Birmingham and Solihull
Mental Health NHS Foundation Trust

Annual report and accounts 2012/13

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

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May 2013

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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, 2012 to March 31, 2013.The past year has presented a mix of challenges and changes to the NHS and we have continued to work hard to improve our Trust, the services it provides and the experience of our service users and their carers.

There have been many examples this year of where our services and dedicated staff were recognised for their work both regionally and nationally.

Our award-winning Rapid Assessment, Intervention and Discharge (RAID) services in A&E units of acute hospitals continued to draw national interest from visitors and media. Health Minister Norman Lamb visited our RAID service at Heartlands Hospital in November 2012, during which he heard how acute care and mental health clinicians work closely to provide an improved patient experience and outcomes.

Several weeks later, in December, Norman Lamb announced BSMHFT was one of six organisations selected to pioneer a new project to improve access to psychological therapies. Our Trust will work with the Spectrum Centre for Mental Health Research, based at Lancaster University, on delivering improvements for people diagnosed with bipolar disorder. This exciting pilot project will continue until October 2013.

During 2012 our perinatal mental health service celebrated its 20th anniversary, which was celebrated with a pirate-themed picnic, a one-day conference and a gala dinner, all of which were attended by staff and service users currently or previously linked with the mother and baby unit.

Our Finance team won the prestigious Havelock Training Award at the Healthcare Financial Management Association (HFMA) Awards in London in December 2013. Their winning initiative was designed to enable Ward Managers to take control of their budgets and to authorise expenditure, such as on bank staff or local service improvements, as part of wider work to empower and devolve responsibility to our front line staff.

December also saw our third medium secure unit, the Tamarind Centre in Bordesley Green, welcome its first patients. The 89-bed facility provides assessment, treatment and rehabilitation for men who need care in a medium secure environment and aims to serve the population in central and north Birmingham, as well as offering specialist services for complex, challenging and long term care.

Finally, Professor Swaran Singh was appointed as a Commissioner to the Equality and Human Rights Commission – as one of six new Board members – in January 2013. Prof Singh, who is also Head of Division, for Mental Health and Wellbeing at University of Warwick and Hub Lead for the Mental Health Research Network at the Heart of England Hub, took up his post on January 14.

However, last year also posed for us many challenges. In September the national CQC Community Patient Survey for mental health Trusts was published. Our results showed that we still had much to do in areas such as ensuring service users receive and feel involved in their care plans, and that service users receive useful and timely additional information on the medication they are prescribed. Whilst it is important to listen and act upon the results of such national surveys, we are continuing to develop our own patient feedback mechanisms which enable more detailed and specific feedback from patients in real time, which can then be acted upon by individual teams and the wider Trust.

We have also become the first NHS mental health Trust to introduce nursing metrics onto our wards. These regular checks and questions are designed to encourage staff to take pride in their duties while instilling “friendly competition” between nursing teams. Matrons also conduct regular checks by walking the wards and service users are also able to give direct feedback on their care and experience.

Carers also often play a vital part in the treatment and support of service users, which is why our Trust has put them at the heart of its new carers’ strategy which was launched at a carers’ conference held in April 2012. A variety of charity and third-sector organisations attended the event, which also featured input from the Meriden Family Programme, which works with service users and their families – who are often those who take on the carer’s role.

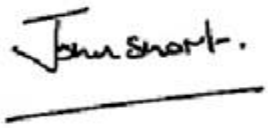
Staff engagement, in a time of such turbulence has also brought its challenges. The NHS Staff Survey is one measure we use to monitor staff experience and engagement in our Trust. This year our results from the survey conducted in October 2012 didn't change significantly from previous years, however our position compared to other mental health Trusts has worsened overall. Since the 2011 survey results a number of areas of work have been undertaken in response to what staff said, but we have to accept that we haven't achieved the change in staff experience we wanted. However in January 2013 we launched a new approach to staff engagement in the form of the nationally regarded Listening into Action. Led directly by the Chief Executive, the essence of the approach is that it puts the views and ideas of front-line staff *at the heart* of how we improve services for patients and the experience of our staff. We are at the start of a long journey with Listening into Action, but early indications suggest it is being well received by staff.

Partnership working has been an important part of our work this year, and will continue to be going forward. We know that through meaningful alliances and taking a holistic view of our service users, patient experience can be improved. For example, in April, we signed the International Declaration on Youth Mental Health at a major conference staged by The Prince's Trust and ourselves. The conference focused on the future of youth mental health services and showcased how both organisations are working together in partnership, which our innovative Youthspace service is part of. We are also keen to further develop our links and relationships with our commissioners as we work to further develop a mental health service that meets the needs of the community we serve.

Towards the end of the year our Trust also saw significant changes to its Board when Chief Executive Sue Turner retired in November 2012 after leading the Trust for more than 16 years. Paul Jennings was appointed as Interim Chief Executive, until the end of March 2013. John Short has since become permanent Chief Executive from April 1st 2013.

In January 2013, 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. The next step in the process was then to consult with a wide range of internal and external stakeholders, such as staff, service users and carers, on the Board's proposals. 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.

In summary, there is no doubt that there is still much to be done to improve the experience of our service users, carers and the staff that work with them. However, we have robust plans and structures in place that will enable us to get there going forward.



John Short
Chief Executive

Sue Davis, CBE
Chair

About our Trust

Our Trust was established as Birmingham and Solihull Mental Health NHS Foundation Trust on July 1, 2008. This annual report covers 12 month period from April 1, 2012 to March 31, 2013 for the financial year 2012/13.

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 approximately 60 sites and serve a culturally and socially diverse population of 1.2 million spread over 172 square miles, have an annual budget of £221 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 will help us to actively engage our staff in shaping how BSMHFT 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 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, however they are 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 will 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 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 three divisions; Youth, Addictions, the Homeless and Birmingham Healthy Minds (YAHBHM); Specialist and Complex Care Services (SCCS), and Adults of Working Age (AWA).

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.

An award-winning Trust

Our Trust's reputation for innovative projects continued to grow in 2012/13, with staff winning awards and recognition for their achievements.

For example, our finance team won the Havelock Training Award at the Healthcare Financial Management Association (HFMA) Awards in London on December 6.

They designed and developed training that would enable managers to control of their budgets and authorise expenditure, such as on bank staff or local service improvements, supporting the work of the Trust in devolving such decision-making to frontline teams in 2011.

This year the Forensic Children and Adolescent Mental Health Service (FCAMHS) has become the first secure service in Britain to receive autism accreditation by the National Autistic Society. The specialist service, based at our Ardenleigh site in Erdington, Birmingham received the accolade in recognition of the special provisions it has made for service users on the autism spectrum.

Youthspace and the Forensic Children and Adolescent Mental Health Service, based at Ardenleigh – were also shortlisted for recognition at the HSJ Awards and Nursing Times Awards this year.

In the spotlight

The past financial year has been an eventful one full of achievements and changes, much of which has made headlines in local, national and specialist media.

As a summary, Birmingham and Solihull Mental Health NHS Foundation Trust featured in 58 news articles. Of these 29 were in local newspapers, four were in national newspapers, 11 were in specialist titles and 12 were stories broadcast on radio and television channels.

In April the Birmingham Mail ran a story on one of our staff nurses, Margaret Mallon, who began her NHS career as a domestic assistant at Reaside but persevered to become a qualified nurse, after completing her nursing degree at Birmingham City University.

Nursing Management published a leading article on the Trust's implementation of nursing metrics for mental health in June. Both articles were very positive in their tone.

However in July a court case, involving a former member of Ardenleigh's staff, attracted negative national and local coverage. She was jailed for 18 months after she was found guilty at Wolverhampton Crown Court for having a sexual relationship with a 17-year-old former patient.

In June Radio 4's Today programme did a feature on NHS innovation, focusing on RAID and interviewed the Trust lead for RAID Prof George Tadros. The service was also featured on another Radio 4 programme, You and Yours in February.

In November 2012, our former Chief Executive Sue Turner's retirement made local headlines in the Birmingham Mail and a public consultation into the future development of mental health services in Solihull also received balanced coverage in the Solihull News and Solihull Observer.

In December the Alzheimer's Society magazine, Living With Dementia, carried a positive two page spread on the work done by leading specialists in older adult care, which featured an interview with Prof Tadros.

Patient care

New services for patients
Changes to our services

Integrated Care Pathway

The Integrated Care Pathway (ICP) will allow us to deliver quality care and improve outcomes for our service users. It will include faster access to our services and easier routes back into the community, supported by our enhanced primary care service. Improving collaboration and integrating teams means we will create better interfaces and relationships across the Trust and with our external partners.

Our commissioners – and our commitment to service users – require us to improve the efficiency and effectiveness of our services. By changing the way people work, there will be clearer leadership and accountability, clearer roles, job descriptions and job plans, this will allow us to achieve the long term benefits of developing an integrated care pathway.

The Zinnia Centre and Orsborn House, in the Central zone, will pilot ICP from mid-April 2013 for three months. An evaluation of that pilot phase will inform when other areas adopt ICP in 2013/14.

Initially community mental health teams and home treatment teams in our adults of working age division will adopt ICP, but it is hoped this will be rolled out across all the Trust's services in due course. This will provide GPs with a single point of access, streamlining the referral process, and provide an enhanced primary care support service with faster access into our services.

For our patients this means they may be seen by a different clinician or GP but these changes will allow us to provide more intensive support to those who need it and more independence for those who can be cared for by their GP.

Nationally there is a drive to deliver care in a more integrated way, which is why we have developed this new pathway which will see us work more collaboratively with our GP colleagues and other local services. ICP presents us with an opportunity to deliver our services more efficiently and improve outcomes for service users by delivering care in more innovative ways that not only drives up quality but also reduces risk. Ultimately this integrated pathway aims to ensure patients are seen by the right person, at the right time, to get the right help.

Improving service user and carer experience

Our service user and carer experience and networking meetings with service user and carer members, Governors and representative ensure that we hear about the perception and experience of our services. We also take the opportunity to explore new ways of working and gain feedback on proposed new initiatives.

We have used feedback regarding our Trust website to expand our sections dedicated to service users and carers. We have plans to launch a new section for our partner organisations to ensure their services are also highlighted and supported. Web links to other organisations such as Birmingham City Council's My Care in Birmingham, Choice and Medication, and MIND have also proved very popular with increasing hit rates.

Our Opportunities Yearbook, which lists nearly 300 opportunities for groups, information and support across Birmingham and Solihull, is extremely popular both in print and online.

A new care card offers key information in a wallet sized card for service users and carers. It has been re-launched and is so successful we have already printed 50,000 copies.

Results from our service user surveys have highlighted specific areas that need focussed attention. With this in mind, and in collaboration with service users and clinical staff, customer relations – PALS team have designed Service User Information Pack to be used in community settings to make service users new to BSMHFT more aware of:

- ✓ The care they are going to be receiving including those who are to be involved (care co-ordinators, CPN's, other lead professionals) and how they can be accessed.
- ✓ Their care plan, its contents and when it needs to be updated.
- ✓ Accurate information relating to medication, purpose and side effects.
- ✓ Other sources of support and help (customer relations, third sector organisations, mental health info etc.) and how they can be accessed.

The pack has been designed in such a way as to empower people by providing them with important information and inviting them to think about their care, and will be fully launched next year.

Our Customer relations - PALS team have also offered training briefings about the changes to welfare benefits to enable staff to have a better understand the difficulties service users face when their benefits are changed or re-assessed. In addition service users and carers have been able to make use of our partnership with Birmingham City Council's welfare rights team. This partnership, now in its second year, was funded by the Stay Warm, Stay Well campaign, and has helped our service users and carers become aware of their entitlements to benefits, and supported applications. In 2012, 520 people have accessed the services, and a total of £1.2 million will have been claimed.

We also have continued to foster relationships with new providers such as Creative Support and Stonham home group to ensure a seamless service for our users and carers. We have also worked with Pohwer advocacy to improve access.

Carers strategy launch and conference

On the April 27, 2012, the Trust hosted its first major event for carers, families and friends at St Andrew's stadium, home of Birmingham City Football Club. The main purpose of the day was to launch the new Trust-wide carer's strategy, which sets out our aims and objectives for future – not only to raise awareness of the vital role that carers, families and friends play, but also improve the involvement of and support to the families and friends of our service users.

It was also important for the Trust to show how much we value and recognise the contribution that our families and friend make in the wellbeing of our service users. A wide range of stakeholders attended, showcasing their services in the market place that was set up, with a wide range of information about support, financial and carer involvement groups.

The event was opened by our Trust Chair Sue Davis, CBE, and speakers included Dee Roach, Executive Director of Quality, Improvement and Patient Experience and Dr Grainne Fadden from the Meriden Family Work Programme.

The Trust's carer's strategy has five guiding principles:

- Raising awareness of carers and their needs
- Improving the involvement of carers
- Supporting carers better
- Sharing and providing information
- Working in partnership with families

Attendance exceeded all expectations, with more than 130 carers, staff and stakeholders coming along. There was a real opportunity to share openly and honestly views on how the Trust is doing now, and offering a chance to share and have more of a say in how things should be done to improve services and support people more, when it is needed. We were overwhelmed with the response and the positive feedback whilst recognising there is still much to do. The next steps for the Trust will be to turn the strategy into real actions and outcomes and to be an organisation that is 'carer aware'.

Service user experience and involvement

The Trust is committed to engaging and involving more service users and carers more in the day-to-day running of services. Not only does this really help us ensure that our services are shaped and improved by the people using them, but it also offers those who wish to get more involved an opportunity to contribute in such a way that can really support recovery.

Mystery shopping, inspections and audits

Mystery shopping in our Trust involves a dedicated and trained team of users and carers who make unannounced visits to centres, wards and units to assess how well we are meeting certain core standards. The results of our mystery shopper programme, which is now in its sixth year, allow us to see how others view us, so we can then improve our services accurately. Many other local NHS Trusts have visited us to replicate this type of programme in their own services. Its success rests upon the use of trained users and carers who offer a truly honest perspective of our services.

We have further developed the team of mystery shoppers to visit all Trust sites, assisting the estates and facilities team with their annual inspections. We are proud that our Trust has been a pilot site for the new national programme of Patient Led Assessment of Care Environments (PLACE) inspections.

Our mystery shoppers are also represented on quality support visits, which seek to offer a collaborative approach to site improvements.

This year some improvements as a result of visits include: better telephone access, improved signage, staff badges worn consistently by staff, welcome information at sites, self-help guides on display, themed noticeboards, and new carpets.

In 2013/14 our mystery shoppers activities will repeat telephone surveys, carer themed checks and a new mystery patient programme, in addition to monthly unannounced visits. We are also taking part in a national mystery shopper conference, the first of its kind in the UK, to share good practice and learn more.

Actively participating in the day to day work of the Trust

Altogether 120 service users and carers have been trained by our HR team in recruitment and selection, and are now regular members of interview panels for staff at every level in the organisation - from front-line to the most senior management and clinical posts. They are now also contributing to every induction programme for all new staff to the Trust.

The Aspire Recovery Coaches project gives those who have overcome their own difficulties with addictions to drugs or alcohol an opportunity to bridge the gap between recovery and the world of work. The recovery coaches get some training and support and then act as ‘meeters and greeters’ in our Trust sites and help new service users not only feel empowered to set their own recovery goals, but also inspire hope and optimism for the future. The training that coaches receive, and their work experience they gain within services can also help future job prospects.

At HM prison Birmingham, prisoners who are also using our healthcare services have become See Me healthcare representatives. They are support by the See Me service user involvement team, and are not only able to gather feedback from prisoners who have mental health and addiction issues, but also signpost and support people to the right service when they are needed. This project is now making a very important contribution in improving healthcare access to vulnerable people. Following release from prison, some of the healthcare representatives are continuing to contribute to services, as well as supporting their own recovery, and have assisted with other service user involvement projects and staff recruitment.

Real time patient feedback

We always learn a great deal from our annual patients’ survey, and the results from the 2012 survey of community service users did show that we have to make some significant improvements in some key areas.

Along with other methods of capturing feedback, the real-time feedback technology gives us insight into our performance from a service user and carer perspective on a much more regular basis. After an extensive real time patient feedback pilot, the Trust made a commitment to invest in this initiative during 2012/13 and beyond.

Throughout this year, real-time patient feedback kiosks have been installed in Trust sites with the highest footfall, making sure that this equipment has the chance to be used as often as possible. A kiosk has also been installed in the Birmingham prison healthcare block, meaning that feedback can be gathered from prisoners about the healthcare they receive. The Trust has also invested in a number of handheld tablets, which are used by our service user involvement workers to gather feedback from across the whole of our organisation on an ad-hoc basis. Results are available on our Patient Information Point screens so that anyone can see how we are doing.

However, this technology is not just about gathering the feedback. Staff and teams find out how people experience services in real-time. Staff will then understand what actions they need to put in place to improve services, and then communicate those improvements to the users and carers.

Customer relations

PALS, complaints and comments, how we handle them

Our customer relations - PALS team provide a fully functioning service from Monday to Friday 08.00-20.00 hours. The team also run weekly surgeries/site visits across all of the Trust's acute in-patient settings.

Our team continue to offer a range of bespoke site based sessions to service users and front line staff on a wide range of initiatives – from the challenges our clients may face whilst navigating their way through the benefit system though to customer services training.

The team also work closely with the local community in providing relevant and factual information to members of the local public.

Our Trust also uses experience gained from dealing with concerns and formal complaints to improve mental health services within Birmingham and Solihull. The Trust welcomes patient feedback and we aim to respond effectively to ensure we learn lessons when things go wrong as they are an important opportunity put things right and improve patient experience.

Following the relocation of the complaints team in February 2012 to our Ardenleigh site there has been much more collaborative working between PALS and complaints to promote a more 'customer relations' approach. We put a lot of focus into ensuring patient and relative concerns can be resolved at the time and in the place they arise. We encourage complaints or concerns to be addressed by relevant front line staff, for example, a Ward Manager or head of department. Ideally problems are resolved on the spot or within a day, but if not, patients/carers can seek support from our Customer Relations Department and a member of the PALS team.

If patients/carers do need to make a formal complaint, they can be referred to the complaints team. Our complaints team provides information and assistance to service users, their relatives and visitors who wish to complain about the service our Trust provides. It also gives help and advice to staff who are involved in the investigation of a complaint.

All complaints are formally acknowledged within 3 working days. Our aim is to provide a full response as speedily as possible, however if we are unable to provide a response within the agreed timescale, the person is contacted to discuss the delay and to agree a new timescale in which a full response is to be provided.

During the period April 2012 – March 2013 a total of 267 complaints were received of which 195 (73%) were responded within the agreed timescale. During 2012 – 2013 a total of 13 cases were referred to the Parliamentary and Health Service Ombudsman for consideration. Of these referred cases 7 have been closed with no further action and we are awaiting a decision on the remaining cases.

Complaints are reported to the local clinical governance meetings to ensure that improvements resulting from complaints are implemented and will monitor any actions identified. They are also reported on at the Trust-wide clinical governance meetings.

For more information about the Customer Relations Team or the Trust's complaints procedure please contact the PALs team on 0800 953 0045 or e-mail PALs@bsmhft.nhs.uk or the complaints team e-mail: complaints@bsmhft.nhs.uk

Quality Support Visits

The Quality Support team initiative forms part of the BSMHFT Framework for Quality. The aim is to create an internal process for reviewing the services we provide, which is supportive to teams and enables continuous improvement for quality.

The process consists of scheduled visits to service areas, ad hoc visits, post-visit support for any improvement activities and structured sharing of best practice. The Trust has decided against having a single team for such visits. Quality is everyone's business and all staff at Band 7 and above are asked to get involved.

The Quality Support Team arranges both scheduled and unannounced visits. Once visit reports are written up, and following executive review of the findings, the outcome is then shared with the management team for the respective area.

Progress on commissioners' targets

In addition to the national targets, we are also required to report to commissioners our progress on locally agreed measures to support the implementation of agreed service plans. Specifically as part of the mental health contract requirements, commissioners receive a monthly performance report which provides an overview of progress on national targets for mental health Trusts as well progress against locally agreed indicators.

Key indicators achieved include:

- Ensuring that at least 95 per cent of admissions of working age adults are managed via crisis resolution home treatment teams prior to admission
- Ensuring that all patients are appropriately followed up within seven days of being discharged from hospital. Evidence has shown that this is the time that some patients feel most vulnerable and are more at risk of committing suicide. We have continued to meet the national target set by Monitor of 95 per cent.
- Minimising delayed transfers of care: We have been working to reduce the numbers of patients ready for discharge who are delayed by the lack of suitable accommodation or support. Our Trust works with its partners including social services and the independent sector to ensure and support appropriate, safe and timely discharge. This ensures that available inpatient capacity is being used effectively reducing the length of stay for patients who no longer need to be in hospital
- Ensuring we record the accommodation and employment status of our service users and demonstrate that we act on any concerns and provide appropriate support.
- We record ethnicity data for our service users
- Ensure we monitor and record our DNAs. (Did Not Attend – for appointments)
- We capture and record emergency re-admission rates
- We monitor numbers of service users who are occupy our beds for unusually lengthy periods of time (more than180 days – inpatients) and (more than three years Non Acute InPatients – NAIPs)

Infection prevention and control

The sustained national high profile of infection prevention and control has enabled infection prevention standards to be embedded into mental health practice. To date 100 infections were reported to the infection prevention and control team (IPCT) in the first three quarters of 2012/13. This is an increase on previous years totals however the Trust, along with neighbouring NHS organisations and the local area, has experienced an increase in the number of cases of diarrhoea and vomiting and norovirus since September 2012.

Hand hygiene awareness continues to be a high priority for the IPCT as hand decontamination remains to be the most effective way of reducing all avoidable infections including norovirus and remains as the key message for containing the spread of diarrhoea and vomiting.

The IPCT have continued to work closely with estates and facilities and the shift in emphasis from containment of infection to a proactive approach to prevention has been promoted through the provision of infection prevention expertise to the design of new builds and refurbishments to ensure hygiene standards can be met through the provision of accessible hand washing facilities and furnishings that can be easily cleaned.

The RiO information system and electronic laboratory reports from City Hospital, have enhanced the infection prevention surveillance system to ensure the IPCT are better informed of infections in a timely fashion to ensure prompt and appropriate action can be taken.

The IPCT continue to develop d the infection control link worker and hand hygiene core training programmes to promote infection prevention awareness across wards and community teams.

By the end of March 2013, in line with the infection control annual audit programme, the IPCT anticipate completion of 25 decontamination, 6 environmental and 40 kitchen audits along with 12 mattress inspections.

From January 2012, the Matrons undertake quarterly hand hygiene audits within their areas and findings are reported back to the Infection Prevention Partnership Committee. Initial findings indicate approximately 85 per cent compliance. The IPCT continue to train core hand hygiene trainers to promote best practice in hand hygiene within ward areas and community teams.

Strategy for professional nursing 2014

We have continued with the implementation of our *Strategy for Professional Nursing 2014 – Proud, Professional, Progressive* to realise our vision of establishing a quality nursing service across all Trust areas.

The strategy was launched on International Nurses Day in 2011 and was a culmination of the work from numerous engagement workshops, focus groups, one to one interviews and feedback provided by nurses, other professionals, service users, and carers and was put together with views of colleagues in other parts of the health economy.

Our strategy was developed under six strategic nursing themes:

- Service user, carer and family experience,
- nursing governance,
- clinical effectiveness,
- research and innovation,
- leadership and professional standards, and
- workforce development and education.

It is underpinned by the following values:

- **Respect:** For the dignity of service users, carers and families premised on confidentiality and acceptance of each person's inherent worth.
- **Sensitivity:** To each person's beliefs and values which requires compassion, responsiveness and self-awareness.
- **Integrity:** The need for reflective practice and continuing professional support in order to maintain professional standards.
- **Recovery:** Respect for the individual and for the person's expertise in their own life journey, requiring active listening, caring and helping to identify the next steps forward.

The Chief Nursing Officer recently launched a national strategy for nursing *Compassion in Practice: Nursing, Midwifery and Care Staff, Our Vision and Strategy*. We are currently revisiting our local plans in light of the advent of the national strategy to ensure that ours supports national developments.

Learning lessons

Ensuring improvements are implemented as a result of incidents, staff experience and feedback from service users is a significant element of our clinical governance processes (how we ensure quality improvement). Our processes for reviewing serious incidents is a key focus to our approach, partly because such incidents - whether they are identified to have been impacted by our care or not - have a significant impact on our service users and carers.

A number of initiatives have been introduced over the year to improve the quality of the reviews of serious incidents demonstrating lessons learnt from incidents is critically dependent on having undertaken appropriate reviews and producing clear recommendations. These initiatives have included:

- The introduction of a serious incident review group to assess and confirm completed reviews. This group is led by a Clinical Director.
- Implementation of the use of a Root Cause Analysis module on our electronic risk management system.
- The development of a distinct investigations team headed by a senior clinical manager to support effective investigations.

The Trust has introduced a 'Learning Lessons bulletin' which is issued bi-monthly to all staff through the email system and aims to highlight incidents where there is scope for wider learning across teams.

A range of issues were highlighted which led to actions to reinforce appropriate practice, in particular the Trust has identified a priority for improving compliance with CPA (Care Programme Approach) arrangements this year and this reflects a range of issues which routinely come up from review of serious incidents. In particular:

- Arrangements for the transfer of patients between teams,
- involving family and carers in service users' care.

Improvements in how we manage risk

Over the year the Trust has successfully introduced its electronic incident reporting system which enables all staff to report incidents electronically through the Trust intranet. The introduction of this system unexpectedly led to a decrease in the number of incidents reported. In some part this appears to be due to the ability for the system to combine the same incident which may be reported by different members of staff – and hence reduce duplication.

During the year the arrangements for management of health and safety and also co-ordination of our serious incident management process have been reviewed. This has led to the introduction of a dedicated team to support serious incident investigations.

Further work will be undertaken over the coming year to develop the use of the risk management system for risk registers.

Looking to the future

This year our Trust has improved and evolved to provide care, facilities and services fit for the 21st century. Our Trust will continue to develop and grow its business, which will be vital as the new NHS takes shape and commissioning clusters start to pick and choose the services they want for their communities.
This growth will be based on our strategic objectives and the needs of the communities we serve across Birmingham and Solihull. Wherever possible, our developments will be made in partnership and after engagement with our service users, carers and members.

The Tamarind Centre

Our new 89-bed male medium secure facility – the Tamarind Centre in Bordesley Green - opened its doors to our first service users in December 2012 and is expected to be fully operational by summer 2013. The new centre provides assessment, treatment and rehabilitation for men who have been assessed as needing care in a medium secure environment and aims to serve the population in central and north Birmingham, as well as offering specialist services for complex, challenging and long term care. This centre was named after Tamarind, which is an African herb which promotes healing and recovery.

Acacia, a rehabilitation ward and Hibiscus, an acute ward, were the first two wards to open at the Tamarind Centre in December. Service users were transferred on a phased basis, so they could be introduced to the new surroundings, with staff on hand helping them to settle in. Cedar ward, which opened in January 2013, provides care for service users who require a longer stay in medium security. The remaining wards will open in phases during the spring and summer, with some service users moving back to Birmingham from units elsewhere in the country, enabling carers and families to be closer to loved ones.

However, opening a new centre is not just about bricks and mortar. Our secure services have been developing a model of care, which sets out the journey our service users will take towards recovery. This pathway was developed in line with our Trust's expertise and experience of secure care and uses a simple scale in which service users will move along.

High on the agenda for secure services has been the recruitment and development of staff to ensure we provide a high quality service. All staff based at the Tamarind Centre will complete an induction programme which will help them develop skills and build relationships between staff and teams who will be working closely together. One of the main aims of the training is to encourage staff to be enthusiastic, confident and inspired to offer the best service possible. The bespoke training programme allows them to have a shared understanding of the values underpinning an excellent service which puts service users firmly at the centre, and of the local and national context within which they are working. In total more than 300 jobs have been created as a result of this new facility ranging from Healthcare Assistants through to Consultant Psychiatrists.

This new hospital builds upon our provision in our forensic services. Reaside Clinic, Hillis Lodge, Ardenleigh women's service and forensic CAMHS.

Innovations in mental health

Our Trust prides itself on blazing the trail forward with new innovations and interventions – and 2012/13 was no exception. Many of our achievements have been pioneered in partnership with other NHS providers, third sector organisation and other stakeholders.

Research and innovation

2012/13 has been a time of transition for the NHS. The Health and Social Care Act 2012 has established clinically-led commissioning of high quality services from providers that compete and deliver research-led innovations and choice. Over the past five years our research achievements have been outstanding, and place the BSMHFT 'brand' in a favourable competitive position. Going forward we have been successful in securing grants totalling nearly £3m for four studies that will begin in 2013/14:

- PARTNERS2: Development and pilot trial of primary care-based collaborative care for people with serious mental illness
- A pilot study to assess the feasibility and impact of motivational intervention on problem drug and alcohol use in adult mental health inpatient units
- A pilot study of the Social Network Intervention for Heroin Users in Opiate Substitute Treatment
- Adaption and feasibility study of a family and social network intervention for young people who misuse alcohol and drugs.

Going forward, we are also looking at a further eight potential studies, if grant applications are successful.

Achievements and impact of research and innovation

Our Research and Innovation Team continue to develop and nurture partnerships with a number of respected universities, including University of Birmingham and University of Warwick, and continue to host the National Institute for Health Research's Mental Health Research Network. These relationships enable the team to conduct high quality research both locally and nationally. Innovations in clinical services during 2012/13 included:

- Development of Youthspace – a youth access care pathway and public health platform (www.youthspace.me) – and the agreement with CAMHS at Birmingham Children's Hospital to pioneer an integrated pathway for 12 to 25-year-olds. This also involved working with the Prince's Trust.
- Reduction in the delay between diagnosis and treatment for first episode psychosis among young people in Birmingham.
- Improved care pathways for BME service users with psychosis.
- Evaluated the Trust's addictions services which resulted in subsequent improvements.
- Delivering an innovative advanced (MSc level) research course for eight of our service users.
- A national evaluation (EDEN) of early intervention in psychosis teams led to redesign of their aims and structure to improve the social outcomes and cost effectiveness.

- An innovative collaboration between voluntary sector, faith groups, user organisations, with a view to delivering culturally appropriate care to BME service users.

Our research and innovation work continues to impact on mental health services across the United Kingdom:

- The ENRICH study, led by Professor Swaran Singh, has impacted on national policy, with the Government accepting that ethnic differences in mental health are due to complex societal factors, rather than institutional discrimination in psychiatric care.
- Professor Max Birchwood was invited to sit on two National Institute for Health and Clinical Excellence (NICE) guideline groups for schizophrenia, which includes evidence from research and innovations led by BSMHFT.
- Dr Peter Bentham's research into drug interventions in Alzheimer's disease will impact upon NHS prescribing and disease-management guidance.
- Our neuropsychiatry research programme has published more than 50 peer-review publications on Huntington's disease, Tourette's syndrome.

Rapid Assessment, Interface and Discharge (RAID) Service

There has been widespread interest in possibilities RAID presents for making significant savings while improving and streamlining patient care. When RAID was launched at City Hospital in partnership with Sandwell and West Birmingham NHS Foundation Trust in December 2009 it was the first service of its kind in the UK to ensure that patients presenting at acute settings received help for their mental health as well as their physical health at the same time, and make significant savings to the public purse. Since the pilot RAID scheme was launched it has improved patient experience and saved the NHS more than £6 million.

Norman Lamb MP, Minister for Health, praised our RAID Service, during a visit in November 2012.
The service, which previously won a HSJ Award for mental health innovation, is delivered at five A&E units across Birmingham and Solihull, including Heartlands Hospital – run by Heart of England NHS Foundation Trust (HEFT) – where the health minister met clinicians from both Trusts.

During the visit he heard how our clinicians work in partnership with colleagues in treating mental health alongside physical health and how this has improved patient experience. RAID's specialist team work closely with doctors and nurses to ensure patients with mental health, alcohol or drugs problems are assessed and treated much earlier. Clinicians aim to see patients in A&E within an hour, and those referred from inpatient wards within 24 hours. This partnership approach has helped avoid unnecessary admissions to busy medical wards, as RAID has shown it can reduce length of stay for patients with dementia, enabling them to return home more quickly.

Medically unexplained symptoms

Medically unexplained physical symptoms (MUS) pose a major challenge to the NHS. They refer to painful, uncomfortable or distressing physical symptoms experienced, for which no underlying organic or biological cause can be found despite testing and examination. Examples include medically unexplained pain anywhere in the body, tiredness, fits, or stomach problems. They are some of the most commonly encountered symptoms across all healthcare settings, accounting for 20 per cent of all GP consultations and 50 per cent of new referrals to hospital clinics.

The cost to the NHS has been calculated at around £3 billion per annum, or around 10 per cent of total NHS expenditure. At present there is hardly any specialist clinical service for most of these patients in Birmingham. Effective evidence-based treatments for MUS do exist. However, these are rarely available due to a lack of specific training for doctors, who often find such symptoms stressful to deal with, and problems with the way health systems are traditionally separated into either physical or mental healthcare. Yet collaboration between mental health and physical health specialists can improve physical symptoms in 67% of cases with a subsequent reduction in frequent attendances to hospital.

The Birmingham MUS project is a primary care-based partnership between our Trust, City Hospital's gastroenterology department and Karis Medical Centre GP surgery. The purpose of the project is to improve the management of patients with gastrointestinal medically unexplained symptoms by piloting a new type of service at the interface of physical and mental healthcare. The project aims to break down the traditional barriers to delivering genuinely integrated physical and mental healthcare. The project has built upon

existing BSMHFT partnerships that developed the successful RAID service.

The project goals are the development of a service that embeds psychological and psychiatric expertise in Medically Unexplained Symptoms into primary and acute care settings. It aims to reduce physical symptoms for patients, improve their quality of life, and increase the confidence of their GPs and hospital doctors in managing such problems. A further objective is to reduce the cost of hospital admissions, outpatient clinic attendances and unnecessary investigations and procedures. The pilot project is currently evaluating its impact upon the management of medically unexplained symptoms across primary and secondary care by measuring clinical and cost-effectiveness outcomes.

Mental Health Outcomes

Mental health outcomes have remained a key focus for BSMHFT in 2012/13. Within mental health services it is vital that we consider outcomes from different angles in line with the National Mental Health Strategy. These perspectives include recovery, physical health, wellbeing, stigma and discrimination, avoidable harm and experience. In 2011/12 we saw an improved understanding at BSMHFT of how we measure, capture and report our outcomes in all of the above areas.

During 2012/13 the Trust has built on this by increasing our understanding of what our existing data tells us about the outcomes that we achieve. Key clinical outcomes data is summarised below:

Adult mental health services

Clinical Outcome and Routine Evaluation (CORE) is the key Patient Reported Outcome Measure (PROM) used across our adult CMHT psychological services. It is well established having been used with service users for several years. This outcome measure covers four dimensions, namely, subjective well-being, problems/symptoms, life functioning and risk/harm. Overall, the average post-therapy outcome measures show that 63% of service users, completing therapy, showed reliable improvements compared with the national benchmark of 58% in CMHTs (Lucock et al., 2003). Where data is available to provide a comparison between BSMHFT and other mental health Trusts serving similar levels of morbidity we compare favourably.

In addition to the above evaluation of adult psychological services, group intervention work is also evaluated using relevant outcome measure tools. The most recent reports show that outcomes that we have achieved as a result of this intervention work includes:

Psychosis group- there were benefits to service users in how they feel about their ability to cope with relapse (FORSE scale) and improvement in their recovery in relation to Trust and help, identity and self-esteem and social networks (recovery star) and positive impact of being around others experiencing similar symptoms.

Depression group- average clients' scores fell from the severe depression range before the depression group to the moderate range on completion of the depression group, indicating an overall improvement in depression symptomatology (Becks Depression Inventory II)

Obsessive Compulsive Disorder group- clients' experience of attending the OCD groups is positive and provides an essential vehicle to reduce the isolation and stigma often suffered by clients with OCD.
In our Non-Acute Inpatient units (rehabilitation units) outcome measure data analysed in one of each type of unit (high dependency unit, long-term complex care and community) demonstrated that engagement increased over the 12 month period in almost all areas. The largest improvements were observed in agreement with treatment in the high dependency unit and active participation in the community unit (Residential Rehabilitation Engagement Scale). In addition the observed frequency of challenging behaviours reduced over the 12 month period. The largest decrease was observed in the long-term complex care unit (Challenging Behaviour Checklist). Further outcome data analysed for the community unit showed that community living skills improve over a 12 month period while at the community unit.

The Health of the Nation Outcome Scale (HoNOS) is the key clinician rated outcome scale that we use in all services as part of the Payment by Results initiative. At present we are unable to extract meaningful outcomes data as further work is required to ensure that there is sufficient data available to analyse outcome over time and also to improve the quality of the data recorded to ensure that it is as accurate as possible. These improvements form part of the work plan for the coming year.

Addictions services
COMPASS is our consultation-liaison service designed to provide integrated treatment and to enhance the response to people with combined mental health and substance use problems. Outcomes data from a recent three year service evaluation showed that clients who completed the brief intervention showed improvements in a number of areas including: Increased engagement with treatment, reduced dependence and improved confidence. In addition a key role of the service is to deliver a structured training package, on a cognitive behavioural integrated treatment approach, to staff within mental health services.

As reported in a peer reviewed journal, it has been demonstrated that following the receipt of training staff confidence in treating individuals with combined psychosis and substance use problems significantly increased and remained high at our most recent follow up 10 years later.

We plan to increase the sophistication of our outcomes reporting. This will mean that outcomes will be reported as part of pathway reports where they are set in context of the needs, morbidity and profiles of the people we see and the resources and interventions that we provide. This will help us to further understand our outcomes in relation to different cluster allocations and diagnostic groups, as well as ethnicity, age and gender and the impact of different resources and interventions provided.

The updated outcomes frameworks for public health, adult social care, quality (GP indicators) and the NHS for 2013/14 will be brought into our thinking along with the CCG Outcome Indicator set as we aim to incorporate any provider level results that are issued through the NHS information centre into our thinking.

Developing our research and innovation strategy for 2013-16

As the NHS evolves into a new structure with new commissioning bodies, the most successful (mental health) Trusts will be those with a major research mission. BSMHFT has a good reputation for high quality research, but it needs to be embedded into our Trust's core business if it is to have the maximum impact on patient experience. Among the key challenges and opportunities facing our research team are:

Academic Health Science Networks (ASHNs) - The central role of research is embedded in the Health and Social Care Act and the NHS Constitution. The Department of Health is creating a number of ASHNs with the aim of improving patient outcomes through research into practice and integrated healthcare systems. BSMHFT has joined forces with universities in Birmingham, Warwick and Keele and other providers to form a West Midlands ASHN. This body will link with the NIHR's Collaborations for Leadership in Applied Health Research and Care (CLAHRC) for Birmingham and the Black Country.

Uniformity of research across BSMHFT - We have five programmes: addiction, ethnicity and mental health, neuropsychiatry, dementia and neurodegenerative disease, and early intervention and prevention – but there are still some major areas of Trust business not represented in research, notably forensic services and adult of working age community services. We need to examine whether these would benefit from research and if so, how it would be funded.

Industry research and clinical engagement - We have a relatively low number of investigators to help recruit service users into studies supported by the National Institute of Health Research. We need to find a way of widening the constituency of research across other areas of the Trust.

Research as core business - The potential exists for the Trust to be enhanced with research and innovation being at the heart of what he public, and our own staff, understands that we do. More needs to be done to bring in senior clinicians from across the Trust into research and innovation projects – and ensuring outcomes from such projects are embedded into practise within our Trust and beyond.

Stakeholder relations

Communication 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.

During the past year, we have engaged with a number of stakeholders to understand their communication needs and their feedback will be used to inform the Trust's communication strategy.

Trust Talk

Our 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. The magazine also highlights the work of the Trust with partners, articles submitted by Governors, Members and Service Users, and 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.

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 550 Twitter followers and our Facebook page has received nearly 70 'likes' in only a few months of being on the site.

YouTube is being used increasingly to post videos about our Trust, virtual tours of sites and general information films. It is a useful platform for demystifying mental health and will continue to be developed over the coming year.

Our membership

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, members 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. Our Trust currently has 12,962 members.

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.

A programme of member seminars, covering topics such as pathways of care for black minority ethnic groups and understanding and managing depression, was launched in 2010 to engage with members, and give them an opportunity to learn about different mental health issues and meet with Trust staff. This has continued throughout 2012/13.

Recruitment activities to date 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.

Individuals (other than staff) may choose which constituency they belong to if they meet either the residence or service user/carer 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.

As of March 31, 2013 the membership for each constituency was as follows:

Public: 6,573
Service user (including carer): 1,326
Staff: 5, 063
Total: 12,962

We are working with Governors to develop and enhance our membership strategy, which seeks to find new ways and build upon existing channels to engage with our members. Part of the strategy will address member benefits, as the Trust recently joined a national discount scheme which will be rolled out to our members in 2012/13. Other work includes the roll out of a new membership database which will allow us to 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).

Engaging with the community

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 numerous events, ranging from recruitment fairs and workplace seminars, to religious events and carnivals.

Mental Health First Aid (MHFA)

Building on the success of the Trust's delivery and development of MHFA in 2011, and subsequently being presented with an award for having "demonstrated exemplary leadership in increasing mental health literacy in their community", the Trust has was also successfully nominated for the second year in a row and attended the award ceremony at the House of Lords in Westminster in February. The nomination was submitted by Continental Star, a social enterprise and a registered charity that offers a range of community services in addition to a growing portfolio of sports activities. Lincoln Moses MBE nominated the Trust after he and his colleagues attended the two day MHFA training that was delivered by the Trust

Musical Connections

The Trust has also worked with partners to secure a Big Lottery Fund Reaching Communities grant for £306,000 to manage a Musical Connections project for the next four years. Musical Connections is a community music project which provides a network for isolated and housebound individuals using music as a tool to create positive change. Members of the project can access a combination of one-to-one and group music making sessions encouraging both individual development and engagement in social activities. In addition to reducing isolation by providing a much needed social network, the project also promotes mental health and wellbeing for members, social inclusion and anti-stigma. The project had been run for the last five years by Sound it Out with the Trust providing some funding and strategic support to the project. Over the next four years the project will benefit and engage people who are isolated, vulnerable and disabled. More than half of Musical Connections members are or have been mental health service users.

Birmingham LGBT

Our Trust works closely with local organisation Birmingham LGBT and supported the making of a new documentary exploring the experiences of five people from the city's lesbian, gay, bi and transgender community as they bravely shared their lived experience of mental ill health and the issues they have faced.

The film was premiered as part of the annual Shout Festival in November 2012 at the Midland Art Centre. The film will be used as a training tool for Trust staff professional development and to ensure good practice. As part of our developing partnership with Birmingham LGBT, we are delighted that a new LGBT Health and Wellbeing Centre has opened in Birmingham city centre.

Women and Theatre

Women and Theatre, in partnership with our Trust, has successfully secured a Time To Change grant to deliver a project entitled Laughing for a Change. The project will deliver four community courses across Birmingham and Solihull, incorporating community comedy evenings and at least 25 performances in open mic slots at mainstream comedy clubs and events in Birmingham and Solihull. The courses will engage with 48 participants, half of which have lived experience of mental health problems.

There will be a six date national tour to venues which will feature six comedians with lived experience of mental health problems. The courses and tour aim to engage with 2512 members of the public.

BSMHFT will support Women and Theatre by providing Mental Health First Aid training to the project team and by referring and supporting people with lived experience in accessing the project.

REP and Hearth partnership event

The partnership, funded by an Awards for All lottery grant worked closely with staff and young people from the Trust's Youthspace in order to host a symposium for young people, mental health practitioners, education professionals and other agencies working with young people to debate and discuss the challenges facing young people when it comes to their mental health. Combining performance with workshops and discussion has proved to have real impact on both young people directly, and on those people in the community that are responsible for their wellbeing.

Engaging with GPs

The Government's healthcare reforms have led the Trust to re-examine and work to strengthen its relationships with a number of stakeholders. One particular area has been its relationships with GPs and clinical commissioners. The objectives of Birmingham and Solihull Mental Health Foundation 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
- To 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.
- Increasing the positive visibility and reputation of the Trust amongst GPs and clinical commissioners.

To allow this to happen the Trust appointed a dedicated GP liaison officer 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 called the GP hub which acts as a portal for direct communication with our Trust, to share their general feedback, comments or complaints, although not patient specific information.

Regular two-way communication with GPs is vital and to ensure this happens we have developed a monthly e-bulletin called GP Matters providing GPs with valuable updates on community mental health teams, Birmingham Healthy Minds, forthcoming GP seminars and useful pharmacy updates.

A series of GP events and seminars have taken place last year at Trust sites, GP surgeries and larger venues. We are committed to supporting educational forums and seminars and have worked with

Staffordshire and West Midlands Probation Trust to arrange several conferences and seminars on offender mental health. Our Community Mental Health Teams across Birmingham and Solihull have also organised open days to allow local GPs to meet their local mental health professionals.

As part of the AGM a team from Yewcroft Community Mental Health team presented a new way of working to GPs which has been trialled at Yewcroft and Longbridge Community Mental Health teams called Head 4 Health. It provides rapid expert assessment and the flexibility to provide treatments delivered by a single professional or by a multidisciplinary team. It increases service user choice and access to psychological services, including specialist psychotherapies.

Partnerships: Working together

City of Birmingham Symphony Orchestra

More than 200 people filled the CBSO Centre as part of a singlaong event to mark World Mental Health Day. The event, which took place on October 10, aimed to highlight the positive impact music can have on mental wellbeing, and also celebrated a new partnership between the City of Birmingham Symphony Orchestra and our Trust. People of all ages came to the CBSO Centre, in Birmingham for an informal day to explore the impact that music - singing in particular - has on mental health and wellbeing as well as addressing issues surrounding the stigma of mental health.

Before the singing began our former chief executive, Sue Turner, and the CBSO's chief executive Stephen Maddock signed an agreement that both organisations will collaborate further to support work in this area.

The second stage of this partnership was a two-day mental health first aid training course for CBSO musicians interested in working with people with mental health issues. Future work includes a joint working community choir.

Prevent: Counter-terrorism initiative

Prevent is part of the UK's counter-terrorism initiative, which aims to identify and work with children and vulnerable people who may be at risk of radicalisation or recruitment by terrorist organisations. The Department of Health have developed specific training – Health Workshop to Raise Awareness of Prevent (WRAP) – which has been rolled out to managers during 2012/13.

Working in partnership with Birmingham City Council and West Midlands Police, we provide clinical psychological input into the Prevent pathway to improve Prevent workers and community mentors' understanding of mental health and psychological issues that may contribute to a person's risk of radicalisation. This Home Office-funded project is an extension to the regional Prevent counter-terrorism programme.

Non-financial reporting

Sustainability and climate change 2012/13

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.

This Financial year (2012/13) has seen a significant service redesign and estate rationalisation programme whereby the Trust has ceased to provide services from a significant number of buildings. The decommissioning of these buildings followed sustainability principles ensuring that where possible furniture and equipment was re-used within the Trust

In addition the Estate rationalisation programme has enabled the Trust to cease its service provision from buildings where they had previously been identified as being energy inefficient or costly to manage and upkeep – this will have long term sustainability benefits.

Managing energy as a finite resource, minimising and mitigating energy wastage is an embedded priority for the Trust. The ever changing Estate has made it difficult to quantify building energy performance as teams have moved, occupancy has increased and thus costs have increased in these buildings. It has to be remembered that 'people use power' and as such the closure of buildings will have created some energy

savings but that some of this consumption and financial savings must be ring-fenced to cover increasing costs at other Trust sites where occupancy and utilisation has increased.

Principles are continually practiced to promote awareness of the Trust's responsibilities and to engage staff, service users and carer's. Specifically with regard to the following, which form part of the NHS Carbon Reduction Strategy for England.

- Raising awareness of the need to manage resources more effectively, reducing consumption, waste, emissions and expenditure.
- Investing in new buildings, plant, equipment and technology to improve efficiency, and provide more with less.
- Adopting procurement practices which promote sustainable development. Consciously specifying, procuring and re-cycling materials from sustainable sources.
- Promoting the need to embed sustainability in / as part of the day-day business of the Trust.

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BSMHFT performance analysis: carbon management

Table 1:

Year	Electricity, gas and oil (tCO_2) - (Taken from properties where actual data is available)	Transport (inc Grey Fleet Vehicles and Fleet Vehicles, taxis) - (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	900 (estimate as data was not available)	91	11,541

Carbon Reduction Commitment (CRC) Energy Efficiency Scheme

At the time of writing this report our Trust has made a declaration and information disclosure on the CRC as required. Our Trust has not traded on the CRC as at this stage we do not meet the qualification criteria, meaning that we have not procured any Carbon Credits (allowances) and have not incurred a financial cost. BSMHFT will respond to and work within guidance being developed by Department for Energy and Climate Change post the most recent Government spending review and will respond to the challenges once quantified .

Waste management

Our Trust recognises the importance of good waste management. We are currently seen as an exemplar of best practice by the Environment Agency with whom we are working with to develop a national pre-acceptance audit tool for hazardous waste.

Table 2:

Waste	Non- financial data	Non- financial data	Non- financial data
	2010/11	2011/12	2012/13
Total waste arising	1229 Tonnes	1186 Tonnes	1191 Tonnes
Waste sent to landfill	263 Tonnes	249 Tonnes	267 Tonnes
Waste recycled	958 Tonnes	931 Tonnes	907 Tonnes
Percentage of waste recycled	77%	79%	77%
Waste Incinerated	8 Tonnes	6 Tonnes	7 Tonnes

Table 3:

	Financial data (£K) 20010/11	Financial data (£K) 2011/12	Financial data (£K) 2012/13
Total expenditure on waste disposal	£217,678	£217,922	£197,428

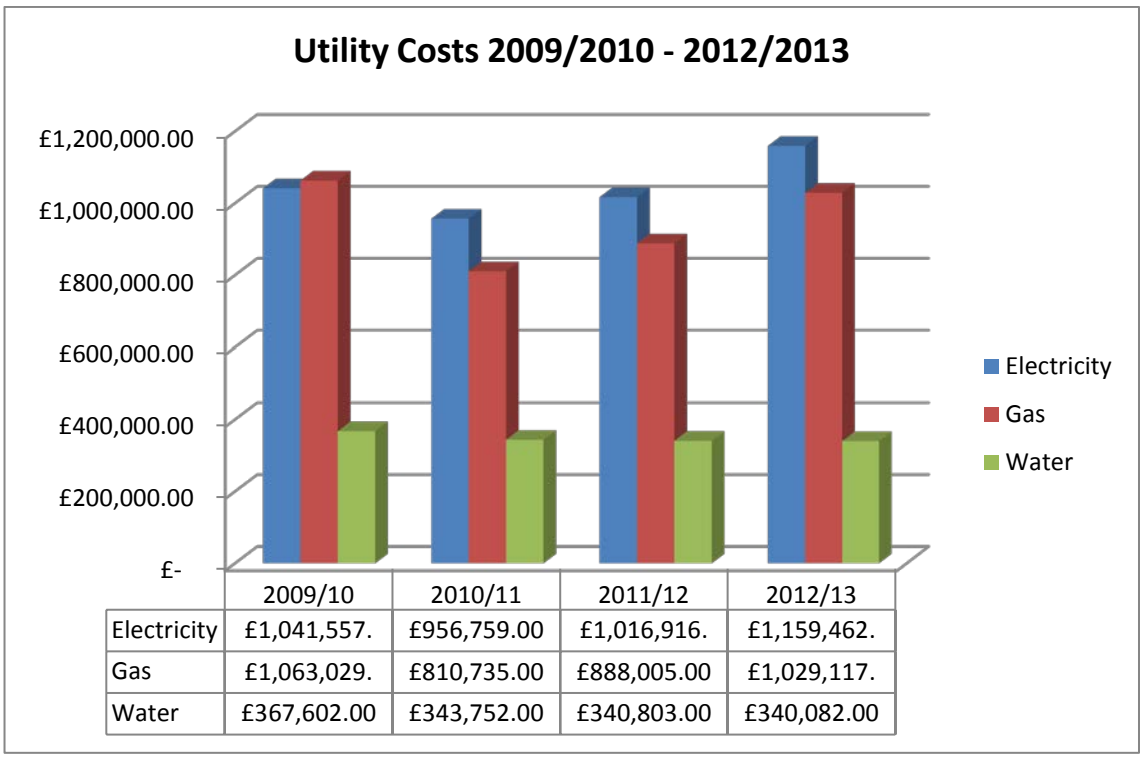
Finite resources

The table and supporting graphs below demonstrate how:-

- **Energy consumption** across the Trust rose by seven per cent against 2011/12. However (Met office issued) degree day data shows that there was on average a 12 per cent greater demand for heat throughout the 2012/13 year against that of 2011/12. In addition although the Trust ceased to deliver services from many buildings during 2012/13, in many cases they were not immediately disposed of, meaning that costs were still incurred. Plus the Trust took possession (and the associated costs) of its superb new forensic facility – The Tamarind Centre - in Q3 of this year.
- **Energy costs** for 2012/13 were £2.19million representing an increase against 2011/12 of 13 per cent. This being set against utility price rises of on average 10 per cent for the same period.
- **Energy procurement** for BSMHFT 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 per cent less than domestic tariffs.

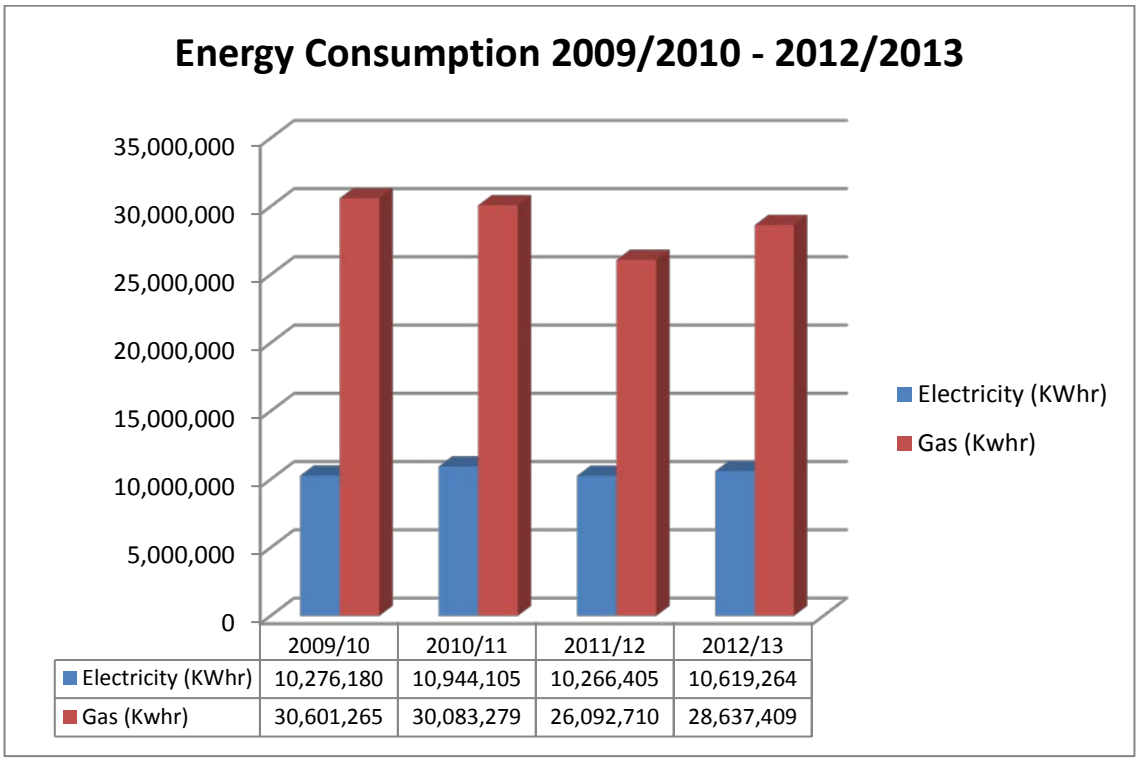
The most energy intensive period of the year, December 2012 to March 2013, given seasonal impacts associated with the winter months have an impact on the actual financial year position.

Figure 4:



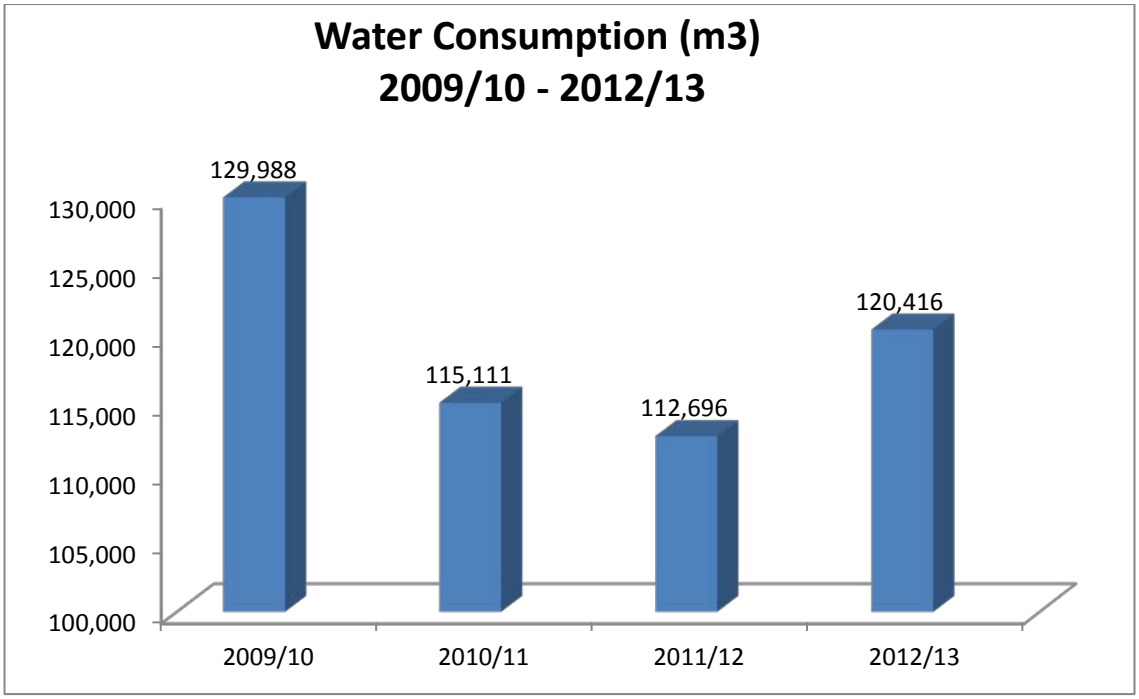
	2009/10	2010/11	2011/12	2012/13
Electricity	£1,041,557.	£956,759.00	£1,016,916.	£1,159,462.
Gas	£1,063,029.	£810,735.00	£888,005.00	£1,029,117.
Water	£367,602.00	£343,752.00	£340,803.00	£340,082.00

Figure 5:



	2009/10	2010/11	2011/12	2012/13
Electricity (KWhr)	10,276,180	10,944,105	10,266,405	10,619,264
Gas (Kwhr)	30,601,265	30,083,279	26,092,710	28,637,409

Figure 6:



Looking ahead into 2013/14, budgets have been set to include a further six per cent increase in gas prices and a 10 per cent increase in 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 per cent of the Trust's carbon tonnage. BSMHFT has a sustainable procurement policy and a sustainable procurement action plan in place. These support the Trust aims in meeting carbon reduction requirements and follows the NHS Flexible Framework Sustainable Procurement model and the Good Corporate Citizenship Assessment model.

All procurement personnel have been 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.

As part of the estate rationalisation programme over 800 items of furniture have been re-used across the Trust avoiding unnecessary procurement costs. All 'white goods' are now screened before orders are accepted and a recent project has been launched to look at stationary and the over ordering and associated wastage.

Bio-diversity

Bio-diversity is important to our Trust – ensuring where possible that in particular our inpatients have access to green spaces. Our new development at Tamarind includes a relaxation area for patients to enable them to have outdoor space. This space is to be landscaped over the coming year. 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. 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. Indeed our Older Adult's division have again reverted to energy champions to help to monitor energy consumption and mitigate energy wastage. Thus building on the achievements made over the last few years our Trust needs to:

- Develop ways of enhancing data and sharing that data with divisions and buildings so that staff know in 'real-time' the impact from a carbon and financial perspective of the healthcare they are providing.
- Review our carbon management plan
- Be innovative in the way it continues to drive down energy wastage. Continually develop a range of tools and materials to promote our commitment to sustainability, engaging with staff and service users.
- Consider a work stream to examine transmission and transportation costs and opportunities for BSMHFT.
- Invest in environmentally efficient and sustainable products and services. For example, power factor correction technology, IT remote energy shutdown software and retrofit of lighting with LED lighting where suitable. These being in addition to renewable energies already in place such as ground source heat pumps and work being undertaken with stakeholder partners for further initiatives such as photovoltaic cells, solar thermal and gas particle realignment.
- Work with our partners to drive down waste, increasing recycling further and seek further financial efficiencies.
- Respond to the NHS Sustainable Development Unit Consultation Strategy, due to be published in May 2013.
- Lead in promoting sustainability in the wider community in collaboration with other organisations from the public, private and voluntary sectors.

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: environmental, financial and social.

Regulatory ratings

Table 7: Table of analysis for 2011/12

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial risk rating	3	3	3	3	3
Governance risk rating	Amber -Red	Amber -Red	Amber -Red	Amber -Red	Amber -Red

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

Review 2011/12

The Trust's planned Governance Risk Rating (GRR) rating submitted to Monitor for 2011/12 was amber-red. This was informed by the known outcomes of the CQC responsive review regarding the safety of healthcare provision across various locations of the Trust during quarter 4 of 2010/11.

The outcome of the CQC review communicated to the Trust on April 4, 2011, related to inspection of three (out of over 100) sites in our Trust. There were four moderate concerns and one major concern (which related to staff understanding and reporting procedures in relation to safeguarding). In line with Monitor's 2011/12 Compliance Framework, any foundation Trust with a 'major' concern identified by the CQC is amber-red rated, hence application of this rating for the 2011/12 plan.

The Trust took actions to address the concerns identified during quarter 1 of 2011/12 and local assurance of compliance was confirmed via the Trust's clinical governance committee, that the critical actions to ensure compliance had been met for the end of June 2011. However, feedback from Monitor indicated that, irrespective of local assurance, the Trust's amber-red rating could only be revised once the CQC itself confirms assurance and lifts the related compliance actions.

This approach resulted in the Trust continuing to declare 'amber-red' rating for subsequent quarter's governance risk rating. 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.

During quarter two 2011/12, the CQC undertook further compliance assessment visits to the Trust's three adult psychiatric intensive care units; Eden, Meadowcroft and the Caffra Units. The Outcome Standards reviewed and the CQC findings are summarised below:

Table 8: Outcome standards reviewed by the CQC

Adult Psychiatric Units reviewed	Outcome Standards Reviewed by the CQC:			
	Outcome 4: Care & Welfare of service users	**Outcome 7: Safeguarding people from abuse**	**Outcome 14: Supporting staff**	**Outcome 16: Assessing & monitoring quality**
Eden ward	Moderate concern	Full compliance	Full compliance	Minor concern
Meadowcroft ward	Moderate concern	Minor concern	Moderate concern	Minor concern
Caffra Unit (Oleaster)	Full compliance with all standards			

Action plans to address the issues have been implemented with a formal report on assurance of compliance presented to the Trust's May 2012 clinical governance committee. It should be noted that moderate concerns did not impact on the Trust's governance risk rating in line with Monitor's compliance framework.

During quarter 3 (January 2012), the CQC undertook a compliance assessment visit to Winson Green Prison. This identified a 'moderate' concern in relation to the provision of medication whilst the prison is in a 'shut down' situation over the weekends. However, this action is outside the Trust's control.

The Trust's GRR for 2011/12 remained amber-red due to the CQC visit undertaken in February 2011 highlighting a 'major' concern and despite local assurance of compliance to address this, this rating was fixed until the CQC repeated its assessment and confirmed compliance.

Review 2012/13

At the time of submitting the GRR plan for 2012/13, the following two issues contributed to the Trust submitting an amber-red rating for governance as part of its 2012/13 plan:

- The major concern identified by the CQC in its February 2011 responsive review was still in place as the CQC had not yet repeated its reassessment, and
- The Board was also unable to declare compliance in relation to the mental health target of CPA formal review within 12 months. An action plan to address the gap was put in place with a plan to achieve compliance against this target by the end of quarter 2, August 2012.

Based on the above issues, the Trust submitted an amber-red rating for governance for quarter 1 of 2012/13.
However, for quarter 2 of 2012/13, the Trust submitted an improved governance risk rating of green due to the following changes:

- The CQC carried out a further review to assess whether Trust headquarters had taken action in relation to five of the CQCs essential standards of quality and safety and confirmed that the Trust was meeting all the essential standards of quality and safety, formal report published in August 2012. As a result there were no compliance actions outstanding in relation to the CQC responsive review of a range of Trust locations undertaken in February 2011.
- The CQC revisited Eden and Meadowcroft PICUs in July 2012. The formal feedback reports from the CQC published in August 2012 indicated both areas to be fully compliant in meeting all the essential standards of quality and safety inspected. There were therefore no compliance actions outstanding in relation to these services.
- The Trust also achieved compliance with the national indicator, CPA formal review within 12 months by end August 2012 in line with its action plan.

Introduction

Welcome to the Birmingham and Solihull Mental Health NHS Foundation Trust Quality Account 2012/13

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health care to those people living in Birmingham and Solihull who experience mental health problems. We serve a culturally diverse population of around 1.2 million people spread across 17 square miles. We have an income of around £200 million, making us one of the largest providers of mental health care in the country. We also have a number of specialist services which provide care to people from across the country.

We have circa 4000 dedicated staff

These Quality Accounts are presented in three parts1:

• **Part 1** is a statement on quality from the Chief Executive of the Trust.

• **Part 2** sets out the organisation's priorities for quality for 2013/14. It also includes a series of statements about the organisation in areas such as clinical audit, research and data quality.

• **Part 3** reviews the last twelve months in terms of quality in the domains of safety, clinical relied on to monitor progress throughout the year.

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 2012/13. The Quality Account is a report about the quality of services provided by an NHS healthcare service. The report is published annually by each NHS healthcare provider 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.

Over the past year significant work has been undertaken to strengthen our focus on quality across the whole organisation. Over the past year our measured outcomes of quality have not all met the ambition for quality which we set last year. We recognise the importance of setting out these targets in a transparent way and that we can learn from lessons for the coming year.

A new strategy for the Trust has been developed and agreed which has a core focus on quality.

The strategy sets out the following ambitions:

1. **Quality:** Continuously improving quality by putting patients at the heart of everything the Trust does to deliver excellence. This will be measured by;
    - Consistency of outcomes
    - Clinical outcomes & effectiveness
    - Safety outcomes
    - Patient and carer experience/survey
2. **People:** To have a workforce that is innovative, empowered, engaged and motivated to deliver the strategic objectives of the Trust.
3. **Stakeholders/Joint Working:** Develop strong, effective, credible, sustainable relationships with key stakeholders, building the Trust's reputation.
4. **Corporate Governance:** To be a well led, effective, and informed organisation, demonstrated by achieving the annual plan.
5. **Financial:** Achieve long-term financial stability by :

- Being top quartile for productivity
- Growth, consolidation and protection of current business
- FRR of 4, discipline and rigour

The annual business plan identifies the following objectives:

- We will be brilliant at CPA: All service users receiving treatment care and support within the Care Programme Approach will have had at least one opportunity every six months to be involved in their own care plan to ensure that they are receiving the right level of care and support
- Our CPA records will be complete and up to date.
- Recovery: People who use our services will be actively involved in planning, delivery and monitoring of their treatment and care in a recovery focused service. They will also be involved in the planning, development and monitoring of our services.
- Addressing poor quality: To ensure all staff are positively supported to raise concerns when they witness any incident of poor / compromised quality or unsafe care in the certain knowledge that their concerns will be actively responded to. (#)
- We will implement a documented Quality Impact Assessment process
- To ensure that the proportion of community service users reporting that they have been treated with dignity and respect matches the sustained high level reported on inpatient services (#)
- Safe care: We will provide service users with a safer environment of care by reducing the number of recurring incidents which result in harm

The priorities identified (#) were particularly included to reflect the recommendations from the Francis Inquiry report. Priorities within our annual business plan have also been identified to address areas for improvement identified from our staff survey.

The 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 key to everything we do and a significant focus on doing this has been developed through the Trusts annual plan and planning process which has been developed over the past 3 months.

This year the focus of the Trust in implementing its quality strategy has been in a number of key areas:

- Annual Planning process: Significant work has been undertaken to develop an integrated planning process as we believe this is key to ensuring organisation wide improvement.
- Quality surveillance: We have developed the use of quality metrics to use to assess quality across the organisation reviewing data and quality metrics in an integrated way from local teams to board level. In response to any identified issues of variance or potential concerns we have implemented a peer review process of 'quality support teams' where staff review identified services against a range of criteria. Service users and our lay managers have been actively part of this process
- Developing a culture where staff focus on doing things right the first time and ensuring concerns are escalated and actions taken.
- Implement a vigorous quality impact assessment process for all significant cost improvement schemes.
- Our GP engagement plan

The Trust has reviewed itself against Monitors quality governance framework on a number of occasions over the past 3 years, and this review led to the development and implementation of the Trust's Quality Strategy. In order to further support progress the Trust commissioned an external review by KPMG to review compliance against Monitor's Quality Governance Framework. In summary, the Trust was scored '11' where an acceptable score would be considered to be below 4. In relation to the core components the following score was identified:

Strategy : 2,
Capabilities and Culture : 1.5,

Processes and Structure : 1.5
Measurement : 6.

The Trust is currently in the process of finalising its action plan to address the issues arising particularly with a focus on the robustness of the quality information. A number of actions have already been completed all had been identified within the Trust to address the report recommendations.

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. The use of electronic reporting to support our root cause analysis process has been piloted and will be developed over the year ahead.

Our efforts to ensure regulatory compliance resulted in a number of positive reports from the CQC. A particular focus at the end of last year has been demonstrating our compliance with outcome 7 in relation to safeguarding. The Trust has appointed a new safeguarding team over the year and put in place improvements in our internal systems and our arrangements for working with our care partners.

The Trust Board is firmly committed to ensuring that the 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 Accounts highlight our commitment, ambition and determination to deliver the kind of healthcare of which we can be rightly be proud of. 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: 

Chief Executive, Birmingham and Solihull Mental Health NHS Foundation Trust

Part Two

2.1 Outcome of priorities set for 2012/13

This section sets out our achievements against the priorities for improvement we set last year.

The Trust set out priorities last year in each quality domain to reflect our drive to improve quality in relation to all aspects of the care programme approach. Whilst we report each of these priorities individually below, our approach has been an integrated one and a summary of this work is set out below.

We convened a Care Programme Approach Improvement Group under the direction of the Deputy Director of Nursing and Quality. The aim was to convene a group of professional and service delivery leads in order to get to address any obstacles and agree workable solutions for implementation across all of our teams. We had our initial action plan identifying in broad terms some of the things that we wanted to achieve. Pivotal was the visible senior leadership for our improvement efforts which was prominently provided by our Medical Director and Executive Director for Quality Improvement and Patient Experience.

At the start of the group's life, a major review of caseloads with each care coordinator was undertaken in our Community Mental Health Teams. The review was led locally by the Service Development Manager and the Lead Nurse for each respective area. In addition, we revisited and trimmed our Care Programme Approach policy and developed a user friendly standards document for all clinical staff – something which we now routinely send out to all on a quarterly basis.

However, in spite of this wholesale review, improvement (as evidenced in quality audits) was patchy and frustratingly slow overall. We were rather hampered by the temporary withdrawal of the Integrated Care Record completeness report (as a result of the move from EPex to the Rio electronic patient record system.) Teams had relied on this report to help identify which forms or sections of forms on the care record had not been filled in correctly. The report has recently been reintroduced and is being actively used to drive up compliance. The reporting against these standards was only achieved at the end of the year which identified a core figure of 42% at the end of March; this figure has increased to 53% in April. All Clinical teams are now able to review their level of compliance in real time through the Trust intranet and understanding of the RIO system and audit process is leading to improvement in core figures.

In February 2013 we had two workshop events for all managers and senior clinical staff in our community teams. These were to enable sharing of good practice and practical solutions to improve the quality of CPA. The outputs of these have been fed into the work of the Improvement Group, including the creation of a structured confirm and challenge support process for teams that are not yet improving.

Patient Safety Priorities:

Priority 1: **Years 2011/12 and 2012/13**	**To reduce the number and severity of recurring assaults caused by individual patients**
Aims:	**To develop triggers for identifying service users where incidents of assaults are recurring and to strengthen processes to prevent reoccurrence, in order to reduce the level of recurring incidents and the degree of harm**

Over the past year there has been a reduction in the total number of assault incidents reported in the Trust. As set out below.

With the use of the electronic risk management system a regular report has been produced which identifies the number of recurring incidents relating to the same patient. Local managers were asked to follow these up with support from our AVERTS team to review arrangements within these individual patients and ensure additional measures have been put in place to reduce further recurrence.

It should be noted that the Trust has introduced a electronic reporting system which has led to a reduction in the total number of incidents reported. Consequently the percentage of reported assaults leading to injury is consistent to last year.

Table 9:

Assaults on Staff (total)				
	Q1	Q2	Q3	Q4
2010/11	261	319	307	392
2011/12	421	382	416	359
2012/13	281	249	264	282

Table 10:

Assaults on staff leading to injury				
	Q1	Q2	Q3	Q4
2010/11	133	176	140	178
2011/12	201	226	233	217
2012/13	192	160	178	171

Table 11:

% of Reported Assaults on staff leading to injury				
	Q1	Q2	Q3	Q4
2010/11	51.00%	55.00%	46.00%	45.00%
2011/12	48.00%	59.00%	56.00%	60.00%
2012/13	68.33%	64.26%	67.42%	60.64%

Priority 2:	**To achieve sustainable improvement in the quality of clinical risk assessments**
Year 2012/13	
Aims:	**All clinical staff will be trained in clinical risk management**
	All service users will have received a comprehensive health and social care needs assessment including risk assessment at an early stage of decision making about their care.

Last year we reported:

- 87.1% of service users were risk assessed on admission.
- 86.5% have a risk management care plan

These figures reflected data provided on our old patient record system and reflected a limited number of services which were still using the system at the time.

- 80% of the risk management plans had been reviewed within schedule

  (Nursing metrics data March 2012)

Training in clinical risk management:

Over the past year we have continued to maintain high levels of compliance with all relevant staff receiving clinical risk management training every three years.

	Compliance with training requirement:
March 2012	84.8%
March 2013	85.7%

The table below highlights that the Trust has not achieved a sustainable improvement in this indicator over the year. As identified above the data available during the year is limited and only reflects in patient units.

Table 12:

Nursing Metrics **To achieve sustainable improvement in quality of risk assessments**												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Risk management plan formulated (In patients)	85.7%	83.0%	78.6%	80.0%	84.9%	82.2%	85.8%	84.1%	79.50%	80.90%	79.30%	81%
Risk Management Plan Reviewed (In patients)	81.9%	79.9%	78.7%	78.1%	81.7%	80.0%	88.1%	85.4%	78.90%	78.90%	78.50%	69.50%

Clinical Effectiveness Priorities

Priority 3:	**Improve reporting of physical health assessments within user records**
Years 2011/12 and 2012/13	
Aims:	**To strengthen arrangements for ensuring service users have received appropriate physical health assessments across all services.**

Last year we reported an improvement in the reporting of physical health assessments as follows:

Patient Related Indicator	**January 2012**	**April 2012**
Physical Health assessment - BMI and BP completed	70.7%	**84.3%** ↑
Weight recorded	85.8%	**93.8%** ↑
Nutrition assessment on admission - Form A	66.7%	**84.3%** ↑
Nutrition assessment on admission - Form B	64.6%	**86.9%** ↑
Care plan on nutritional need	52.3%	**83.2%** ↑

Due to the changes to our RIO record system it has not been possible to produce comparable data. However our Nursing metrics have shown the following improvement:

Table 13:

Nursing Metrics: Physical Health assessment - BMI and BP completed

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Score:		76.3	76.9	74.2	82.2	78.7	73.1	78.0	78.6	76.8	76.2	84.8

Priority 4:	To improve quality at each stage of the CPA process
Year 2012/13	
Aims:	To determine best practice principles for structuring clinical services in order to enable comprehensive attainment of the Care Programme Approach. To compare Quality Audit with baseline at end of quarters 1, 2, 3 ,4 of action plan to demonstrate progress To achieve a green rating for Trust Key Performance Indicator P17 – Integrated Care Record Completeness.

Last year we reported:

- C25 - CPA: People on CPA Reviewed in Last 6 Months 85.1% (green)
- C28 - CPA: People on CPA Reviewed in Last 12 Months 63% (green)
- P17 - ICR Completeness 71% (red) (as above this reflected only those services which remained on the old patient record system at this time).

Overall the Trust has improved performance in relation to the proportion of service users reviewed on CPA in the last 12 months, however improvements in relation to reviews every six months have not been sustained.

Table 14:

People on CPA Reviewed (Trust indicator)												
	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
in Last 6 Months	68.9%	70.3%	72.0%	78.0%	84.1%	84.0%	84.3%	86.0%	83.30%	82.60%	78.10%	75.20%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80%
in Last 12 Months	76.7%	78.8%	80.7%	83.5%	86.8%	87.3%	86.5%	88.2%	87.90%	87.70%	86.80%	87%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Priority 5:	Improve patient satisfaction in relation to care plan and overall levels of care
Years 2011/12 and 2012/13	
Aims::	To introduce electronic real time feedback mechanisms to drive demonstrable improvements to perceived quality of service by service users.

Last year we reported on the pilot project to develop a robust real time monitoring system to provide feedback from service users.

Throughout this year, real-time patient feedback kiosks have been installed in sites with the highest footfall, making sure that this equipment has the chance to be used as often as possible. A kiosk has also been installed in the Birmingham prison healthcare block, meaning that feedback can be gathered from inmates about the healthcare they receive. The Trust has also invested in a number of handheld tablets, which are used by our service user involvement workers to gather feedback from across the whole of our organisation on an ad-hoc basis. Results are available on our Patient Information Point screens so that anyone can see how we are doing.

The system now reports on a monthly basis.

Data reported from this is set out below under priority 6.

Priority 6:	To improve engagement of service users in care planning
Year 2012/13	
Aims:	We will establish a cross-organisational group to direct and lead the routine creation of Advance Statements We will refresh our Patient Experience Committee and enable it to both support services and also hold them to account for continuous improvement in service user and carer engagement

The Trust patient experience committee has been reviewed and changes put into place with a defined work plan and reporting framework to the Trust Clinical Governance committee.

Last year we reported

Division	Service users with a Care Plan	Service Users involved in Care Plan	Service User signed Care Plan
Specialist and Complex Care	28%	21%	9%
Adults of Working Age	66%	54%	36%
Youth, Addictions and Healthy Minds	7%	7%	0%

This data was taken from our former record management system (epex) at the time the Trust was moving to a new record management system and comparable data (on RIO) has only recently begun to be reported.

Table 15:

Service users with a copy of their care plan (Inpatients) Nursing Metrics												
	Apr-12	**May-12**	**Jun-12**	**Jul-12**	**Aug-12**	**Sep-12**	**Oct-12**	**Nov-12**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**
Target:	100%	100%	100%	100%	100%	100%	100%	100 %	100%	100%	100%	100%
Nurse metrics report (Inpatients)	70.60 %	67.20 %	79.70 %	71.40 %	78.20 %	72.60 %	77.30 %	75.2 %	84.90 %	79.50 %	84.40 %	76.50 %

Feedback from our service users through our real time feedback monitoring systems has demonstrated some improvement as follows:

Question: Our Trust standard is that everyone should have a copy of their care plan. Do you?			
REAL TIME FEEDBACK RESPONSE:	**Yes, definitely**	**No**	**I did not want a copy**
MAR 2013	45%	40%	6%
DEC 2012	28%	65%	5%

2.3 Priorities for improvement 2013/14

Reflecting the position highlighted above The Trust Board is not yet satisfied that we have achieved a satisfactory level of sustainable improvement in the delivery of the Care Programme Approach which was identified as a priority for 2012 /13. This is the key priority for the Trust and so the Board have decided to retain the previous Quality Account priorities as set out in the table below.

In making this decision the Trust reviewed this proposal recognising the detailed consultation which took place last year to identify these priorities, further this was reflected in the discussions and consultation which have taken place in developing the new Trust strategy. Further as part of the development of this report further feedback and assurance of the general support for these as follows:

- Staff – through a consultation exercise conducted in December 2012, discussion through Trust Clinical Governance committee.
- Feedback from Service user groups and Governors which has reinforced the identified Trust priority for improvement in Care Programme Approach.
- Commissioners through the Trust Clinical Quality Review Group with our lead commissioners.

The Trust did not undertake wider public consultation on this proposal.

Table 16:

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
Clinical Effectiveness	To improve quality at each stage of the CPA process	(a) ICR data for completeness in relation to: • H&SC • Risk Screening • Care plan • Total ICR audit score (b) % of service users who have a CPA review every 6 months	As above
	Quality Audit	Demonstrable improvements in re audits against CPA quality audit.	As above
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

Rolled over priorities identified in this report (3 and 5) are considered to be integral to our overall aim in relation to CPA and will be reflected in our overall monitoring arrangements of CPA. Priority 1 will be reflected within our patient safety thermometer which will be reported as an indicator in next year's report.

2.4 Statements of Assurance from the Board

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

2.4(a) Review of services

During 2012/13 Birmingham and Solihull Mental Health Foundation Trust provided or subcontracted 16 relevant health services. Birmingham and Solihull Mental Health NHS Foundation Trust has reviewed all of the data available to them on the quality of care in 16 of these relevant services. The income generated by the relevant health services reviewed in 2012/13 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 2012/13.

Part three of this report highlights a range of data which has been used to inform the Trust and review services provided. This data reflects all three quality dimensions of patient safety, clinical effectiveness and patient experience. This year has seen a transition of two major information systems which has impacted on the data provided and available for review. In particular:

- The Trust has been implementing a new patient information system (RIO) which will provide a uniform system for all patient information. This means that data has had to be transferred from one system and reporting requirements have had to be configured. In particular this has impacted on clinical effectiveness information.
- The Trust has also implemented an e reporting system for incidents and risk management.

2.4(b) Participation in clinical audits

During 2012/13 there were two national clinical audits and one national confidential enquiry covered relevant health services that Birmingham and Solihull Mental Health Trust provides.

During 2012/13 BSMHFT participated in 50% national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that BSMHFT was eligible to participate in during 2012/13 are as follows:

1. National Audit of Schizophrenia
2. National Audit of Psychological Therapies for Anxiety and Depression.
3. Prescribing Observatory (POMH-UK)
4. National Confidential Enquiry into Suicide and Homicide by people with Severe and Enduring Mental Illness

The national clinical audits and national confidential enquiries that BSMHFT participated in during 2012/13 are as follows:

1. National Audit of Schizophrenia
2. Prescribing Observatory (POMH-UK)
3. National Confidential Enquiry into Suicide and Homicide by people with Severe and Enduring Mental Illness

The national clinical audits and national confidential enquiries that BSMHFT participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

1. National Audit of Schizophrenia – 98%
2. Prescribing Observatory (POMH-UK) – 4 audit topics
3. National Confidential Enquiry into Suicide and Homicide by people with Severe and Enduring Mental Illness – data not available

The reports of 3 national clinical audits were reviewed by the provider in 2012/13 and BSMHFT intends to take the following actions to improve the quality of healthcare provided.

National Audit of Schizophrenia

1. Improve actions taken when physical health anomalies are identified
2. Improve our service users understanding of their medication, it's purpose and side effects.
3. Run dedicated clinical audit into clozapine prescribing

POMH Prescribing for Personality disorder

1. Construct multidisciplinary clinical guideline for personality disorder
2. Ensure referral pathways are clear

POMH Prescribing antipsychotic medication for people with dementia

1. Results are good. Trust clinical guideline was updated and redistributed.

The reports of 169 local clinical audits were reviewed by the provider in 2012/13 and BSMHFT intends to take the following actions to improve the quality of healthcare provided:

1. Improve the quality of care plans to ensure they are patient focused
2. Improve the completion of risk screening tools within the RAID service
3. Level 3 safeguarding training for FCMAHS staff
4. Adapt training for Deliberate self harm for the youth clinical support team
5. Reduce duplication of physical health information
6. Ensure interview rooms meet the RCPsy standards
7. Introduce routine physical health clinics
8. Review OT programme in Forensic services
9. Develop and AHPO supervision framework
10. Ensure prescriptions are in line with the SOAD consent dorms
11. Ensure Rapid tranquilisation training includes the need to debrief patients
12. Routinely review all admission to ensure medicines reconciliation has taken place
13. Improve the quality of information in RiO following migration from EPEX
14. Improve ECG tracing

2.4(c) Research

The number of patients receiving relevant health services provided or sub-contracted by Birmingham and Solihull Mental Health NHS Foundation Trust in 2012/13 that were recruited during that period to participate in NIHR adopted research and approved by a research ethics committee was 921.

Birmingham and Solihull Mental Health NHS Foundation Trust has 5 research programmes (Addiction; Ethnicity and Mental Health; Neuropsychiatry; Dementia and Neurodegenerative Diseases; Early Intervention and Prevention), hosting 4 NIHR funded studies and acting as a recruiting site for over 30 other NIHR adopted studies during 2011/12. Our leading researchers work in partnership with the Universities of Birmingham and Warwick and published widely in high profile national and international peer-reviewed journals. During 2011/12 we continued to promote participation in industry-led research, investing in two new nurse-led clinical trials facilities and underpinned by sound governance processes overseen by a multi-disciplinary Pharmacotherapy Research Committee. The year 2011/12 witnessed the end of some of our major studies and we have subsequently secured funding for a number of new NIHR studies.

2.4(d) Use of CQUIN payment framework

A proportion of Birmingham and Solihull Mental Health NHS Foundation Trust income in 2012/13 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 2012/13 and for the following 12 month period are available online at: http://www.bsmhft.nhs.uk/about-us/trust-documents/statutory-statements-and-declarations/

The priorities identified for CQUIN for 2012/13 were as follows:

- Use of Outcome Measure
- Local Effective Discharge Planning CMHTs **
- Patient Experience- Net Promoter/ Live Feedback

- Discharge planning for people with dementia who are on antipsychotic medication
- NHS Safety Thermometer
- Lifestyle/Making Every Contact Count
- Payment by Results

In 2012/13 the Trust received payment of £3,816,103 conditional upon achieving quality improvement and innovation goals(out of £4,419,361) in relation to its CQUIN framework. In 2011/12 the Trust received £2,172,500 (out of a potential £2,172,500).

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

Birmingham & Solihull Mental Health Foundation Trust is required to register with the Care Quality Commission and its current registration status is compliant.

The Care Quality Commission has not taken enforcement action against Birmingham & Solihull Mental Health Foundation Trust during 2012/13.

Birmingham & Solihull Mental Health Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13

- Review of Compliance (follow up review) (Mary Seacole PICU) July 2012
- Review of Compliance(follow up review) (Eden PICU) July 2012
- Review of Compliance (follow up review) (Prison Healthcare HMP Birmingham) November 2012

All the reports identified confirmed compliance

2.4 (f) information on the quality of data

Birmingham & Solihull Mental Health Foundation Trust submitted records during 2012/13 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS Number was:

99.0% for admitted patient care; and

99.7% for outpatient care.

accident and emergency care – not applicable for this Trust

- which included the patient's valid General Practitioner Registration Code was:

98.9% for admitted patient care; and

100% for outpatient care.

accident and emergency care – not applicable for this Trust

Birmingham & Solihull Mental Health Foundation Trust's Information Governance Assessment Report overall score for 2012/13 was 80% and was graded Green (Satisfactory).

Birmingham & Solihull Mental Health Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. A formal audit conducted by external auditors on the Trust's clinical coding for 2012/13 found the recording of primary diagnoses to be 98% accurate. However, the results should not be extrapolated further than the actual sample audited.

Birmingham & Solihull Mental Health Foundation Trust will be taking the following actions to improve data quality during 2013/14:

- Introduction of "my dashboard" data quality reports for staff, helping them to identify and correct any gaps or errors in their record-keeping

- Systematic assessment and rating of levels of data quality assurance for all key internal and external performance indicators
- Further development of our work programme to ensure the accuracy of clinical case classification, activity monitoring and clinical outcome measurement information to support the local introduction of "Payment by Results" for mental health
- Further expansion of data quality audit activities looking at all key reporting data sets with special audits to be commissioned should more deep-seated data quality problems be identified

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

Prescribed indicator:	Trust performance this year	Last year	National average	Highest reported score	Lowest	Comments
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. The end year return figure reported by the Trust is: 95.26%	95.5% (Qtr 3 data)	96.2	97.6%	100%	92.5 %	***The Birmingham & Solihull Mental Health 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 & Solihull Mental Health Foundation Trust intends to take or has taken the following actions to improve this, and so the quality of its services, by:*** All cases identified to be non compliant are reviewed and actions taken to prevent reoccurrence. Monitoring and review of this indicator is undertaken through our Performance committee and will in future be reviewed through our Operations committee.
2) The data made available to the Trust by the Information centre with regard to percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period. The end year return figure reported by the Trust is 96.2%	95.4 (Feb)	97.7	98.4%	100%	90.7	***The Birmingham & Solihull Mental Health 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 & Solihull Mental Health 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 committee.

3) The data made available to the Trust by the Information centre with regard to 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.	(i)- N/A (ii) 6.05%	(i)- N/A (ii) 6.34 %	N/A (ii) N/Av	N/A (ii) N/Av	N/A (ii) N/Av	***The Birmingham & Solihull Mental Health 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 & Solihull Mental Health 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 committee.
4) The data made available to the Trust by the Information centre with regard to percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	55%	N/Av	58% (Mental Health Trusts)	83%	43%	***The Birmingham & Solihull Mental Health 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 & Solihull Mental Health 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 implementing a comprehensive exercise to engage staff (called Listening in Action) to ensure that staff can contribute to improvement.
5) The data made available to the Trust by the Information centre with regard to Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	84.8%	86%	87%	91%	82%	***The Birmingham & Solihull Mental Health 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 & Solihull Mental Health 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.
6) The data made available to the Trust by the Information centre with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the (see 7) below): The end year return figure (reported for the full year) reported by the Trust is: 6534	3,397 reported for period April – Sep 2012 Org rate per bed days=41	4737 39.9	Org rate per bed days=23.8	71	5	***The Birmingham & Solihull Mental Health 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 & Solihull Mental Health 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..
7) The data made available to the Trust by the Information centre with regard to number and percentage of such patient safety incidents that resulted in severe harm or death. The end year return figure (reported for the full year) reported by the Trust is: 115 incidents of severe harm or death 1.76%	61 1.8% (fig for period Apr – Sep 2012)	17 0.3%	1.6%	N/Av	N/Av	***The Birmingham & Solihull Mental Health Foundation Trust considers that this data is as described for the following reasons:*** Data is reported to Trust Board or its Quality & safety 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 & Solihull Mental Health 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..

N/A – Not applicable
N/Av – Data not available

Part Three

3.1 Review of quality of performance

The Trust monitors a range of quality indicators to monitor and assure itself of the quality of its performance.

A Clinical Governance dashboard is presented each month to our clinical governance committee and further shared with our commissioners. A range of this information is also reviewed at local operational teams.

Our compliance team review a range of indicators as part of their quality surveillance function and use the data to assess whether together there is any indication that individual teams may be experiencing quality issues. Where this is identified a visit is undertaken to the team to provide assurance that quality is being maintained.

A number of key indicators are set out below which have been monitored and reviewed through the year.

SAFETY

Summary indicators

Comment: The Trust continues to place significant emphasis on the safety of its staff and patients. Overall compliance with the Trusts statutory and mandatory training requirements has improved and processes to ensure that all staff meet their training requirements have been further developed. Whilst the overall compliance in relation to Violence and aggression training has dropped at the end of the year it is anticipated that this will be further improved in the new year.

Target Area	10/11	11/12	12/13		Comments	Data Source	Reason for inclusion
Health and Safety Training	68%	90.23%	**92.3%**	↑	National Benchmark (1) • Trust 62.40% • National Mean 77.08% The Trust has made a significant improvement in the level of mandatory training over the year.	OLM database	Health and Safety training is a mandatory requirement to ensure safe working and care environments
NPSA incident reporting per 1000 bed days	32 (Apr – Sep 2010)	39.9 (Apr – Sept 2011 report)	**41.0** (Apr – Sept 2012 report)	↑	(See section 2 indicators) National Benchmark (2) • NPSA Median 21.1/ 1000 The Trust is one of the highest (25%) mental health Trusts reporting into the national incident system.	National Patient Safety Benchmark Report	This indicates that our staff are reporting and escalating untoward occurrences across the organisation
Violence and aggression training	58.8 % (Feb)	88% (Mar)	**79.2%**	↓	Note final end of year figure for AVERTS 5 day training. Whilst there has been a drop in compliance at the end of the year additional training is being provided to address this.	OLM Database	Training our staff in preventing and managing incidents of violence or aggression is core to reducing such occurrences
Violent assaults on staff	629	876	**701**	↓	Data reflects level of reported physical assaults on staff resulting in injury. This is a reduction in incidents reported which reflects one of the priorities for this year.	Incident Reporting	Level of assaults provides an indicator of safe working for staff and the therapeutic environment.
Never Events*	0	0	**0**	✓	No change	Incident Reporting	Never events are serious patient safety incidents that are thought to be largely preventable
*National Definition – Please see appendix two							

Learning lessons – reducing risks

Ensuring improvements result as a result of incidents, staff experience and feedback from service users is a significant element of our clinical governance processes (how we ensure quality improvement). Our processes for reviewing serious incidents is a key focus to our approach, partly because such incidents - whether they are identified to have been impacted by our care or not - have a significant impact on our service users and carers.

A number of initiatives have been introduced over the year to improve the quality of the reviews of serious incidents demonstrating lessons learnt from incidents is critically dependent on having undertaken appropriate reviews and producing clear recommendations. These initiatives have included:

- The introduction of a serious incident review group to assess and confirm completed reviews. This group is led by a clinical director.
- Implementation of the use of a Root Cause Analysis module on our electronic risk management system.
- The development of a distinct Investigations team headed by a senior clinical manager to support effective investigations.

The Trust has introduced a 'Learning Lessons bulletin' which is issued bi-monthly to all staff through the email system and aims to highlight incidents where there is scope for wider learning across teams.

A range of issues were highlighted which led to actions to reinforce appropriate practice, in particular the Trust has identified a priority for improving compliance with CPA arrangements this year and this reflects a range of issues which routinely come up from review of serious incidents. In particular:

- Arrangements for the transfer of patients between teams,
- involving family and carers in service users' care.

Improvements in how we manage risk

Over the year the Trust has successfully introduced its electronic incident reporting system which enables all staff to report incidents electronically through the Trust intranet. The introduction of this system unexpectedly led to a decrease in the number of incidents reported. In some part this appears to be due to the ability for the system to combine the same incident which may be reported by different members of staff – and hence reduce duplication.

During the year the arrangements for management of Health and Safety and also co-ordination of our serious incident management process have been reviewed. This has led to the introduction of a dedicated team to support serious incident investigations.

Further work will be undertaken over the coming new year to develop the use of the risk management system for risk registers and follow up of actions to reduce risks identified from incidents and national alerts.

Infection prevention and control

The sustained national high profile of infection prevention and control has enabled infection prevention standards to be embedded into mental health practice. To date, 100 infections were reported to the infection prevention and control team (IPCT) in the first three quarters of 2012/13. This is an increase on previous

years totals however the Trust, along with neighbouring NHS organisations and the local area, has experienced an increase in the number of cases of diarrhoea and vomiting and norovirus since September 2012.

Hand hygiene awareness continues to be a high priority for the IPCT as hand decontamination remains to be the most effective way of reducing all avoidable infections including norovirus and remains as the key message for containing the spread of diarrhoea and vomiting.

The IPCT have continued to work closely with estates and facilities and the shift in emphasis from containment of infection to a proactive approach to prevention has been promoted through the provision of infection prevention expertise to the design of new builds and refurbishments to ensure hygiene standards can be met through the provision of accessible hand washing facilities and furnishings that can be easily cleaned.

The RiO information system and electronic laboratory reports from City Hospital, have enhanced the infection prevention surveillance system to ensure the IPCT are better informed of infections in a timely fashion to ensure prompt and appropriate action can be taken.

The IPCT continue to develop d the infection control link worker and hand hygiene core training programmes to promote infection prevention awareness across wards and community teams.

By the end of March 2013, in line with the infection control annual audit programme, the IPCT anticipate completion of 25 decontamination, 6 environmental and 40 kitchen audits along with 12 mattress inspections.
From January 2012, the Matrons undertake quarterly hand hygiene audits within their areas and findings are reported back to the Infection Prevention Partnership Committee. Initial findings indicate approximately 85 per cent compliance. The IPCT continue to train core hand hygiene trainers to promote best practice in hand hygiene within ward areas and community teams.

Clinical Effectiveness

Summary indicators

Comment: As identified in other sections of the report a significant challenge for the organisation this year has been the implementation of the new RIO record system. The benefits of this system in relation to improving clinical effectiveness are therefore still to be fully demonstrated.

Target	10/11	11/12	12/13		Comments	Data Source	Reason for inclusion
CRHT % gate kept* admissions Target 95%	99%	97.7%	**96.2**	✓	(See section 2 indicators) National Benchmark (1) • Nat Mean: 98.4 Trust figure is reflective of benchmark. This is a reduction in performance from 2011/12 but still meets the target.	Key Performance Indicator- Patient Information System	Demonstrates whether our Home Treatment teams are working effectively to support patients in their home where possible and to enable early discharge from hospital
Antipsychotics dementia drugs	40%	36%	21%	↑	This audit was further developed over the year as part of our CQUIN agreed with commissioners. The Trust fully met all of the CQUIN requirements for this.	Local Audit Mental Health Services for Older People	Government estimates are that around two thirds of elderly patients with dementia have antipsychotic medication prescribed for them that they do not need or benefit from
ICR compliance	62.3%	75.6%	42%	↓	Note – Due to changes in electronic patient information systems the audit methodology from previous year is not similar and therefore direct comparison is difficult. The revised method is intended to support further improvement.	Key Performance Indicator- Patient Information System	The Integrated Care Records (ICR) documentation has been developed to reflect the key information requirements that demonstrate good quality care. Compliance with the ICR process will help to ensure compliance with the Care Programme Approach.

*National Definition – Please see appendix two

Mental Health Outcomes

Mental health outcomes have remained a key focus for BSMHFT in 2012/13. Within mental health services it is vital that we consider outcomes from different angles in line with the National Mental Health Strategy. These perspectives include recovery, physical health, wellbeing, stigma and discrimination, avoidable harm and experience. In 2011/12 we saw an improved understanding at BSMHFT of how we measure, capture and report our outcomes in all of the above areas.

During 2012/13 the Trust has built on this by increasing our understanding of what our existing data tells us about the outcomes that we achieve. Key clinical outcomes data is summarised below:

Adult mental health services

Clinical Outcome and Routine Evaluation (CORE) is the key Patient Reported Outcome Measure (PROM) used across our adult CMHT psychological services. It is well established having been used with service users for several years. This outcome measure covers four dimensions, namely, subjective well-being, problems/symptoms, life functioning and risk/harm. Overall, the average post-therapy outcome measures show that 63% of service users, completing therapy, showed reliable improvements compared with the national benchmark of 58% in CMHTs (Lucock et al., 2003). Where data is available to provide a comparison between BSMHFT and other mental health Trusts serving similar levels of morbidity we compare favourably.
In addition to the above evaluation of adult psychological services, group intervention work is also evaluated using relevant outcome measure tools. The most recent reports show that outcomes that we have achieved as a result of this intervention work includes:

Psychosis group- there were benefits to service users in how they feel about their ability to cope with relapse (FORSE scale) and improvement in their recovery in relation to Trust and help, identity and self-esteem and social networks (recovery star) and positive impact of being around others experiencing similar symptoms.

Depression group- average clients' scores fell from the severe depression range before the depression group to the moderate range on completion of the depression group, indicating an overall improvement in depression symptomatology (Becks Depression Inventory II)

Obsessive Compulsive Disorder group- clients' experience of attending the OCD groups is positive and provides an essential vehicle to reduce the isolation and stigma often suffered by clients with OCD.

In our Non-Acute Inpatient units (rehabilitation units) outcome measure data analysed in one of each type of unit (high dependency unit, long-term complex care and community) demonstrated that engagement increased over the 12 month period in almost all areas. The largest improvements were observed in agreement with treatment in the high dependency unit and active participation in the community unit (Residential Rehabilitation Engagement Scale). In addition the observed frequency of challenging behaviours reduced over the 12 month period. The largest decrease was observed in the long-term complex care unit (Challenging Behaviour Checklist). Further outcome data analysed for the community unit showed that community living skills improve over a 12 month period while at the community unit.

The Health of the Nation Outcome Scale (HoNOS) is the key clinician rated outcome scale that we use in all services as part of the Payment by Results initiative. At present we are unable to extract meaningful outcomes data as further work is required to ensure that there is sufficient data available to analyse outcome over time and also to improve the quality of the data recorded to ensure that it is as accurate as possible. These improvements form part of the work plan for the coming year.

Addictions services
COMPASS is our consultation-liaison service designed to provide integrated treatment and to enhance the response to people with combined mental health and substance use problems. Outcomes data from a recent three year service evaluation showed that clients who completed the brief intervention showed improvements in a number of areas including: Increased engagement with treatment, reduced dependence and improved confidence. In addition a key role of the service is to deliver a structured training package, on a cognitive behavioural integrated treatment approach, to staff within mental health services.

As reported in a peer reviewed journal, it has been demonstrated that following the receipt of training staff confidence in treating individuals with combined psychosis and substance use problems significantly increased and remained high at our most recent follow up 10 years later.

We plan to increase the sophistication of our outcomes reporting. This will mean that outcomes will be reported as part of pathway reports where they are set in context of the needs, morbidity and profiles of the people we see and the resources and interventions that we provide. This will help us to further understand our outcomes in relation to different cluster allocations and diagnostic groups, as well as ethnicity, age and gender and the impact of different resources and interventions provided.

The updated outcomes frameworks for public health, adult social care, quality (GP indicators) and the NHS for 2013/14 will be brought into our thinking along with the CCG Outcome Indicator set as we aim to incorporate any provider level results that are issued through the NHS information centre into our thinking.

Rapid Assessment, Interface and Discharge (RAID) Service

There has been widespread interest in possibilities it presents for making significant savings while improving and streamlining patient care. When RAID was launched at City Hospital in December 2009 it was the first service of its kind in the UK to ensure that patients presenting at acute settings received help for their mental health as well as their physical health at the same time.

The Government's mental health strategy, *No Health Without Mental Health* (published in February 2011), recognises that mental wellbeing is closely linked to our physical health – and the need for mental health awareness to be raised in primary care and acute hospital settings.

RAID is a great example of how this strategy is working as, since March 2012, all five hospitals in Birmingham and Solihull - City Hospital, Queen Elizabeth Hospital Birmingham, Heartlands, Good Hope and Solihull – have rolled out RAID services. This promotes partnership working and increases awareness of mental health conditions within their acute settings. RAID was established by our Trust, in partnership with Sandwell and West Birmingham Hospitals NHS Trust: It was the first service of its kind to work with an acute partner, to improve patient outcomes, streamline care and, in the process, make significant savings to the public purse.

Since the pilot RAID scheme was launched at City Hospital in December 2009 it has improved patient experience and saved the NHS more than £6 million.

Research and innovation

The year 2012/13 is a time of transition for the NHS. The Health and Social Care Act 2012 has established clinically-led commissioning of high quality services from providers that compete and deliver research-led innovations and choice. Over the past five years our research achievements have been outstanding, and place the BSMHFT 'brand' in a favourable competitive position. Going forward we have been successful in securing grants totalling nearly £3m for four studies that will begin in 2013/14:

- PARTNERS2: Development and pilot trial of primary care-based collaborative care for people with serious mental illness
- A pilot study to assess the feasibility and impact of motivational intervention on problem drug and alcohol use in adult mental health inpatient units
- A pilot study of the Social Network Intervention for Heroin Users in Opiate Substitute Treatment
- Adaption and feasibility study of a family and social network intervention for young people who misuse alcohol and drugs.

Going forward, we are also looking at a further eight potential studies, if grant applications are successful.

Achievements and impact of research and innovation

Our Research and Innovation Team continue to develop and nurture partnerships with a number of respected universities, including University of Birmingham and University of Warwick, and continue to host the National Institute for Health Research's Mental Health Research Network. These relationships enable the team to conduct high quality research both locally and nationally. Innovations in clinical services during 2012/13 included:

- Development of Youthspace – a youth access care pathway and public health platform (www.youthspace.me) – and the agreement with CAMHS at Birmingham Children's Hospital to pioneer an integrated pathway for 12 to 25-year-olds. This also involved working with the Prince's Trust.
- Reduction in the delay between diagnosis and treatment for first episode psychosis among young people in Birmingham.
- Improved care pathways for BME service users with psychosis.
- Evaluated the Trust's addictions services which resulted in subsequent improvements.
- Delivering an innovative advanced (MSc level) research course for eight of our service users.
- A national evaluation (EDEN) of early intervention in psychosis teams led to redesign of their aims and structure to improve the social outcomes and cost effectiveness.
- An innovative collaboration between voluntary sector, faith groups, user organisations, with a view to delivering culturally appropriate care to BME service users.

Our research and innovation work continues to impact on mental health services across the United Kingdom:

- The ENRICH study, led by Professor Swaran Singh, has impacted on national policy, with the Government accepting that ethnic differences in mental health are due to complex societal factors, rather than institutional discrimination in psychiatric care.
- Professor Max Birchwood was invited to sit on two National Institute for Health and Clinical Excellence (NICE) guideline groups for schizophrenia, which includes evidence from research and innovations led by BSMHFT.
- Dr Peter Bentham's research into drug interventions in Alzheimer's disease will impact upon NHS prescribing and disease-management guidance.
- Our neuropsychiatry research programme has published more than 50 peer-review publications on Huntington's disease, Tourette's syndrome.

PATIENT EXPERIENCE

Summary indicators

Comment: Although this seems to be a difficult issue for all Trusts (with whom we are on a par) we will be making renewed efforts through our plans to address priorities identified in this account. Following the implementation of the Trusts real time feedback systems highlighted above indicators will be developed for the year ahead to further reflect this feedback.

Target	10/11	11/12	12/13				
CPA review in previous 12 months %* Target 95%	95.6 %	96.5%	**92.2**	✗	National Benchmark (1) National mean 80.72 (this reflects data from Q3 2011/12) The Trust failed to meet the target in Quarter 1 but the target has been met in subsequent periods: Qtr 2 - 4:	Key Performance Indicator- Patient Information System	Compliance with this indicator assures that our service user's needs are being reviewed and planned for at the minimum standard of annually
CPA – seven day follow up* Target 95%	96.9 %	96.2%	95.26	✓	**(See Section 2.5 above)** National Benchmark (1) • 97.16% (Trust is within normal range.) • This is a slight reduction in performance from 2011/12.	Key Performance Indicator- Patient	Leaving hospital is a vulnerable time for service users and carers. Active support is essential to ensure the safe transition back to their home environment.
Complaints timeliness	90%	86%	**77% #**		End year figure here is still subject to final outturn figure. This is a slight reduction in performance from 2011/12.	Information System Clinical Governance Dashboard	One of the key features of high performing organisations is the way that they respond to customers who are unhappy about the service that they have received. Listening to people about their experiences enables us to work to resolve issues earlier, learn new ways to improve and prevent the same issues in the future.
Patient Survey – 'Do you have the number of someone to call outside office hours?'	56%	55%	47.9%	↓	National Benchmark 58% All Mental Health Trusts This is a reduction in performance	NHS Patient Survey	Service users and their families need to know how to access support in case of difficulties arising during evenings or weekends.

*National Definition – Please see appendix two

Carers strategy launch and conference

On the April 27, 2012, the Trust hosted its first major event for carers, families and friends at St Andrew's stadium, home of Birmingham City Football Club. The main purpose of the day was to launch the new Trust-wide carer's strategy, which sets out our aims and objectives for future – not only to raise awareness of the vital role that carers, families and friends play, but also improve the involvement of and support to the families and friends of our service users.

It was also felt that it was important for the Trust to show how much we value and recognise the contribution that our families and friend make in the wellbeing of our service users. Outside stakeholders attended, showcasing their services in the 'market place' that was set up, with a wide range of information about support, financial and carer involvement groups.

The event was opened by our Trust Chair Sue Davis, CBE, and speakers included Dee Roach, Executive Director of Quality, Improvement and Patient Experience and Dr Grainne Fadden from the Meriden Family Work Programme.

The Trust's carer's strategy has five guiding principles:

- Raising awareness of carers and their needs
- Improving the involvement of carers
- Supporting carers better
- Sharing and providing information
- Working in partnership with families

Attendance exceeded all expectations, with more than 130 carers, staff and stakeholders coming along. There was a real opportunity to share openly and honestly views on how the Trust is doing now, and offering a chance to share and have more of a say in how things should be done to improve services and support people more, when it is needed. We were overwhelmed with the response and the positive feedback whilst recognising there is still much to do. The next steps for the Trust will be to turn the strategy into real actions and outcomes and to be an organisation that is 'carer aware'.

Comments and complaints: How we handle them

Our Trust uses experience gained from dealing with complaints to improve mental health services within Birmingham and Solihull. The Trust welcomes patient feedback. We aim to respond effectively and ensure we learn lessons when things go wrong.

COMPLAINTS – complaints in themselves are a vial source of feedback - important opportunity to learn, put things right, improve patient experience.

Following the relocation of the Complaints team in February 2012 to our Ardenleigh site in Erdington there has been much more collaborative working between PALs and Complaints. We put a lot of focus into ensuring patient and relative concerns can be resolved at the time and in the place they arise. We encourage complaints or concerns to be addressed by relevant front line staff, for example, a ward manager or head of department. Ideally problems are resolved on the spot or within a day, but if not, patients/carers can seek support from our Customer Relations Department from a member of the Patient Advice and Liaison team (PALs).

If patients/carers do need to make a formal complaint, they can be referred to the Complaints team. Our complaints team provides information and assistance to service users, their relatives and visitors who wish to complain about the service our Trust provides. It also gives help and advice to staff who are involved in the investigation of a complaint.

All complaints are formally acknowledged within three working days. Our aim is to provide a full response as speedily as possible, however if we are unable to provide a response within the agreed timescale, the person is contacted to discuss the delay and to agree a new timescale in which a full response is to be provided.

3.2 Performance against key national priorities

Birmingham and Solihull Mental Health NHS Foundation Trust has also maintained quality of service, meeting or exceeding all Monitor Indicators (as outlined in Appendix B of Monitor's Compliance Framework) and core National Commissioning targets as detailed in the table below.

Table 17:

Monitor Indicators 2012/13			
	Monitor Threshold	**2011/12 outturn**	**2012/13 outturn**
1. Care Programme Approach (CPA) patients receiving formal review in past 12 months	**95%**	**96.5%**	**92.2% (1)**
2. Minimising delayed transfers of care (including social care delays)	**≤7.5%**	**1.9%**	**4.9%**
3. Meeting commitment to serve new psychosis cases based on trajectories agreed with commissioners	**95%**	**100%**	**100%**
4. MHMDS Data Completeness - identifiers recording of NHS number, Date of birth, postcode, gender, GP registered code & commissioning code.	**99%**	**99.5%**	99.4%
5. Access to healthcare for people with learning disabilities	**N/A**	**Compliant**	**Compliant**
6. Data completeness – outcomes for patients on CPA • Recording of employment status • Recording of accommodation status • % having HONOS assessment in last 12 months	**50%**	**88.2%**	**84.6%**
National Commissioning Targets 2012/13			
	Threshold	**2011/12 outturn**	**2012/13**
Clostridium Difficile Infections	**0**	**0**	**0**
MRSA infections	**0**	**0**	**0**

Note (1) Target was met for Quarters 2, 3 and 4.

Appendix One

Birmingham and Solihull Mental Health NHS Foundation Trust

Quality Account 2012/13

Statement of assurance from Birmingham CrossCity CCG May 2013

Birmingham CrossCity CCG as the lead commissioner for Birmingham and Solihull Mental Health NHS Foundation Trust welcomes the opportunity to provide this statement for the Trust's Quality Account 2012/13. 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 and the Area Team for NHS England.

With responsibility for the quality of services it commissions from the Trust the CCG as a newly formed commissioning organisation over the past year has developed challenging but constructive relationships with the Trust's clinicians and managers, reviewing performance through monthly Clinical Quality Review Group meetings and addressing any issues around the quality and safety of patient care with the Trust. Some of the areas we are working on closely with the Trust are detailed below.

Since taking on responsibility as lead commissioner in October 2012/13, we have been working closely with the Trust to resolve an issue regarding the number of outstanding serious incident reports. A detailed plan and trajectory to deliver sustainable improvements will be seen in 2013, and the CCG will be closely monitoring the management and impact of organisational learning from serious incidents through this plan.

Through our work with the Trust, the CCG felt the Quality Account would have benefited in including reflections such as feedback from patients and carers. It is reassuring that the Trust has made reference to the involvement of patients in the Trust's business plan objectives and the development of a carers' strategy. The Quality Account details several methods of collecting data from patients and it would be valuable to include further analysis of how this impacted on patients directly. We look forward to working with the Trust as they focus on the Care Programme Approach, a priority that has been set for the second rolling year. The first year was for developing the Care Programme careplan and the second year rolling out all elements throughout the organisation. The Quality Account would have benefited from fully explaining what specifically the Trust will do differently next year to ensure the identified priorities are achieved in 2013/14 and what this means for patients, carers and frontline staff. We felt the Quality Account would have been enhanced further with the inclusion of some of the positive work the Trust is doing through its schedule of quality visits and the impact the CQUINs have had on patients, carers and direct frontline staff. Some positive developments described in the account included improvements made within some of the specific services such as the addictions service where brief interventions have resulted in better patient outcomes.

We also welcome the improvements that have been made in reducing assaults on staff, the work the Trust is undertaking to improve information governance and the reduction in the use of anti-psychotic drugs for patients with dementia.

Infection prevention is highlighted and the work being taken to reduce infection rates is positive and although there have been increases in the number of cases of norovirus, the Trust is focused on reducing this infection through improvements in hand hygiene and its audit programme.

It is unfortunate the Trust has not included the positive work that was achieved in relation to the issues with the performance of the Introduction to Adult Psychological Therapies (IAPT) service. Commissioners discussed and worked closely with the Trust, which resulted in the agreed action plan being achieved with positive outcomes for patients on the waiting list. The Trust is working hard to improve this further in 2013/14.

We are pleased to see the Trust has a new safeguarding lead and would have expected to see how safeguarding arrangements are being embedded across the diverse range of services and settings operated by the Trust. This should include how the Trust ensures compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.

During the year there have been a number of visits conducted by Care Quality Commission and of late by the CCG. The Trust is aware of the themes and trends identified from these visits. Any concerns identified are being addressed, specifically those aligned to address the capacity and capability of the workforce including skillmix and workforce planning. Intelligence from the staff surveys and from serious incident reports supports the need to improve this identified area of concern. We have been informed the Trust Business Plan will include significant monitoring of this and it will also be a key priority for the monthly Clinical Quality Review Group meetings.

We are informed that the Trust has a number of projects and action plans in place to focus on the points identified within the Quality Account. The Trust will be presenting an overarching development plan at the monthly Clinical Quality Review Group meetings which will be supported by a quarterly progress summit update against this overarching development plan.

In conclusion we welcomed the opportunity to comment on the Trusts Quality Account. A number of achievements were made by the Trust in areas such as IAPT, reducing staff assaults and use of anti-psychotic medications. There were also a number of challenges and the CCG is working closely with the Trust to develop a positive culture of collaboration which is underpinned through clinical engagement and partnership in a supportive structure. In this statement we have highlighted a number of concerns particularly in relation to reflecting patient and carer involvement and impact on outcomes. In summary, we will continue to work in partnership to deliver the quality agenda, ensuring that there is a true sense of momentum and dynamism demonstrated through to patients, carers and staff.

Catherine Griffiths

Interim Chief Accountable Officer

Birmingham CrossCity Clinical Commissioning Group.

Annex: Statement of directors' responsibilities in respect of the quality report

Annex: Statement of directors' responsibilities in respect of the Quality Report
The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation Trust boards should put in place to support the data quality for the preparation of the quality report.
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

☐*the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13;*

☐*the content of the Quality Report is not inconsistent with internal and external sources of information including:*

o *Board minutes and papers for the period April 2012 to June 2013*

o *Papers relating to Quality reported to the Board over the period April 2012 to June 2013*

o *Feedback from the commissioners (Birmingham Cross City Clinical Commissioning Group) dated 26/04/13 and 24/05/13*

o *Feedback from governors dated 29/04/2013*

o *The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2012;*

o *The latest national patient survey (2012) Community Mental Health Patient Survey*

o *The latest national staff survey 2012*

o *The Head of Internal Audit's annual opinion over the Trust's control environment dated 13/5/2013*

o *CQC quality and risk profiles dated March 2013*

☐*the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;*

☐*the performance information reported in the Quality Report is reliable and accurate;*

☐*there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;*

☐*the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).*

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

NB: sign and date in any colour ink except black

24/5/13 Date ..... Chair

23/05/13 Date (J.D. SHORT) ..... Chief Executive

Appendix Two

Indicator definitions (see section: 3.1)

Safety

- **Health and Safety Training** – Compliance with mandatory training for health & safety (annual updates for in patient staff)
- **NPSA incident reporting per 1000 bed days** – Number of incidents reported to national learning system by Trust per 1000 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** - Admissions to inpatient services having access to crisis resolution home treatment teams. This is a mandated indicator: ***National definition****:* This indicator applies only to admissions to the NHS foundation Trusts mental health psychiatric inpatient care. The following cases can be excluded:
    - Internal transfers of service users between wards in a Trust and transfers from other Trusts;
    - Patients recalled on Community Treatment Orders; or patients on leave under Section 17 of the Mental Health Act 1983.
- An admission has been gate kept by a crisis resolution team if they have assessed the service user before admission and if it is documented that they were involved in the decision-making process, which resulted in admission (as per Trust Care Management policy).
- Where an admission is from out of the Trust 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 gatekept in the CR team to assure themselves that gatekeeping was carried out.
- **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.
- **CPA – seven day follow up** - % of Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital. Mandated indicator: National definition: All patients discharged to their place of residence, care home, residential accommodation, Prison or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Follow up is not required for discharges from respite care.

- Exemptions: Patients who die within 7 days of discharge may be excluded or where legal precedence has forced the removal of a patient from the country. Patients who are not UK residents who are discharged to an overseas address. Patients transferred to NHS psychiatric inpatient ward. Patients who are absent without leave. CAMHS (child and adolescent mental health services). The 7 day period should be measured in days not hours and should start on the day after the discharge.
- **Complaints timeliness** - % of complaints responded within timescale originally agreed with complainant.
- **Patient survey** – National Patient survey results Community Mental Health Teams

Independent Auditors' Limited Assurance Report to the Assembly of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Assembly 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 2013 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 in the Quality Report that have been subject to limited assurance consist of the following national priority indicators as mandated by Monitor:

1. 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital; and

2. Admissions to inpatient services had access to crisis resolution home treatment teams.

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

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to in Appendix 2 of the Quality Report (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") 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;

- 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.

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 2012 to the date of signing this limited assurance report (the period);
- papers relating to Quality reported to the Board over the period April 2012 to the date of signing this limited assurance report;
- feedback from the Commissioners Birmingham Cross City Clinical Commissioning Group;
- feedback from Governors;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated September 2012;
- the latest national patient survey dated 2012;
- the latest national staff survey dated 2012;
- Care Quality Commission quality and risk profiles dated 31/03/2013; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 13/05/2013.

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 Assembly of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust as a body, to assist the Assembly 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 2013, to enable the Assembly 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 Assembly 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:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the specified indicators back to supporting documentation;
- comparing the content requirements of the FT ARM to the categories reported in the Quality Report; and
- reading the 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 Directors' interpretation of the Criteria in Appendix 2 of the Quality Report.

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.

Conclusion

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

- the Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- the Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP Chartered Accountants
Cornwall Court
Birmingham

24 May 2013

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.

Our staff, our greatest asset

Workforce profile

Table 18: BSMHFT workforce profile by staff group and gender 2012/13

Staff Group	Female	% Female	Male	% Male	Grand Total
Add Prof Scientific and Technic	200	74.1%	70	25.9%	270
Additional Clinical Services	717	71.0%	293	29.0%	1010
Administrative and Clerical	653	75.6%	211	24.4%	864
Allied Health Professionals	112	89.6%	13	10.4%	125
Estates and Ancillary	111	65.3%	59	34.7%	170
Healthcare Scientists	3	75.0%	1	25.0%	4
Medical and Dental	135	46.6%	155	53.4%	290
Nursing and Midwifery Registered	899	69.1%	402	30.9%	1301
Grand Total	**2830**	**70.2%**	**1204**	**29.8%**	**4034**

Table19: Staff in post: Equality and diversity data for 2012/13

Ethnicity		Trust Profile 2009	Trust Profile 2010	Trust Profile 2011	Trust Profile 2012	Trust Profile 2013	2011 Census Data: Birmingham Population	2011 Census Data: Solihull Population	2011 Census Data: Birmingham & Solihull Population
White	British	54.52%	55.29%	55.20%	55.28%	55.01%	53.10%	85.80%	58.40%
	Irish	3.90%	3.57%	3.47%	3.26%	3.17%	2.10%	1.90%	2.00%
	Other White	2.39%	2.53%	2.50%	2.91%	2.88%	2.70%	1.40%	2.50%
Asian or British Asian	Indian	5.95%	5.86%	6.25%	6.67%	6.52%	6.00%	3.40%	5.60%
	Pakistani	2.49%	2.50%	2.66%	2.53%	2.83%	13.50%	1.70%	11.60%
	Bangladeshi	0.49%	0.51%	0.61%	0.53%	0.62%	3.00%	0.30%	2.60%
	Other Asian	1.41%	1.34%	1.29%	1.20%	1.26%	2.90%	0.70%	2.60%
Mixed	White & Black Caribbean	1.15%	1.17%	1.29%	1.38%	1.41%	2.30%	1.20%	2.10%
	White & Black African	0.44%	0.53%	0.48%	0.45%	0.50%	0.30%	0.10%	0.30%
	White & Asian	0.44%	0.44%	0.53%	0.48%	0.52%	1.00%	0.60%	1.00%
	Other Mixed	0.29%	0.39%	0.38%	0.38%	0.42%	0.80%	0.30%	0.70%
Black or Black British	Black Caribbean	9.05%	9.16%	8.93%	8.70%	8.78%	4.40%	0.90%	3.90%
	Black African	6.56%	6.29%	6.73%	6.79%	6.69%	2.80%		2.40%
	Other Black	0.90%	0.97%	1.04%	1.03%	1.02%	1.70%	0.20%	1.50%
Chinese	Chinese	0.24%	0.27%	0.30%	0.28%	0.32%	1.20%	0.40%	1.10%
Other Ethnic Group	Other Ethnic Group	1.15%	1.07%	1.01%	0.95%	0.99%	2.00%	1.00%	
Undefined	Not Stated	8.63%	8.12%	7.34%	7.19%	7.06%	-	-	,-
Grand Total		**100%**	**100%**	**100%**	**100%**	**100.00%**	**100%**	**100%**	**100%**

Table 20: Workforce age profile

Age Range	Headcount	% Headcount
<20	4	0.1%
20-29	527	13.1%
30-39	1011	25.1%
40-49	1307	32.4%
50-59	959	23.8%
60-64	183	4.5%
>65	43	1.1%
Grand Total	**4034**	**100.0%**

Table 21: Sexual orientation profile

Sexual Orientation	Headcount	% Headcount
Bisexual	10	0.2%
Gay	29	0.7%
Heterosexual	1881	46.6%
I do not wish to disclose my sexual orientation	254	6.3%
Lesbian	14	0.3%
Not Stated	1846	45.8%
Grand Total	**4034**	**100.0%**

Table 22: Gender profile

Gender	Headcount	% Headcount
Female	2830	70.2%
Male	1204	29.8%
Grand Total	**4034**	**100.0%**

Table 23: Religious beliefs profile

Religious Belief	Headcount	% Headcount
Atheism	195	4.8%
Buddhism	10	0.2%
Christianity	1382	34.3%
Hinduism	52	1.3%
I do not wish to disclose my religion/belief	307	7.6%
Islam	140	3.5%
Jainism	2	0.0%
Judaism	6	0.1%
Other	189	4.7%
Sikhism	61	1.5%
Not Stated	1690	41.9%
Grand Total	**4034**	**100.0%**

Table 24: Disability profile

Disability	Headcount	% Headcount
No	2292	56.8%
Not Stated	1632	40.5%
Yes	110	2.7%
Grand Total	**4034**	**100.0%**

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 below provides an overview of our workforce in terms of some of those 'protected characteristics' identified within the Equality Act 2010. We are working towards being able to report on all nine characteristics (listed below) as part of our commitment to implementing the Equality Delivery System (EDS).

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. All staff are required to undertake mandatory equality and diversity training which can be accessed in a variety of ways from e-learning, to drop-in sessions and workshops.

Equalities panel

In late 2012 BSMHFT formed an 'Equalities Panel' consisting of the Executive Medical Director, Executive Director of Organisational Development and Performance Improvement, Director of Community Engagement, a Non-Executive Director, a Consultant Psychiatrist and the Trust Equalities Lead.

Following the publication of a number of internal equality reviews, the strategic group was set up to drive forward the recommendations learning from best practise, research and other intelligence. The group's remit is to put together an Equality, Diversity and Human Rights strategy for the organisation, engaging the appropriate stakeholders and ensuring that BSMHFT adheres to its duties under the Public Sector Equality Duty and Equality Act. The panel currently meets monthly.

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 9 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 transformation programmes. Support is available for staff and in 2013/14 we will be reviewing EIA processes to ensure the approach is of a high quality, clear and consistent.

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.

Recruitment of staff with disabilities

Between April 2012 and March 2013 a total of 27,753 applications were received for employment within the Trust, 1043 of which declared a disability and 229 did not disclose. 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.

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. The networks meet regularly and are active in supporting individual staff issues and reviewing Trust policies.

Fundamental training

Our services are provided through our staff, usually through direct contact with the service user or other member of staff. Given the multicultural environment within which staff work it is vital each member of staff ensures the service they provide is sensitive, and responsive to the needs of all individuals. We therefore 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.

Monitoring

The Trust is engaged in on-going work to harness patient and staff demographic data and to ensure this is provided in a meaningful format. See workforce statistics in tables 18 to 24 on pages 72 to 74.

Publication

We annually publish employment monitoring data, consultations, equality impact assessments, single equality scheme and annual reports.

Going forward

A key focus of work going forward which cuts across operational activity and workforce is the need to look at strategies to ensure where possible the composition of clinical teams reflects the diversity of service users receiving care. The flexing of our workforce through effective staff deployment and recruitment is already a feature of our workforce strategy and will help support progress towards achieving that objective within the actions for 2012/13.

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;
- childcare voucher scheme; and
- access to physical therapies service.

Organisation-wide cultural change

We are continuing to shape our culture to become one where continuous service and organisational improvement is integral to everything we do.

Our organisational development team has been successful in delivering service improvement initiatives, providing internal consultancy and organisational development programmes consistently across our Trust – enabling our staff to deliver real changes from ground level upwards. While we continue to implement a lean approach across the Trust, our commitment to improving our business and clinical practices, and adopting processes to eliminate waste, is undeterred. We continue to encourage every member of staff to adopt lean principles in their work and we have already seen improvements in some areas of our Trust – addictions, care records management processes, inpatient and pharmacy services.

Staff wellbeing

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 were introduced following feedback from staff. The advisors act as independent advocates who provide confidential advice/support and often support and enable staff to resolve issues informally where appropriate. The advisors have supported approximately 100 staff over the past 12 months, receiving positive feedback from staff.

The HR team have enhanced the mechanisms to capture and analyse employee relations casework data and provide this information to directors and senior divisional managers on regular basis to allow a further local comparison and analysis of trends. This will also allow identification of those disciplinary investigations which have been commissioned in response to claims of alleged prejudice against equality targeted groups.
While we have achieved improvements in some areas of the staff survey compared to last year's results, we remain focussed on those areas where we remain in the bottom 20 per cent.

In response to the 2011 survey results, we have taken a more targeted approach with service lines required to provide progress updates. We expect based on those actions to continue to achieve improvements in our staff survey results going forward.

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 and physiotherapy service.

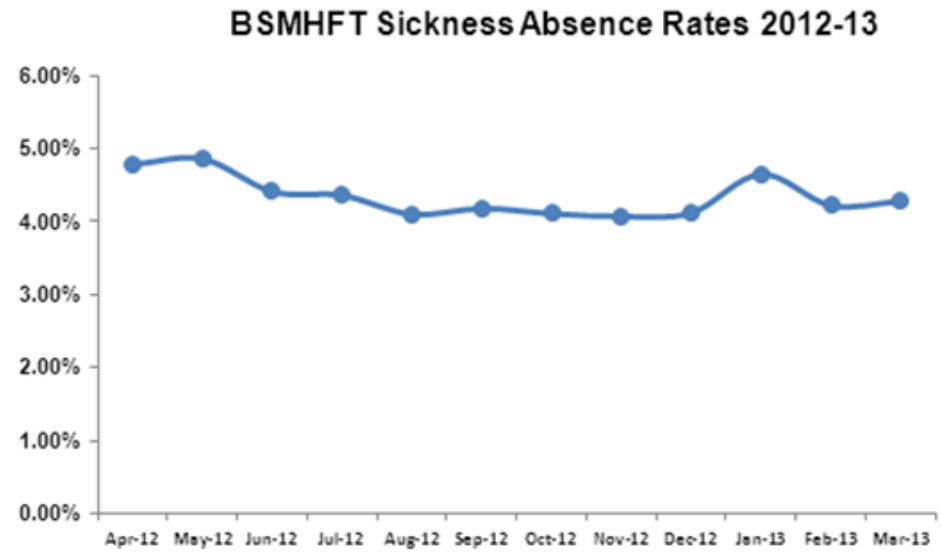
The Trust has put in place a series of actions to improve our sickness absence position in the immediate and long term linked to our stated target of achieving a sickness absence rate of 3.39 % by March 2014. These are focussed on our key hotspots and targeted at the main underlying causes for sickness absence.

Those are combined with a renewed approach to improving the health and wellbeing of our staff which includes the re provision of our occupational health and staff support services.

Table 25: Staff sickness absence 2012/13

Month	Sickness Rate
Apr-12	4.78%
May-12	4.86%
Jun-12	4.41%
Jul-12	4.36%
Aug-12	4.10%
Sep-12	4.18%
Oct-12	4.11%
Nov-12	4.07%
Dec-12	4.12%
Jan-13	4.65%
Feb-13	4.22%
Mar-13	4.28%

Figure 26: Staff sickness absence rates 2012/13



A commitment to learning and development

The year has been a challenging one for learning and development as external sources of funding from the health sector for training and development initiatives have reduced due to the economic climate, however the Trust has continued to invest in a number of critical areas.

Apprenticeships: Nurturing the next generation of nurses

As a large employer Birmingham and Solihull Mental Health NHS Foundation Trust has a responsibility to facilitate career opportunities for our local community, and to embrace government initiatives to recruit from the underrepresented 16 to 24-year-old age group. Last year the Trust took on ten apprentices, as part of its recruitment programme for the Tamarind Centre, under the Trust's first clinical apprenticeship scheme. These apprentices have proved to be a real asset to our forensic services.

More than 500 people applied for a place on the scheme which offered a 12-month placement at Ardenleigh, in Erdington, and Reaside, in Rubery. The apprentices have now settled into their posts and are learning new skills while gaining vital work-based experience on our units.

The pilot was originally devised by Lorraine Conlon, lead nurse in secure services working closely with the Trust's Learning and Development team, to create a programme that would not only support our apprentices, but give them experience of working within a secure healthcare setting.

Team performance

Measuring team performance is crucial as it allows us to continue to identify areas of good practice and the delivery of Trust business. Our Trust uses the Aston team performance inventory and team workbook series as a measurement tool in a number of different settings.

Staff engagement

We have continued to roll out our staff engagement and internal communications strategy to create a consistent message for staff on the strategic direction and values of the organisation, as well as creating opportunities for feedback and two way communications. A further element to this strategy is engagement with managers, so they can inspire their staff and give them a voice.

One of the first areas being developed is staff recognition in order to support employees and valuing their hard work and saying thank you for their contribution. Other areas that have been developed include increased Trust Board visits of sites to enhance the link between the Board and front-line services, a weekly briefing to all staff from the CEO for managers and 'regular temperature checks', which will assist in the planning and evaluation of employee engagement and staff feedback.

Also, as part of the strategy in Summer 2012, our Chief Executive and Chair held a number of Big Conversation road shows to update staff on the progress of our internal plans and also how our Trust fits in to the bigger picture, the changing landscape of the NHS, and what our Trust is doing in response and the part our staff play.

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 front-line 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

The new approach, led directly by the Chief Executive, started with a series of listening events with staff, quickly followed by some 'quick wins' in response to what staff said were issues in the Trust that got in the way of them improving patient experience.

National staff survey 2012/13

Summary of performance

Table 27:

	2010/11		2011/12		Trust improvement/ deterioration
Response rate	**Trust**	**National average**	**Trust**	**National average**	
	54%	54%	55%	55%	1% improvement

Table 28

TOP 5 RANKING KEY FINDINGS	Trust 2011	National Average for Mental Health and learning disability Trusts	Trust 2012	National Average for Mental Health and learning disability Trusts	Trust Improvement or Deterioration
KF 26: % of staff having equality and diversity training in last 12 months (the higher the score the better)	73%	53%	77%	59%	Increase 4%
KF1: % of staff feeling satisfied with the quality of work and patient care they are able to deliver (the higher the score the better)	81%	74%	81%	78%	Remains the same
KF5. % of staff working extra hours (the lower the score the better)	62%	65%	66%	70%	Negative increase 4%
KF8. % of staff having wellstructured appraisals in last 12 months (the higher the score the better)	44%	38%	43%	41%	Decrease 1%
KF10. % of staff receiving health and safety training in last 12 months (the higher the score the better)	79%	83%	76%	73%	Decrease 3%

Table 29

Bottom 5 Ranking Key Findings	BSMHFT 2011/2012		National Average for Mental Health and learning disability Trusts		BSMHFT Improvement or Deterioration
	2011	2012	2011	2012	
KF4: % Effective team working (the higher the score the better)	3.75	3.65	3.81	3.83	Decrease 0.1
KF19: % of staff experiencing harassment, bullying or abuse from staff in last 12 months (the lower the score the better)	18%	30%	13%	21%	Changes have been made to question wording and responses, therefore not directly comparable
KF 20: % of	19%	28%	20%	22%	Negative increase

staff feeling pressure in last 3 months to attend work when feeling unwell (the lower the score the better)					9%
KF 17: % of staff experiencing physical violence from staff in last 12 months (the lower the score the better)	3%	8%	1%	4%	Changes have been made to question wording and responses, therefore not directly comparable
KF14: % of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better)	99%	88%	97%	93%	Decrease 11%

*** the lower the score the better**

Action plans to address areas of concerns

Whilst some improvements have been made since the last survey (2011/12), there remains significant work that the Trust needs to continue to build on.

The Trust is currently working on three initiatives which should positively impact our scores over time in relation to discrimination, bullying and equal opportunities. These are:

- The creation of a long term plan to address the Trust's equality and diversity issues.
- Proactive sickness management approach which should address issues such as work and team climate in areas where sickness rates due to stress and anxiety are high.
- A focus on talent development and succession planning to ensure that talent pools are identified and developed and that individuals with management style and capability appropriate to our desired culture are promoted.
- The implementation of Listening into Action, a new approach to staff engagement, which is a national model that has had substantial success in improving staff survey results.

These initiatives above are central to the People Plan that has been developed by the organisational development and performance improvement division this year. Each area forms a clear programme of work with specific outcome measures and short and long term delivery dates. This work is fundamental to taking forward the Trust and ensuring that staff experience real improvements in their work life.

Communicating with our staff

Devolving decision-making to the frontline, and enabling team managers to have more authority and accountability is the direction our Trust has moved to over the past year. Some of the outcomes of this have included staff at all levels being involved in business planning for their areas, which has helped us build upon our internal values.

As the organisation changes to adapt to the evolving NHS landscape, engaging and communicating with staff becomes more vital. Our Chair has been at the forefront of this, and has been heavily involved in communicating important messages to staff, particularly around the performance of the Trust in relation to both finances and quality of care.

Staff also receive a weekly briefing from the Chief Executive, a news and information resource on the Intranet entitled the Source, enabling staff to post comments and responses to specific issues, and Bite Size a monthly e-bulletin with information about what staff have been up to across the Trust.

As part of our internal communications and engagement strategy we have launched our special thanks and recognition (STAR) scheme. Linked in with our new appraisal and development framework, working better together, the scheme allows staff to recognise when a good job has been done by sending an e-card. This will be developed further throughout the year by highlighting individuals or teams who have demonstrated positive behaviours.

A specific clinical communications entitled 'Learning Lessons Together', which is produced bi-monthly which share examples of good clinical practice, and shared learning that could be of benefit for the wider organisation.

We will also be rolling out other mechanisms to engage with staff during 2013/14 including employee temperature checks to measure staff perception and satisfaction. Two-way communication and feedback still continue to be a key element of our communications strategy. There are a number of opportunities for staff to communicate their views and thoughts from e-forums, a comments function on articles on the intranet, a response mechanism to the CEO brief, face to face events, and contributions to e-bulletins. For example, this year copies of the national NHS Staff Survey was sent to all our staff, giving everyone the opportunity to feedback on our Trust and to help us gain an understanding of how staff are feeling. For more information about the staff survey or to request a copy of our 2012/13 please e-mail. hr.support@bsmhft.nhs.uk. For more information on the staff engagement strategy please e-mail comms.team@bsmhft.nhs.uk.

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 as such, 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.

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 three years.

The Board considers that all of the Non-Executive Directors are independent as defined in the Code of Governance taking into account, character, judgment and length of tenure. None of the Executive Directors hold non-executive appointments.

Sue Turner, who led the Trust – both pre and post-merger – for 16 years retired from her post as Chief Executive in December 2012. Paul Jennings was appointed as an interim chief executive for six months, and Sue's successor – John Short, was announced on Christmas Eve 2012. He is due to take up post in April 2013.
Stan Baldwin also retired from his role as non-executive director in September 2012.

Sue Davis CBE, Chair

Sue Davis CBE was appointed as the new Chair for the Trust, following Professor Peter Marquis, who retired from the role in September.

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 is Chief Executive of Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT).
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

Paul Jennings, Interim Chief Executive (December 2012 to April 2013)

Paul was appointed as Interim Chief Executive in December 2012 to help steer the Trust through a transitional period until a permanent appointment to the post of chief executive could be made. He has more than 30 years' experience in the NHS in various senior roles, most recently as associate national director and stakeholder engagement for the NHS National Commissioning Board. Paul has also held Chief Executive posts at NHS Warwickshire, NHS Walsall and North Birmingham PCT.
Interests: Joint Director/owner of Colouring in Consulting, Chair of Welcome Wellbeing CIC; Director/Trustee of ExtraCare Charitable Trust, and his spouse is Chair of Birmingham Children's Hospital.

Sue Turner, Chief Executive (retired November 2012)

Sue has worked in the NHS for the past 28 years in a variety of senior management roles, serving our Trust as chief executive for the past 15 years. She has led major service reconfigurations and organisational turnarounds initially in London acute hospital services and, more recently, in mental health services across Birmingham and Solihull. A strong advocate of third sector partnerships and service provision, Sue has been a Trustee of charitable organisations and facilitated a range of commercial and public sector partnerships.
Most recently Sue has been the NHS representative on the steering committee which developed the Government's New Horizons national mental health strategy. With a keen interest in personal and organisational development, Sue continues to coach and mentor staff working within public and independent sectors.
Sue holds an honours degree (BSc)
Interests: None declared

Frances Allcock, Director of Organisational Development and Performance Improvement

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

Stan Baldwin, Non-Executive Director (retired September 2012)

Stan, who was appointed as a Non-Executive Director in 2003, has extensive public sector experience including eight years developing community services in Birmingham, and senior posts in Cheshire and Worcestershire. Formerly Chief Executive of Wyre Forest District Council, Stan also has wide-ranging consultancy experience including work with the Audit Commission, the Office for the Deputy Prime Minister, the Regional Office, and Sport England. Previous posts held include Chair of Governors at Kidderminster College, Chair of Birmingham Community Resource and Information Service, and Chair of the Trust's finance committee.
He has an MSc in management, an Med in adult education, is a Fellow of the Chartered Institute of Management, and a member of the Institute of Sport, Parks and Leisure.
Interests: None declared

Sandra Betney, Executive Director of Resources

Sandra joined BSMHFT as the 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 twenty 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 (from February 2013).

Georgina Dean, Acting Executive Director of Resources (acted up until May 2012)
Georgina Dean joined the Trust in 2008 and was Acting Executive Director of Resources in 2011/12. She is a chartered accountant and worked at PricewaterhouseCoopers LLP before joining the Trust. Georgina has worked with a number of NHS organisations providing support for Foundation Trust applications, turnaround and finance function effectiveness.
Interests: Trustee/director, Acacia Family Support.

Andrew Lee, Acting Executive Director of Resources (October 2012 – February 2013)
Interests: Owner/Director, AJL Consultancy Ltd

Martin Sheldon, Executive Director of Resources (May-October 2012)
Interests: Director, Novus Generation Ltd, Trustee, Somerset Sight.

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. In the past year he has served as Vice-Chair of the Trust, Senior Independent Director and Chair of the Mental Health Act 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 Chair and was once a Deputy Director of Samaritans Solihull. 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 (from November 2012).

Dr Peter Lewis, 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.

Alison Lord, Non-Executive Director
Alison was appointed as a non-executive director in 2007. She runs her own consulting company, Allegra Limited, which provides specialist financial and operating performance improvement and restructuring support services, particularly in the health and social care sectors. She is a qualified accountant, she has 25 years' restructuring experience. Alison is a Fellow of the Charted Association of Certified Accountants and a member of the Society of Business Recovery Professionals.
Interests: Chief executive and shareholder, Allegra Limited, and chief executive, Elfin Home Care Group (left 31 August 2012).

Dee Roach, Executive Director of Quality, Improvement and Patient Experience
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.
Interests: None declared.

Dr Nerys Williams, Non-Executive Director
Dr Nerys Williams - who was appointed as a non-executive director on December 1, 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.

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.

Sukhbinder Singh Heer, Non-Executive Director

Sukhbinder was appointed as a Non-Executive Director in 2007. He is the founder and Executive Chair of ic2 Capital, a cross border private equity firm. 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.
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

Jeff Herdman, Non-Executive Director (designate)

Jeff Herdman, was appointed as a Non-Executive Director (designate) on January 3, 2012 to succeed Stan Baldwin in September 2012. He is Chief Executive of a company operating in the financial sector. He has particular experience of risk management. Jeff ceased to be a designate, and became a full Non-Executive Director in October 2012 He subsequently left the Trust board on March 31, 2013.
Interests: Executive director, Oval Group (until June 1, 2012); non-executive director, Investors in Customers (from July 1, 2012); and director of Summerhill Supplies Ltd (from November 2012).

Joy Warmington, Associate Non-Executive Director

Joy Warmington, who was appointed as an Associate Non-Executive Director on 3rd January 2012, 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.
Interests: Chief executive officer, BRAP; vice chair, Gateway Family Services; governor, Solihull College; and chair CIN (BBC).

The board met 12 times during 2012/13. Attendance of these meetings is set out in the table below.

Table 30: Trust board attendance 2012/13

	25.4.12	30.5.12	27.6.12	25.7.12	29.8.12	26.9.12	31.10.12	28.11.12	14.12.12	30.1.13	27.2.13	27.3.13
Sue Davis	X	X	X	X	X	X	X	X	X	X	X	X
Sue Turner	X	X	X	X	X	0	X	X				
Paul Jennings									X	X	X	X
Georgina Dean	X	X										
Martin Sheldon			X	X	X	X	X					
Andrew Lee							X	X	0	X		
Sandra Betney											X	X
Frances Allcock	X	X	X	X	X	X	X	X	X	X	X	X
Peter Lewis	X	X	X	X	X	X	X	X	X	X	X	X
Dee Roach	X	X	X	X	X	X	X	X	0	X	X	X
Stan Baldwin	X	X	X	X	X	X						
David Boden	X	X	X	X	X	X	X	X	X	X	X	X
Jeff Herdman	X	X	X	X	X	X	X	X	X	0	X	X
Sukhbinder Singh Heer	X	0	X	0	X	X	0	X	0	X	X	X
Nerys Williams	X	X	X	X	X	X	X	0	X	X	X	X
Alison Lord	0	X	X	X	X	X	X	X	X	X	X	X

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 of the following Non-Executive Directors: Sukhbinder Singh Heer (Chair), Stan Baldwin, Jeff Herdman David Boden, Alison Lord, Joy Warmington and Dr Nerys Williams It receives advice from both internal and external audit.

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 three of its members are required to be present. The Executive Director of Resources, Medical Director, and Executive Director of Quality, Improvement and Patient Experience 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 below details attendance at the audit committee meetings, which were held every six weeks between April 1, 2012 and March 31, 2013.

Table 31 : Audit committee attendance 2012/13

	17.5.12	12.7.12	13.9.12	21.11.12	20.2.13
Sukhbinder Singh Heer (chair)	✓		✓		
Alison Lord	✓	✓	✓	✓	✓
Stan Baldwin*	✓	✓	✓		
Nerys Williams	✓	✓	✓	✓	✓
David Boden	✓	✓	✓	✓	✓
Jeff Herdman		✓	✓		
Joy Warmington		✓			✓

Stan Baldwin retired in September 2012.

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 will operate 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 to be offered will enable 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 we this is an innovative kind of initiative, this way of working is becoming more commonplace within the NHS and other public sector organisations.

Meet the Governors

Governance of a Foundation Trust is prescribed by legislation, to comprise of 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, 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 Assembly 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 to have the Council of Governors' views taken into account within the primary care system; and
- 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 Assembly 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 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, acting as 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 21 governors across Birmingham and Solihull, comprising of five from public constituencies, four representing service users, three carers, three staff and six 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 feedback 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 the ability to hold the Trust's Board to account, and ultimately have the ability to terminate the Chair or Chief Executive's contract. 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.

As a result of the Health and Social Care Act 2012, our Governors have been preparing for how to discharge 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.
The governors are looking at new ways of working to be implemented in 2013 in order to effectively use their new powers and discharge their responsibilities.

Governors are expected to maintain regular contact with members within their constituencies, which at a minimum involves briefing them on the outcome of assembly meetings. 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.

Nomination and Remuneration Committee

As of the 31st March 2013, the committee's membership is made up of the Trust's Chair and five governors:

- Darren Cooper (Lead Governor, staff constituency)
- Peter Brown (service user constituency)
- Peter Tinsley (public constituency)
- Pat Fleetwood-Walker (carer constituency)
- Paul Illingworth (stakeholder constituency)

The Governors' Nomination and Remuneration Committee met three times between April 1, 2012 and March 31, 2013.

At the meetings on the 17th May 2012 and 18th October 2012, Darren Cooper, Paul Illingworth, Pat Fleetwood-Walker, Maureen Johnson (Governor – public constituency), Elsie Gayle (Governor – service user constituency), and Peter Brown were present.

At the meeting on 21st March 2013, Darren Cooper, Paul Illingworth, Pat Fleetwood-Walker, Peter Tinsley and Peter Brown were present.

The Committee met to agree the process for conducting appraisals for the Chair of the Trust and the NEDs, 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 NEDs.

The Governors also participated in the recruitment of our new chief executive. 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 the resignation of an existing Non-Executive Director.

Governor elections

This year has seen four governor elections. The term for the public, Solihull and service user, rest of England and Wales Governor seats came to an end in December 2012, and as there was more than one candidate standing, these were decided by an externally verified ballot. Members from these constituencies were invited to stand for election. The Solihull public constituency seat had five candidates and went to ballot at the end of December 2012. Dr Sandra George was announced as the chosen Governor in early 2013. The service user, rest of England and Wales seat had no response.

Due to the appointed non-clinical staff Governor standing down, and in anticipation of the term of one of the carer Governor seats coming to an end in May 2013, an election was run for these and the unfilled service user, rest of England and Wales seats in February 2013. There were two candidates in each of the carer and non-clinical staff seats, meaning that these will go to ballot in April 2013 with the results being announced on May 13, 2013.
There was no response with regards to the service user, rest of England and Wales seat.

Our Governors

Public Birmingham

Pat Hemmings - elected in November 2011
Peter Tinsley - elected in November 2011
Khalid Ali – elected in November 2011

Public Solihull
Dr Sandra George – elected January 2013

Public rest of England and Wales
Mary Jones – elected in April 2012

Carer
Pat Fleetwood-Walker – elected unopposed in May 2010
Lawrence Innis – elected in November 2011
Anne McKenzie – elected in November 2011

Service User Birmingham
Faheem Uddin – elected November 2011
Lynda Smith – elected November 2011

Service User Solihull
Peter Brown - elected unopposed March 2012

Service User rest of England and Wales
VACANT – DECEMBER 2013

Staff
Darren Cooper (Clinical non-medical) -elected unopposed October 2011
Dr Asaf Khan (Clinical medical) - elected unopposed October 2011
Non clinical – VACANT

Stakeholder
Paul Illingworth (Birmingham City University) - reappointed January 2013
Maureen Smojkis (Birmingham University) - appointed July 2011
Cllr Sue Anderson (Birmingham City Council) - reappointed July 2011
Dr Peter Lea (Solihull Metropolitan Borough Council) - reappointed July 2011
Tessa Griffiths (Council for Voluntary Services) - reappointed July 2011

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 in September 2012. 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 Assembly of Governors meetings

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

Table 32: *Assembly of Governors, governor attendance 2012/13*

Name	CoG - 12/04/12	CoG - 18/06/2012	CoG - 06/09/2012	AGM - 25/09/2012	CoG - 06/11/2012	Special CoG - 21/12/2012	CoG - 24/01/2013	CoG 21/03/2013
Ali Khalid								
Anderson Sue								
Annakie Sharon								
Brown Peter								
Cooper Darren								
Fleetwood-Walker Patricia								
Gayle Elsie								
George Sandra								
Griffiths Tessa								
Hemmings Pat								
Illingworth Paul								
Innis Lawrence								
Johnson Maureen								
Jones Mary								
Khan Asaf								
Lea Peter								
McKenzie Anne								
Smith Lynda								
Smojkis Maureen								
Tinsley Peter								
Uddin Faheem								
Ward Glen								

Attended
Not a governor at this time

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.

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. At last year's AGM, a 'meet your Governor' session as held over lunch, where members had the opportunity to get to know their Governor on a more informal basis.

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.

December 2012 saw the opening of Tamarind Centre, and having been kept up to date throughout the building process, Governors were able to have a tour of the building before it opened its doors and welcomed its first service users.

Governors also played an active role in the recruitment of our new Chief Executive. Two governors sat on the interview panel and the rest of the Council of Governors held group sessions with each perspective candidate.

The Health and Social Care Act 2012 has seen a change in governor responsibilities. In keeping with this, Governors now attend the private board session, have undertaken training and regularly attend conferences such as those held by the Foundation Trust Governors Association and Foundation Trust Network. 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.

Directors' report

Principal activities

BSMHFT provides a comprehensive mental health service for residents of Birmingham and Solihull, and to communities in the West Midlands and beyond. We serve a culturally and socially diverse population of 1.2 million, working out of approximately 60 Trust sites, spread across 172 square miles, have an annual budget of £221million and a dedicated workforce of 4,000 staff – making ours one of the biggest 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 more financial flexibility, allowing us to provide even better services and to involve our local communities in the bigger healthcare decisions that we make. It also helps us to actively engage our staff in shaping how BSMHFT 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.
To achieve Foundation Trust status we had to demonstrate that we are legally constituted, well governed and financially viable.

BSMHFT provides 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 three division: Adults of Working Age; Mental Health Services for Older People; and Youth, Addictions, Birmingham Healthy Minds and the Homeless. Together, these services include elements of rehabilitation, crisis and home treatment, assertive outreach, early intervention, addictions, day services and mental wellbeing. We provide our services on a local, regional and national basis, dependent upon client group. 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 care plan 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 have, and 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 December 1,2012 and in 2012/13 the principal activity was the lease of the Tamarind Centre to the Trust.

Information on our employees can be found in the chapter - Our staff, our greatest asset.

Information Governance incidents

In 2012/13, a total of 18 information governance-related serious incidents were recorded in the Trust. Three of these incidents were reported to the Information Commissioner, and three are awaiting a final decision as to any final action by the Information Commissioner's Office (ICO).

There is likely to have been a level of unreported information governance incidents reported in the past .This, along with the overall improvement in reporting for all incidents and a greater awareness among staff of information governance issues, has further improved reporting of incidents, which goes some way to explaining the rise in reported incidents this year.

A breakdown of the serious incidents reported to the Information Commissioner's Office were as follows:

- Two of the incidents related to information sent via an insecure email – we are awaiting a response for both of these incidents.
- A service user was found to be in possession of bed management sheets relating to 30 clients – awaiting a response from the ICO

All serious information governance incidents, including the non-ICO reported incidents, are investigated as part of the Trust's serious incident process.

Summary financial accounts

This section provides a commentary on our group financial performance for the financial year 2012/13. 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 £2.4 million before exceptional items, leading to a financial risk rating of 3 from Monitor, 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 short, medium and long term financial plans of the organisation including both the cash flows and income and expenditure position.

Financial performance

The Trust wholly owns a subsidiary Summerhill Supplies Limited which commenced trading on 1 December 2012. 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.

At the beginning of the year we set a deficit plan as we were making investments in key schemes, the largest being the development of the Tamarind Centre which opened to patients in December 2012 in line with our plans. We also set aside money to pay for the costs of making changes linked to the delivery of our savings.

Our year end position is better than planned with an operational income and expenditure surplus of £2.4m before taking into account any exceptional items. This is largely due to some one-off benefits that we received in year, and also 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 a reduction in the value of £5.3m and reorganisational costs of £0.9m. After these are accounted for the group is reporting a deficit of £3.8m.

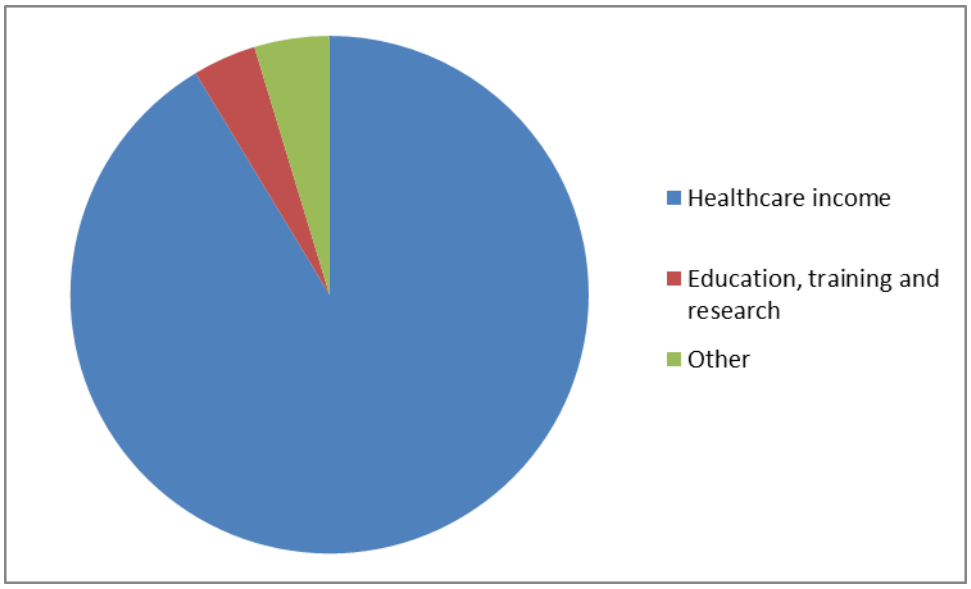
Table 33: Consolidated financial performance 2011/12 and 2012/13

	2012/13 £'000	**2011/12 £'000**
Income from activities	204,498	201,536
Other operating income	19,357	18,616
Total income	223,855	220,152
Operating expenses	(207,715)	(207,181)
EBITDA	16,140	12,971
Capital financing costs	(14,703)	(12,543)
Revaluation/(impairments)	(5,324)	3,536
Profit/(loss) on asset disposal	75	(7)
Surplus/(deficit) including exceptional items	**(3,812)**	**3,957**
Exceptional items:		
(impairments)/Revaluation	(5,324)	3,536
Costs of exceptional restructuring	(911)	(583)
Operating surplus excluding exceptional items	**2,423**	**1,004**
Operating surplus margin	1.1%	0.5%
EBITDA margin	7.2%	5.9%

Income

In the financial year 2012/13 the group generated income of £223.9 million. 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 which has meant that our income is two per cent higher than in the previous year. The chart below shows a breakdown of our income. Most of our income (91 per cent) 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 four per cent of our income.

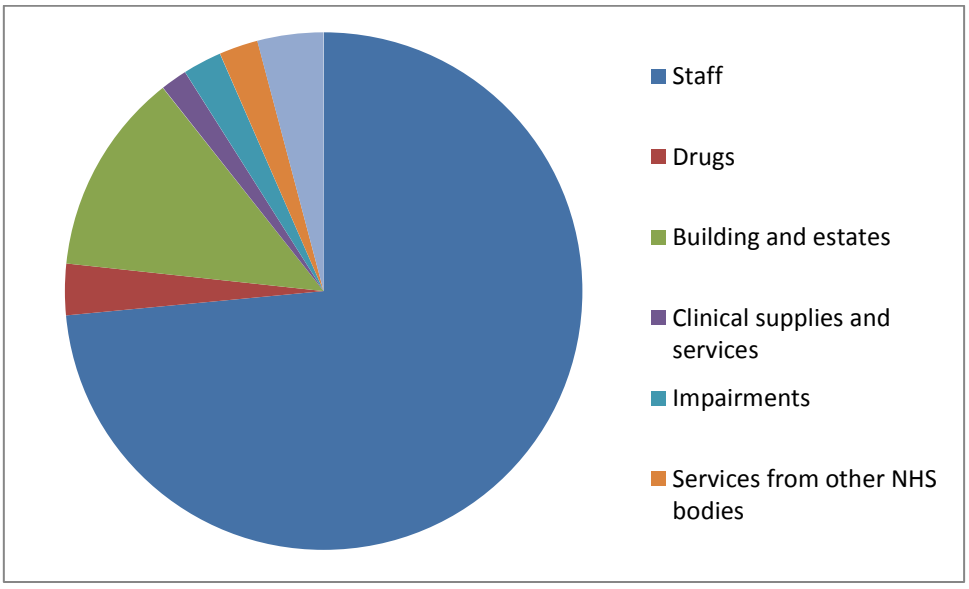
Table 34: Where BSMHFT's income comes from - 2012/13



Expenditure

The chart shows that our staff are our most valuable and significant part of our expenditure. However we also operate from over 60 sites across Birmingham and Solihull and so the cost of our estate is also a significant proportion of our overall spend. We have succeeded in reducing our expenditure in year as required but further work is still needed to fully realise all savings.

Table 35: What expenditure was incurred by BSMHFT - 2012/13



Cash flow

At the end of the financial year our Trust has a cash balance of £32.1m and an agreed working capital facility of £16m which is effectively like an overdraft facility. We have not had to use the working capital facility. This position means that our liquidity remains strong. In line with our Treasury Management Policy, during the year we invested cash reserves in selected banks to maximise the interest received.

Overview of capital investment and asset values

We invested £13.7m in our assets in 2012/13. The largest investment, £9m was in the construction of the Tamarind Centre, our new male medium secure unit. This has been funded through a loan from the Foundation Trust Financing Facility and has been a two year construction project. We were able to reclaim £3.5m of VAT costs on the construction which means that our net capital spend in year was £10.2m.

We also invested £0.7m in our IT infrastructure and new ways of working, £1.2m in backlog maintenance and ensuring our buildings complied with statutory standards, and £1.3m in other projects to modernise our estate and ensure it is fit for purpose.

The Tamarind Centre was re-valued on completion and sold to Summerhill Supplied Limited at this value. This meant the Trust reported a technical adjustment to write down the value prior to the sale by £1.9m. In addition, due to the changing economic climate we have reviewed the value of the rest of our estate. This has resulted in a technical adjustment to reduce the overall value of our buildings by £3.4m. 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

Management costs are defined on the management cost website at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Sitemap/DH_A-Z_AZSI?indexChar=M
The management costs for the year were £12.1 million, which represents 5.4 per cent of income.

External audit

The Trust's Council of Governors appointed PricewaterhouseCoopers LLP as its external auditor in 2010/11 for a period of three years. The audit fee for the statutory audit of the Trust is £56,000 excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in October 2007. In addition, the fee for the audit of the Quality Account is £10,000 excluding VAT.

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 36:

Awaiting numbers	**2012/13 Number**	**2012/13 £'000**	**2011/12 Number**	**2011/12 £'000**
Total NHS invoices paid in the period	666	12,395	618	10,510
Total NHS invoices paid within target	589	11,368	579	10,005
Percentage of NHS invoices paid within target	88%	92%	94%	95%
Total non NHS invoices paid in the period	33,982	50,406	29,589	64,211
Total non NHS invoices paid within target	30,710	47,294	28,317	62,909
Percentage of non NHS invoices paid within target	90%	94%	96%	98%

Management of working capital balances is a priority going into 2013/14 with aged balances being 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
- 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 2013/14, the challenging financial times will continue. Our healthcare income is reducing by a further 1.3%, rise in inflation of costs will continue and we will need to deliver savings of 4 per cent. We recognise that delivery of savings year on year is tough and delivery of savings while maintaining quality of service is our greatest risk.

The change in commissioning arrangements set out in the Health and Social Care Act 2012 came into force from 1 April 2013. We have mechanisms in place to ensure we have engagement and joint working with the new Clinical Commissioning Groups (CCGs). The development of Payment by Results for mental health is also a challenge to us and during the year we will continue to develop local tariffs and so understand the potential impact on us in the future.

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 hundreds of pounds. 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. 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 107. 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.

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 the Independent Regulator of NHS Foundation Trusts (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 group accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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

Signed: JS (J D SHORT)

John Short, Chief Executive
Birmingham and Solihull Mental Health NHS Foundation Trust: Date: May 22, 2013

Appendix Two

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 2013 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 Quality Improvement and Patient Experience who is supported by the Associate Director of Governance (with management responsibility for the risk management department). 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 Quality, Improvement and Patient Experience have joint delegated responsibility for clinical risk management and clinical governance. The Quality and Safety committee was established by Trust Board to improve assurance over all aspects of quality and risk. The Medical Director and Director of Quality Improvement and Patient Experience 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, acts as the Caldicott Guardian and chairs the Information Governance Steering Group.

The Deputy Medical Director 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 Resources and Performance sub committee plays a key role in managing financial risk and in ensuring that resources are deployed economically and effectively.

The **Director of Organisational Development and Performance Improvement** has delegated responsibility for managing risks associated with the recruitment, retention, training and development and remuneration of our workforce. The Director of Organisational Development and Performance also chairs the Performance Management and Improvement Board, ensuring that performance across a range of quality and productivity metrics is monitored and delivered, and that action plans are in place to address any identified weaknesses.

The **Director of Facilities** has overall responsibility for the Trust estate, plant, waste management, fire safety, environmental management.

Three directors of strategic delivery have delegated responsibility for managing operational risk across the three divisions. From January 2013 a **Director of Operations** was established above these posts to strengthen senior director accountability for operations. Clinical directors and the other professional heads have responsibility for the systems of risk management at programme / zone 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 best practice 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 Risk and Control framework:
The risk management policy defines the leadership and a process 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 2012) 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 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 20 matrix for risk scoring and risks identified at a score of 60 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 all senior directors of the Trust 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 used Monitors quality governance framework on a number of occasions over the past 3 years, and this contributed to the development and implementation of the Trust's Quality Strategy. In order to further support progress, in February 2013 the Trust 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. The assessment scored the Trust at 11 and recognised the changes that were occurring at Board level during the assessment and also that although both the Trust's organisational strategy and its quality strategy were in place, these had yet to be fully implemented at the time of the review.

The Trust has developed an action plan to address the issues arising which will be implemented by 15th June 2013 particularly with a focus on the perception of robustness of quality information. A number of actions have already been completed, the majority of the actions had already been identified as part of the annual planning process or were in progress at the time of the review.. The action plan has been further reviewed by members of the Executive Team in April 2013 in order to assess the current status. This self-assessment indicates an improvement in the Trust score to 7. Full implementation of the action plan by 15th June 2013 will reduce the assessment score to 3.5, which is the expected standard for aspirant Trusts.

In carrying out sample testing of data supporting two Quality Account indicators - CPA 7 day follow up and Admissions to inpatient services having access to crisis resolution / home treatment teams - our auditors raised some queries about the definitions used. This led to a retrospective validation of the data which confirmed compliance with the 95% Monitor thresholds for both indicators, but indicated that more formal data quality assurance mechanisms for external performance measures would be helpful, and these will be introduced for 2013/14.

The principle of learning lessons is also stressed - 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.

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. The Trust has introduced a bi monthly 'Learning: Lessons bulletin which is issued to all staff.

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 'fair blame' approach to incidents to ensure appropriate risk reporting.

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 monitors and manages its Information Governance (IG) compliance through the IG assurance framework reporting up to the Information Governance Steering Group (IGSG) which is chaired by the Caldicott Guardian and attended by key IG staff including the Senior Information Risk Owner (SIRO) . The IGSG monitors the Trusts compliance with the Connecting for Health IG Toolkit and approves the IG work plan that is developed year on year in line with the national requirements.

The Trust has implemented a full range of technical and organisational measures in line with national best practice, and has a suite of IG related policies, procedures and guidance documents which are made available to all staff in a variety of ways. Communicating IG to staff is an on-going and extremely important process in ensuring staff are aware of their responsibilities, as detailed in these documents.

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

Future anticipated Risks:

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 (Quality and Safety, Resources and Performance) has strengthened the oversight of risk during the year. Each 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 Trust clinical governance committee regularly reviews local risk registers from individual clinical programmes 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 been established this year with a standard documentation for the planning and review of significant new developments which are required to demonstrate how risks are managed.

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 Group's (CCG's), 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, employers 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 organisations 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 focus on and can demonstrate value for money of our services. The hard work of our staff in 2011/12 has meant that we were able to achieve a risk rating of '4' demonstrating that we have been able to manage our resources effectively. We have achieved this after investing in key areas, including our estate, IT infrastructure and a new electronic care record, which we believe will support our staff to deliver services and to generate future efficiencies.

The Head of Internal Audit Opinion for 2012/13 has provided an overall opinion as follows:
'Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Whilst we have identified some weaknesses in the design and / or inconsistent application of controls that we have reviewed during the year which put the achievement of particular objectives at risk, we have raised recommendations during the year with respect to these control deficiencies. Management have responded with adequate action plans to address these weaknesses in a sufficiently timely manner. '

Management is aware that continued focus and development work is required with respect to recurring control deficiencies in the areas of Pharmacy Stock Management and

Temporary Staff Solutions. We will work with management to provide support with this during 2013/14.

We have continued to use benchmarking information, both internal and external to understand relative performance of services and this has been used to inform planning. Finally, we have continued to use lean thinking methodology in a number of service improvement events, with the aim of redesigning processes and pathways to eliminate waste and errors, improving both cost effectiveness and quality.

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 Clinical Governance processes over the year. Key indicators have been routinely reported to the Trust Board via the Quality and Safety sub committee through the year, reflecting wider review and monitoring undertaken by the Trust. The Performance Management Improvement Board (PMIB) has responsibility within the Trust for reviewing the quality of data in relation to key indicators and targets. This also provides for more detailed analysis and review by individual services or clinical programmes, which receive more detailed data and analysis of indicators relating to their service.

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 drafts and reports being presented to the Clinical Governance committee and commissioners (through the Clinical Quality review group).

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, and the executive managers 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 & 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.

The Board reviews and agrees the Assurance framework which is informed by the wider risk management processes including the Audit committee.

Conclusion:

The Trust has identified further work is required to strengthen its Quality Governance arrangements and data quality reflecting our commissioned review through KPMG and audit of our key Monitor indicators. Actions already taken have reduced our score to 7 and further actions are being implemented to achieve a score of 3.5 by the 16th June.

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 organisations plans, aims and objectives.

Signed.....(JDSHORT)
Chief Executive Date: 23 May 2013

Remuneration report

Remuneration committee

The committee monitors and evaluates the performance of the Chief Executive and the Executive Directors. The Remuneration Committee over the last 12 months have been busy in terms of recruitment of a new Chief Executive and Executive Director of Resources. The Remuneration Committee involved a variety of stakeholders including staff, Governors and external partners in the decision making process. In addition the substantive appointments, the Committee were involved in and approved the interim appointments for the Chief Executive and Executive Director of Resources. The Committee approved the appointment of the interim Director of Operations and have started the process leading into the next financial year of recruiting to this post substantively.

The committee met four times in 2013/14.

- On 17 May 2012 Sue Davis (Chair), Chair David Boden, Non-Executive Director, Sukhbinder Singh Heer, Non-Executive Director, Alison Lord, Non-Executive Director, Dr Nerys Williams, Non-Executive Director and Stan Baldwin, Non-Executive Director were present.
- On 9 October 2012, Sue Davis (Chair), Joy Warmington (Non-Executive Director), David Boden (Non-Executive Director), Alison Lord (Non-Executive Director), Dr Nerys Williams (Non-Executive Director), Sukhbinder Singh Heer (Non-Executive Director) and Jeff Herdman (Non-Executive Director) were present.
- On 31 October 12 Sue Davis (Chair), Joy Warmington (Non-Executive Director), David Boden (Non-Executive Director), Alison Lord (Non-Executive Director) and Dr Nerys Williams (Non-Executive Director) were present.
- 30 January 2013, Sue Davis (Chair), Alison Lord (Non-Executive Director), Dr Nerys Williams (Non-Executive Director), Sukhbinder Singh Heer (Non-Executive Director), David Boden (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.

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.

There are no performance related elements to remuneration. All appointments as Executive Directors are made as permanent appointments, unless appointed on acting basis, in which case a six month term is expected, and will only be terminated on resignation of the employee or a fundamental breach of their employment contract.

The Nomination and Remuneration Committee and Remuneration Committee has considered, during 2012/13 the balance, completeness and membership of the Board. The Trust amended its constitution during the year, which increased the potential number of both executive and non-executive director posts. The purpose of this amendment was to allow maximum flexibility when considering the appointment of a director of operations, which would be a board level appointment. The Remuneration Committee also decided to not replace the post of director of organisational development and performance improvement when the post become vacant in June 2013, as it was satisfied with the composition of the board.

The majority of Executive Directors have a notice period of up to six months for termination included in their contracts and there is no provision for compensation for early termination of their contracts.

Reasons for termination may include where a member of the Trust Board of directors has been adjudged bankrupt or whose estate has been sequested 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 four 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 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.

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 (appointed April 2, 2013) and Executive Directors were appointed via rigorous nationwide recruitment processes in line with national and local guidance.

Table 37: Appointments and tenures of non-executive directors

Name and title			**Date of first appointment / re-appointment tenure**
Sue	Davis	(Chair)	28/11/2011
Sukhbinder	Heer	(Non-executive director)	13/08/2007 01/09/2011 – 31/08/2014
Alison	Lord	(Non-executive director)	01/09/2007/ 01/09/2011 – 31/08/2015
Stan	Baldwin	(Non-executive director)	01/05/2003/ 01/05/2011 – 30/09/2012
David	Boden	(Non-executive director)	12/10/2006/ 01/01/2011 – 30/09/2013
Jeff	Herdman	(Non-executive director: Designate – appointed took over Stan Baldwin's NED role when he stood down in September 2012).	03/01/2012 Resigned March 31st 2013.
Nerys	Williams	(Non-executive director)	01/12/2011
Joy	Warmington	(Non-executive director: Associate (No voting rights at board)	03/01/2012 – 02/01/2014

Table 38 Salary and pension entitlements of senior managers - salaries and allowances

Salary and pension entitlements of senior managers - salaries and allowances								
Name and Title	**Year ending 31 March 2013**				**Year ending 31 March 2012**			
	Salary	**Other remuneration**	**Benefits in kind**	**Total**	**Salary**	**Other remuneration**	**Benefits in kind**	**Total**
	(Bands of £5,000)	**(Bands of £5,000)**	**(rounded to nearest £100)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(Bands of £5,000)**	**(rounded to nearest £100)**	**(Bands of £5,000)**

					£'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			195-200	165-170	-	-	165-170
Sandra Betney (Executive director of resources (appointed 1 February 2013)	20-25			20-25	-	-	-	-
Andrew Lee (Acting executive director of resources) (appointed 22 October 2012, resigned 28 February 2013)	85-90			85-90				
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			60-65	90-95	-	-	90-95
Chris Tidman (Deputy CEO / Executive director of resources) (resigned 27 April 2011)	-	-	-	-	10-15	-	-	10-15
Peter Lewis (Executive medical director)	100-105	60-65		165-170	100-105	65-70	-	170-175
Frances Allcock (Executive director of organisational development and performance improvement)	115-120			115-120	115-120	-	-	115-120
Denise Roach (Executive director of quality, improvement and patient experience)	105-110			105-110	110-115	-	-	110-115
Glynis Markham (Executive director of strategic delivery)	95-100			95-100	95-100	-	-	95-100
Alan Kenny (Interim director of operations) (appointed 11 January 2013)	95-100			95-100	95-100			95-100
Sue Davis (Chair)	45-50			45-50	15-20	-	-	15-20
Peter Marquis (Chair) (resigned 30/08/2011)	-	-	-	-	20-25	-	-	20-25
David Boden (Non-Executive Director)*	15-20			15-20	15-20	-	-	15-20
Sukhbinder Heer (Non-Executive Director)	15-20			15-20	10-15	-	-	10-15
Alison Lord (Non-Executive Director)	10-15			10-15	10-15	-	-	10-15
Stella Layton (Non-Executive Director) (resigned 30/11/2011)	-	-	-	-	10-15	-	-	10-15
Nerys Williams (Non-Executive	15-20			15-20	5-10		-	5-10

Director)						-		
Jeff Herdman (Non-Executive Director)	15-20			15-20	0-5	-	-	0-5
Joy Warmington (Non-Executive Director)	10-15			10-15	0-5	-	-	0-5
Stan Baldwin (Non-Executive Director) (resigned 28 September 2012)	5-10			5-10	10-15	-	-	10-15
* 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 and annual leave.								
* David Boden salary includes remuneration for acting as the Chair between October and November 2011.								
Band of Highest Paid Directors Total Remuneration (£'000)	195-200				170-175			
Median Total Remuneration	28,713				27,625			
Ratio	6.8				6.2			
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 Equival-ent Transfer Value at 31 March 2013**	**Cash Equival-ent Transfer Value at 31 March 2012**	**Real increase in accrued pension during year**	
	(Bands of £2,500)	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**				
	£'000	**£'000**	**£'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	
Denise Roach (Executive	(0-2.5)	(0-2.5)	35-40	115-120	601	561	11	

Director of Quality, Improvement & Patient)								
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.								
Pension benefits 2011/12								
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 2012**	**Lump sum at age 60 related to accrued pension at 31 March 2012**	**Cash Equivalent Transfer Value at 31 March 2012**	**Cash Equivalent Transfer Value at 31 March 2011**	**Real increase in accrued pension during year**	
	(Bands of £2,500)	**(Bands of £2,500)**	**(Bands of £5,000)**	**(Bands of £5,000)**				
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	
Sue Turner (Chief Executive Office)	(0-2.5)	(0-2.5)	60-65	180-185	1150	1037	81	
Chris Tidman (Deputy CEO / Executive Director of Resources) (resigned 27 April 2011)	0-2.5	0-2.5	30-35	100-105	473	348	10	
Georgina Dean (Acting Executive Director of Resources) (appointed 1 May 2011)	0-2.5	2.5-5	5-10	15-20	67	37	26	
Peter Lewis (Executive Medical Director)	0-2.5	5-7.5	15-20	55-60	-	-	-	
Frances Allcock (Executive Director of Organisational Development and Performance Improvement)	0-2.5	0-2.5	10-15	0-5	142	100	39	
Denise Roach (Executive Director of Quality, Improvement & Patient)	7.5-10	25-27.5	35-40	110-115	561	355	194	
Glynis Markham (Executive Director of strategic delivery) (resigned 31 March 2013)	0-2.5	2.5-5	5-10	25-30	0	205	-194	
Remuneration received by non- executive members is not pensionable and so this information is not applicable.								

Reporting related to the Review Tax Arrangements of Public Sector Appointees

For off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012 to 31 March 2013 the Trust only had 2 (two) such appointees. The engagement ceased at the 31 March 2013.

There were no new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than 6 months.

Trust Board and Governor expenses

Table 39:

	Expenses Summary														
	Executive Directors;														
			£	£	£	£	£	£	£	£	£	£	£	£	£
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Turner	S	455	66	-	-	-	-	-	-	-	-	-	-	520
	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	-	1,100
	Kenny	A	249	-	-	622	-	157	130	209	216	232	-	545	2,360
	Markham	G	-	-	-	-	-	-	-	-	-	-	-	-	-
	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	1,043
	Herdman	J	154	69	85	102	-	-	-	-	105	35	-	989	1,538
	Williams	N	-	111	-	178	45	-	34	102	-	128	-	43	640
	Warmington	J	48	11	-	-	-	21	-	-	-	19	28	37	163
	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	-	-	-	-	-	-	-	-	-	-	390
	George	S	-	-	-	-	-	-	-	-	-	-	-	-	-
	Cooper	D	-	-	-	-	-	-	-	-	-	-	-	-	-
	Khan	A	-	-	-	-	-	-	-	-	-	-	-	-	-
	Anderson	Sue	-	-	-	-	-	-	-	-	-	-	-	-	-
	Lea	P	-	-	-	-	-	-	-	-	-	-	-	-	-
	Griffiths	T	-	-	-	-	-	-	-	-	-	-	-	-	-
	Smojkis	M	-	-	-	-	-	-	-	-	-	-	-	-	-
	Illingworth	P	-	-	-	-	-	-	-	-	-	-	-	-	-

Signed: R (JD SHORT)

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

Date: May 23, 2013

Ill health retirements

During the year there were 4 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 £175k

Auditors' opinion

overleaf

Independent Auditors' Report to the Assembly of Governors of Birmingham and Solihull Mental Health NHS Foundation Trust

We have audited the Group and NHS Foundation Trust financial statements of Birmingham and Solihull Mental Health NHS Foundation Trust for the year ended 31 March 2013 which comprise the Group Statement of Comprehensive Income, the Group and NHS Foundation Trust Statement of Financial Position, the Group Statement of Cash Flows, the Group and NHS Foundation Trust Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2012/13 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors

As explained more fully in the Statement of Chief Executive's Responsibilities as the Accounting Officer, 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 2012/13. 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 Assembly 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.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Group and NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Group and 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 and Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view, of the state of the Group and NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure and cash flows for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

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 Trust Annual Reporting Manual 2012/13; and

- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2012/13 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.

A J Breadon

Alison Breadon (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Birmingham

Date: 29 May 2013

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

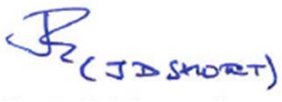
MARCH 31 2013

Birmingham and Solihull Mental Health NHS Foundation Trust

March 31 2013

Foreword to the Accounts

These Accounts for the year ending March 31 2013 have been prepared by Birmingham and Solihull Mental Health NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the 2006 National Health Service Act.



John Short, Chief executive

22nd May 2013

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2013

GROUP STATEMENT OF COMPREHENSIVE INCOME

	note	Year ending 2012/13 £000 PRE EXCEPTIONAL ITEMS	Year ending 2012/13 £000 EXCEPTIONAL ITEMS	Year ending 2012/13 £000 TOTAL	Year ending 2011/12 £000 PRE EXCEPTIONAL ITEMS	Year ending 2011/12 £000 EXCEPTIONAL ITEMS	Year ending 2011/12 £000 TOTAL
Operating income	2	**223,930**	**-**	**223,930**	220,152	-	220,152
Operating costs	4	**(213,302)**	**(6,235)**	**(219,537)**	(212,069)	2,953	(209,116)
OPERATING SURPLUS / (DEFICIT)		**10,628**	**(6,235)**	**4,393**	8,083	2,953	11,036
FINANCE COSTS							
Finance income	7	**132**	**-**	**132**	149	-	149
Finance costs	8	**(5,824)**	**-**	**(5,824)**	(4,971)	-	(4,971)
PDC Dividends payable		**(2,513)**	**-**	**(2,513)**	(2,257)	-	(2,257)
NET FINANCE COSTS		**(8,205)**	**-**	**(8,205)**	(7,079)	-	(7,079)
(DEFICIT)/ SURPLUS FOR THE YEAR		**2,423**	**(6,235)**	**(3,812)**	1,004	2,953	3,957
Other comprehensive (expense)/ income							
Revaluation (losses)/ gains and impairment losses property, plant and equipment				**(2,901)**			2,839
TOTAL COMPREHENSIVE (EXPENSE)/ INCOME FOR THE YEAR				**(6,713)**			6,796

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2013

STATEMENT OF FINANCIAL POSITION		Group		Trust	
		March 31 2013	March 31 2012	**March 31 2013**	March 31 2012
	note	**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	9	**-**	-	**-**	-
Property, plant and equipment	10	**195,602**	202,581	**163,226**	202,581
Subsidiary investments	12	**-**	-	**9,855**	-
Trade and other receivables	13	**2,554**	1,989	**24,956**	1,989
Total non-current assets		**198,156**	204,570	**198,037**	204,570
Current assets					
Inventories	11	**252**	295	**252**	295
Trade and other receivables	13	**14,567**	5,091	**15,013**	5,091
Non-current assets classified as held for sale	10.9	**1,250**	580	**1,250**	580
Cash and cash equivalents	22	**32,140**	35,460	**32,019**	35,460
Total current assets		**48,209**	41,426	**48,534**	41,426
Current liabilities					
Trade and other payables	14	**(26,674)**	(23,382)	**(26,666)**	(23,382)
Borrowings	16	**(3,793)**	(2,320)	**(3,793)**	(2,320)
Provisions for liabilities and charges	19	**(3,459)**	(2,645)	**(3,459)**	(2,645)
Other liabilities	15	**(5,121)**	(9,921)	**(5,121)**	(9,921)
Total current liabilities		**(39,047)**	(38,268)	**(39,039)**	(38,268)
Total assets less current liabilities		**207,318**	207,728	**207,532**	207,728
Non-current liabilities					
Borrowings	16	**(108,256)**	(102,328)	**(108,256)**	(102,328)
Provisions for liabilities and charges	19	**(1,111)**	(736)	**(1,111)**	(736)
Total non-current liabilities		**(109,367)**	(103,064)	**(109,367)**	(103,064)
Total assets employed		**97,951**	104,664	**98,165**	104,664
Financed by (taxpayers' equity)					
Public Dividend Capital		**100,067**	100,067	**100,067**	100,067
Revaluation reserve		**20,759**	23,660	**20,759**	23,660
Income and expenditure reserve		**(22,875)**	(19,063)	**(22,661)**	(19,063)
Total taxpayers' equity		**97,951**	104,664	**98,165**	104,664

The accounts on pages 2 to 5 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 22nd May 2013 and signed on its behalf by:

Signed: ……John Short, Chief Executive

Date: 22nd May 2013

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2013

Group

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at April 1 2012	**104,664**	**100,067**	**23,660**	**(19,063)**
Deficit for the year	**(3,812)**	**-**	**-**	**(3,812)**
Revaluation gains and (impairment losses) property, plant and equipment	**(2,901)**	**-**	**(2,901)**	**-**
Taxpayers' Equity at March 31 2013	**97,951**	**100,067**	**20,759**	**(22,875)**
Taxpayers' Equity at April 1 2011	97,868	100,067	20,879	(23,078)
Surplus for the year	3,957	-	-	3,957
Revaluation gains and (impairment losses) property, plant and equipment	2,839	-	2,839	-
Other transfers between reserves	-	-	(58)	58
Taxpayers' Equity at March 31 2012	104,664	100,067	23,660	(19,063)

Trust

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at April 1 2012	**104,664**	**100,067**	**23,660**	**(19,063)**
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)**
Taxpayers' Equity at April 1 2011	97,868	100,067	20,879	(23,078)
Surplus for the year	3,957	-	-	3,957
Revaluation gains and (impairment losses) property, plant and equipment	2,839	-	2,839	-
Other transfers between reserves	-	-	(58)	58
Taxpayers' Equity at March 31 2012	104,664	100,067	23,660	(19,063)

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2013

GROUP STATEMENT OF CASH FLOWS	note	2012/13 £000	2011/12 £000
Cash flows from operating activities			
Operating surplus		**4,393**	11,036
Non-cash income and expense:			
Depreciation and amortisation	4	**6,499**	5,464
Impairments	4.1/ 4	**5,324**	682
Reversals of impairments	4.1	**-**	(3,536)
(Gain)/Loss on disposal		**75**	-
(Increase)/ decrease in Trade and Other Receivables		**(10,886)**	1,214
Decrease in Inventories		**43**	10
Increase/ (decrease) in Trade and other Payables		**5,832**	(2,230)
(Decrease) / increase in Other Liabilities		**(4,801)**	662
Increase/ (decrease) in Provisions		**1,189**	(1,336)
Other movements in operating cash flows		**0**	31
NET CASH GENERATED FROM OPERATIONS		**7,668**	11,997
Cash flows from investing activities			
Interest received	7	**132**	149
Purchase of Property, Plant and Equipment	10	**(12,532)**	(22,416)
Sales of Property, Plant and Equipment		1,273	103
Net cash used in investing activities		**(11,127)**	(22,164)
Cash flows from financing activities			
Loans received		**10,121**	20,689
Loans repaid to Foundation Trust Financing Facility		**(750)**	-
Capital element of Private Finance Initiative Obligations		**(1,560)**	(1,742)
Interest paid		**(1,405)**	(845)
Interest element of Private Finance Initiative obligations		**(3,929)**	(3,792)
PDC Dividend paid		**(2,338)**	(2,296)
Net cash (used in) /generated from financing activities		**139**	12,014
Decrease / (increase) in cash and cash equivalents		**(3,320)**	1,847
Cash and Cash equivalents at April 1		**35,460**	33,613
Cash and Cash equivalents at March 31		**32,140**	35,460

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2013
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 2012/13 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 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 2013. The shares held are ordinary and aggregate capital and reserves amount to £9,641k as at March 31 2013. Summerhill Supplies Limited made a loss of £214k 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, however there are no such differences at the reporting date. 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.

The Trust is the Corporate Trustee of Birmingham and Solihull Mental Health NHS Foundation Trust Charity (Charity number 1098659). IAS 27 - Consolidation and Separate Financial Statements may consider that the Charity is a subsidiary of the Trust and may require consolidation of the results and position of the Charity. However, as HM Treasury has granted a dispensation until March 31 2013 regarding the application of IAS27 in relation to the consolidation of NHS Charitable Funds, for 2012/13, the Charity has not been consolidated into these accounts.

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 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 Trust commits itself to the retirement, regardless of the method of payment.

1 Accounting policies and other information (continued)

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably;
• 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)

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 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)

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 imposes 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)

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 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 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 Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. 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 Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

1 Accounting policies and other information (continued)

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.

1.8 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 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 Accounting policies and other information (continued)

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 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 Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets 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)

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'. Loans and receivables are recognised initially at fair value, net of 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 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 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 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.

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.

1 Accounting policies and other information (continued)

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. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1 Accounting policies and other information (continued)

1.15 Taxation

Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

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 2013. 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 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 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 2014.

- Property valuations
  The Trusts' land and buildings are valued by external independent valuers. The valuations incorporate professions 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 2013/14:

• IAS 1 Presentation of financial statements (amendment).

• IAS 12 - Income Taxes (amendment).

• IAS 19 (Revised) Employee Benefits

• IFRS 7 Financial Instruments: Disclosures (amendment)

• IFRS 13 Fair Value Measurement – this standard should be applicable for 2013/14, however, HM Treasury has delayed its adoption by government bodies while it finalises some adaptations. The impact on the financial statements is unknown until these adaptations are finalised.

• IAS 27 Consolidated and separate financial statements – removal of dispensation from consolidating NHS charitable funds [NHS bodies need to include an explanation needed of the impact for 2013/14 of consolidating the funds]

• Annual Improvements to IFRS 2011. This standard is potentially applicable to 2013/14 but has not yet been endorsed by the EU and therefore by HM Treasury policy is not available for NHS bodies to apply.

Standards applicable from 2014/15:

• FRS 10 Consolidated Financial Statements [NHS bodies should probably refer here to the IAS 27 dispensation explanation above i.e. NHS charitable funds would be consolidated under IFRS 10]

• 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)

Other standards in issue:

• 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]

1 Accounting policies and other information (continued)

Other changes
HM Treasury has granted dispensation to the application of IAS 27 (revised) by NHS foundation trusts solely in relation to the consolidation of NHS charitable funds for 2011/12 and 2012/13. If this dispensation is not extended then, in 2013/14, it is likely that the NHS bodies will be required to consolidate NHS charitable funds that are controlled by NHS bodies.

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 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 2013

2

Operating Income by classification	**2012/13**	2011/12
	£000	£000
Income from Activities		
Cost and Volume Contract income	**67,575**	64,651
Block Contract income	**136,923**	136,885
Total income from activities	**204,498**	201,536
Other operating income		
Education and training	**10,170**	10,243
Non-patient care services to other bodies	**1,843**	4,089
Other	**7,344**	4,284
Profit on disposal of property, plant and equipment	**75**	-
Total other operating income	**19,432**	18,616
Total operating income	**223,930**	220,152

2.1

Income from activities from mandatory services	**2012/13**	2011/12
	£000	£000
Income from activities arising from mandatory services	**200,918**	197,941
Income from activities arising from non-mandatory services	**23,012**	22,211
	223,930	220,152

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.
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. 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 subsidary 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 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.

Birmingham and Solihull Mental Health NHS Foundation Trust
March 31 2013

3 Segmental Analysis (continued)

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**

Year ended March 31 2012	Healthcare services £000	Commerical trading £000	Inter-Group eliminations £000	Total £000
Total segment revenue	220,152	-	-	220,152
Total segment expenditure	(212,069)	-	-	(212,069)
Operating surplus	8,083	-	-	8,083
Net financing	(4,822)	-	-	(4,822)
PDC dividends payable	(2,257)	-	-	(2,257)
Taxation	-	-	-	-
Retained surplus before non-recurring items	1,004	-	-	1,004
Non-recurring items	2,953			2,953
Retained surplus	3,957	-	-	3,957
Reportable segment assets	245,996	-	-	245,996
Eliminations	-	-	-	-
Total assets	245,996	-	-	245,996
Reportable segment liabilities	(141,332)	-	-	(141,332)
Eliminations	-	-	-	-
Total liabilities	(141,332)	-	-	(141,332)
Net assets	104,664	-	-	104,664

4

Operating expenses	**2012/13**	2011/12
	£000	£000
Services from NHS foundation trusts	**805**	1,901
Services from NHS trusts	**3,721**	3,488
Services from other NHS bodies	**48**	231
Purchase of healthcare from non NHS bodies		
Employee Expenses - Executive directors	**1,128**	901
Employee Expenses - Non-executive directors	**150**	133
Employee Expenses - Staff	**158,549**	158,579
Drug costs	**7,025**	7,502
Supplies and services - clinical (excluding drug costs)	**504**	376
Supplies and services - general	**3,144**	3,852
Establishment	**4,233**	4,461
Transport	**1,302**	1,165
Premises	**16,903**	13,996
(Decrease)/ increase in bad debt provision	**(334)**	309
Termination benefits	**618**	1,344
Depreciation on property, plant and equipment	**6,499**	5,464
Impairments of property, plant and equipment	**-**	682
Audit services - statutory audit	**73**	90
Clinical negligence	**398**	478
Loss on disposal of other property, plant and equipment	**150**	7
Other	**8,386**	7,110
TOTAL	**213,302**	212,069

4.1

Exceptional items	**2012/13**	2011/12
	£000	£000
Impairments/ (reversal of impairments) of property, plant and equipment	**5,324**	(3,536)
Termination benefits	**911**	583
TOTAL	**6,235**	(2,953)

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 charge during the year ended March 31 2013 includes a credit of £900k relating to the release of a provision recognised as exceptional in the prior year.

4.2

Analysis of loss on disposal	**2012/13**	2011/12
	Total	Total
	£000	£000
Disposal of protected assets	**-**	-
Disposal of non-protected assets	**150**	7
TOTAL	**150**	7

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. The audit fee for the year ended March 31 2013 was £56k for the Trust's annual report, £11k for the Trust's quality accounts and £7k for Summerhill Supplies Limited (£65k for the year ended March 31 2012) 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**

	2012/13	2011/12
	£000	£000
Minimum lease payments	**1,626**	1,852

There are no future lease payments due under sub-lease arrangements

The 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 £1,469k which is included within operating costs. The leases for vehicles and equipment range from 1 to 5 years and have an annual charge of £157k which is included within operating costs.

The Trusts most significant lease arrangement is for the lease of Trust Headquarters. This is a 25 year lease expiring in 2030 and has an annual rental charge of £400k. 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 Trust, is being leased to the Trust. The lease term is for 5 years.

4.5 **Total future minimum lease payments**

	2012/13	2011/12
	£000	£000
Not later than one year	**1,736**	2,001
Later than one year and not later than five years	**5,061**	4,050
later than five years	**10,035**	10,959
TOTAL	**16,832**	17,010

5

Directors' remuneration	**2012/13**	2011/12
	Total	Total
	£000	£000
Directors' remuneration	**935**	827
Social security costs	**103**	106
Employer contributions to a pension scheme in respect of directors'	**90**	101
TOTAL	**1,128**	1,034

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 2013 (£69k during year ended March 31 2012), which is not included in the above disclosure, for his non-director responsibilities.

5.1

Directors' advances	**2012/13**	2011/12
	Total	Total
	£000	£000
Amounts due from directors:	**-**	4
	-	4

The advance, for relocation costs, made to the Director is interest free and has been paid during the year ended March 31 2013.

6

Employee Expenses (including executive directors but excluding non-executive directors)	**2012/13**	2011/12
	Total	Total
	£000	£000
Salaries and wages	**130,675**	129,867
Social security costs	**10,260**	10,346
Employers contributions to NHS pensions	**14,993**	14,864
Termination benefits (see note 4 and 4.1)	**1,529**	1,927
Agency/contract staff	**3,749**	4,509
	161,206	161,513
Less capitalised cost	**-**	(106)
TOTAL RECOGNISED IN OPERATING EXPENSES	**161,206**	161,407

6.1

Average number monthly of employees (WTE basis)	**2012/13**	2011/12
	Number	Number
Medical	**259**	273
Administration and estates	**554**	601
Healthcare assistants and other support staff	**766**	769
Nursing and health visiting staff	**1,224**	1,267
Scientific, therapeutic and technical staff	**580**	479
Other	**273**	289
TOTAL	**3,656**	3,678

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 Trust.

	2012/13 £000	2012/13 Number	2011/12 £000	2011/12 Number
No of early retirements on the grounds of ill-health		**4**		6
Value of early retirements on the grounds of ill-health	**175**		405	

6.3 Staff exit packages

Exit package cost band	Number of compulsory redundancies 2012/13	Number of other agreed departures 2012/13	Total number of exit packages by cost band 2012/13	Total number of exit packages by cost band 2011/12
<£10,000	**4**	**-**	**4**	15
£10,000 - £25,000	**5**	**-**	**5**	29
£25,001 - £50,000	**5**	**-**	**5**	20
£50,001-£100,000	**6**	**-**	**6**	13
£100,001 - £150,000	**0**	**-**	**0**	6
£150,001 - £200,000	**1**	**-**	**1**	2
Total number of exit packages by type	**21**	**-**	**21**	85
Total resource cost £'000	**899**	**-**	**899**	3,170

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

	2012/13 £000	2011/12 £000
Interest on Deposits/Investments	**132**	149

8 Finance costs

	2012/13 £000	2011/12 £000
Loans from the Foundation Trust Financing Facility	**1,901**	1,179
Finance Costs in PFI obligations		
Main Finance Costs	**3,012**	3,081
Contingent Finance Costs	**911**	711
TOTAL	**5,824**	4,971

9 Intangible assets

Group and Trust

	Total	Licences and trademarks (purchased)	Development expenditure (internally generated)
	£000	£000	£000
Cost or valuation at April 1 2012, April 1 2013, March 31 2012 and March 31 2013	**274**	253	21
Accumulated amortisation at April 1 2012, April 1 2013, March 31 2012 and March 31 2013	**274**	253	21
Net book value			
NBV - Purchased at March 31 2012 and March 31 2013	**-**	-	-
NBV - Donated at March 31 2012 and March 31 2013	**-**	-	-
NBV total at March 31 2012 and March 31 2013	**-**	**-**	**-**

10 Property, plant and equipment

Group

10.1 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	**211,693**	47,722	123,178	388	24,775	3,352	93	8,352	3,833
Additions - purchased	**9,992**	-	3,274	-	5,503	170	-	901	144
Impairments charged to revaluation reserve	**(2,900)**	(390)	(2,510)	-	-	-	-	-	-
Reclassifications	-	-	22,081	-	(28,220)	726	11	693	4,709
Transfers to non-current assets classified as held for sale (note 10.9)	**(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	**9,112**	-	-	-	-	2,176	93	3,938	2,905
Provided during the year	**6,499**	-	3,706	25	-	285	1	1,872	610
Impairments recognised in operating expenses	**5,324**	326	2,994	363	1,641	-	-	-	-
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.

10.2 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.

10.3 Trust

Property, plant and equipment March 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	**211,693**	47,722	123,178	388	24,775	3,352	93	8,352	3,833
Additions - purchased	**9,992**	-	3,274	-	5,503	170	-	901	144
Impairments charged to revaluation reserve	**(2,900)**	(390)	(2,510)	-	-	-	-	-	-
Reclassifications	**-**	**-**	**-**	-	(1,343)	-	-	693	650
Transfers to non-current assets classified as held for sale (note 10.9)	**(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 2012	**9,112**	-	-	-	-	2,176	93	3,938	2,905
Provided during the year	**6,024**	-	3,551	25	-	237	-	1,872	339
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.

10.4

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	**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.

10.5 Group and trust

Property, plant and equipment March 31 2012	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 2011 as previously stated	185,380	48,287	118,962	375	5,192	3,342	93	5,344	3,785
Additions - purchased	24,698	-	1,853	-	21,304	10	-	1,483	48
Reversal of impairments charged to revaluation reserve	2,839	15	2,824	-	-	-	-	-	-
Reclassifications	-	-	-	-	(1,634)	-	-	1,634	-
Transfers to non-current assets classified as held for sale (note 10.9)	(580)	(580)	-	-	-	-	-	-	-
Transfers from accumulated depreciation*	(510)	-	(436)	13	(87)	-	-	-	-
Disposals	(134)	-	(25)	-	-	-	-	(109)	-
Cost or valuation at March 31 2012	211,693	47,722	123,178	388	24,775	3,352	93	8,352	3,833
Accumulated depreciation at April 1 2011	7,012	-	-	-	-	1,927	93	2,423	2,569
Provided during the year	5,464	-	3,342	22	-	249	-	1,515	336
Impairments recognised in operating expenses	682	-	595	-	87	-	-	-	-
Reversal of impairments	(3,536)	-	(3,501)	(35)	-	-	-	-	-
Transferred to cost or valuation*	(510)	-	(436)	13	(87)	-	-	-	-
Accumulated depreciation at March 31 2012	9,112	-	-	-	-	2,176	93	3,938	2,905
Net book value									
NBV - Purchased at March 31 2011	176,372	47,137	118,170	375	5,192	1,361	-	2,921	1,216
NBV - Donated at March 31 2011	1,996	1,150	792	-	-	54	-	-	-
NBV total at April 1 2011	178,368	48,287	118,962	375	5,192	1,415	-	2,921	1,216
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

*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 £47,868k at March 31 2013 (£46,347k at March 31 2012). Depreciation of £865k was charged on these assets in the year (£834k during the year ended March 31 2012). These assets wholly relate to PFI assets.

10.6

Analysis of property, plant and equipment March 31 2012	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 2012	142,663	30,765	111,898	-	-	-	-	-	-
NBV - Unprotected assets at March 31 2012	59,918	16,957	11,280	388	24,775	1,176	-	4,414	928
Total at March 31 2012	202,581	47,722	123,178	388	24,775	1,176	-	4,414	928

10.7

Economic life of property, plant and equipment	Min Life Years	Max Life Years
Land	-	-
Buildings excluding dwellings	9	60
Dwellings	8	23
Assets under Construction and POA	-	-
Plant and Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & Fittings	5	10

10.8

Valuations

Valuations are carried out by professionally qualified, independent valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last full asset valuations was undertaken in March 2010. The last interim asset valuation was completed in February 2013 with an effective valuation date of March 31 2013. Fair values were determined based on estimates. The impairment gains and loss recognised in the accounts arose due to movement in market prices.

10.9

Non-current assets classified as held for sale	Group		Trust	
	March 31 2013	March 31 2012	**March 31 2013**	March 31 2012
	£000	£000	**£000**	£000
Property, plant and equipment	**1,250**	580	**1,250**	580

Assets classified as held for sale includes a parcel of land at Rubery Hospital and four 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 2014.

11

Inventories	Group		Trust	
	March 31 2013	March 31 2012	**March 31 2013**	March 31 2012
	£000	£000	**£000**	£000
Drugs	**185**	261	**185**	261
Consumables	**67**	34	**67**	34
TOTAL	**252**	295	**252**	295

11.1

Inventories recognised in expenses	March 31 2013	March 31 2012
	£000	£000
Inventories recognised in expenses	**3,709**	4,032
Write-down of inventories recognised as an expense	**22**	18
TOTAL inventories recognised in expenses	**3,731**	4,050

12

Subsidiary investments	Group		Trust	
	March 31 2013	March 31 2012	**March 31 2013**	March 31 2012
	£000	**£000**	**£000**	**£000**
Shares in Group undertakings	-	-	**9,855**	-
TOTAL	-	-	**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 2013.

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 lease the Tamarind Centre (a medium secure mental health facility) to the Trust. Future plans for the year ended March 31 2014 include the provision of a managed property service for the Tamarind centre and to provide outpatient dispensing services to the Trust.

13 Trade and other receivables

Group

	Total	Financial assets	Non-financial assets	Total	Financial assets	Non-financial assets
	March 31 2013	**March 31 2013**	**March 31 2013**	March 31 2012	March 31 2012	March 31 2012
	£000	**£000**	**£000**	£000	£000	£000
Current						
NHS Receivables	**10,142**	**10,142**	-	2,791	2,791	-
Other receivables with related parties	-	-	-	4	4	-
Provision for impaired receivables	**(364)**	**(364)**	-	(698)	(698)	-
Prepayments	**1,789**	-	**1,789**	1,606	-	1,606
PDC receivable	**1**	**1**	-	176	-	176
Other receivables	**2,999**	**2,999**	-	1,212	717	495
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**14,567**	**12,778**	**1,789**	5,091	2,814	2,277
Non-Current						
Prepayments - Lifecycle replacements	**2,554**	-	**2,554**	1,989	-	1989

13.1 Trade and other receivables

Trust

	Total	Financial assets	Non-financial assets	Total	Financial assets	Non-financial assets
	March 31 2013	**March 31 2013**	**March 31 2013**	March 31 2012	March 31 2012	March 31 2012
	£000	**£000**	**£000**	£000	£000	£000
Current						
NHS Receivables	**10,142**	**10,142**	-	2,791	2,791	-
Other receivables with related parties	-	-	-	4	4	-
Provision for impaired receivables	**(364)**	**(364)**	-	(698)	(698)	-
Prepayments	**1,789**	-	**1,789**	1,606	-	1,606
PDC receivable	**1**	**1**	-	176	-	176
Other receivables	**2,996**	**2,996**	-	1,212	717	495
Loan assets*	**449**	**449**	-	-	-	-
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**15,013**	**13,224**	**1,789**	5,091	2,814	2,277
Non-Current						
Prepayments - Lifecycle replacements	**2,554**	-	**2,554**	1,989	-	1,989
Loan assets*	**22,402**	**22,402**	-	-	-	-
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**24,956**	**22,402**	**2,554**	1,989	-	1,989

*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.

13.2 **Group and Trust**

Provision for impairment of receivables		
	March 31 2013	March 31 2012
	£000	£000
At April 1 2012	698	1,395
(Decrease) Increase in provision	(334)	671
Amounts utilised	-	(1,006)
Unused amounts reversed	-	(362)
At March 31 2013	364	698

13.3 **Group and Trust**

Analysis of impaired receivables		
Group and Trust	**March 31 2013**	March 31 2012
	£000	£000
Ageing of impaired receivables		
Up to three months	**108**	453
In three to six months	**54**	64
Over six months	**202**	181
TOTAL	**364**	698

13.4 **Group and Trust**

Ageing of non-impaired receivables past their due date	**March 31 2013**	March 31 2012
	£000	£000
Up to three months	1,706	1,698
90- 180 days (was "In three to six months")	104	480
over 180 days (was "Over six months")	219	289
Total	**2,029**	**2,467**

Group and Trust

14 Trade and other payables

	Total	Financial liabilities	Non-financial liabilities	Total	Financial liabilities	Non-financial liabilities
	March 31 2013	**March 31 2013**	**March 31 2013**	March 31 2012	March 31 2012	March 31 2012
	£000	**£000**	**£000**	£000	£000	£000
Current						
NHS payables	**1,360**	**1,360**	**-**	3,018	3,018	-
Amounts due to other related parties	**-**	**-**	**-**	44	44	-
Trade payables - capital	**1,102**	**1,102**	**-**	3,642	3,642	-
Social security and taxes payable	**3,382**	**-**	**3,382**	3,563	-	3,563
Other payables	**9,399**	**9,399**	**-**	5,958	5,958	-
Accruals	**11,431**	**11,431**	**-**	7,157	7,157	-
TOTAL CURRENT TRADE AND OTHER PAYABLES	**26,674**	**23,292**	**3,382**	23,382	19,819	3,563

A separate schedule for the Trust's trade payables has not been produced as the subsidiary has only £8k of accruals.
Other payables above includes £1,278k at March 31 2013 in respect of outstanding employer Pension contributions (£1,249k at March 2012).

Group and Trust

15 Other liabilities

	Total	Total
	March 31 2013	March 31 2012
	£000	£000
Current		
Deferred Income	**5,121**	9,921

16 Borrowings

Group and Trust

	March 31 2013	March 31 2012
Current	**£000**	£000
Loans from Foundation Trust Financing Facility	**2,183**	760
Obligations under Private Finance Initiative contracts	**1,610**	1,560
TOTAL CURRENT BORROWINGS	**3,793**	2,320
Non-current		
Loans from Foundation Trust Financing Facility	**46,967**	39,432
Obligations under Private Finance Initiative contracts	**61,289**	62,896
TOTAL OTHER NON CURRENT LIABILITIES	**108,256**	102,328

17 Prudential borrowing limit

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

•the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and

•the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trusts Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Trust has £16m of approved working capital facility (£16m at March 31 2012). The Trust had drawn down £nil of its working capital facility at March 31 2013 (£nil March 31 2012).

The Trust had a prudential borrowing limit (PBL) of £128.7m during the year ended March 31 2013 (£129.9m year ended March 31 2012). The Trust has actually borrowed £113.0m as at March 31 2013 (£104.6m at March 31 2012).

17.1 Prudential borrowing limit ratios

Monitor has developed a tier two system which has been applied to the Trust in calculating the PBL of £128.7m. This two tier system is needed as when PFI liabilities are recognised "on statement of financial position" on transition to International Financial Reporting Standards, the tier one ratios are no longer appropriate to sufficiently monitor the Trusts financial performance against the tier one borrowing limit.

The tier two limit is based on four ratios which are set out below along with the actual performance during the year against these ratios.

	Threshold	March 31 2013	March 31 2012
Minimum dividend cover	>1x	**4.5**	6.5
Minimum interest cover	>2x	**2.9**	3.9
Minimum debt service cover	>1.5x	**2.2**	2.9
Maximum debt service to revenue	<10%	**3.5%**	3.0%

The limit of £128.7m is the total cap for borrowings which can be made by the Trust and is deemed sufficient by the Directors to operate the PFI buildings and develop current and future capital schemes.

18 **PFI obligations (on SoFP)**

Group and Trust

Gross PFI liabilities	**March 31 2013**	March 31 2012
of which liabilities are due	**£000**	**£000**
- not later than one year;	**4,553**	4,572
- later than one year and not later than five years;	**16,923**	17,520
- later than five years.	**94,132**	98,083
Finance charges allocated to future periods	**(52,709)**	(55,719)
Net PFI liabilities	**62,899**	64,456
- not later than one year;	**1,609**	1,560
- later than one year and not later than five years;	**5,859**	6,182
- later than five years.	**55,431**	56,714
TOTAL	**62,899**	64,456

18.1 **PFI Obligations**

Group and Trust

The Trust is committed to make the following payments for on SoFP PFIs obligations during the

	March 31 2013 Total	**March 31 2013 PFI 1**	**March 31 2013 PFI 2**	March 31 2012 Total
21st to 25th years (inclusive)	**3,189**	3,189	-	3,018
31st to 35th years (inclusive)	**6,080**	6,080	-	6,383

18.2 **PFI commitments (on SoFP)**

Group and Trust

	March 31 2013	March 31 2012
	£000	£000
Commitments in respect of the service element of the PFI		
- not later than one year;	**9,869**	9,401
- later than one year and not later than five years;	**42,006**	40,011
- later than five years.	**393,172**	394,882
	445,047	**444,294**
Present value of commitments		
- not later than one year;	**9,382**	8,938
- later than one year and not later than five years;	**35,250**	33,585
- later than five years.	**170,686**	167,542
TOTAL	**215,318**	**210,065**

18.3

PFI contract details

The 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 is 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.

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 is 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 Trust to act jointly with UHB.

19 Provisions for liabilities and charges

Group and Trust

	Total	Legal claims	Property	Restructuring	Injury Allowance	Other
	£000	£000	£000	£000	£000	£000
At April 1 2012	**3,381**	375	927	1,529	178	372
Arising during the year	**2,790**	265	466	2,059	-	-
Utilised during the year	**(659)**	(59)	(61)	(458)	(81)	-
Reversed unused	**(942)**	(10)	-	(932)	-	-
At March 31 2013	**4,570**	**571**	**1,332**	**2,198**	**97**	**372**
Expected timing of cash flows:						
- not later than one year;	**3,459**	571	285	2,198	33	372
- later than one year and not later than five years;	**227**	-	150	-	77	-
- later than five years.	**884**	-	897	-	(13)	-
TOTAL	**4,570**	**571**	**1,332**	**2,198**	**97**	**372**

The legal claims provision relates to personal legal claims that have been lodged against the 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 2014. The Trust has £95k of contingent liabilities in respect of legal claims at March 31 2013 (£99k at March 31 2012).

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 2014.

The injury allowance provision relates to permanent injury and early retirement provisions. The liability of the Trust is dependant on the lower of retirement age and life expectancy which is unknown.

The other provision is the likely cost of paying recruitment and retention payments to a population of staff. The exact individuals due this payment have not been identified although payments of this nature have been made in the past. It is likely that claims will be received during the year ended March 31 3014.

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	**863**	594

20 Contractual Capital Commitments

Group and Trust

The Trust was contractually committed to £3,500k at March 31 2013 (£10,099k at March 31 2012) of capital expenditure for the purchase of property, plant and equipment.

21 Third Party Assets

The Trust held £998k cash and cash equivalents at March 31 2013 (£844k March 31 2012) 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.

22 Cash and cash equivalents

	Group		Trust	
	March 31 2013	March 31 2012	March 31 2013	March 31 2012
	£000	£000	£000	£000
At April 1	35,460	33,613	35,460	33,613
Net change in year	(3,320)	1,847	(3,441)	1,847
At March 31	**32,140**	35,460	**32,019**	35,460
Broken down into:				
Cash in hand (petty cash)	35	39	35	39
Cash at Commercial Banks	122	-	-	-
Cash at GBS	31,983	35,421	31,984	35,421
Cash and cash equivalents as in SoFP	**32,140**	35,460	**32,019**	35,460

23 **Ultimate Parent Company**

The Trust is a public benefit corporation established under the NHS Act 2006. Monitor, the NHS Foundation Trust Regulator has the powe 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 Trust's ultimate parent is therefore HM Government.

23.1 **Related Party Transactions**

The 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 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:

	Income >£1.5m 2012/13 £000	2011/12 £000
University Hospital Birmingham NHS Foundation Trust	**1,575**	1,615
London Strategic Health Authority	**6,743**	6,746
West Midlands Strategic Health Authority	**7,529**	7,160
Birmingham East and North PCT	**164,101**	161,644
Heart of Birmingham Teaching PCT	**9,442**	17,540
Sandwell PCT	**1,450**	1,303
Solihull Care Trust	**13,758**	15,401
Department Of Health	**1,177**	1,146
Stoke-on-Trent Primary Care Trust	**7,094**	8

	Expenditure >£1.5m 2012/13 £000	2011/12 £000
Birmingham Community Healthcare NHS Trust	**3,101**	3,254
Heart of England NHS Foundation Trust	**799**	1,666
Prescription Pricing Authority	**3,371**	3,470
Birmingham City Council	**2,399**	3,250

23.2 **Related Party Balances**

At the year end the Trust had material balances with entities within the Whole of Government, details of which are listed below:

	Receivables > £0.5m March 31 2013 £000	March 31 2012 £000
University Hospital Birmingham NHS Foundation Trust	**352**	281
Birmingham East and North PCT	**5,470**	418
Heart of Birmingham	**1,082**	-
London Strategic Health Authority	**1,838**	-
HMRC	**1,170**	-

	Payables > £0.5m March 31 2013 £000	March 31 2012 £000
Heart of England NHS Foundation Trust	**124**	1,677
NHS Business Services Authority	**782**	640
Birmingham City Council	**1,034**	928
Birmingham East and North PCT	**2,411**	-
HMRC	**3,382**	-

The Trust is the Corporate Trustee of Birmingham and Solihull Mental Health NHS Foundation Trust Charity (Charity number 1098659). and provides administration services for the Charity. At March 31 2013 the Trust was owed £104k (£36k at March 31 2012) 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 2103 have been transferred to Clinical Commisioning Groups.

The Trust is parent of the wholly owned subsidiary Summerhill Supplies Limited. At March 31 2013 the Trust was owed £22,851k from the company. Income from Summerhill Supplies Limited during the year amounted to £433k and the expenditure incurred was £712k.

In addition to these balances the Trust was owed £4k at year ended March 31 2012 from a director which has been settled during the year ended March 31 2013, details of which are given in note 5.

All related party balances are not secured, are on standard 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 Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds 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 Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at March 31 2013 are in receivables from customers, as disclosed in the Trade and other receivables note. The risk associated with cash and deposits with financial institutions 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 Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

25 Group

Financial assets by category	**March 31 2013**		March 31 2012	
	Total	**Loans and receivables**	**Total**	**Loans and receivables**
	£000	**£000**	**£000**	**£000**
Assets as per SoFP				
Trade and other receivables excluding non financial assets	**12,778**	12,778	2,814	2,814
Cash and cash equivalents (at bank and in hand	**32,140**	32,140	35,460	35,460
TOTAL AT MARCH 31	**44,918**	**44,918**	38,274	38,274

Trust

Financial assets by category	**March 31 2013**		March 31 2012	
	Total	**Loans and receivables**	Total	Loans and receivables
	£000	**£000**	£000	£000
Assets as per SoFP				
Trade and other receivables excluding non financial assets	**13,224**	13,224	2,814	2,814
Cash and cash equivalents (at bank and in hand	**32,019**	32,019	35,460	35,460
TOTAL AT MARCH 31	**45,243**	**45,243**	38,274	38,274

Group and Trust

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Financial liabilities by category	**March 31 2013**		March 31 2012	
	Total	**Other financial liabilities**	Total	Other financial liabilities
	£000	**£000**	£000	£000
Liabilities as per SoFP				
Borrowings excluding Finance lease and PFI liabilities	**49,150**	49,150	40,192	40,192
Obligations under Private Finance Initiative contracts	**62,899**	62,899	64,456	64,456
Trade and other payables excluding non financial liability	**23,292**	23,292	19,819	19,819
TOTAL AT MARCH 31	**135,341**	**135,341**	124,467	124,467

27 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 130 cases of losses and special payments totalling £139k during the year to March 31 2013 (165 cases totalling £1.2m during the year to March 31 2012). These amounts are reported on an accruals basis but excluding provisions for future losses. The previous year included a specific write off of debt of £0.8m which was fully provided against in previous years.

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 accounts 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) 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 formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending March 31 2004. Consequently, a formal actuarial valuation would have been due for the year ending March 31 2008. However, formal actuarial valuations for unfunded public service schemes have been 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. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting valuation
The Valuation report undertaken as at March 31 2004 was used to determine the contribution rates payable during 2011-12. This report considered the changes to the NHS Pension Scheme taking effect from April 1 2008 and recommended that employer contributions could continue at the existing rate of 14% of pensionable pay from April 1 2008. For employee contributions a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings was introduced from April 1 2008.

The national deficit of the scheme was £3.3 billion as per the last scheme valuation by the Government Actuary for the period April 1 1999 to March 31 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

The NHS Pension Scheme is subject to a full valuation every four years by the Government Actuary. The latest published valuation relates to the period April 1 1999 to March 31 2004 which was published in December 2007 and is available on the NHS Pensions Agency website: http://www.nhsbsa.nhs.uk/Pensions/Documents/Pensions/NHS_Resource_Accounts_2011-12.pdf.

29 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 1.87% of total pensionable earnings over the relevant pensionable service.

With effect from April 1 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 September 30 in the previous calendar year.

A lump sum is payable on retirement. Members in the 1995 Section receive a lump sum which is normally three times the annual pension payment. Members in the 2008 Section receive a lump sum which may be a maximum of 25% of the value of their fund at retirement.

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

For members who die in service a lump sum is payable of twice annual pensionable pay, or average uprated earnings for practitioners. For members who die after retirement an amount is payable which is the lesser of 5 times annual pension less pension already paid, or twice reckonable pay less any retirement lump sum taken. Other death benefits are also payable for members who have a deferred pension.

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.

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