust fell by 5% against 2012/13.
- **energy costs** for 2013/14 were £2.32million representing an increase against 2012/13 of 5%. This being set against utility price rises of on average 8% for the same period.
- **energy procurement** for the Trust is via the Government Procurement Service Utility Frameworks which enables the Trust to procure the energy at best value with a demonstrable audit trail. On average we pay 50% less than domestic tariffs.

Figure 3: Utility costs 2010/11 – 2013/14

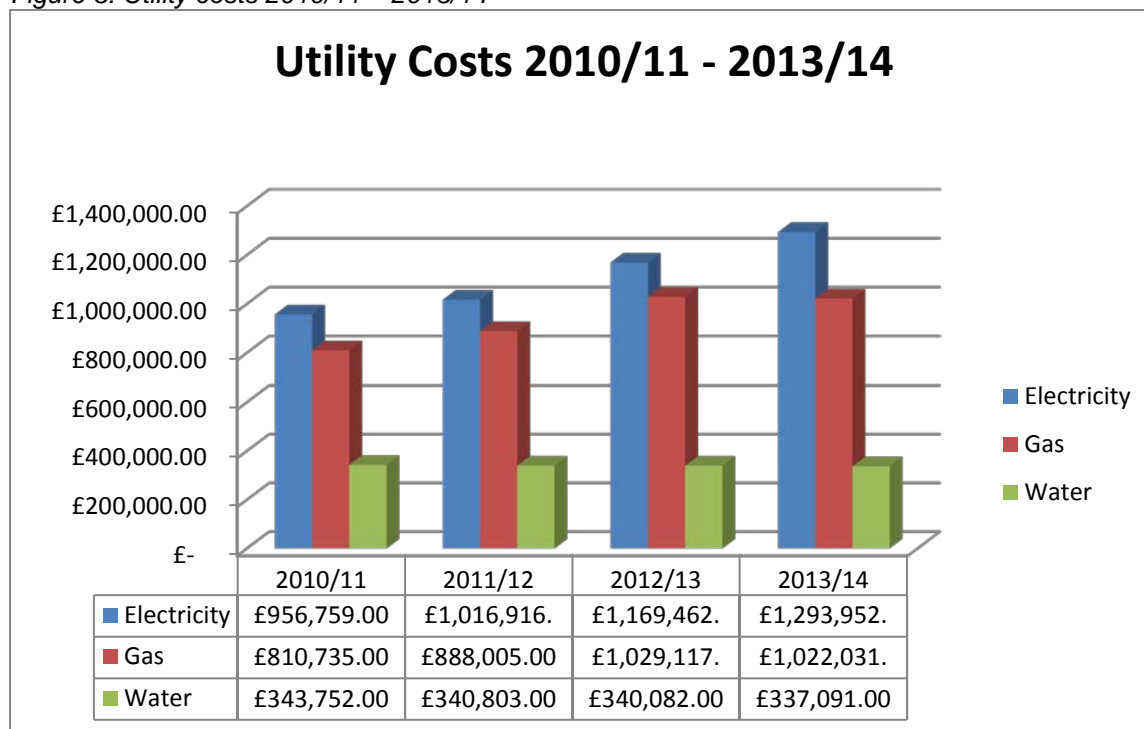


Figure 4: Energy consumption 2010/11 – 2013/14

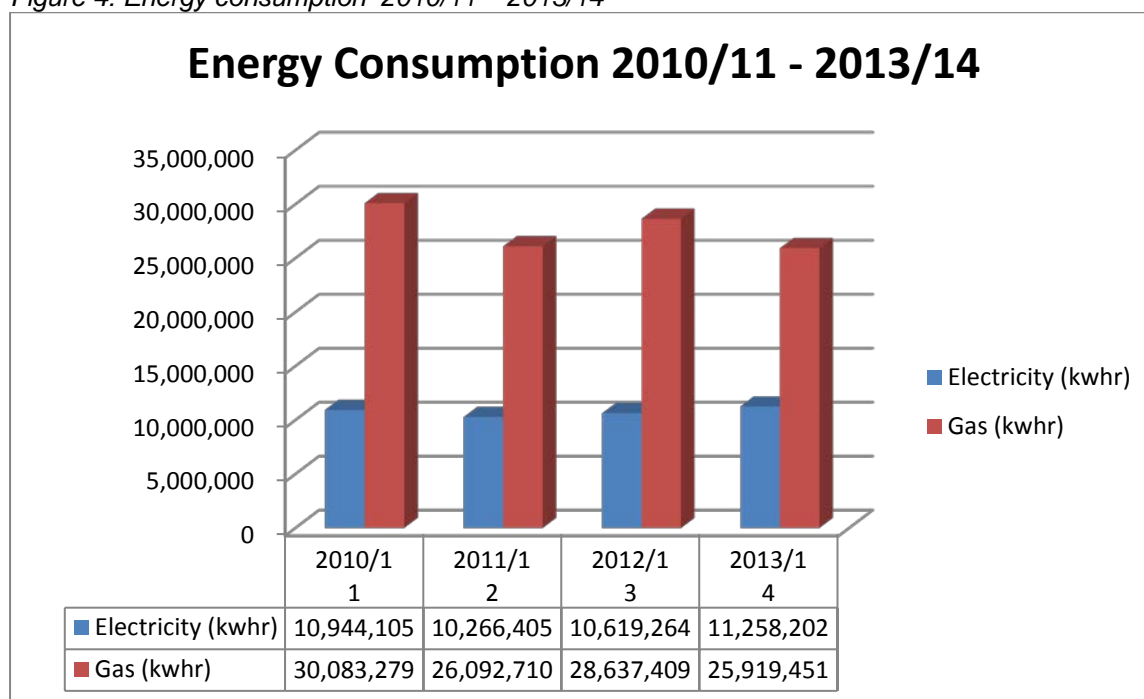
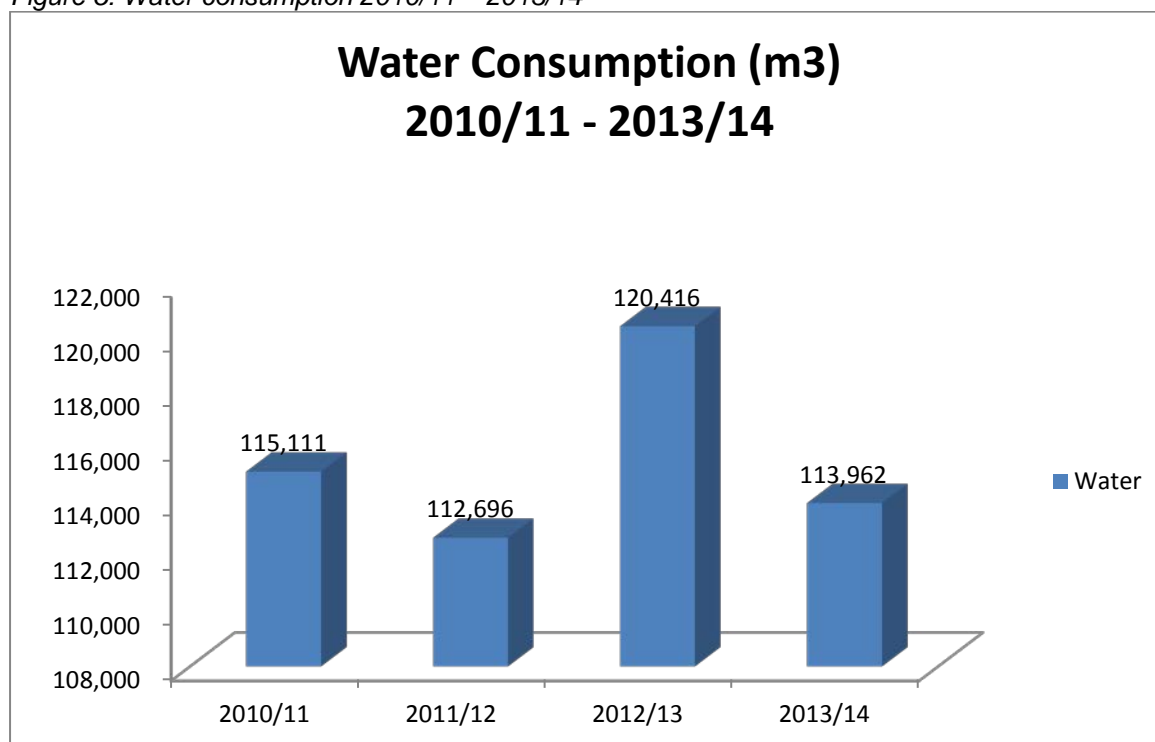


Figure 5: Water consumption 2010/11 – 2013/14



Looking ahead into 2014/15, budgets have been set to include a further change in gas and electricity prices.

Procurement

The Trust recognises the key role that procurement has in controlling and reducing carbon emissions, as the Trust's supply chain accounts for more than 75% of the Trust's carbon tonnage.

The Trust follows the NHS Flexible Framework Sustainable Procurement model and the Good Corporate Citizenship Assessment model.

All procurement personnel are regularly trained on sustainable procurement techniques and environmental criteria are considered when tendering for major, relevant products and services, with products being assessed on a life-time cost basis.

All 'white goods' are now screened to ensure energy efficiency before orders are accepted and a project has been completed to consolidate printing and stationery to reduce carbon emissions.

The Trust recognises the impact that services can have within local communities, and where relevant will include social aspects of the service as part of tender evaluation, such as improvements to the local environment, local community involvement, local employment and so on.

The Trust uses ethical procurement practices in the selection of suppliers, and all tender evaluations now include assessment to confirm that suppliers are acting ethically, for example safe working practices, and adoption of the Living Wage.

Bio-diversity

Bio-diversity is important to our Trust – ensuring where possible that in particular our inpatients have access to green spaces. Investments have been made in 2012/13 to help to improve the quality of the outdoor space for use by our service users. Our Trust also has care programmes that engage with service users at allotments and grounds and gardens within the Trust.

Priorities and achievements

Our Trust has made significant progress in addressing the sustainability agenda as evidenced by national awards over the past five years. We have by nature of our success already achieved the 'quick wins' and have continually driven the message to our staff about being sustainable and reducing wastage.

Building on the achievements made over the last few years our Trust needs to:

- implement the Green Travel Plan and act on the action plan(s), prioritising the schemes that will have the most material impact whilst at the same time being in themselves affordable and sustainable
- continue to develop ways of enhancing data and sharing that data with divisions and buildings so that staff know the impact from a carbon and financial perspective of the healthcare they are providing. To that end a Sustainable Development Day is being considered for later in 2014/15
- review our sustainable development strategy and carbon management plan in line with the new NHS Sustainable Development Strategy
- integrate and embed the ethos of sustainability within the estates strategy and service delivery strategies
- be innovative in the way we continue to drive down resource wastage, continually developing a range of tools and materials to promote our commitment to sustainability, and engaging with staff and service users
- implement the findings of the energy transmission and transportation project
- invest in environmentally efficient and sustainable technologies, products and services. For example, solar photovoltaic power, powerfactor correction technology and retrofit of lighting with LED lighting where suitable (all subject to business case). These being in addition to renewable energies already in place such as ground source heat pumps and work being undertaken with stakeholder partners on further initiatives such as photovoltaic cells, solar thermal and gas particle realignment.

The Trust recognises that 'sustainability' is not a project, and has no end, rather that it is integral to and impacts on all Trust activities, its day-to-day business and the quality and cost of services.

A sustainable health and care system delivers across three dimensions: financial, environmental and social.

Quality report

Part one

Statement on quality from the Chief Executive

Welcome to the Birmingham and Solihull Mental Health NHS Foundation Trust's Annual Quality Account for 2013/14. This document is a report about the quality of services provided by our Trust as a NHS healthcare service. The report is published annually by all NHS providers and is available to the public. Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

The overall corporate strategy for the Trust embraces the quality strategy which was approved by the Board in August 2012. A core component of the quality strategy has been to ensure that quality is at the heart of everything we do. Consequently, significant work has been undertaken to strengthen our focus on quality across the whole organisation.

To maintain and further enhance quality in our organisation I am committed to ensuring that we actively engage service users, families and carers to receive feedback from them and that we have an open culture to enable staff to share and raise any concerns.

Over the year we have developed our systems for receiving real time feedback through electronic questionnaires from our service users. These are located in individual services or supported by our service user workers. The results of the feedback is provided to local teams and also included in reports to our Trust Board. Details are also provided live on our intranet page for staff to review.

This year significant work has been undertaken through our Listening into Action (LiA) programme to engage staff in identifying how services can be improved. In total over 1,110 staff have been involved in Listening into Action events. We have also supported and empowered numerous individual teams to identify where they need to improve. Each team also has an executive sponsor to ensure that the actions identified are supported and followed through. After the success of the first 12 teams, a further 19 teams have now adopted the LiA approach to improve the experience of service users, staff and wider trusts. Ultimately the aim is to ensure that all staff feel empowered to address issues of quality themselves.



Equally the Trust has been committed to ensure that all staff feel supported to raise concerns on quality. For example the Trust has worked to increase the level of incident reporting through our Eclipse system. We have also devised a whole new model of reporting quality concerns through Dear John (www.dearjohn.org.uk), which has proved extremely popular with staff and has seen direct improvements to quality in our Trust, with each concern receiving a direct response from myself. The Trust Board has also put in place a series of site visits that ensures individual Board members visit our services across all areas to get a direct insight into quality and service user experience in our Trust.

The Trust actively aims to support the needs of the diverse communities we serve in the Birmingham and Solihull area and we are committed to working more to achieve this. More importantly we believe in celebrating the diversity of our local communities.

The Trust has pledged its support for the national Time to Change Programme to challenge mental health stigma and discrimination.

We will work with the continuing development of the CCGs, during their first year and we will continue to work with them over time as their needs change. The Trust has worked closely with our local police to tackle the issues of vulnerability of our service users and ensure a greater understanding of mental health issues. The development of a pilot street triage project has been one demonstration of our successful partnership with the police.

As Chief Executive I consider an integral part of my role is getting out and regularly visiting sites, both on an announced and unannounced basis. This means I get to hear directly from staff and our service users what they have to say about quality and where they think there is still work to be done. Overall I receive very positive feedback and have seen for myself the efforts staff make each day to provide a quality service. Equally I have also heard about concerns when we are not able to provide the service that we would like to and have ensured that actions are taken to address these concerns.

The Trust Board has also placed greater emphasis on quality at its meetings. Each meeting starts with a patient or representative sharing their experiences of our services directly with the Board. Such an approach ensures that patient experience and quality is directly at the forefront of the Board's mind when conducting its business. Our Board sub-committee structure also ensures that quality is integral to decision-making and is always considered in wider decisions. The Integrated Quality Committee reviews quality issues at the same meeting as financial considerations.

Both our annual staff survey and patient survey demonstrated improved results this year, but also highlighted areas for further improvement. I am particularly proud that we are in the top five mental health trusts in the country in terms of staff satisfaction with the quality of patient care they are able to deliver. However our staff survey also highlighted that further work needs to be undertaken to support staff experiencing bullying and harassment from patients, relatives or the public and experiencing physical violence.

Our patient survey highlighted that we had improved against our priority areas in relation to giving patients a copy of their care plan and explaining the side effects of medication, however we still need to do more to improve the quality of our care planning arrangements, how we involve family and support networks and also referring to partner agencies.

The Trust is committed to improving the opportunities for learning from serious incidents and has put in place systems to improve the quality of our reviews. We have seen an increase in the number of unexpected deaths of service users and have undertaken reviews of these to ensure that any themes or trends are identified. We have also reviewed cases of homicides where our service users were perpetrators to ensure that we learn from these incidents and also provided assurance that the level of these incidents was not adverse compared to national trends.

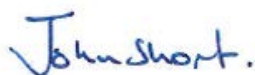
The use of electronic reporting to support our root cause analysis reviews of serious incidents has been piloted and will be developed over the year ahead. All staff also receive our bi-monthly Learning Lessons bulletin where incidents are highlighted and the lessons learnt are shared.

The Trust has reviewed itself against Monitor's quality governance framework on a number of occasions over the past two years, and this review led to the development and implementation of the Trust's Quality Strategy. The Trust has demonstrated an improvement of compliance against Monitor's Quality Governance Framework from a score of 11 recorded early last year, (where an acceptable score would be considered to be below 4), to a score of 6 in July. Further improvements have since been implemented and actions are in place to further improve our compliance.

In summary, the Trust Board is firmly committed to ensuring that Birmingham and Solihull Mental Health NHS Foundation Trust continues to find opportunities to strengthen the voice of those who use or have an interest in our services. The Quality Account highlights our commitment, ambition and determination to deliver the kind of healthcare of which we can be rightly proud. I can confirm that to the best of my knowledge the information within this document is accurate and has received full approval of the Trust Board.

I hereby confirm on behalf of the Birmingham and Solihull Mental Health NHS Foundation Trust that to the best of my knowledge the information in the whole of this report is accurate.

Signed:



.....
John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust

Date: 21 May 2014

Part two

2.1 Priorities for improvement

The Trust is committed to continuous quality improvement. This section of the report sets out what improvements we identified last year and how far these have been met, as well as what improvements we wish to achieve over the coming year.

2.1.1 Review of priorities set for 2013/14

Last year we identified the following priorities for improvement:

Table 42: Priorities for 2013/14

Domain	Priority	How progress to achieve the priorities will be monitored and measured	How progress to achieve the priorities will be reported
Safety	To achieve sustainable improvements in the quality of clinical risk assessments	% service users on CPA who have had a level 1 risk assessment completed. Completion of physical health assessment. Risk assessment audit results (annual update).	Quality Account indicator reported to Trust Board. Monitored via CPA group. See Table 43 indicator 1 for results
Clinical Effectiveness	To improve quality at each stage of the CPA process	(a) ICR data for completeness in relation to: <ul style="list-style-type: none"> • H&SC • Risk Screening • Care plan • Total ICR audit score (b) % of service users who have a CPA review every 6 months	As above See Table 43 indicators 2a-2c & 3 for results
	Quality Audit	Demonstrable improvements in re audits against CPA quality audit.	As above See Tables 44 and 45
Patient Experience	To improve engagement of service users in care planning	(a) % of service users who confirm they have been offered a copy of their care plan (RTF data) (b) % of service users on CPA reported by a member of staff as signing their care plan (to be reviewed with Info dept and confirmation of implementation)	As above See Table 46

Note abbreviations:

ICR = Integrated Care record (The main health record)

CPA = Care Programme Approach

H&SC = Health and Social Care assessment

RTF = Real time feedback – service user feedback system

The Trust has adopted an integrated approach with our Quality Account priorities also reflected as our Trust Quality Goals. As a result indicators have been regularly reported each month across corporate and local meetings including:

- Trust Board report
- Clinical Governance committee
- Local Clinical Governance committees.

2.1.2 Outcome of priority indicators

Table 43: Outcome of priority indicators

Objective	A	M	J	J	A	S	O	N	D	J	F	M	
1: % service users on CPA who have had a risk assessment completed (includes level 1 & 2) Previous performance March 13 = 66% data recorded is not comparable due to difference of systems.	58	63	68	70	75	79	81	80	81	82	78	79	↑
2: ICR data for completeness in relation to:													
2a: H&SC (parts a,b and c) Previous performance March 13 = 54.6% Prior to this date data recorded is not comparable due to difference of systems	55	60	63	66	71	76	78	78	80	82	NA	NA	↑
2b: CPA Care plan Previous performance March 13 = 50% Prior to this date data recorded is not comparable due to difference of systems	50	55	60	64	70	72	74	75	76	77	76	81	↑
2c: Total ICR audit score Previous performance March 13 = 54% Prior to this date data recorded is not comparable due to difference of systems	54	59	63	66	71	75	77	77	78	79	76	80	↑
3: % of service users who have a CPA review every 6 months Previous performance 2012/13 – fy 80.2% 2011/12 – fy 62.6% 2010/11 – not recorded	79	79	79	80	78	78	78	81	81	81	81	82	↔

Note: See abbreviations on page 78

The Trust has achieved a significant improvement in completion of core fields within our care records in relation to care programme approach compliance, ensuring that all clinicians populate key fields of data within individual patient records. The Trust had failed to achieve significant improvement in this report last year, however the steps taken last year have become more embedded and supported this improvement.

Changes were made to the Health and Social care assessment form which means that element 2a is no longer applicable and a single summary assessment form is now in place.

Whilst the level of service users who have received a CPA review every 6 months has only increased by a small level this is viewed positively that this objective has not deteriorated.

4: Demonstrable improvements in re audit against CPA quality audit.

The Trust has demonstrated sustained improvements on its CPA quality audit of care plans and core documentation. A summary of improvements identified is set out below.

Table 44: AWA CMHT re audit

Team	Baseline Quality Care Plan Score (January–November 2012)	Re-Audit Quality Care Plan Score (July 2013)	Re-Audit Quality Care Plan Score (January 2014)
Lyndon	46%	68% (including social care) 75% (excluding social care)	84%% (including social care) 86% (excluding social care)
Handsworth	26%	56%	83%
Zinnia	23%	42%	83%
Newington	51%	70% (including social care) 74% (excluding social care)	82%% (including social care) 81% (excluding social care)
Aston	34%	83%	80%
Patrick House	50%	70%	80%
Warstock	23%	63%	77%
Erdington	50%	68%	76%
Ladywood	33%	59%	76%
Longbridge	41%	Local Audit July –	75%
Kingstanding	29%	69%	73%
Yewcroft	44%	67%	71%
Riverside	59%	67%	64%
Ten Acres	22%	47%	55%
O'Donnell	47%	73%	Audit deferred
Small Heath	51%	52%	Audit deferred

Table 45: MHSOP quality care planning audit

MHSOP Quality Care Planning Audit			
	June 2013	February 2014	% Increase
South Hub	48%	92%	44%
Solihull Hub	52%	88%	36%
East Hub	29%	83%	54%
West Hub	30%	76%	46%
North Hub	33%	71%	38%

There is no previous data for these audits.

Table 46: User experience data

Objective	A	M	J	J	A	S	O	N	D	J	F	M	
5: % of inpatients who confirm they have been offered a copy of their care plan (Nursing metrics)													
Previous performance –													
Mar 13 – 76.5%	79	76	72	82	82	79	82	80	77	89	85	89	↑
Apr 12 70.6%													
Prior to April 2012 this measure was not reported.													

Objective	A	M	J	J	A	S	O	N	D	J	F	M	
% of community patients who confirm they have been offered a copy of their care plan (Nursing metrics) Previous performance – Not measured.					80	62	67	82	77	81	92	71	↓
6: % of service users who felt their views were not taken into account when we planned their care.(Real time feedback data from core questionnaire) Previous performance – Not measured in this form.	20	30	30	22	24	13	25	10	9	17	9	14	
7: % of service users who report that they have not been offered a copy of their care plan (Real time feedback data from core questionnaire) Previous performance – Not measured in this form.	35	24	39	41	63	46	46	41	52	50	42	44	

2.1.2 Priorities for improvement 2014/15

The development of this year's priorities has in part been supported by the Trust Business Planning process. This year a process of local engagement on the development of local business plans was undertaken this involved:

- 7 workshops delivered
- Attended by 100+ operational staff
- Presentation included service user and carer themes
- Presentation at two Council of Governors meetings.

The work on the development of local goals reflected on the review against the strategic ambitions reflected by our strategy and as a result, a number of high level goals to support these were developed through the Executive Team. These were:

QUALITY	
<i>Experience and Effectiveness</i>	<i>Safety</i>
<ul style="list-style-type: none"> • Our service users are always treated with dignity and respect • We continuously use feedback to improve outcomes and experience • There is no Care Plan about me without me, evidenced by Care Programme Approach • Our services deliver equality of outcomes for diverse needs 	<ul style="list-style-type: none"> • We provide service users with a safe environment of care • We continuously learn from incidents and any recurring themes demonstrating improved patient safety • We have a supportive culture, people raise concerns about poor quality or unsafe care, and we act on them
PEOPLE	
<i>Leadership and Development</i>	<i>Staffing</i>
<ul style="list-style-type: none"> • We have the right management and clinical leadership capacity & capability • We have highly visible leadership 	<ul style="list-style-type: none"> • We have the right number and diversity of staff to deliver services • Our staff have the required skills
STAKEHOLDER	
<i>Reputation</i>	<i>Engagement</i>
<ul style="list-style-type: none"> • Service users, carers and staff are happy to recommend us as a place to receive care and a place to work 	<ul style="list-style-type: none"> • We make the Trust a smaller place by excellent staff engagement :you say we listen • Services are responsive to and reflective of their local communities

An exercise was undertaken to review clinical risks, feedback from complaints and service users and issues identified from serious incident reviews in order to develop a long list of priorities for inclusion in this report. These draft priorities were further reviewed from feedback with external partners and also issued to staff through our intranet and various clinical committees for feedback and comments.

As a result the following priorities have been agreed:

(a) SAFETY OBJECTIVES

1) To reduce the level of recurring incidents of assaults through the further development of a structured escalation response to demonstrate the reduction of recurring issues.

Rationale:

This priority has been identified from concerns raised in monitoring of recurring incidents this year and also feedback from service users through our real time feedback over how safe they feel on the ward. Our staff survey has also highlighted that the Trust had a poorer score than average in relation to staff experiencing harassment, bullying or abuse from patients, relatives or the public. The Trust Clinical Governance committee identified this as a priority for improvement.

This priority is also indicative of the wider public concern relating to safety of staff reflected in the recent announcements by the Secretary of State in relation to 'signing up to safety'.

How progress to achieve the priorities will be monitored:

There will be a structured review of all recurring incidents of assaults by service user, the Trust will develop an escalation process for additional support to be provided to teams where issues are identified.

Data will be reported monthly to Trust Board and cascaded to local governance committees.

How progress to achieve the priorities will be measured:

The following measures are highlighted:

- Nursing metrics: Do you feel safe on this inpatient unit? (Current indicator: 92.2%).
- Real time feedback: Do you feel safe on this inpatient unit? (Current indicator: 60%).
- No of recurring assault incidents (Current indicator: Patients with 5+ incidents of aggression 15).

2) Improve the safety of inpatient wards through reduced reliance on temporary staffing and improved compliance with defined staffing levels for adult inpatient wards.

Rationale:

This priority has been identified from risks highlighted by individual services throughout the year. The objective was developed within the HR business plan.

A number of service user concerns identified in complaints and feedback have also highlighted this issue.

This issue is also reflective of wider public concerns nationally arising from the Francis report relating to staffing levels on wards.

How progress to achieve the priorities will be monitored:

Data will be reported monthly to Trust Board and cascaded to local governance committees.

Work is being undertaken to streamline the recruitment process and improve the effectiveness of the temporary staffing service.

How progress to achieve the priorities will be measured:

The following measures are highlighted:

- Number of unfilled temporary staffing shifts across all operational services.
- Increase the level of vacant posts.
- Increase level of activities (RTF data).

(b) CLINICAL EFFECTIVENESS

To continue to improve quality at each stage of the CPA process.

Rationale:

This priority builds on our existing priority this year. This highlights feedback from staff teams and service users on how important this is and the need to continue the work achieved. In addition recommendations from serious incidents and complaints still identify shortfalls in our care planning which impact incidents.

Wider consultation with other public bodies has highlighted the important of this priority.

How progress to achieve the priorities will be monitored?

Data will be reported monthly to Trust Board and cascaded to local governance committees.

A specific working group led by the Deputy Director of Nursing will continue to monitor and review indicators and will target support to those services showing least improvement.

How progress to achieve the priorities will be measured?

The following measures are highlighted:

- ICR data for completeness (to achieve 80% consistency across all services).
- % of service users who have a CPA review every 6 months (to maintain existing performance).
- % of service users who confirm they have been offered a copy of their care plan.
- for all teams to achieve 80% compliance with Quality audit.
- Data for all these indicators is reported in the 2013/14 results of this report.

(c) PATIENT EXPERIENCE OBJECTIVE

Improve compliance with the triangle of care assessment tool to deliver improvements in the level of engagement with family and carers.

Rationale:

This priority reflects feedback received from carer groups and service users over their experience of the engagement of family and carers. This has also been a Trust priority.

This priority is also reflective of wider public concerns relating to openness with family and carers.

How progress to achieve the priorities will be monitored?

Data will be reported monthly to Trust Board and cascaded to local governance committees.

Initial self assessments will be completed by wards and teams these will then be reviewed and assessed leading to feedback to teams identifying areas for improvement where this is appropriate. Assessments will then be further reviewed following the actions taken.

How progress to achieve the priorities will be measured?

The following measures are highlighted:

- Triangle of care assessments.

2.2 Statements of Assurance from the Board

The purpose of this section is to provide formally required evidence on the quality of services. All NHS Trusts and Foundation Trusts are required to follow a similar format for each of the sections below based on national guidance.

2.2(a) Review of services

During 2013/14 The Birmingham and Solihull Mental Health NHS Foundation Trust provided and/or sub-contracted 14 relevant health services.

Birmingham and Solihull Mental Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 14 of these relevant health services.

The income generated by the relevant services reviewed in 2013/14 represents 100 per cent of the total income generated from the provision of relevant health services by Birmingham and Solihull Mental Health NHS Foundation Trust for 2013/14

2.2(b) Participation in clinical audits

During 2013/14 2 national clinical audits and 1 national confidential enquiry covered relevant NHS services that Birmingham and Solihull Mental Health NHS Foundation Trust provides.

During 2013/14 Birmingham and Solihull Mental Health NHS Foundation Trust participated in 100% of national clinical audits and 100% of relevant national confidential enquiries of the national clinical audits and national confidential enquiries.

The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

- National Audit of Schizophrenia
- Prescribing Observatory for Mental Health
 - POMH 7d Monitoring of patients prescribed lithium
 - POMH 4b Prescribing Anti-Dementia Drugs
- National Confidential Enquires into Suicide and Homicide for people with severe and enduring mental illness.

The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in during 2013/14 are as follows:

- National Audit of Schizophrenia
- Prescribing Observatory for Mental Health
 - POMH 4b Prescribing Anti-Dementia Drugs
- National Confidential Enquires into Suicide and Homicide for people with severe and enduring mental illness.

We did not take part in the POMH Lithium Audit which was part of the Prescribing Observatory audit programme due to changes in Pharmacy staffing during the data collection period.

The national clinical audits and national confidential enquiries that Birmingham and Solihull Mental Health NHS Foundation Trust participated in, and for which data collection was completed during 2013/14 are listed overleaf (where we can provide this information) 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 47: National audit of schizophrenia

Audit	Number submitted	Number required
<i>National Audit of Schizophrenia</i>	100	100

Percentage achieved = 100%

The report from 0 national clinical audits was reviewed by the provider in 2013/14 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

(The outcome of this audit has not been reported within the period but is expected to be produced by July 2014).

POMH 11b Prescribing antipsychotic medication for people with dementia

This audit took place in 2012 highlighting issues with documentation and the use of non-pharmacological interventions. The pharmacy team have also carried out regular audits using the POMH audit tool to allow direct comparison of results with the national results. Every audits cycle is fed back to the team and results discussed.

Improvements have been evident of better documentation of the reasoning behind starting/ stopping the use of anti-psychotic medication. It has also been easier to evidence the use of non-pharmacological interventions as, whilst we always knew this work took place it was hard to evidence. These interventions are being documented more thoroughly now. Practice has also changed and decisions to prescribe anti-psychotic medication are being challenged by nursing staff.

The reports of 147 local clinical audits were reviewed by the provider in 2013/14 and Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- **Inpatient controlled drugs audit (ref 475)**

This audit was presented to the PTC audit group in January 2014. Following the 2012 baseline audit lead pharmacists have worked more closely with their teams and ward managers and a model of the correct type of cupboard was provided. The results from the re-audit in 2013 showed a 5% improvement in compliance with the controlled drug standards. 14 wards achieved 100% compliance with standards. This is a significant improvement from autumn 2012 where there were only three.

- **Trustwide audit of use of clozapine to examine whether NICE guidance is adhered to (ref 155)**

This audit was presented to the PTC audit group in November 2013. The audit found that it was difficult to achieve 100% compliance due to some patients' resistance to depot injections. It also highlighted that clinicians often favour other antipsychotics above Clozapine – which is against NICE guidance. As a result the pharmacy team have planned to run an education session to remind clinicians of the need to ensure that implementation and monitoring is in line with NICE guidance.

- **Injection Technique (ref 271)**

This audit was presented to the PTC audit group in November 2013. The results showed that staff were not all clear about how to clean an injection site and 15% of staff had not had training in the last 10 years. There was also a lot of uncertainty about needle size and how long to leave needle in. As a result there are plans to update the injection guidance; develop a checklist for staff to use in clinics and develop and roll out a training package ensuring that staff are trained every 3 years.

- **An Audit of Adherence to the BSMHFT Rapid Tranquillisation Policy in Adults of Working Age (ref 364)**

This audit was presented to the PTC audit group in May 2013. This audit found that there had been small improvements in the reporting of rapid tranquillisation (RT) through Eclipse and the use of RT recording forms although significant numbers of patients had one or both forms missing. Physical health documentation prior to RT was recorded in around 60% to 75% of cases. ECG records occurred in around half of all cases. For Eden ICU, 90% to 100% of physical checks were completed.

Documentation of physical observations during RT occurred rarely and this was a concern that had been raised in previous RT audits. It was also rare for patients to be debriefed and followed up following RT and there is little evidence any patients have an opportunity to record their future RT treatment preferences.

Individual areas of non-compliance have been followed up with the appropriate SDMs. The RT form has been amended to include a drop down box. Meetings have taken place with lead nurses focussing on restraint methods and RT practice.

- **Compliance of the RAID team to the NICE Guidelines for the short term (ref 326)**

There was evidence that staff receive sufficient supervision and training, patients are screened for suicidal intent, their relative or carer is involved if necessary, the Risk Assessment Screening Tool is completed, the action plan is agreed and written up and onward signposting/referrals are made if necessary. Actions arising out of the audit are identified as;

More comprehensive documentation regarding issues discussed during assessments are required (harm minimisation techniques for self-injury, the risks of self-poisoning and screening for suicidal intent). Ensure written copies of the assessment and action plan are always forwarded to the patient's GP. To insure the patient is provided with written information regarding their treatment/action plan, even a brief summary (e.g. You were seen today by, we discussed and the plan is to refer to). As a result of the audit RAID has produced a patient leaflet that has been approved by all of the acute Trusts.

- **The use of non-pharmacological interventions for challenging behaviour in patients with dementia (ref 534)**

Of the 40 incidents of challenging behaviour, 39 had an intervention documented. Although all incidents of challenging behaviour had an outcome documented, none had details of the positive intervention in the care plan. The recommendation was to create a shift summary cue card to act as an aide memoir during handovers. This reminded staff to identify useful non-pharmacological techniques and to add these to the care plan. The audit was presented in the January MHSOP Clinical Governance Committee. The cue card had been created and was being utilised on the ward, with positive feedback from ward staff. The committee was impressed with the cue card and requested the audit is presented at the inpatient improvement group, to consider utilising the cue card on all wards.

- **Section 11 of the Children's Act**

In response to the audit a leaflet is being produced for children and young people to understand their rights in an easy to read format. Level 3 training is being organised. Action learning sets are being carried out in key areas for professional leads. An audit of the quality of safeguarding referrals is underway.

2.2(c) Research

The number of patients receiving relevant health services provided or sub-contracted by Birmingham and Solihull Mental Health NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 841.

Birmingham and Solihull Mental Health NHS Foundation Trust continues to support five successful research programmes (Addiction; Ethnicity and Mental Health; Neuropsychiatry; Dementia and Neurodegenerative Diseases; Early Intervention and Prevention).

Currently (February 2014) the Trust is involved in 27 funded studies adopted by the NIHR (17 non-commercial and 10 commercial). Of these, the Trust leads on 2 NIHR programme grants, 2 research for patient benefit grants, 1 health technology assessment grant, and 1 MRC grant. Our leading clinical researchers work in partnership with the Universities of Birmingham and Warwick and publish widely in high profile national and international peer-reviewed journals. In response to the Health & Social Care Act (2012) the Trust Board approved a new and exciting research strategy for the Trust enabling a wider research constituency to be developed across the Trust, and following the recent draft NHS England Research and Development Strategy a business plan is being developed to support the Trust's new strategy.

2.2(d) Use of CQUIN payment framework

Use of CQUIN payment framework

A proportion of Birmingham and Solihull Mental Health NHS Foundation Trust income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Birmingham and Solihull Mental Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available online at:

<http://www.bsmhft.nhs.uk/about-us/trust-documents/statutory-statements-and-declarations/>

Table 48: Birmingham CCG CQUINs

Goal Number	Indicator Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected financial value of Indicator (£)
1	NHS Safety Thermometer	Data collection & submission	20.00%	£659,843
	NHS Safety Thermometer	Maintenance thresholds for types of harm		
2	Family & carers' engagement	Improve identification & support to carers/family	14.00%	£461,890
3	Meds Management Formulary adherence	The percentage of prescribed items that are prescribed in line with the local formulary	4.00%	£131,969
4	Pressure Ulcers	Recording & reduction of avoidable	12.00%	£395,906
5	PBR		12.00%	£395,906
6.1	Dementia	Dementia Outcomes monitoring	4.80%	£158,362
6.2	Dementia	Service User involvement	4.80%	£158,362
6.3	Dementia	Multi Disciplinary review	3.20%	£105,575
6.4	Dementia	Behavioural/psychological	3.20%	£105,575
7	Falls	Falls Management & prevention	12.00%	£395,906
8	Friends & family test	Testing approaches and methods in mental health services to support local	10.00%	£329,922
Totals:			100.00%	£3,299,215

Above table contains CQUIN goals and the financial values as agreed beginning of the financial year.

Unfortunately during quarter 2 we did not achieve all required for goal number 3 and it was agreed between BSMHFT and Birmingham Cross City CCG that the maximum we can achieve is 80% for this CQUIN.

Our predicted end of year CQUIN position is 96.44% completion paying £3,181,762.95 subject to achievement of Q3 & Q4 submissions.

Table 49: NHS England CCG CQUINs

Goal Number	Goal Name	Description of Goal	Goal Weighting (% of CQUIN scheme available)	Expected financial value of Goal (£)	Quality Domain
	Quality Dashboard (All Specialised Commissioned Services)	To embed and demonstrate route use of the use of specialised services clinical dashboards.	10.000%	£135,646	S,C,E,I
MH1/1a/1b	Optimising pathways (All Specialised Commissioned Services)	To help providers understand the whole care pathway and plan to optimise a individual's length of stay within specialised mental health services.	25.000%	£339,115	CE,PE
MH2/2a/2b	Improving physical healthcare & wellbeing (All Specialised Commissioned Services)	To improve the physical health and wellbeing of all patients, as an integral part of their overall treatment and rehabilitation plan.	25.000%	£339,115	PE
MH3	Provision of literacy, numeracy, IT and vocational skills training (secure adult only)	The provision of resources to improve literacy, numeracy, IT and vocational skills within secure care environments provides better opportunities for future participation in various aspects of life.	5.000%	£67,823	PE
MH4	Improving the Care Programme Approach (CPA) process (All Specialised Commissioned Services)	A baseline audit and development of an action plan to ensure the care plan approach (CPA) process is effective and appropriately identifies unmet need.	5.000%	£67,823	PE
MH5	Increase in use of communications technology (Secure only)	Increased utilisation of communications technology.	5.000%	£67,823	I

Goal Number	Goal Name	Description of Goal	Goal Weighting (% of CQUIN scheme available)	Expected financial value of Goal (£)	Quality Domain
Local	Goal defined access to services in CAMHS (CAMHS only)	To ensure that all patients admitted to a Tier 4 bed are subject to a detailed Care Plan within 72 hours of admission which is outcome focused and timetabled.	5.000%	£67,823	
FCAMHS	Implementation of ESSEN (FCAMHS only)	The Essen Scale is a tool designed to assess the therapeutic climate within a care setting. It explores the degree to which service users feel safe and supported by both their peers and care staff.	10.000%	£135,646	
FCAMHS	Learning from incidents (FCAMHS only)	Highly specialised services clinical outcome collaborative audit workshop.	10.000%	£135,646	
Totals:			100.00%	£1,356,459	

We are on track to achieve 100% of the CQUINS for NHS England.

2.2(e) Registration with the Care Quality Commission (CQC)

Birmingham and Solihull Mental Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is compliant. Birmingham and Solihull Mental Health Foundation Trust has the following conditions on registration: There are no conditions on registration.

The Care Quality Commission has not taken enforcement action against Birmingham and Solihull Mental Health NHS Foundation Trust during 2013/14.

Birmingham and Solihull Mental Health NHS Foundation Trust has participated in one special review or investigation by the Care Quality Commission relating to the following area during 2013/14.

- *Seclusion and Segregation*

Birmingham and Solihull Mental Health NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC.

- *Seclusion policy to be updated to reflect feedback from the visit.*
- *Use of standard terminology to be reinforced with staff.*

Birmingham and Solihull Mental Health NHS Foundation Trust has made the following progress by 31/03/14.

- *Seclusion policy has been revised and is being consulted on.*
- *Standard terminology by staff is being reinforced.*

2.2(f) NHS Number and General Medical Practice Code Validity

Birmingham and Solihull Mental Health NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.6% for admitted patient care
- 99.8% for outpatient care.

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

- 99.9% for admitted patient care
- 100% for outpatient care.

2.2(g) Information Governance Toolkit Attainment Levels

Birmingham and Solihull Mental Health NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 80% and was graded as satisfactory.

2.2(h) Clinical coding error rate

Birmingham and Solihull Mental Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit by the Audit Commission during 2013/14 year.

Birmingham and Solihull Mental Health NHS Foundation Trust will be taking the following actions to improve data quality:

- A continuing programme of work to ensure the accuracy of clinical case classification, activity recording and clinical outcome measurement information to support the mental health "Care Clusters" and "Payment by Results" initiatives
- On-going comparison of service user demographic data with the national NHS Summary Care Record database with correction of any discrepancies in our clinical systems
- Close monitoring of a range of data quality performance indicators and exception reports made available to both clinical and administrative staff to identify and correct data errors.
- Routine audit of data quality underlying key performance indicators, with special audits to be commissioned should more deep-seated data quality problems be identified
- A full review of the Trust's Data Quality Policy and processes to ensure fitness for purpose.

2.3 The following indicators are prescribed to be reported from national guidance.

1) The data made available to the Trust by the Information centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

Table 50:

	This year	Last year	National average	Highest reported score	Lowest
Trust performance	96.7%	95.3%#			
Data Made available to the Trust by the Information centre	95.5%	95.5%	97.4%	100%	77.2%

The variation between the data reported by the Information centre and updated data from the Trust this year is due to changes made to exclude CAMHs patients in our data – which we have been advised should be excluded to ensure parity with national reporting. There were also a number of late data entry and corrections to the data originally presented which were identified through our cleansing process.

Data reported by the Trust last year from the national data portal reflected part year data only.

The Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

This data is reported through our local performance management systems and reviewed at relevant committees. It is reported monthly to Trust Board having been reviewed and signed off by senior managers.

The Birmingham and Solihull Mental Health NHS Foundation Trust intends to take or has taken the following actions to improve this, and so the quality of its services, by:

Monitoring and review of this indicator is undertaken through our Operations committee and will in future be reviewed through our Operations service structures.

2) The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

Table 51:

	This year	Last year	National average	Highest reported score	Lowest
Trust performance	98.2%	96.2%#			
Data Made available to the Trust by the Information centre	97.5%	96.8%	98.3%	100%	0%

The variation between the data reported by the Information centre and updated data from the Trust is due to changes which were made to exclude over 65's in quarter 4 (to reflect national guidance) and a number of late data entry and corrections to the data originally presented which were identified through data cleansing.

Data reported by the Trust last year from the national data portal reflected part year data only.

The Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

This data is reported through our local performance management systems and reviewed at relevant committees. It is reported monthly to Trust Board having been reviewed and signed off by senior managers.

The Birmingham and Solihull Mental Health NHS Foundation Trust intends to take or has taken the following actions to improve this, and so the quality of its services, by:

Monitoring and review of this indicator is undertaken through our Performance committee and will in future be reviewed through our Operations service structures.

3) The data made available to the Trust with regard to the percentage of patients aged (i) 0 to 14; and (ii) 15 or over Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

Table 52:

	This year	Last year	National average	Highest reported score	Lowest
Trust performance	4. 1%	5.6%			
Data Made available to the Trust by the Information centre	Not available	Not available	Not available	Not available	Not available

The Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

This data is reported through our local performance management systems and reviewed at relevant committees . It is reported monthly to Trust Board having been reviewed and signed off by senior managers.

The Birmingham and Solihull Mental Health NHS Foundation Trust intends to take or has taken the following actions to improve this, and so the quality of its services, by:

Monitoring and review of this indicator is undertaken through our Performance committee and will in future be reviewed through our Operations service structures.

4) The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's — Patient experience of community mental health servicesII indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

Table 53:

	This year	Last year	National average	Highest reported score	Lowest
Trust performance	8.2	8.4			
Data Made available to the Trust by the Information centre	8.2	8.4	9.6	Not available	Not available

The Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

This data is undertaken independently to the Trust and in line with national survey requirements.

The Birmingham and Solihull Mental Health NHS Foundation Trust intends to take or has taken the following actions to improve this, and so the quality of its services, by:

As set out in this report the key focus and priority for the Trust is in relation to CPA and improved compliance with CPA is expected to support the improvement on this score.

5) The data made available to the Trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period.

Table 54:

	This year	Last year	National average	Highest reported score	Lowest
Trust performance	4106 reported for period Apr – Sep 2013 Org rate per bed days=41	3,397			
Data Made available to the Trust by the Information centre	4106 reported for period Apr – Sep 2013 Org rate per bed days=41	3,397	2,268	6,609 Org rate per bed days=	0 Org rate per bed days=0

Data is only available by the NRLS for the first six months of the year. Comparative data is reported for the six month period.

The Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

Data is reviewed at all levels of the organisation through the incident review processes. The Trust is reported to be the fourth highest reporter of incidents by the NRLS.

The Birmingham and Solihull Mental Health NHS Foundation Trust intends to take or has taken the following actions to improve this, and so the quality of its services, by:

The Trust is aiming to further improve reporting across the organisation. Plans are in place to focus improvement on professional groups and also community teams which tend to have lower reporting rates.

6) The data made available to the Trust by the Health and Social Care Information Centre with regard to the number and percentage of such patient safety incidents that resulted in severe harm or death

Data is only available by the NRLS for the first six months of the year. Comparative data is reported for the six month period.

Table 55:

	This year	Last year	National average	Highest reported score	Lowest
Trust performance reported for period Apr – Sep 2013	44 (1.1%) Org rate per bed days=41	61 (1.8%)			
Data Made available to the Trust by the Information centre reported for period Apr – Sep 2013Org	44 (1.1%) Org rate per bed days=41	61 (1.8%)	28	94	0

The Birmingham and Solihull Mental Health NHS Foundation Trust considers that this data is as described for the following reasons:

Data is reported to Trust Board or its Integrated Quality committee for review. Data is reviewed at all levels of the organisation through the incident review processes.

NRLS highlight that recording is not necessarily consistent across Trusts which makes comparisons difficult.

The Birmingham and Solihull Mental Health NHS Foundation Trust intends to take or has taken the following actions to improve this, and so the quality of its services, by:

The Trust is aiming to further improve reporting across the organisation. Plans are in place to focus improvement on professional groups and also community teams which tend to have lower reporting rates.

Part three: Other information

Review of quality of performance

This section of the report reviews our performance in relation to quality over the past year.

3.1 Quality Domain: Safety

The Trust identified the following 10 key indicators for monitoring the quality of safety. The outcomes of these are set out in Table 56::

Numbers of Incidents reported

Violent assaults on staff

Recurring incidents which result in harm

Riddor reportable incidents

SI reports

Never Events*

Health and Safety Training

Violence and Aggression Training

Clostridium Difficile Infections

MRSA infections -

The Trust is committed to improving the safety of its service users, staff and the public particularly through learning from a positive culture of incident reporting.

Trust Quality Goals (see below) have reinforced the requirement for all staff to positively report any incident. The Trust has developed the use of its risk management system to make it easier for staff to report an incident whilst also ensuring that this information is used to learn from individual incidents and trends to prevent or reduce reoccurrence.

As a result the number of incidents reported over the year has increased from 1000 to 1300. The Trust is one of the top five reporters of incidents to the national reporting and learning system (NRLS).

Teams are able to review incident trends for their area and also review against other teams. Such reviews take place at all levels of the organisation from team to Board.

******THERE WERE NO NEVER EVENTS REPORTED FOR THE YEAR******

**THE TRUST IS AMONGST THE TOP TEN REPORTERS OF INCIDENTS TO THE NATIONAL
REPORTING LEARNING SYSTEM**

The information below shows the average daily rate of four key incident types that occurred across Trust services in quarter 3.



Table 56: Summary key indicators

	Target Area	Objective Date source: Risk database 'Eclipse':	Average for previous 12 months		Average for previous 3 months		March	Month	Change
Annual Plan Quality Goal	Incidents reported Number of incident reports to increase for each professional group	Nursing	1205		1305		1335		↑
		Doctors	20		21		28		↑
		Psychologists	10		15		20		↑
		Non Clinical	114		153		135		↓
		Pharmacists	17		14		11		↓
		AHPs	25		28		30		↑
		Other	31		48		64		↑
			Last year:		This year:				
	Violent assaults on staff	Number of reported physical assault incidents (where physical assault was the primary incident code) on staff resulting in injury	720		687				↓
			Nov	Dec	Jan	Feb	Mar		
	Recurring incidents which result in harm Not reported in previous years.	Falls (patients with 3 or more incidents)	4	3	7	5	5		-
		Patients with 5 or more incidents of aggression	14	24	27	21	15		↓
	SI reports (Last year av. 42)	Review SIs outstanding with commissioners	1	7	17	9	11		↑
	Riddor reportable incidents (Last year av. 1.5)	Number of statutory reports where any member of staff has been off sick for over 7 working days due to an incident at work.	7	3	1	4	2		
	Never Events*	National benchmark >0 (Last year 0)	0	0	0	0	0		✓
	OTHER INDICATORS			2011/12	2012/13	End Mar 14	performance		
	Health and Safety Training National Benchmark (1) (Staff survey) Trust 75.% National Mean 75%	Source: training database		90.23 %	92.3%	94.9	%		
	Violence and Aggression Training	Source: training database		88%	79.2%	88.4	%		
	Clostridium Difficile Infections - as per national definition			0	0	0			
	MRSA infections - as per national definition			0	0	0			

Note: National benchmark data for incidents reported is difficult to compare. The Trust reports incidents to the NRLS system which is reflected in section 2.4 above and provides the most relevant comparison.

With the exception of NEVER EVENTS, CLOSTRIDIUM DIFFICILE and MRSA infections, all indicators identified are local indicators.

The Trust has actively promoted the reporting of incidents in order to increase risk awareness amongst our staff and, in particular, to ensure that non-nursing staff who have tended to report less incidents do so.

It is worth highlighting that the indicator to reduce the number of physical assault incidents to staff has reduced in numbers whilst the overall number of incidents has increased. Therefore the reduction as a proportion of incidents reported is more significant.

3.1.1 Safeguarding

The Trust works closely with our local authority and other safeguarding partners across Birmingham and Solihull.

Some of the achievements over the past year have included:

- strengthened governance arrangements within the Trust
- improved representation from across the Trust through establishment of a Safeguarding Committee with representation from all areas
- Integrated Action Plan developed to prioritise improvements required from learning
- improved data collection to demonstrate trends and themes
- review and update of training packages in line with legislation and national standards of practice
- improved partnership working through consistent representation at multi-agency Boards, sub-committees etc
- participation in regional PREVENT agenda, approval of Trust Policy and rollout of HealthWRAP training to all staff.

Quality Measures

- Compliance with Children Act 2004; Section 11 audit as per Local Safeguarding Children Boards.
- Compliance/assurance of standards as per Safeguarding Adults Boards.
- Training uptake meets commissioner requirements (over 85%).
- Rolling programme of supervision/action learning sets for staff working in priority areas, eg youth.

Future Work Plans

- Development of bespoke training in response to actions/learning from reviews.
- Rolling programme of audit in response to actions from reviews etc.
- Increase capacity within team to maintain training uptake and assist with data analysis.
- Data to be collated in line with safeguarding adults principles.
- Review and update internal and external website.
- Development of Domestic Abuse Policy.

3.1.2 Infection control

The Trust is required to have systems in place to manage and monitor the prevention and control of infection in order to meet CQC registration requirements ensuring patient safety.

Some of the work undertaken across the Trust in the past year to ensure compliance and support best practice is set out below.

- Training activity which has contributed towards supporting a skilled work force to detect and manage infectious conditions:
 - Extending the number of link workers in community settings.
 - Development of a 'e learning' programme for clinical and non-clinical staff to support compliance with fundamental care training requirements.
 - Delivering training to senior clinicians and medical staff on key infectious conditions that are significant to the management of service users to the trust, e.g. TB, Blood Borne Viruses, Gastro intestinal conditions.
- Strategic partnership working to reduce and control infection:
 - Development of Service User Immunisation Guidance.
 - TB Pilot with Birmingham Chest clinic to promote screening and improve health outcomes.
 - Psychiatrist sitting on Infection Prevention Partnership Committee to support better communication with medical staff.
- Policy and Audit Programme: to evidence compliance with the assurance framework:
 - The Decontamination and Legionella policies have been reviewed and the Trust cleaning strategy has been revised.
 - Environmental Audit and Production Kitchen Audit Programme completed and independent trust wide mattress audit undertaken. This was in addition to planned mattress inspections.
 - Quarterly audit of antibiotic prescribing.
- Surveillance and Outbreak Management:
 - Improved surveillance system enabled detection of outbreak of ESBL Ecoli infection at Hollyhill unit. Further learning from this incident resulted in improvements to cleaning regimes.
 - The number of outbreaks of diarrhoea and vomiting decreased from the level reported in 2012/-13.
- Capital Developments/ New builds/Refurbishments:
 - Forensic CAHMS new unit, Newbridge, Eden George Ward and Reaside. Advice on planning and water management during works to ensure safe and compliant practice.
 - Provision/improvements of hand wash basins in Reservoir Court, Hollyhill, mother and baby units and plans in place for further improvements at Oleaster and Eating disorders unit.

Quality Measures

- Audit programme completed:
 - Internal: Environment, Production Kitchen, Hand Hygiene Mattress inspections.
 - External: Mattress Inspections, Sharps Safety.
- Compliance with SLA for provision of infection control advice by Public Health England.
- Joint inspections by IPCt and Matrons to support them with their IPC responsibilities and improve local monitoring standards and reporting /escalation of issues as necessary to IPPC.

Future Work Plans

- Development of Food Safety e learning package for clinicians.
- Education targeted at staff groups on specific conditions arising from surveillance and clinical review, ie BBVs, Chicken Pox, TB, Mask fit testing.

3.1.3 Health and safety

A new risk and safety team was established to support and co-ordinate our health and safety activities across the Trust.

A three year strategic plan has been developed which defines Trust health and safety objectives for the period. This will be underpinned by local health and safety plans to ensure support at all levels of the organisation. The plan focuses on the development of structures, training and monitoring to ensure that we have effective arrangements in place.

Risk Assessment Process

There is a strengthened working relationship between the Risk and Safety team and the Estates department which has led to many positive outcomes to improving the safety of the physical environment. Both teams work well in jointly identifying risks and suitable, cost effective solutions to ensure safer environments for service users and staff.

Work has also been completed to further improve the forms used for recording the findings of environmental and ligature risk assessments and providing managers with support in doing this. This ensures that significant risks are identified regularly and appropriate measures put in place to ensure safety.

The communication process to allow the follow up of actions arising from both ligature and environmental risk assessments has greatly improved and has allowed enhanced planning for future projects. A number of significant changes have been made to a number of wards to improve safety based on the findings of these assessments.

Alerts System

The Trust continues to demonstrate its commitment to safety with another year where national risk alerts are responded to and where relevant acted upon within the identified national timescales.

Incident Reporting

There has been an improvement in the number of incidents reported to the Health and Safety Executive under the requirements of the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations (RIDDOR) and the current process is being further assessed to ensure it is the most suitable for the Trust. Work continues however to raise awareness amongst managers about the criteria for reporting and the legal framework governing this.

3.1.4 Learning lessons

Over the past year there have been a number of improvements made to support learning from our serious incident reviews.

In order to improve the quality of our reviews a SI review panel was established to sign off completed reviews for submission to commissioners. This panel which is led by one of our Clinical Directors has sought to ensure improved consistency of our review reports and ensure that all issues are appropriately reviewed. In addition the Trust has invited a commissioner to attend each meeting. Feedback from our commissioners has suggested that the quality of our reviews has significantly improved as a result.

At the beginning of the year the Trust was not meeting the timescales for completion of reviews and this was raised as a concern by our lead commissioners. This has placed more pressure on ensuring that reviews are completed promptly. The Trust has found that the need to ensure the quality of reviews and also the timeliness of them is a challenging one, we achieved significant improvement of timeliness up to October but our numbers have since increased again therefore we will be further working to improve on current performance.

The top themes identified for learning from serious incidents have included:

Table 57: Themes for learning from serious incidents

Themes / Issues identified	Actions taken	Further actions identified
Not meeting Trust standards for care planning documentation: <ul style="list-style-type: none"> Risk assessment not completed or out of date Care plan out of date Poor risk assessment Recording on RIO 	This has been reflected by the Trust Quality Goals in relation to improving all aspects of our care management arrangements. Poorly performing teams have been reviewed and actions agreed. Trust wide audit	All teams to achieve an 80% compliance target with our care record audits.
Failure to comply with Trust policy arrangements for the transfer of patients between teams.	Awareness raised through Trust Learning Lessons Bulletin. Reinforcing Trust requirements in relation to the transfer of care between clinical teams. Identified as a core issue for service change to ensure this is factored in.	Formal audit to be undertaken.
Failure to adequately follow up on patients who do not attend appointments.	Policy reinforced for needs to be assessed against risk.	Monitoring of DNA levels.
Physical Health checks not undertaken	Development of physical health clinics.	Audit of compliance.
Care coordinator maintaining contact eg when a service user is in prison	Raised with teams, Clinical Directors. Trust wide communication.	
Ensuring that the bed management process considers a ward's capacity to safely manage the prospective admission or the possible impact a new admission may have on the ward environment	Bed management escalation arrangements amended.	
Improving support to staff in supporting service users with a diagnosis of personality disorder		Proposals for the development of personality disorder services to be reported in 2014/15.

Themes / Issues identified	Actions taken	Further actions identified
Lack of guidance to support the needs of transgender patients	Guidance on treatment of transgender service users - guidance has been approved and issued to staff.	Additional training provided to staff in relation to supporting transgender service users.
Ensuring appropriate observation arrangements.	Review of Observation policy - the revised policy reflecting recommendations from previous SI reviews	Policy reinforced through training.
Lack of clear arrangements to support service users who work for or may have worked for the Trust.	Provision of guidance for treating staff members.	Seeking approval by commissioners of arrangements.
Understanding of a range of ligature risks	Changes to anti ligature risk assessment tool to reflect findings from individual incidents. Strengthened follow up arrangements for risk assessments.	Ongoing review of ligature risk assessments.
Emergency services being able to access buildings at evenings when front line reception staff not on duty.	Implementation of guidance for improving access to buildings for emergency services out of normal working hours.	Reviewed as part of Annual risk assessments.
Inappropriate duties given to health care assistants within Home treatment teams.	Reinforcing roles of health care assistants within Home treatment teams.	Routine monitoring.

Grove Avenue and Hertford House achieved level 1 excellent Accreditation for Inpatient Mental Health Services (AIMS)



As identified throughout this report a major part of the Trust's priorities for this year has related to the Care Programme approach and this work has been identified to support the gaps identified in SI reviews in relation to care planning, transfers of care, care co-ordinator role and risk assessments (see also section 2).

3.2 Quality Domain: Clinical effectiveness

The following indicators are routinely reviewed by the Trust for the ongoing monitoring and review of clinical effectiveness.

Table 58: Indicators for monitoring and review of clinical effectiveness

Indicators		2011/12	2012/13	2013/14
Antipsychotics dementia drugs	Local Audit Mental Health Services for Older People	36%	21%	33%

Indicators in Table 59 were routinely reviewed by the Trust as listed below and have already been reflected in earlier sections of this report.

Table 59: Other indicators

Indicators	Where reported
Range of indicators relating to compliance with Care Programme approach. <ul style="list-style-type: none"> • Risk assessment • Completion of health & social care assessment 	See section 2.1.2
CRHT % gate kept* admissions	See section 2.4

3.2.1 Care Programme Approach

Improvements in how we deliver the Care Programme Approach have been our overall top quality priority for the year. The outcome of this is reported in Section 2 of this report.

Visible senior leadership has continued to be pivotal to the ongoing drive for improvement and to achieving a sustained approach and level of performance.

The CPA quality improvement work stream convened in 2012 is now a well-established forum for addressing operational issues and sharing solutions.

This has generated a number of reporting initiatives designed to aid practitioners in their everyday practice for example – the care co-ordinator caseload report developed to assist Care Coordinators to manage their caseloads.

The integrated care record completeness report has been actively used to monitor and drive up compliance. All Clinical teams are able to review their level of compliance in real time through the Trust intranet and understanding of the RIO system and audit process has led to improvement in core figures from 53% in April 2013 to 78% in December 2013 representing a 25% improvement.

We are currently working to provide teams with an updated In-sight reporting system, which will provide a more defined report, which can be filtered by different factors, such as by Care Co-Ordinator, GP Surgery, CPA review date and even the number of reviews that have been cancelled and how many would need to be done over each month, to cover the number of service users on each team's overall case-load. The aim of the report is to assist care co-ordinators and team managers to plan more effectively for CPA reviews

The structured confirm and challenge support process introduced in February 2013 is also now well established and has received a positive response from teams. This process has enabled us to identify and address operational obstacles and help teams to reach solutions. It has also helped us to identify themes that may impact on CPA performance as a result of which we have now extended this process to the provision of proactive targeted support to teams with new managers or managers in acting positions.

CPA quality

The CPA quality audit is providing evidence that the quality of care plans is improving to ensure that they are patient focused. This has been a gradual but sustained improvement (evidenced in quality audits) 6 adult CMHTs rated as green with the remainder amber and an overall improvement of 35%. 4 of our AOT teams are rated as green with the remaining 2 amber and an overall improvement of 20%.

3.2.2 NICE guidance

The Trust has a systematic process for the review of NICE guidance which is co-ordinated through a Clinical Quality subcommittee. All guidance is reviewed for relevance and where this is identified a review is undertaken to determine whether the Trust meets the guidance or whether it can improve compliance.

Following a review of the NICE Quality Standards for Alcohol dependence and alcohol use disorders (CG100 and CG115) a short life working group was established to see what action could be

taken to improve alcohol awareness across the Trust. The group developed an online training tool which is currently being built. This package incorporates:

Alcohol Facts	<ul style="list-style-type: none"> • How to calculate units • Typical unit values/Experiment with alcohol volume • Recommended limits • What are the risks
Alcohol and Health	<ul style="list-style-type: none"> • Alcohol – The science • Alcohol and the brain • Alcohol and physical health • Alcohol and mental health • Alcohol and social wellbeing
Identification and brief advice	<ul style="list-style-type: none"> • Confusing terminology • Clarifying terms • Identifying the risk • Identification tools • FAST alcohol screening • Brief advice

Autism

The Forensic CAMHS service have been awarded the National Autistic Society accreditation in recognition of their positive work with developmental disorders. They meet all the NAS standards regarding diagnosis, assessment, providing information and interventions. They meet all the relevant standards in the NICE guideline.



Pressure Ulcers (CG 29)

A review of the baseline assessment identified 12 actions that needed to be undertaken. The completed actions are:

- The completion of relevant guidance including an agreement regarding timeliness of risk screening/ risk assessment tool and guidance regarding this.
- The standardisation of high specification foam mattresses, and a system for all Divisions of staff to readily access a mattress within 2 hours of identifying the need.
- Delivery of training packages to Older Adult Divisional link workers, and the delivery of 'tissue viability, a team approach training' and topic specific 'Pressure Ulcer recognition and management' training to other Trust staff.
- Availability of information via resource aids on the Tissue Viability service intranet pages including advice on care if infection is present and basic care of pressure ulcers.
- Incident reporting has improved and is reflected in relevant policies.

There are three actions which have been partially achieved, but require completion. They relate to accessibility of the Waterlow tool. This is in the process of being added to our record system.

3.2.3 Medicines management

Expenditure on medicines across the Trust totals £5.78 million including FP10 costs but not including pharmacy fees. This has fallen by £950k over the past year. The Trust continues to monitor drug expenditure carefully especially high cost long acting injections. These remain subject to scrutiny by Pharmacy to ensure that costs are controlled without impacting on quality or effectiveness. The Trust published its formulary at the beginning of the year and this is available to all prescribers within the Trust and to GPs via the Trust website. The Trust has participated in the

working group to establish the Area Prescribing Committee and will utilise the opportunity to harmonise prescribing guidance on mental health medicines across Birmingham and Solihull. Pharmacy services have demonstrated that prescribing is largely within the formulary. 94% of prescribing is consistent with the formulary, whether via Trust Pharmacies, FP10 prescriptions or through recommendations to GPs. Trust Pharmacy services will be reviewing prescriptions for tier two medicines more closely from April 2014 onwards.

The medicines management audit programme has illustrated compliance with policy and guidance. Audits on secure handling of medicines have shown 90% compliance with policy for both inpatient areas and community teams. We are improving the physical monitoring of medications used in rapid tranquilisation although there is still much progress that needs to be made. Compliance with guidance on the use of antipsychotics in dementia has shown significant improvement over the year. By March 2014, all patients with a primary diagnosis of dementia will have a multidisciplinary review with twelve weeks of initiation with many patients having treatment tapered and stopped in line with guidance.

The Trust Pharmacological Therapies Committee has produced additional guidance for prescribers on initiation of clozapine, management of red blood results with clozapine and clozapine re-challenge as well as guidance on prescribing for women of child bearing age.

Lean Healthcare Academy Award

Carly Craddock (formerly Cooper), who is based at Birmingham and Solihull Mental Health NHS Foundation Trust and is a regional manager for the part of the National Institute for Health Research (NIHR) Clinical Research Network which supports mental health research, was presented with the Lean Healthcare Academy Award.



3.2.4 Street triage

In January the Trust joined forces with West Midlands Police and West Midlands Ambulance Service to pilot a new 'street triage' project to ensure people with mental health issues are kept out of police custody and receive the right treatment and care.

The force is one of a number to be selected by the Department of Health to pilot the 'street triage' scheme, which sees mental health nurses and paramedics accompany police officers to incidents where it's believed people need immediate mental health support.

3.2.5 Place of Safety

In January the Trust also hosted a national conference on best practice for Place of Safety services which was attended by health professionals from across the country.

3.3 Quality Domain: Service user experience

The following 4 indicators are routinely reviewed by the Trust for the ongoing monitoring and review of service user experience:

- Service user feedback: Have you been offered a copy of your care plan. Set out in Table 46.
- CPA review in previous 12 months %*. Set out in Table 60.
- Complaints timeliness. Set out in Table 60.
- Patient Survey – ‘Do you have the number of someone to call outside office hours?’. Set out in Table 60.

Our inpatient services



The following indicators are routinely reviewed by the Trust for the ongoing monitoring and review of service user experience.

Table 60: Indicators for monitoring and review of service user experience

INDICATORS		2011/ 12	2012/ 13	End Mar 14	
CPA review in previous 12 months %*	Target 95% - Patients on CPA who received a formal MDT review of their care in the last 12 months.	92.2 %	93.2	95.7%	
Complaints timeliness	% complaints responded to in the agreed timescale.	77%	90%	58%	
Patient Survey – ‘Do you have the number of someone to call outside office hours?’	Source: NHS Patient Survey National Benchmark 54% All Mental Health Trusts	47.9 %	43%	46%	

3.3.1 User engagement

Recovery, Service User and Carer Experience (See Me Team, Real Time Feedback, Carers Forums, Complaints and PALS)

Achievements

We now have seven real time feedback surveys, which cover most services within the Trust and include the Friends and Family Test.

The 2013 National Patient Survey showed that we had made good improvements in the areas we agreed needed attention from the previous survey.

- We have signed up to The Triangle of Care which will help drive our Carers Strategy.
- We have a thriving carers' forum.
- We have a thriving service user strategy group.
- We continue to support the Positive Mental Health Group.
- We have developed a Recovering Wellbeing Framework which will inform clinical services.
- We have agreed to use Goal Attainment Scales as a Patient Rated.
- Outcome Measure which is being incorporated into our CPA process. This will ensure service users participation in care planning, goal setting and review.

Quality Measures

- Monthly Complaints and Real Time Feedback reports to Trust Board.
- Quarterly full SUCE team reports to CGC and IQC.
- Evaluation of use of Recovery Framework and use of GAS.

Future Plans

- Review our Service User strategy.
- Improve complaints process. Move to single letter, improve time scales and produce responses which are empathic and service user focused.
- Introduce volunteers to help with RTF survey collection.
- Finish preparation for compulsory FFT and introduction of national guidance.

3.3.2 Service user engagement in care planning

Improving engagement of service users in care planning has been a key focus. The CPA quality audit is providing increasing evidence that the views and preferences of service users are being articulated in care plans, and real time feedback is indicating a rise in the number of service users reporting that they have been provided with a copy of their care plan.

There has been considerable feedback about the format of the printable care plan pointing to the need to design a format that it is more engaging and accessible for service users. We are actively engaged in consulting with service users to develop a format that is more visually engaging and easier to read and understand. Our aim is to improve service user engagement and satisfaction with their care plan through improved provision and accessibility of care plans by June 2014.

3.3.3 Complaints

Achievements for the year – Improved link working with PALS in particular in relation to early resolution of issues for patients without having to go through formal complaints process. Improved contact to patients by investigating officers as part of the investigation process, and better quality checking of responses.

Quality measures – Better reporting to Trust Board. Response times. Improved investigation and QA process.

Future plans – Review and re-launch of the complaints process and policy, including continuing improved working with PALS and reporting of themes from early resolution and complaint themes, to better highlight learning. Training areas in dealing with and responding to complaints and improved response to complaints (communication with complainants, timescale and quality investigation).

Performance against key national priorities

Birmingham and Solihull Mental Health NHS Foundation Trust has reported meeting or exceeding all Monitor Indicators (as outlined in Appendix B of Monitor's Compliance Framework). Most indicators have already been reflected in earlier section of this report as below.

Table 61: Performance against key national priorities

Indicator	Ref to report:		
Clostridium Difficile – meeting the Clostridium Difficile objective	See page 96		
Care Programme Approach (CPA) patients, comprising either: receiving follow-up contact within seven days of discharge having formal review within 12 months	95% See Page 91 95% See Page 91		
Admissions to inpatients services had access to crisis resolution/ home treatment teams	95% See Page 91		
Indicator	Threshold	Out turn 12/13	Out turn 13/14
Minimising mental health delayed transfers of care	≤7.5%	4.9%	3.89%
Meeting commitment to serve new psychosis cases by early intervention teams	95%	100%	Met
Data completeness: identifiers	97%	99.4%	99.3%
Data completeness: outcomes for patients on CPA	50%	84.6	82.7
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	Compliant	Compliant

Annex one

Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Birmingham and Solihull Mental Health NHS Foundation Trust

Quality Account 2013/14

Statement of assurance from Birmingham CrossCity CCG May 2014

As lead commissioner Birmingham CrossCity CCG welcomes the opportunity to provide this statement for the Birmingham and Solihull Mental Health NHS Foundation Trust's Quality Account for 2013/14. The Quality Account has been reviewed in accordance with the Department of Health guidance and Monitor's requirements. The statement has been developed in consultation with neighbouring CCGs, Birmingham, Solihull and Black Country Area Team and has also been commented on by the Birmingham CrossCity CCG Patient Council.

Birmingham CrossCity CCG is committed to ensuring that the service it commissions provides the very highest of standards in respect to clinical quality, patient safety and patient experience. Therefore we have worked closely during the year with the Trust's clinicians and managers, monitoring service delivery and reviewing performance through monthly Clinical Quality Review Group meetings and addressing any issues around the quality and safety of patient care with the Trust. In addition to this we have maintained high vigilance in respect to the delivery of care and treatment on the frontline by conducting a number of visits to clinical areas within the Trust in order to obtain appropriate assurance that standards of care are being met.

We acknowledge that over the past year the Trust has made considerable efforts to improve its services and the quality of the care it provides, and note that some of this work has been described within the current draft of the Quality Account. For example:

- We were pleased to see the positive examples of work being undertaken within the Trust in respect of patient engagement. More examples illustrating patient experience and feedback would be welcome including how the Trust is meeting the needs of patients from protected characteristic groups, as defined within the Equality Act. We accept that these gaps in information will be addressed within the final published document. There were, however, a number of significant issues which this document did not adequately explore, for example, there was little reference provided in how the Trust is supporting carers.
- We welcomed the section of the report that focussed on patient safety and learning from serious incidents. Further information could have been included about the recent positive work the Trust has undertaken in respect of unexpected deaths, suicide prevention and information governance breaches. We are pleased that the Trust has highlighted its good incident reporting rates, which make them one of the top 5 Mental Health Trusts nationally for numbers reported, which is commendable. We suggest that the Trust may wish to put this into the context of level of harm and outcomes for patients.
- We also welcome the Trust planned activities as part of the 2014/15 CQUIN which will train service users to review and comment on serious incident investigations. Also we note the plans to improve the management of complaints and to improve response times and the quality of investigations.
- We also support the priority being given to the completion of physical health assessment. Further explanation as to why is work is so relevant to patient safety within mental health settings would have been helpful.

- We were pleased with the reference made to developing the new Street Triage service. More detail of this initiative would promote a greater understanding of the benefits for patients. Inclusion of a supporting statement from the Police and Ambulance Services would also be a useful addition.
- The Learning Lessons section of the Quality Account was considered to be adequate, however could be improved with further detail and by making a clearer link to the priorities of the organisation. In a similar manner, the Accreditations and Reviews 2013/14 section of the document requires further detail to clarify outcomes.
- In respect to Safeguarding although the Trust has outlined some of its achievements and future work plans, there are some significant gaps as the Quality Account does not identify the key strategic issues and challenges for the Trust, either as a result of specific local or national safeguarding priorities. For example, there is a lack of information to identify how the Trust will improve data collection or to define which trends and themes are to be identified and monitored. It is noted that training is not currently available within the Trust for level 3 for children's safeguarding and there is no explicit plan offered as to how this matter will be resolved. There is also no reference to how the Trust will capture patient feedback from children, young people and vulnerable adults who use the service. Additionally there is no specific reference made to the importance of ensuring that the Mental Capacity Act and the Deprivation of Liberty Safeguards are being implemented effectively in practice across the Trust. This is important in light of the recent parliamentary scrutiny report and the findings of local Serious Case Reviews.
- The Quality Account does not appear to make any direct reference to key national reports such as Francis or Winterbourne View and as a general point whilst the Quality Account explores many issues, it often lacks specific detail. For example the 6Cs (Care, Compassion, Competence, Communication, Courage and Commitment) are very briefly mentioned in respect to patient experience metrics and little detail is offered of how they will be used in practice. Medication errors are identified as a topic but it is not clear how the Trust is planning to reduce them.
- Further to this we note that frequently sections of the Quality Account focus more heavily on process rather than achievements, e.g. complaints section contains limited information about performance on complaints responses or information about the nature of learning or outcomes in terms of improving the patient's experience.

Finally, as a general point, we were disappointed that the Quality Account lacked clarity and a level of explanation which would ensure that it is accessible for patients and the public. We noted a significant over reliance on mental health terminology and abbreviations, and assumptions that those reading the document were fully conversant with such concepts as the Care Programme Approach.

In summary, we welcomed the opportunity to comment on the Trust's Quality Account which overall provided a balanced summary. The Quality Account provides description of a number of positive developments and improvements made during the year although in some areas lacked necessary detail and hence provides a limited overview of the Trust's real achievements in 2013/14. We will continue to work in partnership with the Trust to deliver the quality agenda in 2014/15.

Barbara King
Accountable Officer
Birmingham CrossCity Clinical Commissioning Group

Response to the Birmingham and Solihull Mental Health NHS Foundation Trust Quality Account 2013/14

Healthwatch Birmingham recognise that Quality Accounts are a useful contribution to ensuring NHS providers are accountable to patients and the wider public about the quality of the services they provide. We welcome the opportunity to comment on the draft Quality Account for the Birmingham and Solihull NHS Foundation Trust.

We are pleased to see the trends in User Experience data tend to suggest that the percentage of service users who felt their views were not taken into account when their care was planned decreased during the year, and the trend towards high levels of patients being offered a copy of their care plan.

Whilst recognising the intent behind the stakeholder priorities for improvement in the year ahead, the tool of service users and carers being “happy to recommend us as a place to receive care” can be a blunt instrument, particularly in services where people are admitted without choice. The Trust may wish to compare this data with other forms of user feedback.

We are pleased to see the Trust’s positive approach to reporting incidents and note that, whilst the number of incidents reported increased by a third on the previous year, there were no never events reported. The draft data on recurring incidents which result in harm shows an increase in the final Quarter of the year. If this trend continued to year end, we would expect the Trust to be exploring what lies behind such a pattern.

The importance of learning lessons from incidents is well documented in the Quality Account. This chimes with our own experiences of engaging with the Trust during the year. Along with Healthwatch Solihull, we carried out a formal investigation to better understand how the Trust learns lessons from mental health related homicides, in response to some national and regional reporting of homicide rates. The transparency with which the Trust engaged with local Healthwatch is commended, and its commitment to understand serious incidents and learn lessons from them was clear from a series of engagements with the Chief Executive, Chair and a Non-Executive Director. We were left assured of the Trust’s commitment and practice in dealing with such challenging incidents.

During the year Healthwatch Birmingham carried out a number of Enter & View visits to Trust facilities. We focused on re-visiting facilities that had been subject to visits in the year before by Birmingham LINK, and were pleased to find that recommendations from those previous visits had been implemented in full. In addition, the feedback from service users in our visits this year positively complemented the service user data reported in the Quality Account.

Birmingham Healthwatch looks forward to seeing how the Trust continues to implement its commitment to patient and service user involvement in the year ahead, recognising the progress that has been made in 2013/14.



Message sent on behalf of Cllr Susan Barnett, Chair Birmingham Health and Social Care Overview & Scrutiny Committee

The Birmingham Health & Social Care Overview & Scrutiny Committee ("the HOSC") recognises that healthcare providers publishing Quality Accounts have a legal duty to send their Quality Accounts to the HOSC in the local authority where the provider has its registered office, giving the HOSC an opportunity to comment on the Quality Accounts before publication.

The members of the Birmingham HOSC wrote to the Secretary of State for Health in May 2013 and again in November 2013 raising a number of practical issues including the number of Quality Accounts and volume of information, timing of receipt, time constraints within committee meetings, the degree of knowledge and expertise required to make informed comments, the fact that the Quality Accounts are reviewed by both internal and external auditors and the Clinical Commissioning Groups, all of which impact on the ability and capacity of the HOSC to provide a statement on Quality Accounts.

On Wednesday 30th April 2014 there will be an opportunity for Healthcare Provider Trusts to update the HOSC members about their response to the Francis Report, many of which actions will impact on quality and may be reflected in aspects of the Quality Accounts.

However, in the interests of avoiding any potential conflicts of interest and of not fettering its discretion to scrutinise matters which may arise in the course of the year, the Birmingham HOSC will not be supplying an audit statement on the 2013/14 draft Quality Accounts. The HOSC is circulating this statement so as not to hold up publication of the accounts.

Rose Kiely
Group Overview & Scrutiny Manager
Birmingham City Council
3rd Floor (Room 331)
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Victoria Square
Birmingham
B1 1BB

Annex two

Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2013/14*;
- 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 2013 to May 2014
 - papers relating to Quality reported to the Board over the period April 2013 to May 2014
 - feedback from commissioners dated 21/05/14
 - feedback from governors dated 13/03/2014
 - feedback from local Healthwatch organisations dated 16/05/14
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, (not yet produced – reference to quarterly report 23/4/14)
 - [latest] national patient survey 2013
 - [latest] national staff survey February 2014
 - the head of internal audit's annual opinion over the trust's control environment dated May 2014
 - CQC quality and risk profiles dated 31/3/14, 28/2/14, 31/1/14, 30/11/13, 31/7/13, 30/6/13, 31/5/13, 31/3/13.
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

NB: sign and date in any colour ink except black

21/5/14 Date..... Sue Davis..... Chair

21-05-14 Date..... John Short..... Chief Executive

Annex three

Indicator definitions within the Quality Report (where not stated in the report)

Safety

Violent assaults on staff – Number of reported physical assault incidents (where physical assault was the primary incident code) on staff resulting in injury.

Health and Safety Training Compliance with mandatory training for health and safety (annual updates for in patient staff).

NPSA incident reporting per 1,000 bed days – Number of incidents reported to national learning system by Trust per 1,000 bed days.

Violence and aggression training – Compliance with mandatory training requirement for training and annual updates.

Violent Assaults On Staff – Number of incidents reported to Trust.

Never Events – Occurrence of any nationally defined Never Event.

Safety incidents involving severe harm or death - Number of incidents reported to national learning system by Trust which relate to severe harm or death.

Clinical Effectiveness

CRHT % gate kept admissions – Detailed descriptor: The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams in the year ended 31 March 2014.

Data definition:

- the indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards;
- all patients recalled on Community Treatment Order should be excluded from the indicator;
- all patients transferred from another NHS hospital for psychiatric treatment should be excluded from the indicator;
- all internal transfers of service users between wards in the trust for psychiatry treatment should be excluded from the indicator;
- all patients on leave under Section 17 of the Mental Health Act should be excluded from the indicator;
- all planned admission for psychiatric care from specialist units such as eating disorder unit are excluded;
- an admission should be reported as gate kept by a crisis resolution team if they have assessed the service user before admission and if the crisis resolution team were involved in the decision-making process which resulted in an admission;
- an assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient; and
- where the admission is from out of the Trust's area and where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas, the admission should only be recorded as gate kept if the CR team assure themselves that gatekeeping was carried out.

CPA – seven day follow up – Detailed descriptor: The proportion of those patients on a CPA, discharged from inpatient care who are followed up within seven days.

Data definition:

- 'patients discharged' includes patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care, or to prison;
- the indicator excludes patients who die within seven days of discharge;
- the indicator excludes patients removed from the country as a result of legal precedence within seven days of discharge;
- the indicator excludes patients transferred to NHS psychiatric inpatient ward when discharged from inpatient care; and
- the indicator excludes CAMHS (children and adolescent mental health services), i.e. patients aged under 18.
- the seven day period should be measured in days not hours and should start on the day after discharge.

Follow up may be face to face or by telephone contact. This excludes text or phone messages.

Anti-psychotics dementia drugs – Local audits of compliance with NICE guidance.

ICR compliance - % level of completeness of core fields within the patient care record.

Patient Experience

CPA review in previous 12 months – % of Care programme Approach (CPA) patients receiving formal review in past 12 months **National Definition:** The number of people under adult mental illness specialties on CPA who have received secondary mental health services who have had at least one formal review in the last 12 months.

Complaints timeliness – % of complaints responded within timescale originally agreed with complainant.

Patient survey – National Patient survey results Community Mental Health Teams.

Annex four

Report on audit outcomes on two national indicators

CPA 7 day follow up – application of national definition

The national definition states that service users should be followed up within 7 days of discharge from inpatient care and that service users are followed up through direct face to face contact or a telephone call. This is because the time immediately after discharge is recognised as a vulnerable time for service users.

The Trust has interpreted the national definition as follows:

As part of achieving a seamless transition to discharge, for service users on leave, clinical practise is to ensure effective support prior to discharge. Ensuring follow up of patients on leave provides support at a time when service users are most vulnerable ensuring readiness for discharge. Our reporting therefore includes service users on leave. The Trust has regarded follow up within 7 days of patients going on leave as meeting the national definition.

As a result, the Trust's reporting on CPA 7 day follow up includes:

- CPA 7 day follow up (face to face or telephone contact with the service user) is carried out within 7 days after the patient leaves the ward.
- Inclusion of 'indirect' follow ups with private psychiatric units/care home staff.

We believe our interpretation of this indicator is best clinical practice and in line with the spirit of what the target aims to achieve.

The national definition states:

"All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. All efforts must be made to follow up with the patient. It is the responsibility of the trust that discharged the patient to provide follow up patient treatment. Links will need to be established with the receiving institution if a patient is discharged to, for example, a care home, to enable follow up to take place. However, if the patient is transferred to another psychiatric unit to continue psychiatric care, then the responsibility lies with the receiving trust to follow up the patient after they have been discharged."

Excluded for 7 day follow up, exemptions confirmed by Monitor and DoH more explicitly state:

- Patients transferred to NHS psychiatric inpatient ward.
- Patients discharged to another NHS psychiatric inpatient ward.

The issue therefore relates to service users discharged to a non NHS hospital and/or care home with 24-hour specialist mental health staffing. The Trust's policy has been to ensure clinical handover with a 7 day follow up carried out with a member of staff at the unit rather than the patient.

A review of this component of the Trust's reported data for 2013/14 has been carried out. This confirms that the local cases tend to be older people with dementia where the care staff are likely to be able to give a better account of someone's progress than the service user. Other cases tend to be working age adults placed in specialist or overspill units further afield. There were 26 cases in 2013/14 where this type of follow up was relied upon in our figures.

Impact assessment on reported compliance for CPA 7 day follow up:

The Trust's reported position for 2013/14 was 96.7%. Using discharge only (as per national definition) reduces compliance to 94.5%. Removing the indirect follow ups carried out with non-NHS hospitals and care homes reduces compliance further to 93.6%. This means that the performance on CPA 7 day follow up is non-compliant with the 95% target but was previously reported as compliant.

Errors in data entry and recording:

CPA 7 day follow up - findings confirmed the following errors in the sample tested:

- 5 cases where the incorrect 'discharge date' was recorded when compared to patient records. We reviewed these cases and despite incorrect data entry, 7 day follow up was demonstrated.

Crisis Resolution Home Treatment Gatekeeping – The national definition requires that patients transferred from another NHS hospital should be excluded from the indicator calculation. The Audit found the following two errors:

- 2 patients out of a total of 25 tested had been inappropriately excluded from the calculation (as they were recorded as transfers from hospital but were admissions from home) and
- 1 patient out of a total of 25 tested had been incorrectly included within the calculation (as they were a transfer from hospital but recorded as admission from home).

It should be noted that in both cases, service users were gatekept, and therefore there is compliance with the national target in spite of the errors.

We undertook a review of 2013/14 data based on a larger sample to cross check for the above errors. The estimated position is:

- Service users recorded as admissions from home who were admitted from A&E/hospital wards – circa 100.
- Service users recorded as transferred from A&E/other hospitals who were actually admitted from home – circa 40.

This confirms the external audit findings that data entry is not always accurate with respect to admission source but this does not change our overall reported compliance as there is robust demonstration of service users being gatekept where the admission source is either 'from home' or 'transfer from hospital'.

Appendix 1

CPA 7 day follow up - Impact assessment

i) The Trust's reported position and that provided to the Auditors for 2013/14 was as follows:

	<u>Num</u>	<u>Denom</u>	<u>KPI</u>
Q1	551	566	97.3%
Q2	590	607	97.2%
Q3	564	584	96.6%
Q4	527	550	95.8%
Total	2232	2307	96.7%

ii) Based on using discharge dates only reduces trust compliance to 94.5% as follows:

	Passes	Included	KPI
Q1	544	568	95.8%
Q2	579	609	95.1%
Q3	556	587	94.7%
Q4	507	549	92.3%
Total	2186	2313	94.5%

iii) In addition, removing the indirect follow ups carried out with non-NHS hospitals and Care homes reduces compliance further to 93.6% as follows:

	Passes	Included	KPI
Q1	536	568	94.4%
Q2	574	609	94.3%
Q3	550	587	93.7%
Q4	504	549	91.8%
Total	2164	2313	93.6%

Appendix 2 – Summary outcomes of the local data quality review as reported to April 2014 IQC and Trust Board.

1. **CPA 7 day follow up** – Local audit confirmed ‘red’ rating for data entry accuracy, ‘green’ for data entry timeliness and ‘amber’ for reporting accuracy.
 - i) For both, data entry accuracy and data entry timeliness issues, exception action was taken to conduct a full audit that included a review of those 7 day follow ups counted as successful and those that were being reported as unsuccessful to ensure appropriate recording of contacts with service users, as evidenced by progress notes on RIO. The audit recommendations, to be taken forward, include:
 - Updating the RiO ‘Seven-day Follow-up Exceptions’ form to include clearer guidance to staff on its correct use;
 - Considering ways to improve the quality of recording, giving particular attention to the reconciling of appointments with progress notes, and to the use of the 7DFU exceptions form; and
 - Designing and implementing checking and sign-off processes to provide confidence in monthly figures and prevent the need for full year-end audits in future years.
 - ii) Reporting accuracy is amber rated to reflect the Trust’s local guidance which allows for exclusions in line with trust policy which are not identified in national guidance. The report highlighted that due to these local exclusion criteria, any national calculated data for this measure eg by the CQC, commissioners etc will not reconcile with data reported to trust board.

Local interpretations include:

- Patients discharged where no mental health diagnosis is recorded by the clinician are excluded from the indicator as these patients will not be on CPA and 7 day follow up is therefore not applicable.
 - Patients discharged to an overseas address are excluded from the indicator due to the challenge of contacting service users who for example have gone to an address outside the United Kingdom.
 - Patients who are absent without leave (AWOL) at the time of discharge are excluded from the indicator on the basis that they have not been discharged. However, clearly local policy emphasises the priority to locate the patient to minimise risk to the patient and/or the public.
 - Vitivier unit (neuropsychiatry) is excluded from the indicator as these patients are not CPA patients.
2. **Crisis Resolution Home Treatment Gatekeeping** - Local audit confirmed ‘green’ rating for data entry accuracy, data entry timeliness and reporting accuracy.

The local audit reviewed a combination of cases ‘included’ and cases ‘excluded’ from the indicator calculation in line with national definition.

The internal audit focused on whether of those cases ‘Included’, that an admission had been successfully gatekept. Admission sources were not systematically checked against progress notes for this sample, but progress notes covering the period leading up to admission were reviewed for each case to establish the extent of home treatment/other gatekeeping involvement. This element did involve a review of admission source where RAID teams were involved. However, no errors were identified in the sample reviewed.

Independent Auditors' Limited Assurance Report to the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust to perform an independent assurance engagement in respect of Birmingham and Solihull Mental Health NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

<i>Specified Indicators</i>	<i>Specified indicators criteria</i>
100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital	<p>Page 91 'The data made available to the Trust by the Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days of discharge from psychiatric in-patient care during the reported period'.</p> <p>Additional information: Trust has disclosed its figure in addition to the Information Centre outturn. The Trust's own outturn is subject to assurance.</p> <p>Monitor specified criteria (set out within the Trust's Quality Report Annex 3 page 113):</p> <p>Detailed descriptor: The proportion of those patients on a CPA, discharged from inpatient care who are followed up within seven days.</p> <p>Data definition:</p> <ul style="list-style-type: none"> • 'patients discharged' includes patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care, or to prison; • the indicator excludes patients who die within seven days of discharge; • the indicator excludes patients removed from the country as a result of legal precedence within seven days of discharge; • the indicator excludes patients transferred to NHS psychiatric inpatient ward when discharged from inpatient care; • the indicator excludes CAMHS (children and adolescent mental health services), i.e. patients aged under 18; • the seven day period should be measured in days not hours and should start on the day after discharge; and • follow up may be face to face or by telephone contact. This excludes text or phone messages.

<p>Admissions to inpatient services had access to crisis resolution home treatment teams</p>	<p>Page 91 'The data made available to the Trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution (CR) Team acted as gatekeeper during the reporting period'</p> <p>Additional information: Trust has disclosed its figure in addition to the Information Centre outturn. The Trust's own outturn is subject to assurance.</p> <p>Monitor specified criteria (set out within the Trusts Quality Report Annex 3 page 113) :</p> <p>Detailed descriptor: The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams in the year ended 31 March 2014.</p> <p>Data definition:</p> <ul style="list-style-type: none"> the indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards; all patients recalled on Community Treatment Order should be excluded from the indicator; all patients transferred from another NHS hospital for psychiatric treatment should be excluded from the indicator; all internal transfers of service users between wards in the trust for psychiatry treatment should be excluded from the indicator; all patients on leave under Section 17 of the Mental Health Act should be excluded from the indicator; all planned admission for psychiatric care from specialist units such as eating disorder unit are excluded; an admission should be reported as gate kept by a crisis resolution team if they have assessed the service user before admission and if the crisis resolution team were involved in the decision-making process which resulted in an admission; <p>An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient; and</p> <ul style="list-style-type: none"> where the admission is from out of the Trust's area and where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas, the admission should only be recorded as gate kept if the CR team assure themselves that gatekeeping was carried out.
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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 specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "*Detailed requirements for quality reports 2013/14*" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- the Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "*Detailed requirements for quality reports 2013/14*";
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "*2013/14 Detailed guidance for external assurance on quality reports*".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2013 to the date of signing this limited assurance report (the period);
- papers relating to Quality reported to the Board over the period April 2013 to the date of signing this limited assurance report;
- feedback from the Commissioners Birmingham Cross City CCG April 2014;
- minutes of the Council of Governors Meeting 13/03/14;
- feedback from Healthwatch Birmingham dated 16/05/2014;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, for 2013/14 is pending publication in July 2014. A draft version was provided dated May 2014 and Minutes from the Integrated Quality Committee 23/04/2014 setting out Quarter 4 and annual headlines;
- feedback from other stakeholders involved in the sign-off of the Quality Report – Birmingham Health & Social Care Overview and Scrutiny Committee (HOSC), dated 17/04/14
- the 'Quality Health – Birmingham and Solihull Mental Health NHS Foundation Trust - 2013 NHS Community Mental Health Service User Survey Results' latest national patient survey dated 2013;
- the '2013 National NHS staff survey – Brief summary results from Birmingham and Solihull Mental Health Foundation Trust', latest national staff survey dated 2013 and Minutes from the Integrated Quality Committee 19/03/2014 setting out national report key findings;
- Care Quality Commission quality and risk profiles dated 31/03/2014, 28/02/14, 31/01/14, 30/11/13, 30/10/13, 31/07/13, 30/06/13, 31/05/13, 31/03/13; and
- the Head of Internal Audit's annual opinion 2013/14 over the Trust's control environment dated May 2014.

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.

This report, including the conclusion, has been prepared solely for the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust as a body, to assist the Council of Governors in reporting Birmingham and Solihull Mental Health NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, 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 Birmingham and Solihull Mental Health NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 ‘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:

- reviewing the content of the Quality Report against the requirements of the FT ARM and “*Detailed requirements for quality reports 2013/14*”;
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS foundation trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Birmingham and Solihull Mental Health NHS Foundation Trust.

Basis for Adverse Conclusion

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

The 100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge indicator requires that patients are followed up within 7 days of discharge as an inpatient from hospital; and should be followed up through direct face to face contact or a telephone call.

We found that:

- the Trust has incorrectly applied the definition by counting the 7 days from date of leave from the ward, rather than date of discharge;
- for five patients out of a total of 70 tested, the incorrect discharge date had been recorded when compared to the underlying patient records; and
- for one patient out of a total of 35 tested, there had been no direct follow up contact with the patient.

The Admissions to inpatient services had access to crisis resolution home treatment teams indicator requires that patients transferred from another NHS hospital should be excluded from the indicator calculation We found that:

- two patients out of a total of 25 tested had been inappropriately excluded from the calculation; and
- one patient out of a total of 25 tested had been incorrectly included within the calculation.

Conclusion

- In our opinion, because of the significance of matters described in the 'Basis for Adverse Conclusion' paragraphs, both the 100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge and the Admissions to inpatient services had access to crisis resolution home treatment teams indicators have not been prepared in all material respects in accordance with Monitor's national criteria and the six dimensions of data quality set out in the *"2013/14 Detailed guidance for external assurance on quality reports"*.

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014:

- the Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “*Detailed requirements for quality reports 2013/14*”; and
- The Quality Report is not consistent in all material respects with the documents specified above.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP

Chartered Accountants

Cornwall Court

23 May 2014

The maintenance and integrity of the Birmingham and Solihull Mental Health NHS Foundation Trust’s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Statement of chief executive's responsibilities

as the accounting officer of Birmingham and Solihull Mental Health NHS Foundation Trust

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

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

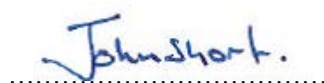
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

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

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

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

Signed:



.....

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust

Date: 21 May, 2014

Annual Governance Statement

Scope of Responsibility

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

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 Birmingham and Solihull Mental Health NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Birmingham and Solihull Mental Health NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Executive Director on the Trust Board with overall accountability for risk management is the **Director of Nursing** who is supported by the Associate Director of Governance and Governance team. These responsibilities include health and safety, local security management (SMS), safeguarding children, safeguarding vulnerable adults, infection control and complaints. The Medical Director and the Director of Nursing have joint delegated responsibility for clinical risk management and clinical governance. The Integrated Quality Committee was established by Trust Board to improve assurance over all aspects of quality and risk. The Medical Director and Director of Nursing jointly chair the Clinical Governance Committee which is responsible for the operational implementation of quality and safety across the Trust.

The **Medical Director** has particular responsibility for overseeing the care programme approach, clinical effectiveness, information governance and acts as the Caldicott Guardian.

The Deputy Medical Director (Clinical Effectiveness), has specific responsibilities for supporting the Caldicott Guardian in using the information governance toolkit to identify and manage risks around data security and data loss.

The **Executive Director of Resources** has responsibility for managing the development, implementation and management of financial control, information systems and IT. The Integrated Quality Committee plays a key role in managing financial risk and in ensuring that resources are deployed economically and effectively. The Executive Director of Resources is the Senior Information Risk Owner and chairs the Information Governance Steering Group. The **Director of Infrastructure and asset management**, reporting to the Director of Resources has overall responsibility for the Trust estate, plant, waste management and environmental management.

The **Executive Director of Operations** is responsible for the operational management of all clinical services and has delegated responsibility for managing risks associated with the recruitment, retention, training and development and remuneration of our workforce.

Reporting to the Executive Director of Operations - Associate Directors of Operations are responsible for the operational performance of their services, Clinical Directors are responsible for Clinical Quality and Governance for their areas. Other professional heads have responsibility for the systems of risk management at service area level and lead their implementation.

The Trust learns from good practice through a range of mechanisms including national guidance / alerts, benchmarking, clinical supervision and reflective practice, individual and peer reviews, performance management, continuing professional development programmes, clinical audit and application of evidence-based practice and meeting risk management standards.

The Trust has a policy for statutory and mandatory training which requires that all senior managers of the organisation receive training and 3 yearly updates on core competences in relation to risk management. The statutory and mandatory training programme reflects all key training requirements for risk management for all staff within the organisation. These requirements are identified having been appropriately risk assessed and systems are in place to monitor compliance with these requirements. The Trust has a real time system to monitor all staff compliance with training requirements which are available as a traffic light dashboard for each member of staff on the Trust intranet. This is reinforced through our regular management supervision process and as a result high levels of compliance are achieved.

The Risk and Control framework

The risk management policy defines the leadership and processes required to manage risk and states the important link to the performance management and business planning systems.

The risk management policy is reviewed by Trust Board on an annual basis (approved September 2013) and the process and criteria for escalation of risks is defined.

The Trust's approach to risk is to ensure that risks are systematically assessed and reviewed, it is recognised that risks cannot always be eliminated and that sometimes risks of a particular intervention need to be balanced against the risk of doing nothing.

It is also emphasised that a completely risk averse culture can sometimes stifle innovation and service improvement. Therefore, the Trust emphasises the importance of measuring and mitigating risk, rather than seeking to eradicate all risk.

The Trust uses a standard 5x 5 matrix for risk scoring and risks identified at a score of 12 or above are required to be reported to Trust Board.

Each director is accountable overall for maintaining a risk register for their responsibilities. The Assurance Framework is developed via a review of all risk registers through the Integrated Quality Committee and reported to the Board on a quarterly basis. The Assurance Framework provides the Board with the required assurance that risks to achieving key strategic objectives are being effectively controlled.

The Trust has continued to apply Monitor's quality governance framework which contributed to the development and implementation of the Trust's Quality Strategy. A review of compliance against Monitor's Quality Governance Framework was commissioned in July by Deloitte and this showed that the Trust had improved its assessment score from 11 (last year) to 6. The report also reinforced the actions which were being undertaken by the Trust to move towards a score of below 4 which is the expected standard for aspirant Trusts. Progress on this work is reviewed through the Integrated Quality Committee and also reported to Trust Board.

The principle of learning lessons is emphasised - it is every staff member's duty to seek to minimise risk and to report untoward incidents where they occur in order to prevent recurrence. All members of staff are responsible for managing risks within the scope of their role and as part of their responsibilities as employees of the Trust, working to professional codes of conduct.

Over the past year the Trust has actively sought to increase the level of incident reporting – particularly for non-nursing staff groups who tend to report less. There has been a significant increase in incidents reported over the past year.

The Trust aims to systematically review and learn from untoward incidents and complaints. Good practice and changes to policies are communicated through email, intranet, divisional reports, newsletters and team briefs. A 'Learning Lessons bulletin' is issued to all staff every two months and a number of actions have been taken through our Internal Risk Alert process to ensure that services confirm changes required.

The focus of investigations around serious incidents is to identify system failures which can then be addressed through action plans. The Trust actively promotes a systems approach to incidents to ensure appropriate risk reporting and support teams to address weaknesses when identified.

There are formal mechanisms in place to ensure that external changes to best practice, such as those issued by the National Institute for Health and Clinical Excellence, are incorporated into Trust policies procedures and clinical guidelines.

Data security risks: The Trust actively monitors and manages its Information Governance (IG) compliance through the IG assurance framework as stipulated in Policy, reporting up to the Information Governance Steering Group (IGSG), which is chaired by the Senior Information Risk Owner (SIRO) and attended by key IG staff including the Caldicott Guardian and Head of IG. The IGSG monitors the Trust's compliance with the HSCIC IG Toolkit, approves the IG work plan that is developed year on year, reviews incidents where they occur and looks to recommend improvements to increase compliance.

The Trust has implemented a full range of technical and organisational measures in line with national best practice, has a suite of IG related policies, procedures and guidance documents which are made available to all staff in a variety of ways and ensure staff are appropriately trained in IG. Communicating IG to Trust staff is an ongoing and extremely important process in ensuring staff are aware of their responsibilities, as detailed in these documents. Where failings are found to occur investigations are carried out, lessons learnt and recommendations made and implemented where appropriate.

The major risks identified by the Trust are as follows:

- Overall co-ordination of care management processes has been identified as a key risk and the Trust has reviewed and revised processes to strengthen our approach and how this is monitored.
- Ensuring compliance with Care Quality Commission (CQC) regulations, particularly in relation to safeguarding arrangements and arrangements for ensuring that the Trust is able to maintain appropriate levels of staffing to meet varying demands and pressures on its services.
- Risk of non-compliance with information governance arrangements leading to significant patient identifiable data loss.
- Not meeting the requirements of the Monitor Quality Governance Framework
- Demand for services, especially adult acute beds where pressures have been most significant.
- Savings targets and allocation of resources.
- Risks relating to harm to patients, family and carers from homicides and serious incidents and ensuring we learn from serious incident reviews and complaints.
- Risks relating to arrangements for ensuring that all employment checks are undertaken and can be demonstrated (as identified by Internal audit – see Internal audit opinion below).

Future anticipated risks:

- CAMHS and Youth Mental Health Services tender; Birmingham drugs and alcohol tender.
Risk of worsening employee relations and climate of industrial action - as we review staff terms and conditions in context of Trust funding gap and changes to competitive market.

The risk of major service reconfiguration due to commissioning intentions and challenges to continue to provide competitive and high quality services.

Through its risk management policies the Trust Board promotes open and honest reporting of incidents, risks and hazards.

The establishment of two new board sub committees (Integrated Quality, Planning and Development) has strengthened the oversight of risk during the year. The Integrated Quality Committee has kept under monthly review key risks identified from the Trust Assurance Framework.

Use of a nationally recognised risk rating tool, supported by agreed assurance level definitions ensures a standard approach is taken to prioritising risks.

The Integrated Quality Committee regularly reviews local risk registers from individual clinical programmes and all Executive Directors to ensure that these are maintained and accurately reflect risks at the clinical interface.

The Trust policy management framework provides a standard process for the development approval and review of all Trust policies. Inherent in this is the requirement for equality impact assessments to be undertaken on all policies. Compliance with all the requirements have to be demonstrated to the Clinical Governance Committee or Trust Board before a policy is approved.

The **Project Management Office (PMO)** has developed a structured project management approach to all significant new developments and potential saving schemes which are required to demonstrate how risks are managed. All projects are reviewed through the Programme Management Board. Integral to each project is the requirement to produce a detailed quality impact assessment. These are required to be approved by the Director of Nursing and Medical Director before projects can proceed.

The focus on training in relation to incident investigations is the use of root cause analysis techniques; this reinforces a positive learning approach with the emphasis on system improvement rather than individual blame.

There are a range of formal mechanisms for engaging with partner organisations, governors, service users and the wider public, ensuring that risks are fully understood and are embedded into business planning and performance management processes.

The Trust works closely with key stakeholders and there are a number of joint structures that already exist between agencies (e.g. strategic partnership boards and commissioning committees). The Trust will endeavour to involve partner organisations in all aspects of risk management.

Service users and carers are involved in a range of processes to review the quality of care, these include a 'mystery shopping' programme and engagement in the peer review process of services. The Trust has developed and successfully piloted a 'real time' user feedback system in a range of services across the Trust this year.

Key partners include providers of shared services to the Trust, Clinical Commissioning Groups (CCGs), other NHS organisations, social care, HMP Birmingham, the police, statutory and voluntary bodies and service user and carer groups.

The foundation 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.

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

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

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

As the economic climate within the NHS becomes more challenging it will be essential that we continue to focus on and can demonstrate value for money of our services.

For 2013/14, we have achieved a Continuity of Service risk rating of 3 demonstrating that we have been able to manage our resources effectively. We have achieved this after investing in key areas, including our estate, where we have built a new facility for women's low secure and Forensic CAMHS services, and our IT infrastructure including a new data centre, which we believe will support our staff to deliver services and to generate future efficiencies.

During 2013/14, we have used a range of methods to identify and deliver efficiency savings, including new business development, redesign of service user pathways and process improvements.

The Head of Internal Audit Opinion for 2013/14 has provided an overall opinion as follows:

Overall Opinion – Core Internal Audit

During 2013/14, we issued nine core internal audit reports and four performance reports and we are pleased to note we issued Substantial assurance ratings with respect to all of the core internal audit reports. As such, my **overall opinion** for the year ended 31 March 2014 is that: **Significant assurance** can be given as there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and / or consistent application of controls put the achievement of particular objectives at risk.

Overall Opinion – Performance Reviews

As part of our annual internal audit plan, we also deliver a number of advisory and performance reviews. We carried out four performance reviews during 2013/14 and two of these reports included high priority recommendations as follows:

Employment checks- five high priority recommendations in relation to:

- Strengthening governance of the Electronic Staff Record (ESR)
- Updating ESR to create valid exception reporting
- Centralised access to employee records
- Documentation of DBS checks
- Introducing DBS exception reporting

Overall Opinion – Performance Reviews

Quality Governance Assurance Framework – six high priority recommendations in relation to:

Updating the Trust risk register

Explicit reporting at a corporate level to demonstrate and assure that all Cost Improvement Programmes (CIPs) have undergone quality impact assessment.

Realigning quality governance arrangements to take into account the operational restructure in progress.

Ensuring staff are encouraged to report issues of bullying and harassment in order that any genuine concerns are addressed.

Developing the quality dashboard so that it incorporates key measures for safety, quality, effectiveness and performance including clear targets for improvement

Embedding data quality systems to ensure that concerns relating to the accuracy of data are addressed.

Management has accepted all of the above recommendations and signed up to formal action plans to address the significant control weaknesses in these areas.

Basis for the Opinion

The **basis** for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning
- Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year

This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Annual Quality Report

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

Quality report priorities and core indicators reported in the Quality Report have been an integral part of the routine governance processes over the year. Key indicators have been routinely reported to the Trust Board and the Integrated Quality Committee through the year, reflecting wider review and monitoring undertaken by the Trust.

The Quality Report has been developed subject to a wider consultation process involving staff, Assembly of Governors, patient and carer groups and commissioners. This has included regular reports being presented to Governance committees and commissioners (through the Clinical Quality review group).

Quality priorities for the year ahead defined within the Quality Report were developed from the Trust business planning process with local service areas and have subsequently been reviewed as part of a wider consultation process.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Audit Committee has an annual programme of work related to identified Trust priorities. All work undertaken by internal and external auditors is reported through the Audit Committee to ensure that a full assessment of effectiveness is achieved.

Other explicit review/assurance mechanisms which support these activities include:

- the Trust Clinical Audit programme which is approved by Trust Board
- annual programme of risk assessments
- reviews against regulation requirements
- compliance programme and quality support team visits.
- business plan review meetings.

The Board reviews and agrees the Assurance framework which is informed by the wider risk management processes including the Audit Committee.

Conclusion

There are no other significant internal control issues identified and the Trust believes that by addressing these issues it will have a system of internal control that supports the achievement of the organisation's plans, aims and objectives.

Signed:

A handwritten signature in blue ink that reads "John Short." followed by a dotted line.

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust

Date: 21 May, 2014

Independent Auditors' Report to the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion:

- the financial statements, defined below, give a true and fair view, of the state of the Group's and of the parent NHS Foundation Trust's affairs as at 31 March 2014 and of the Group's income and expenditure and cash flows for the year then ended 31 March 2014; and
- the Group and parent NHS Foundation Trust financial statements have been prepared in accordance with the NHS Foundation Trusts Annual Reporting Manual 2013/14.

This opinion is to be read in the context of what we say in the remainder of this report.

What we have audited

The Group financial statements and parent NHS Foundation Trust financial statements (the "financial statements"), which are prepared by Birmingham and Solihull Mental Health NHS Foundation Trust, comprise:

- the Group and parent NHS Foundation Trust Statement of Financial Position as at 31 March 2014;
- the Group Statement of Comprehensive Income for the year then ended;
- the Group Statement of Cash Flows for the year then ended;
- the Group and parent NHS Foundation Trust Statement of Changes in Taxpayers' Equity for the year then ended; and
- the notes to the financial statements, which include other explanatory information.

The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2013/14 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

In applying the financial reporting framework, the directors have made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)"). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Group's and the parent NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trusts Annual Reporting Manual 2013/14; and

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Other matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified, on any aspect, our opinion on the Quality Report.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Statement of Chief Executive's Responsibilities the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.



Alison Breadon (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Birmingham

Date: 23 May 2014

Notes:

- (a) The maintenance and integrity of the Birmingham and Solihull Mental Health NHS Foundation Trust website is the responsibility of the Chief Executive; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.
- (b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

**BIRMINGHAM and SOLIHULL MENTAL HEALTH
NHS FOUNDATION TRUST**

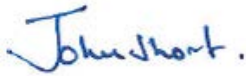
Consolidated Financial Statements

MARCH 31 2014

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014

Foreword to the Accounts

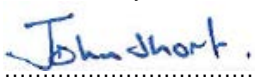
These Accounts for the year ending March 31 2014 have been prepared by Birmingham and Solihull Mental Health NHS Foundation Trust Presented to parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

A handwritten signature in blue ink that reads "John Short."

John Short, Chief Executive
21st May 2014

GROUP STATEMENT OF COMPREHENSIVE INCOME						
		Year ending 2013/14 £000	Year ending 2013/14 £000	Year ending 2013/14 £000	Year ending 2012/13 £000	Year ending 2012/13 £000
	note	PRE EXCEPTIONAL ITEMS	EXCEPTIONAL ITEMS	TOTAL	PRE EXCEPTIONAL ITEMS	EXCEPTIONAL ITEMS
Operating income	2	236,004	-	236,004	223,930	-
Operating costs	4	(225,899)	5,772	(220,127)	(213,302)	(6,235)
OPERATING SURPLUS / (DEFICIT)		10,105	5,772	15,877	10,628	(6,235)
FINANCE COSTS						
Finance income	7	113	-	113	132	-
Finance costs	8	(5,983)	-	(5,983)	(5,824)	-
PDC Dividends payable		(2,217)	-	(2,217)	(2,513)	-
NET FINANCE COSTS		(8,087)	-	(8,087)	(8,205)	-
SURPLUS / (DEFICIT) FOR THE YEAR		2,018	5,772	7,790	2,423	(6,235)
Other comprehensive income / (expense)						
Amounts that will not be reclassified subsequently to income and expenditure						-
Revaluation gains / (losses) and impairment losses property, plant and equipment				4,226		(2,901)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR				12,016		(6,713)

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014

STATEMENT OF FINANCIAL POSITION					
		Group		Trust	
		March 31 2014	March 31 2013	March 31 2014	March 31 2013
	note	£000	£000	£000	£000
Non-current assets					
Intangible assets	9	-	-	-	-
Property, plant and equipment	10	205,620	195,602	172,862	163,226
Subsidiary investments	12	-	-	9,855	9,855
Trade and other receivables	13	3,189	2,554	25,117	24,956
Total non-current assets		208,809	198,156	207,834	198,037
Current assets					
Inventories	11	344	252	251	252
Trade and other receivables	13	8,563	14,567	9,466	15,013
Non-current assets classified as held for sale	10.11	755	1,250	755	1,250
Cash and cash equivalents	22	32,616	32,140	31,116	32,019
Total current assets		42,278	48,209	41,588	48,534
Current liabilities					
Trade and other payables	14	(24,681)	(26,674)	(24,139)	(26,666)
Borrowings	16	(3,887)	(3,793)	(3,887)	(3,793)
Provisions for liabilities and charges	19	(1,385)	(3,459)	(1,385)	(3,459)
Other liabilities	15	(4,321)	(5,121)	(4,321)	(5,121)
Total current liabilities		(34,274)	(39,047)	(33,732)	(39,039)
Total assets less current liabilities		216,813	207,318	215,690	207,532
Non-current liabilities					
Borrowings	16	(104,368)	(108,256)	(104,368)	(108,256)
Provisions for liabilities and charges	19	(2,478)	(1,111)	(2,478)	(1,111)
Total non-current liabilities		(106,846)	(109,368)	(106,846)	(109,368)
Total assets employed		109,967	97,950	108,844	98,164
Financed by (taxpayers' equity)					
Public Dividend Capital		100,067	100,067	100,067	100,067
Revaluation reserve		23,248	20,759	23,248	20,759
Income and expenditure reserve		(13,348)	(22,875)	(14,471)	(22,661)
Total taxpayers' equity		109,967	97,951	108,844	98,165
<p>*Due to rounding issues in previous years the opening balances will not be reflective of the prior year balances.</p> <p>The accounts on pages 137 to 140 and the associated notes were approved by the Audit Committee, who have delegated authority from Trust Board to approve the financial statements. The financial statements were approved on 21st May 2014 and signed on its behalf by:</p> <p>Signed:  John Short, Chief Executive</p> <p>Date: 21st May 2014</p>					

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014

Group

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Total taxpayers equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at April 1 2013 - as previously stated	97,951	100,067	20,759	(22,875)
Surplus / (Deficit) for the year	7,790	-	-	7,790
Revaluation gains and (impairment losses) property, plant and equipment	4,226	-	4,226	-
Transfers to the income and expenditure account in respect of assets disposed of	0	-	(232)	232
Other transfers between reserves *	0	-	(1,505)	1,505
Taxpayers' Equity at March 31 2014	109,967	100,067	23,248	(13,348)
Taxpayers' Equity at April 1 2012	104,664	100,067	23,660	(19,063)
Deficit for the year	(3,812)	-	-	(3,812)
Revaluation losses and impairment losses property, plant and equipment	(2,901)	-	(2,901)	-
Other transfers between reserves				
Taxpayers' Equity at March 31 2013	97,951	100,067	20,759	(22,875)

Trust

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Total taxpayers equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at April 1 2012 - as previously stated	98,165	100,067	20,759	(22,661)
Surplus / (Deficit) for the year	6,453	-	-	6,453
Revaluation gains and (impairment losses) property, plant and equipment	4,226	-	4,226	-
Transfers to the income and expenditure account in respect of assets disposed of	0	-	(232)	232
Other transfers between reserves *	0	-	(1,505)	1,505
Taxpayers' Equity at March 31 2014	108,844	100,067	23,248	(14,471)
Taxpayers' Equity at April 1 2012	104,664	100,067	23,660	(19,063)
Surplus / (Deficit) for the year	(3,598)	-	-	(3,598)
Revaluation gains and (impairment losses) property, plant and equipment	(2,901)	-	(2,901)	-
Taxpayers' Equity at March 31 2013	98,165	100,067	20,759	(22,661)

* This relates to an error in the accounting treatment for two properties sold in previous years that has been uncovered. This consists of a balance of £1.441m relating to a parcel of land which was split and part of it sold and £0.064m relating to a building which has been sold but remained in the revaluation reserve.

*Due to rounding issues in previous years the opening balances will not be reflective of the prior year balances.

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014

GROUP STATEMENT OF CASH FLOWS		2013/14	2012/13
	note	£000	£000
Cash flows from operating activities			
Operating surplus from continuing operations		15,877	4,393
Operating surplus of discontinued operations		-	-
Operating surplus		15,877	4,393
Non-cash income and expense:			
Depreciation and amortisation	4	7,124	6,499
Impairments	4/ 4.1	0	5,324
Reversals of impairments	4.1	(4,861)	0
(Gain)/Loss on disposal		53	75
(Increase)/ decrease in Trade and Other Receivables		5,368	(10,886)
Decrease in Inventories		(92)	43
Increase/ (decrease) in Trade and other Payables		(2,610)	5,832
(Decrease) / increase in Other Liabilities		(799)	(4,801)
Increase/ (decrease) in Provisions		(707)	1,189
Other movements in operating cash flows		-	-
NET CASH GENERATED FROM OPERATIONS		19,353	7,668
Cash flows from investing activities			
Interest received	7	113	132
Purchase of Property, Plant and Equipment	10	(7,361)	(12,532)
Sales of Property, Plant and Equipment		486	1,273
Net cash used in investing activities		(6,762)	(11,127)
Cash flows from financing activities			
Loans received		0	10,121
Loans repaid to Foundation Trust Financing Facility		(2,183)	(750)
Capital element of Private Finance Initiative Obligations		(1,705)	(1,560)
Interest paid		(1,970)	(1,405)
Interest element of Private Finance Initiative obligations		(4,040)	(3,929)
PDC Dividend paid		(2,217)	(2,338)
Net cash (used in) /generated from financing activities		(12,115)	139
Decrease / (increase) in cash and cash equivalents		476	(3,320)
Cash and Cash equivalents at April 1		32,140	35,460
Cash and Cash equivalents at March 31		32,616	32,140

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014
Notes to the Financial Statements

1 Accounting policies and other information

Monitor has directed that the accounts of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FReM) which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the 2013/14 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) 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 with the exception to changes to accounting policies.

These accounts have been prepared on a going concern basis under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.1 Consolidation

Subsidiary entities are those over which the Foundation Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

Birmingham and Solihull Mental Health Foundation NHS Trust has one 100% owned subsidiary, Summerhill Supplies Limited, which commenced trading on December 1 2012. The amounts consolidated are drawn from the published accounts of the subsidiary for the period ending March 31 2014. The shares held are ordinary and aggregate capital and reserves amount to £9,171k as at March 31 2014. Summerhill Supplies Limited made a loss of £470k in the year.

All intra-group transactions, balances, income and expenses are eliminated on consolidation. Adjustments are made to eliminate the profit or loss arising on transactions with the subsidiary to the extent of the Group's interest in the entity. Where the subsidiary's accounting policies are not aligned with those of the Trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material, only one such difference existed at the reporting date relating to the revaluation of the Tamarind Centre. In accordance with the NHS Foundation Trust Annual Reporting Manual a separate income and cash flow statement for the parent (the Trust) has not been presented.

For 2013/14, the divergence from the FReM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Foundation Trust is the Corporate Trustee of Birmingham and Solihull Mental Health NHS Foundation Trust Charity (Charity number 1098659) and therefore should consolidate its financial statements if this is material to the Foundation Trust. The Foundation Trust has not consolidated its NHS charity on grounds of materiality which is a percentage of (1% or 2%) of income, expenditure, assets or liabilities and so the Charitable Funds statements have not been consolidated into the Foundation Trust Accounts. This will be reviewed each financial year.

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014
Notes to the Financial Statements

1 Accounting policies and other information (continued)

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 Foundation Trust is contracts with commissioners in respect of healthcare services. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on Employee Benefits

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 accounts to the extent that employees are permitted to carry-forward leave into the following year.

1.4 Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Foundation Trust commits itself to the retirement, regardless of the method of payment.

NEST Pension Scheme

National Employment Savings Trust is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008.

1 Accounting policies and other information (continued)

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when 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 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 Foundation Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- individually have a cost of at least £5,000;
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Property assets are measured subsequently at fair value. Assets under the course of construction are subsequently measured at fair value once the asset is brought into use. Equipment is held at cost.

1 Accounting policies and other information (continued)

1.6 Property, Plant and Equipment (continued)

Fair Value is to be determined for Operational Assets under IAS 16. Fair Value has been clarified by HM Treasury as being reflected by "Market Value" with the explicit assumption that "property is sold as part of the continuing enterprise in occupation". The approach is reflected primarily on the basis of Depreciated Replacement Cost (DRC) for specialised operational property and Existing Use Value for non-specialised operational property.

DRC valuations from the District Valuer are prepared using the Modern Equivalent Asset method of valuation in accordance with the requirements of HM Treasury and in accordance with the requirements of the RICS Valuation Information Paper 10.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Foundation Trust and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives on a straight line basis which is a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-statement of financial position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Foundation Trust, respectively.

Revaluation and impairment

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

1 Accounting policies and other information (continued)

1.6 Property, Plant and Equipment (continued)

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e;
 - management are committed to a plan to sell the asset;
 - an active programme has begun to find a buyer and complete the sale;
 - the asset is being actively marketed at a reasonable price;
 - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated assets are capitalised at their fair value on receipt. The donation is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1 Accounting policies and other information (continued)

1.6 Property, Plant and Equipment (continued)

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-statement of financial position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17. The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The 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.

The PFI transactions which do not meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual, the PFI payments are recorded as an operating expense. Where the Trust has contributed to land and buildings, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Statement of Comprehensive Income. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset. The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- a) Payment for the fair value of services received;
- b) Payment for the PFI asset, including finance costs; and
- c) Payment for the replacement of components of the asset during the contract "lifecycle replacement".

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within "operating expenses".

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 16. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the year, and is charged to "Finance Costs" within the Statement of Comprehensive Income. The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ("life cycle replacement") are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

Assets contributed by the Foundation Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Foundation Trust's Statement of Financial Position.

1 Accounting policies and other information (continued)

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation 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 Foundation Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Foundation Trust intends to complete the asset and sell or use it;
- the Foundation Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Foundation Trust to complete the development and sell or use the asset; and
- the Foundation Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1 Accounting policies and other information (continued)

1.8 Government grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at average cost and at the lower of cost and net realisable value. Average cost is calculated based on the average purchase price of the inventory held. Provisions are made for slow moving, defective and obsolete inventory if considered necessary by management.

1.10 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation 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. Regular purchases or sales are recognised and de-recognised, as applicable, using the Settlement date. All other financial assets and financial liabilities are recognised when the Foundation 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 Foundation Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Profit and Loss' or Loans and receivables. Financial liabilities are classified as 'Fair Value through Profit and Loss' or as 'Other Financial liabilities'.

1 Accounting policies and other information (continued)

1.10 Financial instruments and financial liabilities (continued)

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 Foundation 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 transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial liabilities

All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Foundation Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision.

1 Accounting policies and other information (continued)

1.11 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest 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 so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12 Provisions

The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates of -1.8%, -1.0% or 2.2 % for 1-5 years, 6-10 years and 10 years respectively in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.35% in real terms.

Contingent Liability

A contingent liability needs to be disclosed in the accounts for redundancy costs that may arise should the Foundation Trust be successful in bidding for a tender commenced during 2013/14.

The Foundation Trust is currently investigating six potential injury allowance applications; due to the nature of the injuries at least one of these applications may result in a significant contingent liability.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 19.1.

Birmingham and Solihull Mental Health NHS Foundation Trust
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Notes to the Financial Statements

1 Accounting policies and other information (continued)

1.13 Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) net cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. The Department of Health has now confirmed that from 2013/14 the GBS balance to be used in the PDC dividend calculation will be calculated on average daily cleared balances in GBS. They have also confirmed that National Loan Fund balances will be treated as part of the GBS balance in the PDC dividend calculation.

1.15 Taxation

Value Added Tax

Most of the activities of the Foundation 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.

Corporation Tax

Healthcare activities of the NHS Foundation Trust are outside the scope of Corporation Tax. Application of Corporation Tax to NHS bodies has been deferred beyond March 31 2014. Summerhill Supplies Ltd is not a charitable organisation so is liable to corporation tax charges.

1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1 Accounting policies and other information (continued)

1.17 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Foundation 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 following balances are areas management have made critical judgements and estimates in the process of applying the Foundation Trust's accounting policies and that have the most significant effect on the amounts recognised in the accounts:

Provisions

Provisions have been recognised in these accounts for restructuring which relates to the cost of restructuring a service where an obligation exists at the year end; the most significant cost being redundancy and termination payments. Provisions are only recognised after a clear decision has been made to remove a post and the decision has been communicated to those affected. It is likely that these amounts will be settled during the year ended 31 March 2015.

Property valuations

The Trusts' land and buildings are valued by external independent valuers. The valuations incorporate professional assumptions to calculate the "Market Value" of the properties; the largest assumptions are made around the value of modern equivalent assets.

Property useful economic lives

The Trusts' buildings and equipments are depreciated over their remaining useful economic lives as described in note 1.6. Management assesses the useful economic life of an asset when it is brought into use and periodically reviews for reasonableness. Lives are based on physical lives of similar class of asset as calculated by the District Valuer and updated by management to make a best estimate of the useful economic life.

Lease of the Tamarind Centre

The Tamarind Centre (a medium secure mental health facility) is owned by Summerhill Supplies Limited and leased to the Trust. The accounting judgement is around the classification of the lease under IAS 17 as either an operating lease or a finance lease.

- Management has reviewed the classification indicators provided within IAS 17 and have assessed that the substance of the transaction is that of an operating lease. The lease term is for 5 years which is a minor part of the economic life of the asset, the lease does not transfer ownership and there is no option to purchase the asset at lower than fair value. The accounting policy for this is described in note 1.11.

The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the 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.

1 Accounting policies and other information (continued)

1.18 Standards applicable from 2014/15:

- IFRS 10 Consolidated Financial Statements
- IFRS 11 Joint Arrangements
- IFRS 12 Disclosure of Interests in Other Entities
- IAS 27 Separate Financial Statements (amendment)
- IAS 28 Investments in Associates and Joint Ventures (amendment)
- IAS 32 Financial instruments: Presentation (amendment)
- IAS 39 (amendment) Financial Instruments: Recognition and Measurement

- IFRS 9 Financial Instruments – this standard will eventually replace IAS 39. It is applicable for periods beginning on or after 1 January 2015, but the standard has not yet been EU endorsed and therefore by HM Treasury policy is not available for NHS bodies to apply.

- IPSAS 32 - Service Concession Arrangement
[This standard isn't mandatory because it is not an IFRS standard, however, HM Treasury may voluntarily choose to adopt certain principles in the FReM]

Standards applicable from 2015/16:

IFRS 13 Fair Value :

- Replaces definitions in most standards
- Property, Plant and Equipment-
- "Highest and best use"
- Reflecting physical, legal and financial possibilities
- FReM adaptation for geographical limitations?
- Additional disclosures for Level 3 inputs (e.g. DRC)

IAS 36 (amendment) Impairment

- Recoverable amount disclosures for non-financial assets

1 Accounting policies and other information (continued)

1.19 Exceptional items

Exceptional items are those significant items which are separately disclosed by virtue of their size or nature to enable full understanding of the Foundation Trusts financial performance including, but not limited to, material asset impairments and material costs of restructuring.

1.20 Cash and cash equivalents

Cash is defined as cash in hand and any deposits with any financial institution repayable on demand without penalty. Cash equivalents are investments that are short-term and are readily convertible to known amounts of cash with insignificant risk of change in value.

1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.22 Operating Segments

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision-maker. The chief operating decision-maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the board that makes strategic decisions.

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014

2	Operating Income by classification	2013/14	2012/13
		£000	£000
	Income from Activities		
	Cost and Volume Contract income	85,871	67,575
	Block Contract income	130,299	136,923
	Total income from activities	216,170	204,498
	Other operating income		
	Education and training	11,324	10,170
	Non-patient care services to other bodies	1,503	1,843
	Other	7,007	7,344
	Profit on disposal of property, plant and equipment	0	75
	Total other operating income	19,834	19,432
	Total operating income	236,004	223,930

2.1	Income from activities from mandatory services	2013/14	2012/13
		£000	£000
	Income from activities arising from mandatory services	212,518	200,918
	Income from activities arising from non-mandatory services	23,486	23,012
		236,004	223,930

2.2	Commissioner Requested Services	2013/14	2012/13
		£000	£000
	Income from activities arising from Commissioner Requested Services	216,170	204,498
	Income from activities arising from Non-Commissioner Requested Services	0	0
		216,170	204,498

3 Segmental Analysis

The analysis by business segment is presented in accordance with IFRS 8 Operating segments, on the basis of those segments whose operating results are regularly reviewed by the Board (the Chief Operating Decision Maker as defined by IFRS 8) as follows:

Healthcare services -

NHS Healthcare is the core activity of the Trust - the 'mandatory services requirement' as set out in the Trust's Terms of Authorisation issued by Monitor and defined by legislation.

This activity is primarily the provision of NHS healthcare, either to patients and charged to the relevant NHS commissioning body, or where healthcare related services are provided to other organisations by contractual agreement.

Revenue from activities (medical treatment of patients) is analysed by type of activity in note 3 to the accounts.

Other operating income is analysed in note 3 to the accounts and materiality consists of revenues from medical education and related support services to other organisations. Revenue is predominately from HM Government and related party transactions are analysed in note 23.1 and 23.2 to the accounts, where individual customers within public sector are considered material.

The healthcare and related support services as described are all provided directly by the Trust, which is a public benefit corporation. These services have been aggregated into a single operating segment because they have a similar economic characteristics: the nature of the services they offer are the same (the provision of healthcare), they have similar customers (public and private sector healthcare organisations) and have the same regulators (Monitor, Care Quality Commission and the Department of Health).

Commercial trading: Summerhill Supplies Limited

The company Summerhill Supplies Limited is a wholly owned subsidiary of the Trust and currently leases the Tamarind Centre to the Trust. As a trading company, subject to additional legal and regulatory regime (over and above that of the Trust), this activity is considered to be a separate business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker).

A significant proportion of the company's revenue is inter segment trading with the Foundation Trust which is eliminated upon the consolidation of these group accounts. The monthly performance report to the Chief Operating Decision maker reports financial summary information in the format of the table overleaf.

3 Segmental Analysis (continued)

Year ended March 31 2014	Healthcare services £000	Commerical trading £000	Inter-Group eliminations £000	Total £000
Total segment revenue	231,125	4,879	(5,664)	230,340
Total segment expenditure	(221,796)	(4,103)	5,664	(220,235)
Operating surplus	9,329	776	-	10,105
Net financing	(4,624)	(1,246)	-	(5,870)
PDC dividends payable	(2,217)	-	-	(2,217)
Taxation	-	-	-	-
Retained surplus before non-recurring items	2,488	(470)	-	2,018
Non-recurring items	5,772	-	-	5,772
Retained surplus	8,260	(470)	-	7,790
Reportable segment assets	249,422	32,595	-	282,017
Eliminations	-	-	(30,930)	(30,930)
Total assets	249,422	32,595	(30,930)	251,087
Reportable segment liabilities	(140,578)	(23,424)	-	(164,002)
Eliminations	-	-	22,882	22,882
Total liabilities	(140,578)	(23,424)	22,882	(141,120)
Net assets	108,844	9,171	(8,048)	109,967

Year ended March 31 2013	Healthcare services £000	Commerical trading £000	Inter-Group eliminations £000	Total £000
Total segment revenue	223,218	712	(725)	223,205
Total segment expenditure	(212,797)	(505)	725	(212,577)
Operating surplus	10,421	207	-	10,628
Net financing	(5,271)	(421)	-	(5,692)
PDC dividends payable	(2,513)	-	-	(2,513)
Taxation	-	-	-	-
Retained surplus before non-recurring items	2,637	(214)	-	2,423
Non-recurring items	(6,235)	-	-	(6,235)
Retained surplus	(3,598)	(214)	-	(3,812)
Reportable segment assets	246,571	32,500	-	279,071
Eliminations	-	-	(32,706)	(32,706)
Total assets	246,571	32,500	(32,706)	246,365
Reportable segment liabilities	(148,406)	(22,859)	-	(171,265)
Eliminations	-	-	22,851	22,851
Total liabilities	(148,406)	(22,859)	22,851	(148,414)
Net assets	98,165	9,641	(9,855)	97,951

Birmingham and Solihull Mental Health NHS Foundation Trust
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4	Operating costs	2013/14	2012/13
		£000	£000
	Services from NHS foundation trusts	1,664	805
	Services from NHS trusts	4,320	3,721
	Services from CCGs and NHS England	79	-
	Services from other NHS Bodies	15	48
	Employee Expenses - Executive directors	819	1,128
	Employee Expenses - Non-executive directors	158	150
	Employee Expenses - Staff	169,586	158,549
	Drug costs	7,267	7,025
	Supplies and services - clinical (excluding drug costs)	482	504
	Supplies and services - general	3,793	3,144
	Establishment	4,742	4,233
	Transport	1,519	1,302
	Premises	16,399	16,903
	Increase / (Decrease) in bad debt provision	33	(334)
	Termination benefits	470	618
	Depreciation on property, plant and equipment	7,124	6,499
	Audit services - statutory audit	62	73
	Clinical negligence	164	398
	Loss on disposal of other property, plant and equipment	53	150
	Other	7,150	8,386
	TOTAL	225,899	213,302

4.1	Exceptional items	2013/14	2012/13
		£000	£000
	(Reversal of impairments)/Impairments of property, plant and equipment	(4,861)	5,324
	Termination benefits	(911)	911
	TOTAL	(5,772)	6,235
	Termination benefits classified as exceptional are restructuring programmes which management consider are outside of normal operating activities due to either their size or nature. The entry during the year ended March 31 2014 relates to a credit of £911k for the release of a provision recognised as exceptional in the prior year.		

4.2	Analysis of loss on disposal	2013/14	2012/13
		Total	Total
		£000	£000
	Disposal of commissioner requested service assets	-	-
	Disposal of non-commissioner requested service assets	53	150
	TOTAL	53	150

The net book value of the land and buildings above was £539k. The value of the sale proceeds was £490k. There was £4k of legal fees. The Foundation Trust Services that were at these locations have been relocated within other Foundation Trust properties.

4 Operating costs (continued)

4.3

Auditor Remuneration

The Board of Governors appointed PricewaterhouseCoopers LLP (PwC) as external auditors of the Trust for the three years commencing 2010/11. This contract was extended for a further year for 2013/14. The audit fee for the year ended March 31 2014 was £56k for the Foundation Trust's annual report, £10k for the Trust's quality accounts and £6k for Summerhill Supplies Limited (£74k for the year ended March 31 2013) excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011. The liability of PwC for all claims connected with services provided (including but not limited to negligence) is limited to £1,000,000.

4.4

Arrangements containing an operating lease

	2013/14	2012/13
	£000	£000
Minimum lease payments	1,615	1,626

There are no future lease payments due under sub-lease arrangements

The Foundation Trust has entered into a number operating lease arrangement for the use of land and buildings, vehicles and equipment. The leases for land and building range from 5 to 99 year terms and have an annual charge of £1,520k which is included within operating costs. The leases for vehicles and equipment range from 1 to 5 years and have an annual charge of £95k which is included within operating costs.

The Foundation Trust's most significant lease arrangement is for the lease of the Foundation Trust Headquarters. This is a 25 year lease expiring in 2030 and has an annual rental charge of £601k. The lease agreement does not contain provision for contingent rentals and does not impose any restrictions on the Trust. The lease has options for early termination, with penalty, in years 15 and 20 of the lease.

The Tamarind Centre (a medium secure mental health facility) which is owned by Summerhill Supplies Limited, a wholly owned subsidiary of the Foundation Trust, is being leased to the Foundation Trust. The lease term is for 5 years.

4.5

Total future minimum lease payments

	2013/14	2012/13
	£000	£000
Not later than one year	1,683	1,736
Later than one year and not later than five years	5,237	5,061
later than five years	10,285	10,035
TOTAL	17,205	16,832

Birmingham and Solihull Mental Health NHS Foundation Trust
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5	Directors' remuneration	2013/14	2012/13
		Total	Total
		£000	£000
	Directors' remuneration	646	935
	Social security costs	81	103
	Employer contributions to a pension scheme in respect of directors'	91	90
	TOTAL	818	1,128

Sue Turner resigned from the Board on November 30 2012. In her capacity as Chief executive officer of Birmingham and Solihull Mental Health NHS Foundation Trust Sue Turner earned a salary of £109,643 during 2012/13 and was paid £86,288 in lieu of notice and annual leave.

The medical director was paid £65k during the year ended March 31 2014 (£65k during year ended March 31 2013), which is not included in the above disclosure, for his non-director responsibilities.

6	Employee Expenses	2013/14	2012/13
	(including executive directors but excluding non-executive directors)	Total	Total
		£000	£000
	Salaries and wages	135,147	130,675
	Social security costs	11,255	10,260
	Employers contributions to NHS pensions	16,314	14,993
	Termination benefits (see note 4 and 4.1)	(441)	1,529
	Agency/contract staff	7,688	3,749
		169,963	161,206
	Less capitalised cost	-	-
	TOTAL RECOGNISED IN OPERATING EXPENSES	169,963	161,206

6.1	Average number monthly of employees (WTE basis)	2013/14	2012/13
		Number	Number
	Medical	261	259
	Administration and estates	575	554
	Healthcare assistants and other support staff	825	766
	Nursing and health visiting staff	1,243	1,224
	Scientific, therapeutic and technical staff	629	580
	Other	281	273
	TOTAL	3,814	3,656

6 Employee Expenses (continued)

6.2 Early retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. The information has been supplied by the NHS Pensions and these costs are not borne by the Foundation Trust.

	2013/14	2013/14	2012/13	2012/13
	£000	Number	£000	Number
No of early retirements on the grounds of ill-health		2		4
Value of early retirements on the grounds of ill-health	179		175	

6.3 Staff exit packages

Exit package cost band	Number of compulsory redundancies	Number of other agreed departures	Total number of exit packages by cost band	Total number of exit packages by cost band
	2013/14	2013/14	2013/14	2012/13
<£10,000	10	-	10	4
£10,000 - £25,000	15	-	15	5
£25,001 - £50,000	14	-	14	5
£50,001-£100,000	6	-	6	6
£100,001 - £150,000	0	-	0	0
£150,001 - £200,000	1	-	1	1
Total number of exit packages by type	46	-	46	21
Total resource cost £'000	1,364	-	1,364	899

Any exit packages in respect of senior managers are not disclosed in this note but, if paid, can be found in the Director Remuneration Report.

7 Finance income

	2013/14	2012/13
	£000	£000
Interest on Deposits/Investments	113	132

8 Finance costs

	2013/14	2012/13
	£000	£000
Loans from the Foundation Trust Financing Facility	1,944	1,901
Finance Costs in PFI obligations		
Main Finance Costs	2,942	3,012
Contingent Finance Costs	1,097	911
TOTAL	5,983	5,824

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014

9	Intangible assets		
	Group and Trust		
		Licences and	Development
	Total	trademarks	expenditure
		(purchased)	(internally
	£000	£000	generated)
			£000
	Cost or valuation at April 1 2013, April 1 2014, March 31 2013 and March 31 2014		
	274	253	21
	Accumulated amortisation at April 1 2013, April 1 2014, March 31 2013 and March 31 2014		
	274	253	21
	NBV total at March 31 2013 and March 31 2014		
	-	-	-

10 Property, plant and equipment
Group

10.1	Property, plant and equipment March 31 2014	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings
		£000	£000	£000	£000	£000	£000	£000	£000	£000
	Cost or valuation at April 1 2013	202,602	46,211	138,255	0	183	2,693	84	8,630	6,546
	Cost or valuation at start of year for new FT's	0	-	-	-	-	-	-	-	-
	Additions - purchased	8,102	-	30	-	8,060	9	-	3	-
	Additions - donated	0	-	-	-	-	-	-	-	-
	Acquisition through business combination	0	-	-	-	-	-	-	-	-
	Impairments charged to revaluation reserve	0	-	-	-	-	-	-	-	-
	Reclassifications	0	(1)	1,771	-	(3,216)	(1)	-	1,300	147
	Revaluation surpluses	4,226	-	4,226	-	-	-	-	-	-
	Transfers to non-current assets classified as held for sale (note 10.11)	0	-	-	-	-	-	-	-	-
	Transfers from accumulated depreciation*	941	-	1,453	-	(512)	-	-	-	-
	Disposals	(46)	-	(44)	-	-	(1)	-	-	(1)
	Cost or valuation at March 31 2014	215,825	46,210	145,691	-	4,515	2,700	84	9,933	6,692
	Accumulated depreciation at April 1 2013	7,000	-	-	-	-	910	74	4,494	1,522
	Accumulated depreciation at start of year for new FT's	0	-	-	-	-	-	-	-	-
	Provided during the year	7,125	-	3,920	-	-	360	2	1,694	1,149
	Acquisition through business combination	0	-	-	-	-	-	-	-	-
	Impairments	512	-	-	-	512	-	-	-	-
	Reversal of impairments	(5,373)	-	(5,373)	-	-	-	-	-	-
	Reclassifications	0	-	-	-	-	-	-	-	-
	Revaluation surpluses	0	-	-	-	-	-	-	-	-
	Transferred to cost or valuation*	941	-	1,453	-	(512)	-	-	-	-
	Disposals	0	-	-	-	-	-	-	-	-
	Accumulated depreciation at March 31 2014	10,205	-	-	-	-	1,270	76	6,188	2,671
	Net book value									
	NBV - Purchased at March 31 2013	193,563	45,061	137,395	-	183	1,754	10	4,136	5,024
	NBV - Donated at March 31 2013	2,039	1,150	860	-	-	29	-	-	-
	NBV total at March 31 2013	195,602	46,211	138,255	0	183	1,783	10	4,136	5,024
	Net book value									
	NBV - Purchased at March 31 2014	203,607	45,060	144,849	-	4,515	1,409	8	3,745	4,021
	NBV - Donated at March 31 2014	2,013	1,150	842	-	-	21	-	-	-
	NBV total at March 31 2014	205,620	46,210	145,691	-	4,515	1,430	8	3,745	4,021

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in accordance with IAS 16 - Property, Plant and Equipment.

The net book value of assets held under finance lease arrangements is £47,562k at March 31 2014 (£47,306k at March 31 2013). Depreciation of £874k was charged on these assets in the year (£894k during the year ended March 31 2013). These assets wholly relate to PFI assets.

The donated assets are restricted to use for the provision of Healthcare education and training.

10.2 Net Book Value split between protected and non-protected assets no longer required.

10 Property, Plant and Equipment (continued)
Trust

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
10.3 Property, plant and equipment March 31 2014									
Cost or valuation at April 1 2012 as previously stated	169,907	40,236	116,329	-	185	1,967	73	8,630	2,487
prior year adjustments	-	-	-	-	-	-	-	-	-
Cost or valuation at April 1 2013	169,907	40,236	116,329	-	185	1,967	73	8,630	2,487
Cost or valuation at start of year for new FT's	0	-	-	-	-	-	-	-	-
Additions - purchased	8,102	-	30	-	8,060	9	-	3	-
Additions - donated	0	-	-	-	-	-	-	-	-
Acquisition through business combination	0	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve	0	-	-	-	-	-	-	-	-
Reclassifications	0	(1)	1,771	-	(3,218)	1	-	1,300	147
Revaluation surpluses	4,226	-	4,226	-	-	-	-	-	-
Transfers to non-current assets classified as held for sale (note 10.1)	0	-	-	-	-	-	-	-	-
Transfers from accumulated depreciation*	(401)	-	111	-	(512)	-	-	-	-
Disposals	(46)	-	(44)	-	-	(1)	-	-	(1)
Cost or valuation at March 31 2014	181,788	40,235	122,423	-	4,515	1,976	73	9,933	2,633
Accumulated depreciation at April 1 2013	6,681	-	-	-	-	863	73	4,494	1,251
Accumulated depreciation at start of year for new FT's	0	-	-	-	-	-	-	-	-
Provided during the year	5,701	-	3,456	-	-	214	-	1,694	337
Acquisition through business combination	0	-	-	-	-	-	-	-	-
Impairments	512	-	-	-	512	-	-	-	-
Reversal of impairments	(3,567)	-	(3,567)	-	-	-	-	-	-
Reclassifications	0	-	-	-	-	-	-	-	-
Revaluation surpluses	0	-	-	-	-	-	-	-	-
Transferred to cost or valuation*	(401)	-	111	-	(512)	-	-	-	-
Disposals	0	-	-	-	-	-	-	-	-
Accumulated depreciation at March 31 2014	8,926	-	-	-	-	1,077	73	6,188	1,588
Net book value									
NBV - Purchased at March 31 2013	161,187	39,086	115,469	-	185	1,075	-	4,136	1,236
NBV - Donated at March 31 2013	2,039	1,150	860	-	-	29	-	-	-
NBV total at March 31 2013	163,226	40,236	116,329	-	185	1,104	-	4,136	1,236
Net book value									
NBV - Purchased at March 31 2014	170,849	39,085	121,581	-	4,515	877	-	3,745	1,045
NBV - Donated at March 31 2014	2,013	1,150	842	-	-	21	-	-	-
NBV total at March 31 2014	172,862	40,235	122,423	-	4,515	898	-	3,745	1,045

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in accordance with IAS 16 - Property, Plant and Equipment.

The net book value of assets held under finance lease arrangements is £47,562k at March 31 2014 (£47,306k at March 31 2013). Depreciation of £874k was charged on these assets in the year (£894k during the year ended March 31 2013). These assets wholly relate to PFI assets.

The donated assets are restricted to use for the provision of Healthcare education and training.

10.4 Net Book Value split between protected and non-protected assets no longer required.

10 Property, Plant and Equipment (continued)
Group

10.5	Property, plant and equipment March 31 2013	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings
		£000	£000	£000	£000	£000	£000	£000	£000	£000
	Cost or valuation at April 1 2012 as previously stated	211,693	47,722	123,178	388	24,775	3,352	93	8,352	3,833
	prior year adjustments	0	-	-	-	-	-	-	-	-
	Cost or valuation at April 1 2012	211,693	47,722	123,178	388	24,775	3,352	93	8,352	3,833
	Cost or valuation at start of year for new FT's	0	-	-	-	-	-	-	-	-
	Additions - purchased	9,992	-	3,274	-	5,503	170	-	901	144
	Additions - donated	0	-	-	-	-	-	-	-	-
	Acquisition through business combination	0	-	-	-	-	-	-	-	-
	Impairments charged to revaluation reserve	(2,900)	(390)	(2,510)	-	-	-	-	-	-
	Reclassifications	-	-	22,081	-	(28,220)	726	11	693	4,709
	Revaluation surpluses	-	-	-	-	-	-	-	-	-
	Transfers to non-current assets classified as held for sale (note 10.11)	(671)	(150)	(521)	-	-	-	-	-	-
	Transfers from accumulated depreciation*	(9,055)	(326)	(6,700)	(388)	(1,641)	-	-	-	-
	Disposals	(6,457)	(645)	(547)	-	(234)	(1,555)	(20)	(1,316)	(2,140)
	Cost or valuation at March 31 2013	202,602	46,211	138,255	-	183	2,693	84	8,630	6,546
	Accumulated depreciation at April 1 2012 as previously stated	9,112	-	-	-	-	2,176	93	3,938	2,905
	prior year adjustments	0	-	-	-	-	-	-	-	-
	Accumulated depreciation at April 1 2012	9,112	-	-	-	-	2,176	93	3,938	2,905
	Accumulated depreciation at start of year for new FT's	0	-	-	-	-	-	-	-	-
	Provided during the year	6,499	-	3,706	25	-	285	1	1,872	610
	Acquisition through business combination	0	-	-	-	-	-	-	-	-
	Impairments recognised in operating expenses	5,324	326	2,994	363	1,641	-	-	-	-
	Reversal of impairments	0	-	-	-	-	-	-	-	-
	Reclassifications	0	-	-	-	-	-	-	-	-
	Transferred to cost or valuation*	(9,055)	(326)	(6,700)	(388)	(1,641)	-	-	-	-
	Disposals	(4,880)	-	-	-	-	(1,551)	(20)	(1,316)	(1,993)
	Accumulated depreciation at March 31 2013	7,000	-	-	-	-	910	74	4,494	1,522
	Net book value									
	NBV - Purchased at March 31 2012	200,501	46,572	122,290	388	24,775	1,134	-	4,414	928
	NBV - Donated at March 31 2012	2,080	1,150	888	-	-	42	-	-	-
	NBV total at March 31 2012	202,581	47,722	123,178	388	24,775	1,176	-	4,414	928
	Net book value									
	NBV - Purchased at March 31 2013	193,563	45,061	137,395	-	183	1,754	10	4,136	5,024
	NBV - Donated at March 31 2013	2,039	1,150	860	-	-	29	-	-	-
	NBV total at March 31 2013	195,602	46,211	138,255	-	183	1,783	10	4,136	5,024

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in accordance with IAS 16 - Property, Plant and Equipment.

The net book value of assets held under finance lease arrangements is £47,306k at March 31 2013 (£47,868k at March 31 2012). Depreciation of £894k was charged on these assets in the year (£865k during the year ended March 31 2012). These assets wholly relate to PFI assets.

The donated assets are restricted to use for the provision of Healthcare education and training.

10.6	Analysis of property, plant and equipment March 31 2013	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings
		£000	£000	£000	£000	£000	£000	£000	£000	£000
	Net book value									
	NBV - Protected assets at March 31 2013	165,061	36,346	128,715	-	1	-	-	-	-
	NBV - Unprotected assets at March 31 2013	30,542	9,865	9,540	-	184	1,783	10	4,136	5,024
	Total at March 31 2013	195,602	46,211	138,255	-	183	1,783	10	4,136	5,024

Property, plant and equipment is classified as protected if it is required for the purposes of providing either mandatory goods and services or mandatory education and training.

10 Property, Plant and Equipment (continued)
Trust

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Constructio n and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings
10.7 Property, plant and equipment March 31 2013									
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at April 1 2012 as previously stated	211,693	47,722	123,178	388	24,775	3,352	93	8,352	3,833
prior year adjustments	-	-	-	-	-	-	-	-	-
Cost or valuation at April 1 2013	211,693	47,722	123,178	388	24,775	3,352	93	8,352	3,833
Cost or valuation at start of year for new FT's	-	-	-	-	-	-	-	-	-
Additions - purchased	9,992	-	3,274	-	5,503	170	-	901	144
Additions - donated	-	-	-	-	-	-	-	-	-
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve	(2,900)	(390)	(2,510)	-	-	-	-	-	-
Reclassifications	-	-	-	-	(1,343)	-	-	693	650
Revaluation surpluses	-	-	-	-	-	-	-	-	-
Transfers to non-current assets classified as held for sale (note 10.11)	(671)	(150)	(521)	-	-	-	-	-	-
Transfers from accumulated depreciation*	(8,900)	(326)	(6,545)	(388)	(1,641)	-	-	-	-
Disposals	(39,307)	(6,620)	(547)	-	(27,109)	(1,555)	(20)	(1,316)	(2,140)
Cost or valuation at March 31 2013	169,907	40,236	116,329	-	185	1,967	73	8,630	2,487
Accumulated depreciation at April 1 2013	9,112	-	-	-	-	2,176	93	3,938	2,905
Accumulated depreciation at start of year for new FT's	-	-	-	-	-	-	-	-	-
Provided during the year	6,024	-	3,551	25	-	237	-	1,872	339
Acquisition through business combination	-	-	-	-	-	-	-	-	-
Impairments recognised in operating expenses	5,324	326	2,994	363	1,641	-	-	-	-
Transferred to cost or valuation*	(8,900)	(326)	(6,545)	(388)	(1,641)	-	-	-	-
Disposals	(4,879)	-	-	-	-	(1,550)	(20)	(1,316)	(1,993)
Accumulated depreciation at March 31 2013	6,681	-	-	-	-	863	73	4,494	1,251
Net book value									
NBV - Purchased at March 31 2012	200,501	46,572	122,290	388	24,775	1,134	-	4,414	928
NBV - Donated at March 31 2012	2,080	1,150	888	-	-	42	-	-	-
NBV total at March 31 2012	202,581	47,722	123,178	388	24,775	1,176	-	4,414	928
Net book value									
NBV - Purchased at March 31 2013	161,187	39,086	115,469	-	185	1,075	-	4,136	1,236
NBV - Donated at March 31 2013	2,039	1,150	860	-	-	29	-	-	-
NBV total at March 31 2013	163,226	40,236	116,329	-	185	1,104	-	4,136	1,236

*These lines represent the elimination of accumulated depreciation against the carrying value of assets which have been revalued in the year in accordance with IAS 16 - Property, Plant and Equipment. The values reported also include an element relating to the previous financial year.

The net book value of assets held under finance lease arrangements is £47,306k at March 31 2013 (£47,868k at March 31 2012). Depreciation of £894k was charged on these assets in the year (£865k during the year ended March 31 2012). These assets wholly relate to PFI assets.

The donated assets are restricted to use for the provision of Healthcare education and training.

10.8

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Constructio n and POA	Plant and Machinery	Transport Equipment	Information Technology	Furniture and Fittings
Analysis of property, plant and equipment March 31 2013									
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
NBV - Protected assets at March 31 2013	137,160	30,371	106,789	-	-	-	-	-	-
NBV - Unprotected assets at March 31 2013	26,065	9,865	9,540	-	184	1,104	-	4,136	1,236
Total at March 31 2013	163,226	40,236	116,329	-	185	1,104	-	4,136	1,236

Property, plant and equipment is classified as protected if it is required for the purposes of providing either mandatory goods and services or mandatory education and training.

10 Property, Plant and Equipment (continued)

10.9	Economic life of property, plant and equipment	Min Life	Max Life
		Years	Years
	Land	-	-
	Buildings excluding dwellings	5	60
	Dwellings	-	-
	Assets under Construction and POA	-	-
	Plant and Machinery	1	8
	Transport Equipment	4	4
	Information Technology	1	5
	Furniture & Fittings	1	8

10.10 Valuations

Valuations are carried out by professionally qualified, independent valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A full asset valuations was undertaken in Jan 2014 with an effective valuation date of 31 March 2014. Fair values were determined based on estimates. The impairment gains and loss recognised in the accounts arose due to movement in market prices.

10.11	Non-current assets classified as held for sale	Group		Trust	
		March 31 2014	March 31 2013	March 31 2014	March 31 2013
		£000	£000	£000	£000
	Property, plant and equipment	755	1,250	755	1,250
	Assets classified as held for sale includes a parcel of land at Rubery Hospital and two properties following approval to dispose of the assets by the Board. It is expected that the sales will occur during the year ended March 31 2015.				

11	Inventories	Group		Trust	
		March 31 2014	March 31 2013	March 31 2014	March 31 2013
		£000	£000	£000	£000
	Drugs	307	185	213	185
	Consumables	37	67	38	67
	TOTAL	344	252	251	252

11.1	Inventories recognised in expenses	March 31 2014	March 31 2013
		£000	£000
	Inventories recognised in expenses	4,022	3,709
	Write-down of inventories recognised as an expense	12	22
	TOTAL inventories recognised in expenses	4,034	3,731

12	Subsidiary investments	Group		Trust	
		March 31 2014	March 31 2013	March 31 2014	March 31 2013
		£000	£000	£000	£000
	Shares in Group undertakings	-	-	9,855	9,855
	TOTAL	-	-	9,855	9,855

The Trust's principal subsidiary undertaking as included in the consolidation as at the reporting date is set out below. The reporting date of the accounts for the subsidiary is the same as for these group accounts - March 31 2014.

Summerhill Supplies Limited

The company is registered in the UK, company number 08015667. The company commenced trading on December 1 2012 and is a wholly owned subsidiary of Birmingham and Solihull Mental Health NHS Foundation Trust with share capital of £9,855,126. The current purpose of the company is to own, and provide a managed lease service for Tamarind Centre (a medium secure mental health facility) to the Trust, and also provide a outpatient dispensing services to the Trust which commenced in September 2013.

13

Trade and other receivables						
Group						
	Total	Financial assets	Non-financial assets	Total	Financial assets	Non-financial assets
	March 31 2014	March 31 2014	March 31 2014	March 31 2013	March 31 2013	March 31 2013
	£000	£000	£000	£000	£000	£000
Current						
NHS Receivables	2,460	2,460	-	10,142	10,142	-
Other receivables with related parties	0	-	-	-	-	-
Provision for impaired receivables	(368)	(368)	-	(364)	(364)	-
Prepayments	2,118	-	2,118	1,789	-	1,789
PDC receivable	0	-	-	1	1	-
Other receivables	4,353	4,353	-	2,999	2,999	-
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	8,563	6,445	2,118	14,567	12,778	1,789
Non-Current						
Prepayments - Lifecycle replacements	3,189	-	3,189	2,554	-	2,554

13.1

Trade and other receivables						
Trust						
	Total	Financial assets	Non-financial assets	Total	Financial assets	Non-financial assets
	March 31 2014	March 31 2014	March 31 2014	March 31 2013	March 31 2013	March 31 2013
	£000	£000	£000	£000	£000	£000
Current						
NHS Receivables	2,460	2,460	-	10,142	10,142	-
Other receivables with related parties	0	-	-	-	-	-
Provision for impaired receivables	(368)	(368)	-	(364)	(364)	-
Prepayments	2,116	-	2,116	1,789	-	1,789
PDC receivable	0	-	-	1	1	-
Other receivables	4,784	4,784	-	2,996	2,996	-
Loan assets*	474	474	-	449	449	-
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	9,466	7,350	2,116	15,013	13,224	1,789
Non-Current						
Prepayments - Lifecycle replacements	3,189	-	3,189	2,554	-	2,554
Loan assets*	21,928	21,928	-	22,402	22,402	-
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	25,117	21,928	3,189	24,956	22,402	2,554

*Loan assets are comprised solely of a loan made to the 100% owned subsidiary Summerhill Supplies Limited. The term of the loan is 25 years.

Birmingham and Solihull Mental Health NHS Foundation Trust
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13 Trade and Other Receivables (continued)
Group and Trust

13.2	Provision for impairment of receivables		
		March 31 2014	March 31 2013
		£000	£000
	At April 1 2013	364	698
	Increase / (Decrease) in provision	33	(334)
	Amounts utilised	(29)	-
	Unused amounts reversed	-	-
	At March 31 2014	368	364

Group and Trust

13.3	Analysis of impaired receivables		
		March 31 2014	March 31 2013
		£000	£000
	Ageing of impaired receivables		
	Up to three months	122	108
	In three to six months	87	54
	Over six months	159	202
	TOTAL	368	364

Group and Trust

13.4	Ageing of non-impaired receivables past their due date		
		March 31 2014	March 31 2013
		£000	£000
	Up to three months	1,895	1,706
	90- 180 days (was "In three to six months")	473	104
	over 180 days (was "Over six months")	89	219
	Total	2,457	2,029

Group							
14	Trade and other payables	Total	Financial liabilities	Non-financial liabilities	Total	Financial liabilities	Non-financial liabilities
		March 31 2014	March 31 2014	March 31 2014	March 31 2013	March 31 2013	March 31 2013
		£000	£000	£000	£000	£000	£000
		Current					
	NHS payables	1,579	1,579	-	1,360	1,360	-
	Amounts due to other related parties	1,667	1,667	-	-	-	-
	Trade payables - capital	1,843	1,843	-	1,102	1,102	-
	Social security and taxes payable	3,324	-	3,324	3,382	-	3,382
	Other payables	7,436	7,436	-	9,399	9,399	-
	Accruals	8,832	8,832	-	11,431	11,431	-
	TOTAL CURRENT TRADE AND OTHER PAYABLES	24,681	21,357	3,324	26,674	23,292	3,382

14.1	Trust						
Trade and other payables		Total	Financial liabilities	Non-financial liabilities	Total	Financial liabilities	Non-financial liabilities
		March 31 2014	March 31 2014	March 31 2014	March 31 2013	March 31 2013	March 31 2013
		£000	£000	£000	£000	£000	£000
Current							
	NHS payables	1,579	1,579	-	1,360	1,360	-
	Amounts due to other related parties	1,667	1,667	-	-	-	-
	Trade payables - capital	1,843	1,843	-	1,102	1,102	-
	Social security and taxes payable	3,312	-	3,312	3,382	-	3,382
	Other payables	7,480	7,480	-	9,399	9,399	-
	Accruals	8,258	8,258	-	11,431	11,431	-
TOTAL CURRENT TRADE AND OTHER PAYABLES		24,139	20,827	3,312	26,674	23,292	3,382

Other payables above includes £1,364k at March 31 2014 in respect of outstanding employer Pension contributions (£1,278k at March 2013).

Group and Trust			
15	Other liabilities	Total	Total
		March 31 2014	March 31 2013
		£000	£000
	Current		
	Deferred Income	4,321	5,121

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014

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Borrowings		
Group and Trust		
	March 31 2014	March 31 2013
Current	£000	£000
Loans from Foundation Trust Financing Facility	2,182	2,183
Obligations under Private Finance Initiative contract	1,705	1,610
TOTAL CURRENT BORROWINGS	3,887	3,793
Non-current		
Loans from Foundation Trust Financing Facility	44,785	46,967
Obligations under Private Finance Initiative contracts	59,583	61,289
TOTAL OTHER NON CURRENT LIABILITIES	104,368	108,256

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Prudential borrowing limit
Prudential Borrowing Limit disclosures are no longer required, the Prudential Borrowing Code having been repealed by the Health and Social Care Act 2012

18

PFI obligations (on SoFP)		
Group and Trust		
Gross PFI liabilities	March 31 2014	March 31 2013
of which liabilities are due	£000	£000
- not later than one year;	4,575	4,553
- later than one year and not later than five years;	16,380	16,923
- later than five years.	90,100	94,132
Finance charges allocated to future periods	(49,767)	(52,709)
Net PFI liabilities	61,288	62,899
- not later than one year;	1,705	1,609
- later than one year and not later than five years;	5,579	5,859
- later than five years.	54,004	55,431
TOTAL	61,288	62,899

18.1

PFI Obligations				
Group and Trust				
The Trust is committed to make the following payments for on SoFP PFIs obligations during the next year in which the commitment expires:				
	March 31 2014	March 31 2014	March 31 2014	March 31 2013
	Total	PFI 1	PFI 2	Total
21st to 25th years (inclusive)	3,269	3,269	-	3,189
31st to 35th years (inclusive)	6,847	-	6,847	6,080

18.2

PFI commitments (on SoFP)		
Group and Trust		
	March 31 2014	March 31 2013
	£000	£000
Commitments in respect of the service element of the PFI		
- not later than one year;	10,116	9,869
- later than one year and not later than five years;	43,056	42,006
- later than five years.	382,006	393,172
	435,178	445,047
Present value of commitments		
- not later than one year;	9,617	9,382
- later than one year and not later than five years;	36,131	35,250
- later than five years.	169,787	170,686
TOTAL	215,535	215,318

18.3

PFI contract details

The Foundation Trust has entered into two PFI contracts:

PFI 1 - Northern PFI Scheme

This is a 35 year contract with Healthcare Support (Erdington) Limited which commenced in April 2002 and is for the provision of six buildings including "hard" facility management services. The service provision is implicitly for the patients, staff and visitors of the Trust. This contract has been treated as being on-statement of financial position by the Trust following a review of the contracts based on Treasury Task force Technical Note 1 "How to account for PFI transactions" which interprets IAS16 "Property, Plant and Equipment" and IFRIC12 "Service Concession Arrangements". The increase in annual Unitary Charge is linked to annual movement in RPIx.

At the end of the concession period, the ownership of the six buildings transfers to the Trust at which point the contract will expire.

The Contract also includes the provision of "soft" facility management services. These services are also linked to the annual movement in RPIx but are subject to a market testing exercise which takes place every 5 years. This commenced in January 2014.

The contract stipulates obligations on the Trust and Healthcare Support (Erdington) Limited. Should either party default on its contractual obligations then the other party has the right to terminate the contract. Provisions for compensation are included within the contract which include the Trust settling the amount of outstanding senior debt.

PFI 2 - Birmingham New Hospital Projects

This is a 38 year contract with Consort Healthcare (Birmingham) Limited which commenced in July 2008 and is for the provision of three buildings including "hard" facility management services. The PFI contract was jointly undertaken by the Trust and University Hospital Birmingham NHS Foundation Trust (UHB) for the "Birmingham Super Hospitals" in Selly Oak of which the Trust provides Mental Health services. Only the assets, liability, income and expenditure directly attributable to the Trust under the contract are disclosed in these accounts. The service provision is implicitly for the patients, staff and visitors of the Trust. This contract has been treated as being on-statement of financial position by the Trust following a review of the contracts based on Treasury Task force Technical Note 1 "How to account for PFI transactions" which interprets IAS16 "Property, Plant and Equipment" and IFRIC12 "Service Concession Arrangements". The annual Unitary Charge is linked to annual movement in RPI. On the 15th anniversary of the commencement of the contract the Unitary Payment is subject to a market testing exercise.

At the end of the concession period, the ownership of the three buildings transfers to the Trust at which point the contract will expire.

The contract contains various termination clauses including voluntary, events of default, Force Majeure, and termination due to material non-availability clauses each having its own compensation mechanism. The voluntary termination clause requires the Foundation Trust to act jointly with University Hospital Birmingham.

19

Provisions for liabilities and charges
Group and Trust

	Total Legal claims	Property	Restructuring	Injury Allowance	Other	
	£000	£000	£000	£000	£000	
At April 1 2013	4,570	571	1,332	2,198	97	372
Arising during the year	2,163	63	-	143	1,418	539
Utilised during the year	(240)	(57)	(3)	(130)	(50)	0
Reversed unused	(2,630)	(415)	-	(1,843)	-	(372)
At March 31 2014	3,863	162	1,329	368	1,465	539
Expected timing of cash flows:						
- not later than one year;	1,385	162	283	368	33	539
- later than one year and not later than five years;	227	-	150	-	77	-
- later than five years.	2,251	-	896	-	1,355	-
TOTAL	3,863	162	1,329	368	1,465	539

The legal claims provision relates to personal legal claims that have been lodged against the Foundation Trust with the NHS Litigation Authority (NHSLA) but not yet agreed. The exact timing or amount of any payment will only be known once the case is heard, although it is expected that all cases will be resolved during the year ended March 31 2015. The Trust has £87k of contingent liabilities in respect of legal claims at March 31 2014 (£95k at March 31 2013).

The property provision consists of amounts payable on onerous leases and dilapidation costs. Dilapidation provisions are based on managements best estimate of settling dilapidation costs contained within lease contracts but the exact liability will only be known once settlement has been agreed with the lessor. The timing of the cash flows is based on the length of the lease.

The restructuring provision relates to the cost of restructuring a service where an obligation exists at the year end; the most significant cost being redundancy and termination payments. Provisions are only recognised after a clear decision has been made to remove a post and the decision has been communicated to those affected. It is likely that these amounts will be settled during the year ended March 31 2015.

The injury allowance provision relates to permanent injury and early retirement provisions. The liability of the Foundation Trust is dependant based on life expectancy.

The other provision consists of £200k for Infomation Governance provision and £339k for Increment Provision.

19.1	Clinical Negligence liabilities		
	Group and Trust	March 31 2013	March 31 2012
		£000	£000
	Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of Birmingham and Solihull Mental Health NHS Foundation Trust	2,016	863

20	Contractual Capital Commitments Group and Trust
	<p>The Trust was contractually committed to £782k at 31 March 2014 (£3,500k at 31 March 2013) of capital expenditure for the purchase of property, plant and equipment.</p>

21	Third Party Assets
	<p>The Trust held £917k cash and cash equivalents at March 31 2014 (£998k March 31 2013) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.</p>

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Cash and cash equivalents		Group		Trust	
		March 31 2014	March 31 2013	March 31 2014	March 31 2013
		£000	£000	£000	£000
At April 1		32,140	35,460	32,019	35,460
Net change in year		476	(3,320)	(903)	(3,441)
At March 31		32,616	32,140	31,116	32,019
Broken down into:					
Cash in hand (petty cash)		39	35	39	35
Cash at Commercial Banks		1,500	122	-	-
Cash at GBS		31,077	31,983	31,077	31,984
Cash and cash equivalents as in SoFP		32,616	32,140	31,116	32,019
Bank overdraft		-	-	-	-
Cash and cash equivalents as in SoCF		32,616	32,140	31,116	32,019

23

Ultimate Parent Company

The Foundation Trust is a public benefit corporation established under the NHS Act 2006. Monitor, the NHS Foundation Trust Regulator has the power to control the Trust within the meaning of IAS 27 'Consolidated and Separate Financial Statements' and therefore can be considered as the Trust's parent. Monitor does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS FT Consolidated Accounts are then included within the Whole of Government Accounts. Monitor is accountable to the Secretary of State for Health. The Foundation Trust's ultimate parent is therefore HM Government.

23.1

Related Party Transactions

The Foundation Trust has taken advantage of the exemption provided by IAS 24 'Related Party Disclosures', where the parent's own accounts are presented together with the consolidated accounts and any transactions or balances between group entities have been eliminated on consolidation.

During the year the Foundation Trust did not enter into any material transactions with Board members, governors, key staff members or parties related to them. The Trust did enter have material transactions with entities within the Whole of Government details of which are listed below. We have disclosed any values over £1.5m as we consider this to be significant (prior period comparatives remain)

	Income >£1.5m	
	2013/14	2012/13
	£000	£000
University Hospital Birmingham NHS Foundation Trust	2,082	1,575
London Strategic Health Authority	(57)	6,743
West Midlands Strategic Health Authority	-	7,529
Birmingham East and North PCT	(59)	164,101
Heart of Birmingham Teaching PCT	(31)	9,442
Sandwell PCT	14	1,450
Solihull Care Trust	(40)	13,758
Department Of Health	1,587	1,177
Stoke-on-Trent Primary Care Trust	3	7,094
NHS Birmingham Cross City CCG	123,008	-
NHS Commissioning Board	55,809	-
NHS Solihull CCG	13,913	-
West Midlands LETB(HEE)	8,443	-
NHS England	7,818	-
NHS Sandwell & West Birmingham CCG	1,973	-
	Expenditure >£1.5m	
	2013/14	2012/13
	£000	£000
Birmingham Community Healthcare NHS Trust	3,331	3,101
Heart of England NHS Foundation Trust	711	799
Prescription Pricing Authority	3,219	3,371
Birmingham City Council	2,575	2,399

23.2

Related Party Balances

At the year end the Foundation Trust had material balances with entities within the Whole of Government, details of which are listed below:

	Receivables > £0.5m	
	March 31 2014	March 31 2013
	£000	£000
University Hospital Birmingham NHS Foundation Trust	893	352
Birmingham East and North PCT	-	5,470
Heart of Birmingham	-	1,082
London Strategic Health Authority	-	1,838
HMRC	1,035	1,170
	Payables > £0.5m	
	March 31 2014	March 31 2013
	£000	£000
Heart of England NHS Foundation Trust	110	124
NHS Business Services Authority	569	782
Birmingham City Council	155	1,034
Birmingham East and North PCT	1,667	2,411
HMRC	3,312	3,382

The Foundation Trust is the Corporate Trustee of Birmingham and Solihull Mental Health NHS Foundation Trust Charity (Charity number and provides administration services for the Charity. At March 31 2014 the Trust was owed £142k (£104k at March 31 2013) from the Charity for expenses incurred by the Trust related to the Charity.

PCT's were formally abolished on 31st March 2013. Any outstanding balances relating to PCT's at year ended March 31 2014 have been transferred to Clinical Commissioning Groups.

The Foundation Trust is parent of the wholly owned subsidiary Summerhill Supplies Limited. At March 31 2014 the Trust was owed £22,402k from the company (£22,851K at 31 March 2013). Income from Summerhill Supplies Limited during the year amounted to £4879k (£712k at 31 March 2013) and the expenditure incurred was £5349k (£926k at 31 March 2013).

All related party balances are not secured, are on standard Foundation Trust terms and conditions and will be settled in cash.

24 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's standing financial instructions and policies agreed by the Board of Directors. The Foundation Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Foundation Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Foundation Trust therefore has low exposure to interest rate fluctuations

Credit risk

Because the majority of the Foundation Trust's income comes from contracts with other public sector bodies, the Foundation Trust has low exposure to credit risk. The maximum exposures as at March 31 2014 are in receivables from customers, as disclosed in the Trade and other receivables note. The risk associated with cash and deposits with financial institutions (National Loan Funds) is considered to be low as trading cash is held with the Government Banking Service and deposits are only placed on a short term basis with highly rated UK banks.

Liquidity risk

The Foundation Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Foundation Trust funds its capital expenditure from funds from robust management of its cashflows. The Foundation Trust is not, therefore, exposed to significant liquidity risks.

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014

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Group

Financial assets by category	March 31 2014		March 31 2013	
	Total	Loans and receivables	Total	Loans and receivables
	£000	£000	£000	£000
Assets as per SoFP				
Trade and other receivables excluding non financial assets	6,445	6,445	12,778	12,778
Cash and cash equivalents (at bank and in hand)	32,616	32,616	32,140	32,140
TOTAL AT MARCH 31	39,061	39,061	44,918	44,918

Trust

Financial assets by category	March 31 2014		March 31 2013	
	Total	Loans and receivables	Total	Loans and receivables
	£000	£000	£000	£000
Assets as per SoFP				
Trade and other receivables excluding non financial assets	7,350	7,350	13,224	13,224
Cash and cash equivalents (at bank and in hand)	31,116	31,116	32,019	32,019
TOTAL AT MARCH 31	38,466	38,466	45,243	45,243

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Group

Financial liabilities by category	March 31 2014		March 31 2013	
	Total	Financial liabilities measured at amortised costs	Total	liabilities measured at amortised costs
	£000	£000	£000	£000
Liabilities as per SoFP				
Borrowings excluding Finance lease and PFI liabilities	46,967	46,967	49,150	49,150
Obligations under Private Finance Initiative contracts	61,288	61,288	62,899	62,899
Trade and other payables excluding non financial liability	21,357	21,357	23,292	23,292
TOTAL AT MARCH 31	129,612	129,612	135,341	135,341

Trust

Financial liabilities by category	March 31 2014		March 31 2013	
	Total	Other financial liabilities	Total	Other financial liabilities
	£000	£000	£000	£000
Liabilities as per SoFP				
Borrowings excluding Finance lease and PFI liabilities	46,967	46,967	49,150	49,150
Obligations under Private Finance Initiative contracts	61,288	61,288	62,899	62,899
Trade and other payables excluding non financial liability	20,827	20,827	23,292	23,292
TOTAL AT MARCH 31	129,082	129,082	135,341	135,341

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Losses and Special Payments

NHS foundation trusts are required to report to the Department of Health any losses or special payments, as the Department of Health still retains responsibility for reporting these to Parliament.

There were 106 cases of losses and special payments totalling £437k during the year to March 31 2014 (130 cases totalling £139k during the year to March 31 2013). These amounts are reported on an accruals basis but excluding provisions for future losses.

Losses and Special Payments (approved cases only)*	2013/14		2012/13	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000's	Number	£000's
LOSSES:				
Losses of cash due to:	Numbers	Value	Numbers	Value
theft, fraud etc	8	0	5	0
Fruitless payments and constructive losses	1	113		
Bad debts and claims abandoned in relation to:				
other	27	5	36	55
Damage to buildings, property etc. (including stores losses) due to:				
theft, fraud etc	1	131		
other	4	14	5	22
TOTAL LOSSES *	41	263	46	77
SPECIAL PAYMENTS:				
Compensation under legal obligation	48	167	57	51
Ex Gratia payments; in respect of; loss of personal effects	17	7	27	11
TOTAL SPECIAL PAYMENTS *	65	174	84	62
TOTAL LOSSES AND SPECIAL PAYMENTS *	106	437	130	139

28 Pensions

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

Birmingham and Solihull Mental Health NHS Foundation Trust
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Notes to the Financial Statements

28 Pensions (continued)
c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Additional Information can be found using the following:

https://whitehall-admin.production.alpha.gov.co.uk/government/uploads/system/uploads/attachment_data/file/302833/2013-14_NHS_pensions_employer_disclosure.pdf

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2014
Glossary to the Financial Statements

Annual accounts

Documents prepared by the FT to show its financial position. Detailed requirements for the annual accounts are set out in the *NHS Foundation Trust Annual Reporting Manual*, published by Monitor. The *Annual Reporting Manual* was previously called the *Foundation Trust Financial Reporting Manual*.

Annual report

A document produced by the FT that summarises the FT's performance during the year, including the annual accounts.

Asset

Something the FT owns – for example a building, some cash, or an amount of money owed to it. Audit Code for Foundation Trusts
A document issued by Monitor, which sets out how FT audits must be conducted.

Audit opinion

The auditor's opinion of whether the FT's accounts show a true and fair view of its financial affairs. If the auditors are satisfied with the accounts, they will issue an unqualified audit opinion.

Available for sale

Assets are classed as available for sale if they are held neither for trading nor to maturity. An example of this would be an investment without a maturity date such as an ordinary share.

Statement of Financial Position

A year-end statement prepared by all public and private sector organisations, which shows the net assets controlled by the organisation and how these have been funded. The balance sheet is known as the Statement of Financial Position under IFRS.

Breakeven

An FT has achieved breakeven if its income is greater than or equal to its expenditure.

Cash and cash equivalents

Cash includes cash in hand and cash at the bank. Cash equivalents are any other deposits that can be converted to cash straight away.

Corporation tax

A tax payable on a company's profits. FTs may have to pay corporation tax in the future. The legislation introducing corporation tax to FTs has

been deferred and 2011/12 was the first year that government introduced corporation tax to FTs.

Current asset or current liability

An asset or liability the FT expects to hold for less than one year.

Depreciation

An accounting charge to represent the use, or wearing out, of assets. As a result the cost of an asset is spread over its useful life.

Earnings before interest, tax, depreciation and amortisation (EBITDA)

A measure of an FT's financial performance excluding interest, tax, depreciation and amortisation. EBITDA is used to calculate some of Monitor's risk ratings.

External auditor

The independent professional auditor who reviews the accounts and issues an opinion on whether the accounts present a true and fair view.

External financing limit

A measure of the movement in cash an FT is allowed in the year, which is set by the government.

Finance lease

An arrangement whereby the party leasing the asset has most or all of the use of an asset, and the lease payments are akin to repayments on a loan.

Financial statements

Another term for the annual accounts.

Foundation Trust Financial Reporting Manual

The key document, published annually by Monitor, setting out the framework for the FT's accounts. Now called the *Annual Reporting Manual*.

Going concern

The accounts are prepared on a going concern basis, in other words with the expectation that the FT will continue to operate for at least the next 12 months.

Impairment

A decrease in the value of an asset.
Intangible asset

Birmingham and Solihull Mental Health NHS Foundation Trust
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Glossary to the Financial Statements

Intangible asset

An asset that is without substance, for example computer software.

International Financial Reporting Standards (IFRS)

The new accounting standards that the NHS has adopted from April 2009.

International Standards on Auditing (United Kingdom and Ireland) (ISAs (UK&I))

The professional standards external auditors must comply with when carrying out audits.

Inventories

Stock, such as clinical supplies.

Liability

Something the FT owes, for example an overdraft, a loan, or a bill it has not yet paid.

Liquidity ratio

Liquidity is a measure of how easily an asset can be converted into cash. Bank deposits are very liquid, debtors less so. The liquidity ratio is a measure of an entity's ability to meet its obligations, in other words how well it can pay its bills from what it owns.

Non-current asset or liability

An asset or liability the FT expects to hold for more than one year.

Non-executive director

Non-executive directors are members of the FT's board of directors but do not have any involvement in day-to-day management of the FT. They provide the board with independent challenge and scrutiny.

Operating lease

An arrangement whereby the party leasing the asset is paying for the provision of a service (the use of the asset) rather than exclusive use of the asset.

Payables

Amounts the FT owes.

Primary care trust

The body responsible for commissioning all types of healthcare services across a specific locality.

Primary statements

The four main statements that make up the

accounts: the Statement of Comprehensive Income; Statement of Financial Position; Statement of Changes in Taxpayers' Equity; and Statement of Cash Flows.

Private Finance Initiative (PFI)

A way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by the FT.

Provision

A liability of uncertain timing or amount.

Prudential Borrowing Code

Monitor's mechanism to limit the total amount an FT is allowed to borrow. The Code sets out how to determine an FT's prudential borrowing limit.

Prudential borrowing limit

The amount of money an FT is allowed to borrow, as agreed with Monitor

Public dividend capital

Taxpayers' equity, or the taxpayers' stake in the FT, arising from the government's original investments in NHS trusts when they were first created.

Receivables

Amounts owed to the FT.

Remuneration report

The part of the annual report that discloses senior officers' salary and pension information.

Reserves

Reserves represent the increase in overall value of the organisation since it was first created.

Statement of Cash Flows

The name for the cash flow statement under IFRS. It shows cash flows in and out of the FT during the period.

Statement of Changes in Taxpayers' Equity

One of the primary statements which shows the changes in reserves and public dividend capital in the period.

Statement of Comprehensive Income

The new name for the income and expenditure

Birmingham and Solihull Mental Health NHS Foundation Trust
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Glossary to the Financial Statements

Statement of Comprehensive Income

The new name for the income and expenditure account, and the public sector equivalent of the profit and loss account. It shows what income has been earned in the year, what expenditure has been incurred and hence the surplus or deficit for the year.

Statement of Financial Position

Year-end statement prepared by all public and private sector organisations, which shows the net assets controlled by the organisation and how these have been funded. It is also known as the Balance Sheet.

Statement on Internal Control

A statement about the controls the FT has in place to manage risk.

Those charged with governance

Auditors' terminology for those people who are responsible for the governance of the FT, usually the audit committee.

True and fair

It is the aim of the accounts to show a true and fair view of the FT's financial position, that is they should faithfully represent what has happened in practice.

UK GAAP (Generally Accepted Accounting Practice)

The standard basis of accounting in the UK before international standards were adopted.

Unrealised gains and losses

Gains and losses may be realised or unrealised. Unrealised gains and losses are gains or losses that the FT has recognised in its accounts but which are potential as they have not been realised. An example of a gain that is recognised but unrealised is where the value of assets has increased. This gain is realised when the assets are sold or otherwise used

Birmingham and Solihull Mental Health NHS Foundation Trust
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Key to the Financial Statements

Noted	Meaning
"k"	'000
" £ m"	'000
" '000 "	'000



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